

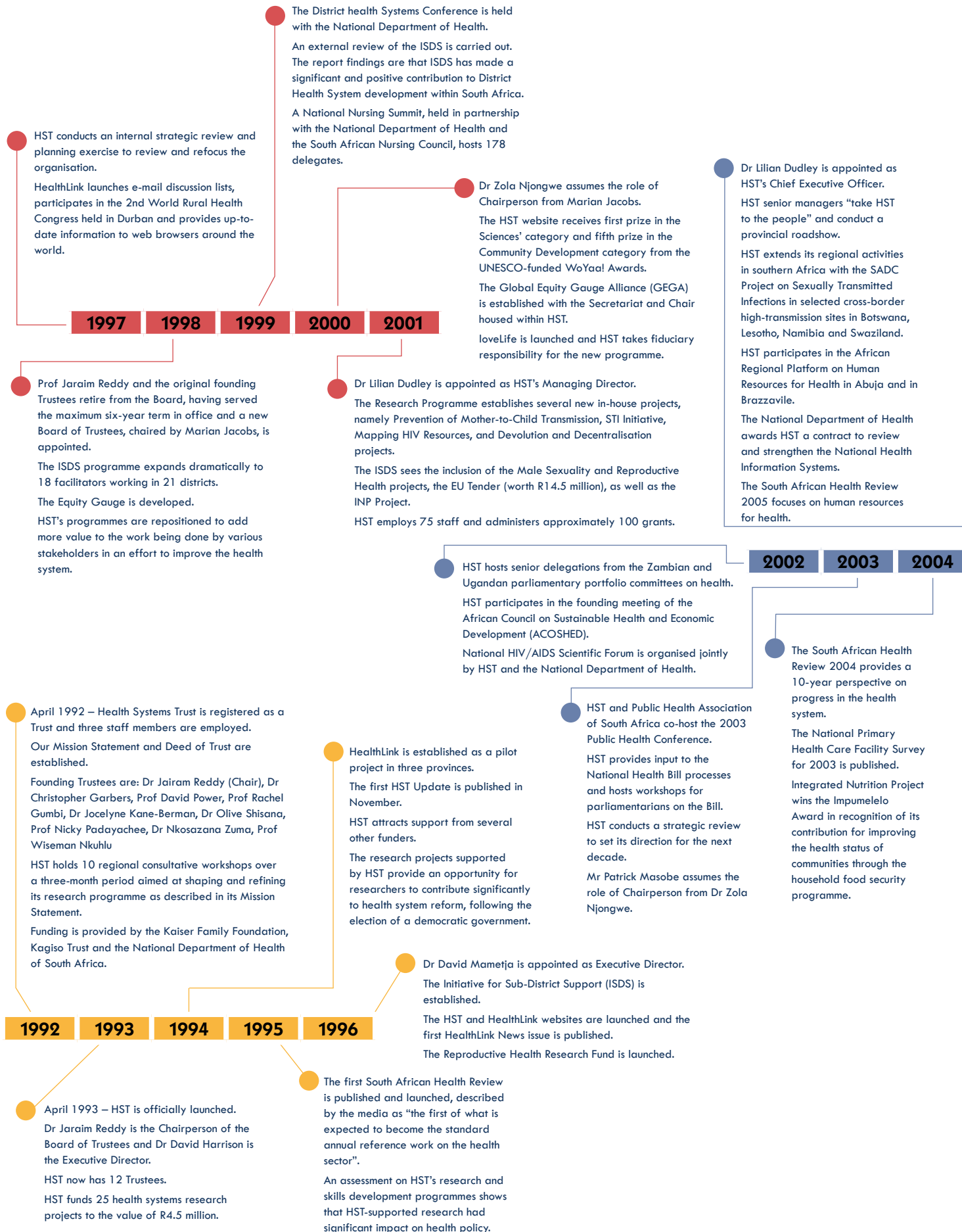
ANNUAL REPORT 2016/17



**HEALTH
SYSTEMS
TRUST**

1992 | *25th Anniversary* | 2017

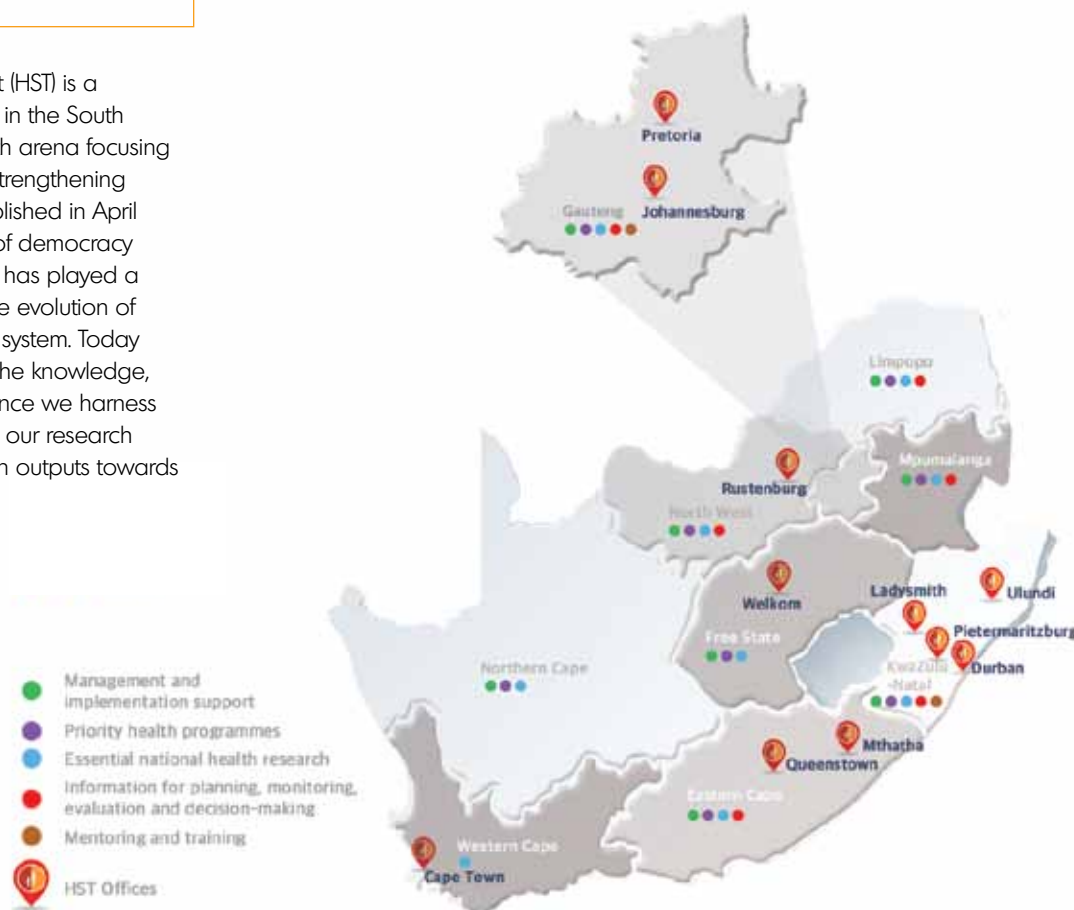
25 years of Health Systems Trust





Health Systems Trust

Health Systems Trust (HST) is a leading role-player in the South African public health arena focusing on health systems strengthening and research. Established in April 1992 on the brink of democracy in South Africa, HST has played a significant role in the evolution of the national health system. Today our strength lies in the knowledge, insight and experience we harness through synergising our research and implementation outputs towards a healthy life for all.



OUR VISION

Health for all through strengthened health systems

OUR MISSION

To be a partner of choice in building comprehensive and equitable health systems

OUR APPROACH

Our approach is based on:

- the primary health care philosophy
- generating evidence-based interventions, good practice and innovations
- providing management, implementation and research support at all levels of the health system
- providing guidance, mentoring and training

- recognising the influence of the social determinants of health on the burden of disease
- tailoring our work to local contexts
- creating, sharing, storing and curating new knowledge

OUR CORE VALUES

We are a learning organisation that is:


- committed to excellence
- people-centred
- honest and transparent
- innovative
- responsive
- knowledge-driven

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Abbreviations and acronyms



AGYW	Adolescent Girls and Young Women
BDCS	Business Development and Communications Section
CCMDD	Central Chronic Medicines Dispensing and Distribution programme
CDC	US Centers for Disease Control and Prevention
CHC	community health centre
CMA	Change Management Approach
DHIS	District Health Information System
DHMO	District Health Management Office
DHS	District Health System
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe
ePHC	eHealth Primary Health Care
FSDR	Framework and Strategy on Disability and Rehabilitation
GP	general practitioner
GPCI	General Practitioner Contracting Initiative
HCT	HIV counselling and testing
HPRS	health patient registration system
HSR	health systems research
HSS	health systems strengthening
HTS	HIV Testing Services
HWSETA	Health and Welfare Sector Education and Training Authority
MCWH	maternal, child and women's health
M&E	monitoring and evaluation
MNCWH	maternal, newborn, child and women's health
NCD	non-communicable disease
NDoh/DoH	National Department of Health/Department of Health
NHI	National Health Insurance
PEPFAR	US President's Emergency Plan for AIDS Relief
PHC	primary health care
PHRC	Provincial Health Research Committee
PMP	Patient Medicine Parcel
PuP	pick-up point
SA SURE	South Africa Sustainable Response to HIV, AIDS and TB project
TB	tuberculosis
UHC	universal health coverage
UTT	universal test and treat
WEL	Wellness for Effective Leadership programme
WHO	World Health Organization

Board of Trustees



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(Ex officio)



Report from the Chairperson

This annual report commemorates the 25th anniversary of the Health Systems Trust (HST). The organisation should feel proud of its accomplishments since inception to date. It has evolved into the major public health organisation it is today with over 400 employees working across the country rolling out the HST mandate. 2017 also marked the publication of the 20th edition of the South African Health Review, which has become the reference work for documenting South Africa's progress in the development and transformation of our health system.

The achievements through the 23 projects highlighted in this year's report reflect our extensive involvement in health systems research and development across all levels of the health system, and the committed work of our staff in providing national, provincial and district health structures with valuable information, evidence, and technical support and tools geared towards providing improved service delivery in our primary health care system.

Despite being a young democracy, South Africa has made significant gains in the transformation of its public health system as it generates novel solutions to respond to its unique challenges while learning from the successes of other developing and established health systems and adapting knowledge and practice to our own national context.

We are pleased to continue supporting the implementation of major national health initiatives and innovating with government in programmes such as the eHealth Primary Health Care (ePHC) programme and the Central Chronic Medicines Dispensing and Distribution (CCMDD) programme as the country moves towards implementation of National Health Insurance and sustaining universal access to quality health services.

During the year, we bid farewell to several Trustees. On behalf of the Board I would like to thank my predecessor Mr Shadrack Shuping, Professor Otto Chabikuli, Dr Victor Lithakanyane and Dr Noncayana Tracey Naledi for their contribution to HST.

We welcome new Trustees, Ms Mandisa Hela, Dr Dumani Kula and Professor David Sanders and look forward to their contribution and support in guiding HST's work in the exciting challenges that lie ahead.

Finally, on behalf of the Board, I wish to express my gratitude to Dr Themba Moeti on his skilled leadership of HST as well as to the directors and staff for their dedication and excellent service.

Dr Flavia Senkubuge
Chairperson: Board of Trustees



Message from the Chief Executive Officer

It gives me great pleasure on the 25th anniversary since HST's formation to report on our health systems research and strengthening work during the financial year 1 July 2016 to 30 June 2017.

The transformation of South Africa's public health sector is dependent upon improving institutional health care management, addressing the inadequate coverage of health care professionals, increasing skills training and enhanced patient information systems in accordance with the National Development Plan's key health care objectives. To that end, HST's work continues to have an impact at national, provincial and district level, through our longstanding partnership with the National Department and various other Provincial Departments of Health. I am pleased to report that we are beginning to make inroads into providing our expertise to regional country partners with the support of the Global Fund.

Against the backdrop of South Africa's progress towards providing universal health coverage for all citizens, several of our health systems research and implementation projects are providing vital information and technical support as the country lays the foundation for National Health Insurance (NHI).

South Africa still faces a quadruple disease burden, namely: communicable diseases with maternal, perinatal and nutritional conditions; HIV and TB; non-communicable diseases (NCDs); and injuries. The 2015/16 District Health Barometer released early in 2017 indicated a decline in the burden of HIV and TB and communicable diseases with maternal, perinatal and nutritional conditions, but a corresponding increase in the burden due to NCDs and injuries was reported. An encouraging indicator has been the steady increase of HIV testing coverage across the country. However, there is still much progress to be made, not only in these priority areas, but also in other emerging health issues facing the country.

Currently, HST is involved in six implementation and 17 research projects which align to the main pillars of creating strong health systems. HST remains in a stable financial position. However, due to the intensity of programme implementation, a significant portion of the surplus of R19m in 2015/16 was utilised to support activities in the current year, which led to HST posting a financial deficit of R10.9m in 2016/17.

