



**HEALTH
SYSTEMS
TRUST**

**ANNUAL REPORT
2012/13**

HEALTH SYSTEMS TRUST (HST)

is a dynamic not-for-profit organisation established in 1992 to support the transformation of the health system in a newly democratic South Africa. Subscribing to a primary health care approach, HST actively supports the current and future development of a comprehensive health system, through strategies designed to promote equity and efficiency in health and health care delivery in southern Africa.

VISION

“Health systems supporting health for all in southern Africa”

MISSION

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



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BOARD OF TRUSTEES



Professor Welile Shasha
Chairperson (outgoing)



Mr Kevin Bellis
Deputy Chairperson



Dr Michael Hendricks
(until 21 June 2013)



Dr Victor Lithakanyane



Professor Kaya Mfenyana
(until 21 June 2013)



Mr Obakeng Mongale



Professor Laetilia Rispel



Mr Shadrack Shuping



Dr Maureen Tong



Ms Gcwalisile Twala



Dr Tim Wilson



Dr Sibongile Zungu
(until 15 March 2013)

A brief resumé of each Trustee can be found on our website at <http://www.hst.org.za/board-trustees>



DR MAUREEN TONG

At the launch of the “World Health Report 2013: Research for Universal Health Coverage”, the Director-General of the World Health Organization, Dr Margaret Chang, called on countries to continue investing in local research in order to develop a system of universal health coverage tailored to each country’s individual needs.¹

I am pleased to share that Health Systems Trust’s research programme, guided by the Department of Health’s Essential National Health Research priorities, definitely supports development of the National Health Insurance (NHI) programme – South Africa’s initiative towards introducing universal health coverage. Our work will contribute much to achieving the WHO call “to ensure that citizens obtain the health services they need, without suffering financial hardship when paying for them”.¹

Much is said about the major contribution made by the National Health Care Facilities Baseline Audit, a project recently completed by a consortium led by Health Systems Trust. The research findings enable meaningful quality improvements in the health services’ physical infrastructure and delivery of patient-centred health care. The National Health Research Database offers a sound platform for co-ordinating research inputs provincially and nationally, while ensuring easy access to the outputs of such research to the benefit of all involved in policy-making and planning.

HST is involved in numerous practical data-gathering exercises that serve the development of the NHI. Examples include: assessing progress in rolling out the PHC Re-engineering Strategy; a benchmarking tool for budgeting for non-negotiable goods and services; developing an appropriate model to strengthen governance and critical support functions in the district health system, using an NHI pilot district for the research; creating a tool to assess and profile the risks to the Eastern Cape’s Health Programme objectives; and developing three complementary competence assessment tools to measure the competence levels of key healthcare managers. These, along with all the other health systems strengthening research and implementation activities, elucidate the unquestionable relevance of HST’s contribution on the ground.

The breadth and scope of HST’s research and implementation endeavours also point toward the relationship of trust that exists between ourselves and

those who commission us to execute investigations and projects. We thank our funders for the faith they place in us and we thank those organisations with whom we collaborate in serving our mandates.

I am aware that in this message I am only scratching the surface of the richness that lies within this Annual Report, and I invite you to peruse this publication, which I present with confidence, to learn more about the organisation of which we are justly proud. I am also aware that, in resonating with the WHO Director-General’s message and concentrating on our research-related activities, I am not giving due recognition to our prodigious implementation-linked projects that are attracting attention from all quarters. These are, however, covered thoroughly in the Programmes section of this report.

I thank my fellow Trustees serving on the Board for their dedication to HST’s wellbeing during this past year. I would especially like to thank Professor Welile Shasha, who stood down as Chair in June this year, for his sterling leadership of the Board over the past five years, and the able way in which he ensured that HST maintained the strong and highly respected position that it currently enjoys. I would also like to thank my fellow Trustees for their confidence in electing me to the position of Chair and I look forward to their support in the years to come. In particular, I would like to record my appreciation for the contribution made by the three Trustees who retired from the Board during the year, namely Dr Sibongile Zungu, Dr Michael Hendricks and Professor Kaya Mfenyana.

As HST enters its 22nd year of dedicated service, I would also like to compliment and thank the staff for keeping the organisation “flying high”. Heartfelt thanks go to our CEO of the last four years, Ms Jeanette Hunter, who accepted a senior Department of Health position in which she continues to serve the country’s health system. I also take this opportunity to introduce to all of our readers our incoming CEO, Dr Themba Moeti, and wish him well in leading a team of such marked potential. I would, in closing, like to express the Board’s appreciation to Ms Ronel Visser for “holding the fort” so ably in the interim period.

Dr Maureen Tong
Chairperson

¹Dye,C, Boerma, T, Evans, D, et al. World Health Report 2013: Research for Universal Health Coverage. Geneva: WHO Press; 2013.

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MESSAGE FROM THE ACTING CEO



MS RONEL VISSER

A sense of considerable pride overcomes me every year with the publishing of Health Systems Trust's Annual Report. Established in April 1992 on the brink of the birth of democracy in our country, HST has supported the evolution of the new national health system and today we pursue the realisation of our mission and vision for effective health systems in the country.

HST has a wealth of talent and powerful assets – including innovation capabilities, credibility, a strong brand and a remarkable passion shared by our 206 employees – to contribute to the improvement of the health system. Amidst the challenges facing our national health service, we are embracing opportunities to assist the Department of Health in the introduction of universal coverage in health services through National Health Insurance, and initiatives such as the re-engineering of primary health care (PHC) and improvement of quality of care. The audit of the country's public health facilities conducted by HST in 2011/12 continues to be a useful baseline to guide the improvement of health infrastructure and quality of care.

Year in review

Over the past year, HST grew as a result of a number of multi-year projects. We now have 13 offices in seven provinces, while our health systems research and health systems strengthening projects are represented in all nine provinces.

Dr René English was appointed as Director for Health Systems Research in January 2013, resulting in the Programmes Unit evolving into two Directorates. At the end of January 2013 our CEO of the past four years, Ms Jeanette Hunter, joined the National Department of Health as Deputy Director-General for Primary Health Care. We thank Jeanette for her leadership and guidance to HST during her tenure, and we are proud of her appointment to such a significant leadership position in the country.

On 2 April 2013, we launched the South African Health Review (SAHR) and District Health Barometer (DHB) in Pretoria. The prestigious event was attended by over 200 guests including DoH officials, partners, clients and funders, and we were honoured to be addressed by both the Minister and Deputy Minister of Health.

Our Health Systems Research Unit continues to undertake relevant health systems research aimed at strengthening the district health system and health programmes. The unit works closely with the Health Systems Strengthening Unit to identify research areas that can intersect towards translating research into policy and practice. The Health Systems Strengthening Unit continues to provide sustainable capacity-building to the Department of Health at all levels through training, mentoring and technical support. Both units are guided by the World Health Organization health systems framework and use a quality improvement lens to enhance the quality of care delivered through the district health system.

Not only do we strive to ensure that all our projects are delivered in a manner that promotes sustainability, but we are also pursuing total quality management initiatives. The efficiency of our Corporate Services directorate is indisputable, having built a seamless record of unqualified audits for the past 21 years. HST is governed by a Board of Trustees that continues to provide support and oversight to the organisation.

The passion for making a difference is profound in HST, and none of our achievements would have been possible without the commitment of HST staff and management. Together we look forward to another successful year.

A handwritten signature in black ink, appearing to read 'Ronel Visser'. The signature is fluid and cursive.

Ms Ronel Visser
Acting CEO

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PROGRAMMES DIRECTORATE REPORT

Ms Ronel Visser
Director:
Health Systems Strengthening



Dr René English
Director:
Health Systems Research



HEALTH SYSTEMS STRENGTHENING

The Health Systems Strengthening Unit employs knowledgeable and experienced staff members and short-term experts to provide sustainable capacity-building to the Department of Health and other clients, through training, mentoring and technical support. The Unit is guided by the WHO health systems framework and uses a quality improvement lens in contributing to achieving functional health districts and health facilities that are able to deliver quality services.

HEALTH SYSTEMS RESEARCH

The Health Systems Research Unit undertakes innovative health systems research to strengthen the district health system, its support systems and priority health programmes. Improving knowledge management, translating research into policy or practice, and building capacity within the paradigm of Essential National Health Research are important areas of emphasis. Future research activities include Human Resources for Health and Health Financing.

Health Systems Trust's mission brings focus to the organisation's vision of "Health systems supporting health for all in southern Africa". HST's mission statement highlights our wish to see comprehensive, effective, efficient and equitable national health systems supported by well-functioning health districts.

At this time, the South African media landscape is awash with stories describing the challenges faced in our national health services. Yet there are noteworthy – sometimes remarkable – efforts underway to effect reforms that will underpin the efficient delivery of health for all in our country.

