

# 3

## Planning Structure and Steps

### 3.1 Plan elements

The district health plan should be structured according to the following elements in the sequence shown.

1. Introductory sections (foreword, table of contents, acknowledgements, executive summary).
2. Overview of district health services (vision, mission, policies and broad strategic objectives, summary of annual report for previous year).
3. Service platform plan.
4. Expenditure projections.
5. Service delivery plan:
  - District management.
  - PHC services.
  - HIV/AIDS, STI and TB control.
  - Integrated nutrition programme.
  - District hospitals.
6. Service gaps.
7. Operational planning

The contents of each of the above elements are described in the following sections.

When preparing the planning document, it is important to note that sub-district health plans are consolidated into one district health plan. Similarly, district health plans are consolidated into one plan for the district health services section of a provincial health plan.

The tables shown here use the figures for the year covered by the annual report, the current year, and the three years in the planning period. The dates shown in the examples of tables are based on a planning period covering the three years of 2003/04, 2004/05 and 2005/06, with comparative actual figures for 2001/02 and estimates for 2002/03. In some of expenditure tables, historical data has been added for an additional year (2000/01) to match with PSP requirements. All tables should be accompanied by narrative explanations. A checklist of tables is provided in Annex B.

A list of relevant definitions and norms can be found in Part F of these guidelines.

## 3.2 Introductory sections

The district health plan document should have some introductory sections, as follows:

- Foreword with statement of commitment by relevant manager.
- Table of contents.
- List of definitions.
- List of acronyms.
- Acknowledgements – recognising the contribution of persons who have helped to provide, obtain and analyse information and who have assisted with producing the plan.
- Executive summary describing the main elements of the plan.
- Introduction - information on the process followed to develop the plan and the sources of data and time periods used.

## 3.3 Overview of district health services

### 3.3.1 Mission, vision, values and policies<sup>2</sup>

This section should start with a brief statement of the health district's mission, vision and values. These should correspond with the provincial statement, since the province, health districts and municipalities should all be involved in developing them. (*See the PSP Format for further information.*)

Next should be a statement of general provincial policies linked to the five-year provincial strategic objectives, such as:

- Provincial decentralisation strategy for district health system development;
- Provincial legislation to enable the implementation of the district health system;
- Development of district based planning, functional integration and mechanisms for community participation;
- Service level agreements with municipalities and non-governmental organisations; and
- Implementation of national health programmes and provision of the comprehensive PHC package.

### 3.3.2 Summary of annual report

Provide a brief summary of the main findings of the annual report for the previous year, focusing on the following:

- Situation analysis.
- Demographic, geographic and socio-economic situation and major changes.
- Health-related activities of other sectors.
- Key health problems and causes, with a table of key health status indicators.
- Health services and expenditure, including equity, effectiveness and efficiency indicators, and information on cross-boundary patient flows.
- Key challenges.

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<sup>2</sup> It is important to use planning terms correctly and consistently to avoid confusion. A list is provided in Part F: Definitions and Norms

### 3.4 Service platform plan

The service platform is the infrastructure of facilities, transport and equipment that are used to provide services, together with the necessary staff and supplies. It covers all provincial facilities, including central, provincial, regional and district hospitals, as well as contracted and subsidised facilities. The service platform plan is mainly a capital investment plan, but must include matching plans for staff and supplies and for asset maintenance. This plan is the main tool for ensuring equity and efficiency in the allocation of services and resources, and it is crucial that health district managers and municipal representatives participate in all stages of its development.

The provincial DOH must prepare a strategic position statement (SPS) every 10 years and update it periodically during that period. The SPS should provide an analysis of the current service platform and scenarios of what the platform should be in ten years time. The different scenarios will be based on national norms and likely funding taking into account the need for equity and cost-effectiveness.

When one of the scenarios has been accepted, a 10-year service platform plan must be developed. (*See Part D: Planning Tools.*) This will describe the annual changes that will be made to get to the 10-year platform, and will be matched with the funding projections for the 10 years. Thus, it will state annual changes to numbers of hospital beds (of different levels and types), CHCs and clinics in each health district and health sub-district. This aspect of the plan must match with the capital funding projections.

The 10-year plan should also include annual target allocations for personnel, drugs, transport and other resources based on the distribution of facilities. These should be drawn up using norms, for example, the number of nurses per clinic, and will be based on utilisation levels as well as catchment populations. The costs of these resources must match the recurrent funding projections.

Even if the 10-year service platform plan is not precise in terms of what facilities and resources should be developed, especially given uncertainties in future funding, the plan should give a general direction to the changes planned for the three-years. This is important in order to avoid developing new facilities or shifting or hiring staff in ways that are not desirable in the long term.

The relevant three-year section of the 10-year provincial plan should be extracted for each district and turned into the three-year district service platform plan. This should drive the number and distribution of facilities, equipment, transport, personnel and other resources for the three years, and must be matched by the regular budget for each year. (The regular budget is that funded from the equitable share and excludes conditional grants). The 10-year plan and funding projections will need to be reviewed and updated every year to ensure that the three-year slice is up-to-date.

The figures for the three-year service platform plan should be extracted directly from the updated 10-year plan and shown in several tables. Explanations of key points must be provided in the accompanying narrative.

Population figures are a major determinant in the service platform plan and are also used in comparing expenditures and setting service delivery targets. It is, therefore, important to use one set of figures throughout. (See Table 1.) These figures must be obtained from the provincial planning committee to ensure that the same set of figures is used in each district plan. The population figures should be shown for each sub-district and for each year. The growth rate used to calculate the population should also be shown for each year. It is useful to show the population density in the same table as it may account for some variations in indicators across the sub-districts. Any changes in district and sub-district boundaries should be described in the narrative.

**Table 1. Population distribution and density projections (example)**

Sub-districts	Population growth rate	Sub-district A	Sub-district B	Sub-district C	District total
<b>Population</b>					
2000/01 Estimated					
2001/02 Estimated					
2002/03 Estimated					
2003/04 Projected					
2005/05 Projected					
2005/06 Projected					
<b>Number of square kilometres</b>					
<b>Population per square kilometre (2003/04)</b>					

Table 2 shows the planned numbers of PHC facilities and hospital beds by sub-district for each of the three years covered by the plan and the two preceding years. As stated above, these numbers should be the basis for the expenditure projections shown in Section 3.5.

The table is divided into blocks, one for each sub-district. The actual and estimated numbers of facilities and numbers per person should be shown in the first two columns. The planned numbers of facilities should be shown in the next three columns. The last column is used to show the numbers of facilities that should be in place according to the provincial norms. Thus, a comparison between the last column and the other columns will show where there are shortfalls or excesses. Any shortfalls should also be shown in a table on service platform gaps, such as Table 28.

The provincial norms used to determine the normative numbers in the last column should be explained in the text, as well as the normative cost per facility or bed. These figures should be derived from the 10-year plan. Based on those costs, the planned platform should match with the MTEF figures shown in the next section. Any differences between provincial and national norms should also be explained in the text.

