Health Systems Trust

ANNUAL REPORT 2009 / 2010

HEALTH SYSTEMS TRUST

VISION

Health systems supporting health for all in southern Africa

MISSION

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

APPROACH

- We embrace a public health perspective with a focus on primary health care
- We undertake health systems development through research and information dissemination, an approach that influences both policy and practice
- We improve the quality of care in priority health programmes by providing support and sharing 'best practice' solutions
- We advocate equitable, efficient and effective health services and the empowerment of health service users
- We operate efficiently and effectively in a multi-disciplinary manner

CORE VALUES

Our work is guided by the following key values:

- transparency and accountability
- innovation and responsiveness
- integrity and nurturance
- embracing diversity
- participatory management
- continuous quality improvement

TABLE OF CONTENTS

Health Systems Trust *is a dynamic non-profit organisation established in 1992 to support the transformation of the health system in a new democratic South Africa. The organisation, now in its 19th year of operation, 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.*

ABOUT HEALTH SYSTEMS TRUST

Health Systems Trust (HST) actively supports the development of comprehensive national health systems through strategies designed to promote optimal health status, and equity and efficiency in health care delivery. Using a Primary Health Care approach, HST currently has six core focus areas:

- the Millennium Development Goals relating to HIV, AIDS and TB, and Maternal, Neonatal and Child mortality, particularly the prevention of mother-to-child transmission (PMTCT);
- sexual and reproductive health;
- implementing the Primary Health Care core package;
- strengthening health systems governance, leadership and management at all levels;
- creating intelligent monitoring and evaluation systems; and
- National Health Insurance.

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 has cumulative experience and expertise in designing and supporting relevant health systems research and in strengthening the district health system through a variety of technical content areas. These content areas include strengthening District Management Teams in developing District Health Expenditure Reviews, District Health Plans, Health Information Systems, Service Turnaround Strategies, Human Dimensions' Management and Continuous Quality Improvement.

In addition, HST is a powerhouse of information dissemination within the health sectors of southern Africa and, increasingly, in the world. HST has established networks and partnerships with various service providers nationally, regionally and internationally.

HST contributes to capacity development through internship programmes and limited grant support.

HST's three operational clusters – District Support and Community Development, HealthLink and the Research Programme – function interdependently, drawing on each other's specific strengths and resources. The work of each cluster is described in the pages that follow.

Entrance to HST Head Office, Westville, Durban

HST Office, Midrand, Johannesburg

Staff outside HST office in Plumstead, Cape Town

CHAIRPERSON'S REPORT

Professor Welile Shasha

The recent global economic crisis has brought home a renewed realisation of the importance of good leadership. Leaders all over the globe are, rightly, stepping up to the plate. From President Jacob Zuma's announcement on World AIDS Day, 1 December 2009, to scale up the fight against HIV and AIDS in South Africa, to President Barack Obama spearheading health reform in the United States through the "Patient Protection and Affordable Care Act" passed into law on 23 March 2010.

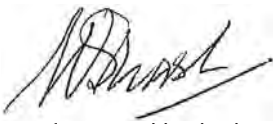
With unyielding commitment to the primary health care approach HST has, during the year being reported on, continued the work that has seen the organisation establish itself firmly as a leader in health systems improvement in South Africa.

In October 2009 HST, as part of a consortium, started a health systems improvement project in Lesotho, thus building on our objective to extend our services into the southern African region.

The staff of HST plan, execute and evaluate relevant projects within the framework of the policies and plans articulated by government through the Ministry and the Department of Health. Staff are also well aware that the rigorous involvement of communities in their own health care is a key success factor in striving towards health systems improvement.

It is my honour, as chairperson of the Board of Trustees, to lead the team of men and women who provide guidance and support to HST management and staff in their commitment to facilitate better health outcomes for the people of southern Africa. To my fellow Trustees I extend my appreciation for your tremendous support to HST during this year. During this year Ms Seadimo Chaba and Dr David Serwadda completed their term and the Board was bolstered by the appointment of Dr Maureen Tong and Ms Gcwalisile Twala.

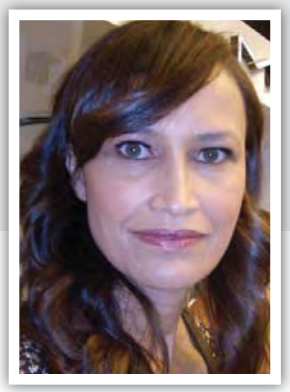
On behalf of the Board I thank our implementation partners as well as all our funders (acknowledged in the report) who have generously supported the work of the organisation during this year. Thank you, too, to all HST staff for your hard work and dedication.



Professor Welile Shasha
Chairperson
Health Systems Trust Boad of Trustees

MESSAGE FROM THE CHIEF EXECUTIVE OFFICER

Ms Jeanette R Hunter



Health Systems Trust's contribution during the year 2009/10 to improved outcomes in priority health conditions in southern Africa comprised projects in the areas of Maternal, Neonatal and Child Health; Nutrition; integrating HIV and Tuberculosis (TB) services; improving health information for planning and decision making; and strengthening health service management. Throughout, continuous quality improvement remains both a focus and a passion.

HST's focus has always been and remains the primary health care approach, with communities being fully involved in their own health care.

In April 2010 HST completed an Atlantic Philanthropies-funded project for strengthening district health management. Through this project HST facilitators impacted directly on 1 011 health professionals through orientation and in-service workshops on the content of the national planning and reporting cycle, also providing on-site coaching in developing District Health Plans linked to District Health Expenditure Reviews.

In the area of Maternal, Neonatal and Child Health and Nutrition (MNCH&N) we worked on a project championed by the South African Department of Health and funded by United Nations Children's Fund (UNICEF). This project supports seven districts in implementing a package of key interventions in MNCH&N to improve health outcomes and to monitor progress in these focus areas. Achievements include completing a baseline study in January 2010 and promoting integrated service delivery to address the factors that contribute to weaknesses in this area. This project continues until September 2010.

In the Eastern Cape, KwaZulu-Natal and Mpumalanga provinces we are working with nurses and community health workers to integrate screening and treatment for TB, as well as provider-initiated counselling and testing for HIV, into antenatal clinics. We are making positive strides concerning co-operation between nurses and community health workers, enabling them to derive maximum benefit from their complimentary roles.

The Women and HIV/AIDS Gauge is an inter-cluster project within Health Systems Trust. The focus is on the impact of HIV and AIDS on women, noting the lack of a sexual and reproductive health and rights approach in addressing prevention, treatment and care in the country. The Gauge has a specific interest and focus, noting the gendered burden of care. During the past year the project has focused on developing HIV Treatment Guidelines for Women of Reproductive Age.

In addition to a number of small projects in the area of health information for planning, monitoring and decision making, we released the fifth edition of the District Health Barometer in May 2010 and work started on the 14th South African Health Review to be released in December 2010. The Review has rapidly become HST's flagship product and is widely read, used and quoted as an authoritative reference work in South Africa and abroad. HST is part of a consortium awarded a 44-month contract to strengthen health systems in Lesotho. The project commenced in October 2009 and will extend until May 2013. The Health Information Systems for Data Capturers' Project, a collaboration between HST, Continuing Education at University of Pretoria and the Health Information Systems Programme (HISP), is in its second year of implementation. The project aims to address both the inadequate opportunities for career development pertaining to health information management in the public sector as well as to build national capacity for data management at health facility level. To date 2 024 data capturers have been trained. Ten per cent of Data Capturer interns per year qualify to receive a scholarship to further their education at an institute of higher learning. The opportunity also exists for data capturers to be absorbed into permanent employment in the public service.

As the Research Programme's report reveals, HST has during the past year conducted research in the areas of:

- The Maternal and Child Health-related Millennium Development Goals
- Community Health Workers and Non-Profit Organisations
- HIV and AIDS
- Tuberculosis
- The Occupational Diseases in Mines and Works Act
- The Distribution of Biostatisticians in South Africa
- Human Resource Capacity and Research Outputs of Academic Health Complexes in South Africa
- The Socio-economic Determinants of Health
- Nutrition in South Africa

Findings from our reports continued to be widely quoted and staff were interviewed in the media on pertinent issues.

We strive to maintain an employment equity picture that is in line with the country's demographics. In this regard black females were in the majority at 47% and black males were 10% of the total number of employees. Overall, 77% of HST's staff are female. During our recruitment processes we encourage people with disabilities to apply. During this year we said goodbye to 12 staff members. We wish them well in their new endeavours. We welcomed 12 new staff members to assist HST in pursuing its goals.

That HST has come through the recent economic recession as a going concern is evidence of the quality of our work and the esteem we enjoy in our environment. The global economic crisis is resulting in an ideological shift from the capitalist model, which has always emphasized the pre-eminent role of markets, to a developmental model that brings the role of the state strongly to the fore. This means that moving forward will require a developmental coalition between the state, private sector and civil society. This, together with a growing emphasis on multi-sectoral action, puts the spotlight on what an organisation such as HST can contribute to the realisation of the vision of a caring and humane society in which all southern Africans have access to affordable, good quality health care.

Our challenge is to keep our eye on the quality ball while at the same time attending to the structural changes required to sustain HST as an organisation of choice. Looking ahead, HST would like to focus its work on:

a. Essential National Health Research that will contribute to improved primary health care services and outcomes.

b. Health information systems yielding quality information for planning, monitoring and evaluation as well as decision making.

c. District Health Management Improvement, with a focus on delivering quality primary health care services.

d. Ensuring a sustainable link and working relationship between community health workers and primary health care clinics, as well as community education pertaining to priority health issues.

To contribute substantially in these areas, HST needs to retain a core of expert staff, while continuing the professional development that has seen former HST colleagues take up key positions in many spheres in South Africa.

My sincere gratitude goes to our funders. Believing in our primary health care approach and demonstrating confidence in our governance structures, they have channelled essential and much-needed financial support to the work we do.

Guidance and support from Trustees during this year in the form of ad hoc problem-solving and inputs at sub-committee and Board meetings contribute immensely to an increased level of direction and confidence.

Thank you to HST directors, managers and staff for the important contribution to health service provision in southern Africa.

Jeanette R Hunter
Chief Executive Officer

DISTRICT SUPPORT AND COMMUNITY DEVELOPMENT CLUSTER

Acting Director: Ms Oumiki Khumisi

The overall aim of the Cluster is, through providing technical support to health districts and developing communities, to strengthen the district health system using a comprehensive primary health care approach and establishing sustainable 'best practice' and learning sites in selected districts. The uniqueness of this approach is that HST facilitators are based at the districts and work closely with health district management teams and health-care workers, thereby transferring skills.

The District Support and Community Development (DSCD) cluster developed seven strategic goals closely aligned with HST's 2009-2014 Strategic and Operational Plans. These goals are to:

- Conduct relevant, focused, operational research and baseline assessments on health systems within a primary health care (PHC) approach that translates into action that results in improved outcomes on DSCD projects;
- Strengthen and improve capacity and skills of health management teams, governance structures and health service providers through facilitation, mentoring and coaching;
- Promote the use of health information for decision-making, monitoring and evaluation and advocacy, leading to effective health services at district, sub-district, facility and community levels;
- Design and implement a quality improvement framework to strengthen programme outcomes;
- Ensure that cluster staff comply with relevant legislation in support of achieving HST's seven focus areas;
- Effect a critical and objective mid- and end-term external review of DSCD projects' performance; and
- Achieve financial stability and growth.

The Cluster's focus areas include:

- Supporting the District Management Teams in planning, budgeting, monitoring and reporting;
- Strengthening key strategic programmes;
- Supporting selected districts in developing partnerships with communities and community-based organisations;
- Enhancing HIV counselling and testing practice to increase community access to quality services; and
- Promoting collaboration of community support structures and networks with antiretroviral therapy (ART) sites to improve community ART treatment, awareness and adherence.

Cluster Approach

The DSCD cluster provides technical support in selected provinces and districts through setting up 'best practice' sites which serve as learning sites. HST facilitators based at the districts provide mentoring and coaching (simultaneously transferring skills) in the implementation of national policies and in strengthening community participation, with a focus on community literacy. Interventions focus on planning, budgeting, expenditure reviews, monitoring performance, reporting and strengthening cross-cutting health systems issues using strategic priority programmes as a lens to identify challenges. In addition, DSCD collaborates with other HST clusters by drawing on their special expertise and competencies in a complementary interaction. An example is the Research Programme cluster assisting with the Maternal, Neonatal and Child Health and Nutrition (MNCH&N) services project's baseline studies.

The Cluster has two divisions – Health Systems Strengthening and Community Development.

HEALTH SYSTEMS STRENGTHENING

Strengthening Management and Planning Capacity of Sub-District Health Teams for Improved Service

This project, funded by The Atlantic Philanthropies, covered the two year period April 2008 to March 2010, but was extended until the end of June 2010. The project used a systems-centered approach to strengthen policy implementation, where development focused on the systems and not only on the capacity of individuals. Formal training and on-site mentoring, coaching and support developed 'champions', thereby enhancing sustainability once the project ended.

The project focused on the management and implementation capacity of district and sub-district management teams, through strengthening their planning,

budgeting and reporting skills in order to attain maximum coverage of health services from allocated resources and consequently to improve health outcomes. More specifically, the project focused on the sub-district as this is the service delivery level at which setting realistic goals and targets could lead to better use of the allocated resources.

The project was implemented in four districts in three provinces – Mpumalanga (Ehlanzeni and Nkangala districts), North West (Dr Ruth Segomotsi Mompati district) and KwaZulu-Natal (eThekwini district).