Lending context to HST's work are South Africa's salutary moves towards introducing universal coverage in health services, through National Health Insurance (NHI); the Primary Health Care (PHC) re-engineering initiative to improve the quality of care in the public health services; and quality improvement initiatives through the Office of Health Standards Compliance and its National Core Standards. Moreover, the Health Minister's Negotiated Service Delivery Agreement (NSDA) focuses on four key areas: increasing life expectancy; combating HIV and AIDS; decreasing the burden of disease from tuberculosis; and improving health systems effectiveness.

HST is, to a greater or lesser extent, involved in all and more of these national initiatives.

Our scope of operation ranges from regional and national levels, though provinces, districts and facilities and into communities. The resultant gains in experience, expertise and evidence-based understanding enhance our offerings in strengthening practice and policies for optimal health service delivery.

In 2012, we celebrated 20 years of dedicated service to our clients and our communities. In 2013, we report phenomenal growth as a result of attracting a number of multi-year, large-scale projects, allowing us to focus more strongly on making a difference.

HST's Programmes Directorate comprises two health systems strengthening units – one focusing on research and the other on implementation perspectives – that work synergistically to deliver on our mandates. The wide array of projects managed by the Directorate is presented below, arranged according to our five core business areas:

- ◆ Good-practice management of health districts and sub-districts
- ◆ Good-practice implementation of priority health programmes through health systems strengthening for improved health outcomes
- ◆ Essential national health research
- ◆ Information for planning, monitoring, evaluation and decision-making
- ◆ Training on good practice

PROGRAMMES DIRECTORATE REPORT (continued)

Although grouping projects into categories is the intention, this is difficult in practice as many of the projects straddle more than one core business area. Mention of the same project in several places highlights the interrelatedness of our different projects towards promoting health for all in southern Africa. Additional information on the reported projects is available on HST's website.

Good-practice management of health districts and sub-districts

To embody the focus of this business area, HST assembled and documented **Good Practices within the South African Public Health Sector** from all nine provinces, in a project funded by the National Department of Health (NDoH). The project encompassed an important approach to the development of health systems through research and information dissemination that influences both policy and practice. The project findings emphasised the crucial role that healthcare professionals play in health systems strengthening, and highlighted the need for ongoing reflective adaptation of interventions to improve health care in South Africa.

Beyond recording existing examples of good practice, a major part of HST's work involves researching and facilitating implementation of good practice in the field. Atlantic Philanthropies, for example, provided a third and final grant to support North West (NW) and Mpumalanga Provinces in building and **Strengthening the Capacity of Districts and Sub-districts to Implement the PHC Re-engineering Strategy**. In the first six months of this final grant cycle, significant strides were made in supporting programme implementation and building capacity through working closely with the provincial and national Departments of Health, thereby ensuring sustainability of the achievements beyond the grant period. Particular outputs of this project, specifically the PHC Re-engineering Implementation Plan and Strategy, together with the province's Task Team model, have proved so successful that they have been adopted by the NDoH and other provincial departments of health. The success of the pilot in North West (NW) Province has resulted in HST being invited to many platforms in the country to share experiences and lessons learnt.

Our effort to help reduce malnutrition in children under five years of age is one such example. The

project, together with the NW DoH's Nutrition Directorate, conducted workshops for community health workers (CHWs) on administering Vitamin A and weighing children during household visits. All respondents to the project assessment commented on the positive role that HST had played in disseminating information up and down the communication chain.



North West Province community health workers in a workshop on administering Vitamin A and weighing children during household visits

Also focusing on supporting the country's PHC re-engineering initiatives, a two-year European Union grant enables HST's **Re-engineering Quality Improvement (RQI)** project to improve PHC management capacity and support quality improvement plans and interventions in two districts in each of two provinces. Partnering or collaborating with other development-orientated organisations and institutions enriches HST's project outputs, and encourages sustainable improvements to healthcare delivery systems. The project partnered with Management Sciences for Health (MSH) to provide training to 230 managers on leadership and management for district, sub-district and facility-level staff.

Enhancing management capacity and, in particular, quantifying this was taken a step further in research into **Facility Managers' Competencies** and an **Assessment of District Hospital Performance**.

In the former project, three complementary competence assessment tools were developed and used to assess the competence levels of PHC facility managers and members of sub-district management

PROGRAMMES DIRECTORATE REPORT (continued)

teams – all being key roleplayers in the implementation of the PHC re-engineering strategy in five provinces. The preliminary results are being used in the ongoing leadership and management initiatives to train these roleplayers. This study promises a valid and reliable national toolkit for assessing the general management and public health competencies of facility managers and sub-district managers.



Phateni Clinic labour ward

The **District Hospital Performance Assessment**, evaluated all district hospitals according to seven key hospital performance indicators, whereafter a qualitative study in 25 selected hospitals determined reasons for good and poor performance. Factors found to impact on the performance of district hospitals are by no means new, but they do serve to emphasise that novel ways of unlocking the solutions to these persistent problems are necessary. The list includes the shortage of human resources (both clinical and non-clinical staff), particularly in rural hospitals that reported severe difficulties in attracting and retaining staff due to poor physical infrastructure, together with lack of staff accommodation, weak referral systems and uneven remuneration.

The list of HST's involvements in good-practice management continues with a number of interesting, and often challenging, initiatives.

A research project to develop a **Patient Referral Policy** aligned to the PHC re-engineering strategy in Free State's Thabo Mofutsanyana District links closely with district hospital performance – particularly with the finding that weak referral systems at all levels of the healthcare delivery spectrum result in some

facilities being overloaded and others underutilised. The findings reinforce the value of the three-pronged PHC re-engineering strategy, as well as the imperative of a multisectoral approach that integrates clinical services with those that are traditionally beyond the health system (e.g. social development, education, environmental health and community-based services).

Crucial to good-practice management is the system within which the management structures function. The Western Cape DoH commissioned a study to develop an **Appropriate Model for Strengthening the District Health System** in the Eden district, one of the country's NHI pilot districts, to strengthen governance and critical support functions – with an emphasis on Human Resources, Finance and Supply Chain Management. The review investigated resources, structures, competence levels, and the degree of centralisation. HST's wide-ranging basket of projects contributes experience and learnings that can be used in recommending solutions to longstanding management challenges.

A project that breaks new ground in South Africa, aimed at **Profiling the Risks to the Health Programme Objectives** outlined in the Eastern Cape DoH Annual Performance Plan. The project combines key elements of corporate risk assessment within the building blocks of the World Health Organization (WHO) health systems framework, while the low-tech and simple-to-use risk rating tools allow for ease of rating through consensus. As a collaborative partnership between the Eastern Cape DoH and National Treasury, early indications are that the project and its tools have captured the imagination of those who want to see change in our country's health system.

Good-practice implementation of priority health programmes through health systems strengthening for improved health outcomes

Improved health outcomes for the uninsured population constitute a "bottom line" result for evaluating South Africa's health services. It is also in this field that HST has shown phenomenal growth over the reporting year by virtue of two multi-million Rand projects in the fields of HIV and maternal and child health.

PROGRAMMES DIRECTORATE REPORT (continued)



The **SA SURE** (South African Sustainable Response to HIV and AIDS) project is in the second of a five-year co-operative agreement with the US-based Centers for Disease Control and Prevention (CDC). The project focuses on Leadership Development, Clinical Governance, and Monitoring and Evaluation (M&E) as programme-strengthening strategies across the six health systems building blocks defined by the WHO in its Framework for Action. Each of the 12 districts (spread across five provinces) identified priority areas of underperformance and the root causes for these, and then developed action plans to improve service delivery. The need for local support and capacity-building is evident, particularly in antiretroviral treatment (ART) initiation, and more so in the eligible paediatric population. Clinical mentors have implemented specific interventions to improve performance and increase the number of children and adults initiated on ART. Some of these interventions include training on new Fixed Dose Combination (FDC) guidelines, and the appointment of NIMART (nurse-initiated management of ART) mentors in each district. Numerous quality improvement initiatives in each supported district have begun to yield programme improvements, notably in the areas of six-week Polymerase Chain Reaction (PCR) testing and treatment uptake.



A project to **Reduce Maternal and Child Mortality through Strengthening Primary Health Care (RMCH)** supports the NDoH to

improve the quality of and access to reproductive, maternal and child health services in the 25 districts identified by the National Health Council, through the implementation of the PHC re-engineering strategy. HST is a partner in the three-year project funded by the United Kingdom's Department for International Development (DFID). The project developed training curricula and led the training of district clinical specialist teams (DCSTs) to strengthen the districts' oversight of MCH services improvement. Central to the project's strategy is a comprehensive mentorship plan for the DCSTs, embedded within a district-based model of health systems strengthening. In addition, CHWs were trained in provision and monitoring of basic obstetric and neonatal services.

The **Maternal Events and Pregnancy Outcomes in a Cohort of HIV-Infected Women Receiving ART in**

Sub-Saharan Africa (MEP) study measured maternal severe adverse events, pregnancy outcomes and congenital birth defects in a cohort of women receiving ART at conception and during pregnancy in South Africa and Zambia. In most resource-limited countries, where there is a high burden of HIV among pregnant women and antiretroviral products are being used extensively to reduce mother-to-child transmission, routine surveillance on birth defects is not done. HST became involved in this study at its midpoint and has seen the project through to completion. Initial findings will provide meaningful information on ART safety and toxicity, specifically to African pregnant women, and could lay the groundwork for the establishment of pharmacovigilance systems and routine surveillance on birth defects.

