In reflecting on the period after political transition in 1994, it is clear that there were very 'soft boundaries' within the South African Health System, which enabled close collaboration between civil society organisations and the public sector. These partnerships were borne out of a shared commitment to public health and the eradication of apartheid. However, the process of developing treatment guidelines would have been more accessible and willing than her predecessor to explore the Mexico Gag rule, so enabling active support for HIV/AIDS and STI prevention and treatment, with the National HIV/AIDS and STI Strategic Plan (NSP) being the overall guiding plan for HIV/AIDS in South Africa. The Treatment has been normalized, embraced and guided by the NSP, which has been the key factor in the process of addressing SRHR in South Africa.

While the process of addressing SRHR in South Africa is important, it is also challenging due to gendered norms and the feminised HIV/AIDS epidemic. Since they are viewed as sensitive and related to core issues of sexuality, important critiques of the Plan have risen, highlighting the need for synergies and collaboration between the HIV/AIDS and SRHR movements. Yet 2009 heralds a time of change and it is important to interrogate and address these gaps.

It is difficult to describe and address many gaps posed by not having a clear lens of SRHR, which has impacted deleteriously on prevention and treatment within the HIV/AIDS arena. Hence, it is difficult to advocate for SRHR within the context of HIV/AIDS. This process draws on the 1994 Women's Health Policy (SANAC), which guidelines are developed as being as important as reproductive health. Collaboration arose from a trust in SANAC – Beijing), dominated by the United States, with President Obama reversing a liminal space has opened with a change in the United States administration, with President Obama reversing the Mexico Gag rule, so enabling active support for SRHR movements. Yet 2009 heralds a time of change and it is important to interrogate and address these gaps.

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E-mail: mstevens@hst.org.za

AN ALTERNATIVE TO CONVENTIONAL MANAGEMENT IN SOUTH AFRICA: THE ROLE OF THE PRIVATE SECTOR WITHIN THE SOUTH AFRICAN HEALTH SYSTEM

HEALTH SYSTEMS TRUST ANNUAL REPORT 2008/09

2

ANNUAL REPORT 2008/09
Health Systems Trust (HST) was established in 1992 as a non-profit organisation to support the transformation of the health system in a democratic South Africa. HST actively supports the development of comprehensive national health systems through strategies designed to promote equity and efficiency in health and health care delivery.

HST has cumulative experience and expertise in the design and support of relevant health systems research, in the strengthening of the district health system, and in a variety of technical content areas such as:

- District Health Expenditure Reviews
- District Health Plans
- Health Information Systems
- Service Turnaround Strategies
- Human Dimensions Management
- Continuous Quality Improvement.

In addition, HST is a powerhouse of information dissemination within the health sectors of Southern Africa and increasingly, in other countries as well. HST has established networks and partnerships with various service providers, nationally and internationally.

Guided by its vision of “Health systems supporting health for all in Southern Africa,” our mission is 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.

Using a Primary Health Care approach, HST currently has six core focus areas:

- The Millennium Development Goals relating to HIV, AIDS and TB as well as Maternal and Child Mortality with a special emphasis on the Prevention of Mother to Child Transmission
- Sexual and Reproductive Health
- The Primary Health Care core package
- Health systems governance, leadership and management at all levels
- Intelligent monitoring and evaluation systems
- Aiding in the successful implementation of the National Health Insurance scheme

Our work is guided by the following key values:

- Transparency and accountability
- Innovation and responsiveness
- Integrity and nurturance
- Embracing diversity
- Participatory management
- Total Quality Management

HST’s unique strength lies in its ability to add value to the critical interface between health systems research, policy development and implementation support.

HST is guided by an independent Board of Trustees representing a diverse group of individuals with professional standing and expertise in health systems development and public health.
During the 2008/09 year under review, South Africa saw a national leadership change through the country’s fourth democratic national elections. The new leadership remains committed to building a developmental state, improving public services and strengthening democratic institutions by working with the people. In the health care arena, the leadership have set goals of further reducing inequalities in health care provision, boosting human resource capacity, revitalising hospitals and clinics and stepping-up the fight against HIV and AIDS, Tuberculosis, and other diseases.

Health Systems Trust (HST) has, during the year being reported on, continued its endeavours of contributing to the improvement of health systems and to making them more equitable.

The World Health Organization’s 2008 World Health Report states that globalisation is putting the social cohesion of many countries under stress, and that health systems are clearly not performing as well as they could or should. Likewise, people are increasingly impatient with the inability of health services to deliver. There is growing recognition that the primary health care approach can enable health systems to respond better and faster.

HST’s focus remains the primary health care approach with rigorous involvement of communities in their own health care. To this end, HST has during this year and by way of their projects, provided training to governance structures such as hospital boards, clinic committees and in some cases, district health councils.

It has been my honour, as chairperson of the Board of Trustees, to lead the team of men and women who have provided guidance and support to HST’s management and staff in their commitment to facilitate better health outcomes for the people of Southern Africa.

I extend my appreciation to my fellow Trustees for the tremendous support that they have provided to HST during this year. During this year Ms Jeanette Hunter, a Trustee since 2003, completed her term and the Board was strengthened by the appointment of Mr Kevin Bellis, Dr Michael Hendricks, Prof Khaya Mfenyana, Mr Obakeng Mongale, Prof Laetitia Rispel, Dr Welile Shasha, Dr Tim Wilson and Dr Sibongile Zungu as new Trustees.

On behalf of the Board, I thank all funders (acknowledged in the report) who have generously supported the work of the organisation during this year.

Thank you, also, to all HST staff for their hard work and dedication throughout the year.
**MESSAGE FROM THE CHIEF EXECUTIVE OFFICER**

HST remains committed to its 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.

During the year 2008/09, it was once again an honour and a privilege for HST to be involved in many worthwhile projects.

The District Support and Community Development (DSCD) cluster continued its approach of providing technical support to selected provinces and districts by setting-up best practice sites that are used as learning sites. The uniqueness of this approach is that HST facilitators are based at the districts and work closely with district health teams, thus ensuring skills transfer. In this way HST facilitators have transferred skills to district management in specific provinces with regard to planning, budgeting and reporting processes with special focus on Maternal, Neonatal and Child Health, HIV and AIDS as well as Tuberculosis (TB).

To disseminate knowledge and to advocate for equity, the HealthLink cluster has:

- Published the 13th edition of the widely acclaimed *South African Health Review* in December 2008. The keynote address at the launch of this edition was delivered by the former Minister of Health, Ms Barbara Hogan.
- Released the 4th edition of the *District Health Barometer*. This publication was launched at the Health Informatics of South Africa (HISA) conference on 6 July 2009, at which the Deputy Minister of Health, Dr Sefularo, delivered the keynote speech.
- Re-branded its project, *The Treatment Monitor*, adopting the new name of *The Women and HIV and AIDS Gauge* in March 2009. The change of focus and subsequent change of name sought to acknowledge the impact of HIV and AIDS on women and their ability to access services within a sexual and reproductive health rights framework.

This year, again, HST publications have been widely cited by academics in South Africa and other countries.

Staff from the HealthLink cluster worked in two provinces (Gauteng and Western Cape) to assist with the improvement of routine data quality. HealthLink staff also assisted Gauteng Province with conducting Client Satisfaction Surveys in the Province’s hospitals.

During the year under review, the Research Programme cluster, in an attempt to categorise and focus studies, was reorganised into four units namely:

- Knowledge Management and Priority Health Programme Studies,
- Gender and Reproductive Health Studies,
- Health Service and Community Studies and
- Socio-economic Determinants of Disease Studies.

HST, in collaboration with partners from the national and provincial Departments of Health, conducted studies, developed policy briefs, guidelines and manuals which provide valuable information for action in the areas of:

- District Health Management development
- Capacity building of community governance structures
- Choice on termination of pregnancy
- Male circumcision

HST’s achievements for the year 2008/09 were made possible by the prescience of funders, the support of partners, guidance and support from the Board of Trustees as well as the skill, dedication and commitment of HST staff. Together we will continue making a worthwhile contribution towards the improvement of health outcomes in the Southern African region.

Thobile Mbengashe

*Chief Executive Officer*
In reflecting on the period after political transition in 1994, it is clear that there were very different dynamics which enabled close collaboration between government and women's groups. Collaboration arose from a trusting relationship borne out of a period of solidarity resulting from the liberation struggle. This changed over time. By 2000, the relationship had become more brittle, with women's groups struggling with a negative funding environment post-International Population and Development Conference (ICPD Cairo) and post-Fourth World Conference on Women (FWCW – Beijing), dominated by the United States Presidential Emergency Plan for AIDS Relief (PEPFAR) and the Mexico Gag Rule, which prohibited funding work that is difficult to describe and address many gaps posed not having a clear lens of SRHR, which has impacted negatively on prevention and treatment within the minimised HIV/AIDS epidemic. Since they are viewed as sensitive and related to core issues of sexuality, important issues remain in the SRHR area. These issues are at the bottom of the agenda. Hence, it is difficult to advocate for synergies and collaboration between the HIV/AIDS and SRHR movements. Yet 2009 heralds a time of change and it is important to interrogate and address these gaps.

A liminal space has opened with a change in the United States administration, with President Obama reversing the Mexico Gag rule, so enabling active support for reproductive health and supporting the United Nations Population Activities (UNFPA). Within South Africa, Minister of Health Barbara Hogan has also become more accessible and willing than her predecessor to explore the process of developing treatment guidelines would create a practical forum to mitigate this obstacle. This process draws on the 1994 Women's Health Policy methodology which viewed the process in which guidelines are developed as being as important as the guidelines themselves.
The Research Programme cluster undertakes innovative health systems research to strengthen the district health system, its support systems and priority programmes, in particular, HIV and AIDS, tuberculosis and the special needs of vulnerable groups such as mothers, infants and children. Improving knowledge management, translating research into policy or practice, and building capacity within the paradigm of Essential National Health Research, are important areas of emphasis.

Faced with the challenges of the Southern African region struggling to cope with a quadruple disease burden and health systems under pressure to improve their efficiencies in resource constrained situations, the Research Programme adds special value to the general health research environment by commissioning or undertaking relevant, high priority, multi-disciplinary, operational and applied research, in a rapid, flexible, cost-effective, cooperative, innovative and principled way.

During the year under review, the Research Programme was reorganised into four units, each led by a senior researcher. Simultaneously with the reorganisation, the Research Director, Dr Irwin Friedman and Deputy-Director, Ms Jaine Roberts, diversified their roles, driving additional fundraising and quality control efforts respectively.

