ANNUAL ANALYTICAL REPORT FY 2018-2019

DR AMBROSOLI MEMORIAL HOSPITAL

KALONGO

Endorsement of Report

This Annual Analytical Report covering the period of Financial Year 2018-2019 has been prepared by the management of Dr Ambrosoli Memorial Hospital. I endorse that it represents the management's views on the position of the hospital in the period under report.

Name: Dr Okot Godfrey Smart

Signature _____

Chief Executive Officer
Dr. Ambrosoli Memorial Hospital

Date _____

This is to acknowledge that I have received this Annual Analytical Report for Dr. Ambrosoli Memorial Hospital- Kalongo covering the period **July 1st 2018 to June 30th 2019.**
I have read it and endorse its authenticity and representativeness of the position of the hospital in the year under report.

Name: His Grace John Baptist Odama

Signature _____

Chairperson of the Board of Governors

Date _____

FOREWORD

This Annual Analytical report for 2018/19 FY provides analysis of the hospitals' performance against set targets, goals, and objectives with a comparative analysis of previous trends of performance. The report is premised on the mission and policy statement of Dr Ambrosoli Memorial Hospital (which mirrors the dedication of the founder; Fr Giuseppe Ambrosoli), as well as departmental work plans.

The report also examines both the internal and external environments of the hospital; which very much brings into context what is achieved, what is not achieved and the challenges experienced.

The threat for the hospital has mainly been the low sustainability rate in the absence of donor funding. This is coupled to the fact that donors' support towards recurrent costs continues to dwindle. Reversing this threat is a huge but surmountable task; demanding that every stakeholder plays its part.

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

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

"Service with love and humility"

Dr Okot Godfrey Smart
Chief Executive Officer

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List of Abbreviations/Acronyms

ACT …… Aids Care & Treatment

AIDS …… Acquired Immuno-Deficiency Syndrome

ALoS …….. Average Length of Stay

ART …… Anti-Retroviral Therapy

BCG …… Bacillus of Calmette-Guérin

BoG …….. Board of Governors

BOR …… Bed Occupancy Rate

CEO …….. Chief Executive Officer

DPT …….. Diphtheria-Pertussis-Tetanus

FSB …….. Fresh Still Birth

FY …….. Financial Year

CB-DOTS …….. Community Based Directly Observed Treatment

CHD …… Child Health Day

CO …….. Clinical Officer

C/S …….. Caesarean Section

DHMT …….. District Health Management Team

HC …….. Health Centre

FY …… Financial Year

HIV …….. Human Immunodeficiency Virus

HTS …… HIV Testing Services

HMIS …….. Health Management Information System

HMT …….. Hospital Management Team

HRM …….. Human Resources Manager

HSD …….. Health Sub-District

HSSP …….. Health Sector Strategic Plan

IDP …….. Internally Displaced People

ITN …….. Insecticide Treated Nets

LLU …….. Lower Level Unit

MDRTB …….. Multi Drug Resistant Tuberculosis

MTB …… Myco bacterium Tuberculosis

MO …… Medical Officer

MoES …… Ministry of Education and Sports

MoH …… Ministry of Health

NSSF …… National Social Security Fund

NTLP …… National Tuberculosis Leprosy Programme

NIDs …… National Immunization Days

OPD …… Out-Patient Department

PCH …… Primary Health Care

PHCCG …… Primary Health Care Conditional Grants

eMTCT …… Elimination of Mother to Child Transmission of HIV …… Human Immunodeficiency Virus

PNFP …… Private Not for Profit

SNO …… Senior Nursing Officer

SUO …… Standard Unit of Output

SLIPTA …… Stepwise Laboratory Improvement Process towards Accreditation

SLMPTA …… Stepwise Laboratory Management Process towards Accreditation

TT …… Tetanus Toxoid

UMHCP …… Uganda Minimum Health Care Package

UCMB …… Uganda Catholic Medical Bureau

UEC …… Uganda Episcopal Conference

UNEPI …… Uganda National Expanded Program for Immunization

UNMEB …… Uganda Nurses Midwives Educational Board

HG …… His Grace

UNFPA …… Uganda National Family Planning Association

Acknowledgements

The management with great honour appreciates all staff of Dr Ambrosoli Memorial Hospital for their continuous collective efforts rendered to the patients. We also thank all those who, in different capacities and ways, have supported the hospital during the Financial Year 2018-2019 and contributed to its sustainability. Notable among them, but not limited to, are the Government of Uganda, Dr Ambrosoli Foundation, Comboni Missionaries, USAID – URC, AMREF, IDEA and the patients.

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

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

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

Important Indicators and Definitions

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

2. **Average Length of stay (ALoS)**

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

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

3. **Bed Occupancy Rate expressed as %**

   = used bed days**/**available bed days

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

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

4. **Throughput**

   =Average number of patients utilising one bed in a year

   =Number of patients**/** Number of beds

5. **Turn over interval**

   =Number of days between patients

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

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

7. ***Post C/S Infection Rate***:

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

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

8. ***Recovery Rate***:

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

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

9. ***Maternal Mortality Rate*** (for the hospital):

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

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

10. ***SUO*** = Standard Unit of Output. All outputs are expressed into a given equivalent so that there is a standard for measurement of the hospital output. It combines Outpatients, Inpatients, Immunisations, Deliveries, Antenatal Clinic etc. that have different weights in terms of cost to produce each of the individual categories. They are then expressed into one equivalent. As the formula is improved in future it may be possible to include 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 presents activities output and interpretation for both Dr. Ambrosoli Memorial Hospital Kalongo and Kalongo Midwifery Training School.
Dr. Ambrosoli Memorial Hospital was founded in 1957 and St. Mary's Midwifery Training School in 1959 by Fr. Dr. Giuseppe Ambrosoli of the Comboni Missionaries. Until now, Kalongo Hospital, being a PNFP, is the only General Hospital in Agago district. It provides both preventive and curative services. Kalongo Town Council currently has a total estimated population of 12,571. Major Key performance indicators are herein summarized as below.

The hospitals current bed capacity is 271. The total OPD attendance was 25,622 patients, representing a decrease of 4.7% from 2017/18. Inpatient (IP) admissions were 14,794; an increase of 9.9% from the previous FY. Malaria followed by injuries, were the leading causes of morbidity in the Inpatient department (IPD), while Respiratory Tract Infections followed by gastrointestinal illnesses were the leading causes in the OPD. Neonatal illnesses followed by malaria, were the leading mortality causes in the IPD. The hospital Bed Occupancy rate (BOR) remains below the optimal level of 85% in all the Wards except Pediatric Ward. The number of deaths in the hospital increased by 67% compared to previous FY, reflecting an overall mortality rate of 1.3% (c.f 0.85%) of all patients treated in the hospital. The recovery rate increased by 0.09% from previous FY.

ANC 1st and 4th visits decreased by 27.9% and 35.4% respectively from the previous FY. Total ANC attendance also increased by 44.3%. Post Natal clinic attendance increased significantly by 369.7%. Deliveries in the hospital increased by 17.5% compared to FY 2017/18. Caesarean section (total) accounted for 14.6% of all deliveries, out of which 95.1% were emergencies.

The members of the BoG and HMT were 14 and 4 respectively. 15 HMT, 2 Ordinary BoG, 1 extra ordinary BoG and 5 Subcommittee meetings were held during the FY. The agenda for each of these meetings were prepared and circulated in advance to the members. One stakeholders meeting was also held in the FY.

The total income for the hospital increased by 12.9% in 2018/19, while that of the school increased by 35% compared to the previous FY. Expenditure in the hospital decreased by 7.7% compared with 2017/18; in the school, it increased by 35.9% in comparison with 17/18. The SUOop in 2018/19 was 309,955; an increment of 23.5% from 2017/18.

The overall patient satisfaction with quality of services offered improved from 81.1% in 2017/18 to 86% in 2018/19.

St Marys' Midwifery Training School has qualified a total of 1,465 students since its foundation. The main challenge faced during the year was academic human resource shortage. The students pass rate decreased to 98% from 100% in the previous FY

CHAPTER ONE

INTRODUCTION

Background

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

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

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

The hospital and its' environment

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

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

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

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

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

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

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

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

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

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

Demographic data for the hospital catchment area

In the FY 2018/2019, the population of Agago district was estimated at 247,257 (Annual Health Sector Report 2018); which is actually the catchment population of the hospital.

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

	Population Group	Formulae	Catchment Area	HSD	District
(A)	Total Population	A	11667	247257	247257
(B)	Total expected deliveries (4.85% of population)	(4.85/100) x A	565.8495	11991.96	11991.96
(C)	Total Assisted Deliveries in Health Facilities		2	2	2
(D)	Total Assisted Deliveries as % of expected deliveries	(C/B) x100	0.017142	0.000809	0.000809
(E)	Children <1 year (4.3%)	(4.3/100) x A	501.681	10632.05	10632.05
(F)	Children < 5 years (20.2%)	(20.2/100) x A	2356.734	49945.91	49945.91
(G)	Women in Child-bearing age (20.2%)	(20.2/100) x A	2356.734	49945.91	49945.91
(H)	Children under 15 years (46%)	(46/100) x A	5366.82	113738.2	113738.2
(I)	Orphans (circa 10%)	(10/100) x A	1166.7	24725.7	24725.7
(J)	Suspected T.B Cases in the Service Area	(A) x 0.003	35.001	741.771	741.771

Community Health Status

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

		FY 2015-2016		FY 2016-2017		FY 2017-18		FY 2018-19	
No.	**Causes of Morbidity**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
1	Malaria	208,384	39.7	192,229	41.4	83,933	29.6	133,109	46.96%
2	No Pneumonia-Cough or Cold	132,976	25.4	124,420	26.8	107,732	38	96,445	34.03%
3	Intestinal Worms	19,528	3.7	19,056	4.1	18,638	6.6	21,761	7.68%
4	Diarrhea	23,084	4.4	20,260	4.4	17,635	6.2	17,352	6.12%

5	Gastro-Intestinal Disorders	14,465	2.8	12,094	2.6	12,298	4.3	13,818	4.88%
6	Skin Diseases	7,091	1.4	7,023	1.5	8,669	3.1	11,028	3.89%
7	Urinary Tract Infections (UTI)	8,022	1.5	7,321	1.6	8,218	2.9	10,590	3.74%
8	Eye conditions	5,987	1.1	6,463	1.4	5,840	2.1	5,725	2.02%
9	Pneumonia	5,332	1	4,049	0.9	3,826	1.3	3,083	1.09%
10	Injuries	5,887	1.1	5,168	1.1	5,820	2.1	1,889	0.67%
	Total attendance	**524,521**		**464,041**		**283,430**		**283,430**	

Opposed to the FY 2017/18, Malaria was the leading cause of morbidity as registered across all the OPDs in the HSD. This was followed by Respiratory tract infections and Intestinal Parasitic infestation. Generally speaking, the community morbidity burden was equal to that experienced in the FY 2017/18. There was 67% reduction in the number of injuries registered compared to the previous FY.

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

Causes of Mortality among Inpatients		2015-2016		2016-2017		FY 2017-2018		FY 2018-2019	
		Number	Case Fatality Rate	No of disease specific deaths	Case Fatality Rate	No of disease specific deaths	Case Fatality Rate	No of disease specific deaths	Case Fatality Rate
1	Other Neonatal Conditions	5	1.79%	4	1.75%	4	2.45%	21	10.94%
2	Malaria	55	19.64%	42	18.34%	48	29.45%	19	9.90%
3	Premature baby (as condition that requires mgt)	5	1.79%	5	2.18%	5	3.07%	14	7.29%
4	Injuries	14	5.00%	27	11.79%	18	11.04%	14	7.29%
5	Pneumonia	15	5.36%	17	7.42%	18	11.04%	13	6.77%
6	Other Cardiovascular Diseases	12	4.29%	18	7.86%	10	6.13%	12	6.25%
7	Anaemia	17	6.07%	11	4.80%	4	2.45%	12	6.25%
8	Respiratory Infections (Other)	3	1.07%	4	1.75%	1	0.61%	11	5.73%
9	Tuberculosis	10	3.57%	6	2.62%	9	5.52%	9	4.69%
10	Gastro-intestinal disorders (non-infective)	15	5.36%	3	1.31%	1	0.61%	6	3.13%
	Total	**280**		**229**		**163**		**192**	

Neonatal conditions were the leading cause of mortality in 2018/19; a significant contrast from the last three (3) FYs. Most newborn deaths were resultant from asphyxia related

causes. This was followed by Malaria. There was a 60% reduction in deaths due to malaria in the last FY.

