

# 3

## Reporting Elements

### 3.1 Summary of elements

The body of the annual report should be preceded by an executive summary.

The main elements in the body of the report are as follows:

- **Background** – demographic, geographic, socio-economic data, and health activities of other sectors.
- **Health status** – epidemiology and key health problems.
- **Service platform** – numbers and distribution of facilities and personnel.
- **Expenditure** – by sub-programme and standard item.
- **Service delivery** – analysis by sub-programme.
- **Challenges** – as a basis for planning.
- **Short-term actions** – problems which will be addressed quickly.

This section of the guidelines describes how these elements can be developed and put into the annual report.

Reports should compare performance in three different ways:

- over time;
- among geographical areas and/or facilities; and
- against pre-determined targets.

The tables and graphs shown here use the figures for the year covered by the annual report, and in some cases with data for the two previous years for comparisons over time. The dates shown in the example of tables and graphs are based on an annual report for 2001/02. All tables and graphs 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. Additional information on collecting and describing background and health status information can be found in *How to Conduct a Rapid Situation Analysis: A Guide for Health Districts in South Africa* (Initiative for Sub-District Support, 1998). An additional important source of definitions and the use of graphs can be found in *Using Information for Action* (The EQUITY Project, 2002).

## 3.2 Background

The background section of an annual report should explain the key factors that influence health status and should give an understanding of the broader environment in which the health services operate. The information should include current or most-recent status, trends, and, where possible, anticipated changes over the next three years.

The following areas should be covered:

### Geography

Include a map showing the sub-districts, municipalities, towns, roads, health facilities and major schools. If possible, the populations should be shown by means of numbers of population in major clusters or by means of dots. Any major problems with the roads should be described together with details of communities that lack access to health facilities. If possible, the map should be done on a computerised geographical information system (GIS), which will make it easier to incorporate additional data or changes in the future. The map can also be published separately as part of a public guide to services, together with a list of service locations and standard services.

### Demography

Population figures are used in several indicators in the annual reports and it is 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 report. The figures should be from the District Health Information System (DHIS).

Use the total population figures including medical aid members, as there are no accurate data on medical aid membership at the district and sub-district level and some of those persons use some public sector services.

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. The population density should also be shown, as it may account for some variations in indicators across the sub-districts.

**Table 1. Population distribution and density for three years (example)**

	Population growth rate	Population			
		Sub-district A	Sub-district B	Sub-district C	District total
<b>Year</b>					
1999/00					
2000/01					
2001/02					
<b>Number of square kilometres</b>					
<b>Population per square kilometre (2001/02)</b>					

A breakdown of the population by sex and age should also be shown, preferably as a population pyramid. (See Figure 2.)

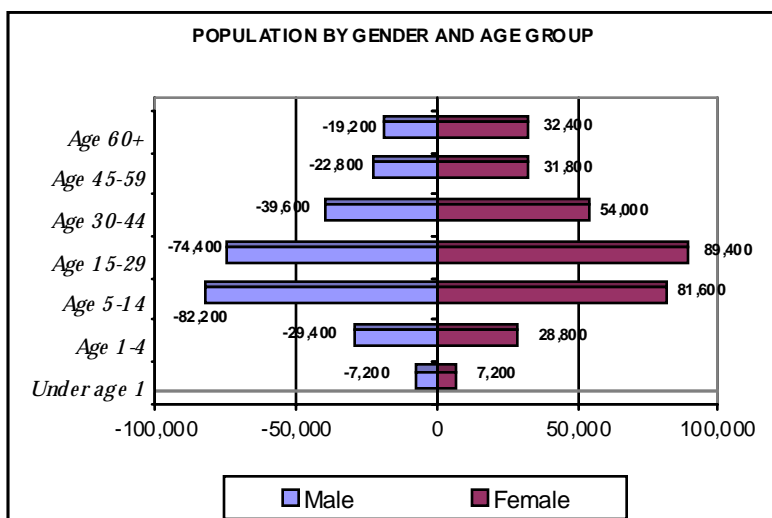


Figure 3. Population pyramid for 2001/02 (example)

### Socio-economic status

Describe the main economic activities, household incomes, rates of unemployment, and basic services (water, electricity, sewage and sanitation). As far as possible, show key data in tables. See Table 3. Identify any communities that are especially vulnerable.

Table 2. Socio-economic profile over three years (example)

	1999	2000	2001
% households with piped water inside			
% households with no toilet			
% households with electricity			
Per capita income			
Unemployment rate			
Etc			

At the district level, the same table should be prepared showing the figures for each sub-district for the year under review. They can also be put into a graph.

### Health-related activities in other sectors

Describe briefly the health-related activities in other sectors (e.g. education, water and sanitation, social services, agriculture). Information can be found from sources like the inter-sectoral committee, Environmental Health Officers and IDPs. This may be best shown in a table. (See Table 3.)

**Table 3. Health-related activities of other sectors for 2001/02 (example)**

Sector	Activity
Water and Forestry	Potable water projects in 7 communities
Education	Life skills – teaching of HIV/AIDS
Social welfare	Community-based care for HIV/AIDS
Etc	

## 3.3 Health status

### 3.3.1 Health status analysis

A description of the main health problems in the district is essential information for stakeholders and forms a vital basis for planning. Necessary information includes basic health indicators, incidence and/or prevalence rates, and main causes of death<sup>1</sup>. They can be shown in one table. (See Table 4.) The main source of data should be the DHIS. (See Part F: Definitions and Norms for information on how these indicators should be calculated.) Show the basis of calculation, the year, and the source for each indicator used. The main list of indicators should be determined by the province and should cover the key objectives used in the plan.

It is important to show the data for the most recent three years and use them to detect trends. The target from the previous year's plan should also be shown to measure performance. It is also important to compare the indicators across sub-districts to see where health problems are greater. This can be done in a separate table (not shown) and in graphs as shown below. The information should ideally be for financial years so that it has a relationship with expenditure data. If that is not possible, use the calendar years.

The health status section of the situation analysis is a key element in developing challenges and other starting points for the objectives. It is, therefore, important to analyse the underlying causes for main health problems identified and include the main ones in the table. In many cases, improving medical treatment will not prevent health problems from arising. For example, high maternal mortality may be a result of nutrition problems, and improving obstetric care will not solve the problem. (See Part E: Planning Tools).

The basic health indicators help to provide an overview of the district health situation. The report should include at least the following:

- Infant mortality rate
- Under-5 mortality rate
- Maternal mortality rate
- Low birth weight rate

<sup>1</sup> Additional information on collecting and describing the health status can be found in *How to Conduct a Rapid Situation Analysis: A Guide for Health Districts in South Africa* (Initiative for Sub-District Support, 1998).

Most of these indicators are impact indicators, which should result from improved health outcomes but which are also influenced by other factors, such as the availability of clean water.

The main causes of death should be shown by age group, as the number of deaths per 100,000. The data should be obtainable from hospital records and Home Affairs by cause, age, sex, and sub-district. Home Affairs may be the best sources as not all deaths appear in hospital records. If infant or under-5 mortality is high, the leading causes should also be shown for that age group.

The incidence and prevalence rates provide information on morbidity and also help to explain causes of mortality. The province should determine which set of indicators will be used, but as a minimum it should cover the key objectives used in the plan.