The following provides a summary of key studies conducted in these four units:

1. Health Priority Programme Studies and Knowledge Management

   Mother and Child Health Research

The Goodstart Study

Funded by PEPFAR. Conducted by Ms Vundli Ramokolo; assisted by Dr Tanya Doherty, in collaboration with the Medical Research Council of South Africa and the University of the Western Cape.

This randomised control trial, a prospective cohort study, examined the relationship between infant feeding, child morbidity and HIV-free survival. Subjects of HIV-positive and HIV-negative or unknown HIV status (women receiving antenatal care at the selected National PMTCT pilot programme sites) were recruited for the cohort study conducted between 2002 and 2005. The study wound-up its data collection at the end of 2007.

During the period under review, the study was in the data analysis and write-up phase, and consortium statisticians focussed on analysing the large amount of multi-centre data that had been accumulated and preparing research publications on different thematic areas. Goodstart involved studying mother-infant pairs living in three different settings in South Africa, namely the Paarl District in the Western Cape, Rietvlei in the Umzimkulu Sub-district of the Eastern Cape, and Umlazi in the Durban-ilembe health district of KwaZulu-Natal. These study sites represent areas of varying HIV prevalence across the country and differing socio-economic situations.

Measuring Progress towards the Achievement of Maternal and Child Health-Related Millennium Development Goals

Conducted by Ms Vundli Ramokolo with assistance from colleagues at the Medical Research Council of South Africa and funded by the National Department of Health (Research Directorate).

This was a secondary analysis of data derived from the data accumulated by the Goodstart Study. The analysis has provided a detailed assessment of antenatal care attendance, the quality of antenatal care (syphilis screening, access to HIV testing), family planning coverage, institutional deliveries, PMTCT access, immunization coverage, infant feeding practices and social grant uptake in the three districts. Both descriptive and bivariate statistical techniques were used to assess the various factors by geographic site. The findings highlighted the vast differences in basic infrastructure, access and quality of health care services across geographic regions, with the poor rural area being the worst-off. This was evidenced by the higher rate of infant deaths, even amongst HIV-unexposed infants, at the rural site. In general, coverage of basic maternal and child health services (such as antenatal care coverage and immunization coverage) appeared reasonable. However, coverage of PMTCT interventions was poor and, given the strong link between HIV and both maternal- and infant-survival, indicated that this programme was in need of urgent strengthening.

The need for a children’s referral hospital in Gauteng: Provision of information to assist in developing a rationale for a national tertiary paediatric hospital

Conducted from March through June 2009 by Dr Irwin Friedman and Dr Tsholofelo Mhlaba for the Nelson Mandela Children’s Fund (NMCF) and funded by the Gauteng Provincial Department of Health.

The purpose of this study was to assist in providing the information necessary to develop a rationale for a national tertiary paediatric hospital.

The study’s finding concluded after considering the facts and a further needs analysis based on paediatric population projections over the next 10 years, the establishment of a dedicated paediatric hospital in Gauteng was imperative.
The study recommended that the Nelson Mandela Children’s Hospital (NMCH) offer highly specialised paediatric services, nationwide.

Tuberculosis and related areas research

The Technical Assistance Support Contract Tuberculosis (TASC 2 TB) Project

Conducted by Dr Elizabeth Lutge and Dr Tsholofelo Mhlaba with colleagues at HST in support of the University Research Corporation, funded by USAID and extended for one further year at the end of September 2008.

The purpose of the project was to support the National TB Control Programme. The project was undertaken in four provinces, namely, KwaZulu-Natal, the Eastern Cape, North West Province and Limpopo. Several of the operational research projects reported on during the 2008 annual report have been completed and the findings of some of these were 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. It suggested that a substantial reason for this was because much of the information available in the clinical records was not transferred to the clinic registers. This has shown that the quality of statistical returns must be improved.

The TB tracer team effectiveness operational research study investigated the use of tracer teams to find patients who defaulted from TB treatment in the Ilembe district of KwaZulu-Natal. The study found that “tracers” do much more than find defaulting patients and are highly valued by TB staff. Recommendations were that more effort should go into addressing the root causes of non-adherence to TB treatment and, that tracers should receive training in approaching patients with sensitivity and compassion and should be legally allowed to transport patients. All patients must be informed that they may be visited at home by tracer teams.

The Understanding poor smear conversion in TB study investigated reasons why smear conversion results have reportedly been so poor. Conducted in the Nelson Mandela Metro in the Eastern Cape Province, and chosen because this Metro is of one of four crisis districts with a high TB caseload and high retreatment load, the study found that 89% of pulmonary TB patients were smear-positive prior to treatment. Only 1.4% of patients had no proof of diagnosis. The remaining patients with no- or negative-smear results had positive culture results. The indication is that TB patients with HIV co-infection present with smear-negative but culture-positive results. In general, the clinics visited showed good bacteriological coverage, but smear conversion rates could be much improved if done within the stipulated period of the electronic TB register.

Overcoming barriers to VCT and ART for TB Patients investigated factors that facilitate or hinder the access of TB patients to Anti Retroviral Treatment (ART). It attempted to quantify the uptake of Voluntary Counselling and Testing (VCT) by TB patients and sought to establish how VCT is provided and the quality of that provision. Generally, the study found that VCT, which was clear and acceptable, was offered to most patients. These results were encouraging, because they showed that the foundation for the integration of the TB and HIV programmes could be laid on favourable ground. Importantly, however, almost a quarter of patients were not offered VCT services at all. Given the number of TB patients co-infected with HIV passing through South African clinics, it is clear that a large number of missed opportunities to treat HIV have occurred. Compounding this, of those who were offered VCT, almost a quarter of patients found it difficult to access this service. On the other hand, only 76% of patients were informed about the link between TB and HIV. Given the crucial importance of this knowledge for patients, so that they are able to recognise the need to access antiretroviral treatment, this figure was too low. Only a quarter of patients were given any reading material on VCT. It was, therefore, recommended that educational material should be provided to patients and, to ensure maximal impact, carefully aimed at patients of varying reading levels – especially in communities where the proportion of patients who have never been to school is high. Because of the sensitivity around HIV status, and the profound implications of testing for the disease, it was suggested that it would be helpful to give patients material to take home to discuss with their families and to think more about on their own.

Evaluation of current TB patient support mechanisms.

This study was significant in that it examined the impact of existing support programmes such as nutrition and related measures. It investigated patients’ perceptions of three mechanisms of material support for patients with TB: the disability grant, food parcels and clinic gardens. Findings were that although patients very much appreciate the support offered, coverage for the three support mechanisms was low. It was recommended that these should be extended to ensure maximum benefit by all patients.

The MDR TB study. This qualitative study investigated the perceptions of the quality of services provided at referral facilities for patients with MDR TB, from a patient and health care provider perspective. The study found that there were several areas of concern for both staff and patients, which required urgent attention in order to improve the quality of services in these facilities. Neither staff nor patients were happy with the conditions they
faced at MDR TB facilities. Staff felt neither well-supported nor adequately resourced, although they showed a high level of dedication. Patients did see the results in terms of the improvements in their states of health, but questioned some of the procedures, conditions and circumstances under which they were treated.

The TB Costing study undertaken in KwaZulu-Natal, primarily by Ms Jackie Smith, examined the flow of funding for TB from national to district level. It identified areas where financing processes need to be clarified. The findings revealed that TB funding, as part of the "equitable share" portion of the provincial budget, was not easy to track. TB allocation, historically, works on the previous year's expenditure with an inflation-related percentage increment. However, hospitals were not budgeting or allocating TB expenditure accurately, nor were clinics managed as cost centres. It was evident that funding flows for TB in KwaZulu-Natal were currently not clear. This made budgeting difficult because true expenditure was not known. A model for the costing of TB services at clinic level was then produced to develop a zero-base method for estimating TB budgets. Zero-based budgeting, possibly using the tool developed during this study, was then suggested as the best way to plan for adequate TB financing in KwaZulu-Natal and nationally.

TB in children, a study undertaken by Dr Tsholofelo Mhlaba and Ms Patela Giyose from March to June 2009, looked at the burden of TB in children in five provinces and reported a higher prevalence of TB in children compared to that reported in developed countries. The study also revealed a greater burden of disease among the youngest age group, which is the most vulnerable group in terms of transmission of TB. It further showed the need to focus rigorously on new cases, PTB no-smear (which is by far the largest category amongst young children) in order to make sure that they complete treatment and are cured. The study highlighted the deficiency of HIV data in the reporting system (DHIS) which is critical to the care and management of co-infected children. It also highlighted KwaZulu-Natal as a province of priority in terms of TB in children.

The Qualitative Observational Study on TB Treatment Adherence, supervised by Ms Sibongile Mkhize assisted by Mr Siyabonga Nzimande, is investigating the experience of patients when taking TB medication in order to understand what factors matter most to them while undergoing treatment. The aim is to identify effective adherence strategies and the challenges patients face when taking their treatment, with a view to the development of a patient assessment guide for service providers and an approach to the most appropriate form of health education guidance.

The Assessment of the Hidden Silico-tuberculosis Epidemic and the Functioning of the Occupational Diseases in Mines and Works Act (ODMWA) was a comprehensive, two-year, social epidemiological study conducted by Ms Jaine Roberts, assisted by Mr Zungezi Thuthu, and funded by the National Department of Health. The focus was an investigation into silicosis and tuberculosis in ex-mineworkers, combined with a health systems review of available services to provide a comprehensive occupational health assessment of the functioning of the statutory compensation mechanism for those with this occupationally-acquired disability. The study engaged close to a 100% sample of former miners in the Ntabankulu region and its findings are capable of being applied to all other labour-sending areas in the Eastern Cape. It was found that 40% of TB ward patients in a district hospital were former miners and almost 20% were repeat TB cases. It was also found that health professionals do not have an adequate knowledge of the Occupational Diseases in Mines and Works Act 78 of 1973 (ODMWA) and of its surveillance and compensation system or the diagnosis of silicosis. Miners, who had a low level of education, also did not have an adequate knowledge of ODMWA or the Compensation for Occupational Injuries and Diseases Act (COIDA). Recommendations from the study included: establishing a demonstration unit to provide medical surveillance at the district hospital closer to the research site; the provision of Benefit Medical Examinations to former miners, which should include x-rays and lung function tests; development of a prototype mobile unit to do medical screening; the decentralisation of the Medical Bureau for Occupational Diseases (MBOD) to provincial level; the training of health personnel on the ODMWA; and the speedy completion of a COIDA/ODMWA review, which many believe should be one mechanism.