The hospital now has in place a dedicated Neonatal Intensive Care Unit equipped to help reduce on the burden of newborn morbidity.

Mortality due to non-communicable diseases continue to be high, albeit a slight reduction in 2018/19. We continue to strengthen our messages on awareness and screening during integrated outreach programs.

CHAPTER TWO

HEALTH POLICY AND DISTRICT HEALTH SERVICES

Health Policy

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

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

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

District Health Services

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

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

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

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

Sub-Counties	Total Population	No of Hospitals	No of HC IV	No of HC III	No of HC II	Total Immunizations Static Stations
Kalongo Town Council	12,571	1	0	0	0	1
Omiya Pacwa	12,571	0	0	0	2	2
Paimol	22,856	0	0	1	1	2
Lapono	23,895	0	0	1	5	6
Adilang	21,921	0	0	1	3	4
Patongo	24,518	0	0	0	0	0
Patongo Town council		0	0	1	0	1
Kotomor	13,713	0	0	1	2	3
Omot	14,544	0	0	0	2	2
Arum	12,778	0	0	1	0	1
Lamiyo	9,246	0	0	0	2	2
Lira Palwo	17,661	0	0	1	4	5
Wol	25,141	0	0	1	3	4
Parabongo	12,363	0	0	1	2	3
Lukole	16,934	0	0	0	3	3
Agago Town Council	6,545	0	0	1	0	1
Total for HSD and District	**247,257**	**1**	**0**	**9**	**30**	**40**

Table 2.2: Population, health units and staffing in Agago District FY 2018-2019 by Sub-county

Sub-Counties	Populations FY 2018-2019	Health units (Level & ownership)	Staffing levels		Staffing gap
			Staffing Norm	No. available	
Lira Palwo	17,661	Lira Palwo HC III Gov.	19	14	-5
		Acuru HC II Gov.	9	3	-6
		Obolokome HC II Gov.	9	3	-6
		St Janani HC II CoU	9	7	-2
		Lanyirinyiri HC II Gov.	9	3	-6
Omot	14,544	Omot HC II Gov.	9	9	0
		Geregere HC II Gov.	9	5	-4
Adilang	21,921	Adilang HC III Gov.	19	11	-8
		Ligiligi HC II Gov.	9	4	-5
		Alop HC II Gov.	9	6	-3
		Orina HC II Gov.	9	4	-5
Lamiyo	9,246	Kwonkic HC II Gov.	9	5	-4
		Lamiyo HC II Gov.	9	7	-2
Arum	12,778	Acholpii HC III Gov.	19	18	-1
Kotomor	13,713	Kotomor HC III Gov.	19	3	-16
		Odokomit HC II Gov.	9	8	-1

		Onudapet HC II Gov.	9	3	-6
Omiya Pacwa	12,571	Omiya Pacwa HC II Gov.	9	4	-5
		Layita HC II Gov.	9	4	-5
Lapono	23,895	Lira Kato HC III Gov.	19	13	-6
		Lira Kaket HC II Gov.	9	5	-4
		Ongalo HC II Gov.	9	5	-4
		Amyel HC II Gov.	9	5	-4
		Ogwangkamolo HC II Gov.	9	3	-6
		Abilonino HC II Gov.	9	3	-6
Wol	25,141	Wol HC III Gov.	19	10	-9
		Kuywee HC II Gov.	9	6	-3
		Toroma HC II Gov.	9	4	-5
		Okwadoko HC II Gov.	9	3	-6
Paimol	22,856	Paimol HC III Gov.	19	16	-3
		Kokil HC II Gov.	9	5	-4
Parabongo	12,363	Pakor HC II Gov.	9	4	-5
		Pacer HC III Gov.	19	18	-1
		Kabala HC II Gov.	9	6	-3
Lukole	16,934	Lapirin HC II Gov.	9	6	-3
		Olung HC II Gov.	9	6	-3
		Otumpili HC II Gov.	9	2	-7
Agago Town Council	6,545	Lukole HC III Gov.	19	14	-5
Patongo Town Council	24,518	Patongo HC III Gov.	19	25	-6
Patongo S/C					
Kalongo Town Council	12,571	Kalongo Hospital NGO	190	251	61
Total HSD	**247,257**	**38 Govt. and 2 NGO Units**	**567**	**491**	**-76**

Table 2.3: Structure of the District Health Office team

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

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

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

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

Funding

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

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

Health Infrastructure

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

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

The hospital, through its' principal partner; the Ambrosoli Foundation, secured funds towards the reconstruction and refurbishment of the Children's ward; and it is now work in progress.

Prevention and Health promotion services

The hospital currently does not have a dedicated public health department. This however is strongly engraved in the strategic vision for the institution. Despite this, the hospital carries out a range of health prevention and promotion activities like routine health education and immunization, as well as offering support supervision to the lower level units. In 2018/19, the hospital continued to allocate more resources towards strengthening integrated outreach PHC activities across the HSD, especially in hard to reach areas (the outputs are reflected in Table 2.5 below).

The HC II function of the hospital

The catchment area within which the hospital carries out its' HC II function is Kalongo Town Council; with a population of 12,571(2018).

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

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

Activity: TT to child bearing ages	Hospital	HSD/District	Hospital output as % of HSD/District
Pregnant women			
TT 1	4,082	9,829	41.53%
TT 2	1,670	5,901	28.30%
TT 3	58	1,341	4.33%
TT 4	1	785	0.13%
TT 5	0	3638	0.00%
Non Pregnant women			
TT 1	1148	4,570	25.12%
TT 2	729	2,540	28.70%
TT 3	517	1,852	27.92%
TT 4	302	1,188	25.42%
TT 5	129	854	15.11%
Immunization in school			
TT 1	292	1,856	15.73%
TT 2	200	1,284	15.58%
TT 3	89	742	11.99%

TT 4	56	385	14.55%
TT 5	50	269	18.59%
Total TT 2 in all categories	2,599	9,725	26.72%
Immunization in Children			
BCG	3,955	10,452	37.84%
Protection at Birth for TT (PAB)	3,311	6,168	53.68%
Polio 0	4,078	10,071	40.49%
Polio 1	1114	10,711	10.40%
Polio 2	1074	10,143	10.59%
Polio 3	1361	10,347	13.15%
PCV 1	1125	10,578	10.64%
PCV 2	1075	10,069	10.68%
PCV 3	1369	10,143	13.50%
DPT-HepB+Hib 1	1120	10,876	10.30%
DPT-HepB+Hib 2	1071	10,400	10.30%
DPT-HepB+Hib 3	1363	10,462	13.03%
Measles	1055	7,929	13.31%
Total Immunisation in Children	**23,071**	**124,131**	**18.59%**
Total Family Planning attendances	0	19,182	0.00%
Total ANC attendance	8,721	36,807	23.69%
Deworming	10,702	79,737	13.42%
Vitamin A Supplementation	4,393	31,001	14.17%

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

There was 64.6% increase in the amount of TT antigens administered to girls of child bearing age in 2018/19 compared to 2017/18. The total antigens administered to children also increased by 26.9% in 2017/18. Areas that needs critical attention includes family planning services and TT5.

In the FY 2019/20, the hospital will continue to strengthen more the integrated outreach activities in especially hard to reach settings.

CHAPTER THREE

GOVERNANCE

The Board of Governors

The Board of Governors (BOG) is the supreme policy maker and controlling body of Dr. Ambrosoli Memorial Hospital and St. Mary's Midwifery Training School. However, the Hospital Management Team remain fully responsible for all operational aspects of the hospital and the school. As enshrined in the hospital Statute, a maximum of two (2) ordinary BOG meetings should be held in a year. In the FY 2018-2019 the hospital held two (2) ordinary BOG meetings and one (1) Extra Ordinary BOG Meeting.

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

Table 3.1: Summary of BOG meetings held in the FY 2018-2019

BOG meetings	Reports presented / Key issues handled / Decision taken	Members present
22nd June 2018	• Investments in the defunct AGARU SACCO • Secondment of staff by Government • Mismanagement of funds • Review of staff salaries	11
5th July 2018	• Budget performance review • External audit review • Staff discipline	9
24th November 2018	• User fees review • Follow up of forensic audit • Writing off bad debts • Proposed transfer of shares from Centenary bank	11

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

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

Table 3.2: Table showing functionality of the Board Committees

Name of committee	Required No. of meetings per year	No. of meetings held	Percentage of required meetings held
Finance Committee	2	3	150%
School Committee	2	1	50%
Human Resources& Disciplinary Committee	2	1	50%

Hospital Management

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

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

The core members of the Hospital Management Team are:

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

Table 3.3: Frequency of HMT meetings FY 2018-2019

No of planned Management meeting	No. of Management meeting held	Average No. of members present	Reports / key issues handled
24	15	4	Minutes of each meeting were prepared and circulated by the CEO

Statutory commitments compliance

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

The UCMB established an accreditation program for the hospitals of the catholic network. Kalongo hospital satisfied this requirements for the year 2018/19. This accreditation entitles the hospital to the full range of services provided by UCMB for the period ending on the 31st December 2019.

Table 3.4: Statutory commitments compliance

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

Internal Regulatory Documents

DAMHK has in place manuals and guidelines that regulates decisions and practices in both the hospital and the school. These documents includes: The Employment manual, the finance and material resource manual and the procurement manual. The employment manual has been considered for review in the next FY; the finance and material resource manual revision is ongoing at the moment. The school fees policy and the rules and regulations for the Midwifery

school was approved by the BOG in the FY, as well as the user fee manual. The management is putting in place measures to ensure that these policies are adhered to.

Advocacy, lobby and negotiation

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

CHAPTER FOUR

HUMAN RESOURCES

Staff Establishment

Over the years the total number of staffs (clinical and non-clinical) have increased gradually. The hospital has also been increasing the scope of its services over the years. Projects that required more staff to implement, also came up during the FY. Currently the hospital is a 271 bed capacity general hospital being run by 151 clinical staff; below the recommended 190 for a 100 bed capacity general hospital by MOH.

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

Category		FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Clinical[1]	Qualified	108	130	116	131	136
	Unqualified	18	18	34	17	15
	Total Clinical	126	148	150	148	151
Not Clinical[2]	Qualified	86	38	61	43	42
	Unqualified	27	59	40	62	58
	Total Non-Clinical	113	97	101	105	100
Total Qualified		194	168	177	174	175
Total Unqualified		45	77	74	79	76
Grand Total		**239**	**245**	**251**	**253**	**251**
% of qualified clinical staff/total staff		**45%**	**53%**	**46%**	**51.8%**	**54.20%**

Staff turn-over[3]

The turn-over rate is higher among enrolled nurses compared to the other cadres in the hospital, as shown in table 4.2. The hospital salary scale and benefit packages are still not competitive with the Government and other institutions in the area. There was an increase in the turnover rate for the clinical work force (13.50% from 8.7% in the previous FY).

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

[1]Clinical Staff includes: Medical Doctors, Paramedics, Nurses, Midwifes, and Nursing Assistants.

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

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

Table 4.2: Turn-over trends of enrolled cadres[4] in the last 3 FYs

Cadres	FY 2016-17	FY 2017-18	FY 2018-19
Total staff	251	253	251
Enrolled cadres (all combined)	69	70	68
Turn-over for enrolled cadres	24.6%	8.6%	2.78%

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

Clinical Staff	FY 2016-17	FY 2017-18	FY 2018-19
Total staff	251	253	251
Total arrivals of key health personnel	55	26	34
Total departures of key health personnel	47	22	34
Turn-over rate	19.0%	8.7%	13.50%

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

The hospital provides accommodation for a large proportion of its employees (152 staff and their families, 61% of the total staff) in the staff quarters located within its premises. This housing facilitation includes also availability of water and electricity. The hospital embarked on expansion and refurbishing of the accommodation facilities to a more conducive living environment; with funding from the Ambrosoli Foundation.

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

[4]Enrolled Nurses, Enrolled Comprehensive Nurses and Enrolled Midwives.

Human resources development and career progression

The hospital continued to implement the staff training and development policy by providing capacity development. This is aimed at guaranteeing sustainability in the culture, workman ethics and forward development of the institution. This capacity development comes in the form of; CMEs, short trainings, on site mentorship, and advance courses of relevance to the institution.

The HMT envision capacity development as a mode of retention and motivation. We intend to evolve more our training plan through establishing realistic collaboration and ensuring continuity in the training programs.

