Annual Report 2011

Year ending 30 September 2011

Contents

Thanks

The directors and staff of Right to Care extend their warmest thanks and appreciation to the US government, the United States Agency for International Development (USAID), and the President's Emergency Plan for AIDS Relief (PEPFAR) for providing grant funding and other support, which has enabled us to provide clinical care, and treatment to tens of thousands of individuals suffering from HIV and associated diseases.

We are grateful for the tremendous support provided by Dr Melinda Wilson, Technical Advisor, USAID. Dr Wilson's commitment and assistance has played an invaluable part in the success of Right to Care. We extend our thanks and appreciation to the Global Fund for entrusting us with the responsibility of Principal Recipient for the Round 10 of funding.

We thank the national and provincial health departments for effective partnerships that resulted in the delivery of clinical services to our people burdened by the pandemics of HIV and TB. We thank our colleagues—too numerous to mention by name—at the National Department of Health (DoH), Gauteng DoH, Mpumalanga DoH, Northern Cape DoH, Free State DoH, and Western Cape DoH.

Acknowledgements

The directors and senior managers of Right to Care

Report Contents

Kurt Firnhaber	Report project oversight
Bruce Conradie	Editing and Photography
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Fiona Ingham	Proofreading
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BMW SA	Show Your Hand photograph

Disclaimer

Ten years of innovative quality care

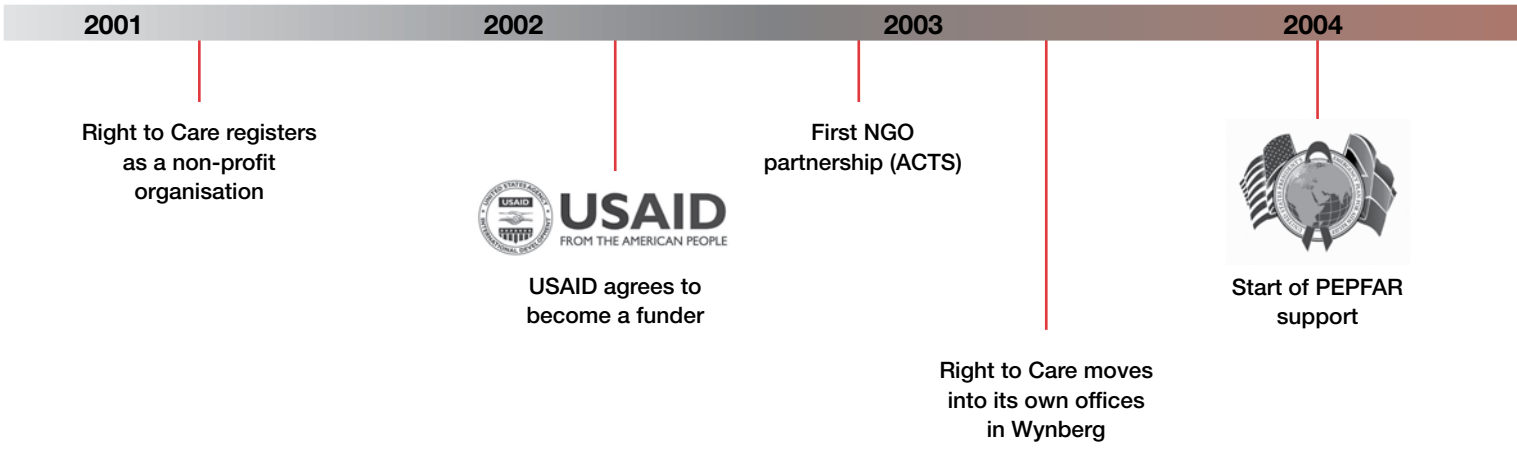
Celebrating Right to Care's tenth anniversary in 2011

Right to Care

2001	Right to Care registers as a non-profit (section 21) organisation
2001	TherapyEdge adopted as patient management database
2002	First funding from USAID
2003	Right to Care moves into its own offices in Wynberg, Johannesburg
2004	Start of PEPFAR support
2004	Head office moves to Helen Joseph Hospital
2005	Training department formally established
2008	Right to Care Health Services registers as a (Pty) Ltd
2008	Staff complement reaches 500
2009	Major expansion of head office at Helen Joseph Hospital
2009	Exceeded 800 staff members
2010	Appointed a Principal Recipient for Global Fund, Round 10
2011	USAID-funded programmes start transition from service delivery to technical assistance
2011	Staff members author 35 peer-reviewed journal articles, bringing total published articles to 133 (2003 to 2011)

Technology innovations and developments

2008	TherapyEdge database goes live (online in realtime)
2009	VSAT satellite communications network
2009	TextAlert, SMS notifications to patients
2009	Laborite web-based employee performance management system
2010	Web-based employee self-service system
2010	Biometric identification for logging staff attendance
2010	NHLS laboratory and TherapyEdge system integration
2011	Jobs.co.za for advertising vacancies
2011	RightMax custom-built grants management system



VIP visits to Right to Care

2006 Mark R Dybul, US Global AIDS Coordinator
2007 Jendayi Frazer, US Deputy Secretary of State
2008 US Congressman Howard Berman and delegation
2009 Queen of Swaziland, Queen Dr Sibonelo Mbikiza
2009 First Lady, Madam Tobeka Madiba-Zuma
2010 Minister of Health, Dr Aaron Motsoaledi
2011 US Deputy Secretary of State, Thomas Nides
2011 USAID Director for the African Bureau of Southern Africa, Michaela Meredith

Gauteng

2004 Start of support for Gauteng DoH
2004 Rea'phela, Right to Care's first NGO CCMT clinic established
2006 Facilities at Rea'phela outgrown; Rea'phela closed and patients transferred to Alexander Clinic
2007 Support begins for Sedibeng district
2007 Support for Ekurhuleni district increase substantially to 13 sites
2008 TB Focal Point established at Helen Joseph Hospital
2009 More than 40 sites supported with direct service delivery
2011 Ekurhuleni sites transferred to another PEPFAR partner and some of staff transferred to the DoH
2011 Under PEPFAR realignment, district support consolidated to two districts, West Rand and City of Johannesburg
2011 Support extended to 99 sites

Free State

2009 Provincial office opened in Bloemfontein, Pelonomi Hospital supported
2009 Staff complement exceeds 30
2009 At Pelonomi Hospital, province's first TB Focal Point established
2011 Under PEPFAR realignment, provincial office relocated to Bethlehem and a new sub-district, Maluti-a-Phofung, acquired
2011 First steps to technical assistance with appointment of first site coordinators and a clinical trainer
2011 Satellite office in Maluti-a-Phofung opened and staffed with two site coordinators

2005

Head office moves to Helen Joseph Hospital

2006

Launch of Proudly Tested

Proudly tested™
TESTING FOR TREATMENT

Training department formally established

2007

Launch of TB programme

Mpumalanga

2003 First NGO partnership formed, with ACTS
2006 Start of Right to Care's support for DoH, Ehlanzeni district
2007 Provincial office opened
2008 Expansion to Gert Sibande district
2010 Appointed PEPFAR coordinating partner for Gert Sibande and Ehlanzeni districts
2010 Launch of MMC programme (first site in Piet Retief)
2010 Decentralised support to more than 70 PHC facilities
2010 Initiated HIV Clinicians Forum
2010 Provided technical and clinical advisor to provincial HIV, AIDS & TB programmes
2010 Implemented decentralised cervical cancer screening in six sub-districts
2011 Under PEPFAR realignment, acquired site in Carolina
2011 Mentorship programme rolled out in Ehlanzeni and Gert Sibande districts
2011 Main technical assistance provider to the province's regional training centre

Northern Cape

2006 First Right to Care employee appointed in Northern Cape
2006 First HCTs conducted
2007 Treatment-site staff appointed
2008 Infrastructure upgraded at three of seven supported sites
2008 X-ray machine purchased for Jan Kempdorp Hospital
2008 Right to Care collaborates with FPD in the Compass Project
2008 First clinical mentorship programme: mentors from USA based at two sites for six weeks
2009 VIA services started
2010 Support structure changed from site-based to district-based
2010 Participated in the presidential HCT campaign

2007

10 000 patients on ARV therapy

Jendayi Frazer, US Deputy Secretary of State, visits Right to Care

2008

Congressman Howard Berman visits

TherapyEdge database goes live (online in realtime)

Award of the UGM grant

Launch of PMTCT and Paediatric HIV programmes

2009

Health Services registers as a (Pty) Ltd

Right to care HEALTH SERVICES

Launch of Cervical Cancer programme

NGOs become partners

2002 CHRU

2003 ACTS

2004 Witkoppen Clinic; Ndlovu; CARe; He²ro; Refilwe

2005 Friends for Life; Vuselela

2006 Alexandra Clinic

2007 Bhubezi; Topsy; Hlokomela; ThemCare; Blue Cross

2008 Amcare; AgriAIDS; South African Institute of Health Care Management; Keimos Diocese; Waterberg Welfare Society

2009 Lifeline Rustenburg; GOLD; Catholic Relief Services; Cell-Life

2010 South to South

NGO partnerships

2004 First NGO sub-recipients appointed

2004 Right to Care establishes Re'aphela

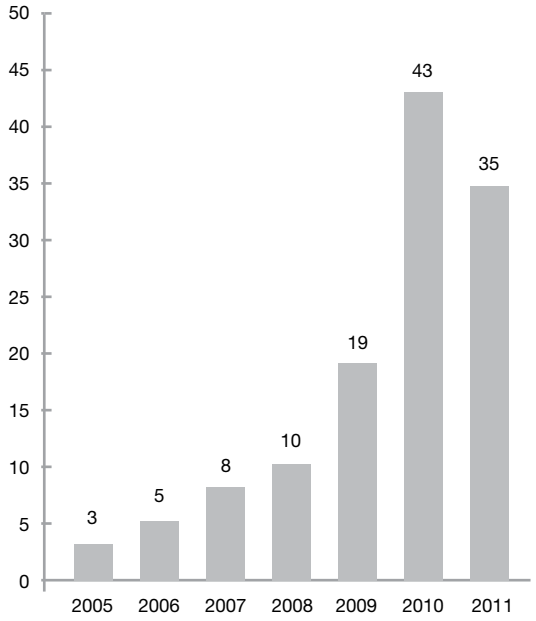
2007 Re'aphela closed and clinic operations moved to Alexandra Clinic

2007 Government accredits Witkoppen ARV clinic and Alex clinic supporting all drugs and laboratory tests

2008 Award of the USAID UGM grant

2009 Government accredits Ndlovu, Bhubezi, ACTS, Hlokomela and Topsy

PEER-REVIEWED JOURNAL ARTICLES AUTHORED OR CO-AUTHORISED BY RIGHT TO CARE STAFF MEMBERS



Western Cape

2007 Pepfar support starts, at Grabouw Day Hospital, through Themba Care

2008 First Right to Care employee appointed in Western Cape

2010 Site staff deployed in the Overberg and Central Karoo

2010 Awarded the Provincial Employees Assistant Programme contract in the Central Karoo and Overberg

2011 With the Desmond Tutu HIV Foundation, launch of the Tutu Tester Treater Overberg, a mobile testing and treatment unit in the Overberg

2011 Launch of the GeneXpert MTB/RIF in the Central Karoo

2010

Launch of MMC programme

Minister Aaron Motsoaledi visits

2011

Launch of Pharmacy Supply Chain Management programme

Right to Care ten years anniversary

2012

Launch of RightMax grants management system

Appointed Principal Recipient by the Global Fund

Chairman and CEO report

Chairman and Chief Executive Officer report

The year 2011 marked the tenth anniversary of Right to Care. Right to Care has grown into a mature organisation with over 600 staff members and grant funding from two of the world's biggest HIV funders, USAID and the Global Fund for AIDS, TB and Malaria. Today Right to Care is supporting the clinical care of 126 000 patients, of which 118 000 are on ARV therapy (ART). There are 8400 paediatric patients on ART and 6000 employees enrolled in workplace HIV management programmes.

