Health Systems Trust

ANNUAL REPORT 2007 / 2008

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

VISION

Health systems supporting health for all in Southern Africa.

MISSION

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

APPROACH

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

CORE VALUES

- Transparency and accountability
- Innovation and responsiveness
- Integrity and nurturance
- Embracing diversity
- Participatory democracy

HEALTH SYSTEMS TRUST

TABLE OF CONTENTS

CHAIRPERSON'S REPORT

A primary objective of the Health Systems Trust (HST) includes supporting the establishment of functional health districts within South Africa and the greater Southern African region as a whole. Properly functioning health districts are key to ensuring the provision of quality primary health care. In reviewing the projects and activities of HST for the past year, I am pleased to report that the organisation has implemented innovative methods to achieve this objective.

HST has also invested in initiatives to build our human and intellectual capital for the purpose of improving our internal efficiency. All of these changes will help make HST more relevant and more effective in achieving its goals and objectives.

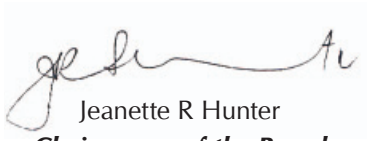
The Trust has succeeded in building strong governance structures across the organisation; we have developed stronger oversight functions by strengthening the role of our sub-committees on audit, finance, personnel and technical programmes. HST is therefore confident that its governance structures meet the stringent criteria required to provide strong and robust management oversight.

The Trust remains alert and ready to meet the challenges and opportunities which present themselves as it continues to operate within the public health sector. HST believes that its mission remains relevant in a changing environment

and commits itself to assist in facilitating the development, management and maintenance of South African health systems that meet the growing needs of the general public.

This is my last report as the Chairperson of the Board of Trustees. I feel privileged to have been part of the work and achievements of HST and would like to thank my fellow Trustees and the staff, under the leadership of Dr Thobile Mbengashe, for their unwavering commitment to strengthening health systems.

We owe a huge debt of gratitude to our donors, from both the public and private sectors, for their generous and continued support over the past 15 years. The social pact we share allows us to make health-for-all a reality in Southern Africa.



Jeanette R Hunter
Chairperson of the Board
July 2008

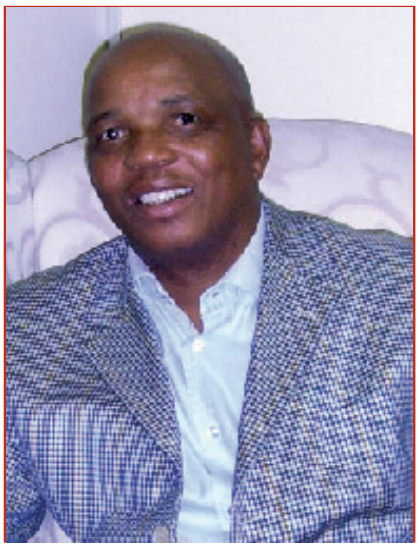
MESSAGE FROM THE CHIEF EXECUTIVE OFFICER

The year under review has been an exciting time for the Health Systems Trust (HST). Changes in global financial markets have necessitated the scrutiny of our policies and our traditional ways of working, and have required that we become more focused and more competitive in a resource-scarce environment. At our conference to mark the fifteenth anniversary of the organisation, we celebrated our various contributions to building the public health sector in South Africa and re-committed ourselves to providing cutting-edge research and materials to further our aim of health systems-strengthening both within and beyond the borders of South Africa. The conference also provided us and our partners with a platform to review our work and to identify key public health research and implementation issues that the organisation should be focusing on.

Together with a team of three Directors, I have had the privilege of leading this organisation since November 2007 and have been humbled by the achievements and commitment of the staff of HST.

Under the tutelage of Irwin Friedman, the Research Programme Cluster has contributed to health policy dialogue and to the health system reform debate by conducting essential national research studies on prioritised public health population needs. The Research Programme Cluster has conducted important research on maternal and child health, particularly on the impact of maternal education on infant feeding and the achievement of maternal and child health related Millennium Development Goals. Recognising the dual nature of the HIV and TB epidemic, the cluster has produced a significant body of knowledge on various aspects of both TB and reproductive health, with a special emphasis on adherence and support systems. The cluster has continued to conduct health systems research on diverse issues such as occupational illnesses, work processes, human resources and capacity building.

Under the leadership of Ronel Visser, the HealthLink Cluster continued to provide independent and objective policy reviews on health systems performance through the publication of the fourteenth *South African Health Review*. This year's *Review* focused on primary health care, thirty years



after the Declaration of Alma Ata, and provides an analysis of just how far South Africa has come in this area. The cluster also actively supported district health systems development by monitoring performance on an annual basis through the *District Health Barometer*. Now in its fourth year of publication, the *Barometer* continues to garner much national and international interest. Monitoring the implementation of the National Strategic Plan is another key activity of this cluster and the Treatment Monitor has also developed international links and has contributed to UN reports and other multi-country initiatives. The Secretariat of the Global Equity Gauge Alliance continues to be hosted by HST, with plans for the production of a second edition of the *Global Health Watch* currently underway.

With Nomonde Bam at the helm, the District Support and Community Development Cluster has worked tirelessly to provide a wide-range of capacity building, training and mentoring services, in order to improve services at a sub-district level. The cluster has provided training and support to both health personnel and community-based organisations, strengthening the delivery and integration of primary health care. Working to underpin the process and outcomes of district health planning was a key focus of this cluster and this has contributed to the introduction of monthly primary health care reviews, where District Health Plan indicators and targets are monitored and tracked. Working with

some of the basic determinants of health, such as food security, remains the mainstay of this cluster's work and interventions in this regard include steps to improve household food availability and to improve the health status of vulnerable groups, particularly children, pregnant and lactating mothers, and malnourished patients.

Collective action, taken to achieve the transformation of our health systems through health systems research, and the use of proven evidence-based interventions, remain our best tools to strengthen health system performance and to attain health care for all. I look forward to continuing to work with our partners, the HST Board of Trustees and the Trust's staff in the year ahead.

I would like to thank our Board of Trustees, our funders, and our partners at the Department of Health, for their confidence and support during my tenure as Chief Executive Officer. I also extend my sincere gratitude to all HST staff for their unstinting commitment to achieve the goals and mission of the Trust.

All of us at HST share the collective conviction that the inequity amongst, and lack of access to, universal and high-quality primary health care services by all South Africans, remains the greatest challenge to achieve the noble goal of good health for all. We at the Trust will continue to commit to the overcoming of such challenges that lie before us during the years ahead.

Thobile Mbengashe
Chief Executive Officer
July 2008

RESEARCH PROGRAMME CLUSTER

Director: Irwin Friedman

The Research Programme Cluster undertakes innovative health systems research to strengthen the district health system, its support systems and priority programmes and, in particular, HIV & AIDS, tuberculosis and the special needs of vulnerable groups such as mothers and children. Improving knowledge management, translating research into policy and practice, and building capacity within the paradigm of Essential National Health Research, are important areas of emphasis.

Mother and Child Health Research

The *Goodstart* and *PROMISE* studies have, together, formed a randomized control trial comparing the impact of maternal education on infant feeding to an improved access to social grants, using indicators such as child morbidity and HIV-free survival. Health Systems Trust (HST) participated in the research as part of the Goodstart Consortium which, in the South African-arm of the study, currently consists of the Medical Research Council as the lead partner, with the University of the Western Cape, Cadre and HST as contributing partners. The project is part of a four-country comparison, which includes other researchers operating in Zambia, Uganda and Mali with funding from the European Union and Centres for Disease Control (through the United States President's Emergency Plan for AIDS Relief, (PEPFAR).

The studies completed data collection at the end of 2007. A first data analysis workshop was held in early June 2008 to examine the data and to assign responsibilities to various investigators. By the end of June, the team was still in the data analysis and write-up phase with a follow-up workshop planned for the first week of September. There have been major challenges facing the project, with statisticians, from the four countries involved, cleaning the data and integrating the datasets.

The significance of the findings of these various studies could be of considerable importance in shaping our understanding of infant feeding practices and the role of social grants in disadvantaged, high HIV–prevalent, communities. A change of practice resulting from this study could have a potentially profound impact on the relatively high infant mortality rate that has been rising ever since the onset of the HIV and AIDS pandemic in South Africa.

In addition to the *Goodstart* study mentioned above, HST has also been involved in two other mother and child health studies during the first six months of 2008. Both studies are funded by the Research Directorate of the National Department of Health (NDoH).

The first study, *Measuring Progress towards the Achievement of Maternal and Child Health-Related Millennium Development Goals*, which is nearing completion, provides a detailed assessment of: antenatal care attendance; quality of antenatal care (syphilis screening, access to HIV testing); family planning coverage; institutional deliveries; prevention of mother to child transmission (PMTCT) access; immunisation coverage; infant feeding practices and social grant uptake, at the Paarl site. The analysis is based on data collected at the site over the past few years.

The second study investigates the *Health Impacts of the Child Support Grant in South Africa*. Data collection has commenced at the Paarl site and this study is continuing. The work is undertaken in conjunction with the Medical Research Council (MRC).

Reproductive Health Research (including HIV and AIDS)

The qualitative *Antiretroviral Adherence Study in five sites in KwaZulu-Natal*, (the ADHERE study), is a qualitative exploration of adherence to antiretroviral treatment (ART) undertaken in

partnership with MEASURE evaluation and funded by USAID. It seeks to develop a set of tools that can be used to collect and share information on patients' experiences taking anti-retroviral drugs (ARVs) and to make recommendations that could be useful to ART managers in understanding the strategies that patients use when achieving high adherence. All data collection was completed within the first six months of the year. The study is now in the analysis phase and seeks to clarify factors affecting adherence to HIV therapy.

