

DR. AMBROSOLI MEMORIAL HOSPITAL KALONGO



ANNUAL ANALYTICAL REPORT FY 2022/2023

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Endorsement of Report

The management of Dr. Ambrosoli Memorial Hospital has diligently prepared this Annual Analytical Report, encompassing the Financial Year 2022-2023. I hereby affirm that it accurately reflects the perspectives of the management regarding the hospital's performance during the reporting period.

Name: Dr. Okot Godfrey Smart

Signature _____

Chief Executive Officer

Dr. Ambrosoli Memorial Hospital

Date _____

I hereby acknowledge the receipt of the Annual Analytical Report for Dr. Ambrosoli Memorial Hospital- Kalongo, encompassing the period from July 1st, 2022 to June 30th, 2023. Having thoroughly reviewed the report, I affirm its authenticity and confirm that it accurately reflects the position of the hospital during the aforementioned reporting year.

Name: His Grace John Baptist Odama

Signature _____

Chairperson of the Board of Governors

Date _____

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
UNFPA	Uganda National Family Planning Association
URMCHIP	Uganda Reproductive, Maternal and Child Health Improvement Project.
UPMB LSDA	Uganda Protestant Medical Bureau Local Service Delivery Activity

ACKNOWLEDGEMENTS

The management of Dr. Ambrosoli Memorial Hospital would like to extend heartfelt appreciation to each and every member of our esteemed staff for their unwavering dedication and tireless efforts in providing exceptional care to our patients. We are also deeply grateful to all those who have supported the hospital in various capacities and contributed to its sustainability during the Financial Year 2022-2023, including the government of Uganda, the Dr. Ambrosoli Foundation, the Comboni Missionaries, USAID – URC, UPMB LSDA, IDI, and our patients.

We are particularly indebted to UCMB for their invaluable technical support and guidance, which has been instrumental in our success. We would also like to express our gratitude to H.G. Dr. John Baptist Odama and the entire Board of Governors for their exemplary leadership and supportive oversight of the hospital.

Lastly, we would like to extend our sincere appreciation to all members of our hospital staff and school, who have played a pivotal role in every achievement described in this report, regardless of their qualifications or responsibilities. While this recognition is well-deserved, we hope it will also serve as a source of motivation to maintain and even enhance the same level of commitment 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 mothers 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 Out-patients' 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 encompasses the activity output and interpretation of both Dr. Ambrosoli Memorial Hospital Kalongo and Kalongo Midwifery Training School. The hospital was established in 1957 by Fr. Dr. Giuseppe Ambrosoli of the Comboni Missionaries, along with St. Mary's Midwifery Training School in 1959. Kalongo Hospital is the sole general hospital in the Agago district, and it provides both curative and preventive services. The current estimated population of Kalongo Town Council is 101,343. The report presents the major Key Performance Indicators, which are summarized below.

Currently, 287 beds exist at the hospitals. Inpatient (IP) admissions decreased by 11% from the prior FY21/22. We recorded 29,444 patients visiting the outpatient department in total, an increase of (6.72%). In the inpatient department (IPD), intestinal worms, coughs or colds without pneumonia, and malaria were the main causes of morbidity. Malaria, injuries and pneumonia were the main causes of mortality in the IPD.

The primary causes of death in the IPD, exactly like in the previous FY21/22, were still malaria and pneumonia. In FY 22/23, the bed occupancy rate fell by 17.72% to 50.16. The number of hospital deaths decreased by 11.9% to 352 deaths as compared to the prior financial year. The recovery rate remained almost the same at 96.49%.

When compared to the previous financial year, the first ANC visit dropped by 9.2% while the fourth visit fell by 29.2%. The total ANC attendances decreased in comparison to the previous FY by 10%. Post-natal attendances dropped by 6.6%. The total hospital deliveries dropped slightly from the previous year to 2659 deliveries this FY 22/23. 27% of the total deliveries were by cesarean section which is higher than the previous year (25%).

The members of the BoG and HMT were 14 and 5 respectively. 7 HMT, 1 Ordinary and 1 extraordinary BoG, and 7 Subcommittee (of BOG) meetings were held during the FY. The agenda for each of these meetings were prepared and circulated in advance to the members.

In comparison to the prior FY, there was a decrease by 13.12% in the total income for the hospital., but the total income for the midwifery school expanded by roughly 8% as compared to the last financial year. Unlike in the previous FY, the FY22/23 saw an increase in the total expenditure of the hospital by 14.5. Similarly, the school's expenditure rose by 42.58% in the FY 22/23 as compared to the previous FY.

The cost per patient per day and the cost per SUOop also recorded a significant increase. In 22/23, overall patient assessment of hospital quality of care increased. Patients' perception of

the clinical outcome they experienced increased by 37%, while the humanity of the care they received decreased from the previous year.

Since its founding, St Marys' Midwifery Training School has graduated both diploma and certificate in Midwifery students. The school spent 88% of the planned budget. This year's expenditure was more than for the previous year.

CHAPTER ONE: INTRODUCTION

Fr. Dr. Giuseppe Ambrosoli of the Comboni Missionaries founded Dr. Ambrosoli Memorial Hospital Kalongo (DAMHK) and St. Mary's Midwifery Training School in 1957 and 1959, respectively. This private not-for-profit hospital is part of the UCMB's Catholic health facilities network. The Catholic Diocese of Gulu is the owner of the hospital.

This rural hospital serves a remote, impoverished community in northern Uganda that has been devastated by war for the past two decades. Regionally, northern Uganda is the most vulnerable region to poverty. According to the 2021 household survey, income poverty worsened in the sub-regions of Acholi from 35 percent to 67.7 percent. The patients at this hospital are among the poorest of the poor and earn much less than the national poverty threshold.

The hospital and its' environment



DAMHK is situated in Kalongo Town Council (Oret Parish) of Agago district. Agago district is bordered on the west by Pader, on the north by Kitgum, on the east by Kotido and Abim, and on the south by Otuke and Alebtong. The district is populated to 373,780 people, with 88% of them residing in rural areas.

Due to the lack of functional hospitals in several of these bordering districts, DAMHK also serves their populations for

medical needs requiring hospitalization. Agago has one of the worst road networks in the country, with no tarmac and most in poor condition, making it impossible to carry out operations such as transferring patients for emergency care, immunization programs, supervising LLUs and home visits, and adding extra expenditures to all transportation activities.

Dr. Ambrosoli Memorial Hospital is a complex that includes the health care delivery wing and the health training wing. It has 286 beds divided among Surgical, Medical, Pediatrics, Obstetrics/Gynecology, and Private Wards, and offers a variety of general health care services including curative, promotional, preventive, and rehabilitative care, as well as holding MOH specialist medical camps.

The hospital is housing the laboratory HUB which is undergoing MOH SLMPTA program and was rated 3 stars by the African Society of Laboratory Medicine (ASLM) during accreditation. The HUB oversees up to 10 labs in the district and parts of neighbouring Pader district. A specialized midwifery training school offering certificate and diploma programs is located in the Health Training Wing. Technical consultation is already in progress as part of the institution's long-term vision to upgrade this school to a degree-awarding institution. The training school also welcomes students from various educational institutions for training purposes, with the goal of expanding this

cooperation in the long run. The literacy rate of the residents of this district is alarmingly low, estimated at less than 30%. Additionally, the majority of the population, especially women, cannot speak or write English. The main ethnic group is the Acholi. The Langos, on the other hand, are an ethnic minority in the southern region.

Agriculture is the core economic activity in the region, with the majority of agricultural production being small-scale and intended for personal consumption.

Unfortunately, commercial activities have not begun due to lack of industrialization and mechanization of agricultural processes.

Demographic Data for the Hospital Catchment area.

DAMHK oversees one health sub-district in the Agago district. The health sub-district has oversight for 17 sub-counties. DAMHK is the only hospital in the Agago district and serves as a referral center. Despite the economic challenges provided by the post COVID-19 pandemic, the hospital made a significant contribution to meeting the district's 22/23-year targets.

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

Population Group		Formulae	Catchment Area	District
(A)	Total Population	A	101,343.0	248,900
(B)	Total expected deliveries (4.85% of population)	$(4.85/100) \times A$	4,915.1	12,071.65
(C)	Total Assisted Deliveries in Health Facilities	$(0.12/100) \times B$	589.8	1448.6
(D)	Total Assisted Deliveries as % of expected deliveries	$(C/B) \times 100$	12.0	12.0
(E)	Children <1 year (4.3%)	$(4.3/100) \times A$	4,357.7	10,702.7
(F)	Children < 5 years (20.2%)	$(20.2/100) \times A$	20,471.3	50,277.8
(G)	Women in Child-bearing age (20.2%)	$(20.2/100) \times A$	20,471.3	50,277.8
(H)	Children under 15 years (46%)	$(46/100) \times A$	46,617.8	114,494
(I)	Orphans (circa 10%)	$(10/100) \times A$	10,134.3	24,890
(J)	Suspected T.B Cases in the Service Area	$A \times 0.003$	304.0	746.7

Table 1.2 Top ten causes of morbidity in the HSD OPDs

No	Causes of Morbidity	FY 2019-20		FY 2020-21		FY 2021-22		FY 2022-23	
		Number	%	Number	%	Number	%	Number	%
1	Malaria	297,061	61.7%	258,474	57.9%	205,079	56.6%	278,774	43.2%
2	Cough or cold - No pneumonia	109,295	22.7%	98,685	22.1%	83,351	23.0%	101,175	15.7%
3	Intestinal Worms	17,918	3.7%	20,331	4.6%	15,624	4.3%	18,116	2.8%
4	Gastro-Intestinal Disorders (non-Infective)	10,891	2.3%	12,551	2.8%	11,157	3.1%	13,465	2.1%
5	Diarrhoea – Acute	15,607	3.2%	14,942	3.3%	10,381	2.9%	11,193	1.7%
6	Urinary Tract Infections (UTI)	7,837	1.6%	9,019	2.0%	8,130	2.2%	11,141	1.7%
7	Skin Diseases	10,561	2.2%	7,030	1.6%	4,842	1.3%	6,057	0.9%
8	Malaria in Pregnancy	4,084	0.8%	4,099	0.9%	4,054	1.1%	4,695	0.7%
9	Bacterial Conjunctivitis	2,806	0.6%	3,508	0.8%	3,279	0.9%	3,938	0.6%
10	Epilepsy	3,086	0.6%	3,675	0.8%	3,721	1.0%	3,641	0.6%
11	All others	13,288	2.8%	27,091	6.1%	22,709	6.3%	28,713	4.4%
		481,691		446,215		362,344		645,246	

In the FY 22/23, there was an overall increment in the number of OPD attendances in Agago district with a total of 645,246 attendances. Of these, malaria (43.2%) accounted to the greatest percentage of morbidity followed by common cold / no pneumonia (15.7%). The lack of use of mosquito nets has been recognized as a factor leading to the high frequency of malaria

coupled with a suspected malaria resistance in the region. Due to insufficient toilet coverage and limited usage of hand washing facilities, intestinal worms continue to be a major problem in this population. District officials should step up the intensity of water and sanitation programs that has continued to be a problem.

Table 1.3: Relative percentage of the top 10 causes of mortality during the last 2 FYs in the HSD

Causes of Mortality among Inpatients		FY 2021-22			FY 2022-23		
		Cases Admitted	Deaths	Case Fatality Rate	Cases Admitted	Deaths	Case Fatality Rate
1	Malaria	9268	54	0.58%	8849	58	0.66%
2	Pneumonia	1264	35	2.77%	1261	34	2.70%
3	Other Neonatal Conditions	228	17	7.46%	246	20	8.13%
4	Premature baby (as condition that requires mgt)	160	11	6.88%	128	16	12.50%
5	Anaemia	395	9	2.28%	455	13	2.86%
6	Injuries - Trauma due to other causes	1401	17	1.21%	1283	12	0.94%
7	Acute sepsis	326	3	0.92%	542	12	2.21%
8	Tuberculosis	170	6	3.53%	211	8	3.79%
9	Heart failure	44	10	22.73%	27	8	29.63%
10	SAM	296	15	5.07%	185	7	3.78%
All others		1737	26	1.50%	2083	32	1.54%

Among the top causes of mortality in the HSD was malaria and pneumonia. Despite numerous efforts put in the prevention of malaria and pneumonia, the government needs to identify other strategies in addition to the already existing programs to combat mortalities against malaria and pneumonia as seen as the top causes of mortality at 26.3% and 15.45% respectively. The leading causes of death from injuries were car accidents and gunshot wounds. Other neonatal-related illnesses continue to be a prominent cause of death among in-patients at the HSD.

CHAPTER TWO: HEALTH POLICY AND DISTRICT HEALTH SERVICES

The Uganda National Health Policy places a heavy emphasis on vulnerable populations, early disease identification and treatment, and improving the health sector's ability to meet the UMHCP. The MoH Strategic Plan 2020/21 - 2024/25 builds on the Human Capital Development Component of the National Development Plan III and lays a foundation for movement towards Universal Health Coverage. The primary purpose of health sector policy is to reduce mortality, morbidity, and fertility rates, as well as associated disparities.

Dr. Ambrosoli Memorial Hospital continues to carry out the Uganda National Health Policy (NHP) and Health Sector Strategic Plan by providing the primary aspects of the Uganda Minimum Health Care Package. These include integrated maternity and child health care, the prevention and management of major communicable and noncommunicable illnesses, and cross-cutting areas such as health promotion, community health initiatives, and gender health. DAMHK also follows the norms established by the Uganda Episcopal Conference via the UCMB. It also takes part in DHMT meetings and operational plans for common activities that are part of the district health plan.

District Health Services

Health care delivery is done through a decentralized framework. The district health structure is responsible for all structures in the district except the Regional Referral Hospitals where they exist. Administratively, the Agago District consists of one (1) HSD and three (3) counties (Agago North County, Agago County, and Agago West County). Kalongo Hospital, located in Agago North County, is still operated as a district referral hospital. The district is divided into sixteen (16) sub counties. The distribution of health services by Sub County is shown in Table 2.1 below.

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

Sub-Counties	Total Populatio n	No of Hospital s	No of HC IV	No of HC III	No of HC II	Total Immunization s Static Stations
Kalongo Town Council	12739	1	0	0	0	1
Omiya Pacwa	12739	0	0	1	2	2

Paimol	23161	0	0	1	1	2
Lapono	24214	0	0	1	5	6
Adilang	22213	0	0	1	3	4
Patongo	24845	0	0	1	1	1
Patongo Town council						
Kotomor	13896	0	0	1	2	3
Omot	14738	0	0	1	2	2
Arum	12948	0	0	1	0	1
Lamiyo	9369	0	0	0	2	2
Lira Palwo	17896	0	0	1	4	5
Wol	25476	0	0	1	3	4
Parabongo	12528	0	0	1	2	3
Lukole	17160	0	0	1	3	3
Agago Town Council	6632	0	0	1	0	1
Total for HSD and District	248900	1	0	13	30	40

Physical access to health services is limited due to a lack of health infrastructure. This, along with a shortage of competent labor, high levels of illiteracy, and unreliability of community involvement decrease the quality of health-care services delivered even further. All of these difficulties contribute to growing healthcare gaps, such as increased maternal and newborn morbidity and death, as well as malnutrition. The district's weak road network exacerbates the district's already debilitated referral system. In rare circumstances, roads for ambulances may become impassable, or maintenance expenditures may become unsustainable.

Table 2.0-1 Population, health units and staffing in Agago District FY 2022-2023 by Sub-County

Sub-county	Population	Total OPD attendance	Organisation unit name	Staffing levels		Staffing gap
				Staffing Norm	No. available	
Adilang	31,822	40,469	Adilang HC III	19	17	2
			Alop HC II	9	5	4
			David Fagerlee's Medical Centre	19	15	4
			Ligiligi HC II	9	6	3
			Orina HC II	9	5	4

Agago Town Council	10,022	13,860	Lukole HC III	19	14	5
Arum	22,235	12,697	Acholpii HC III	19	13	6
Kalongo Town Council	15,427	27,591	Kalongo Ambrosoli Memorial Hospital	334	253	81
Kotomor	20,098	20,986	Kotomor HC III	19	14	5
			Odokomit HC II	9	7	2
			Onudapet HC II	9	5	4
Lamiyo	19,201	10,841	Kwonkic HC II	9	4	5
			Lamiyo HC II	9	8	1
Lapono	38,965	35,532	Abilonino HC II	9	5	4
			Amyel HC II	9	6	3
			Lira Kaket HC II	9	5	4
			Lira Kato HC III	19	15	4
			Ogwang Kamolo HC II	9	5	4
			Ongalo HC II	9	6	3
Lira Palwo	42,329	34,731	Acuru HC II	9	5	4
			Lanyirinyiri HC II	9	5	4
			Lira Palwo HC III	19	16	3
			Obolokome (Lira) HC II	9	5	4
			St. Janani HC II	9	5	4
Lukole	27,026	24,976	Lapirin HC III	19	9	10
			Olung HC II	9	5	4
			Otumpili HC II	9	5	4
Omiya Pachwa	17,351	15,747	Layita HC II	9	13	-4
			Omiya Pacwa HC II	9	5	4
Omot	9,914	18,322	Geregere HC II	9	7	2
			Omot HC II	9	11	-2
Paimol	25,188	21,950	Kokil HC II	9	6	3
			Paimol HC III	19	15	4
Parabongo	18,102	22,006	Kabala HC II	9	4	5
			Pacer HC II	9	12	-3
			Pakor HC II	9	5	4
Patongo	18,896	13,162	Opyelo HC III	19	9	10
Patongo Town Council	20,635	17,485	Patongo HC III	19	24	-5
			Patongo Prison HC II	9	1	8
Wol	36,108	31,989	Kuywee HC II	9	6	3
			Okwadoko HC II	9	5	4
			Toroma HC II	9	5	4
			Wol HC III	19	13	6
Total HSD	373,319	362,344	40 Govt. and 3 NGO Units	832	604	228

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	1
Senior Accounts Assistant	1
Office Attendant	1
Health Educator	1
Nursing Officer/MCH	1
Cold Chain Assistant	1
Theatre Assistant	1
Records Assistant/HMIS focal person	1
Office Assistant	1
Grand Total	13

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

Human Resources (Cadre)	Current Number
Nursing Officer/MCH	0
Cold Chain Assistant	0
Theatre Assistant	0
Records Assistant/HMIS focal person	0
Account Assistant	0
Office Assistant	0
Guard-0	0
Grand Total	0

Funding

More than 60% of the hospital's recurrent expense funding still comes from outside sources and partners. Because it has become increasingly difficult to attract contributors to meet recurring expenses. There is currently a significant financing gap and entire reliance on the minimal user fees paid by patients.