In all three provinces there was notable improvement in planning capacity from district to facility level, as evidenced by the submission of better quality District Health Plans (DHPs) and District Health Expenditure Reviews (DHERs). More effective writing skills were also noted in all areas. Moreover, in all provinces there is evidence that the DHPs and DHERs are now better aligned to national and district strategies, policies and guidelines. A large number of health professionals were trained and there is improved understanding of how to present and use health data effectively for monitoring and evaluating performance – this through monthly PHC reviews at sub-district level and quarterly reviews at district level.

In May 2010 HST hosted a "*Strengthening the District Health System for Service Delivery*" summit in Mpumalanga Province where beneficiaries of the project shared 'best practices' with participants from other non-participating districts and from the Eastern Cape province. The next summit is scheduled to be held in KwaZulu-Natal province.

HST commissioned an external evaluator during April 2010 to determine the extent to which the expected project outputs were attained. The report, in which the evaluators have made a number of recommendations, has been forwarded to the funder. An important recommendation is the need to roll the project out to other provinces and districts, with greater focus on the training component to contribute in a structured manner to the continuing development of health professionals. Again, based on the findings and recommendations of the external evaluators, HST requested further funding to further strengthen the interventions in the current sites and to roll out the project to other districts within the same three provinces over a two year period. The current sites will be used as learning sites with the sub-district champions serving as co-facilitators in the roll-out of the interventions. Maternal, Neonatal and Child Health (MNCH) will be used as a lens to identify gaps in management systems and these systems will then be used to strengthen programme content.

Project team *(alphabetically by surname): Tumelo Mampe, Muzi Matse and Makhosazane Nyawo*

Implementation of the District Health System and Primary Health Care in Gauteng

This project was funded by the Gauteng Province Department of Health's District Health Systems Support (DHSS) Directorate for the period June 2006 to March 2010. The project aimed to improve PHC service delivery in all districts by supporting:

- District Health System development and integration;
- Implementation of Clinic Supervisory Policy; and
- Development and implementation of DHERs and DHPs.

The project was implemented in all six districts – Tshwane and Metsweding (Region C), Johannesburg and West Rand (Region A) and Ekurhuleni and Sedibeng (Region B) – in a collaboration between HST and the following three directorates: DHSS (Director and District Managers in the six districts); Health Information Systems; and Monitoring and Evaluation.

Despite the revision of the DHP's format during 2009/10 and 2010/11 a major achievement of the project was building district managers' capacity in completing DHERs, DHPs and Operational Plans and then monitoring their implementation through the quarterly district performance reviews and monthly PHC reviews. Planning, budgeting, monitoring and evaluation, as well as reporting, improved – as evidenced in these documents. Co-operation between Provincial and Local Government also improved during this period. Successful training on understanding and interpreting indicators for improved programme performance was conducted. Data quality was enhanced by standardising population figures, including uninsured population, for the province, districts, sub-districts and facilities. Clinic Supervision processes were streamlined and poorly performing sub-districts were provided with additional support.

At the report-back session the Chief Director: District Health Systems requested a report on the state of DHS in the province, including improvements that are still necessary. HST was also requested to assess the capacity of management in all six districts using the Management, Economic, Social and Human Resource (MESH) monitoring tool.

Project team *(alphabetically by surname): Oumiki Khumisi and Frank Tlamama*

COMMUNITY DEVELOPMENT

Antiretroviral Therapy Literacy Project: Building Organisational and Governance Capacities of Community-Based Organisations in 67 Clinic Catchment Areas, Mpumalanga Province

The Mpumalanga Department of Health and Social Development commissioned HST to empower 13 community-based organisations (CBOs) and have them registered as non-profit organisations (NPOs). The project was implemented in two phases and this report covers the second phase implemented between July 2009 and June 2010.

The first phase, from 2005 to 2008, was to improve ART literacy, ART adherence, reduction of HIV infection and the impact of HIV and AIDS in 67 feeder clinics in the catchment areas of 18 clinics in Dr J S Moroka and Emalahleni sub-districts (Nkangala district) and in Govan Mbeki sub-district (Gert Sibande district). This phase was reported in HST's 2008/09 Annual Report.

The aim of Phase Two was similar to the Phase One but focused on promoting and strengthening ART literacy in the clinic catchment areas of the feeder clinics supporting the accredited ART sites in Mpumalanga province. The project was implemented in three districts – Ehlanzeni, Gert Sibande and Nkangala – and focused on the 67 PHC facilities in six sub-districts. Ten of these PHC facilities are ART accredited sites.

An integrated and comprehensive referral system was set up to ensure adequate co-ordination within the health sector and between the PHC facilities and the CBOs. A total of 19 Community Resources Centres were established and 295 792 people were reached in clinic catchment areas. Fifty-two community support groups provided adherence support to 5 135 people on treatment. Fifty-five (83% of the total) CBO-Exco members were trained on applied project management. A total of 1 161 community condom distribution points were established from which over 1.25 million condoms were distributed. Eight CBOs were registered as NPOs and five applications were re-submitted and are awaiting acceptance. Fifty-eight food gardens were established. A major accomplishment was the development of a Trainers' Manual for training CBO leaders in the governance of CBOs implementing community-based ART literacy.

Two further documents

- Building an Effective Organisation - A Participants' Resource Guide, and
- Basic Accounting, Budgeting and Fundraising for CBOs – a participants' training guide,

were produced by adapting guides compiled by The Education and Training Unit, a local NPO, to suit local conditions.

Project team *(alphabetically by surname): Wanda Mthembu and Sakumzi Ntayiya*

Improving Maternal, Neonatal and Child Health Outcomes in Seven Selected Health Districts

HST entered into a Project Co-operation Agreement with UNICEF to support improvement of Maternal, Neonatal and Child Health outcomes in seven selected health districts during the period July 2009 to September 2010. The overall project, of which this project forms but a part, aims to enhance the capacity of the provinces to meet the health-related Millennium Development Goals, specifically goals 4, 5 and 6, in all 18 priority districts identified by the NDoH for the improvement of maternal and child health outcomes using facility-based, quality improvement strategies and community-based interventions.

The project is being implemented in six of the 18 priority districts: Eastern Cape province – Alfred Nzo, Amathole, Cacadu and Chris Hani districts; Mpumalanga province – Ehlanzeni district; North West province – Dr Ruth Segomotsi Mompati district and one metro in KwaZulu-Natal province – eThekwini metropolitan district.

A baseline assessment was conducted from September to November 2009 on the health and nutritional status of women and children and their access to MNCH&N services. The findings indicated that although all districts provided basic maternal and child health services, bottlenecks in the implementation of protocols and gaps in the quality of care existed. Integrated MNCH&N Plans were developed in collaboration with other development partners and these were incorporated into the DHPs. A baseline assessment report was compiled consolidating the findings from all seven districts.

Health-care workers and managers from all levels in the district were trained and mentored in improving the quality of MNCH&N services. Post-training follow-up visits, conducted together with PHC supervisors and programme managers, provide further on-site support. In the Eastern Cape a total of 320 professional nurses were trained on these strategies in the seven districts while 38 professional health workers (24 doctors and 14 midwives) have been trained on essential steps in managing obstetric emergencies (ESMOE), prevention of mother-to-child transfer (PMTCT) and basic antenatal care (BANC).

The project emphasised routine CD4 count testing and WHO staging for all HIV-positive pregnant women. Discussions were held with the Mpumalanga Department of Health and Social Development regarding increasing the Comprehensive Care, Management and Treatment (CCMT) sites from 34 to 64; establishing functional nerve-centres to monitor the progress of HIV counselling and testing (HCT) at all levels; and initiating weekly reporting of the HCT data to the provincial information manager. Each clinic supervisor monitored poorly-performing facilities closely, using the two DHIS indicators, and corrective interventions were introduced.

To scale up community-based participation in delivering the MNCH&N package the project used the two-pronged social mobilisation approach, using community health workers (CHWs) already functioning within the community and assigned to clinics. Training was provided to 909 CHWs to support community health promotion and illness prevention activities, which includes visiting households to advocate on health-seeking behaviours. A four-day training was conducted, together with the Health Promoters, Community Liaison Officers and Community Health Facilitators in a Train-the-Trainer initiative, focusing on the household community component of the Integrated Management of Childhood Illness (HHC-IMCI); post-natal care (including visiting new mothers within two days of delivery); and PMTCT and treatment adherence. CHWs, community caregivers (CCGs) and traditional births attendants were identified as the best target for this training so as to increase health-seeking behaviours. A community-based monitoring tool was developed and is used to report on, amongst other issues, HIV-exposed infants referred for a Polymerase Chain Reaction (PCR) test at six weeks. This information formed part of the community baseline data and also assisted the CHWs in identifying mothers, children and pregnant women that require support at household level. After receiving training on the reporting tools in March 2010, CHWs and CCGs have started referring babies at six weeks for PCR testing.

Other project activities and issues included:

- Discussions with eThekwini district to support their use of teams to focus on care of pregnant women and children, with emphasis on clinical IMCI and access to ART;
- Mentoring and coaching District Management Team members, clinic supervisors (or area managers), sub-district co-ordinators and programme managers as "champions" so as to promote the sustainability of the gains made by the project;
- Meeting with KwaZulu-Natal's provincial MCWH&N Chief Director to improve the quality of maternal and neonatal care and infant feeding practices through the mother- and baby-friendly facility initiative; and
- NDoH Maternal Health Directorate taking the lead in developing the PMTCT and MNCH&N services report card.

Project team *(alphabetically by surname): Nomthandazo Magingxa (Acting Project Manager), Mzikazi Masuku, Mumsey Mnguni, Ntombomhlaba Nyanga, Lwandlekazi September and Thulisile Thabethe*

Strengthening Routine Offering of HIV Counselling and Testing / Provider-Initiated HIV Counselling and Testing

HST, in partnership with the University Research Company (URC), supported facilities to scale-up provider-initiated HIV counselling and testing and to improve the quality of the HCT services. The project, which started in 2006 and runs until December 2010, is funded by the Centre for Disease Prevention and Control, USA with URC as the Primary Grantee.

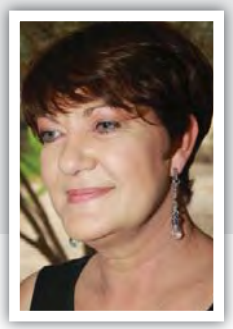
The project aims to reduce missed opportunities for HIV identification, to reduce the spread of HIV infections and to build a network of service outlets providing Provider-Initiated HIV Counselling and Testing and Routine Counselling and Testing (PICT/RCT).

The project is being implemented in 15 health facilities in Amathole and Cacadu districts (Eastern Cape province), 18 health facilities in Sisonke and Ugu districts (KwaZulu-Natal province) and 20 health facilities in Nkomazi sub-district in Ehlanzeni district (Mpumalanga province).

Project staff visit facilities to monitor HCT interventions. Professional nurses were coached and mentored and are now willingly providing PICT during client consultations. Data quality has improved as corrective action was taken for gaps and errors in the date of birth/ages, referral for ART and Highly Active Antiretroviral Therapy (HAART), and recording WHO staging and CD4 count results. Data collected, verified and submitted to URC indicated an increase in PICT uptake due to group health education on HCT and successful mass mobilisation campaigns. A reduction in the number of refusals for testing has been noted. High numbers of self-referred males are being counselled and tested. Discordant results were noted but these were attributed to test kits that were due for replacement. An encouraging parallel improvement in the management of TB services and TB suspects was also noted. Facilities were provided with copies of the HCT guidelines and the project conducted training on the HCT and PMTCT guidelines.

Project team *(alphabetically by surname): Nonceba Languza, Thembekile Lushaba and Tshitshi Ngubo*

HEALTHLINK CLUSTER



Director: Ms Ronel Visser

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

SOUTH AFRICAN HEALTH REVIEW

Since 1995 HST has published the South African Health Review (SAHR) on an annual basis. This has rapidly become a flagship product of the organisation, widely read, used and quoted as an authoritative reference work in South Africa and abroad. The Review is commissioned and edited by an expert team of health systems professionals and is peer reviewed by senior Department of Health staff at national and provincial level, the HST Board of Trustees, senior HST staff as well as a group of independent peer reviewers who are considered experts in their respective fields.

While earlier Reviews focused on policy development, of late there has been increased attention on analysis of progress with regard to implementation. As new structures for the health system were being put in place, the Reviews provided important factual information outlining the structure of national and provincial departments of health.

In recent times the Reviews have provided information on new local government boundaries. Earlier Reviews contributed to understanding the development and thinking underpinning quite a broad range of programmatic areas. More recently, there has been a concentration on HIV and AIDS, TB and maternal and child health reflecting the health burden of the country. Chapters on legislation, health financing, human resources and information systems are common to all Reviews. The monitoring data are updated annually and have been considerably strengthened over the years.

Previous copies of the SAHR can be viewed in PDF format on the HST website, while printed or compact disc versions can be ordered from our Resource Centre.

DISTRICT HEALTH BAROMETER

Funders: The Atlantic Philanthropies and the Development Bank of Southern Africa (DBSA)

The District Health Barometer (DHB) project, an annual HST publication, forms a crucial part of South Africa's efforts in collecting, processing, analysing and using health data for decision making. It strives to provide improved access to health information and statistics in the public domain related to the monitoring of health services delivery at district level with the aim of improving the quality of and access to primary health care services.

The fifth edition of the District Health Barometer (launched in May 2010) has followed a somewhat different format to previous editions. This succinct electronic edition was provided to improve on the timeliness and availability of the information and the draft chapters were released live on the HST website as they became available. This approach allowed users to read the chapters on-screen as news stories or to download them to read later in their own time. The publication can be downloaded chapter by chapter or as the entire document from the HST website and is available on compact disc from HST offices.

In this 2008/09 edition of the DHB two new financial input indicators and two new PMTCT indicators have been added. Short analyses and league tables on most indicators have been introduced for the recently-identified 18 priority sub-districts. Up to nine years of trend data are available for most indicators, thus providing a much needed picture of the progress in many key health areas.