Support to capacity development comes from our key benefactor, the Ambrosoli Foundation; as well as direct contribution from the hospital. Table 4.4 below presents the list of employees who enrolled in training through the hospitals scholarship program in key areas of needs.

Table 4.4: Hospital Staff who attended courses in FY 2018-2019

S/N	Name	Designation	Course	Date of start	Date of End
1	Ocen Godfrey	Laboratory Assistant	Diploma in Laboratory Technology	August, 2016	May, 2019
2	Okot John Paul	Diploma in Nursing	Diploma in Anaesthesia	Sept, 2016	May, 2018
3	Adokorach Pamela Lalam	Enrolled Midwife	Diploma in Midwifery	May, 2017	Nov, 2018
4	Adong Agnes	Enrolled Midwife	Diploma in Midwifery	May, 2017	Nov, 2018
5	Awor Ruth	Clinical Instructor	BA Medical	Aug, 2016	Jul, 2019
6	Atimango Sarah	Enrolled Nurse	Diploma in Nursing (Lacor Training School)	May-17	Nov-18
7	Ojera Alex Latim	Registered Nurse	BA in Public Health (Lira University)	Aug-17	Jun-20
8	Sr. Acan Santina	Double Trained Nurse	BA in Midwifery (Lira University)	Aug-17	Jun-21
9	Aneno Irene Jackline	Registered Midwife	Diploma in Anesthesia (Lacor Training School)	Sep-17	Jun-19
10	Olanya Richard	Nursing Aide	Certificate in Nursing (St. Joseph Kitgum)	Oct-17	Jun-20
11	Okao Maurice	Medical Officer	MMed Paediatrics	Sept, 18	June, 21
12	Lajara Molly	Enrolled Nurse	Diploma in Midwifery	July, 18	Dec, 2019

13	Amonyi Agnes	Enrolled Nurse	Diploma in Midwifery	July, 18	Dec, 2019
14	Oting Betty	Enrolled Nurse	Diploma in Midwifery	July, 18	Dec, 2019
15	Akello Gladys Ojara	Enrolled Nurse	Diploma in Midwifery	July, 18	Dec, 2019
16	Aketo Janneth	Enrolled Nurse	Diploma in Midwifery	July, 18	Dec, 2019
17	Acanna Bonny	Enrolled Nurse	Diploma in Nursing (Lacor Training School)	July, 18	Dec, 2019
18	Akot Polly	Dep. Principal	MA Public Health	Feb, 2019	Jan, 2020

Majority of the staff will be completing their training in the FY 19/20, and are expected to beef up the work force of the hospital. Next year, the hospital intends to enroll more doctors for Masters' programs.

CHAPTER FIVE

FINANCES

The FY 18/19 saw the hospital and school realise increments in total income received, 12.9% and 35% respectively. There was slight increase of 8.4% in cash donations in the hospital; accounting for 56.6% of the total income received. Donation in kind remained more less the same with the previous FY, only 0.6% increment, accounting for 22.4% of the total income.

These figures highlights how heavily the hospital is still donor dependent with very low sustainability rate, in the absence of donor funds; which continue to dwindle towards recurrent cost support.

Compared to the FY 17/18, the hospitals' expenditure reduced by 7.7%. The total expenditure was however 3.2% more than the total income generated in the year. In the year 19/20, the management plans to embark on a cost reduction campaign in order to curb expenditure.
The subsequent tables below show the trend of financial statements for the hospital. The school's financial statement will be reviewed under the section for the school (Chapter 9).

Income

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

Income over the last 5 Years						Variance 2017/18 Vs. 2018/19
Income Item	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**	**FY 2017-2018**	**FY 2018-2019**	
HOSPITAL						
User Fees	429,341,811	537,697,285	490,794,376	515,399,441	805,406,207	290,006,766
PHC CG cash	506,731,434	496,440,741	488,334,860	251,159,632	251,159,542	- 90
Government donations in kind (Drug/Lab)	17,549,163	251,710,481	243,072,352	346,633,198	294,661,401	- 51,971,797
Other donations in kind	1,073,509,815	1,171,239,924	1,023,496,908	787,210,769	845,619,113	58,408,344
Donations in cash (including project funding)	1,976,532,864	1,352,092,200	3,811,677,210	2,403,785,395	2,626,348,706	222,563,311
Others Financial sources (Deposit Interests & others)	82,600,220	76,684,887	326,116,116	56,168,380	162,796,288	106,627,908

Technical Department	56,945,511	70,879,020	213,555,605	141,070,362	93,943,603	- 47,126,759
Sub-Total Hospital	4,143,210,818	3,956,744,538	6,597,020,427	4,501,427,177	5,079,934,860	578,507,683
SCHOOL						-
Fees (private)	383,325,954	81,206,100	182,308,450	236,974,842	336,578,535	99,603,693
PHC CG School/PAF Delegate funds	55,634,813	53,939,020	53,021,152	24,264,900	24,264,900	-
Donations and other income	153,923,602	471,872,451	317,297,684	187,713,340	245,355,733	57,642,393
Sub-Total School	592,884,369	607,017,571	552,627,286	448,953,082	606,199,168	157,246,086
HSD						-
Sub-Total HSD	12,356,576	12,401,032	60,473,163	0	0	-
Grand-Total	**4,747,676,188**	**4,576,163,141**	**7,210,120,876**	**4,950,380,259**	**5,686,134,028**	**735,753,769**

The user fee revenue generated in the year increased by 56.3% from that of 17/18. This significant rise was due to the reorganization of the payment system in the hospital, whereby patients are now expected to pay before accessing services, except those that require emergency situations. The number of patients who escape without paying bills also reduced significantly in the year. The hospital continue to implement one of the lowest user fee schemes in the UCMB network.

The PHC conditional grant subsidy received was equal to that of the previous FY. We continued to operate within the revised implementation guidelines. 50% of the PHC funds is now sent directly to the drug supplier (JMS) by the MOH; the hospital only submits quarterly orders for the drugs and medical sundries. The total grant amount has remained constant over the last FYs even if the cost of health care has continued to rise.

Funding towards the HSD operations stopped in the FY 17/18. The MOH now prefers to send funds directly to LLUs' accounts to support PHC activities. The hospital is no longer directly involved in the implementation roles of the HSD; which are now directly coordinated by the office of the DHO.

Expenditure

Employment cost was the key driver of expenses in 18/19, accounting for 36.9% of the total expenditure. This was also an increase of 16% from the previous FY. In the FY 18/19, the hospital embarked on recruiting to fill all key positions, notably; the Senior Nursing Officer, Clinical Programs Manager and Internal Auditor. This is coupled to the minor salary adjustments made at the beginning of the FY.

Medical consumables accounted for 29.8% of the total expenditure, representing 9.2% reduction from the previous year. The costs of medical goods continue to rise yearly. As an institution, controlling wastage is one key strategy envisioned to control costs in the next FY.

Table 5.2: Trend of Expenditure over the last 5 FYs

Expenditures over the Last 5 Years					
Expenditure Item	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
HOSPITAL					
Human Resource cost	1,454,269,387	1,571,469,625	1,742,346,590	1,670,778,158	1,937,322,775
Administration & Governance Costs	86,721,317	95,753,358	159,589,078	148,417,998	256,159,365
Medical goods and supplies (included drugs)	1,436,533,515	1,937,705,529	1,978,701,042	1,723,605,199	1,564,891,236
Non-medical goods / supplies	137,391,003	119,594,489	136,173,475	1,126,086,235	481,599,381
Property Costs	232,835,274	240,980,620	268,887,558	311,950,518	342,469,799
PHC	250,856,300	331,106,130	1,235,279,987	235,268,336	287,069,131
Transport & Plant Costs	147,434,856	140,006,217	237,801,122	204,022,401	209,423,206
Capital Development	42,812,692	0	85,087,450	261,422,729	165,112,516
Hospital Total Expenditure	3,788,854,344	4,436,615,968	5,843,866,302	5,681,551,574	5,244,047,409
SCHOOL					
Employment	216,704,264	200,984,878	203,568,991	195,750,295	255,244,790
Administration	77,132,419	87,858,321	67,647,686	37,652,900	39,400,393
Students costs	139,925,472	148,001,835	136,801,294	115,564,162	180,483,191
Transport & Travelling	34,442,227	71,521,000	60,641,850	23,987,550	25,463,900
Property, Supplies, Services	12,821,329	59,910,050	9,572,678	48,034,600	31,022,821
Capital Development	0	0	0	14,448,597	60,336,306
School Total Expenditure	481,025,711	568,276,084	478,232,499	435,438,104	591,951,401
HSD					
HSD Total Expenditures	12,456,576	12,401,032	60,473,163	0	0
Grand Total	**4,241,686,664**	**5,017,293,084**	**6,382,571,964**	**6,116,989,678**	**5,835,998,810**

Administration/Governance costs increased by 72.6% from the FY 17/18, accounting for 4.9% of the total expenditure. The key areas of costs under this category were; external audit, security and stationary expenses. Property cost accounted for 6.5% of the total expenses, representing 9.8% increase from the FY 17/18. Property cost expenses is expected to rise every year, given the old and dire state of most buildings in the institution.

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

	Average Fees				
	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
OPD Adult Male	11,317	12,000	9,700	11,500	15,000
OPD Adult Female	11,317	12,000	10,500	12,000	16,500
OPD Children < 5yrs	3,499	4,500	4,500	4,500	9,500
OPD Children 5-13 yrs	6,507	7,000	7,000	7,000	12,000
IP Medical Male	25,149	26,000	24,000	25,000	30,000
IP Medical Female	24,276	26,000	24,000	25,000	30,000
IP Maternity	18,351	20,000	16,050	15,850	36,900
IP Paediatric < 5 yrs	8,300	8,500	6,100	8,500	15,500
IP Paediatric 5-13 yrs	8,300	8,500	6,100	9,000	16,000
IP Surgical Ward	19,306	25,000	21,700	23,200	24,000

The average user fee per patient increased by more than 30% for every department. As already stated above, the hospitals' user fees were not revised. However, the efficiency of revenue collection improved during the FY. The hospital still continues to have instances when patients escape without paying user fees.

In the FY 18/19, the hospital had 15.9% cost recovery rate, representing an increase of 6.4% from the previous year. Even with the increase, the data highlights the nearly total dependence on donor funding by the hospital.

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

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Total User fees *(a)*	429,341,811	537,697,285	490,794,376	515,399,441	805,406,207
Total Recurrent Expenditure *(b)*[5]	3,746,041,652	4,436,615,968	5,757,781,852	5,416,639,845	5,078,934,893

[5] Total Recurrent Expenditure = Total Expenditure – Capital Development

Cost Recovery Rate = *(a/b)x100*	11.5%	12.1%	8.5%	9.5%	15.9%

The average cost per bed reduced by 6.2% in the year 18/19. Meaning the average cost of treating one patient admitted in the hospital per day was lower compared to the previous year. The cost per SUOop reduced by 24.2% from the previous year. Overall, in 2018/2019; the hospital was more economically efficient.

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

Indicator	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Cost per bed[6]	13,823,032	16,371,277	20,061,958	19,987,601	18,741,457
Cost per IP/day[7]	56,428	51,055	56,897	56,783	53,243
Cost per SUO_{op}	15,771	11,527	15,904	21,622	16,386

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

In 18/19, the hospital was 20.9% sustainable in the absence of any sort of donor funding. This also reflects a 7.8% increase from the year 17/18. The much improved sustainability ratio mirrors the changed and more efficient revenue collection mechanisms implemented during the year. As we strive to strike the balance between sustainability and ensuring universal health coverage; we aim at achieving 40% sustainability ratio in the next 3 years.

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

Without PHC CG	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Total Local Revenues (a)	568,887,542	685,261,192	1,030,466,097	712,638,183	1,062,146,116
Total Recurrent Expenditures (b)	3,746,841,652	4,436,615,968	5,757,781,852	5,420,128,845	5,078,934,893
Sustainability Ratio = (a/b)x100	15.1 %	15.4%	17.9%	13.1%	20.9%

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

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

Considering local revenues and Government contributions in the FY 18/19, the hospital was 31.7% sustainable. This is a 7.5% increase from the previous year. Improvement of locally generated revenue coupled with more efficient utilization of resources, guarantees better sustainability of an institution.