As we reflect on the previous year, we have seen many challenges in the transformation of the public health sector generally and organisationally. The awarding of new US Centers for Disease Control and Prevention (CDC) funding in September 2016 for the SA SURE Plus project has seen the focus of our work shift towards providing direct service delivery to bring HIV and TB testing closer to communities and to link them to care in line with the ambitious UNAIDS 90-90-90 targets. This is an important imperative towards hastening progress in the fight against HIV, saving lives and preventing new infections. As the largest project managed by HST, the shift in project priorities from the previous to the new grant meant onboarding new skills which resulted in staff turnover. However, I am happy to report that skilled management during the transition period allowed for minimal disruption to our day-to-day operations.

The Central Chronic Medicines Dispensing and Distribution (CCMDD) programme, in which HST has been involved since inception of the project, is now being implemented to non-NHI districts. The outcomes of this project promise to positively influence the health landscape for the implementation of universal test and treat (UTT). The associated CCMDD electronic system developed for the National Department of Health (NDoH) to automate prescriptions for CCMDD patients and other essential workflow processes connected with this complex project has changed the face of health care provision through the deployment of technology. It is extremely gratifying to report that, for the first time in South Africa, patient level data is available in real time through the CCMDD electronic system.

I am also pleased to report on The Unfinished Business of Paediatric and Adolescent HIV project funded by ELMA Philanthropies which is being implemented in partnership with the KwaZulu-Natal Department of Health and several partners.

Other accomplishments during the year included the appointment of Dr René English to the National Commission on High Quality Health Systems (HQSS), the country-level representation of the Lancet Global HQSS Commission, which will be overseen by the National Department of Health. The Commission will make recommendations on high-quality health systems and health care in the era of the Sustainable Development Goals.



From left: HST's Sibongile Shezi, Themba Moeti, Martha Mavundla, Thandeka Khumalo receiving the MASEA Award.

It was also with great pride that HST was presented with a special award from the KZN Department of Health at the MEC's 2017 Annual Service Excellence Awards (MASEA) in recognition of its commitment to service.

In this regard, I would like to acknowledge all HST staff who work at the coalface and behind the scenes and whose efforts have resulted in this symbol of appreciation.

Organisational changes within the HST included the formalisation of the Business Development and Communications Section (BDCS), which is now more adequately staffed to drive our strategic business priorities. The key areas of focus for the BDCS will be to generate donor funding and create non-grant revenue streams, in order to sustain the organisation and benefit its critical work.

During 2017 we embarked on a process of developing a new HST strategic plan which will guide us through the next three to five years of bringing our expertise to build health systems at a district, national and regional level. It is anticipated that the new business plan will be finalised for implementation in the first quarter of 2018.

In parting, I wish to acknowledge the support of our funders and partners, the public health facilities and various community-based structures whose valuable collaborations have contributed to making a difference in our public health system and health care.

Our Board of Trustees have played a significant role in guiding our unique organisation and I extend a great debt of gratitude for the commitment and encouragement provided in the course of our work.

Lastly, our passionate, motivated and skilled staff who form the backbone of HST, deserve great praise for their unwavering loyalty and tireless endeavours to live our vision of "health for all through strengthening health systems".

Dr Themba Moeti
Chief Executive Officer

Directorates' reports

HST operates through its Programmes, Corporate Services, Business Development and Communications, and Human Resources units. The wide variety of projects managed by HST are cross-cutting and involve interdisciplinary collaboration. An overview of HSR and HSS projects is presented under the five core business areas of HST and these are:

- providing management and implementation support in health districts
- supporting implementation of priority health programmes
- conducting essential national health research
- generating information for planning, monitoring, evaluation and decision-making
- offering guidance, mentoring and training on good practice development.



René English
Director: Health Systems Research

Programmes' Directorate



Ronel Visser
Director: Health Systems Strengthening

Health Systems Research and Strengthening Units

The Programmes' Directorate consists of the Health Systems Research (HSR) Unit, focusing on research, and the Health Systems Strengthening (HSS) Unit, focusing on implementation of technical support perspectives. HST's programmatic support work has evolved to extend across all levels of the health system, including national, provincial and district health bodies, as well as community-based structures. Together they work seamlessly to deliver on our mission to be a strong partner in building comprehensive and equitable health systems.

Led by Dr René English, the Health Systems Research Unit conducts policy-relevant health systems research to strengthen the district health system, its support mechanisms and priority national programmes. The Unit focuses on improving knowledge management, translating research into policy and



Tess Padayachee
Programme Manager:
HSR

practice, and building capacity within the paradigm of essential national health research. During the past financial year, the research unit has been involved in 17 research projects using a variety of methodological approaches to contribute to various aspects of South Africa's health systems strengthening agenda.

Led by Ms Ronel Visser, the Health Systems Strengthening Unit provides implementation support through strategic use, analysis and distribution of information about health and related fields to enhance evidence-based management and scale up of priority programmes. District-based HST facilitators work closely with health district management teams and healthcare workers, transferring skills for sustainable quality improvement in service delivery through training and mentoring. Public health care in South Africa has steadily improved since 1994. HST continues to play a key role in providing district-level support, to health service delivery and systems strengthening in areas as diverse as HIV and AIDS, TB,



Jackie Smith
Programme Manager:
HSS



Rakshika Bhana
Programme Manager:
HSS

and maternal, child and women's health (MCWH) and health management information systems.

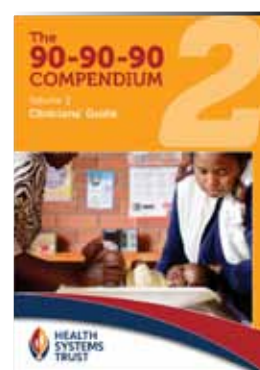
PROVIDING MANAGEMENT AND IMPLEMENTATION SUPPORT IN HEALTH DISTRICTS

The **SA SURE Plus** project deals with Programmatic, Implementation and Technical Assistance for HIV/AIDS and Tuberculosis Prevention, Care and Treatment Services throughout the health system in South Africa under the President's Emergency Plan for AIDS Relief (PEPFAR), which commenced in October 2016 and has an envisaged completion date of September 2021. The project incorporates an extension of a sixth year of the original PEPFAR funded grant, and commenced its first year in the seven focus districts (Chris Hani and OR Tambo Districts in the Eastern Cape; Lejweleputswa District in the Free State; and in KwaZulu-Natal, eThekweni (in 18 facilities), uMgungundlovu, uThukela and Zululand Districts). The project strengthens and supports local capacity to provide sustainable HIV and TB-related care and treatment service delivery in South Africa through training, mentoring, coaching and direct service delivery (DsD). As the largest HST project, it currently deploys over 300 staff members both above and below district site level. The project activities are accompanied by a monitoring and evaluation (M&E) framework to track changes in service delivery and to monitor and evaluate the impact of the project interventions. This broad approach allows the project to adapt, improve and innovate, thereby supporting the health system through a commitment to sustainability and local ownership to strengthen health systems and achieve quality service delivery, while improving linkage and access to health care and positive outcomes.

In November 2016 the project published Volume 1 of an anthology of 12 SA SURE **Stories of Change** describing how SA SURE project teams have partnered with Health Department personnel to apply policy in contextual practice in facilities across the country. These stories encapsulate valuable experiences of how key challenges have been addressed through promising approaches and techniques to support service quality improvement at clinic level.

Health Systems Trust was selected to implement the **Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS)** project in the eThekweni and uMgungundlovu Districts in KwaZulu-Natal Province. The project provides technical assistance in HIV prevention, care and treatment to adolescent girls and young women (AGYW) and males aged 20 to 49. Drawing on considerable experience gained through serving as a district support partner for the past five years, HST uses its pool of evidence-based approaches and methodologies to work closely with the Department of Health and other PEPFAR-supported partners in strengthening existing effective interventions, with a focus on innovative approaches for scaling up access for AGYWs.

During this year the project produced the first two volumes in a 90-90-90 Compendium. Volume 1 – An Introduction to 90-90-90 in South Africa and Volume 2 – The Clinician's Guide.



HST has been the primary support partner to the National Department of Health in seven districts for the implementation of the **Central Chronic Medicines Dispensing and Distribution (CCMDD)** programme, which is a sub-project of the SA SURE

Plus project. Further support was provided to the non-supported districts by the provincial co-ordinators. The programme's objectives were to improve access to chronic medicines by establishing alternative pick-up points (PuPs) for patients to collect repeat prescriptions, which in turn would increase the retention of patients on antiretroviral therapy (ART) and improve the follow-up of defaulting patients. The improved availability of epidemiological and medicine utilisation data emanating from the project would inform policy formulation and improve the supply chain management of medicines.

Table 1: Implementation CCMDD Programme – progress at 30 June 2017

Provinces	Number of Districts where implemented	Number of facilities registered	Number of patients registered	External PuPs appointed
KwaZulu-Natal	11	672	736 248	213
Limpopo	5	407	88 310	30
North West	4	327	119 099	36
Eastern Cape	8	724	190 224	68
Free State	5	146	68 483	58
Gauteng	4	174	196 326	202
Mpumalanga	3	238	115 025	34
Northern Cape	5	126	24 790	12
Totals	45	2 814	1 538 505	653

The activities also comprised the development of a business model for private sector involvement in improving access to medicines for chronic conditions in the public sector, as well as piloting National Health Insurance (NHI) implementation as described in the NHI white paper.

During the year in review, HST supported the national and district health structures with guidance on CCMDD policy development and implementation, financial administration of the programme, decanting of patients from facilities, monitoring the programme's effectiveness and efficiency, and training and development by a team of pharmacy policy specialists and co-ordinators.

Communications with new and existing patients were addressed with the mass production and distribution of multi-lingual promotional material and patient collection cards in all districts, as well as the initiation of a SMS message service reminding patients to collect their parcels from their selected PuP. A total of 15 new generic Standard Operating Procedures (SOPs) were developed in order to augment gaps identified in the programme, which led to the development of a toolkit to guide stakeholders on programme implementation. The Monitoring and Evaluation (M&E) Framework for the programme was reviewed and data collection tools were developed and distributed for implementation.

Some key challenges faced during the reporting period included sub-optimal Monitoring and Evaluation for the programme at district level and strengthening thereof will be a priority during facility and PuP visits. Innovative ways to address the lack of PuPs in some areas are being explored through the use of adherence clubs and outreach PuPs.

By 30 June 2017, a total of 1 538 505 patients were enrolled in the programme, thus exceeding the National Department of Health (NDoH) target of 1 500 000. The programme has been implemented in 45 districts across 2 814 facilities and a total of 653 external PuPs were appointed (see table 1). The utilisation of external PuPs and fast lane queues at facilities have resulted in alleviating congestion at facilities. Patient and healthcare provider testimonials support the intended benefits of the programme to improve access to medications and reduce facility workloads enabling more focus on UTT efforts.

An integral part of the CCMDD programme was the development of the web-based **CCMDD electronic system** which automates the CCMDD processes of online registration, electronically generated prescriptions and Patient Medicine Parcels (PMPs) tracking, and reporting. The incorporation of Standard Treatment Guidelines (STGs) and Essential Medicine Lists (EMLs) into the system promotes compliance with treatment protocols and minimises medication errors.

Table 2: Pilot healthcare facilities and associated PuP Sites for the CCMDD electronic system

District	Facility Name	Pick-up Point
KwaZulu-Natal		
uMzinyathi	Wasbank (Umzinyathi)	Wasbank clinic
	Hlathi Dam (Umzinyathi)	Dr Khubeka Surgery
		Dr Mgabe Surgery
		Community Orphanage Centre (MediLogistics)
eThekwini (Metro)	Prince Zulu CDC	Clicks Pinetown
		MediRite Pavillion
		Clicks Pavillion
		Clicks Musgrave
		Clicks Westguard – West Street
		Clicks Workshop
		Clicks Bridge City
		Clicks Game City
		Clicks Gateway
Eastern Cape		
OR Tambo	Ngangelizwe Mthatha Gateway Clinic	Clicks BT Ngebs Mall
		Clicks Mthatha Plaza
		Clicks Circus Triangle
		MediRite Mthatha
Chris Hani	Ezibeleni Clinic	Ezibeleni Clinic
	Gardens Clinic	Gardens Clinic
	New Rest Clinic	New Rest Clinic
	Nomzamo CHC	Nomzamo CHC
	Philani Clinic	Philani Clinic

The piloting of the CCMDD electronic system included provinces and districts serviced by two service providers in KwaZulu-Natal (KZN) and Eastern Cape (EC). The pilot commenced in September 2016 in KZN to test communication between the system and the service provider's internal systems and PuPs in uMzinyathi District and eThekweni Municipality. The EC service provider integrated their system with the CCMDD electronic system and piloting in the EC began in the OR Tambo district in late October 2016 (see table 2).