Presentations on the 2008/09 DHB were done at National District Health Systems Committee (NDHSC) meetings,

an African National Congress Health and Education sub-committee meeting, a provincial seminar on Strengthening the District Health System and the Revitalisation of Primary Health Care (Mpumalanga) and at the Global Health Information Forum in Bangkok.

One of the major achievements of the District Health Barometer project is that these publications are being utilised at national, provincial and to a lesser extent district level by the Department of Health for monitoring, reporting and planning purposes. Health researchers and policy makers are also urged to make use of the valuable information available in the District Health Barometer publications to identify areas which require deeper research into the underlying issues contributing to the indicator values and their trends. Information in the DHB has contributed to identifying specific kinds of deficiencies within the health information system at the various levels, enabling appropriate strategies and interventions to be developed.

The District Health Barometer is guided by an advisory committee of key stakeholders from the health services and the research and academic sectors. A number of editors work together in compiling a DHB publication. Numerous individuals and groups are also instrumental in the realisation of the project. The project was funded by the Development Bank of Southern Africa in 2009.

Project team *(alphabetically by surname): Peter Barron, Candy Day, Ross Haynes, Halima Hoosen Preston, Marcus Jones, Fiorenza Monticelli (manager), Elliot Sello, Phil Smit and Jackie Smith*

HEALTH MANAGEMENT INFORMATION SYSTEMS

Health Systems Strengthening Technical Assistance in Lesotho

Funder: Millennium Challenge Account, Lesotho

HST is part of a consortium awarded a 44-month contract to strengthen health systems in Lesotho. The project commenced in October 2009 and will extend until May 2013. The partners in the consortium are the National Institute for Health and Welfare, Finland (Lead Partner), Health Systems Trust and In-Develop-IPM, Sweden. The project, with a total value of US$ 7 517 527, is funded by the United States of America through "The Millennium Challenge Corporation".

The Health Systems Strengthening Technical Assistance is expected to augment the efforts of the Ministry of Health and Social Welfare (MOHSW) in implementing the ongoing National Health Sector Reform Programme. The design of the project is to mitigate the negative economic impacts of poor maternal health, HIV and AIDS, tuberculosis and other diseases by substantially strengthening the country's health-care infrastructure and its ability to deliver quality health services to the Basotho.

The support defined under this project is in the following four programme areas:

- Human Resources Capacity Development;
- Decentralisation of Health and Social Welfare Services;
- Strengthening the Use of Health Management Information in the Health and Social Welfare Sector; and
- Strengthening of MOHSW Capacity for Co-ordination and Implementation of Research Activities.

HST provides one full-time staff member together with part-time staff in variety of project areas, including the project manager. The specified tasks for strengthening health management information systems (HMIS) in the country are:

- Develop an appropriate HMIS for managing for results at the local level;
- Revise current HMIS to support decentralised health services;
- Assist the MOHSW and District Health Management Teams (DHMTs) in determining appropriate IT systems for the revised HMIS;
- Assist the MOHSW and DHMTs in building capacities for improved utilisation of the revised HMIS; and
- Establish an electronic medical recording (EMR) system to be used by the Ministry and health partners.

Performing a review of the current HMIS and developing a plan based on the findings was, as part of conceptualisation, a crucial first step in ensuring the effective management of the HMIS sub-system in Lesotho. Due to the technical nature of this assignment a team of three short term experts (STEs), each with their own area of expertise, was provided by HST to complete the assignment. The STEs included a data quality assessor, an information and communication technology (ICT) expert and an EMR systems expert. The three specific areas within the HMIS covered by this assignment are:

1. Conduct an intensive data quality assessment, review and diagnosis of the current Lesotho long-term health sector HMIS to determine if the system is meeting the monitoring and evaluation needs of the MOHSW. Develop a plan to implement recommendations, including timelines and performance benchmarks.
2. Working with the MOHSW ICT Department and other Government agencies, determine appropriate, efficient and sustainable information technologies for HMIS at all levels of the health information system, with specific reference to the development of a tool ('dashboard') that will enable the importation/integration of all health data (including financial and human resource data) in one system at central level.
3. Review all current Electronic Medical Recording Systems in Lesotho-based hospitals and determine what level of electronic medical records is appropriate.

Appropriate interventions based on the findings will be used for planning purposes and transformed into specific activities that can be translated into realistic annual work plans for the Lesotho MOHSW Planning and Statistics Department.

Project team *(alphabetically by surname): Stiaan Byleveld (manager), Imeraan Cassiem, Ronel Visser. Consultant: Johan Steenkamp*

Health Information Systems for Data Capturers (HISDC) Project

Funder: National Department of Health

HISDC students and lecturers

The Health Information Systems for Data Capturers' Project, a collaborative project between HST, Continuing Education at University of Pretoria and the Health Information Systems Programme (HISP) is in its second year of implementation. The project aims to address both the inadequate opportunities for career development in the public sector as well as to build national capacity for data management at the level where health data are collected, i.e. facility level. To date 2 024 Data Capturers have been trained to fulfil their one-year internship in health-care facilities nationally. Additionally, 10% of interns per year qualify to receive a scholarship to further their education at an institute of higher learning. The opportunity also exists for Data Capturers to be absorbed into permanent employment in the public service.

Actual placement of the trained Data Capturers into permanent posts following the internship period has varied across provinces. Provinces cite the lack of funding as a major challenge in appointing Data Capturers into permanent positions. HST has been integrally involved in supporting Data Capturers during and after the training period to facilitate their smooth placement and entry into the health sector.

Project team *(alphabetically by surname): Rakshika Bhana (manager), Imeraan Cassiem, Hlengiwe Ngcobo. Consultants: Marie Fourie, Margaret Loxton, Susan Naidoo, Maretha Scheepers and Dayalan Thaver*

Evaluation of the BroadReach ART Down-Referral Model

Funder: Abt Associates Inc., International Health Division

This project documented the BroadReach designed and implemented contracting-out model for provision of Antiretroviral Therapy in the North West province. The project findings contribute to the basket of evidence on models for contracting-out HIV and AIDS and related services to for-profit service providers. The BroadReach model has been implemented in the Dr Kenneth Kaunda district since 2005 and this evaluation explored key innovations introduced by the model in improving the quality of care, as well as the sustainability and feasibility of expanding or replicating the model. This short-term project commenced in April and extends to August 2010.

Project team *(alphabetically by surname): Rakshika Bhana, Imeraan Cassiem, Hlengiwe Ngcobo and Jackie Smith (manager)*

Development of a Data Quality Assessment Toolkit

Funder: Macro International Inc.

In March 2010 HST was requested to provide assistance to the World Health Organization (through a sub-contract with Macro International Inc) in developing a data quality assessment toolkit as part of the follow-on activities of the five-year evaluation of the Global Health Impact Study and to participate in workshops where the toolkit is introduced. Input was provided on the toolkit and HST was represented at the first workshop – Strengthening country health sector reviews and Millennium Development Goals (MDGs) progress monitoring: Workshop on data quality assessment and analysis, Kenya, 12-16 April 2010. The tools and concepts are divided broadly into the following categories: Data Quality Assessment and Adjustment (DQAA); tracking progress against MDGs; Health Systems Performance Assessment (HSPA); health equity, addressing gaps in data quality and availability; epidemiological tools for planning; and financial tools for planning.

Project team *(alphabetically by surname): Rakshika Bhana, Candy Day (manager) and Jackie Smith*

Strengthening of Health Information Systems in the Western Cape Province

Funder: Western Cape Department of Health

The Service Level Agreement with the Western Cape (WC) Department of Health to support employees in the use of routinely collected data and information has been extended on a six-monthly basis since 2007. The HST HMIS Facilitator has been actively involved in strengthening both provincial- and district-level information management structures and processes. In addition to the ongoing capacity development initiatives to strengthen the use of information for management, the facilitator has also provided strategic input on the implementation of the revised National Indicator Data Set (NIDS) that has been approved by the NDoH. A work plan for the implementation of the NIDS was developed in collaboration with the WC province and input was

provided at the national level on data element and indicator definitions.

Project team: *Naomi Massyn*

TREATMENT MONITOR / WOMEN AND HIV/AIDS GAUGE

Funders: ATHENA Network, Ipas, Open Society Foundation of South Africa, Open Society Foundation of Southern Africa, Open Society Initiative New York, Raith Foundation, Sonke Gender Justice Network, Women's Global Network for Reproductive Rights

The Women and HIV/AIDS Gauge is an inter-cluster project within Health Systems Trust. The focus is on the impact of HIV and AIDS on women, noting the lack of a sexual and reproductive health and rights approach in addressing prevention, treatment and care in the country. This is informed by an acknowledgement that the HIV epidemic is feminised with most infections infecting and affecting women. The Gauge has a specific interest and focus on human resources, noting the gendered burden of care.

During the past year the project has focused on developing HIV Treatment Guidelines for Women of Reproductive Age. During this phase mapping of ten content areas was completed, which included a review of current literature, the processes taking place and the people involved in this work. For the second phase of this work, ten content groups of ten to fifteen members each were formed. Membership was balanced to include clinicians, academics, health workers, policy analysts, activists and HIV-positive women. Each group focuses on a gap highlighted by the project, ranging from fertility planning to lesbian health and to the gendered burden of care. The first content group meetings held in March and April 2010 resulted in the development of the first draft guidelines. The project has employed participatory processes and methodology to enable wide application and engagement. The process of refining the guidelines is taking place on the on-line NING site. Currently some 90 persons have joined the process. The Guidelines are scheduled for dissemination before December 2010

Other networking and policy activities of the Women's Health Group have included engaging in the international policy processes of the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) and the local policy processes on cervical cancer, abortion and pregnancies amongst school-going learners. The project enjoyed a successful report following an evaluation of the 60percent e-list in March 2010.

Project team *(alphabetically by surname): Nombulelo Bomela, Nicole le Roux and Marion Stevens (manager)*

INFORMATION DISSEMINATION

HST disseminates information relevant to health systems strengthening as widely as possible, primarily through our website. Visited by over 15 000 unique visitors a month from countries as diverse as China and Senegal, HST's website is recognised as an authoritative resource and database for health and socio-economic information indicators, publications and health-related news articles. It is accessed by public, academic, international and local organisations alike. To date, HST has published over 500 reports and provides free electronic access to more than 600 health systems related reports, publications and papers.

HST hosts a variety of electronic discussion lists (e-lists). Moderated by internal and external experts in their particular fields, the lists provide a forum for members to discuss issues of interest. Subscribing to a list is done either through the HST website or, where required, by approval of the moderator. Examples of the discussion lists include 'druginfo', which provides cutting edge information on developments in the pharmaceutical sector, the 'mailadoc' list, a space for medical doctors working particularly in rural areas to share their experiences and expertise, and the 60percent list, dedicated to discussing and sharing information related to sexual and reproductive health rights.

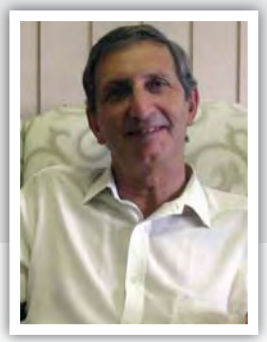
HST has been working with partners to develop and host a web portal for exclusive and confidential use by participants in the on-going Political Leadership in Health (PLIH) Programme – a collaboration between the National Ministry of Health, the Henry J. Kaiser Family Foundation and the Atlantic Philanthropies. This site is password protected and only approved subscribers may access the site. The objective of this site is to provide parliamentarians access to useful and timely information of direct relevance to current South Africa health policy, programmes and service priorities.

The HST Bulletin – of interest to health workers, policy-makers, journalists, researchers, donor organisations and consultants – provides information and links to various news articles, current resources, publications, events, training courses and job opportunities. The Bulletin focuses on areas such as health systems development, primary health care, public health and HIV. Sent to over 1 500 subscribers on a fortnightly basis, the HST Bulletin aims to distil and package key public health information for its subscribers.

The Resource Centre, based in HST's Durban office, stores and disseminates HST's own published materials in hard copy format in a library and by electronic format on the HST website. The Resource Centre is open to the public and is utilised by students, government officials, funders and professional public health practitioners.

Project team *(alphabetically by surname): Mary Dorosami, Ian Higginson, Halima Hoosen Preston and Ashnie Padarath (manager)*

RESEARCH PROGRAMME CLUSTER



Director: Dr Irwin Friedman

HST's Research Programme undertakes innovative health systems research to strengthen the district health system, its support systems and priority health programmes. HIV and AIDS, tuberculosis and the special needs of vulnerable groups such as mothers, infants and children receive particular attention. 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, HST's 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, co-operative, innovative and principled way.

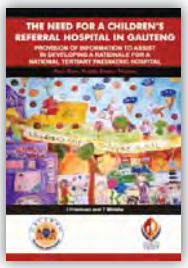
During the year under review the Research Programme was organised into four units, each led by a senior researcher. These four units were Health Priority Programme Studies and Knowledge Management (Dr Tsholofelo Mhlaba), Gender and Reproductive Health Studies (Ms Sibongile Mkhize), Health Service and Community Studies (Ms Nandy Mothibe) and Socio-economic Determinants of Disease Studies (Dr Elizabeth Lutge). Guidance and support was provided to the research teams by the Research Director, Dr Irwin Friedman, and Deputy-Director, Ms Jaine Roberts. Other research staff during the reporting period were researchers Catherine Ogunmefun, Rhulane Madale and Thokozani Mbatha; junior researchers Zimisele Ndlela, Siyabonga Nzimande and Zungezi Thuthu; as well as research interns Khethiwe Danisa and Sylvia Hadzhi. Core funding for the year was generously provided by the Health Research Directorate of the National Department of Health. Other sources of funding are specifically noted.