The numbers of visiting points (scheduled stops made by a mobile clinics) are also shown in the table. It is difficult to decide how many visiting points are needed in a sub-district, which will depend on factors such as population distribution and density. The decision must be made by sub-district health managers based on local circumstances, including the demand from communities. The numbers of visiting points should be used as a basis for determining the number of mobile clinic and the numbers of staff to run them.

If there are any regional hospitals in the district which have level 1 beds, the number of beds should be shown separately in Table 2.

It is also useful to include a map showing roads, towns, schools, current and proposed health facilities and population density .

**Table 2. District service platform plan by sub-district (example)**

	Actual 2001/02	Estimated 2002/03	Planned 2003/04	Planned 2004/05	Planned 2005/06	Normative numbers
<b>Sub-District 1</b>						
<b>Numbers</b>						
Visiting points						
Clinics						
CHCs						
District hospital beds						
<b>Per person</b>						
Population per clinic						
Population per CHC						
District hospital beds per 1,000 people						
<b>Sub-District 2</b>						
<b>Numbers</b>						
Visiting points						
Clinics						
CHCs						
District hospital beds						
<b>Per person</b>						
Population per clinic						
Population per CHC						
District hospital beds per 1,000 people						
<b>Etc</b>						
<b>District Total</b>						
<b>Numbers</b>						
Visiting points						
Clinics						
CHCs						
District hospital beds						
<b>Per person</b>						
Population per clinic						
Population per CHC						
District hospital beds per 1,000 people						

*(Visiting points are the scheduled stops that a mobile clinic makes. Satellite clinics should also be included.)*

Table 3 shows the numbers of mobile clinics planned for the three years, together with the figures for the current and previous year. The table shows the projected numbers of visiting points and numbers of mobile clinics, and the target number of visiting points per vehicle used to estimate the need. This table can be used to develop a procurement plan, taking into account the current number of vehicles and the need for periodic replacement, and serves as a basis for recurrent expenditure projections shown in Table 19.

**Table 3. Mobile clinic plan by sub-district (example)**

Sub-District/ Location	Actual 2001/02		Estimated 2002/03		Planned 2003/04		Planned 2004/05		Planned 2005/06		Target Average VPs per MC
	VPs	MCs	VPs	MCs	VPs	MCs	VPs	MCs	VPs	MCs	
Sub-district A											
Sub-district B											
Etc											
Total											

*VP = Visiting Point, MC = Mobile Clinic*

Table 4 shows the projected numbers of support vehicles, such as those used for supervision and administration. If any vehicles are used mainly for patient transport, those numbers should be shown separately. The norm used to estimate the numbers of vehicles needed should be described in the text.

**Table 4. Support vehicles plan by sub-district (example)**

Sub-District/ Location	Actual 2001/02	Estimated 2002/03	Planned 2003/04	Planned 2004/05	Planned 2005/06
Sub-district A					
Sub-district B					
Etc					
Total					

Table 5 shows the current and projected numbers of personnel by category and estimated total expenditure on each category. The expenditure totals must be the same as those shown in Table 11. The projected numbers should be those required to fully operate the planned numbers of facilities and should come from the 10-year service platform plan. If they are not, the reasons should be explained in the text. It should be noted that the staffing levels should be based on utilisation levels as well as catchment population. (See Part D: *Planning tools*).

**Table 5. Planned numbers of personnel and expenditure (example)**

Categories	Numbers					Rands				
	Actual 2001/02	Estimated 2002/03	Planned 2003/04	Planned 2004/05	Planned 2005/06	Actual 2001/02	Estimated 2002/03	Planned 2003/04	Planned 2004/05	Planned 2005/06
Medical officers										
Medical specialists										
Dentists										
Dental specialists										
Professional nurses										
Staff nurses										
Nursing assistants										
Student nurses										
Pharmacists										
Allied health professionals and technical staff										
Managers, administrators and logistical support staff										
Total										

1. This table should be for combined provincial and local government health personnel.
2. Interns should be included under medical officers and pharmacists.
3. Allied health professionals and technical staff comprises 'health therapists' (eg. physiotherapists, speech therapists, occupational therapists, clinical psychologists, radiographers, environmental health officers) and specialised auxiliary service staff.
4. The average time worked by sessional staff should be converted into full time equivalents (FTEs) and included in the relevant section.

Table 6 describes what types of service changes are planned each year over the three-year period. The changes in facilities, transport and major equipment are shown in the first column. Changes in staff, supplies and other recurrent resources are shown in the second column. The fourth column is used to show the value of shifts in resources, and the fifth column is used to show the value of additional budgetary funding. Reductions in facilities or resources should also be shown in the table.

**Table 6. District service platform changes – District A (Rands) (example)**

Facilities	Resources	Source	Budget shifts	Budget additions
<b>Year 1</b>				
Build new CHC 20 beds and 3 new 5-day clinics. Add 2 more vehicles.	Construction and equipment	Capital budget		R 4,000,000
	2 extra vehicles	Capital budget		R 300,000
	20 more professional nurses	Shift 20 professional nurses from District B	R 2,000,000	
	Additional drugs etc	Shift drugs budget from District B	R 200,000	
Etc				
<b>Year 2</b>				
Etc				

## 3.5 Expenditure projections

### 3.5.1 Introduction

Expenditure projections represent the estimated funding required to supply the resources needed for implementing the plan. Once the plan and MTEF have been approved by the provincial DOH and Treasury, the first year's MTEF figure represents a budget commitment. The second and third year figures are projected figures.

Expenditure projections and trends are shown here for the overall district health services DHS.

The expenditure projections should be based on the planned service delivery platform. (*See Section 3.4.*) The figures are presented according to:

- Sub-programme;
- Economic classification;
- Transfers to municipalities and non-governmental organisations (NGOs); and
- Capital expenditure and maintenance.

The figures comprise funds from the regular budget as well as conditional grants. The HIV, STI and TB Programme and the Nutrition Programme conditional grants are shown

separately under the respective budget sub-programmes. Other conditional grants, such as for hospital rehabilitation, may be included under sub-programme totals together with regular budgetary funding.

The regular budget should reflect the equitable and efficient allocation of resources used to provide the basic service platform, as described in the previous section. Conditional grants provide additional resources to address exceptional problems, such as hospital rehabilitation and the HIV/AIDS epidemic.

Each expenditure table should be accompanied by a narrative section that explains significant changes in the figures shown.

### 3.5.2 Expenditure projections by sub-programme

Table 7 shows expenditure trends and projections for the overall DHS budget programme. It provides direct inputs into the equivalent table in the PSP Format. Any changes in the content of the budget programme and sub-programmes over the years shown should be explained.

The figures should include expenditure made from municipalities' own funds<sup>3</sup> and any capital spending made by the Department of Public Works (DPW). Any expenditure by DPW on repairs and maintenance should be included, but shown separately. Any other expenditure related to district health services that is not under the DHS budget programme should be described in the accompanying narrative. For example, conditional grants handled at the provincial level and capital expenditure included under another budget programme.