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

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Total in-country funding (c)	1,075,618,976	1,181,701,933	1,518,800,957	1,310,431,013	1,607,967,059
Total Recurrent Expenditures (d)	3,746,841,652	4,436,615,968	5,757,781,852	5,420,128,845	5,078,934,893
Sustainability Ratio = (c/d)x100	28.7 %	26.6%	26.4%	24.2%	31.7%

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

CHAPTER SIX

SERVICES

The range of services offered by the hospital are those recommended by the government for a general hospital, and have not changed from the previous years.

These include:

Obstetrics & Gynecology Services

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

General Surgical Services

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

Internal Medical Care

- HIV Care and Treatment (ART clinic)
- OPD services
- Emergency medical care
- IPD medical care
- TB screening and treatment
- Internal medicine clinic

Pediatrics & Child Health

- Young child clinic
- Therapeutic Feeding Centre
- Neonatal intensive care (NICU)
- IPD pediatric care
- EPI abd health education

Community Health

- Health education
- Immunization
- VCT and counselling
- Nutritional assessment and education
- Primary Health Care

Medical and Nursing Training

- Midwifery course for diploma and registered Midwives
- Surgical and Obstetric Internship for Medical Doctors
- Practices for student Clinical Officers, Pharmacy, Nurses, Laboratory

OUT PATIENT DEPARTMENT

Dr. Ambrosoli Memorial Hospitals' Out Patients Department (OPD) is located at the main entrance to the hospital. The OPD operates six (6) days a week from Monday to Friday from 8.00 am to 9.00 pm, and Saturday, from 8:00 am to 2:00 pm. During night, Sundays and Public Holidays, acute cases are attended to in the respective Wards. The increasing need to streamline access of outpatients to Hospital services demands revision of the existing working hours. A plan for 24 h activities and, a second one foreseeing OPD open 7 days a week is presently under evaluation by HMT. This will as well involve consultation and exchange visits to facilities implementing similar models of OPD operation.

Staffing composition

OPD is managed by six Clinical Officers. In 18/19, the OPD had six (6) enrolled nurses, three (3) nursing assistants, one (1) nursing officer and one (1) nursing aide. Nursing and clinical students from the midwifery school and other institutions of learning often joins up with the team in OPD, as they conduct their practice. Medical Officers run specialized clinics following a weekly plan: Gynecological Clinic, Monday; Sickle Cell Clinic and pediatric review, Tuesday; Surgical Clinic, Wednesday; Medical Clinic, Thursday. Overall, the total number of staff reduced in the OPD compared to previous FY.

Table 6.1: The staff composition in OPD in the FY 2017-18 and FY 2018-19

Cadre/ Discipline	Qualification	FY 2017-18	FY 2018-19
Clinical officers	Diploma in clinical Medicine	6	5
Pharmacy Assistant	Certificate in Pharmacy	2	2
Double Trained Nurse/Midwife	Diploma in Nursing / Midwifery	1	1
Enrolled Midwife	Certificate in Midwifery	2	0
Enrolled Nurse	Certificate in Nursing	3	4
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	3	2
Nursing Assistant	Certificate in Nursing Assistance	3	3
Cashier	Diploma in Business Studies	2	2

Nursing Aide	Trained on the job	1	1
Data Clerk	Certificate in Medical records	2	2
Total		**25**	**22**

Given all the plans the management has to diversify service delivery in the OPD, the current staffing norms and numbers are likely to change significantly in the next FY. This will further be compounded by the need for specialized clinics in the OPD.

OPD key indicators

Utilization of OPD showed slight decline (4.7%) compared to the previous FY. Under five (5) morbidity (new attendance and re attendance) reduced by 15.3% and 8.6% respectively. As already experienced in the previous FYs, women utilized the OPD more. Reduction in OPD services utilization was a common trend across all the facilities in the HSD.

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

			FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
FEMALE	New Attendance	0-4 yrs	2,642	3,372	3,539	2,442	2,037
		Over 5 yrs	10,690	12,294	13,743	11,095	10,835
	Re-attendance	0-4 yrs	122	90	49	124	129
		Over 5 yrs	1,511	1,077	1,738	2,097	1,934
MALE	New Attendance	0-4 yrs	3,188	3,794	3,984	2,720	2,337
		Over 5 yrs	5,311	6,785	7,423	6,121	6,193
	Re-attendance	0-4 yrs	161	97	78	203	170
		Over 5 yrs	1.971	1,374	1,819	2,089	1,987
All New Attendances			21,761	26,245	28,689	22,378	21,402
All Re-attendances			3,765	2,638	3,684	4,513	4,220
All Attendances			25,526	28,883	32,373	26,891	25,622

Generally speaking, the population was fairly healthy across the HSD OPDs in 18/19.

Morbidity Trend in the OPD

Respiratory tract infections (no pneumonia) remained the leading cause of morbidity in the OPD followed by Gastro Intestinal disorders. We experienced a surge of Malaria in the last quarter, accounting for the slight increase (3.7%) in the number of cases treated in the OPD. Injuries (Trauma) reduced by 26.6% from the previous year.

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

	Causes of Morbidity	FY 2017-2018		FY 2018-2019	
		No. of cases	% on all diagnoses	No. of cases	% on all diagnoses
1	No Pneumonia - Cough or Cold	3685	15%	2566	11%
2	Gastro-Intestinal Disorders (non-Infective)	2538	10%	2538	11%
3	Malaria	2063	8%	2140	9%
4	Urinary Tract Infections (UTI)	1322	5%	1845	8%
5	Injuries (Trauma Due To Other Causes)	1679	7%	1233	5%
6	Skin Diseases	858	3%	855	4%
7	Diarrhoea	1087	4%	808	3%
8	Pneumonia	690	3%	738	3%
9	Pelvic Inflammatory Disease (PID)	584	2%	668	3%
10	Epilepsy	113	0%	576	2%
	All other diagnoses	6003	24%	6080	25%
	Total diagnoses for the year	**24,570**		**24088**	

The morbidity trend seen in the OPD above, is a complete opposite picture to that observed across the HSD OPDs, where malaria was the leading reason for patient attendance.

ANTENATAL CLINIC

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

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

The staffing norm of the ANC did not change from that of the previous FY. The team is headed by one (1) registered midwife and assisted by seven (7) enrolled midwives, one (1) counsellor and one (1) laboratory assistant.

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

ANTENATAL	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
ANC 1st Visit	1,817	1,890	2,041	1,874	2,397
ANC 4th Visit	1,217	1,075	1,236	1,217	1,648
Total ANC visits new clients + Re-attendances	5,909	5,743	5,883	6,045	8,721
ANC Referrals to unit	0	0	1	2	2
ANC Referrals from unit	0	1	3	0	0
POSTNATAL					
Post Natal Attendances	847	620	927	952	4,472
Number of HIV + mothers followed in PNC	26	8	100	124	164
Vitamin A supplementation	847	599	927	952	90
Clients with premalignant conditions for breast	0	0	0	0	0
Number of clients screened for cancer cervix					
Clients with premalignant conditions for cervix	0	0	0	0	0

Total ANC attendance increased by 44.3% in 2018/19; so did 1st and 4th visits by 27.9% and 35.4% respectively. Post Natal Care services utilization increased significantly by 369.7%. The improved utilization data was most likely due to increased access provided to mothers in our catchment area through the USAID Voucher system.

1st ANC attendance in the 1st trimester is still low (just like in previous years). This picture however, cuts across the entire HSD facilities. It is most times difficult for mothers to recollect the time they got pregnant, coupled to the culture of just attending ANC when the pregnancy is already visible; are probable contributing factors.

The hospital offers cervical cancer screening services in the ANC; funded by the Mario Sideri foundation through the Ambrosoli foundation. Cervical cancer screening is conducted every Tuesdays and Thursdays, during working hours. The project will very soon introduce in the hospital colposcopy and cryotherapy, to supplement efforts in the fight against cervical cancer. These services are free of charge to all women of child baring age.

HIV/AIDS Clinic

The HIV/AIDS clinic was initiated in November 2005, under the support of CRS AIDS relief. Support to the clinic's activities have undergone transition from CDC to USAID. The clinic is

currently funded and supported by USAID RHITES N Acholi Activity. The services offered are substantially integrated into the hospital services. The Program provides comprehensive HIV/AIDS care, including Antiretroviral Therapy, Prophylaxis for and Treatment of Opportunistic Infections, HTS, eMTCT, SGBV, and DSDM; a community HIV treatment model.

The clinic is headed by a Medical officer who coordinates the activities of the Clinic. The personnel involved in the project activities in FY 2018/19 included: 1 Medical Doctor, 1 Registered Nurse, 1 Enrolled Comprehensive Nurse, 1 Psychiatric Nurse, 2 Enrolled Nurses, 1 Laboratory Assistant, 2 Pharmacy Assistants, 4 Counsellors, 2 Sample Transporters, 1 Nursing Aid, 1 Community Coordinators, 2 Linkage facilitators and 60 Community Health Volunteers. Personnel responsible for data collection included; 1 Adherence Coordinator, 1 Monitoring & Evaluation Officer and 2 Record Assistants.

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

The higher number of patients implies an increased demand for HIV/AIDS services, often not commensurate with the available resources. The HIV/AIDS Clinic is located in a temporary structure used for dispensing drugs, nursing care, counselling, clinical consultation, storage of files, data entry and information management. Currently there is a pressing demand for expansion in order to accommodate every activity required to take place in the clinic. This demand is met with the prevalent funding challenges; even from the existing Implementing Partner.

HIV Testing Services (HTS)

HIV Testing Services (HTS) seeks to address the first 90 of the UNAIDS 90 90 90 global agenda (to ensure that 90% of the target population know their HIV status).

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).

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

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Number Tested					
Male	991	3,251	14,144	10,532	4,736
Female	1,683	5,028	6,478	10,995	6,993
TOTAL (Tested)	2,674	8,279	20,622	21,527	11,729
Tested +ve for HIV					
Male	54	243	316	386	160
Female	96	335	389	437	222
TOTAL (+ve Tests)	150	578	705	823	382
Positivity Rates of HCT					
Male	5.40%	7.50%	2.20%	3.70%	3.4%
Female	5.70%	6.70%	6.00%	4%	3.2%
Both sexes	5.60%	7.00%	3.40%	3.80%	3.3%

A total of 11,729 clients accessed HIV counselling & testing services during FY 2018-2019; a decline of 46% from the previous year (still meeting more than 80% of the PEPFAR target for the year). More women continue to access HTC compared to the men. Male and female involvement in HTC reduced by 55% and 36.4% respectively. Positivity rate was high among men compared to women. This reverses the previous years' trends. In 19/20, more emphasis will be put towards male involvement in HTS.

The total number of clients tested for HIV (all HTS) was 16,312. Out of these, 434 positive clients (positivity rate of 2.66%) were identified and linked to care.

Table 6.6: HIV test by purpose during FY 2018 – 2019

Types of test	HCT	PMTCT*	SMC	Total
Number of clients tested for HIV	11,759	3,318	1,235	16,312
No. of HIV +ve tests	382	40	12	434
Positivity Rate (%)	3.25%	1.21%	0.97%	2.66%

The above figure is for total test done purely for HIV screening & excludes quality control tests done during the FY 2018-19.
**Source: Laboratory records*

Table 6.7: Performance Indicators of the PMTCT Programme in FY 2018-2019

A. Antenatal	**No.**
A1. Mothers re-tested later in pregnancy, labour or postpartum	779
A2. Mothers testing positive on a retest	7

A3. New pregnant and lactating mothers newly enrolled into psychosocial support groups.	57
A4. HIV positive pregnant women already on HAART before 1st ANC visit /Current pregnancy	112
A5. Pregnant women who received services at the health facility after referral from the community	2397
A6. HIV (+) lactating mothers followed up in community for infant feeding, early infant diagnosis, or linkage into chronic care	141
A7. HIV positive Pregnant women initiated on Cotrimoxazole	11
A8a. Mothers assessed using CD4	0
A8b. Mothers assessed using WHO clinical staging only	0
A9a. HIV + pregnant women initiated on HART (Option B+) for EMTCT - CD4 >350 or Stage I and 1I (ART-T)	31
A9b. HIV + pregnant women initiated on HART (Option B+) for EMTCT - CD4 <350 or Stage III and IV(ART-T)	0
B. Maternity	
B1. HIV positive deliveries initiating ARVs in Labour	1
C. Postnatal	
C1. Postnatal mothers newly tested for HIV	6
C2. Postnatal mothers testing HIV positive	4
C3. Postnatal mothers initiating ARVs in PNC period	8
D. Early Infant Diagnosis (EID)	
D1. HIV-exposed infants (<18 months) getting a 2nd DNA PCR	127
D2. HIV-exposed infants initiated on Cotrimoxazole prophylaxis	208
D3a. 1st DNA PCR results returned from lab within 2 weeks of dispatch	148
D3b. 2nd DNA PCR results returned from lab within 2 weeks of dispatch	145
D4a. Total HIV-exposed infants who had a serological/rapid HIV test at 18 months or older.	110
D4b. Positive Number of HIV-exposed infants who had a serological/rapid HIV test at 18 months or older	2
D5. DNA PCR results returned from the lab that are positive	5
D6. HIV-exposed infants whose DNA PCR results were given to caregiver	149
D7. Number of referred HIV positive-infants who enrolled in care at an ART clinic	3

The number of pregnant women referred from other facilities increased by 119750% from last FY. The number of mothers initiated on ARVS in labor reduced significantly (44.8%) in 18/19; an in depth analysis is in place to understand the likely reasons. DNA PCR utilization slightly reduced from last year by 15.3%.

