

ANNUAL ANALYTICAL REPORT FY 2017-2018



**DR AMBROSOLI MEMORIAL
HOSPITAL
KALONGO**

Endorsement of Report

This Annual Analytical Report covering the period of Financial Year 2017-2018 has been prepared by the management of Dr Ambrosoli Memorial Hospital. I endorse that it represents the management's views on the position of the hospital in the period under report.

Name: Dr Okot Godfrey Smart

Signature _____

Chief Executive Officer
Dr. Ambrosoli Memorial Hospital

Date _____

This is to acknowledge that I have received this Annual Analytical Report for Dr. Ambrosoli Memorial Hospital- Kalongo covering the period **July 1st 2017 to June 30th 2018**.

I have read it and endorse its authenticity and representativeness of the position of the hospital in the year under report.

Name: His Grace John Baptist Odama

Signature _____

Chairperson of the Board of Governors

Date _____

FOREWORD



This Annual Analytical report for 2017/18 FY provides analysis of the hospitals' performance against set targets, goals, and objectives with a comparative analysis of previous trends of performance. The report is premised on the mission and policy statement of Dr Ambrosoli Memorial Hospital (which mirrors the dedication of the founder; Fr Giuseppe Ambrosoli), as well as departmental work plans.

The report also examines both the internal and external environments of the hospital; which very much brings into context what is achieved, what is not achieved and the challenges experienced. The FY 2017/18 has been full of ups and downs for the hospital.

The threats of the hospital has mainly been the low sustainability rate in the absence of donor funding. This is coupled to the fact that donor support towards recurrent cost continues to dwindle.

Reversing this threat is a huge but surmountable task; demanding that every stakeholder plays their part.

The works done over the year could not have been accomplished without the tireless effort of our dedicated staff, as well as the help of the Government and the Local Authorities and the generosity of many people and Organisations, above all the Dr. Ambrosoli Foundation, and the Comboni Missionaries. This generosity is carrying a message of solidarity and collaboration amongst peoples.

As a hospital, we strive to carry forward both the positive and negative lessons learnt during the FY, to enable us face the threats of the new FY with the right attitude.

“Service with love and humility”

Dr Okot Godfrey Smart

Chief Executive Officer

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List of Abbreviations/Acronyms

ACT	Aids Care & Treatment
AIDS	Acquired Immuno-Deficiency Syndrome
ALoS	Average Length of Stay
ART	Anti-Retroviral Therapy
BCG	Bacillus of Calmette-Guérin
BoG	Board of Governors
BOR	Bed Occupancy Rate
CEO	Chief Executive Officer
DPT	Diphtheria-Pertussis-Tetanus
FSB	Fresh Still Birth
FY	Financial Year
CB-DOTS	Community Based Directly Observed Treatment
CHD	Child Health Day
CO	Clinical Officer
C/S	Caesarean Section
DHMT	District Health Management Team
HC	Health Centre
FY	Financial Year
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
HMIS	Health Management Information System
HMT	Hospital Management Team
HRM	Human Resources Manager
HSD	Health Sub-District
HSSP	Health Sector Strategic Plan
IDP	Internally Displaced People
ITN	Insecticide Treated Nets
LLU	Lower Level Unit
MDRTB	Multi Drug Resistant Tuberculosis

MTB	Myco bacterium Tuberculosis
MO	Medical Officer
MoES	Ministry of Education and Sports
MoH	Ministry of Health
NSSF	National Social Security Fund
NTLP	National Tuberculosis Leprosy Programme
NIDs	National Immunization Days
OPD	Out-Patient Department
PCH	Primary Health Care
PHCCG	Primary Health Care Conditional Grants
eMTCT	Elimination of Mother To Child Transmission
of HIV	Human Immunodeficiency Virus
PNFP	Private Not For Profit
SNO	Senior Nursing Officer
SUO	Standard Unit of Output
SLIPTA	Stepwise Laboratory Improvement Process
towards Accreditation	
SLMPTA	Stepwise Laboratory Management Process
towards Accreditation	
TT	Tetanus Toxoid
UMHCP	Uganda Minimum Health Care Package
UCMB	Uganda Catholic Medical Bureau
UEC	Uganda Episcopal Conference
UNEPI	Uganda National Expanded Program for
Immunization	
UNMEB	Uganda Nurses Midwives Educational Board
HG	His Grace

Acknowledgements

The management with great honour appreciates all staff of Dr Ambrosoli Memorial Hospital for their continuous collective efforts rendered to the patients. We also thank all those who, in different capacities and ways, have supported the hospital during the Financial Year 2017-2018 and contributed to its sustainability. Notable among them, but not limited to, are the Government of Uganda, Dr Ambrosoli Foundation, Comboni Missionaries, USAID – URC, and the patients.

We have a special debt of gratefulness to UCMB for the continuous and valuable technical support and guidance.

We would also like to thank H.G. Archbishop John Baptist Odama and all the members of the Board of Governors for the leadership and encouraging supervision given to the hospital.

Last but not least, we extend our utmost appreciation to all the employees of the hospital and of the School who, at all levels and with different qualifications and responsibilities, have been the makers of all achievement that are presented in this report. This acknowledgement is certainly due, but wants to be also an encouragement to maintain and possibly enhance the same spirit in the future.

Important Indicators and Definitions

1. Inpatient Day / Nursing Day / Bed days= days spent by patients admitted to the health facility wards.

2. Average Length of stay (ALoS)

= Sum of days spent by all patients/ Number of patients

= Average length of days each in-patient spends during each admission. The actual individual days vary.

3. Bed Occupancy Rate expressed as %

= used bed days/available bed days

= Sum of days spent by all patients/ (365 x No. of beds)

=ALOS x Number of patients / (365 x Number of Beds)

4. Throughput

=Average number of patients utilising one bed in a year

=Number of patients/ Number of beds

5. Turn over interval

=Number of days between patients

= [(365 x number of beds) – (Occupied bed days)]/number of patients

6. FSB (Fresh Still Birth): This is a baby born with the skin not peeling / not macerated. The foetal death is thought to have occurred within the 24 hours before delivery.

7. Post C/S Infection Rate:

= (Number of mothers with C/S wounds infected / Total number of mother who had C/S operations in the hospital) x 100.

= The rate of caesarean section wounds getting infected. It is an indicator of the quality of post-operative wound care as well as pre-operative preparations.

8. Recovery Rate:

= % of patients admitted who are discharged while classified as “Recovered” on the discharge form or register.

= (Number of patients discharged as “Recovered” / Total patients who passed through the hospital) x 100

9. Maternal Mortality Rate (for the hospital):

= Rate of mothers admitted for delivery who die due to causes related to the delivery

= (Total deaths of mothers related to delivery / Total number of live birth) x 100

10. SUO = Standard Unit of Output. All outputs are expressed into a given equivalent so that there is a standard for measurement of the hospital output. It combines Outpatients, Inpatients, Immunisations, Deliveries, Antenatal Clinic etc. that have different weights in terms of cost to produce each of the individual categories. They are then expressed into one equivalent. As the formula is improved in future it may be possible to include Outpatients’ equivalence of other activities that may not clearly fall in any of the currently included output categories.

11. SUO_{op} = SUO calculated with inpatients, immunizations, deliveries, antenatal attendance, and outpatients all expressed into their outpatient equivalents. In other words, it answers to the questions: what would be the equivalent in terms of managing one outpatient when you manage for instance one inpatient from admission to discharge?

12. TB case notification rate = total cases of TB notified compared with the expected number for the population in one year = Total cases of TB Notified / Total population x 0.003.

13. OPD Utilisation = Total OPD New attendances in the year / Total population of the area.

Executive Summary

This Annual Analytical Report presents activities output and interpretation for both Dr. Ambrosoli Memorial Hospital Kalongo and Kalongo Midwifery Training School.

Dr. Ambrosoli Memorial Hospital was founded in 1957 and St. Mary's Midwifery Training School in 1959 by Fr. Dr. Giuseppe Ambrosoli of the Comboni Missionaries. Until now, Kalongo Hospital, being a PNFP, is the only General Hospital in Agago district. It provides both preventive and curative services. Kalongo Town Council currently has a total estimated population of 11,573. Major Key performance indicators are herein summarized as below.

The hospitals current bed capacity is 271. The total OPD attendance was 26,891 patients, representing a decrease of 17% from 2016/17. Inpatient (IP) admissions was 13,460; a reduction of 34.2% from the previous FY. Malaria was the leading cause of morbidity in both the OPD and Inpatient department (IPD); it was also the leading cause of mortality in the IPD. This picture was reflected throughout all the facilities in the HSD. The reduced OPD/IPD utilisation was due to reduced malaria burden witnessed in the hospital. The BOR decreased from 103.6% in the previous FY to 69.3% in 2017/18. The total mortality rate in the hospital decreased from 1.0% in previous FY to 0.85% in 2017/18.

ANC 1st and 4th visits decreased by 8.1% and 1.5% respectively from the previous FY. Total ANC attendance also increased by 2.8%. Post Natal clinic attendance increased by 2.7%. Deliveries in the hospital increased by 2.7% compared to FY 2016/17. Caesarean section (total) accounted for 15.7% of all deliveries, out of which 95.3% were emergencies.

The members of the BoG and HMT were 14 and 4 respectively. 16 HMT, 2 Ordinary BoG, 1 extra ordinary BoG and 5 Subcommittee meetings were held during the FY. The agenda for each of these meetings were prepared and circulated in advance to the members. One stakeholders meeting was also held in the FY.

The total income for the hospital decreased by 33% in 2017/18, while that of the school decreased by 19% compared to the previous FY. Expenditure in the hospital decreased by 3%

compared with 2016/17; in the school, it reduced by 9%. The SUOop in 2017/18 was 253,209; a reduction of 30.1% from 2016/17.

St Marys' Midwifery Training School has qualified a total of 1,409 students since its foundation. The main challenge faced during the year was academic human resource shortage. The students pass rate increased to 100% from 95% in the previous FY; the quality of passing also improved for both certificate and diploma students.

The overall patient satisfaction with quality of services offered improved from 79.7% in 2016/17 to 81.1% in 2017/18.

CHAPTER ONE

INTRODUCTION

Background

Dr. Ambrosoli Memorial Hospital Kalongo (DAMHK) and St. Mary's Midwifery Training school were founded in 1957 and 1959 by Fr. Dr. Giuseppe Ambrosoli of the Comboni Missionaries. It is a Private Not for Profit Health provider and a member of the network of Catholic health facilities under the coordination of UCMB.

The legal and registered owner of the hospital is the Catholic Diocese of Gulu.

Even with the elevation of Kalongo to a town council; the institution still remain a general rural hospital. This is mainly because the community and its neighbors remain remote with soaring levels of poverty. The hospital operates in a very difficult and complex socio economic environment. The over two decades of civil war in northern Uganda devastated the regions' economy, with majority of the inhabitants in dire need, suffering and despair.

The patients served by this institution are still among the poorest of the poor and live well below the poverty line. Much as the IDP camps have been disbanded and the local population now have access to their land; it will take more than a decade for the regions' economy to stabilize.

The hospital and its' environment

DAMHK is located in Kalongo Town Council (Oret Parish), Agago district. Agago district is bordered by 6 Districts: Pader to the West, Kitgum to the North, Kotido and Abim to the East, Otuke and Alebtong to the South. The majority of these neighboring districts do not have functional hospitals and, therefore, DAMHK serves also their population for all conditions requiring hospitalization.

The District still has one of the worst road networks in the country. There are no tarmac roads and most are in poor maintenance conditions, occasionally disrupting routine field activities

(transfer of patients for emergency care, immunization campaigns, supervision of LLUs, home visiting) and adding extra costs to all transport activities.

Dr. Ambrosoli Memorial Hospital is a complex comprising of the Health service delivery wing and the Health training wing.

The health service delivery wing has 271 beds; distributed through Surgical, Medical, Pediatrics, Obstetrics/Gynecology, and Private Wards. It offers general health care services ranging from curative, promotive, preventive and rehabilitative services as well as serving as a site for MOH specialist medical camp activities. The approach of Kalongo hospital is to supplement the governments' efforts in health service provision.

DAMHK also hosts the laboratory HUB; which is currently undergoing the MOH SLIPTA program. The HUB supervises up to 11 laboratories across the district. As the head of Kalongo HSD, she still continues to supervise 33 LLUs (8 HC III and 25 HC II).

The health training wing has a Specialized Midwifery training school, which offers both certificate and Diploma courses. In the long term strategic vision of the institution; there is a plan to upgrade this school to a degree offering institution (currently, technical consultation is already underway).

The hospital also serves as a satellite training site for Gulu University School of Pharmacy. In addition, it opens its' doors to students from many institutions of learning to train. The long term plan is to strengthen collaborations with these institutions of learning.

In the district population; the level of literacy still remain low and a large proportion of the inhabitants, especially women, do not speak or write English. Acholi is the main ethnic group. The spoken language is Acholi, with Lango being the other minority ethnic group in the southern areas.

The main economic activity of the surrounding community is agriculture; most of it being low scale production for household subsistence benefits. Commercial activities still remain low in the district due to the lack of industrialization as well as mechanization of agriculture.

Demographic data for the hospital catchment area

In the FY 2017/2018, the population of Agago district was estimated at 238, 000 (Annual Health Sector Report 2017); which is actually the catchment population of the hospital.

Table 1.1: Demographic Data of the Hospital, HSD and Agago district

	Population Group	Formulae	Catchment Area	HSD	District
(A)	Total Population	A	11,573	238,000	238,000
(B)	Total expected deliveries (4.85% of population)	$(4.85/100) \times A$	561	11,543	11,543
(C)	Total Assisted Deliveries in Health Facilities		2	2	2
(D)	Total Assisted Deliveries as % of expected deliveries	$(C/B) \times 100$	0.36%	0.36%	0.36%
(E)	Children <1 year (4.3%)	$(4.3/100) \times A$	498	10,234	10,234
(F)	Children < 5 years (20.2%)	$(20.2/100) \times A$	2,338	48,076	48,076
(G)	Women in Child-bearing age (20.2%)	$(20.2/100) \times A$	2,338	48,076	48,076
(H)	Children under 15 years (46%)	$(46/100) \times A$	5,324	109,480	109,480
(I)	Orphans (circa 10%)	$(10/100) \times A$	1,157	23,800	23,800
(J)	Suspected T.B Cases in the Service Area	$(A) \times 0.003$	35	714	714

Community Health Status

Table 1.2: Top ten causes of morbidity in the HSD OPDs

No	Diagnoses	FY 2014-2015		FY 2015-2016		FY 2016-2017		FY 2017-18	
		Number	%	Number	%	Number	%	Number	%
1	No Pneumonia-Cough or Cold	113,443	31.6	132,976	25.4	124,420	26.8	107,732	38.0
2	Malaria	69,765	19.5	208,384	39.7	192,229	41.4	83,933	29.6
3	Intestinal Worms	19,679	5.5	19,528	3.7	19,056	4.1	18,638	6.6
4	Diarrhea	23,287	6.5	23,084	4.4	20,260	4.4	17,635	6.2
5	Gastro-Intestinal Disorders	14,123	3.9	14,465	2.8	12,094	2.6	12,298	4.3
6	Skin Diseases	8,232	2.3	7,091	1.4	7,023	1.5	8,669	3.1
7	Urinary Tract Infections (UTI)	7,522	2.1	8,022	1.5	7,321	1.6	8,218	2.9
8	Eye conditions	7,488	2.1	5,987	1.1	6,463	1.4	5,840	2.1
9	Injuries	7,100	2.0	5,887	1.1	5,168	1.1	5,820	2.1
10	Pneumonia	4,817	1.3	5,332	1.0	4,049	0.9	3,826	1.3
	Total attendance	358,443		524,521		464,041		283,430	

As it was in the FY 2016/17, Respiratory tract infections remained the leading cause of morbidity as registered across all the OPDs in the HSD. This was followed by Malaria and Intestinal Parasitic infestation. Generally speaking, the community was healthier in the FY 2017/18 compared to 2016/17.

Table 1.3: Relative percentage of the top 10 causes of mortality during the last 4 FYs in the HSD

No.	Causes of Mortality	FY 2014-2015		FY 2015-2016		FY 2016-2017		FY 2017-18	
		Number	%	Number	%	Number	%	Number	%
1	Malaria	23	11.0	60	21.4	46	20.1	22	13.5
2	Pneumonia	24	11.5	15	5.4	18	7.9	13	8.0
3	Injuries	15	7.2	13	4.6	28	12.2	11	6.7
4	Cardiovascular diseases	18	8.6	14	5.0	20	8.7	10	6.1
5	Anaemia	15	7.2	17	6.1	19	8.3	7	4.3
6	Prematurity	0	0	3	1.1	5	2.2	5	3.1
7	Malnutrition	0	0	1	0.4	2	0.9	5	3.1
8	Hepatitis B	0	0	3	1.1	2	0.9	4	2.5
9	Meningitis	6	2.9	6	2.1	7	3.1	4	2.5
10	Liver Cirrhosis	1	0.5	3	1.1	7	3.1	3	1.8
	Total	209		280		229		163	

Malaria continued to be the leading cause of Mortality across the HSD (13.5%) in 2017/18. This also reflects a reduction of approximately 52% from 2016/17. The intervention by Government of Uganda on ITN and IRS seems to have played significant role in the decline in mortality.

Mortality due to non-communicable diseases continue to be high, albeit a slight reduction in 2017/18. We continue to strengthen our messages on awareness and screening during integrated outreach programs.

CHAPTER TWO

HEALTH POLICY AND DISTRICT HEALTH SERVICES

Health Policy

The focus for the Uganda NHP is on health promotion, disease prevention and early diagnosis and treatment of disease with emphasis on vulnerable populations as well as strengthening health systems capacity to deliver the UMHCP.

Dr. Ambrosoli Memorial Hospital continues to implement the Uganda National Health Policy (NHP) and Health Sector Strategic Plan by providing the key components of the Uganda Minimum Health Care Package. These includes in-patient, out-patient and community based services; with emphasis on diagnostic, therapeutic and preventive services. It also adheres to the guidelines set by the Uganda Episcopal Conference through UCMB.

Kalongo hospital participates in the DHMT meetings and the operational plans for the common activities are incorporated in the district health plan.

District Health Services

Administratively, Agago district is composed of two (2) counties (Agago North and Agago County); with only one (1) HSD. Kalongo hospital is located within Agago North County; it still continues to serve both as a district hospital as well as the head of the HSD. There are sixteen (16) sub counties in the district. The distribution of health services by Sub County are shown below in table 2.1.

Inadequate health infrastructure lowers physical accessibility to health services. This coupled with lack of qualified human resources further lowers the quality of health services provided. All this challenges add up to contribute to more health service gaps like; Increasing Morbidity and Mortality of Mother and Child, and Malnutrition among others.

The poor road network in the district further impounds negatively on the already crippled referral system. Sometimes roads are impassable for Ambulances or simply makes the cost of maintenance unbearable.

