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ANNUAL HOSPITAL REPORTS IN THE CONTEXT OF PRIMARY HEALTH CARE

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Introduction

This document has been developed through the generous overall support of Medicus Mundi Internationalis, in order to assist the World Health Organization in its efforts towards orienting hospitals to primary health care. The National Council for Public Health and the Institute for Health Care in the Developing World of the University of Nijmegen, both in the Netherlands, have alloted the authors - who have worked in the developing world - time and facilities to work on this document.

The aim of this document is to contribute to the enhancement of hospital management by improving the quality of annual hospital reports. The ideas and suggestions to reach that goal are condensed in part two of this document: a guideline for annual hospital reports, with particular reference to developing countries.

The following considerations are basic to the ideas and suggestions in the "guideline":

1. Hospitals should not merely give an account of data and events concerning the hospital itself, but should relate hospital information to the local health system that aims at improving the health status of the community.

2. The annual hospital report should serve as a tool for reviewing and reflecting on hospital policies and activities.

In PART ONE, the first paragraph, a general outline is presented of the primary health care approach and the potential of hospitals in its support. This general outline is followed by a discussion on the potential and limitations in support of primary health care at the first referral level hospital. Then some remarks are made on the importance of annual hospital reports and on the choices that hospitals will have to make concerning the information that can be included in them. The first paragraph of part one ends with some thoughts on the role of annual hospital reports as a tool for reviewing and reflecting on hospital policies and activities.

In the second paragraph of part one, the guideline is introduced as an example of how an annual hospital report can be made. Attention is paid to the purpose and the structure of the guideline. Although the guideline is intended for use in a flexible manner, and must be adapted to the circumstances in which it is used, it also aims at providing a framework for standardization of annual hospital reports.

In PART TWO - the guideline - the issues of part one are blended together into a practical instrument that hospitals might find useful to consult for writing annual reports. The set-up of the guideline is similar to the suggested set-up of an annual report. The guidelines should be seen as an instrument enabling hospitals to express their concern for the health of the community and thereby to investigate the potential of contributing to health improvements.

Any feedback that could materially improve this document, comments or suggestions based on practical experience from those involved in writing or reading annual hospital reports, would be highly appreciated as well as a copy of their current reports. Reactions can be sent to SHS division, World Health Organization, CH-1211 Genève, Switzerland, as well as requests for additional copies.

PART ONE: CONSIDERATIONS

1.1 Hospitals and primary health care

As partners in local health systems, hospitals play a crucial role in support of primary health care (PHC). Dr H. Mahler, Director-General of the World health Organization, sees this role as follows:

> "a health system based on PHC cannot, and I repeat, cannot be realized, cannot be developed, cannot function and simply cannot exist without a network of hospitals with responsibilities for supporting primary health care, promoting community health development action, basic and continuing education of all categories of health personnel, and research".

Commitment to the goal of "Health for All through the PHC approach" should spur hospitals to reconsider their present activities. Are these in support of primary health care? Is notice being taken of the essence of PHC philosophy - that health and health care is in the first place a matter for the community and not merely a medical-technical affair?

In reconsidering activities one might look at aspects of PHC in the light of a) health programme, b) health infrastructure and c) health organization. For each of these three facets a brief outline will be given to facilitate hospitals in realligning their activities in relation to them.

Eight elements of PHC are seen as the minimum or core of health programmes:

- education concerning prevailing health problems and the method of preventing and controlling them;
- promotion of food supply and proper nutrition;
- safe water supply and basic sanitation;
- maternal and child health care including family planning;
- immunization against the major infectious diseases;
- prevention and control of locally endemic diseases;
- appropriate treatment of common diseases and accidents;
- provision of essential drugs.

Apart from the PHC programme elements there is a need for a health infrastructure to enable meaningful functioning of the elements as a health system. This infrastructure includes:

- An information system, including community assessment, ongoing surveillance of health problems and needs, monitoring of programmes;
- Management functions, including planning, implementing, financing, evaluation;
- Manpower development, including recruitment, training, supervision, continuing education;
- Logistics, including supplies, transport, communications, maintenance.

Most hospitals have activities that are in line with the PHC elements and even with those of the health infrastructure. It is through application of the elements of health organization that PHC is implemented. Elements of health organization include:

- existence of referral system
- intersectoral cooperation
- community involvement
- training and supervision.

For each of the aspects of the health programme and the health infrastructure the question should be raised as to what extent these organizational aspects are taken into consideration. For example:

- In the case of water supply and basic sanitation: is the community asked for views and priorities; is it involved in implementation; what about collaboration with other sectors?
- In the case of mother and child care services, is there in practice a possibility for referral; are the people asked for their views on child rearing and malnutrition; are they involved in the programming of mobile teams?
- In what way and at what levels is the community involved in drawing up local health policy and in carrying out health activities?

It is by questions like these that the concern with the social goal for health for all as advocated by the primary health care philosophy, can become apparent.

In each of the chapters of the guideline (part two of this document) remarks and suggestions are made intended to help hospitals to pose the questions that relate reported activities to their bearing on the community. Answers may hopefully lead to a process of change in the way activities are given prominence.

In conclusion it can be stated that looking at activities in relation to the health programme, the health infrastructure and the health organization will enable the hospital to get a clear view of its contribution to the development of primary health care in the local health system.

1.2 The hospital at the first referral level

In view of the programme, infrastructure and health organization, hospitals may wonder whether they will be capable of functioning in line with all of them. Prevailing circumstances and not intentions might well be the limiting factor. Such misgivings will definitely and understandably be present in the hospital at the first referral level - the focus in this document.

The hospital at the first referral level is understood here to mean a health facility in the local health system with beds, medical staff and sufficient other resources to perform health activities that cannot be carried out at a lower level. It is perceived as the interface between health care at the lower levels of complexity and the rest of the system. In this sense the hospital at the first referral level is seen as serving two functions:- one, that of a first level facility for patients that come in, mostly from its immediate surroundings and second, that of a referral hospital. The hospital is seen as the focus for referral and support for both the clinical and the public health aspects of PHC. Referral then is understood in two ways: people problems and public health/administrative problems. In this view referral is a vital form of support - at the heart of the relationship between other health functions and the hospital itself. In reality there is most of the time no equal balance between the two aspects of referral - the clinical aspect is in most cases predominant. Even then most hospitals cannot respond to their referral responsibility to the full. The reasons for this are probably that:

a. When the other facilities in the local health system do not function properly, patients just bypass them and go straight to the hospital;

b. Even when patients are properly referred they might not be able to come to the hospital for lack of transport or means of subsistence;

To make things more complicated, many hospitals - at least in developing countries - find themselves in a position of having to deal with, on the one hand an increasing workload and, on the other, the same level or sometimes even declining resources. So it may be that such hospitals find it difficult to reflect on their contribution and respond to the exigencies of PHC development, depending upon their sensitivity to all these elements.

Does one therefore dare to ask hospitals to support PHC, let alone redirect their resources? Is this possible without lowering the hospitals' present standards? Hospitals need to be frank in answering these questions, as it is through their involvement in PHC that their activities really affect the community.

Nonetheless it is encouraging that hospitals reporting to WHO in 1985 have not only shown their solidarity in the attainment of the goal of health for all and the PHC approach, but have demonstrated practical involvement.

The guideline in part two of this document provides information that may enable hospitals to make this contribution.

1.3 General Remarks about Annual Hospital Reports

In virtually every hospital information exists which can be used as the starting point for an annual report. As a matter of routine (departmental) records are kept on a variety of items arising from information requirements for day to day hospital management. Besides that, much more information is available although not recorded for daily requirements.

Only part of the information available to hospitals will appear in annual reports. Unless guidelines from health care authorities exist, hospitals will have to make choices as to what information will be reported on in the annual report, and what not.

An annual report is important for the following reasons:

- it is often the only public document about health and health services to the community, the government and other relations;
- it enables an informed discussion about the development of the hospital; only through information about the hospital can understanding of hospital functioning, also in support of primary health care, be improved;
- it enables review and reflection on a hospital's explicit statements and policies, also in relation to primary health care;
- it can serve to draw attention to problems;
- it can be a mechanism to facilitate communication between different organizational levels within the health sector and with other relevant sectors, as well as a mechanism for joint policy development and planning, for instance in a health development committee.

Annual reports serve various purposes and can be directed to various users. Unless guidelines exist from national/regional health care authorities, hospitals will need to ask themselves what information should be presented, as information is relevant principally to a goal or a target. Thus hospitals should seek to include in annual reports the information which is needed for clearly defined purposes and users of such knowledge.

The purpose of these reports could be, and often is a mixture of:

- the provision of clear and digestible information;
- explanatory and factual information - clear, concise, and simple;
- new proposals - the pros and cons of change;
- a basis for planning;
- reviewing and reflecting on information as a means of self-evaluation or self-assessment. <u>This is the central theme in this document</u>.

Determining who the users are and what information they need is another important aspect in the process of selecting the data to be included in the annual report. Annual reports can be and often are directed to a combination of the following groups or persons:

- a group or individuals reponsible for and involved in the overall policy of the institution: members of the board of governors, hospital advisory committee; hospital management team;
- representatives of organized community groups if they are not participating in hospital management: trade unions, women's groups, religious groups, youth groups;
- other health care institutions or health care workers;
- representatives of health related sectors (education, water, housing, etc.);
- representatives of local government;
- officials at the district health office, regional health office, Ministry for Health, or other coordinating or advisory health care organizations;
- sponsors of the hospital; the employer.