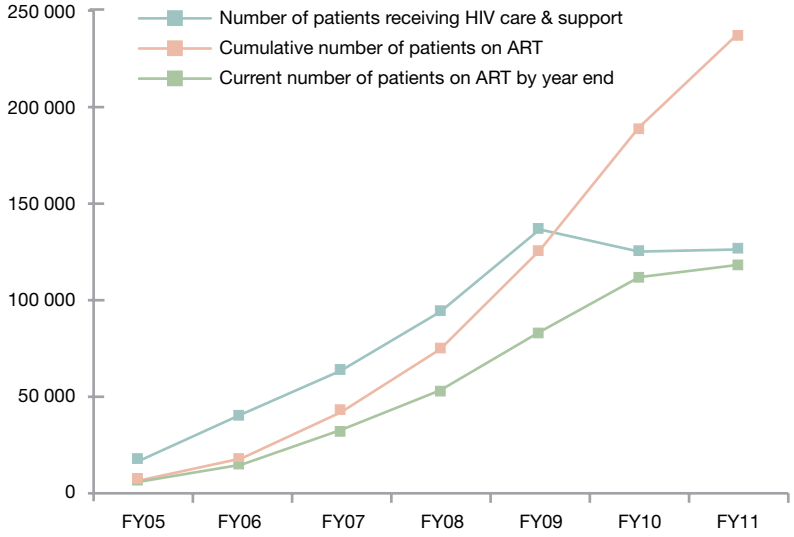
Prevention programmes have been expanded and, in the year under review, 330 000 HIV tests and 13 300 medical male circumcisions (MMCs) were performed. ARV prophylaxis was provided to 8000 pregnant women and 7500 infants.

In October 2000, Right to Care was launched as a programme for "enhanced HIV care". The following year, 2001, saw the registration as a non-profit (Section 21) organisation. In 2002, USAID agreed to become a major funder and in 2004 the first patients were initiated on treatment under USAID funding, through the President's Emergency Plan for AIDS Relief (PEPFAR).

Thanks to USAID funding and support, the organisation grew rapidly. After just four years (2008) the staff numbered 500 and 75 000 patients had been initiated on ART. Other milestones, since inception:

2001	TherapyEdge-HIV™ adopted as patient management database
2002	First NGO partnership formed (with CHRU)
2006	First of four provincial offices opened (in the Northern Cape)
2008	Right to Care Health Services (Pty) Ltd founded
2008	Award of the USAID Umbrella Grants Management (UGM)
2010	Appointed as the Principal Recipient for Global Fund, Round 10

CORE PROGRAMME GROWTH



The rapid scale-up of Right to Care in response to the HIV epidemic was made possible by USAID and PEPFAR support. In particular, we extend our warmest thanks and appreciation to Dr Melinda Wilson, Clint Cavanaugh, and Jeff Borns of USAID for their exceptional contributions to Right to Care's success.

Strategic direction

Today, Right to Care is an innovative mature organisation that responds rapidly to the vision of its leadership and to the needs of the public healthcare system. Greater emphasis is being placed on health systems strengthening and on prevention of new infections. This has seen more resources allocated to prevention of mother-to-child transmission (PMTCT), cervical cancer screening, HIV counselling and testing (HCT), MMC, and INH Preventative Therapy (IPT) for TB.

The transition from direct service delivery to technical assistance began in the previous year and continues to expand. The technical assistance activities are founded on research, technological developments, information technology innovation, and clinical best practices. Operational research is underway in all provinces. The goal is to develop affordable interventions to reduce disease-related mortality and morbidity and to prevent new HIV and TB infections.

The transition has made it possible to expand the operational reach of the organisation and the number of sites that Right to Care supports has more than doubled from 170 to 470. The process of transferring clinical staff to employment in the Department of Health (DoH) continues and has been successful.

Operational efficiencies have been achieved through the PEPFAR partner district realignment. This has resulted in Right to Care concentrating support in 14 districts in five provinces, representing 27% of the districts in South Africa.

Right to Care has been pivotal in assisting provinces in the development of provincial strategic plans and in providing input for the National Strategic Plan for 2012–2016.

Mentoring and training is being provided to healthcare workers at all levels in both the private and public sectors. A key component of this is nurse-initiated and managed ARV therapy (NIMART). Across all provinces, Right to Care has invested considerably in the rollout of NIMART and in the training of nurse mentors.

Leadership

Right to Care is led by a balanced and diverse board of directors, three executive and eight non-executive, under the chairmanship of Dr Ali Bacher. The non-executive directors are actively engaged in promoting the success of the organisation. In 2011, the board of directors emphasised the importance of good corporate

HCT target exceeded every consecutive year for

Seven years

Percentage of patients with an undetectable viral load within six months of starting ART

79%

governance, sustainability, financial control, risk management, and human resources management.

Since the close of the financial year, Dr Alan Knott-Craig has resigned from the board. Alan's valuable contribution will be sorely missed.

Partnerships

Right to Care continues to maintain increasingly strong relationships with the national and provincial departments of health. Right to Care advisory teams are now participating actively in government planning structures and influence decisions made at provincial, district, and sub-district management levels. The collaboration between the DoH and Right to Care is formalised in memoranda of understanding which detail programme objectives and implementation plans. We acknowledge and thank the national, provincial, and local health departments in Gauteng, Mpumalanga, Northern Cape, Free State, and the Western Cape for their support and collaboration.

At the same time, Right to Care enjoys fruitful relationships with grant sub-recipients. There are 18 sub-recipients, receiving grants ranging from $50 000 to $3-million per year. They provide a wide range of core and ancillary services for HIV and TB prevention and treatment.

The NGO and Grants Managements departments have developed a secure, accountable, and transparent grants management system. In the year under review, Right to Care developed RightMax, a financial reporting and data management system that integrates a wide range of processes, among which are financial reports, accounting documents, and monitoring and evaluation. RightMax is a significant innovation and a major step forward in the management of grant funding.

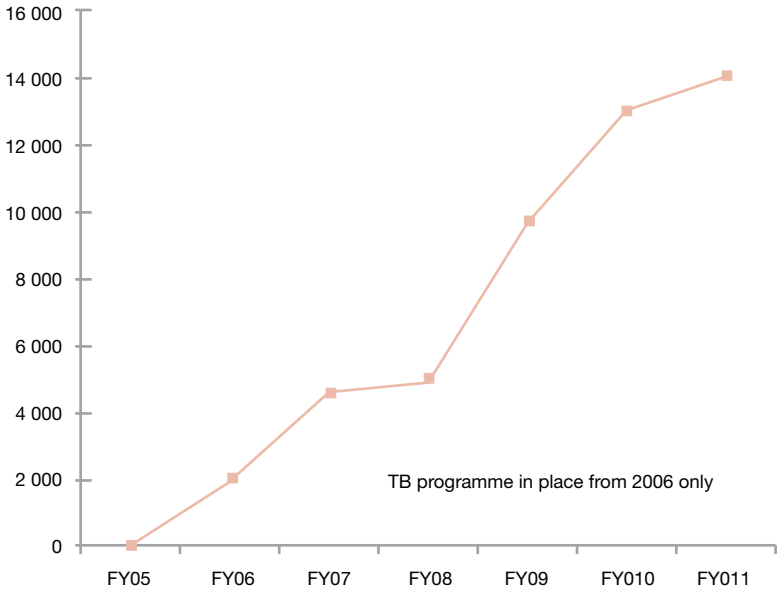
Successful partnerships with the University of the Witwatersrand, Boston University, and the University of North Carolina have given Right to Care a sound foundation of research translating into evidence-based medical best practices, guideline revisions, and technical assistance to the DoH for strategic decision making.

With regard to our own staff, we applaud them for their outstanding dedication and commitment to the cause of fighting HIV. This has been fundamental to the success of the organisation.

Financial performance and funding

The leadership of Right to Care has adopted a strategy of diversifying programme and funding sources to ensure growth and sustainability. Right to Care has created the management capacity to manage large grants successfully. The bulk of funding received goes to programme delivery, with overheads contained to just 8% of the total.

NUMBER OF PATIENTS NEWLY REGISTERED ON TB TREATMENT



In the 2010/2011 financial year, the amount of funding awarded to Right to Care by US government agencies in Rand terms rose from R303.8-million to R321.2-million, an increase of 5.7%.

Grant and financial management are vital to meeting donor requirements. Right to Care is widely recognised as the most successful South African grant management organisation and is currently the only South African organisation to be a USAID UGM appointee.

In 2010, Right to Care was selected as the Round 10 civil society Principal Recipient for the Global Fund. Intensive budget negotiations followed and budgets were negotiated for the first phase (two years) of the programme, which resulted Right to Care being allocated $16-million.

Sub-recipients and service providers were identified through an open competitive process. They will provide a range of services, among which are increased TB and Gene Xpert laboratory capacity, enhanced HIV drug-resistance monitoring, medical male circumcision, and intensified case HIV and TB case finding areas with a high burden of the disease and among most-at-risk populations. The Global Fund programme is expected to become operational in 2012.

Right to Care Health Services, a wholly owned for-profit subsidiary of the non-government organisation, has had a successful year. Revenue was R67-million, with growth of 6.9%. Profits were R4.1-million (8% over target). This division is the foundation from which the organisation will compete for healthcare revenue from the private sector, in advance of the full rollout of the National Health Insurance.

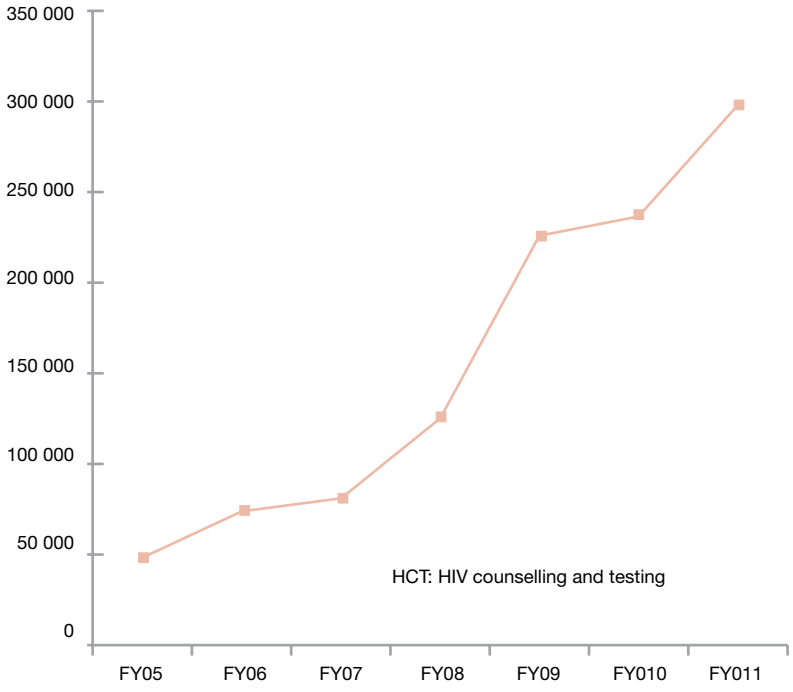
Patients with diagnostic work-up for TB

64 833

Patients on ART

118 447

CLIENTS PROVIDED WITH HCT (excluding PMTCT-related), 2003-2011



Clinical programmes

The emphasis remains on healthcare systems strengthening, providing technical assistance, and capacity building. While the transition to technical assistance is in progress, Right to Care continues with extensive direct service delivery, in particular to under-served HIV and TB patient populations.

Right to Care's core programmatic outputs, namely, adult and paediatric HIV treatment, TB-HIV integration, cervical dysplasia and cancer screening, down-referral, and data management solutions, remain strong. In addition, the organisation is now making a significant contribution to technical assistance for pharmacy supply chain management and pharmacovigilance.

Right to Care continues to demonstrate innovation by using technology to address capacity shortages in public healthcare in a resource-poor setting. The strategy is aligned with international standards, such as GSM, HL-7, ICD-10 coding, convergence, and integration of multiple systems. The patient and the doctor or nurse are placed into the centre of system development, enabling the healthcare provider and user to receive instant benefits from quality clinical information.

The collaboration with TherapyEdge-HIVtm is a core component of Right to Care. This patient and clinic management system has led to major improvements in quality of care by providing decision support (in accordance with treatment guidelines), IT-supported task shifting, transfer and monitoring of patients to down-referral sites, and supply chain management.

The integration of clinic data systems with the National Health Laboratory Services has been successfully implemented and is bearing fruit. The consistent and immediate access to laboratory test results has considerably improved efficiency and quality of care.