MATERNAL AND CHILD HEALTH STUDIES

Measuring Progress towards the Achievement of Maternal and Child Health-Related Millennium Development Goals, funded by the NDoH, was a study completed during 2008/09 but written up during the current year. The report provided a detailed secondary analysis of data collected during previous studies over a number of years comprising an assessment of antenatal care attendance, quality of antenatal care (syphilis screening, access to HIV testing), family planning coverage, institutional deliveries, PMTCT access, immunisation coverage, infant feeding practices and social grant uptake. The results from the semi-urban Paarl area (Western Cape), urban Umlazi (KwaZulu-Natal) and rural Rietvlei (Eastern Cape) were compared. The results highlighted the vast differences in health outcomes across diverse geographic regions with different basic infrastructure, access and quality of health care services. This was evidenced by the higher rate of infant death even amongst HIV-unexposed infants in the rural site. Findings from this study suggest that greater attention must be paid to the rural, under-serviced regions of South Africa to improve access to basic infrastructure, such as piped water, safe sanitation and electricity, if the MDGs related to infant mortality are to be realised.

Implementation of IMCI in the Eastern Cape Districts: Role of Community Health Workers and Facility Health Workers in Maternal and Child Survival, funded by the NDoH, assessed a programme to reduce infant and maternal mortality that is of particular importance to the MDGs. The study supported HST's District Support and Community Development cluster's work in training Community Care Workers (CCWs), that formed part of a comprehensive plan to improve child and maternal health. The primary purpose of this study was to evaluate the availability and performance of CCWs in supporting maternal and child health care and their link with health facilities in one Eastern Cape priority district, Amathole. The Research Programme conducted a formative evaluation of the CCW training. The majority (98%) of CCWs interviewed were female with a mean length of service of six years.

Diarrhoea was the most frequently-mentioned cause of infant death followed by HIV (75% and 51% respectively). These were followed by malnutrition 44%, Measles 39%, Pneumonias 20% and tuberculosis 15%. Other reported causes included poor immunisation, poor breastfeeding practices, home deliveries, failure to book for antenatal care, neglect and abuse, paraffin poisoning and burns. A high proportion of CCWs were able to identify the general IMCI signs and symptoms with an average of more than 75% fully correct answers for all syndromes probed. It was of concern, however, that their ability to recognise danger signs for the more serious conditions that caused significant mortality was correspondingly poor. A further disturbing finding, which requires further elucidation, was that those CCWs who were specifically IMCI trained did not perform significantly better than untrained CCWs.



A Review of the Business Case for the Nelson Mandela Children's Hospital was a study undertaken for the Nelson Mandela Children's Fund that, with strong support from Government and other stakeholders, developed a strong rationale for the development of the new Children's Hospital in Gauteng to serve the southern African Development Community. The proposal envisages a 200-bed, eight-theatre tertiary/quaternary central facility with state-of-the-art diagnostic and therapeutic capabilities that could be further expanded to approximately 300 beds. HST was asked to review the proposals underlying the business case and validate the results against current Government strategy. The findings suggest that the rationale for the hospital is sound and the modelling reasonably robust. It accords with the declared intention of the President and Minister of Health to develop programmes to reduce child mortality, revitalise infrastructure and modernise tertiary care.

TUBERCULOSIS AND TUBERCULO-SILICOSIS RESEARCH

The TASC II operational research study, funded indirectly by USAID and PEPFAR by means of a sub-grant through the University Research Corporation (URC), was completed on 30 September 2009. A new agreement has recently been concluded with URC for the period 1 July 2010 to 30 June 2011 for a new TB programme known formally as the *USAID TB TEST Programme in SA*.

The Burden of Childhood Tuberculosis in Five Provinces was a study of childhood TB disease in five provinces based on data from the Electronic TB Register. The study showed that the youngest age groups are the most vulnerable and that active tracing of children who are likely to be exposed should be prioritised. This entails following up all adult index patients to find children exposed at home. The proportion of smear positive results was higher in school-going children who are therefore more likely to be infectious. Interventions to prevent child transmission at schools by, for example, strengthening the index of suspicion among teachers are therefore warranted. KZN was found to have a high burden of childhood TB compared to other provinces. Pulmonary TB smear positive and no smear categories showed higher treatment success rates compared to other forms of childhood TB. Due to lack of HIV data, the study did not set out to study the impact of HIV on TB. Testing children for HIV is consequently a crucial step in combating TB. It is recommended, therefore, that such studies be conducted to strengthen management of co-infected children. Integration of HIV care in child health programmes is important. TB treatment adherence counselling and support to caregivers should be offered to improve treatment completion and reduce drug resistance in children. Robust regional and provincial data are needed on prevalence of HIV and co-infection in children. Structured adherence modules to caregivers on TB should be instituted in facilities. Unfortunately this study did not include child nutrition data, which means that the link between TB and malnutrition could not be explored. Problems with access to health care, unemployment and substance abuse are common in households. Caregivers should be supported at household level if higher cure rates are to be achieved and the incidence of drug resistance in children reduced.

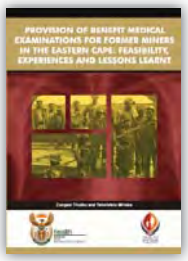
An Investigation into the Management of Suspected MDR TB Cases at Select TASC II TB Health-care Facilities in Kwazulu-Natal and Limpopo Provinces studied the management of multiple drug-resistant (MDR) TB suspects (i.e. those who showed at least Isoniazid and Rifampicin resistance). The study aimed at exploring the effectiveness of health systems in the prompt identification and management of MDR TB, anticipating that in the presence of national guidelines practice amongst the health facilities would not differ significantly. Sixteen facilities, eight each in two provinces, KwaZulu-Natal and Limpopo, were purposively sampled with the assistance of the TASC TB Provincial Co-ordinators and included both urban and rural health care settings. The study found that while TB programme facility staff felt they were doing their best to make the programme efficient, there were problems in the management of MDR TB suspects. These problems included health systems issues such as dysfunctional community DOT programmes, relatively slow drug sensitivity testing turnaround times (compared to the short times feasible with the advent of rapid molecular testing). Additional systems issues included shortage of beds at the MDR TB treatment centres, poor documentation, congested clinics, inadequate multi-sectoral collaboration, staff shortages and a lack of specific MDR TB training. Patient factors included defaulting, migration for various reasons, alcoholism and traditional healer consultations.

All these issues require improved strategic management at both policy and facility level. Increased management support is urgently needed to avoid TB programme staff becoming apathetic with possible negative repercussions for the TB programme. TB programme managers need to adopt and foster an attitude of 'we are all in this together' in relation to the TB facility staff.

Following the completion of the first phase of **An Assessment of the Hidden Silico-tuberculosis Epidemic and the Functioning of the Occupational Diseases in Mines and Works Act** in 2009, the second phase commenced in early 2010. This involved research translation as well as determining the prevalence of silicosis among the ex-mineworkers identified in the first phase. The immediate aim of the research translation process was the organisation of a symposium in the Eastern Cape in January 2010 with a range of national and provincial stakeholders to discuss the Phase One findings and to strategise on possible approaches to overcome the current bottlenecks in assessing and compensating ex-mineworkers suffering the delayed effects of silicosis.

Exploring Solutions to Address the Plight of Former Underground Miners in South Africa, a process funded by the NDoH, reported on the proceedings of the Symposium and sought ways to ensure prompt diagnosis of occupational lung diseases, such as silicosis, as well as to improve the compensation mechanisms, in terms of the Occupational Diseases in Mines and Works Act (Act 78 of 1973), for former miners. The report revealed the plight of ex-miners who had previously worked on South African gold mines and who had not, despite provisions in the Act, been offered any Benefit Medical Examination (BME) since they had left the mine employment. The report also revealed that neither the ex-mine workers nor the health personnel knew the provisions of the Occupational Diseases in Mines and Works Act regarding free heath care in public health facilities and the right to compensation for occupational lung diseases. The symposium adopted recommendations regarding the best approach to address the issue of compensation for occupational diseases and the role of all stakeholders in reducing the impact of occupational lung diseases in the country.

The Provision of Benefit Medical Examinations (BME) for Former Miners in the Eastern Cape: Feasibility, Experience and Lessons Learned study, funded by the NDoH, was a Phase Two study to translate the findings of previous research into action. Phase Two, therefore, assisted ex-miners obtain their first BME since leaving mine employment, thereby facilitating access to compensation for those eligible under the Occupational Diseases in Mines and Works Act and gathered additional information on the prevalence of silicosis amongst 196 former miners.



A key recommendation eminating from Phase One was the establishment of a demonstration unit, in collaboration with the Eastern Cape Department of Health and the Medical Bureau of Occupational Diseases (MBOD). The unit was established at the small, but modern and well equipped, Madzikane district hospital in the Alfred Nzo health district. The immediate goal was to conduct BMEs for the 196 surviving ex-miners - eight of the original group who were interviewed in Phase One had already passed away – while simultaneously collecting information on silicosis prevalence. The seemingly simple task of obtaining BMEs proved much more complex than anticipated. By the end of June, after about four months of work, a cohort of only 17 patients was x-rayed and assessed. Through experiencing the issues first hand the research team learned about the mine workers' constraints in accessing compensation. Bottlenecks included the provision of BME forms, difficulty in collecting and transporting ex-miners (some of whom were very ill), some nurses' unhelpful attitudes, the non-availability of doctors, the lack of lung function test equipment, the rough terrain of the Eastern Cape, x-ray film being out of stock and the paucity of community field workers. This reflects the situation of hundreds of thousands of ex-miners.

Phase Two recommendations include:

- that the MBOD facilitates access to BME forms through legitimate organisations;
- that the Provincial Occupational Health and Safety (OHS) Unit plays a more active role in ensuring that this and other hospitals' OHS Units are operational with permanent staff assigned to assist in the ex-miners programmes;
- that a doctor be assigned to see ex-miners or, alternatively, that private practitioners be used for BME examinations to reduce hospital doctors' workloads;
- that lung function testing equipment be procured;
- that the ex-miners be provided with a more appropriate mode of transport; and
- that the MBOD explores ways of facilitating the provision of the necessary x-ray film.

KNOWLEDGE MANAGEMENT

Knowledge Management in Health Research is a cluster of studies funded by the NDoH with the aim of providing tools and guidance for national health research policy-makers to gauge the extent to which agreed national health research priorities are reflected in the research activities of public health authorities, academic institutions and health research agencies. Activities included strengthening **Provincial Health Research Committees** and refinement of the **National Health Research Database**.

The roles of National and Provincial Health Research Committees have become increasingly important over the past few years since promulgation of the National Health Act (Act 61 of 2003) (NHA), since it requires greater co-ordination of research and ethical oversight of all research in the country. HST's Research Director has used information gathered in these studies to provide guidance to the National Health Research Committee, of which he is a member. A National Health Research Database (NHRD), a web-based repository of health research undertaken in South Africa since 1994, including abstracts and full-text articles from peer-reviewed as well as grey literature, was developed. Another tool, seamlessly integrated into the NHRD, is the Research Application Management System (RAMS) that provides a web-based application that enables Provincial Health Research Committees (PHRCs) to manage more efficiently the large number of applications that they receive. Work continued over the past year to refine the NHRD and to train all the PHRCs in its use, thus allowing the PHRCs and the NDoH to themselves monitor trends in research.

HEALTH SERVICE STUDIES

A Study on the Distribution of Biostatisticians in South Africa, undertaken at the request of the NDoH Research Directorate, identified that the scarcity of biostatisticians' skills in the public health sector is problematic. The study assessed the availability and demographic characteristics of statisticians and biostatisticians in South Africa. Data were gathered from human resources departments of all institutions that employ statisticians.

Of the 884 statisticians identified in the study, 713 (80%) are employed by Statistics South Africa. Gender distribution was balanced. Black Africans comprised 68% of the StatsSA group and 22% were white. Indians (2.7%) and coloureds (8.2%) formed a very small proportion of South Africa's statisticians. Of the 884 statisticians assessed, 70% were in the 20 to 39 year age group, with 12% over 50 years old. Fifteen (2%) have specialised in biostatistics, but only nine of these were appointed as biostatisticians in their institutions. Of the 457 statisticians for whom educational qualifications were obtained, almost half (46%) had a bachelors degree, 15.5% an honours degree, with 19% each for master's and doctoral degrees. The majority of black African statisticians had a bachelor's degree (84%) in contrast with the white statisticians who predominantly had masters (52%) or doctoral degrees.

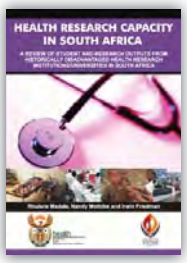
A review of **Human Resource Capacity and Research Outputs of Academic Health Complexes in South Africa**, an issue identified as a health priority in the Government's 10 Point Plan and Plan of Action, was undertaken for the NDoH.

The NHA (Act 61 of 2003) made provision for the creation of Academic Health Complexes (AHCs) in South Africa. AHCs are a critical resource and their three core roles – training, research and clinical services – have received widespread acceptance and support among local, state and public officials, health-care providers and the communities within which the AHCs exist. Government highlighted concerns regarding the capacity of AHCs to produce the required human resources, including health research capacity.

The study findings revealed considerable variation. While all AHCs endeavour to adhere to their three core roles, there was little else in common. None of the AHCs appear to conform to current legislative mandates - even those universities that are signatories to a Memorandum of Agreement with the provincial Departments of Health, this reportedly due to the lack of a coherent national framework for the governance, planning and funding of AHCs in South Africa. The governing structures outlined in the Academic Health Centre Act of 1993 differ from other envisaged AHC frameworks. The AHC Act provides for the establishment of supervisory boards, while the subsequent 1997 White Paper on the transformation of health services proposes a National Council with a different composition. The NHA is silent on governance structures to manage these complexes. The various unaligned legislative and policy documents regarding the governing of AHCs could be the reason why institutions have developed their own frameworks, resulting in the Departments of Health and Education resorting to a co-operation agreement to ensure continuity of services.