**Table 7. DHS – evolution of expenditure by budget sub-programme in current prices (R million) (example)**

Sub-programme	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	MTEF 2003/04 (budget)	MTEF 2004/05 (projection)	MTEF 2005/06 (projection)
District management						
Community Health Clinics						
Community Health Centres Community Based Services						
Other Community Services						
HIV/AIDS						
Nutrition						
District hospitals						
<b>Total DOH expenditure</b>						
Municipal own expenditure						
Department of Public Works						
<b>Total DHS</b>						

<sup>3</sup> Expenditure made by a municipality from its own funding, excluding expenditure funded from DOH subsidies.

Table 8 compares the total expenditure on district health services in constant prices<sup>4</sup>. It is used to indicate whether more or fewer resources are purchased over time. The figures are calculated by applying the consumer price index figures (which should be available from the provincial planning committee) to the previous and future years figures (from Table 7) to adjust them to current year prices. Capital expenditure should be excluded as it distorts trends in operating (recurrent) expenditures.

**Table 8. DHS – evolution of recurrent expenditure by budget sub-programme in constant 2002/03 prices (R million) (example)**

Expenditure	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	Average annual change(%)	2003/04 (budget)
District management					
Community Health Clinics					
Community Health Centres					
Community Based Services					
Other Community Services					
HIV/AIDS					
Nutrition					
District hospitals					
<b>Total DOH expenditure</b>					
Municipal own expenditure					
Department of Public Works					
<b>Total DHS</b>					
Inflation rate					

1. The total figures for the base year (2002/03 in the example) must be the same as those shown in Table 7.
2. Capital expenditure should be excluded from the figures.
3. To adjust the actual expenditure for 2001/02 to the constant 2002/03 price, multiply the figure for 2001/02 by  $(100 + \text{the inflation rate for 2001/02})$ . To adjust the actual expenditure for 2000/01 to the constant 2002/03 price, multiply the figure for 2000/01 by  $(100 + \text{the inflation rate for 2000/01})$  and the result by  $(100 + \text{the inflation rate for 2001/02})$ .
4. The Treasury formula for calculating the annual average change is  $((\text{outer year/base year})^{\text{number of years from base to outer}} - 1) / \text{number of years from base to outer}$ . In the above table the number of years from base to outer would be 2 (2001/02 to 2002/03).
5. If it is difficult to calculate the average annual change over the three years, the change from each year to the next can be shown.

<sup>4</sup> Constant price comparisons between one year and another are made by adjusting the expenditure of one of the years by the inflation experienced or projected over the period between the two years.

Table 9 is used to show the expenditure per person (capita), and shows if more or fewer resources can be purchased per person in the population. The figures for expenditure per uninsured person are not calculated at the district level as there are no official statistics on the numbers of uninsured persons below the provincial level. The figures are calculated by dividing the expenditure figures shown in Table 8 by the estimated population for each year shown in Table 1.

**Table 9. DHS – evolution of recurrent expenditure by budget sub-programme per person in constant 2002/03 prices (Rands) (example)**

Expenditure	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	Average annual change (%)	2003/04 (budget)
District management					
Community Health Clinics					
Community Health Centres					
Community-based Services					
Other Community Services					
HIV/AIDS					
Nutrition					
District hospitals					
<b>Total DOH expenditure</b>					
Municipal own expenditure					
Department of Public Works					
<b>Total DHS</b>					

1. The Treasury formula for calculating the annual average change is (outer year/base year) to power of (1/number of years from base to outer) 1. In the above table the number of years from base to outer would be 2 (2000/03).
2. If it is difficult to calculate the average annual change over the 3 years, the change from each year to the next can be shown.

Table 10 shows the allocation of expenditure by sub-district. This is important for showing how equitable the allocations to the sub-districts are. The totals should agree with those in Tables 7 and 9. Municipal own expenditure should be included, but capital expenditure should be excluded as it distorts the trends. The equity trends are best seen from the figures for expenditure per person.

**Table 10. DHS – evolution of recurrent expenditure by sub-district in total and per person (example)**

Sub-district	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	MTEF 2003/04 (budget)	MTEF 2004/05 (projection)	MTEF 2005/06 (projection)	% change 2002/03 to 2005/06
<b>Total expenditure (R million)</b>							
Sub-district A							
Sub-district B							
Etc							
<b>Total</b>							
<b>Expenditure per person (Rands)</b>							
Sub-district A							
Sub-district B							
Etc							
<b>Total per person</b>							

*(This table would only be completed at the district level.)*

### 3.5.3 Expenditure projections by economic classification

Table 11 shows expenditure by economic classification (standard items) for DOH expenditure. This shows changes over time in expenditure on key resources such as personnel and supplies. The totals must be the same as those for Total DOH Expenditure in Table 7.

A separate table should be prepared for municipal expenditures showing the breakdown by economic classification. This should preferably be done using the DOH classification so that a combined DOH and municipal table can then be prepared. The municipal expenditure figures should cover both the amounts funded from own-funding as well as those funded from DOH subsidies. To avoid double counting when combining the two sets of figures, the subsidies should be deducted from the DOH transfer payments totals. The figures used for subsidies must be the same as those shown in Table 12.

**Table 11. DHS – evolution of expenditure by economic classification  
(R million) (example)**

Resource type	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)
<b>Standard Item</b>						
<b>Current:</b>						
Personnel						
Transfer payments (current)						
Administrative expenditure						
Stores						
Professional and special services						
Other current expenditure						
<b>Total current expenditure</b>						
<b>Capital:</b>						
Transfer payments (capital)						
Equipment						
Land and Buildings						
Infrastructure						
Other capital expenditure						
<b>Total Capital Expenditure</b>						
<b>Total DHS programme expenditure</b>						

### 3.5.4 Transfers

Table 12 shows the amounts transferred to each municipality and NGO. The totals should agree with the Transfers figure in Table 11. The table should be accompanied by a narrative section explaining any significant changes in expenditure over the years. A short description of the purpose of the transfer to each NGO should also be provided in the text. The expenditure and description of purpose must reflect the aspects of the PHC services delivery plan described under Section 3.6.4.

**Table 12. Transfers to municipalities and non-government organisations (R '000)<sup>1</sup>(example)**

Municipalities	Purpose of transfer	Base year 2002/03 (estimate)	Year 1 2003/04 (budget)	Year 2 2004/05 (MTEF projection)	Year 3 2005/06 (MTEF projection)
Municipality 1					
Municipality 2					
Municipality 3					
Etc					
<b>Total municipalities</b>					
<b>NGOs</b>					
NGO 1					
NGO 2					
NGO 3					
Etc					
<b>Total NGOs</b>					

\* Any transfers not included in the GFS book should be specified as such.

### 3.5.5 Capital investment and maintenance

It is important to pay special attention to the planning of capital projects and rehabilitation and maintenance. A set of three tables is required to show expenditure trends and projections on buildings and equipment.