The Ugandan government continued to give support (both in cash and in kind) through the PHC conditional grant subsidy. PHC release continues to be erratic and out of line with planned projections, affecting drugs and other medical consumables and supplies.

Health Infrastructure

The hospital's housing needs to accommodate her work employees remain significantly high. Unfortunately, financial resources are insufficient to meet these demands. With increase in the range of services provided by the hospital, this has led to the demand of more workforce which further pauses challenges to the already existing accommodation gaps. It is expected that the living circumstances of the personnel in the quarters will improve, and that the hospital would house practically all of the staff. Funding was obtained from the Ambrosoli Foundation, the hospital's primary partner under the AICS project

Prevention and Health promotion services

The hospital has a PHC department that oversees health education in the community, immunization services, cervical cancer screening, and provision of support supervision to the lower-level facilities.

Village Health Teams (VHTs) are overseen by the PHC department and play an important role in health prevention and promotion. These VHTs help the PHC by controlling communicable diseases, with a focus on malaria, STI/HIV/AIDS, and tuberculosis, as well as promoting sexual and reproductive health and rights. There was a reduction in the resources that were provided to boost the HSD's integrated PHC outreach initiatives. The outreach initiatives eventually gradually encompassed additional community-based interventions, such as screening and prevention of noncommunicable diseases.

The HC II function of the hospital

A health center II is a facility, serving a few thousand people, should be able to treat common diseases like malaria. According to the Ugandan government's health policy, every parish is intended to have an HC II. The catchment area for the hospital's HCII function is Kalongo Town Council. DAMHK continued to provide immunizations through its mobile and static units.

Table 2.5 shows the outcomes in terms of vaccinations administered. Patients from all across the area continue to visit the OPD, which is open up to 15 hours a day, seven days a week.

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

Table 2.0-2 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	1,300	7,546	17.23%
TT 2	1,035	6,428	16.10%
TT 3	27	2,085	1.29%
TT 4	18	1,329	1.35%
TT 5	1	873	0.11%
Non-Pregnant women			
TT 1	561	4,439	12.64%
TT 2	416	2,842	14.64%
TT 3	240	1,796	13.36%
TT 4	148	1,335	11.09%
TT 5	91	1,026	8.87%
Immunization in school			
TT 1	310	3,070	10.10%
TT 2	295	1,907	15.47%
TT 3	45	958	4.70%
TT 4	12	552	2.17%
TT 5	7	457	1.53%
Total TT 2 in all categories	1,746	11,177	15.62%
Immunization in Children			
BCG	2,664	9,738	27.36%
Protection at Birth for TT (PAB)	2,633	7,600	34.64%
Polio 0	2,494	9,331	26.73%
Polio 1	873	10,816	8.07%
Polio 2	761	10,359	7.35%
Polio 3	787	10,498	7.50%
PCV 1	930	10,861	8.56%
PCV 2	873	10,495	8.32%
PCV 3	878	10,590	8.29%
DPT-HepB+Hib 1	916	10,770	8.51%
DPT-HepB+Hib 2	819	10,388	7.88%
DPT-HepB+Hib 3	881	10,567	8.34%
Measles	903	10,908	8.28%

Total Immunisation in Children	16412	132921	12.35%
Total Family Planning attendances	1,538	36,232	4.24%
Total ANC attendance	5,874	45,310	12.96%
Deworming	9,893	196,297	5.04%
Vitamin A Supplementation	18,084	215,039	8.41%

The aforementioned data includes UNEPI vaccination outputs as well as certain outreach statistics. Vaccinations have increased from the traditional six to about twelve on the immunization schedule with the introduction of new vaccines such as the injectable polio vaccine, the pneumococcal conjugate vaccine, the rotavirus vaccine, the HPV vaccine, and the measles-rubella vaccine. Kalongo Hospital also participates in NIDs, Family Health Days, and special immunization initiatives. The contribution to the provision of district health services remained significant.

CHAPTER THREE: GOVERNANCE

The Board of Governors

The Board of Governors (BOG) is Dr. Ambrosoli Memorial Hospital's and St. Mary's Midwifery Training School's primary decision-making and governing body. However, the Hospital Management Team remains exclusively responsible for all hospital and school operations. The hospital Statute allows for a maximum of two (2) Ordinary BOG meetings and two (2) Extra Ordinary meetings each year. In the FY 22/23, the BOG held one (1) ordinary and one (1) extra ordinary meeting.

The board received and discussed hospital management reports that highlighted significant concerns linked to hospital and school operations and obstacles. The reports highlighted areas of accomplishment as well as work in progress.

Table 3.1: Summary of BoG meetings held in the FY 2022-2023

Table 3.1 Summary of BoG meetings held in the FY 2022-2023

BoG meetings	Reports presented / Key issues handled / Decision taken	Members present
4th July 2022	Hospitals' technical and financial performance	9
Ordinary Meeting	Staff welfare	
	Capital development in the institution	
	External Audit	
	Board subcommittee reports	
23rd September 2022	Extraordinary support to Multipurpose building	6
Extra Ordinary meeting	construction	

The school Subcommittee (now known as the Governing Council), the Finance Committee, and the Human Resources and Disciplinary Committee are already in place, according to the Statute. The BOG may appoint further committees as needed. The responsibility of the subcommittee is to analyze Management reports and suggestions in advance and to provide comments and recommendations to the BOG during plenary meetings.

Table 3.2: Table showing functionality of the Board Committees

Name of committee	Required No. of meetings per	No. of meetings held	Percentage of required meetings
Finance Committee	2	3	150%
Governing Council	2	3	150%
Human Resources& Disciplinary	2	2	100%

Hospital Management

The Hospital Management Team, led by the Chief Executive Officer, is the group in charge of making decisions about the hospital and the school. The Hospital Management Team shares the strategic objectives and targeted outcomes specified by the Board of Governors. It has operational autonomy within the framework of the hospital's strategic plan, established policies, manuals, and procedures. This group meets at least once a month. The core members of the Hospital Management Team are:

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

Table 3.3: Frequency of HMT meetings FY 2022-2023

No of planned Management meeting	No. of Management meeting held	Average No. of members present	Reports / key issues handled
12	7	4	Key issues discussed relates to general hospital operations. Minutes of each meeting were prepared and circulated by the CEO

Statutory commitments compliance

The Hospital complies with all legal standards established by the government, the ministry of health, and the UCMB, as detailed in Table 3.4 below. The UCMB established an accreditation program for the Catholic network's hospitals. Kalongo Hospital met these requirements for the financial year 2022/23.

Table 3.4: Statutory commitments compliance

No	Requirement	Did you achieve? (Yes, Partly, No)	Comment
Government / MOH Requirements			
1	PAYE	Partly	Regularly observed unless if there are no funds
2	NSSF	Partly	Regularly observed unless if there are no funds
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)	Partly	Under revision
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)	Partly	Under Revision

9	Manual Financial Management (still valid)	Partly	Under Revision
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 include; The employment manual, the finance and material resource manual and the procurement manual. The management continues to ensure that these policies are adhered to. The documents are periodically reviewed to ensure that they remain at pace with the changing needs of the institution.

Advocacy, lobby and negotiation

The Hospital has not yet formalized its advocacy strategy. According to the needs, the institution keeps frequent touch with local leaders, international NGOs, and large funders, such as the Dr. Ambrosoli Foundation and Comboni Missionaries. The hospital's management has made it a priority to seek cooperation from all stakeholders in order to ensure the hospital's long-term viability.

In the future, the community health insurance policy currently being enacted by the government would help very much in bridging some of these funding gaps.

CHAPTER FOUR: HUMAN RESOURCES

Staff Establishment

The number of staff has gradually increased over the years for both clinical and non-clinical staff. Currently, the hospital has a capacity of 286 beds and is staffed by 168 clinical staff, which is less than the MOH's suggested 190 for a facility with a 100-bed capacity. 58% of the clinical staff are qualified professionals; just slightly higher than last year.

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

Category		FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Clinical^[1]	Qualified	136	138	139	144	153
	Unqualified	15	17	17	15	15
	Total Clinical	151	155	156	159	168
Not						
Clinical^[2]	Qualified	42	45	45	45	46
	Unqualified	58	52	31	47	48
	Total Non-Clinical	100	97	76	92	94
Total Qualified		175	183	184	189	199
Total Unqualified		76	69	48	62	63
Grand Total		251	252	232	251	262
% of qualified clinical staff/total staff		54%	55%	60%	57%	58%

Staff turn-over

Over the years, the hospital's core workforce has experienced significant turnover.

Table 4.2 shows that turn-over among enrolled cadres (1.52%) has been lower than in the preceding final year. The hospital's compensation scale and benefit packages have improved although still not comparable with those of the government and other local organizations. This

has contributed to the high employee turnover rate in the past years. Other factors that have played a role in reducing the turnover rate include: creating opportunities for capacity building (trainings and providing scholarship opportunities for those who qualify for scholarships).

Table 4.2: Turn-over trends of enrolled cadres¹ in the last 3 FYs

Cadres	FY	FY	FY
	2020-21	2021-22	2022-23
Total staff	232	251	262
Enrolled cadres (all combined)	58	66	72
Turn-over for enrolled cadres	4%	5%	1.52%

A majority of workers work between 40 and 42 hours a week. The in-charge of the department/ward is responsible for communicating work schedules and shifts on a monthly basis to the responsible personnel in the various departments. In staff quarters, the hospital provides accommodation to approximately 62 % of its employees and their families. Water and electricity are also included in this housing facilitation. The staff salaries have regularly been paid and any statutory obligations (NSSF and PAYE) are remitted according to the current legislation except when the funds are not available.

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

Clinical Staff	FY	FY	FY
	2020-21	2021-22	2022-23
Total Clinical staff	156	159	168
Total arrivals of key health personnel	17	50	10
Total departures of key health personnel	31	28	18
Turn-over rate	19.87%	17.61%	10.71%

¹Enrolled Nurses, Enrolled Comprehensive Nurses and Enrolled Midwives.

Table 4.3b: Turn-over trends of General Staff

General Staff	FY	FY	FY
	2020-21	2021-22	2022-23
Total staff	232	251	262
Total arrivals of personnel	21	64	15
Total departures of personnel	41	45	26
Turn-over rate	17.67%	17.90%	5.72%

Human resources development and career progression

The hospital adhered to its personnel training and development policy by providing capacity development. This is done to secure the institution's future growth as well as the preservation of its culture and work ethics.

CMEs, quick trainings, on-site mentoring, and advanced courses relevant to the institution are some of the methods used to enhance capacity. Currently, the majority of employees undergoing training use online learning. Due to the relaxation of the restrictions, a few employees were able to attend physical events near the end of the fiscal year.

The HMT sees capacity development as a means of retaining and motivating employees. We seek to improve our training strategy by developing realistic collaboration and maintaining program continuity. The Ambrosoli Foundation, as well as the hospital, contribute directly to capacity development. The list of personnel who enrolled in training under the hospital's scholarship program in major areas of need is presented in Table 4.4 below.

Table 4.4: Hospital Staff who attended courses in FY 2022-2023

S/N	Name	Designation	Course	Date of start	Date of End
1	Sr. Ayaka Hellen	Registered Nurse	BSc. Nursing (UCU)	Jan, 2020	Dec, 2023
2	Oling Francis	Electrician	Dip in Bio-medical Engineering	March, 2022	Feb, 2024
3	Oyet Patrick	Medical Officer	MMed Ortho	March, 2022	Jul, 2026

4	Ajalo Christine	Enrolled Midwife	Dip in Midwifery	Dec, 2021	Jul, 2023
5	Aber Paska Sharon	Enrolled Midwife	Dip in Midwifery	Dec, 2021	Jul, 2023
6	Anywar Oscar	Enrolled Nurse	Dip. In Ophthamology	Jan, 2023	Jan, 2026
7	Apilla Thomas	Enrolled Nurse	Dip. In Clinical Psychiatry	Jan, 2023	Jan, 2026
8	Okot Galdino	Enrolled Nurse	Dip. In Clinical Psychiatry	Jan, 2023	Jan, 2026

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. There was a decrease by 13.12% in the total income for the hospital. This was mainly due to a decrease in the user fee collection that dropped by 47.3% from the previous FY 21/22. The other sources of income remained almost the same amounts over the year. The PHC conditional grant increased somewhat in FY 22/23 compared to the previous year. Nonetheless, the PHC line medical consumables were realized, and we continue to urge the government to give ongoing support and enhance the amount of the PHC conditional grant to offset the daily rising costs of medical consumables. This is done to supplement the government's efforts to promote community health.

By and large, the hospital continues to depend to a great extent on donations, which account for more than 70% of the recurrent budget. We proceed to believe that the GOU bolstered community health financing modules will support sustainability endeavours.

The total income for the midwifery school expanded by roughly 8% as compared to the last financial year. There was an overall increase within the sum collected from private students and an increase in the donations.

The financial statement patterns for the hospital and school are shown within the tables that follow. In Chapter 9 of this report, extra comments are made with respect to school finances.

Income

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

Income over the last 5 Years						
Income Item	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	Variance 2019/20 Vs. 2020/21
HOSPITAL						
User Fees	805,406,207	918,631,455	724,456,625	1,029,262,390	643,655,130	304,805,765
PHC CG	251,159,542	251,159,632	492,117,659	480,809,025	490,609,362	-11,308,634
cash						
Government						
donations in						
kind	294,661,401	279,299,838	469,333,874	478,592,584	449,326,867	9,258,710
(Drug/Lab)						

Other donations in kind	845,619,113	1,410,912,848	1,264,283,983	1,332,703,237	1,582,167,736	68,419,254
Donations in cash (including project funding)	2,626,348,706	3,128,079,686	2,294,082,763	2,674,489,300	2,686,929,206	380,406,537
Others Financial sources (Deposit Interests & others)	162,796,288	92,546,915	51,770,039	99,348,095	126,852,620	47,578,056
Technical Department	93,943,603	136,116,992	59,583,590	54,708,270	75,511,057	-4,875,320
Sub-Total Hospital	5,079,934,860	6,216,747,366	5,355,628,533	6,149,912,901	6,055,051,978	794,284,368
SCHOOL						
Fees (private)	336,578,535	160,475,145	235,067,000	360,800,000	377,503,000	125,733,000
PHC CG School/PAF Delegate funds	24,264,900	152,386,215	15,641,098	-	-	-15,641,098
Donations and other income	245,355,733	312,861,360	428,420,077	254,770,381	336,954,015	-173,649,696
Sub-Total School	606,199,168	625,722,720	679,128,175	615,570,381	714,457,015	-63,557,794
HSD						
Sub-Total HSD						
Grand-Total	5,686,134,028	6,842,470,086	6,034,756,708	6,765,483,282	6,769,508,993	807,713,378

Expenditure

Unlike in the previous FY, the FY22/23 saw an increase in the total expenditure of the hospital by 14.5%. The hospital expenses were mainly driven by human resource expenses and medical supplies and consumables. Similarly, the school's expenditure rose by 42.58% in the FY 22/23 as compared to the previous FY. The expenditure were mainly employment costs. To keep

costs under control, the management will continue to mobilize appropriate cost-control strategies that are constantly being evaluated.

Table 5.2: Trend of Expenditure over the last 5 FYs

Expenditures over the Last 5 FYs					
Expenditure Item	FY	FY	FY	FY	FY
	2018-19	2019-20	2020-21	2021-22	2022-23
HOSPITAL					
Human Resource cost	1,937,322,775	2,220,512,253	2,281,897,544	2,378,741,751	2,868,550,900
Administration & Governance Costs	256,159,365	176,454,730	281,947,329	266,260,862	225,490,408
Medical goods and supplies (included drugs)	1,564,891,236	2,048,954,822	1,906,084,286	1,638,112,842	1,905,551,941
Non-medical goods / supplies	481,599,381	237,715,358	95,862,373	111,514,065	102,370,339
Property Costs	342,469,799	277,795,146	263,900,824	318,974,217	315,222,125
PHC	287,069,131	408,008,500	212,414,809	168,309,000	260,488,126
Transport & Plant Costs	209,423,206	198,506,748	220,474,884	181,012,623	192,833,154
Capital Development	165,112,516	621,477,605	782,214,141	395,180,275	379,499,268
Hospital Total Expenditure	5,244,047,409	6,189,425,162	6,044,796,191	5,458,105,635	6,250,006,262
SCHOOL					
Employment	255,244,790	289,320,411	260,168,468	233,134,106	320,109,976
Administration	39,400,393	125,364,301	28,658,219	54,572,994	99,087,299
Students costs	180,483,191	149,127,572	130,125,198	159,721,701	93,609,001
Transport & Travelling	25,463,900	25,901,800	18,872,400	24,398,400	30,948,900
Property, Supplies, Services	31,022,821	16,403,572	29,529,301	38,020,290	57,117,917
Capital Development	60,336,306	35,543,000	9,720,500	27,836,340	165,751,628
School Total Expenditure	591,951,401	641,660,656	477,074,086	537,683,831	766,624,721

The user fees charged per patient for each department have remained constant, and there have been no changes to the hospital's user fees. Nevertheless, the hospital has seen an improvement in revenue collection efficiency during the financial year. Despite this, there are still instances where patients depart the hospital without paying the user fees, which continues to pose a challenge for the management due to the numerous potential areas of weakness around the hospital fence.