Health information systems and knowledge management studies

Work Processes within the Government Hospital Setting that can Benefit Most from Automation was a study whose findings were presented at the Health Informatics Conference in June 2008 and then received a great deal of interest from the Information Technology community. In the first phase of the study, the pharmacy component of hospitals was identified as the area that would benefit most from automation. Drug management, in particular, was important, both because it had a high rate of repetitive actions and a large turnover as well as high financial and safety risks. Implementing automated systems is likely to reduce waiting times, save time, space and resources, reduce human error, produce valuable...
data, reduce duplication and ensure better control. The study was undertaken by Ms Ronelle Nitt and Dr Irwin Friedman. Funding for the study was extended by its donor, Intel, to undertake a further evaluation of a before-and-after assessment of a computerisation intervention, introduced by the Gauteng Department of Health to Sebokeng Hospital. A baseline study was undertaken before computerisation and the post-implementation assessment will be done later this year.

The following studies dealing with Knowledge Management were funded by the National Health Research Directorate of the National Department of Health, with research primarily undertaken by Mr Thokozani Mbatha and supported by Dr Irwin Friedman.

Knowledge Management in Health Research is a cluster of studies using a knowledge management approach to provide guidance to national health research 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. This includes the continuing refinement of the National Health Research Database (NHRD), a web-based library of over 30,000 South African health research records extracted from public domain data sources as well as the grey literature. During 2008/2009 links to this database were prominently placed on the National Department of Health’s website’s home page.

Strengthening Provincial Health Research Committees (PHRCs) has become much more important recently since the National Health Act required greater coordination of research and ethical oversight of all research in the country. In relation to this, Dr Irwin Friedman, as Research Director, serves on the National Health Research Committee and has been providing information gleaned during this project through to the Committee. One of the outputs of this project, a review of all PHRC research undertaken in South Africa since 1994, was presented at the PHASA conference in June. Other aspects of this project have included research into The use of Routine Data from the DHIS to Inform Research Priorities. To assist PHRCs a Research Application Management System (RAMS) was developed to seamlessly integrate with the NHRD to provide a web-based resource to manage all the research protocols being submitted to PHRCs throughout the country for approval. This tool, once fully implemented, will be able to document, review and coordinate a wide range of health research being conducted in the country.

2. Health Service and Community Studies

The Formative Evaluation (Phase 2) of VCT infrastructure development in Mpumalanga, Eastern Cape and KwaZulu-Natal Provinces research project was finally completed after an investigation of the situation at 77 facilities distributed over the three provinces. After several years in preparation, and working closely with the Development Bank of South Africa, the study, managed by Ms Nandy Mothibe, who was assisted by Ms Siphiwe Hlongwane and Ms Catherine Ogunmefun, provided a comparative analysis of the findings of a baseline survey undertaken in 2004 with the situation in 2008, as a means of assessing the impact of infrastructure improvements on the quality of counselling and testing services. The study has shown that important progress was achieved by the facilities in improving VCT services and that, in comparison to the 2004 study, there was a significant increase in 2008 in the number of facilities offering group education, group counselling, couple counselling, support groups, individual pre-test counselling, and individual post-test counselling.

Updating the South African HIV and AIDS research database. The study involved working closely with colleagues in the National Department of Social Development (DSD) and their funders, the Joint Economic AIDS and Poverty Programme (JEAPP), to: identify gaps in the database of HIV information available to DSD; update the database; design a user manual and train selected members of DSD staff to use the database stored in a bibliographic programme known as Reference Manager (Ver. 12). The study was managed by Ms Nandy Mothibe and conducted by Mr Thokozani Mbatha.

The status of clinic committees in primary level public health sector facilities in South Africa. Ms Ashnie Padarath and Dr Irwin Friedman investigated the governance functions of clinic committees which are intended to give expression to the principle of community participation at a local and district level. The aim of this study was to assess the functioning and effectiveness of clinic committees in order to identify opportunities for strengthening their role in health governance. Of 3077 clinics in the country, 2054 clinics were surveyed by telephone. About 60% (1241) had a clinic committee. Of those that had a committee, 77% (958) had a committee constitution and 93% (1152) reported that they met monthly. The results suggested that more clinic committees exist in provinces where there has been explicit political support for the creation of and building-up of the capacity of these structures. Poor socio-economic conditions and a context of poverty were important determinants of whether or not clinic committees flourished. The study found that a failure to attend meetings (often due to transport costs) and the lack of a stipend for clinic committee members...
were some of the reasons why facilities did not have clinic committees. The results also suggested that while most clinic committees met on a monthly basis, the activities of the clinic committees appeared to be mostly confined to problem solving between the community and the health facility, health education and to the volunteering of their services in the facility. The issue of the roles and responsibilities of clinic committee members’ needs attention as the research has highlighted the gap that exists in this regard.

3. Gender, Reproductive, Behavioural and Vulnerable Group Studies

Reproductive Health Research

The Qualitative Antiretroviral Adherence Study in Five Sites in KwaZulu-Natal research project was undertaken by Ms Sibongile Mkhize and Mr Siyabonga Nzimande in partnership with Mr Stanley Yoder of MEASURE Evaluation, and funded by USAID. The study sought to clarify factors affecting adherence to HIV therapy, and also to develop a set of tools, that could be used to collect and share information on patients’ experiences of taking antiretrovirals, which was intended to be useful to antiretroviral treatment (ART) managers in understanding the strategies that patients could use to achieve high adherence.

The findings revealed that the two key factors relating to high adherence were: having a committed and informed treatment supporter, and a willingness to disclose their HIV status to family, friends or close associates. Individuals still in an ART programme had managed to deal with their side effects. Patients who stopped taking their ARVs were particularly vulnerable both socially and economically as very few of them had an adequate and dependable source of income and few sources of social support. ART patients with a TB history were treated as a separate group to explore whether they had benefited from adhering to a TB treatment regimen in their adherence to ART. The study did not find evidence to support this expectation. The findings indicated that achieving high adherence, judged by not missing doses, depended less on a particular strategy for remembering when to take ARVs than on how that strategy was maintained within a household. They suggested that ART programmes should examine how individuals are situated within their household when considering the assistance patients need to maintain high adherence.

Costs of ART

An Economic Evaluation of the Impact of Widespread Antiretroviral Treatment on Secondary Hospitals in South Africa: Case Study of the GF Jooste Hospital Antiretroviral Referral Unit. This research study, undertaken by Mr Sebastian Kevany, a PhD student, as part of the Treatment Monitor project, was published during the period under review. The study is important because it presents a partial economic evaluation of the current and anticipated impact of widespread antiretroviral treatment on the secondary hospital system in South Africa. The evaluation encompassed the treatment and care of HIV-positive inpatients and outpatients on or preparing for highly active antiretroviral therapy (HAART) at the secondary level. A range of research and policy recommendations based on these findings were also presented.

4. Socio-Economic Determinants of Disease

The Economic Incentives for Improving Clinical Outcomes in Patients with TB study is a randomised controlled trial currently investigating the role that cash grants play, in the form of food vouchers, in improving adherence in TB treatment and TB outcomes. Currently undertaken by Dr Elizabeth Lutge, supported by Mr Zimisele Ndlele and funded by the National Department of Health, the Dutch TB funder KNCV and the Wellcome Trust, the study aims to evaluate the feasibility and impact of providing a monthly grocery voucher on the adherence and outcomes of a cohort of patients on TB treatment. In addition, it is also assessing the responses and attitudes of health care managers, workers and patients towards the vouchers, as well as the technical, administrative and financial feasibility of this programme, and the impact that this has on patients’ household economies.

The Health Impacts of the Child Support Grant in South Africa study commenced during 2009 and is continuing. The work, exploring the health impacts of the child support grant, is being undertaken by Ms Wanga Zembe in conjunction with the Medical Research Council of South Africa.

A Fifteen-Year Review of Poverty Alleviation in South Africa, undertaken by Dr Irwin Friedman and Dr Lungile Bhengu, was commissioned by the Presidency during the previous year and presented at a national summit during February 2007. The results were again presented at a national meeting of the Public Service Commission during this year, and are likely to be influential in determining future poverty alleviation policy. Findings were that the levels of poverty and unemployment remained very high throughout the 1990s, and although there appears to have been some improvement since the early-2000s, continue to remain at unacceptably high levels, with little prospect that the Millennium Development Goal of halving poverty by 2015 will be reached. Formal efforts, to improve education and increase economic growth, may still take several decades to reduce poverty. The most significant
contribution to poverty alleviation efforts undertaken by government was the gradual extension of social grants, particularly the child support grant.

5. Capacity Building / Human Resources

The Evaluation of the Learning Complexes Project of the Centre for Rural Health at the University of KwaZulu-Natal, is a multi-pronged approach aimed at developing the health facilities in Area 3 of KwaZulu-Natal into learning organisations. The study has entered into the last of its three-year span. The project developed formal and informal learning opportunities for health professionals in three northern KwaZulu-Natal districts. Sub-projects intervened in specific areas of the health system, such as, neonatal and perinatal care, referral and support systems, HIV (the use of data to inform practice), and the use of information technology to facilitate service provision. A further part of the project was the development of the Centre for Rural Health as a learning organisation itself. Dr Elizabeth Lutge was responsible for the main formative and summative evaluation, with Dr Irwin Friedman and Ms Sibongile Mkhize assisting with organisational development. The final evaluation report was submitted towards the end of 2008, aiming to comment on the Project in its entirety, and giving a broad overview of its aims and objectives, the methodologies used and the extent to which the Project aims were met.
The project is implemented at selected sites in four districts and in three provinces:

- Dr Ruth Segomotsi Mompati (RSM) district (Kagisano sub-district): North West Province
- Ehlanzeni district (Bushbuckridge sub-district): Mpumalanga Province
- Nkangala district (Thembisile sub-sistrict): Mpumalanga Province
- In the eThekwini district (KwaZulu-Natal Province), project support is provided at district level as there are no demarcated sub-districts.

Project background

The project’s concept was based on the District Health System, which seeks to ensure equity in resource allocation, and to deliver health care according to the principles of the Primary Health Care Approach.

In line with applicable South African legislation, districts are expected to adopt a single and inclusive strategic plan, the District Health Plan (DHP), which links, integrates and coordinates resources. The DHP sets out the goals and strategies that will enable health districts to best meet the health needs of their populace and ensure that there is a proper utilisation of allocated resources.

Health planning is a cyclical process that relies upon using data of high quality from all health facilities within a sub-district or district. The cycle includes measuring the performance of programmes (including financial and non-financial data) against the DHP; translating the finalised and approved DHP into an operational implementation plan; conducting final budget reviews with Provincial Departments of Health and, once completed, subjecting these to a review of expenditure and publication within the Annual Report.

Project focus areas

Accelerated interventions, focused and targeted at those areas of poor performance based on selected programme indicators, occurred in the four supported health districts, particularly in the key strategic health programmes of Maternal and Child Health, HIV and AIDS, and Tuberculosis (TB).