Essential national health research

HST's research programme is largely funded by and links very strongly with the Department of Health's broader national health priority research areas.

An important aspect of National Health Insurance is assessing the quality of care provided by the healthcare services, along with the infrastructure status of the over 4 000 public health facilities in the country, to determine what is needed to have them comply with the National Core Standards quality improvement framework. HST led a consortium in conducting a **National Health Care Facilities Baseline Audit** that focused on the six ministerial priority areas for improving patient-centred care. The final national summary report (available on the NDoH and HST's websites) provided a high-level summary of the findings of the audit. The recommendations detailed current and future planning investments for health system strengthening towards implementation of National Health Insurance and PHC re-engineering. At implementation level, the results of the audit are being used by districts in an NDoH-driven initiative using health facility improvement teams (HFITs) to strengthen capacity for continuous quality improvement. These teams develop evidence-based strategies that guide the foundational health systems priorities in the NHI pilot districts.

A project of many years' standing, but growing in value every year, is the **National Health Research Database (NHRD)**. Originally developed to strengthen and support the activities of the Provincial Health

PROGRAMMES DIRECTORATE REPORT (continued)

Research Committees (PHRCs), the database was designed to offer two important functionalities to these Committees – firstly, support of the PHRC administrative processes through a Research Application Management System, and secondly, a repository of health research that allows PHRCs to track provincial research trends against the national health priority research areas. The database system is undergoing further development and maintenance. The NHRD will provide a standardised research approval process across the nine provinces, along with standardised reporting templates to aid monitoring and evaluation of research across the country. The database was piloted in two provinces in the first quarter of 2013, followed by training for all PHRC administrators.



HST presenting the National Health Research Database (NHRD) handbook to the National Department of Health.

In 2010, provinces were informed by the NDoH that they were to implement the PHC Re-engineering Strategy, which is pivotal for reforming the health sector. To address the limited and fragmented information on the roll-out of the PHC re-engineering model, HST collaborated with the NDoH to **Assess the Status of Roll-out of the PHC Re-engineering Strategy** in South Africa. The findings will highlight broad milestones of PHC re-engineering, reflect on good practices across the three streams of the strategy, and identify key steps that should be taken to advance its implementation. Preliminary findings in the North West indicate that the province has made significant progress in implementing the PHC re-engineering initiative, and that HST's technical support has contributed positively – both to the process in the province and to the body of knowledge in the country.

Evidence-informed information is essential for management decision-making and for subsequent M&E following implementation of decisions. HST is often called upon to conduct rapid data-gathering exercises. Three such projects are summarised as follows:

With a short-term aim of identifying high-risk population sub-groups and sub-areas and a long-term goal of establishing a robust injury surveillance system, HST was commissioned by the Provincial Government of the Western Cape to conduct a **Rapid Assessment of the Injury Morbidity Burden at Health Services in Three High Violence Communities in the Western Cape**. The findings showed clear patterns of violence-related injuries, often linked to alcohol use, especially among the youth. The study also showed the value of collecting facility-level data versus using mortality data for decision-making, as the percentages of women and children suffering non-fatal violence are much higher than are reflected in mortality statistics.

To assist National Treasury in costing and budgeting for NHI, HST was commissioned to determine **Benchmarks for Budgeting of Non-negotiable Goods and Services** for provincial departments of health. A draft report provides a summary of optimal benchmarks and/or norms and standards for each of 13 non-negotiable items, ranging from HIV, AIDS and TB services and children's vaccines, through medicines and laboratory services, to medical waste disposal and security services. Benchmarks will be used to calculate Medium-term Expenditure Framework budgets for each non-negotiable item, as well as an analysis of variance between actual and suggested budgets, and calculation of overall budget implications for South Africa.

“Too many registers and too much administration work” is a frequent lament emanating from health facilities, and this scenario is seen to hinder healthcare providers in their primary task of assisting clients. Appropriately, the NDoH has commissioned a pilot project aimed at the **Rationalisation of Vertical Health Programme Registers**. This project will test the feasibility, acceptability and effectiveness of reducing to six the current 54 registers used in health facilities to collect vertical programmes data. Although at this stage the pilot will be restricted to a single district, it does take cognisance of excessive administrative tasks at health facilities. In fact, HST staff have observed that the PHC re-engineering initiative is creating an environment

PROGRAMMES DIRECTORATE REPORT (continued)

conducive to reflection, innovation and action rallied towards service delivery improvement, and are justly proud that our efforts to make a meaningful difference have contributed to this environment.

Information for planning, monitoring, evaluation and decision-making

Knowing that a consistently applied M&E tool is frequently lacking in our health management systems, HST has long been involved in initiatives to strengthen the country's Health Management Information System (HMIS). HST has been involved in a variety of projects linked to health information and general information dissemination to strengthen decision-making in health services delivery. Foregrounding its importance, Health Information is one of the six building blocks in the WHO health systems framework. The **EC DoH Risk Assessment project**, reported earlier in this chapter, identified health information as an eighth risk factor that straddled all seven of the other programme-related key risk areas.

In December 2010, the NDoH introduced the Tiered ART Monitoring Strategy comprising paper-based (Tier 1), non-networked (Tier 2) and networked (Tier 3) systems for patient monitoring in line with the WHO's 3-Tiered ART M&E strategy. The goal of the three-tiered approach is to facilitate standardised reporting and to support information management, as well as patient management, nationwide. The **SA SURE project** provided support to 12 districts to do readiness assessments, train data capturers and facility staff, and then electronically back-capture ART records. In the 112 supported facilities, approximately 154 000 records were back-captured over nine months. The facilities were assisted with data cleaning and sign-off on Tier 2, and the use of information from the Tier system.

Following the introduction of the PHC Re-engineering Strategy in 2011, HST has worked with the University of the Western Cape (UWC) to pilot a national M&E system for PHC Outreach Teams. On the AP-funded project entitled **Strengthening the Capacity of Districts and Sub-districts to Implement the PHC Re-engineering Strategy**, HST supported the training of staff and the testing of M&E tools resulting in the revision and adoption of the tools by the National Health Information System committee (NHISSA) for national use. Further data audits and workshops have been held to address data quality improvements. The

electronic capture of the household profile data from 24 pilot sites in North West Province allows for detailed analysis to inform service planning at ward level. HST also partnered with UWC, the Medical Research Council and Mobenzi to pilot a mHealthⁱⁱ solution for data capture by CHWs at household level, resulting in commitment shown by the province to have the pilot scaled up and funded by NW DoH.

The many lessons learned in supporting implementation of these national strategies are proving to be useful in informing further implementation in the supported provinces and beyond.

In Lesotho, a decision was taken to computerise the Health Management Information System (HMIS) from district level upwards, including a fully packaged Electronic Medical Record (EMR) system. Support by HST, through the **Millennium Challenge Corporation (MCC) Lesotho Health Systems Strengthening project**, offered a unique opportunity to achieve this during the three-and-a-half year project that commenced in Lesotho in November 2009. Lessons from the Lesotho experience will inform decisions on the appropriate level of EMR systems for roll-out to outpatients departments and PHC clinics in other countries. This experience proposes a phased implementation, beginning at a pilot site, and replicating it to remaining sites after incorporating adjustments from lessons learned.

In a further practical application of strengthening HMIS in health systems, HST has since 2007 been engaged in **Strengthening of Health Information Systems in the Western Cape Province**. The project, which ended in November 2012, contributed to ensuring optimal availability, quality and flow of health data, and trained information officers and managers in the use of such data. The project implementer's final task was to train the trainer appointed by the Western Cape Department of Health in the use of SINJANI (the computer programme for data and information management used by the Western Cape Department of Health), as well as in national and provincial Indicator Data Set data element definitions, the use of data collection tools and indicator definitions, and the analysis, interrogation and presentation of data.

HST continues to **disseminate information** relevant to health systems strengthening to as wide an audience as possible. We regularly maintain and update our

ⁱⁱmHealth (also written as m-health or mobile health) is a term used for the practice of medicine and public health, supported by mobile devices. The term is most commonly used in reference to using mobile communication devices.

PROGRAMMES DIRECTORATE REPORT (continued)

website, which is characteristically visited by over 17 000 unique visitors a month. We host a variety of electronic discussion lists, moderated by internal and external experts in their particular fields, thus providing a forum for members to discuss issues of interest. The HST Bulletin, sent to over 1 800 subscribers on a fortnightly basis, distils and packages key public health information for subscribers.

Often seen as a key event in the health information calendar, the 2013 **South African Health Review** (in its 16th edition) was officially launched in April by the Minister of Health. This flagship product is widely read, used and quoted as an authoritative reference work in South Africa and abroad. The Review combines detailed information on health status and care with in-depth analysis of policies and practices affecting the provision of health services, as well as insight into the degree of success that has been achieved in policy implementation.