After several years in preparation, and working closely with the Development Bank of South Africa (DBSA), which also funded the project with support from the German Government, the *Formative Evaluation (Phase 2) of VCT infrastructure development in Mpumalanga, Eastern Cape and KwaZulu-Natal Provinces* study was finally initiated. The fieldworkers gathered data from some 80 facilities distributed over the three provinces. The study is now in the final phase of analysing the data and comparing the results with the baseline study undertaken in 2005 as a means of assessing the impact of infrastructural improvements on the quality of counselling and testing services.

Tuberculosis Research

As an area of research, tuberculosis (TB) has been a major focus over the last few years in the Research Programme. *The Technical Assistance Support Contract Tuberculosis Project* (TASC II TB) which HST has been conducting, in conjunction with the University Research Corporation (URC), and that is funded by USAID and PEPFAR, has entered the last year of its five-year programme and is due to end in September 2008.

Several operational research (OR) projects were undertaken during the year under review. Some were due to be presented at an international TB Conference in Durban during early July 2008. *The TB Data Management* study investigated why electronic TB records in the eThekwini sub-district showed such poor results. *A Rapid Appraisal of XDR-TB* has helped provide a better understanding of this national emergency. The *TB tracer team effectiveness operational research* study provided valuable insights into a novel approach to overcome defaulting. *Understanding poor smear conversion in TB* is investigating reasons why smear conversion results have been so poor. A further OR initiative on *Overcoming barriers to VCT and ART for TB Patients* will investigate factors that facilitate or hinder the access of TB patients to ART. Later in the year, a study that will provide a summative TASC II TB evaluation will conclude the operational research for the year.

In addition to work being undertaken as part of TASC II TB, several other high-priority TB research projects funded by the Research Directorate of the NDoH are being conducted. One study, concluded during the past six months, was the *Evaluation of current TB patient support mechanisms*. This study is significant in that it examined the impact of existing TB support programmes, such as nutrition and related measures.

Unfortunately, the process of obtaining ethical and provincial permission to undertake studies has been more difficult in the last year. This has delayed the commencement and completion of an intervention study on *Economic incentives for improving clinical outcomes in patients with TB* which is investigating the role of cash grants or food vouchers in improving adherence to treatment by patients with TB. This study is also receiving additional funding support from the Wellcome Trust and KNCV. Other TB studies also started (but not completed by the end of June 2008), included an *Assessment of MDR Treatment Programmes, the Costing of TB services and a Qualitative observational study on TB adherence* which will comprise a follow-up to the ARV-adherence study referred to previously.

Health Systems Research

First, in this group of studies, is an *Assessment of the Hidden Epidemic of Silicosis and Silico-Tuberculosis and the Functioning of the Occupational Diseases in Mines and Works Act (ODMWA)* in the Eastern Cape. This research project investigates the epidemiology of silicosis, silico-tuberculosis and tuberculosis in ex-mineworkers, combined with a health systems review of available services and an assessment of the functioning of surveillance and compensation mechanisms provided for in the Occupational Diseases in Mines and Works Act (ODMWA). The ODMWA is a responsibility of the Department of Health. The research is funded by the National

Research Directorate and is being undertaken in the Alfred Nzo and OR Tambo Districts of the Eastern Cape (EC). After obtaining ethical approval and permission from the EC Department of Health in December 2007, preliminary meetings were held in early 2008 with the relevant Headmen, Chiefs, and Councillors, and with the Eastern Cape Regional office of the National Union of Mineworkers. Subsequent to community meetings held in March 2008 to explain the purpose of the research and obtain community agreement, research assistants were recruited from the areas in which the research was to be undertaken, and trained. Research fieldwork began in April 2008 with in-depth interviews being conducted covering occupational history, medical surveillance history, health and socio-economic status. Interviews are being undertaken with clinics and district hospitals to assess knowledge and functioning of the ODMWA.

Horse transport waiting patiently outside a district hospital in the Eastern Cape.

Careful consultation with all stakeholders required an extensive lead-in time before fieldwork-proper could begin. It was important that the parameters and limitations of the research project were explained and accepted as there was a real danger that rising expectations could have developed that the research would solve all problems with medical surveillance and compensation. The fieldwork was extremely demanding as study participants were interviewed in their homes in deep-rural areas. Interviews with health personnel were equally demanding in covering clinics and district hospitals spread far apart within the study area. The study methodology of gathering both qualitative and quantitative data through in-depth interviews, conducted mostly in isiXhosa and then transcribed and translated, means that data capture will be equally demanding. Inadequate surveillance, management and the failure to compensate silico-tuberculosis, forms one of the major groups of occupationally-acquired disease that continues to exert a major burden on the affected individuals, as well as on the public health system. This study is uncovering issues related to disease surveillance, management and compensation mechanisms in a major labour-sending area of the country. It has significant policy and practice implications.

Second in the group of studies was an investigation of *Work Processes within the Government Hospital Setting that Can Benefit Most from Automation*, funded by Intel. This study was presented to the Health Informatics Conference (HISA) in June and has received a great deal of interest from the information technology (IT) community. The project was extended by its donor, Intel, to undertake a before-and-after assessment of an automation intervention by the Gauteng Department of Health.

The third study completed during the period was a *Fifteen Year Review of Poverty Alleviation in South Africa* undertaken for the Presidency with support from GTZ. The study was a desk top review of progress that has been made in dealing with income poverty in the country since the democratic elections of 1994 and was presented at a national summit during February. It is likely to be influential in determining future poverty alleviation policy.

Capacity building/human resources

Knowledge Management in Health Research is a cluster of studies that aims to provide guidance for policy makers by undertaking research which explores the extent to which national health research efforts among public health authorities, academic institutions and health research agencies, reflect agreed national health research priorities. It has involved, inter alia, developing a web-based *National Health Research Database* which already features over 30,000 abstracts and other material on health research undertaken in southern Africa since 1994. Another aspect of the work is the *Strengthening of Provincial Health Research Committees*. The role of Provincial Health Research Committees has become more important over the past year or two since the

National Health Act required greater coordination of research and greater ethical oversight of all research in the country. This has been a work in progress and comprehensive reports have been produced since the initiative first started in 2006. In relation to this, the Research Director was invited by the National Minister to serve on the National Health Research Committee and has been feeding information gleaned during this project through to the committee. One of the outputs of this project has been a *Review of all PHC research undertaken in South Africa since 1994*, which was presented at the Public Health Association of South Africa's (PHASA's) conference in June. It will also inform a review for the SAHR this year. Other aspects of this project have included research into the use of *Routine Data from the DHIS to Inform Research Priorities*. In *Investigating an approach to developing a surveillance system for measuring the impact of CHW Programmes and the implications for Social Spending*, the use of mobile phone technology was compared to paper-based systems to establish the applicability of the new technology and its potential usefulness in gathering data on a set of indicators that are proposed for nation-wide adoption. The study was undertaken at the Cape Peninsula University of Technology and is funded by the Research Directorate of the NDoH.

The Evaluation of the Learning Complexes Project of the Centre for Rural Health (CRH) of the University of KwaZulu-Natal, funded by Atlantic Philanthropies, has entered into the last of its three years' duration. The comprehensive evaluation for the project is developing formal and informal learning opportunities for health professionals in three northern KwaZulu-Natal districts.

DISTRICT SUPPORT AND COMMUNITY DEVELOPMENT CLUSTER

Director: Nomonde Bam

The overall goal of the Cluster is to support health systems strengthening and an improvement in the quality of care. The approach adopted by the cluster is to provide technical support to selected provinces and districts by setting-up best practice sites that are used as learning sites. This approach is unique, as HST facilitators are based in the districts and work closely with district health teams and thus skills transfer occurs. The Cluster has also championed collaboration between Primary Health Care facilities and community-based health care activities, by increasing knowledge of prevalent health conditions. Through enhanced health promotion, prevention, treatment, care and support, community-based activities are aimed to effect change in behaviour and to encourage greater community response.

Strengthening Sub-District Health Management Teams for Improved Service

The Cluster, through funding from Atlantic Philanthropies, supports the development of capacity of sub-District Managers in order to improve service delivery and an improved health outcome. The project is a partnership between the National and Provincial Departments of Health, with HST as the implementing agency. Some of the achievements of the project are the introduction of monthly PHC reviews where District Health Plans (DHP) indicators and targets are monitored and tracked, and increased team-work and collaboration between local government and the province. In addition, a total of 22 DHPs for the 2007/08 financial year from KwaZulu-Natal, Mpumalanga, North West and Northern Cape were analysed. The findings were consolidated into a National DHP analysis report with recommendations to improve district health planning in South Africa. Recommendations included the use of appropriate indicators and targets, strengthening data quality and the use of information for planning and strengthening performance monitoring in subsequent phases.

Integrated Primary Health Care (IPHC)

The Integrated Primary Health Care (IPHC) Project is a consortium consisting of HST, Management Sciences for Health (MSH) and the University Research Corporation (URC). The IPHC Project focused much of its efforts on strengthening the district health system as a vehicle for primary health care (PHC) service delivery. By prioritising facility level interventions, in selected sites, the IPHC Project built a cadre of health care workers competent in planning, implementing and evaluating comprehensive, high-quality PHC in a sustainable manner. Some of the lessons learnt from the project include: the importance of regular clinic supervision, monthly sub-district PHC reviews and quarterly district reviews to improve quality of care at this level. The project also found that consistent monitoring of Health Programmes improved data quality at facility level and the introduction of regular reviews improved performance/competition amongst sub-district managers and facilities that resulted in team work, resource rationalisation, improved reporting and a stronger work ethic.

District Health Systems Development in Gauteng

This project is funded by the Gauteng Provincial Department of Health: District Health Systems Support Directorate and seeks to improve the quality of Primary Health Care in all districts by supporting District Health Systems development and integration, implementation of Clinic Supervisory Policy, and development and implementation of District Health Expenditure Reviews (DHERs) and DHPs.