Table 2.1: Distribution of Health Service points by Sub-county

Sub-Counties	Total Population	No of Hospitals	No of HC IV	No of HC III	No of HC II	Total Immunizations Static Stations
Kalongo Town Council	11,573	1	0	0	0	1
Omiya Pacwa	12,408	0	0	0	2	2
Paimol	14,547	0	0	1	1	2
Lapono	18,109	0	0	1	5	6
Adilang	23,037	0	0	1	3	4
Patongo	24,302	0	0	0	0	0
Patongo Town council		0	0	1	0	1
Kotomor	15,338	0	0	1	2	3
Omot	12,123	0	0	0	2	2
Arum	10,251	0	0	1	0	1
Lamiyo	12,062	0	0	0	2	2
Lira Palwo	22,216	0	0	1	4	5
Wol	25,787	0	0	1	3	4
Parabongo	16,802	0	0	1	2	3
Lukole	12,631	0	0	0	3	3
Agago Town Council	6,814	0	0	1	0	1
Total for HSD and District	238,000	1	0	9	30	40

Table 2.2: Population, health units and staffing in Agago District FY 2017-2018 by Sub-county

Sub-Counties	Population FY 2017-	Health units (Level & ownership)	Staffing levels		Staffing gap
			Staffing Norm	No. available	
Lira Palwo	22,216	Lira Palwo HC III Gov.	19	14	-5
		Acuru HC II Gov.	9	3	-6
		Obolokome HC II Gov.	9	3	-6
		St Janani HC II CoU	9	7	-2
		Lanyirinyiri HC II Gov.	9	3	-6
Omot	12,123	Omot HC II Gov.	9	9	0
		Geregere HC II Gov.	9	5	-4
Adilang	23,037	Adilang HC III Gov.	19	11	-8
		Ligiligi HC II Gov.	9	4	-5
		Alop HC II Gov.	9	6	-3
		Orina HC II Gov.	9	4	-5
Lamiyo	12,062	Kwonkic HC II Gov.	9	5	-4
		Lamiyo HC II Gov.	9	7	-2
Arum	10,251	Acholpii HC III Gov.	19	18	-1
Kotomor	15,338	Kotomor HC III Gov.	19	3	-16
		Odokomit HC II Gov.	9	8	-1

		Onudapet HC II Gov.	9	3	-6
Omiya Pacwa	12,408	Omiya Pacwa HC II Gov.	9	4	-5
		Layita HC II Gov.	9	4	-5
Lapono	18,109	Lira Kato HC III Gov.	19	13	-6
		Lira Kaket HC II Gov.	9	5	-4
		Ongalo HC II Gov.	9	5	-4
		Amyel HC II Gov.	9	5	-4
		Ogwangkamolo HC II Gov.	9	3	-6
		Abilonino HC II Gov.	9	3	-6
Wol	25,787	Wol HC III Gov.	19	10	-9
		Kuywee HC II Gov.	9	6	-3
		Toroma HC II Gov.	9	4	-5
		Okwadoko HC II Gov.	9	3	-6
Paimol	14,547	Paimol HC III Gov.	19	16	-3
		Kokil HC II Gov.	9	5	-4
Parabongo	16,802	Pakor HC II Gov.	9	4	-5
		Pacer HC III Gov.	19	18	-1
		Kabala HC II Gov.	9	6	-3
Lukole	12,631	Lapirin HC II Gov.	9	6	-3
		Olung HC II Gov.	9	6	-3
		Otumpili HC II Gov.	9	2	-7
Agago Town Council	6,814	Lukole HC III Gov.	19	14	-5
Patongo Town Council	24,302	Patongo HC III Gov.	19	25	-6
Patongo S/C					
Kalongo Town Council	11,573	Kalongo Hospital NGO	190	251	61
Total HSD	238,000	38 Govt. and 2 NGO Units	567	491	-76

Table 2.3: Structure of the District Health Office team

Human Resources (Cadre)	Current Number
DHO	1
Assistant DHO	1
Biostatistician	1
Environmental Officer	1
EPI FP/Health Assistant	2
Senior Accounts Assistant	1
Office Attendant	1
Health Educator	1
Total	9

Table 2.4: Structure of the Health Sub District team at the referral facility

Human Resources (Cadre)	Current Number
Nursing Officer	1
Cold Chain Assistant	1

Theatre Assistant	1
Records Assistant	1
Account Assistant	1
Office Typist	1
Office Assistant	1
Guard	1
Grand Total	8

Funding

Health funding has been constant but static and does not fully meet the health needs. This impacts critical performance. The amount of PHC conditional grant has remained the same as with the previous FYs. The critical issue here is the fact that the cost of health care has continued to rise annually. The operation of the PHC conditional grant was revised by the Government in 2017/18. 50% of the money meant for medicines and medical consumables are now sent directly to JMS; the hospital only makes orders quarterly for the commodities. The key set back with this arrangement is the lack of flexibility; some items may be missing with the principal supplier, leaving the hospital to wait with stock outs of the commodity.

Funding towards the HSD was stopped by the government in 2017/18. Government now prefers to send funds directly to LLUs' accounts. Majority of the supervision functions of the HSD has been transferred back to the Districts' department of health. The hospital now find it increasingly difficult to continue shouldering the responsibilities of the HSD without any funding support from Government.

Health Infrastructure

The gaps in the infrastructure has not been addressed in the HSD. The accommodation challenges in some of the facilities creates a situation where the staffs have to commute from distant towns; in essence meaning the staff cannot have enough time to attend to the patients.

Kalongo hospital together with the Dr. Ambrosoli foundation embarked on the construction of more houses towards staff accommodation in the FY 2017/2018. Unfortunately, the housing needs remains too high that funding availability cannot match these demands.

The hospital, through its' principal partner; the Ambrosoli Foundation, secured funds towards the reconstruction and refurbishment of the Children's ward. This project is expected to start in the next FY.

Prevention and Health promotion services

The hospital currently does not have a dedicated public health department. This however is strongly engraved in the strategic vision for the institution. Despite this, the hospital carries out a range of health prevention and promotion activities. These includes routine health education and immunization as well as offering support supervision to the lower level units. In 2017/18, the hospital allocated more resources towards strengthening integrated outreach PHC activities across the HSD, especially in hard to reach areas (the outputs are reflected in Table 2.5 below).

The HC II function of the hospital

The catchment area within which the hospital carries out its' HC II function is Kalongo Town Council; with a population of 11,573 (2017).

DAMHK continued to carry out immunization in its mobile and static units. Table 2.5 summarizes the out puts in terms of vaccines administered.

Table 2.5: Hospital contribution to prevention &health promotion services of the HSD/District

Activity: TT to child bearing ages	Hospital	HSD/District	Hospital output as % of HSD/District
Pregnant women			
TT 1	2,042	8,173	25.0%
TT 2	1,420	6,129	23.2%
TT 3	30	1,665	1.8%
TT 4	16	990	1.6%
TT 5	22	745	3.0%
Non Pregnant women			
TT 1	282	4,802	5.9%
TT 2	249	2,991	8.3%
TT 3	278	2,530	11.0%
TT 4	192	1,468	13.1%
TT 5	151	1,240	12.2%
Immunization in school			
TT 1	278	2,676	10.4%

TT 2	172	3,487	4.9%
TT 3	142	1,058	13.4%
TT 4	125	586	21.3%
TT 5	60	618	9.7%
Total TT 2 in all categories	1,841	12,607	14.6%
Immunization in Children			
BCG	3,491	9,762	35.8%
Protection at Birth for TT (PAB)	2,914	6,184	47.1%
Polio 0	3,481	9,418	37.0%
Polio 1	908	10,086	9.0%
Polio 2	787	9,690	8.1%
Polio 3	798	10,034	8.0%
PCV 1	907	10,346	8.8%
PCV 2	816	9,827	8.3%
PCV 3	819	9,973	8.2%
DPT-HepB+Hib 1	923	10,366	8.9%
DPT-HepB+Hib 2	860	9,961	8.6%
DPT-HepB+Hib 3	821	10,183	8.1%
Measles	652	8,301	7.9%
Total Immunisation in Children	18,177	124,131	14.6%
Total Family Planning attendances	2,379	49,383	4.8%
Total ANC attendance	6,045	33,025	18.3%
Deworming	11,278	126,677	8.9%
Vitamin A Supplementation	3,814	40,701	9.4%

The above data includes the UNEPI vaccination outputs and some of the outreach figures. Kalongo hospital also participates in the NIDs and family health days, as well as special immunization drives.

There was 28% increase in the amount of TT antigens administered to girls of child bearing age in 2017/18 compared to 2016/17. The total antigens administered to children also increased by 24% in 2017/18. Looking at these parameters and all the other indicators reflected in Table 2.5 above, the impacts of the integrated outreach activities in 2017/18 can be seen.

In the FY 2018/19, the hospital plans to strengthen more the integrated outreach activities in especially hard to reach settings.

CHAPTER THREE

GOVERNANCE

The Board of Governors

The Board of Governors (BOG) is the supreme policy maker and controlling body of Dr. Ambrosoli Memorial Hospital and St. Mary's Midwifery Training School. However, the Hospital Management Team remain fully responsible for all operational aspects of the hospital and the school. As enshrined in the hospital Statute, a minimum of two (2) BOG meetings should be held in a year. In the FY 2017-2018 the hospital held two (2) ordinary BOG meetings and one (1) Extra Ordinary BOG Meetings.

The BOG received and discussed the hospital management report that highlighted key issues pertaining to the activities and challenges affecting the hospital and school. This report also highlighted areas of successes and work in progress.

In the FY 2017/18, DAMHK management team successfully organized a stakeholders meeting; which was largely a very successful event. This meeting attracted many stakeholders from both within and outside Agago district; who freely expressed opinions and way forward to various points that had been raised. Some of the key points were again discussed by the hospitals' management and the BOG before considerate actions could be taken. The tradition of giving a chance to different stakeholders to play a role in discussing the institutions' critical issues is expected to be carried on into the next FYs.

The hospital also involved its' staff in community charity activities, as part of cooperate social responsibilities. This is a platform that we plan to strengthen in coming years as means to bring the stakeholders closer to the hospital.



Hospital staff participating in a town cleaning event as part of community charity activities. Photo credit: Boniface Opota

Table 3.1: Summary of BoG meetings held in the FY 2017-2018

BoG meetings	Reports presented / Key issues handled / Decision taken	Members present
18 th November 2017	Secondment of staff by the government, Introduction of Degree program in Midwifery, Review of the procurement manual.	14
12 th May 2018	Investments lost in the defunct AGARU SACCO, Review of the SACCO members' resolutions.	9
22 nd June 2018	Budget performance reviews, Disciplinary issues involving core members of Finance and Administration Department	11

The Statute enumerates 3 key thematic committees that have to be in place and functioning: Human Resources & Disciplinary Committee, Finance Committee and School Committee. The BOG can appoint additional committees if needed. Their role is to examine in advance reports and proposals from the Management and to present comments and suggestions to the BOG during the plenary meetings.

Although it is required that each committee meets at least twice a year; it has been difficult to keep up with this practice due to unavoidable circumstances. For instance, most members may be caught up with other responsibilities. All BOG members are being encouraged to routinely attend and contribute in meetings.

Table 3.2: Table showing functionality of the Board Committees

Name of committee	Required No. of meetings per year	No. of meetings held	Percentage of required meetings held
Finance Committee	2	4	200%
School Committee	2	1	50%
Human Resources & Disciplinary Committee	2	0	0

Hospital Management

The Hospital Management Team headed by the Chief Executive Officer is the body responsible for decision making on all matters regarding the hospital and the school.

The Hospital Management Team collectively shares the task of achieving the strategic objectives and the specific targets decided by the Board of Governors. It is granted operational autonomy within the scope of the hospital strategic plan, approved policies, manuals and procedures. This Team meets at least once every month.

The core members of the Hospital Management Team are:

- The Chief Executive Officer
- The Medical Director
- The Administrator
- The Senior Nursing Officer
- The Principal Tutor of the School

Table 3.3: Frequency of HMT meetings FY 2016-2017

No of planned Management meeting	No. of Management meeting held	Average No. of members present	Reports / key issues handled
24	16	4	Minutes of each meeting were prepared and circulated by the CEO

Statutory commitments compliance

The Hospital regularly complies with all statutory commitments set by Government, Ministry of Health and UCMB as displayed in details below in Table 3.4.

The UCMB established an accreditation program for the hospitals of the catholic network. Kalongo hospital satisfied this requirements for the year 2017/18. This accreditation entitles the hospital to the full range of services provided by UCMB for the period ending on the 31st December 2018.

Table 3.4: Statutory commitments compliance

No	Requirement	Did you achieve? (Yes, Partly, No)	Comment
Government / MOH Requirements			
1	PAYE	YES	Regularly observed
2	NSSF	YES	Regularly observed
3	Local service tax	YES	Regularly observed
4	Annual operational licence	YES	Regularly observed
5	Practicing licence for staff	YES	Regularly observed
7	Monthly HMIS	YES	Regularly observed
UCMB statutory requirement			
1	Analytical Report end of FY year	YES	Regularly observed
2	External Audit end of FY year	YES	Regularly observed
3	Charter (still valid)	YES	Revised
5	Contribution to UCMB for the year	YES	Regularly observed
6	HMIS 107 PLUS financial report / quality indicators ending FY	YES	Regularly observed
7	Report Status of staffing as of end of FY	YES	Regularly observed
8	Manual of Employment (still valid)	YES	Revised
9	Manual Financial Management (still valid)	NO	Currently being revised
10	Report on Undertakings & Actions of FY	YES	Regularly observed

Internal Regulatory Documents

DAMHK has in place manuals and guidelines that regulates decisions and practices in both the hospital and the school. These documents includes: The Employment manual, the finance and material resource manual and the procurement manual. The employment manual was successfully revised during the FY; however, the finance and material resource manual revision is also ongoing at the moment. The HMT has also reviewed the school fees policy and

the rules and regulations for the Midwifery school (before approval by the BOG). There are also a number of policies which are still work in progress. These includes; the waiver policy and the user fee manual. Management is putting in place measures to ensure that these policies are adhered to.

Advocacy, lobby and negotiation

The Hospital has not yet developed a formal advocacy agenda; however, it has maintained constant contacts with local leaders, international NGOs, and major donors, e.g. Dr. Ambrosoli Foundation and Comboni Missionaries, according to the needs. The management has been actively contacting potential donors to solicit for more support; although, it has proven difficult to find donors for recurrent cost. More efforts still needs to be put to attract more support from partners.

CHAPTER FOUR

HUMAN RESOURCES

Staff Establishment

Over the years the total number of staffs (clinical and non-clinical) have increased gradually. The hospital has also been increasing the scope of its services over the years. Projects that required more staff to implement, also came up during the FY. Currently the hospital is a 271 bed capacity general hospital being run by 148 clinical staff; below the recommended 190 for a 100 bed capacity general hospital.

Table 4.1: Total number of employees in the hospital in the last 5 FYs

Category		FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Clinical ¹	Qualified	97	108	130	116	131
	Unqualified	26	18	18	34	17
	Total Clinical	123	126	148	150	148
Not Clinical ²	Qualified	41	86	38	61	43
	Unqualified	48	27	59	40	62
	Total Non-Clinical	89	113	97	101	105
Total Qualified		138	194	168	177	174
Total Unqualified		74	45	77	74	79
Grand Total		212	239	245	251	253
% of qualified clinical staff/total staff		45.8%	45%	53%	46%	51.8%

Staff turn-over³

The turn-over rate is higher among enrolled nurses compared to the other cadres in the hospital, as shown in table 4.2. The hospital salary scale and benefit packages are still not competitive with the Government and other institutions in the area. There has however been a reduction in the turnover rate for the clinical work force (8.7% from 19.0% in the previous FY).

Other factors that may also have played a role in attrition are) end of contract (almost all contracts are lasting only one year), b) personal interest for capacity building (staff leave as self-sponsored), c) remoteness of the hospital location (lack of amenities and quality social services), and d) personal issues (many staff's families are not living in Kalongo).

¹Clinical Staff includes: Medical Doctors, Paramedics, Nurses, Midwives, and Nursing Assistants.

²Non Clinical Staff includes: Administration Officers, Procurement Officers, Accountants, Accountant Assistants, Record Assistants Clerks, Guards, Store Keepers, Cooks, Tailors, Porters and Nursing Aides.

³Turn Over rate for each year is calculated as in the following example for FY 2015-2016: Total staff lost in FY 2015-2016/[(Total staff available on June 30th 2015 + Total staff available on June 30th 2016)/2]

Table 4.2: Turn-over trends of enrolled cadres⁴ in the last 3 FYs

Cadres	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Total staff	239	245	251	253
Enrolled cadres (all combined)	68	69	69	70
Turn-over for enrolled cadres	19%	39.4%	24.6%	8.6%

Table 4.3: Turn-over trends of Clinical Staff in the last 3 FYs

Clinical Staff	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Total staff	239	245	251	253
Total arrivals of key health personnel	48	48	55	26
Total departures of key health personnel	27	37	47	22
Turn-over rate	21.7%	27.0%	19.0%	8.7%

The working hours for all the staff are between 40 and 42 per week. Work schedule of shifts for subsequent month is communicated by the in charge before the end of the current month to the concerned personnel in the departments.

The hospital provides accommodation for a large proportion of its employees (146 staff and their families, 58% of the total staff) in the staff quarters located within its premises. This housing facilitation includes also availability of water and electricity. During the FY, the hospital embarked on expansion and refurbishing of the accommodation facilities to a more conducive living environment; with funding from the Ambrosoli Foundation.

Salaries have been regularly paid and any statutory obligations are regularly remitted (PAYE and NSSF) according to the current legislation.

⁴Enrolled Nurses, Enrolled Comprehensive Nurses and Enrolled Midwives.

Human resources development and career progression

In order to guarantee sustainability in the culture, workman ethics and forward development of the institution; it is imperative for the hospital to provide capacity development to its employees. This capacity development comes in the form of; CMEs, short trainings, on site mentorship, and advance courses of relevance to the institution.

The HMT therefore revised and enforced the staff training and development policy which offers guidance on training procedures. The training needs are planned for and approved through the BOG at the beginning of every FY. However certain trainings may be sanctioned during the course of the year depending on the need and financial availability. Capacity development is also viewed as a retention strategy to employees since it renders career security.

Table 4.4 below presents the list of employees who enrolled in training through the hospitals scholarship program in key areas of needs.

Table 4.4: Hospital Staff who attended courses in FY 2017-2018

S/N	Name	Designation	Course	Date of start	Date of End
1	Ocen Godfrey	Laboratory Assistant	Diploma in Laboratory Technology	August, 2016	May, 2019
2	Okot John Paul	Diploma in Nursing	Diploma in Anaesthesia	Sept, 2016	May, 2018
3	Adokorach Pamela Lalam	Enrolled Midwife	Diploma in Midwifery	May, 2017	Nov, 2018
4	Adong Agnes	Enrolled Midwife	Diploma in Midwifery	May, 2017	Nov, 2018
5	Awor Ruth	Clinical Instructor	Bachelor of Medical Education (Makerere)	Aug, 2016	Jul, 2019
6	Dr. Myango Patient K	Medical Officer	MMed OBGY	Aug, 2016	Jul, 2019
7	Sr. Ayakaka Hellen	Enrolled CN	Diploma in Nursing (St. Francis Hospital Nsambya)	May 2016	Nov 2017
8	Sr. Aलोbo Hellen	Clinical Instructor	Bachelor in Medical Education (Mulago, Makerere University)	August 2015	July 2018
9	Moi Geoffrey	Senior Accounts Assistant	BA Business Administration (Gulu University)	August 2015	July 2018

10	Okwir Denis	Accounts Assistant	BA Business Administration (Gulu University)	August 2015	July 2018
11	Atimango Sarah	Enrolled Nurse	Diploma in Nursing (Lacor Training School)	May 2017	November 2018
12	Ojera Alex Latim	Registered Nurse	Bachelors of Public Health (Lira University)	August 2017	June 2020
13	Sr. Acan Santina	Double Trained Nurse	Bachelors of Midwifery (Lira University)	August 2017	June 2021
14	Aneno Irene Jackline	Registered Midwife	Diploma in Anesthesia (Lacor Training School)	September 2017	June 2019
15	Olanya Richard	Nursing Aide	Certificate in Nursing (St. Joseph Kitgum)	October 2017	June 2020

CHAPTER FIVE

FINANCES

Dr Ambrosoli Memorial Hospital and St. Mary's Midwifery Training School finances are managed distinctly. The two financial statements are also audited separately. However, the financial transaction of the two institutions are overseen by the HMT. As indicated, funding for recurrent cost continues to dwindle over the years due to either donor fatigue or shift in donor priority.

The subsequent tables below show the trend of financial statements for the hospital and the HSD. The school's financial statement will be reviewed under the section for the school (Chapter 9).