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

	Average Fees					
	FY	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
OPD Adult Male	11,500	15,000	15,000	15,000	15,000	15,000
OPD Adult Female	12,000	16,500	15,000	15,000	15,000	15,000
OPD Children < 5yrs	4,500	9,500	9,500	9,500	9,500	9,500
OPD Children 5-13 yrs	7,000	12,000	9,500	9,500	9,500	9,500
IP Medical Male	25,000	30,000	30,000	30,000	30,000	30,000
IP Medical Female	25,000	30,000	30,000	30,000	30,000	30,000
IP Maternity	15,850	36,900	35,000	35,000	35,000	35,000
IP Paediatric < 5 yrs	8,500	15,500	15,000	15,000	15,000	15,000
IP Paediatric 5-13 yrs	9,000	16,000	16,500	16,500	16,500	16,500
IP Surgical Ward	23,200	24,000	28,000	28,000	28,000	28,000

In the financial year 21/22, the hospital achieved a cost recovery rate of 10.96%, which was a decrease of 9.34% from the previous year. The hospital has consistently spent more on patients' medical needs than it receives from them, putting the sustainability of high-quality services at risk. To ensure the long-term viability of the hospital, it is crucial to effectively bridge the gap between donor support and local revenue generation, especially considering the growing trend of donor fatigue.

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

Income Item	FY	FY	FY	FY	FY
	2018-19	2019-20	2020-21	2021-22	2022-23
HOSPITAL					
User Fees (a)	805,406,207	918,631,455	724,456,625	1,029,262,390	643,655,130

Total Recurrent Expenditure (b)[2]	5,078,934,893	5,567,947,557	5,262,582,049	5,062,925,360	5,870,506,994
Cost Recovery Rate = (a/b)x100	15.86%	16.50%	13.77%	20.30%	10.96%

In the FY 22/23, there was increase of 11.91% in the average cost per bed. Similarly, the cost per patient per day and the cost per SUOp also recorded a significant increase. This highlighted the burden of care placed on the hospital by the patients it served, as there was a reduced efficiency in the use of resources for patient care.

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

Indicator	FY	FY	FY	FY	FY
	2018-19	2019-20	2020-2021	2021-2022	2022-2023
Cost per bed[1]	18,741,457	20,545,932	18,400,637	18,081,876	20,526,248.23
Cost per IP/day[2]	53,243	62,026	76,018	79,564.46	112,120.30
Cost per SUOp	16,386	15,854	19,859	19,173	23,821

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

Source: UCMB

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

Without PHC CG	FY	FY	FY	FY	FY
	2018-19	2019-20	2020-2021	2021-2022	2022-2023
Total Local Revenues (a)	4,828,775,673	918,631,455	724,456,625	1,029,262,390	846,018,807
Total Recurrent Expenditures (b)	5,078,934,893	5,567,947,557	5,262,582,049	5,062,925,360	5,870,506,994
Sustainability Ratio = (a/b)x100	95.10%	16.50%	13.80%	20.30%	14.41%

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

In the FY22/23, the hospital was 71.4% sustainable when considering local income and government contributions; showing a decline of 8.6% compared to the previous financial year.

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

	FY	FY	FY	FY	FY
	2018-19	2019-20	2020-2021	2021-2022	2022-2023
Total in-country funding (c)	5,079,935,215	3,907,443,605	3,888,851,326	4,043,280,957	4,192,447,265
Total Recurrent Expenditures (d)	5,078,934,893	5,567,947,557	5,262,582,049	5,062,925,360	5,870,506,994
Sustainability Ratio = (c/d)x100	1.00	0.70	0.74	0.80	0.71

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

CHAPTER SIX: SERVICES

The hospital offers the following services: The hospital continues to provide the same set of services that the government has recommended for a general hospital over the years. These include;

Obstetrics & Gynecology Services

Antenatal, Delivery, Postnatal care

Elimination of MTCT of HIV

Emergency Obstetrics and Neonatal care

General and Specialized Obstetrics and Gynaecological Surgery

Emergency medical care

Electro-Cardiogram (ECG) services

Medical Admissions and care TB Diagnosis and treatment

Communicable and Non-Communicable Diseases care, treatment and prevention

General Surgical Services



Trauma and Emergency Care

Surgical Outpatient clinic

Minor Orthopedics services

Burns care

Anesthesia

General surgical operations (minor and major surgery)

Pediatrics & Child Health



Young child clinic

Inpatient and Outpatient Therapeutic care (ITC and OTC)

Neonatal intensive care services

Pediatric admissions and care

Immunization and health promotion

Sickle cell Disease care

Paediatric Outpatient Clinic

Internal Medical Care

HIV Care and Treatment

General and private Out-patient Clinic

Community Health



Health promotion outreaches.

Immunization

Health education

Primary Health Care

staff in the area of discipline.

Physiotherapy services & rehabilitation



Physiotherapy clinic and rehabilitation

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

Ophthalmic Services



Eye disease screening

Minor surgery

Ophthalmic OPD and IPD service

OUT PATIENTS' DEPARTMENT



The OPD serves as the first point of contact for patients seeking DAMHK services. Dr. Ambrosoli Memorial Hospital's Out Patients Department (OPD) is located near the hospital's main entrance. The OPD is open seven (7) days a week, from 8:00 a.m. to 9:00 p.m. on Monday through Friday and 8:00 a.m. to 8:00 p.m. on Saturdays and Sundays (including public holidays). In

the coming year, we plan to investigate the feasibility of implementing a 24-hour system. Our pharmacist assistants efficiently manage the OPD pharmacy, ensuring proper dispensing practices are upheld.

To cater for a diverse range of client requirements, we have established a robust patient flow and payment system. The OPD has also improvised an emergency room in one of the rooms. The Emergency Department/Department is staffed by clinical staff based at the OPD and assisted by medical staff as needed.

Staffing composition

In general, the number and norm of OPD staffing remained unchanged from prior years. OPD was administered by five clinical officers, five enrolled nurses, three nursing assistants, two nursing officers, and two nursing aides. Nursing and clinical students from the midwifery school and other educational institutions are usually welcomed to join the OPD team in their work. Medical officers oversee specialty clinics on a weekly basis, including gynecological clinic on Monday, sickle cell clinic and pediatric outpatient clinic on Tuesday, surgical outpatient clinic on Wednesday, and medical clinic on Thursday.

Table 6.0-1: The staff composition in OPD in the FY 2021-2022 and FY 2022-2023

Cadre/ Discipline	Qualification	FY	FY
		2021-22	2022-2023
Clinical officers	Diploma in clinical Medicine	5	5

Ophthalmic Clinical officers	Diploma in clinical Ophthalmology	0	1
Ophthalmic Assistant	Cert. in Nursing / Cert.in Ophthalmology	0	1
Pharmacy Assistant	Certificate in Pharmacy	2	2
Registered Nurse/Midwife	Diploma in Nursing / Midwifery	2	2
Enrolled Midwife	Certificate in Midwifery	0	0
Enrolled Nurse	Certificate in Nursing	4	3
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	1	1
Nursing Assistant	Certificate in Nursing Assistance	3	3
Cashier	Diploma in Business Studies	2	2
Nursing Aide	Trained on the job	2	2
Records Assistant	Certificate in Records mgt	1	1
Total		22	23

OPD key indicators

In general, the OPD attendances increased as compared to the previous years. All new attendances increased by 3.14%, 17.48% for the reattendances and 6.72% for all attendances. Patients listed as new attendees outweighed those indicated as re-attendants. Morbidity among children under the age of five has generally increased. This could be due to an increase in flu-like infections among this age groups. Women continue to attend the hospital at a higher rate than men, as is widely acknowledged.

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

			FY	FY	FY	FY	FY
			2018-19	2019-20	2020-21	2021-22	2022-23
New							
FEMALE	Attendance	0-4 yrs	2,037	3,014	1,600	1,944	2,189

		Over 5					
		yrs	10,835	8,978	9,260	10,703	10,412
Re-							
attendance		0-4 yrs	129	121	97	41	179
		Over 5					
		yrs	1,934	4,097	7,836	4,166	4,461
New							
MALE	Attendance	0-4 yrs	2,337	2,976	1,818	2,446	2,615
		Over 5					
		yrs	6,193	8,492	5,631	5,623	6,151
Re-							
attendance		0-4 yrs	170	118	123	82	163
		Over 5					
		yrs	1,987	3,262	5,230	2,586	3,274
All New							
Attendances			21,402	23,460	18,309	20,716	21,367
All Re-							
attendances			4,220	7,598	13,286	6,875	8,077
All							
Attendances			25,622	31,058	31,595	27,591	29,444

Morbidity Trend in the OPD

Similarly, like last year, malaria (11.72%) was the leading cause of all morbidity in the OPD despite a drop in the overall figure. Cough or cold or no pneumonia was the 2nd leading cause of morbidity in OPD. This is a change from last year that was gastro-intestinal disorders as the second cause of morbidity. Anemia is still one of the leading causes of morbidity. This could be attributable to the existence of malaria-related complications as well as other reasons such as chronic illness anemia. Blood availability is a problem in Agago District, affecting clinical care for this patient group.

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

Causes of Morbidity		FY 2021-2022		FY 2022-2023	
		No. of cases	% on all diagnoses	No. of cases	% on all diagnoses
1	Malaria	3994	14.48%	3450	11.72%

2	Cough or cold no Pneumonia	751	2.72%	2225	7.56%
3	Other types of Anaemia	1030	3.73%	888	3.02%
4	Sickle Cell Anaemia	627	2.27%	803	2.73%
5	Urinary Tract Infections (UTI)	1232	4.47%	753	2.56%
6	Gastro-Intestinal Disorders (non-Infective)	1353	4.90%	701	2.38%
7	DIARRHEA ACUTE	385	1.40%	484	1.64%
8	Pneumonia	851	3.08%	448	1.52%
9	PELVIC INFLAMMATORY DISEASE	627	2.27%	372	1.26%
10	Skin Diseases	420	1.52%	326	1.11%
	All others	5070	18.38%	6270	21.29%
	Total OPD attendance	27591		29444	

ANTENATAL CLINIC

Antenatal care presents the first contact opportunity for a woman to connect with formal health services and linking women with pregnancy complications to a referral system and involves education, screening, counseling, treatment of minor ailment, and immunization services. The ANC is open five days a week, from 8:00 a.m. to 5:00 p.m., Monday through Friday. Saturdays, Sundays, and all public holidays are closed.

EMTCT services are available at the ANC clinic. All expecting moms and their spouses are tested for HIV at the ANC, and those who test positive are put on option B+ to reduce transmission to the unborn child. These mothers are closely watched during their pregnancy, delivery, and postpartum period. Their exposed infants are enrolled in mother-baby care centers where EID is done and are tracked until they reach the age of 18 months, at which point their ultimate HIV status is confirmed. They are discharged if they are negative, and enrolled in chronic care at the ART clinic if they are positive.

Table 6.4: Antenatal and Postnatal indicators during the last 5 FYs

ANTENATAL	FY	FY	FY	FY	FY
	2018-19	2019-20	2020-21	2021-22	2022-23
ANC 1st Visit	2,397	1,606	1,566	1,515	1,376
ANC 4th Visit	1,648	1,217	878	1,990	842
Total ANC visits new clients + Re-attendances	8,721	7,388	6,390	6,550	5,874
ANC Referrals to unit	2	0	0	31	110
ANC Referrals from unit	0	0	0	12	110

POSTNATAL					
Post Natal Attendances	4,472	3,939	3,629	4,107	3,836
Number of HIV + mothers followed in PNC	164	906	246	243	221
Vitamin A supplementation	90	0	0	0	0
Clients with premalignant conditions for breast	0	0	0	0	0
Clients with premalignant conditions for cervix	0	0	0	0	0

The total ANC attendances decreased in comparison to the previous FY by 10%, whereas the number of referrals increased by almost 72%. This was due to the increasing efforts by the Implementing partners in the region in conjunction with ministry of health on the importance of referrals from lower-level centers to higher centers to avert maternal mortalities. The hospital provides cervical cancer screening services in the ANC on a daily basis during working hours. The positive rate of screening tests among women of reproductive age has remained low. If continuous financing is obtained, the activity must be expanded to reach a bigger demographic.

HIV/AIDS Clinic

The HIV/AIDS clinic was created in November 2005 with the assistance of CRS AIDS relief. The CDC has transitioned its support for the clinic's activities to USAID. The clinic is now funded and kept operational by the Uganda Protestant Medical Bureau, Local Service Delivery Activity (USAID funded). The services provided are primarily encompassed in the hospital services. It offers comprehensive HIV/AIDS care, including Antiretroviral Therapy, Opportunistic Infection Prophylaxis and Treatment, HTS, eMTCT, SGBV, and DSDM; and a community HIV treatment model. A medical officer coordinates the clinic's operations and serves as its coordinator. The number of HIV+ clients in the HIV program grows year after year. The HIV/AIDS Clinic is housed in a temporary structure that also serves as a data entry station, nursing care, counseling, clinical consultation, file storage, and other information management services. There is currently an urgent need for expansion in order to manage all of the clinic's required activities. Despite continuous budget constraints, this requirement is handled even by the present Implementing partner, whose policies do not support any structural development requests. The clinic's budget assistance has diminished over time, which has had an impact on its operations, ranging from personnel reductions to planned activities.

HIV Testing Services (HTS)

HIV testing services (HTS) provide a unique opportunity and a door for persons identified with HIV to begin lifesaving treatment as soon as possible, as well as for those at higher risk of contracting the virus to have quick access to the effective recommended package of prevention services in order to remain negative. The first of the United Nations' 95-95-95 aims for ending the HIV epidemic is for 95% of HIV-positive people to know their HIV status by 2025. Obtaining "the first 95" requires HIV testing. HIV testing services include the full range of services that should be provided alongside HIV testing, including counseling (pre-test information and post-test counselling); referral to appropriate HIV prevention, treatment, and care services, as well as other clinical and support services; and coordination with laboratory services to support quality assurance and the delivery of correct results.

HTS activities currently includes also community-based services. The concept of HTS in the community is based on targeted testing (Targeting the at-risk population).

In the FY 22/23, the total number of people that accessed the HTS was 12,323 an increase of 22.28% from the previous FY 21/22. This is also reflected in the total number of those who tested positive.

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

	FY	FY	FY	FY	FY
	2018-2019	2019-20	2020-21	2021-22	2022-23
Number Tested					
Male	4,736	7,347	4,088	4,498	4,533
Female	6,993	6,721	6,172	5,580	7,790
TOTAL (Tested)	11,729	14,068	10,260	10,078	12,323
Tested +ve for HIV					
Male	160	103	86	56	82
Female	222	149	107	94	89
TOTAL (+ve Tests)	382	252	193	150	171
Positivity Rates of HCT					
Male	3.4%	1.4%	2.1%	1.2%	1.8%
Female	3.2%	2.2%	1.7%	1.7%	1.1%
Both sexes	3.3%	1.8%	1.9%	1.5%	1.4%

Table 6.6: HIV test by purpose during FY 2022 – 2023

Types of test	HCT	PMTCT*	SMC	Total
Number of clients tested for HIV	8,644	3,015	664	12,323

No. of HIV +ve tests	148	22	1	171
Positivity Rate (%)	1.71%	0.73%	0.15%	1.39%

The above figure is for total test done purely for HIV screening & excludes quality control tests done during the FY 2022-23

**Source: Laboratory records*

Table 6.7: Performance Indicators of the PMTCT Programme in FY 2022-2023

Performance Indicators of the PMTCT Programme in FY 2018-2023	2018-19	2019-20	2020-21	2021-22	2022-23
A. Antenatal					
A1. Mothers re-tested later in pregnancy, labour or postpartum	779	444	285	1958	1074
A2. Mothers testing positive on a retest	7	8	2	68	4
A3. New pregnant and lactating mothers newly enrolled into psychosocial support groups.	57	31	8	0	0
A4. HIV positive pregnant women already on HAART before 1st ANC visit /Current pregnancy	112	98	123	412	104
A5. Pregnant women who received services at the health facility after referral from the community	2397	0	0	43	110
A6. HIV (+) lactating mothers followed up in community for infant feeding, early infant diagnosis, or linkage into chronic care	141	250		74	118
A7. HIV positive Pregnant women initiated on Cotrimoxazole	11	14	15	26	16
A8a. Mothers assessed using CD4	0	0	0	0	0
A8b. Mothers assessed using WHO clinical staging only	0	0	0	0	0
A9a. HIV + pregnant women initiated on HART (Option B+) for EMTCT - CD4 >350 or Stage I and II (ART-T)	31	14	15	26	16
A9b. HIV + pregnant women initiated on HART (Option B+) for EMTCT - CD4 <350 or Stage III and IV(ART-T)	0	0	0	0	3
B. Maternity				0	
B1. HIV positive deliveries initiating ARVs in Labour	1	129	3	1	4
C. Postnatal					
C1. Postnatal mothers newly tested for HIV	6	74	85	31	784
C2. Postnatal mothers testing HIV positive	4	7	1	1	6
C3. Postnatal mothers initiating ARVs in PNC period	8	8	1	1	6
D. Early Infant Diagnosis (EID)					
D1. HIV-exposed infants (<18 months) getting a 2nd DNA PCR	127	116	113	124	132

D2. HIV-exposed infants initiated on Cotrimoxazole prophylaxis	208	121	100	149	124
D3a. 1st DNA PCR results returned from lab within 2 weeks of dispatch	148	90	118	124	118
D3b. 2nd DNA PCR results returned from lab within 2 weeks of dispatch	145	88	99	108	110
D4a. Total HIV-exposed infants who had a serological/rapid HIV test at 18 months or older.	110	131		111	134
D4b. Positive Number of HIV-exposed infants who had a serological/rapid HIV test at 18 months or older	2	4		3	7
D5. DNA PCR results returned from the lab that are positive	5	4		3	7
D6. HIV-exposed infants whose DNA PCR results were given to caregiver	149	44		6	14
D7. Number of referred HIV positive-infants who enrolled in care at an ART clinic	3	3		3	7

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

		FY 2018-2019	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
ELIGIBLE FOR ART						
Male	<5 yrs	6	4	2	4	4
	5-<18 yrs	8	6	5	3	7
	18 and above	129	96	70	54	64
Female	<5 yrs	6	6	1	3	3
	5-<18 yrs	13	8	7	6	3
	18 and above	221	120	91	85	84
TOTAL ELIGIBLE FOR						
	ART	383	240	176	155	165
STARTED ON ART						
Male	<5 yrs	6	4	2	4	4
	5-<18 yrs	8	6	5	3	7
	18 and above	129	96	70	54	64
Female	<5 yrs	6	6	1	3	3
	5<18 yrs	13	8	7	6	3
	18 and above	221	120	91	85	84

TOTAL STARTED ON

ART	383	240	176	155	165
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The total number of new positives for the year increased. Nonetheless, links were established and care was initiated for all tested and qualifying individuals. Throughout the year, there were issues with dropouts and missing follow-up with current clients. These individuals would then be pursued and either returned to care or enrolled in one of our community drug distribution programs.

