HOW TO CONDUCT
A RAPID SITUATION ANALYSIS
A Guide for Health Districts in South Africa
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ANALYSIS

A guide for Health Districts in South Africa

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Lesley Bamford
South Africa has embarked on a journey to implement the District System throughout the country. All district-level health services (community-based health care, clinics, health centres and district hospitals) within a particular boundary must now come together under a single management structure. This will allow more relevant, appropriate and effective health planning and promote better collaboration with the private and traditional health sector, other social service departments and the community.

One of the most important requirements for all this to happen is INFORMATION. This allows people to act and make decisions on an informed basis. The Initiative for Sub-District Support has also found that the process of collecting information for a district helps to make the health district concept more of a reality.

This manual is designed to help newly appointed district managers and Interim District Management Teams to rapidly collect the information required to produce a comprehensive situation analysis of a health district.

The structure and framework in this manual for producing a report on a health district has been used in a number of districts across the country, and has been found to be useful. We wish you luck in the creation of a health report for your district!

At the end of this manual, there is a form on which we invite you to send us your comments on how this manual can be improved for the future. An electronic copy of this manual can be obtained from Health Systems Trust by sending a stamped and self-addressed envelope big enough to contain a computer diskette.
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Section 1: INTRODUCTION

11 What is a Situation Analysis?

As the District Health System is implemented in South Africa, many district-level health managers are being encouraged (or required) to undertake a situation analysis of their district.

A situation analysis for a health district describes and analyses the situation regarding the health status and health services of a district. Information about different aspects of health and the health services is collected, in order to provide an overall picture of the district. At the district level, the situation analysis is primarily an assessment of the extent to which health services address health needs. It aims to describe an analyses of the situation, to explain what is happening and to identify factors which are facilitating or preventing progress in the district. As a result, it will also identify and highlight the priority problems and needs of the district so that plans and strategies for addressing these issues can be developed, and help to form part of a District Health Plan. Eventually, the situation analysis forms the basis of the District Health Report.

12 Why do a Situation Analysis?

Information is required for effective district health planning and management. Conducting a comprehensive situation analysis of the district can be seen as a step in the collection and use of information. A well documented situation analysis is helpful in a number of ways:

- It forms the first step of a planning cycle for the health district (see Figure 1). Undertaking a situation analysis is therefore often the first task of a newly formed District Management Team.
- By documenting the problems and proposed strategies of a district, it can be used as a monitoring and evaluation tool.
- It can bring the different types and categories of health worker together in a team-building exercise whereby the DMT begins to work together and take responsibility for all the services in the district.
- It can form the basis for the District Health Plan and the District Health Report. Subsequent reports can be regarded as updates and improvements of the situation analysis.
- It identifies gaps or deficiencies in the information that is available, and in this way it contributes towards the development of a district health information system.
13 The scope of a Situation Analysis

The district situation analysis should include information on all the factors that impact on the health of the catchment population. Try and collect the following information during your situation analysis.

- The geography of the district as well as the people and communities who live there.
- The socioeconomic profile of the district.
- The health status of the people in the district.
- The health services in the district.
- The management systems which support the provision of health services.
- The political and policy environment of the district.
- The activities of other sectors which are important in determining the health status of the population eg. Education, Housing, Water affairs, and Welfare.

Broadly speaking there are two different types of information: quantitative information and qualitative information.

Quantitative information is based on numbers. It includes census figures, routine clinic statistics and types of epidemiological information that is measured through surveys eg. the HIV prevalence rate amongst women receiving antenatal care.

Quantitative information is based on numbers. It includes census figures, routine clinic statistics and types of epidemiological information that is measured through surveys eg. the HIV prevalence rate amongst women receiving antenatal care.
Qualitative information is based on the opinions, perceptions and experiences of people. This type of information should be seen as complementing quantitative data. Although numbers and figures provide useful information, they do not always provide adequate explanations, or answer the question why? For example, figures may show a low immunisation coverage rate for a particular district, but other information will be required to understand and explain why the rate is low.

Interviews or discussions with health care providers or community members to determine their attitudes, opinions and experiences can provide descriptive information and useful insights for planning and management. For example, “what do people think about the quality of care they receive in clinics?”, or “what do nurses feel to be their biggest training need?”.

14 The presentation of information

The presentation of information in the situation analysis is very important if the document is going to be read widely and if it is to be useful as a planning tool. It is important to use information which is clear, appropriate, accurate and up-to-date. Where possible, compare your district to other districts, or against accepted norms and standards.

Maps

Every situation analysis should also include a map of the district. Physical features such as roads, rivers, towns and health facilities are important features to mark on the map. A map also encourages people to think of the district as a single unit, and is an invaluable tool for planning.

Example of a map showing the location of hospitals and clinics in a district
Tables

Figures should, where possible, be presented in tables and in a way that allows easy cross-comparison between different facilities or different services, or across time, as shown below.

Example of a table comparing routine maternal health service data across six different clinics

<table>
<thead>
<tr>
<th></th>
<th>Number of booking visits (%)</th>
<th>Total ANC attendances (%)</th>
<th>Number of deliveries (%)</th>
<th>Number of Caesarian sections</th>
<th>Number of unbooked deliveries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinics “A”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic “B”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic “C”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic “D”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic “E”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic “F”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Example of a table comparing routine maternal health service data across time

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total ANC attendances</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of deliveries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average gestational age at booking</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of unbooked deliveries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caesarian section rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Graphs

The presentation of information in the form of graphs or diagrams is an even more powerful and elective way of presenting data, as it makes it easier for people to understand the information being presented. Some examples are shown below:

Example of a bar graph: Age distribution in the Kalahari Region

Example of a pie chart: Main source of domestic water in the Northern Cape
Section 2: CONDUCTING A SITUATION ANALYSIS

Conducting a situation analysis

Step 1: Determine a framework
Step 2: Identify what information is already available
Step 3: Identify what information is still required
Step 4: Collect the required information
Step 5: Compile and write the report
Step 6: Distribute and disseminate the report

STEP 1: Determine a Framework

A framework provides a structure for presenting the information in a logical way. The Initiative for Sub-District Support has developed a framework which is shown below. It is only one of a number of options, but has been found to be useful. This framework can be adapted to fit your needs. Some sections may need to be excluded and others added according to the particular circumstances of a district. If situation analyses are being done in a number of districts in one region or province it will be useful to use a standard format to make comparisons easier. However, there should be enough room to reflect the unique features of each district.

STEP 2: Identify what information is already available

When doing a situation analysis it is useful to list down all the available information and all the potential information sources. Often, a lot more information is available than most people realise at first. A lot of the information for a situation analysis consists of writing down, in a structured way, things that are already known by the people who live and work in the district.

A feature of many health services is that a lot of statistics are collected, but are seldom used for planning and management. When doing a situation analysis it is important to take a careful look at what figures are available and what information they provide. Unfortunately many of these statistics are not relevant and/or are inaccurate. In this way, the situation analysis also informs the development of a health information system.

There are often other sources of information about the district which are collected by other departments. These include census information, information from the Education Circuit Office and from non-governmental and community-based organisations.
Framework for a Situational Analysis

1. Assessment of the health district
   a. Geography
   b. Demography
   c. Socio-economic profile
2. Health Status and Problems
3. Progress Towards Implementation of a District Health System
4. The Management of Support Systems
   4.1 Financial Management
   4.2 Transport
   4.3 Drug and vaccine supply, distribution and control
   4.4 Communication
   4.5 Health Information
   4.6 Human Resources
5. Public Health Sector
   5.1. Facilities
      a. Hospitals
      b. Clinics and Community Health Centres
   5.2 Referral system
6. Other Health Care Providers
   6.1 Private sector
   6.2 Traditional sector
   6.3 NGO sector
7. Assessment of Key Programmes
   7.1 Maternal and Reproductive Health
   7.2 Child Health & EPI
   7.3 School Health
   7.4 Nutrition & growth monitoring
   7.5 STDs/HIV
   7.6 Tuberculosis
   7.7 Environmental Health
   7.8 Oral health
   7.9 Mental health
   7.10 Rehabilitation and disability services
   7.11 Chronic diseases
8. Other Sectors which Impact on Health
9. Summary of Key Health Problems and Conclusion
Special research projects may have been undertaken in the district or in the region, for example, by universities or by the Medical Research Council. Information about the province can also give an idea of the picture within a district. For example, the annual HIV survey of antenatal women that is conducted every year can be used to contextualise the situation regarding HIV within the district.

**STEP 3: Identify what information is still required**

When the available information is fitted into the framework, it will soon be apparent where gaps exist. The DMT will have to decide how best to fill these gaps. At this point it is important to set realistic objectives. The situation analysis must be completed within a given period of time. There is no point in drawing up an extensive “wish list” of information which is impractical to collect. If you wait until the situation analysis is “perfect”, it will never be published.

**STEP 4: Collect the required information**

Once the required information has been identified, plans must be drawn up to collect the information. Tasks must be clearly delegated to the appropriate person with a clear timeframe.

**STEP 5: Compile and write the report**

Once the information has been collected, the situation analysis can be written. This is best done using a computer because it allows the information to be easily corrected or updated.

**STEP 6: Distribute and disseminate the report**

Once the situation analysis has been completed, it should be distributed to all relevant people or organisations. This includes all facilities and health service providers (both public and private) in the district, managers at regional and provincial level, other sectors and local government representatives. A mechanism should be in place to allow for feedback to the DMT concerning the situation analysis.
Section 3: GUIDELINES FOR CONDUCTING A SITUATION ANALYSIS

This section acts as a guide for collecting the information which is outlined in the framework.

Examples from district situation analyses that have been conducted are included:

3.1 Assessment of the Health District

This section provides an overall description of the district and the people and communities who make it up make it up.