The implementation of District Quarterly Reviews are guided by the Clinic Supervision Guidelines of 2005 and National Treasury requirements as outlined in the Guidelines for District Health Planning and Reporting of 2003. These reporting guidelines which facilitate quarterly reviews are aimed at strengthening monitoring and reporting of both financial and non-financial information. During the review process, progress on programme performance indicators i.e.

outputs, outcomes and impacts are presented and discussed to measure performance based on targets set in the DHPs and operational plans. The quarterly reviews provide a platform for monitoring strategies outlined in various planning documents to ensure that allocated resources are used to improve health outcomes and quality of care.

Support to the province was provided for compilation of the DHPs for 2009/10. This process initially commenced with an analysis of DHPs for 2008/09. In addition, support was also provided for conducting the District Health Expenditure Reviews (DHER) for the period 2007/08. Key recommendations and lessons learnt for strengthening health care planning and monitoring processes include:

- The need for standardisation of the DHER templates which are implemented.
- The need to sustain DHER Task Teams and District Management Teams for continuity of processes and to build capacity and skills.
- The need for accurate population figures, including the uninsured population for the province, districts, sub-districts and facilities.
- Integration of financial and non-financial data for decision-making, planning, monitoring and evaluation.
- Greater need for technical support in setting targets, strategy formulation and understanding and interpretation of indicators.

Antiretroviral Therapy Literacy Project

The goal of this project is to promote and strengthen Antiretroviral Therapy (ART) literacy in the clinic catchment areas of sixty-seven clinics which feed into the accredited ART sites in Mpumalanga Province. To this end, an integrated and comprehensive referral system was set-up to ensure a coordinated referral system existed within the health sector, and between PHC facilities, and community based organisations (CBOs). To date, a total of 897 clients were provided with adherence and ART treatment readiness support. In addition, a total of 28 community resource centres (CRCs) were successfully established and are functional at various project sites. These CRCs ensure the easy access of community members to various community health and related services. The project has also established 940 condom distribution points in the Ehlanzeni District. Since the project's intervention, a total of 38 clinic catchment areas have food gardens, and 31 active support groups for people living with HIV and AIDS have been established. A knowledge survey conducted shows that community information on HIV-prevention and transmission, and the use of ARVs, is higher in communities where the project has been in existence.

A clinic food garden

Integrated Nutrition Project

The integrated nutrition project works to improve household food availability through multi-faceted strategies that empower vulnerable communities. Some of the project's highlights include setting-up community health care systems comprising community bases; a referral, follow up and home visit system; and communal and clinic gardens. One of the strengths of the project has been that CBO members and volunteers are local people who understand the community; and their linkage with the PHC facility stimulates interaction between formal and informal health care systems (e.g. traditional healers). The project has also produced a cadre of trained volunteers, that conduct growth monitoring and apply their skills in key family practices of Integrated Management of Childhood Illnesses within local communities. This allows nutritional and other health-related problems to be detected and managed at an early stage.

Growth monitoring is one of the key activities conducted by the volunteers and a professional nurse has been employed to build the capacity of facility staff and volunteers on growth monitoring

and promotion through the use of a Road to Health Chart Master Chart.

Strengthening Routine HIV Counselling and Testing

This project seeks to improve the quality and uptake of HIV-counselling and testing at health facilities and to enhance the continuum of care. The project is implemented in partnership with University Research Corporation (the primary grantee) with HST supporting implementation in selected Districts of Mpumalanga, the Eastern Cape and KwaZulu-Natal. The integration of HIV-counselling and testing with other PHC services, at supported sites, has improved significantly. For example, in one province the integration of HIV with STI increased from 8% to 34%; integration of TB services increased from 25% to 39%, antenatal care from 30% to 87.5%; and family planning from 2% to 15%. One facility supported by the project was identified by the provincial department of health as a best-practice site for PMTCT in KZN.

Weighing of children by a community volunteer.

Global Dialogue of Sexual Health and Well-Being

The goal of the Africa Regional Sexuality Resource Centre (ARSRC) is to promote a more informed and affirming public dialogue on human sexuality, and to contribute to positive changes in the emerging field of sexuality, by creating mechanisms for learning at a Regional level. Activities under the initiative focus on four of the most populous countries in Africa: Egypt, Kenya, Nigeria and South Africa. During this period, HST partnered with universities and other institutions to conduct seminars on Understanding Human Sexuality as a means of promoting and affirming informed dialogue on sexuality.

Client Satisfaction Survey

The implementation of the Client Satisfaction Survey (CSS) was funded by the Gauteng Department of Health. The CSS tool which is based on a set of indicators includes all factors pertaining to the process of health care delivery identified as important to patients and aims to measure the satisfaction levels of clients utilising hospital services. The results of the survey have important implications for ensuring that health care service delivery is more responsive to clients' expectations. The CSS was conducted at Chris Hani Baragwanath Hospital and Tshwane Rehabilitation Hospital and a total of 13 522 randomly selected patients were interviewed as they exited the hospital in the week of the survey. The survey results highlighted the following universal problem areas experienced in public health facilities: access to hospitals, safety in hospitals, long waiting times and short visiting hours. In addition, the CSS also pointed to the urgent need to inculcate a culture of continuous quality improvement in order to bridge and address gaps in health care service delivery.

HEALTHLINK CLUSTER

Director: Ronel Visser

The HealthLink Cluster facilitates the strategic use and dissemination of health and related information and is also involved in advocacy projects which serve to improve the quality and availability of reliable information. The cluster also focuses on equity in health and is actively involved in supporting the implementation of the National Strategic Plan.

Treatment Monitor

The role of the Treatment Monitor project has evolved from monitoring the number of people on antiretroviral treatment (ARVs), to playing a key role in focusing on sexual and reproductive health and rights in relation to HIV and AIDS. As part of this adjusted focus, it also seeks to address the rights and well-being of health-workers, largely female, who are the frontline providers of care for persons living with HIV and AIDS.

Key activities include: providing input on proposed amendments to the Choice on Termination of Pregnancy Amendment Act; hosting and moderating the 60% list which provides a space to discuss HIV and AIDS within the context of gender; women's rights and sexual and reproductive health and rights through the continuum of prevention, treatment and care; leading research into developing indicators for sexual and reproductive health rights for the United Nations General Assembly Special Session on HIV and AIDS; and, providing technical assistance to various organisations both nationally and internationally on various issues related to treatment and care.

Governance and Equity

This project sought to provide support and training to governance structures and to monitor their functioning and effectiveness in order to identify opportunities to strengthen them.

The project has worked with mostly clinic committees, hospital boards and, in some cases, District Health Councils, in the Free State province and in KwaZulu-Natal. Following consultations with members of these governance structures, guidelines and training manuals for the structures were developed. A two-day training course was also developed which dealt with issues such as roles and responsibilities, organisational development, and working with communities. To date, over 50 workshops have been conducted in the provinces. The project also provides ongoing support and capacity building to selected clinic committees where assistance has been provided in developing a constitution, identifying a set of indicators, which clinic committees would find useful in understanding the health needs and status of their communities, and developing and creating links with other governance structures in the area.

The District Health Barometer

The *District Health Barometer* (DHB), funded by Atlantic Philanthropies, is an annual publication that compares the overall performance of health districts in the provision of primary health care in South Africa. The DHB assists in monitoring progress towards strategic health goals (including the Millennium Development Goals); in supporting improvement of equitable provision of primary health care and in supporting the improvement of the quality of routinely collected health data.

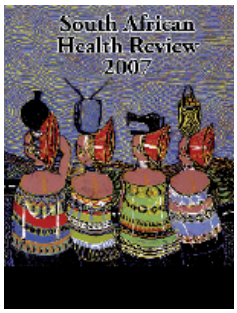
The 2006/07 DHB report, released in February 2008, has been widely welcomed and is used by a variety of national and international stakeholders. For example, the report is listed on the World Health Organization's (WHO's) website as a resource and an example of monitoring primary health care at a sub-national (district) level.

Salient achievements of the project include: the effective communication of district-level data to a wide range of users (including the non-health sector) and the acceptance and use of the publication by the National Department of Health (NDoH). The growing awareness of the importance of ensuring quality of data at a sub-national level as well as the improved interrogation of such data by managers is another achievement of this project.

The Global Equity Gauge Alliance

HST continues to host the Secretariat of the Global Equity Gauge Alliance (GEGA). Following the launch of the first *Global Health Watch* in 2006, the past year has been devoted to the finalisation of the second publication of the *Global Health Watch*. The work of the GEGA was presented at a variety of international fora including the People's Health Movement Global Steering Council Meeting, the Middle East Health Forum, the Geneva Health Forum 2008, the World Health Assembly and the Public Health Association of South Africa conference. The second *Global Health Watch*, which is widely seen as an alternative health report, is due to be released in November 2008.

The South African Health Review



The *South African Health Review* (SAHR), an annual publication of HST since 1995, provides a South African perspective on prevailing local and international public health issues. The 2007 SAHR, which focused on the "Role of the Private Sector" within the South African Health System, was launched on 5 December 2007 in Cape Town, and since then more than 600 copies were distributed. HST website logs for January 2007, the month following the launch, recorded more than 3000 visits to download individual chapters or the full PDF version of the 2007 SAHR. The SAHR was also widely covered and quoted by the media.

The 2008 edition of the SAHR, which focuses on critical issues within Primary Health Care and a review of 30 years of achievement in South Africa since the Alma Ata Declaration, is due to be published in December 2008.

All copies of the SAHR can be viewed in PDF format on the HST website and can also be ordered either in print or on compact disk. This publication has been generously funded by Atlantic Philanthropies.