The number of people enrolling in community drug distribution modules such as the CCLAD, CDDP, and others has increased in recent years. The goal is to enroll all qualified clients in one of the modules listed above in order to alleviate facility congestion and promote adherence (by bringing drugs closer to the clients). Enrollment in private pharmacies to assist with drug distribution to approved clients is expected to commence in the coming year in an effort to reduce stigma and increase compliance.

Table 6.9: Number of PLHAs started on ARV by age group and gender in FY 2022-2023

Data Element	No. of Children < 19yrs		No of Individuals 20–24 yrs		No. of Individuals 25+ yrs		Total
	M	F	M	F	M	F	
Number of new patients enrolled in HIV care at this facility during the year	11	6	6	29	58	55	165
Number of pregnant women enrolled into care during the year.		2		12		10	24
Cumulative Number of individuals on ART ever enrolled in HIV care at this facility							4445

Number of HIV positive patients active on pre-ART Care	0	0	0	0	0	0	0
Number of HIV positive cases who received CPT/Dapson at last visit in the year	123	119	6	59	162	679	1148
No. of newly identified positives that are initiated on ART int the same FY	11	6	6	29	58	55	165
No. of pregnant & Lactating women started on ART at this facility during the quarter (Subset of HC11)		2		12		10	24
No. active on ART screened for TB at last visit in the quarter	123	119	31	79	965	1663	2980
No. active on ART with presumptive TB during the quarter	1	2	0	3	5	9	20
No. active on ART diagnosed with TB during the quarter	0	0	0	3	4	6	13
Net current cohort of people on ART in the cohort completing, 12 months during the year	8	10	5	15	48	72	158

Number of clients surviving on ART in the cohort completing, 12 months on ART during the year		7	8	4	13	40	57	129
Number of people accessing ARVs for PEP		7	16	20	15	25	16	99
No. active on ART on 1st line ARV regimen		89	75	13	61	941	1559	2738
No. active on ART on 2nd line ARV regimen		35	46	19	21	79	156	356
No. active on ART on 3rd line or higher ARV regimen		0	0	1	0	0	0	1
Number of clients on ART who had a viral load test during the past 12 months (most recent test)	Total Tested	107	105	26	55	731	1296	2320
	Suppressed viral load	78	82	22	51	705	1256	2194
Number active on	FBIM	12	12	13	27	282	371	717
	FBG	58	54	11	40	12	205	380

ART enrolled in DSD approach	FTDR	5	4	6	8	216	327	
								566
	CDDP	43	55	3	7	434	700	
								1,242
	CCLAD	2	0	0	0	76	112	
								190

Orthopaedical Services

The predominant way of treatment is still non-operative orthopedic care, with surgery performed at surgical camps on occasion. Patients from the hospital and district are still unwilling to be recommended for cultural and financial reasons. Given the high number of orthopedic patients, it is vital to strengthen operative treatment. Although the hospital does not have an orthopedic surgeon, there is a medical officer in training who will be bonded to the facility and provide surgical orthopedic care. In addition, among the orthopedic services is a "club foot" clinic.

Table 6.10: Main procedures in orthopaedics and physiotherapy done in the last 5 FYs

Procedures	FY	FY	FY	FY	FY
	2018-19	2019-20	2020-21	2021-22	2022-23
Plaster (POP)	985	364	707	1434	844
Physiotherapy	44	157	76	814	538

Tuberculosis (TB) treatment

The Dr. Ambrosoli Memorial Hospital offers tuberculosis treatment as part of the usual operations of general medical care. The TB screening process begins in the emergency department, when all coughers are identified and isolated. Confirmed cases are admitted to the TB treatment unit as soon as possible for the duration of the rigorous phase of therapy before being discharged on CB-DOTs. All therapy follow-ups are conducted on the unit. Table 6.11 displays the total number of TB patients registered over the last five (5) fiscal years. There was an increase in the number of patients registered under TB treatment. We continue to see a high number of TB cases among children under the age of five, particularly among underweight and/or immunocompromised infants. Many health care providers still struggle with TB diagnosis. As a result, a higher level of suspicion is always used. Homestead screening and

presumption diagnosis, particularly among malnourished admissions, are being expanded to increase case identification rates.

Table 6.11: TB patients registered for treatment in the last 5 FYs

	FY	FY	FY	FY	FY
	2018-19	2019-20	2020-21	2021-22	2022-23
No. of patients registered (all)	196	325	270	194	210
Children (< 5 yr.)	16	38	38	32	19
Disaggregation by Disease					
New Pulmonary Positive	82	84	83	145	145
Relapses Pulmonary Positive	7	10	5	7	2
Failure Pulmonary Positive	1	7	1	5	0
Lost to follow up Pulmonary Positive	10	0	3	0	8
New pulmonary Negative	82	206	167	31	52
Relapses Pulmonary Negative	0	6	7	4	1
Default Pulmonary Negative	0	4	0	0	0
Pulmonary no smear done	0	0	0	0	0
Extra Pulmonary	14	8	4	2	2
Disaggregation by Treatment					
New Patients	198	298	250	178	199
Re-treatment	18	27	20	11	11
Other Patients					
Transferred in	7	0	0	0	0

MDR TB is still a major public health issue in the surrounding community. It's important to remember that not all cases are discovered (there could be more out there). Mechanisms for intense awareness and case identification must be developed

Table 6.12: MDR/MTB diagnosis during the FY 2022-23

Age group	Samples Collected	Samples Tested	MTB positive Cases	MDR positive (Rifampicin Resistant TB)	MDR cases referred
< 15 years	542	525	5	0	0
15 yrs.& above	2715	2663	157	5	5
Total	3257	3188	162	5	5

TB treatment outcome

Treatment for tuberculosis significantly reduces mortality and should maximize cure, limiting continued transmission and TB sequelae. The mortality rate among TB patients remains high, with a 41% increase from the previous year. The majority of these were caused by malnutrition as well as co-HIV infection. When compared to the previous year, the number of patients cured declined by

60%. Although a few patients' complete treatment, bacteriological tests are required to prove cure. These are rarely available, and supply from the National Medical Store is inconsistent. The majority of patients who could not be easily located from their parent community (some of whom moved to other regions) remain key issues.

Table 6.13: Results of TB treatment in the last 5 FYs

Outcome of treatment	FY 2018-19 Number	FY 2019-20 Number	FY 2020-21 Number	FY 2021-22 Number	FY 2022-23 Number
Cured	53	38	48	35	59
Treatment Completed	101	126	222	201	79
Died	28	24	34	17	24
Failure	2	0	2	0	1
Defaulted	24	1	0	0	0
Transfer out	36	3	0	0	0
Lost to follow Up			5	13	13
Not Evaluated			4	5	16
Total	244	192	315	271	192

Table 6.14: Results of TB treatment smear positive Pulmonary TB patients in the last 5 FYs

Outcome of treatment	FY	FY	FY	FY	FY
	2018-19	2019-20	2020-21	2021-22	2022-23
Cured	53	36	48	33	59
Treatment Completed	26	43	33	37	50
Died	6	10	6	8	17
Failure	2	0	1	0	1
Defaulted	9	1	0	0	0
Transfer out	29	2	0	0	0
Lost to follow Up			6	5	10
Not Evaluated			2	3	14
Total	125	92	96	86	151

Mental health clinic

Specialized mental health treatments are no longer limited in the Agago district due to presence of professionals and infrastructure to deliver mental health care. Mental health is now fully integrated into the hospital's basic service scopes. Nonetheless, other clinicians continue to examine these patients when the number is overwhelming. Epilepsy is still the leading cause of mental illness in our OPD, followed by depression and alcohol/substance addiction.

Despite the hospital's best efforts, staff sustainability remains a serious challenge (the majority depart for brighter pastures). The lack of mental health medications and beds for these persons is a big issue. The table below 6.15 displays the cases reviewed in the OPD during the fiscal year.

Table 6.15: Mental health cases reviewed in OPD in the last 5 FYs

Diagnosis	FY		FY		FY		FY		FY	
	2018-2019		2019-20		2020-21		2021-22		2022-23	
	No.	%	No.	%	No.	%	No.	%	No.	%
Epilepsy	576	85.3%	1,171	84.5%	702	80.8%	745	76.73%	728	3033.33%
Drugs/alcohol abuse	46	6.8%	3	0.2%	60	6.9%	68	7.00%	35	145.83%
Depression & post-traumatic stress disorders	21	3.1%	75	5.4%	31	3.6%	99	10.20%	47	195.83%

Psychosis										
(schizophrenia)	1	0.1%	12	0.9%	7	0.8%	3	0.31%	0	0.00%
Bipolar affective										
disorder	5	0.7%	3	0.2%	8	0.9%	12	1.24%	26	108.33%
Attempted suicide	0	0.0%	3	0.2%	16	1.8%	9	0.93%	0	0.00%
HIV related										
Psychosis	3	0.4%	19	1.4%	11	1.3%	1	0.10%	15	62.50%
Other mental										
illnesses	23	3.4%	99	7.1%	34	3.9%	34	3.50%	24	100.00%
Total	675	100.0%	1,385		869		971		875	

Palliative Care

Palliative care is specialised medical care for those who are suffering from a terminal illness. This style of care focuses on relieving the symptoms and stress of the illness. The goal is to improve the patient's and family's quality of life.

Despite a number of implementation problems, palliative care efforts are taking shape.

A paucity of money continues to impede the supply of critical palliative care products and patient follow-up. In order to address these concerns, the hospital has included palliative care into its PHC activities in addition to recruitment of a social worker.

Figure 6.16 summarizes the palliative care services given in the fiscal year 21/22.

Table 6.16: Number of Patients who received Palliative Care in the FY 2022-23

Clinical Condition	No. of patients that need palliative Care	No. of patients who received palliative Care
Cancer	18	15
HIV/AIDS	80	73
Sickle cell	10	10
Others	228	225

INPATIENTS DEPARTMENT

The overall bed capacity of the hospitals is 286. In 22/23, the hospital employed five (5) medical officers. The hospital continues to face a serious shortage of specialists. When funding allows, management intends to develop capabilities in this area. There are currently four

specialists, which include two surgeons, a pediatrician, and an obstetrician who was recently added. The average number of beds per nurse/midwife has remained almost the same. The medical ward currently has the most beds per nurse/midwife, while the NICU has the fewest, as it did the previous year. These metrics vary, for example, during high malaria seasons, there are even greater cases, which further expands the ratios.

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	12	4.92
TB Ward	18			
Surgical Ward	76	2 Surgeon	13	5.85
		1 Medical Officer		
		1 Orthopedic Officer		
		1 Physiotherapist		
Maternity & Gyn Ward	75	2 Medical Officer	20	3.75
		1 Gynecologist		
Pediatric Ward	61	1 Medical Officers	19	3.21
NICU	15		12	1.25
		1 Paediatrician		
Total	286	4 Specialist Doctor and 5 Medical Officers		

Utilization indicators

In FY 22/23, the overall number of admissions decreased by 11%. The overall recovery rate remained almost the same, the average length of stay reduced, and the number of self-discharges decreased by nearly 48.48%. The ALOS was below the national standard of 4.7 days. The management has devised measures to further limit fee-free escapes and hopes to lower this even further in the future year.

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

Indicator	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
No. of beds	271	271	286	286	286
Total Admissions discharged	14,794	16,779	12,203	12,913	11,473
Patient days	69,329	89,761	69,228	63,633	52,359
Average Length of Stay	4.7	5.35	5.67	4.93	4.56
Turn over interval	2.0	0.5	2.9	3.2	4.5
Throughput per bed	54.6	61.9	42.7	45.2	40.1
BOR	70.09	90.75	66.32	60.96	50.16
No. Deaths	192	373	343	386	352
Mortality Rate	1.3%	2.5%	2.3%	2.6%	2.4%
Recovery Rate	97.09%	97.42%	95.85%	96.24%	96.49%
Self-discharges	67	60	164	99	51

Bed Occupancy Rate (BOR) and Throughput per Bed

In fiscal year 22/23, the bed occupancy rate fell by 17.72% to 50.16. As in the previous year, the paediatrics ward had the greatest BOR (61.65), followed by the obstetrics and gynaecology ward (61.11). Malaria and its consequences were still responsible for the increasing BOR noted in the Children's and Maternity wards in FY 22/23, as they were in FY 21/22. In general, throughput per bed decreased to 40.1. Except for the TB ward, this was observed on all wards.

MEDICAL WARD				
	FY	FY	FY	FY
	2019-20	2020-21	2021-22	2022-23
No of beds	41	41	41	41
Total Admissions	2,684	1,834	2,141	1,713
Patients days	12,549	7,542	9,285	7,886
ALOS	4.7	4.1	4.3	4.6

SURGICAL WARD[1]				
	FY	FY	FY	FY
	2019-20	2020-21	2021-22	2022-23
No of beds	76	76	76	76
Total Admissions	1,925	1,521	1,584	1,577
Patients days	15,189	13,701	13,776	8,830
ALOS	7.89	9.01	8.70	5.60

Throughput per bed	65.46	44.73	52.22	41.78
BOR	83.18	50.40	62.04	52.70
No of Deaths	113	140	142	140
Mortality rate	4.21%	7.63%	6.63%	8.17%
Recovery rate	95.45%	89.59%	92.81%	91.24%
Self-discharges	9	51	12	10

PAEDIATRIC WARD				
	FY	FY	FY	FY
	2019-20	2020-21	2021-22	2022-23
No of beds	61	76	76	76
Total Admissions	7,615	4,437	4,398	3,819
Patients days	43,503	29,304	20,960	17,103
ALOS	5.71	6.60	4.77	4.48
Throughput per bed	124.84	58.38	57.87	50.25
BOR	195.39	105.64	75.56	61.65
No of Deaths	217	157	183	158
Mortality rate	2.85%	3.54%	4.16%	4.14%
Recovery rate	96.53%	94.79%	95.52%	95.78%
Self-discharges	47	74	14	3

Throughput per bed	25.33	20.01	20.84	20.75
BOR	54.75	49.39	49.66	31.83
No of Deaths	32	30	45	38
Mortality rate	1.7%	2.0%	2.8%	2.4%
Recovery rate	98.1%	97.0%	96.0%	96.3%
Self-discharges	4	15	18	20

OBSTETRICS & GYNECOLOGY WARD				
	FY	FY	FY	FY
	2019-20	2020-21	2021-22	2022-23
No of beds	75	75	75	75
Total Admissions	4,226	4,144	4,595	4,154
Patients days	16,519	17,441	17,522	16,728
ALOS	3.91	4.21	3.81	4.03
Throughput per bed	56.35	55.25	61.27	55.39
BOR	95.45	0.64	64.01	61.11
No of Deaths	4	11	5	7
Mortality rate	0.09%	0.27%	0.11%	0.17%
Recovery rate	99.91%	99.3%	98.7%	99.4%
Self-discharges	0	20	55	18

TB WARD				
	FY	FY	FY	FY
	2019-20	2020-21	2021-22	2022-23
No of beds	18	18	18	18
Total Admissions	329	267	195	210
Patients days	2,001	1,240	2,090	1,812
ALOS	6.08	4.64	10.72	8.63
Throughput per bed	18.28	14.83	10.83	11.67
BOR	30.46	18.87	31.81	27.58
No of Deaths	7	5	11	9
Mortality rate	2.13%	1.87%	5.64%	4.29%
Recovery rate	97.87%	98.13%	94.36%	95.71%
Self-discharges	0	0	0	0

[1] Source: HMIS 108 Male Surgical Ward + Female Surgical Ward + Other Wards (Children Surgical Ward)

Inpatient referrals

The overall number of hospital referrals grew by 12.66%. The number of referrals out of hospital increased as compared to the previous year. The hospital is still the principal referral hospital for Agago and four (4) other adjacent districts.