Table 13 shows expenditure on facility construction, upgrades and rehabilitation for district hospitals, health centres and clinics on a project by project basis. The figures shown here should be compatible with the service platform changes shown in Table 2. The linkages between capital and recurrent expenditure are synchronised through the service platform plan.

If this expenditure falls under more than one programme or sub-programme, a separate table should be included showing the total from each one for each of the years. Any expenditure by DPW should be included.

**Table 13. DHS - facility construction, upgrades and rehabilitation – district hospitals, health centres and clinics (R '000)\* (example)**

New construction	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)	Total project estimate
- Project 1 - Project 2 etc							----
<b>Total new construct.</b>							----
<b>Upgrading/rehab .</b>							
- Project 1 - Project 2 etc							----
<b>Total upgrading and rehabilitation</b>							----

*\*If not funded from the provincial budget, details should be presented in separate note. Conditional grant expenditure should be identified where possible.*

Table 14 shows expenditure on facility maintenance. This should be the total from the various sub-programmes. It may be useful to show the total from each sub-programme in the table.

**Table 14. DHS - facility maintenance (R '000) (example)**

<b>Maintenance</b>	<b>2000/01 (actual)</b>	<b>2001/02 (actual)</b>	<b>2002/03 (estimate)</b>	<b>2003/04 (budget)</b>	<b>2004/05 (MTEF projection)</b>	<b>2005/06 (MTEF projection)</b>
Community Health Centres						
Clinics						
Etc						
Total						
Total as % of district health expenditure/budget						

Table 15 shows expenditure on medical equipment and maintenance. This should be the total from the various sub-programmes. It may be useful to show the total from each sub-programme in the table.

**Table 15. DHS - medical equipment purchase and maintenance (R '000) (example)**

<b>Equipment purchase</b>	<b>2000/01 (actual)</b>	<b>2001/02 (actual)</b>	<b>2002/03 (estimate)</b>	<b>2003/04 (budget)</b>	<b>2004/05 (MTEF projection)</b>	<b>2005/06 (MTEF projection)</b>
Total purchase						
Total maintenance						
Maintenance as % of provincial health expenditure/budget						

*A similar table should be prepared for motor vehicles and for office equipment.*

## **3.6 Service delivery plan**

### **3.6.1 Structure and contents**

The service delivery plan contains the goals and objectives that relate to services and their expected health outcomes<sup>5</sup>. The targets set for the objectives must be feasible, based on the facilities and resources to be provided under the service platform plan shown in Section 3.4., and the expenditure projections shown in Section 3.5.

<sup>5</sup> A list of definitions of terms can be found in Part F: Definitions and Norms – under the hierarchy of planning.

The service delivery plan should be split according to the management areas that reflect the budget sub-programmes:

- **District management**
- **PHC services (see below)**
- **HIV/AIDS, STI and TB control**
- **Integrated Nutrition Programme**
- **District hospitals**

The funding for PHC services is covered under four budget sub-programmes: **Community Health Clinics, Community Health Centres, Community Based Services and Other Community Services**. The four sub-programmes should be covered by one plan since they are all complementary. Municipal expenditure is also taken into account.

The overall district health goals and objectives are shown under the District Management budget sub-programme since district managers are responsible for ensuring that they are achieved them. The other budget sub-programmes include objectives that contribute to the achievement of those overall objectives. Any special objectives for rural development nodes and urban renewal nodes should be shown separately in the plan.

The plan must show the objectives and activities with target indicators for the three planning years and compare them with the indicators for the current and preceding years. If estimates are not available for the current year, the targets from the operational plan for that year should be used, and noted in the text. The title of the manager responsible for the implementation of each section plan should be noted in the section.

The goals and objectives must take into account the findings and challenges identified in the annual report and summarised in Section 3.3 of this document. Those findings that are relevant to each section of the plan should be shown in the narrative introduction to it.

When drawing up the objectives it is important to look at the required set of performance indicators shown in *Part C: Preparing Annual Reports*. Objectives should be developed to address any indicators that need to be significantly improved, since managers' performance will be evaluated partly on the basis of these indicators.

An analysis of important constraints relating to the implementation of policies and objectives should be described in the narrative under each section of the plan. Particular constraints in rural development nodes and urban renewal nodes should be explained. The analysis should cover finance and financial management, human resources (people and skills), logistics (drug lab, equipment, condom procurement), clinical and other technical constraints.

### **3.6.2 Linking objectives and budgets**

The **service platform plan** describes the resources to be provided. For example, it may state that a particular community will have a clinic with two nurses and support staff, and an adequate budget for supplies and other needs. It will also state how the resources will be made available. Those resources should be funded through the regular budget.

The **service delivery plan** shows what activities will be carried out with those regular budget resources and what objectives will be achieved. For example, it might say that the clinic

will improve its TB cure rate, and that to do that one of the nurses will spend some time tracing TB defaulters. Where conditional grants will be used to supplement the regular budget to achieve certain health goals, they should be linked with specific service delivery objectives.

It should be noted that the same resources can sometimes be used to achieve more outputs or outcomes. (*See cost-effectiveness in Part D: Planning Tools.*) This should be examined within the context of a service delivery network<sup>6</sup>, which comprises PHC and hospital services and thus cuts across budget sub-programmes. For example, it may be more cost-effective for hospital doctors (and better for patients) to see some referral patients in the clinics rather than at the hospital.

If the provincial health targets cannot be achieved with the available service platform, the objectives should be reduced. For example, if the need is to immunise 80% of children and there are only enough resources to immunise 75%, only 7,500 children will be covered instead of 8,000. Determining exactly what levels of targets are achievable is difficult, but way of estimating generally is described in section 3.6.4.2.

A shortfall may relate partly to a deficit in the service platform and partly to what can be achieved with that platform over the three-year period. The plan should clearly show this shortfall, together with some estimate of the additional resources that would be required to bridge the gaps. (*See Table 28.*) This will provide a good basis for any negotiations over the funding allocation to the district and provides a tool for lobbying for additional funds from the provincial Treasury and provincial Parliament.

### **3.6.3 District management**

#### **3.6.3.1 Key district health goals**

The district management section should start with a list of the key health goals for the district as a whole. (*See Table 16.*) These should be determined in joint provincial, district and municipality workshops, which will ensure that they are properly aligned. They should take into account the provincial five-year priorities, the planned service platform, and the challenges described in the annual reports.

The key health goals should generally relate to highest-priority general health problems, such as high infant mortality, and specific health problems, such as immunisation or TB. The number of goals should be limited as many districts do not have sufficient resources to focus heavily on many priorities at once. The purpose of selecting a few high priority problems is to focus resources on resolving them. For example, if there are insufficient quantities of drugs for high priority services, and the drug budget is limited, ways could be sought to reduce the procurement of drugs for services that are not high priority. Information on methods for selecting priorities can be found in *Part D: Planning Tools*.

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<sup>6</sup> A service delivery network is a cluster of facilities that cover the health needs of a community or group of communities. For example, a district hospital and the health centres and clinics that refer patients to that hospital would be a network.