3.1.1 Geography

This section should include a description of the chief physical features of the area. An example is shown below:

Box 1: Geography of The Kalahari Region*

The Kalahari region is one of the six regions of the Northern Cape Province. The region comprises of two magisterial districts - the Kuruman magisterial district and the Postmasburg magisterial district. The Kalahari region covers an area of 50 015 km², which is 13% of the total area of the Northern Cape.

The region is bordered by the Diamond Fields Region in the south the Lower Orange Region in the west, Botswana in the north, and the North West Province in the east. The border on the east with the Kudumane area of North West Province represents a legacy of the Bantustan policy, whereby Kuruman was declared a “white” town. The border was drawn in such a way that the surrounding Black villages became part of the Bophuthatswana homeland. When the new provinces were delineated, the area was included in the North West Province together with the rest of the homeland. However, people living in the area still use Kuruman as their centre and many people from the North West Province therefore, make use of the Northern Cape health services. This situation complicates the implementation of the DHS in this area as it divides the community in half and makes planning difficult.

The area is semi-desert and covered with Kalahari scrub. The annual rainfall is only 350 mm/yr. There are no perennial rivers and the only major permanent sources of fresh water in the region are the Eye of Kuruman and the water of the Sishen mine in Kathu.

* In the Northern Cape a “region” is the equivalent to a ”district“ in other provinces.
Other important geographic features that have an impact on health and health care delivery should also be described. For example, the state of roads in a district. A brief description of the roads in a district in KwaZulu-Natal and how it affects health is shown below:

**Roads in the Impendle, Underberg and Pholela district of KwaZulu-Natal**

“The poor condition of roads is one of the major problems facing the district. In almost all the meetings in different sub-districts, people wanted to know what plans exist for the building and upgrading of roads. In one of the district meetings, nine roads were reported as requiring urgent upgrading and maintenance, and ten new roads were requested.

The only tarred roads are the national roads R617 and R612 and a short strip into Pholela clinic. The road from the national road into the Impendle village is being tarred and is expected to be completed in the second half of 1997. Driving to other sub-districts and health facilities is quite a problem particularly in the rainy season when one has to go from St. Apollinaris hospital in Centocow via Ixopo and Richmond to get to Pietermaritzburg. This demonstrates the problems the people experience in trying to reach some of the health facilities.”

From printed topographical maps that are available from cartography offices, a simplified map of the district can be drawn by hand or traced using tracing paper. These simplified maps can be reproduced so that the following features can be shown:

- Town/villages/informal settlements
- Major roads
- Health facilities and mobile clinic points
- Schools (primary and secondary)
- Creches and Early Child Development Centres
- Location of NGO/CBO projects
- Location of local authority offices
- Other important features
### 3.12 Demography

Demography is concerned with the size, composition and location of human populations and how these factors impact on health service planning and delivery. It is important to state where the information was obtained and how accurate it is thought to be. If accurate figures are not available, estimated numbers should be given. The population of the district can be shown using a table like the one shown below:

<table>
<thead>
<tr>
<th>The demography of the Mount Frere district</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population of province</td>
<td>6,552,951</td>
</tr>
<tr>
<td>Total population of health district</td>
<td>292,184</td>
</tr>
<tr>
<td>District population as % of provincial total</td>
<td>4.5%</td>
</tr>
</tbody>
</table>
**Population breakdown**

When planning health services it is useful to also know the age and gender breakdown of the population. This will give an indication of the type of health problems that should be anticipated, and the type of health services that may be required. For example, “what percentage of the population is made up of children under 5 years of age”, and, “how many elderly people live in the district?” Some of this data can be collected and presented using the following format:

Disaggregation by gender

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Disaggregation by age group

<table>
<thead>
<tr>
<th>Age group</th>
<th>Number</th>
<th>Percentage</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 1 year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-4 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-9 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-14 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-44 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45-64 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65 + years</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In certain districts it may be important to disaggregate the population using other criteria. For instance, it may be important to break the population down according to whether they live in urban or rural areas, or according to home language.

**Geographical and spatial distribution of the population**

This information will help to ensure that you can plan to improve access to health services. By knowing the spread and location of your population, you can assess, for example, the number of people who live more than 5 km from the nearest clinic. From the environmental health point of view, it is important to know which parts of the district predominantly consist of households without access to clean water and adequate sanitation.
3.13 Socio-economic profile

Information about the socio-economic conditions of the district include:

- the main economic activities in the district;
- household income eg. average household income, and percentage of families living below the poverty line;
- employment and unemployment figures;
- communities or groups who are particularly vulnerable;
- housing conditions;
- the provision of basic services: water, electricity, sewage and sanitation;
- telecommunications in the district eg. how many households have telephones, the reliability of the postal service, and plans for the improvement of telecommunications.

If information for the district is not available, information for the whole province or region can be used as a fair guesstimate (see Table below).

Example of a table showing a selection of socio-economic findings for the Eastern Cape

<table>
<thead>
<tr>
<th>Source of water</th>
<th>National</th>
<th>E/Cape</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of households with tap water in dwelling</td>
<td>51.4</td>
<td>27.6</td>
</tr>
<tr>
<td>Percentage of households with tap water or borehole on site of dwelling</td>
<td>22.6</td>
<td>17.0</td>
</tr>
<tr>
<td>Percentage of households with rainwater tank</td>
<td>1.8</td>
<td>8.0</td>
</tr>
<tr>
<td>Percentage of households with other source of water (eg. streams, water tanks)</td>
<td>24.2</td>
<td>47.4</td>
</tr>
<tr>
<td>If water has to be collected, how far away is it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 100m of household</td>
<td>50.9</td>
<td>37.6</td>
</tr>
<tr>
<td>&gt; 1 km of household</td>
<td>11.4</td>
<td>19.8</td>
</tr>
<tr>
<td>Sanitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of households with flush toilet in dwelling</td>
<td>43.9</td>
<td>24.6</td>
</tr>
<tr>
<td>Percentage of households with flush toilet on site</td>
<td>13.8</td>
<td>7.0</td>
</tr>
<tr>
<td>Percentage of households with no sanitation facility</td>
<td>7.7</td>
<td>15.9</td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability of phone in dwelling</td>
<td>30.1</td>
<td>17.5</td>
</tr>
<tr>
<td>If no telephone in dwelling, distance to nearest telephone:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 100m</td>
<td>23.2</td>
<td>18.6</td>
</tr>
<tr>
<td>More than 1 km away</td>
<td>41.8</td>
<td>55.1</td>
</tr>
</tbody>
</table>

Source: 1995 October Household Survey
Example of socioeconomic information presented in a graphical form

Main type of sanitation facility in the Northern Cape

Source: October Household Survey, 1993

If figures are not available then the situation can also be described. For instance, you can simply say, “most people in the rural areas of the district collect water from rivers; people living in informal settlements use communal hand-pumps (with approximately 40 families using one tap); and all houses in the town have taps”. This gives a useful picture of the main source of water supply in the district, even though no accurate figures are available.

An example is shown below from the Kakamas area in the Northern Cape where there are very few facts and figures available. Using some information which has been collected about the province in general, combined with a description of the area, a good picture of the area can be obtained.

Socio-Economic Conditions in the Kakamas Sub-district

Agriculture is the major economic activity in the area. The main produce are grapes and sun-dried fruits. Although the water supply limits the development of agriculture, exploitation of overseas markets provides opportunity for some economic growth. Apart from some food processing (wine and sun-dried fruits), there is no manufacturing or industrial activity.

There are no accurate unemployment figures for the Northern Cape, but the October Household Survey of 1994 estimated that 32.5% of an estimated 278 743 economically active people were unemployed. Rates were higher for Coloureds (37.9%) and Blacks (39.4%), than for Whites (7.2%). Fifty-seven percent of unemployed people had been unemployed for more than a year at the time of the survey. Almost seventy-five percent of unemployed people are not trained or skilled for specific work.

Employment opportunities are limited with strong seasonal variation in the availability of work. Pensions and other grants form an important source of income for many households. Although there are no accurate figures, there is no doubt that a sizable proportion of the population live in poverty. In comparison to other regions in the province, more people live in rural areas with poorer access to basic services when compared to the provincial figures.
All houses within the municipal area have access to a tap (on-site) and refuse is collected regularly. Most houses are supplied with electricity and sanitation is provided via waterborne sewerage or, in some cases, the bucket system. The bucket system is presently being phased out.

The situation in the smaller towns within the sub-district is more varied, although refuse is removed from all settlements. Although variable, living conditions on many farms are poor. At present there are no services in Riemvasmaak.

3.2 Health status and health problems

When describing and assessing the health status and health problems of a district, both quantitative and qualitative information should be used. Although statistics and indicators give some indication of the health status of the population, these figures are often incomplete or unreliable. Discussions with health workers and community members can help to add to this information as well as to reveal the perceived needs and health problems of the district.

Below are some important indicators of health status. Some of the figures which are required to calculate the indicators can be obtained from the magisterial office (e.g., information about births, deaths and notifiable conditions). If a health district is made up of more than one magisterial district, figures will have to be combined. Other indicators require information that should be available from clinics and hospitals.

3.2.1 Health Indicators

The health indicators shown below consist of some basic health indicators that every district should be expected to have. The list is not exhaustive, and a more complete list of health indicators for the district is being developed by the Department of Health.