With demand growing for implementation of the system in facilities in other districts, a site visit was conducted at five facilities in the Chris Hani District in the Eastern Cape where it was concluded that the infrastructure was appropriate and required very little support in terms of connectivity from HST, offering a viable option for the expansion of the pilot. The system was implemented in Chris Hani District from 6 March 2017 (see table 2). In KZN expansion of the system to other districts was requested, and that the system be implemented in a further three districts in the province; uMgungundlovu, eThekweni and Zululand.

A challenge encountered at healthcare facilities was the lack of information technology infrastructure, resulting in HST

providing interim IT hardware until the districts would be able to resolve equipment installation issues. In order to ensure efficient electronic communication, multiple changes to the system were necessary during the pilot phase, an inevitable course of action when designing a generic system to suit all stakeholders.

A total of 2 628 new CCMDD patients were registered on the electronic system as at 30 June 2017 (see table 3). Currently, only new CCMDD patients, who have one or more of the five conditions pre-entered into the system, will be registered on the CCMDD electronic system. This number is likely to increase as soon as more conditions are populated on the system and following the decision to register existing CCMDD patients.

Since implementation, the system has ensured standardisation of care in accordance with STGs, a notable improvement in prescribing practice has been recorded and better tracking of PMPs has been achieved. During and since the piloting phase a high level of acceptance of the system by the users has been demonstrated. An automated reporting site allows for easy access to real-time data, e.g. epidemiological data and pharmaco-economic data. Due to the success of the pilot phase, a request was made by Sector Wide Procurement to develop a new e-Prescribing system that will cater for all levels of healthcare in South Africa. Other district support partners have requested HST to implement the system in their districts.

The next phase of the CCMDD electronic system will see its expansion into three districts in KZN. Further development of the reporting module will allow for report generation at various levels, namely: national, provincial, district, facility, and service providers (including PuPs). A request has been made by the NDoH to develop a new electronic prescribing system that will cater for all levels of care in preparation for NHI. The functionality of the e-Prescribing system will be derived from the existing CCMDD electronic system. The system will allow integration with various other health information systems, e.g. Essential Medicines Electronic Access (EMeA), Health Patient Registry System (HPRS), Rx Solutions®, and National Health Laboratory Services (NHLS).

The **Unfinished Business of Paediatric and Adolescent HIV project in KZN** which commenced in October 2016 is funded by ELMA Philanthropies and is being implemented in partnership with the KZN Department of Health. The project adopts quality improvement strategies to accelerate the identification of HIV-positive children and adolescents and their enrolment in treatment, ensuring that clinical and community linkages are improved so that they are retained in care. The project, a collaboration of nine implementing organisations – Zoe-Life, HST, MatCH, AIDS Foundation SA, NACOSA, NACCW, mothers2mothers, CHIVA and HealthEnabled is implemented in four districts in KZN with HST supporting three districts (Zululand, eThekweni and uMgungundlovu), which are also SA SURE Plus districts.

Table 3: Number of patients registered on the CCMDD electronic system (September 2016 – June 2017)

Province	District	Facility Name	Patient Count
Eastern Cape	Chris Hani	Ezibeleni	50
		Gardens	88
		New Rest	78
		Nomzamo CHC	140
		Philani Clinic (Queen)	69
	Chris Hani District Total		425
	OR Tambo	Mthatha Gateway	303
		Ngangelizwe CHC	289
	OR Tambo District Total		592
Eastern Cape Total			1 017
KwaZulu-Natal	eThekweni	Prince Zulu CDC Clinic	1 322
		Stonebridge Clinic	1
	eThekweni District Total		1 323
	uMgungundlovu	Central City Clinic	2
		Eastwood Clinic	1
		Howick Clinic	6
	uMgungundlovu District Total		9
	uMzinyathi	Hlathi Dam Clinic	119
		Wasbank Clinic	160
	uMzinyathi District Total		279
KwaZulu-Natal Total			1 611
Total Number of Patients Registered on CCMDD Electronic System			2 628

This project aligns directly with the NSP priorities as well as the goals of the National Adolescent and Youth Health Policy of 2017, which calls for the government, development partners and communities to integrate and streamline their activities and objectives towards meeting the UNAIDS 90-90-90 targets. Central to the implementation approach of the project is to strengthen the linkages between the facility and community through the implementation of evidence-based theory of change models that are sustainable. The project focuses on HIV case finding and retention on treatment at both health facility and community levels, through an integrated approach that will also strengthen case-finding of malnutrition and TB in children and establishment of child, adolescent and youth-friendly services. Towards meeting this objective, the project implementation phase kicked-off in March 2017 with the roll-out of the KidzAlive case-finding approach (a national child health strategy) for targeting index patients' children for testing and initiation on treatment and building health worker skills in child HCT, disclosure and adherence. By the end of June 2017, 125 facility staff were trained in this approach across the 62 supported facilities and were mentored to establish systems to support active case finding in the target population 0-19 years.

The **HIV Counselling and Testing (HCT) – Voluntary Counselling and Testing II (VCTII) project** is delivered through

the implementation of a social franchising model which has been branded as the “Power of Knowing”, funded by the KfW Entwicklungsbank (the German Development Bank) through the Development Bank of Southern Africa. The project promotes formal collaboration among public, private and non-government sectors in order to increase free HIV Counselling and Testing (HCT) coverage provided by service providers (NGOs, general practitioners, nurses and pharmacies) in the Limpopo and Northern Cape provinces.

As a result of its overachievement of project targets, this three-year project has been extended with additional funding for a further 18 months until December 2018.

As at June 2017 the project enabled counselling and testing of 341 305 people in the private sector (103% of its overall project testing target) and contracted over 250 private service providers to provide the service across the two provinces. These providers have been orientated and trained on the various components of the model to deliver HCT services in line with the latest National HIV Testing Services (HTS) Guidelines.

A key component of the project has been to ensure that the testing data collected from contracted service providers is reported and made accessible in the District Health Information System (DHIS) data files of the two provinces as part of the overall national HCT data.

The project has demonstrated the high level of interest and buy-in from the private sector to provide HCT services and to extend services to provide HIV treatment and other services, which has implications for NHI planning. Among the findings were that close collaboration between the private and public sector in the rendering of services is possible, but requires an administrative and supportive intermediary partner.

SUPPORTING IMPLEMENTATION OF PRIORITY HEALTH PROGRAMMES

Following the successful conclusion of the Rationalisation of Registers project encompassing the audit of 52 types of registers found to be in use in the health facilities and subsequent development into six key data collection

registers, HST provided support for **Scaling-up the roll-out of rationalised vertical health registers and optimising patient administration systems in primary health care facilities**. The project aims were two-fold: namely to improve data quality by ensuring efficient data collection processes in PHC facilities and, to improve the quality of patient experience as well as facility and patient management through the introduction and optimisation of patient administration systems.

The project set out to procure and supply rationalised registers, bulk filing cabinets, facility-held patient records and other supplies and to implement the National Patient Administration Systems in all infrastructure-ready Primary Health Care facilities.

All South African provinces, with the exception of the Western Cape Province – which is not implementing the rationalised registers – adopted the rationalised registers by 1 April 2016. The handover of print-ready layout and artwork of rationalised registers to the Government Printers took place in May 2016. A total of 3 800 000 facility-held patient records were printed and distributed by HST to facilities in the 10 participating NHI districts. Out of the targeted 678 facilities, 541 (80%) in the 10 NHI districts were infrastructure-ready and received bulk filing cabinets by 31 March 2017. This was followed by the delivery of print-ready layout and artwork of patient records to the National ePHC programme management for handover to the Government Printers in March 2017.

During the project, HST ensured compliance to audit standards, the cost of supplies was kept low through rigorous procurement and tender processes, and services were in accordance with HST's standards and the National Department of Health requirements.

This project has demonstrated how research can be translated into action and scale-up and has been widely lauded by our NDoH partners as a major success.

CONDUCTING ESSENTIAL NATIONAL HEALTH RESEARCH

Injury Morbidity Surveillance in Khayelitsha and Nyanga was a joint research project by HST, South African Medical Research Council, University of Cape Town and the Health

Impact Assessment Unit of the Provincial Government of the Western Cape (PGWC) that aimed to establish a risk profile for non-fatal injuries presenting to district-level hospitals and community health centres (CHCs) in Khayelitsha and Nyanga. These are two out of five areas previously identified by the provincial government's Injury Prevention Work Group as requiring targeted injury prevention efforts.

Key findings were that 34.5% of all emergency room (ER) visits during the five survey periods were acute first-presentation injuries. Violence remains the leading cause of injury accounting for 60.3% of injuries overall, followed by unintentional (25.6%) and transport-related (11.7%) causes.

The odds of presenting with a violent injury were 50% higher for males compared to females



Professional nurse, Dominica Ramabina counsels a patient during a community HTS event

(OR 1.50, 95% CI 1.26–1.78); eight times higher in the 15–24 year (versus 0–15 year) age-group (OR 8.01, 95% CI 6.05–10.60) and over four times higher in those with suspected alcohol use compared to those without (OR 4.27, 95% CI 3.38–5.39). There were notable differences in patterns of violent injury by gender with regard to specific cause, relationship with and number of perpetrators.

The predicted probability of presenting with a transport-related injury was found to be highest in the 0–14 year age group for both genders. After adjusting for other factors, the relative risk of a transport-related injury was twice as high for those who reported alcohol use compared to those who did not (RRR 2.15, 95% CI 1.43–3.22).

The results were fed back to the PGWC and the Khayelitsha community forum. In addition, an abstract was successfully presented at the International Conference on Violence Prevention held in Cape Town in September 2016. A manuscript on the findings from the inaugural study that took place in 2012 was submitted for journal review in February 2017.

The **Case study on the role of general practitioner contracting in strengthening health systems towards universal health coverage in South Africa** was part of a series of multi-country case studies commissioned by the World Health Organization's (WHO's) Alliance for Health Policy and Systems Research (AHPSR) looking at the role of non-state providers in strengthening health systems towards universal health coverage. As part of supporting the NHI pilot and PHC re-engineering strategy, the NDoH has embarked on an initiative to improve and expand access to healthcare services through the General Practitioner Contracting Initiative (GPCI). The primary objective of the GPCI was to contract GPs working in the private sector (i.e. for-profit private non-state providers) to render sessional services in public sector primary health care (PHC) facilities in the NHI pilot sites, as part of the initial phased approach. The GPCI started early in 2013 and has reached a stage where the initiative would benefit from a deeper understanding of its contribution to health systems strengthening in the public sector and ultimately supporting universal health coverage in South Africa.

This mixed-method multiple case study therefore aims to explore the extent of implementation of the GPCI in three purposively selected NHI districts, how actors at various levels of the health system (national, provincial and district) went about implementing it and what key factors enabled or hindered the implementation thereof with a focus on processes of engagement and the relationships between the various actors. The study specifically reviewed the process of policy implementation since its formal introduction in 2013.

Qualitative data were collected in the form of key informant interviews and focus group discussions with GPs purposively selected by senior managers at district, provincial and national levels of the health system. Quantitative secondary data included descriptive information on demographic, socio-economic, burden of disease, health service and process indicators for each district, collected through document review.

Now in the final project stages, the team has successfully completed all phases of data collection, with data analysis currently underway. The findings will provide insight into the three models of GP contracting that emerged during the pilot phase of this initiative, factors that influenced the evolution and implementation thereof as well as how various actors understood and perceived the GPCI. Two journal articles are under preparation for publication with guidance from members of the AHPSR and Johns Hopkins University's Technical Support Centre. To this end, two team members attended a data analysis and writing workshop hosted by the AHPSR in Dubai in 2017. The findings will be disseminated to national, provincial and district level stakeholders. It is envisaged that the information gained through this body of work will inform policy in South Africa and provide lessons learned that could also be shared with other countries.

GENERATING INFORMATION FOR PLANNING, MONITORING, EVALUATION AND DECISION-MAKING

The **National Health Research Database (NHRD)** was developed by HST to enable provinces and the National Department of Health (NDoH) to monitor research activities and use the information to set priorities for the country's research agenda as prescribed in the 2001 National Health Research Committee Policy. The project therefore hosts and maintains the NHRD which provincial and national departments of health now use to track and manage health research and to research ethical approval activities in the provinces. As an added support HST conducts regular visits to the Provincial Health Research Committees' (PHRC) administrators to ensure effective use of the NHRD functionalities and provides advice on how to market the database within their respective provinces.