Annual report information may be collected for policy, technical, and managerial purposes at local level and for use at intermediate or national level. This information may be analyzed, interpreted and presented in different ways, depending on these purposes. The intermediate and central levels of the health care system are often primarily concerned with supervision, coordination and support rather than service delivery.

A lot of information is collected and some of it is often of questionable utility. Thus, in the first place, one needs to sift through and assess what is really needed in the report.

Then there is the question of what a hospital's capacity is in terms of investment in reporting - time, materials, money. What should the balance be vis-à-vis what is assigned to hospital activities per se.

1.4 Using Annual Reports for Review and Reflection

As inferred above, hospital strategy requires reorientation so as to respond more effectively to what PHC calls for. Hospitals should be engaged in developing or updating strategies to determine their role in primary health care.

The local health (care) system, including hospitals is clearly dependent upon the way in which resources are obtained and used to meet the health needs of a community. The need for resources is always greater than their supply . This implies that choices have to be made as to how to allocate resources amongst many competing activities.

Activities of hospitals may take place in various locations: on the hospital compound (treatment of the sick), in other health care institutions (supportive visits to primary health care units), in the community at large (education, work with community leaders or committees), in households (home visits) and in institutions of other social sectors (schools, workplace etc.).

Hospitals carry heavy service loads and therefore do not often step back to consider whether what was intended is being achieved or whether current directions are likely to result in a satisfactory balance between different competing activities. Sometimes there is even a lack of concern with identifying objectives at operational level. It is hardly surprising then to find this mirrored in a lack of concern with PHC or health development priorities, i.e. the relative weighting of different objectives.

Once these objectives are set, monitoring of progress is needed to assess whether targets are being reached. Merely defining objectives, targets and strategies for reaching them does not guarantee success. Nor does it mean that they are necessarily the most appropriate or economic ones. Hence the need for a systematic process of review and reflection. It is a matter of thinking about and discussing "what we are and what we are doing, how we got there (i.e. past trends) and where we are going, or, subject to planning, where we want to go". Hospitals can do this type of reflection or research to increase performance. In this way results can easily be implemented stepwise and lead to health development.

To enable hospitals to know whether they are making progress in their contribution to the attainment of an acceptable level and balance of activities, annual reports can be used as an instrument. For that reason they deserve much effort and attention. Writing annual reports for review and reflection can be a systematic way of learning from experience and using the lessons learned, a way to improve current activities and promote better planning by careful selection of alternatives and priorities for future action. It can help to make health activities more relevant, more effective and more efficient.

The responsibility for writing the hospital annual report devolves on the individual(s) or group(s) who are responsible for hospital management. Writing annual reports calls for an attitude of constructive criticism and frankness leading to sound judgement. It also requires willingness of all concerned to communicate freely.

Review and reflection can take place at two interlinked hospital levels: the policy level and the managerial or technical level.

At policy level there should be a need to know whether the health status of the population is improving and whether revision of policies, strategies and plans of actions is required.

At managerial level there is a need to know whether programmes are properly formulated, whether corresponding services/activities for implementing them are being adequately designed, whether programmes are being efficiently implemented through suitably operated health (related) services.

Hospitals should try to review and reflect on the basis of the following:

1. efficiency: how economically, i.e. without wasting resources, are the activities or the results being produced;
2. coverage: the proportion of people who actually avail themselves of specific health activities;
3. effect/impact/outcome of activities: the changes in health status which can be attributed to hospital health care.

Measurement of these aspects requires increased sophistication of the information system as one proceeds from efficiency to impact, but it remains the impact/outcome/effect which ultimately counts in assessing performance.

Hospitals will need indicators to find out whether they are making progress in their contribution towards reaching a level of health that is "satisfactory" or "the highest possible" given the circumstances of the hospital. Four categories of indicators can be differentiated:

- social and economic indicators;
- health policy indicators;
- indicators for the provision of health services;
- indicators for health status.

In order to pass judgement on indicators, criteria/yardsticks have to be devised. Criteria can be technical or social in nature. A judgement can rarely be arrived at just by studying figures. Nevertheless, criteria for reflection or (self) evaluation by hospital management should be quantified wherever possible and feasible. In practice this will not always be easy, particularly where social criteria are used. It is therefore often necessary to resort to reflection based on qualitative rather than quantitative assessment. Often indicators measure a complex situation, but if measured sequentially over time they can provide criteria/yardsticks whereby hospitals can compare their own progress with that of other hospitals, especially hospitals at similar levels of socio-economic development.

It is important that hospitals share their experiences. Apart from that there is an even more important need to share down-to-earth experiences, both positive and negative, between the hospital and the health system including patients, the community, and other participants in the local health system. These processes can be strengthened using annual reports. Improvement of annual reports must therefore be considered, with emphasis on action at local level and exchange of experience and ideas.

The emphasis on action at local level implies that hospitals should look at annual report information in the context of the local health system, so that information will be in line with requirements at that level. The content and format of the report should be developed or decided upon in collaboration with other health care authorities and facilities in the local health system.

Besides that, mechanisms could be provided for the exchange of hospital information at intermediate or central levels. The Ministry of Health or another coordinating agency could, in collaboration with hospitals:

- indicate what data should be supplied and when the information should be provided;
- assess rules on the way and the format in which data should be provided;
- designate a ministerial department or another organization to collect and process the data;
- establish rules that have to be taken into account, for instance rules related to feedback of information to the hospitals.

2. Introduction to a Guideline for Annual Hospital Reports with particular reference to Developing Countries

A great deal of work goes into writing and producing annual reports. Despite this, very often they are not as useful and interesting as they could be. It is important that the end result be of maximum use, whether as a general source of information, or for evaluation or planning. The annual report of the hospital often provides the only impression of a community's health and wellbeing and often is the most important public source of information about health care to a community.

Annual reports vary a good deal. They differ depending on variables on the part of the author (capabilities, time available, etc), the purpose of the report and the target groups. It is of course only natural and very understandable that format, emphasis and style vary. On the other hand it is clear that some minimum basic content and some degree of uniformity and standardization would make annual reports more useful. A guideline has now been made in an attempt to increase the quality of annual reports, particularly for hospitals in countries where no clear instructions exist.

The guideline contains a framework for an annual hospital report and contains ideas and suggestions as to content. It is intended for use in a flexible manner and must be adapted to the circumstances in which it is used. The guideline is not a set of rules to be followed, but rather a set of suggestions that one might find useful to consult for writing annual hospital reports.

2.1 Purpose of the Guideline

The purpose of the guideline is to improve the quality of annual reports in four respects:

a. The clarity of the report: the information should be presented in a logical sequence, so as to make it more interesting.

b. The accessibility of the information: the reader should be able to get a general view quickly, and should also be able to find more specific information in the report easily.

c. The relevance of the information: only information that is considered essential should be included.

d. Problem analysis in the report: the report should have a reflective or evaluative character or a problem/action-oriented approach so that it is used as a management tool.

2.2 Structure of the guideline

The set-up of the guideline is similar to the suggested set-up of an annual report. It has three elements: a contents page, a descriptive part and appendices.

2.2.1 Contents page

The contents page shows the reader what and where items may be found in the report. It shows the numerical arrangement, titles and page numbers of the (sub)chapters and paragraphs in the descriptive part, and of the appendices in the statistical part.

The contents of the guideline does not cover each and every situation in which a hospital could find itself. For instance, a nutrition rehabilitation unit, major building activities or hospital mergers are not included. When deemed necessary, extra elements can be added in between the other elements. On the other hand, if an element is not applicable, for instance because there is no training institution attached to the hospital, then of course skip it.

2.2.2 Descriptive part

The descriptive part in itself is supposed to enable the reader to obtain a fair idea of what happened in the year under review. The guideline has 11 chapters for the descriptive part, with sub-chapters and paragraphs. In each of these elements of the descriptive part, suggestions are provided for reflection; they are presented as keywords or short phrases.

For some of the questions raised through these suggestions, it might be difficult to find clear-cut answers. Despite that, it has been considered useful to include them in the guideline as they can enhance awareness of managerial issues and stimulate hospital management to direct its efforts accordingly.

Not all suggestions are applicable to each hospital. It is therefore up to the hospital to judge what is relevant in its particular situation and whether to include it in the report or not.

The diagram below is the basis of the descriptive part of the guideline and may be useful to keep in mind when writing the report. The figures between brackets refer to the chapters of the guideline.

<table>
<tr><th>input/resources</th><th>output/activities/services</th><th>effect/impact/outcome</th></tr>
<tr><td colspan="3">G E N E R A L   R E V I E W   O F   T H E   Y E A R   (1)</td></tr>
<tr><td colspan="3">H E A L T H   P O L I C Y   A N D   I N F R A S T R U C T U R E   (4)</td></tr>
<tr><td rowspan="3">Staff (6)
Finances (7)</td><td>Management (5)
Hospital services (8)
Training (9)</td><td rowspan="3">Community and health status (3)</td></tr>
<tr><td colspan="2">P L A N N I N G   F O R   T H E   F U T U R E   (10)</td></tr>
</table>

The diagram shows various chapters of the guideline in relation to input/resources of the hospital, hospital output/activities/services, and last but not least, the effect/impact/outcome of hospital activities on the health status of the community.