- Infant mortality rate - number of infant deaths per 1,000 live births
- Under-5 mortality rate - number of deaths in children under 5 per 1,000 live births
- Perinatal mortality rate - number of perinatal deaths per 1,000 deliveries
- Maternal mortality rate - number of maternal deaths per 100,000 live births
- Low birth weight rate - percentage of babies whose birth weight is less than 2,500g
- Nutrition status - for example, percentage of children under five who are underweight for age, or proportion of primary school entrants who are stunted.
- TB case-holding rate - proportion of patients with pulmonary TB who complete their therapy.
- Proportion of births delivered outside a health facility.
- Unbooked delivery rate - percentage of deliveries in the district that did not receive any antenatal care.
- Teenage pregnancy rate - percentage of deliveries in the district to women aged under 20 yrs.
- Immunisation coverage rate - for example, proportion of children aged 2 yrs or less who are fully immunised for their age.
Proportion of hospitals that conform to the Baby Friendly Hospital Initiative.
Number of terminations of pregnancy, age and reason for termination.
Number of people presenting with STDs.
Exclusive breastfeeding rate at 4 months.

3.2.2 Notifications of diseases and conditions
Health personnel are legally obliged to notify certain diseases and conditions which have been designated as “notifiable conditions”. This will indicate how common certain diseases and condition are in a district. This information can be presented as the number of people presenting with the condition in a year per 100 000 people.

Many of the conditions are preventable and analysis of the figures may point to important areas for intervention. A table showing the most common or important notifiable conditions in the district could be drawn up in the following way:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number of cases notified</th>
<th>No. of cases per 100,000 people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute flaccid paralysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congenital syphilis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malaria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pesticide poisoning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Rheumatic fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculous meningitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typhoid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholera</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food poisoning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rabies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.2.3 Cause of death
The leading causes of death in a district provide important information for choosing priorities. Ideally, deaths should be categorised by cause of death and by age group. In this way the leading causes of death for each age group become apparent (for example, as shown in the Table below). Although this information should be available from the local magisterial office,
information about cause of death is often inaccurate and incomplete, making analysis and interpretation difficult. The implementation of a new national maternal mortality notification form should mean that accurate information on the deaths of pregnant women will become more accurate and available.

An example of a table used to summarise the number of deaths broken down by age and cause of death

<table>
<thead>
<tr>
<th>Causes of death</th>
<th>Number of deaths (% of total deaths for age group)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt; 1 yr</td>
</tr>
<tr>
<td>ARI/pneumonia</td>
<td></td>
</tr>
<tr>
<td>Diarrhoea</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
</tr>
<tr>
<td>Violence</td>
<td></td>
</tr>
<tr>
<td>Motor vehicle accidents</td>
<td></td>
</tr>
<tr>
<td>AIDS</td>
<td></td>
</tr>
<tr>
<td>Acute/severe malnutrition</td>
<td></td>
</tr>
<tr>
<td>Cardio-vascular disease</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Complications of pregnancy</td>
<td></td>
</tr>
</tbody>
</table>

### 3.3 Progress towards the implementation of a district health system

The National Department of Health has committed itself to providing comprehensive primary health care through the District Health System. This section of the situation analysis is used to describe the progress your district has made towards the implementation of the District Health System. The factors facilitating or hindering progress should be presented, and it should also include a description of:

- provincial and regional structures, and how they relate to the district;
- how the fragmentation of the old health system is being integrated into a district health system;
- the proposed organogram for the district (where appointments have been made the names of responsible people should be included);
the progress made in establishing the District Management Team;
the governance of the health district; and
community involvement in health.

There are also a number of important administrative factors that help to improve the effectiveness and efficiency of a district health management team. These include:

- proper offices and office space;
- good communication assisted by a working telephone and a fax machine;
- reliable clerical and secretarial support;
- a photocopier; and
- computers and printers.

Below are several examples of how to describe the development of the DHS.

The integration of fragmented services in Tsepho district, Free State

The Tsepho district of the Free State demonstrates the typical fragmentation of the old health system. Within the boundaries of the district there are a variety of different health providers and management structures all working independently of each other. These include:

- Two separate Level 1 hospitals run by independent hospital management structures.
- Seven separate local authorities that run thirteen different primary level clinics - although they are almost entirely funded by the provincial health department, they are managed independently by the local authority.
- Mobile health services which provide health care to the rural areas that lie outside the boundaries of the local municipalities. They are managed as a separate entity from the hospital and fixed clinics.

In addition to this, the ambulance service, the laboratory and other components of a DHS are managed separately.

In order to overcome this fragmentation, a workshop was held in September 1997 involving representatives from all the different segments of the district health services. The purpose of the workshop was to set up a district co-ordinating team to bring all the different services, facilities and management structures under one umbrella.

During the workshop, the health workers said that they began to feel that they worked for a single district rather than for a single facility. The district co-ordinating team is hoping to meet for the first time in October 1997.
The Development of the District Management Team in Mount Frere

There are four health and welfare districts in Region E of the Eastern Cape. Within these four districts, the Mount Frere district manager is the only person in a district management post who is fully appointed. The other posts have not yet been established. The interim district health and welfare management team (IDMT) is therefore made up of seconded staff.

Secondment or appointment to a district management post does not mean that the person stops working in his/her previous role. For example, the district pharmacy officer would continue to play her role as the hospital dispensary officer, whilst having district-wide duties and responsibilities. According to provincial policy, the functions of the IDMT include:

- the co-ordination, joint management and rationalisation of all community and district level public sector health and welfare services;
- the promotion of co-operation and co-ordination of health and welfare services between the various authorities;
- the formulation of a district health and welfare plan;
- an audit of all health and welfare facilities, services, personnel, transport, equipment and finances within the district;
- consultation with local health, welfare and development forums; and with the private and NGO sector in the district; the establishment and strengthening of community health and welfare committees, and hospital boards;
- the determination of the health and welfare needs of the district; and

In February 1997, the IDMT held a four day workshop to clarify the areas of responsibility and lines of accountability for the following: the IDMT, the Hospital Management Teams and the Regional Health Office. In addition, the workshop began to define the organisational structure of the IDMT, the roles and responsibilities of the IDMT members and how the management structures mentioned above relate to each other.

The following tasks still need to be done:

- place people against the various positions in the organisational structure; and
- write-up job descriptions for the various positions with an emphasis on defining their respective areas of responsibility, channels of communication and lines of accountability.

These activities consist of the on-going evolution and development of the IDMT. The refinement of the roles and functions of the IDMT and the various personnel need to take place constantly as the health service itself continues to evolve and develop.
The district office in Mount Frere

At the moment the district office is temporarily located in offices in Mary Theresa Hospital. This is an unsatisfactory arrangement for a number of reasons. It has only recently received a direct telephone line, which is also used for the fax machine and the e-mail connection. Having to use one line for the telephone, the fax machine and for e-mail is sub-optimal. Previously, the district office had to go through the hospital switchboard. It has a new photocopy machine and one computer. The district manager has also been issued with a cell phone which has made communication easier.

A lack of good clerical support in the district office makes for inefficiencies. The district manager has to do a lot of his own secretarial work. Papers and files are said to often get lost within the office.

Efficient communication is also an important element of good management. Communication between the regional and district office is thought to be especially problematic. The problem of communication between the regional and district offices are due to a number of reasons:

- the District Manager and the Regional Deputy Directors are the same rank, and there is a lack of clarity about who is accountable to whom;
- it is physically easier to communicate directly with the Regional Office, so that the District Office is sometimes by-passed, undermining the authority of the District Manager, and preventing the district office from fulfilling its role of co-ordinating communication between the district and the region;
- inefficient communication and planning results in frequent meetings being called by the Regional Office without enough notice and without a clear agenda;
- inefficient communication and planning also results the hospital management team being called to the Regional Office too frequently. At times the management team is not at the hospital for up to four days of the week.
Community Involvement in the Agincourt District Health Site

"Although clinic committees were established by government health services during the 1980s, they did little to encourage ordinary people to become involved in the health problems directly affecting them."

The composition of the clinic committees tended to be decided by local headmen, and the scope of the committees was circumscribed by the (sometimes haughtily expressed) opinions of professional health-care providers. In short, the old apartheid-style state services were suspicious of too much freedom being given to communities to participate. As a result, the popular perception of communities was that the clinic committee system did not offer effective representation, did not address real issues, and did not produce workable solutions to problems.

In the early 1990s, health workers from Agincourt (led by Elizabeth Malomane, a Tintswalo nurse working with the HSDU) took on the task of transforming this unsatisfactory situation. Using the 1978 Alma-Ata model as a guide, they tried to develop community structures which actually worked.

Efforts in this direction met with considerable scepticism from communities, and also with some understandable opposition from government health professionals, more used to the old top-down approach. Nevertheless, "progress has been made", says Sam Hlatswayo, the health committee organiser.

New pilot committees were started in three of the 20 Agincourt villages. The name of these bodies was changed from "clinic committees" to "local health committees", a change which focused attention on the broader scope of the committees: that of village health in total rather than merely of clinic matters. The old system of appointing members of the community was replaced by a process of village elections; existing community organisations were brought into the process; and the equal participation of women was deliberately fostered.

Source: Agincourt - A District Health Demonstration Site, HST 1997

3.4 The management of support systems

This section looks at the support systems which need to be managed at a district level to ensure that health facilities and health care activities are effectively and efficiently managed. Six support systems should be considered. These are:

- Financial management
- Transport management
- Drug and vaccine supply, distribution and control
- Communication
- Health Information
- Human resources

Each section should contain information on the following:

- The needs and problems of each system.
- The individual or individuals responsible for the management of the system
The resources available to manage each system.

The extent to which the system is meeting the district’s requirements.

3.4.1 Financial Management

The situation regarding expenditure and resource allocation is very confusing in many districts. This is partly because there is rarely a single global budget for the district. Many districts may have funds that have come from various different sources, for example, from the national Department of Health, from province, from local government and from the RDP.

As the district system is implemented, funds will increasingly be pooled together into a single district budget. This will allow for greater clarity on how money is being spent in the district, and will allow for more relevant health planning.