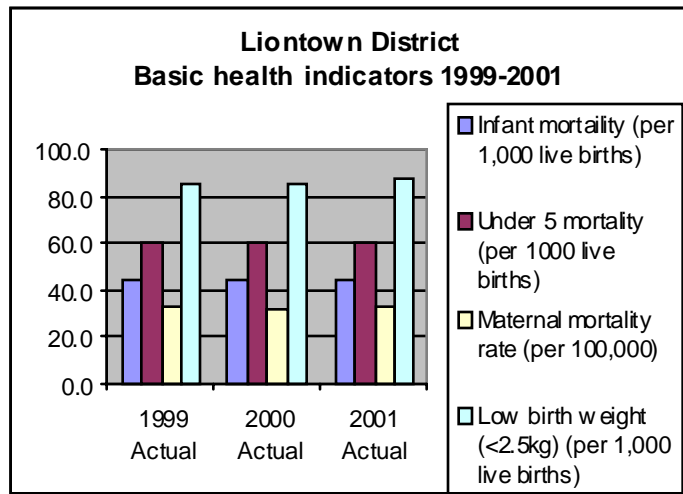
**Table 4. Health status targets and indicators reasons for shortfalls (example)**

	Target 2001/02	Actual 1999/00	Actual 2000/01	Actual 2001/02	Prime causes	Secondary causes
<b>Basic Health Indicators</b>						
Infant mortality rate						
Under 5 mortality rate						
Maternal mortality rate						
Low birth weight rate						
Etc						
<b>Main Causes of Death</b>						
AIDS						
TB						
Trauma						
Heart						
<b>Incidence and Prevalence</b>						
HIV prevalence						
Syphilis prevalence rate						
Reported cases of malaria						
Reported cases of viral hepatitis						
Hypertension prevalence						
Etc						

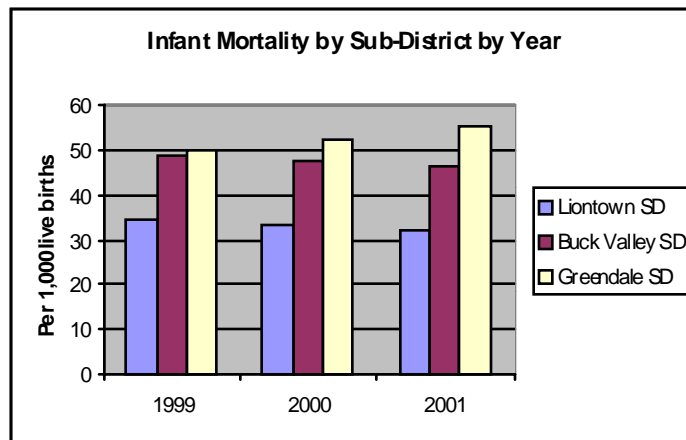
At the district level, the same table should be prepared showing the figures for each sub-district for the most recent year. They can also be put into a graph.

Health indicators can often be seen best in graphic form. The following three graphs show different ways in which the indicators can be shown, using the basic health indicators as examples. These same three formats can be used for other health indicators.

- **Figure 4** shows four indicators over three years for the district as a whole.
- **Figure 5** shows one indicator over three years for 3 sub-districts.
- **Figure 6** shows four indicators for one year for 3 sub-districts and the district average.



**Figure 4. Basic health indicators for 1999-2001 (example)**



**Figure 5. Infant mortality for 1999-2001 by sub-district (example)**

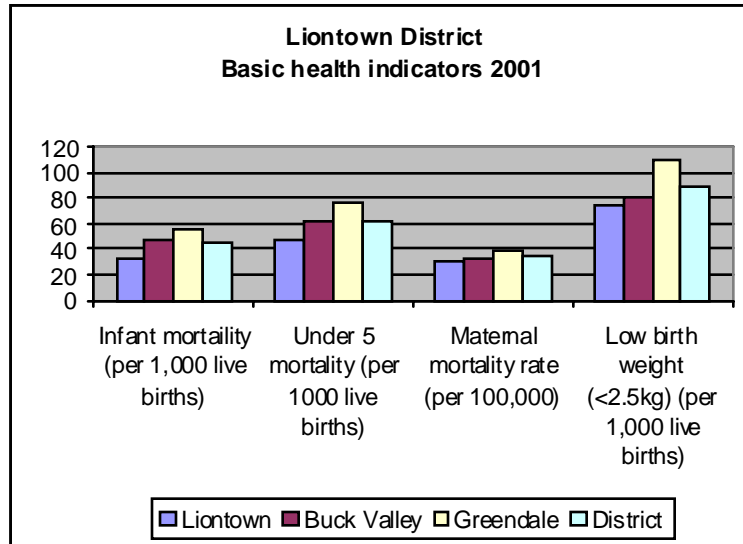


Figure 6. Basic health indicators for 2001 by sub-district (example)

### 3.3.2 Key challenges

The key challenges resulting from the background and health status analyses should be listed. These will be mainly drawn from the health status information shown in Table 4.

## 3.4 Service platform

### 3.4.1 What is the service platform?

The **service platform** is the infrastructure of facilities, transport and equipment used to provide services, together with the necessary staff and supplies.

The analysis of the service platform includes a review of the numbers and distribution of facilities and transport, and the state of infrastructure and physical condition of the facilities. It also includes a comparison of the required staffing with the approved and actual staffing levels.

Supplies and other resources are related to the service platform plan through the budgets. In other words, the budget allocations for the three years of the plan should cover the planned changes to the service platform plan. In the same way, the actual expenditures incurred for the year under review should match the service platform in place. The narrative accompanying the expenditure tables should explain the relationship to the service platform and to the changes made in the platform during the year.

The tables shown in the next sections should be compiled for each sub-district report to review facilities. They are then consolidated at the district-level.

### 3.4.2 Distribution of facilities and vehicles

An analysis of facilities and vehicles by sub-district is important to see if the distribution is equitable and if it meets targets.

Table 5 is used for an analysis of facilities. The actual figures should be shown for the three years and the targets for the most recent year. The provincial norms can also be shown, so that shortfalls can be easily seen. Where any regional hospitals in the district have district-level beds, these should be shown separately in the table and described in the narrative.

**Table 5. DHS facilities by sub-district (example)**

	Actual 1999/00	Actual 2000/01	Actual 2001/02	District Target 2001/02	Provincial Norm
<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					

1. Data on rural development nodes and urban renewal nodes should be identified specifically.
2. Populations should be those of resident people. Any major cross boundary flow of patients should be explained in the text.
3. The uninsured population need be used only for the province wide value.
4. Satellite clinics should be included with visiting points.
5. Both provincial and local government facilities should be included.
6. State-aided and contracted district hospitals should be included but shown separately.

Transport is a critical part of the service delivery and support structure and an analysis of the distribution and use of vehicles is important.

The following tables should be completed at district and sub-district levels. The district tables group the vehicles by sub-district. Sub-districts should group the vehicles according to location (e.g., hospital, CHC). A description of transport problems should be provided in the narrative, including the size of the fleet, and the age and condition of vehicles<sup>2</sup>. The running costs of vehicles are analysed in Section 3.6.2.3.

Table 6 shows the distribution and use of mobile clinics. The number of mobile clinics in each sub-district should be compared with the number of visiting points. The average number of kilometres per vehicle should also be calculated. An explanation of variations in the numbers of visiting points per vehicle should be provided.

A more detailed analysis of the equity and efficiency of the use of mobile clinics would be useful. This would include looking at the population distribution and density and access to services, referral patterns, and the location and utilisation of visiting points. The link with community visits, including tuberculosis and home-based care should be taken into account.

**Table 6. Mobile clinics in 2001/02 (example)**

Sub-District/ Location	Visiting points	Number of vehicles	Average visiting points per vehicle	Total annual kms	Average kms per vehicle
Sub-district A					
Sub-district B					
Etc					
Total					

Table 7 shows the number and use of support vehicles. The easiest way to measure the distribution of these vehicles is to compare them with the total population. The average number of kilometres per vehicle will give an idea of the relative use. If any vehicles are used mainly for patient transport, those numbers should be shown separately.