Knowledge Management

HST website and information dissemination services

The HST website provides a wide array of knowledge, research, links and information about health systems and Primary Health Care in Southern Africa. The website, which is continuously updated, showcases HST's work across its various programmes and projects and holds an extensive database of HST and other publications, all of which can be freely downloaded.

HST's website's statistics indicate that there was an average of nearly 15 500 unique visitors per month between July 2007 and June 2008.

In the last year, HST has also provided support to other initiatives for establishment and maintenance of "independent" websites. These include:

- Global Equity Gauge Alliance
- Global Health Watch
- Madibeng Centre for Research
- National Bioproducts Institute
- Public Health Association of South Africa
- Rural Doctors Association of Southern Africa
- Technical Support Facility of Southern Africa, UNAIDS
- Technical Support Facility of Southern Africa, UNAIDS – Resources Repository

Health and Related Indicators

An online database of indicators on the HST website complements the "Health and Related Indicators" chapter in the SAHR, and includes nearly 19 000 items of indicator data drawn from over 300 sources spanning a period of over ten years. This resource is continuously updated as new sources of data become available.

The work on health indicators is tightly integrated with the District Health Barometer project. Links are emerging with other national and international networks involved in the strengthening of the quality and application of health statistics, such as the South African Medical Research Council, the Health Metrics Network and the Institute for Health Metrics and Evaluation.

Electronic discussion lists

HST manages 56 electronic discussion lists of which 19 are for clients external to the organisation. The Druginfo (386 members), DHIS (556 members), Disability (170 members), Mailadoc (160), the JCSMF (195), 60percent (375 members) and HHRNet (99 members) lists are HST-hosted lists that have been the most active, with some achieving many thousands of postings during the year.

HST uses the lists extensively to disseminate publications and relevant data to a wide audience, while keeping the health sector abreast of the latest public health sector news, views, education and support.

HealthLink Bulletin

HST continues to produce the HealthLink Bulletin, a bi-monthly electronic newsletter, which remains a main information dissemination tool. The Bulletin provides information and links to various news articles, current resources, publications, events and job opportunities focusing on areas such as health systems development, primary health care, public health and HIV. Each successive Bulletin is accessible on the HST website and is also sent to more than 1 800 subscribers by email.

Resource Centre

The Resource Centre continues to respond to information enquiries ranging from telephonic, email and walk-in requests. HST publications and other material are also exhibited and distributed at key public health conferences in the country.

Health Management Information Systems Monitoring and Evaluation

Assessing requirements to establish a monitoring and evaluation system for the Mpumalanga Department of Health and Social Services

HST was awarded an open tender by the Mpumalanga Department of Health and Social Services to scope for the requirements to establish a monitoring and evaluation (M&E) system. The aim of the project was to strengthen health service delivery in Mpumalanga by developing an effective system for ongoing monitoring and periodic evaluation of health programme implementation.

The proposed Results-Based M&E System was accepted for implementation by the Mpumalanga Department of Health and Social Services.

TB Facilities Alignment Project

To facilitate TB data to be easily imported and integrated into the DHIS, the organisational structure of the two systems need to be aligned. The DHIS organisational structure is accepted as the unofficial standard for South Africa.

Funded through the University Research Cooperation, the TB II TASC project aimed to strengthen the TB programme and improve access to TB data at all levels of the health care system by making the data available in the DHIS for evidence-based planning. The facility names of all provinces were aligned in the two systems and were submitted to the ETR.Net software developers for incorporation in the new version of the ETR.Net software for implementation in all provinces in the financial year 2008/09.

Development of a Strategic Planning Database

A critical function of the National Department of Health: Strategic Planning Directorate is to analyse, compare and report on performance data submitted by provinces. To support this function, HST was contracted by the Directorate to develop a Strategic Planning and Reporting database in DHIS 1.4. This development would enable a comparative and strategic analysis of data submitted by provinces in their annual Provincial Annual Performance Plans (APPs) from the period 2003/04. The project was undertaken over a period of eight-months (August 2007 to March 2008) and the database functionality includes the generation of static and user-defined reports based on both data submitted from provincial APPs and routine District Health Informatin System (DHIS) data. Further development of the database is being planned to expand and update its ability to include data from the Provincial Annual Reports (PAR) as well as the Provincial Quarterly Reporting System (PQRS).

Review of structures, competencies and training interventions to strengthen district management in the national health system

International evidence reveals that the lack of management capacity impacts on the ability of health systems to deliver effective health care. Information on managers and district management structures within the South African health system is limited and this has prevented and inhibited managerial workforce planning, monitoring and development.

Funded by Atlantic Philanthropies, this national qualitative study, which is in phase one of implementation, seeks to describe firstly, the district management establishment throughout South Africa, both in terms of functional models of district management, as well as the number, levels and staffing of district management posts. Secondly, information on training and other capacity development initiatives targeted at district managers is being reviewed in order to develop a national database of training interventions and to make recommendations on training programmes and capacity development needs for district management. Phase two of the study involves the development of an implementation strategy for strengthening district management capacity based on the findings of phase one. The HST project team has been collaborating with the National Department of Health: Primary Health Care and District and Development Cluster through the National District Health System Committee (NDHSC). Project "champions" in the nine provinces have supported the project in the provinces and the District Managers and their respective teams from the selected districts have offered amazing cooperation.

Facilitation of the Environmental Health Indicator Data Set

The National Indicator Data Set for the Environmental Health Service (EHS) was ratified by the NDHSC in May 2006. Technical support and training was provided by HST in all provinces in 2007/08 to facilitate the implementation of the data set in the DHIS with the aim of improving access to Environmental Health information for managing Environmental Health Services in the country.

Western Cape Data Clean-up project

Technical support was provided by HST to the Western Cape Department of Health to promote the availability of good quality health data that is essential for management, planning and monitoring of health services. This support was provided to the Department through a data clean-up exercise which was conducted over a period of 15 workdays during September 2007 to October 2007.

Strengthening the HMIS in the in the Western Cape Province

The Western Cape Department of Health entered into a Service Level Agreement with HST in October 2007 to provide technical support, at both provincial and district levels, on the use of data and information to improve management of the health system and health programmes in the province. Specific emphasis has been placed on training information management personnel on SINJANI, which is the routine data collection system implemented in the province.

Training on the Use of Information for Management

To strengthen management systems for effective health service delivery, the Gauteng Department of Health contracted HST to train 200 Health Managers on the use of information for management. The 5-day training courses were conducted over a period of nine-months and focussed on the use of data and information to support, evidence-based planning, monitoring and evaluation.

The Support Services unit provides an array of services to the various clusters which ensures that staff are equipped to provide the necessary services effectively, efficiently and economically.

HUMAN RESOURCES

At the end of June 2008 HST had a staff complement of 79 employees - comprising 77 full-time staff and two interns. The staff profile remains largely female and black, exceeding statutory employment equity profiles. During the year under review, five new appointments were made; six staff members resigned and three were promoted to senior positions. The employee turnover rate was 7.59% for the period April to June 2008 which compared reasonably well to the rate of 6.02% for the first quarter of 2008.

Skills Development

HST has revised its induction programme for new staff members to ensure that staff start off on a strong footing and are able to become productive within a shorter time period due to a more streamlined and smoother settling-in process.

Of the eight interns employed by HST, three were promoted to Research Assistants within the organisation and three left after completing the internship programme. The current internship programme is also in the process of being reviewed to ensure that it reflects the best practice possible and that interns are afforded the best development exposure that is available.

Performance Management

HST is now in its second year of using the performance management system and staff are more comfortable and confident in the use of the system.

FINANCE

The annual financial statements as at 30 June 2008 reflect assets to the value of R37m which indicates HST's financial stability. HST has once again secured unqualified reports from both the internal and external auditors which reinforces our adherence to good governance and accountability. The Finance and Audit Committees play an important oversight role in the governance of the organisation and continue to provide strategic advice and guidance to the Finance team.

INFORMATION TECHNOLOGY

HST continues to utilise open source software and its network servers run on Linux. The Information Technology (IT) department has also leased an off-shore server to ensure minimum downtime during maintenance and this server also ensures that staff are able to access the many services that we offer. There are few organisations of HST's size, particularly in a non-government organisation environment, that can provide services to staff and partners by using free and open source software. HST can proudly claim to be a "best practice" site for the use of such software.

SHARING KNOWLEDGE: HEALTH SYSTEMS TRUST CONFERENCE

"STRENGTHENING HEALTH SYSTEMS IN SOUTHERN AFRICA 1992 – 1997"

October 2007

The 2007 Health Systems Trust Conference celebrated HST's 15-year long involvement in the promotion of primary health care in South Africa. Coinciding with the 30th anniversary of the Alma Ata Declaration on Primary Health Care, the conference was opened by Dr Yogan Pillay, representing the Minister of Health, who, in setting out the challenges facing the South African health system, extended an invitation to HST to continue to undertake relevant research while working in partnership with government in order to attain national goals in health.

The keynote speech, delivered by Dr Freddie Sengooba, stressed the necessity of "networking" when seeking to optimise opportunities for policy change and effective policy and programme implementation. Relating examples of such networking Dr Sengooba used illustrations demonstrating how organised networking has resolved workforce and health systems challenges in Uganda.

HST's own organisation and history was relayed to the Conference by CEO Lillian Dudley who also indicated the future direction the organisation would follow.

The three main clusters within HST, the Research Programme, District Support and Community Development (DSCD), and HealthLink were then each invited to give a short overview of their focus areas and projects.

Research's Dr Irwin Friedman led the participants through a review of the focus areas of the cluster, namely, tuberculosis, sexual health and reproduction, child health, gender and health, nutrition and chronic diseases. The projects were outlined over the last fifteen years with emphasis on current projects and the way forward.