Resource allocation to the district

This should include a description of both the process of allocation and the amounts allocated to the district. Remember that some programmes receive funding directly from the province and that these amounts are not reflected in the district budget eg. PSNP and clinic upgrading.

By taking the previous year’s expenditure and dividing it by the total population of the district, this will give a per capita expenditure figure. This can then be compared with the provincial per capita average. Below is a description of the allocation of finances between the regions of the Eastern Cape.

The Health Economics Unit of the University of Cape Town has recently conducted a study looking at how finances were distributed in the Eastern Cape for the 1996/97 financial year.

<table>
<thead>
<tr>
<th>Region</th>
<th>Population</th>
<th>Total Expenditure (R)*</th>
<th>Per capita Expenditure (R)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region A</td>
<td>1 067 268</td>
<td>661 886 619</td>
<td>620</td>
</tr>
<tr>
<td>Region B</td>
<td>804 554</td>
<td>292 682 704</td>
<td>364</td>
</tr>
<tr>
<td>Region C</td>
<td>1 911 024</td>
<td>748 496 696</td>
<td>392</td>
</tr>
<tr>
<td>Region D</td>
<td>1 011 544</td>
<td>422 121 057</td>
<td>417</td>
</tr>
<tr>
<td>Region E</td>
<td>1 070 611</td>
<td>236 881 460</td>
<td>221</td>
</tr>
<tr>
<td>Total</td>
<td>5 865 000</td>
<td>2 362 068 536</td>
<td>403</td>
</tr>
</tbody>
</table>

*This includes expenditure on specialised/tertiary and regional hospitals.

The findings of their study, shown above, indicate a maldistribution of funds between the different regions of the province, with Region E faring the worst. It can be seen that during 1996/97, R184 was spent per person on Region E, whilst R394 was spent per person in Region A.
The financial management system and financial management capacity in the district

This section documents how money is controlled within the district. Who is authorised to spend money and what checks are in place. It should provide a description of the way in which finances are managed in the district.

Resource allocation within the district

This section should explain how money is being spent within the district. The two biggest recurrent items of expenditure in the health service are on personnel salaries, and on pharmaceuticals. Particular attention should be paid to these two areas. Another way of disaggregating the expenditure of a district is according to the type of facility or service.

In addition to recurrent expenditure, try and list down the amount of capital expenditure for the previous financial year within the district. Capital expenditure includes money spent on:

- renovating and upgrading health facilities;
- building new facilities/structures;
- new vehicles; and
- new medical equipment

A description of the financial allocation process in the Northern Cape’s Kalahari Region

The system of resource allocation and financial management is changing at present with a move towards greater control of the budget by the region. The regional budget for the 1997/98 financial year was R15 million.

Although primary health services are provided by local authorities, a large amount of the funding comes from the provincial health budget. The allocation of funds to each Local Authority is calculated using the following formula:

Allocation to local authority = Cost of staff salaries + 12% of the cost of staff salaries (to cover other running costs)

From next year however the budget will be allocated by the regional manager in consultation with the local authorities. At present the region receives no feedback as to how money is spent and each local authority is responsible for the control of its allocation. It is hoped that a system of reporting on expenditure will be introduced during the year.

Drugs are not included in the running costs of the various facilities and are paid for from a separate regional budget. The regional manager retains control over this budget. The budgets for emergency services (transport) and environmental health are separate from the regional budget and are allocated directly from the province to the relevant service providers. The hospitals in the region are allocated funds on the basis of the financial management system that was used under the old Cape Provincial Administration.

* In the Northern Cape a “region” is the equivalent to a “district” in other provinces.
Example of one way to present financial data for a district

The allocation of finances within the Kalahari district 1997/8

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Kuruman Hospital</th>
<th>Postmasburg Hospital</th>
<th>Olifantshoek Hospital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R3 432 000</td>
<td>3 200 000</td>
<td>1 494 000</td>
<td>8 126 000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Local Authorities</th>
<th>Kalahari District Council</th>
<th>Danielskuil Municipality</th>
<th>Kathu Municipality</th>
<th>Kuruman Municipality</th>
<th>Olifantshoek Municipality</th>
<th>Postmasburg Municipality</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>806 000</td>
<td>462 000</td>
<td>206 000</td>
<td>134 000</td>
<td>147 000</td>
<td>274 000</td>
<td>2 029 000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regional Office</th>
<th>Administration</th>
<th>Facilities</th>
<th>Pharmaceuticals</th>
<th>Nutrition</th>
<th>Transport</th>
<th>Oral health</th>
<th>Drugs</th>
<th>Doctors</th>
<th>Equipment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>365 000</td>
<td>1 880 000</td>
<td>131 700</td>
<td>198 600</td>
<td>87 400</td>
<td>169 000</td>
<td>1 188 000</td>
<td>1 590 000</td>
<td>150 000</td>
<td>5 760 500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Environmental Health Budget</th>
<th>Kalahari District Council</th>
<th>Danielskuil Municipality</th>
<th>Dibeng Municipality</th>
<th>Kathu Municipality</th>
<th>Kuruman Municipality</th>
<th>Olifantshoek Municipality</th>
<th>Postmasburg Municipality</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>26 000</td>
<td>6 000</td>
<td>4 000</td>
<td>21 000</td>
<td>28 000</td>
<td>3 000</td>
<td>15 000</td>
<td>103 000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Service Budget</th>
<th>Kalahari District Council</th>
<th>Danielskuil Municipality</th>
<th>Olifantshoek Municipality</th>
<th>Postmasburg Municipality</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>823 000</td>
<td>293 000</td>
<td>197 000</td>
<td>252 000</td>
<td>565 000</td>
</tr>
</tbody>
</table>

| Grand Total                      |                           |                         |                            |                         | R17 583 500 |
3.4.2 Transport

This section describes the transport resources, uses, needs and problems of the district. Because the health services have to make use of vehicles for a number of different purposes (e.g., delivering drugs to clinics, providing outreach services, transporting staff within the district, and referring patients for emergency care), an assessment of the way that vehicles are managed is important. Some of the questions to answer include the following:

Control of vehicles

- Is there a person in charge of looking after and regulating the use of these vehicles?
- If yes, what is his name and position?
- Is there any misuse of vehicles (for example, vehicles being used for non-health related activities, or vehicles being driven by drunk drivers)?
- If yes, why is this the case?

Maintenance of vehicles

- What is the procedure and mechanism for the maintenance and repair of vehicles?
- How often are the vehicles maintained?
- What are the problems with the current system of vehicle maintenance?

Inventory of vehicles

An inventory of all health service vehicles in the district should be undertaken. This would include ambulances and mobile clinics. It is important to document whether these vehicles are allocated to specific tasks and whether they are in a good state of repair, for example, does the vehicle belong to a general pool of vehicles, or is it, specially allocated to a specific programme such as TB? A form for collecting this information is shown below.
## Inventory of Vehicles

<table>
<thead>
<tr>
<th>Registration</th>
<th>Make</th>
<th>Model</th>
<th>Engine Size</th>
<th>Condition 1</th>
<th>Vehicle Based 2</th>
<th>Allocated 3</th>
<th>Major Use 4</th>
<th>Engine No.</th>
<th>Chassis No.</th>
<th>Total Kilometres 5</th>
<th>Average Kms per Month 6</th>
<th>Average Days Used Per Month 7</th>
<th>Main Driver 8</th>
</tr>
</thead>
</table>

### Notes for filling in the form:

1. 1 = excellent (no work required); 2 = good (some work required within 6 months); 3 = fair (roadworthy but needs major work); 4 = poor (unreliable, not for long distance); 5 = off road (awaiting repair); 6 = beyond economic repair.

2. Physical location of the vehicle.

3. Where is the vehicle allocated eg. hospital, pool, social welfare, individual etc.

4. Indicate one: 1 = administration; 2 = patient transfer; 3 = meetings/ training; 4 = monitoring/ supervision; 5 = health care delivery; 6 = social welfare delivery; 7 = other (please specify).

5. Give the speedometer/odometer current reading. Indicate “B” if broken.

6. Estimate the average kilometres travelled by the vehicle in one month.

7. Estimate the average number of days the vehicle is used in one month.

8. Identify who normally drives the vehicle: 1 = government driver; 2 = mainly one staff member 3 = multiple drivers.

### Expenditure Information

- How much money has been spent on the running costs (maintenance, repairs, fuel) of all the vehicles in the district?
- How much money has been spent on the purchase of new vehicles?

### Transport needs

- Which services and programmes are limited because of inadequate transport?
Transport management in the Mount Frere health district

Transport is one of the biggest problems in the district. In 1996 there was poor coordination in the district, with different facilities and services having control over different vehicles. Clinics do not have their own transport, and are reliant on either hospital transport, or on vehicles managed by the district office.

The transport problem is not simply due to a lack of vehicles. Four other factors contribute to the transport problem:

- poor maintenance of vehicles (at present there is no government garage nearby so the maintenance and repairs are contracted out to private garages which are said to be unreliable one vehicle was once sent back 8 times for the same problem);
- lack of appropriate vehicles to contend with the poor state of the roads;
- undisciplined drivers; and
- theft - a brand new vehicle was stolen in 1996.

As a result of these problems, there have been:

- poor and inconsistent supplies of drugs, equipment and gas cylinders to the clinics;
- inadequate supervision and contact with clinic staff;
- difficulties in referring patients from clinics to hospital;
- infrequent visits to schools by the school health team;
- a lack of community outreach health services;
- no mobile clinic services in half the district for several years up until recently; and
- patients waiting for up to six hours before an ambulance arrives.