The guideline has been written with the intention of making the annual report serve as a tool for review and reflection in the hands of hospital management. Bearing this in mind, hospitals should consider to whom reports will/should be sent. The information requirements of users could lead to the provision of (additional) information that hospital management itself might take for granted. Examples are information on a hospital's location and physical environment, the area's socio-economic level of development, information on surrounding health care facilities, etc.

On the other hand, the information requirement of users will condition the degree of detail in the report. For instance, a reflection on the results of major operations in the hospital might be useful for hospital (medical) management, but it is not likely to be of interest to the majority of users.

Thus the writer has to strike a balance that fits a given situation. A highly selective approach should be adopted and only that information should be included in the annual report which has been identified as being crucial for both hospital management and other users.

In general the bare minimum information requirements will be what the health administrative level above hospital level will require to perform its tasks.

2.2.3 Appendices

The guideline suggests that all basic quantitative data be presented in appendices. Appendices may also include other information. They can be attached to each element of the descriptive part. They have the same numerical arrangements and the same titles as the corresponding elements of the descriptive part. One appendix may include several sections for the information provided. When elements of the descriptive part have an appendix attached, the most important and striking information of the appendix can be summarized, referred to, analyzed or commented upon in the desciptive part.

Most data proposed in the appendices of the guideline are collected at departmental level. The extensiveness of the appendices as presented in the guideline serves the purpose of offering the hospital a framework for data collection at departmental level. It is not suggested that appendices in annual reports should be as extensive as in the guideline. Hospitals will have to decide what data are considered necessary for inclusion in the annual report. The hospital should aim at striking a balance between the perceived needs of hospital management for review and reflection and the perceived information requirements of people to whom the report is sent.

The appendices contain among other things the following groups of quantified basic data:

- information about the size of the population (or groups).
- information about hospital morbidity/mortality.
- information about hospital input (staff and finances).
- information about hospital output/activities.

From these quantified basic data many ratios can be calculated. Some examples are:

- ratios of hospital morbidity/mortality to population (groups); these might provide a basis for inferences about prevalence/incidence of certain diseases in the area.

- ratios of hospital services to population (groups); these might provide a basis for inferences about utilization of the hospital by patients (coverage, accessibility).

- ratios of hospital inputs to activities; these provide information on hospital efficiency or productivity.

- ratios of (specific) hospital staff or hospital financial resources to population; this gives an indication as to the adequacy of hospital resources.

- ratios of supporting para-medical activities (for instance laboratory examinations) to medical workload (number of admissions or nursing days; number of outpatient attendances).

- ratios of staff to financial information of staff, providing information of the cost per unit of staff.

It should be emphasized that the nature of most ratios is relative or comparative, that is, that these ratios often do not provide meaningful information unless they are compared with previous year(s) and/or with other hospitals.

To stimulate hospitals to compare with the past, the appendices of the guideline provide room for information on the previous year in virtually all appendices. In order to create a better time or trend perspective, the hospital could add figures of more previous years in their annual report. To stimulate comparison with other hospitals, authors advocate standardization of the format of annual reports and of methods and concepts used in hospital practice.

2.3 Internal and External Standardization of Hospital Annual Reports

The guideline provides a framework for standardization of hospital annual reports. Standardization enables reports to become better instruments for reflection on the performance of hospitals.

Standardization is useful from two perspectives:

1. Internal standardization: standardization of the annual report of an individual hospital, so that it is easier for the hospital to compare its information from year to year.

2. External standardization: standardization of annual reports between hospitals, so that comparison between hospitals is made easier.

Both types of standardization are not mutually exclusive, on the contrary. External standardization provides an additional element for reflection about an individual hospital.

2.3.1 Internal standardization

The guideline offers each hospital an opportunity to develop a standard structure for its annual report. This will make it easier to write it. A satisfactory standard also helps to maintain the quality of the report; the quality will be less dependent on the capacity of the author.

For the hospital a satisfactory standard will make it easier to review the various activities or aspects from year to year. This is important, because often the progress in one particular year is difficult to judge unless a time perspective is introduced. With a standard for the annual report it will be easier for management to reflect on what took place on the basis of internal yardsticks or criteria that can be derived from annual reports of previous years.

2.3.2 External Standardization

At hospital level external standardization will enhance the accessibility of information in reports of other hospitals. This will make it easier for hospital management to comprehend the activities, problems, approaches to problems, etc. in other hospitals and it will therefore shed fresh light on the situation of its own hospital. It will be easier to review and reflect on its own activities in for example the field of training, curative activities and in preventive or promotive activities by looking at reports of other hospitals. It might stimulate exchanges of primary health care experiences of hospitals. However, at hospital level possibilities of comparison are limited. If hospitals compare, they will do so with only a few other hospitals. They are not in a position and they do not have time to get an overview.

At the intermediate or national level, standardization of annual reports will be useful in identifying problems and solutions in the field. It will enable that level to work more effectively towards pursuing and developing goals, policies and targets on behalf of the hospitals they administer.

The advantage of a uniform presentation of important quantitative information in annual reports is that the results of many hospitals can be combined for statistical use. At intermediate or national coordinating level calculations can be made, on a variety of ratios. The results of such calculations can then be presented to the hospital(s). The effect will be that hospitals, besides the internal yardstick of comparing with the past, are provided with a second-external-yardstick to assess the information in their annual report and act on it.

External standardization is a valuable aid in altering perceptions in the hospital and it can indicate broadly speaking where a self-examination might be profitable. It can increase the capacity of annual reports in terms of problem-analysis. Annual reports written in a standard manner can help to perceive and fulfil health needs in an innovative way which are relevant to the implementation of health care. Whether annual reports are used in such a way depends primarily on motivation at hospital and coordinating level.

2.4 Limitations of the guideline

The guideline does not go into such questions as how figures are gathered or how reliable they are. The guideline also does not provide definitions of concepts used and the way concepts are measured.

The kind of data in the guideline are those that can often be found in annual reports. The guideline does not always specifically indicate how figures can be related to each other, that is to say how basic data should or can be interpreted.

Sometimes hospitals report in a comprehensive way about health centres and dispensaries. For these hospitals it might be useful to develop a "guideline for annual reports of district health care", particularly in a situation where hospitals would like to report on many or all health care institutions and health care related aspects in a certain area. In such a guideline it will be easier to relate information about health services to data on the population.

PART TWO : A GUIDELINE FOR HOSPITAL ANNUAL REPORTS WITH PARTICULAR REFERENCE TO DEVELOPING COUNTRIES

A N N U A L R E P O R T 1985

Name of the hospital :

Address :

Telephone :

CONTENTS PAGE

1. GENERAL REVIEW OF THE YEAR (see appendix 1)

This chapter is a summary of the main problems, developments, conclusions and recommendations in the following chapters. It describes in a general way what achievements or improvements have been made this year in health and in health activities and what problems or set-backs have been encountered. It gives the opportunity to dwell on the factors that have influenced the functioning of the hospital and its activities. It discusses the extent to which it has been possible to adhere to priorities set in previous annual reports.

The chapter can be structured according to the chapters of the annual report or on a monthly basis.

The year under review can be placed in a wider context by presenting a table that shows the development of some important hospital figures over the last (five) years.

2. HOSPITAL AND ENVIRONMENT

In this chapter the hospital and some features of the environment are introduced to the reader. Once done, the introduction will hardly change.

History of the hospital: year of foundation, major changes in facilities and ownership/management. Category of management/ownerschip: government, parastatal, voluntary agency, private, etc. Type of hospital: consultancy, regional, district or rural; specialized hospital: e.g. leprosy, psychiatric, tuberculosis, etc.

The geographical location of the hospital: region and district; consider a map, also indicate other health facilities in the area, their distances to the hospital and ownership. Location of district headquaters, main townships. Communication facililties: roads, (public) transport, telephone, radio, air-strip. Climate and water resources.

3. COMMUNITY AND HEALTH STATUS (see appendix 3)

Features of the community: social organisation, ethnic origin, religion, languages, main food and cash crops, industries, trade, cost of living, income distribution.

Demographic information: discuss trends and indicate consequences for health services.

Health status and related indicators: pay attention to the prevailing morbidity and mortality pattern, particularly to the share of communicable and deficiency diseases. What social or age/sex groups are most at risk? Nutritional status; causes of malnutrition; people's view of malnutrition. Describe factors influencing health. Situation on notifiable diseases, epidemics, measures taken. Changes in health status noticable?

Where data specific to the area are not available, present the national data when they are considered applicable to the catchment area of the hospital.

4. HEALTH POLICY AND HEALTH INFRASTRUCTURE

Presence of a district health development plan. Particulars about the elements of primary health care (promotion of proper nutrition and an adequate supply of safe water; basic sanitation; maternal and child care, including

family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; education concerning prevailing health problems and the methods of preventing and controlling them; and appropriate treatment for common diseases and injuries) and the organisation of a supportive infrastructure (information and monitoring system, manpower development and supervision, logistics, financing). Distribution of responsibilities on health care in the district. Involvement of other sectors in preparation and implementation of the health development plan. Participation of the people: involvement of recipients of health care. Attention to underprivileged groups. Presence of health programmes with different lines of authority and resources (EPI, TB, Leprosy, Diarrhoeal Disease Control) and cooperation with them.