Only these key health goals need to be reported in the PSP, although provinces can include more if they wish. The goals must be the same across all the districts and sub-districts so that they can be consolidated at the provincial level. The targets will vary according to the circumstances in each district and sub-district, but in aggregate must equal the provincial target. The goals for HIV/AIDS, STI and TB, and for nutrition should be included here, and will be covered in more detail in the plans for those sub-programmes.

**Table 16. District management – examples of key health goals**

Focus Areas / Objectives/Activities	2001/02 (actual)	2002/03 (estimate)	2003/04 (target)	2004/05 (target)	2005/06 (target)
<b>Key Health Goals</b>					
<b>Impact:</b>					
Reduce maternal mortality rate to 200 per 100,000	300	320	260	130	200
Reduce infant mortality rate to 10 per 1,000	20	18	16	13	10
<b>Outcome:</b>					
1. Reduce HIV/AIDS infection rate from 21% to 15% (from 100,000 to 75,000 persons per year)	20%	21%	19%	17%	15%
2. Reduce the number of new TB cases from 200 to 150 per 100,000	200	200	180	165	150
3. Increase TB cure rate from 60% to 80% (600 to 560 persons)	60%	61%	67%	74%	80%
4. Reduce number of measles cases per 100,000 population	5	6	2	0	0
Etc					

*In the above table, 2003/04, 2004/05 and 2005/06 are the years being planned for and 2001/02 and 2002/03 are for comparison.*

The examples in the table have been split into impact goals and outcome goals. **Impact goals** are those which represent general health problems, such as infant mortality, and which are generally affected by non-health issues, such as water and sanitation, or poverty. **Outcome goals** relate to specific health problems, such as TB, and which are mainly affected by direct health interventions. (*See Part F: Definitions and Norms.*)

### 3.6.3.2 District management objectives

District management objectives should also be included in this part of the plan, but listed in a separate table using the same format shown in Table 16. These might include objectives such as DHS programme expenditure per person or the appointment of sub-district managers (which are key indicators for the PSP).

This section should also include a narrative description of planned interventions to improve the quality of care. Measures to improve quality in prioritised areas, such as rural development nodes and urban renewal nodes should be emphasised. In planning quality improvements, reference should be made to the *National Policy on Quality in Health Care* and to *Provincial Policy on Quality*. The measures should be described by level of care: community, PHC services, hospitals, and programme management.

The section should also include an organisational chart, a governance plan and any plans for public/private partnerships.

### 3.6.3.3 Resource plans

District managers are also responsible for the planning and management of the resources that are used in the district. Plans and budgets should be prepared for each major resource category, namely personnel, pharmaceutical and medical supplies, laboratory services, and transport<sup>7</sup>. These plans should be prepared at both district and sub-district levels, and also, if possible, for each cluster of PHC facilities<sup>8</sup> and each hospital. Each of these plans should account for the total amount under the respective line items, as shown in Table 11.

The plan covering the numbers of personnel and expenditure by category has been included under the service platform plan. (*Section 3.4., Table 5.*) However, it is important to also have a plan for the training of personnel. If training is not properly planned and managed, some personnel may remain untrained or too many personnel can be absent from a facility at one time. The co-ordination of training is especially difficult since funding for training may come from different sources.

The information in the plan should include the numbers of persons to be trained and the type of training for each year as well as the estimated expenditure for that training. (*See Table 17.*) A separate summary table of sources of funding used for the training should be included to ensure that all sources have been taken into account (format not shown). Further details, such as types of personnel to be trained, can also be provided in a separate table, using a format similar to the one shown in Table 31.

**Table 17. Staff training plan (example)**

Technical area	Number of personnel					Rands				
	2001/02 (actual)	2002/03 (estimate)	2003/04 (target)	2004/05 (target)	2005/06 (target)	2001/02 (actual)	2002/03 (estimate)	2003/04 (target)	2004/05 (target)	2005/06 (target)
HIV/AIDS										
TB										

*In the above table, 2003/04, 2004/05 and 2005/06 are the years being planned for and 2001/02 and 2002/03 are for comparison. Both provincial and local government personnel should be included.*

<sup>7</sup> See the Handbook for District Managers: Chapter 8 (Human Resources) Chapter 9 Transport, and Chapter 10 Drugs for more details. Further details on drugs planning and budgeting can be found in *Managing Drug Supply*, 1997, The Equity Project.

<sup>8</sup> Where a sub-district contains more than one municipality, the facilities could be clustered by municipality.

After personnel, stores often constitute the next highest expenditure category. The total expenditure on stores is shown in Table 11, but it is important to have a breakdown of that amount to see the projected expenditure on drugs etc. The breakdown should be shown in a separate table using the same format as Table 11.

A more in-depth planning of the procurement of drugs, vaccines and medical supplies is important to ensure that they are in accordance with the planned levels of services, both in terms of total expenditure but also in terms of the types of drugs and supplies required.

The best way to link the procurement plan with the health programme objectives is to estimate the numbers of defined daily doses required for each therapeutic group. (See Table 18.) This is based on the expected numbers of patients to be treated and the treatment regimens to be followed. Using the average cost of drugs, the projected expenditure can be shown for each therapeutic group. The district pharmacist should be able to assist with this calculation. If it is not possible to estimate the defined daily doses or the projected expenditure by therapeutic group, the projected expenditure by specific drug should be shown, either for the high priority drugs or for the drugs on which most money are spent.

**Table 18. Pharmaceuticals and Medical Supplies Plan and Budget (example)**

Therapeutic Group	# Daily Doses					Rands				
	2001/02 (actual)	2002/03 (estimate)	2003/04 (target)	2004/05 (target)	2005/06 (target)	2001/02 (actual)	2002/03 (estimate)	2003/04 (target)	2004/05 (target)	2005/06 (target)

*In the above table, 2003/04, 2004/05 and 2005/06 are the years being planned for and 2001/02 and 2002/03 are for comparison.*

If possible, the projected expenditure should also be shown for laboratory tests, either broken down by therapeutic group or for high-priority tests, or for the tests on which most funding is spent.

It is also important to plan for the operating costs of vehicles (the procurement should have been planned under Section 3.4.). A table should be included relating the operating costs to the planned numbers of vehicles. All operating costs should be included, such as fuel, oil, repairs and maintenance. (See Table 19.) This can be done using the estimated total number of vehicles in operation, the average numbers of kilometres per vehicle, and the average expected cost per kilometre. If the projected annual budgets are less than these totals, the shortfalls should be noted in the text along with a proposal for addressing the problem. If possible, mobile clinics, patient transport and administrative vehicles should be shown separately as the costs and implications of funding shortfall are both different.

Under this section it would also be useful to include a revenue generation plan and revenue forecasts for the period.