Income

Table 5.1: Trend of Income by source over the last 5 years

Income Item	Income over the last 5 Years					Variance 2016-17 vs. 2017-18
	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	
HOSPITAL						
User Fees	399,799,594	429,341,811	537,697,285	490,794,376	547,113,427	11%
PHC CG cash	494,379,756	506,731,434	496,440,741	488,334,860	251,159,632	-49%
Government donations in kind (Drug/Lab)	13,240,715	17,549,163	251,710,481	243,072,352	223,912,042	-8%
Other donations in kind	1,019,614,218	1,073,509,815	1,171,239,924	1,023,496,908	1,014,273,481	-1%
Donations in cash (including project funding)	2,261,661,058	1,976,532,864	1,352,092,200	3,811,677,210	2,158,718,147	-43%
Others Financial sources (Deposit Interests & others)	119,265,960	82,600,220	76,684,887	326,116,116	70,423,720	-78%
Technical Department	64,191,141	56,945,511	70,879,020	213,555,605	138,268,473	-35%

Sub-Total Hospital	4,372,152,442	4,143,210,818	3,956,744,538	6,597,020,427	4,403,868,922	-33.2%
HSD						
Sub-Total HSD	98,668,800	12,356,576	12,401,032	60,473,163	-	-
Grand-Total	4,947,846,528	4,747,676,188	4,576,163,141	7,210,120,876	4,403,868,922	-38.9%

There was 33.2% reduction in the total revenue generated by the hospital in 2017/18 compared to the previous FY. This picture cut across all income lines for the hospital. As already anticipated in the previous FY, donor support towards recurrent costs has continued to dwindle. In 2017/18, the hospital experienced a 43% reduction in donation in cash. This significant reduction was due to the absence of certain HIV related activities like Voluntary Medical Male Circumcision, which contributed to revenue in the previous FY.

The PHC conditional grant reduced by 49% in 2017/18. Government revised the guidelines on the operation of the PHC grant in the FY. 50% of the PHC funds is now sent directly to the drug supplier (JMS) by the MOH; the hospital only submits quarterly orders for the drugs and medical sundries. However, the total grant amount has remained constant over the last FYs even if the cost of health care has continued to rise.

The hospital realised 11% increase in the total revenue realised from user fee collection. It is important to note that the user fee of the hospital was not increased but rather the number of patients who escape without payment of fees reduced significantly during the year.

Funding towards the HSD operations stopped during the FY. The MOH now prefers to send funds directly to LLUs' accounts to support PHC activities. The change has totally disrupted the supervision function of the HSD. It is anticipated that this will continue into the next FY.

Expenditure

Table 5.2: Trend of Expenditure over the last 5 FYs

Expenditure Item	Expenditures over the Last 5 Years					Variation FY2016/17 Vs. FY2017/18
	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	
HOSPITAL						
Human Resource cost	1,481,676,063	1,454,269,387	1,571,469,625	1,742,346,590	1,732,988,559	-1%
Administration & Governance Costs	137,309,190	86,721,317	95,753,358	159,589,078	289,871,890	82%
Medical goods and supplies (included drugs)	1,629,096,034	1,436,533,515	1,937,705,529	1,978,701,042	1,404,990,561	-29%
Non-medical goods / supplies	137,391,003	119,594,489	136,173,475	226,243,037	394,354,176	74%
Property Costs	232,462,749	232,835,274	240,980,620	268,887,558	293,631,126	9%
PHC	242,976,850	250,856,300	331,106,130	1,235,279,987	990,417,897	-20%
Transport & Plant Costs	157,759,179	147,434,856	140,006,217	237,801,122	211,688,263	-11%
Capital Development	112,542,651	42,812,692	0	85,087,450	368,297,883	333%
Hospital Total Expenditure	4,130,179,652	3,788,854,344	4,436,615,968	5,843,866,302	5,686,240,355	-3%
HSD						
HSD Total Expenditures	98,668,800	12,456,576	12,401,032	60,473,163		
Grand Total	4,671,670,416	4,241,686,664	5,017,293,084	6,382,571,964	5,686,240,355	-10.9%

In 2017/18, the hospital spent in excess of revenue generated by 29.1%. Most of these expenditures were due to the increased market prices for goods and services which were not anticipated. The total expenditure was however 3% lower than the expenditure from the previous FY.

Capital development increased by 333% from the previous FY, because of the construction of staff houses together with the water and sanitation project; which was funded by the Ambrosoli Foundation. The capital development project is expected to continue into the new FY.

The hospital spent 74% and 82% more on non-medical goods and Governance/Administration costs, respectively in 2017/18 than in the previous FY. Property costs also increased by 9% from the previous FY; most of the institutions' structures are old and therefore require routine maintenance.

Cost containment continues to be a main challenge for the hospital. This is partly because of the ever changing market trends. However, the management has embarked on controlling wastage as a means of cost containment.

Table 5.3: Trend of average user fees by department in the last 5 FYs

	Average Fees				
	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
OPD Adult Male	9,400	11,317	12,000	9,700	11,400
OPD Adult Female	9,400	11,317	12,000	10,500	14,200
OPD Children < 5yrs	3,300	3,499	4,500	4,500	4,900
OPD Children 5-13 yrs	4,800	6,507	7,000	7,000	9,800
IP Medical Male	18,868	25,149	26,000	24,000	16,700
IP Medical Female	18,868	24,276	26,000	24,000	16,700
IP Maternity	17,368	18,351	20,000	16,050	18,250
IP Paediatric < 5 yrs	6,343	8,300	8,500	6,100	6,450
IP Paediatric 5-13 yrs	6,343	8,300	8,500	6,100	6,450
IP Surgical Ward	27,689	19,306	25,000	21,700	24,460

The average user fee per patient by department has only had minor variations. As already stated above, the hospitals' user fees were not revised. However, the efficiency of revenue collection improved during the FY. The hospital still continues to have instances when patients escape without paying user fees.

In 2017/18, the cost recovery rate increased by 1.7%. This is a positive trend from the previous FY. The hospitals' projected target for cost recovery is at least 30% in the next 3 to 5 years. As we ponder about user fee revision; revenue collection needs strengthening in order to recover what patients escape with. Waste reduction is another critical area that needs attention.

Table 5.4: Trend of Cost Recovery from Fees in the last 5FYs

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Total User fees (a)	399,799,594	429,341,811	537,697,285	490,794,376	547,113,427
Total Recurrent Expenditure (b) ⁵	4,017,367,001	3,746,041,652	4,436,615,968	5,757,781,852	5,317,942,472
Cost Recovery Rate = (a/b)x100	10.0 %	11.5%	12.1%	8.5%	10,2%

The hospitals' economic efficiency reduced significantly in the FY 2017/18 by 26% since the cost of producing one SUOop increased from 15,904 to 21,495. The cost of treating one patient per day also increased by 37%. The trend for average cost per bed reduced by 2.2%. This is not necessarily reduced efficiency, given that many times the hospital does not have direct control over market trends.

Table 5.5: Trend of indicators of efficiency in utilisation of financial resources

Indicator	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Cost per bed ⁶	13,302,540	13,823,032	16,371,277	20,061,958	19,623,404
Cost per IP/day ⁷	52,338	56,428	51,055	56,897	77,927
Cost per SUO _{op}	15,566	15,771	11,527	15,904	21,495

⁵ Total Recurrent Expenditure = Total Expenditure – Capital Development

⁶ Cost per bed = Total Recurrent Expenditure /Number of beds

⁷ Cost per IP/day = Total Recurrent Expenditure/(Number of Admissions*days spent in the hospital)

Cost per per bed = Total Recurrent Expenditure/Number of Beds

(NB: $Total\ SUO_{op} = Total\ OP + 15*IP + 5*Deliveries + 0.5*Total\ ANC + 0.2*Total\ Immunisation$)
 Source: UCMB

In the absence of donor funding (including government subsidy), the hospital was only 14% sustainable in 2017/18. This a 3.7% reduction from the previous FY. Given the ever dwindling donor support, there is a strong need for the BOG to consider avenues that can guarantee the future of the hospital. The user fee also needs to be selectively and consciously reviewed in the next FY.

Table 5.6: Sustainability ratio trend without donors and PHC CG funding, in the last 5 FYs

Without PHC CG	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Total Local Revenues (a)	583,256,695	568,887,542	685,261,192	1,030,466,097	743,310,430
Total Recurrent Expenditures (b)	4,017,637,001	3,746,841,652	4,436,615,968	5,757,781,852	5,317,942,472
Sustainability Ratio = (a/b)x100	14.5%	15.1 %	15.4%	17.9%	14%

(Local Revenues includes User Fees, Other Financial Sources and Technical Department)

In the absence of donor support but with the PHC conditional grant, the hospital was only 26.4% sustainability in 2017/18. This was exactly the same situation of the previous FY.

Table 5.7: Sustainability ratio trend in absence of donor funding but with PHC CG - last 5 FYs

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Total in-country funding (c)	1,090,877,166	1,075,618,976	1,181,701,933	1,518,800,957	1,404,088,571
Total Recurrent Expenditures (d)	4,017,637,001	3,746,841,652	4,436,615,968	5,757,781,852	5,317,942,472
Sustainability Ratio = (c/d)x100	27.2 %	28.7 %	26.6%	26.4%	26.4%

(In-country funding includes User Fees, Other Financial Sources, Technical Department, PHC CG, Local Government contributions, IGAs, etc)

CHAPTER SIX

SERVICES

The hospital offers a variety of services as recommended by Government of Uganda for a general hospital. These includes:

- Communicable and Non-Communicable Diseases care and prevention

Obstetrics & Gynecology Services

- Antenatal, Delivery & Postnatal care
- Prevention of MTCT of HIV
- Emergency Obstetric and Neonatal care
- General and Specialized Obstetric and Gynecologic Surgery

Pediatrics & Child Health

- Young child clinic
- Malnutrition Therapeutic feeding
- Neonatal intensive care
- Pediatric admissions and care
- Immunization and health promotion

General Surgical Services

- Trauma and Emergency care
- Surgical Clinic
- Minor Orthopedics services
- Burns care
- Anesthesia
- General surgical operations

Community Health

- Health promotion outreaches.
- Immunization
- Health education
- Primary Health Care

Internal Medical Care

- HIV Care and Treatment
- General and private Out-patient Clinic
- Emergency medical care
- Electro Cardiogram (ECG)
- Medical Admissions and care
- TB Detection and treatment

Health Training

- Midwifery training
- Internship for Medical Doctors
- Opportunities also provided to other cadres like Clinical Officers, Pharmacy, Nurses, Midwives and laboratory students for attachments during holidays; guidance is usually provided by a senior staff in the area of discipline.

OUT PATIENT DEPARTMENT

Dr. Ambrosoli Memorial Hospital runs a general Out Patient Department (OPD) located at the main entrance of the hospital. The OPD operates six (6) days a week from Monday to Saturday from 8.00 am to 9.00 pm; excluding Sundays and Public Holidays, when the out patients are managed from the wards. The hospitals' management is currently studying the feasibility of extending the working time to 24 hours/7 days a week, given the increasing demand for these services. When funds are available; there is a plan to construct and annex to it the accident and emergency unit.

Staffing composition

OPD is run by a clinical team consisting of; Clinical Officers, Nurses, Midwives, Nursing Assistants and Nursing Aids. This team is headed by a nursing officer and are responsible for every daily activities in the OPD. On most occasions, there are students from various institutions of learning who come to practice from here. The duties of all this clinical team are arranged in shifts to ensure that every employee gets enough rest from work. The specialized clinics are run by Medical officers and specialists.

These clinics includes; Gynecological Clinic – Monday, Sickle Cell Clinic – Tuesday, Surgical Clinic – Wednesday, and Medical Clinic – Thursday. Recently the Mental Health clinic was introduced on every last Friday of the month, with support from a local CBO. The OPD has not yet attained the optimal staffing level due to lack of personnel in areas such as Psychiatry, Ophthalmology and ENT. The hospital still faces difficulty in finding and attracting these cadres.



Students and staff of the OPD holding routine health education and discussion with patients in the morning.

In the FY 2016/17 a dedicated non – communicable disease clinic was introduced in the OPD; Diabetes and Cardiovascular – Friday. The clinic continues to follow up and offer care to these category of patients as well as screen more people for non-communicable disease risks.

Table 6.1: The staff composition in OPD in the FY 2016-17 and FY 2017-18

Cadre/ Discipline	Qualification	FY 2016-17	FY 2017-18
Clinical officers	Diploma in clinical Medicine	6	6
Pharmacy Assistant	Certificate in Pharmacy	2	2
Double Trained	Diploma in Nursing / Midwifery	1	1
Enrolled Midwife	Certificate in Midwifery	2	1
Enrolled Nurse	Certificate in Nursing	3	4
Enrolled Comprehensive	Certificate in Comprehensive	3	3
Nursing Assistant	Certificate in Nursing Assistance	3	3
Cashier	Diploma in Business Studies	2	2
Nursing Aide	Trained on the job	1	1
Total		23	23

OPD key indicators

During the FY 2017-2018, the hospital registered a decrease in OPD utilization, with total OPD attendance decreasing from 32,373 (2016/17) to 26,891 (2017/18) (decrease of 17%). This downward trend was also reflected by the decrease in the number of new attendance, from 28,689 (2016/17) to 22,378 (2017/18) (decrease of 22%). The decreased OPD utilization in

2017/18 is not necessarily a bad sign. As also witnessed across the LLUs in the HSD, there has generally been a downward trend in OPD attendance. Malaria which has been a key driver in OPD attendance, also reduced in 2017/18.

Table 6.2: Trend OPD attendance by gender & age in the last 5 FYs

			FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
FEMALE	New Attendance	0-4 yrs	3,156	2,642	3,372	3,539	2,442
		Over 5 yrs	11,997	10,690	12,294	13,743	11,095
	Re-attendance	0-4 yrs	202	122	90	49	124
		Over 5 yrs	1,599	1,511	1,077	1,738	2,097
MALE	New Attendance	0-4 yrs	3,469	3,188	3,794	3,984	2,720
		Over 5 yrs	6,413	5,311	6,785	7,423	6,121
	Re-attendance	0-4 yrs	188	161	97	78	203
		Over 5 yrs	1,748	1,971	1,374	1,819	2,089
All New Attendances			25,035	21,761	26,245	28,689	22,378
All Re-attendances			3,737	3,765	2,638	3,684	4,513
All Attendances			28,772	25,526	28,883	32,373	26,891

As experienced in the previous FYs, more females attended the OPD compared to men. It may not necessarily mean the female were sicker than the men, but rather have better health seeking behaviour than the men.

Morbidity Trend in the OPD

Respiratory tract infections was the leading cause of morbidity in the OPD; increasing by 8.3% in 2017/18. This reverses the trend of Malaria being the leading disease burden in the previous FYs. The intervention of ITNs and IRS, and more community awareness seems to have played a crucial role here.

Injuries continue to be on the rise (an increase of 2.4% in 2017/18). However the pattern of the injuries have been mixed. We registered an increase in assaults due to domestic violence and a relatively constant number of road traffic injuries due to boda boda cyclists. Violence is still rampant among the local community, mostly linked with increased alcohol consumption and land wrangles.

Table 6.3: Top ten diagnoses in OPD in the last 2 FYs

Causes of Morbidity		FY 2016-17		FY 2017-18	
		No. of cases	% on all diagnoses	No. of cases	% on all diagnose
1	No Pneumonia- Cough or Cold	3,404	10.9%	3,685	15.0%
2	Gastro-intestinal disorders (non-	3,298	10.6%	2,538	10.3%
3	Malaria	6,694	21.5%	2,063	8.4%
4	Injuries	1,640	5.3%	1,679	6.8%
5	UTIs (Urinary Tract Infections)	1,470	4.7%	1,322	5.4%
6	Diarrhoea	947	3.0%	1,087	4.4%
7	Skin diseases	1,089	3.5%	858	3.5%
8	Pneumonia	747	2.4%	690	2.8%
9	P.I.D	520	1.7%	584	2.4%
10	Intestinal Worms	303	1.0%	465	1.9%
	All other diagnoses	6,609	21.2%	6,003	24.4%
	Total diagnoses for the year	31,187		24,570	

ANTENATAL CLINIC

The Ante Natal Clinic (ANC) is an outpatient clinic providing specialized services to pregnant women and their unborn children and to non-pregnant women of child bearing age. ANC is open and operational 5 days a week, from Monday to Friday, from 8.00 am to 5.00 pm. The clinic is closed on Saturdays, Sundays and all public holidays.

ANC is autonomous from OPD and is hosted in the same building with eMTCT Care Point, Natural Family Planning, cervical cancer screening and HCT clinics. These clinics provide a wide range of services to clients, yet the rooms available are clearly not sufficient for all these activities and, as a norm, are quite congested. With availability of funding, the entire area needs to be re-designed and improved to provide adequate working space and waiting shelter for the mothers and children attending the clinics.

ANC staffing Composition

The staffing norm of the ANC did not change from that of the previous FY. The team is headed by one (1) registered midwife and assisted by seven (7) enrolled midwives, one (1) counsellor and one (1) laboratory assistant. With the increasing scope of activities implemented in the clinic, there is need to review the efficiency of this structure to ensure continued quality service delivery.

Table 6.4: Antenatal and Postnatal indicators during the last 4 FYs

ANTENATAL	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
ANC 1st Visit	1,817	1,890	2,041	1,874
ANC 4th Visit	1,217	1,075	1,236	1,217
Total ANC visits new clients + Re-attendances	5,909	5,743	5,883	6,045
ANC Referrals to unit	0	0	1	2
ANC Referrals from unit	0	1	3	0
POSTNATAL				
Post Natal Attendances	847	620	927	952
Number of HIV + mothers followed in PNC	26	8	100	124
Vitamin A supplementation	847	599	927	952
Clients with premalignant conditions for breast	0	0	0	0
Clients with premalignant conditions for cervix	0	0	0	0

There was decrease in 1st and 4th ANC visits registered in 2017/18 by 8.1% and 1.5% respectively. However, the total ANC visits increased by 2.8% compared to 2016/17. Overall, the utilization of ANC increased in 2017/18. There were no referrals out.



A midwife attends to a pregnant mother in the ANC.
Photo credit: Dr Smart

Post Natal Clinic attendances increased by 2.7%. The number of HIV+ mothers followed in the PNC also increased by 24% in 2017/18.

Cervical cancer Screening

The cervical cancer screening activity was introduced in the ANC during the FY. Thanks to funding from the Mario Sideri Foundation together with the Ambrosoli Foundation. The program seeks to reach out to all women (including girls) of reproductive age, from Agago and neighbouring districts; to access free cervical screening and diagnosis and eventual referral for definitive management.

Cervical cancer screening was incorporated into the routine scope of activities of the ANC. Since its inception in June 2017, a total of 379 women were screened for cancer of the cervix by June 2018. Out of these; Fifty Eight (58) were VIA positive and Four (4) were Pap smear positive. The Pap smear positive patients were later assessed for the disease progress and referred accordingly for more definitive treatment.

In the next FY, the project will scale up awareness campaigns and expand on training programs to build local staff capacity to carry out colposcopy and examine histology slides. The biggest challenge of the project is the heavy cost of delivering histology samples to Kampala for interpretation, since there are no laboratories in the region with that capacity.

HIV/AIDS Clinic

The HIV/AIDS clinic was initiated in November 2005, under the support of CRS AIDS relief. Support to the clinic's activities has undergone transition from CDC to USAID. In 2017/18, the clinic was funded and supported by USAID SUSTAIN activities and later USAID RHITES N Acholi Activity. The services offered in the clinic are substantially integrated into the hospital services. The Program provides comprehensive HIV/AIDS care, including Antiretroviral Therapy, Prophylaxis for and Treatment of Opportunistic Infections, HTS, eMTCT, SGBV, and DSDM; a community HIV treatment model.

The clinic is headed by a Medical officer who coordinates its activities. The personnel involved in the project activities in FY 2017-2018 included: 1 Medical Doctor, 1 Registered Midwife, 1 Enrolled Comprehensive Nurse, 1 Psychiatric Nurse, 2 Nurses, 1 Laboratory Assistant, 2 Pharmacy Assistants, 4 Counsellors, 2 Sample Transporters, 1 Nursing Aid and 60 Community

Health Volunteers. Personnel responsible for data collection included; 1 Adherence Coordinator, 1 Monitoring & Evaluation Officer and 2 Record Assistants.