Antiretroviral therapy

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

		FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-2019
ELIGIBLE FOR ART						
Male	<5 yrs	0	0	0	6	6
	5-<18 yrs	0	0	0	9	8
	18 and above	20	10	5	216	129
Female	<5 yrs	0	0	0	3	6
	5-<18 yrs	0	0	0	8	13
	18 and above	15	11	7	306	221
TOTAL ELIGIBLE FOR ART		35	21	12	553	383
STARTED ON ART						
Male	<5 yrs	4	3	4	6	6
	5-<18 yrs	7	5	2	9	8
	18 and above	108	137	131	216	129
Female	<5 yrs	5	9	1	3	6
	5<18 yrs	4	10	9	8	13
	18 and above	169	90	201	306	221
TOTAL STARTED ON ART		**297**	**254**	**348**	**553**	**383**

The number of HIV positive clients enrolled on ART decreased by 30.7%. These represent 88.2% of those who tested positive during the financial year. It is important to note that some of the clients who test positive opt to enrol in facilities that are closer to them; given that all HC IIIs are offering HIV care.

Table 6.9: Number of PLHAs started on ARV by age group and gender in FY 2018-2019

Category	No. of individuals < 2years (24months)		No. of individuals 2-< 5years		No. of individuals 5-14 years		No. of Individuals 15years and above		Total
	M	F	M	F	M	F	M	F	
Number of new patients enrolled in HIV care at this facility during the year	2	3	5	4	9	7	127	218	375
Number of pregnant women enrolled into care during the year.						0		57	57
Cumulative Number of individuals on ART ever enrolled in HIV care at this facility	51	50	49	42	73	78	1356	2303	4002
Number of HIV positive patients active on pre-ART Care	0	0	0	0	0	0	0	0	0
Number of HIV positive cases who received CPT/Dapson at last visit in the year	1	3	8	5	38	31	98	135	319
Number eligible patients not started on ART	0	0	0	0	0	0	0	0	0
Number of new patients started on ART at this facility during the year	2	3	5	4	8	6	130	225	383
Number of pregnant women started on ART at this facility during the year						0		57	57
Number of HIV positive patients assessed for TB at last visit in the year	1	2	13	11	77	76	870	1509	2559
Number of HIV positive patients started on TB treatment during the year	0	0	0	0	0	0	3	4	7
Net current cohort of people on ART in the cohort completing, 12 months during the year	0	1	2	1	1	3	61	70	139
Number of clients surviving on ART in the cohort completing, 12 months on ART during the year	0	0	2	1	1	3	42	55	104
Number of people accessing ARVs for PEP	0	0	1	2	4	3	57	53	120
Number of individual on ART FIRST LINE	0	0	7	3	58	57	859	1571	2555
Number of individual on ART SECOND LINE	2	3	7	8	24	21	61	68	194
Number of individual on ART THIRD LINE	0	0	0	0	0	0	1	2	3

Tuberculosis (TB) treatment

Dr. Ambrosoli Memorial Hospital offers TB treatment services. These services are all integrated into the general medical care activities. The screening process starts in the OPD where all coughers are identified and isolated. Confirmed cases are immediately admitted to the TB treatment unit for the duration of the intensive phase of treatment before being discharged on CB-DOTs. All treatment follow ups are done from the unit. Table 6.10 summarizes the number of registered TB patients in the last five (5) FYs.

The number of smear positive TB identified dropped in 2018/2019. Decline in active case findings both at OPD level and in the community might explain the reduced number of patients enrolled. TB in children remains a possible underestimated problem. Due to the difficulty in diagnosis, a higher index of suspicion must be employed homestead screening and presumptive diagnosis especially among the malnourished admissions.

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

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
No. of patients registered (all)	192	233	223	243	196
Children (< 5 yr.)	11	9	4	11	16
Disaggregation by Disease					
New Pulmonary Positive	97	154	175	109	82
Relapses Pulmonary Positive	4	5	4	6	7
Failure Pulmonary Positive	8	3	2	0	1
Default Pulmonary Positive	9	7	8	12	10
New pulmonary Negative	26	26	49	99	82
Relapses Pulmonary Negative	4	2	0	1	0
Default Pulmonary Negative	4	3	1	3	0
Pulmonary no smear done	0	27	19	0	0
Extra Pulmonary	0	6	34	16	14
Disaggregation by Treatment					
New Patients	161	213	207	224	198
Re-treatment	25	20	16	22	18
Other Patients					
Transferred in	0	3	0	0	7

Identification of MDR/MTB cases, in the adult population remain low. Patients identified are referred to the MOH treatment center in Kitgum.

Table 6.11: MDR/MTB diagnosis during the FY 2018-19

Age group	Samples Collected	Samples Tested	MTB positive Cases	MDR positive (Rifampicin Resistant TB)	MDR cases referred
< 15 years	151	151	3	0	0
15 yrs.& above	1316	1316	154	2	2
Total	1467	1467	157	2	2

TB treatment outcome

Mortality among TB patients remains high. Late diagnosis and comorbidities contribute to the high death toll. HIV and malnutrition are the main leading diseases aggravating the clinical outcome. Final causes of death are often severe respiratory failure and hypoglycaemia in severely wasted patients. It is clear that a strategy to reduce mortality has to go along early identification of cases first; maintaining a high level of suspicion especially among risk category.

Unfortunately, rapid screening test, like TB Lam, provided free of charge to patients (from MOH) has been unavailable for very long time.

Defaulters are also still a high group of patients. This is coupled by lack of proper follow up of patients on treatment. In 19/20, strategies to ensure active case identification and retention on care are in place, to improve the facility performance.

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

Outcome of treatment	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**	**FY 2018-19**
	Number	Number	Number	Number
Cured	44	20	49	53
Treatment Completed	19	28	52	101
Died	13	19	27	28
Failure	1	0	2	2
Defaulted	70	7	13	24
Transfer out	45	18	N/A	36
Total	**192**	**92**	**143**	**244**

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

Outcome of treatment	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Cured	28	38	19	47	53
Treatment Completed	17	16	24	14	26
Died	8	6	18	6	6
Failure	2	2	0	0	2
Defaulted	42	30	1	0	9
Transfer out	22	31	2	N/A	29
Total	**119**	**123**	**64**	**67**	**125**

Orthopaedic Services

Orthopaedics services was run by two Orthopaedics officers. Non operative treatment is still the main treatment provided, while surgery is performed, out of the listed surgical camps occasionally. Patients from the hospital and the district are still reluctant to referrals, both for cultural and financial reasons. The high number of orthopaedic patients call for strengthening of the operative treatment. The hospital does not have an orthopaedic surgeon.

Another challenge is represented by the lack of a qualified physiotherapist, who offers crucial support to the proper management of patients. So far orthopaedic officers also care for this aspect of treatment.

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

Procedures	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Plaster (POP)	622	236	421	765	985
Physiotherapy	72	62	72	67	44

Mental health clinic

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

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

In our OPD, Epilepsy still remain the leading psychiatric problem encountered. Organic psychosis and alcohol abuse also increased.

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

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

Diagnosis	FY 2015-16		FY 2016-17		FY 2017-18		FY 2018-19	
	No.	%	No.	%	No.	%	No.	%
Epilepsy	130	76.4	238	72.3	1,001	88.70%	576	85.3%
Drugs/alcohol abuse	19	11.2	33	10	37	3.30%	46	6.8%
Depression & post-traumatic stress disorders	6	3.5	21	6.4	28	2.50%	21	3.1%
Psychosis (schizophrenia)	3	1.8	2	0.6	6	0.50%	1	0.1%
Bipolar affective disorder	2	1.2	4	1.2	36	3.20%	5	0.7%
Attempted suicide	1	0.6	0	0	2	0.20%	0	0.0%
HIV related Psychosis	1	0.6	4	1.2	2	0.20%	3	0.4%
Other mental illnesses	8	4.7	27	8.2	16	1.40%	23	3.4%
Total	**170**	**100**	**329**	**100**	**1,128**	**100.00%**	**675**	**100.0%**

Regular support (once a month) is offered by "Basic Needs" Uganda, a UK funded partner CBO that offer free psychiatric services to patients affected by various mental conditions (within the facility) on a monthly basis. Below is a summary of the activities (Note: these excludes figures from the hospital above)

The table above shows patients diagnosed with mental disorder and epilepsy from June 2018 to July 2019

Diagnosis	MALE	FEMALE	TOTAL
Alcohol Use Disorder	4	1	5
Alcohol Use/Depression	0	1	1
Alcohol Use/Drug Use/Psychosis	1	0	1
Alcohol Use/Epilepsy	1	0	1
Alcohol Use/Psychosis	3	0	3
Behavioral Disorder	1	0	1
Behavioral Disorder/Developmental Disorder	1	0	1
Behavioral/Developmental/Psychosis	1	0	1
Behavioral/Epilepsy	1	0	1
Depression	3	29	32
Depression/Psychosis	0	1	1
Developmental Disorder	3	2	5
Drug Use Disorder	1	0	1
Epilepsy/Seizure	102	74	176
Psychosis	9	10	19
Developmental Disorder/Epilepsy	1	2	3
Epilepsy/Psychosis	1	0	1
Total	**159**	**94**	**253**

Out of the 253 PMDE's who have been enrolled, 96 are females and they compose a total percentage of 38% and the 159 (62%) are males.

Dental Clinic

Dental services remain an outstanding unmet need in Agago District. The hospitals' clinic located in the OPD has since closed more than four (4) years ago. The machines and equipment required have either worn down with aging or mechanically broken down.

Minor dental services continue to be integrated inside routine hospital activities on a case by case basis (e.g tooth extraction), this however, is far from addressing the actual problem. In the next FYs, we shall continue to lobby through available partners with support to revamp the unit.

Palliative Care

Palliative care services utilization continues to take shape albeit numerous implementation challenges. Understanding the concepts of palliative care has been a challenge to many care

givers. This daunts perception and attitude. The other main challenge facing palliative care implementation is; lack of funding towards patient follow up and provision of essential palliative care supplies.

In the subsequent FYs, there is a plan by the management to integrate palliative care outreaches into PHC activities. Table 6.16 summarizes the number of patients (by diagnosis) who accessed palliative care in 18/19.

Table 6.16: Number of Patients who received Palliative Care in the FY 2018-19

Clinical Condition	Number
HTN	10
CCF	7
SCD	7
ASTHMA	6
HIV	6
BRONCHLITIS	5
DKA	5
HEP B	5
LIVER CHIRROSIS	5
ANEAMIA	4
Diabetes Mellitus	4
Tuberculosis IN ISS	4
RENAL FAILURE	4
COPD	3
SEV. MALARIA	3
Others	61
Total	**139**

INPATIENTS DEPARTMENT

Summary of beds and qualified health personnel

The hospitals' bed capacity has remained 271. In the FY 18/19, a total of six (6) Medical Officers worked in the hospital; five (5) in the wards and one attached to ART clinic. A Pediatrician covered the Pediatrics ward. The surgical ward was covered by a Surgeon, who also doubled as the CEO until the arrival of a second Surgeon at the end of January. During the entire year, volunteer doctors from Idea onlus (Italy), have been attached with a three (3)

months' rotation in Pediatric and Medical wards. Their presence bridged significantly critical HRH gaps and also provided mentorship to the local medical staff.

Other Specialists offered their temporary collaboration to the hospital activities in the field of: Obstetrics & Gynecology, Urology and Radiology, and Anesthesia. These were in the form of organized medical missions with support from the Ambrosoli foundation.