Alignment with the National DoH monitoring and evaluation strategy (Tier 1 to 3) is in progress. Right to Care M&E officers have qualified as Master trainers for the Tier system and are providing training in the provinces Right to Care supports.

Integrated programmes

Right to Care supports 60 TB facilities at which more than 21 500 patients were recorded in TB registers, with 83% of these having their HIV status recorded. IPT was provided to 15 300 HIV-infected patients. Simplified TB symptom screening (of cough, fever, weight loss or night sweats) was performed on 93% of HIV-infected patients. A total of 65 000 diagnostic work-ups were done for TB and 11 500 patients were diagnosed with active TB.

Since 2009, the Cervical Cancer programme has provided more than 20 doctors and 25 nurses with training in screening and treatment. In that time, 18 000 Pap smears, 4200 colposcopies, and 2000 large loop electrical excisions were performed. The incidence of high-grade lesions found on Pap smears averages 20%.

Right to Care Health Services now offers a comprehensive integrated wellness programme providing a wide array of health and wellness solutions to employers.

The services include health and wellness screening, health risk assessments, management of chronic diseases, psychological counselling, legal and financial counselling, occupational healthcare services, executive wellbeing, and disability management. Right to Care Health Services serves a population of over 100 000 employees. In the year under review, it conducted 40 000 HIV tests on employees, and managed 6000 HIV patients on pre-ART and ART. ■

Dr Ali Bacher
Chairman

Prof Ian Sanne
CEO

Board of directors

The eleven members of the board

1. Dr Alan Knott-Craig - BSc Elec Eng (UCT), MBL (Unisa), DBL (Honoris causa), DBA (Honoris causa)
Non-Executive Director
Alan is a former MD of Vodacom and CEO of Vodacom Group. In January 2012, he was appointed CEO of Cell C, effective April 2012. He served on the boards of Nedbank, CSIR, and Murray & Roberts from 2009 until 2012.

2. Kurt Firnhaber - MNM (Regis)
Director
Kurt joined Right to Care in 2006, as the Grants Management Operations Officer, and in October of that year was appointed Chief Operations Officer and to the board of directors. He manages the Human Resources, Finance and Operations departments, including infrastructure development, NGO operations, and grant management.

3. Mthandazo Peter Moyo - BCompt (Hons) (Unisa), HDip Tax Law (Wits), AMP (Harvard), CA (SA)
Non-Executive Director
Peter is a director and shareholder of Amabubesi Group. He is the chairman of Vodacom Group, Willis SA, and CSC SA and a non-executive director of Liberty Holdings, Liberty Group, and Transnet. Peter is the chairman of the Audit Committee of the Auditor-General's office and serves on the Advisory Council of the Stellenbosch Business School.

4. Dr Gustaaf Wolvaardt - MBChB (Pret), M.Med (Int) (Pret), FCP (SA), AMP (Manch), PGCHE (Pret)
Non-Executive Director
Gustaaf is the MD of the Foundation for Professional Development. He serves on the boards of the SA Institute for Health Care Managers (SAIHCM), Dira Sengwe Conferences, and Aids Accountability International. In 2007, Gustaaf was recognised by SAIHCM as one of the 25 most influential SA healthcare leaders.

5. Dr Thembisile Xulu - MBChB (UKZN), Dip Obst (SA), Dip HIV Man (SA), MPH (Wits), World Fellow 2010 (Yale University)
Clinical Director
Thembisile joined Right to Care in 2004 and in 2007, she was appointed to the board and placed in charge of clinical programmes. After four years of leading government provincial programmes, she was appointed Managing Director of Right to Care Health Services.

6. Reginald Muzariri - CA (SA), Hons BCompt (Unisa)
Non-Executive Director
Reginald is a co-founder of the Utho Group, an investment banking advisory firm. He leads the asset-based finance business Utho Asset Finance and is also active as a director in the Utho Capital Infrastructure Fund. He is the Non-Executive Chairman of Alexkor Ltd.

7. Peter Goldhawk - CA (SA)
Non-Executive Director
Peter is the director of Goldhawk Corporate Advisory. He is a member of the JSE Listings Advisory Committee and an alternate director of the Directorate of Market Abuse of the Financial Services Board. He is a retired partner of PricewaterhouseCoopers.

8. Dr Ali Bacher - MBBCh (Wits)
Chairman
Ali was the captain of the national cricket team in 1970 and has spent more than 30 years involved in the business and promotion of cricket. Ali was the Chief Executive of the International Cricket Council's World Cup, held in South Africa in 2003. He holds honorary doctorates from Rhodes and Wits Universities.

9. Prof Ian Sanne - MBBCH, FCP (SA), FRCP, DTM&H
CEO
Ian is the founding Director and CEO of Right to Care. He is an Associate Professor of Internal Medicine and Infectious Diseases, University of the Witwatersrand, where he is head of the Clinical HIV Research Unit and International Scientific Officer of the AIDS Clinical Trials Group (NIH), and Director of the Health Economics and Epidemiology Research Office in collaboration with Boston University, where he holds an Adjunct Professor position.

10. Dr Brian Brink - BSc (Med), MBBCh, DA (SA)
Non-Executive Director
Brian is the Chief Medical Officer at Anglo American. He is the chairman of the International Women's Health Coalition, based in New York, and a board member of the AIDS Law Project in South Africa. He is the head of the Private Sector delegation on the board of the Global Fund and is a director of Discovery Holdings.

11. Stanley Mabuza - MBA, MAP (Wits), PG Dip, PDM, BA
Non-Executive Director
Stanley is the Chief Strategy Officer and member of the Executive management team at the South African National Blood Services. He has occupied senior management roles at several companies such as Standard Bank and the IDC. ■

RightMax grants management system

Grants management

NGOs have struggled with inadequate tools for grants management for years. Historically, grants management departments have used spreadsheets for reports and requisitions. Some of the problems this creates are difficulty with following an audit trail, errors in formulae, inconsistently captured data, sub-recipients' inability to work with advanced Excel functions, and version control difficulties.

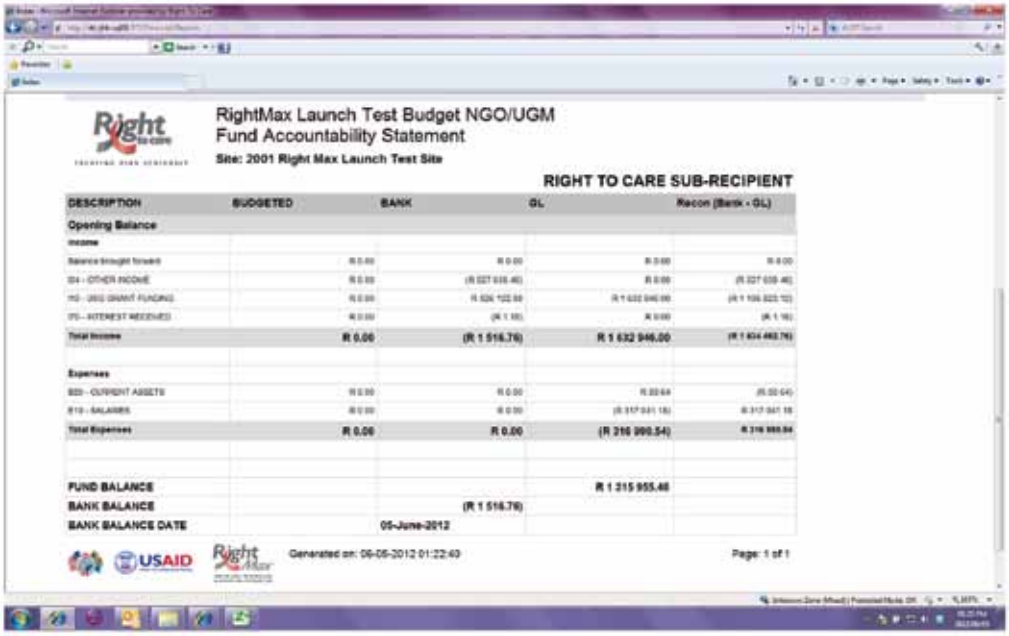
In response to this, Right to Care has developed RightMax, an information and reporting tool that has revolutionised grant management. RightMax is an integrated system of financial reporting and data management that stores data entered by dispersed users in a central data warehouse. The strengths of the system include Web-browser access, user friendliness, version control, and immediate availability of digitally stored supporting documents.

RightMax integrates a wide range of systems, among which are financial reports, monitoring and evaluation (M&E), narrative reports, contracts, purchase orders, and payment requisitions. On receiving reports from sub-recipients, supporting documents are barcoded and scanned using handheld scanners. The system stores each supporting document on a server and links the document to relevant transactions. Templates for M&E and financial reporting can be downloaded and uploaded again. Different levels of authorisation are being applied, ensuring segregation of authorisation and operational duties.

Using defined business rules, RightMax manages the process flow from capturing information to approving expenses. The system enhances the integration of information by eliminating multiple versions of a document. Moreover, all information is housed in a single location, available to multiple users, thus improving transparency and accountability.

Monthly expenses and bank transactions are uploaded into RightMax. For the purpose of grants management, reports, including monthly expenses and banking, funds accountability statement, M&E, and compliance reports, are generated. This forms part of an audit trail and reduces audit time, as questions and answers are in the system before an audit begins. Moreover, the system is able to provide auditors with view-only access. This further reduces audit time by minimising travel, reducing audit costs. Controls governing the advancement of funds are managed and enforced.

MAXIMISING INFORMATION & REPORTING INTEGRATION


RightMax Launch Test Budget NGO/UGM
Fund Accountability Statement
Site: 2001 Right Max Launch Test Site

RIGHT TO CARE SUB-RECIPIENT

DESCRIPTION	BUDGETED	BANK	GL	Recon (Bank - GL)
Opening Balance				
Income				
Balance brought forward	R 0.00	R 0.00	R 0.00	R 0.00
04 - OTHER INCOME	R 0.00	(R 327 939.46)	R 0.00	(R 327 939.46)
Total Income	R 0.00	(R 1 516.78)	R 1 632 946.00	(R 1 634 462.78)
Expenses				
820 - CURRENT ASSETS	R 0.00	R 0.00	R 20.64	(R 20.64)
810 - SALARIES	R 0.00	R 0.00	(R 317 941.18)	R 317 941.18
Total Expenses	R 0.00	R 0.00	(R 316 920.54)	R 316 920.54
FUND BALANCE			R 1 315 955.48	
BANK BALANCE		(R 1 516.78)		
BANK BALANCE DATE		05-June-2012		

USAID

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RightMax has a user-friendly browser-based interface

In future, RightMax will support the medical male circumcision programmes with a system requiring scanning of consent forms. These will be linked to M&E data and invoices, enabling tight control of programme funding and outputs.

RightMax improves information flow between prime recipients, sub-recipients, and donors through better accountability, reliability, and accuracy. ■

Government partnerships

National and provincial departments of health

Right to Care continues to see the benefit of increasingly healthy relationships with national and provincial departments of health.

In keeping with the PEPFAR and Department of Health (DoH) realignment, we are gradually phasing out some of our direct service delivery over the next couple of years in favour of technical assistance. This transition means various staff employed by Right to Care will be moved to the DoH. This process has already begun.

The transition to technical assistance has considerably affected our operations. We are now participating actively in government planning structures. We influence decisions made at provincial management level and through the implementation teams in the districts and sub-districts as well.

A major component of technical assistance is mentoring and training, which we are providing to healthcare workers at all levels, in both the private and public sectors. Nurse-initiated and managed ARV therapy (NIMART) is a key component of this. This supports the government's goal of expanding HIV services into primary healthcare services. We have invested considerable resources in the rollout of NIMART and in the training and appointment of nurse mentors as part of district technical assistance teams across all provinces.

We are working to influence the policies of the nursing and pharmacy regulatory bodies with regard to the scripting and dispensing of ARVs by nurses.

We have been pivotal in assisting provinces in the development of provincial strategic plans and in providing input for the National Strategic Plan 2012–2016.

Prevention is receiving greater attention. This has seen more resources being allocated to our PMTCT, cervical cancer screening, HIV counselling and testing (HCT), medical male circumcision (MMC), and INH Preventative Therapy (IPT) programmes. We are assisting the paediatric ARV management programme to facilitate the transfer of stable children and the initiation of newly infected ones at a primary healthcare facility.