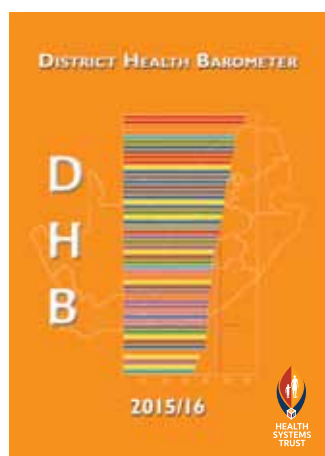
A significant development during the course of this financial year was the complete overhaul and streamlining of the NHRD database to provide a more efficient and user-friendly experience. These modifications are now complete and HST launched the new NHRD Version 2 at the end of July 2017. The NHRD Version 2 database provides for a single application to be made to multiple provinces and includes a National portal, providing the NDoH with access to aggregated national level data on research activities in South African public health facilities. In addition, the NHRD Version 2 provides sophisticated automated reporting features which



provide easy access to data that can be used to monitor key performance indicators relating to operational and strategic activities of PHRCs. Since its launch in 2013, the NHRD now has 4 089 unique researcher profiles registered on the database and a total of 5 158 research studies recorded to date.

The **District Health Barometer (DHB)** project seeks to develop an annual publication containing the results of the analysis and interpretation of aggregated and disaggregated data that monitors trends for key health system indicators. The publication seeks to highlight inequities in health outcomes, health-resource allocation and delivery, and to track the efficiency of health processes across all provinces and districts. The publication is also used by training institutions.

The DHB has been issued every year since 2005 and has generated eleven publications, the most recent being the District Health Barometer 2015/16. The publication has been funded by the National Department of Health since 2011/12. The 2015/16 DHB draws data from the District Health Information Software, the Ideal Clinic Realisation and Maintenance system, Statistics South Africa, the National Treasury Basic Accounting System, the National Health Laboratory Service, the National Income Dynamics Study, the National Electronic Tuberculosis Register and the Electronic Drug-resistant Tuberculosis Register.



Compilation of the DHB is guided by an advisory committee made up of managers from the National Department of Health, as well as public health experts. The 2015/16 publication included 44 indicators with trend illustrations and profiles of South Africa, the nine provinces and 52 districts. The district chapters give an analysis of all the indicators

per district and identify the priority issues that need attention. It also includes a chapter on burden of disease with thirty authors contributing to this year's publication.

The indicators have been approved by the National Department of Health. The indicators chosen are those linked to measuring the National Department of Health's Annual Performance Plan (APP), the provincial APPs and the implementation of District Health Plans.

The publication was released in February 2017 and 1 000 books were distributed to the National Department of Health, Provincial Departments of Health and health districts as well as to other institutions and individuals on request. The publication is also available on the website of Health Systems Trust at www.hst.org.za.

The year 2017 marks the 20th edition of the **South African Health Review (SAHR)**, an accredited peer-reviewed publication which has been produced by the Health Systems Trust since 1995. As an annual journal of research on health

policy development, reform, implementation and intervention for systemic improvement, the SAHR represents and expresses the Health Systems Trust's vision and mission of enabling equitable access to quality health services in our country through strengthened health systems.

Generated in the context of partnership with the policy-makers, planners, health managers, researchers, and health and development organisations – both locally and abroad – who constitute the sources and the audience of the Review's content, the knowledge shared through this publication enlightens regional and international thought and action around people-centred health care.

Consisting of 19 chapters contributed by over 100 authors and 50 peer reviewers, this year's edition contains information on policy and legislative changes, progress reports on initiatives to transform and improve the health system, and accounts of innovative approaches applied at facility and district level that contain salutary lessons for scale-up and replication across the country.



This year's winner of the Emerging Public Health Practitioner award presented by HST is Candice Fick who submitted an article reviewing 20 years of Integrated Management of Childhood Illness implementation in South Africa.

Building on SAHR work, the aim of the project **Identifying non-communicable disease "hot spots"** in South Africa is to develop a methodology to identify NCD "hot spots" and their risk factors in South Africa. By combining and analysing existing geo-referenced epidemiological surveys with data on relevant social and environmental determinants, information would be generated to guide public health priorities through enhanced public health planning in order to inform resource allocation.

Non-communicable diseases (NCDs) and related risk factors are on the rise in South Africa. Data from many parts of the world indicate that it is too simplistic to conceive this as an individual, lifestyle-related problem and there is strong evidence that NCDs are correlated with/caused by social determinants (e.g. socio-economic status, education). It is likely that the physical/built environment is a determinant as well (e.g. access to healthy and affordable food, fast-food chains, adverts for soft drinks, 'bikeability', 'walkability'), and this is also likely to be the case in South Africa. Related epidemiological data are scarce and funds for relevant preventive and curative health care services are limited.

The first phase of the project identified available data sources for monitoring NCDs and their risk factors and the results of this analysis were published in the South African Medical Journal (SAMJ). The article assessed the strength, weakness, usability

and availability of surveys and routine systems available for monitoring NCDs. The second component of this project sought to develop a modified food environment index for the Gauteng Province to measure the ratio of healthy and less healthy food retailers in a given area. The information provided by the project will act as a guide where further investigation into food swamped/desert areas is required.

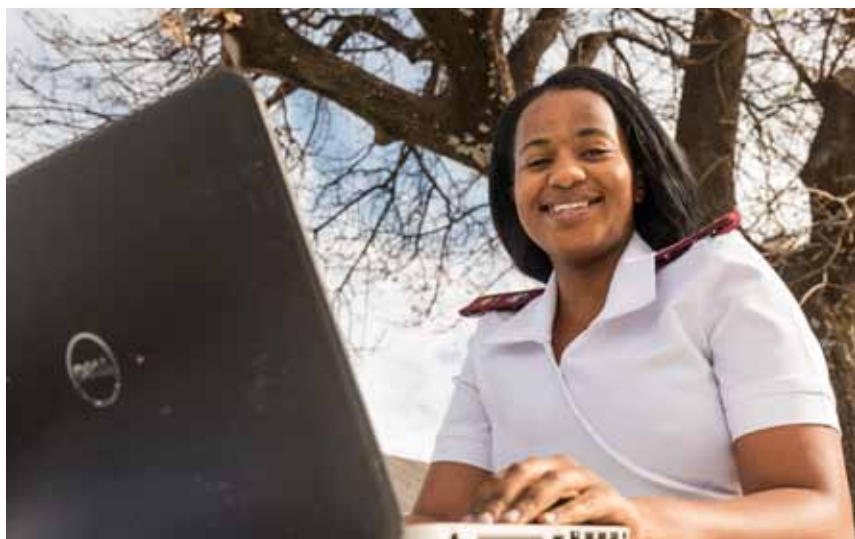
Health Systems Trust was awarded a project to support **Implementation of the Global Fund's (GF) Programmatic Quality Assurance and Improvement Approach** in Namibia and Swaziland by the Global Fund to Fight AIDS, Tuberculosis and Malaria for the period from February to May 2017. HST co-ordinated and developed a joint workplan and budget for the Health Facility Assessment/Data Quality Review (HFA/DQR) and worked with the GF country team and the Ministries of Health (MoH) of both countries to ensure that a sound technical plan was developed and that quality assurance approaches were built into the process. The project formed part of a wider global activity of programme and data quality assessments in GF-supported country projects. The objectives for the project were to:

- Facilitate a co-ordination process that ensures that the MoH and other relevant donors or stakeholders are included in the process of planning and budgeting;
- Develop a joint workplan and budget with clear timelines and roles and responsibilities and descriptions of the expected HFA/DQR in terms of sampling as well as the extent and general content of the survey. This relates, in particular, to the implementation, the dissemination, and follow-up action plan of the HFA/DQR;
- Determine clear roles and responsibilities for each aspect of the HFA/DQR workplan especially for the applicable Ministries of Health and other relevant donors or stakeholders.

HST will provide independent quality assurance of the HFA/DQR in both countries to be implemented by the Ministries of Health in the period July to December 2017.

In 2016 the NDoH commissioned HST to conduct a **Waiting Time Study** to collect detailed information about patient flow and waiting time of patients in PHC facilities and to assess the effect of the implementation of an electronic appointment system within the scope of the eHealth programme.

The study was initially designed as a mixed-method pre-post study with control group, and baseline data collection was carried out in six PHC clinics in the North West province in July 2016. Direct observation and interviews with key staff were undertaken to identify the factors potentially impacting waiting times. Barcode stickers and electronic readers were then used to track the flow of more than 4 000 patients within



Thandiswa Mayekiso, nurse clinician in the field

the facilities, from entry to exit.

Owing to changes in the implementation of the electronic appointment system, continuation of the original study design was not possible. HST therefore proposed a new approach, making use of simulation modelling, to use the readily available data to reach an answer on the original research question. Simulation modelling has seen increased use in healthcare research, particularly in high-income countries, but its applications in low-income countries, especially in PHC contexts, has been somewhat limited.

The model developed by the HST team performed well in representing the observed data and enabled the researchers to simulate the implementation of the appointment system and draw conclusions about its potential effectiveness. Owing to its flexibility, the model has also been used beyond the original aims of the project, to simulate the potential effects on a large series of interventions aimed at reducing waiting times, including staff increases, changes in opening hours and reduction of service times.

The model was presented to the NDoH and it has attracted considerable interest as a valuable tool for policy-makers that could provide preliminary analyses of potential effects of organisational interventions at primary health care clinic level.

Commissioned by the NDoH, HST conducted the study **Assessing patient experiences of care in primary health care facilities in South Africa** aimed to fast-track the implementation of the Patient Experiences of Care (PEC) survey – an activity in the current National Department of Health (NDoH) Annual Performance Plan. The study assessed the experiences of care of patients accessing public sector health facilities in selected facilities across the nine provinces of South Africa, with a particular focus on differences in study variables by Ideal Clinic performance categories.

Using an adapted questionnaire provided by the NDoH, and a questionnaire developed by HST, the project sought to determine the experiences of care, identify the key factors

influencing patient experiences, and make recommendations to address identified gaps.

Prior to survey data collection, the training of fieldworkers and piloting were completed for the purposes of assessing the feasibility of survey instruments developed and to prepare the fieldworkers for the data collection phase. The training of fieldworkers and piloting of survey tools was held over four days in Bloemfontein, Johannesburg and East London, respectively.

Table 4: Data collection activities

Data collection groups	Data collection dates
Free State, Northern Cape and North West	24 January – 14 February
Gauteng, Limpopo and Mpumalanga	27 February – 17 March
Western Cape, Eastern Cape and KwaZulu-Natal	28 March – 12 April

In total, 168 health facilities were visited across the country, 19 health facilities per province, excluding Mpumalanga and Northern Cape provinces where 18 and 17 facilities were visited, respectively. A total of 7 124 patients aged 18 years and above were interviewed. All survey facilities were classified (based on their Ideal Clinic score) into the Ideal Clinic categories of either poor, moderate, high-performing facilities or facilities without a score. Descriptive data analysis and reporting of the unweighted survey data was completed by the end of June 2017. Advanced statistical analysis including application of modelling techniques to identify significant factors related to patient experiences of care is in progress in preparation for submission of the consolidated survey report to the NDoH.

Considered to be a critical factor towards achieving the third goal of the 90-90-90 strategy, the **Viral Load Documentation** project involved using a change management approach (CMA) to improve viral load documentation in order to track the continuity of HIV care in the 2016/2017 CDC financial year. Adapted from previous documentation created for the NDoH's Ideal Clinic Realisation and Maintenance (ICRM) project, the change management approach for viral load documentation (CMVL) capacitated facility managers and healthcare workers to improve documentation of viral load testing at facility level.

The CMA consisted of a five-day implementation training and three one-day Field Support Visits. Specific materials developed for the CMVL included a toolkit for ease of reference in the facilities.

Facility managers from Chris Hani district were the recipients of the CMA. Quantitative and qualitative data were measured to ascertain levels of improvement. The viral load completion rate and the viral load suppression rate per facility per month after the five-day CMA were collected. Viral load completion rates showed an improvement from 4 to 30%, 0 to 31%, 4 to 22%, and 3 to 30% between June and July 2017 in four facilities. Other facilities were not able to provide complete

data and were therefore not listed. Similarly, viral load suppression rates improved from 50 to 88%, 0 to 100%. One facility showed no improvement because both before and after results were 100%. Another showed a decrease from 100% to 77% as the large increase in viral load completion rates was also accompanied by a decrease in viral load suppression.

Qualitative data from focus group discussions highlighted an improved management of the flow of viral load results. Furthermore, the CMAVL provided a useful guide for highlighting the importance of viral load documentation, the participants had a better understanding of the issues at hand and felt equipped with necessary tools and strategies to achieve greater improvements in viral load documentation.

The Primary Health Care (PHC) Re-engineering Strategy focuses on revitalising South Africa's health system through community-based PHC services. Improving the performance of the district health system (DHS) and is fundamental to achieving a revitalised PHC. In South Africa, the implementation of service delivery is informed by the package of PHC services. This package guides the provision of health services in the health district, availability of and accessibility to services. The district health management team (DHMT) is responsible for co-ordinating services within the DHS. This is done through the provision of appropriate oversight, governance and leadership in delivery of the PHC package of services. The implementation of the PHC package may be influenced by contextual variations in rural and urban health districts. An exploration of these variations will inform stakeholders, including the DHMT, on approaches to strengthen PHC service delivery toward improving the performance of the DHS.