The average number of beds per nurse/midwife reduced to 3.4 from 5.2 last year, with Medical Ward being the ward with the highest ratio beds to nurse/midwife (7.4) and Maternity Ward the lowest (3.9).

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	8	7.4
TB Ward	18			
Surgical Ward	76	1 Surgeon 1 Medical Officer 2 Orthopedic Officers	11	6.9
Maternity & Gyn Ward	75	2 Medical Officers	19	3.9
Pediatric Ward	61	1 Medical Officer 1 Pediatrician (July 2018 – October 2018)	10	6.1
Total	271	2 Specialist Doctors and 5 Medical Officers	48	3.4

Utilization indicators

The total admissions slightly increased in 2018-19 (9.9% increase). The overall recovery rate has remained more or less constant at 97.09% in 2018/19. Overall mortality raised to 1.3% from 0.85%. The increased mortality was related to AIDS, cardiovascular disorders and malaria complications.

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

Indicator	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
No. of beds	271	271	267	271	271
Total Admissions discharged	12,799	22,274	20,446	13,460	14,794
Patient days	66,386	86,898	100,930	68,521	69,329
Average Length of Stay	5.2	3.9	4.9	5.1	4.7
Turn over interval	2.5	0.5	-0.17	2.26	2.0
Throughput per bed	47.2	82.2	76.6	49.7	54.6
BOR	67.10%	87.90%	103.60%	69.30%	70.10%
No. Deaths	180	251	204	115	192
Mortality Rate	1.40%	1.10%	1.00%	0.85%	1.3%
Recovery Rate	98.50%	98.00%	98.80%	97.00%	97.09%
Self-discharges	11	14	48	20	67

Patient Days and Average Length of Stay (ALOS)

The number of days of inpatient services increased slightly by 1.2% in 18/19. The ALOS reduced by 7.8%. This was still above the national recommendation of 4.5 (ALOS). The reduction meant most of our care was offered in the less expensive outpatient setting; pointing towards more efficiency towards reduction of cost of treatment.

Bed Occupancy Rate (BOR) and Throughput per Bed

The hospital Bed Occupancy rate (BOR) remains below the optimal level of 85% in all the Wards except Pediatric Ward. Surgical Ward registered the lowest BOR followed by Maternity (in agreement with the ALOS above). Malaria and its' associated complications was responsible for the increased BOR observed in the CHW. On the other hand, maternity ward had the highest number of patients treated per bed (82.2%) followed by CHW (67.9%). Surgical and Maternity wards had the lowest throughput per bed in 18/19.

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

Overall, the number of deaths in the hospital increased by 67% compared to previous FY. This reflects an overall mortality rate of 1.3% (c.f 0.85%) of all patients treated in the hospital. The recovery rate increased by 0.09% from previous FY. Mortality rate was highest in the TB ward (4.64%) followed by Medical ward (3.84%). This was mainly due to HIV associated comorbidity and non-communicable diseases.

Maternal Mortality increased significantly by 450% from the previous FY. The mortality audits conducted revealed late referrals and complications of septic abortion as the major causes of this increase. The hospital has improved collaborative efforts with the office of the DHO to bridge this gap, which remains a problem to date.

Forty seven (47) more people self-discharged from the hospital in 18/19 c.f 17/18. 65.7% of these self-discharges were from the CHW, followed by Medical ward, 28.4%. Patients often self-discharge in the form of escapes to avoid paying medical bills invoiced to them. This indirectly speaks about the attitude that may have come about by the prevailing poverty levels in the neighboring community.

Table 6.19: Key indicators per ward in the last 5 FYs

MEDICAL WARD					
	FY 14-15	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
No of beds	41	41	41	41	41
Total Admissio	2,053	3,088	2,792	2,072	2,237
Patients days	7,954	10,392	14,880	11,334	11,310
ALOS	3.9	3.4	5.5	5.5	5.1
Throughput per bed	50.1	75.3	68.1	50.5	54.6
BOR	53.20%	69.40%	99.40%	75.70%	75.60%
No of Deaths	94	95	79	63	86
Mortality rate	4.60%	3.10%	2.82%	3.04%	3.84%
Recovery rate	95.40%	95.30%	97.1	95.50%	95.31%
Self-discharges	2	6	2	4	19

SURGICAL WARD[1]					
	FY 14-15	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
No of beds	76	76	71	76	76
Total Admissions	1,974	2,060	2,171	2,024	2,055
Patients days	14,870	16,055	17,833	17,995	14,721
ALOS	7.5	7.8	16.4	8.9	7.2
Throughput per bed	26	27.1	30.6	26.6	27.0
BOR	53.60%	57.90%	68.80%	64.90%	53.10%
No of Deaths	22	40	27	13	31
Mortality rate	1.10%	1.90%	1.24%	0.64%	2%
Recovery rate	98.40%	94.60%	98.4	98.80%	98.35%
Self-discharges	10	7	7	4	3

PAEDIATRIC WARD					
	FY 14-15	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
No of beds	61	61	61	61	61
Total Admissions	3,741	10,706	9,671	3,810	4,143
Patients days	17,498	33,596	44,765	19,783	20,188
ALOS	4.7	3.1	4.6	5.2	4.8728
Throughput per bed	61.3	175.5	158.5	62.5	67.9
BOR	78.60%	######	201.1	88.90%	90.70%
No of Deaths	48	102	83	36	59
Mortality rate	1.30%	1%	0.85%	0.94%	1.42%

OBSTETRICS& GYNECOLOGY WARD					
	FY 14-15	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
No of beds	75	75	75	75	75
Total Admissions	4,845	6,195	5,593	5,302	6,165
Patients days	22,173	22,673	20,107	17,331	20,984
ALOS	4.6	3.6	5.1	3.3	3.4
Throughput per bed	63.8	82.6	74.6	70.7	82.2
BOR	81%	82.80%	73.5	63.30%	76.70%
No of Deaths	8	4	6	1	7
Mortality rate	0.16%	0.06%	0.11%	0.02%	0.11%

Recovery rate	99.30%	98.60%	99.10%	98.70%	97.51%
Self-discharges	0	0	2	10	44

Recovery rate	99.80%	99.60%	99.90%	99.40%	99.9%
Self-discharges	1	0	1	0	0

TB WARD					
	FY 14-15	**FY 15-16**	**FY 16-17**	**FY 17-18**	**FY 18-19**
No of beds	18	18	19	18	18
Total Admissions	186	225	219	252	194
Patients days	3,891	4,182	3,345	2,078	2,126
ALOS	20.9	18.6	8.2	8.2	11.0
Throughput per bed	10.3	12.5	11.5	14	10.8
BOR	59.20%	63.70%	48.20%	31.60%	32.40%
No of Deaths	8	10	10	2	9
Mortality rate	4.30%	4.40%	4.56%	0.79%	4.64%
Recovery rate	95.70%	95.10%	95.40%	99.20%	94.85%
Self-discharges	0	1	0	0	1

Inpatient referrals

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

	FY 2014-15	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**	**FY 2018-19**
Referrals to hospital	474	449	1,328	1,378	1552
Referrals from hospital	87	173	137	267	171
Total	**561**	**622**	**1,465**	**1,645**	**1723**

There was a 4.7% increase in the number of hospital referrals. Referrals to the hospital which was solely responsible for this, increased by 12.6%. The hospital has continued as the referral facility for Agago and four (4) other neighboring districts. Increased referral support towards MCH by USAID agencies may have contributed to these. The number of referrals out reduced by 36% from the previous year. The hospital plans to consolidate more specialized work force to further reduce referral needs.

Morbidity causes

As it was in 17/18, malaria remained the leading morbidity cause (27.13% of all admissions) followed by Injuries (13.94%). The malaria data also reflect a 21.1% increase from previous FY. It's important for more interventions to be directed towards community prevention of malaria spread; as often, it is more difficult to manage the complications that results from

malaria infection. The pattern of injuries observed was a mix of community alcohol related violence and a few road traffic accidents.

As already anticipated in the previous FYs, NCDs continue to pose a significant threat; accounting for 12.32% of all admissions (others), a rise of up to 99% from the previous FY. Our public health intervention integrates messages aimed at creating NCD awareness for the mass.

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

		FY 2017-2018		FY 2018-2019	
	Causes of Morbidity	**No. of cases**	**% on all diagnoses**	**No. of cases**	**% on all diagnoses**
1	Malaria	1844	17.90%	3159	27.13%
2	Injuries	1639	15.91%	1623	13.94%
3	Other Complications Of Pregnancy	292	2.83%	548	4.71%
4	Pneumonia	453	4.40%	534	4.59%
5	Abortions	499	4.84%	509	4.37%
6	Anaemia	420	4.08%	463	3.98%
7	Respiratory Infections (Other)	325	3.16%	345	2.96%
8	Septicemia	643	6.24%	283	2.43%
9	Diarrhoea	267	2.59%	278	2.39%
10	Gastro-intestinal disorders (non-infective)	316	3.07%	227	1.95%
	All others	637	6.18%	1435	12.32%
	Total	**10,300**	**100.00%**	**11,646**	**100.00%**

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

	FY 2014-15	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**	**FY 2018-19**
Malaria cases	1,513	9,664	7,950	1,844	3,159
% of all diagnosis	6%	40.16%	34.10%	22.40%	27.00%

Mortality causes

Cardiovascular diseases and their complications were the leading cause of death in 18/19 (mortality rate of 13.95%). New-born morbidities followed with 11.54%. New born deaths

were predominantly related to asphyxia and early onset sepsis, usually compounded by prematurity. The establishment of the New born Intensive Care Unit services in Kalongo was timely and saw referrals from LLUs of new-borns increase dramatically.

Table 6.23: Top ten causes of death among inpatients all wards FY 2017-18 and FY 2018-19

	Causes of Mortality among Inpatients	FY 2017-2018			FY 2018-2019		
		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	Other Neonatal Conditions	4	93	4.30%	21	182	11.54%
2	Malaria	48	1844	2.60%	19	2788	0.68%
3	Premature baby (as condition that requires management)	5	90	5.56%	14	142	9.86%
4	Injuries	18	1581	1.14%	14	1623	0.86%
5	Pneumonia	18	460	3.91%	13	534	2.43%
6	Other Cardiovascular Diseases	10	87	11.49%	12	86	13.95%
7	Anaemia	4	203	1.97%	12	463	2.59%
8	Respiratory Infections (Other)	1	325	0.31%	11	345	3.19%
9	Tuberculosis	9	247	3.64%	9	194	4.64%
10	Gastro-intestinal disorders (non-infective)	1	189	0.53%	6	227	2.64%

MEDICAL WARD

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

Staff Composition

The ward was 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 2018-19

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

Key Indicators in Medical ward

The total admissions remained stable in 2018/19 with an increasing trend due to malaria outbreak towards the end of FY. The ALoS remained around 5.1. The BOR slightly decreased to 75.57% in 2018/19. As already mentioned above, these indicators point towards reduced utilization since most of the patients were treated in the OPD, however, the patients spent relatively long time on admission. The clinical efficiency of the ward remained stable.

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

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
No. of beds	41	41	41	41	41
Total Admissions	2,053	3,088	2,792	2,072	2,237
Bed days	7,954	10,329	14,880	11,334	11,310
ALoS	3.9	3.4	5.5	5.5	5.1
BOR	53.20%	69.40%	99.40%	75.70%	75.57%
Throughput	50.1	75.3	68.1	50.5	54.6
Turnover interval	3.4	1.5	0.03	1.75	1.63
Deaths	94	95	79	63	86
Death Rate	4.60%	3.10%	2.82%	3.04%	3.84%
Recovery Rate	95.40%	95.30%	97.10%	95.50%	95.31%
Self-discharges	2	6	2	4	19

Morbidity causes

As experienced in the previous FY, Malaria was the leading cause of admission into the medical ward (accounting for 29.12% of the total admission) followed by Gastrointestinal

disorders (accounting for 10.51% of all admissions. Infectious disease remains the big burden of diseases. Septicemia reduced by 83.5% during the FY. The overall morbidity burden on the ward increased by 8%.