Project achievements

a. District Health Expenditure Reviews. An analysis of 2007/2008 District Health Expenditure Reviews (DHERs) was conducted for the supported districts to assess compliance with the provisions of the Public Finance Management Act and to gauge...
service performance against expended resources. This process was also useful in laying a foundation of aligning service planning with financial planning by using the four criterions of equity, resource allocation, efficiency and sustainability. All the DHERs that were reviewed highlighted the problems of the unavailability of data and the quality of both financial and non-financial data as limiting factors to the DHER process. Three of the four supported districts lacked skills needed to interpret the data for the DHER and outputs indicators (i.e. calculated information from the DHER tool). All four districts reviewed used different cost classification and coding methods. This was a major challenge because, if resource items are not properly classified, it becomes difficult to properly conduct an inter- district/sub district resource utilisation comparison across cost centres.

b. Improved Human Resource Skills Development Plans for District Health Management Teams. Capacity development needs were identified and as an ongoing process, have been linked to the districts’ skills development plan. The lack of key competencies in management was also identified by the Atlantic Philanthropies-funded HST study that evaluated management infrastructure, and capacity development. These results will be presented to the districts with a possibility of being incorporated into the Human Resources Skill Development Plan. This plan will be utilised to improve the skills base of district management teams. To date, the project has provided orientation and short-term training to 1011 health personnel on the planning and budgeting cycle, on programme indicators, and on monitoring and evaluation using prescribed national tools.

c. Implementable and replicable training programme and curriculum and ongoing mentoring and support. A comprehensive manual for the in-house training of district and sub-district teams has been collated from existing tools which are prescribed for planning by the Department of Health. Copies of the manual have been circulated to all districts and sub-districts to be used for structured formal training and on-site mentoring and coaching by HST Provincial Coordinators. This model is replicable as all the materials used in the training are prescribed by the Department of Health, and the planning and budgeting process is a legal requirement.

d. Improved quality of DHPs to be consistent with provincial strategies. HST acknowledges that the improvement in the quality of DHPs, and their use to improve health outcomes, is a long-term process, especially in view of the analysis that was done at the start of the process. However, during the reporting period, the organisation utilised the gaps identified during the 2008/09 district health planning process, to support the Districts in improving the quality of their DHPs.

The findings of the baseline assessments indicate that the capability of lower-level managers must be strengthened if quality improvements in planning are to be sustained.

e. Enhanced capacity to effectively integrate District Health Plans into Integrated Development Plans. Government policy stipulates the importance of integrated planning in a geographic area and, consequently, HST has facilitated the integration of District Health Plans (DHPs) into Local Government Integrated Development Plans (IDPs). A baseline report using the Management Economic Social and Human Resource Monitoring (MESH) tool was prepared. It is hoped that the emphasis that HST is placing in facilitating planning sessions between Local Government and Health Districts will lead to a breakthrough in improving implementation of plans during the next phase.

f. Increased evidence of effective use of health data. Through supported programmatic facility reviews, monthly PHC reviews and quarterly reviews, managers were assisted to engage with information to identify shortcomings in performance, develop corrective measures and use information to monitor progress. The availability of quality health data seems to be a challenge in all the different phases of the planning, budget and reporting cycle; the focus is therefore on strengthening the skills of lower level managers and also strengthening the “bottom-up” approach to planning.

2. TB Management Training

The Italian Corporation funded a project, in KwaZulu-Natal, from September 2008 to December 2009, which trained health practitioners from the Umzinyathi district in the management of TB; while, during the reporting period, managers and professional nurses working in MDR units were trained in Multi (Extremely) Drug Resistant (XDR) TB management.

In utilising the current district records during training, it became apparent that MDR infections were mainly the result of the high rate of patients who defaulted their TB treatment. As a counter-strategy, the district has formulated community tracer teams to follow up on defaulters.

A further training need identified during the TB management training was the recording, reporting and monitoring of outcomes of the programme both at facility level and at management level. HST has embarked on training the district officials in monitoring and evaluation, including recording. Two such training sessions have now taken place.

Training manuals have been developed for TB...
management, whilst HST has also supported the province in the development of training material for XDR.

3. Governance Training

Health governance is a platform that allows and encourages meaningful community participation in health service delivery matters enabling the discussion and formulation of solutions, by both health management and the community, at different levels of the health system.

Training is intended to improve the functioning of governance structures, to define their roles and responsibilities, and to improve communication between such structures and their management teams.

As HST has a long track record in providing training to governance structures they were contracted to conduct training for clinic committees in Limpopo. Training was conducted in February and March 2009 in all Limpopo Districts where 545 clinic committee members were trained. The outcome of the training has been acknowledged as having been successful, with HST receiving feedback that clinic committee members are now meaningfully participating in clinic governance issues.

4. Routine Offer of HIV Counselling and Testing Services

Aim of the project

This project was designed to improve the quality and uptake of HIV Counselling and Testing (C&T) services by strengthening the capacity of health care providers to implement a routine offer of C&T services.

During this reporting period, the focus was on HIV C&T services integration with primary health services.

Achievements at selected supported sites:

- Health workers became aware of, and understood the need for expanding access to HIV counselling and testing by integrating this into primary health services
- Health workers were able to apply a systems approach to ensure quality interventions at facility level
- Health workers understood and were able to perform HIV rapid tests, accurately, and reliably, in a safe and professional manner
- Attitudes, knowledge and skills of health workers about quality and safety was enhanced to prevent infections at testing sites
- Monitoring quality interventions at facility level was carried out by health workers
- Standard operating procedures for C&T were followed
- Health workers understood the role that documents and records play in the quality and monitoring of programmes
- Shared understanding of TB and HIV policies and guidelines by all health workers at the facilities
- Quarterly District Reviews of the project were conducted at Districts.

5. Mpumalanga Community-Based Organisations Governance Training

The goal of the project is to consolidate capacity development and service provision of thirteen Community Based Organisations (CBOs) in Mpumalanga Province by: supporting CBO registration as Non-Profit Organisations (NPOs); building CBO capacity for the sound business management of their organisations; strengthening capacity for service provision for health prevention and promotive strategies specifically relating to the key priority health programmes of HIV/AIDS, Maternal and Child Health; and Nutrition.

Achievements to date:

- All CBOs have been trained in basic aspects of HIV and AIDS, treatment literacy, project management and financial management
- Five of thirteen CBOs have been successfully registered as NPOs, while the rest are in the process of registration. The registration process as a NPO will ensure the sustainability of the CBO as it will then qualify the CBO to apply for funding
- Thirteen Local Project Coordinators were recruited, hired and trained on team leadership, supervision, monitoring, evaluation and reporting
- An organisational development training manual for CBOs has been developed and finalised

HST facilitators are currently running a series of on-site training sessions for CBO leadership teams using participatory training methodologies, as well as on-going mentoring and coaching, to improve the governance and organisational capacity of the CBOs. In addition, peer supporters also conduct training workshops for traditional health practitioners.
6. The Maternal Neonatal and Child Health Project

The purpose of this project is to improve the health outcomes of maternal and child health, through quality-improvement strategies at health facilities and community-based interventions, in seven selected sub-districts in four Provinces.

The project deliverables are to:

- Assess the health and nutritional status of women and children and their access to Maternal, Neonatal and Child Health and Nutrition interventions in the seven sub-districts
- Support the development of integrated plans for accelerating Maternal, Neonatal and Child Health and Nutrition interventions, including the recommendations of the Saving Mothers report
- Scale-up access to HAART and other testing in PHC facilities through the down-referral of services
- Scale-up community-based Maternal, Neonatal and Child Health and Nutrition packages
- Improve the quality of maternal and neonatal care and infant feeding practices through the Mother-Baby Friendly Hospital Initiative
- Develop a report card on PMTCT, Maternal, Neonatal and Child Health and Nutrition in the seven sub-districts

This project commenced towards the end of June 2009; during the current reporting period the project was in its planning phase.
**HEALTHLINK CLUSTER**

**Director: Ronel Visser**

*The overall goal of the HealthLink cluster is to disseminate knowledge. This is undertaken through the strategic use, analysis and distribution of health and related information to enhance evidence-based management. HealthLink is also involved in advocacy and equity projects which serve to improve the quality and availability of reliable information and support the implementation of the National Strategic Plan.*

1. **The South African Health Review**

The 13th edition of the widely-acclaimed *South African Health Review* was launched in December 2008, with the keynote address being delivered by the Minister of Health, Barbara Hogan. This edition of the Review focused on primary health care in South Africa, 30 years after the historic Alma Ata Declaration which famously linked health and health status to the broader social determinants of health. The Review included a national and international perspective of primary health care, focussing on areas such as policy and legislation, determinants of health, lifestyle, infectious diseases, mental health, maternal and child health, nutrition and environmental health. The Review also featured issues around human resources, finance, and information and concluded with an Indicators chapter, that presents a selection of the best available data on the functioning and performance of the South African health system.

2. **District Health Barometer**

*Funder: Atlantic Philanthropies and Development Bank of Southern Africa*

The *District Health Barometer* (DHB) publication provides an overall view of district health performance at primary health care level. The DHB uses health data in an effective manner by making use of selected indicators to provide clear and easily understandable information for appropriate decision making.

The project, funded by Atlantic Philanthropies and the Development Bank of South Africa, has been in existence since 2005 and the 4th edition (DHB 2007/08) was launched at the Health Informatics of South Africa conference on 6 July 2009 where the Deputy Minister of Health, Dr Sefularo, provided the keynote speech.

Information in the 2007/08 report includes 32 indicators, up to 8 years of data with trend illustrations, profiles (for South Africa and each of the 9 provinces and 52 districts - each with colour coded rankings), and an accompanying CD with various files, resources and definitions. The DHB provides an original source of data on a deprivation index, per capita expenditure and cost per patient day equivalent at district level. A web-enabled Geographic Information System provides indicator data by district.

Requests for the underlying data, particularly for the calculations done on the deprivation index at sub-district level, have come from a wide range of interested parties, in the private-, public-, and academic-sectors illustrating a cross-discipline use beyond the field of health.

An external evaluation on the project conducted by Kedibone Health Systems Consultants, show that the DHB is widely disseminated and has been found to be instrumental in developing capacity.

The publication has been widely cited by academics in SA and by those from international institutions. The approach, however, remains on making the report practically useful and bringing it closer to the people who need it the most.