Health infrastructure to carry out the health policy. Type and number of health facilities other than the hospital. Consider indicating in an appendix the main characteristics of each, such as number and qualification of staff, presence of MCH-clinic, expenditure, number of out-patient contacts,size of the assigned catchment area per facility, etc.. The percentage of villages with or without static or mobile facilities and village/community health workers. Factors influencing the functioning of health facilities: resource allocation (manpower, equipment, staff), physical condition, logistics, supervision. Functioning of the two-way referral system and factors of influence, both for the medical and for the administrative aspects of referral.

Health care (related) organizations in which the hospital participates on local or district level, for instance health development committee(s). The role of the hospital according to the district health plan. Capacity to redirect hospital resources in support of primary health care activities. Hospital overall policy and strategy with regard to clinical activities versus support for primary/community health care activities.

5. MANAGEMENT (see appendix 5)

This chapter describes and assesses structure and functioning of the main management bodies of the hospital:

- the body responsible for (or advising with regard to) overall hospital policy-making and administration, f.i. board of governors/trustees, diocesan medical board, hospital advisory board. How have they been functioning: policies and priority problems on the agenda, frequency of meetings. Representation of community organised groups (women, youth), other health care organisations (health centres, dispensaries, district health office), other sectors that have a bearing on health and of the political/administrative system.

- the body responsible for execution of hospital policies, e.g.: hospital management committee, daily board. How have they been functioning: main topics and policies on the agenda, frequency of meetings.

Hospital subcommittees (workers committee, drug committee, etc.) could be included here as well, but details are more likely to appear in following chapters.

Health care (related) organisations in which the hospital participates on regional and national level.

6. STAFF (see appendix 6)

This chapter summarises and assesses in an overall way various aspects of the manpower situation.

Total number of employees, compared to previous year(s) and to what is desired as defined by health care authorities or the hospital itself. Under-staffing in the various categories of staff. Vacancies. Recruitment problems: remoteness, housing, etc.. Turnover of staff: total arrivals and departures and staff changes of key-workers. Manpower planning.

Facilities and incentives for employees: staff houses, social activities, bonuses, etc.

Career development: oppportunities for upgrading, training and refresher courses, see also 9.2, and for promotion to higher salary scales. Job rotation. Workers committee.

Temporary exchange of employees with other health care institutions. Engagement of staff in activities outside the hospital.

Details of the manpower situation for various hospital activities are included in chapters 8 and 9. Is the potential of the community as a source of labour tapped?

7. FINANCES (see appendix 7)

This chapter summarises and assesses the development of the financial situation of the hospital. A picture of the financial situation of the hospital can be given by information about:

- income and expenditure on current account;
- income and expenditure on capital/development account;
- the balance sheet.

Recurrent expenditure (=expenditure on current account) or recurrent costs: classified if possible according to national/governement regulation. Is any depreciation included? Compare total expenditures or main expenditure categories with last (five) years or with previous year, what trends? Compare the main expenditure categories with the budget or allocation for these categories; what are the reasons for deficit or surplus on the expenditure budget: is it inflation, quantities bought, other reasons? Efforts towards cost containment: internal budgetting; involvement of departmental heads. Is it possible to use the overall budget for other inputs or activities than according to allocation? Can resources be shifted to priority activities?

Operating income to cover recurrent expenditure. Compare total operating income or main income categories with previous year or with last (five) years, what trends?. Compare actual operating income of the most important income categories with estimated income for these categories; what are the reasons for a deficit or surplus on income budget? Efforts to increase income; whom to approach? Which patients/groups cannot afford hospital services? How to deal with these problems? Changes in the structure of the fee for service system?

The difference between recurrent expenditure and operating income: surplus or deficit on current account. Consequences of a deficit for the hospital's ability to pay salaries and bills (liquidity on the balance sheet).

Information about services and goods donated free of charge to the hospital is presented particularly when these donations are not included in the running costs and if they constitute a substantial support without which hospital services will not be maintained at present level. The financial relation to school(s) or other health care institutions could be mentioned.

Try to have a notion of the expenditures on the various hospital activities. Hospitals could calculate the recurrent expenditures per inpatient day and per outpatient contact for last years; indicate how the calculation is done; provide the information together with indications for inflation. Are outpatient contacts in the hospital for a particular disease more expensive than in other health care facilities?

Information about income and expenditure on capital/development account: extensions or replacements of buildings, equipment, furniture, transport facilities, etc. Expected (in)direct effects of these investments on patient care and/or on community/public health care. Expected effects on future running costs.

The balance sheet: reserves for irregular development of expenditure flow and income flow. Size of reserves as a percentage of yearly expenditures.

Is the accounting system open to public scrutiny to ensure confidence by the people?

8. HOSPITAL ACTIVITIES

This chapter describes the activities of the hospital with regard to care for patients and the community. The chapter is divided in three sub-chapters:

- curative services: medical, dental and paramedical services;
- preventive and promotive services, directed at individuals, groups and the community at large;
- supporting services: non-curative paral-medical services and other supporting services.

Each subchapter consists of several paragraphs.

In the paragraphs of this chapter you will often read "intro of 8". This refers to the following text:

a. In each paragraph the conditions can be described that have had a particular or predominant positive or negative influence on the size, quality, effectiveness or efficiency of the services. Some examples are:

- the weather, public transport, the economic situation, structure of patient fees, epidemics, public relations, etc.;
- the availability of resources: personnel, material supplies (medicines and medical aids/appliances, nursing supplies, water chemicals, food, energy), capital goods (equipment, machinery, buildings) and financial means;
- the organisation and management of available resources: waiting time and routing of patients, hygiene, morale of staff, storage, maintenance, etc.

The above-mentioned conditions differ to the extent to which they can be influenced by hospital management. Measures or plans to change the conditions could be discussed.

b. The term "catchment area" is widely used but with different meanings:

- catchment area may be taken to mean the assigned area, for which the hospital is (on paper) responsible. Usually assigned catchment areas follow the administrative (sub)divisions of the country. The assigned catchment area indicates the number of people who are dependent on the hospital in respect of functions that specifically and solely belong to the hospital and that are therefore not performed by other health care facilities.

- in practice the outreach of the hospital refers to an area which is smaller than the assigned catchment area: the actual catchment area. The place of residence of inpatients or outpatients could be plotted on a map, as well as the places visited by hospital staff on a regular basis. The analysis will show where the population does not have equal access to the hospital. It is important to know the actual catchment area of the hospital in order to estimate coverage and intensity of use and also in order to indicate effectiveness. The difference between assigned and actual catchment area provides indications to estimate the unserved population.

- better management and other feasible improvements may change the "boundaries" of the actual catchment area towards the outreach that is both desirable and possible with the level of resources available: the target catchment area. When (management of) resources is adequate, the target catchment area might coincide with the assigned catchment area.

Catchment areas have to be considered in relation to the various functions performed by the hospitals, e.g. the catchment area for the operation room is bigger than the catchment area for (non-referred) outpatients; the catchment area for the referral function of the Outpatient Department is bigger than the catchment area of the health centre or dispensary function of the OPD.

8.1 CURATIVE SERVICES

8.1.1 General Outpatient Department (OPD) (see appendix 8.1.1)

Intro of 8. Registration of attendances. Hospital's definition of new cases (first visits/attendances) and reattendances: policy on registration of patients who visit several departments (medical consultation room, dressing room, injection room, laboratory, pharmacy, etc.); registration outside business hours; registration when more hospital departments are visited on the same day, f.i. referral from MCH to general OPD or discharges from wards via OPD-pharmacy. Do patients take OPD card home?

Utilization. Patients' waiting time. Seasonal variations in OPD-attendances. Referral function of the OPD judged by the percentage of new cases (first visits/attendances) referred by lower level health care facilities and referred to higher level facilities. Standard procedures for referral back to lower level facilities. Where do patients, referred and non-referred, come from in terms of distance to homestead? The percentage of patients that could/should have been treated at other health care facilities; reasons for this "improper" use; recommendations. Other factors influencing utilization: availability (OPD in the weekend, outside business hours), affordability (fees), acceptability (by social or cultural standards), functioning of other health facilities; consequences for health policy (of the hospital).

Registration of diagnoses: short list of international classification of diseases, hospital list, symptom based? Are multiple diagnoses per patient registered? When a reliable system is absent, give an impression rather than to suggest accuracy by presenting figures. Can conclusions be drawn from the observed morbidity pattern at the OPD for the morbidity in the catchment area? Consequences for health policy (of the hospital).

8.1.2 Wards (see appendix 8.1.2)

Intro of 8. Admissions. Reflect (per ward) on number of beds, admissions, nursing days, occupancy rate, average length of stay, number of deaths. Absconding of patients. Policy on indication for admission and discharge. Persons authorised to admit and discharge. Percentage of admissions referred by lower level health care facilities. Standard procedures for discharge to lower level health care facilities. Where do patients come from in terms of distance to homestead?

Care and treatment. Quality and organization of nursing care. Containment of hospital infections. Routine procedures on admissions. Treatment schedules, standing orders. Visits of medical specialists. Selfcare units, hostel for relatives. Spiritual care.

Diagnoses. Registration of diagnoses; which classification, are multiple diagnoses per patient registered? Give special attention to communicable and deficiency diseases. Comment on the trends observable in the top-ten diagnoses tables of the appendix. Can inferences be made from the morbidity/mortality pattern of the hospital for morbidity/mortality in the catchment area? Consequences for the health policy (of the hospital). What percentage of inpatients could/should have been taken care of on an ambulatory basis or at lower level facilities? Consequences for the health policy (of the hospital).