Operational research is underway in all provinces. This includes MDR-TB research (particularly at Sizwe Hospital), and GeneXpert research at the TB Focal Points we support.

Gauteng

In Gauteng, Right to Care supports two districts, City of Johannesburg (CoJ) and West Rand. In CoJ we support Regions A, B, C and E and in the West Rand we support all four sub-districts, namely, Mogale, Randfontein, Merafong and Westonaria.

In the previous financial year, through the transition from direct service delivery to technical assistance, we expanded support from 35 to 99 sites. In future, staff members we appoint at DoH sites will be mainly in technical assistance positions. These changes are in response to PEPFAR's district realignment and to the expanded programme goals announced by the government in 2009. They also contribute to the organisation's sustainability in the long-term.

Capacity building took place in all programme areas, including prevention, treatment, care, and support. A key success area was the training of nurses in NIMART. Our mentors supervised and mentored NIMART nurses at primary healthcare facilities and ensured the necessary support to increase antiretroviral therapy (ART) initiation was available. An example of this is the West Rand district where, with our support, almost all of 52 primary healthcare facilities have implemented NIMART. This has considerably relieved the pressure on the public healthcare system caused by the shortage of doctors.

Through site coordinators deployed in each sub-district, we have improved the quality of care by implementing and monitoring the six quality standards of government policy for public health facilities.

Our centre of excellence, Themba Lethu Clinic at Helen Joseph Hospital, has hosted various delegations from both public and private sectors. This facility is being used as a benchmark site for clinical best practice and for developing strategies to manage HIV service delivery. By sharing our knowledge and experience, we potentially enhanced quality standards well beyond Right to Care supported sites.

Various training courses were offered to healthcare workers. Our monitoring and evaluation officers have undergone Master training (in the DoH's chosen Tier system) and are training staff in public facilities in readiness for the Tier system.

Patients initiated on ART at government sites

30 555

Patients currently down-referred from government sites

2472

1. **Gladys Bogoshi, CEO, Helen Joseph Hospital (seated left), and Dr Thembi Xulu, Director, Right to Care (seated right), renew the MoU between the organisations**

2. **Dietician Carmen Alexander counsels an HIV-positive mother with a three-month old HIV-positive baby, Kuruman, Northern Cape**

3. **The Mpumalanga MEC for Health, DG Mahlangu, and USAID's Dr Melinda Wilson open the new MMC clinic, Piet Retief Hospital, Mpumalanga**

Newly HIV+ persons tested for CD4 at government sites

43 450

Mpumalanga growth in patients on ART

14%

We continue to innovate in the use of medical technology. Three developments warrant mention. First, we are using GeneXpert at Themba Lethu Clinic for the diagnosis and treatment of drug-resistant TB. This has shortened the diagnosis time for mono-resistant MTB. Second, we have integrated our TherapyEdge database with the NHLS. This has made laboratory results available online at point-of-care. Third, patient loss-to-follow-up was reduced by using SMS to contact patients and by confirming deaths by means of the Web-based death registry of the Department of Home Affairs.

A focus on operational efficiencies in the year under review resulted in improved performance in supported districts and enhanced working relations. We met and, in some cases, exceeded our programme targets. The numbers of patients on ART grew by 10% for adult patients and 28% for paediatric patients. We achieved a notable improvement in mother-to-child prevention, bringing the transmission rate down from 5% to 2% at six weeks.

We consolidated our partnership with the provincial government by extending our MoU to the next funding period. By participating in government structures we have ensured our support influences the programme in line with DoH and Right to Care objectives. The structures in which we participate ensure we are ready for the National Health Insurance rollout and the primary healthcare reengineering programme.

Mpumalanga

Right to Care Mpumalanga has grown considerably, providing leadership and supporting all three levels of DoH (provincial, district, and sub-district). We were thus responsible for drafting the provincial MMC plan and PEPFAR appointed us as the provincial MMC coordinator of PEPFAR partners.

The MMC programme has grown from four to seven supported sites. Tonga, Piet Retief, and Themba hospitals are high-volume centres; Barberton is low volume; and Shongwe, Embuleni, and Rob Ferreira are technical assistance sites. This has resulted in 10 000 men and boys being circumcised, a contribution of 90% to the total circumcisions in the province.

We supported the PEPFAR strategy to realign the districts in which its recipients operate. Carolina Hospital and three referral clinics in the Albert Luthuli sub-district have been transferred from Broadreach to us.

Technical assistance and district health systems strengthening have been key focus areas. Hence, we have altered our organisational structure to parallel that of the DoH, a step that anticipates the transfer of operational staff to the DoH.

We developed a technical assistance model, a primary healthcare reengineering plan, and a clinical mentorship plan and presented these to each level of the DoH. All have been most favourably received and will be implemented in the districts we support.

We formed experienced district teams (comprising a doctor, a district coordinating nurse, a pharmacist, and a dietician) to advise the Ehlanzeni and Gert Sibande DoH districts managers on the management of HIV and TB.

As part of technical assistance, the sites we support are visited weekly by a doctor who mentors the clinical team. We launched a mentorship programme in partnership with the DoH's regional training centre at Evander and several healthcare workers have been trained in the management of HIV patients. In addition, a further 178 healthcare workers were trained in PMTCT in all three districts. We also played a key role in the development of the curriculum used by the regional training centre.

At Shongwe Hospital, 258 nurses completed two weeks of NIMART training. An outreach team goes from site to site monitoring and mentoring these nurses. These measures enabled our main CCMT sites to transfer patients to primary healthcare clinics to the extent that initiation of most patients on ART is now done at primary healthcare level. This relieves pressure on the main CCMT sites.

The cervical cancer programme has been successfully implemented at Bethal and Barberton hospitals. Patients no longer need to travel to Shongwe for treatment of cervical cancer.

In Barberton, we converted a former kitchen into rooms to be used for a paediatric school of excellence. It was opened at end of 2011. At Shongwe Hospital, we renovated nine doctors' houses and equipped them with air conditioning. This is part of a strategy to retain personnel with scarce skills (thus maintaining programme sustainability). We also provided basic medical equipment for 15 of the clinics that refer to Shongwe and Tonga hospitals.

We are responsible for running a clinical forum. It comprises HIV clinicians, pharmacists, and dieticians who meet monthly to discuss the challenges of managing HIV and TB. The forum approves provincial HIV and TB management programme protocols and guidelines.

We have fully supported the Tier data system. All our supported sites have completed a baseline assessment for implementation of Tier 1.

Free State patients on ART

6918

Growth in HCTs at government sites

35%

1a.

1b.

1. **Speaking at the Fifth SA AIDS Conference, Durban: Right to Care's Dr Nomtha Mayisela (1a) and Prof Ian Sanne (1b)**

2. **Minister Aaron Motsoaledi visits Right to Care**

2.

HIV patients started on INH Preventative Therapy at government sites

13 580

Patients receiving HIV care at government sites

97 091

In the coming year, our focus will be on migrating further towards technical assistance, laying the groundwork for the NHI, the primary healthcare reengineering programme, district health systems strengthening, and enhancing programme sustainability.

Northern Cape

Right to Care Northern Cape took part in the review of the provincial strategic plan that informs the national strategic plan. We also worked with the provincial DoH in drawing up a provincial programme for mother, child, women, youth health services, and district health.

In 2011, we cooperated closely with the DoH to scale up HCT services and to decentralise and integrate ART services into primary healthcare services. Stable ART patients were transferred from main treatment sites to primary healthcare sites. This enabled Galeshewe Day Hospital to reduce patients numbers from an average of 150 to 50 per day. Our role in this was to mentor and supervise NIMART-trained nurses.

Of our 17 counsellors, 14 began the one-year Ancillary Health Worker training course offered by Hospice. This was in anticipation of a call from the Minister of Health for community health services, monitored by a professional nurse, to be offered in households in allocated wards.

In response to PEPFAR's district realignment, we transferred Pixley Ka Seme district and Jan Kempdorp Hospital to PEPFAR partner ICAP. We transferred four staff members to the DoH and four staff members to Health Systems Trust, a partner of the US government's Centres for Disease Control.

In January 2011, the provincial three counsellors were sponsored for basic ambulance skill training and are awaiting appointment by the DoH. These measures contributed to fulfilling our strategic goal of strengthening the province's health services.

By June 2011, we reached 96% of the HCT targets set for us by the National HCT office. We tested 11 779 people during the year, 13% of whom were found to be HIV-positive. We participated in ministerial campaigns in three of our four districts and trained 35 retired nurses in HCT and counsellors in finger pricking (blood sampling technique).

As a health initiative for women, we ran a cervical screening campaign in Kuruman using a mobile unit stationed for a week at a shopping mall. VIA cervical screening is now operational at Tshwaragano Hospital, with patients being referred to Kuruman Hospital for colposcopies. In 2011, 764 women were screened through this initiative.

Bus fitted with equipment for maternal health services, including colposcopies, before deployment in the Western Cape

As a health initiative for men, we were involved in the development of an implementation plan for MMC in the province.

Right to Care is involved in the community-based Drug-Resistant TB Management programme being piloted in the province and we continue to serve on the Drug Resistant Clinical Review Committee. In January 2011, the provincial TB Directorate from the DoH embarked on a one-month advocacy communication and social mobilisation campaign in Siyanda. The district has a heavy caseload and defaulter rate. We played a pivotal role by conducting information and education campaign talks and screening for TB.

Regarding monitoring and evaluation, Right to Care was selected as Tier system Master trainers in the province and are thus involved with a range of activities, among which are site assessments, training, and system implementation. One of our M&E officers serves on the provincial Tier system task team.

We worked with the Medical Research Council on a project researching Vitamin A uptake by the liver in children. The study aims to assess if there is a need for Vitamin A supplementation at the primary healthcare level. The findings have not yet been reported.

Northern Cape patients on ART

6350

Western Cape patients on ART

3660

At year end, we had 7227 adult patients in HIV care and 6350 on ART, and 662 paediatric patients on ART.

Free State

In the Free State, we forged excellent relationships with government, at both provincial and district levels. We established our credibility as an organisation that is able to deliver on its promises. Evidence of this is that the Free State DoH's use of our Themba Lethu Clinic as a model for CCMT-site best practice and clinical benchmarks. We are supporting the Free State DoH mainly in Thabo Mofutsanyane, having been allocated this district under the PEPFAR district realignment. This has resulted in our moving out of Motheo, where we were supporting the Pelonomi and Heidedal sites. We are now fully established in the Maluti-a-Phofung sub-district. Two of our site coordinators are responsible for this district, overseeing 33 sites in all.

The move to technical assistance led to the appointment of four site coordinators in three sub-districts. In addition, as a move to decentralise training to provincial level, we appointed a clinical trainer. The technical assistance plan for the Free State has been developed and approved with new technical assistance posts. This will strengthen the clinical skills, M&E, and pharmaceutical programmes in the new financial year.

Agreements have been reached with the province to add cervical cancer screening as a new programme area in identified clinics. As a result, all our programmes will be operational in the province (adult ART, paediatric ART, PMTCT, HCT, TB, and cervical cancer).

The purchase of gazebos has assisted with an increase in the uptake of HCT in supported districts. As a result, most of the sites have exceeded their targets for the national HCT campaign.

Significant steps were undertaken to improve monitoring and evaluation. We placed additional trained data staff at sites, which helped considerably in preparing clinics for the implementation of the Tier system.

Western Cape

We continue to enjoy excellent working relationships with the district management teams of the DoH and are regarded as an integral part of the health service in two districts, the Overberg and Central Karoo.

The provincial DoH is moving towards decentralised control and to this end has devolved greater responsibility to district level. As the district PEPFAR partner, we have aligned ourselves with the district model, resulting in an increased emphasis on technical assistance, health system strengthening, and capacity building.

We made a number of proposals to the DoH district management teams and these have been implemented. One proposal was to employ a NIMART-trained nurse to be a site coordinator in the Central Karoo. We are overseeing the duties and functions of this nurse.

We continue to focus on community-based HCT strategies. Moreover, we now offer point-of-care CD4 monitoring. With access to CD4 measurement, we are identifying those that qualify for ART and preparing them for ART initiation. ARVs are supplied to these patients via our mobile service in the Overberg.