In order to address some of these problems, a transport officer for the district has been identified. In addition, a “transport task team” was set up in early 1997 to help develop a transport management system and policy for the district. This task team has drafted a transport policy which is said to have resulted in an improvement in the allocation, co-ordination, control and use of vehicles. Members of the transport task team include the district manager and representatives from welfare, PHC, environmental health and the drivers.

3.4.3 Drug and vaccine supply, distribution and control

This section describes the supply and distribution of drugs to the various facilities and services within the district. Shortages or non-delivery of drugs to clinics is a major problem in many areas of South Africa. The first step in addressing this problem is to understand how drugs are supplied. This includes mapping out the ordering and distribution systems, both to the district and within the district. Once this has been done bottlenecks or problem areas can be identified. Some of the questions to answer include the following:

Procurement, ordering and distribution

- How do facilities and services order their drugs?
- Where are the drugs supplied from?
How often are drugs supplied?
How are these drugs paid for?
Are there any problems with the supply of drugs?
Are there any problems with the “cold chain” for vaccines?

Stock control

How is the stock control managed in the different facilities?
Do drugs ever run out because of poor stock control?
Are there any problems with the storage of drugs (and vaccines), eg. inadequate space?

Pharmacy personnel

Who is responsible for the management of drugs in the district?
What pharmacy personnel are employed in the district?
Is there one person responsible for ensuring that all facilities and services receive an adequate and reliable drug supply?

Prescribing

Rational prescribing can be regarded as a cornerstone of good clinical health care. A national Essential Drug List (EDL) has been drawn up in an effort to provide cost-effective treatment. It is important that nursing staff have access to the EDL and have received training in rational prescribing.
An example of a brief situation analysis
of a district’s drug management system

The inadequate supply of drugs and supplies to clinics as been a serious problem in the Mount Frere district. In November 1996, several clinics had not received proper drug supplies for about five months. As a result, patients had virtually stopped coming to the clinics. The main problems with drug supply appear to be related to the following:

- the supply of drugs from the Central Medical Stores is insufficient;
- a lack of transport;
- a lack of adequately trained personnel - there is no pharmacist in the whole region;
- theft and mismanagement;
- poor communication with the Central Medical Stores; and
- a lack of monitoring of usage/consumption.

The drug supply, ordering and distribution system works in the following way:

Drug for the district come from the Central Medical Stores (CMS) situated in Umtata. Drugs are delivered separately to each of the two hospitals. The ordering of drugs for the entire district is done via these two hospitals every six weeks. In the case of Mary Theresa Hospital, a dispensary assistant places a bulk order with the CMS. There is also a “fridge nurse” at the hospital who is in charge of ordering and maintaining the supply of vaccines. Orders for vaccines are placed on a separate form which goes to the CMS with the hospital bulk order.

The hospital uses cards to order drugs from the CMS. One card is used for each drug. These cards go to the CMS and come back with the drugs and vaccines. The drugs that are delivered from the CMS are accounted for on delivery notes specifying the quantity of drugs that have been delivered.

Orders for or drugs which have run out can be made on an ad hoc basis in between the six weekly bulk orders. These orders have to be fetched from the CMS using hospital transport by the dispensary assistant or the fridge nurse herself. This is only possible if there is already transport going to Umtata Hospital to transfer patients. Failure to get to the CMS by a certain time means that they are unable to get the orders, thus wasting an entire trip and working day.

In the clinics, the sister-in-charge makes an order to the dispensary assistant in the hospital using a dispensary book which is sent via the community matron. After issuing the drugs, the dispensary assistant keeps the original order form and a copy goes back to the clinic. If there is no transport to take the drugs to the clinics, the clinic sisters may have to make their own arrangements to visit the hospital at their own expense.

Drugs in Mary Theresa Hospital are stored in a room in the basement on wooden shelves. There is not enough space on these shelves, so some drugs are kept on the floor in boxes. Vaccines are kept in the refrigerator at the OPD controlled by the “fridge” nurse. In the clinics, drugs are stored in whatever room is available. The refrigerators in the clinics are often out of order due to gas supplies running out.
3.4.4 Communication

It is important to describe and analyse of communication within the district. Developing a clear communication system is important for developing a well-functioning district. Once areas of responsibility have been defined within the district, clear channels of communication are necessary to ensure elective management.

Communication channels need to work both ways so that, for instance, clinic staff not only receive information and instructions from their supervisors, but can also inform their supervisors of the problems they are experiencing. Clear communication channels are also important to avoid conflicts and confusion. Therefore use this section to describe the common forms of miscommunication.

Inventory of communication infrastructure

- An inventory should include an assessment of the available means of communication within the district together with an assessment of how well (or badly) they operate.
- Telephones - both fixed and mobile;
- Radio
- Faxes (make a distinction between faxes with dedicated phone lines and phone/faxes)
- Post - official and internal (within the Department of Health);
- Electronic mail

Describe any problems relating to a lack of communication. For example, clinics that are unable to call for an ambulance. A facility-based inventory of the communication infrastructure may be useful, using the following format:

<table>
<thead>
<tr>
<th>Facility</th>
<th>Phone</th>
<th>Working phone</th>
<th>Radio</th>
<th>Working radio</th>
<th>Fax machine</th>
<th>Fax with dedicated line</th>
<th>E-mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic “A”</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Clinic “B”</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Clinic “C”</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Communication skills audit

It is also useful to know if staff have the skills to make use of the available communications equipment.

3.4.5 Health Information

Having good information about the health of the population and the health services in the district is fundamental to effective district health management. It is useful to therefore conduct an “information audit” as part of the situation analysis. An “information audit” describes the following:
Description of information flow

- Who collects data and for whom it is collected.
- What data is collected and on what forms.
- When data is collected and how often it is reported on and acted upon.
- Where data is sent - is it collated at a central point and analysed by the district before going to higher authorities?
- Why is the data collected, and is it useful to the district?
- How is the data transformed into useful information?
- Do facilities receive feedback after the data is analysed?
- Who in the district is responsible for managing all the data in the district - is there a district information officer?

It is also useful to get an idea of how long staff spend on such tasks and how useful they see them as being.

The information flow can be depicted in a diagram like the one shown below that was drawn up for Mitchell’s Plain in the Western Cape.

Source: A health and management information system for the Western Cape; final report of a working group for Western Cape; final report of a working group for Western Cape Health Services Strategic Management Team, Dec. 1994. At the end of the “information audit” summarise the main problems with the information system in the district.
At the end of the “information audit” summarise the main problems with the information system in the district.

**A description of the health information system in Mount Frere**

Data appears to be collected with no clear goals, indicators or targets. It is collected by nurses who are not trained to do so and this results in poor data collection and a waste of nursing time. Data is not converted into useful information. Data is merely shuffled to the provincial and national level with no or little feedback to the staff.

Nursing staff have attended workshops designed to give them guidelines on how to collect data, but never on data analysis and interpretation. This results in poor motivation and affects the reliability, validity and ultimate quality of the data.

There are no mechanisms set up for clinic or hospital staff to routinely assess their work or to measure progress, achievements and constraints. Most workers have no idea of the coverage or quality of the services they provide. The volume of data collected is enormous with minimal output of useful information.

At the magistrate’s office, the process of storing information is very poor. Data is scattered across the office so that we had to spend the whole day trying to figure out what goes where. No one knows exactly where the information is kept and who has access to it. Information on the notification of diseases was not readily available. We found ourselves scratching for information, going through the files which were lying on open shelves collecting dust.

Source: Report by two medical students on their elective in December 1996

During a workshop in July 1997, clinic nurses made the following points about the clinic information system:

1. There are too many clinic registers being used.
2. There are many forms being filled in.
3. It is often difficult sending information to the hospital or district office because of a lack of transport or a lack of regular visits to the clinics.
4. There is never any feedback.
5. There is a lot of duplication of data collection.
6. There are no clerks or administrative staff to help with the collection of information.
7. There is some important information which is not being collected.

**3.4.6 Human Resources**

The district management team should have a list of all posts in the district and whether or not they are filled. If this is not available, it is important to compile such a list as part of the situation analysis. This information can be presented in a number of ways but should be available according to category of health worker as well as by facility.

Below is an example of the staff breakdown from the Impendle/Pholela/Underberg District in KwaZulu-Natal. Other categories of staff to include in a similar table would include midwives, therapy assistants, community liaison officers and dietitians.
### Example of Impendle/Pholela/Underberg public sector health staff establishment

<table>
<thead>
<tr>
<th>Facilities</th>
<th>Gomane</th>
<th>Gwala</th>
<th>Kilmun</th>
<th>Nqamalaba</th>
<th>Polela</th>
<th>Sandanezwe</th>
<th>Underberg</th>
<th>Polela School</th>
<th>St. Apoll (Mobile)</th>
<th>St. Apoll (Hosp.)</th>
<th>PHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gomane</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
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<td>2</td>
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<tr>
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<td>1</td>
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<td>5</td>
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<td>5</td>
<td>4</td>
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<td>45</td>
</tr>
<tr>
<td>Polela</td>
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<td>5</td>
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<td>2</td>
<td>2</td>
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<td>1</td>
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<tr>
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<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>28</td>
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<tr>
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<td>3</td>
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<td>1</td>
</tr>
<tr>
<td>Polela School</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>St. Apoll (Mobile)</td>
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<td>Staffing in relation to Functional units</td>
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<tr>
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<tr>
<td>General Assistant / Cleaner</td>
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<td>3</td>
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<td>3</td>
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</tr>
<tr>
<td>Other</td>
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</tr>
<tr>
<td>120bed/HN</td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>85bed/NH</td>
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<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>52paid</td>
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<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>2paid</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHC</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
It is also useful to display information about staffing levels in relation to the population size of the district (see example from the Mount Frere district below). This provides a staff population ratio which can be used to compare your district with the regional or provincial average.