8.1.3 Obstetrical Department (see appendix 8.1.3)

Intro of 8. Admission for obstetrical reasons. Comment on the figures in table A (for those on deliveries see B, maternity). Percentage of admissions on referral. Inferences of observed morbidity for that in the catchment area(s). Consequences for (hospital's) policy in ante-natal care.

Maternity and deliveries. Hospital policy on indication for admission, including policy on deliveries without medical indication. Share of deliveries without medical indication as percentage of total deliveries. Admissions for delivery as percentage of total hospital admissions. Policy during labour, use of partogram. Hospital definition of abnormal delivery (episiotomy included?). Discharge policy after normal delivery: next day, via MCH?

Number of patients admitted for delivery referred from ante natal clinics. Number of (ab)normal deliveries in the hospital in relation to the expected number of deliveries in the catchment area(s). Consequences for (hospital's) policy in antanatal care. Policy on Caesarian Sectio; rate of caesarian sectio's. Maternal mortality rate and causes, inferences for the catchment area, conseqences.

Newborns. Total, number of stillbirth. Hospital perinatal and neonatal mortality rate. Inferences for catchment area, consequences. Birthweight at intervals of 250 gram. Consider to relate parity to birthweight and to peri/neonatal mortality; birthweight to peri/neonatal mortality.

Premature ward; hospital definition of prematurity, policy on discharge. Special measures concerning temperature, humidity.

8.1.4 Theatre (see appendix 8.1.4)

Intro of 8. Major operations, anaesthesia used. Minor procedures or day-surgery. What major operations performed by (senior) medical assistants? Policy on elective surgery. Definition used for emergency operations. Death related to operations. Comment on trends when an overview is presented of the number of operations in the main operation categories during last (five) years.

8.1.5 Tuberculosis and Leprosy (see appendix 8.1.5)

Intro of 8. Is the hospital's policy and way of registration tuned to a (national) TB/Leprosy program. The figures of the appendix in relation to (local or national) figures on prevalence and incidence. Coverage by the program or the hospital in assigned area. Policy on admission and discharge. Treatment schedules. Drug resistance. Follow-up activities. Compliance of patients and program.

8.1.6 Dentistry (see appendix 8.1.6)

Intro of 8. Nature and quantity of services provided. What percentage of the population in the catchment area make use of the services. Prevalence of caries. Involvement in services outside the hospital (school health).

8.1.7 Ophthalmology (see appendix 8.1.7)

Intro of 8. Nature and quantity of services provided. Discussion on morbidity. Number of tests for vision accuracy; number of spectacles prescribed and issued.

8.1.8 Physiotherapy

Intro of 8. Nature and quantity of services provided.

8.1.9 Other Curative Services

Intro of 8. Other curative activities such as sickle cell clinic, mental health care, etc.

8.2 PREVENTIVE AND PROMOTIVE SERVICES

8.2.1 Mother and Child Health Care (MCH) (see appendix 8.2.1)

Intro of 8. Outline of MCH services in the area. Involvement of the hospital. Highlights of the report of the district MCH-coordinator.

MCH-attendances at hospital compound, by mobile clinics organized by the hospital, and at static MCH-facilities supervised by the hospital. Coverage: relate the number of first visits by children under-five to the estimated size of target group; relate the number of pregnant women registered for antenatal care to the estimate number of pregnant women (number of newborns); relate the number of women registered for family planning to the number of women in reproductive age (15-44 years). Monitor coverage performances per facility, strategies to solve low attendance problems. Involvement of social structures in the community. Supply of supportive drugs and milk as incentives.

MCH-immunizations at hospital compound, by hospital mobile clinics and at static MCH facilities supervised by the hospital. Policy on immunizations: when the child is ill; multiple immunizations; boosters. Supply and storage of vaccines; potency of the vaccines at the time of application. Coverage: relate the number of immunizations, with single dose or first, second and third dose, for children below one year and for pregnant women to the size of the respective target groups. System for second and third dose defaulters. Set immunization targets for next year(s). Coverage in relation to national figures.

8.2.2 Health Education

Intro of 8. Aim and objectives. What is done, where, by whom? Involvement of the community and health related sectors (media, schools).

8.2.3 Other Preventive and Promotive Activities

Intro of 8. Information concerning school health, occupational health, environmental health, special health care activities, cmmpaigns, community development efforts, etc., in which the hospital plays a role. For training of village community health workers, see chapter 9.

8.3 SUPPORTING SERVICES

8.3.1 Laboratory and Blood transfusions (see appendix 8.3.1)

Intro of 8. The number of examinations, compared to previous years. Percentage of positive findings per type of examination, conclusions on the adequacy of requests; conclusions for the workload, i.e. the number of examinations per staff member.

When examinations are recorded separately for in- and outpatients, than give the number of each examination per 100 admissions and 100 outpatient attendances (total of app. 8.1.1).

Specification of anaemia possible? and done? Availability of blood donors: family, secondary schools, army, blood bank? Distribution of blood groups and rhesus factor.

8.3.2 Pathology and Postmortem Examinations

Intro of 8. Number of specimens sent to the pathologist compared with previous year(s). Information about postmortem examinations.

8.3.3 Pharmacy (see appendix 8.3.3)

Intro of 8. Pharmaceutical supplies: ordering system, availability, supplies, storekeeping, theft. Frequency of stocktaking. Conditions of store: temperature, humidity, burglar proof. Control on expiring of drugs. The pharmacy and therapeutic committee; contact with herbalists. Information/education on drugs to patients; patient's compliance to drug treatment. List of essential drugs according to national policy, or a hospital list derived from it?

Hospital formulary. Treatment schedules, authority to prescribe various drugs. Hospital production of ointments, fluids and oral rehydration sachets. Problems of resistance (e.g. for antimalaria and antibiotic drugs); availability of alternatives.

Total expenditure on drugs, percentage of expenditures for the 20 most issued drugs by the pharmacy, with the quantity of units as criterium. Cost of drugs per outpatient contact and inpatient day, how calculated. Possibilities for economising on drug expenditure.

8.3.4 X-ray Department (see appendix 8.3.4)

Intro of 8. Policy on chest X-ray in suspected T.B. cases.

8.3.5 Ambulance services

Intro of 8. Number of trips; costs of each trip, patient's contribution. Area for which the ambulance actually serves.

8.3.6 Domestic Department

Intro of 8. Catering, dietetics, cleaning, laundry and linen service. Food prices and expenditures on food per inpatient day, compared to previous year(s). The daily caloric intake aimed at through food supply. Facilities for relatives to cook. Animal husbandry, hospital vegetable garden, hospital firewood supply, nursery. Sanitary facilities: toilets, water supply, sewage system, waste disposal (pit, furnace).

8.3.7 Technical Services

Intro of 8. Water supply. Fuel and electricity supply, solar energy. Machinery, transport (log-book), equipment, buildings, maintenance and overhauling, etc. Facilities of a technical department. Degree of support from external organisations, for instance ministry of public works, other hospitals, commercial organizations. The role of a technical department for other health care facilities.

8.3.8 Administration and Medical Records Department

Intro of 8. The administration department including stores and accounting and the medical records department.

System of (medical) recording at departments, supporting services. Control of the accuracy of the recording; monthly (cumulative) recording practised?

8.3.9 Other supporting services:

9. TRAINING

9.1 Name of the training centre (see appendix 9.1)

Here information is given concerning any training institution attached to the hospital.

Short history of the school. Review of the year. Enrollment and examinations. Is training capacity fully used? Curriculum development, clinical teaching and village training. Library facilities and subscriptions. Organisation of students: student committees, social activities, self-reliance projects.

Composition and functioning (frequency of meetings, main policies and topics discussed) of management bodies such as schoolboard, school committee, disciplinary committee, etc.. Level and quality of teaching staff and other

employees, are trainers sufficiently trained? Finances: expenditure and income; cost per student per year. Teaching materials and other supplies. Buildings and equipment. Transport, etc.

9.2 Other training and educational activities

Courses, workshops, seminars organized by the hospital. The role of the hospital in training and support (supervision) of staff for and at lower level health care facilities. Training of village/community health workers. Regular lectures to groups outside the hospital: women clubs, development committees, schools, farming groups, etc. Students temporary attached to the hospital as trainees. Library facilities and subcriptions.

Hospital workers sent for or returned from training, upgrading and refresher courses, seminars, workshops or other training meetings. On the spot training of hospital workers: clinical meetings, other training activities; are these meetings also attended by staff of other health care institutions?

10. PLANNING FOR THE FUTURE

This chapter elaborates on hospital policies and priorities. When previous chapters contain recommendations, these recommendations are listed in an order of priority. Has the hospital a (written) development plan for the next (3-5) years?

Involvement of the hospital in the district overall health and health care development policy, with emphasis on health (or health care) problems in their (full) social, economic and environmental context rather than in a (narrow) medical one. Hospital policies to involve the population and other sectors that have a bearing on health.

Hospital policies as well as overall local health policies should also take into account:

- the identification and analysis of health problems (chapter 3 and chapter 8);
- the capacity and utilization of resources in the hospital, other health care facilities, other sectors, the people themselves;
- particular circumstances, social and economic structures and political and administrative systems;
- the role of the hospital in the local health care plan.