Further projects launched in the Central Karoo include a mobile unit for cervical-screening and woman's health, and point-of-care GeneXpert TB testing at remote sites. This mobile unit was sponsored by a partnership with First for Women.

The DoH has recognised the need to assume more funding responsibility and we have transferred a number of our staff members to positions within the department. This has allowed us to ensure maximal use of donor funds and to concentrate our resources on capacity building and HIV prevention.

We have identified training and mentoring as key components of technical assistance. Our team has acquired the skills to train and mentor all levels of healthcare workers (from doctors and nurses to counsellors and community-based workers). Our doctors have been mentoring nurses in NIMART.

In line with the DoH's strategic shift towards primary healthcare, the number of ART sites has continued to grow, bringing care closer to communities. We have supported this process by training and skills development at the primary healthcare level.

Our HCT outreach team continues to spread the awareness message and to offer HCT. The emphasis is on ensuring good "linkage to care". The term refers to ensuring people who test positive are absorbed into the healthcare system. In February, we launched a mobile HCT wellness unit, the Tutu Tester Treater Overberg. By September the unit had tested 2603 people.

The service is community-, rather than facility-based, and is thus able to monitor the link to care. Included in this is a drive to serve "key populations," in particular migrant labour and prison inmates. In the Central Karoo, we launched the GeneXpert MTB/RIF TB-diagnosis initiative, which will look at point-of-care TB diagnosis in remote rural communities and the influence this will have on reducing the time for diagnosis and initiation of TB treatment.

As part of the prevention strategies of the DoH, we have been the driving force in getting MMC started in our districts, both with training and implementation. ■

NGO partnerships

Sub-recipients and UGM partners

Right to Care supported 18 grant sub-recipients the provision of technical assistance, direct service delivery, prevention, advocacy, development of best practices, and health systems strengthening.

ACTS Clinic

ACTS Clinic serves the community of Masoyi, outside White River in Mpumalanga. ACTS provides ARV therapy (ART), TB screening and treatment, pharmacy support, in-patient support, HIV counselling and testing (HCT), prevention of mother-to-child transmission (PMTCT), and cervical cancer screening.

Through Legogote Clinic, the Mpumalanga Department of Health (DoH) provides ARV drugs and pathology to patients at ACTS. In the review year, ACTS treated 3213 patients on ART, initiated 423 on TB treatment, and initiated 39 paediatric patients on ART. ACTS performed 13 465 HCTs, 449 cervical cancer screens, and 48 PCR tests.

AgriAids

AgriAids, founded in 2004, is an NGO providing HIV and wellness programmes for farm workers in Limpopo, North West, KwaZulu Natal, and Mpumalanga. AgriAids employs district coordinators who are responsible for the planning, organising and implementation of project-related activities. Under the Umbrella Grants Management (UGM) grant, Right to Care is supporting AgriAids in delivering HIV prevention and awareness, HCT, and wellness programmes. In the review year, AgriAids reached 7890 farm workers with sexual prevention messages; of whom 7614 were tested for HIV and 1340 were offered care and support on receiving their test results.

Alexandra Clinic

The Alexandra Health Centre and University Clinic, Johannesburg, is a full-service primary healthcare facility, including 24-hour casualty and maternity care. Right to Care supports the Phatsima Khanya HIV clinic that forms part of the clinic complex. Phatsima Khanya is accredited as a CCMT site under the City of Johannesburg and, as such, the DoH provides ARVs, related medications, test kits, and covers pathology costs. Phatsima Khanya treats both adult and paediatric patients. Patient numbers are now 6681 receiving HIV and TB care. In the review year, the clinic performed 4532 HCTs and 301 Pap smears.

Amcare

Alberton Methodist Care and Relief Enterprise (Amcare) is based in Alberton, Ekurhuleni. Amcare offers HCT and HIV wellness services and is a down-referral site for Germiston Hospital. Amcare has 393 HIV patients. Around 20 patients per month are prepared for ART initiation and patients are often initiated at first visit.

HCT counsellors were trained to perform finger pricks, which boosted the HCT programme. Three years ago, Amcare was performing around 30 HCTs per month. This has risen to over 200 per month. As a result, in the year under review, the HCT target of 1800 was exceeded by 227 tests.

Amcare is involved in the cervical cancer screening programme and has been working with Natalspruit Hospital as its referral centre for colposcopy. Approximately 30% of patients who had a Pap smear were found to have abnormal cells.

CARe

Community AIDS Response (CARe) provides a range of services, among which are home-based care and counselling. HCTs were provided to 19 659 clients. Of these, 34% tested HIV-positive, of whom 63% were women. Health education and pre- and post-test counselling were provided as an entry to point to care. Once an individual, a couple, or a family has been tested for HIV, they are referred for other services, depending on their needs. CARe made 13 314 referrals to ART care and support services, TB integration, and PMTCT programmes.

CARe provided technical support to the government by training 185 learners in HWSETA Accredited Social Auxiliary Work. CARe conducted community health profiling in ten informal settlements in Gauteng, which covered more than 15 000 individuals.

CARe was commissioned by the Department of Social Development Population Unit to conduct a national study on factors associated with teenage pregnancy and was commissioned to evaluate the effectiveness of the community capacity enhancement model piloted by the Department of Social Development and the Nelson Mandela Children Fund.

CHRU

The Clinical HIV Research Unit (CHRU), based at Helen Joseph Hospital, is a strategic founding partner of Right to Care, a syndicate of the Wits Health Consortium and a research unit of the Department of Medicine, University of the Witwatersrand. CHRU provides Right to Care with technical expertise and assistance, training of healthcare personnel, quality assurance assessments of sites, and clinical support services. CHRU has implemented a third-line ART clinic at Themba Lethu Clinic, and serves as a referral site for patients failing

NGO HCTs performed at NGO sites

46 637

NGO HIV/TB co-infected persons started on TB treatment at NGO sites

30% growth


1.

2.


3.


4.

1. Last day at ACTS for retiring founders Dr Margie Hardman and Harry Munnings

2. US Deputy Secretary of State, Thomas R. Nides, visits Alexandra Clinic

3. Hollywood script writers visit Ndlovu as part of a medical education programme aimed at raising the profile of health issues in film and television programming

4. CHRU's Dr Mohammed Rassool conducts a routine examination of an ART patient

NGO HCT provided by NGO-operated mobile units

20 197

NGO HCT provided by NGO-operated healthcare facility

23 766

ART. CHRU places research staff in the clinic. They train, implement new diagnostic tools, and assist in the running of the clinic.

CHRU enhances Right to Care's academic foundation. CHRU has assisted Right to Care with providing input into the national treatment guidelines, increased collaboration with the commercial sector, and programme improvements arising from operational research.

In the review year, Right to Care supported CHRU with funding for human resources, operating costs, and equipment. In addition, Right to Care provided funding for ART and pathology monitoring for patients who have difficulty accessing ART through the national programme, especially those who had failed first- and second-line ART regimens.

DMMH

The Department of Molecular Medicine and Haematology (DMMH) is an academic division of the School of Pathology in the Faculty of Health Sciences of the University of the Witwatersrand. Its core activities include teaching (doctors and scientists), basic research into therapeutics and disease ontologies (such as malaria, HIV and haematological diseases) and service provision through affiliation with the NHLS.

This was the first year that the DMMH received PEPFAR funding. DMMH participated in a collaboration project between five PEPFAR partners and DMMH was tasked with investigating the implementation of the Xpert MTB/RIF TB diagnostic assay. The group assists clinical partners in the implementation of Gene Xpert at point of care (POC) countrywide.

They assist with site installation, develop Xpert training materials and standard operating procedures, a POC Xpert quality assessment programme and POC Xpert data management and connectivity solutions. They also investigate the integration of TB and HIV services to develop policy frameworks for the NHLS and National DoH.

DMMH developed training materials to teach non-laboratory personnel how to use Xpert by compiling a starter-kit for sputum samples to be processed at POC. A total of 25 personnel were trained centrally and those who initiated Xpert testing were assessed at sites.

The materials developed by the DMMH were provided to the NHLS National Priority Programme for the implementation of Xpert in 30 laboratory centres countrywide. For newly initiated Xpert sites, the group developed a Gene Xpert instrument verification protocol using inactivated M.Tuberculosis culture spots to ensure diagnostic instruments are accurate before reporting clinical results.

Friends for Life

Friends for Life (FFL) is a non-medical NGO based in Alexandra, Johannesburg. FFL provides HCT services in Alexandra and surrounding areas, including Bramley and Lombardy. Since 2005, FFL has partnered with Right to Care which provides funding for HCT counsellors based at FFL, Alexandra Clinic, and Edenvale Hospital. In the year under review, FFL performed 4027 PEPFA-funded HCTs. Of these, 21% were positive (1723 males and 1755 females). For PMTCT, 502 women were tested, of whom 25% were positive.

Hlokomela

Hlokomela coordinates health and educational development initiatives for 69 agricultural businesses associated with the Hoedspruit Training Trust, a not-for-profit organisation. Hlokomela improves the health and reduces the vulnerability of farm workers and their families to HIV, TB, and other chronic diseases. This is achieved by improving awareness, access to services, and living conditions.

At year end, Hlokomela had 386 active ART patients. The PMTCT programme is working well and since its start in 2007 only two babies were born positive (both mothers were defaulting treatment and not attending the clinic on a regular basis). In 2011, in collaboration with the DoH, Hlokomela conducted 32 outreach sessions, during which educational pamphlets were handed out and 1981 HCTs performed. Of these 20% tested HIV positive. All positive patients were screened for TB; 105 had positive signs and were referred for Acid Fast Bacilli tests and x-rays.

Life Line

Life Line Rustenburg provides personal empowerment and life skills training and various forms of counselling. It trains HIV counsellors, in partnership with the provincial DoH. Life Line has counsellors placed at health clinics throughout the Bojanala District, with 351 counsellors serving 172 health facilities. In the review year, Life Line performed HCTs on 37 742 individuals, 12% of whom tested positive.

Ndlovu Care Group

Ndlovu Care Group, based in Elandsdoorn, Limpopo, employs 200 people in Limpopo and Mpumalanga. In

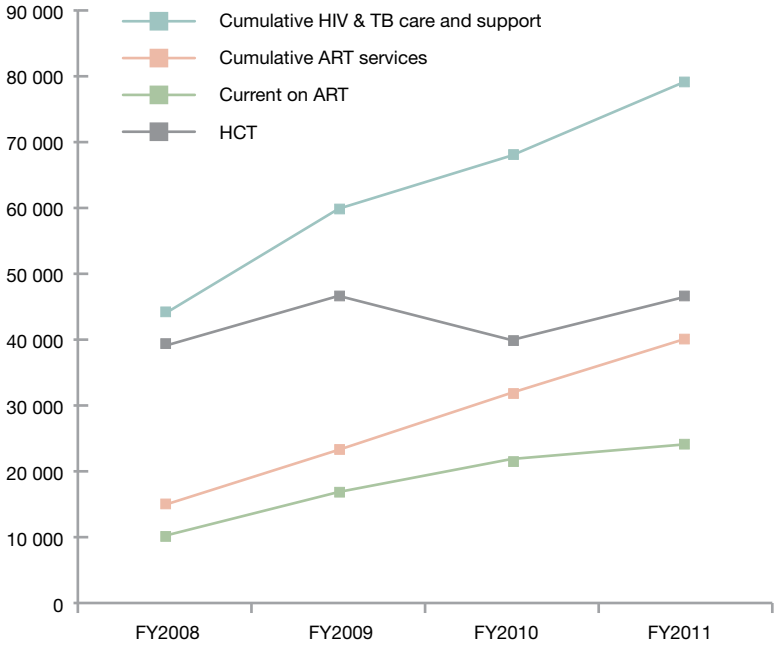
NGO Eligible antenatal clients provided with a CD4 test at NGO sites

98%

NGO patients receiving HIV care

27 498

NGO PARTNER PERFORMANCE OVER PAST FOUR YEARS



2009, Ndlovu signed a service level agreement with the Mpumalanga DoH, ensuring that ARVs, medications for opportunistic infections, test kits, and pathology monitoring of HIV patients would be provided by the DoH through a relationship with the primary health care clinic at Agincourt.

In Bushbuckridge, Mpumalanga, Ndlovu operates the Bhubezi Community Health Centre. It offers primary healthcare services, TB, and HIV treatment. I

n the review year, Ndlovu provided ART to 7038 patients. Bhubezi and Ndlovu Elandsdoorn performed 5583 TB tests and initiated 578 patients on TB treatment.