Recommendations of the study call for revisiting the legislative frameworks governing AHCs in South Africa. A uniform National Framework is essential to govern the joint agreements between the National Departments of Health and Education in fulfilling their roles of guiding the development of AHCs in South Africa. Other recommendations deal with the high vacancy rates in most institutions; the need for validation of this preliminary study's findings before extrapolation; and a human resource strategy that will quantify an appropriate medical student intake in order to fulfil the mandates of AHCs.

A Review of Student and Research Outputs from Historically Disadvantaged Health Research Institutions/ Universities in South Africa was a further study emanating from concerns expressed by both the National Health Research Directorate and National Health Research Committee that historically disadvantaged institutions (HDIs) are being marginalised in the research field. The study was funded by the NDoH.



This study researched the assumption that HDIs are not able to produce a sufficient number of master's and doctoral students with health research expertise and that the research outputs from these institutions had not improved since the restructuring of the higher education system in South Africa. This post-1994 restructuring was intended to bridge the gap between the HDIs and the historically advantaged institutions (HAIs) and to ensure that HDIs received a fair share of resources to enable better outcomes for higher education in South Africa.

The Council for Higher Education on the Restructuring of the Education System reported that until 2001 the restructuring process had not yet resulted in better outcomes. In fact, the literature indicated a drop in research outputs of the merged institutions compared to those that remained independent.

The study revealed that together HDIs produced less than 30% of the master's and doctoral students with research experience. Of these students the majority of master's graduates were female while the majority of doctoral graduates were males. In terms of race the results revealed little change from earlier times when the majority of students were white.

The findings also indicated a slight increase of research outputs from the majority of HDIs, although in some of the institutions where the HDIs and HAIs were merged the outputs showed a decrease when compared to the outputs for HAIs alone. For instance, the University of Natal on its own produced more than 120 publications per year prior to merging but this figure dropped to 80 publications per year after the merger with University of Durban-Westville.

A further finding is that HDIs have already initiated strategies to admit more female doctoral students which will contribute to normalising the gender balance.

Recommendations of the study include:

- that each university should develop a strategy to manage/improve the intake of students in order to improve both the standard of the research outputs and the ability of students to do research; and
- that a study be conducted to identify the cause of the decline in the number of master's and doctoral students.

As a first step towards **research translation** in this area the Cluster plans to run a one-week training programme, based on a WHO manual entitled "A Practical Guide for Health Researchers", for participants from all the HDI Universities during August 2010. This programme will not only consolidate the skills of a representative group of lecturers from these institutions but contribute to developing a core research module as well. The training could also contribute to overcoming infrastructural and human resources problems. HST plans to use a similar approach toward strengthening the research capacity of district management teams in certain priority districts as a means to supporting HST's DSCD and HealthLink clusters in various ways.

COMMUNITY STUDIES

The Gauteng NGO Evaluation and Assessment Study. At the request of the Gauteng Department of Health (GDoH) a study was conducted to understand referral patterns and linkages between not-for-profit organisations (NPOs) and health-care facilities at all levels in the provincial health system. The study was initially to be implemented in two phases but, as a result of a breadkdown in communication between the consultants managing the project on behalf of the Department and the Department itself, only the first phase could be implemented and the second phase has been postponed. Phase One outcomes were a brief literature review and an analysis of secondary data on NPOs and health facilities in Gauteng provided by the GDoH. Phase Two will involve collection of primary quantitative and qualitative data to further examine the referral patterns between NPOs and health facilties.

A National Audit of Home-Based/Community-Based Care (HCBC) Organisations was undertaken for the national Department of Social Development with funding from the Joint Education, AIDS and Poverty Programme (JEAPP). The outcomes included a web-based database and a comprehensive report on the national situation regarding HCBC organisations.

In 1999 Cabinet mandated the Departments of Social Development (DSD) and Health (DoH) to oversee the implementation of the HCBC programme. The study comprised a national audit to collect information on all registered and unregistered non-profit organisations (NPOs) rendering HCBC services in South Africa, to update the existing provincial and national departments' HCBC lists and database(s) and to expand the databases' functionality to include a range of additional lists and related databases.

Many of the available lists were incomplete. The NPO Directorate database, which contained over 56 000 organisations across the nine provinces, was cleaned of entries not meeting DSD and DoH criteria for HCBC organisations. A web-based data entry form was developed. This data-entry system was developed further to provide an ongoing maintenance tool for the consolidated national database.

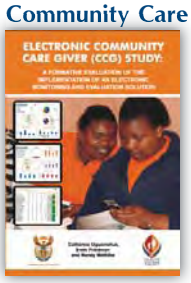
The audit commenced with telephonic interviews with all non-government organisations (NGOs), community-based organisations (CBOs) and faith-based organisations (FBOs) whose contact details were available from the national and provincial offices of the two responsible departments and other stakeholders. During the fieldwork, conducted mainly in the last quarter of 2009, 2 001 organisations

participated in the telephonic audit. Of these, 1 824 met the criteria to qualify as HCBC organisations. Three hundred and ten HCBC organisations were visited on-site.

Policy implications of this study, based on the findings, the lessons learnt and the recommendations made, are as follows:

- Mandatory utilisation of the new web-based database by all DSD and DoH officials in the three spheres of Government, to facilitate the two responsible departments' access to information on HCBC programmes countrywide;
- DSD and DOH officials in all three spheres to retain and use the audit's web-based data-entry tool as a standardised tool for collecting data on HCBC programmes;
- Provide print-outs to departmental officials who do not have access to the Internet;
- Increase stipends to encourage improvement of the quality of CCGs services, although the added financial demand may impact negatively on the sustainability of HCBC programmes;
- Expand the funding base for HCBC programmes to include private organisations, businesses and companies; and
- Ensure that all HCBC organisations, especially in the Western Cape, participate in future audits.

During the period under review the first phase of an evaluation entitled **Formative Evaluation of the Nompilo Community Care Givers (CCG) Monitoring System** was completed. This involved a baseline assessment of a cell-phone and IT infrastructure programme implemented in three sites in Limpopo, KwaZulu-Natal and Western Cape provinces. The follow-up summative assessment will enable a cost/benefit analysis of the system and establish its suitability for wider use.



From a literature review conducted by the NDoH in June 2007 it was clear that there was no standardised monitoring and evaluation (M&E) framework for non-profit organisations and that setting up a new framework operational across the country would take time. In an effort to develop an integrated, standardised M&E framework using mobile telecommunications technology, an electronic/mobile information and communication system infrastructure, known as the e-MuM® solution, has been developed.

The study evaluated the utilisation, efficiency and effectiveness of the e-Mum solution in strengthening and supporting the management of CCGs working for three not-for-profit organisations (NPOs) in the three provinces. Each of the NPOs selected 20 CCGs to implement the electronic solution – a total of 60 in the three sites. An equal number of CCGs not implementing the solution were selected as a control group for comparison.

The findings of the formative evaluation indicated that virtually all the e-MuM® CCGs favoured the electronic solution as it speeded up collecting patients' information and their records remained confidential. Time was saved during home visits in a number of ways through the use of cell-phones, while the CCGs could keep track of their clients' information and there was less paperwork. A few CCGs reported, however, that some patients were sceptical about their cellular phones as they did not know what the CCGs did with the information captured. Some CCGs also reported challenges they were having with the cellular phones – for instance, not being able to scan a barcode – and concerns about possible weather damage and theft.

GENDER, REPRODUCTIVE, BEHAVIOURAL AND VULNERABLE GROUP STUDIES

Gendered Perspectives on Progress towards Maternal and Child Health related Millennium Development Goals. This study, funded by the NDoH, investigated whether there was a significant difference in the way that men and women saw maternal and child health issues and whether such differences might impact adversely or beneficially on the Maternal and Child Health programme. More specifically, the study sought to ascertain men's knowledge on health issues affecting women and children, to promote local participation by community members to devise for themselves mechanisms for dealing with local health problems or challenges and, thirdly, to encourage men, young and old, to collaborate with women in tackling local health problems and challenges.

The study was undertaken in partnership with Amandla Madoda, "Men Power", a local NPO operating in KwaZulu-Natal's uMkhanyakude district and Umhlabuyalingana sub-district, prioritised by the NDoH for attention during the current five year period.

Respondents' views on prenatal care varied but it was generally considered important for woman to attend prenatal care, as indicated in the following quote:

> *"... to have some blood tests because in this time we are living in there are so many diseases, you see ... if they find that you have been infected with the diseases [meaning HIV] there are some tablet that you can get from the hospital so that you can have a healthy baby..."*
>
> [38yr old female, Hluhluwe]

Decisions regarding the use of traditional medicine by pregnant women and those who have given birth lies

largely with the family elders, the grannies in particular, and, for those who are married, their husbands. This emphasizes the need for family-orientated discussion and family involvement in health promotion programmes.

The concept of men being 'responsible' arose frequently during discussions with male respondents. This issue will be pursued in the research translation activities together with the local partner, Amandla Madoda.

While both termination of pregnancy (ToP) and circumcision are major elements of the NDoH Plan of Action, qualitative research into these issues is complicated by respondents' being uncomfortable discussing sensitive, sexually-related topics. Such findings provide a clear warning that challenges must be anticipated in the implementation of such programmes.

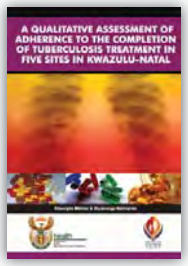
Overall, the study revealed that while there may be some variations in how men and women view maternal and child health, interviewee variation was not as large as might have been anticipated. Education campaigns appear to have played an important role in educating the communities regarding maternal and child health, particularly on the issues of HIV, AIDS and TB.

Implications for policy and practice are:

- both males and females had a fair knowledge of health issues affecting women and children, albeit with varied opinions on how to address the problems associated with these;
- some women in the district still prefer to use traditional medicine after giving birth although the majority reported on the importance of visiting the clinic for postnatal care; and
- health care can be improved by strengthening the traditional healers' abilities in using evidence to guide their actions.

The Antiretroviral Treatment Adherence Study was a qualitative study undertaken in five sites in KwaZulu-Natal and completed during the previous reporting period. Several aspects to research translation have, however, been undertaken. A set of tools was developed to collect and share information on patients' experiences of taking ARVs. The findings can inform ART managers on the strategies that patients develop to achieve high adherence. Intensive, separately-funded research translation activities were implemented to disseminate information to service providers at the research sites, to share the tools with them and to encourage their integration to improve practice. The findings were presented at both provincial and national levels in an effort to influence policy. The study was followed up with two further closely related studies – one on TB adherence and comparing the findings with HIV adherence in the same sites. All these studies deepen our understanding of the broader adherence issues and how these impact on a variety of diseases, while also contributing to best practice in approaches to improving HIV and TB adherence.

A Qualitative Assessment of Adherence to the Completion of Tuberculosis Treatment in Five Sites in KwaZulu-Natal was one of the follow-up studies referred to above, funded by the NDoH. This sought to deepen our understanding of ART adherence and applying a similar strategy to understanding adherence issues pertaining to TB. Like its predecessor this study comprised a qualitative assessment of adherence to TB treatment and completion in five sites in KwaZulu-Natal. The methods largely comprised listening and documenting the experiences of patients with their TB treatment and their views of the TB programme. In addition to their experiences, discussions were held with health-care providers (HCPs) about treatment and the TB programme as a whole to enrich this assessment. This study was designed to provide information on how to improve the TB programme.



The study revealed a number of circumstances that encourage or impede adherence. Those which encourage adherence have to be improved while those that impede adherence need to be explored and solutions found to reduce the rate of defaulting, whether on a personal, household or programmatic level.

Specific recommendations which impact on multiple health systems issues were offered regarding the importance of patient centred education, TB/HIV integration, more explicit inclusion of men, improved management of side effects, strengthening food security, assistance with transport, home visiting by HPCs, enhancing the functioning of tracer teams, improving the TB service environment, addressing human and infrastructure resources, avoiding treatment stock-outs and recognising that staff feel that they need some form of recognition for placing themselves at risk in providing TB services.

Follow-up to this study during the research translation phase will be to encourage a more integrated HIV and TB programme working closely with other aspects of PHC and other role players in the Social Development Cluster.

Trading Health for Wealth: A Critical Examination of the Relationship Between the HIV/AIDS Disability Grant and Patient Adherence to State Funded ARV Medication. The current HIV and AIDS disability grant (DG) policy provides that a grant be provided to HIV-positive individuals whose CD4 count is below 200. The grant is, however, subject to a six-monthly review and the grant is withdrawn when a grantee's CD4 count rises above 200. The consequences of this policy have had both devastating and unintended consequences. The current literature on this subject reveals that people are quite literally '"trading" their lives for the grant. There are indications that patients who rely on the grant as a means of paying for food and other essentials for their families deliberately default on treatment in

order to gain access to this much-needed income. This illustrates the predicament faced by many individuals in the same situation and is illustrative of these individuals' desire to continue receiving financial remuneration even at the expense of their own wellbeing. The decision is triggered by different reasons, including unemployment, poverty and other unforeseen circumstances.

This study, funded by the NDoH, identified the factors and most common reasons for dropping out of the ART programme and investigated the relationship between ARV adherence and receiving a disability grant.

The study found distinct differences in ability and willingness to adhere to ART treatment among those who were receiving a disability grant compared to those who were not. In general terms there was an extremely high risk of those respondents who were not receiving the grant and who had no other means of support of defaulting from the programme.