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

	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Referrals to hospital	1552	153	694	695	783
Referrals from hospital	171	33	105	81	138
Total	1723	186	799	776	921

Morbidity causes

Malaria (25.61%), injuries (8.72%), and pneumonia (6.19%) were the leading causes of morbidity in the wards. These top morbidity causes are comparable to the previous year. Because managing the complications caused by malaria infection is frequently more difficult, it is critical that more activities geared toward community malaria transmission prevention be implemented. The observed injury pattern was made up of a combination of community alcohol-related violence and a few traffic accidents, in addition to the insecurity produced by the Karimojong warriors a usual problem.

Table 6.21: Top ten causes of admission in all the wards in the FYs 2021-2022 & 2022-2023

Causes of Morbidity	FY 2021-22		FY 2022-23	
	No. of cases	% on all diagnose	No. of cases	% on all diagnose
1 Malaria	3,246	25.14%	2,938	25.61%
2 Injuries: (Trauma due to other causes)	1,182	9.15%	1,001	8.72%
3 Pneumonia	926	7.17%	710	6.19%
4 Abortion due to other causes	553	4.28%	529	4.61%
5 Septicemia	504	3.90%	535	4.66%
6 Anaemia	344	2.66%	384	3.35%
7 Malaria in pregnancy	165	1.28%	210	1.83%
8 Diarrhoea - Acute	342	2.65%	373	3.25%
9 Other complication in pregnancy	354	2.74%	452	3.94%
10 Other Neonatal Conditions	227	1.76%	244	2.13%
All others	449	3.48%	708	6.17%
Total	12,913		11,473	

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

	FY	FY	FY	FY	FY
	2018-19	2019-20	2020-21	2021-22	2022-23
<i>Malaria cases</i>	1,844	3,159	6,989	3246	2938
<i>% of all diagnosis</i>	22.40%	21.35%	41.65%	25.14%	25.61%

Mortality causes

The two leading causes of death were pneumonia and malaria, with case fatality rates of 1.77% and 4.51%, respectively. Neonatal deaths continue to be a burden, especially in light of the continued delay in newborn referrals from lower-level facilities. Other newborn disorders were linked to the second-highest CFR (7.49 percent).

Table 6.23: Top ten causes of death among inpatients all wards FY 2021-22 and FY 2022-23

Causes of Mortality among Inpatients		FY 2021-22			FY 2022-23		
		No of disease specific deaths	No of cases admitted in the hospital	Case Fatality Rate	No of disease specific deaths	No of cases admitted in the hospital	Case Fatality Rate
1	Malaria total	49	3,246	1.51%	52	2,938	1.77%
2	Pneumonia	35	926	3.78%	32	710	4.51%
3	Other Neonatal Conditions	17	227	7.49%	20	244	8.20%
4	Injuries - Trauma due to other causes	17	1,182	1.44%	12	1,001	1.20%
5	Malnutrition	15	227	6.61%	7	127	5.51%
6	Premature baby (as condition that requires mgt)	11	160	6.88%	16	128	12.50%
7	Hypertension	9	141	6.38%	5	95	5.26%
8	Heart failure	9	44	20.45%	8	25	32.00%
9	Anaemia	8	344	2.33%	13	384	3.39%
10	Tuberculosis	6	165	3.64%	8	210	3.81%
	All others	22	449	4.90%	27	681	3.96%

MEDICAL WARD

The department can accommodate 41 patients total between its main ward and its nearby private wing. There are 11 beds in the private ward, three of which are independent rooms. Plans are underway for renovations to this, one of the hospital's oldest complexes; when funding is available. The activities of the TB ward are managed by the medical ward and are annexed to the same building.

Staff composition

The ward is run by a Medical Officer and 12 nursing/supportive staff. The overall responsibility of the ward is in the hand of the Medical Officer assisted by the Nursing in charge.

Table 6.24: Staff Composition in Medical Ward FY 2022-2023

Cadre/ Discipline	Qualification	Number
Medical Doctor	Bachelor Degree in Medicine and Surgery	1
Registered Nurse/Midwife	Diploma in Comprehensive Nursing	2
Enrolled Nurse	Certificate in Nursing	7
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	1
Nursing Assistant	Certificate in Nursing Assistant	1
Nursing Aid	Trained on the Job	0
Total		12

Table 6.25: Key indicators in Medical Ward in the last 4 FYs

	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
No of beds	41	41	41	41
Total Admissions	2,684	1,834	2,141	1,713
Patients days	12,549	7,542	9,285	7,886
ALOS	4.7	4.1	4.3	4.6
Throughput per bed	65.46	44.73	52.22	41.78
BOR	83.18	50.40	62.04	52.70
No of Deaths	113	140	142	140
Mortality rate	4.21%	7.63%	6.63%	8.17%
Recovery rate	95.45%	89.59%	92.81%	91.24%
Self-discharges	9	51	12	10

In the FY 22/23, the number of admissions decreased by 20% to 1713. This is likely attributed to increased functionality of the surrounding health centres, increased health prevention and promotion activities carried by the hospital. However, the ALoS increased slightly while the BoR decreased. The mortality rate increased and this was due to late referrals of very sick patients from the health centres.

The number of self-discharges also slightly reduced due to improved tracking of patients who haven't paid by the staff on duty.

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

Causes of Morbidity in Medical Ward	FY 2021-2022		FY 2022-2023	
	No. of cases admitted	% on all admissions in Medical Ward	No. of cases admitted	% on all admissions in Medical Ward
1 Malaria	649	30.31%	584	34.09%
2 Sepsis	238	11.12%	274	16.00%
3 Pneumonia	133	6.21%	114	6.65%
4 Poisoning	95	4.44%	27	1.58%
5 Hypertension	88	4.11%	93	5.43%
6 Acute Gastritis	86	4.02%	107	6.25%
7 Liver disease	68	3.18%	63	3.68%
8 Anaemia	55	2.57%	242	14.13%
9 PUD	53	2.48%	59	3.44%
10 UTI	53	2.48%	67	3.91%
Total Admission	2,141		1,713	

NCDs remain among the leading causes of mortality in medical ward majority of who are old cases with a few newly diagnosed. The main challenge is not keeping appointments despite having a weekly medical OPD clinic and thus presenting with complications. The reduction in the utilization indicators is also linked to the reduced malaria burden observed, compared to the year before. The Medical ward, is one of the wards where many patients escape. The management will be working closely with the team in the ward to address this problem

Table 6.27: Top 5 common causes of death in Medical ward in the last FY 2022-2023

Causes of Mortality in Medical Ward				
		No. of disease specific deaths	No. of cases admitted	Case Fatality Rate
1	Pneumonia	20	114	17.54%
2	Anaemia	19	242	7.85%
3	malaria	14	584	2.40%
4	Hypertension	12	93	12.90%
5	Liver disease	8	63	12.70%

Surgical Ward

The Surgical Ward is housed in one of the hospital's oldest facilities, but it was partially renovated in late 2022. However, a more extensive refurbishment is still required involving the structure as well as the furnishings (beds, lockers, mattresses, etc.) since they are in disrepair. This not only jeopardizes patient comfort but also has a significant impact on staff work and hygiene. The ward has 71 beds with both female and male sides, as well as a private wing though currently non-functional.

Staff composition

The overall number of employees was 17 as shown below. The Ward is led by a Surgeon and aided by a Medical Officer. The supervision of the operation theater falls under their purview as well. The MOH Internship program was maintained, with an average of four Intern doctors assigned to their surgical fields on a regular basis.

In collaboration with the Njokuti Foundation, the ward was also able to hold an orthopaedic surgery camp, where consultation and surgical operations were provided to the community at no cost.

Table 6.28: Staff composition in Surgical Ward in the FY 2022-2023

Cadre/ Discipline	Qualification	Number
Surgeon	Bachelor Degree in Medicine and Surgery and	2
	Master in Surgery	

Medical Officer	Bachelor Degree in Medicine and Surgery	1
Registered		
Midwife/Nurse	Diploma in Midwifery and Nursing	2
Enrolled		
Comprehensive Nurse	Certificate in Comprehensive Nursing	0
Enrolled Nurse	Certificate in Nursing	9
Nursing Aid	Trained on the job	0
Orthopedic Officer	Diploma in Orthopedic	1
Physiotherapy	Dip. In Physiotherapy	1
Total		17

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

	FY	FY	FY	FY
	2019-20	2020-21	2021-22	2022-23
No of beds	76	76	76	76
Total Admissions	1,925	1,521	1,584	1,577
Patients days	15,189	13,701	13,776	8,830
ALOS	7.89	9.01	8.70	5.60
Throughput per bed	25.33	20.01	20.84	20.75
BOR	54.75	49.39	49.66	31.83
No of Deaths	32	30	45	38
Mortality rate	1.7%	2.0%	2.8%	2.4%
Recovery rate	98.1%	97.0%	96.0%	96.3%
Self-discharges	4	15	18	20

As seen in the table above, there was a very slight drop in total admissions compared to the previous fiscal year, with a commensurate decrease in the BOR. Despite staying high in comparison to the national average of 4.5, the ALoS declined by 3.1. Given the nature of the services provided (surgical operations), it is the highest when compared to the other wards, which raises treatment costs.

Given the drop in total admission, the overall consumption of inpatient services in the surgical ward decreased. While some were referred, 96.3% of all admissions were successfully discharged home. Fractures had the highest case fatality rate, unlike last year which had septic wounds as the highest cause.

Table 6.30: Top 10 causes of admissions in Surgical Ward-FYs 2020-2021, 2021-2022 & 2022-2023

		FY 2020-2021		FY 2021-2022		FY 2022-2023	
Causes of Morbidity in Surgical Ward		No. of cases admitted	% on all admissions in Surgical Ward	No. of cases admitted	% on all admissions in Surgical Ward	No. of cases admitted	% on all admissions in Surgical Ward
1	Fracture	250	16.44%	209	13.19%	295	19.88%
2	Laceration	98	6.44%	198	12.50%	56	3.77%
3	Abscess	134	8.81%	113	7.13%	132	8.89%
4	Head injury	148	9.73%	104	6.57%	125	8.42%
5	Hernia	68	4.47%	89	5.62%	80	5.39%
6	Cellulitis	55	3.62%	58	3.66%	57	3.84%
7	Blunt abdominal trauma	41	2.70%	56	3.54%	48	3.23%
8	Intestinal Obstruction	61	4.01%	40	2.53%	16	1.08%
9	Septic wound	65	4.27%	33	2.08%	47	3.17%
10	Snake bite	20	1.31%	31	1.96%	21	1.42%

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

S/n	Top 5 Causes of Mortality among Inpatients	No of Disease specific deaths	Total No of cases of the disease admitted	Case Fatality Rate
1	Fracture	3	295	1.017
2	Wound	1	47	0.021
3	Head injury	1	125	0.008
4	Blunt abdominal trauma	1	48	0.021
5	Others	13	145	0.090

Surgical operation theatre

The operating theatre of the hospital is open seven (7) days a week, 24 hours a day. The structure was built in 2015 with a Japanese government grant. The unit has specified elective surgery days, but emergency procedures run 24 hours a day, seven days a week, with staff allocated to adequately cover the shifts.

The unit's staffing is as below, with no significant changes in the cadres, however there are now four anesthetic officers, just like last year. Retaining anesthetic staff is still an issue because none of the four are full-time employees of the hospital because wages do not adequately compete with what other institutions provide.

Table 6.32: Staff Composition in the operating theatre FY 2022-20223

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

Surgical Procedures

The overall number of procedures conducted in the hospital slightly decreased as the number of individuals seeking health care services decreased. In terms of major surgeries, Caesarean section leads the way, with the bulk of them being emergencies with only a few being elective. The high number of teenage pregnancies is ascribed to Caesarean sections. Overall, the number of surgical procedures decreased.

Table 6.33: Top major surgical procedures performed in the FY 2022-23

No.	Top major surgical procedures	Number of Patients	Proportion (%)
1	Caesarian sections	659	41.79%
2	Herniorrhaphy	86	5.45%
3	Orthopedic Surgery	127	8.05%
4	Laparotomy	71	4.50%
5	Plastic/ reconstructive surgery	18	1.14%
6	Other Major procedures	325	20.61%
Total		1235	

Table 6.34: Top minor surgical procedures done in FY 2022-23

No.	Top minor surgical procedures	Number of	
		Patients	Proportion (%)
1	Minor Orthopedic Surgery	626	39.70%
2	Incision and drainage of abscesses	298	18.90%
	Debridement and care of wounds and skin		
3	grafting	185	11.73%
4	Safe Male Circumcision	6	0.38%
5	Other Minor procedures	789	50.03%
	Total	1904	

Table 6.35: Trend of surgical activities in last 5 FYs

	FY 2018- 2019	FY 2019- 2020	FY 2020- 2021	FY 2021- 2022	FY 2022- 2023
Total Operations	3286	3139	1652	1901	1759
Major operations (including C/S)	1314	1235	963	989	1105
Minor operations	1,972	1904	689	912	654
Emergencies	585	620	704	765	104
Emergencies as % of total major operations	44.52%	50.20%	73.10%	77.35%	9.41%

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

Type of Anesthesia	FY 2018-19	FY 2019-20	FY 2020-2021	FY 2021- 2022	FY 2022-2023
Local Anesthesia	163	146	163	165	135
General Anaesthesia with IV					
Ketamine	645	933	731	749	708
Spinal Anesthesia	263	737	678	773	828
General Anesthesia with ETT	65	88	78	65	49

General Anesthesia with LMA	13	2	21	19
Regional Anaesthesia	1	0	12	0
Total	1136	1918	1652	1785

Paediatrics Ward

The ward has a capacity of 76 beds, distributed in the general ward which has an acute, subacute, private and a section for the stable children then Nutrition and Isolation sections.

The refurbishment of the ward both the structure and furniture with funding from CEI was completed.

The department has a number of projects running including the RBF and Sickle cell projects with support from the foundation and ISP respectively and all this is with the aim of improving quality services we are offering to the community. Towards late in the FY 22/23, the paediatrics got involved in a research project aimed at studying severe malaria in children.

Staff Composition

Since March 2022, the ward has been led by a pediatrician who also serves as the hospital's Medical Director. The daily ward operations, on the other hand, are overseen by a single MO who also controls activities in the NICU. Despite a few nurses leaving for various reasons, the nursing workforce remained stable. Throughout the year, the ward received assistance from a visiting Italian pediatrician volunteer and other resident volunteers.

Table 6.37: Personnel assigned to Paediatric Ward in FY 2022-23

Cadre/ Discipline	Qualification	Number
Paediatrician	M.MED	1
Medical officers	Bachelor Degree in Medicine and Surgery	1
Clinical Officer	Diploma in Clinical Medicine	1
Enrolled Midwife	Certificate in Midwifery	2
Registered Nurse	Diploma in Nursing	3
Nutritionist	Dip. In Human Diet and Nutrition	1
Enrolled Nurse	Certificate in Nursing	9
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	2
Nursing Assistant	Certificate in Nursing Assistant	3
Total		23

Key ward indicators

The total number of admissions in the pediatric ward reduced greatly. This was due to functionalization of the surrounding health centers in the district but also majority seek treatment from VHTs and even private clinics before coming to the hospital.

Despite a decline in overall malaria occurrences, malaria remains the major cause of admissions in the department, with pneumonia and sepsis coming in second and third, respectively. Both the BOR and the ALOS have decreased significantly, which enhances the quality of services provided.

Malnutrition is still a problem which is often linked to the surrounding community's high poverty and low literacy levels. Given the high incidence of teenage pregnancies and poor ANC attendance, prematurity was the major cause of NICU hospitalizations.

Table 6.38: Paediatric Ward indicators over the last 4 FYs

	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
No of beds	61	76	76	76
Total Admissions	7,615	4,437	4,398	3,819
Patients days	43,503	29,304	20,960	17,103
ALOS	5.71	6.60	4.77	4.48
Throughput per bed	124.84	58.38	57.87	50.25
BOR	195.39	105.64	75.56	61.65
No of Deaths	217	157	183	158
Mortality rate	2.85%	3.54%	4.16%	4.14%
Recovery rate	96.53%	94.79%	95.52%	95.78%
Self-discharges	47	74	14	3

Table 6.39: Top ten causes of admission in Paediatric Ward - FY 2021-22 and FY 2022-23

Causes of Morbidity	FY 2021-2022		FY 2022-2023	
	No. of cases admitted	% on all admissions	No. of cases admitted	% on all admissions
1 Malaria	2,183	56.8%	1,554	46.7%

2	Pneumonia	399	10.4%	418	12.6%
3	Diarrhoea	16	0.4%	250	7.5%
5	Sepsis	358	9.3%	228	6.9%
4	SCD	100	2.6%	202	6.1%
6	SAM	136	3.5%	101	3.0%
7	RTI	61	1.6%	82	2.5%
8	Anaemia	174	4.5%	66	2.0%
9	Bronchiolitis	48	1.2%	59	1.8%
10	UTI	18	0.5%	48	1.4%
		3,842		3,326	

Table 6.39b: Top ten causes of admission in NICU Ward - FY 2021-22 and FY 2022-23

Causes of Morbidity	FY 2021-2022		FY 2022-2023	
	No. of cases admitted	% on all admissions	No. of cases admitted	% on all admissions
1 Prematurity	196	39.76%	142	28.80%
2 Neonatal sepsis	128	25.96%	103	20.89%
3 Birth asphyxia	114	23.12%	70	14.20%
4 Respiratory Distress Syndrome	66	13.39%	89	18.05%
5 Pneumonia	19	3.85%	11	2.23%
6 Meconium Aspiration	16	3.25%	2	0.41%
7 Malaria	4	0.81%	4	0.81%
8 Neonatal Jaundice	4	0.81%	21	4.26%
9 Gastroschisis	3	0.61%	2	0.41%
10 Transient tachypnea of the new born	3	0.61%		0.00%
Total Admission	589		493	

Mortality causes

The highest cause of the mortality in the ward was malaria followed by pneumonia. SAM had the highest case fatality rate (7.9%). In addition to the large catchment area, the majority of those who died frequently presented late after seeking assistance from private clinics or medical facilities. As a result, they show up in critical condition, and there is a shortage of blood supplies for patients with severe anemia who require an immediate blood transfusion. Emergency blood services are in place to prevent some of these deaths, while some will

succumb as the process continues. Furthermore, because the hospital is a PNFP, it is an expensive undertaking, raising concerns about sustainability.