South to South

The South to South Programme for Comprehensive Family HIV Care and Treatment (S2S) is a programme of the Department of Paediatrics, Faculty of Health Sciences, Stellenbosch University. S2S strengthens clinical health systems in the areas of PMTCT, paediatric HIV and psychosocial programming. S2S supports other USAID partners and the DoH through district-specific capacity building activities; human resource development (through training and mentoring); technical assistance to implementing partners and the National DoH; and by developing training resources.

S2S trained and mentored 2768 healthcare workers in 2011. Multi-disciplinary technical teams supported the Foundation for Professional Development in two districts: Moretele in the North West and Tshwane in Gauteng (support was provided for PMTCT and child health programmes). For USAID partners, S2S held 11 one-week Comprehensive Paediatric HIV Care and Treatment training courses at Tygerberg, Cape Town.

For DoH staff, S2S held five one-week Performance and Capacity Enhancement (PACE) workshops. S2S facilitated and coordinated various National DoH workshops. It developed training curricula and tools in support of PMTCT, paediatric HIV, and psychosocial public health programmes.

Topsy Foundation

The Topsy Foundation provides medical and social services to communities in Mpumalanga and the Free State. Topsy offers care and support, adult ART, paediatric ART, HCT, post-exposure prophylaxis, cervical cancer screening, and TB screening and treatment services. In the review year, Topsy performed 2519 HCTs. On children, 29 PCRs were performed and none tested HIV-positive. Since 2007, when Topsy started receiving support from Right to Care it has provided care to an accumulative 5049 patients.

In the review year, Topsy initiated 815 patients on ART and by year end 2157 patients were receiving treatment. TB treatment was started on 563 individuals out of 793 that were diagnosed TB-positive and the remaining 230 were referred to clinics closer to their homes. Topsy performed 663 Pap smears and 81 colposcopies.

Witkoppen Clinic

The Witkoppen Health and Welfare Centre, known as Witkoppen Clinic, provides integrated services that include HCT, PMTCT, TB diagnosis and treatment, care and treatment of HIV for adults and children, and cervical cancer screening and treatment. Right to Care supports Witkoppen Clinic with most of the human resources required by the programme, while the DoH provides ARVs, related medications, and test kits, and covers pathology costs. Patients on ART now number 4409. HCT services were provided to 12 336 clients, including antenalal clinics. A total of 2807 were tested for TB and 592 started TB treatment. Pap smears were performed on 2976 women. A focus area is NIMART and its target for the coming year is to have nurses initiate 30% of patients.

Witkoppen Clinic's counsellors are being trained in rapid HIV finger-prick testing. Thus, HCT is streamlined, with a counsellor doing the entire process. Another strategy is to decrease the burden of TB in people living with HIV and to this end they focus on the '3 Is' (intensified case finding, INH preventative therapy, and infection control). Through a study funded by the National Institutes of Health, Witkoppen Clinic is able to use the Gene Xpert for diagnosing TB at point of care. ■

Integrated programmes

Paediatric HIV, TB, and cervical cancer

Right to Care has responded to the HIV epidemic with public healthcare programmes that are integrated across treatment sites and localities. These are the Paediatric HIV programme, Prevention of Mother-to-Child Transmission (PMTCT), the TB programme, and the Cervical Cancer programme. These programmes are in operation in all five provinces in districts where the organisation has a presence.

Paediatric HIV

The Paediatric HIV Department was established in 2008 and by September 2011, at sites receiving technical assistance for paediatric HIV the number of children on ARV therapy (ART) had grown to 8400. The year under review was a highly successful one for the department.

The paediatric team, led by Dr Leon Levin and Dr Pippa Macdonald, provides technical assistance to all the Right to Care supported sites in the form of training, mentoring, and the Paediatric HIV Helpline. The helpline handled over 259 requests for help. It allows healthcare workers, from both Right to Care and other sites nationwide, to access immediate clinical advice from a paediatric HIV expert.

We held one-day conferences on paediatrics and PMTCT in the various provinces. Attendance at these totalled 521. Moreover, we held the first of a conference that will be held annually, titled 'Emerging problems in Paediatric HIV'. Expert speakers were brought together from around the country. More than 150 delegates attended and it was a resounding success.

An innovation in 2011 was the holding of three workshops to train paediatric experts nationally in the management of Paediatric HIV patients whose treatment is no longer working (patients with viral resistance). This workshop established our paediatric team as a leader in its field.

PMTCT

PMTCT is an essential prevention element in the fight against HIV and in reducing maternal and child morbidity and mortality. Effective implementation of PMTCT will move SA closer to the Millennium Development Goals.

A comprehensive PMTCT approach includes four components: (a) primary prevention of HIV among women of child-bearing age; (b) prevention of unintended pregnancy among HIV-positive women; (c) prevention of transmission from HIV-positive women to their infants; and (d) provision of appropriate treatment, care, and support to HIV-positive parents and their children.

Right to Care's PMTC programme is strengthened through the leadership of HIV expert and author, Dr Clive Evian. Our integrated PMTCT and Maternal & Child Health unit works with DoH provincial teams to improve timely antenatal clinic booking; postnatal follow up of women and infants; infant-feeding practices; initiation of antenatal clinic patients on AZT or lifelong ART; and retesting rates for pregnant women who test negative. Antenatal clinic HCT uptake in Right to Care supported facilities reached 98%. This is above national baseline of 95%.

We have improved the monitoring and evaluation component to monitor the progress of our PMTCT interventions. We have also developed standard operation procedures in accordance with guidelines.

TB

Right to Care supports 60 TB facilities at which more than 21 500 patients were entered in TB registers, irrespective of their HIV status. In keeping with the national average, 77% of TB patients are HIV-positive.

IPT was provided to 15 300 HIV-infected patients. Simplified TB symptom screening as advocated by the WHO (of current cough, fever, weight loss or night sweats) was performed on 92% of HIV-infected patients who attended our facilities. A total of 65 000 diagnostic work-ups were done for TB and 11 500 HIV-infected patients were diagnosed with active TB.

Our TB agenda is led by Prof Ian Sanne and Dr Francesca Conradie, in collaboration with Prof Annelies van Rie of the University of North Carolina. In line with the Obama Global Health Initiative, Right to Care has expanded its TB/HIV activities in five ways.

First, we have expanded the number of TB Focal Points (TBFPs). The rationale for a TBFP is to ensure that any patient suspected of having TB is investigated appropriately. A sputum induction facility at Themba Lethu TBFP has reduced by 10% the number of patients who cannot produce sputum, leading to improved testing rates. This effective model is being replicated at other sites.

Second, we are increasing the use of the '3 Is': Intensified case finding; INH Preventative Therapy (IPT); and Infection control in health facilities. This is standard WHO policy for TB control.

We provide TB symptom screening at all healthcare visits. This includes implementing the Practical Approach to Lung Health (PAL), a symptomatic approach to the management of patients who attend primary healthcare services for respiratory symptoms.

Regarding IPT, despite a growing body of evidence for the efficacy of IPT, less than 1% of HIV-positive adults and children living with HIV receive this therapy. In 2010, SA adopted the simplified mechanism for IPT (without PPD) and the numbers are slowly increasing. What prophylaxis, if any, should be given to a patient with drug-resistant TB remains the subject of debate. Our MDR TB collaboration with USAID will provide the opportunity to investigate this by targeting household contacts and following them up as part of a prospective cohort.

Paediatric patients (0-14) new initiated on ART

2274

Infants tested for HIV by PCR at around 6 weeks

7814

1.

2.

3.

1. **PEPFAR partner TB collaboration meeting, hosted by Right to Care**

2. **Cervical cancer mobile screening unit deployed in the Central Karoo**

3. **An HIV-positive eight-year old girl and her stepmother are counselled in the taking of the child's ARV medication, Gordonia Hospital CCMT, Upington**

Newly HIV+ persons screened for TB at HCT

63 177

Papsmears performed

9324

Third, we are investigating and expanding the use of the Cepheid GeneXpert MDR TB Rif. We have been at the forefront of the rollout of this technology and have worked to find a place for it in the diagnostic algorithm of pulmonary TB, with particular emphasis on the HIV co-infected patient. We will continue to investigate the use of GeneXpert for the diagnosis of extra-pulmonary TB, including lymph nodes and cerebrospinal fluid. Furthermore, we will evaluate other molecular and Elisa diagnostics, for example, measurement of urinary Lipoarabinomannan, a virulence factor associated with M. Tuberculosis.

Paediatric TB remains a diagnostic challenge. Most childhood TB diagnoses are based, not on microbiological proof, but on exclusion of other diagnoses and on a high index of suspicion. We are reinforcing best practices at all sites and are validating newer diagnostic tests for this vulnerable group.

Fourth, we build capacity to diagnose and manage Multidrug and Extensively Drug-Resistant TB (M/XDR-TB). SA has the fourth highest MDR-TB burden in the world and the highest MDR-TB/HIV co-infection rate. We have collaborated with the DoH at Sizwe Tropical Diseases Hospital, the referral site for M/XDR-TB in Gauteng. Since 2007 more than 1500 HIV-infected patients have received integrated TB and HIV care at Sizwe.

In 2010, with the introduction of the national ARV guidelines that recommended that all HIV and MDR-TB co-infected individuals be started on ART irrespective of CD4+ count, we have provided technical assistance for implementation of this programme. This included training of staff members and educating patients.

Fifth, we continue to develop primary research capacity involving community-based strategies and other novel interventions.

Cervical cancer

In Africa, the cancer with the highest prevalence in HIV-positive women is cervical cancer. HIV-infected women in Africa are at significant risk for cervical cancer due to poor access to screening and treatment of pre-cancerous dysplasia, a lack of an HPV vaccine programme, and significant immunosuppression. Our most important weapon against cervical cancer is an effective screening and treatment programme to detect and remove early dysplastic lesions.

When the ART rollout began in SA, Right to Care realised that women would live longer, placing them at greater risk of developing cervical cancer. This led to the launch of our cervical cancer screening and treatment programme at Themba Lethu Clinic, in 2005 lead by Dr Cindy Furnhaber. This greatly improved access to care for women, 75% of whom had never had a pap smear. Early results showed that 51% of women had early dysplasia and 33% of these dysplastic results were of high grade. Complications hampered referrals to other clinics for colpscopic biopsy to confirm diagnosis and treatment if required. As a result, many women would wait for as long as nine months for treatment or were not treated at all.

We trained our HIV medical officers to perform colposcopic biopsies and large loop electrical excisions (LLETZ). These procedures were added to the screening programme in our HIV clinics and greatly improved access to treatment.

Since 2009, we have expanded this highly effective model to 25 clinics in five provinces. We have trained more than 20 doctors and 25 nurses in screening and treatment. Since May 2009, we have performed more than 18 000 pap smears, 4200 colposcopies and 2000 LLETZ procedures. The incidence of high-grade lesions found on pap smears depends on the clinic and ranges from 15% to 50%, with an average of 20%.

We will continue to train staff in screening and treatment. In addition, we obtained funding from a private company, First for Women Insurance, to develop a mobile clinic for screening in remote areas. The unit is based at Beaufort West and covers the greater part of the Central Karoo.

Most of our programme takes the form of technical assistance, consisting of training government healthcare workers at government clinics. In the next two years, the division will transfer the remaining Right to Care staff in these clinics to government positions. In addition, we have developed a quality assurance programme involving visits to supported sites every 6 to 12 months. At these visits, the following are examined: the physical site, flow of patients, availability and cleanliness of supplies and equipment, turnaround time for results, the response of patients, further training needs, and quality of results.

We have two part-time gynaecologists training and consulting on difficult cases. We have equipped and trained sites in the use of a simple retail digital camera to take photographs that are sent to the head office for consultation by a gynaecologist. This type of technical support, training, and quality assurance will be extended to additional sites over the next two years.

We have participated in the South African HPV working group to evaluate screening methodologies. We also guided the National Strategic plan for HIV care, advocating that cervical cancer screening in HIV-positive women be part of this plan. In addition, we have been innovating in several implementation and epidemiological evaluation projects to better understand cervical cancer in HIV-infected African women and how best to screen them for the disease. ■

Training

Training of staff and partners

Since April 2010, Right to Care's Training Department has been actively participating in the organisation's transition to technical assistance. In response to the new strategic direction, training has been decentralised at provincial level. This allows for more onsite training and mentoring. The department now supports 457 sites in five provinces.