Assessment of the bearing of present hospital activities for PHC development. Possibilities to redirect resources in support of primary health care; consequences for the more "traditional" activities of the hospital.

Priorities described can be evaluated in the annual report(s) of following year(s).

11. EPILOGUE/ACKNOWLEDGEMENTS

Word of thanks to employees, visitors and benefactors.

Place and date: .....

Signature(s), name(s) and position(s) of person(s) responsible for the information in the annual report: .....

APPENDIX 1: GENERAL REVIEW OF THE YEAR

1A SOME IMPORTANT HOSPITAL FIGURES, 1981-1985

	1981	1982	1983	1984	1985	see app.
Inhabitants in assigned catchment area						3.
Total of hospital employees						6.
Total hosp. recurrent expend.						7.
Beds available						8.1.2
Patients admitted						8.1.2
Length of stay per adm. (days)						8.1.2
Occupancy rate (%)						8.1.2
Deliveries						8.1.3
Major theatre operations						8.1.4
Minor procedures						8.1.4
Attendances at the General OPD						8.1.1
Attend. at hosp. MHC-clinic						8.2.1
- by children under five						
- by pregnant women						
- for family planning						
Attend. at other hosp. clinics						....
Total hosp. outpatient contacts	+	+	+	+	+	
Daily average hosp. outpat. contacts (divide by 300 days)						
Attend. at mobile MCH-clinics:						
- by children under five						8.2.1
- by pregnant women						8.2.1
- for family planning						8.2.1
Lab. examinations						8.3.1
X-rays taken						8.3.4

Hospitals could consider to present this table or a similar one in the descriptive part of the annual report instead of presenting it here, since all information of the table is included in other appendices.

APPENDIX 3: POPULATION AND HEALTH STATUS

3A POPULATION AND AGE GROUPS IN THE ASSIGNED CATCHMENT AREA IN 1985*

	in per-centages	no. of habitants
0-1 years		
1-4 years		
5-14 years		
15-44 years (of whom ..... women)		
45-65 years		
65 years and over		
Total population 1985	100%	

* Source: ..... of 19..; figures are extrapolated based on a population increase of ...% per year.

3B SELECTED HEALTH STATUS AND SOCIO-ECONOMIC INDICATORS

	percentages and/or numbers*	source/year(s)
Crude Birth Rate (CBR)		
Crude Death Rate (CDR)		
Annual Population Growth		
Fertility Rate		
Women using contraception		
Life expectancy at birth		
Infant Mortality Rate (0-1 years)		
Child Mortality Rate (1-4 years)		
Maternal Mortality Rate		
Caloric intake as % of requirement		
Protein intake/caput (gr/day)		
Primary school enrollment male/female (%)		
Female/male literacy rate (%)		
Persons per square km. land		
Urban/rural population (%)		
Land available for cultivation per house-hold		
Dwellings without adequate** waste disposal facilities		
Dwellings without adequate*** access to safe water		
Income per caput (local currency)		
Annual growth of income per caput		
Annual rate of inflation		
Unemployment		

* where applicable
** defined as .....
*** defined as .....

APPENDIX 5: MANAGEMENT

5A BOARD OF GOVERNORS

Name	designation*

5B HOSPITAL MANAGEMENT COMMITTEE

Name	designation*

* The term designation refers to for instance, a representative of a community organized group (women's association, youth League, etc.), a position in the Ministry of Health, a position in the hospital (nursing officer in charge), a position in the political structure (member of Parliament), a position in society (school teacher), etc.

APPENDIX 6: STAFF

6A ESTABLISHMENT AS PER DECEMBER 31st, 1985

		No. of workers 31.12.1984		No. of workers 31.12.1985	
Medical and dental	subtotal		..		..
medical officer		..		..	
medical assistant		..		..	
dental assistant		..		..	
rural medical aid		..		..	
Nursing	subtotal		..		..
nursing officer		..		..	
nurse-midwife grade A		..		..	
nurse-midwife grade B					
nurse grade B					
nursing auxiliary					
nursing attendant					
Laboratory	subtotal				
Lab. technician					
Lab. assistant					
Pharmaceutical	subtotal				
pharmaceutical assistant					
Radiography	subtotal				
X-ray assistant					
Other paramedical	subtotal				
physiotherapist					
Domestic	subtotal				
cook					
gardener					
watchman					
tailor					
cleaner					
Technical	subtotal				
plant attendant					
carpenter					
driver					
labourer					
Administrative	subtotal				
hospital secretary					
hospital administr. ass.					
recorder grade II					
Total number of staff			..		..

The above table should be adapted to the prevailing categories and qualifications of health care workers in the country. The categories, e.g. medical and dental, nursing etc., as well as the qualifications within the various categories, are recorded as much as possible on the basis of a "scheme of service" of the Ministry of Health or that of other Ministries.

The table includes the total number of people working in the hospital. The number refers to employees on the payroll (including those who are expected to return after upgrading or training), and -when not on the payroll- also to missionaries, expatriates and employees under secondment, i.e. employees of other organisations attached to the hospital. Students and trainees in the hospital are excluded.

Official ranks are mentioned (medical officer, nursing officer) instead of positions or tasks in the organisation of the hospital (doctor, matron).

Depending on the purpose of the report and on the particular manpower situation of the hospital, one could present additional information, in one or more additional columns or in a few lines at the bottom of the table, for instance:

- the number of employees in previous years, in which case the (nine) categories might suffice;
- the desired number of workers at the end of the year in one or more future years;
- the expatriate employees included ih the columns:
- the number of employees under secondment included in the columns;
- the employees sent on training and therefore absent at the end of the year.

6B ARRIVALS OF STAFF

Name, rank/qualification in staff category; name, rank/qualification in staff category; etc.

6C DEPARTURES OF STAFF

Name, rank/qualification in staff category; name, rank/qualification in staff category; etc.

APPENDIX 7: FINANCES

7A RECURRENT EXPENDITURE AND OPERATING INCOME*

RECURRENT EXPENDITURE	Actual expenditures 1984	Actual expenditures 1985	Allocation/ expend. budget 1985
Categorized according to either:			
1 national (or government) classification			
2 hospital's classification			
3 main expenditure categories of 1 or 2, e.g.:			
. personal emoluments		(.%)	
. drugs		(.%)	
. food		(.%)	
. hospital supplies		(.%)	
. other income		(.%)	
Totals		(100%)	

OPERATING INCOME	Actual income 1984	Actual income 1985	Expected income 1985
Categorized according to either:			
1 national classification			
2 hospital's classification			
3 main income categories of 1 or 2, f.i.			
. government allocation		(.%)	
. income from patients		(.%)	
. donations		(.%)	
. other income		(.%)	
Totals		(100%)	
DEFICIT(d) or SURPLUS(s)	d/s	d/s(.%)	

* The amounts can be rounded off when the annual report does not serve accounting purposes.

If the "financial year" of the hospital does not coincide with the calendar year of the annual report, the hospital will have to choose between the following possibilities:

1. Calculate and present amounts that relate to the calendar year of the annual report.
2. Present expenditure and income for the period covering the financial year (this information lags behind). To avoid spending a lot of time in re-analyzing financial information, this possibility might be advisable.

Trends can become apparent by comparison with previous years. A table could be presented that indicates the year-by-year percentual change per expenditure and income category and for total expenditures and incomes. It could also be worthwhile to compare the share of each income/expenditure category as a percentage of total incomes/expenditure in 1985 with their respective shares for previous years.

7B. CAPITAL EXPENDITURES AND INCOME

CAPITAL EXPENDITURES	1984	1985
totals		
SOURCES OF FUNDS		
Totals		
DEFICIT(d) or SURPLUS(s)	d/s	d/s

APPENDIX 8.1.1: GENERAL OUTPATIENT DEPARTMENT (OPD)

8.1.1A ATTENDANCES AT THE GENERAL OUTPATIENT DEPARTMENT

	1984	1985
New Cases Re-attendances		
Total number of attendances		
of which were referred in	%	%
of which were referred out to lower level facil.	%	%
of which were referred out to higher level facil.	%	%

Indicate what definitions regarding attendances at the OPD are used in the hospital.

A system commonly used is one that differentiates in new cases and re-attendances based on the criterium of a new spell of disease. Every patient who presents at the general OPD with a new spell of disease, is considered to be a new case, irrespective whether the s(he) has been registered at the hopital before. Attendances on following days concerning that spell of disease are counted as re-attendances. So each day a visit to the OPD is counted only once. After registration as (re)attendance all visits that day to sub-departments of the OPD are not again counted as re-attendances.

When a person has been cured but later on falls victim to another or the same disease, (s)he is again registered as a new case because it concerns a new spell of (the same) disease.

Attendances outside business hours are included in the figures of the table. Not included are persons attending MCH-clinics or other special outpatient clinics, unless they are referred to the general OPD.

8.1.1B DIAGNOSES AT THE GENERAL OUTPATIENT DEPARTMENT

Consider a table on the top-ten diagnoses, discuss trends over the last (five) years.

8.1.1C UTILIZATION OF THE GENERAL OUTPATIENT DEPARTMENT

When in the descriptive part the results are discussed of sample-surveys, consider to present the figures here.

APPENDIX 8.1.2: WARDS

8.1.2A CAPACITY AND UTILIZATION

Wards	No. of beds	No. of admis.	No. of nursing days	Occup. rate(%)	Aver.stay p.admis.	No. of deaths	Death rate(%)
Male							
Female							
Maternity*							
Premature							
Children (age)							
TB/Leprosy							
Other							
Totals 1985							
Totals 1984							

*Healthy new borns are not counted as inpatients.