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

Causes of Morbidity in Medical Ward		FY 2017-18		FY 2018-19	
		No. of cases admitted	% on all admissions in Medical Ward	No. of cases admitted	% on all admissions in Medical Ward
1	Malaria	364	31.20%	651	29.12%
2	Gastrointestinal disorders not infective	155	13.30%	235	10.51%
3	Urinary Tract Infection	50	4.30%	102	4.56%
4	Hypertension	84	7.20%	93	4.16%
5	Pneumonia	65	5.60%	84	3.76%
6	Septicaemia	225	19.30%	71	3.18%
7	Respiratory Tract Infections-(not Pneumonia)	62	5.30%	55	2.46%
8	Cardio vascular Disease	99	8.50%	53	2.37%
9	Asthma	54	4.60%	37	1.66%
10	Typhoid Fever	10	0.90%	16	0.72%

Mortality causes

In the FY 18/19, suicide was the leading mortality cause (CFR 14.29%), with a 169.6% increase. Suicide causation was largely related to alcohol and other substance abuse. The community, currently faced with ravaging poverty is also recovering from a long standing war conflict. This compounded by the lack of proper dedicated mental health services support in the district contributes to the rising suicidality and suicide.

NCDs have continued to contribute significantly to mortality causation in the ward. Liver cirrhosis (mostly due to alcohol and other drugs toxicity) was the second leading cause of death (CFR 5.13%). Of late, Liver cirrhosis due to hepatitis B is on the rise. Mortality due to cardiovascular diseases reduced by 67.2% in 18/19.

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

	Causes of Mortality in Medical Ward	FY 2017-18			FY 2018-2019		
		No. of disease specific deaths	No. of cases admitted	Case Fatality Rate	No. of disease specific deaths	No. of cases admitted	Case Fatality Rate
1	Suicide attempt	1	19	5.30%	2	14	14.29%
2	Liver Cirrhosis	3	37	8.10%	2	39	5.13%
3	Pneumonia	5	65	7.70%	4	84	4.76%
4	Cardiovascular Disease	11	99	11.10%	2	55	3.64%
5	Septicaemia	2	225	0.80%	1	71	1.41%
	Total	**22**	**445**		**11**	**263**	

SURGICAL WARD

Surgical Ward is accommodated in one of the oldest structures in the hospital, with 71 beds. Despite some recent repairs, the Ward shows several structural problems and attention should be put on its renovation. Beside the physical structure of the building, furniture's (beds, bed locker, mattresses etc.) are in a very poor status. This not only compromise the comfort of the patients but greatly affects staff work and hygiene.

Staff composition

The total number of staff was not constant during the fiscal year. The Ward is headed by a Surgeon with the help of a Medical Officer. Under their responsibility falls also the supervision of the operation theater. The Internship program, started in 2016 is still running with an average of three Intern doctors attached periodically. During the course of the year, visiting surgeons have also operated in the hospital alongside the local team.

Table 6.28: Staff composition in Surgical Ward in the FY 2018-2019

Cadre/ Discipline	Qualification	Number
Surgeon	Bachelor Degree in Medicine and Surgery and Master in Surgery	1
Medical Officer	Bachelor Degree in Medicine and Surgery	2
Registered Midwife/Nurse	Diploma in Midwifery and Nursing	2
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	2

Enrolled Nurse	Certificate in Nursing	7
Nursing Aid	Trained on the job	0
Orthopedic Officer	Diploma in Orthopedic	2
Physiotherapist Assistant	Certificate of Physiotherapist Assistant	0
Total		**16**

Key Indicators in surgical ward

The number of admissions remained stable compared to previous year. The ALoS slightly reduced by 19.1% from the previous year. This was nonetheless high, compared to the national average of 4.5. The BOR also reduced by 18.2%. The Throughput per bed and Turnover interval on the other hand increased by 1.5% and 31.3% respectively. Overall the utilisation of inpatient services in the surgical ward reduced. The patients however, spent longer than usual in admission; likely increasing cost of care. 98% of all patients treated in the surgical ward fully recovered. Mortality rate increased by 136%.

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

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
No. of beds	76	76	71	71	71
Total Admissions	1,974	2,060	2,171	2,024	2,055
Bed days	14,870	16,055	17,833	17,995	14,721
ALoS	7.5	7.8	16.4	8.9	7.2
BOR	53.60%	57.90%	68.80%	64.90%	53.07%
Throughput	26	27.1	30.6	26.6	27.0
Turnover interval	6.5	5.7	3.7	4.8	6.3
Deaths	22	40	27	13	31
Death Rate	1.10%	1.90%	1.24%	0.64%	1.51%
Recovery Rate	98.40%	94.60%	98.40%	98.80%	98.35%
Self-discharges	10	7	7	4	3

Morbidity causes

The leading cause of admission remains injury, which account for 69.06% of total admissions. Unfortunately the cases of domestic violence, SGBV and injuries related to alcohol intoxication remain very high. Little or nothing is done concerning trauma prevention in the

community. Conflict solving, family counselling and safety on roads should receive more attention among local leaders and Health Educators.

Beside trauma, the pattern of remaining diseases in the ward present a marked shift towards emergency surgery and surgery of poverty (abscesses and osteomyelitis).

Table 6.30: Top 10 causes of admissions in Surgical Ward-FYs 2017-2018 & 2018-2019

	Causes of Morbidity in Surgical Ward	FY 2017-18		FY 2018-2019	
		No. of cases admitted	% on all admissions in Surgical Ward	No. of cases admitted	% on all admissions in Surgical Ward
1	Injuries due to other causes	1338	68.20%	1402	69.06%
2	Abscess	211	10.80%	186	9.16%
3	Hernias	154	7.90%	125	6.15%
4	Injuries due to Road Traffic Accident [RTA]	65	3.30%	73	3.59%
5	Intestinal Obstruction	22	1.1	59	2.90%
6	Hydrocele	49	2.5	55	2.70%
7	Snake bites	47	2.4	49	2.41%
8	Injuries due to Burn	40	2	36	1.77%
9	Osteomyelitis	10	0.5	31	1.53%
10	Urinary Tract Infections	25	1.3	24	1.18%

Mortality causes

Injuries accounted for more number of deaths in the FY followed by Intestinal Obstruction. However, Dental abscesses registered the highest case fatality rate, followed in order by Intestinal Obstruction and Injuries. These cases mostly present late in the disease course, complicating any possibility to offer lifesaving interventions. Diagnostic challenges has also made it impossible to correctly diagnose and treat major head injuries; the nearest town with available CT scan services is more than 300 kilometers away. Clinicians have had to often rely on clinical judgement to treat these patients.

It is important to note that the hospital does not have intensive care unit services, complicating further the care for critical post-operative patients, who are in need of airway support. In the next FY, the management plans to start the process of creating a HDU in order to bridge service gaps for the critical post-operative patients.

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

	Top 5 Causes of Mortality among Inpatients	No of Disease specific deaths	Total No of cases of the disease admitted	Case Fatality Rate
1	Injuries due to other causes	5	98	5.10%
2	Intestinal obstruction	3	51	5.88%
3	Abdominal cases	2	49	4.08%
4	Dental abscess	2	33	6.06%
5	Others	1	49	2.04

OPERATING THEATER

The hospitals' operating theater runs seven (7) days a week, 24 hours a day. The theater is housed in the newly constructed building with grants from the Japanese Government, in 2015. The work in the theater is arranged to cover for elective and emergency operation schedules, with staff distributed to cover these schedules.

Below is the staff compositions. It is to be reported that the number and composition of staff kept changing during the course of the year. While some left the Hospital, others were moved to different departments. It has been (and is still) a major challenge for the hospital to retain anesthetic staff for a long time, since emoluments do not adequately compete with what other institutions offer.

Table 6.32: Staff Composition in the operating theatre

Cadre/ Discipline	Qualification	Number
Anesthetist Officer	Diploma in Anesthesia	3
Registered Nurse	Diploma in Nursing	1
Enrolled Midwife	Certificate in Midwifery	1
Enrolled Nurse	Certificate in Nursing	1
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	2
Medical Theatre Assistant		4
Nursing Assistant	Certificate in Nursing Assistant	3
Nursing Aid	Trained on the Job	4
Total		**19**

Surgical Procedures

The total number of surgeries performed in the hospital has continued to exponentially rise over the course of the past years. The FY 18/19 saw a 2.3% increase in major surgeries and slight decline in minor surgeries. 44.52% of the surgeries performed were emergency operations. Of these, more than 45% are emergency C/S. The hospital has continued as the MOH accredited internship center for surgical disciplines.

Table 6.35: Trend of surgical activities in last 5 FYs

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Total Operations	1,913	1,790	2,639	3,425	3286
Major operations (including C/S)	565	661	994	1,285	1314
Minor operations	1,348	1,129	1,645	2,140	1,972
Emergencies	327	282	381	530	585
Emergencies as % of total major operations	57.90%	42.70%	38.30%	41.20%	44.52%

The hospital had collaborations with organizations such as; Njokuty foundation, AMREF health Africa, Lions club of Gulu and the MOH to arrange surgical/medical camps and bridge the gap for unmet surgical needs in the region. The hospital also partnered with volunteer doctors from the USA to arrange surgical camps. Numerous medical and surgical camps were also arranged through the Ambrosoli Foundation, whereby volunteer doctors and nurses from Italy worked with the hospital to offer free or heavily subsidized services to the population.

The largest volume of major surgeries performed were Caesarean sections, contributing to 18.5% of procedures. This is slightly above the MOH recommendation of less than 15%. The vast majority of the C/S performed are a consequence of referrals (often late) from LLUs. Orthopedic surgery increased, thanks to the partnership with the Njokuty foundation. The hospital intends to build on these and offer training opportunity to locally based orthopedic surgeon in the next FY.

Table 6.34: Top major surgical procedures performed in the FY 2018-19

No.	Top major surgical procedures	Number of patients	Proportion (%)
1	Caesarian sections	609	46.3%
2	Orthopedic Surgery	147	11.2%
3	Herniorrhaphy	121	9.2%
4	Laparotomy	105	8.0%
5	Plastic/ reconstructive surgery	25	1.9%
6	Other Major procedures	283	21.5%
	Total	**1,314**	

Among minor procedures abscesses and surgery of septic conditions were very high, mainly as result of the general poor living conditions and nutritional status of the population.

Table6.34: Top minor surgical procedures done in FY 2018-19

No.	Top minor surgical procedures	Number of Patients	Proportion (%)
1	Minor Orthopedic Surgery	1238	62.8%
2	Incision and drainage of abscesses	235	11.9%
3	Debridement and care of wounds and skin grafting	187	9.5%
4	Circumcision	8	0.4%
5	Other Minor procedures	304	15.4%
	Total	**1,972**	

Generally speaking, anesthesia use in 18/19 was 38.6% lower than in 17/18. The vast majority of surgery performed were under general anesthesia (without intubation). The use of ETT in general anesthesia has been stable in the FY.

The hospital faces major challenges in the sustainability of anesthetic officers as a work force, who often seek greener pastures elsewhere.

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

Type of Anesthesia	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Local Anesthesia	569	276	269	344	163
General Anaesthesia	1030	1,149	1,101	1,175	645
Spinal Anesthesia	290	335	247	262	263
General Anesthesia with ETT	24	30	41	69	65
Total	1,913	1,790	1,658	1,850	1136

SURGICAL CAMPS

As already stated above, there were multiple surgical camps held in the hospital as a result of collaborations built with other institutions. These collaborations are in most instances, cost

sharing between the hospital and the partner organization. The hospital intends to consolidate these relationships to continue providing and bridge service gaps in the region.

These camps are either completely free of charges (like the Njokuty Foundation camps) or heavily subsidized for the beneficiaries (like the AMREF coordinated camps).

Table 6.36 (b): Table showing the surgical camps in the FY 18/19

Period	Organization	Total surgeries performed
August 2018	Orthopedic Camp NJOKUTY Foundation	69
November 2018	Orthopedic Camp NJOKUTY Foundation	19
March 2019	Eye surgery Camp AMREF/MOH/Kalongo Hospital	155
April 2019	Surgical Camp Orthopedic NJOKUTY	42
June 2019	Plastics Surgery AMREF/MOH/Kalongo hospital	80

Several other medical missions were also arranged during the FY in collaboration with the Ambrosoli Foundation in Italy. These medical missions not only bridge unmet needs but also offer critical mentorship opportunities to the local work force.

PEDIATRIC WARD

The ward has a capacity of 61 beds, distributed in main the general ward, Nutrition and Isolation Units. With funding secured from the Italian Episcopal Conference, through the Ambrosoli foundation; total refurbishment and reconstruction of the Pediatrics ward started. Construction works will continue for an estimated period of two years, organized in slot so that medical activities can continue running. A more functional ward is expected to be realized that will be able to assist pediatric cases, including an ICU for critical patients.