**Table 7. Support vehicles in 2001/02 (example)**

Sub-District/ Location	Number of vehicles	Population	Population per vehicle	Total kms	Average kms per vehicle
Sub-district A					
Sub-district B					
Etc					
Total					

<sup>2</sup> See *Transport Management for District Managers*, Chapter 9 in the Handbook for District Managers, DOH, July 1998 for further information.

### 3.4.3 Facility infrastructure

It is also important to understand the degree to which facilities have the basic infrastructure necessary for them to function properly. Table 8 is used for this.

**Table 8. Basic infrastructural services in district facility network by sub-district for 2001/02 (example)**

Health district <sup>1</sup>	Facility type	No.	No. (%) with electricity supply from grid	No. (%) with piped water supply	No. (%) with fixed line telephone
Sub-District A	Clinics <sup>2</sup>				
	CHCs				
	District hospitals				
Sub-District B	Clinics <sup>2</sup>				
	CHCs				
	District hospitals				
Etc					
District	Clinics <sup>2</sup>				
	CHCs				
	District hospitals				

1. Data on rural development nodes and urban renewal nodes should be identified specifically.
2. Both provincial and local government facilities should be included.

### 3.4.4 Physical condition of facilities

Table 9 shows the physical condition of the facilities using provincial audit gradings.

**Table 9. Physical condition of district facility network for 2001/02 (example)**

Sub-district	Facility type	No.	Average 1996 NHFA condition grading <sup>1</sup>	Any later provincial audit grading (with date)	Outline of major rehabilitation projects since last audit
Sub-district A	Visiting points <sup>2</sup>		---		
	Clinics <sup>3</sup>		---		
	CHCs				
	District hospital 1				
	District hospital 2				
Sub-district B	Visiting points <sup>2</sup>		---		
	Clinics <sup>3</sup>		---		
	CHCs				
	District hospital 1				
	District hospital 2				
Etc					
District Total	Visiting points <sup>2</sup>		---		
	Clinics <sup>3</sup>		---		
	CHCs				
	District hospitals				

1. A summary of the National Health Facilities Audit gradings is given in the PSP Format.
2. Satellite clinics should be included with visiting points.
3. Both provincial and local government clinics should be included.

### 3.4.5 Personnel

It is important to compare the numbers of personnel required to fully staff the existing facilities with the numbers planned, approved and actually employed. (See Table 10.) This will indicate if there are shortages and in which areas. The figures for “required numbers of personnel” should be extracted from the 10-year service platform plan. (See Part D: Planning Tools.) If those numbers are not feasible for the year under review, the planned numbers should also be shown.

**Table 10. Required, planned, approved and actual numbers of personnel for 2001/02 (example)**

Categories	Required numbers of personnel	Planned numbers of personnel	Approved number of posts	Actual number of personnel	Approved as % of required	Actual as % of required
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						
<b>Total</b>						

1. This table should be for combined provincial and local government health personnel.
2. Interns should be include under “medical officers” and “pharmacists.”
3. Allied health professionals and technical staff comprises 'health therapists' (e.g. 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 and included in the relevant section.

### 3.4.6 Performance against planned objectives

Performance against the service platform development plan for the year under review should also be measured. (See Table 11.) The actual and planned numbers of facilities and personnel are compared in Tables 5 and 10. The relationship with changes in expenditure during the year should be expanded in the narrative, if necessary.

The contents of the first five columns in the table should be exactly the same as they were in the plan for the year. (See Part B: Developing Plans.) The sixth column is used to report on achievements and problems.

**Table 11. Achievements against planned district service platform changes for 2001/02 (example)**

Facilities	Resources	Source	Budget shifts (Rands)	Budget additions (Rands)	Achievements
<b>Year 1</b>					
Build new CHC 20 beds and 3 new 5-day clinics. Add 2 more vehicles.	Construction and equipment	Capital budget		4,000,000	One new CHC was built and is fully functional. Only two clinics were built. The third was delayed due to legal issues. 18 nurses were transferred. Only one vehicle was bought due to lack of funding, The second will be bought next year. R500,000 of the drugs budget was shifted from District B.
	2 extra vehicles	Capital budget		300,000	
	20 more professional nurses	Shift 20 professional nurses from District B	2,000,000		
	Additional drugs etc	Shift drugs budget from District B	200,000		

### 3.4.7 Service platform challenges

The key challenges resulting from service platform analysis should be listed here. These should relate to shortages or mal-distribution of facilities or staff, or poor infrastructure or condition of facilities. The service gap tables shown in (Part B: Developing Plans) can be used to help present the information.

## 3.5 Health expenditures

### 3.5.1 Expenditure figures

Complete the following tables to give an overview of expenditure for the District Health Services (DHS) budget programme for the three years. These tables form a basis for the expenditure tables used in the district health plan and some of them are required for the PSP. Much of this information will have been provided to Treasury during the year in quarterly and monthly progress reports.

Note that the figures are totals for the district and come directly from the financial reports. In sub-district reports, the same tables would be shown with sub-district totals. As previously stated, each table should be accompanied by a narrative statement explaining any significant changes or other issues. The relationship of expenditures to the service platform and to the

changes made in the platform during the year (as described in the previous section) should also be explained.

Any changes in the accounting structure (budget programme, sub-programmes structure or economic classification) over the years shown can affect the comparisons and must be explained in the text.

### 3.5.2 Expenditure by sub-programme

An analysis of district level DHS expenditure by sub-programme over three years shows trends over time and shifts among sub-programmes. The expenditure is shown in three ways: in total current prices, in total constant prices, and in constant prices per person (per capita). These tables feed directly into the PSP. An additional two tables show DHS expenditure by sub-district.

Table 12 shows DHS expenditure by sub-programme in current prices for three years. Actual sub-programmes are shown as an example. The expenditure on each sub-programme should also be shown as a percentage of the total programme expenditure, which helps to indicate shifts among sub-programmes over time.

The expenditure figures should include municipal own expenditure and any spending made by the Department of Public Works (DPW). If DPW expenditure is both capital and recurrent (e.g., repairs), the figures should be shown separately. The table shown in the PSP format has been expanded so that municipal and DPW figures can be included but shown separately.

District managers are only accountable for expenditure under their control, and thus the performance elements of this report relate to the total DOH expenditure figures shown in Table 12. Any expenditure incurred in the district that appears under a different budget programme (including capital expenditure and conditional grants) should be reported in the accompanying narrative.

In the narrative analysis, it is important to reflect separately on expenditure funded from the regular budget and expenditure from conditional grants. The degree to which the budgeted amounts were under- or over-spent should also be stated, also differentiating between regular budgets and conditional grants.

**Table 12. DHS - expenditure trends by sub-programme current prices (R million) (example)**

Sub-programme	Actual 1999/00		Actual 2000/01		Actual 2001/02	
	R (mill)	%	R (mill)	%	R (mill)	%
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 expenditure</b>		100%		100%		100%

*The sub-programmes shown are illustrative.*

The figures from Table 12 are shown in constant prices in Table 13 (i.e., after adjusting for inflation). These figures indicate whether more or fewer resources have been purchased over time. Capital expenditure made by the DOH, Municipalities or DPW should be excluded from the constant price comparisons as the trends are operating (recurrent) expenditures are most important.

The figures are calculated by applying the consumer price inflation rates to adjust previous years to current year prices. These rates should be provided by the provincial planning committee, and should be based on figures provide by Statistics South Africa (STATS SA). The inflation rates should be shown at the bottom of the table.