Emanating from work to develop a framework for district health management offices, HST conducted a **rapid assessment of availability of primary health care (PHC) services in two districts in South Africa**. The study was initiated in April 2015 and funded by the NDoH with the aim of identifying key factors affecting the delivery of the PHC package of services in Dr Ruth Segomotsi Mompati (Dr RSM) and Tshwane districts. Since June 2016 the funding stream changed to the CDC under the SA SURE grant. The objectives of the study entailed determining the availability of PHC services in health facilities and identifying the key enablers and barriers of PHC services in each district.

Data were collected through individual interviews, focus group discussions, a literature review and quantitative data analysis. Data were analysed for thematic findings related to the availability of the PHC package of service and key factors required to support the provision of PHC services.

The findings provided insight into factors that facilitate availability of PHC services in urban and rural health districts and approaches used to address the barriers to service delivery. Thematic barriers identified related to human resource recruitment and management processes, shortages of human resources; equipment and drugs and inadequate consultation with staff at the coalface of service delivery when implementing top-down policy change.

The report, *A rapid assessment of primary healthcare services in Dr RSM and Tshwane districts in South Africa* is being prepared for review. The findings of this study have the potential to inform approaches to improve service delivery in PHC in both rural and urban health districts and their respective district health management systems.

In the past decade the South African public health policy environment has evolved substantially in support of further efforts to strengthen the district health system and the primary health care service delivery platform. Unsurprisingly, priority has been given to programmes directly related to combatting the quadruple burden of disease. Active steps have been taken to move away from vertical health programmes towards facilitating programme integration and improved service delivery configurations that promote easier access to services and improved service delivery standards. However, the revision of policies guiding disability inclusion and the integration of rehabilitation services into primary health care specifically, has tended to lag behind. The NDoH has recognised this and has taken active steps to ensure that rehabilitation services are brought to the fore by recently revising the Policy Framework and Strategy for Disability and Rehabilitation. HST was commissioned to undertake an **Assessment of the status of disability and rehabilitation services within the KwaZulu-Natal public health sector and the preparedness for the implementation of the South African Framework and Strategy on Disability and Rehabilitation (FSDR)** to support and inform the implementation of the strategy. The study aimed to assess key barriers to implementation of the FSDR and document emerging models of rehabilitation with various healthcare settings. Collaborators on this project included the National Department of Health, the Health Systems Trust, Medical Research Council, University of KwaZulu-Natal and the University of Cape Town. Fieldwork for the study was completed in May 2017 and findings of the study were presented to the NDoH in August 2017.

The aim of the **assessment of the extent of implementation of the Integrated Clinical Services Management (ICSM) Model in Zululand District** is to assess the extent of implementation of the ICSM model in selected facilities in Zululand District. The specific objectives were to:

- describe how facilities implemented the ICSM model;
- describe which service configurations (structural and operational) required by the ICSM model were implemented;
- identify the facilitators and barriers in the implementation of the ICSM model;
- assess adherence to treatment and management guidelines for chronic illnesses included in the ICSM service package; and
- describe the operations and functioning of the selected facility by determining the experiences of care of patients accessing health care at selected facilities.

The project proposal was submitted for ethical approval with the University of KwaZulu-Natal Biomedical Research Committee with the outcome expected early in the fourth quarter of 2017. Provincial and district health research committee approvals will be sought once ethics approval has been obtained. Project activities can only commence once all approvals have been obtained.

An **assessment of the functionality, integration and effect on service utilisation of Ward-based Outreach Teams (WBOTs) in Gert Sibande District, Mpumalanga Province** evaluated the effectiveness of the introduction of ward-based PHC outreach teams in Gert Sibande District, Mpumalanga, given the province's policy and programme intentions, with the following objectives:

- to assess the functionality and integration of WBOTs within mainstream PHC services in selected sub-districts in



HST research unit meeting

the Gert Sibande district in Mpumalanga Province, South Africa, since the introduction of the programme in 2012;

- to assess the effect of WBOTs on health service utilisation; and
- to explore the role of PHC governance structures in relation to WBOTs.

This cross-sectional study employed a mixed-method design to collect and analyse both quantitative and qualitative data on the same phenomenon, and to converge the results during interpretation in five purposively selected districts. The design included a retrospective analysis of trends in service delivery utilisation as well as relevant outcomes of existing routine data. The study consisted of primary (qualitative and quantitative) and secondary (desktop/document review) data collection approaches.

Five of the seven sub-districts in Gert Sibande were purposively selected on the basis that only WBOTs that have been in existence between 2012 and 2015/16 would be included in the study. The sampling frame comprised of:

- WBOT team members (community health workers, environmental health practitioners, health practitioners) – although most teams comprise mainly of community health workers;
- WBOTs team leaders (PHC Professional Nurse);
- PHC facility managers for those facilities linked to WBOTs;
- PHC governance structure members; and
- Sub-district and district managers and managers at provincial level.

Preliminary findings of the study have been presented to district and provincial management teams in Mpumalanga Province.

The **District Health Management Office Framework and job profiles** project was commissioned in 2014 by the NDoH building on a previous study that revealed a need for leadership and management capacity-building. In addition, the recent *District Health Systems Policy Framework and Strategy 2014 to 2019* highlights improved governance, leadership and management of the DHS as one of seven key goals to be achieved over the next five years.

The project aimed to develop a framework for district health system (DHS) management, clinical and support staffing that would outline key core functions of a health district (tailored to the local South African setting), an ideal standardised composition for a District Health Management Office (DHMO), including technical, administrative and support staff as well as to develop job profiles (required purpose, functions, qualifications, skills and competencies) for each DHMO member.

The finalised DHMO framework underwent a review to assess the feasibility, appropriateness and costs of implementation of the health management organogram and job profiles in terms of future roll-out of a standardised district organogram, with a focus on the current human resource regulatory, legislative and policy contexts.

Key findings included:

- not all provinces have DHMO structures that are approved in terms of legislation; District Managers have overly broad spans of control, with an average span of 17 managers to one District Manager which has led to poor functional integration within the district;
- job descriptions of similar posts within provinces differ vastly and there is limited participation of DHMO in departmental job evaluation processes;
- managers lack delegated decision-making power leading to inefficient management;
- there are no approved frameworks for delegated powers in most provinces. Four options for proposed DHMO structures were developed based on the HR/OD evaluation, input from managers and the NDoH and costed.

Key recommendations to the NDoH for future implementation included:

- limiting uniformity of the framework to only the office of the District Manager and Tier one and two managers, engaging provinces early to ensure that they agree on the process to be followed and the contents of the framework;
- ensuring that a Framework of Delegations is developed, approved and implemented for all provinces in terms of the Public Service Act and Public Service Regulations to provide managers with the authority to effectively execute their management duties;
- the NDoH, with approval of provinces, should take ownership with respect to drafting of job descriptions and job grading of posts on the management structure;
- to obtain an estimation of the funding required for a DHMO structure; and
- the need for further exploration of the relationship between health expenditure and district size in terms of population density and number of facilities.

The project was completed and findings and recommendations presented to the National Health Council Technical Committee in October 2016. It is hoped that the recommendations emanating from this work will contribute to a strong evidence base to underpin the interventions that will subsequently be implemented to improve the level of competence of all levels of staff functioning within the district health system.

Another project addressing the critical area of human resources, **Development and testing of Public Health and General Management competency needs assessment tools for District Health Managers in South Africa**, addressed the documenting of District Health Management Office (DHMO) structures and the job profiles of DHMO staff in order to standardise roles, functions and competencies across the country. The project supports the National Department of Health's initiative to strengthen management leadership and governance across the district health system in South Africa.

Following a phase of consultations in 2015/16, the next stage of the project focused on the development of competency assessment tools for district managers and to conduct competency needs assessments with selected district managers in South Africa. Once completed, the tool will be used to inform future management enhancement initiatives either at district level, and/or at academic level in order to tailor training programmes for performance management in the workplace.

The project outcome included the development of a competency enhancement tool comprising a framework with key functions, identified competencies and skills required for district managers. The second section of the tool provided definitions for key competencies, and technical and process skills within the context of the district managers' roles. Lastly, the self-assessment tool provided district managers with further instruments to enable self-reflection and personal development. An internal validation of this tool was conducted with relevant internal stakeholders and the project team and the tool was piloted with district managers in seven districts supported through HST's SA SURE project.

Future activities will involve an analysis of the input from the pilot study and the tool will be adapted and loaded into the NDoH knowledge hub system for future district managers' competency assessments.

OFFERING GUIDANCE, MENTORING AND TRAINING ON GOOD PRACTICE DEVELOPMENT

Wellness for Effective Leadership (WEL) strengthens the health system by supporting the development of public sector leaders and managers that are better able to manage, lead teams, practice self-care and better team functioning that leads to improved service delivery. The project has two main objectives:

- to provide leadership and management development and a healing and transformational process in a seven-day programme taking place over a six-month period with a closed group of 14–16 participants; and
- to provide a two-day Leadership and Management training from the interpersonal level outwards. This is particularly useful in addressing “transformational fatigue” and team-building and can be done with groups of 25 people thus addressing scale up as it is able to reach more people. The theory of change posits that increased self-awareness leads to different choices that may result in change.

A WEL process was undertaken with the Ann Latsky Nursing College Midwifery team in Gauteng which led to improved team functioning within the College. Furthermore, elements of the WEL approach were adopted and implemented as part of the HST change management approach.

Whilst there is a need for this capacity-building programme in the context of overburdened healthcare professionals, the current constrained funding environment has impacted expanded uptake of the programme.

Detailed feedback from participants is that the WEL process was successful in addressing long-standing internal obstacles where conventional methods had not been successful.

The WEL monthly newsletter serves to sustain the gains made and introduce practical tips and practices for WEL participants to share with their teams. It is also shared with partners, stakeholders and potential funders.

The next steps for the WEL process are to achieve accredited training status for the two-day programme. There are also plans for this programme to form part of a pilot for the Patient Centred Care approach supported by the NDoH with potential for scale-up.

The health governance project **A developmental approach to develop, test and evaluate a best practice model guiding the establishment of functional Ward AIDS Committees (WACs)** sought to develop and test a guide to strengthen the functionality of Ward AIDS Committees (WACs) including provision of a learning programme with facilitator and learner support materials using a developmental approach.

A situational analysis conducted in uThukela, uMgungundlovu, Zululand and King Cetshwayo districts in KZN prior to the project found that most WACs were dysfunctional and existed within an unsupportive system. As a result, HST in collaboration with the HIV and AIDS Directorate in the Office of the KwaZulu-Natal Premier agreed to pursue a developmental and participatory approach to develop and test a possible best practice model for KZN that will guide the establishment of functional WACs.

By means of the developed tools, the project intends to effectively strengthen and support the WACs to synergise their data collection tasks with the public health facilities. This will further facilitate more effective monitoring of key performance indicators relating to treatment initiation rates, as well as improve linkages to care at community level.

Implementation of the project commenced with two phases of training led by HST facilitators in Umgeni District and a third phase entailing a final follow-up meeting in August 2017.

The facilitator and participants' reference guides have undergone testing and several rounds of review throughout the project, and compilation of the project report is currently underway.

During the period under review, a feasibility study provided positive indications that operation of an expanded **Training Unit** offering accredited programmes that meet current health service delivery and management needs, and reflect HST's unique capabilities and experience, could make important contributions to capacity development in the public sector and at community level. The “niche” programmes considered can complement what is currently available in the market and meet identified service gaps. The growth and expansion of the training unit offerings will build on the already existing knowledge, material, expertise and networks that have been established over time.

Several milestones have been achieved including the accreditation of service providers and programmes, as follows:



HST Engcobo Sub-District team

- the accreditation of the HST Midrand office in January 2017 as a Health and Welfare Sectoral Education and Training Authority (HWSETA) accredited satellite campus. Owing to the system change at the HWSETA the results of several courses are still pending and will be finalised in the near future;
- four HST administrative staff have been trained on a HWSETA accredited programme “HIV in the workplace” in-house. They have developed a draft policy on HIV in the workplace for HST and post-exposure prophylaxis posters and guidelines on caring for an employee with HIV;
- verification of the portfolios of evidence of the four administrative staff that were trained as well as the 22 previously trained students from HST Durban campus will be completed in 2017;
- two of the trainees of the HWSETA Learning Performance Link Assessor programme completed the programme and submitted their portfolios of evidence;
- application for Department of Higher Education and Training (DHET) accreditation was submitted end-June 2017; and
- The Training Unit co-ordinated skills training for HST and supported HST projects such as SA SURE, and VCT II (see table 5).