The program registers an ever expanding number of HIV+ Clients every year. This is due to the high number of new HIV/AIDS infection and the increasing referrals from other facilities.

The higher number of patients implies an increased demand for HIV/AIDS services, often not commensurate with the available resources. The HIV/AIDS Clinic is located in a temporary structure used for dispensing drugs, nursing care, counselling, clinical consultation, storage of files, data entry and information management.

The eMTCT component along with HCT/VCT activities of HIV/AIDS services is provided in the ANC Clinic adjacent to HIV/AIDS Clinic.

HIV Testing Services (HTS)

HIV Testing Services (HTS) formerly referred to as HTC/VCT, is a voluntary service which aims at reinforcing the strategy against HIV fighting. This is in line with the UNAIDS global agenda of the 90 90 90. It seeks the first 90 (to ensure that 90% of the target population know their HIV status).

HTS was expanded outside the HIV clinic to include the Provider Initiated Testing (Testing of every patient/their attendants in all the wards) as well as incorporating into community outreach activities. The concept of HTS in the community is based on targeted testing (Targeting the at risk population).

Table 6.5: Trend of HCT/VCT results in the last 5 FYs

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
<i>Number Tested</i>					
Male	1,632	991	3,251	14,144	10,532
Female	1,886	1,683	5,028	6,478	10,995
TOTAL (Tested)	3,518	2,674	8,279	20,622	21,527
<i>Tested +ve for HIV</i>					

Male	118	54	243	316	386
Female	138	96	335	389	437
TOTAL (+ve Tests)	256	150	578	705	823
Positivity Rates of HCT					
Male	7.2 %	5.4 %	7.5 %	2.2%	3.7%
Female	7.3 %	5.7 %	6.7 %	6.0%	4%
Both sexes	7.3 %	5.6 %	7.0 %	3.4%	3.8%

With the emergence of new strategies like Provider Initiated Testing & Counselling (PITC), Routine Counselling & Testing (RCT), and mandatory HIV testing in ANC and Maternity for the elimination of Mothers to Child Transmission (eMTCT) a total of 26,492 clients accessed HIV counselling & testing services during FY 2017-2018; an increase of 8.3%. Male involvement in HTS reduced by 25.5% whereas female involvement increased by 69.7%. More emphasis needs to be aimed at testing more men in 2018/19. Positivity rate remained high among women (4.0%), a reduction of 2% from 2016/17.

Table 6.6: HIV test by purpose during FY 2017 – 2018

Types of test	HCT	PMTCT*	SMC	Total
Number of clients tested for HIV	21,471	3,066	1,955	26,492
No. of HIV +ve tests	823	36	1	860
Positivity Rate (%)	3.83%	1.17%	0.05%	3.25%

The above figure is for total test done purely for HIV screening & excludes quality control tests done during the FY 2017-18.

*Source: Laboratory records

Table 6.7: Performance Indicators of the PMTCT Programme in FY 2017-2018

A. Antenatal	No.
A1. Mothers re-tested later in pregnancy, labour or postpartum	991
A2. Mothers testing positive on a retest	24
A3. New pregnant and lactating mothers newly enrolled into psychosocial support groups.	64
A4. HIV positive pregnant women already on HAART before 1st ANC visit /Current pregnancy	133
A5. Pregnant women who received services at the health facility after referral from the community	2
A6. HIV (+) lactating mothers followed up in community for infant feeding, early infant diagnosis, or linkage into chronic care	388

A7. HIV positive Pregnant women initiated on Cotrimoxazole	32
A8a. Mothers assessed using CD4	0
A8b. Mothers assessed using WHO clinical staging only	21
A9a. HIV + pregnant women initiated on HART (Option B+) for EMTCT - CD4 >350 or Stage I and II (ART-T)	32
A9b. HIV + pregnant women initiated on HART (Option B+) for EMTCT - CD4 <350 or Stage III and IV(ART-T)	0
B. Maternity	
B1. HIV positive deliveries initiating ARVs in Labour	181
C. Postnatal	
C1. Postnatal mothers newly tested for HIV	2
C2. Postnatal mothers testing HIV positive	0
C3. Postnatal mothers initiating ARVs in PNC period	0
D. Early Infant Diagnosis (EID)	
D1. HIV-exposed infants (<18 months) getting a 2nd DNA PCR	140
D2. HIV-exposed infants initiated on Cotrimoxazole prophylaxis	168
D3a. 1st DNA PCR results returned from lab within 2 weeks of dispatch	166
D3b. 2nd DNA PCR results returned from lab within 2 weeks of dispatch	175
D4a. Total HIV-exposed infants who had a serological/rapid HIV test at 18 months or older.	219
D4b. Positive Number of HIV-exposed infants who had a serological/rapid HIV test at 18 months or older	4
D5. DNA PCR results returned from the lab that are positive	5
D6. HIV-exposed infants whose DNA PCR results were given to caregiver	176
D7. Number of referred HIV positive-infants who enrolled in care at an ART clinic	0

Antiretroviral therapy

Table 6.8: PLHAs eligible for ART and started on ART by age group and gender - last 5 FYs

		FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
ELIGIBLE FOR ART						
Male	<5 yrs	2	0	0	0	6
	5-<18 yrs	5	0	0	0	9
	18 and above	102	20	10	5	216
Female	<5 yrs	0	0	0	0	3
	5-<18 yrs	1	0	0	0	8
	18 and above	71	15	11	7	306
TOTAL ELIGIBLE FOR ART		181	35	21	12	553
STARTED ON ART						

Male	<5 yrs	18	4	3	4	6
	5-<18 yrs	15	7	5	2	9
	18 and above	142	108	137	131	216
Female	<5 yrs	15	5	9	1	3
	5-<18 yrs	25	4	10	9	8
	18 and above	282	169	90	201	306
TOTAL STARTED ON ART		497	297	254	348	553

The number of HIV positive clients enrolled on ART increased in 2017/18 by 59%. These represents only 64.3% of those who tested positive during the financial year. It is important to note that some of the clients who test positive are transferred to be enrolled in facilities that are closer to them; given that all HC IIIs are offering HIV care.

Other than ART services, the HIV/AIDS clinic also offers the following care packages:

- Training of youths on life skills where abstinence is advocated for;
- Training of married couples on being faithful in their marriages;
- Adherence monitoring through home visits;
- Community meetings for health talks;
- Gender Based Violence (GBV) support services to victims of GBV
- Food security & livelihood support to PLWHA, especially to infected & affected Children.

Table 6.9: Number of PLHAs started on ARV by age group and gender in FY 2017-2018

Category	No. of individuals < 2years (24months)		No. of individuals 2-< 5years		No. of individuals 5-14 years		No. of Individuals 15years and above		Total
	M	F	M	F	M	F	M	F	
Number of new patients enrolled in HIV care at this facility during the year	4	2	7	2	10	3	196	239	463
Number of pregnant women enrolled into care during the year.						0		68	68
Cumulative Number of individuals on ART ever enrolled in HIV care at this facility	32	35	58	44	78	84	1220	2076	3627

Number of HIV positive patients active on pre-ART Care	0	0	0	0	0	0	3	5	8
Number of HIV positive cases who received CPT/Dapson at last visit in the year	2	1	18	11	78	84	924	1570	2688
Number eligible patients not started on ART	0	0	0	0	0	0	0	0	0
Number of new patients started on ART at this facility during the year	5	3	6	0	9	8	216	306	553
Number of pregnant women started on ART at this facility during the year						0		68	68
Number of HIV positive patients assessed for TB at last visit in the year	1	1	15	10	75	83	762	1338	2285
Number of HIV positive patients started on TB treatment during the year	0	0	0	0	0	0	71	39	110
Net current cohort of people on ART in the cohort completing, 12 months during the year	0	1	1	0	1	2	32	27	64
Number of clients surviving on ART in the cohort completing, 12 months on ART during the year	0	1	1	0	1	2	32	27	64
Number of people accessing ARVs for PEP	0	0	1	0	0	2	32	25	59
Number of individual on ART FIRST LINE	2	1	18	11	77	84	886	1518	2597
Number of individual on ART SECOND LINE	0	0	0	0	1	0	38	52	91

Tuberculosis (TB) treatment

Dr. Ambrosoli Memorial Hospital offers holistic TB treatment services. These services are all integrated into the general medical care activities. TB treatment takes place in the TB ward, annexed to the Medical ward. The screening process starts in the OPD where all coughers are identified and isolated to a dedicated coughers' corner. These patients are handled with the urgency they deserve. Confirmed cases are immediately admitted to the TB treatment unit for the duration of the intensive phase of treatment before being discharged on CB-DOTs. All treatment follow ups are done from the unit.

The treatment unit also function hand in hand with the ART clinic due to HIV-TB co-infection. All HIV positive clients who also test positive for TB are immediately referred to the TB treatment unit. Table 6.10 summarizes the number of registered TB patients in the last five (5) FYs.

The number of smear positive TB dropped in 2017/2018 by 38%. This however still remain a huge public health concern, since these are the most infectious category in the community.

Table 6.10: TB patients registered for treatment in the last 5 FYs

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
No. of patients registered (all)	252	192	233	223	243
Children (< 5 yr.)	0	11	9	4	11
Disaggregation by Disease					
New Pulmonary Positive	89	97	154	175	109
Relapses Pulmonary Positive	6	4	5	4	6
Failure Pulmonary Positive	7	8	3	2	0
Default Pulmonary Positive	17	9	7	8	12
New pulmonary Negative	91	26	26	49	99
Relapses Pulmonary Negative	3	4	2	0	1
Default Pulmonary Negative	6	4	3	1	3
Pulmonary no smear done	0	0	27	19	0
Extra Pulmonary	33	0	6	34	16
Disaggregation by Treatment					
New Patients	213	161	213	207	224
Re-treatment	39	25	20	16	22
Other Patients					
Transferred in	2	0	3	0	0

Kalongo Hospital continued implementing the Government of Uganda drive of active case notification and identification in the community. In 2017/18, a total of 2026 samples were screened for MDR/MTB (reduction of 82%). In 2017/18, the district of Agago acquired an additional TB screening site alongside DAMHK; significantly contributing to the decline in the figures from 2016/17. The positivity rate increased from 0.03% in 2016/17 to 10% in 2017/18. More MDR positive TB were identified in 2017/18 (increase of 100%). This represents a gross public health concern for the community.

Table 6.11: MDR/MTB diagnosis during the FY 2017-18

Age group	Samples Collected	Samples Tested	MTB positive Cases	MDR positive (Rifampicin Resistant TB)	MDR cases referred
< 15 years	254	254	8	0	0
15 yrs.& above	1772	1772	195	6	6
Total	2026	2026	203	6	6

TB treatment outcome

Deaths due to TB has increased gradually over the last three years. In 2017/18, it accounted for 11.2% of all cases; an increase of 42% from 2016/17. Most of these were due to late stage HIV-TB co-infection. Early case identification complemented by reinforced case follow up strategies is still crucial in the new FY. It is however important to note the improvement in follow up of cases; which explains the increase in the number of patients who completed treatment (an increase of 85.7%) from 2016/17. However, the number of people who default treatment continue to rise. The hospital undertakes to strengthen treatment follow up in the next FY.

Table 6.12: Results of TB treatment in the last 4 FYs

Outcome of treatment	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2017-18
	Number	Number	Number	Number	(Percent)
Cured	32	44	20	49	42%
Treatment Completed	59	19	28	52	23.8%
Died	15	13	19	27	11.2%
Failure	2	1	0	2	0.4%
Defaulted	100	70	7	13	4.4%
Transfer out	44	45	18	N/A	
Total	252	192	92		

Table 6.13: Results of TB treatment smear positive Pulmonary TB patients in the last 4 FYs

Outcome of treatment	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Cured	28	38	19	47
Treatment Completed	17	16	24	14
Died	8	6	18	6
Failure	2	2	0	0
Defaulted	42	30	1	0
Transfer out	22	31	2	N/A
Total	119	123	64	

Orthopaedic Services

The hospital currently does not offer fully fledged orthopaedic services except for minor ones. These are incorporated into the hospitals' general surgical department. The department has two (2) orthopaedic officers. The services offered includes; closed reduction of fractures/POP application, Skin/Skeletal traction, selected external Fixation application as well as orthopaedic infections care. Table 6.14 below only shows the number of physiotherapy/POP applied during the FY.

Table 6.14: Main procedures in orthopaedics and physiotherapy done in the last 5 FYs

Procedures	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Plaster (POP)	582	622	236	421	765
Physiotherapy	106	72	62	72	67

The hospital, however maintains a long term plan to start offering orthopedics' services when funds are available to train an orthopedic surgeon.

Mental health clinic

In this part of Acholi sub region, access to specialize mental health is very limited. The nearest treatment centre is located at GRRH; with the soaring poverty rates, it is almost impossible for the locals to access treatment from Gulu.

The hospital still does not have mental health services fully integrated into its' core service scopes. However, clinicians continue to review this patients with the help of a registered psychiatric nurse.

In our OPD, Epilepsy still remain the leading psychiatric problem encountered; representing 88.7% of all cases reviewed, an increase of 320.6% from 2016/17. Organic psychosis and alcohol abuse also increased.

Much as the hospital strives to improve in mental health care; personnel sustainability remains a heavy challenge (majority leave for greener pastures), lack of availability of mental health drugs and admission space for these patients provides a major challenge. The table below 6.15 shows the cases which were reviewed in the OPD during the FY.

Table 6.15: Mental health cases reviewed in OPD in the last 4 FYs

Diagnosis	FY 2014-15		FY 2015-16		FY 2016-17		FY 2017-18	
	No.	%	No.	%	No.	%		
Epilepsy	211	55.3	130	76.4	238	72.3	1,001	88.7%
Drugs/alcohol abuse	13	3.4	19	11.2	33	10.0	37	3.3%
Depression & post-traumatic stress disorders	38	9.9	6	3.5	21	6.4	28	2.5%
Psychosis (schizophrenia)	4	1.0	3	1.8	2	0.6	6	0.5%
Bipolar affective disorder	2	0.5	2	1.2	4	1.2	36	3.2%
Attempted suicide	36	9.4	1	0.6	0	0.0	2	0.2%
HIV related Psychosis	18	4.7	1	0.6	4	1.2	2	0.2%
Other mental illnesses	60	15.8	8	4.7	27	8.2	16	1.4%
Total	382	100	170	100	329	100	1,128	100.0%

Dental Clinic

The hospitals' dental clinic was not operational throughout 2017/18. This was due to the lack of equipment to offer dental care. The hospital however plans to set up a dental unit in the future when funds are available. In the meantime, all patients who are in need of dental care are referred to GRRH.

Palliative Care

Palliative care is now fully integrated among routine patient care in the hospital. The palliative care program within the hospital covers patients suffering from terminal illnesses and those having severe pain due to various conditions. The uptake of these services is increasing in the hospital. In 2017/18, 303 patients were enrolled in Palliative care; a decrease of 16.3% from

2016/17. Thanks to the collaboration with St. Columbus Hospital which led to capacity building of more staffs on palliative care.

Table 6.16: Number of Patients who received Palliative Care in the FY 2017-18

Clinical Condition	Number
Sickle Cell Crisis	23
Diabetes Mellitus	20
Liver Diseases	35
Heart Diseases	47
Stroke	8
Hepatitis B	7
HIV wasting	8
Tuberculosis in HIV	22
Anaemia	15
Hypertension	23
Meningitis	6
Arthritis	4
Renal Failure	6
HIV Psychosis	4
Asthmatic Attack	2
Other	73
Total	303

Eye care clinic

The hospital does not have a specialized eye clinic due to the lack of personnel. These activities were covered under the specialist outreach co-sponsored by the hospital, AMREF and the Ministry of Health. During which 100 consultations and 58 surgeries were done. These services were free of charge. The specialist outreach services are expected to continue in the new FY through support from AMREF.

INPATIENTS DEPARTMENT

Summary of beds and qualified health personnel

In FY 2017-2018, DAMHK maintained a total of 271 beds, 2 Specialist Doctors and 5 Medical Officers worked in the 5 wards along with 52 Nurses and Midwives. The average number of beds per nurse/midwife was 5.2, with Surgical Ward being the ward with highest number of beds per nurse/midwife (6.9) and Maternity Ward the lowest (3.3).

Table 6.17: Summary of beds and qualified health personnel per ward

Ward	No. of Beds	Medical Personnel	No. of Nurses & Midwives	No. of beds per Nurse/MW
Medical Ward	41	1 Medical Officer	9	6.6
TB Ward	18			
Surgical Ward	76	1 Surgeon 1 Medical Officer 1 Orthopedic Officer	11	6.9
Maternity & Gyn Ward	75	2 Medical Officers	23	3.3
Pediatric Ward	61	1 Medical Officer 1 Pediatrician	9	6.8
Total	271	2 Specialist Doctors and 5 Medical Officers	52	5.2

Utilization indicators

The total admissions reduced in 2017/18 compared to 2016/17 (reduction of 34.2%). The total number of deaths in the hospital reduced by 43.6%. The overall recovery rate has remained almost constant at 97.0% in 2017/18. The reduced total admission was also reflected in all the wards across the hospital (Medical, Pediatrics, Maternity, and Surgical).

Table 6.18: Key indicators for the entire hospital in the last 5 FYs

Indicator	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
No. of beds	302	271	271	267	271
Total Admissions discharged	13,805	12,799	22,274	20,446	13,460
Patient days	76,758	66,386	86,898	100,930	68,521
Average Length of Stay	5.6	5.2	3.9	4.9	5.1
Turn over interval	2.4	2.5	0.5	-0.17	2.26
Throughput per bed	45.7	47.2	82.2	76.6	49.7
BOR	69.6%	67.1%	87.9%	103.6%	69.3%
No. Deaths	219	180	251	204	115
Mortality Rate	1.6%	1.4%	1.1%	1.0%	0.85%
Recovery Rate	98.2%	98.5%	98.0%	98.8%	97.0%
Self-discharges	34	11	14	48	20

Patient Days and Average Length of Stay (ALOS)

The number of patient days decreased by 32.1% compared to the previous FY. The Average Length of Stay increased: from 4.9 days in FY 2016-2017 to 5.1 days in FY 2017-2018. These increased ALOS were more in Surgical (8.9 days), followed by TB ward (8.2 days) where either patients are on intensive phase of TB treatment; and certain post-operative patients spent a much longer time in admission.

Bed Occupancy Rate (BOR) and Throughput per Bed

The hospital Bed Occupancy rate (BOR) decreased from 103.6% in the previous FY to 69.3% in 2017/18; and a throughput per bed reduction of 35.1%; representing a significant reduction from the previous FY. The hospitals' target for BOR is at least 85%. It also relates to the decreased bed occupancy across all the departments. The utilization of the available beds have been poor.

Number of deaths, Mortality Rate, Recovery Rate and self-discharges

There was a 43.6% reduction in the number of deaths in the hospital compared to FY 2016/17. This also reflects the reduced mortality rate in the hospital during the FY; 0.85%. 97% of the patients recovered following the medical interventions given to them. There was a reduction in the number of self-discharged patients compared to FY 2016/17 (reduction of 58.3%). These are the category the management continue to pay close attention to in the new FY, since they contribute to reduced revenue collection.