This 2013 edition of the SAHR also celebrated the inaugural **Emerging Public Health Practitioner Award** that provides a voice for young and upcoming public health professionals. We hope that in years to come this award will inspire such practitioners to add to new and ongoing public health debates and to present novel and innovative solutions to problems that plague our health system.

The seventh annual **District Health Barometer (DHB)** was launched along with the SAHR in April 2013. The DHB provides an overall view of district health performance at the primary health level, including district hospitals, and is the only publication of its kind in South Africa offering comparative data of the different health services at implementation level. HST is building up a suite of accessible resources of this kind to address the paucity of comparable health information available in the public domain, drawing together health-related data from the Department of Health's District Health Information System (DHIS), Statistics South Africa, the Electronic TB Register, National Treasury and multiple other sources.



Highlights of the launch



The Honourable Minister of Health, Dr Aaron Motsoaledi, addressing the guests at the combined launch of the 2012/13 South African Health Review and 2011/12 District Health Barometer

This year marked the production of the first **Annual Health Statistics Publication**, commissioned by the NDoH, as an authoritative document that collates the best health statistics available for South Africa. The brief was to focus primarily on data from routine health information systems and to provide disaggregated data down to sub-district level, where feasible. This publication breaks new ground in providing detailed and comprehensive health indicators in the public domain, in a format that is instructive, attractive and accessible.

PROGRAMMES DIRECTORATE REPORT (continued)

A third analytical document, aimed specifically at providing health information to sub-district managers, is the long-discussed but now emerging **Sub-district Health Data Quality Improvement Initiative** (also known as the Sub-district Barometer). This publication offers a critical analysis of key service delivery indicators to monitor progress in maternal and child health in sub-districts of the 11 NHI districts.

In an interesting consultancy, the **Soul City Institute of Health and Development Communication** commissioned HST to conduct a literature review on primary health care, focusing on the role of communities in strengthening PHC and improving quality of care. This literature review will contribute towards the development of the Soul City Series 12 and the Soul Buddyz Clubs.

Training on good practice

Unless improvements, innovation and good practice are embedded in day-to-day health service delivery, they will seldom be sustained and health services will risk lurching from peak to trough with corresponding fluctuations in the quality of the services provided. Apart from the critical role of sound management, a crucial component in sustaining good practice is appropriate training of healthcare workers and managers at all levels.

Following the development of a **Research Methodology Training Manual** aimed at healthcare workers, three two-day workshops on research methodology were conducted for provincial and district managers and staff selected by the clients. The participants expressed interest in further in-depth training in this area. HST will expand this training to respond to the growing demand for such capacity-building efforts within the health sector.

In addition to training activities reported in the brief project descriptions in the first four core focus areas, perusal of a selection of HST's current project objectives reveals training components in many of our other current projects.

Examples of these training-related objectives include:

- 1 Profiling risks to the health programme objectives of the Eastern Cape Department of Health**
- 2 Patient referral policy aligned with the PHC Re-engineering Strategy for Thabo Mofutsanyana District, Free State Province**
To train district-based staff on the implementation, monitoring, and evaluation of the policy
- 3 Documenting good practices within the South African public health sector (policy to practice)**
To share lessons learnt for those wishing to replicate the practices
- 4 Assessment of the status of roll-out of the PHC Re-engineering Strategy**
To make recommendations on methods to improve the implementation of policy based on the findings of the study
- 5 South Africa's Sustainable Response to HIV and AIDS and TB (SA SURE)**
The SA SURE mentors embrace a philosophy and approach designed especially for this project that can be used at any level of the health system. Standardised tools have been created to scan performance, identify areas for improvement, develop and implement QI plans, evaluate progress and give feedback to roleplayers.

The SA SURE case study is beginning to show how an NGO can model a collaborative and comprehensive approach for health systems strengthening, generating some key lessons for effective association. In a short time, SA SURE has demonstrated successes in improved planning processes, support for programme implementation through capacity-building and mentoring of health workers, addressing backlogs in data capture on routine health information systems, and facilitating innovative quality improvement activities.

HST has an opportunity to support the newly-formed Academy for Leadership and Management in Health Care. From research conducted to understand the management competency gaps through the District Managers Study of 2008 and the more recent Facility Managers Competency Study, we have translated this

PROGRAMMES DIRECTORATE REPORT (continued)

knowledge into practice through the SA SURE project by applying the findings in developing our training and mentoring approach to capacitate district and facility managers.

The SA SURE project approach is

- (a) to develop personal effectiveness of healthcare managers through the Wellness for Effective Leadership (WEL) programme, and
- (b) to develop the capacity of healthcare providers at district, sub-district and facility level to utilise the Leadership Development Programme (LDP) management practices to improve service delivery and outcomes.

The WEL Programme was developed in response to a crisis in service delivery and was designed to address stress, burnout and lack of agency in healthcare managers. The programme focuses on improving self-awareness and understanding self and self-care, in order to develop emotional intelligence and so become more effective as a manager and leader,



WEL training sessions



- Facility questionnaire
- Cascade of indicators - identify poor performance
- Other audit assessments
- National Core Standards Assessment report



- Stakeholder engagement
- Community dialogue
- Skills audit
- Data audits (register reviews, record reviews, DQA)
- Observation of clinical practice



- Facilitation of the development of a comprehensive QI plan for facility/district mentorship and coaching



- Monitoring and evaluation of the plan
- Feedback to roleplayers

SA SURE approach to health system strengthening

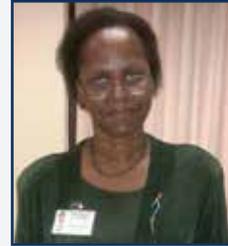
with the aim of improving service delivery. For the period July 2012 to June 2013, the WEL programme completed 19 groups and reached 265 participants as part of the SA SURE project. Participants reported improved interpersonal relationships, improved team-work, improved self-care, ability to share limited resources, decreased absenteeism and improved adherence to deadlines. Personal stories of transformation and change, and how this intervention has had a positive impact on their work environment, have also been shared.

The LDP aims to build the capacity of healthcare providers in the supported districts and sub-districts to identify gaps in service delivery, mobilise the necessary stakeholders, analyse the root causes, develop and implement action plans to address these challenges and finally, to monitor and evaluate the results. This is an organisational process that develops people at all levels to learn leadership and management practices, face challenges and achieve measurable results. The programme enables district teams to use leadership theories, values and behaviours to produce desirable health outcomes.

The following case story showcases the successful endeavours of Mrs Daphne Memela – a district manager of 12 years' standing – in recording project-related improvements in clinic supervision. Mrs Memela also shares her realisation that the training gave the participant managers the courage to communicate more effectively with their colleagues and to work as a team, recognising other people's abilities to contribute towards resolving problems.

PROGRAMMES DIRECTORATE REPORT (continued)

REFLECTIONS ON THE 'WEL' WORKSHOP by Mrs Daphne Memela



HST is working in Zululand District as an NGO partner helping with sustainable health systems development. After conducting a situational analysis, HST developed a plan that was agreed to by the district and is currently being implemented. Part of the plan was to strengthen management capacity to deal with the challenges confronting the district. One of the interventions was to provide training for the district management team (DMT).

Fifteen managers were selected from all institutions to attend the Wellness for Effective Leadership (WEL) Training.

The training package included the following:

- ◆ Checking in
- ◆ Self-management strategies
- ◆ River of life
- ◆ Stress and burnout prevention and management
- ◆ Team work
- ◆ Theory of character profiling and the four basic human temperaments
- ◆ Leadership
- ◆ Listening / understand and active listening, self-care and the buddy system
- ◆ Switching on and off – emotional intelligence personality
- ◆ Communication and focus
- ◆ Conflict resolution.



One of the ways recommended to assist managers to take care of themselves and their colleagues was the “buddy system”. Managers were advised to pick a buddy and then work together on a visible project to help each other develop effective management skills.

Nonhlanhla Buthelezi and I picked each other as buddies. We agreed to work jointly towards improving PHC supervision in Nongoma Municipality, where Nonhlanhla had been working for about six months as a new manager. She had experience in PHC supervision from her previous appointments, and was now overseeing the work of 12 fixed clinics, three mobile teams and one school health team.

After the PHC supervision improvement initiative, we reported to the DMT on how we applied our effective management and leadership skills training in Nongoma Municipality, Zululand District ...

PROGRAMMES DIRECTORATE REPORT (continued)

Background

Nongoma Municipality is one of five municipalities in the Zululand District, with a population of 208 062 inhabitants. Nongoma is a remote rural area with only one tar road running through the municipality. Three other tarred roads are still under construction. The municipality has 12 fixed clinics, two PHC Supervisors and a PHC Manager (Nonhlanhla Buthelezi). The PHC Manager started working in Nongoma in December 2011.

Problem

The PHC supervision rate in Nongoma Municipality was 55% in the first quarter (Q1) of 2012/13 (April to June 2012). The PHC Supervisors were mainly involved in hospital and district office meetings. There was no dedicated PHC transport for PHC supervision. No PHC supervision reports were compiled, nor were PHC supervision scheduled.