We now record all training activities, including mentoring, on a centralised database. This enables accurate monitoring and instant feedback. Furthermore, the database structure has been modified to suit the needs of the Department of Health (DoH).

We created and staffed the post of Quality Assessment and Implementation Training Officer to ensure quality of service delivery by standardising training materials throughout the organisation. This post also entails pursuing accreditation with the Health and Welfare Sector Education and Training Authority for the Skills Programme: HIV/AIDS Counselling, and applying for CPD points on behalf of doctors.

We are conducting skills audits to determine knowledge gaps and the need for didactic training. We conduct didactic training, onsite mentoring, and in-service training. Trainers are trained as mentors, assessors, and moderators, and are registered with the HWSeta to enable consistent and reliable processes against relevant unit standards and qualifications. We have implemented two methodologies: Integrated Management of Childhood Illnesses (IMCI), and PALSA PLUS (guidelines for the management of lung health, TB, HIV, and STI patients). All courses follow revised National DoH guidelines.

In accordance with the DoH's primary healthcare reengineering strategy, we will be sending our lay counsellors for ancillary healthcare training. Since February 2010, 45 lay counsellors have been studying for the 18-month Further Education and Training Certificate: Counselling. On completion, they will become fully fledged counsellors.

In the year under review, we developed a number of innovations. Training delegates are now required to complete workbooks, as a portfolio of evidence. A clinical marker reviews the workbooks, identifies gaps, and, where these exist, informs the relevant trainer and mentor of the need for follow-up mentoring.

Didactic training

Our core activity of didactic (classroom-based) training continues. We offer 18 courses altogether, three of which are for doctors, six for nurses, five for lay counsellors, two for healthcare providers, and two for non-medical personnel.

We developed course material on the finger-pricking method of blood sample collection. This skill enables counsellors to provide continuity of care during a testing session. Moreover, it relieves the burden on nurses. A total of 53 lay counsellors were trained. Competency was measured through both formative and summative assessments.

Trainers are qualified to teach the IMCI HIV Module, which was incorporated into the didactic training for Paediatric NIMART on the Paediatric HIV Management Course.

The Mpumalanga Regional Training Centre held its HIV and Aids, STI, TB (HAST) Training of the Trainer course in Randburg, which was attended by 12 trainers. These trainers also completed IMCI NIMART training of the trainer. Moreover, we have plans in place to assist the National DoH with delivering the eleven-day IMCI course.

In October 2010, we conducted the first adult NIMART training of nurses, including PALSA PLUS. Since then we have trained in the City of Johannesburg, West Rand, Sedibeng, and Ekurhuleni (this was before the PEPFAR partner realignment).

Mentoring

In the review year, technical assistance in the form of mentoring was considerably expanded. In Gauteng, we conducted more than 400 mentoring sessions for 141 staff members, 103 of whom are initiating adult antiretroviral therapy.

In Mpumalanga, 52 nurses attended a two-week adult NIMART training programme, which included mentoring support, and of these 34 are now initiating antiretroviral therapy.

We have further responded to the needs of the National DoH by sending mentors and trainers on the mentorship course provided by PEPFAR partner I-Tech. All our clinical trainers are now qualified PALSA PLUS facility trainers and two have become Master trainers (that is, enabled to train facility trainers). We have been authorised by the National DoH to host the I-Tech/National DoH mentorship programme.

We participated in the SANAC Symposium aimed at "building partnerships to implement community-based health services in primary healthcare". We contribute actively to the guidelines developed by the symposium's training track.

Site supported with training

457

Number of people trained

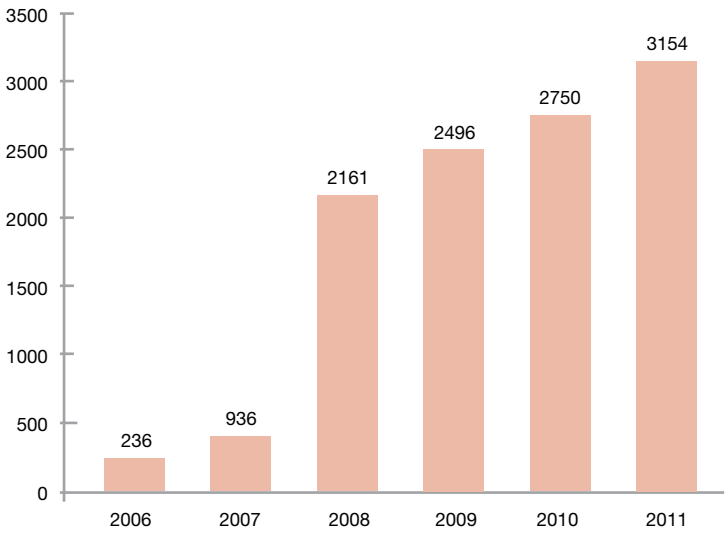
3154

Getting to Zero conference, White River, Mpumalanga, organised by Right to Care and sponsored by Novagen

NUMBER OF SITES SUPPORTED PER DISTRICT

Province	Total sites	District	District total
Free State	77	Thabo Mofutsanyane	75
		Motheo	2
Mpumalanga	108	Ehlanzeni	67
		Gert Sibande	41
Northern Cape	162	Namakwa	67
		Siyanda	58
		John Taolo Gaetsewe	23
		Frances Baard	14
Western Cape	17	Overberg	10
		Central Karoo	7
Gauteng	93	City of Johannesburg	48
		West Rand	45

NUMBER OF PEOPLE TRAINED



Pharmacy

Pharmacy supply chain management

Right to Care is one of few local institutions that has acquired expertise in pharmaceutical management. Through our pharmacy support programme, our objective is to use a pharmaceutical system-strengthening approach that results in a sustainable improvement in the delivery of pharmacy services (and thus on patient outcomes).

We provide support at national, provincial, district, and facility levels, in line with National Department of Health (DoH) policies. Programme staff hold key support positions at national and provincial levels and play an important role in the development and implementation of pharmaceutical policy. Our technical assistance and system-strengthening activities take various forms.

We strive to tackle pharmaceutical staffing needs at supported sites through strategic secondments of pharmacy personnel and the training and capacity building of targeted personnel, such as pharmacist assistants and nurses.

In the year under review we worked with the DoH to develop a strategic plan for training of pharmacist assistants and we are playing a role in the implementation of this. We managed a learnership programme for pharmacist assistants and supported the registration of prospective tutors and sites with the South African Pharmacy Council.

For NGO partners, we provide technical assistance for medicine supply-chain activities and for compliance with pharmacy practice and regulatory standards. In some provinces, this includes technical assistance at provincial depot level.

In collaboration with other PEPFAR partners, we supported the site-level implementation of computerised pharmacy dispensing and information management systems. This includes integration of clinical data systems and pharmacy management systems to streamline pharmacy operations. These integration efforts support feasibility assessments of automated dispensing systems that may enhance access to ARVs and related medicines for stable HIV patients.

We successfully implemented a supply-chain management strategy for down-referred patients to providers in the private sector.

We provide technical assistance for pharmacovigilance activities that deal with key safety priorities in HIV and TB programme implementation (through participation in the SANAC Treatment Technical Task Team). We supported the development of active cohort safety surveillance systems.

We have facilitated agreements with PEPFAR-supported NGO partners and provincial authorities to enable access to ARVs and related drugs from provincial depots.

We participated in the USAID and National DoH ARV Bridging Programme Task Team, which was established to implement the US government ARV donation programme and manage US government ARV procurements to the DoH. Our contribution was technical, regulatory, clinical, and covered supply chain advice and support.

We supported the Medicines Control Council for the registration and regulation of medicines and clinical trials where activities include developing regulatory strategies for new drug technologies, fixed dose combination products and biomedical prevention (for example, microbicides) for clinical trials, and the registration of these medicines. ■

Constance Tsume and Tracey Cunningham, Gordonia Hospital, Upington

Right to Care Health Services

A wholly owned subsidiary of Right to Care

Right to Care Health Services (RTCHS) has expanded its service range into a comprehensive integrated wellness programme providing a wide array of health and wellness solutions to employers and other organisations. The services include health and wellness screening, health risk assessments, management of chronic diseases (including HIV & AIDS and TB), psychological counselling, absenteeism, incapacity and disability management, project management and implementation, and financial cost benefit analysis.

The service package dove-tails with existing health services, thus avoiding duplication of costs. Moreover, our clients are provided with comprehensive and integrated reports on all healthcare aspects within their organisations. The target market is organisations who understand that employee wellness interventions yield multiple benefits. Among these are fulfilling a social responsibility role and positively influencing the finances of the client through improvements in productivity and occupational safety as well as reductions in absenteeism and staff turnover.

Performance highlights

The financial performance of the company remains on track. Revenue for the year is R67-million, with a profit of R4.1-million (8% over target). This is a revenue growth of 6.9%.

In the review year, we acquired three new clients: Hyatt Regency, BEMAS Medical Scheme, and Xstrata Alloys. See sidebar for a complete list of clients, p. 29.

While HCTs provided to the broad public (Access HCT) remained stable at 42 502, HCTs provided to private companies grew by 34% to reach 31 380. This yielded a net increase of 12% for total HCTs (73 882). Prevalence remained constant at 7% but the number of patients in HIV care increased by 10% to 5944. Patients on ART increased 38% to 3229. We ramped up the health risk assessments considerably, performing 45 200, which is 84% more than in the previous year.

Technological innovation

We developed and launched E-Booker, an online booking system that enables employees of client companies to make a confidential booking for a wellness test. By reducing queuing times, the system minimises employees' time away from work. Booking is done via a secure login to a website. An email and an SMS are sent confirming the date, time, and place of testing.

The system has led to significant improvements in the uptake of testing. Moreover, resources can be more efficiently deployed, since it is possible to see in advance whether testing services are in over- or under-supply at a given location. At one client, of the 3000 employees in the company, 1400 used the system to make a booking.

We developed an online learning management system for nurses and doctors who provide us with clinical services. Through the system, doctors and nurses can be informed of updated RTCHS protocols and procedures, to ensure optimal quality treatment and care of our patients.

World AIDS Day

For World AIDS Day 2012, we created an innovative campaign aimed at raising awareness for HIV. "Show Your Hand" encouraged employees and the public to wear red gloves and a T-shirt on World AIDS Day in symbolic support of the fight against HIV. The campaign was adopted by many of our clients. The public was also exposed to the campaign when, on World AIDS Day, our staff took to the streets around the head office. Wearing their red gloves and shirts, the staff handed out education leaflets to pedestrians and passing motorists.

Disease management success

We gauge the success of our treatment and care programme annually by analysing sick absenteeism rates. The measurement that is used is the Sick Absence Rating (SAR). SAR is the number of workdays lost due to illness divided by the number of potential workdays.

$$\textbf{SAR} = \frac{\text{Number of sick leave days}}{\text{Potential number of work days}}$$

The SAR is directly related to the amount of the payroll paid to absent employees. Therefore, if the staff SAR is 2%, it means that 2% of salaries are paid to them when they are absent. The successful management of HIV & AIDS and TB has resulted in an average reduction in the SAR of 25% when comparing patients managed by RTCHS to patients on another programme, that is, medical aid or a government programme.

Key differentiators

Our service range has a number of key differentiators that provide it with a competitive advantage. The consulting team members are leaders in integrated wellness consulting, wellness policies and development of strategic frameworks for wellness and their work is used as benchmarks and best practices by other wellness providers. We provide a fully integrated professional service, which includes all aspects of employee wellbeing with no duplication in costs or in reporting.

Our staff complement is more than 60 permanent employees, of whom more than 50% are professionally qualified and registered with their respective professional bodies, such as the Health Professions Council of SA and the SA Nurses Council. The call centre is staffed by competent professional medical staff, trained in counselling

RTCHS growth in HIV tests provided to client companies

34%

RTCHS growth in health risk assessments performed

87%

1. **HIV testing in a mobile unit, World TB Day event, Goldfields mine, Carltonville**

2. **Almost 6000 patients in care are supported through the Expert Treatment Programme call centre, which is staffed by professional nurses**

3. **HCT offered to miners at Assmang Manganese Black Rock Mining Operations, near Kuruman, Northern Cape**

RTCHS revenue growth

6.9%

RTCHS growth in patients currently on ART

38%

on psycho-social and trauma aspects, as well as in clinical management of chronic diseases.