3. **Health Management Information Systems**

*Health Information Systems for Data Capturers (HISDC) Project*

*Funder: National Department of Health*

The Department of Health, as part of an innovative sub-programme of the Expanded Public Works Programme, initiated the recruitment, training and employment of matriculants throughout the country in order to improve
data collection, capturing and processing. HST, in collaboration with the University of Pretoria and the Health Information Systems Programme, was appointed by the National Department of Health in August 2008 to train 3535 delegates from all nine provinces, over a period of three years, on the Basic Routine Health Systems for Data Capturers (HISDC) certification course. The HISDC project comprises three waves each comprising three distinct phases: pre-training, training and post-training. The first wave’s training phase, in which 1064 data capturers were trained, was concluded in March 2009, while the post-training phase is currently in progress.

Strengthening of Health Information Systems in the Western Cape Province

**Funder: Department of Health, Western Cape Province**

The Western Cape Province Department of Health entered into a Service Level Agreement with HST to assist and support employees of the Department in their use of health management information data to improve the management of the health system and health programmes in the province.

The objectives of the project are to ensure the optimal availability of health data, its quality and flow, and to train managers in the use of such data.

Health Data Quality Improvement in the Gauteng Province

**Funder: Department of Health, Gauteng Province**

The Gauteng Provincial Government reports on various critical areas to its stakeholders using the following provincial reports:
- Provincial Health Council Technical Committee report
- Quarterly Review System
- District Health Plan
- Annual Performance Plan
- District Health Expenditure Review

Prior to the initiation of this project, the various provincial reports provided different values for the same indicator for the same reporting period. The data integrity was therefore questioned to such an extent that the data on the reports were not trusted to be used for decision making. As a result, HST and the Health Information Systems Programme were contracted to support the Gauteng Department of Health in its Data Quality Improvement Project. The project commenced in June 2009.

The outcomes were two-fold: the initial phase of the project improved the data quality of the major provincial reports, and in the final phase HST was responsible for reaffirming provincial and national norms and targets.

Client Satisfaction Surveys in Hospitals in the Gauteng Province

**Funder: Department of Health, Gauteng Province**

Receiving regular feedback from clients is a basic requirement of any quality assurance system. The Gauteng Department of Health has used a variety of tools to conduct such assessments this in the past, but the tools have never been standardised and used on a continuous basis in health care institutions. The Quality Assurance Directorate of the Gauteng Department of Health requested HST’s assistance to support the implementation of standardised Client Satisfaction Surveys (CSS) to measure the satisfaction levels of patients in Gauteng hospitals and to produce evidence-based results to be integrated into action plans of Hospital Management Teams for improvement of its services.

Two rounds of surveys were conducted and hospitals that required assistance in the capturing of their survey data were trained on the use of the District Health Information Software CSS module.

This project ended in 2009.

4. Review of Structures, Competencies and Training Interventions to Strengthen District Management in the National Health System

**Funder: The Atlantic Philanthropies**

A national qualitative study to assess existing district management structures, competencies and current training programmes commenced in October 2007 and was completed in January 2009. The study design was observational, descriptive and cross-sectional. It used qualitative research methodology to review current district management structures, capacity and training interventions and had as its aim the provision of information needed to inform a national strategy and plan to strengthen district management capacity to ensure the effective delivery of primary health care in South Africa.

The assessment coverage of the study included all nine
provinces in South Africa, with two health districts per province selected as the sample, while its study population included district managers and district management teams from the two sample health districts in each province. Data was primarily collected by means of focus group discussions with the district management teams and face-to-face interviews with the District Managers.

All provincial reports were summarised into a national summary report containing recommendations towards a national plan of action for strengthening district management structures in the country. The final report was presented at a National District Health Systems Committee meeting in February 2009. The detailed District Management Study report is available for download from the HST and National Department of Health websites.

5. Development of a Health Plan and Vision for 2020 for the Eastern Cape Department of Health

**Funder: Department of Health, Eastern Cape Province**

The Eastern Cape Department of Health embarked on a long-term strategic vision and planning process called the “Service Development Plan”. HST was contracted by the Department to provide technical assistance. The first phase of this project, the completion of an “Issues Paper” and a consultative process to capture the public’s views and aspirations regarding their health status and service delivery, ended in 2007/08. In the second phase a comprehensive report presenting a 2020 Health Vision Statement, linked to the Health Care Plan for the Eastern Cape Province was prepared. These reports were presented and discussed at the Eastern Cape Department of Health Extended Executive Committee in March 2009.

6. Treatment Monitor / Women and HIV & AIDS Gauge


“The Women and HIV & AIDS Gauge” (WHG) was launched in March 2009, a re-branding of the “Treatment Monitor”. The change of focus and subsequent change of name sought to acknowledge the feminised nature of the HIV epidemic with most infections infecting and affecting women. The WHG focuses on the impact of HIV and AIDS on women and their ability to access services within a sexual and reproductive health and rights framework. The WHG also notes the impact the epidemic has had on women from a gendered burden-of-care perspective. In keeping with this, and as part of our advocacy strategy, project staff contribute a monthly column to *Nurses Update*, the Nurses Journal. The theme for the column has been HIV and AIDS and Women’s Health. Articles have included subject areas such as mental health, adolescent sexuality, tuberculosis, cervical cancer, abortion, political engagement of women and medical male circumcision.

The project also provides technical support to the National Department of Health regarding the finalisation of the medical Termination of Pregnancy guidelines, with a particular emphasis on HIV and AIDS and sexual and reproductive health and rights care integration. Similarly, the project has also worked in collaboration with the Global Women’s Network for Reproductive Rights, the Medical Abortion Consortium, the Open Society Initiative for Southern Africa and the South African Law Commission, with a view to documenting gaps and questions in the area of abortion and HIV.

The project continues to host the “60percent” discussion list which has grown substantially. The list continues to grow and has over 370 members and a high traffic load. The project has also been responsible for developing policy briefs, and hosting satellite sessions at key conferences. Other initiatives that the project has been involved with include: working with the International Community of HIV Positive Women in their forced sterilisation project, and also co-hosting their Southern African regional strategic planning workshop in October 2008. Plans for forming a HIV Positive Women’s South African organisation have been developed. The project is also represented on the regional UNAIDS/WHO team to consider the implementation of medical male circumcision for Southern Africa and has contributed to the development of the manuals used by technical experts in this area.

7. Governance and Equity Project

**Funders: Departments of Health, Limpopo and Free State Provinces, Open Society Foundation for South Africa.**

In keeping with HST’s long history of working with communities to enable their active participation and decision-making in the delivery of health services at a local level, the Governance and Equity Project has focussed on providing training to governance structures such as hospital boards, clinic committees and in some...
cases, district health councils. The project has been responsible for training governance structure members in the Free State, KwaZulu-Natal and Limpopo provinces. To date, over 2500 community members have been trained to fulfil their roles and responsibilities as members of governance structures.

The project was also responsible for compiling a research report into the number of functioning clinic committees in South Africa. Commissioned by the Research Directorate of the National Department of Health, this work took the form of a national audit of all clinics and community health centres in the country in order to ascertain whether clinic committees existed at such facilities. The results from this study indicate that while national legislation has created a political climate receptive to community participation, the lack of provincial guidelines and resource allocation, and the limited capacity of committees (as a result of a lack of formal guidelines, training, monitoring and evaluation or oversight of committee activities) limit their abilities to actively fulfil their intended roles and responsibilities. The project has also produced policy briefs on subjects such as the use of information and health information systems and Integrated Development Plans (IDPs), and sought to build the capacity of community members to understand, and engage with, the process of developing IDPs.

8. Global Equity Gauge Alliance (GEGA)

*Funders: Rockefeller Foundation and Swedish International Agency*

The Global Equity Gauge Alliance (GEGA) is an alliance of eleven Equity Gauges located in ten countries in the Americas, Africa and Asia. The GEGA secretariat is based at HST and it supports country-level Gauges through advocacy and capacity development initiatives. The alliance focuses on changing inequities in health and health systems, by addressing the socio-political causes, using a three pillar strategy of advocacy, community development and monitoring and evaluation. HST has hosted the GEGA Secretariat for the past nine years and has played a key role in the production of Global Health Watch 2. Like its highly acclaimed predecessor, Global Health Watch 1, the second edition of the Global Health Watch, continued to explore what contributes to the inequalities of health globally, and present some alternatives to the current neo-liberal models. Widely accepted as an alternative health report, the Global Health Watch 2 was launched in the United Kingdom in October 2008, with twenty other subsequent launches in countries such as Australia, Belgium, Canada, Egypt, South Africa, Zimbabwe and the Netherlands.

9. Information Dissemination

**The HST website**

The HST website (http://www.hst.org.za) provides a wide array of knowledge, research, links and information about health systems and Primary Health Care in Southern Africa. The website, which is continuously updated, showcases HST’s work across its various programmes and projects and holds an extensive database of HST’s and other publications – all of which can be downloaded for free.

HST’s website’s statistics indicate that there was an average of 15 500 unique visitors, per month, between July 2008 and June 2009. Statistics indicate that the visitors to our website are from countries as diverse as Ukraine, the United States, Great Britain, Senegal and China.

In the last year, HST has also provided support to other initiatives for establishment and maintenance of “independent” websites. In most cases, HST either does not charge for these services or charges a nominal fee. The websites hosted by us include the following:

- 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 – Resources Repository

**Electronic discussion lists**

HST continues to provide an electronic health information service by hosting over 100 electronic discussion forums and mailing lists. The lists are dynamic and responsive tools for information sharing and networking around public health issues, locally and internationally. The hosted lists have grown from strength to strength, continuing to provide peer support and a social space to discuss prevailing public health and policy issues. Some of the discussion topics of the past year include:

- Heated debates over the Occupation Specific Dispensation issue
- The management, information and misinformation around the H1N1 Virus
- The proposed National Health Insurance policy
- Sexual and Reproductive health issues within a human rights framework

The bi-weekly HST Bulletin, an e-mail based news bulletin featuring news articles, events, job opportunities and the latest research remains a popular service with over 1500 subscribers.
Resource Centre

The Resource Centre continues to function as a user-friendly, versatile and central system that is a repository of the organisation’s work and which provides relevant public health information to its users which include HST staff as well as external users such as students, academics, government officials and funders. In addition, HST publications and other material are also exhibited and distributed at key public health conferences in the country by Resource Centre staff.

Launch of the Resource Centre
Director: Deena Govender

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

1. Human Resources

At the end of June 2009, HST had a total staff complement of 66. During the year under review, four new appointments were made, two staff members resigned, and, two staff members were promoted. The employee turnover rate stood at 3.03% for the period April to June 2009, which compared reasonably well to the rate of 10.38% for the period January to March 2009.