Given the current widespread, chronic shortage of blood products, anemia will continue to offer a significant problem in the care of severe anemia cases.

Respiratory distress Syndrome had the greatest case fatality rate among newborns, followed by prematurity, which is related with RDS, and then other prematurity problems.

The NICU's equipment is insufficient since the number of admissions can be overwhelming at times.

Table 6.40: Top five causes of death in Paediatric Ward in FY 2022-23

	Causes of Mortality	No of disease-specific deaths	No of cases of the disease admitted in Paediatric Ward	Case Fatality Rate
1	Malaria	24	1,554	1.5%
2	Pneumonia	8	418	1.9%
3	SAM	8	101	7.9%
4	SCD	7	202	3.5%
5	Sepsis	6	228	2.6%

Table 6.40b: Top five causes of death in NICU in FY 2022-23

	Causes of Mortality (NICU)	No of disease-specific deaths	No of cases of the disease admitted in NICU	Case Fatality Rate
1	Prematurity	33	142	23.24%
2	Birth asphyxia	8	70	11.43%
3	Respiratory Distress Syndrome	21	89	23.60%
4	Neonatal Jaundice	6	21	28.57%
5	Neonatal sepsis	9	103	8.74%

Maternity Ward



The maternity unit is the hospital's largest ward, with 75 beds. In the pre-delivery section, there is an admission room, a first stage room, a PET room, and a labor suite. The IPD field includes postnatal, post-Caesarian, and gynecology. The ward layout includes a doctors' office, nurse in charge office, duty room, private rooms, and isolation unit.

One obstetrician and a medical officer are assisted by intern doctors who visit the ward every six months for their surgical rotations, with obstetrics and gynecology as their minor rotation because the clinic did not have a specialist by then. The nursing and midwifery team is as given in the table below, and this team is directly in charge of managing the care of all admitted patients in this unit.

Given that St. Mary's Midwifery students use maternity as their primary practical training ward, they also provide training and supervision to students.

Due to the conclusion of World Bank-funded MOH RBF initiative, which strengthened the URMCHIP intervention; there has been a challenge with maternal and under 5 referral ambulance services that were provided at no cost to the patients, this led to poor pregnancy outcomes.

Table 6.41: Staff Composition in Maternity Ward in FY 2021-22

Cadre/ Discipline	Qualification	Number
Gynecologist	M.MED Obys & Gyn	1
Medical officer	Bachelor Degree in Medicine and Surgery	1
Clinical Officer	Dip. In Clinical Mentoring/Nursing/Midwifery	1
Registered Midwife/Nurse	Diploma in Midwifery and Nursing	1
Registered Midwife	Diploma in Midwifery	4
Enrolled Midwife	Certificate in Midwifery	25
Nursing Aide	Primary Leaving Examination (P.L.E)	2
Total		35

Key Indicators

Overall admissions dropped by 9.6% over the previous year with an increase in the ALOS to 4.0 from 3.8 the previous year. The BOR dropped to 61.11, indicating that the facility can manage variations in health service demand while maintaining effective patient flow.

The rate of maternal deaths increased from 0.11% to 0.17% higher than the previous year as a result of increased referrals of very sick mothers. Regular audits of maternal and neonatal fatalities assist the team in identifying missed chances in order to avoid similar occurrences.

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

	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
No. of beds	75	75	75	75	75
Total Admissions	6,165	4,226	4,144	4,595	4,154
Bed days	20,984	16,519	17,441	17,522	16,728
ALoS	3.4	3.9	4.2	3.8	4.0
BOR	76.65	60.34	63.71	64.01	61.11
Throughput	82.2	56.35	55.25	61.27	55.39
Turnover interval	1.04	2.57	2.40	2.14	2.56
No. Deaths	7	4	11	5	7
Death Rate	0.11%	0.09%	0.27%	0.11%	0.17%
Recovery Rate	99.9%	99.9%	99.2%	98.7%	99.4%
Self-discharges	0	0	24	55	18

Birth indicators

The total hospital deliveries dropped slightly from the previous year to 2659 deliveries this FY 22/23. Of these 73% were normal deliveries. 27% of the total deliveries were by cesarean section which is higher than the previous year (25%). There were 2% neonatal deaths of the total deliveries in the facility.

Stillbirths accounted for 2.6% of deliveries, with 64.3% of these being macerated stillbirths, and are still attributable to low ANC attendance, with the majority of expecting mothers beginning ANC visits after the first trimester. This is still accompanied by late referrals from LLUs, and this will worsen with the end of the free ambulance services that came with the RBF initiative, allowing for the rapid transfer of women from LLUs.

Premature births clearly maintained a significant burden, as evidenced by NICU hospitalizations. Premature births were connected to diseases such as malaria and UTI, hard labor by mothers, and a rise in the incidence of teenage pregnancies.

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

	FY	FY	FY	FY	FY
	2018-19	2019-20	2020-21	2021-22	2022-23
Total deliveries	4,169	2,707	2,576	2,899	2,659
Normal deliveries in unit	3,617	2,187	2,576	2,200	1,941
Abnormal deliveries (incl. C/S)	529	552	647	693	718
Live birth in units	4,142	2,654	2,486	2,886	2,622
Babies born with low birth weight	732	517	504	175	361
Fresh Still births in unit	24	23	30	33	25
Macerated still births in unit	35	46	31	35	45
New-born deaths (0-7 days)	69	59	55	75	55
Maternal Deaths	9	5	10	5	6
Live Births					
Full term normal weight	3,384	2,084	1,694	2,124	2,169
Full term low birth weight	601	451	357	437	33
Premature cases	157	223	435	325	490
Caesarean Sections					
Elective C/S	30	33	5	18	28
Emergency C/S	579	519	642	675	631
Caesarean Sections total	609	552	647	693	659
C/S as % of total deliveries	14.61%	20.39%	25.12%	23.90%	24.78%
Emergency C/S as % of all C/S	95.07%	94.02%	99.23%	97.40%	95.75%

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

Within the Catchment Area of Agago District (distances of 2 km to < 58 km)

Sub-County	FY	FY	FY	FY	FY
	2018-19	2019-20	2020-21	2021-22	2022-23
Adilang	46	37	41	59	64
Kotomor	35	25	20	17	25
Patongo	58	53	63	86	62
Patongo T.C.					
Lukole	68	51	72	79	76
Lukole T.C.					

Kalongo T.C.	69	69	52	47	49
Paimol	53	50	27	30	44
Parabongo	40	40	40	42	44
Omot	38	26	28	14	11
Acholpii	25	21	13	13	13
Lamiyo	37	29	8	11	10
Lapono	39	41	51	69	64
Lira Palwo	35	35	114	54	59
Omiya Pacwa	41	33	13	20	22
Wol	25	27	37	55	60
Total	609	537	579	596	603

Table 6.45 Continuation

Outside the Catchment Area of Agago District (distances of 58 km and above)					
District	FY	FY	FY	FY	FY
	2018-19	2019-20	2020-21	2021-22	2022-23
Pader	10	8	42	48	33
Kitgum	1	2	4	6	7
Abim	0	5	16	18	5
Other	0	0	6	25	11
Total	11	15	68	97	56

Patient referrals continue to be one of the district's most difficult tasks. The poor condition of the roads, the lack of operating ambulances, the majority of households' poverty level, combined with the hospital's large catchment area, pose a chronic hazard to pregnant mothers. The hospital still has a waiting shelter where high-risk mothers stay until their due date.

Gynecology Ward

The availability of professional obstetrics and gynaecological care has made gynaecological services easier to provide. Because the hospital is located in a rural area, finding and retaining

such cadres has proven problematic but strategies are being put in place to retain those who come.

The Gynaecologist and medical officer, who also ran the weekly gynaecologic clinics in OPD every Monday, treated all gynaecological diseases, and those that proved difficult were frequently referred for other care.

The most common reason for admission was abortion, the majority of which were spontaneous abortions, followed by malaria in pregnancy and other pregnancy-related problems.

Table 6.46: Admissions in Maternity Ward not related to maternity conditions

Diagnosis of admission	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Pelvic Inflammatory Disease	52	4	30	7	41
Urinary Tract Infection	0	108	4	126	2
Cancer of cervix	13	1	0	0	23
Uterine Fibroid	3	8	7	3	14
Ovarian Cyst	32	23	3	5	9
Vaginal Candidiasis	0	4	1	7	0
Bartolini's Cyst	0	3	0	0	1
Peritonitis	0	1	2	0	0
Other Gyn conditions	143	117	43	42	60
Total	243	269	90	190	150

TB ward

The TB ward is attached to the main building of the Medical Ward, and its activities are likewise overseen by the medical ward team. Despite the fact that tuberculosis is a major public concern in the Agago district, overall admissions increased slightly by 7% compared to last year, which could be attributable to increased efforts by Implementing partners to strengthen Tb activities in the region. The TB cast campaign was carried out in collaboration with the district, and screening for TB in the community was carried out, revealing the unmet screening demand. Following this discovery, the cast campaign will be repeated twice next year, with screening at all access points tightened. As a result, we anticipate an increase in case detection rate next year.

Given the increased number of bacteriologically proven TB patients and early treatment, ALOS and BOR both decreased by 6.1 and 12.94%, respectively. The death rate decreased

considerably, primarily among HIV co-infected persons who also had improved ART adherence, resulting in better management of advanced HIV illness. High default rates continue to be a problem, despite efforts to follow up on clients in the community, which are insufficient.

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

	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
No. of beds	18	18	18	18	18
Total Admissions	194	329	267	195	210
Bed days	2,126	2,001	1,240	2090	1812
ALoS	5.8	6.08	4.6	10.7	8.6
BOR	32.36	30.46	18.87	31.81	27.58
Throughput	10.8	18.3	14.83	10.83	11.67
Turnover interval	22.9	13.9	20.0	23.0	22.7
Deaths	11	7	5	9	9
Death Rate	5.67%	2.13%	1.87%	4.62%	4.29%
Recovery Rate	94.33%	97.87%	98.13%	95.38%	95.71%
Self-discharges	0	0	0	0	0

Diagnostic services

The hospital laboratory is a HUB system that delivers services to ten (10) lower-level facilities in the Agago and Pader districts. The hub's activities performed successfully throughout the fiscal year. Providing laboratory testing services to all samples of HIV positive individuals collected from LLUs, organizing hub coordination meetings, managing all level laboratories, sending samples for tests that could not be performed to the Central Public Health Laboratory, and keeping the district up to date on all Laboratory activities.

Table 0-2Table 6.47: Trend of laboratory testing workload in the last 5 FYs

	Type of Tests	FY 2018- 19	FY 2019-20	FY 2020- 21	FY 2021- 22	FY 2022- 23
Parasitology	Malaria Microscopy, Malaria RDTs, Other	23,793	28,676	17,513	24,446	

	Haemoparasites, Stool Microscopy.					24,703
Haematology	HB, WBC Total, WBC Differential, Film Comment, ESR, RBC, Bleeding time, Prothrombine time, clotting time, blood transfusion tests, & Others	23,156	28,456	20,989	27,055	23,641
Biochemistry	Urea, Calcium, Potassium, Sodium, Creatinine, ALT, AST, Albumin, Total protein, Triglycerides, Cholesterol, CK,LDH, AlkalinePhos, Amylase, Glucose, Uric Acid, Lactate, Others	2,069	2,504	1,243	1,851	2,817
Bacteriology	ZN for AFBs, Cultures and Sensitivities, Gram, Indian Ink, Wet Preps, Urine Microscopy	6,633	15,327	15,619	12,569	9,547
Serology	VDRL IRPR, TPHA, Shigella Dysentery, Syphilis Screening, Hepatitis B, Brucella, Pregnancy Test, Vidal Test, Rheumatoid Factor	12,845	9,989	7,174	9,981	11,526
Immunology	CD4 tests & others	2,722	4,847	3,554	2,684	1,931
HIV tests by purpose	HCT, PMTCT, Quality control and clinical diagnosis	22,762	20,691	14,414	14,212	14,408
	Total tests	92,141	110,490	80,506	92,798	88,573
	Total lab staffs	10	10	10	10	10
	Average tests per Lab staff	9,214.1	11,049.0	8,051.0	9,279.8	8857.3

In the laboratory, the total number of tests performed per employee decreased by 4.5% over the year compared to the previous year, although the number of staff remained unchanged. There was almost an unchanged figure in malaria cases reported by the laboratory.

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

Type of Test	FY 2021-2022			FY 2022-2023		
	Total	Positive	% Positive	Total	Positive	% Positive
Malaria (both slide and RDT)	24,246	8,501	35.06%	24,402	8,168	33.47%
VDRL/RPR	4,816	460	9.55%	4,895	573	11.70%
Hepatitis B	3,092	289	9.35%	2,205	202	9.16%
Brucella	12	0	0.00%	225	11	4.89%

The hospital receives blood from the Gulu Regional Blood Bank. Numerous factors, including insufficient stock at the blood bank, road difficulties during wet seasons, and large distances, significantly limit the constant flow and availability of blood products.

The overall blood shortage in the area has continued, resulting in severe anemia, particularly in children under the age of five. In order to save lives in emergency situations, the hospital has occasionally had to accept local blood donations from qualified attendants and volunteers after passing the requisite screening tests, which has raised the laboratory's operational costs.

RH+ blood products for blood groups O and A are still the most commonly used, as seen in the table below. Because it is difficult to obtain RH- donors, the demand for RH- increased in FY 22/23, providing a considerable challenge. Demand for specialized blood products such as platelet concentrates and fresh frozen plasma continues to be an issue that is difficult to resolve because the regional bank regional bank does not supply these blood products.

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

FY 2021-2022						FY 2022-2023					
Group	Group	Group	Group	RH	RH	Group	Group	Group	Group	RH	RH
A	B	AB	O	+	-	A	B	AB	O	+	-
32.70%	16.52%	4.56%	44.40%	98.18%	1.82%	34.06%	15.90%	4.47%	45.57%	99.01%	0.99%

IMAGING SERVICES

X ray and Ultrasonography

Following the recruitment of a part-time radiographer, the department is managed by one medical imaging technologist, one sonographer and a dark room attendant. Some of the Mos with background knowledge and skill in providing the ultrasound services performed emergency ultrasound scans.

Maintaining core staff, such as radiographers, remains an issue, disrupting important medical services; however, the hospital discovered a method of temporarily filling this gap by sending one of its employees to a short course and returned recently.

The overall number of X-rays performed was higher than the previous year, with chest x-rays being the most commonly performed, with the most common indications being trauma, as well as r/o related consequences of respiratory infections and as a screening test for tuberculosis infection. The hospital is currently using a digital X-ray system, and images are digitally relayed to clinicians for quick review. Given the high cost of digital cassettes, providing patients with a printed copy has proven challenging.

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

	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23
Chest	1,459	2,009	1,849	1,461	1,556
Upper extremities	997	877	1,013	714	885
Lower extremities	710	735	821	676	716
Vertebral column	283	335	291	323	359
Skull and mandible	158	150	137	235	282
Shoulder and clavicle	139	178	0	152	125
Pelvis and hip	153	176	81	176	169
Abdominal – plain	155	203	198	143	179
Abdominal -contrast	2	0	0	0	0

Screening	0	5	0	0	0
Total	4,056	4,668	4,390	3,880	4,271

Table 6.51: Ultrasound examinations conducted in the last 3 FYs

	FY 2020-21	FY 2021-22	FY 2022-2023
Obstetrics	0	176	807
Gynaecology	0	281	214
Abdomen	0	238	942
Others	0	43	144
Total	0	738	2,107

PHARMACY ACTIVITIES

The Unit Dose System (UDS) for drug management at the hospital has remained operational, with significant improvements in its implementation and performance. All of the Wards contain emergency drugs in specifically made boxes that are routinely inspected by pharmacy dispensers.

Routine MTC trainings organized by MOH and UPMB were attended by three hospital staff members, including the pharmacist. Efforts were underway and complete functionalization of the hospital's existing MTC was achieved. This group was in charge of ensuring that drugs are used efficiently and cost-effectively in the hospital.

Table 6.52: Staff composition in Pharmacy and General Store in the FY2022-2023

Cadre/ Discipline	Qualification	Number
Pharmacist	Bsc.in Pharmacy	1
Pharmacy Technician	Diploma in Pharmacy	3
Pharmacy Assistant	Certificate in Medical Pharmacy	3
Nursing Aide	Trained on the Job	2
Store Assistant	Diploma in Store Management	0
Store Attendant	Trained on the Job	2
Total		11

STORAGE

Drugs are stored on shelves, with the heavier ones placed on floor pallets: tablets and capsules are kept on the same shelves, whereas parenteral, oral liquids, and topical creams and liquids are kept on separate shelves. To reduce losses owing to expiry, the FEFO (first expiry, first out) principle is used. Cold storage items are maintained in the refrigerator, and the temperature is checked daily to ensure it is within the desired range of 2°C to 8°C.