The calculation of occupancy rate and average length of stay per admission is based on the number of "inpatient-days" or "nursing-days":

$$\text{Occupancy rate} = \frac{\text{No. of inpatients days}}{\text{No. of beds} \times 365} \times 100 = ..\%$$

$$\text{Average length of stay per admission} = \frac{\text{No. of nursing days}}{\text{No. of admissions}} = ..\text{days}$$

To calculate the number of nursing days two methods are possible:

1. At a fixed time every day the number of patients admitted in each ward is counted. When a patient is discharged and the same day another patient is admitted in the same bed, only one nursing day is counted.

2. By calculations from the admission and discharge book as kept at the ward or at a central point. When in this second method both the day of admission and the day of discharge is counted as a nursing day, the total number of nursing days will be higher than in the first method. This inflates the occupancy rate and average length of stay by about 10% as compared to the first method.

Hospitals should indicate how the nursing days are counted.

If there is no special T.B. and/or leprosy ward the suggestion is to calculate the average length of stay for each of these diseases. That figure is of interest because is can influence the overall length of stay considerably.

8.1.2B INPATIENT DIAGNOSES*

		No. of diagnoses			Deaths		
		Child**	Adult	Total	Child	Adult	Total
I	Infectious and parasitic diseases						
II	Neoplasms						
III	Endocrine, metabolic and immunological diseases						
IV	Diseases of blood and blood forming organs						
V	Mental disorders						
VI	Diseases of the nervous systems and sense organs						
VII	Diseases of the circulatory system						
VIII	Diseases of the respiratory system						
IX	Diseases of the digestive system						
X	Diseases of the genito-urinary system						
XI	Pregnancy, childbirth and puerperium						
XII	Diseases of the skin and subcutaneous tissue						
XIII	Diseases of the musculo-skeletal system and connective tissue						
XIV	Congenital anomalies						
XV	Conditions in the perinatal period						
XVI	Injury and poisoning						
	TOTALS 1985						

* As multiple diagnoses per patient are registered the number of diagnoses is bigger than the number of admissions.

** For the hospital, childhood ends at age ...

With regard to the presentation of statistics about diagnoses the report should follow government regulations when available. Hospitals could indicate what classification of diagnoses is used in the hospital.

At present classifications differ widely among hospitals. Hospitals are referred to the "International Classification of diseases" (ICD) of the WHO. In the ICD diseases are classified in 17 main groups, each of which has subgroups. Each disease has an unique figure code. In the table above, the main groups of diagnoses are mentioned only. It is for the hospital to decide whether also to report according to subgroups or diseases.

Following are some remarks from the introduction to the I.C.D.:

- For morbidity statistics multiple conditions should be entered.
- In the annual report of the hospital or other publications all diseases that did not occur that year should be omitted from the list, to maintain clarity.
- For mortality use the same list, but only score once, being the underlying cause of death.
- It is most important to bear in mind that this list can be expanded and reduced. The only unanimity should be the system.
- A suggestion may be to score monthly and at the end of the year compile the 12 lists.
- The list has the advantage that the results of many hospitals could be combined for statistical use.

Consider top ten tables on diseases both for morbidity and mortality, each for adults and children. In these tables absolute figures can be given together with the percentage of each, referring to the grand total of table 8.1.2B. Compare with previous years.

APPENDIX 8.1.3: OBSTETRICAL DEPARTMENT

8.1.3A ADMISSIONS FOR OBSTETRICAL REASONS

	1984	1985
First half of pregnancy		
Second half of pregnancy		
For delivery		
Puerperium		
Total admissions		
Percentage referred in		

Admissions for obstetrical reasons occur in the maternity and female wards.

8.1.3B DELIVERIES AND BIRTHS

	1984	1985
Normal deliveries	....	....
Abnormal deliveries	....	....
Total admitted for delivery	....	....
Born alive	....	....
Stillbirth	....	....
Total number of children born	....	....

As multiple pregnancies do occur, the number of children born is usually bigger than admissions for delivery. Indicate when a delivery is considered as abnormal.

8.1.3C PROCEDURES DURING LABOUR

Procedures	Number	Indication for Caesarian	Number
Induction		Prolaps of arm/cord	
Episiotomy		Transverse lie	
Symphysiotomy		Placenta Praevia	
Forceps		CPD	
Vacuum extraction		Foetal Distress	
Caesarian section		Other	

8.1.3D PARTICULARS OF HOSPITAL LIFE BIRTHS

	1984	1985
Normal life births	....	....
Abnormal life births:	....	....
-Premature	....	....
-Congenital dysformation	....	....
Total life births	....	....

8.1.3E HOSPITAL PERINATAL AND NEONATAL MORTALITY RATE

	1984	1985
Perinatal mortality rate		
Neonatal mortality rate		

APPENDIX 8.1.4: THEATRE

8.1.4A MAJOR OPERATIONS *

		Number of operations 1985	
1A. General elective surgery	subtotal		.....
Herniotomy ing. hernia unilateral		....	
Other herniotomy		....	
Other elective surgery		....	
1B. General emergency surgery	subtotal		.....
Laparatomy for: bowel obstruction		....	
perforation/rupture		....	
2. Genito - Urinary	subtotal		.....
Hydrocelectomy		....	
Other		....	
3. Gynaecological	subtotal		.....
Enucleation myoma			
(Sub)total hysterectomy			
Ovariectomy			
Tube ligation			
4. Obstetrical	subtotal		....
Ectopic			
Caesarean Section			
Uterus rupture			
5. Ophtalmological	subtotal		.....
Cateract removal			
Eye enucleation			
6. Orthopaedical	subtotal		.....
Amputation			
Osteosynthesis			
Sequestrectomy			
7. Plastic Surgery	subtotal		.....
Skingraft			
Z-and other plastics			
8. Miscellaneous	subtotal	.....	
TOTAL NUMBER OF MAJOR OPERATIONS IN 1985			.....
OF WHICH ARE EMERGENCY			.....

*The numbers refer to performances. As combinations do occur, the number of performances is bigger than that of patients operated upon. Deaths related to operations could be indicated and discussed.

8.1.4B MINOR PROCEDURES

		Number		Number
Eye	removal foreign body		Skeletal	
Ear	syringing		p.o.p. for fractures	
	removal F.B.		bandages for fractures	
	paracentesis		amputation finter/toe	
Nose	removal F.B.		dislocations reduced	
	removal polyps		Gynaecological	
Throat	tongue tie cut		speculum examination	
	abscess incision/drai-		installation I.U.D.	
	nage		pertubations	
Skin	wound toilet		dilatation/curretage	
	wound suturing		Urological	
	skin grafts		cathererisation	
	removal of ganglia/		circumcision	
	lipoma etc.		reduction paraphimosis	
	removal F.B.		tapping hydrocele	
Lumbar punction			Miscellaneous	
Aspiration from cavities			tooth extractions in absence	
Biopsy for pathology			of dental staff	
			TOTAL 1985	
			TOTAL 1984	

Minor procedures are procedures performed by medical staff. The table refers to all kind of procedures, most of them performed in the minor theatre. Some procedures however are performed elsewhere in the hospital, depending on need (L.P. and cutdowns on wards) and facilities (D. and C. in maternity/ female ward).

APPENDIX 8.1.5: TUBERCULOSIS & LEPROSY

8.1.5A ADMISSIONS FOR TB

	Total 1985	Pulm AFB+	Pulm AFB-	Extra Pulm	Total 1984
Children					
Adults					
TOTALS					

With regard to the diagnoses, a breakdown is given here of the overall figures possibly presented in app. 8.1.2B, group I.

In the annual report of many hospitals information about TB and Leprosy is presented in much more detail than information about other diseases. This is often caused by the existence of TB and Leprosy programmes and the involvement of hospitals in execution of the programmes. As a consequence the figures presented in annual reports are often not merely restricted to activities on the hospital compound.

Though the annual report basically confines itself to hospital activities, it is suggested that in relation to TB and Leprosy the figures on out-patients and control are given concerning the programme-area. The hospital figures alone might not provide sufficient insight in the dynamics of the diseases.

8.1.5B T.B. OUTPATIENTS*

	Total 1984	Total 1985	Pulm AFB+85	Pulm AFB-85	Extra Pulm 85
Patients on treatment per 1.1	...	...	...	...	...(+)
New registrations	...	...	...	...	...(+)
- patients previously untreated	...	...	...	...	...
- relapses					
- transferred in from elsewhere					
- returned to treatment					
Struck off register	...	...	...	...	...(-)
- declared cured	...	...	...	...	...
- died	...				
- out of control (two consecutive months without treatment)					
Patients on treatment per 31.12	...	...	...	...	...(=)
Expected no. of patients in catchment area	...	...			

*Indicate what the figures refer to: hospital outpatients or area assigned to the hospital.

8.1.5C T.B CONTROL

	No. of patients 1984		No. of patients 1985	
Total of newly-diagnosed patients in previous year*	...	(100%)	...	(100%)
Declared cured (AFB- after 1 year of continuous treatment)	...	(..%)	...	(..%)
Transferred out		(..%)		(..%)
Died		(..%)		(..%)
Still on treatment (irregular attendance)		(..%)		(..%)
Lost of control		(..%)		(..%)
AFB still + after one year of treatment (drug resistant)		(..%)		(..%)

*For 1985 : Analysis of AFB + patients diagnosed between 1.1.1984 and 31.12.1984 (previous annual report) after 1 year of treatment, without the patients transferred in from other health care institutions.