Table 6.19: Key indicators per ward in the last 4 FYs

MEDICAL WARD				
	FY 14-15	FY 15-16	FY 16-17	FY 17-18
No of beds	41	41	41	41
Total Admissions	2,053	3,088	2,792	2,072
Patients days	7,954	10,39	14,88	11,33
ALOS	3.9	3.4	5.5	5.5
Throughput per	50.1	75.3	68.1	50.5
BOR	53.2%	69.4%	99.4	75.7
No of Deaths	94	95	79	63
Mortality rate	4.6%	3.1%	2.82%	3.04%
Recovery rate	95.4%	95.3%	97.1	95.5%
Self-discharges	2	6	2	4

SURGICAL WARD⁸				
	FY 14-15	FY 15-16	FY 16-17	FY 17-18
No of beds	76	76	71	76
Total Admissions	1,974	2,060	2,171	2,024
Patients days	14,87	16,05	17,83	17,99
ALOS	7.5	7.8	16.4	8.9
Throughput per	26	27.1	30.6	26.6
BOR	53.6%	57.9%	68.8%	64.9%
No of Deaths	22	40	27	13
Mortality rate	1.1%	1.9%	1.24%	0.64%
Recovery rate	98.4%	94.6%	98.4	98.8%
Self-discharges	10	7	7	4

PAEDIATRIC WARD				
	FY 14-15	FY 15-16	FY 16-17	FY 17-18
No of beds	61	61	61	61
Total Admissions	3,741	10,70	9,671	3,810
Patients days	17,49	33,59	44,76	19,78
ALOS	4.7	3.1	4.6	5.2
Throughput per	61.3	175.5	158.5	62.5
BOR	78.6%	150.9	201.1	88.9%
No of Deaths	48	102	83	36
Mortality rate	1.3%	1%	0.85%	0.94%
Recovery rate	99.3%	98.6%	99.1%	98.7%
Self-discharges	0	0	2	10

OBSTETRICS& GYNECOLOGY WARD				
	FY 14-15	FY 15-16	FY 16-17	FY 17-18
No of beds	75	75	75	75
Total Admissions	4,845	6,195	5,593	5,302
Patients days	22,17	22,67	20,10	17,33
ALOS	4.6	3.6	5.1	3.3
Throughput per	63.8	82.6	74.6	70.7
BOR	81%	82.8%	73.5	63.3%
No of Deaths	8	4	6	1
Mortality rate	0.16%	0.06%	0.11%	0.02%
Recovery rate	99.8%	99.6%	99.9%	99.4%
Self-discharges	1	0	1	0

TB WARD				
	FY 14-15	FY 15-16	FY 16-17	FY 17-18
No of beds	18	18	19	18
Total Admissions	186	225	219	252
Patients days	3,891	4,182	3,345	2,078
ALOS	20.9	18.6	8.2	8.2
Throughput per	10.3	12.5	11.5	14.0
BOR	59.2%	63.7%	48.2%	31.6%
No of Deaths	8	10	10	2
Mortality rate	4.3%	4.4%	4.56%	0.79%
Recovery rate	95.7%	95.1%	95.4%	99.2%
Self-discharges	0	1	0	0

⁸Source: HMIS 108 Male Surgical Ward + Female Surgical Ward + Other Wards (Children Surgical Ward)

Medical ward had the highest mortality rate (3.04%) compared to the other wards. Maternal Mortality reduced from 0.11% in 2016/17 to 0.02% in 2017/18.

Inpatient referrals

Table 6.20: Pattern of referrals to and from the hospital in the last 5 FYs

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Referrals to hospital	311	474	449	1,328	1,378
Referrals from hospital	81	87	173	137	267
Total	392	561	622	1,465	1,645

The number of referrals to the hospital increased by 3.8% in 2017/18. AVSI continued to offer fuel subsidy towards referrals. The number of referrals outside the hospital also increased during the FY; typically reflecting the lack of specialised care for patients in the hospital.

Morbidity causes

As experienced in 2016/17, Malaria remained the leading cause of admission (17.9% of all admissions). The number of malaria cases in the inpatient department reduced by up to 76.8% in 2017/18. Injuries of all kinds were very rampant in 2017/18; mostly alcohol related violence and land wrangles. Table 6.21 below summarises the top ten causes of admissions in 2017/18.

Table 6.21: Top ten causes of admission in all the wards in the FYs 2016-2017 & 2017-2018

Causes of Morbidity		FY 2016-17		FY 2017-18	
		No. of cases	% on all diagnoses	No. of cases	% on all diagnoses
1	Malaria	7,950	34.10%	1,844	17.9%
2	Injuries	1,679	7.20%	1,639	15.9%
3	Septicaemia	521	2.23%	643	6.2%
4	Abortions	547	2.35%	499	4.8%
5	Pneumonia	679	2.91%	453	4.4%
6	Anaemia	607	2.60%	420	4.1%
7	Gastro-Intestinal disorder (non-	205	0.88%	316	3.1%
8	Diarrhoea Diseases	219	0.94%	267	2.6%
9	Tuberculosis	205	0.88%	252	2.4%
10	Hernias	156	0.67%	153	1.5%
	All other diagnoses	10,549	45.24%	637	6.2%
	Total	23,317	100.00%	10,300	100.0%

Over the last three (3) FYs, the incidence of malaria has been gradually reducing. Which may represent the effectiveness of the preventive intervention in place. This reduction was registered throughout the HSD.

Table 6.22: Trend in Malaria admissions over the last 5 FYs

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Malaria cases	1,505	1,513	9,664	7,950	1,844
% of all diagnosis	11 %	6 %	40.16 %	34.1%	22.4%

Mortality causes

Liver disease had the highest case fatality rate (14.3%) in 2017/18, followed by meningitis (14.0%). However, Malaria remained the leading cause of death compared to 2016/17. Despite the significant reduction in the number of cases admitted, the number of disease specific deaths have remained the same. Deaths due to cardiovascular diseases reduced in 2017/18 despite registering an increase in the number patients treated.

Table 6.23: Top ten causes of death among inpatients all wards FY 2016-17 and FY 2017-18

Causes of Mortality among Inpatients		FY 2016-17			FY 2017-18		
		No of disease specific deaths	No of cases admitted in the	Case Fatality Rate	No of disease specific deaths	No of cases admitted in the hospital	Case Fatality Rate
1	Malaria	48	7,950	0.6%	48	1,844	2.6%
2	Injuries	18	1,679	1.1%	18	1,639	1.1%
3	Pneumonia	18	679	2.7%	18	453	4.0%
4	Anaemia	11	607	1.8%	14	420	3.3%
5	Cardiovascular	20	136	14.7%	12	169	7.1%
6	Liver Diseases	10	56	17.9%	10	70	14.3%
7	Tuberculosis	10	219	4.6%	9	252	3.6%
8	Septicaemia	9	521	1.7%	9	643	1.4%
9	Meningitis	6	22	27.3%	6	43	14.0%
1	Premature Babies	5	76	6.6%	5	90	5.6%

MEDICAL WARD

Medical Ward has 41 beds; located in one main block, divided into male and female sections. It has also an adjacent private wing which has four two-bed rooms and three self-contained rooms for private patients. The complex is one of the oldest in the hospital and therefore needs urgent attention towards major renovation. It also has the TB ward annexed to it.

Staff Composition

The ward is run by a Medical Officer; who supervises 12 other staffs. The duties of these staffs are arranged in such a way that they offer cover to the TB ward annexed. Just like any other wards in the hospital; the staff provide outpatient services to patients who come over Sundays and after 9pm when the OPD is closed.

The staff also offer mentorship to the students from the Midwifery School who are attached there for their clinical rotations. The total number of staff decreased from 14 to 13.

Table 6.24: Staff Composition in Medical Ward FY 2016-17

Cadre/ Discipline	Qualification	Number
Medical Doctor	Bachelor Degree in Medicine and Surgery	1
Registered Comprehensive	Diploma in Comprehensive Nursing	1
Enrolled Nurse	Certificate in Nursing	5
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	3
Nursing Assistant	Certificate in Nursing Assistant	3
Nursing Aid	Trained on the Job	0
Total		13

Key Indicators in Medical ward

The total admissions decreased by 25.8% in 2017/18. This was mainly due to the reduction in the malaria cases admitted. The ALoS remained constant at 5.5. The BOR decreased to 75.7% in 2017/18. The turn over interval increased from 0.03 to 1.75. The recovery rate reduced by 1.6%. These data implies a reduction in work load of the ward, as well as its clinical efficiency.

Table 6.25: Key indicators in Medical Ward in the last 5 FYs

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
No. of beds	58	41	41	41	41
Total Admissions	3,410	2,053	3,088	2,792	2,072
Bed days	19,449	7,954	10,329	14,880	11,334
ALoS	5.7	3.9	3.4	5.5	5.5
BOR	91.9%	53.2%	69.4%	99.4%	75.7%
Throughput	58.8	50.1	75.3	68.1	50.5
Turnover interval	0.5	3.4	1.5	0.03	1.75
Deaths	113	94	95	79	63
Death Rate	3.3%	4.6%	3.1%	2.82%	3.04%
Recovery Rate	95.1%	95.4%	95.3%	97.1%	95.5%
Self-discharges	8	2	6	2	4

Morbidity causes

As experienced in the previous FY, Malaria was the leading cause of admission into the medical ward (accounting for 31.2% of the total admission). The number of malaria cases was however reduced in 2017/18 by 68.4%. Septicaemia and Gastrointestinal disorders increased by 57.3% and 11.5% respectively. The upward trend of non-communicable diseases continued in 2017/18. Cardiovascular disease and Hypertension increased by 12.5% and 6.3% respectively.

Table 6.26: Top 10 causes of admission in Medical Ward in the last two FYs

Causes of Morbidity in Medical Ward		FY 2016-17		FY 2017-18	
		No. of cases admitted	% on all admissions in Medical Ward	No. of cases admitted	% on all admissions in Medical Ward
1	Malaria	1153	47.3%	364	31.2%
2	Septicaemia	143	5.1%	225	19.3%
3	Gastrointestinal disorders not infective	139	5.0%	155	13.3%
4	Cardio vascular Disease	88	3.2%	99	8.5%
5	Hypertension	79	2.8%	84	7.2%
6	Pneumonia	87	3.1%	65	5.6%
7	Respiratory Tract Infections-	82	2.9%	62	5.3%
8	Asthma	37	1.3%	54	4.6%
9	Urinary Tract Infection	102	3.7%	50	4.3%
10	Typhoid Fever	28	1.0%	10	0.9%

Mortality causes

Cardiovascular disease was the leading cause of death in the Medical ward during the FY; accounting for 11 disease specific deaths. It also had the highest case fatality rate, 11.1%. The number of cases admitted due to suicidal attempts increased by 58.3% in 2017/18. The growing number of attempted suicide could be related to the excessive alcohol consumption behavior rampant in the district.

Table 6.27: Top 5 common causes of death in Medical ward in the last two FYs

Causes of Mortality in Medical Ward		FY 2016-17			FY 2017-18		
		No. of disease specific deaths	No. of cases admitted	Case Fatality Rate	No. of disease specific deaths	No. of cases admitted	Case Fatality Rate
1	Cardiovascula	7	88	8.0%	11	99	11.1%
2	Pneumonia	4	87	4.6%	5	65	7.7%
3	Liver Cirrhosis	2	28	7.1%	3	37	8.1%
4	Septicaemia	7	143	4.9%	2	225	0.8%
5	Suicide	1	12	8.3%	1	19	5.3%
	Total	21	358		22	445	

SURGICAL WARD

The surgical ward is accommodated in one of the oldest structures in the hospital, with 71 beds. There remains a strong need for funding to do major renovation works to improve the quality and safety of the ward.

Staff composition

The total staffing decreased from 17 to 13 in 2017/18. The ward is headed by a surgeon who supervises and coordinates the activities of the ward and those of the operating theater. In addition, the ward has a Medical officer attached. These human resources have made it possible to offer training and mentorship to the intern doctors, Midwifery students and students from other institutions of learning.

Table 6.28: Staff composition in Surgical Ward in the FY 2016-2017

Cadre/ Discipline	Qualification	Number
Surgeon	Bachelor Degree in Medicine and Surgery and Master in Surgery	1
Medical Officer	Bachelor Degree in Medicine and Surgery	1
Registered Midwife/Nurse	Diploma in Midwifery and Nursing	1
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	4
Enrolled Nurse	Certificate in Nursing	6
Nursing Aid	Trained on the job	0
Orthopedic Officer	Diploma in Orthopedic	1
Physiotherapist Assistant	Certificate of Physiotherapist Assistant	0
Total		13

Key Indicators in surgical ward

The number of admissions decreased by 6.8% in 2017/18. ALoS decreased from 16.4 in 2016/17 to 8.9 in 2017/18. The BOR reduced to 64.9%; as a result of the decrease in total admissions. The turnover interval increased from 3.7 in 2016/17 to 4.8 in 2017/18. The number of patients who escaped from surgical ward reduced in 2017/18.

Table 6.29: Key indicators in Surgical Ward in the last 5 FYs

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
No. of beds	76	76	76	71	76
Total Admissions	766	1,974	2,060	2,171	2,024
Bed days	7,676	14,870	16,055	17,833	17,995
ALoS	10	7.5	7.8	16.4	8.9
BOR	27.7%	53.6%	57.9%	68.8%	64.9%
Throughput	10.1	26	27.1	30.6	26.6
Turnover interval	26.2	6.5	5.7	3.7	4.8
Deaths	7	22	40	27	13
Death Rate	0.9%	1.1%	1.9%	1.24%	0.64%
Recovery Rate	97.9%	98.4%	94.6%	98.4%	98.8%
Self-discharges	25	10	7	7	4

Morbidity causes

Admission due to injuries from other causes other than burns and RTA increased from 1203 in 2016/17 to 1338 in 2017/18; contributing to 68.2% of all admissions in the ward. Most of these are various forms of assaults related to alcohol induced violence and land disputes. Injuries resulting from RTA decreased considerably (from 213 to 65), contributing to 3.3% of all admissions. The other conditions contributing to the top ten causes of morbidity have remained relatively stable in frequency with only minor variation in frequency of occurrence.

Table 6.30: Top 10 causes of admissions in Surgical Ward-FYs 2016-2017 & 2017-2018

Causes of Morbidity in Surgical Ward		FY 2016-17		FY 2017-18	
		No. of cases admitted	% on all admissions in Surgical Ward	No. of cases admitted	% on all admissions in Surgical Ward
1	Injuries due to other causes	1203	55.4%	1338	68.2%
2	Abscess	189	8.7%	211	10.8%
3	Hernias	103	4.7%	154	7.9%
4	Injuries due to Road Traffic Accident [RTA]	213	9.8%	65	3.3%
5	Snake bites	54	2.5%	47	2.4
6	Injuries due to Burn	61	2.8%	40	2.0
7	Hydrocele	43	2.0%	49	2.5
8	Intestinal Obstruction	36	1.7%	22	1.1
9	Osteomyelitis	16	0.6%	10	0.5
10	Urinary Tract Infections	16	0.6%	25	1.3

Mortality causes

More patients died due to injury related causes than any other causes in surgical ward during the FY. Collectively, they contributed for up to 10 disease specific deaths. Septic shock and bleeding Benign Prostatic Enlargement had the highest case fatality rates (50% each) in 2017/18.

Table 6.31: Top 5 common causes of death in Surgical Ward in the current FY

	Top 5 Causes of Mortality among Inpatients	No of Disease specific deaths	Total No of cases of the disease admitted	Case Fatality Rate
1	Injuries due to other causes	10	1338	0.7%
2	Intestinal obstruction	2	22	9.1%
3	Scorpion bites	1	6	16.7%
4	Colitis + Septic shock	1	2	50%
5	Benign Prostatic Hyperplasia (BPH)	1	2	50%

OPERATING THEATER

Constructed with support from the government of Japan; the operating theater continues to be a core part of this hospital. Its functions are closely coordinated to those of maternity and surgical wards. It remains operational 24 hours a day and 7 days a week.

The theater runs 4 elective operation days (Surgery and Obstetrics) during the week; reserving the rest of the days and nights for emergencies and minor procedures.

Staff Composition

The theater was under the leadership of a registered nurse; who organizes and supervises the duty of all the staffs. The surgeon also supplements additional leadership to the theater.

Table 6.32: Staff Composition in the operating theatre

Cadre/ Discipline	Qualification	Number
Anesthetist Officer	Diploma in Anesthesia	2
Registered Nurse	Diploma in Nursing	1
Enrolled Midwife	Certificate in Midwifery	0
Enrolled Nurse	Certificate in Nursing	2
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	1
Medical Theatre Assistant		1
Nursing Assistant	Certificate in Nursing Assistant	3
Nursing Aid	Trained on the Job	4
Total		14



One of the resident surgeons posing in front of the theater complex. Photo credit: Dr Smart

Surgical Procedures

The total number of major surgeries performed increased from 994 in 2016/17 to 1,285 in 2017/18. Caesarean section still tops the list of major operations; contributing to 43.3% of all major surgical procedures undertaken.

Table 6.33: Top major surgical procedures performed in the FY 2017-18

No.	Top major surgical procedures	Number	of	Proportion (%)
1	Caesarean section	556		43.3
2	Herniorraphy	152		11.8
3	Orthopaedic Surgery	135		10.5
4	Laparotomy	96		7.5
5	Plastic/Reconstructive Surgery	71		5.5
6	Other major procedures	275		21.4
	Total	1,285		

Minor orthopedic surgeries predominated the minor surgical procedures. The total number of minor surgical procedures increased from 1,645 in the last FY to 2,065 in 2017/18.

Table 6.34: Top minor surgical procedures done in FY 2017-18

No.	Top minor surgical procedures	Number of Patients	Proportion (%)
1	Minor Orthopaedic surgery	970	47.0
2	Debridement and wound care	426	20.6
3	Incision and drainage of abscesses	272	13.2
4	Safe Male Circumcision	2	0.1
5	Other Minor Procedures	395	19.1
	Total	2,065	

There was 29.8% increase in the number of surgeries performed during the FY. Major operations accounted for 37.5% of all these surgeries; an increment of 29.3% from the previous FY. Out of these, 41.2% were emergency operations; including cesarean sections (increase of 39.1% from 2016/17).

Over the last five (5) years, it can be observed the increasing demand for surgical services in the hospital; underlining the importance of a specialist role in the hospital.

Table 6.35: Trend of surgical activities in last 5 FYs

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Total Operations	2,886	1,913	1,790	2,639	3,425
Major operations (including C/S)	663	565	661	994	1,285
Minor operations	2,223	1,348	1,129	1,645	2,140
Emergencies	416	327	282	381	530
Emergencies as % of total major operations	62.7%	57.9%	42.7%	38.3%	41.2%

Table 6.36: Pattern of anesthesia used during the last 5FYs

Type of Anesthesia	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Local Anesthesia	1,287	569	276	269	344
General Anaesthesia with IV Ketamine	1,039	1030	1,149	1,101	1,175

Spinal Anesthesia	518	290	335	247	262
General Anesthesia with ETT	42	24	30	41	69
Total	2,886	1,913	1,790	1,658	1,850

PEDIATRICS WARD

The pediatric ward is the oldest block in the hospital and therefore requires a total overhaul. It has annexed to it, the pediatric isolation and Nutrition wards. The ward is a 61 bed capacity unit.

Staff Composition

This department was run by a Pediatrician who supervises a medical officer and 13 other staff. Two (2) Volunteer residents of Pediatrics from the University of Torino, under IDEA ONLUS also supported the team. The medical team were responsible for all the curative and preventive services offered in the ward. The ward provides training and mentorship to students from the midwifery school and other institutions of learning in the region.

Table 6.37: Personnel assigned to Paediatric Ward in FY 2016-17

Cadre/ Discipline	Qualification	Number
Pediatrician	MMed Pediatrics	1
Medical officers	Bachelor Degree in Medicine and Surgery	1
Enrolled Midwife	Certificate in Midwifery	0
Registered Nurse	Diploma in Nursing	1
Registered Comprehensive		1
Enrolled Nurse	Certificate in Nursing	6
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	1
Nursing Assistant	Certificate in Nursing Assistant	4
Total		15

Key ward indicators

There was a 60.6% reduction in the number of admissions in the FY. The reduction in admission also reflects the reduction of the malaria burden in the year. The ALoS increased from 4.6 in the previous FY to 5.2 in 2017/18. The turnover interval reduced to 0.65%. BOR decreased from 201.1% in 2016/17 to 88.9% in 2017/18. We registered a significant number of children who escape the facility as self-discharges.