Black females represent 48% of the total number of employees, and are also dominant in the professionally qualified and experienced specialist and mid-management category at 16% – which resembles the pattern in the broader market environment. HST will continue to pay attention to demographics as a factor when selecting staff, and will also afford opportunities to suitably qualified disabled persons.

The ethnicity and gender of HST staff is illustrated below:

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<thead>
<tr>
<th>Ethnicity</th>
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<th>Female</th>
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2. Finance

The annual financial statements as at 30 June 2009 reflect assets to the value of over R42 million which indicates HST’s financial stability. The Finance and Audit committees continue to provide strategic direction and play an important oversight role in the governance of the organisation.

3. Information Technology

HST continues to promote the use of open source software with most of its servers running on Linux. With the use of a leased off-shore server, and mirrored drives in the different offices, HST has given IT security and recovery procedures urgent attention. The IT department ensures that minimum downtime is achieved with all support requests and will continue to keep abreast of changing technologies which may be of benefit to the organisation. Despite operating in an NGO environment, HST is able to provide its staff and other stakeholders with access to current technologies and services. The free and open source software (FOSS) rests entirely with in-house technical staff and skills. HST is still in a position to act as a “best practice” site for the use of FOSS, particularly in the NGO environment, offering not just a theoretical concept, but a live network.

4. Office Relocations

During June 2009, the HST head office relocated from its offices in Maritime House (in Durban’s CBD) to Essex Terrace, Westville (a suburb of Durban). The Johannesburg and Pretoria offices, previously located in Braamfontein and Faerie Glen respectively, consolidated and relocated to Midrand. The Cape Town office in Observatory relocated to Plumstead. The HST Pietermaritzburg office was closed and staff relocated in both Durban and Howick.
1. **HST Publications:**


Kevany, S. 2005. *An Economic Evaluation of the Impact of Widespread Antiretroviral Treatment on Secondary Hospitals in South Africa: Case Study of the GF Jooste Hospital Antiretroviral Referral Unit*. Cape Town: University of Cape Town and Durban: Health Systems Trust (Submitted to the Health Economics Unit, Department of Public Health, University of Cape Town, in partial fulfilment of the requirements for the Master of Public Health (Health Economics Specialisation) Degree.).


2. **Conference Presentations:**


Stevens, M. 2008. London. ATHENA. Strategic task team consultation on sexual and reproductive health and rights.
3. HST Contributions to Other Publications:


CEO’S OFFICE
Thobile Mbhengashe, CEO
Halima Hoosen Preston
Marcus Jones

DISTRICT SUPPORT & COMMUNITY DEVELOPMENT CLUSTER
Nomonde Bam, Director
Evangeline Shivambu
Frank Tlamana
Khosi Nyawo
Lwandlekazi September
Muzi Matse
Mzi Masuku
Nomkita Gobodo
Nonceba Languza
Ogrinah Ngobeni
Oumiki Khumisi
Thando Ford Ngomane
Thembekele Lushaba
Thulisile Thabethe
Tshitshi Ngubo
Tumelo Mampe
Wanda Mthembu

HEALTHLINK CLUSTER
Ronel Visser, Director
Ashnie Padarath
Bridgegette Lloyd
Candy Day
Elliot Sello
Fiorenza Monticelli
Hlengiwe Ngcobo
Imeraan Cassiem
Josianne Roma-Reardon
Jackie Smith
Jan Baloyi
Julia Elliot
Linda Meyiwa
Marion Stevens
Naomi Massyn
Nombulelo Bomela
Nongaba P Mzana
Rakshika Bhana
Ross Haynes
Sithandwiwe Nyawose
Stiaan Byleveld

RESEARCH PROGRAMME CLUSTER
Irwin Friedman, Director
Elizabeth Lutge
Jaine Roberts
Madibata Matji
Nandy Mothibe
Patela Giyose
Sibongile Mkhize
Siyabonga Ndimande
Thokozane Mbatha
Tsholofela Tsholo
Vundli Ramakolo
Zimisele Ndlela
Zungezi Thuthu

SUPPORT SERVICES
Deenadayalan Govender, Director
Charmaine Singh
Duduzile Zondi
Fazila Khan
Jurie Thaver
Jonathan McKeown
Joyce Mareme
Khuphukile Nyawose
Monde Mevana
Mahomed Hoosen Imam
Mpume Xulu
Nomsi Khalipa
Prudence Mngomezulu
Portia Ramakgolo
Primrose Ndokweni
Quintin Dreyer
Ricardo Ngcobo
Rosheen Seale
Rachel James
Rakesh Brijlal
Salome Selebano
Chairperson, **Ms Seadimo Chaba**, is a Human Resources Management expert working in the private sector. She also serves on the executive of the Black Management Forum. Seadimo was previously the Chief Executive Officer of Snyman & Vennote (Pty) Ltd; the Executive Manager for Public Works and Management Services, Gauteng Province; and also served as Chief Director for HR in the Office of the Premier of Gauteng. She has a degree in Economics and Industrial Psychology and diplomas in Human Resources and Diagnostic Radiography. Seadimo brings to the Board her experience in management and human resources in both public and private sectors.

(From left to right) Seated : Prof. Shasha, Ms Chaba (Chairperson), Prof. Serwadda and Prof. Rispel. 
First row: Prof. Mfenyana, Ms Bam (Director: DSCD) Ms Visser (Director: HealthLink), Mr Govender (Director: Finance and Support Services) Back row: Dr Friedman (Director: Research), Ms Hunter (Outgoing Chairperson), Dr Wilson, Mr Mongale. Not in the photograph: Mr Bellis, Dr Hendricks, Mr Pillay and Ms Zungu.

Ms Chaba is supported by the following people:

**Prof. David Serwadda** is Director of the Institute of Public Health at Makerere University in Uganda and is also an Associate Professor of the university. David’s 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, amongst others.

**Prof. Kaya Mfenyana** holds a PhD in Community Higher Education Service Partnership, and Master’s degrees in Educational Administration and Family Medicine. He is currently the first Professor and Head of Department of Family Medicine at the Walter Sisulu University in the Eastern Cape. He brings his academic experience as well as management and leadership skills to the Board.

**Mr. Kevin Bellis** holds a BSc Joint Honours in Geography and Sociology and is currently a Technical Manager on the DFID Multi-sectoral HIV and AIDS programme in South Africa. He brings to the Board his vast experience in project management, management and institutional development, operational and strategic planning, financial planning, health systems, tuberculosis, HIV and AIDS, operational research and monitoring and evaluation.

**Prof. Laetitia Rispel** is currently an Adjunct Professor and senior researcher at the Centre for Health Policy, School of Public Health, at the University of the Witwatersrand and holds a Doctorate in Health Systems from the same University. Before joining CHP, Laetitia was the Executive Director of the Social Aspects of HIV/AIDS and Health Research Programme at the Human Sciences Research Council of South Africa. Laetitia brings to the Board her expertise in management, research, public health, monitoring and evaluation, and the social determinants of health.
Dr. Michael Hendricks is the former Provincial Director-General of the Northern Cape Provincial Administration, as well as the former Head of Department of the Northern Cape Department of Health. He holds an MSc (Med) in Community and Child Health, a Post-Graduate Diploma in Health Management as well as certificates in economics and finance. He brings to the Board his experience and skills in management, leadership, financial management and knowledge of the national health system.

Mr. Obakeng Mongale holds a Master’s degree in Industrial Psychology and a post-graduate Diploma in Management (Finance) from the University of the North West. He is currently the Head of Department for Community Safety in the North West Province (NW). Obakeng previously also served as Head of Department for the Health Department and the Public Works Department in the NW. During his tenure as accounting officer, his provincial departments won key and prestigious Premier Awards. Obakeng has had extensive interaction with politicians, parliamentary committees, NGO’s, labour unions, academic institutions and the private sector.

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

Dr. Sibongile Zungu is currently the head of KwaZulu-Natal Department of Health and is a qualified medical doctor with a Post-Graduate Diploma in Health Services Management. Dr Zungu also holds key certificate qualifications from a number of national and international universities. Dr Zungu has delivered several papers and presentations covering topics on rural women and development, the role of traditional leaders in local government and options for integration of traditional leadership structures and contemporary governance structures. She received several awards of which one was for being in the Top 20 Influential Leaders in the South African Health Sector in 2007. She brings to the Board extensive experience in management and leadership and in-depth knowledge of the national health system.

Dr. Tim Wilson retired in 2006 from his position as Cluster Manager: PHC, Districts and Development in the National Department of Health, and has since been a senior research associate for the CIET Africa, a non-governmental organisation that conducts community-based research related to the delivery of public services. He holds a Master’s degree in Community Health and Epidemiology. From 1994 to 1995 he was the special advisor to the Minister of Health. He brings to the Board skills and experience related to the National Health System, PHC and Hospital services as well as expertise in management and leadership.

Prof. Welile Shasha is currently a research consultant and was the team leader for evaluating the HIV and AIDS programme in South Africa. He is the former CEO of the ilimaletu Development Association as well as the Head of the WHO Office in South Africa from 1996 to 2005. He holds a Master’s degree in Medicine and Community Health and established the Department of Community Medicine at the then University of Transkei, where he was Professor and Head of the Department. He brings to the Board his experience in community health, research as well as an in-depth knowledge of the national health system and international experience.
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 annual 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, Deloitte & Touche, 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. The Deloitte & Touche audit report is presented on page 32.

APPROVAL OF THE ANNUAL FINANCIAL STATEMENTS BY THE BOARD OF TRUSTEES.

The annual financial statements set out on pages 33 to 43 were approved by the Board of Trustees on 26 March 2010 and signed on its behalf.
The Trust for Health Systems Planning and Development confirms its commitment to the principles of openness, integrity and accountability as advocated in the King II Code on Corporate Governance. Through this process stakeholders may derive assurance that the Trust is being ethically managed according to prudently determined risk parameters in compliance with generally accepted corporate practices. Monitoring the Trust’s compliance with the King Code on Corporate Governance forms part of the mandate of the Trust’s Audit Committee. The Trust has complied with the Code in all respects during the year under review.

BOARDS OF TRUSTEES
RESPECTIVE RESPONSIBILITIES
The Board of Trustees 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 the 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 once during the 2009 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:

- S Govindsamy (External member)
- DN Pillay (Trustee)
- I Lax (External member)
- M Hendricks (Trustee)

The Audit Committee addressed its responsibilities properly in terms of the charter during the 2009 annual financial year. No changes to the charter were adopted during the 2009 financial year.

Management has reviewed the annual 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.

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. Whenever necessary, the Committee is advised by independent professional advisers. The Committee met twice during the 2009 annual financial year.
The Personnel Committee consists of the following Trustees:

- S Chaba (Trustee)
- J Hunter (Trustee)
- M Modipa (External member)
- I Matsheka (External member)

**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:

- M Hendricks
- K Bellis

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.