**Table 13. DHS – current expenditure by sub-programme in constant 2001/02 prices (R million) (example)**

<b>Sub-programme</b>	<b>1999/00</b>	<b>2000/01</b>	<b>2001/02</b>
District management			
Community Health Clinics			
Community Health Centres			
Community Based Services			
Other Community Services			
HIV/AIDS			
Nutrition			
District hospitals			
<b>Total DOH recurrent expenditure</b>			
Municipal own expenditure			
Department of Public Works			
<b>Total DHS recurrent expenditure</b>			
<i>Inflation rate</i>			

1. Capital expenditure should be excluded.
2. To adjust the actual expenditure for 2000/01 to the constant 2001/02 price, multiply the figure for 2000/01 by  $(100 + \text{the inflation rate for 2000/01})$ . To adjust the actual expenditure for 1999/00 to the constant 2001/02 price, multiply the figure for 1999/00 by  $(100 + \text{the inflation rate for 1999/00})$  and the result by  $(100 + \text{the inflation rate for 2000/01})$ .

Table 14 is used to show the expenditure in constant prices on a per person (per capita) basis. This shows if more or fewer resources can be purchased per person in the population. Capital expenditure should be excluded. The population figures used in this and other tables must be those shown in Table 1 to ensure consistency. The figures for expenditure per uninsured person are not calculated at the district level as there are no reliable statistics on the numbers of uninsured persons below the provincial level. The figures are calculated by dividing the total constant expenditure figures in Table 13 by the estimated population for each year as per Table 1.

**Table 14. DHS – recurrent expenditure by sub-programme per person in constant 2001/02 prices (Rands) (example)**

<b>Sub-programme</b>	<b>1999/00</b>	<b>2000/01</b>	<b>2001/02</b>
District management			
Community Health Clinics			
Community Health Centres			
Community Based Services			
Other Community Services			
HIV/AIDS			
Nutrition			
District hospitals			
<b>Total DOH recurrent expenditure</b>			
Municipal own expenditure			
Department of Public Works			
<b>Total DHS recurrent expenditure</b>			

*Capital expenditure should be excluded.*

Table 15 shows expenditure by sub-district for the year. Capital expenditure should be excluded. This will give a clear indication of the equitable allocation of resources across the sub-districts for the year. Any significant changes in these allocations over the last three years should be noted in the accompanying text. The total DOH expenditure for the district must be the same as the total for 2001/02 in Table 12.

**Table 15. DHS – 2001/02 recurrent expenditure per person by sub-programme by sub-district (example)**

<b>Sub-programme</b>	<b>Sub-District A</b>	<b>Sub-District B</b>	<b>Sub-District C</b>	<b>Total</b>
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>				

It is also useful to analyse the trend in allocations across the sub-districts to see if and where greater equity is being achieved. Table 17 is used to show the total expenditure per district in current prices and in standard prices (following the method used in Table 14). Capital expenditure should be excluded. The expenditure in standard prices is then divided by the population to get the expenditure per person in standard prices.

**Table 16. District Health Expenditure - recurrent expenditure by sub-district in total and per person (example)**

<b>Sub-district</b>	<b>1999/00 (actual)</b>	<b>2000/01 (actual)</b>	<b>2001/02 (actual)</b>	<b>2001/02 (budgeted)</b>
<b>Total expenditure in current prices</b>				
Sub-district A				
Sub-district B				
Etc				
<b>Total</b>				
<b>Total expenditure in standard 2001/02 prices</b>				
Sub-district A				
Sub-district B				
Etc				
<b>Total</b>				
<b>Expenditure per person in standard 2001/02 prices</b>				
Sub-district A				
Sub-district B				
Etc				
<b>District average</b>				

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

### 3.5.3 Expenditure by economic classification

It is also important to show trends in expenditure according to economic classification. This indicates trends in expenditure on the types of resources purchased. The expenditure is shown under standard items.

Table 17 shows the expenditure trends over three years. This shows changes over time for expenditure on key resources such as personnel and supplies, which can help to identify key challenges. Explain in the narrative if the standard item structure has changed over the period shown. The expenditure on each standard item should also be shown as a percentage of the total programme expenditure, which will help to indicate shifts in the composition of resources over time. This table can also be done in constant prices so that trends in purchasing power can be seen for different resources (format not shown).

When analysing these figures it is important to note that transfer payments include personnel and other standard items, and professional and special services may also include payments to health professionals for services.

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 19.

**Table 17. Provincial DOH expenditure by standard item in current prices (R million) (example)**

Standard Item	1999/00		2000/01		2001/02	
	Rand	%	Rand	%	Rand	%
<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>		100%		100%		100%

*The standard items shown are illustrative.*

Table 18 shows the expenditure for the year under review broken down by sub-district. This shows differences in spending on resources such as personnel and supplies, which can help to identify challenges. The expenditure on each standard item should be shown as a percentage of total programme expenditure, which will help to indicate differences in the composition of resources. This table can also be done on a per person (per capita) basis (format not shown). A separate table should be prepared showing the breakdown, of municipal expenditure by standard item. A consolidated table can then be prepared.

**Table 18. Summary of provincial DOH expenditure by standard item by sub-district for 2001/02 (example)**

Standard Item	Sub-District A		Sub-District B		Sub-District C		Total	
	Rand	%	Rand	%	Rand	%	Rand	%
<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>		100%		100%		100%		100%

*The total must be the same as those shown under DOH Expenditure in Table 17.*

### 3.5.4 Transfers

Table 19 shows the amounts transferred to each municipality and non-governmental organisation (NGO). These should include transfers to state-aided and contracted district hospitals, if such transfers are included under the DHS budget programme. If these transfers are not under the DHS budget programme, they should be described in the narrative. The totals should agree with the figures for transfers in Table 17. The table should be accompanied by a narrative section explaining any significant changes in expenditure over the years. A short description of how the funds have been used by each NGO should also be provided in the text.

**Table 19. Transfers to municipalities and non-governmental organisations (R '000) (example)**

<b>Municipalities</b>	<b>Purpose of transfer</b>	<b>1999/00</b>	<b>2000/01</b>	<b>2001/02</b>
Municipality 1				
Municipality 2				
Municipality 3				
Etc				
<b>Total municipalities</b>				
<b>Non-government organisations</b>				
NGO 1				
NGO 2				
NGO 3				
Etc				
<b>Total NGOs</b>				

### 3.5.5 Capital investment and maintenance

It is also important to show expenditure on capital projects and rehabilitation and maintenance. Three tables are required. This information is used to prepare the provincial tables for the PSP.

Table 20 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 described in Section 3.4.

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 20. DHS - facility construction, upgrades and rehabilitation – district hospitals, health centres and clinics for three years (R '000) (example)\***

	1999/00 (actual)	2000/01 (actual)	2001/02 (actual)	2001/02 (budgeted)
<b>New construction</b>				
- Project 1 - Project 2 etc				
<b>Total new construction</b>				
<b>Upgrading/rehabilitation</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 22 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 21. DHS - facility maintenance for three years (R '000) (example)**

Maintenance	1999/00 (actual)	2000/01 (actual)	2001/02 (actual)	2001/02 (budgeted)
Total				
Total as % of district health expenditure/budget				

Table 22 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 22. DHS - medical equipment purchased and maintenance (R '000) (example)**

Equipment purchased	1999/00 (actual)	2000/01 (actual)	2001/02 (actual)	2001/02 (budgeted)
Total purchased				
Total maintenance				
Maintenance as % of provincial health expenditure/budget				

*Similar tables can be prepared for motor vehicles and for office equipment.*

### 3.5.6 Expenditure challenges

The key challenges resulting from the analysis of expenditure should be listed here.