Building the Capacity of Traditional Healers to Undertake Research. HST has been working with the National Health Research Directorate and the Nelson Mandela Faculty of Medicine at UKZN to develop the capacity of traditional healers to undertake health research. The aim is to encourage this important group within the health sector to understand the value of evidence. Two exploratory meetings were held with a group of Traditional Health Practitioners from around the country to assess their interest in learning the basic principles of research.

The Traditional Health Practitioners in the meeting all expressed interest in being trained in research methods, seeing the training as important for their future activities and practice generally. They also showed interest in learning to conduct their own research in their areas of interest, such as in indigenous knowledge systems. HST agreed to conduct the training with the DoH providing technical and other support.

SOCIO-ECONOMIC DETERMINANTS OF DISEASE STUDIES

Economic Incentives for Improving Clinical Outcomes in Patients with TB, funded by the NDoH, Wellcome Trust and KNCV TB Foundation, aims to test the feasibility of delivering monthly vouchers to patients in KwaZulu-Natal (KZN) with pulmonary TB to improve their TB treatment outcomes and to assess the effectiveness of the vouchers as a strategy. Funding from the Wellcome Trust provides for a PhD Fellowship and is channelled through the South African Medical Research Council.

The trial, which is being conducted in one urban and one rural district in KZN, started at the beginning of July 2009. Recruitment continued until 31 March 2010 and to date over 1 200 patients have received vouchers and are eligible for analysis.

Some of the challenges encountered in conducting this study include:

- Individual patients receiving vouchers more than once in a month;
- Shops experiencing delays in being paid, resulting in their becoming impatient and, on occasions, stopping administration of the vouchers until payment is received; and
- Delays in recording receipt of the vouchers into the study database, resulting in an underestimation of the total number of patients receiving vouchers at any one time.

The administration of vouchers will end on 31 August 2010 and the fieldwork for the various sub-studies will end in December 2010. Results will be analysed between December 2010 and April 2011.

The Socio-economic Determinants of Health and Nutrition in South Africa: A Review of the Literature. This study, funded by the NDoH, comprised a desk-top review which investigated poverty as an important determinant of health in South Africa. Few interventions have been specifically tested for their effect on poverty-related diseases but, based on observations at population level, some do seem to have a significant impact on these diseases. Such interventions include nutritional support, micro-finance programmes and social grants. In South Africa, the social grants programme has been shown to be of benefit in households affected by HIV and AIDS. Other poverty alleviation programmes have been too small in scale to have any meaningful impact. It is suggested that the coverage and value of social grants be increased, that a system of universal social protection be implemented, that opportunities for work be actively created (both as part of the Expanded Public Works Programme as well as in broader sectors of the economy) and that relatively new interventions such as micro-finance programmes be used more widely. Further research should be done on the possible perverse incentive effects of social support and intervention studies in the field of poverty-related health.

Climate Change in South Africa: Health and Health-Related Effects. This desk-top review was funded by the NDoH. Climate change is a real phenomenon, resulting largely from the use of fossil fuels that drive production. Although developed countries have contributed most to the emission of greenhouse gases, the effects of climate change will be felt most severely by developing countries that lack the capacity to adapt to or mitigate against these effects.

The review found that South Africa has elements of both developed and developing countries. As one of the world's largest producers of greenhouse gases, South Africa may be described as a developed country but with the large population of poor people and vast areas of under-development, it may also be classified as

a developing country. South Africa is a signatory to the major international agreements relating to climate change but, as yet, climate change does not feature highly in government policies other than those arising from the Department of Environmental Affairs and Tourism.

The health effects of climate change in South Africa are likely to arise from water shortages, decreased crop yields and changing patterns of infectious diseases that may result from climate change. Food insecurity may increase, leading to increased incidence and severity of malnutrition, particularly in children. Diseases related to malnutrition, such as TB, may increase in incidence. Lack of potable water, especially in informal settlements, may increase the spread of diarrhoeal diseases, which will further exacerbate malnutrition. Warmer weather may also foster the spread of parasitic infections, important causes of diarrheoa.

These health problems are not new to the country but strategies to address them may need to change in the face of increasing numbers of affected people.

SUPPORT SERVICES

Director: Mr Deena Govender

The Support Services unit provides an array of services to the various clusters that ensures that project staff are supported to deliver effectively and efficiently. This arrangement enables project staff to concentrate on their specific activities while the routine administrative activities are handled by experienced support staff.

HUMAN RESOURCES

At the end of June 2010 HST had a total staff of 62 employees. Staff demographic background is as follows:

Race	Male	Female	Total
Black	6	29	35
Coloured	1	5	6
Indian	3	8	11
White	3	7	10
Total	**13**	**49**	**62**

During the year under review twelve new appointments were made and there were twelve terminations.

In terms of categories, black females were in the majority at 47% of the total number employed, as well as in the *"professionally qualified and experienced specialist and mid-management"* category at 16%. This pattern is to be expected as it matches that of the broader market environment. Continuance of the pattern is favoured by the organisation's selection processes.

HST's recruitment process also encourages suitably qualified, disabled people to apply for vacant positions. Special efforts will be made to make this known during advertising and in talent searches.

ACCREDITATION

Health Systems Trust is in the process of becoming accredited as a training provider and is currently awaiting the Health and Welfare SETA's approval.

FINANCE

The annual financial statements as at 30 June 2010 reflect assets to the value of R74 million, which indicates HST's financially stable position. The Finance and Audit committees continue to provide strategic direction and play an important oversight role in the governance of the organisation.

INFORMATION TECHNOLOGY

HST continues to promote the use of free and open source software (FOSS) with most of its servers running on Linux. Through the use of a leased, off-shore server and mirrored drives in the different offices, HST has strengthened IT security and recovery procedures. Despite operating in an NGO environment, HST has provided its staff and other stakeholders with access to current technologies and services. The IT department ensures minimum downtime through immediate attention to all support requests and continues to keep abreast of changing technologies which may benefit the organisation. HST serves 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. The free and open source software is maintained through in-house technical staff and skills.

SHARING KNOWLEDGE: PUBLICATIONS AND CONFERENCE PRESENTATIONS

HST PUBLICATIONS

Day C, Monticelli F, Haynes R, Barron P, Smith J, Sello E, eds. *The District Health Barometer 2008/09*. Durban: Health Systems Trust, February 2010

Friedman I, Mothibe N, Ogunmefun C, Mbatha T. *A national audit of registered and unregistered home- and community-based care (HCBC) organisations in South Africa*. Durban: Health Systems Trust, 2010

Lutge EE, Friedman I, Ndlela Z. *The socio-economic determinants of health and nutrition in South Africa: a review of the literature*. Durban: Health Systems Trust, 2010

Lutge E, Ndlela Z, Friedman I. *Assessment of current support strategies for patients with TB in KwaZulu-Natal*. Durban: Health Systems Trust, 2010

Lutge EE, Lewin S, Volmink J, Friedman I, Ndlela Z. *Economic incentives for improving clinical outcomes in patients with TB in South Africa: an interim report*. Durban: Health Systems Trust, 2010

Madale R, Mothibe A. *A review of human resource capacity and research outputs of academic health complexes in South Africa*. Durban: Health Systems Trust, 2010

Madale R, Mothibe N, Friedman I. *Health research capacity in South Africa: a review of student and research outputs from historically disadvantaged health research institutions/universities in South Africa*. Durban: Health Systems Trust, 2010

Madale R, Mothibe N, Friedman I. *A rapid appraisal of the available statisticians and biostatisticians in South Africa*. Durban: Health Systems Trust, 2010

Mbatha T, Mkhize S, Friedman I, Danisa K. *Gendered perspectives on progress towards maternal and child health related Millennium Development Goals (MDGs)*. Durban: Health Systems Trust, 2010

Mhlaba T, Giyose P, Lutge E, Mbatha T, Friedman I. *An investigation into the management of suspected MDR TB cases at select TASC TB healthcare facilities in KwaZulu-Natal and Limpopo provinces*. Durban: Health Systems Trust, 2010

Mhlaba T, Giyose P, Lutge E, Mbatha T, Friedman I. *Burden of childhood tuberculosis in five provinces*. Durban, Health Systems Trust, 2010

Mhlaba T, Giyose P, Bomela N, Ogunmefun C, Friedman I. *Implementation of Integrated Management of Childhood Illness in an Eastern Cape district: role of community care workers in maternal and child survival*. Durban: Health Systems Trust, 2010

Mkhize S, Nzimande S. *A qualitative assessment of adherence to the completion of tuberculosis treatment in five sites in KwaZulu-Natal*. Durban: Health Systems Trust, 2010

Ndlela Z, Lutge E. *Climate change in South Africa: health and health-related effects*. Durban: Health Systems Trust, 2010

Ndlela Z, Lutge E, Friedman I. *An assessment of the quality of services offered at facilities providing treatment for multi-drug resistant TB in South Africa*. Durban: Health Systems Trust, 2010

Nzimande S. *Trading health for wealth: a critical examination of the relationship between the HIV/AIDS disability grant and patient adherence to state funded ARV medication*. Durban: Health Systems Trust, 2010

Ogunmefun C, Friedman I, Mothibe N. *Electronic Community Care Giver Study: a formative evaluation of the implementation of an electronic monitoring and evaluation solution for CCG programmes*. Durban: Health Systems Trust, 2010

Ramokolo V, Doherty T. *Measurement of progress towards the maternal and child health Millennium Development Goals*. Durban: Health Systems Trust, 2009

Smith J, Lutge EE. *A study of the funding flow for the tuberculosis programme in KwaZulu-Natal, South Africa*. Durban: Health Systems Trust, 2010

Thuthu Z, Giyose P, Mhlaba T, Friedman I. *The hidden epidemic amongst former miners – Health Systems Trust symposium report*. Durban: Health Systems Trust, 2010

Thuthu Z, Mhlaba T. *Provision of Benefit Medical Examinations for former miners in the Eastern Cape: feasibility, experience and lessons learnt*. Durban: Health Systems Trust, 2010

CONFERENCE PRESENTATIONS

Bam N. "*Health Systems Trust approach to health systems strengthening and project overview.*" Paper presented at Mpumalanga Province Health Systems Seminar: Strengthening the district health system for service delivery. White River, 12 May 2010

Day C. "*Key district hospital cost drivers for chronic care and MNCH – what do we know?*" Paper presented at PRICELESS – SA (Priority Cost Effective Lessons for Systems Strengthening): A research and development agenda for chronic disease and maternal and child health. Cape Town, March 2010

Davidson LL, Susser IS, Kauchali S, Taylor M, Mkhize S, Mnguni S, Griffiths K, Mellins CA, Chhagan M. "*Triangulating ethnography and epidemiology findings iteratively in the ASENZE study of health and psychosocial need in children: Understanding caregiving for children in a community based by HIV.*" Poster presented at XVIII International AIDS Conference. Vienna, Austria, 18-23 July 2009

Griffiths K, Mkhize S, Mnguni S, Susser I, Kauchali S, Davidson LL. "*Transnational mentoring in ethnography for the ASENZE study: Building capacity from the USA to South Africa.*" Poster presented at XVIII International AIDS Conference. Vienna, Austria, 18-23 July 2009

Lutge EE, Gray A. "*The medical use of cannabis in patients with HIV/AIDS.*" Paper presented at 5th Public Health Association of South Africa conference. Durban, 30 November to 2 December 2009

Lutge EE, Ndlela Z, Friedman I. "*The role of poverty in patient adherence to TB treatment.*" Paper presented at 5th Public Health Association of South Africa conference. Durban, 30 November to 2 December 2009

Mbatha T, Mhlaba T, Friedman I. "*National Health Research Database.*" Poster presented at 5th Public Health Association of South Africa Conference. Durban, 30 November to 2 December 2009

Mhlaba T, Giyose P, Lutge E, Mbatha T, Friedman I. "*Burden of childhood tuberculosis in five provinces, South Africa.*" Paper presented at 2nd TB conference. ICC, Durban, 1-4 June 2010

Mhlaba T, Giyose P, Thumbi P, Thuthu Z, Friedman I. "*An investigation into the management of suspected multi-drug resistant tuberculosis cases at select TASC TB health-care facilities in KwaZulu-Natal and Limpopo provinces, South Africa.*" Paper presented at 2nd TB conference. ICC, Durban, 1-4 June 2010

Mkhize S. "*Qualitative studies of ART and TB treatment adherence.*" Paper presented to Oxfam Australia's Intersections Partner Event. Pietermaritzburg, 26 October 2009

Monticelli F. "*District Health Barometer.*" Paper presented at Mpumalanga Province Health Systems Seminar: Strengthening the district health system for service delivery. White River, 12 May 2010

Ngcobo H, Haynes R. "*Health governance and its challenges.*" Paper presented at 5th Public Health Association of South Africa conference. Durban, 30 November to 2 December 2009

Ndlela Z, Lutge EE, Friedman I. "*An Assessment of the quality of services offered at facilities providing treatment for multi-drug resistant TB in South Africa.*" Poster presented at 2nd National TB Conference. Durban, 1-4 June 2010

Ndlela Z, Lutge EE, Friedman I. "*The quality of services at referral facilities for multi-drug resistant TB in South Africa.*" Poster presented at 5th Public Health Association of South Africa conference. Durban, 30 November to 2 December 2009

Ogunmefun C, Mothibe N. "*A national audit of registered and unregistered home and community-based care organisations in South Africa.*" Paper presented at Vulnerable Children Focused Research and Dissemination Workshop, NACCA. Birchwood Hotel, Gauteng, 30 September to 2 October 2009

Ogunmefun C. "*The national home and community-based care audit.*" Paper presented at the Joint Economic Aids and Poverty Programme Dissemination Workshop – The challenges of HIV and AIDS, poverty and development. Sheraton Hotel, Pretoria, 19 May 2010