The Trust assessed its internal control system as at 30 June 2009 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 annual financial statements. The Trust believes that its system of internal control over financial reporting and safeguarding of assets against unauthorised acquisitions, use, or disposition, met those criteria.

**INTERNAL AUDIT**

The Trust's internal audit function 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 previously. This ensures that the audit coverage is focused on and identifies areas of high risk.

**ETHICAL STANDARDS**

The Trust has developed a Code of Conduct, 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.

**ACCOUNTING AND AUDITING**

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

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

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

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

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

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

REPORT ON THE ANNUAL FINANCIAL STATEMENTS

We have audited the annual financial statements of the Trust for Health Systems Planning and Development, which
comprise the report of the Trustees’, the balance sheet as at 30 June 2009, 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 25.

Trustees’ Responsibility for the Annual Financial Statements
The Trust’s Trustees are responsible for the preparation and fair presentation of these annual 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 annual 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 annual 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 annual
financial statements. The procedures selected depend on the auditor’s judgement, including the assessment of the risks
of material misstatement of the annual 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 annual
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 annual 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 annual financial statements fairly present, in all material respects, the annual financial position of
the Trust as at 30 June 2009, 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.

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

Deloitte & Touche
Per M Luthuli
Registered Auditor

26 March 2010
HEALTH SYSTEMS TRUST ANNUAL REPORT 2008/09

The Board of Trustees present their annual report, which forms part of the audited annual financial statements of the Trust for Health Systems Planning and Development for the year ended 30 June 2009.

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

1. Full details of the financial results are set out on pages 11 to 25 in the attached annual financial statements.
2. As set out in the annual financial statements, the Trust has a net surplus/(deficit) for the year of R3 200 003 (2008: R2 808).

3 TRUSTEES

The Trustees of the Trust for the year ended 30 June 2009 are set out below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Date appointed</th>
<th>Date resigned/Tenure ended</th>
</tr>
</thead>
<tbody>
<tr>
<td>D Serwada (Uganda)</td>
<td>5 March 2004</td>
<td></td>
</tr>
<tr>
<td>S Chaba</td>
<td>5 March 2004</td>
<td></td>
</tr>
<tr>
<td>J Volmink</td>
<td>1 June 2006</td>
<td>20 February 2009</td>
</tr>
<tr>
<td>P Masobe</td>
<td>7 March 2002</td>
<td>7 March 2008</td>
</tr>
<tr>
<td>J Hunter</td>
<td>7 March 2003</td>
<td>7 March 2009</td>
</tr>
<tr>
<td>DN Pillay</td>
<td>29 July 2004</td>
<td></td>
</tr>
<tr>
<td>W Shasha</td>
<td>1 August 2008</td>
<td></td>
</tr>
<tr>
<td>T Wilson</td>
<td>1 August 2008</td>
<td></td>
</tr>
<tr>
<td>L Rispel</td>
<td>1 August 2008</td>
<td></td>
</tr>
<tr>
<td>K Mfenyana</td>
<td>1 August 2008</td>
<td></td>
</tr>
<tr>
<td>S Zungu</td>
<td>1 August 2008</td>
<td></td>
</tr>
<tr>
<td>K Bellis</td>
<td>1 August 2008</td>
<td></td>
</tr>
<tr>
<td>M Hendricks</td>
<td>1 August 2008</td>
<td></td>
</tr>
<tr>
<td>O Mongale</td>
<td>26 June 2009</td>
<td></td>
</tr>
<tr>
<td>E Buch</td>
<td>7 March 2002</td>
<td>7 March 2008</td>
</tr>
<tr>
<td>Y Pillay</td>
<td>29 July 2004</td>
<td></td>
</tr>
</tbody>
</table>

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 2009, 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

The Land and buildings as described in note 7 were which was acquired on the 9th June 2006 by the Trust for the price of R2 300 000 was sold for the sum of R2 150 000 on the 1st November 2009. Proceeds received were used to settle the long term debt with Standard Bank as detailed in note 12.
### TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

#### BALANCE SHEET

**AS AT 30 JUNE 2009**

<table>
<thead>
<tr>
<th>Notes</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td><strong>ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-current assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>7</td>
<td>3 327 778</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>8</td>
<td>28 028</td>
</tr>
<tr>
<td>Current assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>9</td>
<td>6 774 743</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>10</td>
<td>32 269 629</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td></td>
<td>42 400 178</td>
</tr>
<tr>
<td><strong>EQUITY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust capital and funds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust capital and accumulated surplus funds</td>
<td>13</td>
<td>13 477 134</td>
</tr>
<tr>
<td><strong>Total equity</strong></td>
<td></td>
<td>13 477 134</td>
</tr>
<tr>
<td><strong>LIABILITIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-current liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest bearing borrowings</td>
<td>13</td>
<td>1 790 542</td>
</tr>
<tr>
<td>Current liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>11</td>
<td>26 903 568</td>
</tr>
<tr>
<td>Current portion of interest bearing borrowings</td>
<td>13</td>
<td>228 934</td>
</tr>
<tr>
<td><strong>Total liabilities</strong></td>
<td></td>
<td>28 923 194</td>
</tr>
<tr>
<td><strong>Total equity and liabilities</strong></td>
<td></td>
<td>42 400 178</td>
</tr>
</tbody>
</table>

#### INCOME STATEMENT

**FOR THE YEAR ENDED 30 JUNE 2009**

<table>
<thead>
<tr>
<th>Notes</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>Grant income</td>
<td>3</td>
<td>36 618 947</td>
</tr>
<tr>
<td>Other income</td>
<td></td>
<td>110 946</td>
</tr>
<tr>
<td>Project expenses</td>
<td>(28 488 300)</td>
<td>(29 728 340)</td>
</tr>
<tr>
<td>Grants paid</td>
<td>(1 233 400)</td>
<td>(5 935 387)</td>
</tr>
<tr>
<td>Administration expenses</td>
<td>(5 636 286)</td>
<td>(5 710 872)</td>
</tr>
<tr>
<td><strong>Surplus/(deficit) funds</strong></td>
<td>2</td>
<td>1 371 907</td>
</tr>
<tr>
<td>Finance costs</td>
<td>5</td>
<td>(249 071)</td>
</tr>
<tr>
<td>Finance income</td>
<td>5</td>
<td>2 077 167</td>
</tr>
<tr>
<td><strong>Surplus/(deficit) funds before income tax</strong></td>
<td></td>
<td>3 200 003</td>
</tr>
<tr>
<td>Income tax expense</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td><strong>Surplus/(deficit) funds for the year</strong></td>
<td></td>
<td>3 200 003</td>
</tr>
</tbody>
</table>
TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT
STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2009

<table>
<thead>
<tr>
<th>Cash Flow Statement</th>
<th>Notes</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td><strong>Cash flows from operating activities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash from operations</td>
<td>12</td>
<td>2 999 796</td>
<td>7 681 936</td>
</tr>
<tr>
<td>Net finance income</td>
<td></td>
<td>1 828 096</td>
<td>2 206 464</td>
</tr>
<tr>
<td>Net cash from operating activities</td>
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<tr>
<td><strong>Cash flows from investing activities</strong></td>
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<td>Proceeds from disposal of property, plant and equipment</td>
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<td>(53 907)</td>
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<td>Net cash used in investing activities</td>
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<td>(115 863)</td>
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<td><strong>Cash flows from financing activities</strong></td>
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<td>(1 637 599)</td>
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<td><strong>Net increase in cash and cash equivalents</strong></td>
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<td>Net increase in cash and cash equivalents</td>
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<td>Cash and cash equivalents at end of year</td>
<td>32 269 629</td>
<td>27 643 927</td>
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TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT
NOTES TO THE ANNUAL FINANCIAL STATEMENTS
FOR THE YEAR ENDED 30 JUNE 2009

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.

1.2 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:

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<th>Asset Category</th>
<th>Estimated Life</th>
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<tr>
<td>Land and buildings</td>
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<tr>
<td>Motor vehicles</td>
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</tr>
<tr>
<td>Computer equipment</td>
<td>4 years</td>
</tr>
<tr>
<td>Computer software</td>
<td>2 years</td>
</tr>
<tr>
<td>Furniture and fittings</td>
<td>6 years</td>
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</table>

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 1.3).

1.3 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.

1.4 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.

1.5 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.

1.6 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.
1.7 Funded projects

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

1.8 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 in 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

1.9 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.

1.10 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.

1.11 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.
### 2 Surplus/(deficit) funds

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<th>Notes</th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
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<td>R</td>
<td>R</td>
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<tr>
<td></td>
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<tr>
<td>The following items have been charged/(credited) in arriving at the surplus/(deficit) funds:</td>
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<tr>
<td>Depreciation on property, plant and equipment</td>
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<td>376 826</td>
</tr>
<tr>
<td>(for detailed breakdown of depreciation refer to note 7)</td>
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<td></td>
</tr>
<tr>
<td>Amortisation of intangible assets</td>
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<td>18 783</td>
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<td>108 000</td>
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<td>20 000</td>
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<tr>
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<tr>
<td></td>
<td>111 600</td>
<td>133 520</td>
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<tr>
<td>Loss on disposal of property, plant and equipment</td>
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<td>6 133</td>
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<td>(8 309)</td>
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<td>41 076</td>
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<tr>
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<tr>
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<td>129 494</td>
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<td>1 386 532</td>
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<td>Staff costs (see note 4)</td>
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<td>23 062 861</td>
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</table>