The readings for the room are taken three times daily because of temperature changes during the day. At the end of the month, an average value is calculated. The temperature frequently reaches beyond 30°C in the afternoon, posing numerous risks and problems to the safe storage of pharmaceuticals. It is obvious that the pharmacy requires the installation of air conditioners in order to maintain the correct temperature even during the dry seasons.

Table 6.53: Average temperature and humidity recorded in Pharmacy Department FY2022-23

Reading Time	Temperature	Humidity
8:15 am	25.4	58%
12.00 pm	28.8	60%
5.00 pm	27.6	64%

Pharmaceutical supplies

As in previous years, supplies are generally ordered through Joint Medical Stores (JMS). The open market or Abacus are used to buy items that JMS does not stock. JMS also supplies the HIV Clinic's primary antiretroviral drug and TB commodities, while some commodities, such as isoniazid, are occasionally out of stock. However, mechanisms for monitoring stock levels are in place to handle such difficulties before they occur.

Procurement system

Drugs and other items are often purchased every three months. However, due to financial constraints, it has become necessary to adopt a more fragmented structure to fulfill the Wards' urgent requirements.

At the store level, where procurement begins, orders are placed and buffer stock levels are tracked. Orders are expected at least a month before the buffer stock is expected to be depleted. The Drug and Therapeutic Committee reviews orders before they are submitted to the procurement department for implementation.

Certain goods were frequently in low supply at the hospital. Specifically, neither the country nor its suppliers have access to such commodities.

Inventory management

A manual and digital inventory system aids in the management of purchases and stock movements. Physical counts are made every month to ensure accountability, and stock takes are performed every two years. Management also permitted spontaneous stock inventories in order to efficiently monitor real-time status.

Distribution and use

The Pharmacy delivers drugs to the various wards and departments after implementing a Unit dose system. Medication is distributed following a prescription, resulting in less medication being wasted.

Table 6.54: Most used drugs (excluded HIV/AIDS clinic) - FY 2021-2022 and FY 2022-2023

Drug description	FY		FY	
	2021-2022		2022-2023	
	Quantity issued tablets/vial	Monetary value (UGX)	Quantity issued tablets/vial	Monetary value (UGX)
Paracetamol 500mg	206,174	4,973,382.87	238,494	5,485,362.00
Amoxicillin 250mg	137,118	9,648,001.66	117,497	8,812,275.00
Metronidazole 200mg	127,377	3,706,786.12	129,256	3,748,424.00
Folic acid 5mg	122,736	1,945,159.85	119,480	1,792,200.00
Folic acid + Ferrous Sulphate	58,748	2,321,316.40	34,796	1,217,860.00
Ferrous sulphate 200mg	53,309	1,523,126.49	25,437	686,799.00
Cloxacillin 250mg	37,198	3,856,191.43	34,796	2,609,700.00
Ampicillin 500mg	26,383	28,443,885.20	25,437	29,099,928.00
Carbamazepine 200mg	43,514	4,152,681.04	47,375	3,363,625.00
Ibuprofen 200mg	59,182	2,608,232.53	38,014	1,672,616.00
Vitamin B complex	60,202	680,227.63	63,752	828,776.00
Ampicillin/cloxacillin 500mg	22,349	3,086,444.67	15,795	2,542,995.00
Prednisolone 5mg	30,968	914,950.89	32,670	1,045,440.00
Omeprazole 20mg	34,300	1,763,917.57	28,693	1,262,492.00

Ciprofloxacin 500mg	27,394	3,235,953.92	22,325	3,125,500.00
Frusemide 40mg	33,440	995,325.32	31,061	1,025,013.00
Erythromycin 250mg	55,053	6,964,628.51	61,900	7,428,000.00
Benzympenicillin 1MU	17,463	15,800,898.41	6,216	5,109,552.00
Penicillin V 250mg	15,804	1,231,572.36	18,894	1,454,838.00
Metronidazole 5mg/ml 100ml	5,124	5,347,854.24	7,831	9,600,806.00
Total		103,200,537.11		91,912,201.00

Intravenous fluid consumption

This year, the consumption of intravenous fluids grew by more than 16 million Ugandan shillings in terms of hospital costs, which might be linked to an increase in the number of very sick patients attending services at the facility.

Table 6.55: Consumption of IV fluids in FY 2021-2022 & FY 2022-2023

FLUID DESCRIPTION	QUANTITY (IN BOTTLES) 2021-22	VALUE(UGX) FOR 2021-22	QUANTITY (IN BOTTLES) 2022-23	VALUE(UGX) FOR 2022-23
WATER FOR INJECTION 10 ML	40,511	4,882,608.48	50,661	6,256,633.00
SODIUM CHLORIDE 0.9% IV 500 ML	11,041	16,826,917.71	15,404	25,621,935.00
DEXTROSE 5% IV 500 ML	6,514	9,791,213.64	5,643	8,536,673.00
DEXTROSE 5% IV 250 ML	0	0.00	0	0.00
SODIUM LACTATE COMPOUND IV 500 ML	8,153	12,350,760.18	10,145	15,832,692.00
DEXTROSE 50% IV 100 ML	798	2,128,620.36	2,437	6,494,093.00
GELATINE/POLYGELINE SOLUTION 3.5% IV 500 ML	0	0.00	0	0.00
DARROW'S HALF STRENGTH 500 ML	435	1,032,575.67	398	880,519.00
TOTAL		47,012,696.04		63,622,545.00

CHAPTER SEVEN: SUPPORT SERVICES

Pastoral care

Pastoral care is the practice by which a pastor cares for the emotional, physical, and spiritual needs of their congregation. A vital component of the comprehensive care plan offered to patients is pastoral care. The services were continued for personnel to provide both emotional and spiritual support. The ability of the pastoral team to sit with a patient and their family and explore the complex emotions felt, from frustration to fear, guilt to grief and all possible expressions of love, is crucial. These services are provided by volunteers on behalf of the Kalongo Catholic deaconry. A social worker, a catechist, and a priest make up the team. During the year, 381 patients accessed pastoral care services, a decrease by 5%.

Table 7.1: Activities trend in clinical pastoral care of the sick during the last 5 FYs

Activity / Indicator	FY 2018- 2019	FY 2019- 2020	FY 2020- 21	FY 2021- 22	FY 2022- 23
No. patients visited and counselled	454	161	116	396	376
No. of patients given sacrament of Marriage	0	0	0	2	0
No. of patients anointed	7	9	1	4	5
Total	461	170	117	402	381

Ambulance services

Ambulance services were made available to patients throughout the district and beyond. Response times are affected or delayed in numerous regions of the district during the rainy season due to bad road conditions. Ambulance maintenance is still a major issue due to frequent failures caused by bad roads.

The current ambulances are extremely old and prone to breakdowns. As a result, the hospital is in desperate need of a new full-fledged ambulance and is continuing to beg for any assistance in this regard.

Technical services

The hospital's Technical and Maintenance Department (TD) is in charge of ensuring that all buildings and machinery, including hospital and school vehicles, are periodically maintained. It also provides technical support and monitoring. Larger construction projects and remarkable renovations are contracted out. To help maintain the hospital's long-term existence, the TD also engages in a few minor income-generating projects. Financial constraints significantly limited the TD's ability to undertake its obligations, and hence it was unable to complete them. The revenue generation operations of the department will be updated in the following year. The TD is responsible for monitoring and controlling fuel usage in the hospital, which is overseen by the Administrator. The consumption of diesel dropped 17.6% from the previous year while that of petrol increased by 29.9%. Just like in the previous year, the generator was the biggest user of diesel due to the unstable power in the district. Petrol usage increased due to motor bike use to reduce on the usage of the vehicles that are expensive to repair and maintain.

In the fiscal year 22/23, both petrol and diesel usage are illustrated in the table below.

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

	FY	FY	FY	FY	FY
	2018-19	2019-20	2020-21	2021-22	2022-23
DIESEL TOTAL	87,648.6	55,835	58,598	48,499	39,965
Board of Governors Fuel Refund to members	350	180	265	270	0
Generators	38,182.8	29,946	39,133	29,040	20,869
Vehicles	42,599.7	19,133	18,462	18,460	17,007
Workshop	25	24	20	0	0
Incinerator	2004	655	618	624	624
Others	4,487.10	5,897	100	105	1,465
PETROL TOTAL	6,917	3,179.5	2,978.0	2,630.0	3,751.5
Administration	315	57	25	0	8
Donation	0	70	0	50	30
Generators	29	0	0	0	25
Vehicles	12.5	0	0	0	50
Motorcycles	6,509.5	2,969.5	2,885.0	2,507.0	3,538.0

Workshop	32	20	68	63	50.5
Others (Sales)	19	63	0	10	50
KEROSENE TOTAL	0	0	0	0	0
Workshop	0	0	0	0	0
Pharmacy	0	0	0	0	0
Main store	0	0	0	0	0
Others	0	0	0	0	0

DOMESTIC SERVICES

Water Supply

Three wells supply the hospital's water supply, as well as the School, the Comboni Fathers, and the Convent of the Little Sisters of Mary Immaculate. The hospital is around 1,300 meters away from the wells. The water is pumped into two big tanks with a total capacity of 90,000 liters. Each building has a variety of reserve tanks of varying sizes. Pumps regularly fail and necessitate costly replacements, which are usually not fully covered by the hospitals' budget due to the extraordinarily heavy workload required to meet this high demand.

The existing wells run dry throughout the dry seasons, resulting in severe water shortages. To alleviate the immense strain on the hospital, surrounding institutions are increasingly required to supplement their water needs from the national water supply line.

Power Supply

The hospital is powered by the national electrical grid. Because this supply connection is problematic, the institution has frequently had to rely on backup generators for power. All hospital employees receive discounted electricity on the hospital grounds.

A working photovoltaic (PV) system would significantly reduce this cost. The hospital has tried, and continues to try, to advocate for projects that would deploy such energy-efficient solar systems.

Sewage system

The drainage system serves the entire hospital, St. Mary's Midwifery Training School, staff residences, the local parish, and convents. A lagoon around 600 meters from the hospital is utilized to dispose of all sewage.

The sewage system has been operational since its renovation in 2014. The most challenging challenge is routine upkeep as a result of recurrent vandalism by some community members. To prevent encroachment, the fence containing the sewage lagoon system must be rebuilt.

Waste disposal

The institution continues to generate massive amounts of waste material, both medical and non-medical. Because the incinerator's support crew lacks adequate training in medical waste management, efficient waste segregation and management remains a serious challenge. The infection prevention and control committee has begun a training program to boost local knowledge of proper waste segregation. They also want to investigate possibilities for recycling some of the household waste created.

CHAPTER EIGHT: QUALITY OF CARE AND PATIENTS' SAFETY

Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes.

Quality indicators:

The hospital was allowed to undertake reviews and other quality improvement activities. The quality improvement team was fully involved and participated in a few projects to improve hospital quality during the fiscal year. The following is a summary of the key criteria used to evaluate output quality.

The percentage of clinically qualified workers at the hospital has increased. Because the hospital does not provide particularly competitive compensation packages, maintaining these cadres has been the most difficult challenge.

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

Indicators	FY 2018- 19	FY 2019- 20	FY 2020- 21	FY 2021- 22	FY 2022-23
Total No. of employees	251	252	232	251	262
Qualified staff[1]	196	183	184	189	199
Clinical qualified staff[2]	138	138	127	144	153
Total Clinical staff[3]	153	155	141	159	168
Proportion of clinical qualified staff over all qualified staff	70.41%	75.41%	69.02%	76.19%	75.95%
Proportion of clinical qualified staff over all clinical staff	90.20%	89.03%	90.07%	90.57%	91.07%
Proportion of clinical qualified staff over the total hospital staff	54.98%	54.76%	54.74%	57.37%	58.39%

Quality of care

The total recovery rate after discharge decreased by 3.6%. The maternal mortality rate grew by 0.03 percent. Maternal deaths were mostly caused by delayed referrals and hypertensive crises during pregnancy, as they were the previous year. To counteract this, significant interventions have been developed and are now being implemented.

The number of premature births has increased. Despite a high teen pregnancy rate, the district as a whole has a high rate of preterm deliveries. In FY 22/23, the NICU received significantly higher referrals of premature neonates from LLUs. The efficacy of referrals and interventions is strongly dependent on when they are made. Early neonatal death rates and caesarean infection rates dropped significantly.

Table 8.2: Indicators for the quality and safety measures

Indicators	FY 2018- 19	FY 2019- 20	FY 2020- 21	FY 2021- 22	FY 2022- 23	Explanation
Recovery rate on discharge	97.09%	99.64%	94.83%	99.20%	95.60%	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	0.15%	0.02%	0.26%	0.11%	0.14%	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	0.58%	0.85%	1.21%	1.14%	0.94%	Fresh still birth rate: Fresh Still births have intact, smooth and not macerated skin,
Caesarean sections infection rate	0.82%	1.27%	2.78%	2.02%	0.46%	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	1.22%	2.18%	2.21%	2.59%	2.07%	Early neonatal death rate. Number of babies who die within the 7th day of life, divided by the total number of deliveries in the hospital in that year, expressed in percentage.
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In an annual survey of 100 randomly selected patients from the hospital, using standardized tools designed by the UCMB (and adopted by MOH), patients' perception of the clinical outcome they experienced increased by 37%, while the humanity of the care they received decreased from the previous year. Because to a slightly improved waiting times and reduced drug shortages, patients' perceptions of clinical outcomes have improved. Despite the limitations, we encourage our team to take a client-centered approach to treatment.

The biggest issue, as it was last year, was the significant increase in patient waiting times. Despite difficult-to-change issues such as turnaround time for tests required by doctors, our quality improvement team did a root cause analysis and set guidelines to address the problems. In 22/23, overall patient assessment of hospital quality of care increased.

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

Financial Year	FY	FY	FY	FY	FY
	2018-19	2019-20	2020-21	2021-22	2022-23
Clinical outcomes	64%	90%	94%	56%	93%
Humanity of care	92%	88%	91%	91%	75%
Organization of the care / waiting time (OPD)	46%	71%	58%	74%	79%
The healthcare environment	98%	88%	80%	96%	73%
Overall score	86%	81%	83%	79%	80%

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

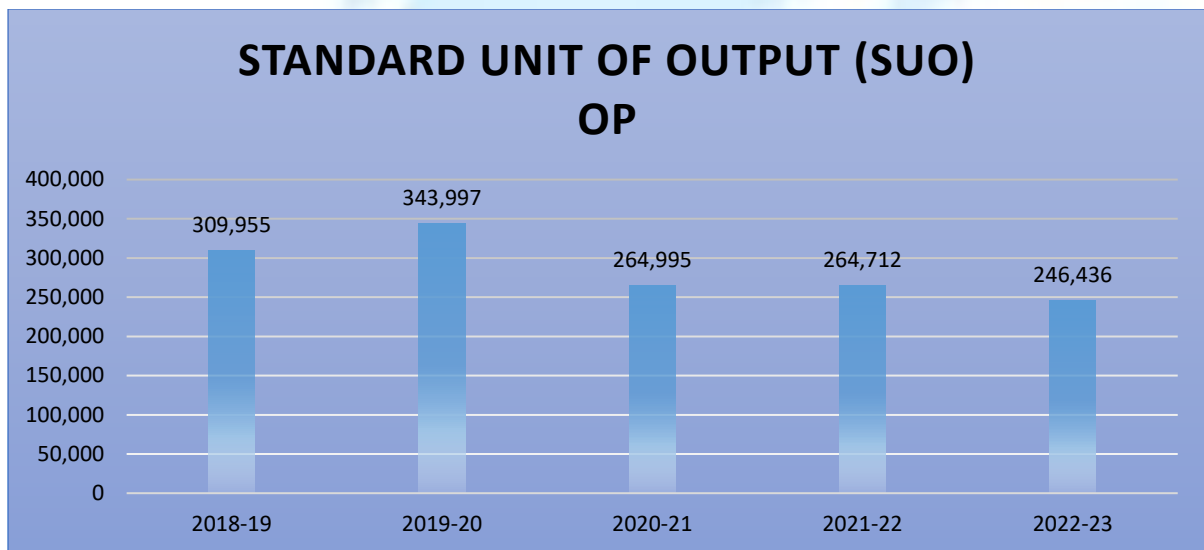
1 SUOop = 1*Outpatients contacts + 15*Inpatients + 5*Deliveries + 0.2*Immunizations in children + 0.5*(ANC+Post Natal Attendance + FamilyPlanning clients) + 20*Major Sugery

FAITHFULNESS TO THE MISSION

Access

The SUOop declined slightly from FY 21/22. OPD utilization improved during the year. Inpatient admission reduced, as well as ANC attendances. Overall, the hospital has remained accessible.