Smith J, Lutge E. "*Developing a funding framework to promote the efficient utilisation of resources to combat Tuberculosis.*" Poster presented at 5th Public Health Association of South Africa conference. Durban, 30 November to 2 December 2009

Smith J, Lutge E. "*Implementing a simple budgeting tool to assist with TB management at a PHC facility level.*" Poster presented at 2nd TB conference. ICC, Durban, 1-4 June 2010

Yoder S, Mkhize S, Nzimande S. "*Patient experiences with antiretroviral therapy programmes in KwaZulu-Natal, South Africa.*" Paper presented at the 5th Public Health Association of South Africa Conference. Durban, South Africa, 30 November to 2 December 2009

HST STAFF

OFFICE OF THE CHIEF EXECUTIVE OFFICER

Jeanette Hunter, *CEO*
Lindiwe Nhlapo
Marcus Jones (until 30 April 2010)
Ross Haynes

DISTRICT SUPPORT AND COMMUNITY DEVELOPMENT CLUSTER

Nomonde Bam, *Director* (until 31 May 2010)
Oumiki Khumisi, *Acting Director*
Frank Tlamama
Lwandlekazi September
Makhosazane Nyawo
Mumsey Mnguni (until 31 January 2010)
Muzi Matse
Mzikazi Masuku
Nomthandazo Magingxa
Nonceba Languza
Ntombomhlaba Nyanga
Thando Ford Ngomane (until 30 April 2010)
Thembekile Lushaba
Thulile Mthunzi
Thulisile Thabethe
Tshitshi Ngubo
Tumelo Mampe
Wanda Mthembu (until 31 May 2010)

HEALTHLINK CLUSTER

Ronel Visser, *Director*
Ashnie Padarath
Candy Day
Elliot Sello (✝ 22 June 2010)
Fiorenza Monticelli
Halima Hoosen Preston
Hlengiwe Ngcobo
Ian Higginson (until 30 April 2010)
Imeraan Cassiem
Jackie Smith
Marion Stevens
Mary Dorasami
Naomi Massyn
Nicole le Roux (until 23 January 2010)
Nombulelo Bomela
Nonqaba Mzana (until 31 August 2009)
Rakshika Bhana
Stiaan Byleveld

RESEARCH PROGRAMME CLUSTER

Irwin Friedman, *Director*
Catherine Ogunmefun
Elizabeth Lutge
Jaine Roberts (until 31 August 2009)
Khethiwe Danisa
Madibata Matji (until 31 October 2009)
Nandy Mothibe
Patela Giyose
Rhulane Madale
Sibongile Mkhize
Siyabonga Nzimande
Sylvia Hadzhi
Thokozani Mbatha
Tsholofelo Mhlaba
Zimisele Ndlela
Zungezi Thuthu

SUPPORT SERVICES

Deena Govender, *Director*
Andrew Mohlala (until 30 April 2010)
Beverley Hamiel
Beverley Vezi (until 28 February 2010)
Charmaine Singh
Delene King
Duduzile Zondi
Fazila Khan
Joyce Mareme
Julia Elliott
Kemona Pillai
Khuphukile Nyawose
Mahomed Hoosen Imam
Mpume Xulu
Primrose Ndokweni
Quintin Dreyer
Racheal James
Rakesh Brijlal
Salome Selebano
Siemonne Ogle

BOARD OF TRUSTEES

Professor Welile Shasha (Chairperson) 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 Ilimalethu 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 and an in-depth knowledge of the national health system, and international experience.

Mr Kevin Bellis (Deputy Chairperson) holds a BSc Joint Honours in Geography and Sociology. He is a Technical Manager for HLSP working on health systems management of tuberculosis and HIV. He brings to the Board his international experience in management and institutional development, operational and strategic planning, financial planning, operational research and monitoring and evaluation.

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.

Professor Kaya Mfenyana holds Masters' degrees in Educational Administration and Family Medicine, and was awarded a Fellowship of the College of Family Physicians by Peer Review. 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 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 Executive Manager for Specialised Hospitals and Medical Support Services in the North West Department of Health and Social Development. Obakeng previously served as the Head of Department for Community Safety in North West Province (NW), Head of Department for the Health Department and the Public Works Department in 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 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 United Kingdom 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.

Professor Laetitia Rispel is currently an Adjunct Professor at the Centre for Health Policy, School of Public Health, at the University of the Witwatersrand, Johannesburg and holds a Doctorate in Health Systems from the same University. She is the current president of the Public Health Association of South Africa (PHASA). 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 health policy and systems research, management, public health, monitoring and evaluation, and the social determinants of health.

Ms Gcwalisile Twala is a law graduate from the University of the Witwatersrand. She holds a Diploma in Corporate Governance from the Graduate Institute of Management and Technology. She practices as an attorney and is a director of a commercial law firm. She specialises in commercial law, pension law and corporate governance. Ms Twala serves as member of the Transport Appeal Tribunal, a tribunal under the National Department of Transport and is also a board member of Aristocrat (Pty) Ltd and Zico Gaming (Pty) Ltd. She is also a member of the Disciplinary Committee of the Law Society of the Northern Provinces.

Dr Maureen Tong holds a PhD in International Law (Strasbourg University) focussing on rights of people to self-determination and restitution. She is currently the interim Head of the Thabo Mbeki Institute for African Leadership, a partnership between the Thabo Mbeki Foundation and the University of South Africa. She previously worked as Operations Manager at the United Nations Development Programme, as Chief Operations Officer at the then Department of Land Affairs, and as Chief of Staff at the then Ministry for Agriculture and Land Affairs. Maureen was Deputy Director for the Centre for Human Rights at the University of Pretoria and Street Law Co-ordinator at the Centre for Socio-Legal Studies at the University of KwaZulu-Natal.

Dr Tim Wilson is a paediatrician who spent 12 years in the national Department of Health, 1994-2006. He served first as Special Advisor to the Minister, then as Chief Director Hospital Services and, finally, five years as Cluster Manager PHC, Districts and Development. After retiring in 2006 he worked again for NGOs including CIET and CSVR, and since late 2008 has been a consultant to the national department, supporting services and their managers in rural areas, mostly in the Eastern Cape. He brings to the Board skills and experience related to the national health system, PHC and hospital services, management and leadership.

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.

Trustees whose term of office ended during the reporting period

Ms Seadimo Chaba
(Accepted 05 March 2004, completed 4 February 2010)

Professor David Serwadda
(Accepted 05 March 2004, completed 4 February 2010)

ANNUAL FINANCIAL STATEMENTS

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

STATEMENT OF RESPONSIBILITY FOR FINANCIAL REPORTING BY THE BOARD OF TRUSTEES

for the year ended 30 June 2010

The Board of Trustees is responsible for the preparation of the financial statements of the Trust For Health Systems Planning and Development ("the Trust") and to ensure that proper systems of internal control are employed by or on behalf of the Trust. In presenting the annual financial statements IFRS for SMES 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 has 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 believes that all representations made to the independent auditors during their audit were valid and appropriate. The Deloitte & Touche audit report is presented on page 34.

APPROVAL OF THE ANNUAL FINANCIAL STATEMENTS BY THE BOARD OF TRUSTEES

The annual financial statements set out on pages 35 to 44 were approved by the Board of Trustees on 19 November 2010 and signed on its behalf by:

Chairperson

Trustee

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

CORPORATE GOVERNANCE STATEMENT

for the year ended 30 June 2010

The Trust for Health Systems Planning and Development ("the Trust") confirms its commitment to the principles of openness, integrity and accountability as advocated in the King III 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 where practical, forms part of the mandate of the Trust's audit committee. The Trust has complied with the Code, relative to HST's business during the year under review.

BOARD OF TRUSTEES

RESPONSIBILITIES

The Board of Trustees ("the Board") was established on the basis of a legal Deed of Trust document, supplemented by a formally approved written charter. Its composition is balanced so that no individual or small group dominates decision-making. The Board meets regularly, at least three times per year, 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 executive 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 executive management and the internal and external auditors. The committee met three times during the 2010 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 members :

	Attendees		
	2/09/2009	2/03/2010	27/07/2010
S Govindsamy (External member)	✓	✓	✓
DN Pillay (Trustee)	✓	✓	No
I Lax (External Member)	✓	✓	✓
M Hendricks (Trustee)	✓	✓	No

The audit committee addressed its responsibilities properly in terms of the charter during the 2010 annual financial year. No changes to the charter were adopted during the 2010 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 on 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 executive remuneration, Trustees honorariums and fees and service contracts. Whenever necessary, the committee is advised by independent professional advisers. The committee met twice during the 2010 annual financial year.

The personnel committee consists of the following members:

	Attendees	
	5/03/2010	30/07/2010
O Mongale (Trustee)	✓	✓
M Tong (Trustee)	No	✓
G Twala (Trustee)	✓	✓
M Modipa (External Member)	No	No
I Matsheka (External Member)	No	✓

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:

	Attendees		
	8/06/2009	5/03/2010	28/07/2010
M Hendricks	✓	✓	✓
K Bellis	✓	✓	No
G Twala	No	✓	No
O Mongale	No	No	✓

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 2010 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 internal audit was not conducted during the year under review due to a change in auditors. Gobodo Inc have recently been appointed internal auditors and will be presenting their coverage plans to the audit committee for approval.

ETHICAL STANDARDS

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

In summary, the Code requires that, at all times, all Trust personnel act with the utmost integrity and objectivity and in compliance with the letter and the spirit of both

the law and trust policies. Failure by employees to act in terms of the Code results in disciplinary action.

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

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.

Deloitte.

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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 Board of Trustees', the statement of financial position as at 30 June 2010, the statement of comprehensive income, 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 8 to 23.

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 the International Financial Reporting Standard 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 of 30 June 2010, and its financial performance and its cash flows for the year then ended in accordance with the International Financial Reporting Standard 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 24 to 28* 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
Registered Auditors
Per M Luthuli
Partner
19 November 2010

* These additional pages are not included in this Annual Report.

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT
REPORT OF THE BOARD OF TRUSTEES
for the year ended 30 June 2010

The Board of Trustees presents its 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 2010.

1. GENERAL REVIEW

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

GOALS

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

2. FINANCIAL RESULTS

2.1 Full details of the financial results are set out on pages 36 to 44 in the attached annual financial statements.

2.2 As set out in the annual financial statements, the Trust had a total surplus for the year of R1 328 646 (2009: R3 200 003).

2.3 The ratio of administration expenses (excluding the unusual and extraordinary items), against gross income is 12% which is in line with the prescribed limit as set out in the trust deed.

3. TRUSTEES

Trustees serve on a voluntary basis and are not remunerated for their services.

The Trustees of the Trust for the year ended 30 June 2010 are set in the table:

Name	Date appointed	Date resigned/ tenure ended
W Shasha	1 August 2008	
D Serwada (Uganda)	5 March 2004	February 2010
S Chaba	5 March 2004	February 2010
Y Pillay	29 July 2004	December 2009
DN Pillay	29 July 2004	July 2010
T Wilson	1 August 2008	
L Rispel	1 August 2008	
K Mfenyana	1 August 2008	
S Zungu	1 August 2008	
K Bellis	1 August 2008	
M Hendricks	1 August 2008	
O Mongale	26 June 2009	
M Tong	01 April 2010	
G Twala	01 April 2010	

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 2010, 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. This has correctly not been recorded in the financial statements, as the property is owned by The Lovelife Trust. Management of The Lovelife Trust were informed of this matter and have taken steps to rectify this.

5. MATERIAL EVENTS AFTER YEAR END

The trustees are not aware of any maters or circumstances which are material to the financial affairs of the trust, that have occurred between year end and the date of approval of the financial statements.

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 ensure that the audit coverage is focused on and identifies areas of high risk.