**Table 19. Transport operating costs (example)**

Sub-district/ Location	Number of vehicles					Operating costs (Rands)				
	2001/02 (actual)	2002/03 (estimate)	2003/04 (target)	2004/05 (target)	2005/06 (target)	2001/02 (actual)	2002/03 (estimate)	2003/04 (target)	2004/05 (target)	2005/06 (target)
Sub-district A										
Etc										
Total										
Average kms per vehicle						---	---	---	---	---
Average Rands per km						---	---	---	---	---

*In the above table, 2003/04, 2004/05 and 2005/06 are the years being planned for and 2001/02 and 2002/03 are for comparison.*

### 3.6.4 PHC services

#### 3.6.4.1 Objectives

The funding for PHC services is covered under four budget sub-programmes: **Community Health Clinics, Community Health Centres, Community Based Services and Other Community Services**. The four sub-programmes should be covered by one plan since they are all complementary. The expenditure for these sub-programmes is shown in Table 7, and these figures can be summarised in a separate table to get a clear view of the total expenditure. (See Table 20.) Transfers to municipalities and NGOs for PHC activities should also be included, and a row has been put in for this expenditure in case it is not already under one of the sub-programmes shown in the table. Municipal own expenditure is also shown in the table as it usually relates to PHC services. The total figures should be converted to expenditure in constant prices and in constant prices per person, on the same bases used in Tables 8 and 9.

**Table 20. PHC services – total expenditure by budget sub-programme (example)**

Sub-programme	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)
<b>Current Prices (R '000)</b>						
Community Health Clinics						
Community Health Centres						
Community Based Services						
Other Community Services						
Transfers						
<b>Total DOH expenditure</b>						
Municipal own expenditure						
<b>Total DHS</b>						
<b>Total DHS in constant 2002/03 prices (R '000)</b>						
<b>Total DHS in constant 2002/03 prices per person (Rands)</b>						

It may be useful to also provide a table with the projected expenditure by standard item for PHC services, using the format shown in Table 11.

The full range of PHC goals and objectives should be shown under the PHC services plan. (See Table 21.) The PHC goals and objectives will contribute heavily to most, if not all, of the key health goals for the district health service programme as a whole, as shown in Table 16. The PHC plan will also include other PHC objectives that are not in the list of key health goals and objectives.

Services provided by municipalities and NGOs must be included in the plan, and each municipality and NGO and its role should be clearly identified. This information must be consistent with what has been shown under Transfers. (See Section 3.5.4.) All these services must be covered under service level agreements.

This plan serves as a combined plan for the PHC facilities and also for the health programmes. Although some health programme activities may be included under other sub-programme plans (e.g, district hospitals), most of them fall under the PHC programme.

Thus, while the plan covers the activities of the PHC facilities, **the goals and objectives should be grouped according to health programme**. The accompanying narrative should also be divided according to health programme and should include confirmation that the goals and objectives are feasible with the overall sub-programme budget projections. These goals and objectives will mostly be represented by **outcome indicators**. Output indicators should also be shown (numbers of services to be provided) as this will help managers to link outcomes with planned expenditure. (See Section 3.6.4.2)

Since the plan covers both PHC facilities and health programmes, **the goals, objectives, activities and targets must be agreed upon between the service managers and health programme managers**. This should be easier where one district or sub-district manager is in charge of both PHC services and health programmes.

The goals for HIV/AIDS, STI and TB control and for Nutrition should be included in the plan to ensure that these are taken into account when looking at the resource requirements. The objectives and targets can be shown under the separate HIV/AIDS, STI and TB and Nutrition sub-programme plans.

The plan should also include any objectives that relate to improving services as a whole, such as quality of care improvements, transport use, or expenditure control. These would relate mostly to the input, process, quality and efficiency indicators shown in the PHC services section of *Part C: Preparing Annual Reports*.

As stated earlier, it is crucial that the **objectives and activities be linked with the resource plans** shown under the section 3.6.3.3, since the service managers rely on those resources to meet their objectives. For example, if every health objective has activities for training clinic nurses, it may be impossible to do all that training without disrupting services. The institution managers must set a limit on the amount of training and must ensure that it is focused on priority services, which may mean

reducing or postponing training for other services. The combined training activities must then be reflected in the training plan. (See Table 17.)

**Table 21. PHC service goals and objectives (example)**

Focus Areas / Objectives/Activities	2001/02 (actual)	2002/03 (estimate)	2003/04 (target)	2004/05 (target)	2005/06 (target)
<b>Health Programmes</b>					
<b>Maternal, Child and Womens' Health</b>					
Reduce teenage pregnancies by 20% from 10% to 8% of under 18 year old girls					
Improve early detection of cervical cancer by increasing the number of Pap-smears					
Etc					
<b>Mental health</b>					
Etc					

*In the above table, 2003/04, 2004/05 and 2005/06 are the years being planned for and 2001/02 and 2002/03 are for comparison.*

### 3.6.4.2 Service outputs

When health service delivery is integrated, specific health programme goals and objectives cannot be easily related to the projected expenditure. For example, while increasing the immunisation rate will involve additional staff time on immunisations, it cannot easily be related directly to staffing levels, as the staff are used to provide an integrated set of services, of which immunisation is only one.

The link between health programme objectives and expenditure is best explored by relating the outcome targets to outputs, which can be related to staffing, and staffing related to expenditure. To do this, it is necessary to provide a break down of PHC outputs in the form of health services by type of service. (See Table 22.) These data should be available from the district health information system. It should be possible to relate the health outcome targets to these output figures. For example, increasing immunisation coverage will require an increase in the number of child visits to the clinics.

To make this easier, **expected numbers of outputs** (service provided) **should be shown for each health programme** in the plan format shown in Table 21. These numbers should then be put into Table 22 for each year. The total numbers of services can be calculated and converted to a total headcount by using the average numbers of services per visit. If a norm has not been developed for this average, the actual ratio for the current year can be estimated and used in the future years.

If the total headcount is less than the headcount used in the service platform plan, there should be sufficient resources to meet the health objectives. If the total headcount is more than the headcount used in the service platform calculation, there may be insufficient resources to meet the health objectives, and some of them may have to have their targets reduced.

All services, including community visits, must be included. Inpatient and maternity services at CHC should also be included and factored into the workload and staffing requirements. The number of inpatient days can be converted to ambulatory service equivalent using a ratio, such as 1:3. Services provided by municipalities should be included, but service provided through NGOs should only be included if they have an impact on DOH resources, such as staffing.

To link the objectives and activities at the district level with those at the sub-district level, it may be useful to prepare tables showing the breakdown of objectives and activities by sub-district. The format would be the same as the sample table shown here, but the columns would be used to show the figures for each sub-district, instead of the targets for each year<sup>9</sup>. The targets for the first year of the plan should be used.