DSCD's Ms Nomonde Bam outlined the history of the cluster's current expansion into the southern African region and highlighted the publications generated by the projects in the cluster. The approach of setting up best practice sites in selected districts was introduced and it was explained that the uniqueness of this approach is that HST facilitators are based at the districts and work closely with district teams and thus skills transfer occurs.

HealthLink's Ms Ronel Visser took participants through the clusters key functions of Knowledge Management, Governance, Health Information Systems, Monitoring and Evaluation, Publishing, and the maintenance of the Resource Centre. Pre-eminent amongst HST's published titles are the well-known *South African Health Review and District Health Barometer,* whilst the Treatment Monitor, an HST inter-cluster project supporting the National Strategic Plan 2007-2011 in South Africa, identifies and shares information on models of best practice and lessons learnt.

There was no doubt that, as participants left the 2007 Conference with a sense of renewed and invigorated commitment to ensuring an accessible and equitable public health system for all in South and Southern Africa, HST's current and future role in strengthening the public health system remains as relevant as it did 15 years ago, and will become evermore so as health challenges in the twenty first century become increasingly complex and daunting.

SHARING KNOWLEDGE: PUBLICATIONS & CONFERENCE PRESENTATIONS

PUBLICATIONS

Apalata T, Kibiribiri ET, Knight S and **Lutge E.** *Refugees' Perceptions of their Health Status & Quality of Health Care Services in Durban, South Africa: A Community-Based Survey.* Durban: Health Systems Trust; 2007

Baek C, Mathambo V, **Mkhize S, Friedman I**, Apicella L, Rutenberg N. *Key Findings from an Evaluation of the mothers2mothers Program in KwaZulu-Natal, South Africa.* Durban: Health Systems Trust; 2007

Barron P, Day C and Monticelli F. *The District Health Barometer - Year 2006/07.* Durban: Health Systems Trust; 2007

Clarke M, Schoeman H and **Friedman I**. *Towards a generic surveillance system to measure the impact of Community Health Worker programmes in South Africa: a comparison of paper-based and mobile/cell phone methods.* Durban: Health Systems Trust; 2007

Friedman I and Bhengu L. *Fifteen Year Review Of Income Poverty Alleviation Programmes In The Social and Related Sectors*. Durban: Health Systems Trust; 2008

Friedman I, Mothibe N, Bhengu L, Mafuleka A and Reynolds N. *A Baseline Study on Opportunities for Expansion of the EPWP social sector work opportunities in the social sectors: an institutional needs analysis with regards to mainstreaming of the EPWP.* 4 volumes. Durban: Health Systems Trust; 2007

Friedman I, Ramalepe M, Matjuis F, Bhengu L, Lloyd B, Mafuleka A, Ndaba L and Boloyi B. *Moving Towards Best Practice: Documenting and Learning from Existing Community Health/Care Worker Programmes.* Durban: Health Systems Trust; 2007

Gabela SD. *Health Care Waste Management In Public Clinics in the Ilembe District: A Situational Analysis*. Durban: Health Systems Trust; 2007

Harrison S, **Bhana R, Ntuli A**, editors. *South African Health Review 2007.* Durban: Health Systems Trust; 2007.

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Loveday M, Thomson L, **Ndlela Z** and **Dudley L**. *The implementation of the National Tuberculosis Control Programme (NTCP) at a regional/district hospital and three of its feeder clinics: A Case Study.* Durban: Health Systems Trust; 2007

Lutge E and Mbatha T. *PHC Facility Infrastructure: A Situation Analysis of Data Available.* Durban: Health Systems Trust; 2007

Lutge E and Mbatha T. *Strengthening Research Capacity In South Africa: An Audit of Provincial Health Research Committees*. Durban, Health Systems Trust, 2007

Mkhize S and Nzimande S. *Carrier Choices in relation to Nursing.* Durban: Health Systems Trust; 2007

Monticelli F, Haynes R, Sello E. *Utilisation Survey on the District Health Barometer.* Durban: Health Systems Trust. February; 2008

Niit, R and Friedman I. *Work Processes within the Government Hospital Setting that can Benefit Most from Automation*. Durban: Health Systems Trust; 2008

Nkonki L, **Doherty T**, Hill Z, Chopra M, Schaay N and Kendall C. *Missed opportunities for participation in prevention of mother to child transmission programmes: Simplicity of nevirapine does not necessarily lead to optimal uptake, a qualitative study.* Durban: Health Systems Trust; 2007

Pagett C, Padarath A. *A review of codes and protocols for the migration of health workers.* Equinet Discussion Paper 50. Equinet. 2007

Roberts J. *Barriers to Women's Rights in Implementation of the Choice on Termination of Pregnancy Act in KwaZulu-Natal.* Durban: Health Systems Trust; 2007

Stevens M, Mathijs F and **Bomela N**. Task Shifting considering legal and regulatory barriers. DENOSA and HST. March 2008.

Stevens M, Sinanovic, E., Regensberg, L and Hislop, L. *HIV and AIDS, STI and TB in the Private Sector.* In South African Health Review 2007.

Stevens M and De Vos, M. *Monitoring the UNASS Goals on Sexual and Reproductive Health.* UNGASS AIDS Forum South Africa. HST and MOSAIC. June 2008

Stevens M. *'Language…an area to inform decision making'* AIDS Legal Quarterly. June 2007 24-28.

Stevens M. *'South African Case Study' in "Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health: Why it exists and how we can change it"* Eds G Sen and P Östlin Final Report to the WHO Commission on Social Determinants of Health September Women and Gender. Equity Knowledge Network. WHO. 2007.

Stevens M. *Adolescent sexual and reproductive care*. Nursing Update. June 2008, p36-37

Stevens M and Bomela N. *Cervical cancer - is vaccination the way to go?* Nursing Update. May 2008, pg37

Stevens M. *The importance of choice*. Nursing Update: April 2008, pg32-33

PRESENTATIONS AT CONFERENCES

Bomela N and Stevens M. *Cervical Cancer and HIV/AIDS in the Workplace*. Wits HIV/AIDS and the Workplace Conference. Johannesburg 29 May 2008

Bomela N. and Stevens M. *Development in Progress: A policy analysis of the South African Cervical Cancer Policy, factoring in HIV/AIDS*. PHASA. 2 June 2008

Day C, Sello E. *'Making key health indicator data more accessible, The District Health Barometer Web GIS'.* HISA conference; on Innovation and Challenges in Health Informatics, Durban. June 2008

Monticelli F. *The District Health Barometer in South Africa*. Health Metrics Network. International Meeting on Monitoring Health Systems Strengthening. Dar es Salaam, 16-17 April 2008

Monticelli F. *Alma Ata and Primary Health Care Where are we now? Monitoring progress.* 30th Alma Ata Celebration The South Africa National Conference on Primary Health Care, 10-11 April 2008

Monticelli F. *The District Health Barometer.* Gauteng Health Summit, Turfontein Conference Centre, 17 October 2007

Mthembu W. *Community mobilization strategy for community based interventions: The ART Literacy Project experience.* Global Forum on Human Resources for Health, Kampala 2-7 March 2008

Mthembu W and Shivambu, E. *Community mobilization strategy for community based interventions: The ART Literacy Project experience.* PHASA Conference, Cape Town 2-4 June 2008

Stevens M. *Abortion and HIV/AIDS, HIV/AIDS and abortion: how best to provide HIV positive women with choice?* Global Dialogue on Safe Abortion. London. 24 October 2007

Stevens M. *HIV/AIDS and Abortion: challenges for Consideration.* 3rd African conference on Sexual health and Rights: 'Sexuality, Poverty and Accountability in Africa". Abuja, Nigeria. 4-8 February 2008

Stevens M. *Using a sexual and reproductive health and rights lens in providing care.* Wits HIV/AIDS and the Workplace Conference. Johannesburg 29 May 2008

Stevens M. *UNGASS Sexual and Reproductive Health and Rights Indicators.* PHASA. 3 June 2008

HST'S STAFF

Thobile Mbengashe, *CEO*

HR AND ADMINISTRATION

Ricardo Ngcobo, *Manager*
Duduzile Zondi
Farana Bibi Khan
Joyce Mareme
Jurie Thaver
Khuphukile Nyawose
Mpho Monyatsi
Noncedo Kalipa
Nomzi Kalipa
Portia Ramokgolo
Primrose Mbuli
Selverani James
Salome Selebano

FINANCE AND IT

Deenadayalan Govender, *CFO*
Charmaine Singh
Deon Olivier
Fazila Khan
Jonathan McKeown
Mahommed Hoosen Imam
Quintin Dreyer
Rakesh Brijlal
Rosheen Seale

RESEARCH PROGRAMME CLUSTER

Irwin Friedman, *Director*
Amos Soxa
Elizabeth Lutge
Jaine Roberts
Madibata Matji
Nandy Mothibe
Nontombi Memela
Patela Giyose
Pumza Mbenenge
Sibongile Mkhize
Siphiwe Hlongwane, Intern
Siyabonga Nzimande, Intern
Thantaswa Mbenenge
Thokozani Mbatha, Intern
Vundli Ramokolo
Zungezi Thuthu, Intern
Zimisele Ndlele, Intern

DSCD CLUSTER

Nomonde Bam, *Director*
Evangeline Shivambu
Frank Tlamama
Khosi Nyawo
Lwandlekazi September
Muzi Matse
Mzikazi Masuku
Noluthando Ford-Ngomane
Nomkita Gobodo
Nonceba Languza
Orgrinah Ngobeni
Oumiki Evelyn Khumisi
Thembekile Lushaba
Thulisile Thabethe
Tumelo Mampe
Wanda Mthembu

HEALTHLINK CLUSTER

Ronel Visser, *Director*
Ashnie Padarath
Bridget Lloyd
Candy Day
Christa Van Den Bergh
Crizelle Nel
Elliot Sello, Intern
Faith Kumalo
Fiorenza Monticelli
Halima Hoosen Preston
Hlengiwe Ngcobo
Imeraan Cassiem
Jacqueline Smith
Jan Baloyi, Intern
Josianne Roma Reardon
Julia Elliot
Marion Stevens
Naomi Massyn
Nombulelo Bomela
Nonqaba Mzana
Rakshika Bhana
Ronélle Niit
Ross Haynes
Sithandiwe Nyawose
Stiaan Byleveld

SPECIALIST TECHNICAL ADVISORS

Antoinette Ntuli
Lilian Dudley
Peter Barron

THE HST BOARD OF TRUSTEES

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

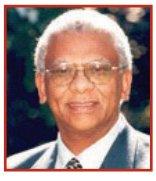
Ms Jeanette Hunter (Chairperson: 2008), is Chief Information Officer for Gauteng Department of Health and was previously Director for Knowledge Management in the North West Province Department of Health. She brings to the Board wide experience in policy analysis and implementation, planning, monitoring and evaluation, as well as in Health Information Systems Implementation and Maintenance.