Table 5: Accredited skills training conducted

Course	Number of participants trained	Categories
Adult Primary Care 101 (full course)	104	Professional Nurses
Adult Primary Care 101 (Orientation)	143	Managers; doctors
Adult Primary Care 101 (Update)	24	Professional Nurses
Integrated Clinical Services Management	14	Professional Nurses
Rapid test quality improvement initiative II	56	HIV Testers (professional nurses and lay counsellors)

Table 6: Skills training conducted for HST employees

Skills training	Number of participants trained
Effective Fleet and Transport Management Strategies Workshop	2
Road Transport Legislation Workshop	2
Health and Safety Training	2
Monitoring and Evaluation of Health and Development Programmes	8
SharePoint 2013 End-User	28
Individual Tax Return (ITR12)	2
Monitoring and Evaluation	2
Introduction to DHIS 2-Web based	3
Using Health Information for Effective Management	4
Assessor course	8
MS Excel 2010 Essentials	7
MS Excel Data Analysis Level 2	13

The Training Unit assisted the CCMDD programme (NDoH) with the development of material for an e-learning programme.

A database has been developed for assessors and moderators and a once off training for assessors was done.

The unit also conducted a desktop review on “mentoring and coaching” and developed a proposal for CDC on mentoring and coaching of operational managers. The unit is currently

in the process of developing training for a coaching and mentoring programme

A provider was sourced to develop a learner management system (LMS) and an e-learning platform that will be handed over to HST after completion.

The development of a quality management system (QMS ISO 9000 [2015]) which commenced in June 2017 and is scheduled for completion in November 2017 will ensure that the Training Unit is compliant with Higher Education (HE) requirements and international quality managed standards.

A by-product of the process includes the development of Training Unit educational policies, processes, and systems.

Internal capacity development was an important objective for the unit this year. The Training Unit administrator was trained as a Skills Development Facilitator (SDF) and now co-ordinates implementation of HST’s skills development plan working in collaboration with the HR Unit, BEE reporting and training of HST staff.

Other Training Unit activities included the Workplace Skills Programme (WSP) for 2017 and Annual Training Report (ATR) based on the 2015–2016 skills development plan.

The unit explored collaborations in the current year with the Nursing Education Association (NEA), Democratic Nursing Organisation of South Africa (DENOSA), SA Pharmacy Council, Monash University and Sefako Makgatho University. Building on an existing collaboration with JUTA Pty (LTD), the unit is working on provision of an ICD10 training course that will be implemented as soon as the training material is accredited by HWSETA.



Outreach planning meeting at the HST Queenstown office



Deena Govender
Director: Corporate Services

Corporate Services Directorate

Through its specialist units – finance, information technology, and administration – the Corporate Services Directorate, under the leadership of Mr Deena Govender, supports HST's operational mandate and responds to new directions and ensures that HST finances are maintained to a high standard.

FINANCE, GRANTS AND COMPLIANCE

Led by Ms Melini Moodley, the Finance, Grants and Compliance team ensures that HST remains abreast with relevant changes to the rules, regulations and guidelines affecting both local and international funders. During the period under review, there has been an increased focus on strengthening the capacity within our Grants and Compliance offices.

This enables HST to effectively manage sub-recipients in a structured way in accordance with applicable funder regulations as well as to monitor HST's day-to-day adherence to policies and standard operating procedures.

The Grants office is responsible for managing and monitoring a large number of sub-recipients ranging from small grass-roots community-based organisations to larger multi-national organisations and institutions.

The Finance staff continues to work closely with line managers to provide them with relevant and timely reports for the projects they manage. This enables them to manage their budgets and ensure that all deliverables are met within the prescribed timeframes. With a robust system of internal controls and processes, HST has once more received an unqualified audit report.

ADMINISTRATION

Led by Ms Delene King, the Administration team, with its staff complement of 43, ensures seamless administrative and logistical support to all personnel and stakeholders both internally and externally. It is through the team's excellent standards of implementation and stringent compliance with procedures that HST's policies are upheld, underpinned by a high level of combined experience and professionalism.

INFORMATION AND COMMUNICATIONS TECHNOLOGY

During the year under review the Information and Communications Technology (ICT) team successfully managed an uptime of 99.8% for server availability ensuring that HST's

staff across the country, who are predominantly field-based, remained connected to the organisation and were able to effectively perform their tasks supported by a reliable ICT system.

Some of the major activities during the year saw rebuilding of the indicators' database and the hosting of this key data on HST's servers.

In response to the increased staff number, the network infrastructure was improved to accommodate the projected growth in user activity.

The implementation of Windows 10 was effected on all new laptop deployments.

In light of recent ransomware, virus and malware threats, HST rolled out more secure endpoint protection to further enhance laptop security, as well as conducting a high level risk assessment of our network infrastructure. The result was that HST servers are reasonably secure and potential loopholes were addressed to ensure that the network would not be compromised. User education will also form part of the initiatives to ensure that employees adhere to organisational policies designed to protect ICT assets.

ICT's goal for the coming year is to continue to improve on support services, ensure back-end systems are running optimally and to continue to align itself with the goals and strategies of HST going forward.



Melini Moodley
Finance Manager



Delene King
Administration Manager



Robert Hendricks
Manager: Human Resources

Human Resources

Mr Robert Hendricks, the Human Resources (HR) Manager, together with his team manages the HR function and provides human resource support to meet the needs of HST staff.

The year in review was a busy one for the HR function with significant changes in scope of the organisation's largest grant. This resulted in significant organisational adjustments including a major exercise of restructuring of the SA SURE team, recruitment of staff to meet the new skill requirements and regrettably a number of retrenchments. Wherever possible, employees were absorbed into other HST projects through a commendable process of organisation-wide collaboration.

New recruitments were a major part of the unit's work in the current year with the commencement of the DREAMS and ELMA projects. During the period under review, 142 employees left the organisation and 145 joined HST. The total headcount at the end of this period stood at 442.

From a staff development perspective, HR worked closely with the Training Unit to facilitate handover of some of the training functions, with the two units identifying roles and responsibilities. During the year under review, 14 employees received bursaries to further their academic studies, culminating in one employee graduating with a PhD. Several staff members attended various training courses, including MS Excel, Financial and Compliance Rules, Health and Safety, Leadership Development, Fleet and Transport Management, HR Premier Job Management, VCT Phase II HIV Counselling and Testing Training, and Budgeting, Forecasting and Cost Management Using Excel, among others.

The current performance management system is based on the balanced scorecard principles and, through constant quality checks and raising awareness, HST has managed to create uniformity and common understanding of what is expected from both the line manager and the employee.



Zinhle Ngwane, Sinead Parsee, Chante Williams, Nombuso Dlamini, Robert Hendricks, Karen Jacobs, and Sanele Ngubane



Innocent Nkata
Head: Business Development and Communications

Business Development and Communications Section

During the past twelve months, HST's business development activities took place within a dynamic environment where the growing pressure for better service delivery is requiring NGOs to develop new business models and perform more hands-on roles; ICT advances are enabling the adoption of mobile tech-driven health innovations and there is an increased demand for health systems strengthening activities which can be provided on a consultancy basis.

At the same time, the residual impact of the global financial crisis is driving more international NGOs to the global South, thus increasing competition for limited donor funding in middle income countries.

Despite the above challenges, HST took significant steps forward following the launch of a new business development strategy whose goal is to improve the organisation's financial sustainability through an innovative approach to business development.

In relation to the first objective to grow and diversify restricted project funding, the following new grants were secured during the year:

- CDC one-year extension to the original SA SURE five-year grant;
- CDC new five-year grant for the SA SURE Plus project;
- ELMA Philanthropies co-funding for the DREAMS project;
- Funding for health information technology support as a sub-grantee to the University of Cape Town on the Gates Foundation grant;
- The Global Fund contracts to provide quality assurance assistance for health facility assessments in Namibia and Swaziland;
- Pre-qualified as service provider for KwaZulu-Natal's Global Fund programme;
- Development Bank of Southern Africa one-year grant extension for the VCT II project with funding from KfW Entwicklungsbank, the German Development Bank; and
- European and Developing Countries Clinical Trials Partnership grant as part of a consortium led by the London School of Hygiene and Tropical Medicine;

HST continued to engage with like-minded organisations to build partnerships for leveraging our programme and resource mobilisation efforts. These include: the Nelson Mandela Children's Fund; Nelson Mandela Metropolitan University; Mothers2mothers; Praekelt.org; Accenture; Mobenzi; ASG; Household Surveys Foundation; VP Health; Qonda Consulting; Phillips Africa; Broadreach; Society for Family Health; FHI360; University of Newcastle; Equinet; KPMG; EOH; Amref Health Africa; Health Partners International/Southern Africa; Africa Health Placements; Africa Interprofessional Education Network; I-TECH South Africa; Gamified; FR Research and the Wits Perinatal HIV Research Unit.

In relation to the second objective to grow and diversify unrestricted income, HST has made progress in its business expansion strategy and continued exploration of opportunities to grow its regional footprint with a long-term view towards achieving financial sustainability.

During the year in review, the Communications Unit (CU) continued to render a range of marketing, communications, editing and layout services to the organisation and the projects, as well as external clients. The finalisation of a new communications strategy has redirected the CU's focus towards increased brand-building initiatives to support HST's core work and repositioning the HST as the "go to" health systems organisation in South Africa and the region.

Among the highlights, was the redesign and development of the new HST website to improve navigation and access to the rich public health information and publications curated over two decades. The website continues to attract an average of 30 000 unique visitors on a monthly basis, indicating that the repository of health-related information remains a valuable resource to the platform's new and returning users.

In July 2016, the CU working in collaboration with the HSS Programmes Unit launched the SA SURE "Better Off Knowing" social mobilisation campaign with messaging aligned to the 90-90-90 targets encouraging people to know their status with an HIV and TB test, get onto treatment and to adhere to medication. The integrated campaign utilised advertising in community newspapers, billboards, community radio and digital platforms in the SA SURE supported districts in Limpopo, Free State, Eastern Cape and KwaZulu-Natal.



Other platforms included a dedicated website, social media channels, as well as printed and promotional materials. Face-to-face engagement was a strong element in the campaign, including outreach to the community through edutainment events accompanied by the provision of on-site HTS, stakeholder briefings and lay counsellor workshops.

Engagement on the provocative messaging, bold creative execution and engaging dialogue – aimed predominantly at young people, girls and key populations – has been extremely encouraging, most noticeably on social media, where the campaign's Facebook likes were close to 14 000 and Twitter following totalled approximately 1 400.

The initial mass campaign was implemented for three months and was extended on radio and social media until December 2016. Continued content management on social media has demonstrated a need for reliable and timeous information on HIV and TB.

HST hosted exhibition stands at the World Nutrition Congress and SA AIDS Conference to raise its profile at these key health-related events.

Future plans will see HST embarking on more innovative communications methods to optimise opportunities to profile the critical work of HST.

Conclusion

The 2016/17 financial year has been another positive year for Health Systems Trust of building strong and accessible health systems through our diverse portfolio of research and implementation projects.

Notable among our many successes have been HST's contribution to the Ideal Clinic initiative, change management projects in all levels of the health system, the development of an efficient patients' records system through the rationalisation of registers project, and our monitoring and evaluation initiatives in Primary Health Care. HST has been involved as a non-state provider with the CCMDD project since its inception the results which have now become the model adopted by the NDoH for wide-spread implementation.

Against a backdrop of declining donor funding which has left many not-for-profit organisations (NPOs) struggling to survive, HST has managed to maintain a stable financial footing. Our longstanding partnerships, for example, with the National Department of Health, and our diverse portfolio of health systems development support, have enabled us to continue to produce essential national health research and provide pertinent technical support which over the years has

informed decision-making towards building a resilient health system. Newly-funded projects demonstrate the confidence in HST's ability to deliver outcomes of quality and relevance in pursuit of creating equity in health for all our citizens. The uncertainty being experienced by the NPO sector created by constrained funding has crystallised the importance of a sustainable NPO sector given its significant role in health service delivery. This has informed our pursuit of a business model that includes the development of non-grant revenue streams for greater financial sustainability.

Looking ahead, as we continue to strengthen and develop our health systems offerings at a local level, HST will be exploring new opportunities in the region. The 2030 agenda for Sustainable Development commits to leave no-one behind and places sustainable development at the forefront of the public health agenda. HST believes that it is ideally positioned to strengthen partnerships and collaborations across sectors and communities, not only in South Africa, but also within the region to promote integrated and resilient health systems.



Publications and reports

● **Day C**, Gray A. Health and Related Indicators. In: **Padarath A**, Barron P, editors. South African Health Review 2017. Durban: Health Systems Trust; 2017.

Massyn N, **Peer N**, **English R**, **Padarath A**, Barron P, **Day C**, et al. District Health Barometer 2015/16. Durban: Health Systems Trust; 2016.

Wandai M, Aagaard-Hansen J, **Day C**, Sartorius B, Hofman KJ. Available data sources for monitoring non-communicable diseases and their risk factors in South Africa, South African Medical Journal; 2017.

Padarath A, Barron P. South African Health Review 2017, editors. Durban: Health Systems Trust; 2017.