**Table 22. Numbers and mix of PHC services provided by CHCs, clinics and mobiles (example)**

	2001/02 Actual	2002/03 Estimate	2003/04 Target	2004/05 Target	2005/06 Target
<b>Facility-based ambulatory services</b>					
Maternal and reproductive health	150,000				
Child health	160,000				
EPI	50,000				
Nutrition	10,000				
HIV/AIDS	30,000				
STIs	30,000				
TB	10,000				
Chronic diseases	150,000				
Malaria and cholera	10,000				
Mental health	20,000				
Rehabilitation and disability	10,000				
Trauma, rape, abuse, assaults	5,000				
Oral health	5,000				
Minor ailments	360,000				
<b>Total ambulatory services</b>	<b>1,000,000</b>				
Head count	830,333				
Average number of services per visit	1.2				
Inpatient days (including maternity)	1,000				
<b>Ambulatory service equivalents</b>	<b>3,000</b>				
<b>Community-based services</b>					
Nutrition	5,000				
HIV/AIDS	10,000				
TB	5,000				
<b>Total community-based services</b>	<b>20,000</b>				
<b>Total services</b>	<b>1,023,000</b>				
Average services per day	4,092				
Number of professional nurses	100				
Average daily workload per professional nurse	41				

Assume average days open = 52 x 5 less 10 days public holiday = 250

The workload figure may differ somewhat from that shown in the DHIS due to different calculation methods.

In the above table, 2003/04, 2004/05 and 2005/06 are the years being planned for and 2001/02 and 2002/03 are for comparison.

<sup>9</sup> Note that when producing an average of sub-district figures when they are also averages. The nominator and denominator must be recalculated and a new average calculated. It is not correct to take an average of the averages.

If it is not possible to reconcile objectives with budgets directly using the proposed method, then it is important to explain in the narrative how the objectives would be achieved with the given funding

### **3.6.5 HIV/AIDS, STI and TB control**

A separate plan for HIV/AIDS, STI and TB control must be included here. This plan should cover all the activities of the control programme in the district or sub-district, not just those covered by the dedicated funding shown under the sub-programme budget. The projected expenditure for the sub-programme is shown in Tables 7, 8 and 9.

A summary of the findings of the situation analysis should be included here. Specific issues to be covered include:

- Home-based care;
- Step down care;
- Voluntary Counselling and Testing (VCT) services;
- Prevention of mother-to-child transmission (PMCT) services;
- Condom distribution;
- Diagnostic, management and protocol development;
- Education and awareness campaigns;
- TB treatment services including application of revised DOTS strategy, DOTS coverage, and patient recording and reporting system;
- Availability of quality assured TB sputum microscopy and specimen-laboratory-results turn around time;
- Uninterrupted availability of anti-TB drugs;
- NGO involvement and service level agreements; and
- Staff training and supervision.

The standard strategic objectives table must be completed. (*See Table 23 for an example.*) A standard set of performance indicators must be reported on annually. (*See Part C: Preparing Annual Reports.*) It is important to review these indicators when determining the key objectives for the programme. Managers should always plan how they will achieve those targets for which performance is to be measured.

The objectives used by each district should have already been agreed for the province as a whole, since the same set of key objectives must be used for all districts so that they can be consolidated at the provincial level. The key objectives should have been included in the table of key objectives for the district and in the PHC plan. As explained earlier, the targets should be translated into outputs that can be included in Table 22.

**Table 23. Strategic objectives for the HIV/AIDS, STI and TB control programme –example**

	Focus Areas/ Objectives/Activities	2001/02 (actual)	2002/03 (estimate)	2003/04 (target)	2004/05 (target)	2005/06 (target)
	<b>PHC Services</b>					
<b>Goal 1</b>	<b>HIV/AIDS,STI &amp; TB</b>					
Obj1.1	Reduce HIV/AIDS infection rate from 21% to 15% (from 100,000 to 75,000 persons per year)	20%	21%	19%	17%	15%
Act A	Increase # of peer educator groups from 5 to 16	3	5	9	12	16
Act B	Increase avg # of condoms distributed from 20 to 100	10	20	40	70	100
Obj1.2	Increase care and support for HIV/AIDS & TB from 60% to 80% of those infected and affected	50%	60%	65%	72%	80%
Act A	Increase # of VCT projects from 7 to 24	5	7	12	18	24
Act B	Increase % of persons receiving HBC from 10% to 50%	2%	10%	20%	30%	50%
Obj1.3	Inc avail. of HIV/AIDS,STI and TB drugs from 75% to 95% in all PHC facilities	70%	75%	80%	85%	95%
Act A	A Etc					
Obj 2	Reduce the number of new TB cases from 200 to 150 per 100,000	200	200	180	165	150
	Etc					

*Obj = Objective, Act = Activity. In the above table, 2003/04, 2004/05 and 2005/06 are the years being planned for and 2001/02 and 2002/03 are for comparison.*

### 3.6.6 Nutrition programme

A separate plan for the nutrition programme must be included here. This plan should cover all the activities of the programme in the district or sub-district, not just those covered by conditional grant funding shown under the sub-programme budget. The projected expenditure for the sub-programme is shown in Tables 7, 8 and 9.

A summary of the findings of the situation analysis should be included here. Specific issues to be covered should include:

- Disease-specific nutrition support;
- Treatment and counselling for prevention and rehabilitation of nutrition related conditions;
- Growth monitoring and promotion;
- Nutrition promotion, education and advocacy;
- Micronutrient malnutrition control through direct supplementation for vulnerable groups, dietary diversification and fortification of commonly consumed foods;
- Food service management for provision of balanced nutrition to groups in the community and in public institutions;
- Promotion, protection and support for breast feeding; and
- Contribution to household food security including school feeding and community poverty relief projects.

The standard strategic objectives table must be completed. (See example in Table 24.) The PSP has a standard set of performance indicators and targets that are shown in *Part C: Preparing Annual Reports*. These are to be reported annually, and it is important to review these indicators when determining the key objectives for the programme. Managers should always plan how they will achieve those targets for which performance is to be measured.

**Table 24. Strategic objectives for the Integrated Nutrition Programme - example**

Objective	2001/02 (actual)	2002/03 (estimate)	2003/04 (target)	2004/05 (target)	2005/06 (target)
Reduce % of underweight children under five years from x to y					
Reduce % of vitamin A deficient children under five years from x to y					
Reduce % of iron deficient children under five years from x to y					

*In the above table, 2003/04, 2004/05 and 2005/06 are the years being planned for and 2001/02 and 2002/03 are for comparison.*

The objectives used by each district must have already been agreed upon for the province as a whole, since the same set of key objectives must be used for all districts so that they can be consolidated at the provincial level. The key objectives should have been included in the table of key objectives for the district and in the PHC plan. As pointed earlier, some targets may need to be translated into outputs that can be included in Table 22.

### 3.6.7 District hospitals

A separate plan for district hospitals must be included here. The projected expenditure for the sub-programme is shown in Tables 7, 8 and 9. It may be useful to provide a table with the projected expenditure by standard item, using the format shown in Table 11.