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

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

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

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



Professor John Volmink, started his academic career at the University of Western Cape, and completed his PhD in Mathematics Education at Cornell University, NY, in 1988. He has held various teaching positions, including at the University of Western Cape, University of Cape Town and Cornell University. As Director for the Advancement of Science and Mathematics Education in Durban, he has been involved in development initiatives.

Dr Yogan Pillay, has worked in the South African National Department of Health since January 1996. He was first responsible for setting up the district health system, then moved to strategic planning and is now the Deputy Director-General responsible for strategic health programmes, which includes HIV/AIDs and TB. He has a PhD in health policy and planning from Johns Hopkins University and more recently completed an executive management course at the University of South Africa's (UNISA) business school.

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

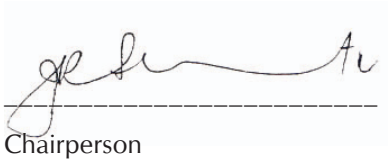
STATEMENT OF RESPONSIBILITY BY THE BOARD OF TRUSTEES FOR THE YEAR ENDED 30 JUNE 2008

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

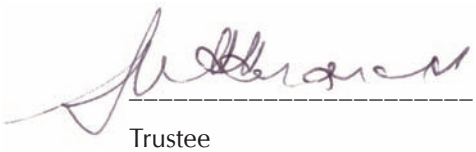
The financial statements have been prepared on the going concern basis, as the Board of Trustees have no reason to believe that the Trust will not be a going concern in the foreseeable future based on reserves forecasts, available cash resources, and on the assumption that the trust will continue to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

The annual financial statements have been audited by the independent accounting firm, PricewaterhouseCoopers Inc., which was given unrestricted access to all financial records and related data, including minutes of all meetings of members, the Board of Trustees and committees of the Board. The Board of Trustees believe that all representations made to the independent auditors during their audit were valid and appropriate. PricewaterhouseCoopers Inc. audit report is presented on page 8.

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



Chairperson



Trustee

Date: 12 FEBRUARY 2009

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

CORPORATE GOVERNANCE STATEMENT FOR THE YEAR ENDED 30 JUNE 2008

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 two times during the 2008 financial year.

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

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

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

Selva Govindsamy (External Member)
Sagie Pillay
Ilan Lax (External Member)

The audit committee addressed its responsibilities properly in terms of the charter during the 2008 financial year. No changes to the charter were adopted during the 2008 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 2008, and of the results of its operations, changes in equivalents and cash flows for the period ended then, in accordance with statements of South African Generally Accepted Accounting Practice for Small and Medium-sized Entities (SA GAAP for SME"s) 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 two times during the 2008 financial year.

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

S Chaba
J Hunter
Y Pillay

FINANCE COMMITTEE

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

The finance committee consists of the following Trustees:

J Volmink
E Buch
P Masobe

The trustees have expressed their concern about the ongoing delays with the Masters office in updating of the Trustee's Letter of Authority and Trust Deed.

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 refers to the potential for loss to occur due to a breakdown in control information, business processes, and compliance systems. Key policies and procedures which 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 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 is 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 2008 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 2008, its system of internal control over financial reporting and over safeguarding of assets against unauthorised acquisitions, use, or disposition, met those criteria.

INTERNAL AUDIT

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

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

SUSTAINABILITY

The trust supports the concept of "triple bottom line" reporting as set out in the King II report.

ETHICAL STANDARDS

The trust has developed a Code of Conducts (the Code),

which has been fully endorsed by the board and applies to all trustees and employees. The Code is regularly reviewed and updated as necessary to ensure it reflects the highest standards of behaviour and professionalism.

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

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

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

ACCOUNTING AND AUDITING

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

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

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

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

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

The audit committee set principles that were considered and accepted by the stakeholders for using external auditors for non-audit services.

PRICEWATERHOUSECOOPERS

PricewaterhouseCoopers Inc
Reg. no. 1998/012055/21
102 Essenwood Road
Berea 4001
P O Box 1049
Durban 4000
Telephone +27 (31) 250 3700
Facsimile +27 (31) 202 8220
www.pwc.com/za

INDEPENDENT AUDITOR'S REPORT TO THE TRUSTEES OF TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

REPORT ON THE FINANCIAL STATEMENTS

We have audited the annual financial statements of Trust for Health Systems Planning and Development, which comprise the report of the trustees and the balance sheet as at 30 June 2008, the income statement, the statement of changes in equity and cash flow statement for the year then ended, and a summary of significant accounting policies and other explanatory notes, as set out on pages 9 to 26.

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

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

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

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

Opinion
In our opinion, the financial statements present fairly, in all material respects, the financial position of the trust as of 30 June 2008, and its financial performance and its cash flows for the year then ended in accordance with South African Statements of Generally Accepted Accounting Practice for Small and Medium-sized Entities, and in the manner required by the trust deed.

Report on Other Legal and Regulatory Requirements
With the written consent of all trustees, we have performed certain accounting and secretarial duties.

Other matter
We draw attention to the fact that the supplementary information set out on pages 27 to 32 do not form part of the annual financial statements and is presented as additional information. We have not audited these schedules and accordingly we do not express an opinion on them.

PricewaterhouseCoopers Inc.
Director: N Ramlagan
Registered Auditor

12 February 2009

C Beggs — Chief Executive Officer
F Tonelli — Chief Operating Officer
S J Ashforth — Director – Managing KwaZulu-Natal region and Durban office
Resident Directors — S J Ashforth, S Bauristhene, J S Dixon, A K Essack, H N Govind, M E Jones, K N Kooverjee, N R C Mbhele, T P J McCarthy, M R Mthethwa, B K Rajkaran, N Ramlagan, H Ramsumer, S F Randelhoff, M H Telfer, T S White
The Company's principal place of business is at 2 Eglin Road, Sunninghill where a list of directors' names is available for inspection.
PricewaterhouseCoopers Inc is an authorised financial services provider.
VAT reg.no. 4950174682

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

REPORT OF THE BOARD OF TRUSTEES FOR THE YEAR ENDED 30 JUNE 2008

The Board of Trustees present their annual report, which forms part of the audited financial statements of the trust for the year ended 30 June 2008.

1 GENERAL REVIEW

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

GOALS

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

2 FINANCIAL RESULTS

2.1 Full details of the financial results are set out on pages **11 to 26** in the attached financial statements.

2.2 As set out in the annual financial statements, the trust has a net (deficit)/surplus for the year of (R2 808) (2007: R3,147,534).

3 TRUSTEES

The following served as trustees during the current year:

E Buch	Y Pillay
S Chaba	DN Pillay
J Hunter	D Serwada (Uganda)
P Masobe	J Volmink

4 The Lovelife Trust's assets and liabilities

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

As at 30 June 2008, land and buildings comprising the remainder of Erf 5 Wierda Valley Township were still registered in the name of Trust for Health Systems Planning and Development. Management of The Lovelife Trust were informed of this matter and have taken steps to rectify this.

5 MATERIAL EVENTS AFTER YEAR END

No matter which is material to the financial affairs of the trust has occurred between the balance sheet date and the date of approval of the financial statements.

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT
BALANCE SHEET
AS AT 30 JUNE 2008

	Notes	2008 R	2007 R
ASSETS			
Non-current assets			
Property, plant and equipment	7	**3,568,937**	3,827,722
Current assets			
Trade and other receivables	8	**6,170,470**	25,743,375
Cash and cash equivalents	9	**27,643,927**	19,508,990
		33,814,397	45,252,365
Total assets		**37,383,334**	49,080,087
EQUITY			
Trust capital and funds			
Trust capital and accumulated surplus funds		**10,571,622**	12,188,577
Total equity		**10,571,622**	12,188,577
LIABILITIES			
Non-current liabilities			
Interest bearing borrowings	12	**2,026,281**	2,030,827
Current liabilities			
Trade and other payables	10	**24,755,931**	34,812,277
Current portion of interest bearing borrowings	12	**29,500**	48,406
		24,785,431	34,860,683
Total liabilities		**26,811,712**	36,939,916
Total equity and liabilities		**37,383,334**	49,080,087

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT
INCOME STATEMENT
FOR THE YEAR ENDED 30 JUNE 2008

	Notes	2008 R	2007 R
Grant income	3	**39,010,990**	51,224,439
Other income		**154,338**	412,696
Project expenses		**(29,728,340)**	(31,458,159)
Grants paid		**(5,935,387)**	(9,284,082)
Administration expenses		**(5,710,872)**	(9,378,285)
(Deficit)/surplus funds	2	**(2,209,272)**	1,516,609
Finance costs	5	**(247,476)**	(158,605)
Finance income	5	**2,453,939**	1,789,528
(Deficit)/surplus funds before income tax		**(2,808)**	3,145,534
Income tax expense	6	-	-
(Deficit)/surplus funds for the year		**(2,808)**	3,145,534