<table>
<thead>
<tr>
<th>Provision of public sector health worker (per 100 000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Pharmacists</td>
</tr>
<tr>
<td>Doctors</td>
</tr>
</tbody>
</table>

Source: Eastern Cape ReHMIS report. The Mount Frere ratios are based on an estimated population figure of 290,000 and on 1997 staffing levels.

In addition to describing the composition and size of the district's health personnel, it is important to document the support which is available to staff in terms of ongoing supervision and training. Are clinics visited regularly by clinic supervisors or PHC coordinators? Are there opportunities for in-service and other training? Have local staff been able to attend post-basic or post-graduate training courses, and if so, who and what did they train in?
3.5 The Public Health Sector

3.5.1 Facilities

Hospitals

Description of the hospital

This should include the location of the hospital, the state of repair of the building and the services which the hospital offers. A brief description of the problems which the hospital is facing is also useful. Where available, use hospital statistics to give an indication of the workload of the hospital. These are particularly useful when there is more than one hospital in the district so that the hospitals can be compared with each other. An example of a description of a district hospital is shown below:

<table>
<thead>
<tr>
<th>Basic annual hospital statistics</th>
<th>Hospital “X”</th>
<th>Hospital “Y”</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of beds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ave. no. of OPD visits per month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ave. bed occupancy rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total no. of in-patient admissions in previous year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of full-time doctors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of full-time professional nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of theatre operations per month</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of general anaesthetics per month</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In addition, describe the most common causes of admission and referral, as well as the referral system to secondary and tertiary level hospitals.
A brief description of a district hospital

The condition of Mary Theresa Hospital is poor. In some parts of the hospital, the electricity doesn’t work. There is peeling paint, leaking water taps and broken windows. There is no water in some parts of the hospital. Water comes from the town supply and is sometimes switched off. During this time, the hospital uses rain water from the tanks. Electricity is also sometimes a problem. The hospital uses a generator during these periods.

Last October, a newspaper article described Mary Theresa as being “on the verge of collapse”. Many of the wards in Mary Theresa Hospital lie half empty because patients have lost confidence in the quality of care provided. Part of this is due to the shortage of doctors. People prefer to go to private practitioners or to the hospital in Kokstad.

The OPD is generally managed by nurse clinicians. Patients are only referred to the doctors if they are unable to cope. The hospital has twelve inpatient wards: two adult medical wards, two adult surgical wards, two postnatal wards, one children’s ward, one isolation ward for infectious diseases, one labour room, one nurse and two TB wards with 40 beds. The post-caesarian section ward is empty most of the time because these operations are done in Umtata.

The laboratory is run by a lab assistant. She has no easy way of consulting specialists or getting support. The X-Ray Department is run by a radiographer. The theatre is mainly used for minor surgery. The kitchen is run by a private catering company, which prepares all the hospital meals. The pharmacy’s run by a dispensary assistant. There is no physiotherapist or occupational therapist at the hospital.

The X-Ray Department also has a number of problems. For example, at present, there is only one working machine in the entire district. When the X-Ray machine at Sipetu Hospital broke down, the radiographer did not know what to do. She says that she has tried to get advice from the provincial office but has failed not received an answer. If the X-Ray machine in Mary Theresa Hospital breaks down, the entire district will be without radiographic services.

The floor of the X-Ray room is “sinking”. Structural faults in the construction of the room has led one end of the room to be several inches lower than the other end of the room. As a result, the X-Ray machine fittings on the ceiling has become distorted resulting in the X-Ray machine being damaged. In addition, many of the walls of the X-Ray machine are beginning to show serious cracks and faults. These problems are causing the X-Rays to be of poor quality, and have meant that the normal servicing of the X-Ray machine has been suspended. As a result, there is a potential health hazard to the patient, and the radiographers have therefore stopped carrying out non-urgent X-rays.

Clinics

An inventory of all the fixed, satellite and mobile clinics in the district is essential. All the clinics should be clearly marked on a map. It may be useful to draw a circle indicating a ten kilometer radius around each clinic. This gives an idea of how accessible the clinics are to the people in the district. The information can be presented in a tabulated form or it can be described as a case study (see examples below). Use the following headings:
**Infrastructure**

How many clinics are without basic infrastructure, piped water, electricity, security fencing and a telephone? If piped water and/or electricity are not available, document how staff get power and water.

**Services provided by the clinics**

This includes hours of opening as well as the range of services provided by the clinics. Try and include some basic statistics about the workload and types of consultations seen as shown in the example below:

---

### Attendances at clinics in the IPU District, March 1997

<table>
<thead>
<tr>
<th>Clinics</th>
<th>Antenatal</th>
<th>Family Planning</th>
<th>Immunisation</th>
<th>STD</th>
<th>Psychiatry</th>
<th>Other Adults</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gomane</td>
<td>190</td>
<td>388</td>
<td>302</td>
<td>101</td>
<td>25</td>
<td>2,025</td>
<td>3,031</td>
</tr>
<tr>
<td>Gwala</td>
<td>113</td>
<td>142</td>
<td>184</td>
<td>35</td>
<td>30</td>
<td>1,007</td>
<td>1,511</td>
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<tr>
<td>Gqumeni</td>
<td>72</td>
<td>8</td>
<td>206</td>
<td>33</td>
<td>6</td>
<td>66</td>
<td>1,025</td>
</tr>
<tr>
<td>Mnヤnマナ</td>
<td>44</td>
<td>78</td>
<td>56</td>
<td>17</td>
<td>7</td>
<td>626</td>
<td>1,025</td>
</tr>
<tr>
<td>Nヤnマララ</td>
<td>72</td>
<td>8</td>
<td>206</td>
<td>33</td>
<td>6</td>
<td>66</td>
<td>1,025</td>
</tr>
<tr>
<td>Nヤnマララ (Mobile)</td>
<td>15</td>
<td>44</td>
<td>66</td>
<td>12</td>
<td>19</td>
<td>190</td>
<td>780</td>
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<td>Pholela</td>
<td>125</td>
<td>93</td>
<td>404</td>
<td>42</td>
<td>7</td>
<td>676</td>
<td>1,706</td>
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<td>6</td>
<td>676</td>
<td>1,706</td>
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<td>Sandaneze</td>
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<td>56</td>
<td>90</td>
<td>12</td>
<td>19</td>
<td>190</td>
<td>780</td>
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<tr>
<td>Underberg (Mobile)</td>
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<td>820</td>
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<td>140</td>
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</tr>
<tr>
<td>Underberg</td>
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<td>290</td>
<td>1,067</td>
<td>68</td>
<td>160</td>
<td>1,025</td>
<td>3,226</td>
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<tr>
<td>St. Apollinaris (PHC)</td>
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<td>204</td>
<td>466</td>
<td>53</td>
<td>1,483</td>
<td>1,483</td>
<td>3,226</td>
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<td>Fixed</td>
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<td>Total</td>
<td>838</td>
<td>1,654</td>
<td>2,945</td>
<td>2,945</td>
<td>8,099</td>
<td>8,099</td>
<td>17,067</td>
</tr>
</tbody>
</table>
These figures show again that more time is spent on curative service than on preventive care. The Underberg Mobile clinic is the only one which seems to have more emphasis on the preventive as shown by its family planning and immunisation figures. The reason for this increase in preventive services are thought to be due to Specialised Auxiliary Service Officers running the Immunisation Position and due to the fact that there is a full family planning professional nurse.

### Problems experienced by the clinics

Often the best way to do this is to take one or two clinics and use them as case-studies. Here is an example taken from the Mount Frere situation analysis.
<table>
<thead>
<tr>
<th>Clinic</th>
<th>Electrification</th>
<th>Communications:</th>
<th>Fencing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Radio-phone</td>
<td>Poor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Struck by</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>lightning twice</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>&amp; isn't working</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone line,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>not working</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone line,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>last worked</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>8 years ago</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Working</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>but not now</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Working</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Working</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone line,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Working</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone line,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Working</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone line,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Working</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone line,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Working</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone line,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Working</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone line,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Working</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone line,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Working</td>
<td></td>
</tr>
</tbody>
</table>

| Source:   | District Office of Mount Frere, April 1997 |

Key: S = Solar  T = Temporary  UC = Under construction  P = Permanent  NO = No  YES = Yes  NIL = Not applicable
3.5.2 Referral System

An important element of a well functioning district is having a good working relationship between clinics and hospitals. It is important to explain the relationship between clinics and hospitals within the district and also the mechanisms for referral of patients to secondary or tertiary centres. Try and provide answers to the following questions in the situation analysis.

- Is there a clear and documented referral policy for patients?
- Do staff receive adequate feedback regarding their referrals?
- Is the referral system working well?
- Are patients being referred appropriately?
- What are the major problems regarding the referral of patients?

3.6 Other health care providers

3.6.1 The private medical sector

The number, names and addresses of private sector health care providers should be listed together with the types of services offered. Retail pharmacists may be included, especially in rural areas. The relationship and degree of co-operation between the public and private sector should also be described.