A summary of the findings of the situation analysis should be included here and should cover specific issues such as:

- Rehabilitation, rationalisation and development of the hospital facility network in relation to the data presented in the situation analysis, the provincial strategic position statement and the hospital revitalisation strategy;
- Planning and implementation of organisational development;
- Delegations of financial, procurement and personnel functions: the provincial framework, capacity development and monitoring systems;
- Quality improvement measures including actions plans, client satisfaction surveys, monitoring systems and adverse reporting systems;
- Increased efficiency (e.g. higher bed occupancy, reduced lengths of stay);
- Implementation of standardised services packages, including gap identification and reduction and reconfiguration of tertiary services;

- Governance including appointment of Chief Executive Officers (CEOs) or equivalent institutional managers, appointment of CFOs or equivalent financial officers, performance agreements, and introduction and roles of hospital boards;
- Management system development including cost centre accounting and information systems; and
- Uses of conditional grants.

Hospital goals and objectives should be shown in two tables. The first is a table summarising the key goals, which is used to compile the provincial strategic plan. The second is a complete list of all the goals and objectives, which is used by the district and hospital.

Table 25 is used to show the summary of key goals. These should be determined in joint provincial, district and municipal workshops, which will ensure that they are properly aligned. The same set of key objectives must be used for all districts so that they can be consolidated at the provincial level. The key goals should reflect service delivery needs where possible, such as expanding or improving hospital services, rather than management needs, such as appointing CEOs or improving efficiency.

Goals and objectives should be determined taking into account the provincial five-year priorities, the planned service platform, and the challenges shown in the annual report. The list should be limited to a few key issues. *Part C: Preparing Annual Reports* has a required set of performance indicators to be reported annually, which are largely drawn from the PSP. It is advisable to consider developing objectives relating to some of these indicators, since managers' performance will take these indicators into account. Each hospital should have its own three-year plan, the highlights of which should also be included in the district health plans.

The table will be used for the cluster of district hospitals in the district and the objectives and targets will be for the whole cluster. It may also be useful to prepare a table showing the contribution of each hospital to the consolidated targets using the same format as Table 25, but with a column for each hospital instead of for each year. The figures for the first year of the plan can be used.

**Table 25. District hospitals – key goals (example)**

Objective	Indicator <sup>1</sup>	2001/02 (actual)	2002/03 (estimate)	2003/04 (target)	2004/05 (target)	2005/06 (target)
Increase the number of usable beds from x to y (excluding step down beds)						
Increase the number of step-down beds from x to y						
Increase the average length of stay from x to y						
Increase bed utilisation rate from x to y						
Increase the number of nurses from x to y						
Decrease case fatality rate for surgery separations from x to y						

*In the above table, 2003/04, 2004/05 and 2005/06 are the years being planned for and 2001/02 and 2002/03 are for comparison.*

Table 26 is used to show the complete range of hospital goals, objectives and activities. This plan does not have to be submitted to Treasury, since the key health goals will be provided as in the previous section. All the health programme goals will be shown here, including the key goals listed in Table 25. The objectives and activities needed to achieve each goal must be listed under the goal.

**Table 26. District hospitals – detailed goals, objectives and activities (example)**

Focus Areas / Objectives/Activities	2001/02 (actual)	2002/03 (estimate)	2003/04 (target)	2004/05 (target)	2005/06 (target)
<b>District Hospital Services</b>					
Reduce average length of stay from x to y					
Improve scheduling of theatre					
Etc					

*In the above table, 2003/04, 2004/05 and 2005/06 are the years being planned for and 2001/02 and 2002/03 are for comparison.*

It would also be useful to include a table showing some basic data for each district hospital. This should include the numbers of PHC and referral outpatient visits, separations and bed days.

**Table 27. Basic hospital data (example)**

Indicator	2001/02 (actual)	2002/03 (estimate)	2003/04 (target)	2004/05 (target)	2005/06 (target)
Population					
Beds					
Separations (deaths and discharges)					
Bed days					
PHC outpatient visits					
Referral outpatient visits					
Total outpatient visits					

### 3.7 Service Gaps

It is important not just to show what objectives and targets will be achieved with the available resources, but also to show **these service gaps and the estimated resources needed** to bridge them. These are the gaps between services required to meet the needs and the services that can be provided with the resources that are available<sup>10</sup>. It is important to describe the main service gaps to make it clear to both the DOH and provincial Parliament and Treasury why some needs and national targets cannot be met, as well as to show priorities for additional funding.

The gaps should be reflected in two tables.

<sup>10</sup> These are gaps at the district or sub-district level, and should not be confused with facility-level audits to determine, for example, what elements of the PHC package are being provided.

Table 28 shows the service platform gaps identified in Section 3.4. These are the gaps between the affordable service platform included in the plan, and the platform required according to norms. These gaps are best shown in terms of numbers of facilities and hospital beds, staffing and funding. The figures should be extracted from the updated 10-year service platform plan. A summary of the methodology and norms used to derive the needs should also be extracted from the 10-year service platform plan and described in the narrative. Any differences between national and provincial norms should be described in the text.

**Table 28. Service platform gaps (year 3) (example)**

	<b>Facilities</b>	<b>Staff</b>	<b>Funds</b>
<b>Needed</b>			
Clinics	200	1,000	100,000,000
CHCs	12	240	
Hospital beds	2,000	6,000	
<b>Affordable</b>			
Clinics	180	900	90,000,000
CHCs	10	200	
Hospital beds	1,900	5,600	
<b>Gap</b>			
Clinics	20	100	10,000,000

Table 29 shows the gaps between the targets for the key health goals shown in Table 16 and the provincial targets. Other goals and objectives where there are important gaps can also be listed, for example, relating to the key hospital goals. Some of the gaps listed will relate to the service platform gaps shown in Table 28, and, if so, this should be noted.

The first column in Table 29 should be used to show the district objective and target from the plan. The second column is used to show the provincial target. The third column shows the number of services needed to achieve the provincial target (for example if the number of children that need immunisation is 10,000, then the target of 80% would mean that 8,000 children would need to be immunised). The fourth column shows the number of services according to the plan, which in this example is 7,000. That number is less than the number of services needed because of a constraint. The fifth column shows the service delivery gap, which in the example is the number of services needed less the number of services planned. The additional resources required to immunise those children are listed in the last column, namely R5,000 worth of vaccines and supplies. In this case, it is assumed that the staff provided under the service platform plan are sufficient to provide the extra services.

**Table 29. Service delivery gaps for plan (year 3) (example)**

<b>Planned Objective</b>	<b>Provincial Target</b>	<b>Needed Services</b>	<b>Planned Services</b>	<b>Service Gap</b>	<b>Additional Funding Required</b>
<b>Health services</b>					
Increase in immunisation rate from 60% to 70%	Increase to 80%	8,000	7,000	1,000	R5,000 vaccines and supplies in the clinics
Etc.					

### **3.8 Operational planning**

An operational plan for the first year of the three-year plan must also be prepared. (*See Table 30 in Annex A.*) The objectives should be the same as in the first year of the three-year plan, but must provide greater detail in terms of activities, the time required and the months in which they are scheduled. More detailed operating plans for resources may also be necessary, for example, for training. (*See tables 31 and 32.*)

Likewise, the budget for the first year of an MTEF will be the operating budget for that year. If any adjustments are made before the beginning of the financial year, the plans will need to be adjusted accordingly.