**Expenses by nature:**

<p>| | 2009     | 2008     |
| | R        | R        |
| Consultants legal support and license fees | 32 383 | 41 076 |
| Depreciation | 347 089 | 376 826 |
| Staff costs | 22 862 043 | 23 062 861 |
| Operating lease rentals | 1 481 617 | 1 386 532 |
| Travel and accommodation | 4 135 766 | 4 272 038 |
| Other expenses | 4 938 502 | 10 305 956 |
| Printing and stationery | 610 494 | 907 623 |
| Telephone and fax | 954 484 | 1 021 687 |
| Total administration and project expenses | 35 362 378 | 41 374 599 |</p>
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<th>Grantee for the year ended 30 June 2009</th>
<th>Healthlink</th>
<th>DSCD</th>
<th>Research</th>
<th>Admin</th>
<th>Total</th>
<th>Accrued Income</th>
<th>Deferred Income</th>
<th>Total</th>
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<td>-</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>(31 878)</td>
<td>-</td>
<td>31 878</td>
</tr>
<tr>
<td>Unifem</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(7 465)</td>
<td>-</td>
<td>7 465</td>
</tr>
<tr>
<td>Full Circle Events</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<td>(6 200)</td>
<td>-</td>
<td>6 200</td>
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<tr>
<td>KNCV</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(160 730)</td>
<td>-</td>
<td>160 730</td>
</tr>
<tr>
<td>Management Sciences for Health</td>
<td>-</td>
<td>3 482 781</td>
<td>801 638</td>
<td>-</td>
<td>4 284 419</td>
<td>-</td>
<td>-</td>
<td>4 284 419</td>
</tr>
<tr>
<td>University of KZN</td>
<td>-</td>
<td>-</td>
<td>21 923</td>
<td>-</td>
<td>21 923</td>
<td>-</td>
<td>-</td>
<td>21 923</td>
</tr>
<tr>
<td>University Research Council</td>
<td>284 200</td>
<td>2 414 326</td>
<td>1 302 503</td>
<td>-</td>
<td>4 001 029</td>
<td>-</td>
<td>-</td>
<td>4 001 029</td>
</tr>
<tr>
<td>University of Western Cape</td>
<td>-</td>
<td>-</td>
<td>161 065</td>
<td>-</td>
<td>161 065</td>
<td>-</td>
<td>-</td>
<td>161 065</td>
</tr>
<tr>
<td>Global Equity Watch</td>
<td>57 455</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>57 455</td>
<td>-</td>
<td>-</td>
<td>57 455</td>
</tr>
<tr>
<td>Equinet</td>
<td>103 081</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>103 081</td>
<td>-</td>
<td>-</td>
<td>103 081</td>
</tr>
<tr>
<td></td>
<td><strong>8 864 980</strong></td>
<td><strong>18 520 825</strong></td>
<td><strong>9 538 360</strong></td>
<td><strong>2 086 826</strong></td>
<td><strong>39 010 990</strong></td>
<td><strong>788 636</strong></td>
<td><strong>(22 072 569)</strong></td>
<td><strong>60 294 924</strong></td>
</tr>
</tbody>
</table>
4 Staff costs

4.1 Executive management salaries
Average number of employees
3 412 259  3 285 951
6  6
4.2 Salaries and wages
Average number of employees
19 449 784  18 790 829
85  84

5 Finance income/(costs)

5.1 Interest paid
Bank (249 071) (247 476)
5.2 Interest received
Bank 2 077 167 2 453 939

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

<table>
<thead>
<tr>
<th>Land and buildings</th>
<th>Motor Vehicles</th>
<th>Computer Equipment</th>
<th>Furniture and Fittings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>Year ended 30 June 2009</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening net carrying amount</td>
<td>2 801 368</td>
<td>9</td>
<td>634 542</td>
<td>73 368</td>
</tr>
<tr>
<td>Additions/improvements</td>
<td>-</td>
<td>-</td>
<td>178 424</td>
<td>1 806</td>
</tr>
<tr>
<td>Disposals</td>
<td>-</td>
<td>-</td>
<td>(14 650)</td>
<td>-</td>
</tr>
<tr>
<td>Depreciation charge (refer note 2)</td>
<td>-</td>
<td>-</td>
<td>(314 027)</td>
<td>(33 062)</td>
</tr>
<tr>
<td>Closing net carrying amount</td>
<td>2 801 368</td>
<td>9</td>
<td>484 289</td>
<td>42 112</td>
</tr>
</tbody>
</table>

As at 30 June 2009

<table>
<thead>
<tr>
<th>Cost</th>
<th>R</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year ended 30 June 2008</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening net carrying amount</td>
<td>2 758 031</td>
<td>9</td>
</tr>
<tr>
<td>Additions/improvements</td>
<td>43 337</td>
<td>-</td>
</tr>
<tr>
<td>Disposals</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Depreciation charge (refer note 2)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Closing net carrying amount</td>
<td>2 801 368</td>
<td>9</td>
</tr>
</tbody>
</table>

Land and buildings comprise the property described as ERF 26726 Observatory, Cape Town. The property is held as security over the mortgage bond. (refer note 12).

8 Intangible Assets

<table>
<thead>
<tr>
<th>Computer software</th>
<th>R</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reconciled as follows:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening net carrying amount</td>
<td>28 028</td>
<td>59 650</td>
</tr>
<tr>
<td>Additions</td>
<td>3 749</td>
<td>53 907</td>
</tr>
<tr>
<td>Depreciation</td>
<td>(35 371)</td>
<td>(18 783)</td>
</tr>
<tr>
<td>Transfer</td>
<td>-</td>
<td>(4 623)</td>
</tr>
<tr>
<td>Closing net carrying amount</td>
<td>28 028</td>
<td>59 650</td>
</tr>
</tbody>
</table>
### 9 Trade and other receivables

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receivables</td>
<td>R 3 865 231</td>
<td>R 5 097 398</td>
</tr>
<tr>
<td>Accrued income</td>
<td>R 2 510 447</td>
<td>R 788 636</td>
</tr>
<tr>
<td>Receiver of Revenue - Value added Tax</td>
<td>R 243 978</td>
<td>R 79 789</td>
</tr>
<tr>
<td>Deposits</td>
<td>R 119 402</td>
<td>R 204 647</td>
</tr>
<tr>
<td>Prepaid expense</td>
<td>R 35 685</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>R 6 774 743</td>
<td>R 6 170 470</td>
</tr>
</tbody>
</table>

### 10 Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current accounts</td>
<td>R 4 772 037</td>
<td>R 3 812 099</td>
</tr>
<tr>
<td>Call accounts</td>
<td>R 27 494 823</td>
<td>R 23 828 297</td>
</tr>
<tr>
<td>Cash on hand</td>
<td>R 2 769</td>
<td>R 3 531</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>R 32 269 629</td>
<td>R 27 643 927</td>
</tr>
</tbody>
</table>

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

- Research: R 7 312 154 (2008: R 7 416 309)
- DSCD/ISDS and Community Development: R 18 507 302 (2008: R 10 809 618)
- Healthlink: R 1 046 270 (2008: R 4 205 833)
- CORE: R 5 403 903 (2008: R 5 212 167)

### 11 Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accruals</td>
<td>R 2 646 360</td>
<td>R 1 522 250</td>
</tr>
<tr>
<td>Deferred income</td>
<td>R 23 258 460</td>
<td>R 22 072 568</td>
</tr>
<tr>
<td>Provision for audit fees</td>
<td>R 110 000</td>
<td>R 110 000</td>
</tr>
<tr>
<td>Provision for leave pay</td>
<td>R 888 748</td>
<td>R 1 051 113</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>R 26 903 568</td>
<td>R 24 755 931</td>
</tr>
</tbody>
</table>

### 12 Cash from operations

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus/(deficit) funds</td>
<td>R 1 371 907</td>
<td>(R 2 209 272)</td>
</tr>
<tr>
<td>Adjusted for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Profit)on disposal of property, plant and equipment</td>
<td>(R 3 444)</td>
<td>(R 2 176)</td>
</tr>
<tr>
<td>Depreciation</td>
<td>R 382 460</td>
<td>R 376 826</td>
</tr>
<tr>
<td>Adjustment to opening retained earnings</td>
<td>(R 294 491)</td>
<td>-</td>
</tr>
<tr>
<td>Movement in working capital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Increase)/decrease in receivables and prepayments</td>
<td>R 604 273</td>
<td>R 19 572 905</td>
</tr>
<tr>
<td>Increase/(decrease) in trade and other payables</td>
<td>R 2 147 637</td>
<td>(R 10 056 347)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>R 2 999 796</td>
<td>R 7 681 936</td>
</tr>
</tbody>
</table>

### 13 Interest-bearing borrowings

- Non-current
  - Mortgage bond – Standard Bank: R 2 019 476 (2008: R 2 055 781)
  - Less: Short term portion transferred to current liabilities: (R 2 288 934) (2008: R 29 500)

The mortgage loan is secured by a mortgage over the property with a net book value of R 2 801 368 (refer note 11). These loans bear interest at 8.85% (2008: 13.35%) per annum and are repayable in 228 monthly instalments of R 19 008 (2008: R 24 905), inclusive of finance charges.
14 Operating lease commitments

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

- Not later than 1 year: R 1,125,904 (2008: R 728,080)
- Between 2 and 5 years: R 4,328,423 (2008: R 19,194)

Total future minimum lease payments: R 5,454,327 (2008: R 747,274)

15 Correction of error

During the year, based on new information it was noted that an amount of R 294,491 was incorrectly accounted for in the prior year. The above has the following effect on opening retained earnings:

- Decrease in opening retained earnings: (R 294,491) (2008: R 8,715,572)

Effect on the net profit for the year:
- Decrease in grant income: -
FUNDERS AND FUNDING PARTNERS

- ATHENA Network
- Centre for Rural Health
- Charles Kendall and Partners Ltd
- National and Provincial Departments of Health, South Africa
- Development Bank of Southern Africa
- Intel Corporation
- Italian Cooperation
- Joint Economics AIDS and Poverty Programme
- Koninklijke Nederlandse Centrale Vereniging (KNCV) Tuberculosis Foundation
- Management Sciences for Health
- Measure Evaluation
- Medical Research Council
- Open Society Foundation for South Africa
- Open Society Initiative for Southern Africa
- President’s Emergency Plan for AIDS Relief (PEPFAR)
- Raith Foundation
- Swedish International Development Agency
- The Atlantic Philanthropies
- UNICEF
- University Research Company
- USAID
- Wellcome Trust
- WK Kellog Foundation
- Womens’ Global Network for Reproductive Rights
In reflecting on the period after political transition in South Africa, Minister of Health Barbara Hogan has also been important to interrogate and address these gaps. Yet 2009 heralds a time of change and it is important to consider the role of the private sector within the National HIV/AIDS and STI Strategic Plan (NSP), which is the overall guiding plan for HIV/AIDS in South Africa. The process of addressing SRHR in South Africa is impeded by gaps in the NSP, which has been linked to recovery from the Mexico Gag rule, so enabling active support for reproductive health. This process draws on the 1994 Women's Health Policy which enabled close collaboration between women's groups struggling to create a practical forum to mitigate this obstacle.

While the process of addressing SRHR in South Africa is challenging, there are also opportunities for synergies and collaboration between the HIV/AIDS and reproductive health and supporting the United Nations Fund for Population Activities (UNFPA). Within South Africa, the Mexico Gag rule has been linked to redefining the role of the private sector, which has impacted the policy environment and created a liminal space with a change in the United States administration, with President Obama reversing the Mexico Gag rule, so enabling active support for reproductive health. This process draws on the 1994 Women's Health Policy which enabled close collaboration between women's groups struggling to create a practical forum to mitigate this obstacle.

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