## 3.6 Service delivery

### 3.6.1 Sub-programmes and data sources

District health services performance should be measured using a separate set of indicators for each budget sub-programme:

- **District management;**
- **Primary health care (see below);**
- **HIV/AIDS, STI and TB control;**
- **Nutrition;**
- **District hospitals;**

The funding for primary health care (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. Additional expenditure on PHC services is shown under Transfers.

The DHIS and financial management system are the main sources of data for this section. The population, service and expenditure data used in determining the indicators must be for the same year so that per capita allocations and unit costs can be accurately determined. If data are only available for calendar years, the year used should be the one in which the financial year started. Municipal financial years run from July through June and their figures may need to be adjusted for incorporation in the situation analysis. (*See the DHER Guidelines.*)

The information must be compatible with that provided to Treasury in the quarterly progress reports required by the Public Finance Management Act. These quarterly reports provide both financial and non-financial information in accordance with the objectives and indicators and are due shortly after the end of each quarter.

### 3.6.2 District management

#### 3.6.2.1 DHS programme as a whole

District managers are responsible for the planning and implementation of the overall DHS budget programme, which comprises all the sub-programmes. District managers are responsible for seeing that the performance indicators of all the sub-programmes are met, as shown in the following sections.

The key objectives for the district as a whole should have been shown in the plan for the year under review. (*See Part B: Developing Plans.*) Table 23 is used to show performance against those objectives. If possible, the same indicators should also be shown for the two previous years. The accompanying narrative should explain any major issues and should also comment on local government performance against relevant IDP health objectives.

**Table 23. District management – performance against key health goals for three years (example)**

Focus Areas / Objectives/Activities	1999/00 actual	2000/01 actual	2001/02 actual	2001/02 target
<b>Key Health Goals</b>				
<b>Impact</b>				
Reduce maternal mortality rate to 200 per 100,000				
Reduce infant mortality rate to 10 per 1,000				
<b>Outcome</b>				
1. Reduce HIV/AIDS infection rate from 21% to 15% (from 100,000 to 75,000 persons per year)				
2. Reduce the number of new TB cases from 200 to 150 per 100,000				
3. Increase TB cure rate from 60% to 80% (600 to 560 persons)				
4. Reduce number of measles cases per 100,000 population				
Etc				

*The examples in the table have been split into impact goals and outcome goals. When analysing performance it is important to remember that impact goals are also 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.*

### 3.6.2.2 District management sub-programme

In addition, a short set of performance indicators that relate specifically to district management should be completed. (See Table 24.<sup>3</sup>) These include the overall expenditures per person and two impact indicators, which relate to the DHS programme as a whole.

**Table 24. Performance indicators for district management for 3 years (example)**

Objective and Indicator	1999/00 actual	2000/01 actual	2001/02 actual	2001/02 target
<b>Input</b>				
Provincial DHS expenditure per person	R140	R145	R150	
Provincial and municipal DHS expenditure per person	R145	R150	R160	
<b>Process</b>				
% of health sub-districts with appointed managers	50%	50%	100%	100%
% of health sub-districts with formal district plans	0%	0%	100%	100%
% of health sub-districts with a formal quality improvement plan	0%	0%	100%	

*This set of indicators is from the National DOH and may change over time.*

<sup>3</sup> These have been extracted from the table of performance indicators for DHS in the PSP Format.

Performance should also be compared against the objectives shown in the District Management section of the operating plan for the year (which should have been based on the previous three-year plan). This should be done briefly in a table showing the key objectives and targets, the achieved results, and reasons for over or under performance. (See Annex A.) The accompanying narrative should explain any major issues.

### 3.6.2.3 Resource use

An important part of district management is to ensure **that sufficient resources are available and that they are used properly**. The use of key resources, including personnel, pharmaceutical and clinical supplies, laboratory tests and transport, should be reported on. The following tables should be completed at both district and sub-district levels.

Table 25 gives information on personnel. If possible, the table should also be completed separately for PHC services and for each hospital, as it will provide valuable information on the efficiency of those services. The actual numbers of personnel employed must agree with the numbers in Table 10.

**Table 25. Public health personnel in DHS for 2001/02 (example)<sup>1</sup>**

Categories	Actual numbers Employed	% of total number employed	Number per 1000 people <sup>2</sup>	Vacancy rate	Total expenditure <sup>6</sup>	% of total personnel budget	Average annual cost per staff member
Medical officers <sup>3</sup>							
Medical specialists							
Dentists							
Dental specialists							
Professional nurses							
Staff nurses							
Nursing assistants							
Student nurses							
Pharmacists <sup>3</sup>							
Allied health professionals and technical staff <sup>4</sup>							
Managers, administrators and logistical support staff			---				---
<b>Total</b>		100%				100%	---

1. This table should be for provincial health personnel. If data are available, another table for local government personnel should be added, as well as a third table showing public health personnel in total (provincial plus local government).
2. Populations should be those of resident people.
3. Interns should be included.
4. This group comprises health therapists (e.g. physiotherapists, speech therapists, occupational therapists, clinical psychologists, radiographers, environmental health officers) and specialised auxiliary service staff.
5. The average time worked by sessional staff should be converted into full time equivalents and included..
6. The total of this column must agree with the total personnel expenditure figure in Table 17.

The numbers of personnel and numbers per 1,000 population should also be broken down by sub-district, which will indicate any inequities in distribution. (See Table 26.)

**Table 26. Numbers of personnel by sub-district for 2001/02 (example)**

Categories	Sub-District A		Sub-District B		Sub-district C		Total	
	Number	Per 1000 people <sup>2</sup>	Number	Per 1000 people	Number	Per 1000 People	Number	Per 1000 people
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								
<b>Total</b>								

A report of personnel trained during the year should also be included. This should be based on the table included with the operational plan. (See Part B: Developing Plans.)

After personnel, drugs often constitutes the next highest expenditure category. It is important that the procurement of drugs is in accordance with the health priorities and utilisation of services. The tables for these resources should be completed at the sub-district and district levels, and if possible separately for PHC services and hospitals. The provincial and district pharmacist should be able to assist with these tables.

Table 27 shows the ten therapeutic groups on which most expenditure is made, with the highest first. Use the Anatomical Therapeutic Chemical (ATC) classification, which is used in the national Essential Drugs List (EDL).

**Table 27. ABC analysis by therapeutic group for 2001/02 (example)**

Therapeutic Group	Expenditure	% of Total Expenditure	Cumulative Expenditure %	Cumulative number of items %
Total expenditure on drugs				

Table 28 shows the ten individual drugs on which most expenditure is made, with the highest first. Typically, 80% of the expenditure goes on 20% of the items. Show if the drug is Vital, Essential or Non-Essential (VEN) in the appropriate column, based on prior classification. If this classification has not been made, leave the column blank.

**Table 28. ABC Analysis by drug for 2001/02 (example)**

Drug	Expenditure	% of Total Expenditure	Cumulative Expenditure %	Cumulative number of items %	VEN
Total expenditure on drugs					
Total number of items					

If possible, also show an ABC an analysis of the ten main types of expenditure on laboratory tests. It should be possible to obtain this information from the National Laboratories.

The efficient management of transport is important, given the vital role that it place in the DHS. Table 29 can be used to show condition and average cost of vehicles. The vehicles should be split into mobile clinics and others.

**Table 29. Transport costs in 2001/02 (example)**

Location	Number of vehicles	Avg number of vehicles working	Total Kms	Total Rands				Rands per Km			
				Fuel and Oil	Repairs and Maint	Other	Total Cost	Fuel and Oil	Repairs and Maint	Other	Total Cost
<b>Mobile clinics</b>											
Sub-district A											
Sub-district B											
Etc											
Total											
<b>Other vehicles</b>											
Sub-district A											
Sub-district B											
Etc											
Total											

### 3.6.3 PHC Services

#### 3.6.3.1 Situation analysis

Funding for PHC services is covered mainly 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 situation analysis and one performance review, since they are all complementary. The expenditure for these sub-programmes can be seen in Tables 12, 13 and 14. Transfers to municipalities and non-governmental organisations should also be taken into account as they also relate to PHC services and may be under another sub-programme, such as District Management.