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT
STATEMENT OF FINANCIAL POSITION
for the year ended 30 June 2010

	Notes	2010	2009
		R	R
ASSETS			
Non-current assets		905 411	3 355 806
Property, plant and equipment	6	884 619	3 327 778
Intangible assets	7	20 792	28 028
Current assets		73 345 351	39 044 372
Trade and other receivables	8	3 303 402	4 264 296
Cash and cash equivalents	9	65 768 364	32 269 629
Accrued revenue	5	4 273 585	2 510 447
Total assets		74 250 762	42 400 178
EQUITY			
Accumulated surplus funds		14 805 780	13 477 134
LIABILITIES			
Non-current liabilities			
Interest bearing borrowings	11	-	1 790 542
Current liabilities		59 444 982	27 132 502
Trade and other payables	10	3 835 695	3 645 108
Current portion of interest bearing borrowings	11	-	228 934
Deferred revenue	5	55 609 287	23 258 460
Total liabilities		59 444 982	28 923 194
Total equity and liabilities		74 250 762	42 400 178

STATEMENT OF COMPREHENSIVE INCOME
for the year ended 30 June 2010

	Notes	2010	2009
		R	R
Grant income	2	42 374 976	36 618 947
Other income		1 093 912	110 946
Project expenses		(35 681 085)	(28 488 300)
Grants paid		(2 131 850)	(1 233 400)
Administration expenses		(5 753 444)	(5 636 286)
(DEFICIT)/SURPLUS BEFORE INTEREST AND TAXATION	3	(97 491)	1 371 907
Interest paid	4	(62 669)	(249 071)
Interest received	4	1 488 806	2 077 167
SURPLUS BEFORE TAXATION		1 328 646	3 200 003
Taxation	5	-	-
NET SURPLUS AFTER TAXATION		1 328 646	3 200 003
Other comprehensive income		-	-
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		1 328 646	3 200 003

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT
STATEMENT OF CHANGES IN EQUITY
for the year ended 30 June 2010

	District Support Community Development (DSCD)	Research	HeathLink	Central Admin (CORE)	Total
Opening balance as at 1 July 2008	4 515 328	180 313	853 389	5 022 592	10 571 622
Restatement of opening balance accumulated profits	-	-	(294 491)	-	(294 491)
Total surplus/(deficit) for the year	(1 429 698)	1 844 231	2 597 933	187 537	3 200 003
Opening balance as at 1 July 2009	3 085 630	2 024 544	3 156 831	5 210 129	13 477 134
Total surplus/(deficit) for the year	3 903 714	(636 837)	(757 149)	(1 181 082)	1 328 646
Closing balance as at 30 June 2010	6 989 344	1 387 707	2 399 682	4 029 047	14 805 780

STATEMENT OF CASH FLOWS
for the year ended 30 June 2010

	Notes	2010	2009
		R	R
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash generated from operations	A	32 692 334	2 999 796
Interest paid		(62 669)	(249 071)
Interest received		1 488 806	2 077 167
Net cash flows from operating activities		34 118 471	4 827 892
CASH FLOWS FROM INVESTING ACTIVITIES			
Proceeds from disposal of property, plant and equipment		2 157 125	18 094
Acquisition of property, plant and equipment		(728 335)	(180 230)
Acquisition of intangible assets		(29 050)	(3 749)
Net cash flows from/(used in) investing activities		1 399 740	(165 885)
CASH FLOWS FROM FINANCING ACTIVITIES			
Re-payment of long term loan		(2 019 476)	(36 305)
Net cash flows used in financing activities		(2 019 476)	(36 305)
Net increase in cash and cash equivalents		33 498 735	4 625 702
Cash and cash equivalents at beginning of year		32 269 629	27 643 927
Cash and cash equivalents at end of year		65 768 364	32 269 629
A. RECONCILIATION OF SURPLUS BEFORE TAXATION TO CASH GENERATED FROM OPERATIONS			
Surplus before taxation		1 328 646	3 200 003
Adjustments for:			
Depreciation		348 573	347 089
Amortization		36 285	35 371
Loss/(profit) on disposal of property, plant and equipment		651 368	(3 444)
Assets scrapped		14 429	-
Interest paid		62 669	249 071
Interest received		(1 488 806)	(2 077 167)
Adjustment to opening retained earnings		-	(294 491)
Cash generated from operations before working capital changes		953 164	1 456 432
Working capital changes:			
(Increase) in trade and other receivables		(802 244)	(604 273)
Increase in trade and other payables		32 541 414	2 147 637
Cash generated from operations		32 692 334	2 999 796

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

NOTES TO THE ANNUAL FINANCIAL STATEMENTS

for the year ended 30 June 2010

1. Summary of significant accounting policies

1.1 Basis of preparation

The annual financial statements have been prepared in accordance with the International Financial Reporting Standard for Small and Medium-sized Entities ("IFRS for SME's") for the first time.

The financial statements have been prepared under the historical cost convention.

This is the first annual financial statements prepared in accordance with the International Financial Reporting Standard for Small and Medium-sized Entities ("IFRS for SME's"). The transitional requirements require that a reconciliation be prepared to disclose the effects of the adoption of this framework. However there is no impact on the financial statements arising from their adoption and hence no reconciliation has been prepared.

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:

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

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

An asset's carrying amount is written down immediately to its recoverable amount if the asset's carrying amount is greater than its estimated recoverable amount (refer note 1.3).

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

1.3 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 of the period in which it becomes receivable.

Income from sale of publications is included in other income.

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

Interest income - as it accrues

1.9 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 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 Grant income:
Grantee for the year ended 30 June 2010

	HealthLink	DSCD	Research	Admin	Total	Accrued Income	Deferred Income	Total
The Atlantic Philanthropies	154 924	11 842 568	-	-	**11 997 492**	-	-	**11 997 492**
Department of Health	5 442 086	2 951 977	6 616 396	-	**15 010 459**	-	2 431 346	**17 441 805**
DBSA	330 000	-	-	-	**330 000**	-	-	**330 000**
Jeapp	-	-	957 680	-	**957 680**	-	-	**653 396**
KNVC TB Foundation	-	-	376 495	-	**376 495**	-	-	**376 495**
Marco International	-	-	76 621	-	**76 621**	-	-	**76 621**
Millennium Challenge account	1 497 270	-	-	-	**1 497 270**	(646 611)	-	**850 639**
National Lottery Board	-	-	-	-	**-**	-	52 731 528	**52 731 528**
Nelson Mandela's Children's Fund	-	-	75 000	-	**75 000**	-	-	**75 000**
Aids Foundation of South Africa	450 000	-	-	-	**450 000**	-	-	**450 000**
Treatment Monitor Income	1 161 187	-	-	-	**1 161 187**	-	446 413	**1 607 600**
UNICEF	-	6 826 896	-	-	**6 826 896**	(3 044 404)	-	**3 782 492**
University Research Council	-	2 448 831	560 347	-	**3 009 178**	(247 644)	-	**2 761 534**
Wellcome Trust	-	-	606 698	-	**606 698**	(334 926)	-	**271 772**
TOTAL	**9 035 467**	**24 070 272**	**9 269 237**	**-**	**42 374 976**	**(4 273 585)**	**55 609 287**	**93 406 374**

Grantee for the year ended 30 June 2009

	HealtLink	DSCD	Research	Admin	Total	Accrued Income	Deferred Income	Total
The Atlantic Philanthropies	2 631 422	3 111 350	-	-	**5 742 772**	(1 971 039)	11 842 568	**15 614 301**
W K Kellogg Foundation	-	2 054 484	-	-	**2 054 484**	-	-	**2 054 484**
Department of Health	5 732 470	6 858 901	4 625 214	-	**17 216 585**	(419 408)	8 242 719	**25 039 896**
DBSA	220 000	-	320 880	-	**540 880**	-	330 000	**870 880**
UNICEF	-	-	-	-	**-**	-	2 400 240	**2 400 240**
Intel Corp	80 000	-		-	**80 000**	-	-	**80 000**
Aids Foundation of South Africa	(614 608)	-	-	-	**(614 608)**	-	-	**(614 608)**
Italian Corp	235 067	627 129	-	-	**862 196**	-	-	**862 196**
Charles Kendall & Partners Ltd	-	-	-	-	-	-	-	**-**
Open Society Foundation of South Africa	2 533 079	-	-	-	**2 533 079**	(120 000)	-	**2 413 079**
WGNRR	71 534	-	-	-	**71 534**	-	-	**71 534**
Athena	33 763	-	-	-	**33 763**	-	-	**33 763**
Dalhouse University	1 235	-	-	-	**1 235**	-	-	**1 235**
MRC	-	-	173 426	-	**173 426**	-	-	**173 426**
Raith Foundation	40 267	-	-	-	**40 267**	-	442 933	**483 200**
Nuffield Institute for Health	-	-	234 476	-	**234 476**	-	-	**234 476**
Centre for Rural Health	-	-	211 689	-	**211 689**	-	-	**211 689**
KNCV	-	-	160 730	-	**160 730**	-	-	**160 730**
Measure Adhere	-	-	219 477		**219 477**	-	-	**219 477**
Management Sciences for Health	-	964 040	-	1 326 896	**2 290 936**	-	-	**2 290 936**
Jeapp	-	-	262 080	-	**262 080**	-	-	**262 080**
University of KZN	-	-	-	-	**-**	-	-	**-**
University Research Council	-	2 714 630	1 789 316	-	**4 503 946**	-	-	**4 503 946**
TOTAL	10 964 229	16 330 534	7 997 288	1 326 896	**36 618 947**	(2 510 447)	23 258 460	**57 366 960**

3.(DEFICIT)/SURPLUS BEFORE INTEREST AND TAXATION

(Deficit)/surplus before interest and taxation is stated after taking the following into account:	2010 R	2009 R
Expenses:		
Depreciation on property, plant and equipment (refer note 6)	348 573	347 089
Amortisation of intangible assets (refer note 7)	36 285	35 371
Auditors' remuneration	47 500	111 600
- current year	82 500	75 000
- prior year (overprovision)/underprovision	(35 000)	36 600
Loss on disposal of property, plant and equipment	651 368	947
Profit on disposal of property, plant and equipment	- (4 391)	
Assets scrapped	14 429	-
Consultants legal support and license fees	45 933	32 383
Operating lease rentals	1 864 314	1 481 617
Land and buildings	1 731 376	1 340 569
Other	132 938	141 048
Travel and accommodation	6 338 913	4 135 766
Director's emoluments	3 205 983	3 412 259
Total cost to company		
• Thobile Mbengashe	-	1 207 816
• Jeanette Hunter	814 183	-
• Deena Govender	558 133	491 799
• Irwin Friedman	593 791	536 422
• Ronel Visser	597 327	559 798
• Nomonde Bam	642 549	616 424
Staff costs	23 188 276	19 449 784

4. INTEREST PAID AND RECEIVED

Total interest paid	(62 669)	(249 071)
Total interest received	1 488 806	2 077 167
Net interest received	1 426 137	1 828 096

5. TAXATION

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.

6. PROPERTY, PLANT AND EQUIPMENT

	Land and buildings	Motor Vehicles	Computer Equipment	Furniture and Fittings	Total
	R	R	R	R	R
2010					
Opening net carrying amount	2 801 368	9	484 289	42 112	3 327 778
Additions/improvements	-	287 825	358 639	81 871	728 335
Disposals	(2 801 368)	-	(21 533)	-	(2 822 921)
Depreciation	-	(47 971)	(274 800)	(25 802)	(348 573)
Closing net carrying amount	-	239 863	546 575	98 181	884 619
Cost	-	710 985	1 325 775	642 336	2 679 096
Accumulated depreciation	-	(471 122)	(779 200)	(544 155)	(1 794 477)
Closing net carrying amount	-	239 863	546 575	98 181	884 619
2009					
Opening net carrying amount	2 801 368	9	634 542	73 368	3 509 287
Additions/improvements	-	-	178 424	1 806	180 230
Disposals	-	-	(14 650)	-	(14 650)
Depreciation	-	-	(314 027)	(33 062)	(347 089)
Closing net carrying amount	2 801 368	9	484 289	42 112	3 327 778
Cost	2 801 368	423 063	2 159 422	560 465	5 944 318
Accumulated depreciation	-	(423 054)	(1 675 133)	(518 353)	(2 616 540)
Closing net carrying amount	2 801 368	9	484 289	42 112	3 327 778

Land and buildings comprised of property described as ERF 26726 Observatory, Cape Town. This property was sold on the 1st November 2009. Proceeds received were used to settle the mortgage bond with Standard Bank. (refer note 11).

7. INTANGIBLE ASSETS

	2010	2009
	R	R
Computer software	20 792	28 028
Reconciled as follows:		
Opening net carrying amount	28 028	59 650
Additions	29 050	3 749
Amortisation	(36 285)	(35 371)
Closing net carrying amount	20 792	28 028

8. TRADE AND OTHER RECEIVABLES

	2010	2009
	R	R
Receivables	2 327 860	3 865 231
Accrued interest income	143 464	-
Receiver of Revenue - Value added Tax	730 447	243 978
Deposits	84 189	119 402
Prepaid expense	17 441	35 685
	3 303 402	4 264 296

9. CASH AND CASH EQUIVALENTS

Current accounts	4 372 642	4 772 037
Call accounts	61 395 722	27 494 823
Cash on hand	-	2 769
	65 768 364	32 269 629

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

Research	5 502 150	7 312 154
DSCD/ISDS and Community Development	6 345 147	18 507 302
HealthLink	680 739	1 046 270
CORE	53 240 328	5 403 903
	65 768 364	32 269 629

10. TRADE AND OTHER PAYABLES

Accruals	1 930 177	2 646 360
Provision for audit fees	82 500	110 000
Provision for leave pay	994 750	888 748
Provision for salaries	645 690	-
Operating lease liability	182 578	-
	3 835 695	3 645 108

11. INTEREST-BEARING BORROWINGS

Non-current		
Mortgage bond – Standard Bank	-	2 019 476
Less: Short term portion transferred to current liabilities	-	(228 934)
	-	1 790 542

The mortgage bond was settled with the proceeds from the sale of the property in Cape Town (ERF 26726 Observatory). (Refer note 6)

The mortgage loan was secured by a mortgage over the property with a net book value of R2 801 368. These loans beared interest at 8.85% per annum and were repayable in 228 monthly installments of R19 908, inclusive of finance charges.

12. OPERATING LEASE COMMITMENTS

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

Not later than 1 year	1 348 801	1 125 904
Between 2 and 5 years	2 971 938	4 328 423
	4 320 739	5 454 327

13. CONTINGENT LIABILITIES

The trust is not aware of any contingent liabilities that existed at year end.

FUNDERS AND FUNDING PARTNERS

- Abt Associates Inc.
- AIDS Foundation of South Africa
- ATHENA network
- Centers for Disease Prevention and Control, USA
- Development Bank of Southern Africa
- Ipas, South Africa
- Joint Economics Aids And Poverty Programme
- KNCV Tuberculosis Foundation
- Macro International Inc.
- Medical Research Council, South Africa
- Millennium Challenge Account, Lesotho
- National and Provincial Departments of Health, South Africa
- National Lottery Distribution Trust Fund
- Nelson Mandela Children's Fund
- Open Society Foundation for South Africa
- Open Society Foundation of Southern Africa
- Open Society Initiative, New York
- Sonke Gender Justice Network
- The Atlantic Philanthropies
- The Henry J. Kaiser Family Foundation
- The Raith Foundation
- United Nations Children's Fund
- University Research Co., LLC
- Wellcome Trust
- Women's Global Network for Reproductive Rights

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HEALTH SYSTEMS TRUST