Barron P, **Padarath A**. Twenty Years of the South African Health Review. In: **Padarath A**, Barron P, editors. South African Health Review 2017. Durban: Health Systems Trust; 2017.

Conferences and presentations

● **Annakie-Eriksen J**, **Wileman L**, Cachalia C. "Better Off Knowing": an innovative HIV and TB media campaign motivating young people in South Africa to get tested, get treated and live longer, HEAIDS Conference, 9–11 June 2017, Durban, South Africa.

Bhana R. DHIS Use-Case Bazaar: Case Demonstrations of DHIS initiatives from three countries, eHealthALIVE 2016 Towards eHealth Excellence in Southern Africa, 6–7 September 2016, Gauteng, South Africa.

Gray AL, **Day C**. Joining the dots – making sense of medicines utilisation data, The South African Association of Hospital and Institutional Pharmacists (SAAHIP) Annual Conference, 23–26 March 2017, Drakensberg, KwaZulu-Natal, South Africa.

Mureithi L, **Africa A**, **Wandai M**, **Van Schaik N**, Naledi T, Hawkrigde A, Matzopoulos R and **English R**. A profile of violent injuries presenting to health facilities in two high-violence communities in Cape Town, South Africa: findings

from repeated cross-sectional surveys, International Conference on Violence Prevention: From Scientific Excellence to Effective Practice, 8–9 September 2016, Cape Town, South Africa.

Cachalia C, **Nkata I**, **Annakie-Eriksen J**. "Better Off Knowing": a social mobilisation campaign to increase uptake of HIV and TB services in four South African provinces, 8th SA AIDS Conference, 15–18 June 2017, Durban, South Africa.

Smith J. Implementation of quality improvement activities to improve viral load results in PHC facilities, PEPFAR Satellite – Closing the loop in provision of Medical Laboratory Services through Strengthening of the Clinic-Lab Interface, 8th SA AIDS Conference, 15–18 June 2017, Durban, South Africa.

Smith J. Implementation of quality improvement activities to improve viral load results in a PHC setting. Poster, 8th SA AIDS Conference, 15–18 June, Durban, South Africa.

Summarised Financial Statements

The summarised financial statements were derived from the full set of audited annual financial statements based on management's decision on what contributes a broad, but transparent overview of HST's financial results.

Trust Information

Trust for Health Systems Planning and Development registration numbers:

Non-profit Organisation	020/700/NPO
Public Benefit Organisation	18/11/13/3137
Trust (Masters Office – Pretoria)	1098/92
Registered address:	34 Essex Terrace Westville 3630
Postal address:	PO Box 808 Durban 4000
Auditors:	Deloitte & Touche Durban
Bankers:	First National Bank, Nedbank

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

Summarised Financial Statements for the year ended 30 June 2017

STATEMENT OF RESPONSIBILITY FOR FINANCIAL REPORTING BY THE BOARD OF TRUSTEES

The Board of Trustees is responsible for the preparation of the financial statements of the Trust for Health Systems Planning and Development ("HST"). The summarised financial statements have been prepared in accordance with the International Financial Reporting Standard for Small and Medium-sized entities and the requirements of the Trust Deed, including accounting policies.

The Board of Trustees is also responsible for ensuring that proper systems of internal control are employed by or on behalf of the Trust. These controls are designed to provide reasonable, but not absolute, assurance as to the reliability of the financial statements and to adequately safeguard, verify and maintain accountability for assets, to record liabilities, and to prevent and detect material misstatement and loss. The systems are implemented and monitored by suitably trained personnel with an appropriate segregation of authority and duties. Nothing has come to the attention of the Board of Trustees to indicate that any material breakdown in the functioning of these controls, procedures and systems has occurred during the year under review.

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

The annual financial statements have been audited by the independent auditors, Deloitte & Touche, who was given unrestricted access to all financial records and related data, including minutes of all meetings of members, the Board of Trustees and committees of the Board of Trustees. The summarised financial statements in this annual report have been derived from the full set of audited annual financial statements. The Board of Trustees believes that all representations made to the independent auditors during their audit were valid and appropriate. The Deloitte & Touche audit report is presented on pages 34–35.

PREPARATION OF THE SUMMARISED FINANCIAL STATEMENTS

The summarised financial statements have been prepared in accordance with the International Financial Reporting Standard for Small and Medium-sized entities and the requirements of the Trust Deed by M Moodley (CA) SA, Finance Manager.

APPROVAL OF THE SUMMARISED FINANCIAL STATEMENTS BY THE BOARD OF TRUSTEES

The summarised financial statements set out on pages 38–42 are derived from the full set of audited annual financial statements approved by the Board of Trustees on 20 October 2017 and signed on its behalf by:

A handwritten signature in black ink, appearing to read 'L. Moodley', with a stylized flourish at the end.

Chairperson

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

Summarised Financial Statements for the year ended 30 June 2017

CORPORATE GOVERNANCE STATEMENT

The Trust for Health Systems Planning and Development ("HST") confirms its commitment to the principles of openness, integrity and accountability as advocated in the King III Code on Corporate Governance. Through this process stakeholders may derive assurance that the Trust is being ethically managed according to prudently determined risk parameters in compliance with generally accepted corporate practices. Monitoring the Trust's compliance with the King Code on Corporate Governance where practical, forms part of the mandate of the Trust's Audit and Risk Committee. The Trust has complied with the Code, relative to HST's business during the year under review.

BOARD OF TRUSTEES

Responsibilities

The Board of Trustees ("the Board") was established on the basis of a legal Deed of Trust document, supplemented by a formally approved written charter. Its composition is balanced so that no individual or small group dominates decision-making. The Board meets regularly, and is responsible for oversight and ensuring proper accountability by the Executive Management. The Executive Management attends the Board meetings by invitation.

The roles of Committee chairpersons and executives do not vest in the same persons and the chairpersons are non-executive Trustees. The chairpersons and chief executive provide leadership and guidance to the Trust and encourages proper deliberation on all matters requiring the Board's attention, and they obtain optimum input from the other Trustees. New appointments to the Board are submitted to the Board as a whole for approval prior to appointment.

The Board has ultimate responsibility for the management and strategic direction of the Trust, as well as for attending to legislative, regulatory, and best practice requirements. Accountability to stakeholders remains paramount in Board decisions, and this is balanced against the demands of the regulatory environment in which the Trust operates, and the concerns of its other stakeholders.

	Attendees		
	21/10/16	17/03/17	23/06/17
Prof N Chabikuli (resigned 15 November 2016)	X	-	-
Mr A Kader (Deputy Chairperson)	✓	✓	X
Prof E Kibuka-Sebitosi (Deputy Chairperson)	X	✓	X
Ms M Hela (appointed 31 March 2017)	-	-	✓
Dr D Kula (appointed 31 March 2017)	-	-	✓
Dr V Lithakanyane (retired 31 October 2016)	X	-	-
Dr U Mahlati (appointed 24 June 2016)	✓	X	✓
Mr T Masilela	✓	X	X
Ms W Matthews (resigned 15 August 2017)	✓	X	✓
Dr N Naledi (resigned 8 December 2016)	X	-	-
Ms F Nzama-Rabeng	✓	✓	✓
Prof D Sanders (appointed 31 March 2017)	-	-	✓
Dr F Senkubuge (Chairperson)	✓	✓	✓
Mr S Shuping (retired 31 March 2017)	✓	✓	-
Ms E Skweyiya	X	✓	X

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

Summarised Financial Statements for the year ended 30 June 2017

CORPORATE GOVERNANCE STATEMENT (CONTINUED)

GOVERNANCE STRUCTURES

To assist the Board in discharging its collective responsibility for corporate governance, several committees have been established, to which certain of the Board's responsibilities have been delegated. These committees operate with written terms of reference and comprise, in the main, non-executive Trustees. The chairperson of each committee is a non-executive Trustee with the exception of the Audit and Risk Committee who is an independent external member. The following Committees play a critical role to the governance of the Trust:

Audit and Risk Committee

The role of the Audit and Risk Committee is to assist the Board by performing an objective and independent review of the functioning of the organisation's finance and accounting control mechanisms and risk management framework. It exercises its functions through close liaison and communication with executive management and the internal and external auditors. The committee met three times during the 2017 financial year.

The Audit and Risk Committee operates in accordance with a written charter authorised by the Board, and provides assistance to the Board with regard to:

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

The Audit and Risk Committee consists of the following non-executive members:

	Attendees		
	21/09/2016	15/02/2017	17/05/2017
Mr J Deodutt (Chairperson, External member)	✓	✓	✓
Dr V Litlhakanyane (Trustee) (retired 31 October 2016)	✓	-	-
Mr E A Moolla (External member)	✓	✓	✓
Dr F Senkubuge (Trustee, alternate member) (appointed 20 June 2014)	-	✓	X
Ms E Skweyiya (Trustee)	✓	✓	✓

The Audit and Risk Committee addressed its responsibilities properly in terms of the charter during the 2017 annual financial year. No changes to the charter were adopted during the 2017 financial year.

Management has reviewed the annual financial statements with the Audit and Risk Committee, and the Audit and Risk Committee has reviewed them without management or the external auditors being present. The quality of the accounting policies was discussed with the external auditors. The summarised financial statements in the annual report are derived from the full set of audited annual financial statements.

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

Summarised Financial Statements for the year ended 30 June 2017

CORPORATE GOVERNANCE STATEMENT (CONTINUED)

GOVERNANCE STRUCTURES (CONTINUED)

Personnel Committee

The Personnel Committee advises the Board on human resources and other personnel related policies including remuneration packages, and other terms of employment for senior executives. Its specific terms of reference also include recommendations to the Board on matters relating, inter alia, to executive remuneration, Trustees honorariums and fees and service contracts. Whenever necessary, the committee is advised by independent professional advisers. The committee met three times during the 2017 financial year.

The Personnel Committee consists of the following members:

	Attendees		
	22/09/2016	16/02/2017	18/05/2017
Mr A Kader (Chairperson, Trustee)	✓	✓	✓
Ms L Matsau (External member)	X	✓	✓
Ms W Matthews (Trustee)	✓	✓	✓
Ms F Nzama-Rabeng (Trustee)	X	X	X

Finance Committee

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

The Finance Committee consists of the following Trustees:

	Attendees		
	22/09/2016	16/02/2017	18/05/2017
Mr A Kader (Trustee)	✓	✓	✓
Dr U Mahlati (Trustee)	✓	X	X
Ms W Matthews (Chairperson, Trustee)	✓	✓	✓

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

Summarised Financial Statements for the year ended 30 June 2017

CORPORATE GOVERNANCE STATEMENT (CONTINUED)

GOVERNANCE STRUCTURES (CONTINUED)

Governance Committee

The Governance Committee operates in accordance with a written charter authorised by the Board, and provides assistance to the Board in the overall governance of the organisation in a manner that will ensure that best practice is exercised.

The Governance Committee consists of the following Trustees:

	Attendees		
	20/09/2016	14/02/2017	16/05/2017
Dr V Litlhakanyane (Trustee) (retired 31 October 2016)	✓	-	-
Mr T Masilela (Chairperson, Trustee)	✓	✓	✓
Ms F Nzama-Rabeng (Trustee, alternate member) (appointed 16 October 2015)	-	✓	✓
Mr S Shuping (Trustee) (retired 31 March 2017)	✓	✓	-

Executive Management

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

Risk management and internal control

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

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

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

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

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

Summarised Financial Statements for the year ended 30 June 2017

CORPORATE GOVERNANCE STATEMENT (CONTINUED)

Risk management and internal control (continued)

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

The Trust assessed its internal control system as at 30 June 2017 in relation to the criteria for effective internal control over financial reporting. The internal control process has been in place up to the date of approval of the annual report. The Trust believes that its system of internal control over financial reporting and safeguarding of assets against unauthorised acquisitions, use, or disposition, met those criteria.

Internal Audit

SizweNtsalubaGobodo served as internal auditors for the financial year. Their findings have been received by management and appropriate measures have been implemented to address the areas of improvement noted.

Ethical Standards

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

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

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

Accounting and Auditing

The Board places strong emphasis on achieving the highest level of financial management, accounting, and reporting to stakeholders. The Board is committed to compliance with the International Financial Reporting Standards for Small and Medium-sized Entities. In this regard, Trustees shoulder responsibility for preparing financial statements that fairly present:

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

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

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

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

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

INDEPENDENT AUDITOR'S REPORT ON THE SUMMARISED FINANCIAL STATEMENTS

TO THE TRUSTEES OF TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

Opinion

The summarised financial statements of Trust for Health Systems Planning and Development, which comprise the summarised statement of financial position as at 30 June 2017, the summarised statements of profit or loss and other comprehensive income, changes in equity and cash flows for the year then ended, and notes to the summarised statement of cash flows, are derived from the audited financial statements of Trust for Health Systems Planning and Development for the year ended 30 June 2017.