Objective

To improve the PHC supervision rate from 55% to 80%. The district's norm is one PHC Supervisor for six clinics. Nongoma has two supervisors, each responsible for supervising six clinics.

Intervention

The PHC Manager enlisted the support of the HST technical support team to strengthen the implementation of PHC supervision. The PHC Manager approached the hospital CEO to request dedicated transport. Transport was scheduled so that the two PHC Supervisors would visit clinics on alternate days. The PHC Supervisors also visited clinics over the weekend to ensure coverage. The HST leadership mentor accompanied both PHC Supervisors on visits to clinics to develop improvement plans on aspects needing attention.

The PHC supervision tool was implemented as follows:

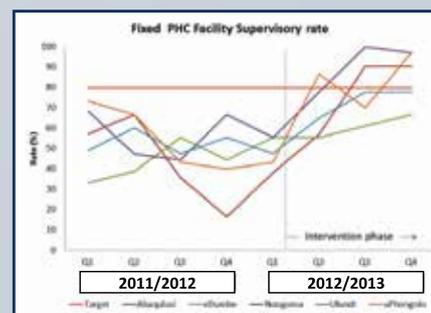
- ◆ 12 Sept: EPI - 91% clinics were visited
- ◆ 10 Oct: TB - 100 % clinics were visited
- ◆ 12 Nov: HIV / AIDS - 100% clinics were visited
- ◆ 12 Dec: Red Flag - 100% clinics were visited
- ◆ 13 Jan: Chronic - 91% clinics were visited
- ◆ On 13 March the PHC Supervisors conducted follow-up visits to review progress in addressing gaps identified between September 2012 and February 2013.

As manager-buddies, Nonhlanhla and I shared the information, swapped ideas and encouraged each other. The district office's Monitoring Team updated us on PHC supervision institutional performance. The DMT agreed to declare PHC supervision a non-negotiable output. Clinics are now supported to develop plans to address gaps identified during supervisory visits.

The DMT agreed to review the PHC supervision rate every quarter. Any municipality not showing an improvement will be held accountable and required to provide an explanation and to implement an improvement plan. Feedback was given to institutions at the end of Q2 and Q3. PHC supervision was also considered during managers' performance reviews during September 2012.

Results

Graphs for the five municipalities in the district illustrate the marked improvement in the PHC supervision rate in the Nongoma Municipality, resulting from the management strengthening initiative implemented between Q2 and Q4 of 2012/13. Each clinic supervisor wrote and submitted a report to the PHC Manager. Gaps identified were addressed through improvement plans.



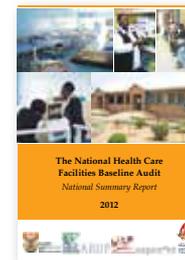
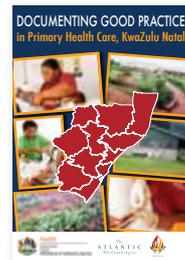
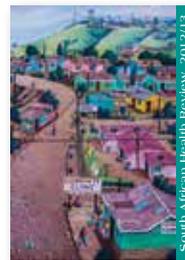
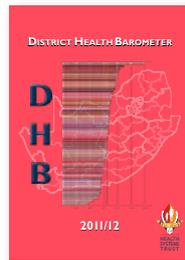
Conclusion

The improvement in PHC supervision in Nongoma Municipality in the Zululand District resulted from:

- ◆ improved communication skills;
 - ◆ support from the hospital CEO;
 - ◆ provision of resources;
 - ◆ sharing of ideas; and
 - ◆ HST's technical support,
- all supported by the commitment of the PHC manager.

05

PUBLICATIONS & RESOURCES



Annual Health Statistics 2012

Pretoria: National Department of Health; 2013.

Cadegan M, English R, Pillay Y, Barron P.

A brief summary of the Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa 2012–2016

Durban: Health Systems Trust; 2012

[Kwik Skwiz series, 2(2)]

Cadegan M, English R, Pillay Y, Barron P.

A summary of the National Strategic Plan on HIV, STIs and TB 2012–2016

Durban: Health Systems Trust; 2012

[Kwik Skwiz series, 2(3)]

Day C, Gray A.

Health and Related Indicators

In: Padarath A, English R, editors.

South African Health Review 2012/13.

Durban: Health Systems Trust; 2013.

English R.

Guest Editorial

HIV Nursing Matters

2012 Dec; 3(4):2-3.

Jassat W, Naicker N, Naidoo N, Mathee A.

Rodent control in urban communities in Johannesburg, South Africa: from research to action

International Journal of Environmental Health Research. 2013.

doi:10.1080/09603123.2012.755156

Massyn N, Day C, Barron P, Haynes R, English R, Padarath A, editors.

District Health Barometer 2011/12.

Durban: Health Systems Trust; March 2013.

Moyo S, Madale R, Ogunmefun C, English R.

Public health and management competency requirements for primary health care facility managers at sub-district level in the District Health System in South Africa

Durban: Health Systems Trust; 2013.

[(Research Snapshot series, 1(1))]

Mureithi L, van Schaik N, English R.

Changes to South African Antiretroviral Treatment Guidelines 2012

Durban: Health Systems Trust; 2012

[Kwik Skwiz series, 2(4)]

Padarath A, English R, editors.

South African Health Review 2012/13

Durban: Health Systems Trust; 2013.

Names that are underlined indicate external authors.

PUBLICATIONS & RESOURCES (continued)

Padayachee T, Jassat W, Seunanden T, Nyawo K, Blanchard C, English R.

Documenting good practices in primary health care, KwaZulu-Natal

Durban: Health Systems Trust; October 2012.

Verguet S, Jassat W, Bertram M, Tollman S, Murray C, Jamison D, Hofman K.

Impact of supplemental immunization activity (SIA) campaigns on health systems: findings from South Africa

J Epidemiol Community Health. 2013.

Nov 1;67(11):947-52.

Visser R, Bhana R, Monticelli, F.

National Health Care Facilities Baseline Audit: National Summary Report

Durban: Health Systems Trust; 2013.

Unpublished Project Reports

Byleveld S.

Health Management Information Systems Strategic Plan 2013–2017

Millennium Challenge Corporation: Lesotho Health Systems Strengthening Technical Assistance Project of the Lesotho Ministry of Health.

Durban: Health Systems Trust; May 2013.

Byleveld S, Vermeulen R.

Report on the development of a client-centered Integrated Health Management Information System for the country

Millennium Challenge Corporation: Lesotho Health Systems Strengthening Technical Assistance Project of the Lesotho Ministry of Health.

Durban: Health Systems Trust; December 2012.

Byleveld S, Visser R.

Pilot report on the implementation of an Electronic Medical Record System in a Lesotho Outpatient Department, Leribe District, Lesotho

Millennium Challenge Corporation: Lesotho Health Systems Strengthening Technical Assistance Project of the Lesotho Ministry of Health.

Durban: Health Systems Trust; September 2012.

Cassiem I, Jassat W.

SA SURE project progress report on TIER.net implementation

Durban: Health Systems Trust; May 2013.

Hunter J, Padayachee T, Smith C, Madale, R, Seunanden T, English R.

Establishment of a Health Programme Risk Profile for the Eastern Cape Department of Health: a pilot study

Durban: Health Systems Trust; February 2013.

Jassat W, Ogunmefun C, Tathiah N.

Literature review: revitalisation of primary health care

Durban: Health Systems Trust; April 2013.

Mureithi L, van Schaik N, Matzopolous R, Misra M, Naledi I, English R.

Report on the rapid assessment of the injury morbidity burden at health services in three high violence communities in the Western Cape

Durban: Health Systems Trust; February 2013.

Rommelzwaal B, Byleveld S, Phafoli S, Leretholi K.

Lesotho Health Systems Strengthening Technical Assistance end-of-project report

Millennium Challenge Corporation: Lesotho Health Systems Strengthening Technical Assistance Project. Maseru: Lesotho Ministry of Health; May 2013.

doi:10.1136/jech-2012-202216

Names that are underlined indicate external authors.

06

CONFERENCE PRESENTATIONS



Byleveld S.

Lessons learned from implementing a fully-packaged Electronic Medical Records system in Lesotho Outpatient Departments

Health Information of South Africa (HISA) Conference; Port Elizabeth, 3-5 July 2013.

Day C, McIntyre D.

Country measurement of situation and progress towards universal coverage

Measurement of trends and equity in coverage of health interventions in the context of Universal Health Coverage. World Health Organization; Bellagio, 17-21 September 2012.

Jassat W.

Leadership and management panel discussion

SA AIDS Conference; Durban, 18-21 June 2013.

Magingxa N.

National core standards for health establishments in South Africa

10th National Midwifery Congress; Johannesburg, 5 December 2012.

Mampe T.

Implementing the PHC Re-engineering Strategy: An analysis of household profile registrations from 24 pilot sites in the North West Province

Joint Public Health Association of South Africa (PHASA) and Rural Doctors Association South Africa (RuDASA) Conference; Bloemfontein, 5-7 September 2012.