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2008

	Note	2008	2007
		R	R
Trust capital and accumulated surplus funds			
Balance at beginning of year - restated		**12,188,577**	7,786,826
Comprises as follows:			
District Support Community Development (DSCD)		**3,524,176**	3,372,640
Opening balance		**3,524,176**	14,936,005
Correction of error	15	**8,715,572**	-
Change in accounting policy	14	-	(11,563,365)
Research		**(1,203,465)**	5,702,088
Opening balance		**(1,203,465)**	7,565,555
Change in accounting policy	14	-	(1,374,560)
Less: Transfer		-	(488,907)
Central Administration (CORE)		**5,135,839**	5,675,376
Opening balance		**5,135,839**	5,587,461
Less: Transfer		-	87,915
Healthlink		**3,117,880**	307,410
Opening balance		**3,117,880**	4,656,770
Change in accounting policy	14	-	(3,890 707)
Less: Transfer		-	(458,653)
Heath-e		**1,614,147**	859,645
Opening balance		**1,614,147**	-
Less: Transfer		-	859,645
Add : (Deficit)/Surplus for the period		**(2,808)**	3,147,532
District Support Community Development (DSCD)		**991,152**	151,536
As previously reported		**991,152**	151,536
Research		**1,383,778**	1,180,280
Central Administration (CORE)		**(113,247)**	(539,537)
Healthlink		**(2,264,491)**	1,600,751
Health-e		**(1,614,147)**	754,502
At end of year			
District Support Community Development (DSCD)		**4,515,328**	3,524,176
Research		**180,313**	(1,203,465)
Central Administration (CORE)		**5,022,592**	5,135,839
Healthlink		**853,389**	3,117,880
Health-e		-	1,614,147
Balance at year end		**10,571,622**	12,188,577

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT
CASH FLOW STATEMENT
FOR THE YEAR ENDED 30 JUNE 2008

	Notes	2008 R	2007 R
Cash flows from operating activities			
Cash receipts from grants		**41,516,172**	40,459,619
Cash paid in respect of projects and to employees		**(33,834,236)**	(51,509,806)
Cash from/(used in) operations	**11**	**7,681,936**	(11,050,187)
Net finance income		**2,206,464**	1,630,923
Net cash from/(used in) operating activities		**9,888,400**	(9,419,264)
Cash flows from investing activities			
Proceeds from disposal of property, plant and equipment		**24,851**	13,776
Transfers of property, plant and equipment		**136,910**	-
Acquisition of property, plant and equipment		**(275,626)**	(3,286,833)
Net cash used in investing activities		**(115,865)**	(3,273,057)
Cash flows from financing activities			
Transfer from reserves		**(1,614,147)**	-
Proceeds from interest bearing borrowings		**(23,452)**	2,079,233
Net cash (used in)/from financing activities		**(1,637,599)**	2,079,233
Net increase/(decrease) in cash and cash equivalents		**8,134,937**	(10,613,088)
Cash and cash equivalents at beginning of year		**19,508,989**	30,122,077
Cash and cash equivalents at end of year	**9**	**27,643,926**	19,508,989

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

NOTES TO THE ANNUAL FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2008

1 Summary of significant accounting policies

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

1.1 Basis of preparation

The financial statements have been prepared in accordance with the South African Statement of Generally Accepted Accounting Practice for Small and Medium-sized Entities ("SA GAAP for SME's") for the first time. The financial statements have been prepared under the historical cost convention.

The preparation of financial statements in conformity with GAAP for SME's requires the use of certain critical accounting estimates. It also requires management to exercise its judgement in the process of applying the company's accounting policies. During the period under review there were no areas involving a higher degree of judgment or complexity, or areas where assumptions and estimates are significant to the financial statements.

The disclosure required by SA GAAP for SME's concerning the transition from South African Statements of Generally Accepted Accounting Practice to SA GAAP for SME's are explained in note 1.2.

1.2 Explanation of transition to GAAP for SME's

As stated in note 1.1, this is the first annual financial statements prepared in accordance with SA GAAP for SME's.

The transitional provisions of SA GAAP for SME's require that a reconciliation be prepared to disclose the effects of the adoption to this framework. However there is no impact on the financial statements arising from the adoption of SA GAAP for SME's and hence no reconciliation has been prepared.

1.3 Property, plant and equipment

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

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

Depreciation is calculated using the straight-line method to allocate their cost to their residual values over their estimated lives as follows:

Land and buildings	50 years
Motor vehicles	4 years
Computer equipment	4 years
Computer software	2 years
Furniture and fittings	6 years

The assets' residual values and useful lives are reviewed, and adjusted if appropriate, at each balance sheet date.

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

Gains and losses on disposals are determined by comparing proceeds with carrying amount and are recognised within 'project and administration expenses' in the income statement.

1.4 Impairment of non-financial assets

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

1.5 Trade and other receivables

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

1.6 Cash and cash equivalents

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

1.7 Trade and other payables

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

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

1.8 Funded projects

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

1.9 Revenue recognition

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

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

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

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

Income from sale of publications is included in other income.

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

- Interest income - as it accrues

1.10 Leased assets

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

1.11 Financial risk management

Financial risk factors:

Foreign exchange risk

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

Interest rate risk

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

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

Credit risk

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

Liquidity risk

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

Fair value estimations:

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

1.12 Borrowings

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

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

	2008 R	2007 R
2 Surplus funds		
The following items have been charged/(credited) in arriving at the surplus funds:		
Depreciation on property, plant and equipment (for detailed breakdown of depreciation refer to note 7)	**376,826**	375,454
Auditors' remuneration		
Audit fees – current year	**108,000**	88,000
Underprovision in prior year	**20,000**	5,095
Other services	**5,520**	3,429
	133,520	96,524
Loss on disposal of property, plant and equipment	**6,133**	605
Profit on disposal of property, plant and equipment	**(8,309)**	(7,263)
Consultancy fees paid	**986,081**	1,386,736
Operating lease rentals		
Land and buildings	**1,257,038**	1,416,879
Other	**129,494**	213,408
	1,386,532	1,630,287
Staff costs (see note 4)	**22,076,780**	24,513,095
Expenses by nature:		
Consulting fees paid	**986,081**	1,386,736
Depreciation	**376,826**	375,454
Staff costs	**22,076,780**	24,513,095
Operating lease rentals	**1,386,532**	1,630,287
Travel and accommodation	**5,006,331**	5,898,252
Other expenses	**8,298,844**	12,823,296
Printing and stationery	**865,590**	1,388,217
Project facilitation	**1,355,926**	1,015,029
Telephone and fax	**1,021,688**	1,090,160
Total administration and project expenses	**41,374,599**	50,120,526

3 Grant income

Grantee	Healthlink	DSCD	Research	Admin	Total	Accrued Income	Deferred income	Total
The Atlantic Philanthropies	3,423,690	125,705	294,972	1,039,590	**4,883,957**	-	(8,198,920)	**13,225,878**
W K Kellogg Foundation	-	2,463,994	-	-	**2,463,994**	-	(2,054,484)	**4,518,478**
Department of Health	2,183,917	10,034,019	3,030,627	1,047,236	**16,295,799**	307,778	(10,698,361)	**26,686,382**
DBSA	-	-	1,197,475	-	**1,197,475**	-	-	**1,197,475**
Intel Corp	-	-	285,285	-	**285,285**	-	-	**285,285**
SIDA	1,036,700	-	-	-	**1,036,700**	265,573	-	**771,127**
UNC	-	-	829,427	-	**829,427**	215,285	-	**614,142**
WHO	232,500	-	-	-	**232,500**	-	-	**232,500**
Iitalian Corp	76,500	-	-	-	**76,500**	-	-	**76,500**
Charles Kendall & Partners LTD	989,469	-	-	-	**989,469**	-	-	**989,469**
Open Society Foundation of South Africa	332,607	-	-	-	**332,607**	-	(841,501)	**1,174,108**
MRC	-	-	1,144,065	-	**1,144,065**	-	-	**1,144,065**
German Devel Corp	-	-	71,820	-	**71,820**	-	-	**71,820**
Population Council	-	-	178,382	-	**178,382**	-	-	**178,382**
Raith Foundation	133,861	-	-	-	**133,861**	-	-	**133,861**
NHLS	11,000	-	-	-	**11,000**	-	-	**11,000**
Nuffield Institute for Health	-	-	219,178	-	**219,178**	-	-	**219,178**
Action Health Incorporated	-	-	-	-	-	-	(30,000)	**30,000**
Mosaic	-	-	-	-	-	-	(43,030)	**43,030**
IPAS SA	-	-	-	-	-	-	(31,878)	**31,878**
Unifem	-	-	-	-	-	-	(7,465)	**7,465**
Full Circle Events	-	-	-	-	-	-	(6,200)	**6,200**
KNCV	-	-	-	-	-	-	(160,730)	**160,730**
Management Sciences for Health	-	3,482,781	801,638	-	**4,284,419**	-	-	**4,284,419**
University of KZN	-	-	21,923	-	**21,922**	-	-	**21,922**
University Research Council	284,200	2,414,326	1,302,503	-	**4,001,029**	-	-	**4,001,029**
University of Western Cape	-	-	161,065	-	**161,065**	-	-	**161,065**
Global Equity Watch	57,455	-	-	-	**57,455**	-	-	**57,455**
Equinet	103,081	-	-	-	**103,081**	-	-	**103,081**
	8,864,980	**18,520,825**	**9,538,360**	**2,086,826**	**39,010,990**	**788,636**	**(22,072,569)**	**60,294,924**