<table>
<thead>
<tr>
<th>Town</th>
<th>Number of private practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edenburg</td>
<td>1</td>
</tr>
<tr>
<td>Fauresmith</td>
<td>2</td>
</tr>
<tr>
<td>Gariep Dam</td>
<td>1</td>
</tr>
<tr>
<td>Jacobsdal</td>
<td>1</td>
</tr>
<tr>
<td>Jagersfontein</td>
<td>1</td>
</tr>
<tr>
<td>Koffiefontein</td>
<td>1</td>
</tr>
<tr>
<td>Luckhoff</td>
<td>0</td>
</tr>
<tr>
<td>Oppermansgronde</td>
<td>0</td>
</tr>
<tr>
<td>Petrusburg</td>
<td>1</td>
</tr>
<tr>
<td>Philippolis</td>
<td>1</td>
</tr>
<tr>
<td>Reddersburg</td>
<td>1</td>
</tr>
<tr>
<td>Springfontein</td>
<td>1</td>
</tr>
<tr>
<td>Trompsburg</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
</tr>
</tbody>
</table>
As with the public health sector, medical services in the private sector are lean. Only 12 private practitioners could be identified in the entire district, and the only town having more than one GP was Fauresmith. Both Luckhoff and Oppermansgronde have none, and patients from these towns have to avail themselves of visiting practitioners elsewhere. This small number of medical practitioners for a population of about 80,000 renders a doctor:population ratio of about 15 per 100,000. While this presents a more positive picture than for the Free State as a whole (in 1994 the doctor:population ratio stood at 1, 1 per 100,000), it compares poorly with Gauteng (44 per 100,000), or the Western Cape (35 per 100,000).

Although a large part of the national population does not make use of private practitioners, in the Gariep district almost all the public medical services are rendered on a part-time, sessional and contractual basis by the practitioners.

Source: Centre for Health Systems Research and Development, 1997. The Health of Gariep. Published by Health Systems Trust

3.6.2 The traditional health sector

If possible, a list of all registered traditional health practitioners should be drawn up. Any interaction between the traditional health sector and the health services should also be documented. Describe the extent to which the local population makes use of traditional healers.

3.6.3 The NGO sector

Make a list of all NGOs that are active in health in the district, together with a brief description of their activities.

3.7 Assessment of key health programmes and services

This section of the situation analysis focusses attention on what is being done. It describes what activities are taking place within the different key health programmes and services. An analysis should be conducted to identify the strengths and weaknesses of these programmes and services, and to assess whether the activities are appropriate, effective and efficient.

Health programmes are supposed to ensure the coordination of the different health care activities that are related to a specific group of conditions (eg. malnutrition), or to a specific target group of the population (eg. pregnant women). They should include community-based care, clinic-based care and hospital-based care. They should be comprehensive in terms of providing preventive, promotive, curative and rehabilitative health services.

Where possible, for each programme or health service, provide some information on the following:

- the aims, objectives and targets of the services and programmes;
- the current set of activities and services;
- the person or people responsible for managing and supervising these activities;
the personnel available to work in the programme;
the quality of care provided;
the problems and constraints involved with the implementation of the required activities;
how the activities relate to other services provided in the district;
the problems that need to be solved in order to improve the effectiveness and efficiency of the activities.

A critical assessment of how the programme or service is contributing to meeting the overall needs of the district should also be included. Below is a list of these programmes and some suggestions about the types of activities which could be described.

**Maternal and Reproductive Health**
- Antenatal care.
- Management of normal and complicated deliveries.
- The care of newborn babies.
- Post-natal care.
- Family planning.
- Termination of pregnancy.
- Management of home deliveries.

**Child Health & EPI**
- Immunisation coverage and immunisation campaigns.
- The distribution of vaccines and the maintenance of the cold chain.
- Integration of preventive and curative child care.
- Management of common childhood illnesses, especially diarrhoeal disease and acute respiratory infections.
- In-patient paediatric care and access to specialist services.
- Services for children with disabilities and special needs.

**School Health**
- The number of schools in the district.
- School health promotion.
- Health education in the school curriculum.
- Special schools.
- Inter-sectoral collaboration between the health and education sectors.
Nutrition and growth monitoring

- PEM Scheme.
- Growth monitoring.
- Community Based Nutrition Programmes.
- The Primary School Nutrition Programme.
- Nutrition education and health promotion.
- Inter-sectoral collaboration.

STDs/HIV

- Diagnosis and treatment of STDs.
- Health promotion.
- The management of people with HIV/AIDS.

Tuberculosis

- Diagnosis.
- Compliance rate and the system of supervision for the treatment of patients with TB.
- Assessment of resistant TB in the district.

Environmental Health

- Inter-sectoral collaboration.
- Community participation.
- Distribution of environmental health-related services and training.
- Environmental health education.
- Sanitation and sewage.
- Vector surveillance and vermin extermination.
- Meat inspection services.
- Domestic water supplies.

Oral Health

- Personnel.
- Services.
- Specialist care.
- Preventative strategies
Mental Health
- Personnel.
- Services.
- Specialist care.
- Community-based care.
- Intersectoral collaboration.

Rehabilitation and disability services
- Personnel.
- Services, eg. provision of aids such as wheelchairs in the district.
- Specialist care.
- Preventative strategies.
- Welfare services for grant applications etc. for disabled people.

Chronic diseases
- Management of diabetes.
- Management of asthma.
- Management of hypertension.

Example of three very brief descriptions of health programmes from the IPU district of KwaZulu-Natal.

Mental Health
These services are provided in the district but district health workers feel that the services are fragmented and that clients are not receiving optimal services. Most of the fixed clinics refer acutely ill patients and follow up chronic ones. Ill patients are referred to the “mother hospitals”.

Psychiatric drugs are presently dispensed by the district surgeon only in the Underberg sub-district and by the community - based team from Edendale hospital team which visits clinics in the Impendle and Pholela sub-districts, and these are not always available.

Other facilities available for clients in the district are:
- Hlanganani Ngothando centre which is a non-government organisation catering for children with profound mental handicap
- Pevensey place for mentally handicapped adults.
- Sunnyside farm for the mentally handicapped
Oral Health
At present there are no dental services in the district. There is a dentist room with some equipment in Pholela Clinic, but it is not used. People have to go to “mother hospitals” or to Ixopo dental clinic which opens on Tuesday and Thursday mornings only. An oral hygienist who was investigating dental problems believes that there is an urgent need for dental services in the district both in schools, and in the broader community.

School Health Service
These services are available in the Impendle and Pholela sub-districts, but the Pholela sub-district seems to be the only one that is still active. Services in the Underberg sub-district were provided until about 1993. The staff rendering these services are based at Edendale Hospital except for the two nurses based at Pholela.

There are 146 schools in the whole district. The school health teams visit the schools once or twice a year, but recently services have been erratic. At the beginning of 1997, new nurses were introduced to the district and have immunised children in preschools. As the school health teams are based at Edendale hospital and only come to the district when they need to visit a certain school, there is a problem of integration with other services. There needs to be a review of these services.

3.8 OTHER SECTORS WHICH IMPACT ON HEALTH

The Primary Health Care Approach emphasises the importance of providing a multi-sectoral approach to health care delivery. The welfare, education, agriculture, and water affairs sectors, for example, have a very important role to play in addressing the problems of malnutrition. The HIV epidemic, violence, substance abuse, diarrhoeal disease and tuberculosis are other examples of health problems that require a multi-sectoral approach to elective health care delivery.

When writing a rapid situation analysis of a health district, it is therefore useful to briefly describe the following:

- the extent to which the district health services plan and implement activities together;
- the important health-related activities of the other sectors; and
- the forums that exist to allow for inter-sectoral collaboration.
**Description of Inter-sectoral Collaboration from the Gariep District of the Free State**

Most of this interaction consists of the “normal” duties of officials (such as a police officer working together with a medical officer in conducting a post mortem examination). On the other hand, when such an officer plays an active role in informing the community of the visit of the state dentist, this is an indication of an effort to assist local health providers. Instances do occur in Gariep where health providers interact with officials from other departments. However, in Gariep, there does not appear to be any concerted strategy by various state departments to combat any particular health or health-related threat or problem.

**Intersectoral collaboration in health in the Gariep-district, mid-1997**

<table>
<thead>
<tr>
<th>Department</th>
<th>Aspects/issues</th>
<th>Towns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture</td>
<td>· Sanitation and environmental health supervision</td>
<td>Jagersfontein, Koffiefontein and Oppermansgronde</td>
</tr>
<tr>
<td></td>
<td>· Regular interactive meetings with Department of Health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Establishment of food gardens</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Information days</td>
<td></td>
</tr>
<tr>
<td>Department of Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Establishment of food gardens</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Information days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Health education amongst prisoners regarding AIDS</td>
<td>Fauresmith</td>
</tr>
<tr>
<td>Correctional Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Health education amongst prisoners regarding AIDS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Dental service at schools</td>
<td>Edenburg, Fauresmith, Jagersfontein, Koffiefontein and Luckhoff</td>
</tr>
<tr>
<td></td>
<td>· Health Education services at schools</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Establishment of food gardens</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Referral of ill or abused children to clinic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Feeding schemes at schools</td>
<td></td>
</tr>
<tr>
<td>Department of Labour</td>
<td></td>
<td>Koffiefontein</td>
</tr>
<tr>
<td></td>
<td>· Work together with regard to work-related injuries and illnesses in terms of the Occupational Health and Safety act and the Compensation for Occupational Injuries and Diseases Act</td>
<td></td>
</tr>
<tr>
<td>Social Services</td>
<td></td>
<td>Fauresmith, Jagersfontein, Koffiefontein, Luckhoff and Oppermansgronde</td>
</tr>
<tr>
<td></td>
<td>· Work together with Nutrition Sub-directorate with regard to feeding scheme for creches</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Health educational talks at social development projects</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Family pathology monitoring</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Social grants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Referral of drug and alcohol abusers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Social workers visit clinics twice per month to address welfare problems</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Sanitation subsidies</td>
<td></td>
</tr>
</tbody>
</table>
South African Police Service

- Referral community members to appropriate health services
- Help with dissemination of health information
- Assist health and social workers in rape and child abuse cases
- Contact transport contractors in emergency cases
- Consult with district medical officers regarding emergency cases

Source: Centre for Health Systems Research and Development, 1997. The Health of Gariep. Published by Health Systems Trust

### 3.9 Summary of key health problems and conclusion

The final section of the situation analysis should consist of a summary of the following:

- Important areas of progress and development in the district over the previous year.
- The most important and urgent health problems of the district.
- An indication of how these priority problems will be addressed.