Table 6.38: Paediatric Ward indicators over the last 5 FYs

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
No. of beds	61	61	61	61	61
Total Admissions	4,607	3,741	10,706	9,671	3,810
Bed days	22,325	17,498	33,596	44,765	19,783
ALoS	4.8	4.7	3.1	4.6	5.2
BOR	100.3%	78.6%	150.9%	201.1%	88.9%
Throughput	75.5	61.3	175.5	158.5	62.5
Turnover interval	0.0	1.3	-1.1	-2.3	0.65
Deaths	78	48	102	83	36
Death Rate	1.7%	1.3%	1%	0.85%	0.94%
Recovery Rate	98.3%	99.3%	98.6%	95.4%	98.7%
Self-discharges	1	0	0	0	10



Students and staff of Pediatrics ward giving health talks to mothers and their children.

Morbidity causes

Like in the other wards of the hospital, Malaria was the leading cause of admissions; accounting for 39.4%. This was however a reduction of 77.8% from the previous FY. There was a significant reduction in the number of pneumonia cases admitted into the Pediatrics ward; accounting for 10.2% of the total admission in 2017/18 (a reduction of 34% from previous FY). The incidence of severe malnutrition reduced by 15.1%. The other morbidity causes either slightly increased or remained constant during the FY.

Table 6.39: Top ten causes of admission in Paediatric Ward - FY 2015-16 and FY 2016-17

Causes of Morbidity		FY 2016-17		FY 2017-18	
		No. of cases admitted	% on all admissions	No. of cases admitted	% on all admissions
1	Malaria	6867	71.0%	1524	39.4%
2	Septicaemia	413	4.3%	490	12.7%
3	Pneumonia	600	6.2%	396	10.2%
4	Rubella	144	1.5%	369	9.5%
5	Respiratory Tract	209	2.2%	338	8.7%
6	Gastroenteritis /	236	2.4%	260	6.7%
7	Sickle Cell Disease	137	1.4%	172	4.4%
8	Anaemia	892	9.2%	140	3.6%
9	Gastro-Intestinal disorder	136	1.4%	136	3.5%
10	Severe Malnutrition	53	0.5%	45	1.2%

Mortality causes

Malaria was the leading cause of mortality; accounting for 28 disease specific deaths. However, pneumonia which was the second leading cause of mortality, had the highest case fatality rate (2.3%).

Table 6.40: Top five causes of death in Paediatric Ward in FY 2017-18

Causes of Mortality		No of disease-specific deaths	No of cases of the disease admitted in Paediatric	Case Fatality Rate
1	Malaria	28	6867	0.4%
2	Pneumonia	14	600	2.3%
3	Septicaemia	4	413	1.0%
4	Sickle Cell Disease	3	137	2.2%
5	Anaemia	5	892	0.6%

NEONATAL INTENSIVE CARE UNIT (NICU)

The Neonatal intensive care unit (formerly special care unit) was set up during the FY. With funding from the Ambrosoli Foundation and other benefactors, we were able to refurbish equip the unit with the necessary equipment essential to sustain and support the life of a new born.

The unit is annexed to the Maternity ward, but was run by Pediatrics ward doctors. In the next FY, it is planned to have the unit independent, as well as improve significantly data management in it.

The unit was run by a Clinical officer and Four (4) midwives. These were supervised by the Pediatrician and other doctors from Pediatrics ward.

The unit has an admission capacity of 17 neonates; often times, this capacity is exceeded depending on the admission needs. Admission into the NICU is governed by scientific protocols, which is based on MOH recommendation.

In 2017/18, a total 273 neonates were admitted and managed for various ailments in the NICU. The leading causes of admission were; Prematurity (low birth weight) accounting for 35.5% of all admissions and Birth Asphyxia accounting for 13.9% of all admissions. Other causes were: Congenital abnormality, Sepsis, and Pneumonia.

The Newborn Mortality rate reduced to 0.39% from 0.78% in 2016/17. The leading mortality cause was birth asphyxia (62%).

MARTERNITY WARD

The Maternity Ward is the largest ward in the hospital with 75 bed capacity. It is a complex subdivided into various sections which includes; the Labor Room and Admission Rooms (Post Natal, Caesarean, and Gynecology). It also has the Doctors office, Sister In-charge office, Duty Room, Private Rooms, Premature Nursery, and the Isolation unit annexed to it.

This ward was run by one Medical Officer (Specialist in tropical medicine) from Holland and a local Medical Officer from Uganda. There were 23 Midwives who were directly responsible for management of all admitted patients. They also offer training and mentorship to students; given that maternity is the principal practical training ward for students from St. Mary's Midwifery Training School.

There is a strong need to increase the number of registered midwives in the department. This is in order to not only improve on quality service delivery but to beef up clinical mentorship to the students.

Table 6.41: Staff Composition in Maternity Ward in FY 2017-18

Cadre/ Discipline	Qualification	Number
Medical officer	Bachelor Degree in Medicine and Surgery, Masters in Tropical Medicine	2
Registered Midwife/Nurse	Diploma in Midwifery and Nursing	1
Registered Midwife	Diploma in Midwifery	2
Enrolled Midwife	Certificate in Midwifery	20
Total		25

Key Indicators

The total admissions decreased by 5.2% in the FY. The ALoS increased to 3.3 from the previous FY; meanwhile the BOR decreased to 63.3%. The turnover interval increased to 1.9, meanwhile death rate decreased from 0.11% in 2016/17 to 0.02% in 2017/18. These data depicts a reduction in productivity and workload of the ward. The clinical efficiency remained the same with the previous FY.

There was a slight reduction in recovery rate; from 99.9% in the previous FY to 99.4% in 2017/18.

Table 6.42: Key indicators in Maternity Ward (Obs & Gyn) in the last 5 FYs

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
No. of beds	75	75	75	75	75
Total Admissions	4,756	4,845	6,195	5,593	5,302
Bed days	21,987	22,173	22,673	20,107	17,331

ALoS	4.6	4.6	3.6	5.1	3.3
BOR	80.3%	79.9%	82.8%	73.5%	63.3%
Throughput	63.4	63.8	82.6	74.6	70.7
Turnover interval	1.1	1.1	0.8	1.3	1.9
No. Deaths	6	8	4	6	1
Death Rate	0.12%	0.16%	0.06%	0.11%	0.02%
Recovery Rate	99.8%	99.8%	99.6%	99.9%	99.4
Self-discharges	0	1	0	1	0

Birth indicators

There was 2.7% increase in the total number deliveries. Of these, 15.7% were caesarean sections. Still births accounted for 0.96% of all deliveries in the unit. Emergency caesarean sections accounted for 95.3% of the total caesarean sections done in 2017/18. Almost all these caesarean sections are attributed to factors compounded by referral delays from the LLUs.

Table 6.43: Maternity Ward Deliveries & Births indicators in the last 5 FYs

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Total deliveries	3,003	3,247	3,465	3,453	3,547
Normal deliveries in unit	2,532	2,816	3,111	2,918	2,977
Abnormal deliveries (incl. C/S)	449	431	354	535	570
Live birth in units	2,934	3,238	3,445	3,340	3,499
Babies born with low birth	283	384	443	652	577
Fresh Still births in unit	22	32	20	20	18
Macerated still births in unit	18	28	26	22	16
New-born deaths (0-7 days)	34	33	34	27	14
Maternal Deaths	5	3	4	6	1
Live Births					
Full term normal weight	2,598	2,860	2813	2,925	2977
Full term low birth weight	261	378	572	606	577
Premature cases	95	n.a.	60	101	90
Caesarean Sections					
Elective C/S	46	42	26	24	26
Emergency C/S	360	327	292	392	530
Caesarean Sections total	406	369	318	416	556
C/S as % of total deliveries	13.5%	11.3%	9.2%	12.0%	15.7%
Emergency C/S as % of all C/S	88.7%	88.6%	91.8%	94.2%	95.3%

The caesarean section rate was very high in 2017/18 compared to the previous FY; majority were due to two or more previous scars, at term. The top 8 causes of CS in the FY were:

1. Foetal distress
2. Previous scars
3. Prolonged labor
4. Obstructed labor
5. Malpresentation
6. Cord prolapse
7. Big baby
8. Ruptured uterus

Table 6.44: Origin of mothers who delivered through C/S in the last 5 FYs⁹

Within the Catchment Area of Agago District (distances of 2 km to < 58 km)					
Sub-County	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Adilang	34	28	20	28	49
Kotomor	12	14	10	9	16
Patongo	38	32	15	31	52
Patongo T.C.			13	12	
Lukole	39	45	29	38	58
Lukole T.C.			4	10	
Kalongo T.C.	49	21	23	35	39
Paimol	17	25	19	20	32
Parabongo	30	14	18	21	46
Omot	30	14	14	17	34
Acholpii	15	11	5	0	4
Lamiyo	7	5	7	2	9
Lapono	49	36	34	34	60
Lira Palwo	28	17	24	20	28
Omiya Pacwa	26	19	12	10	25
Wol	24	30	25	29	40
Total	398	311	272	316	498

Of all the mothers who underwent CS in the hospital, 89.6% were from within Agago district and 10.4% were from the neighboring districts of Kitgum, Abim, Pader and Otuke.

⁹Note: Data for Patongo town council and Patongo Sub county are not disaggregated; the same applies to Lukole Town Council and Lukole Sub county (source: Kalongo Hospital theatre, operation book FY 2011-2012 to FY 2015-2016)

Due to the poor referral means (mostly Boda boda/motorcycle) and conditions of roads, many pregnant mothers often arrive in the hospital in advanced stage of labor or in critical conditions, which requires emergency C/S.

Poor infrastructures, including transport means and roads are the main factors preventing pregnant women to access the hospital at the right time. A waiting shelter is available for mothers attending ANC and detected with some problems or living far from the hospital. An average of 80 pregnant mothers are hosted in the shelter and are coming every day to the ward for routine checkups. This practice allows timely admission and actions.

Table 6.45 continuation

Outside the Catchment Area of Agago District (distances of 58 km and above)					
District	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Pader	35	30	28	18	17
Kitgum	7	8	4	7	10
Abim	6	11	1	4	7
Other	3	9	10	71	23
Total	51	58	43	300	58

Gynaecological ward

The FY 2017/18 saw admissions into the gynaecological ward reduce by 53.4% from the previous FY. Pelvic inflammatory diseases was the leading cause of admission; 23.9% increase from the previous FY. Urinary tract infections increased significantly. The other morbidity causes remained relatively constant.

Table 6.46: Gynaecological morbidity causes

Diagnosis of admission	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Pelvic Inflammatory Disease	106	37	44	46	57
Urinary Tract Infection	91	57	55	1	64
Cancer of cervix	25	10	7	27	19
Uterine Fibroid	16	7	10	6	17
Ovarian Cyst	12	23	28	31	16
Vaginal Candidiasis	6	5	12	2	4
Bartolini's Cyst	6	7	0	1	1
Peritonitis	2	1	0	0	1
Other Gyn conditions				270	124
Total	243	147	403	384	179

TB WARD

The TB ward is accommodated in the oldest building in the hospital. It is annexed to medical ward; and its duties are coordinated under the general duties of Medical ward. The activity data regarding the TB treatment programme have already been discussed under the specialist clinics, OPD. We shall review admissions under this section.

The total admission in the TB ward increased from 219 to 252 in the FY. The ALoS remained the same with the previous FY, 8.2. BOR reduced (31.6%). The turn over interval increased (17.8). However, the death rate decreased during the FY (from 4.56% to 0.79%). HIV TB co-infection still remains a challenge. Many affected clients continue to come late for care, and the dropout rate is still very high. The hospital has embarked on intensifying active case identification and notification; this is a concerted effort with the district health department.

Table 6.46: Key indicators in TB Ward in the last 5 FYs

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
No. of beds	24	18	18	19	18
Total Admissions	266	186	225	219	252
Bed days	5,321	3,891	4,182	3,345	2,078
ALoS	20.0	20.9	18.6	8.2	8.2
BOR	60.7%	59.2%	63.7%	48.2	31.6
Throughput	11.1	10.3	12.5	11.5	14.0
Turnover interval	12.9	14.4	10.6	16.4	17.8
Deaths	13	8	10	10	2
Death Rate	4.9%	4.3%	4.4%	4.56%	0.79%
Recovery Rate	95.1%	95.7%	95.1%	95.4%	99.2%
Self-discharges	0	0	1	0	0

DIAGNOSTIC SERVICES

Laboratory services

The hospital laboratory is a HUB that serves a total of ten (10) lower level facilities in Agago and Pader district. The activities of the hub continued effectively throughout the FY. These includes: Offering Laboratory testing services to all samples for HIV positive persons from LLUs, Referral of samples for tests that could not be performed to the Central Public Health

Laboratory, Organizing hub coordination meetings, supervising all the level laboratories and timely reporting to the district on all the activities of the Laboratory.

The Laboratory continued to participate in the MOH SLIPTA program, and we remain expectant of achieving accreditation by 2022.

Table 6.47: Trend of laboratory testing workload in the last 5 FYs

	Type of Tests	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Parasitology	Malaria Microscopy, Malaria RDTs, Other Haemoparasites, Stool Microscopy.	14,319	16,178	33,969	36,283	23,320
Haematology	HB, WBC Total, WBC Differential, Film Comment, ESR, RBC, Bleeding time, Prothrombine time, clotting time, blood transfusion tests, & Others	10,980	26,917	102,373	166,984	111,917
Biochemistry	Urea, Calcium, Potassium, Sodium, Creatinine, ALT, AST, Albumin, Total protein, Triglycerides, Cholesterol, CK,LDH, AlkalinePhos, Amylase, Glucose, Uric Acid, Lactate, Others	2,813	6,242	11,729	30,335	13,518
Bacteriology	ZN for AFBs, Cultures and Sensitivities, Gram, Indian Ink, Wet Preps, Urine Microscopy	6,438	11,141	9,510	8,291	7,262
Serology	VDRL IRPR, TPHA, Shigella Dysentery, Syphilis Screening, Hepatitis B, Brucella, Pregnancy Test, Vidal Test, Rheumatoid Factor	16,300	21,186	12,111	21,260	13,270
Immunology	CD4 tests & others	2,373	4,432	3,916	5,123	5,080
HIV tests by purpose	HCT, PMTCT, Quality control and clinical diagnosis	11,301	12,897	16,057	26,913	28,211
	Total tests	64,524	98,993	189,665	295,189	202,578
	Total lab staffs	8	8	8	11	11
	Average tests per Lab staff	7,934	12,290	23,708	26,835	18,416

In 2017/18, the volume of tests conducted by the laboratory reduced by 31.4%. As evidenced by the overall low disease burden in the HSD and the hospital in the FY, the quantity of

individual tests performed also reduced. The scope of tests performed remained the same like in the previous FY.

Table 6.48: Percentage of positive findings per selected examinations in the two last FYs

Type of Test	FY 2016-17			FY 2017-18		
	Total	Positive	% Positive	Total	Positive	% Positive
Malaria (both slide and RDT)	27,331	9,400	34.4%	15,967	3,103	19.4%
VDRL/RPR	5,029	298	5.9%	4,010	270	6.7%
Hepatitis B	8,433	1,557	18.5%	4,594	474	10.3%
Brucella	1,942	66	3.4%	799	86	10.8%

Table 6.49: Proportion distribution of blood groups and Rhesus Factor D

FY 2016-17						FY 2017-18					
Group A	Group B	Group AB	Group O	RH +	RH -	Group A	Group B	Group AB	Group O	RH +	RH -
32.9%	16.3%	4.7%	44.9%	98.8%	1.2%	33.7%	17.3%	3.4%	44.9%	99.4%	0.6%

IMAGING SERVICES

X ray and Ultrasonography

The department was run by two (2) trained on the job staff (Dark room attendants) and one (1) radiographer. With support from the Ambrosoli Foundation, the x ray department was refurbished, and a new donation of a digital x ray machine was delivered and installed in the unit.

The number of x ray examinations performed during the FY reduced by 66.4%, in keeping with the reduced number of patients treated in the hospital.

Table 6.50: X-Ray examinations done in the last 5 FYs

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Chest	3,176	2,974	2,752	2,062	572
Upper extremities	1,118	1,172	1,022	848	458
Lower extremities	1,067	959	1,160	800	278
Vertebral column	336	314	390	338	83

Skull and mandible	330	269	351	332	53
Shoulder and clavicle	221	234	195	135	69
Pelvis and hip	142	276	258	196	60
Abdominal – plain	142	226	175	130	51
Abdominal -contrast	4	1	1	0	0
Screening	0	0	0	0	0
Total	6,536	6,423	6,304	4,841	1,624

On the other hand, the number of ultrasound examinations performed increased by 33.1%. This was because of the acquisition of a radiographer during the FY with the technical ability to conduct ultra sound examinations.

Table 6.51: Ultrasound examinations conducted in the last 2 FYs

	FY 2016-17	FY 2017-18
Obstetrics	635	728
Gynaecology	726	1,326
Abdomen	1,136	1,344
Others	308	336
Total	2,805	3,734

PHARMACY ACTIVITIES

The central pharmacy was supervised by a technician, supported by three (3) pharmacy assistants. The pharmacy supervises multiple dispensing points within the hospital. The general store was supervised by a Store assistant and two (2) additional store attendants. Pharmacy continued to implement the Unit Dose System (UDS) of drugs management in the hospital.

Table 6.52: Staff composition in Pharmacy and General Store in the FY2017-2018

Cadre/ Discipline	Qualification	Number
Pharmacy Technician	Diploma in Pharmacy	1
Pharmacy Assistant	Certificate in Medical Pharmacy	2
Nursing Aide	Trained on the Job	1
Store Assistant	Diploma in Store Management	1
Store Attendant	Trained on the Job	2
Total		7

Storage

Drugs are stored on shelves and the heavy ones are placed on floor pallets: tablets and capsules are kept on the same shelves, while separate shelves are used for parenteral, oral liquids and topical creams and liquids. The concept of FEFO (first expiry first out) is applied in order to minimize losses due to expiry.

Cold storage items are kept in the fridge and the temperature is monitored every day to ensure it is within the desired range of 2°C to 8°C.

The readings for the room are taken 3 times a day because of variations during the day. An average value is obtained at the end of the month. The temperature, starting from the afternoon, often exceeds the 30°C which creates a lot of risks and problems for the storage of drugs.

The hospital plans to procure additional temperature monitoring equipment to be availed to all the rooms in the pharmacy where drugs are kept.

Table 6.53: Average temperature and humidity recorded in Pharmacy Department FY 2017-18

Reading Time	Temperature	Humidity
8:15 am	25.0 ⁰ C	43%
12.00 pm	27.4 ⁰ C	50%
5.00 pm	31.0 ⁰ C	29%

Stocks are checked regularly during the monthly counts for near expiry and expired drugs. The near expiry drugs are consumed or donated before they expire. The expired drugs are removed from the store and prepared for collection by National Medical Stores through the Health Sub District.

Pharmaceutical supplies

The supplies are mainly ordered from Joint Medical Stores (JMS). Items not available at JMS are bought from Abacus or other open market options. JMS and Medical Access Uganda Limited (MAUL) were the main suppliers for the antiretroviral drugs for the HIV Clinic.

Procurement system

Drugs and sundries are procured in most cases on a quarterly basis. The items to be purchased are selected according to the needs of the hospital in line with the essential drugs list of Uganda and the treatment policies. The quantity to be purchased is based on the quantity at hand, average monthly consumption and the available finances. Occasionally, emergency orders are made for certain drugs that get finished and are urgently needed.

Inventory management

There is a manual and computerized inventory system that helps to manage purchase and stock movements. Stock taking is done biannually and physical count monthly to ensure accountability.

Distribution and use

The Pharmacy issues drugs to the different wards and departments according to their consumption and average number of patients. The wards and clinics request for drugs using ward order or requisition books following prescription by a clinician or a doctor.