Massyn N.

Supporting the implementation of a data management improvement intervention in the Western Cape Province – Compliance and Audit Readiness assessment tools

Joint Public Health Association of South Africa (PHASA) and Rural Doctors Association South Africa (RuDASA) Conference; Bloemfontein, 5-7 September 2012.

CONFERENCE PRESENTATIONS (continued)

Masuku M.

Planning for PHC re-engineering: Listening to the voices of community through community dialogues in the North West Province

Joint Public Health Association of South Africa (PHASA) and Rural Doctors Association South Africa (RuDASA) Conference; Bloemfontein, 5-7 September 2012.

Matse M.

PHC re-engineering experience from the North West Province

Re-engineering Public Health Care in Gauteng Symposium; Johannesburg, 28 February 2013.

Matse M.

Sharing experiences on PHC re-engineering implementation in the North West and Mpumalanga provinces

Rural AIDS and Development Action Research (RADAR) Conference; Acornhoek, 5-7 June 2013.

Matse M.

Strategic leadership and planning in the implementation of PHC re-engineering in the North West Province

Joint Public Health Association of South Africa (PHASA) and Rural Doctors Association South Africa (RuDASA) Conference; Bloemfontein, 5-7 September 2012.

Mbatha T, Padayachee T, English R.

The National Health Research Database

Joint Public Health Association of South Africa (PHASA) and Rural Doctors Association South Africa (RuDASA) Conference; Bloemfontein, 5-7 September 2012.

Monticelli F.

Using strategic information to identify areas of intervention for health systems strengthening

ANOVA Health Symposium; Shifting Paradigms: Strengthening Health Systems for Better Outcomes; Johannesburg, 16 August 2012.

Ogunmefun C.

Implementing the PHC Re-engineering Strategy: An audit of community health workers in the districts of the North West Province

Joint Public Health Association of South Africa (PHASA) and Rural Doctors Association South Africa (RuDASA) Conference; Bloemfontein, 5-7 September 2012.

Padayachee T.

Documenting good practices in the South African public health sector: Creating momentum towards service excellence

Joint Public Health Association of South Africa (PHASA) and Rural Doctors Association South Africa (RuDASA) Conference; Bloemfontein, 5-7 September 2012.

Padayachee T, English R.

A tool for documenting good practices in the public health sector of South Africa

Joint Public Health Association of South Africa (PHASA) and Rural Doctors Association South Africa (RuDASA) Conference; Bloemfontein, 5-7 September 2012.

Seunanden T, Padayachee T, Nyawo K, Jassat W, English R.

A process of documenting primary healthcare good practices in KwaZulu-Natal

Joint Public Health Association of South Africa (PHASA) and Rural Doctors Association South Africa (RuDASA) Conference; Bloemfontein, 5-7 September 2012.



DEENA GOVENDER

Corporate Services provides effective and efficient support to HST's various operational sectors. Running a comprehensive and integrated Finance, HR, IT, Administration, Travel and Communications service, this well-trained and experienced team enables the Programme staff to concentrate on their core health system strengthening and research activities.

FINANCE

HST's annual financial statement as at 30 June 2013 reflected assets to the value of R57 050 993, clearly demonstrating sustained financial viability. HST boasts once again an unqualified audit which reflects its robust financial policies and procedures. The Finance and Audit Committees provide strategic direction, while playing an important oversight role in governance of the organisation. HST's internal audit function is outsourced.

HUMAN RESOURCES

For the second year in succession HST expanded its workforce, recruiting mainly project-linked staff members to meet the increased human resource demands of longer-term projects. Overall, staff numbers increased by 96% from 105 in June 2012 to 206 in June 2013. During the year, 137 appointments were made and, regrettably, 36 staff members were lost. Many of those leaving HST do, however, continue to serve the health needs of the population in other – often senior – capacities.

A formal staff retention policy is being developed to minimise the loss of experienced human capital from our workforce.

HST strives to achieve equity in the workplace. Currently, the organisation's staff composition is predominantly female (75%) of which 69% are black. Overall, black employees comprise 94% of the total staff complement, whilst 99% of the total workforce comprises previously disadvantaged individuals.

INFORMATION TECHNOLOGY

With the opening of 11 new satellite offices across the country and staff numbers increasing, HST had to invest more in its ICT infrastructure. Employees working in both the metro and rural areas are dependent on the HST network to conduct their daily activities. The ICT department's functions, although outsourced, are regularly measured against a service level agreement to ensure that network and workstation downtime is minimised.



Delene King, Ashnie Padarath and Bareng Aphiri at the launch of the District Health Barometer in Pretoria

08

HST STAFF

OFFICE OF THE CEO

Jeanette Hunter, Chief Executive Officer (until 31/01/2013)
 Ronel Visser, Acting Chief Executive Officer (as from 01/02/2013)
 Natasha Chetty, Manager: Business Development Unit
 Zanele Mazibuko
 Bareng Aphiri

CORPORATE SERVICES

Deena Govender, Director: Corporate Services
 Delene King, Manager: Administration
 Melini Moodley, Manager: Finance
 Robert Hendricks, Manager: Human Resources

Ajay Haripersadh	Kemona Pillai
Antoinette Batuule	Krishen Harisaran
Beverly Hamiel	Leo Moodley
Blessing Mncwabe	Mahomed Imam
Bongi Mthembu	Natasha Esau
Bonisile Tshabalala	Ndumiso Jali
Brian King	Nomandisinde Mndende
Charmaine Singh	Nombuso Dlamini
Cindy Singh	Nompumelelo Xulu
Debbie Leadbetter	Ntando Mdletshe
Dhanasagree Govender	Robert Morupane
Dudu Zondi	Simmi Moodley
Fezile Ngubane	Sinead Parsee
Joyce Mareme	Therusha Nandhlal
Julia Elliot	Vivian Makoki
Karen Jacobs	Vuyokazi Lwana
Kedibone Leeuw	Yandiswa Magwevana

PROGRAMMES

Ronel Visser, Director: Health Systems Strengthening
 Rene English, Director: Health Systems Research
 Rakshika Bhana, Programme Manager: Health Systems Strengthening
 Thesandree Padayachee, Programme Manager: Health Systems Research
 Waasila Jassat, Programme Manager; Health Systems Strengthening

Abraham Malaza	Bongi Ngubane	Cebile Ndwandwe	Elise Levendal
Algernon Africa	Bongiwe Thwala	Christopher Kaangundue	Esther Mungai
Anna Modikwa	Bruce Andinda	Cornelius Jack	Esther Tshaka
Annah Springbok	Bulelwa Magadla	Dikeledi Mosia	Evelyn Goeieman
Anne Ochieng	Busisiwe Mbanjana	Dimakatso Thapelo	Fazila Khan
Annibale Cois	Candy Day	Dineo Mtshali	Fikile Ngema
Ashnie Padarath	Carlo Muller	Dorcas Gumede	Fiorenza Monticelli
Baliswa Ncanywa	Carmen Sisam	Douglas Ngcobo	Gadifele Kgwasa
Blessing Mavela	Catherine Ogunmefun	Edith Moosa	Geoffrey Ngqabayi



Cape Town staff



Effective Management and Leadership training



HST year-end celebrations - Shipwrecked!



Year-end teambuilding

HST STAFF (continued)