In our opinion, the accompanying summarised financial statements are consistent, in all material respects, with the audited financial statements of Trust for Health Systems Planning and Development, in accordance with the International Financial Reporting Standard for Small and Medium-sized Entities and the requirements of the Trust Deed as applicable to summarised financial statements.

Summarised Financial Statements

The summarised financial statements do not contain all the disclosures required by the International Financial Reporting Standards for Small and Medium-sized Entities and the requirements of the Trust Deed as applicable to financial statements. Reading the summarised financial statements and the auditor's report thereon, therefore, is not a substitute for reading the audited financial statements and the auditor's report thereon. The summarised financial statements and the audited financial statements do not reflect the effects of events that occurred subsequent to the date of our report on those financial statements.

The Audited Financial Statements and our Report Thereon

We expressed an unmodified audit opinion on the audited financial statements in our report dated 20 October 2017. That report also includes:

- A statement that describes other information within the financial statements. The other information includes the Statement of Trustees' Responsibility and Approval, Corporate Governance Statement, Supplementary Schedules and the Report of the Board of Trustees. The paragraph states that the opinion on the financial statements does not cover the other information and we do not express an opinion or any form of assurance thereon. The paragraph also states that, based on reading these reports, we have not identified any material misstatements of the other information included.

Trustees' Responsibility for the Summarised Financial Statements

The trustees are responsible for the preparation of the summarised financial statements in accordance with International Financial Reporting Standard for Small and Medium-sized Entities and the requirements of the Trust Deed and for such internal control as the trustees determine is necessary to enable the preparation of the summarised financial statements that are free from material misstatement, whether due to fraud or error.

National Executive: *LL Bam Chief Executive Officer *TMM Jordan Deputy Chief Executive Officer *MJ Jarvis Chief Operating Officer
*AF Mackie Audit & Assurance *N Sing Risk Advisory *NB Kader Tax TP Pillay Consulting S Gwala BPS *K Black Clients & Industries
*JK Mazzocco Talent & Transformation MG Dicks Risk Independence & Legal *TJ Brown Chairman of the Board
Regional leader: *R Redfearn

A full list of partners and directors is available on request

* Partner and Registered Auditor

B-BBEE rating: Level 1 contribution in terms of the DTI Generic Scorecard as per the amended Codes of Good Practice

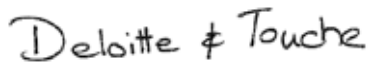
Associate of Deloitte Africa, a Member of Deloitte Touche Tohmatsu Limited

INDEPENDENT AUDITOR'S REPORT ON THE SUMMARISED FINANCIAL STATEMENTS

TO THE TRUSTEES OF TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

Auditor's Responsibility

Our responsibility is to express an opinion on whether the summarised financial statements are consistent, in all material respects, with the audited financial statements based on our procedures, which were conducted in accordance with International Standard on Auditing 810 (Revised), *Engagements to Report on Summary Financial Statements*.

A handwritten signature in dark ink that reads "Deloitte & Touche". The script is cursive and fluid, with the ampersand clearly visible.

Deloitte & Touche

Registered Auditors

Per: Camilla Howard-Browne CA (SA), RA

Partner

22 December 2017

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

Summarised Financial Statements for the year ended 30 June 2017

REPORT OF THE BOARD OF TRUSTEES

The Board of Trustees presents their annual report for Trust for Health Systems Planning and Development for the year ended 30 June 2017.

1. General review

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

Goals

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

2. Financial results

- 2.1 Full details of the financial results are set out on pages 38 to 42 in the attached summarised financial statements.
- 2.2 As set out in the summarised financial statements, the Trust had a total deficit for the year of R10 918 870 (2016: surplus of R19 708 733).
- 2.3 The ratio of administration expenses (excluding the unusual and extraordinary items), against gross income is 12% which is in line with the prescribed limit as set out in the Trust deed.

3. Trustees

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

The Trustees of the Trust during the financial year and at the date of the report are:

Name	Date appointed	Date resigned/tenure ended
Prof N Chabikuli	20 June 2014	Resigned 15 November 2016
Mr A Kader	20 June 2014	
Prof E Kibuka-Sebitosi	14 March 2014	
Ms M Hela	31 March 2017	
Dr D Kula	31 March 2017	
Dr V Litlhakanyane	19 November 2010	Retired 31 October 2016
Dr U Mahlali	24 June 2016	Resigned 21 August 2017
Mr T Masilela	14 March 2014	
Ms W Matthews	13 October 2013	Resigned 15 August 2017
Dr N Naledi	24 June 2016	Resigned 8 December 2016
Ms F Nzama-Rabeng	16 October 2015	
Prof D Sanders	31 March 2017	
Dr F Senkubuge	20 June 2014	
Mr S Shuping	01 February 2011	Retired 31 March 2017
Ms E Skweyiya	13 October 2013	

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

Summarised Financial Statements for the year ended 30 June 2017

4. Material events after year-end

The trustees are not aware of any matters or circumstances which are material to the financial affairs of the Trust that have occurred between year-end and the date of approval of the annual financial statements, and the summarised financial statements derived from them. The effect of subsequent events between the date of approval of the annual financial statements and the date of the summarised financial statements has not been considered.

5. Going concern

The annual and summarised financial statements have been prepared on the basis of accounting policies applicable to a going concern. This basis presumes that funds will be available to finance future operations and that the realisation of assets and settlement of liabilities, contingent obligations and commitments will occur in the ordinary course of activities of the Trust.

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

Summarised Financial Statements for the year ended 30 June 2017

STATEMENT OF FINANCIAL POSITION

	2017 R	2016 R
ASSETS		
Non-current assets	15 215 533	24 725 639
Property, plant and equipment	15 215 533	24 725 639
Intangible assets	–	–
Current assets	112 765 812	174 544 308
Trade and other receivables	22 165 453	25 420 078
Cash and cash equivalents	80 888 418	142 616 343
Accrued revenue	9 711 941	6 507 887
Total assets	127 981 345	199 269 947
EQUITY		
Accumulated surplus funds and reserves	71 599 751	82 518 621
LIABILITIES		
Current liabilities	56 381 594	116 751 326
Trade and other payables	23 768 471	36 398 460
Provisions	8 326 827	8 395 298
Deferred revenue	24 286 296	71 957 568
Total equity and liabilities	127 981 345	199 269 947

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

Summarised Financial Statements for the year ended 30 June 2017

STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME

	2017 R	2016 R
Grant income	484 271 652	399 659 674
Other income	3 534 799	9 559 234
Project expenses	(445 367 008)	(358 865 567)
Administration expenses	(59 288 908)	(36 863 378)
(DEFICIT) / SURPLUS BEFORE INTEREST	(16 849 465)	13 489 963
Interest paid	(58 429)	-
Interest received	5 989 024	6 218 770
(DEFICIT)/ SURPLUS BEFORE TAXATION	(10 918 870)	19 708 733
Taxation	-	-
NET (DEFICIT) / SURPLUS AFTER TAXATION	(10 918 870)	19 708 733
Other comprehensive income	-	-
TOTAL COMPREHENSIVE (DEFICIT) / INCOME FOR THE YEAR	(10 918 870)	19 708 733

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

Summarised Financial Statements for the year ended 30 June 2017

STATEMENT OF CHANGES IN EQUITY

	HSS R	HSR R	CDC R	Corporate Services R	HST Reserve Fund R	Total Equity R
Closing balance as at 30 June 2015	10 052 731	1 043 423	7 005 365	27 126 727	17 581 642	62 809 888
Total surplus/(deficit) for the year	(3 065 110)	2 401 345	(5 047 845)	25 420 343	–	19 708 733
Transfers to Reserve Fund	(659 545)	(463 747)	–	(5 541 904)	6 665 196	–
Closing balance as at 30 June 2016	6 328 076	2 981 021	1 957 520	47 005 166	24 246 838	82 518 621
Total deficit for the year	(158 738)	(480 177)	(2 315 976)	(7 963 979)	–	(10 918 870)
Transfers to Reserve Fund	–	(249 268)	–	–	249 268	–
Closing balance as at 30 June 2017	6 169 338	2 251 576	(358 456)	39 041 187	24 496 106	71 599 751

TOTAL EQUITY COMPRISES THE FOLLOWING:

Accumulated Surplus funds
HST Reserve Fund

2017 R	2016 R
47 103 645	58 271 783
24 496 106	24 246 838
71 599 751	82 518 621

Being mindful of the fact that HST operates in a very competitive environment, the Board of Trustees approved the creation of a Reserve Fund for the sustainability of the organisation. The Reserve Fund is governed by the applicable approved policy.

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

Summarised Financial Statements for the year ended 30 June 2017

STATEMENT OF CASH FLOWS

	Notes	2017 R	2016 R
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash (utilised by) / generated from operations	A	(68 507 118)	48 975 837
Interest received		5 989 024	6 218 770
Interest paid		(58 429)	–
Net cash (outflow) / inflow from operating activities		(62 576 523)	55 194 607
CASH FLOWS FROM INVESTING ACTIVITIES			
Proceeds from disposal of property, and equipment		6 057 105	6 264 281
Acquisition of property and equipment		(5 208 507)	(12 105 774)
Net cash generated by / (used in) investing activities		848 598	(5 841 493)
Net (decrease) / increase in cash and cash equivalents		(61 727 925)	49 353 114
Cash and cash equivalents at beginning of year		142 616 343	93 263 229
Cash and cash equivalents at end of year		80 888 418	142 616 343

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

Summarised Financial Statements for the year ended 30 June 2017

NOTES TO THE STATEMENT OF CASH FLOWS

	2017 R	2016 R
A. RECONCILIATION OF (DEFICIT) / SURPLUS BEFORE TAXATION TO CASH (UTILISED BY) / GENERATED FROM OPERATIONS		
(Deficit) / Surplus before taxation	(10 918 870)	19 708 733
Adjustments for:		
Depreciation	11 037 830	10 059 982
Amortisation	–	23 707
(Decrease) / Increase in provisions	(68 471)	710 588
Profit on disposal of property, plant and equipment	(2 376 322)	(3 219 824)
Interest paid	58 429	–
Interest received	(5 989 024)	(6 218 770)
Cash (outflows) / inflows from operations before working capital changes	(8 256 428)	21 064 416
Working capital changes:		
Decrease / (increase) in trade and other receivables and accrued revenue	50 571	(12 897 737)
(Decrease) / increase in trade and other payables and deferred revenue	(60 301 261)	40 809 158
Cash (utilised by) / generated from operations	(68 507 118)	48 975 837

Funders and Partners

FUNDERS

US Centers for Disease Control and Prevention
The Global Fund to Fight AIDS, Tuberculosis and Malaria
The ELMA Philanthropies
National Treasury
National Department of Health
The German Development Bank (KfW) through the Development Bank of Southern Africa (DBSA)
WHO Alliance for Health Policy and Systems Research
Gauteng Department of Health
Mpumalanga Department of Health
University of Cape Town (through a grant from the Bill & Melinda Gates Foundation)

GRANT PARTNERS AND COLLABORATORS

ASG
University of Cape Town Centre for Infectious Disease Epidemiology and Research (CIDER)
University of KwaZulu-Natal (UKZN)
Save the Children, UK
SA Medical Research Council
UKZN Centre for Rural Health
University of the Western Cape (UWC)
Aurum Institute
University Research Council (URC)
Department of Health – Eastern Cape
Department of Health – Free State
Department of Health – Gauteng
Department of Health – KwaZulu-Natal
Department of Health – Limpopo
Department of Health – Mpumalanga
Department of Health – Northern Cape
Department of Health – North West
Department of Health – Western Cape
The National Health Research Committee

National Health Laboratory Services (NHLS)
PRICELESS
Philanjalo
Mobenzi
US Centers for Disease Control and Prevention
Soul City Institute
VP Health
Council for Scientific and Industrial Research (CSIR)
Health Information Systems Programme (HISP)
Khethimpilo
National Institute of Communicable Diseases (NICD)
Africare
The Southern African Catholic Bishops' Conference AIDS Office (SACBC)
The AIDS Foundation of South Africa
Grounded Media
The Office of Health Standards Compliance
Society For Family Health (local branch of Population Services International)
FHI360
Mothers2Mothers
Praekelt.org
Accenture
Nelson Mandela Children's Fund
Africa Health Placements
South African Civil Society Coalition for Women, Adolescents and Children's Health (SACSoWACH)
University of Newcastle, UK
London School, Zambart

Durban (Head Office)

34 Essex Terrace, Westville 3630

Tel: +27 (0)31 266 9090

Johannesburg

1st Floor, Block J, Central Park

400 16th Road, Midrand 1682

Tel: +27 (0)11 312 4524

Cape Town

Block B, Aintree Office Park

Doncaster Road, Kenilworth 7700

Tel: +27 (0)21 762 0700

Central fax

086 588 0394

General email

hst@hst.org.za

www.hst.org.za