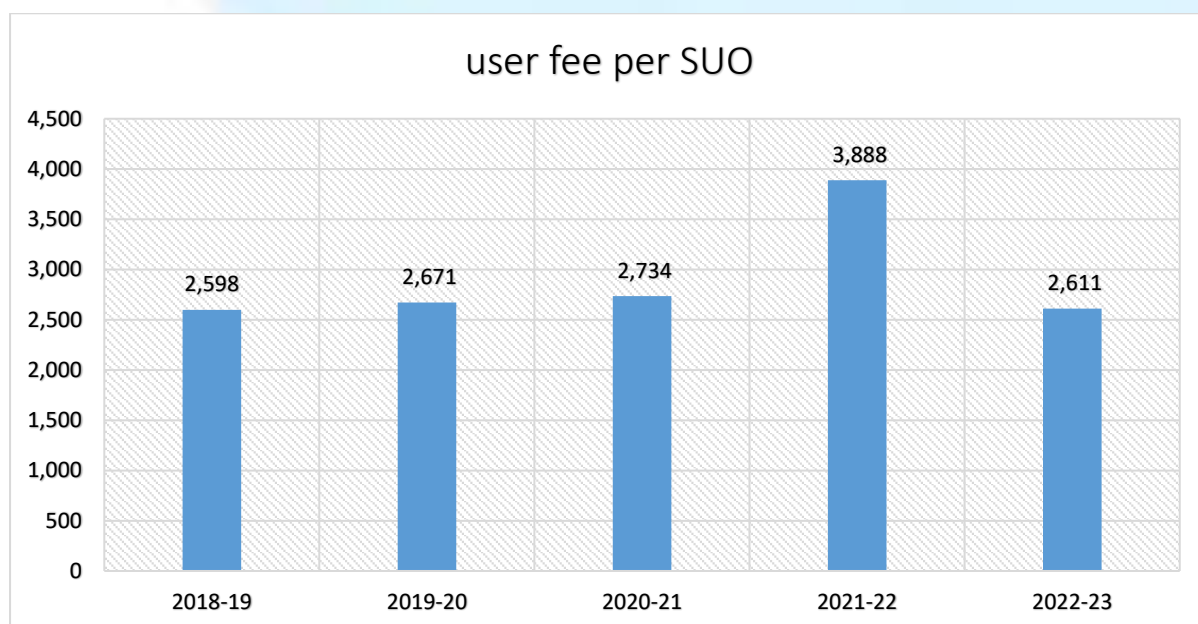
Figure 8.1: Trend of SUOop (do more people come?)



Equity

The average user fee per SUO declined. The user fees at the hospitals are among the lowest in the UCMB network. Revenue collection efficiency has improved; however, this does not compensate for rising operational costs. As a result, the average user fee per SUO decreased.

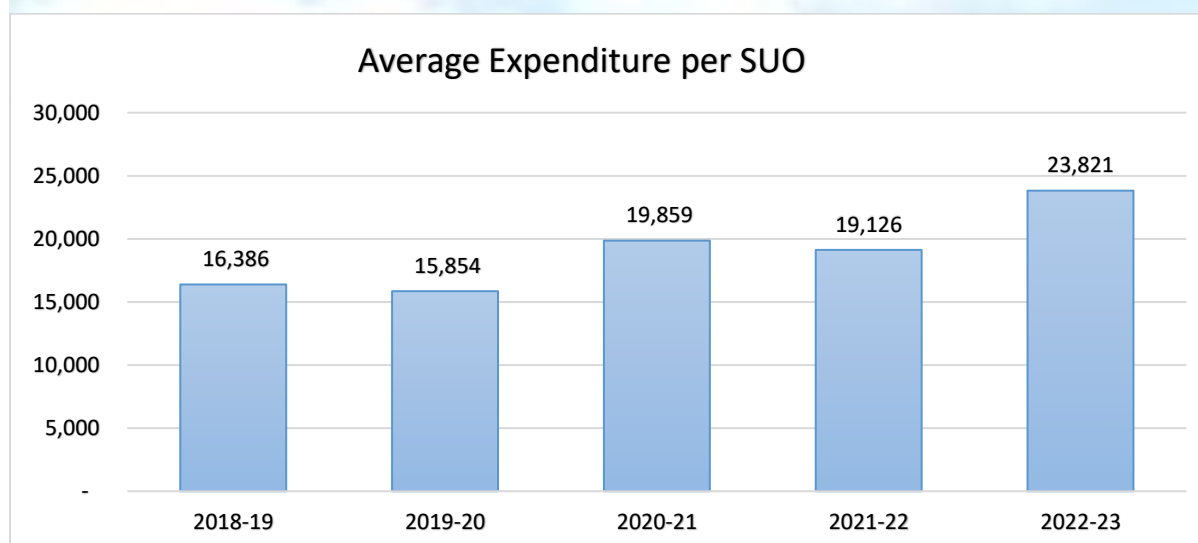
Figure 8.2: Trend of Average Fees per SUO (do people, on average, pay more or less?)



Efficiency

The hospital's financial efficiency declined slightly. In comparison to the previous year, we used somewhat more to make one SUO. Even with marginally improved efficiency, waste remains a concern, although overall market trends for all consumables, both medical and non-medical, have improved. Efficiency decreased in 22/23.

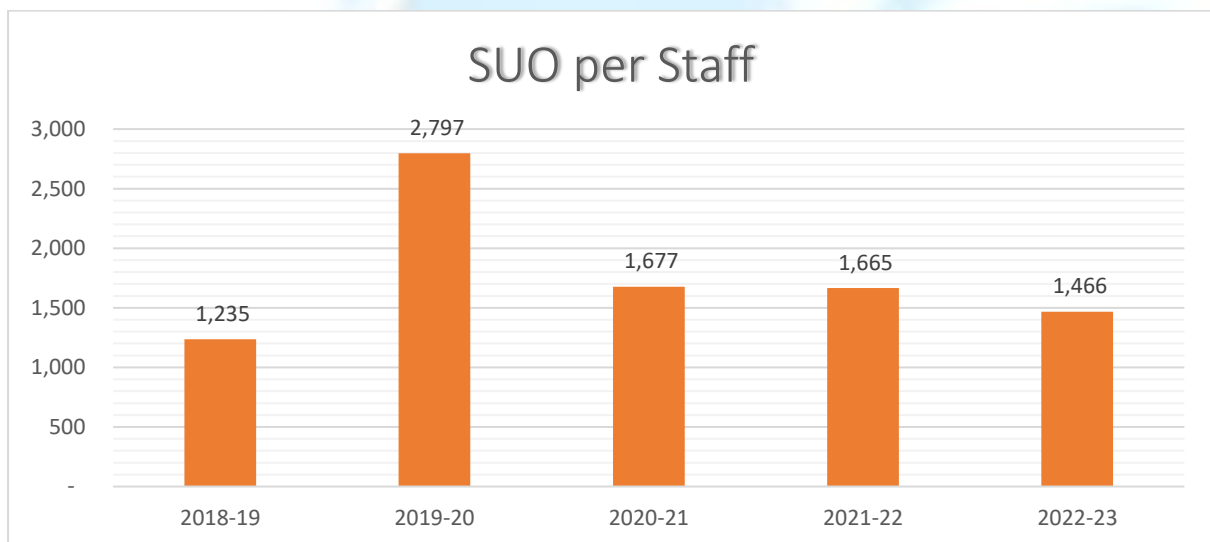
Figure 8.3: Trend of Average Expenditure per SUO (do we spend more or less to produce our services?)



Productivity

Our staff's output declined as compared to the previous years with the same resources. Despite the fall of the pandemic and an increase in service demand, the number of personnel remained the same. We'll maintain engaging our employees realistically in order to get the most out of them.

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



Dr. Ambrosoli Memorial Hospital includes St. Mary's Midwifery Training School. Fr. Dr. Giuseppe Ambrosoli established the school as an enrolled midwifery school in 1959. The school provides specialized midwifery training courses such as;

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

Human resources management and development

The training school is still having a difficult time hiring qualified teachers. Because of the school's isolated location, staff attrition is a serious concern. Hospital staff are still hired part-time by the school to assist in teaching subjects related to their field of employment.

Table 9.1: School staff and support staff establishment FY 2022-2023

Qualified Staff	Established	Actual	Shortage	Surplus
Tutors	6	4	2	0
Untrained clinical instructors	0	0	0	0
Accountant	1	1	0	0
Account Assistant	1	1	0	0
Cashier	1	0	1	0
Record Assistant	1	1	0	0
Total Qualified Staff	14	11	3	0
Trained clinical mentor (Hospital)	4	5	0	1
Support Staff	Established	Actual	Shortage	Surplus

Store Assistant/Library Attendant	1	1	0	0
Office Attendant	1	0	1	0
Farm Assistant	1	1	0	0
Cooks	4	4	1	0
Driver	1	1	0	0
Watchmen	4	4	4	4
Total Support Staff	12	11	1	0
Total School Staff	26	22	4	0

Staff development

Staff development is a priority in accordance with the school's strategic plan. A number of trainings have been held since. Trainings included both virtual and physical training.

Table 9.2: Workshops and courses attended by the teaching staff

S/N	Workshop	Organized by	Number of staff	Duration
1	Clinical assessment for students	UNMEB	2	5days
2	Midwifery best practices	Maternal life International Midwifery	2	5days
3	IMNCI	Uganda Health Activity	2	5days
4	Mental Health Gap	Ambrosoli Foundation/You are not alone project	2	5days
5	Diabetes Assessment	Ambrosoli Foundation/You are not alone project	2	5days

The enrollment of students in the school was determined by the institution's real capacity. The passing rate for both certificate and diploma students has remained constant at 100%. The school administration and staff continued to assist students not only academically, but also in other elements of their lives that affected their performance.

Table 9.3: Student Enrollment in years 1st -2nd -3rd and success rate in the FY 2022-23

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
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C/M	143	24	50	69	162	106	106	100%
D/M	19	7	12	0	7	12	12	100%
Total	162	31	62	69	169	118	118	100%

School Finances

St. Mary's Midwifery Training School is a semi-autonomous institution linked with her mother hospital, Dr. Ambrosoli Memorial Hospital. All of the school's accounts are overseen by the principal, who is also one of the signatories to the bank accounts. She is the general controller of the school's operations and reports to the CEO. Each financial year, the school develops its own budget and year plan. The hospital hires an external auditor to provide audited financial accounts for both the school and the hospital.

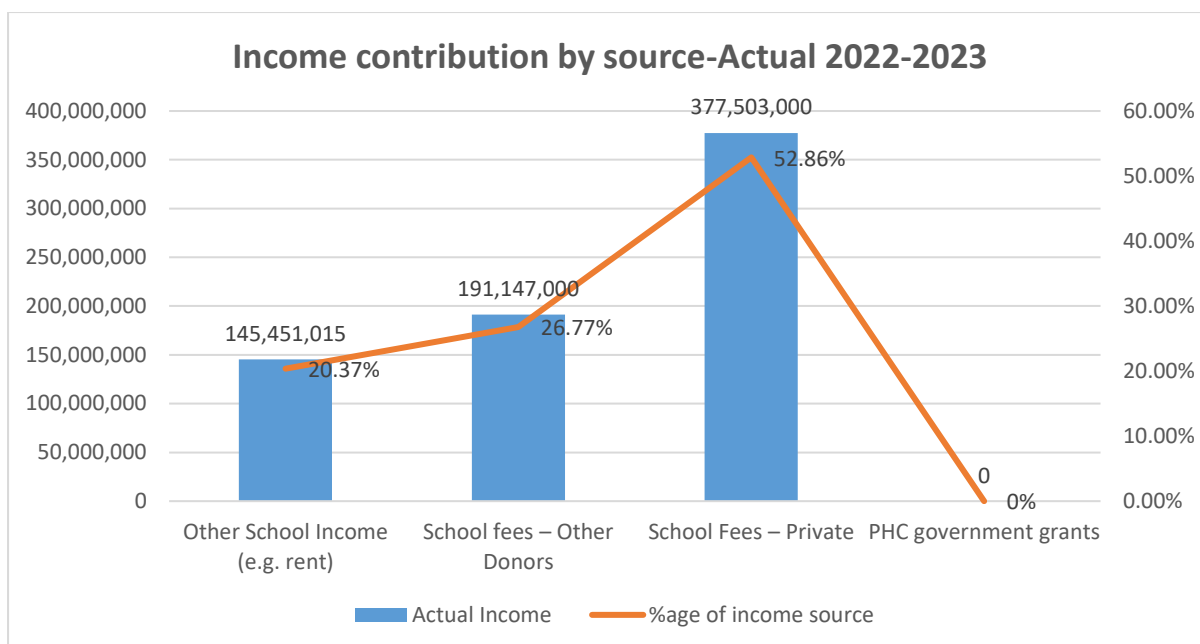
Income

The actual revenue from school fees and contributions remains the principal source of funding. Given that specific donors' assistance is dwindling and sustainability is jeopardized, donor dependence is a serious issue. Support for school fees came from UNFPA, Copeland Foundation, Straight talk foundation, Gretta foundation, Dr. Ambrosoli Foundation and Fondazione Ceresio.

The school achieved 81.88% of its budget.

Table 9.4: Planned, actual and unrealized income in the FY 2022-2023

Income Sources	Planned Income (UGX)	Actual Income (UGX)	Budget Gap (UGX)	Variance Comment Surplus/Deficit
Other School Income (e.g. rent)	283,900,000	145,451,015	138,448,985	Deficit
School fees – Other Donors	158,857,992	191,147,000	-32,289,008	Surplus
School Fees – Private	429,347,742	377,503,000	51,844,742	Deficit
PHC government grants	0	0	0	
TOTAL	872,105,734	714,101,015	158,004,719	



Expenditure

The school spent 88% of the planned budget. This year's expenditure was more than for the previous year (due to limited operation caused by COVID restrictions).

Table 9.5: Planned, actual expenditure and unspent balance in the FY 2022-2023

PLANNED EXPENDITURE	ACTUAL EXPENDITURE	UNSPENT BALANCE
872,105,734	766,624,721	105,481,013

Relation with external partners

External partners continued to play significant roles in the school's evaluation and performance improvement by providing financial aid through student sponsorship, technical assistance, contributions of teaching and learning tools, and staff training. Furthermore, the more partners who engage, the more staff are exposed to new information and networking opportunities, which they can share with their coworkers in addition to the new material they receive during the weekly CME.

Dr. Ambrosoli Foundation, Copeland Foundation, UCMB, UNFPA, MOEs, and the Gretta Foundation were the partners with which the school worked closely during the course of the financial year.

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

The Total number of students at present =

$$169 \times 100\% = 112.7\%$$

Total Capacity of the School 150

The capacity of the school was exceeded by 112.7% due to the back log that was enrolled when the COVID restrictions were lifted.

Total number of students 169

Average school fees paid per student increased. Our school fees remain one of the lowest of all the HTIs in the UCMB network. Equity reduced in 22/23.

Quality

Total number of students who passed = 118

$$\times 100\% = 100\%$$

Total Number of Students who sat 118

The quality of passing has been maintained at 100%, just like the case of the previous year.

Efficiency

Total Recurrent Costs 766,624,721=

$$4,536,240/=$$

Total number of students 169

Compared to last year, efficiency reduced. But this was largely due to the fact that schools were reopened after COVID and costs slightly went up. Operational costs have been constantly rising over the past 5 years.

Equity

Total fees Collected = 568677000 =

$$3,364,952/=$$

CHAPTER TEN: CONCLUSIONS

A number of extraordinary situations dominated FY 22/23, as they did the previous year. The hospital and school were still struggling financially. Sustainability remains at the forefront of all actions and projects undertaken or launched by the Hospital.

The hospital is still heavily reliant on donations. Although local revenue has increased, it is still insufficient to meet operation obligations.

Access to MCH services is limited in East Acholi, as it was the previous year. This is exacerbated by the referral network's frailty. Furthermore, the ending MOH Results-Based Financing activities presented a difficulty owing to financial cuts, which resulted in a reduction in ambulance services for expectant mothers and children under the age of five in emergency situations. As a result, we continue to appeal to the GOU to allow the restart of such programs (MCH-based efforts) with increased financing capacity to East Acholi in order to cover these vitally required service gaps.

The Ambrosoli Foundation, Comboni Missionaries, and UPMB - LSDA, who together donated about 80% of the hospitals' annual budget, deserve our heartfelt thanks. We kindly request that they continue to provide this critical support.

We thank the MOH and the Government of Uganda's support of the PHC conditional grant, which contributed approximately 15% of the hospital's income.

The hospital maintained its commitment to its mission and received UCMB accreditation. Despite the limitations outlined above, it has remained accessible. We want to emphasize the positive features while addressing the negative ones.

Pending Issues

- Because the hospital complex's structures are extremely old the majority of the hospital wards require extensive improvements. The coming financial years will be spent to pushing for funds to renovate these facilities.
- The perimeter fence around the institution, as well as last year, need a comprehensive reconstruction. We faced many security threats during the financial year due to the fence's numerous porous areas.

ANNEXES

Annex 1. Members of Board of Governors and designation as per 30th June 2023

	Name	Designation	Title
1	H.G. John Baptist Odama	Chairperson	Archbishop of Gulu
2	Sr. Liberata Amto	Member	Diocesan Health Coordinator Gulu
3	Msgr. Matthew Odong	Member	Vicar General Gulu
4	Ms. Giovanna Ambrosoli	Member	Representative Ambrosoli Foundation
5	Fr. Achilles 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 Dezu 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 2023

	Name	Designation
1	Dr. Okot Godfrey Smart	Chief Executive Officer
2	Mr. Alex Ojera	Principal Nursing Officer
3	Dr. OkaoMaurice	Medical Director
4	Sr. Carmel Abwot	Principal Tutor
5	Sr. Ogwal Hellen Aloba	Senior Nursing Officer
6		

Annex 3.

Our vision and mission statement.

Vision

“A Private Not For Profit (**PNFP**) General Hospital serving Agago and neighboring districts, offering quality care and ensuring access for the poor and vulnerable people”.

Mission statement

“To imitate Christ and His deeds; promote life to the full and heal, providing services to treat and prevent diseases, with a preferential option for the poor and less privileged being at the Centre of our activities as well as providing Training services.