Other key differentiators:

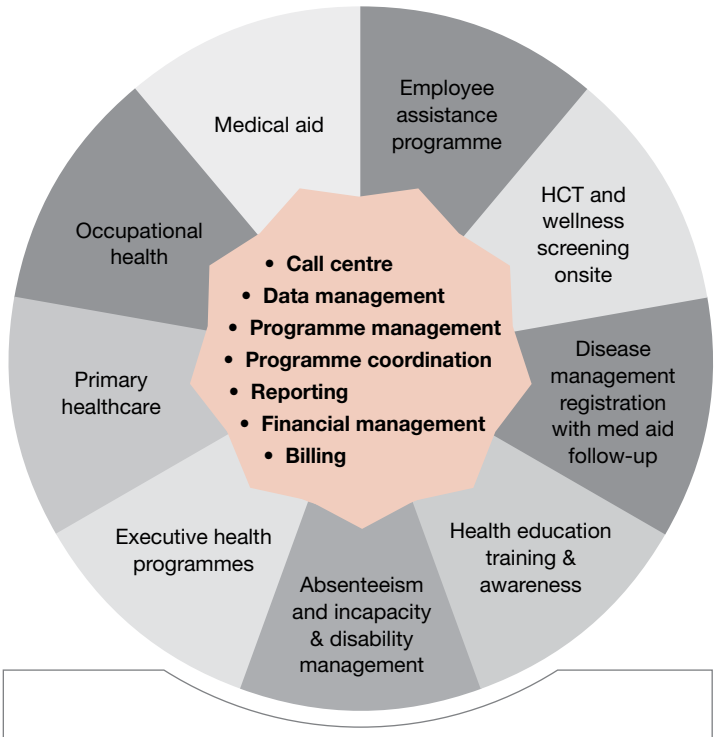
- Our clients receive fully integrated wellness reports, including the financial implications of wellness on the organisation
- We have the capacity to manage large wellness screening events and wellness days
- Every HIV-positive employee and dependant is facilitated into care ensuring early intervention through care, treatment, regular follow-up and support
- We have more than 150 mobile units, such as gazebos, buses, and caravans, that are used during wellness screening events
- A 24-hour medical and counselling call centre is equipped with the most advanced call centre and medical software.
- The call centre operates in all South African languages, as well as French and Portuguese. ■

Client base

Following the acquisition of three new clients, Right to Care's corporate and institutional client base is:

- Alexander Forbes Group
- BEMAS Medical Scheme
- British High Commission
- Comztek
- Housing for HIV
- Human Sciences Research Council
- Hyatt Regency
- Investec
- Lancet Laboratories Group
- Massmart
- MIH Holdings
- MMed Medical Aid
- Mustek
- National Ceramic Industries SA
- PG Bison
- Rectron
- Silica Fund Administration Systems
- Telkom SA
- The Development Bank of Southern Africa
- The Oprah Winfrey Leadership Academy Foundation
- Tongaat Hulett Starch
- Unicef
- Virgin Active SA
- Vodacom Group
- Xstrata Alloys ■

RTCHS INTEGRATED SERVICE OFFERING



RTCHS VISION: To be the leading healthcare provider of quality innovative clinical and well-being support services to the corporate and private sectors, through holistic, comprehensive, and fully integrated health and wellness solutions.

Right to care HEALTH SERVICES

RTCHS KEY OUTPUTS, 2010 AND 2011

	PROGRAMME OUTPUT	FY 2010	F Y 2011
HCT	HCT (Access)	42 386	42 502
	HCT (Private)	23 334	31 380
	Total HCT	65 720	73 882
	Tested Prevalence	7.0%	7.10%
HIV care & treatment	Patients currently in care	5398	5958
	Patients currently on ART	2345	3229
	Viral suppression (12 month cohort)	85%	89%
	PMTCT	157	183
	PEP provided	238	240
TB	TB screening done	65 720	79 779
	IPT provided	0	55
	Patients initiated on TB treatment	84	126
Other health	Health risk assessments	24 521	45 831

Notes: Viral suppression is a viral load of less than 400

Abridged Financial Statements

Right to Care (NPC)

Report of the Directors 30 September 2011

The following is an abridged version of the audited group and company annual financial statements of Right to Care NPC as at and for the year ended 30 September 2011. A full version of the statutory financial statements can be viewed at the company's registered office.

Financial results

The results of the group and the company and the state of its financial affairs are set out in the attached abridged financial statements.

Directors' responsibility for the statutory financial statements

The directors are responsible for the preparation and fair presentation of the annual financial statements in accordance with International Financial Reporting Standards and the Companies Act of South Africa, as well as the abridged version set out in this report.

Project continuity

"We note that this coming financial year 2012 marks the end of the main five year funding of USAID for RTC. The dominant future funding source of RTC for the next five years through USAID is in the process of being determined. To address this, RTC has competed for multiple USAID awards in HIV, TB, Innovation and Medical Male Circumcision. Almost 30% of the existing funding has been secured through the recent award of Medical Male Circumcision as well as the continuation of funding under the Umbrella Grants Management. RTC has also been short listed as a lead competitor in the future five year funding for HIV technical assistance services to the Department of Health. Multiple awards in other programmatic areas have been submitted and will be adjudicated in the current financial year.

Although indications from USAID appears highly positive, in the unlikely event that RTC fails to secure funding from USAID management has prepared for implementation a restructuring plan to ensure that RTC continues in operation in the foreseeable future at a reduced level of activity. This plan has been developed by management and approved by the Board of Directors."

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Johannesburg
South Africa

Postal address
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Private Bag X2600
Houghton
South Africa
2041

Report of the Independent Auditors on the Abridged Financial Statements to the members of Right to Care NPC

The accompanying abridged financial statements of the group and company, which comprise the abridged statements of financial position as at 30 September 2011, the abridged statements of comprehensive income, condensed statements of changes in equity and abridged statements of cash flows for the year then ended, and related notes, are derived from the audited financial statements of Right to Care NPC for the year ended 30 September 2011.

We expressed an unmodified audit opinion on those financial statements in our report dated 10 May 2012. Those financial statements, and the abridged financial statements, do not reflect the effects of events that occurred subsequent to the date of our report on those financial statements.

The group and company abridged financial statements do not contain all the disclosures required by International Financial Reporting Standards. Reading the abridged financial statements, therefore, is not a substitute for reading the audited financial statements of Right to Care NPC.

Directors' Responsibility for the Abridged Financial Statements

The directors are responsible for the preparation of the group and company abridged financial statements in accordance with the framework concepts and the measurement and recognition requirements of International Financial Reporting Standards (IFRS).

Auditor's Responsibility

"Our responsibility is to express an opinion on the group and company's abridged financial statements based on our procedures, which were conducted in accordance with International Standard on Auditing (ISA) 810, "Engagements to Report on Summary Financial Statements."

Opinion

In our opinion, the group and company's abridged financial statements derived from the audited financial statements of Right to Care NPC for the year ended 30 September 2011 are consistent, in all material respects, with those financial statements, in accordance with the framework concepts and the measurement and recognition requirements of International Financial Reporting Standards (IFRS).

Deloitte & Touche
Registered Auditors
Per: Allan W Brown, Partner, 11 June 2012

Abridged Statements of Comprehensive Income

For the year ended 30 September 2011

	* Group		** Company	
	2011/09/30	**2010/09/30**	**2011/09/30**	**2010/09/30**
	R	**R**	**R**	**R**
Revenue	362 645 126	339 218 494	321 191 754	303 824 424
Cost of sales	(27 922 521)	(28 370 574)	—	—
Gross profit	334 722 605	310 847 920	321 191 754	303 824 424
Other income	823 027	2 997 756	1 568 972	3 140 348
Operating expenses	(332 203 776)	(304 814 867)	(323 593 687)	(302 751 874)
Surplus (deficit) for the year	3 341 856	9 030 809	(832 961)	4 212 898
Interest received	1 680 332	1 784 793	1 647 467	1 783 677
Interest repaid to USAID	(1 626 911)	(1 759 055)	(1 625 379)	(1 715 357)
Surplus (deficit) before taxation	3 395 277	9 056 547	(810 873)	4 281 218
Taxation	(973 746)	(1 823 615)	—	—
Surplus (deficit) for the year	2 421 531	7 232 932	(810 873)	4 281 218

* Consolidation of Right to Care NPC and Right to Care Health Services (Pty) Ltd
** Right to Care NPC

Abridged Statements of Financial Position

At 30 September 2011

	* Group		** Company	
	2011/09/30	**2010/09/30**	**2011/09/30**	**2010/09/30**
	R	**R**	**R**	**R**
Non-current assets				
Property, plant and equipment	18 086 206	16 382 563	16 239 539	15 099 442
Intangible assets	5 346 235	7 735 888	5 346 235	7 381 319
Investment in subsidiary	—	—	100	100
Deferred tax asset	224 517	84 233	—	—
Total non-current assets	23 656 958	24 202 684	21 585 874	22 480 861
Current assets				
Inventories	—	213 681	—	213 681
Trade and other receivables	17 353 620	10 310 825	5 132 872	2 522 950
Affiliated account receivable	—	—	2 455 543	3 901 143
Taxation	1 227 218	—	—	—
Bank and cash balances	66 842 417	38 066 914	64 312 025	30 690 181
Float accounts	2 274 072	1 935 797	—	—
Total current assets	87 697 327	50 527 217	71 900 440	37 327 955
Total assets	111 354 285	74 729 901	93 486 314	59 808 816
Capital and liabilities				
Capital and reserves				
Accumulated surplus	38 783 039	36 361 508	30 491 304	31 302 177
Current liabilities				
Float liabilities	2 274 072	1 935 797	—	—
Trade and other payables	11 612 717	16 318 920	4 310 553	9 583 603
Unutilised USAID funding	58 684 457	18 923 036	58 684 457	18 923 036
Taxation	—	1 190 640	—	—
Total non-current liabilities	72 571 246	38 368 393	62 995 010	28 506 639
Total capital and reserves	111 354 285	74 729 901	93 486 314	59 808 816

Abridged Statements of Changes in Equity

For the year ended 30 September 2011

	Accumulated Surplus	Total
	R	R
*** Group**		
Balance at 30 September 2009	29 128 576	29 128 576
Surplus for the year	7 232 932	7 232 932
Balance at 30 September 2010	36 361 508	36 361 508
Surplus for the year	2 421 531	2 421 531
Balance at 30 September 2011	38 783 039	38 783 039
**** Company**		
Balance at 30 September 2009	27 020 959	27 020 959
Surplus for the year	4 281 218	4 281 218
Balance at 30 September 2010	31 302 177	31 302 177
Deficit for the year	(810 873)	(810 873)
Balance at 30 September 2011	30 491 304	30 491 304

Abridged Statements of Cash Flows

For the year ended 30 September 2011

	* Group		** Company	
	2011/09/30	2010/09/30	2011/09/30	2010/09/30
	R	R	R	R
Cash flows from operating activities				
Cash generated from operations	44 746 967	13 679 348	44 428 143	1 943 352
Interest received	1 680 332	1 784 793	1 647 467	1 783 677
Interest paid	(1 626 911)	(1 759 055)	(1 625 379)	(1 715 357)
Taxation paid	(3 531 888)	(1 479 461)	—	—
Net cash from operating activities	41 268 500	12 225 625	44 450 231	2 011 672
Cash flows used in investing activities				
Additions to property, plant and equipment	(9 950 837)	(3 733 124)	(8,286,227)	(3 251 219)
Purchased on intangible assets	(2 542 160)	(10 921 978)	(2 542 160)	(10 921 978)
Net cash used in investing activities	(12 492 997)	(14 655 102)	(10 828 387)	(14 173 197)
Net increase (decrease) in cash and cash equivalents	28 775 503	(2 429 477)	33 621 844	(12 161 525)
Cash and cash equivalents at the beginning of the year	38 066 914	40 496 391	30 690 181	42 851 706
Cash and cash equivalents at the end of the year	66 842 417	38 066 914	64 312 025	30 690 181