HST travel office staff Leo Moodley and Simmi Moodley

Gugulethu Sokhela	Masego Seupe	Nomfanelo Ximiya	Sibongile Shezi
Happycdance Mdikeli	Maselaelo Legodi	Nomso Arosi	Sindisiwe Khumalo
Hester du Bruyn	Matodzi Cherane	Nomthandazo Magingxa	Sizulu Moyo
Hlengiwe Ngcobo	Matshedisho Mahabane	Nomtutuzela Kgotlagomang	Sne Khuzwayo
Imeraam Cassiem	Matshidi Sekgopo	Nomvula Radebe	Somikazi Nodunyelwa
Isaac Nyoka	Mbali Dladla	Nonceba Languza	Songezo Madyibhi
Itumeleng Leburu	Mercedes Fredericks	Nonqaba Mzana	Sonia Lupondwana
Jabulile Dube	Mesuli Ntshalintshali	Nonsikelelo Nontswabu	Sophie Madute
Jabulile Ngubane	Mimi Teffo	Noziphiwo Balfour	Stiaan Byleveld
Jackie Smith	Mioara Marcu	Ntombazana Makinana	Susanna Naude
Jaqueline Habana	Moeketsi Thobeli	Ntombizine Bam	Tamlyn Seunanden
Joany Matthee	Moeketsi Toli	Pateka Twakadi	Thabo Phakati
Johanna Dippenaar	Mohamed Manesen	Patrick Madhlopa	Thandeka Khumalo
Johannes Reachable	Mokete Maselo	Paulina Banda	Thenjiwe Jankie
Johannes van Schalkwyk	Momo Mokoena	Petronella Kegakilwe	Thembakazi Mantshule
Joseph Rasethe	Monica Puley	Phelelani Ndlela	Thembekile Lushaba
Joyce Majiba	Monnye Rammekwa	Phumzile Gubevu	Thembinkosi Mkhize
Judith King	Morton Mashishi	Pitso Rasiile	Thembisile Mofokeng
Juliet Nyasulu	Mosibudi Manthata	Portia Shai Mhatu	Thembisile Shongwe
Kebareng Lekoto	Motlalentso Mohlahlo	Pretty Buthelezi	Thokozani Mbatha
Kgomotso Nyandwi	Motshabi Modise	Puleng Lerite	Thuso Tsholwe
Lehlohonolo Mokoena	Mpitizeli Wogqoyi	Puleng Tlhoaele	Tseko Makhosane
Linda Mureithi	Mukelisiwe Mlotshwa	Queeneth Mashaba	Tseliso Shale
Lindelwa Mjali	Mutheiwana Dombo	Rally Moropa	Tshitshi Ngubo
Lindiwe Msimang	Muzi Matse	Rebecca Motsoeneng	Tumelo Mampe
Livhuwani Mashamba	Myekeni Thibane	Reitumetse Ratsomo	Victoria Shandu
Lizze Afrikaner	Mzikazi Masuku	Rhulane Madale	Vuyokazi Ntshakaza
Lulama Mhlongo	Nancy Zitha	Robert Nyathi	Wandile Shuping
Lulama Molusi	Nandy Mothibe	Roger Tevan	Wendy Jasson da Costa
Lungi Melane	Naomi Massyn	Ross Haynes	Willias Zendera
Madimabe Moleba	Nazia Peer	Sandra Qolesa	Xolela Somahela
Makhosazana Khoza	Ndivhuho Mangale	Sanet Klaasen	Xolisa Jabe
Malibongwe Daweti	Nienke van Schaik	Sarah Sefako	Xoliswa Lute
Mangwele Seko	Njabulo Mbanda	Sello Moremi	Zinhle Sokhela
Manqoba Mthembu	Nokuthula Khumalo	Sharon Ngomane	Zodwa Mdoda
Maria Pheiffer	Nolwazi Dlamini	Shirlane Douglas	
Maria Sithole	Nomazwi Tembani	Sibongile Mnisi	

INTERNS

Over the past eight years, Health Systems Trust has hosted interns from many different parts of the world, mainly through the intern co-ordination services of Human Rights Internet in Ottawa, Canada.

In 2012/13, HST benefited from the skills and passion of the following interns, to whom we are grateful:

James Aluri	University of Southern California, Los Angeles, USA
Michael Cadegan	St. Francis Xavier University, Nova Scotia, Canada
Cordelia Martin	Michigan State University, Detroit, USA
Stephanie Ortynsky	University of Saskatchewan, Saskatoon, Canada
Carlos Requena Farinos	Oklahoma State University, Stillwater, USA

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

STATEMENT OF RESPONSIBILITY FOR FINANCIAL REPORTING BY THE BOARD OF TRUSTEES
for the year ended 30 June 2013

The Board of Trustees is responsible for the preparation of the financial statements of the Trust For Health Systems Planning and Development ("the Trust"). In presenting the annual financial statements IFRS for SMEs has been followed, appropriate accounting policies have been used, while prudent judgments and estimates have been made.

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

The annual financial statements have been audited by the independent accounting firm, Deloitte & Touche, which was given unrestricted access to all financial records and related data, including minutes of all meetings of members, the Board of Trustees and committees of the Board. The Board of Trustees believe that all representations made to the independent auditors during their audit were valid and appropriate. The Deloitte & Touche audit report is presented on pages 8 to 9.

APPROVAL OF THE ANNUAL FINANCIAL STATEMENTS BY THE BOARD OF TRUSTEES

The annual financial statements set out on pages 10 to 25 and the supplementary information set out on pages 26 to 30 were approved by the Board of Trustees on 18 Oct 2013 and signed on its behalf by:


Chairperson

These annual financial statements are an abbreviated version of the full audited version signed at the Board of Trustees meeting as recorded above and are not, in themselves, audited. Copies of the full, audited version of the annual financial statements are available on request. Page numbers mentioned in this abbreviated report refer to the full version of the annual financial statements.

ANNUAL FINANCIAL STATEMENTS (continued)

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT CORPORATE GOVERNANCE STATEMENT *for the year ended 30 June 2013*

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

BOARD OF TRUSTEES

Responsibilities

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

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

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

Attendees at Board Meetings				
	17/08/12	16/11/12	15/03/13	21/06/13
Prof. Welile Shasha	✓	✗	✓	✓
Ms Gcwalisile Twala	✓	✗	✓	✓
Mr Shadrack Shuping	✓	✗	✓	✗
Dr Timothy Wilson	✓	✓	✗	✓
Dr Victor Litlhakanyane	✓	✓	✓	✓
Dr Michael Hendricks	✗	✓	✗	✗
Prof. Kaya Mfenyana	✗	✗	✓	✗
Prof. Laetitia Rispel	✗	✓	✓	✓
Dr Sibongile Zungu (resigned 15 March 2013)	✗	✗	-	-
Dr Maureen Tong	✗	✓	✓	✓
Mr Obakeng Mongale	✗	✗	✗	✗
Mr Kevin Bellis	✗	✗	✓	✓

ANNUAL FINANCIAL STATEMENTS (continued)

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT CORPORATE GOVERNANCE STATEMENT for the year ended 30 June 2013 (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, in the main, comprise non-executive Trustees. The chairperson of each committee is a non-executive Trustee, with the exception of the Audit Committee, whose Chairperson is an independent external member. The following committees play a critical role to the governance of the Trust:

Audit committee

The role of the Audit Committee is to assist the Board by performing an objective and independent review of the functioning of the organisation's finance and accounting control mechanisms. This Committee exercises its functions through close liaison and communication with executive management and the internal and external auditors. The Committee met twice during the 2013 financial year.

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

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

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

	Attendees	
	22/10/2012	22/05/2013
S Govindsamy (External member)	✓	✓
I Lax (External Member)	x	✓
M Hendricks (Trustee)	✓	x
V Litlhakanyane (Trustee)	✓	✓

The Audit Committee addressed its responsibilities properly in terms of the charter during the 2013 annual financial year. No changes to the charter were adopted during the 2013 financial year.

Management has reviewed the annual financial statements with the Audit Committee, and the Audit Committee has reviewed these statements without management or the external auditors being present. The quality of the accounting policies was discussed with the external auditors.

ANNUAL FINANCIAL STATEMENTS (continued)

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT CORPORATE GOVERNANCE STATEMENT for the year ended 30 June 2013 (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. The Personnel Committee's specific terms of reference also include recommendations to the Board on matters relating, inter alia, to executive remuneration, Trustees' honoraria and fees, and service contracts. Whenever necessary, the Committee is advised by independent professional advisers. The Committee met four times during the 2013 financial year.

The Personnel Committee consists of the following members:

	Attendees			
	18/07/2012	06/11/2012	21/02/2013	23/05/2013
O Mongale (Trustee)	✓	✓	✓	✓
M Tong (Trustee)	✓	x	x	✓
G Twala (Trustee)	x	✓	✓	x
M Modipa (External Member)	x	x	x	x
I Matsheka (External Member)	✓	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			
	03/08/2012	10/10/2012	14/02/2013	23/05/2013
M Hendricks (Trustee)	x	x	x	x
G Twala (Trustee)	x	✓	x	✓
O Mongale (Trustee)	x	x	x	✓
S Shuping (Trustee)	✓	✓	✓	x
W Shasha (Alternate member)	✓	-	-	-
K Bellis (Alternate member)	-	-	✓	✓

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.

ANNUAL FINANCIAL STATEMENTS (continued)

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT CORPORATE GOVERNANCE STATEMENT for the year ended 30 June 2013 (continued)

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 the Trust's 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 that are in place to manage operating risk involve segregation of duties, transactions authorisation, supervision, monitoring, and financial and managerial reporting.

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

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

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

The Trust assessed its internal control system as at 30 June 2013 in relation to the criteria for effective internal control over financial reporting. The internal control process has been in place up to the date of approval of the annual report and annual financial statements. The Trust believes that its system of internal control over financial reporting and safeguarding of assets against unauthorised acquisitions, use or disposition, met those criteria.

INTERNAL AUDIT

Gobodo Inc 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) that has been fully endorsed by the Board and applies to all Trustees and employees. The Code is regularly reviewed and updated as necessary to ensure it reflects the highest standards of behaviour and professionalism.

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

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

ANNUAL FINANCIAL STATEMENTS (continued)

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT CORPORATE GOVERNANCE STATEMENT *for the year ended 30 June 2013 (continued)*

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

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

REPORT ON THE ANNUAL FINANCIAL STATEMENTS

We have audited the annual financial statements of the Trust for Health Systems Planning and Development, which comprise the statement of financial position as at 30 June 2013, the statement of comprehensive income, the statement of changes in equity and statement of cash flows for the year then ended, and a summary of significant accounting policies and other explanatory notes, as set out on pages 12 to 25.