3 Grant income (continued)

FOR THE YEAR ENDED 30 JUNE 2007

	Health E	Healthlink	DSCD	Research	Admin/CORE Income	Total Income	Accrued Income	Deferred Reversal	Prior Year Receipts	Total
The Atlantic Philanthropies	2 700 000	46 801	1 831 859	128 387	917 350	**5 624 397**	(1 749 232)	1 215 590	1 880 088	**6 970 843**
W K Kellogg Foundation	-	-	2 494 743	-	-	**2 494 743**	-	761 026	-	**3 255 769**
Department of Health	-	9 491 056	14 251 662	4 612 034	1 049 081	**29 403 833**	(8 669 139)	1 471 679	(9 881 787)	**12 324 592**
DBSA	-	-	-	1 193 519	-	**1 193 519**	(78 208)	334 874	249 816	**1 700 000**
SADC	-	-	1 490 808	-	-	**1 490 808**	-	-	-	**1 490 808**
SIDA	-	2 334 382	-	-	-	**2 334 382**	(251 972)	-	(80 452)	**2 001 958**
HISP SA	-	-	-	-	49 027	**49 027**	-	-	-	**49 027**
Charles Kendall & Partners LTD	-	216 905	-	-	-	**216 905**	-	386 709	153 433	**757 047**
Open Society Foundation of South Africa	-	150 392	-	-	-	**150 392**	-	199 608	-	**350 000**
Stitching Wemos	-	37	-	-	-	**37**	-	-	(37)	**-**
Population Council	-	462 714	-	347 116	-	**809 830**	-	26 772	(318 072)	**518 530**
Raith Foundation	-	266 242	-	-	-	**266 242**	(66 191)	-	-	**200 051**
IDRC	-	576 899	-	-	-	**576 899**	-	-	-	**576 899**
Nuffield Institute for Health	-	-	-	382 255	-	**382 255**	(185 559)	-	(104 808)	**91 888**
Action Health Incorporated	-	-	65 284	-	-	**65 284**	-	-	-	**65 284**
Management Sciences for Health	-	-	1 338 791	452 534	-	**1 791 325**	(452 534)	909 163	1 210 895	**3 458 849**
University of KZN	-	-	-	175 198	-	**175 198**	-	21 922	-	**197 120**
University Research Council	-	-	1 003 532	681 609	-	**1 685 141**	-	874 557	351 392	**2 911 090**
Africon	-	-	-	-	22 940	**22 940**	-	-	-	**22 940**
University of Western Cape	-	-	-	1 625 631	-	**1 625 631**	-	115 259	857 442	**2 598 332**
CDC	-	-	-	52 500	-	**52 500**	-	-	-	**52 500**
Equinet	-	245 113	-	-	-	**245 113**	-	52 944	-	**298 057**
Health and Development Africa	-	-	-	-	568 038	**568 038**	-	-	-	**568 038**
	2 700 000	**13 790 541**	**22 476 679**	**9 650 783**	**2 606 436**	**51 224 439**	**(11 452 835)**	**15 085 675**	**(5 682 084)**	**40 459 622**

	2008	2007
	R	R
4 Staff costs		
Salaries and wages	**22,076,780**	24,513,095
Average number of employees	**90**	112
5 Finance income/(costs)		
5.1 Interest received		
Bank	**2,453,939**	1,789,528
5.2 Interest paid		
Bank	**247,476**	158,605

6 Tax

No provision for taxation has been made as the trust is 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

	Land and buildings	Motor Vehicles	Computer Equipment	Computer Software	Furniture & fittings	Total
	R	R	R	R	R	R
Year ended 30 June 2008						
Opening net carrying amount	2,758,031	9	926,793	29,149	113,740	**3,827,722**
Additions/improvements	43,337	-	159,204	53,907	19,177	**275,625**
Disposals	-	-	(22,674)	-	-	**(22,674)**
Depreciation charge (refer note 2)	-	-	(322,432)	(18,783)	(35,611)	**(376,826)**
Transfers	-	-	(106,349)	(4,623)	(23,938)	**(134,910)**
Closing net carrying amount	2,801,368	9	634,542	59,560	73,368	**3,568,937**
As at 30 June 2008						
Cost	2,801,368	423,063	2,001,906	303,236	558,658	**6,088,231**
Accumulated depreciation	-	(423,054)	(1,367,364)	(243,586)	(485,290)	**(2,519,294)**
Closing net carrying amount	2,801,368	9	634,542	59,560	73,368	**3,568,937**

Depreciation expense of R376,826 (2007: R375,454) has been charged in project expenses. Land and buildings comprise the property described as ERF 26726 Observatory, Cape Town. The property is held as security over the mortgage bond. (refer note 12)

Year ended 30 June 2007						
Opening net carrying amount	-	2,426	747,868	41,074	132,084	**923,452**
Additions/improvements	2,758,031	-	444,326	59,073	25,403	**3,286,833**
Disposals	-	-	(7,109)	-	-	**(7,109)**
Depreciation charge (refer note 2)	-	(2,417)	(258,292)	(70,998)	(43,747)	**(375,454)**
Closing net carrying amount	2,758,031	9	926,793	29,149	113,740	**3,827,722**
As at 30 June 2007						
Cost	2,758,031	423,063	2,544,521	254,153	568,291	**6,548,059**
Accumulated depreciation	-	(423,054)	(1,617,728)	(225,004)	(454,551)	**(2,720,337)**
Closing net carrying amount	2,758,031	9	926,793	29,149	113,740	**3,827,722**

	2008	2007
	R	R
8 Trade and other receivables		
Receivables	**5,097,398**	10,088,422
Accrued income	**788,636**	14,971,225
Receiver of Revenue - Value added Tax	**79,789**	492,479
Deposits	**204,647**	191,249
	6,170,470	25,743,375

	2008	2007
	R	R
9 Cash and cash equivalents		
Current accounts	**3,812,099**	3,351,579
Call accounts	**23,828,297**	16,154,411
Cash on hand	**3,531**	3,000
	27,643,927	19,508,990
For the purpose of the cash flow statement, the year end cash and cash equivalents comprise the following:		
Current accounts	**3,812,099**	3,351,579
Call accounts	**23,828,297**	16,154,411
Cash on hand	**3,531**	3,000
	27,643,927	19,508,990
Cash and cash equivalents as stated above related to the various departments as follows:		
Research	**7,416,309**	5,515,803
DSCD/ISDS and Community Development	**10,809,618**	2,813,374
Health-E	-	56,247
Healthlink	**4,205,833**	7,171,871
Core	**5,212,167**	3,951,695
	27,643,927	19,508,990
10 Trade and other payables		
Payables		
Accruals	**1,522,250**	2,075,162
Deferred income	**22,072,568**	31,605,210
Provision for audit fees	**110,000**	88,000
Provision for leave pay	**1,051,113**	1,043,905
	24,755,931	34,812,277
11 Cash from/(used in) operations		
(Deficit)/surplus funds	**(2,209,272)**	1,516,611
Adjusted for:		
(Profit)/loss on disposal of property, plant and equipment	**(2,176)**	(6,668)
Depreciation	**376,826**	375,454
Movement in working capital		
Increase in receivables and prepayments	**19,572,905**	(15,208,493)
Decrease in trade and other payables	**(10,056,347)**	2,148,509
Provisions	-	124,400
	7,681,936	(11,050,187)
12 Interest-bearing borrowings		
Non-current		
Mortgage bond – Standard Bank	**2,055,781**	2,079,233
Less: Short term portion transferred to current liabilities	**(29,500)**	(48,406)
	2,026,281	2,030,827

The mortgage loan is secured by a mortgage over the property with a net book value of R2,758,031 (refer note 7). These loans bear interest at 13,35% (2007: 10,85%) per annum and are repayable in 228 monthly instalments of R24,905 (2007: R22,434), inclusive of finance charges.

13 Operating lease commitments

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

Not later than 1 year	**728,080**	1,190,486
Between 2 and 5 years	**19,194**	1,494,490
	747,274	2,684,976

14 Change in accounting policy

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

	2008	2007
	R	R
The above adjustment, when applied retrospectively, has the following effect on opening retained earnings:		
Decrease in grant income	-	(5,682,084)
Decrease in deferred tax	-	-
Decrease in opening retained earnings	-	(5,682,084)
The above adjustment has had the following effect on the net profit for the year:		
Decrease in grant income	-	-
Decrease in income tax expense	-	-
Decrease in net profit for the year	-	-

15 Correction of error

During the year, based on new information it was noted that an amount of R8,715,572 should have been deferred from prior years to current year based on the accounting policy.

The above has the following effect on opening retained earnings:		
Decrease in opening retained earnings	**(8,715,572)**	-
Effect on the net profit for the year		
Decrease in grant income	-	8,715,572

FUNDERS AND FUNDING PARTNERS

- Action Health Incorporated
- Charles Kendall & Partners
- Department of Health
- Development Bank of Southern Africa
- Equinet
- Full Circle Events
- German Development Corporation
- Intel Corporation
- IPAS South Africa
- Italian Corporation
- KNCV Tuberculosis Foundation
- Management Sciences for Health
- Medical Research Council
- Mosaic
- National Health Laboratory Services
- Nuffield Institute for Health
- Open Society Foundation South Africa
- Population Council
- Raith Foundation
- Unifem
- Swedish International Development Agency
- The Atlantic Philanthropies
- University of Kwa Zulu-Natal
- University North Carolina
- University Research Co. LLC
- University of Western Cape
- W.K. Kellogg Foundation
- World Health Organization

HEALTH SYSTEMS TRUST

- **DURBAN (HEAD OFFICE)**
  34 Essex Terrace, Westville, 3630
  Tel: +27-31-266 9090
  Fax:+27-31-266 9199

- **JOHANNESBURG**
  400 Central Office Park, Block J, 1st Floor, 16th Road, Halfway House, Midrand, 1682
  Tel: +27-11-312 4524
  Fax: +27-11-312 4525

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

WEB: http://www.hst.org.za
EMAIL: hst@hst.org.za

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