Finally there should be an honest assessment of the strengths and weaknesses of the district that lay out the challenges for the future. The conclusion should also describe some of the factors that lie outside of the district which may hamper continued progress and development. Below is an example of the concluding section of the report from the Impendle/Pholela/Underberg district of Kwazulu-Natal as an example.
### Future plans for the IPU District

The district teams have plans to tackle each of the following problems:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Specific</th>
<th>Way forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug supply systems</td>
<td>System chaotic at present</td>
<td>Feasibility study - district depot</td>
</tr>
<tr>
<td>Equipment</td>
<td>Maintenance Replacement Requisition</td>
<td>Draw up list of essential equipment for clinics and hospitals List requirements of each clinic</td>
</tr>
<tr>
<td>Information</td>
<td>Time spent on form filling without benefit</td>
<td>Information workshop to set up new systems</td>
</tr>
<tr>
<td></td>
<td>No feedback</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inadequate knowledge about the population</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>Channels of communication poor. No contact people. Little access to sources of information for communication.</td>
<td>Resource list of contact people. Telephone meetings. Telkom/Healthlink</td>
</tr>
<tr>
<td>Provinicial and Regional support</td>
<td>Poor and unclear support.</td>
<td>Clear commitment to process is required from the region and province.</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>Nurses accommodation needs to be addressed so as to get staff.</td>
<td>Consolidated inventory and assessment of infrastructure needs Clinic Upgrading and Building Programme</td>
</tr>
<tr>
<td></td>
<td>Upgrading Pholela Water supply to clinics Telephone at Gwala &amp; Pholela Clinics.</td>
<td></td>
</tr>
<tr>
<td>Staffing numbers/ allocation</td>
<td>Allocation of posts</td>
<td>Staff profile to be drawn up Staff situation in relation to population/utilisation</td>
</tr>
<tr>
<td></td>
<td>Utilisation of services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Use of posts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- district manager</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- trainer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- management team</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Security</td>
<td></td>
</tr>
</tbody>
</table>
Following identification of these plans the district needed to look at allocation of portfolios in order to ensure that these tasks are done. The allocation was as follows:

- Management system - Terrence Stafford
- Information - Mr. Sipho Msimang
- Communication - Sr. Lindiwe Zuma
- Infrastructure - Dr. Liz Thomson
- Staffing - Mrs. Nontobeko Mchunu and Mrs. Jean Nzimande
- Staff training and skills development - PHC Training Coordinating Committee

An urgent requirement towards implementing these plans includes having funds to:
- employ the full time district manager;
- provide an office for him/her;
- employ an information officer (possibly on a 2 year contract) and an administration clerk;
- provide a car for the district manager; and
- employ a full time trainer for the district.

Conclusion

IPU district is an ISDS site that has a number of needs, problems and resources. The identification of these has helped the teams see the way forward. The teams that are in place are very active and committed.

The district staff is aware of the commitment that the province and the region has pledged towards the district health system, but is at this point facing a problem of not knowing how best to address problems and needs because of poor support. There are questions and problems with which these two offices could help the district. The most urgent one is that the staff is allocated to the district but are not released from their other duties.

Attempts have been made to bring all role-players on board. This has been achieved to some extent but ongoing effort is still needed. Impendle sub-district seem to be taking a lead on this as it already has a sub-district action team that is meeting regularly. This move has been very positive and helpful particularly at this stage when there is a need to address the issue of community involvement in health.
Section 4: USEFUL INFORMATION SOURCES

Your provincial department of health should be able to supply you with some of the information that you need for conducting the analysis. This section aims to provide some suggestions of additional sources which may provide you with useful information.

4.1 Offices of the Central Statistics Services (Website: http://www.css.gov.za)

The CSS publish regular reports in a number of formats. Provincial reports that combine information from various sources (including the October Household Surveys) contain information that may be useful when undertaking a district situation analysis such as census data and socio-economic indicators. The regional offices are listed below:

**EASTERN CAPE**

Bisho (Head Office)  
B22 Chungwa House  
Bisho Shopping Centre  
Private Bag X0044  
5605 Bisho  
Tel: 0401 99 2457  
Fax: 0401 99 2458

Port Elizabeth  
186 Govan Mbeki Avenue  
Private Bag X6069  
6000 Port Elizabeth  
Tel: 041 52 3801/2  
Fax: 041 55 4798

Umtata  
Private Bag X5004  
5100 Umtata  
Tel: 0471 305 2038  
Fax: 0471 25 782

**FREE STATE**

SA Eagle Building (3rd Floor)  
Maitland Street  
Bloemfontein  
Private Bag X20541  
9300 Bloemfontein  
Tel: 051 447 7766/7  
Fax: 051 47 8402

**GAUTENG**

Pretoria (Head Office)  
Steyns Building (8th Floor)  
Schoeman Street  
Pretoria  
Private Bag X44  
0001 Pretoria  
Tel: 012 310 8911  
Fax: 012 310 8500
Johannesburg
Trust Bank Building
Cnr. Wolf and Voortrekker Streets
Kempton Park
Private Bag X04
1620 Kempton Park
Tel: 011 394 3420/1
Fax: 011 394 3463

KWAZULU-NATAL
Escoval House (17th Floor)
437 Smith Street
Private Bag X54337
4000 Durban
Tel: 031
Fax: 031

MPUMALANGA
Jaco Nel Building
17 Henshall Street
Nelspruit
Private Bag XI 1290
1200 Nelspruit
Tel: 013 753 2455/6
Fax: 013 753 2279

NORTH WEST PROVINCE
Head Office
Garonas Building (2nd Floor)
Dept. of Economic Affairs
Mmabatho
Private Bag A20
2570 Klerksdorp
Tel: 018 462 4324
Fax: 018 464 1440

NORTHERN CAPE
New Public Buildings (4th Floor)
Cnr Knight and Stead Street
Kimberley
Private Bag X5053
8300 Kimberley
Tel: 0531 33 965/6
Fax: 0531 25 407

NORTHERN PROVINCE
Gani House
90 Bok Street
Pietersburg
Private Bag X9941
0700 Pietersburg
Tel: 0152 295 7521
Fax: 0152 291 1302

WESTERN CAPE
Volkskas Building (9th Floor)
132 Adderley Street
Cape Town
Private Bag X 9072
8000 Cape Town
Tel: 021 23 1040
Fax: 021 22 1741
4.2 Provincial ReHMIS Reports

These are health service reports published by Health Systems Trust using data from 1994. Some provinces are planning to update these reports.

4.3 Provincial Development Council Reports

Development Councils are in the process of being set up in each province. They will publish regular reports regarding all aspects of development. Only the Western Cape office is open at present.

11th Floor
Wale Street Chambers
33 Church Street
8000 Cape Town

PO Box 15134
8018 Vlaebeg
Tel: 021 26 2825

4.4 Maps

The provincial department of health should be able to supply districts with maps. If they are unable to, it may be useful to approach the provincial Informatics or Local government departments. Maps can also be obtained from the following government departments. If ordering by post it is important to state clearly the areas for which maps are required.

Free State
Surveyor-General
Private Bag 30634
9300 Bloemfontein

Tel: 051 48 0955

Gauteng
Government Printers
Private Bag X85
0001 Pretoria

Tel: 011 323 7205

KwaZulu-Natal
Surveyor-General
PO Box 396
3200 Pietermaritzburg

Tel: 0331 45 1215

Western Cape
Department of Land Affairs
Private Bag 10
Rhodes Avenue
7700 Mowbray

Tel: 021 685 4070
4.5 Other Information Sources

If you have access to the Internet, you visit the HealthLink website (http://www.healthlink.org.za). All ISDS publications can be accessed (under District Health Systems) as well as the DOH’s District Health News (on Healthlink site). The South African Health Review is also available. These resources can also be obtained by writing to:

Healthlink
504 General Building
Corner of Smith and Field Streets
Durban
PO Box 808
4000 Durban
Tel: 031 307 2954
Fax: 031 304 0775

Maternal and Child Health Information and Resource Centre
Child Health Unit
46 Sawkins Road
7700 Rondebosch
Cape Town
PO Box 808
4000 Durban
Tel: 021 685 4103
Fax: 021 689 5403
E-mail james@rmh.uct.ac.za

Women’s Health Resource Centre
Women’s Health Project
PO Box 1038
2000 Johannesburg
Tel: 011 489 9927
Fax: 011 489 9922

Medical Research Council
Information Services Division
PO Box 19070
7505 Tygerberg
Tel: 021 938 0435
Fax: 021 938 0315

Human Sciences Research Council
Library & Information Services
Information Helpdesk
Toll-free 0800 11 7733
Enquiries 012 302 2925 Elke de Beer
Evaluation and feedback form

The purpose of this form is to provide us with feedback on how this manual could be improved in future editions.

Name: ___________________________ Job description: ______________________

Question 1: What are your general comments and suggestions about this manual? How can it be improved? ______________________

Question 2: Section 3 of this manual, how did you rate the various sub-sections?

<table>
<thead>
<tr>
<th>Sub-section</th>
<th>Not useful</th>
<th>Useful</th>
<th>Very useful</th>
<th>Comments/ Suggestions</th>
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Question 3: In Section 4, are there any other sources of information that you think should be listed? If so, what are they:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Question 4: Are there any data-collecting tools that you would recommend? If so please could you send examples of these to ISDS.

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Thank you for your contribution.

Please return this form to:

ISDS
Health Systems Trust
504 General Building
Cnr Smith & Field Streets
Durban 4001
South Africa