Trustees' Responsibility for the Annual Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In our opinion, the annual financial statements fairly present, in all material respects, the financial position of the Trust for Health Systems Planning and Development as of 30 June 2013, and its financial performance and its cash flows for the year then ended in accordance with the International Financial Reporting Standards for Small and Medium-sized Entities, and in the requirements of the Trust Deed.

National Executive: LL Barn Chief Executive AE Swiegers Chief Operating Officer GM Pinnock Audit
DL Kennedy Risk Advisory NB Kader Tax TP Pillay Consulting K Black Clients & Industries
JK Mazzocco Talent & Transformation CR Beukman Finance M Jordan Strategy S Gwala Special Projects
TJ Brown Chairman of the Board MJ Comber Deputy Chairman of the Board
Regional Leader: GC Brazier

A full list of partners and directors is available on request

B-BBEE rating: Level 2 contributor in terms of the Chartered Accountancy Profession Sector Code

Member of Deloitte Touche Tohmatsu Limited

ANNUAL FINANCIAL STATEMENTS (continued)

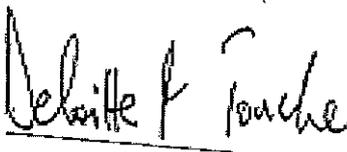
INDEPENDENT AUDITOR'S REPORT TO THE TRUSTEES OF TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT (continued)

Other matters

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

Other reports

As part of our audit of the financial statements for the year ended 30 June 2013, we have read the Report of the Board of Trustees for the purpose of identifying whether there are material inconsistencies between this report and the audited financial statements. This report is the responsibility of the preparer. Based on reading this report we have not identified material inconsistencies between this report and the audited financial statements. However, we have not audited this report and accordingly do not express an opinion on the report.



Deloitte & Touche
Registered Auditors
Per M Luthuli
Partner

These annual financial statements are an abbreviated version of the full audited version signed at the Board of Trustees meeting as recorded above and are not, in themselves, audited. Copies of the full, audited version of the annual financial statements are available on request. Page numbers mentioned in this abbreviated report refer to the full version of the annual financial statements.

ANNUAL FINANCIAL STATEMENTS (continued)

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT REPORT OF THE BOARD OF TRUSTEES *for the year ended 30 June 2013*

The Board of Trustees present their annual report for Trust for Health Systems Planning and Development for the year ended 30 June 2013.

1. GENERAL REVIEW

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

Goals

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

2. FINANCIAL RESULTS

- 2.1 Full details of the financial results are set out on pages 12 to 25 in the annual financial statements.
- 2.2 As set out in the annual financial statements, the Trust had a total surplus for the year of R 9 683 805 (2012: R6 221 075).
- 2.3 The ratio of administration expenses (excluding the unusual and extraordinary items) against gross income is 11%, 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 at year-end and the date of this report are:

Name	Date appointed	Date resigned/ tenure ended
W Shasha	01 August 2008	
T Wilson	01 August 2008	
L Rispel	01 August 2008	
K Mfenyana	01 August 2008	21 June 2013
S Zungu	01 August 2008	15 March 2013
K Bellis	01 August 2008	
M Hendricks	01 August 2008	21 June 2013
O Mongale	26 June 2009	
K M Tong	01 April 2010	
G Twala	01 April 2010	
V Litlhakanyane	19 November 2010	
S Shuping	01 February 2011	

ANNUAL FINANCIAL STATEMENTS (continued)

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT

REPORT OF THE BOARD OF TRUSTEES *for the year ended 30 June 2013 (continued)*

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.

5. GOING CONCERN

The annual 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
STATEMENT OF FINANCIAL POSITION
as at 30 June 2013

	2013	2012
	R	R
ASSETS		
Non-current assets	9 327 602	8 407 885
Property, plant and equipment	6 406 852	2 370 756
Intangible assets	2 920 750	6 037 129
Current assets	47 723 391	27 944 433
Trade and other receivables	3 816 055	7 400 620
Cash and cash equivalents	37 624 559	14 820 347
Accrued revenue	6 282 777	5 723 466
TOTAL ASSETS	57 050 993	36 352 318
EQUITY		
Accumulated surplus funds and reserves	37 991 118	28 307 313
LIABILITIES		
Current liabilities	19 059 875	8 045 005
Trade and other payables	11 577 701	5 963 524
Deferred revenue	7 482 174	2 081 481
TOTAL EQUITY AND LIABILITIES	57 050 993	36 352 318

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT
STATEMENT OF COMPREHENSIVE INCOME
for the year ended 30 June 2013

	2013	2012
	R	R
Grant income	129 789 597	86 376 372
Other income	10 025 661	7 588 430
Project expenses	(114 386 377)	(79 333 128)
Administration expenses	(15 242 411)	(9 249 135)
SURPLUS BEFORE INTEREST	10 186 470	5 382 539
Interest paid	(1 555 771)	(25 396)
Interest received	1 053 106	863 932
SURPLUS BEFORE TAXATION	9 683 805	6 221 075
Taxation	-	-
NET SURPLUS AFTER TAXATION	9 683 805	6 221 075
Other comprehensive income	-	-
TOTAL COMPREHENSIVE INCOME FOR THE YEAR	9 683 805	6 221 075

TRUST FOR HEALTH SYSTEMS PLANNING AND DEVELOPMENT
STATEMENT OF CHANGES IN EQUITY
for the year ended 30 June 2013

	HSS	HSR	Heathlink	SA SURE (CDC)	Central Admin- istration (CORE)	Total Equity
	R	R	R	R	R	R
Opening balance as at 1 July 2011	6 756 158	726 082	(616 685)	-	15 220 683	22 086 238
Consolidation of units	(966 299)	277 545	616 685	-	72 069	-
Total surplus for the year	5 789 859	1 003 627	-	-	15 292 752	22 086 238
	1 540 908	1 105 051	-	1 479 568	2 095 548	6 221 075
Closing balance as at 30 June 2012	7 330 767	2 108 678	-	1 479 568	17 388 300	28 307 313
Total surplus for the year	9 308 867	(295 293)	-	(1 942 980)	2 613 211	9 683 805
Closing balance as at 30 June 2013	16 639 634	1 813 385	-	(463 412)	20 001 511	37 991 118

TOTAL EQUITY COMPRISES THE FOLLOWING:

	2012	2013
	R	R
Accumulated Surplus funds	23 711 757	28 307 313
HST Reserve Fund	14 279 361	-
	37 991 118	28 307 313

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
STATEMENT OF CASH FLOWS
for the year ended 30 June 2013

	Notes	2013	2012
		R	R
CASH FLOWS FROM OPERATING ACTIVITIES			
Cash generated from /(used in) operations	A	27 827 135	(12 298 396)
Interest paid		(1 555 771)	(25 396)
Interest received		1 053 106	863 932
Net cash flows used in operating activities		<u>27 324 470</u>	<u>(11 459 860)</u>
CASH FLOWS FROM INVESTING ACTIVITIES			
Proceeds from disposal of property and equipment		1 794 046	48 819
Acquisition of property and equipment		(6 260 174)	(1 985 404)
Acquisition of intangible assets		(54 130)	(10 963)
Net cash flows used in investing activities		<u>(4 520 258)</u>	<u>(1 947 548)</u>
Net decrease in cash and cash equivalents		22 804 212	(13 407 408)
Cash and cash equivalents at beginning of year		<u>14 820 347</u>	<u>28 227 755</u>
Cash and cash equivalents at end of year		<u>37 624 559</u>	<u>14 820 347</u>

A RECONCILIATION OF SURPLUS BEFORE TAXATION TO CASH GENERATED FROM OPERATIONS

	2013	2012
	R	R
Surplus before taxation	9 683 805	6 221 075
Adjustments for:		
Depreciation	1 362 101	406 388
Amortisation	3 170 509	277 864
Gain from donated intangible assets	-	(6 287 876)
(Profit)/loss on disposal of property, plant and equipment	(932 069)	2 138
Interest paid	1 555 771	25 396
Interest received	(1 053 106)	(863 932)
Cash flows from operations before working capital changes	<u>13 787 011</u>	<u>(218 947)</u>
Working capital changes:		
Decrease/(increase) in trade and other receivables	3 025 254	(563 974)
Increase/(decrease) in trade and other payables	11 014 870	(11 515 475)
Cash used in operations	<u>27 827 135</u>	<u>(12 298 396)</u>

A full copy of HST's Audited Financial Report is available on request.

FUNDERS & FUNDING PARTNERS



Belgian Development Agency (BTC)



Centers for Disease Control and Prevention (CDC)



Continuing Education at University of Pretoria



Department for International Development (DFID)



Department of Health – Free State (FSDoH)



Department of Health – National (NDoH)



Department of Health – Western Cape (WCDoH)



Department of National Treasury South Africa



European Union (EU)



Futures Group



Juta & Co.



Millennium Challenge Account, Lesotho (MCA)



Provincial Government of the Western Cape (PGWC)



Soul City Institute



The Atlantic Philanthropies



THL, Finland



University Research Co., LLC (URC)



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