8.1.5D LEPROSY OUTPATIENTS*

	Total 1984	Total 1985	Paucibacill 1985	Multibacill. 1985	
Patients on treatment per 1.1	...	...	...		...(+)
New registrations:	...	...	...		...(+)
- patients previously untreated	...	...	...	...	
- relapsed					
- transferred in					
- returned to treatment					
Struck of register:	...	...	...		...(-)
- declared cured	...	...	...	...	
- transferred out					
- died					
out of control (no treatment in '83)					
Patients on treatment per 31.12	...	...	...		...(=)
Expected no. of patients in the catchment area	...	...			

*Indicate what the figures refer to: hospital outpatients or area assigned to the hospital.

8.1.5E LEPROSY CONTROL

	Total 1984	Total 1985	Paucibacill 1985	Multibacill 1985
Attendance rate up to 74%				
Attendance rate 75-100%				
Attendance rate unknown				
Patients on treatment per 31.12				

APPENDIX 8.1.6: DENTISTRY

8.1.6A ATTENDANCES IN THE HOSPITAL

	Total 1984	Total 1985	Adults 1985	Children 1985
New attendances				
Re-attendances				
Total attendances				
Referred in				

Diagnoses		Treatment	
Caries	...	Dentures	...
Peridontal disease	...	Extraction	...
Trauma	...	Fillings	...
Others	...	Others	...

8.1.6B ATTENDANCES OUTSIDE THE HOSPITAL

The same division as under A.

APPENDIX 8.2.1: MOTHER AND CHILD HEALTH CARE (MCH)

8.2.1A ATTENDANCES FOR ANTENATAL CARE

Name of the station	First visits (a)	Total visits (b)	Estimated Target population (c)	Coverage 1985 (d)	Coverage 1984
Hospital				%	%
.....				%	%
.....				%	%
.....				%	%
TOTALS 1985				%	n.a.
TOTALS 1984				n.a.	%

(a) First visits = the number of new registrations during the year. The colomn could be subdivided in before or after 28 weeks of pregnancy at attendance.

(b) The average number of antenatal visits per pregnancy = (b):(a).

(c) If data on fertility are not available, use number of newborns instead of pregnant women. Number of newborn = (estimated) crude birth rate x (estimated) size of population.

(d) Coverage = total number of first visits: target population= (a):(c)x100%

8.2.1B ATTENDANCES FOR CHILD CARE

Name of the station	First visits (a)	Total visits (b)	Estimated Target Population (c)	Coverage 1985 (d)	Coverage 1984
Hospital	...	...	...	%	%
.....	...	...	...	%	%
.....	...	...	...	%	%
.....	...	...	...	%	%
				%	%
				%	%
				%	%
TOTALS 1985				%	n.a.
TOTALS 1984				n.a.	%

(a) First visits = the number of new registrations during the year. The colomn could be subdivided in below or over 6 months of age at attendance.
(b) The average number of visits per child = (b) : (a)
(c) Estimated target population = estimated number of newborns.
(d) Coverage = total number of first visits: total target population = (a):(c)x100%

8.2.1C ATTENDANCES FOR FAMILY PLANNING

Name of the station	First attendances 1985*	Re-attendances 1985	Total 1985	Total 1984
Hospital				
Total no. of attendances				

* No. of women registered.

8.2.1 NUMBER OF IMMUNIZATIONS AND COVERAGE PER STATION

Station	Target Population	BCG	DPT 1	DPT 2	DPT 3	OPV 1	OPV 2	OPV 3	Measels	TT 1	TT 2
Hospital	.....	No. (Cov.)	No. (Cov.)	No. (Cov.)							
Name	.....	No. (Cov.)									
etc.	....										
Totals	....	....	...	...	...	...	...	...	...	...	...
Overall 1985 coverage		.. %	..%	..%	..%	..%	..%	..%	..%	..%	..%
Overall 1984 coverage		..%	..%	..%	..%	..%	..%	..%	..%	..%	..%

Coverage = number of immunizations performed : estimated target population. Estimated target population is the "No. of children below one year" or "estimated No. of pregnant women". In the table the size of these target groups is considered to be equal.

APPENDIX 8.3.1 LABORATORY & BLOODTRANSFUSIONS

8.3.1 A LABORATORY EXAMINATIONS

	Inpatients		Outpatients		All patients	
	Total	% pos	Total	% pos	Total	% pos
A. Parasitology						
1. Bloodslides examined	...	...				
Pos.for: Plasmodia		...				
other						
2. Urine samples examined						
Pos.for: schist.haemat.						
3. Stool specimens examined						
Pos.for parasites						
4. Rectal snips examined						
Pos.for schist. mansoni						
SUBTOTAL A		n.a.		n.a.		n.a.
B. HAEMATOLOGY						
Haemoglobine tested	...		...		...	
below 70% (arbitrary)		...		...		...
E.S.R.	...		...		...	
W.B.C. total only	...		...		...	
W.B.C. plus differentiation	...		...		...	
Red B.C.	...		...		...	
Red bloodcell morphology	...		...		...	
Haematocrit	...		...		...	
M.C.V.; M.C.H.C.	...		...		...	
Sickling tests done	...	...	...	...	...	...
SUBTOTAL B		n.a		n.a.		n.a.
C. BIOCHEMISTRY						
1. Blood tests (total:)						
electrolytes						
glucose						
urea						
liver enzymes						

	Inpatients Total	% pos	Outpatients Total	% pos	All patients Total	% pos
2. Urine samples (total:)						
albumen qualitative						
glucose qualitative						
bilirubine						
pregnosticon						
3. Cerebro spinal fluid (total:)						
glucose						
protein						
SUBTOTAL C		n.a.		n.a.		n.a.
D. SEROLOGY						
Kahn						
Widal						
VDRL						
Other tests						
SUBTOTAL D		n.a.		n.a.		n.a.
E. BACTERIOLOGY						
Smears for G.O.						
Sputum gram stain						
Sputum Z.N. stain for Myc T.						
Skin smear for Myc.L.						
Cerebro Spinal Fluid						
SUBTOTAL E		n.a.		n.a.		n.a.
F. BLOODGROUPING AND CROSS MATCHING						
Bloodgrouping						
Crossmatching						
SUBTOTAL F		n.a.		n.a.		n.a.
TOTAL NUMBER OF LAB. EXAMS 1985 (Totals A-F)						
TOTAL 1984						

In this example the most common examinations are mentioned. The table could be extended to show the possibilities of the laboratory.

Consider a table representing the subtotals, A-F over the last 5 years. One could also relate each year's total number of lab. examinations for inpatients and outpatients to the number of admissions and OPD attendances in these years.

8.3.1B BLOODTRANSFUSIONS

	1984	1985
Bottles donated		
Patients who received transfusions		

APPENDIX 8.3.3: PHARMACY

8.3.3A TWENTY DRUGS MOST OFTEN PRESCRIBED

Generic name of the drug	unit in which present ..mg/ml per vial/cap/ tabl.	cost per unit in 1985 (currency)	No. of units issued (x 1000)	Percentage to inp/outp	% of expend on drugs to this item
Acetylsal. acid etc.					

The table refers to the 20 drugs most often issued in terms of quantity of units. Other possibilities for such a table would be to base it on courses issued, or on cost per unit (or course).

8.3.3B PRODUCTION OF SELF MADE FLUIDS/OINTMENT/ETC.

APPENDIX 8.3.4: X-RAY DEPARTMENT

8.3.4A NUMBER OF X-RAYS TAKEN

1. Skull and mandible	6. Screening - chest
2. Spinal column	- other
3. Abdomen - plain	7. Shoulder and clavicle
contrast used	8. Upper extremities
4. Pelvis and hip	9. Lower extremities
5. Chest - large	
- Odelca (70x70mm)	TOTAL EXAMS 1985
	TOTALS EXAMS 1984

APPENDIX 9.1 : NAME OF THE TRAINING INSTITUTION

9.1A ENROLLMENT

	No. of students		Discontinuations	
	31.12.84	31.12.85	1984	1985
First year				
Second year				
Third year				
Midwifery				
TOTAL				

9.1B EXAMINATIONS

	No. of candidates		No. of students passed	
	1984	1985	1984	1985
Nursery exams				
Midwifery exams				
TOTAL				

9.1C ESTABLISHMENT

	No. of workers 31.12.84	No. of workers 31.12.85
Teaching staff: ranks/qualifications		
Other staff: -do-		
TOTAL		

9.1D ARRIVALS AND DEPARTURES OF STAFF

Name, designation, etc..

9.1E FINANCES

RECURRENT EXPENDITURE	Actual expenditure 1984	Actual expenditure 1985	Allocation/ expenditure budget 1985
If possible categorized according to national or government regulation			
total recurrent expend.			

OPERATING INCOME	Actual expenditure 1984	Actual expenditure budget 1985	Allocation/ expendidditure 1985
Government allocation/grant			
Schoolfees			
Other income			
Total operating income			
DEFICIT(d) OR SUPLUS(s) ON CURRENT ACCOUNT	d/s	d/s	

-o-o-o-o-