Since the expenditure on PHC services is under different budgets it is useful to summarise it in a table. (See Table 30.) Capital expenditure should be excluded. Transfers to municipalities and NGOs for PHC activities should be included, and a row has been put in for this expenditure in case it is not already under one of the sub-programmes already shown in the table. Municipal own expenditure is also shown in the table as it usually relates to PHC services. Any DPW expenditure on repairs and maintenance for PHC facilities can also be included. The total figures should be converted to expenditure in constant prices and in constant prices per person, on the same bases used in Tables 13 and 14.

**Table 30. PHC services – total recurrent expenditure by budget sub-programme**

Sub-programme	1999/00 (actual)	2000/01 (actual)	2001/02 (actual)	2001/02 (budgeted)
<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 2001/02 prices (R '000)</b>				
<b>Total DHS in constant 2001/02 prices per person (Rands)</b>				

It may be useful to also compile a table with the projected expenditure by standard item, using the format shown in Table 17.

A specific situation analysis relating to PHC services should be provided. It should include reference to the health status described in Section 3.3., the service platform described in Section 3.4., and the expenditures described in Section 3.5.

It should also include a table showing the numbers and mix of PHC services provided. (See Table 31.) The actual figures for three years should be shown as well as the targets for the year under review, if any were set. Municipal services should be included. The numbers for this table must come from the DHIS, and it is not expected that any district should collect these figures separately. The data should also be shown according to the categories used in the DHIS. If any of the numbers are not in the DHIS, the row should be left blank, and the total headcount figure used to estimate the workload.

The headcount figures should be entered as well as the numbers of services. The total number of services is divided by the headcount to get the average number of services per visit. If this average is high or low, it indicates that the numbers of services or the headcount figure may be incorrect. The number of in-patient days should also be included,

and converted to ambulatory care services using a ratio, such as the ratio of 1:3 that is used at district hospitals. The number of community-based services provided by facility-based personnel should also be included. Services provided by NGOs should be shown separately, since they do not relate to DOH personnel. The total number of services for the year is converted to the average number of services per day using the average number of days that the facilities are open during the year. The average number of services per day is divided by the number of professional nurses to arrive at the average daily workload per nurse.

**Table 31. Numbers and mix of services provided by CHCs, clinics and mobiles for three years (example)**

	1999/00 Actual	2000/01 Actual	2001/02 Actual	2001/02 %	2001/02 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				
ST Is	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				
Total ambulatory services	<b>1,000,000</b>			100%	
Headcount	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.*

The same table should be completed to show the totals for the year under review for each sub-district, which will indicate variations in mix and performance across the sub-districts.

### 3.6.3.2 Performance indicators

A basic set of performance indicators is used to measure overall performance, and these indicators are required for the PSP. Other indicators can be included, but these should be agreed with the province and used by all districts and sub-districts, so that comparisons can be made. Some of these indicators may relate to objectives previously set for the year and some may also appear in the Health Status section of the report. In both cases, it is important that the figures are consistent.

At the district level, comparisons should be made over three years using the average figures for the district as a whole<sup>4</sup>. (See Table 32.) If targets have been set for any indicators, they should also be shown.

The accompanying narrative should analyse the performance of PHC services as a whole using the indicators in the table as well as other information. To facilitate this analysis, the key indicators in the table are grouped by type: **input, process, output, quality, efficiency and outcome**. In reviewing those indicators the following questions should be asked:

- Were enough **inputs** provided to **achieve** the **objectives** (e.g. nurses per population)?
- Were the **processes** in place to allow **objectives** to be achieved (e.g. community committees)?
- Were the **inputs** used **efficiently** (e.g. nurse workload)?
- Have those **inputs** and **processes** produced the expected **outputs** (e.g. visits per population)?
- Is the **quality** of care satisfactory (e.g. doctor attendance)?
- Have the **inputs, processes** and **quality** changes resulted in the **achievement** of the expected **outcomes** (e.g. tuberculosis cure rate)?

With all of the above questions one should also ask if the indicators have improved over the three years and if targets were reached.

Using a separate table, the same indicators should be compared across sub-districts (format not shown) to assess the equitable distribution of resources and to see which sub-districts are performing better. While some equity indicators, such as expenditure per person, should be compared in the PSP, differences can be mentioned in the narrative here. A brief statement of the key expenditure review findings for each sub-district should also be included in the narrative.

The outcome indicators shown in Table 32 relate to specific health programmes and cannot be related directly to the other types of indicators (e.g. expenditure and staffing inputs) which relate to the sub-programme as a whole. Expenditures (except for health programme conditional grants) are only coded according to facility and line item, not by health programme. Likewise, most staff work on many different health programmes, and their time cannot be routinely allocated to health programmes.

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<sup>4</sup> Note that the new district averages must be calculated by aggregating the district data, not by averaging the sub-district averages.

However, the link between outcomes, outputs and staffing can be explored to some degree. To do this, the health outcomes are compared with numbers of services shown in Table 31. If the operational plan has been completed using the proposed format, expected outputs will have been shown. For example, a change in the TB cure rate can be related to a change in the number of TB services provided.

**Table 32. Performance indicators for the PHC element of DHS for three years (example)**

Objective and Indicator	1999/00 actual	2000/01 actual	2001/02 actual	Target
<b>Input</b>				
Population served per fixed public PHC facility	13,423	12,512	12,307	10 000
Provincial PHC recurrent expenditure per person	R140	R145	R150	
Provincial and municipal PHC recurrent expenditure per person	R145	R150	R160	
Provincial and municipal PHC recurrent expenditure on personnel per person	R30	R34	R40	
Number of professional nurses per 1,000 population in fixed public PHC facilities	1.36	1.38	1.4	
% of fixed public PHC facilities offering the full package of PHC services <sup>4</sup>	75%	80%	90%	100%
<b>Process</b>				
% of public PHC facilities with functioning community participation structures	25%	25%	60%	100%
<b>Efficiency</b>				
% of patients referred to doctor (% of PHC headcount)	15%	13%	12%	
PHC nurse daily workload	40	35	30	
Provincial expenditure per visit at provincial PHC facilities	R70	R69	R65	
Provincial and municipal expenditure per visit at public PHC facilities	R72	R74	R70	
<b>Output</b>				
Number of visits (headcount) at public PHC facilities per person	2	2.1	2.3	3.5
% of children under one year fully immunised	60%	58%	70%	90%
<b>Quality</b>				
% of fixed public PHC facilities in facility audit condition 4 or 5	75%	75%	80%	
% of public PHC facilities visited at least once per month by a supervisor who produces a written report	25%	25%	75%	100%
% of public PHC facilities supported by a doctor at least once a week to 100%	25%	75%	100%	100%
% of public PHC facilities without vaccines at any time of year	60%	50%	40%	0%
<b>Outcome</b>				
Number of measles cases per 100,000 population	5	6	2	0
HIV/AIDS infection rate	20%	21%	19%	
Number of new TB cases per 100,000 population	200	200	180	
TB cure rate from 60% to 80%	60%	61%	67%	

1. Indicators relating to uninsured populations have been omitted as data are not available at the district level.
2. Hospital figures (eg expenditure, staff) must be excluded from the above.
3. The expenditure figures used in the table should exclude capital expenditure
4. A method for measuring the provision of the PHC package can be found in Part D, Planning Tools.
5. This set of indicators is from the National DOH and may change over time.