Table 6.54: Most used drugs (excluded HIV/AIDS clinic) - FY 2016-2017 and FY 2017-2018

Drug description	FY 2016-18		FY 2017-18	
	Quantity issued tablets/	Monetary value (UGX)	Quantity issued tablets/	Monetary value (UGX)
Paracetamol 500mg	366,120	6,422,961.97	319,008	5,598,084.57
Amoxicillin 250mg	297,264	14,624,120.14	242,398	12,763,510.23
Metronidazole 200mg	203,121	3,810,004.00	157,866	3,145,817.94
Folic Acid 5mg	144,182	1,482,554.53	138,315	3,301,671.85
Erythromycin 250mg	141,592	12,650,698.10	63,977	6,450,532.50
Multivitamin	104,676	1,766,775.53	124,391	2,125,268.99
Ampicillin/Cloxacillin 500mg	101,078	10,906,769.59	79,128	9,162,081.10
Ciprofloxacin 500mg	93,497	8,740,418.18	71,677	6,518,760.27
Folic Acid/Ferrous Sulphate	90,753	2,795,113.90	63,876	2,816,417.39
Carbamazepine 200mg	84,986	4,217,190.10	81,594	5,026,376.13
Vitamin B complex	83,985	1,072,907.70	74,036	916,641.20
Ibuprofen 200mg	81,389	1,788,895.85	65,192	1,757,851.81
Ampicillin 500mg	69,121	34,336,744.82	57,465	26,720,250.19

Ferrous Sulphate 200mg	57,544	1,705,725.04	68,635	1,874,057.37
Prednisolone 5mg	53,670	1,857,687.85	64,127	1,952,155.14
Cloxacillin 250mg	46,247	2,857,554.84	54,568	3,812,702.83
Frusemide 40mg	40,960	787,413.55	45,373	870,822.80
Chloramphenicol 250mg	38,300	3,773,740.02	26,321	2,870,915.56
Diclofenac 50mg	32,178	414,764.78	40,285	484,745.09
Omeprazole 20mg	31,068	1,314,252.40	25,465	1,024,789.31
Total		117,326,292.8		99,193,452.27

The consumption of essential medicines reduced by 15.5% in 2017/18.

Intravenous fluid consumption

The consumption of intravenous fluid reduced by 13.5% in the FY. Overall the amount of fluids procured were also lower than those from the previous FY.

Table 6.55: Consumption of IV fluids in FY 2016-2017 & FY 2017-2018

Fluid Description	Quantity (in)	Value (UGX) for	Quantity (in)	Value (UGX) for
Water for Injection 10 ml	81,811	7,545,515.76	61,140	5,920,709.45
Sodium Chloride 0.9% IV 500 ml	18,886	24,413,717.0	18,418	24,434,842.6
Dextrose 5% IV 500 ml	7,474	9,815,517.20	5,148	6,583,735.14
Dextrose 5% IV 250 ml	4,056	5,298,273.08	1,952	2,632,896.64
Sodium Lactate Compound IV 500	4,770	6,260,733.03	5,252	6,867,076.87
Dextrose 50% IV 100 ml	1,607	3,450,784.41	1,227	2,648,277.75
Gelatine/polygeline Solution 3.5%	132	3,395,000.31	95	2,738,556.27
Darrow's Half Strength 500 ml	228	414,085.61	311	576,124.21
Total		60,593,626.4		52,402,218.9

Drug and therapeutic committee

The Drug and Therapeutic Committee was established with Terms of Reference and a clear mandate to address the various aspects of drug management. In order to regulate consumption and prescription practices during the next FY, the committee is effectively reviewing the essential drugs list as well as conduct continued medical education on the rational use of antibiotics and healthy prescription practices.

CHAPTER SEVEN

SUPPORT SERVICES

Pastoral care

Pastoral care is provided to all patients in the hospital for free. These services are offered under the Kalongo Catholic Denary by volunteers. The team comprises of a social worker, a catechist and a Priest. In 2017/18, 453 patients accessed pastoral care services. Next FY, these services will also be integrated with general staff recollection.

Table7.1: Activities trend in clinical pastoral care of the sick during the last 5 FYs

Activity / Indicator	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
No. patients visited and counselled	120	228	243	94	452
No. of patients given sacrament of Marriage	0	0	1	0	0
No. of patients anointed	11	4	3	18	1
Total	131	232	247	112	453

Ambulance services

Ambulance services were offered to patients across the district. The terrible state of roads hinders or delays response to some parts of the district during the raining seasons. Ambulance maintenance is still a big problem due to frequent break downs from the bad roads. The hospital has only one operational Ambulance; the backup got involved in an accident and requires a lot of money to be put back on road.

Technical services

The Technical and Maintenance Department (TD) of the hospital is mandated to ensure the ordinary maintenance of all structures and equipment, including vehicles, for both the hospital and the school. It provides also technical assistance and supervision. Extraordinary renovations and bigger scale constructions are contracted out. The TD also carries out some limited income generating activities in order to contribute to the sustainability of the hospital.

Table 7.2: Consumption of fuel by destination in the last 5 FYs

	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
DIESEL TOTAL	40,509	33,128	29,242	39,111	45,142
Board of Governors	140	417	205	428	315
Generators	18,618	11,890	8,961	14,222	17,391
Vehicles	20944	19,769	19,265	22,546	26,341
Workshop	47	26	47	20	10
Incinerator	255	260	750	1,018	1,065
Others	505	766	60	877	20
PETROL TOTAL	2,020	2,709	3,474	2,905	3,054
Administration	0	0	0	5	494
Donation	59	0	40	85	0
Generators	0	0	10	78	0
Vehicles	184	15	338	75	0
Motorcycles	1,340	2,275	2,551	2,284	2,335
Workshop	64	0	37	25	116
Others (Sales)	373	419	499	354	111
KEROSENE TOTAL	172	105	58	75	36
Workshop	7	78	19	75	25
Pharmacy	0	3	0	0	0
Main store	1	0	5	0	0
Others	164	24	34	15	11

In 2017/18, diesel consumption increased by 15.4%. This was mainly because of increased generator use (22.3%) due to frequent power black outs and more vehicle movements (16.8%), as a result increased PHC and outreach activities. The petrol consumption was average. This is because petrol is reserved only for motorcycle movements.

DOMESTIC SERVICES

Water Supply

The hospital water supply is provided by three wells that serve also the School, the Comboni Fathers and the Convent of the Little Sisters of Mary Immaculate. The wells are located at approximately 1,300 metres from the hospital. The water is pumped to two main tanks with a total capacity of 90,000 litres.

The distribution and storage of water is provided by a network of pipelines that were installed many years ago and currently show signs of wearing with frequent leakages that increase the costs of the supply. All the buildings are provided with reserve tanks of different capacities.

The analysis on the yield capacity of the wells and the quality of the water pumped indicated that; the pumps had very excellent yield capacity, but there was need to consider the installation of a chlorination system to fight contamination from the environment and the worn out pipes (being considered for next FY).

The process of gradually replacing the worn out pipes and extending water points to all the staff quarters started during the FY. This will also include extension of the sewerage lines to the staff quarters.

Power Supply

The hospital receives power from the national electricity grid. However, this supply line is unstable and often times the institution has had to rely on backup generators for power supply. Electricity is provided to all the staffs within the hospital premises free of charge. This practice is however proving to be non-sustainable since the cost of the electricity bills continue to rise every month, therefore in next FY, the hospitals' management review the possibility of introducing cost sharing as a means of regulating electricity bill in the quarters.

There are limited solar systems installed to cover certain areas of the institution, especially the areas that require critical power supply. The future plan is to expand on the solar systems to cover the entire institution, in order to curb down on unsustainable electricity consumption.

Sewage system

The sewage system serves the entire hospital, St. Mary's Midwifery Training School, the staff houses, the nearby parish and convents. All sewage is disposed through a lagoon at about 600 meters from the hospital.

Since its rehabilitation in 2014, with funding from *Wamba Anthena Onlus-Caripao*; we realized a more efficient and environmentally friendly sewage system. The latrine coverage of the institution is being improved too. However, access to the sewage system is only limited to the hospital and doctors' quarters. In the near FY, there is a plan to expand this access to all the staff quarters (together with the construction project for the staff quarters).

Waste disposal

Huge amounts of both medical and non-medical wastes continue to be produced in the institution. Proper waste segregation and management is still a big challenge; because of lack of sufficient training on medical waste management to the support staff working in the incinerator. There is need to design a proper waste management plan for the hospital, accompanied by training of staff on proper waste segregation.

Intercom telecommunication and Wi-Fi systems

The intercom system still covers only a limited section of the hospital. This followed the lightning incident with the mother board. Even the available lines are very erratic, and has greatly affected communication within the hospital; making it increasingly difficult to access certain key officers when urgently required.

The Wi-Fi installed in the previous FY is functioning well and significantly bridging communication gaps with other institutions and partners. A systems administration department was set up to support with the management and maintenance of the various networks within the hospital.

CHAPTER EIGHT

QUALITY OF CARE AND PATIENTS' SAFETY

Quality indicators:

With support from development partners and the MOH; the hospital has been able to engage in continuous quality improvement reviews and activities. The quality improvement team was fully active during the FY and took part in a couple of activities aimed at quality improvement in the hospital.

Availability of qualified clinical staffs

The total number of clinical staff reduced by 1.3% in 2017/18. The proportion of clinical qualified staff over the total hospital staff increased to 51.8% from 46.2% in previous FY.

Table 8.1: Proportion of clinical qualified staff in the hospital in the last 5 FYs

Indicators	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18
Total No. of employees	212	239	245	251	253
Qualified staff ¹⁰	138	194	168	177	174
Clinical qualified staff ¹¹	97	108	130	116	131
Total Clinical staff ¹²	123	126	148	150	148
Proportion of clinical qualified staff over all qualified staff	70.3%	55.7%	77.4%	65.5%	75.3%
Proportion of clinical qualified staff over all clinical staff	78.9%	85.7%	87.8%	77.3%	88.5%
Proportion of clinical qualified staff over the total hospital staff	45.8%	45.2%	53.1%	46.2%	51.8%

¹⁰Qualified staff includes all staff with a degree in line with their role in the hospital.

¹¹Clinical Qualified Staff includes: Medical Doctors, Paramedics, Nurses and Midwives.

¹²Clinical Staff includes: Medical Doctors, Paramedics, Nurses, Midwives, and Nursing Assistants.

Quality of care

The recovery rate on discharge slightly decreased from 98.8% to 97.0%. The maternal death rate decreased from 0.17% to 0.02%. Early neonatal death rate decreased from 0.78% to 0.39%. The establishment of the Neonatal Intensive Care Unit (NICU) contributed to this reduced death rates. Post caesarean section infection rate was at 5.58%. The main factors contributing to this were; patient hygiene, and base line immune states of certain patients.

Table 8.2: Indicators for the quality and safety measures

Indicators	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	Explanation
Recovery rate on discharge	97%	97.8%	98.1%	98.8%	97.0%	Recovery rates on discharge: annual percentage of patients discharged as clinically recovered from a specific episode of disease (from all wards) following treatment.
Maternal death rate after admission in maternity	0.11%	0.06%	0.10%	0.17%	0.02%	Maternal death rates: it is not the population based maternal mortality rate or ratio that is generally used by statisticians. It is a hospital indicator.
Fresh still birth rate	0.6%	0.99%	0.58%	0.58%	0.51%	Fresh still birth rate: Fresh Still births have intact, smooth and not macerated skin,
Caesarean sections infection rate	4.0%	ND	1.27%	ND	5.58%	Infection rate of caesarean sections: if mothers are discharged before the 8th day, information is also collected from the post-natal clinic, where the mothers will show up if they get infections.
Early neonatal death rate	1.4%	0.86%	0.89%	0.78%	0.39%	Early neonatal death rate. Number of babies who die within the 7 th day of life, divided by the total number of deliveries in the hospital in that year, expressed in percentage.

Patient satisfaction survey

The overall patient satisfaction about the quality of services increased in the FY (81.1% from 79.7% in the previous FY). The waiting time/organization of care in the OPD reduced significantly (46.1% from 85%). The Quality Assurance Committee has put in place clear strategies for implementation in the new FY; towards improving quality of patient care with particular attention to reducing patient waiting time in the OPD.

Table 8.3: Satisfaction levels per core area for the last 5 FYs

Financial Year	FY 2013-14	FY 2014-	FY 2015-	FY 2016-17	FY 2017-18
Clinical outcomes	95%	94%	100.0%	93%	88.3%
Humanity of care	100%	85%	85.1%	98%	98.9%
Organization of the care / waiting time (OPD)	78%	56%	50.0%	85%	46.1%
The healthcare environment	100%	99%	99.2%	98%	98.9%
Overall score	77.6	79.3%	75.2%	79.7%	81.1%

FAITHFULNESS TO THE MISSION

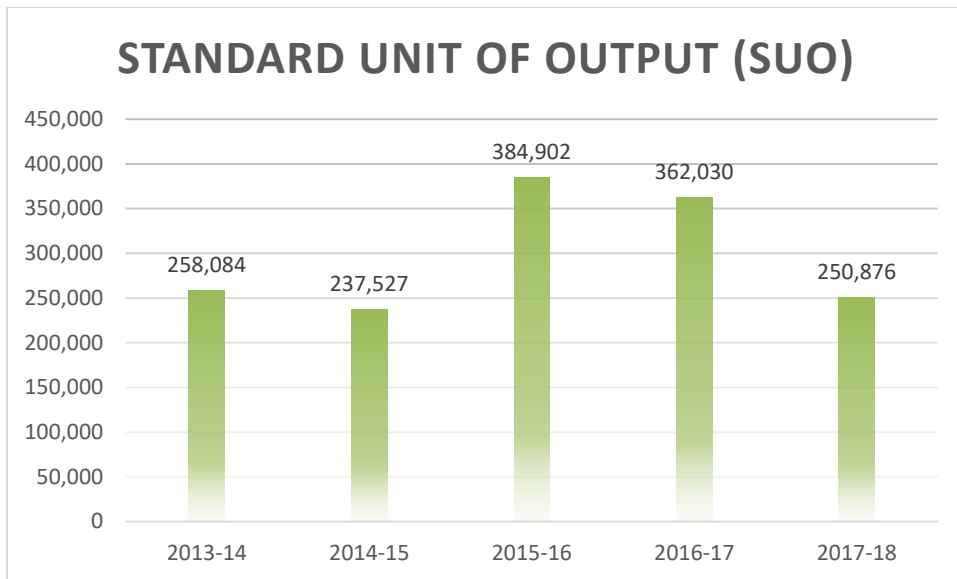
Access

There was 30.7% reduction in the Standard Unit of Output (SUO) in 2017/18 compared to 2016/17. This was due to reduced inpatient admission, as a result of the reduced malaria burden. Looking at the trend in the last five (5) FYs and general attendance in OPD across the HSD LLUs; Access increased in 2017/18.

The formula of the SUOop (utilised by MoH) is:

$$1 \text{ SUOop} = 1 * \text{Outpatients contacts} + 15 * \text{Inpatients} + 5 * \text{Deliveries} + 0.2 * \text{Immunizations in children} + 0.5 * (\text{ANC} + \text{Post Natal Attendance} + \text{Family Planning clients})$$

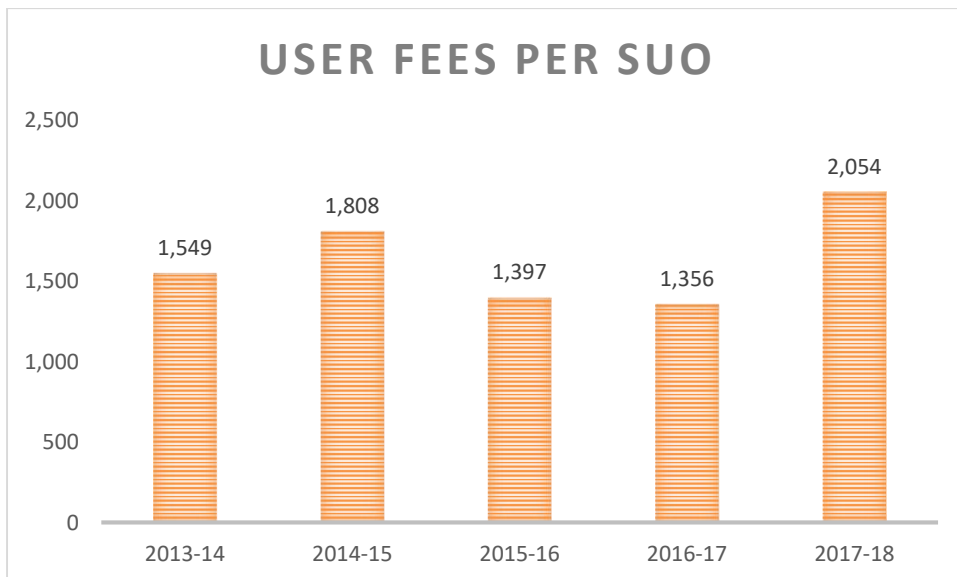
Figure 8.1: Trend of SUOop (do more people come?)



Equity

The average user fees per SUO increased by 51.5%. Even with this, our user fee remains one of the lowest of all the UCMB facilities in the country. Equity decreased slightly in the FY.

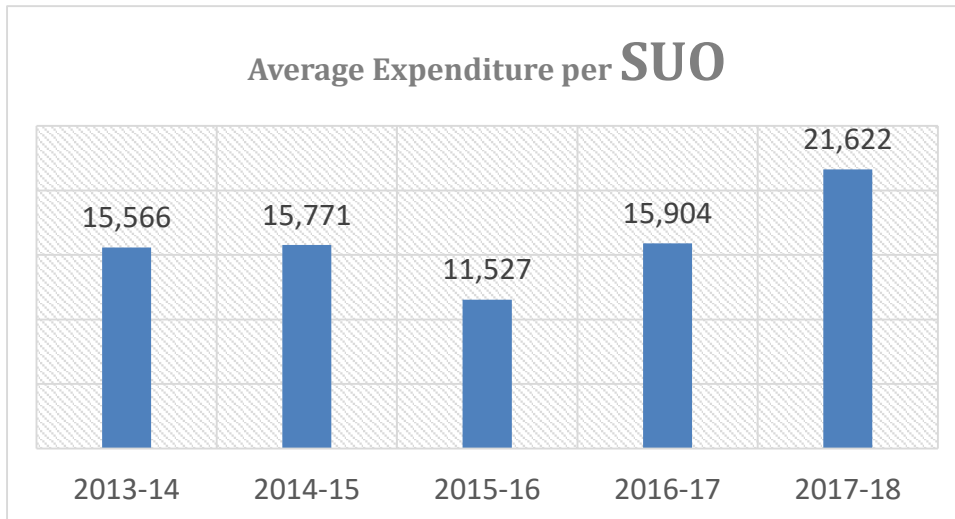
Figure 8.2: Trend of Average Fees per SUO (do people, on average, pay more or less?)



Efficiency

The hospital's economic efficiency decreased by 36%. The cost of producing one SUO increased from 15,904 to 21,622. More prudent cost containment measures needs to be adopted in the new FY with particular regard to waste reduction.

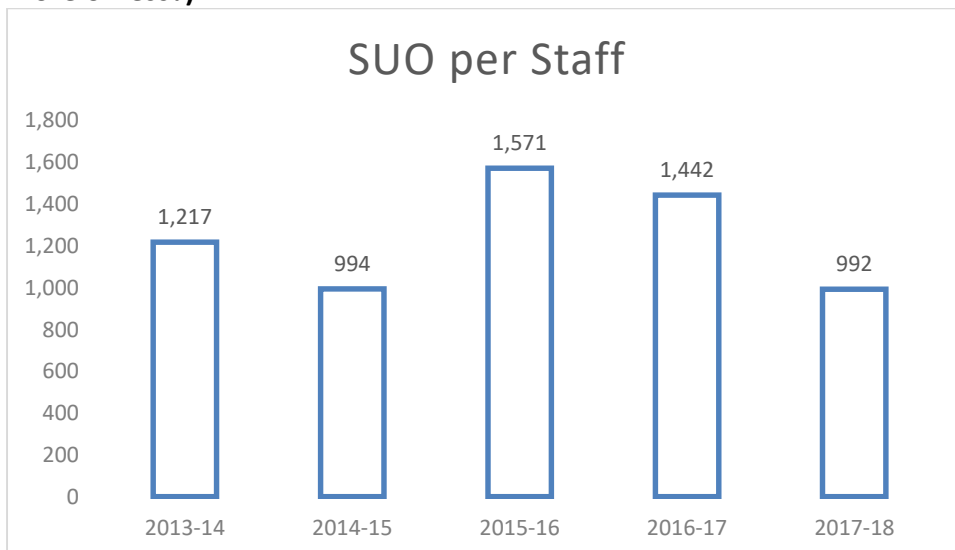
Figure 8.3: Trend of Average Expenditure per SUO (do we spend more or less to produce our services?)