### 3.6.3.3 Key sub-district indicators

Each sub-district should use the same indicators to measure overall PHC performance over the three years. (*See Table 32.*) In this case, most of the indicators will be averages for all PHC facilities.

Each sub-district should also describe the key findings from a review of facility expenditures. These expenditure reviews should be conducted before the annual reports are developed using the DHER approach<sup>5</sup>. The key findings may be best shown by including the following tables or graphs directly from the expenditure review, with explanations in the accompanying narrative:

- Catchment population per facility, if possible (from DHER Table 3)
- Expenditure by service level (from DHER Table 7)
- Visits per capita across clinics and CHCs (from DHER Table 7)
- Expenditure per capita across facilities (from DHER Table 7)
- Major expenditure categories across facilities (from DHER Table 8)
- Expenditure per visit/bed day across facilities (from DHER Table 9)
- Stores and livestock expenditure per visit / bed day across facilities (from DHER Table 9)
- Percent of services provided DOH (from DHER Table 10)
- Percent of services funded by DOH (from DHER Table 10)
- Average revenue per visit or PDE across facilities (from DHER Table 11)
- Percent under/over spending of budget across facilities (from DHER Table 11)

At the sub-district level, the reports should include additional information, such as details of each clinic, CHC and hospital (name, address, phone, opening hours etc) for all government-funded providers.

### 3.6.3.4 Performance against planned objectives

**Performance** should also be compared against the key objectives shown in the PHC services section of the operating plan for the year (which should have been based on the previous three-year plan). This should be done briefly in a table showing the key objectives and targets, the achieved results, and reasons for over or under performance. (*See Annex A.*) The accompanying narrative should explain any major issues and should also comment on local government performance against relevant IDP health objectives.

This narrative should be divided into sections, including one for each health programme, excluding the HIV/AIDS, STI and TB control programme and the Integrated Nutrition Programme, which are covered under the next two separate sections.

The health programme analysis is included here as most of the services are provided through the PHC programmes. However, some aspects may also be provided through district hospitals. The analysis should, therefore, cover all aspects of prevention, promotive and treatment services at community, clinic, CHC and district hospital levels.

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<sup>5</sup> See *Guidelines for District Health Expenditure Reviews in South Africa*, (Health Systems Trust, 2000).

If there are no specific national performance indicators, the ones used by the district in setting its measurable objectives should be used. The causes and consequences of the health problems, as determined in the situation analysis, should be included under each programme.

### 3.6.4 HIV/AIDS, STI and TB Control

#### 3.6.4.1 Situation analysis and key indicators

The resources used in implementing this programme are funded through different DHS budget sub-programmes, in particular the various PHC sub-programmes and the district hospitals sub-programme. In addition, dedicated funding from specific conditional grants are shown under the HIV budget sub-programme. The analysis and indicators covered in this section relate to the HIV/AIDS, STI and TB programmes as a whole, not just the activities covered by conditional grants.

This section should include more detailed information than that provided in *Section 3.3. Health Status*. It should include:

- epidemiological information
- appraisal of existing services and performance during the past year
- key challenges over the strategic plan period

When determining the key challenges, identify the causes and consequences of the problems. A problem tree, such as that shown in *Part D: Planning Tools*, can be useful.

The information presented here is not intended to be exhaustive and districts should include any additional details they consider relevant. The information presented here is in addition to that shown in the general format for strategic plans.

The situation analysis should cover the integrated programme, and should include at least the quantitative data shown in Table 33.

**Table 33. Baseline data on HIV/AIDS/STI/TB control programme for three years (example)**

Condition	1999		2000		2001	
	No.	No. per 100 000 people	No.	No. per 100 000 people	No.	No. per 100 000 people
HIV antenatal seroprevalence						
VCT uptake		---		---		---
PMCT		---		---		---
– HIV positive		---		---		---
– HIV negative		---		---		---
– counselled/tested		---		---		---
– on nevirapine		---		---		---
STIs (total cases)						
Syphilis cases						
PTB smear positives						
All TB smear positives						

*This set of indicators is from the National DOH and may change over time.*

The performance review should cover the target indicators used in the plan. The recommended indicator set is shown in Table 34.

**Table 34. Performance indicators for the HIV/AIDS/STI/TB control programme over three years (example)**

Indicator	1999/00	2000/01	2001/02	National target by 2005
<b>Input</b>				
1. Total dedicated expenditure on HIV/AIDS activities (sub-programme)				
2. Percentage of public PHC facilities** where condoms are freely available				100%
3. Percentage of provincial hospitals and fixed PHC facilities** offering VCT				
4. Percentage of facilities of all types offering syndromic management of STIs				
5. Number of health districts using Directly Observed Treatment Short-course (DOTS) (with names)				All districts
6. Number of TB/HIV health districts (with names)				
7. Percentage of TB cases with a DOT supporter				
<b>Process</b>				
8. HIV/AIDS plan formulated with stakeholders				
9. Percentage of TB cases reported on				100%
<b>Output</b>				
10. Number of people trained in syndromic management of STIs				
11. Smear positive PTB cases as percentage of all PTB cases				50-70%
12. New smear positive PTB cases as percentage of expected number of cases				70%
<b>Quality</b>				
13. Average TB specimen turn around time				< 48 hours
14. Percentage of TB cases who are being re-treated				6-8%
15. Percentage of new smear positive PTB cases who interrupt treatment				< 10%
<b>Efficiency</b>				
16. Percentage of dedicated HIV/AIDS budget spent				100%
<b>Outcome</b>				
17. Antenatal HIV seroprevalence rate				
18. Syphilis prevalence rate at sentinel sites				
19. PTB smear conversion rate at 2 months for new cases				> 85%
20. PTB smear conversion rate at 3 months for re-treated cases				> 80%
21. Percentage of new smear positive PTB cases cured at first attempt				> 85%
22. Percentage of TB cases that are MDR				< 1%

\*\* 'Public' means provincial plus local government facilities. 'Fixed' means clinics plus community health centres. This set of indicators is from the National DOH and may change over time.

At the district level, where possible the performance indicators for the most recent year should also be compared across the sub-districts. Table 34 should be used with the columns for the different years replaced with a column for each sub-district and one for the district average.

#### **3.6.4.2 Performance against planned objectives**

Performance should also be compared against the key objectives shown in the HIV/AIDS, STI and TB section of the operating plan for the year (which should have been based on the previous three-year plan). This should be done briefly in a table showing the key objectives and targets, the achieved results, and the reasons for over- or under-performance. (*See Annex A.*) The accompanying narrative should explain any major issues and should also comment on local government performance against relevant IDP health objectives.

### **3.6.5 Integrated Nutrition Programme**

#### **3.6.5.1 Situation analysis and key indicators**

Nutrition activities should be planned and implemented under the national integrated nutrition programme.

This section should include more detailed information than that provided in Section 3.3. Health Status. It should include:

- epidemiological information
- appraisal of existing services and performance during the past year
- key challenges over the strategic plan period

When determining the key challenges, identify the causes and consequences of the problems. A problem tree, such as that shown in *Part D: Planning Tools* can be useful.

The information presented here is not intended to be exhaustive and health departments should include any additional details they consider relevant.

The performance review should cover the target indicators used in the plan. The recommended indicator set is shown in Table 35.

At the district level, where possible the performance indicators for the most recent year should also be compared across the sub-districts. Table 35 should be used with the columns for the different years replaced with a column for each sub-district and one for the district average.

**Table 35. Performance indicators for the Integrated Nutrition Programme for three years (example)**

<b>Indicator</b>	<b>1999/00</b>	<b>2000/01</b>	<b>2001/02</b>	<b>National target by 2005</b>
<b>Input</b>				
1. Percentage of nutrition posts filled at all levels against staff establishments				100%
<b>Process</b>				
2. Provincial business plan submitted and approved by national department by 15 March each year				Each province
3. Provincial monthly financial reports submitted to national department by 10th working day of following month				Each province
4. Provincial quarterly progress reports submitted to national department by 10th working day of following quarter				Each province
<b>Output</b>				
5. Percentage of newborn babies provided with road to health chart				85%
6. Percentage of targeted primary schools with feeding programmes				96%
<b>Quality</b>				
7. Percentage of hospitals accredited as baby friendly				15%
8. Percentage of schools where actual servings for school feeding comply with requirements and specifications of the standardised menu options				100%
<b>Efficiency</b>				
9. Percentage of INP conditional grant spent				100%
10. Percentage of special allocation for poverty relief spent				80%
11. Number of actual school feeding days as percentage of target number of school feeding days				156 days
<b>Outcome</b>				
12. Percentage of stunted children under five years				< 20%
13. Percentage of underweight children under five years				< 10%
14. Percentage of wasted children under five years				< 2%
15. Percentage of severely underweight children under five years				< 1%
16. Percentage of vitamin A deficient children under five years				0%
17. Percentage of iodine deficient children under five years				0%
18. Percentage of iron deficient children under five years				0%
19. Percentage of infants exclusively breast fed at six months				10%

*This set of indicators is from the National DOH and may change over time.*

### 3.6.5.2 Performance against planned objectives

Performance should also be compared against the key objectives shown in the nutrition section of the operating plan for the year (which should have been based on the previous 3-year plan). This should be done briefly in a table showing the key objectives and targets, the achieved results, and reasons for over or under performance. (*See Annex A.*) The accompanying narrative should explain any major issues and should also comment on local government performance against relevant IDP health objectives.

## 3.6.6 District hospitals

### 3.6.6.1 Situation analysis and key indicators

Provide a situation analysis relating specifically to the district hospitals. It should include reference to the health status described in Section 3.3., the service platform described in Section 3.4., and the expenditures described in Section 3.5. A table showing expenditure by standard item would also be useful.

Include a table showing basic data for the year each district hospital. (*See Table 36.*) This information is used in the key indicators table. At sub-district level the same data will be shown for each hospital for each of the three years.

**Table 36. Basic hospital data for 2001/02**

Indicator	Hospital A	Hospital B	Hospital C	District Total
Population				
Beds				
Separations (deaths and discharges)				
Bed days				
PHC outpatient visits				
Referral outpatient visits				
Total outpatient visits				

District hospitals are funded through the district hospitals budget sub-programme. Performance is measured using a set of national indicators. (*See Table 37.*) These indicators are consolidated at the provincial level in the PSP.

At the district level, the indicators are aggregated for all the district hospitals funded through the sub-programme. Performance is compared over three years and with the targets set for the year. A separate table should be used to compare performance for the one year across the individual hospitals and with the aggregate target and/or district average (format not shown here).

At the sub-district level, performance for the hospital will be measured only over the three years. If there is more than one hospital, the same indicators should be used to compare them.

**Table 37. Hospital key performance indicators – all district hospitals for three years (example)**

<b>Indicator</b>	<b>Actual 1999/00</b>	<b>Actual 2000/01</b>	<b>Actual 2001/02</b>	<b>2001/02 Target</b>
<b>Input</b>				
1. Expenditure on hospital staff as percentage of total hospital expenditure				
2. Expenditure on drugs for hospital use as percentage of total hospital expenditure				
3. Expenditure on hospital maintenance as percentage of total hospital expenditure				
4. Useable beds per 1000 people				
5. Hospital expenditure per person				
<b>Process</b>				
6. Percentage of hospitals with operational hospital board				
7. Percentage of hospitals with appointed (not acting) CEO in place				
8. Percentage of hospitals with business plan agreed with provincial health department				
9. Percentage of hospitals with up to date asset register				
10. Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level				
<b>Output</b>				
11. Separations per 1000 people				
12. Patient day equivalents per 1000 people				
13. PHC visits as % of total outpatient visits <sup>1</sup>				
14. Patient fee income per separation				
<b>Quality</b>				
15. Percentage of hospitals in facility audit condition 4 or 5				
16. Percentage of hospitals that have conducted and published a patient satisfaction survey in last 12 months				
17. Percentage of hospitals with designated official responsible for coordinating quality management				
18. Percentage of hospitals with clinical audit (M&M) meetings at least once a month				
<b>Efficiency</b>				
19. Average length of stay				
20. Bed utilisation rate (based on useable beds)				
21. Expenditure per patient day equivalent				
<b>Outcome</b>				
22. Case fatality rate for surgery separations				

1. When these data are available.

All hospitals funded through the DHS programme budget must be included. Explain in the narrative if there are any other district-level hospitals that are funded or subsidised under another programme budget. Also describe briefly any other public hospitals in the district, such as state-aided hospitals, contracted hospitals, TB or psychiatric hospitals. Finally, explain if there are any higher level public hospitals in the district that provide some district level services.

Planning and reporting according to budget sub-programmes means that the performance of PHC services and hospitals are measured separately. In the written explanation of performance it is important to take into account relationships between the two services. Hospitals and their feeder CHCs and clinics function as networks, and quality and efficiency can best be achieved when they are treated as such. For example, having the hospital doctor provide services at the CHCs can shift patients from the hospital to the CHCs, which will increase costs at the CHCs but decrease costs at the hospital. Overall, this may result in the network functioning more efficiently.

### **3.6.6.2 Performance against planned objectives**

Performance should also be compared against the key objectives shown in the district hospitals section of the operating plan for the year (which should have been based on the previous three-year plan). This should be done briefly in a table showing the key objectives and targets, the achieved results, and reasons for over or under performance. (*See Annex A.*) The accompanying narrative should explain any major issues and should also comment on local government performance against relevant IDP health objectives.

### **3.6.7 Service delivery challenges**

The key challenges resulting from the analysis of service delivery performance should be listed here. These will cover all the sub-programmes: district management, PHC services, HIV/AIDS, STI and TB, nutrition, and district hospitals, and should include cross cutting issues that affect more than one sub-programme.

## **3.7 Challenges**

The key challenges listed in each of the previous sections should be summarised here. They will serve as a basis for planning.

The key challenges can be divided into four groups:

- **Health challenges:** summarised from the challenges identified in the situation analysis section and focused on particular health problems such as TB.
- **Service platform challenges:** summarised from the service platform section and focused on issues such as shortages of facilities or personnel.
- **Finance challenges:** summarised from the expenditure section and likely to relate to service platform and services delivery challenges.
- **Service delivery challenges:** summarised from the service delivery section and likely to relate to difficulties in meeting health programme needs or targets.

Where some of these challenges relate to others it should be noted. For example, a service delivery challenge of meeting the immunisation target may relate to a lack of staffing identified under the service platform challenges, which may in turn relate to a finance challenge.

### **3.8 Short-term actions**

The findings of an annual report serve as the basis for the plan for the next year but one. In other words, there is a gap of a year.

Where the analysis indicates problems, it may be possible to take action in the short term (i.e., during the current year). For example, staff that are under-utilised in one clinic may be shifted to a nearby clinic, or an over-expenditure on drugs in one sub-district can be investigated and resolved. However, it is crucial that managers discuss findings with staff, community representatives and other stakeholders before deciding what actions to take. Further investigation and analysis may well be required, particularly where the findings of one sub-district vary greatly from others, or where there are major differences from norms or over time. The first step is generally to check if the original data provided are correct.