Productivity

Each clinical staff produced 992 SUOop in 2017/18; a decrease of 31.2% from the previous FY. This reflects a decline in the clinical staff productivity.

Figure 8.4: Trend of Average SUO per staff (with the same resources, do our staff produce more or less?)



CHAPTER NINE

ST. MARY'S MIDWIFERY TRAINING SCHOOL

Introduction

St. Mary's Midwifery Training School, is part of Dr. Ambrosoli Memorial Hospital. The school was founded in 1959 as an Enrolled Midwifery School by Fr. Dr. Giuseppe Ambrosoli.

The school offers two courses:

- Diploma in Midwifery (D/M)
- Certificate in Midwifery (C/M)

The total capacity of 150 students has been maintained.

Since its beginning, the school has qualified so far a total of 1,409 competent staff serving in various parts of the country as well as outside Uganda:

- 1,128 Enrolled/Certificate Midwives (EM/CM),
- 241 Registered/Diploma Midwives (RM/DM),
- 40 Enrolled Comprehensive Nurses/Certificate Comprehensive Nurse (ECN/CCN)

Human resources management and development

Availability of qualified teaching staff remains a major challenge for the training school. The high attrition rate experienced in the hospital also equally affects the school. Many skilled and experienced human resources have left the school over the years. Often times; external help is sought from other training institutions and the hospital, to facilitate teaching activities.

Table 9.1: School staff and support staff establishment FY 2017-2018

Qualified Staff	Establishe	Actual	Shortage	Surplus
Tutors	6	5	1	0
Untrained clinical instructors	0	3	0	3
Accountant	1	1	0	0
Account Assistant	1	1	0	0
Cashier	1	1	0	0
Record Assistant	1	1	0	0
Total Qualified Staff	10	12	1	2
Trained clinical mentor	7	5	2	0
Support Staff	Establishe	Actual	Shortage	Surplus
Store Assistant/Library	1	1	0	0

Office Attendant	1	1	0	0
Cooks	6	5	1	0
Driver	1	1	0	0
Watchmen	2	2	0	0
Total Support Staff	11	10	1	0
Total School Staff	21	22	2	1

Staff Attrition

In 2017/18, the attrition rate among the qualified teaching staff was 0%. Of the two tutors sent to school for further training, one successfully returned. There is however still a strong need to recruit more tutors to support training of the students.

The support staff have always been more stable in their work places because they are trained on the job with no formal qualification and live in Kalongo.

Staff development

One staff from the hospital is pursuing a course for Tutorship in Mulago Health Tutors' College. Other staff participated in professional refresher courses in different subjects, organized by different stakeholders. The staff use the information received from these seminars or workshops for teaching or Continuous Medical/Professional Education/Development (CME/CPD).

Workshops and meetings organized by UNMEB, MoH, and INTRAHEALTH were attended by the different staff in rotation as indicated in table 9.2.

Table 9.2: Workshops and courses attended by the teaching staff

S/N	Workshop	Organized by	Number of staff	Duration
1	Review of Midwifery Curriculum	INTRAHEALTH	One Tutor	1 week
2	Review of Midwifery Curriculum	INTRAHEALTH	Two Tutors	1 week
3	Nutritional Assessment	Tutors' college	One tutor	1 week

School Performance

The enrollment of students in the school was driven by the actual capacity of the school. More Diploma students enrolled during the FY 2017/18 than in the previous FY.

The passing rate for the certificate students increased from 95% in the previous FY to 100% in 2017/18. The quality of passing also improved.

The school administration together with the school staff continued to help the students not only academically, but also in other aspects of their lives affecting their performance.

Table 9.3: Student Enrollment in years 1st -2nd -3rd and success rate in the FY 2017-18

Course	Students Enrolled in the year	Students in 1 st year	Students in 2 nd year	Students in 3 rd year	Number of students currently	Students who sat for final exams	Students who pass final exams	Success rate
C/M	44	45	34	47	126	34	34	100%
D/M	14	0	0	14	14	14	14	100%
Total	58	45	34	61	140	48	48	100%

School Finances

St. Mary's Midwifery training school is a cost center in Dr. Ambrosoli Memorial Hospital.

All the school's accounts are being controlled by the Principal Tutor of the school and she is one of the signatories of all the bank accounts. She is the overall controller of the school's activities and she reports to the CEO. Each financial year the school's prepares its own budget and year plan. The hospital engages an external auditor for both the hospital and the school and provides two separate audited financial statements.

Income

The actual realization from school fees and donors still represents the main source of funding. This donor dependency is posing a major challenge as some donors support is diminishing and sustainability is seriously threatened.

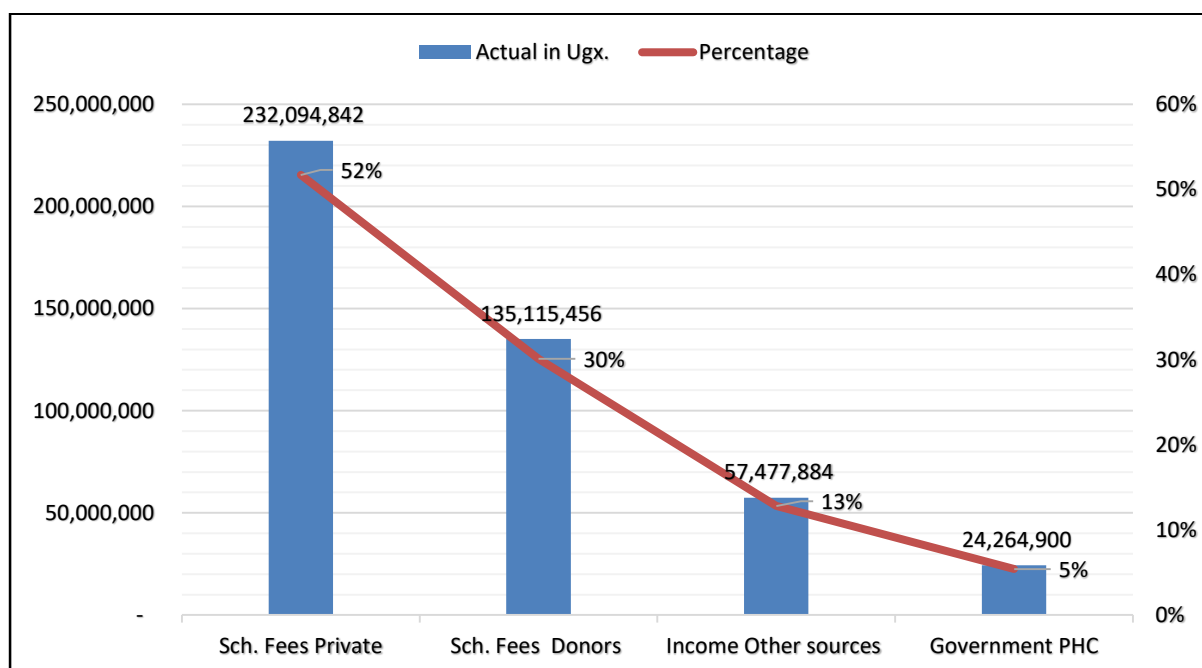
Support for school fees came from UNFPA, Copeland Foundation, Dr. Ambrosoli Foundation, Intra Health – Uganda Capacity Building Program, Light Ray and Gretta Foundations.

Other sources of income are sales, hire of halls, fines, and renting. Income from these sources is not consistent since activities are erratic. Some key sponsors also withdrew abruptly due to changes in their financial environment. Government subsidy in the form of PHC conditional grant continue to trickle despite rising running costs.

Table 9.4: Planned, actual and unrealized income in the FY 2017-2018

Income Sources	Planned Income (UGX)	Actual Income (UGX)	Budget Gap (UGX)	Variance Comment
Other School Income (e.g. rent)	157,434,000	57,477,884	99,956,116	Deficit
School fees – Other Donors	183,096,111	135,115,456	47,980,655	Deficit
School Fees – Private	223,540,000	232,094,842	8,554,842	Surplus
PHC government grants	53,949,888	24,264,900	29,684,988	Deficit
TOTAL	620,019,999	448,953,082	171,066,917	Deficit

Figure 9.1: Income contribution by Sources FY 2017/2018



Expenditure

In the FY 2017/18, the school managed to control its expenditure such that a bigger margin was realized between the planned and the actual expenditure.

Table 9.5: Planned, actual expenditure and unspent balance in the FY 2017-2018

PLANNED EXPENDITURE	ACTUAL EXPENDITURE	UNSPENT BALANCE
620,019,999	435,438,104	184,581,895

Support from Dr. Ambrosoli Memorial Hospital

- The Hospital and the School share a Management Team.
- Supervision of students in the wards is jointly done by the hospital's and school's staff.
- Rotation of staff is done and some hospital staff can be posted to work in the school.
- CEO is the main signatory of both the School's and the Hospital's Banks accounts.
- Hospital's administrator is the head of finance for both the School and the Hospital.
- Lobbying for fund from donors is done by both School and the Hospital.

Relation with external partners

The external partners continued to play vital roles in the evaluation and performance improvement of the school in terms of financial support through sponsoring of students, technical assistant, donation of teaching and learning materials, and training of staff. In addition, the more the partners involved themselves, the more staff are exposed to new information and networking that they can transfer to their colleagues with the new knowledge acquired during the weekly CME.

The partners that the school closely related with in the FY were; Dr. Ambrosoli Foundation, Copeland Foundation, Intra health – Uganda Capacity Program, UNFPA, Light Ray, and the Gretta Foundation. Exchange visits involving Faculty staffs and students from Kansas University and Johnson County College and Research Medical center continued during the FY.

PHC activities

Just like in the previous FY, the school carried out PHC activities mainly targeting mental health and parenting.

These workshops were organized for the community leaders and Village Health Team (VHT) from 5 different counties within Kalongo.

The activities helped the staff both from the hospital and other Districts to gain insights on some of the current health problems affecting the communities and how to address them. It has also helped the school to give more services to the community through Health Promotion (HP).

Faithfulness to the Mission

To evaluate the adherence of St. Mary’s Midwifery Training School to the mission, four indicators have been used during the years: Access, Equity, Efficiency and Quality.

Access

$$\frac{\text{The Total number of students at present}}{\text{Total Capacity of the School}} = \frac{140}{150} \times 100\% = 93\%$$

There has been a 3% reduction in the access compared to the FY 2016/17. This is because some students dropped during the course of the year due to disciplinary reasons. The institution strives to achieve its full capacity every year.

Quality

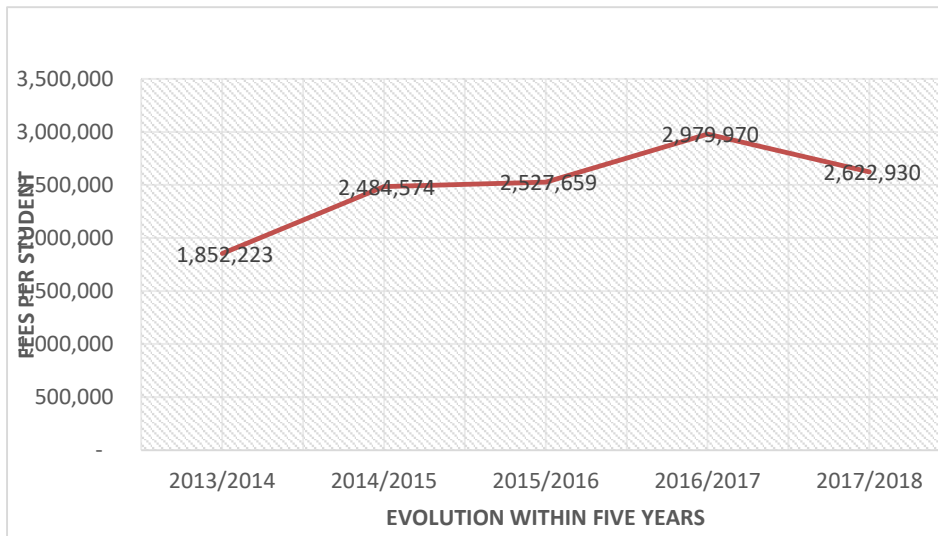
$$\frac{\text{Total number of students who passed}}{\text{Total Number of Students who sat}} = \frac{48}{48} \times 100\% = 100\% \text{ (Success rate)}$$

The overall success rate increased to 100% for both Diploma and Certificate in Midwifery. The quality of passing also increased.

Equity

$$\frac{\text{Total fees Collected}}{\text{Total number of students}} = \frac{367,210,298}{140} = 2,622,930/=$$

Figure 9.2: Trend in equity 2013-2017



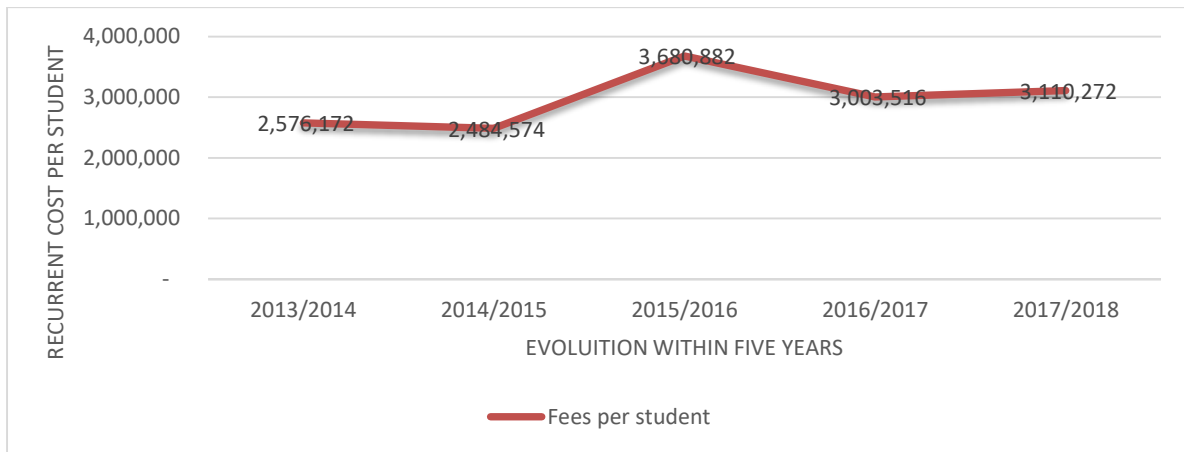
Equity increased in 2017/18. There was an upward adjustment of the school fees to match the rising cost of maintenance and living in the previous FY. The dropped in the average user fee per student is caused by the dropped in the number of students enrolled during the FY.

Efficiency

<u>Total Recurrent Costs</u>	<u>435,438,104 /=</u>	3,110,272/=
Total number of students	140	

There was 3.6% increase in the average cost per student in 2017/18. Market trend for prices continue to spiral for both training goods and feeding requirement for students. However, the school still managed to contain costs to within realistic limits. The school was economically efficient in 2017/18.

Figure 9.3: Trend in Efficiency 2013-2017



CHAPTER TEN

CONCLUSIONS

2017/18 was a financial year of mixed experiences for the institution. The issue of sustainability is still at the center of all activities and initiatives that the Hospital will implement or introduce. In order to meet all these challenges the Hospital must strengthen its governance bodies and its managerial capacity and embark in substantial reorganizational efforts.

The hospital is still heavily reliant on donations. We extend our utmost appreciation to our major donors of the FY (The Ambrosoli Foundation, The Comboni Missionaries, and USAID - URC); who supported nearly up to 80% of the hospitals' annual budget. We ask them to continue with this much needed support.

We are grateful to the MOH and Government of Uganda for the PHC conditional grant which accounted for 11.4% of the total revenue. The amount of the grant has however remained stagnant over many years despite rising costs of medical goods and services.

Income from user fees contributed to 12.4% of the annual revenue, an 11% increase from the previous year. It is important to note that our user fees was not adjusted and is still the lowest of all the PNFPs. Even then, stringent revenue collection mechanisms will be adopted and deployed to reduce on moneys lost to patients who escape. In the next FY, the hospital management plans to selectively review certain fees to support towards cost recovery.

Expenditures have been very high too in the FY. We realized a 29.1%% increment in expenditure compared to the revenue generated in the FY. This was however a 3% reduction from the expenditure of the previous FY. Controlling major expenditure areas is very fundamental in the next FY.

Consolidating the existing senior work force was another area of priority. In the revised employment policy, capacity development plan and various forms of staff motivation strategies predominates. During the year, a number of our employees were sent back to school under the capacity development framework.

The hospital management/BOG reviewed salaries for all employees during the FY. It is important to note that, due to financial constraints, we are unable to march the government scales; hence almost inevitable to control attrition to greener pastures. However, it is still pivotal to address staff welfare with keen interests.

We unfortunately lost our Senior Nursing Officer during the FY, Rev. Sr. Alice Amal (May her soul rest in peace). It was very difficult for the hospital to find an immediate replacement for such a gallant character. We continue to pray for her soul.

The hospital continued to be faithful to its mission and was accredited by the UCMB. It has been accessible. Clinical productivity and financial efficiency decreased though. These are key areas for improvement in the next FY, and also reflected in the overall performance of the hospital among general hospitals in the country. We were ranked tenth (10) out of the 132 general hospitals in the country (Annual Health Sector performance report).

The HMT has laid down strategies which includes strengthening core committees, who will ensure improved quality of care. These committees are; the quality improvement committee, the infection control committee, and Drugs and therapeutic committee.

Pending Issues

- The hospital complex has very old structures, and therefore most of the wards require major renovations. The lobbying plan for funds to renovate this structures remain a priority in the next FYs.
- The perimeter fence around the institution also needs a complete overhaul. During the FY, we had multiple security threats due to the many porous points in the fence.
- Most of the old water pipes are rusted and very prone to contamination from the environment, the hospital therefore needs to lobby for a complete overhaul of all the water pipe networks.

ANNEXES

Annex 1. Members of Board of Governors and designation as per 30th June 2018

	Name	Designation	Title
1	H.G. John Baptist Odama	Chairperson	Archbishop of Gulu
2	Sr. Liberata Amito	Member	Diocesan Health Coordinator Gulu
3	Msgr. Matthew Odong	Member	Vicar General Gulu
4	Ms. Giovanna Ambrosoli	Member	Representative Ambrosoli Foundation
5	Fr. Achilles Kiwanuka Kasozi	Member	Provincial Superior Comboni Missionaries
6	Fr. Guido Miotti	Member	Parish Priest Kalongo
7	Mr. Louis Odongo	Member	Lawyer - P.O. Box 800, Gulu
9	Mr. Anywar John Kennedy	Member	District Local Councillor 5 - Kalongo T.C
10	Ms. Rose Ogaba	Member	Representative of the Local Community
11	Dr. Emmanuel Otto	Member	DHO Agago District
12	Sr. Susan Deeze Clare	Member	Superior General LSMIG
13	Dr. Okot Godfrey Smart	Secretary	Chief Executive Officer
14	Dr. Pamela Atim	Member	Med. Sup. St Joseph's Hospital – Kitgum
15	Mr. Nicholas Gregory Okello	Member	Lecturer, Gulu University

Annex 2. Members of the Management Team and designation as per 30th June 2018

	Name	Title
1	Dr. Okot Godfrey Smart	Chief Executive Officer/Ag. Medical Director
2	Mr. Alex Obonyo	Administrator
3	Sr. Carmel Abwot	Principal Tutor
4	Sr. Dorothy Amony	Deputy Senior Nursing Officer