Staff Composition

The ward was run by two MOs and a Pediatrician from Italy, who also supervise activities in the NICU. The number of nursing staff remained stable despite some few Nurses leaving for further studies. Idea onlus, an Italian organization, has maintained its collaboration with Ambrosoli Hospital by sending volunteer doctors at their final years of Master in Pediatric. Each volunteer spend three months attached to the department in collaboration with MO.

Table 6.37: Personnel assigned to Paediatric Ward in FY 2018-19

Cadre/ Discipline	Qualification	Number
Medical officers	Bachelor Degree in Medicine and Surgery	2
Pediatrician	Specialist	1
Registered Nurse	Diploma in Nursing	1
Registered Comprehensive Nurses		0
Enrolled Nurse	Certificate in Nursing	8
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	1
Nursing Assistant	Certificate in Nursing Assistant	4
Total		**17**

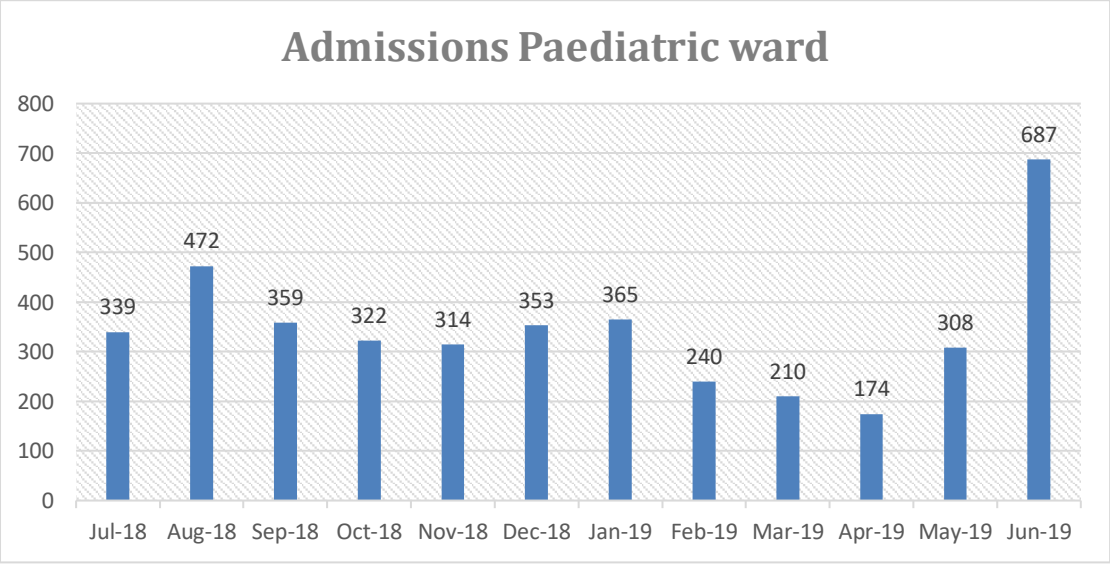
Key ward indicators

The trend of admissions in CHW saw a drastic increase from May. The delay of rainy season created the conditions for an upsurge of malnutrition cases. At the same time the arrival of the rains associated with an increase in malaria cases.

Table 6.38: Pediatric Ward indicators over the last 5 FYs

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
No. of beds	61	61	61	61	61
Total Admissions	3,741	10,706	9,671	3,810	4,143
Bed days	17,498	33,596	44,765	19,783	11,310
ALoS	4.7	3.1	4.6	5.2	4.9
BOR	78.60%	150.90%	201.10%	88.90%	90.70%
Throughput	61.3	175.5	158.5	62.5	67.9
Turnover interval	1.3	-1.1	-2.3	0.65	2.644219
Deaths	48	102	83	36	59
Death Rate	1.30%	1%	0.85%	0.94%	1.42%
Recovery Rate	99.30%	98.60%	95.40%	98.70%	97.51%
Self-discharges	0	0	0	10	44

The ALoS was optimal, with a 90.70% BOR. The children were admitted and discharged more frequently. Malaria and malnutrition outbreak completely distorted the ward routine. The complications resulting from these ailments accounted for the increased death rate in the ward (51.1% increase from previous year).



Morbidity causes

Communicable diseases represents the major morbidity burden in the pediatric age, in Agago district. Malaria was the leading cause of admissions, accounting for 50.03% of all cases. This was also a 68% increase in the number from the previous FY. Gastroenteritis/Diarrhea followed with 92% rise from previous year, and accounted for 9.75% of all admissions. The

top two causes of morbidity, are easily preventable illnesses with prudent public health interventions (an area we shall monitor closely in the next year).

Anemia increased by 40.7%, a direct consequence of the increased malaria cases. Septicemia, which was the second leading morbidity cause in the previous FY reduced by 66% in 18/19. The total number of children admitted due to pneumonia increased by 14.9%. On the other hand, respiratory tract infections reduced significantly by 77%. This most likely points towards late presentation of the children when the disease has progressed.

Table 6.39: Top ten causes of admission in Paediatric Ward - FY 2017-18 and FY 2018-19

Causes of Morbidity	FY 2017-2018		FY 2018-2019	
	No. of cases admitted	% on all admissions	No. of cases admitted	% on all admissions
Malaria	1524	39.40%	2561	50.03%
Gastroenteritis / diarrhea	260	6.70%	499	9.75%
Pneumonia	396	10.20%	455	8.89%
Anemia	140	3.60%	197	3.85%
Sickle cell disease	172	4.40%	187	3.65%
Septicemia	490	12.70%	167	3.26%
Malnutrition	45	1.20%	116	2.27%
Bacteremia	89	1.94%	104	2.03%
Sepsis	47	1.02%	85	1.66%
Respiratory Tract Infection-(not Pneumonia)	338	7.36%	78	1.52%

Mortality causes

Malaria was responsible for the highest number of disease specific deaths in 18/19. However, pneumonia followed by anemia, were the most deadly illnesses (CFR; 2.37% and 1.53% respectively). These conditions were compounded by the lack of intensive care services with adequate oxygen support for the children. Uganda experienced a general shortage of blood products. It was therefore almost impossible to save lives of the children who presented with anemia complications. The hospital tried in vain to seek a waiver of sorts, to allow it mobilize and collect certain blood products and only request the regional blood bank to screen for infections.

Table 6.40: Top five causes of death in Paediatric Ward in FY 2018-19

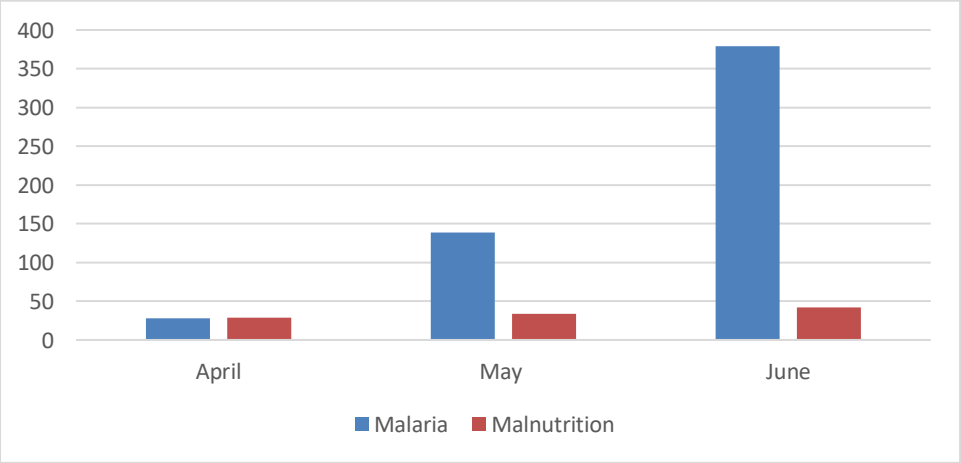
	Causes of Mortality	No of disease-specific deaths	No of cases of the disease admitted in Paediatric Ward	Case Fatality Rate
1	Malaria	14	2160	0.65%
2	Pneumonia	11	465	2.37%
3	Septicaemia	2	222	0.90%
4	Sickle Cell Disease	2	217	0.92%
5	Anaemia	6	393	1.53%

Nutrition unit

The nutrition unit is an annex of the pediatric ward, sharing both doctors and nurses. The FY 18/19 registered a surge in the total cases admitted to the unit (157.8%). The combined delay of rains and outbreak of malaria greatly affected the population of the district chronically challenged by food shortage and poverty. The persistent food insecurity of the region and the baseline poverty remain high risk factors for the vulnerable population.

Support towards nutrition services is significantly lacking, and often so meager (from the regional government stores). The hospital has often had to look for extra resources to support these services, albeit not maintaining a specific budget line. These gaps must be bridged by the MOH/UNICEF in order to meet malnutrition needs in the district.

Trend of admissions malaria and malnutrition



MARTERNITY WARD

Maternity Ward is the largest ward in the hospital with 75 bed capacity. It includes a predelivery area with admission room, first stage room, PET room and labor suite. IPD area is organized in postnatal, post caesarian section and gynecology. The layout of the Ward includes a Doctors' office, Sister In-charge office, duty Room, private rooms and isolation unit. This ward was run by 2 Medical Officers and 17 Midwives who were directly responsible for management of all admitted patients. They also offered training and mentorship to students; given that maternity is the principal practical training ward for students from St. Mary's Midwifery Training School.

Table 6.41: Staff Composition in Maternity Ward in FY 2018-19

Cadre/ Discipline	Qualification	Number
Medical officer	Bachelor Degree in Medicine and Surgery	2
Registered Midwife/Nurse	Diploma in Midwifery and Nursing	1
Registered Midwife	Diploma in Midwifery	1
Enrolled Midwife	Certificate in Midwifery	17
Total		**21**

Key Indicators

The total admissions increased in the FY 18/19 by 16.3%. The ALoS remains stable with a slight improvement in BoR, raised to 76.65%. The turnover interval improved to 1.04, meanwhile death rate raised to 0.11%. The increased death rate were related to late referrals from the LLUs. 99.9% of all admitted patients recovered and were discharged.

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

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
No. of beds	75	75	75	75	75
Total Admissions	4,845	6,195	5,593	5,302	6,165
Bed days	22,173	22,673	20,107	17,331	20,984
ALoS	4.6	3.6	5.1	3.3	3.4

BOR	79.90%	82.80%	73.50%	63.30%	76.65%
Throughput	63.8	82.6	74.6	70.7	82.2
Turnover interval	1.1	0.8	1.3	1.9	1.04
No. Deaths	8	4	6	1	7
Death Rate	0.16%	0.06%	0.11%	0.02%	0.11%
Recovery Rate	99.80%	99.60%	99.90%	99.40%	99.9%
Self-discharges	1	0	1	0	0

Birth indicators

Total deliveries in the hospital increased by 17.5%. This follows the upward trend in utilization of maternal health services already observed in the last five (5) FYs. The USAID, Uganda Voucher plus activity played a pivotal role in increasing access to MCH services for all vulnerable mothers in the district. Caesarean section accounted for 14.6% of total deliveries in 18/19. This is below the MOH recommendation of not more than 15%. 95.1% of the C/S done are emergencies, most of which are referrals from LLUs.

Premature delivery was certainly a big burden. The hospital registered a 74.4% increase. The increase was observed to be related to maternal heavy work and infections (malaria and urinary tract infections). These plus other premature neonates referred from LLUs were managed at the Neonatal Intensive Care Unit of the hospital.

The number of babies born with low birth weight increased by 4.2%. Low birth weight in our catchment area seems to be directly related to maternal nutritional status, which are often poor.

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

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Total deliveries	3,247	3,465	3,453	3,547	4,169
Normal deliveries in unit	2,816	3,111	2,918	2,977	3,617
Abnormal deliveries (incl. C/S)	431	354	535	570	529
Live birth in units	3,238	3,445	3,340	3,499	4,142
Babies born with low birth weight	384	443	652	577	732
Fresh Still births in unit	32	20	20	18	24
Macerated still births in unit	28	26	22	16	35
New-born deaths (0-7 days)	33	34	27	14	69
Maternal Deaths	3	4	6	1	9
Live Births					

Full term normal weight	2,860	2813	2,925	2977	3,384
Full term low birth weight	378	572	606	577	601
Premature cases	n.a.	60	101	90	157
Caesarean Sections					
Elective C/S	42	26	24	26	30
Emergency C/S	327	292	392	530	579
Caesarean Sections total	369	318	416	556	609
C/S as % of total deliveries	11.30%	9.20%	12.00%	15.70%	14.61%
Emergency C/S as % of all C/S	88.60%	91.80%	94.20%	95.30%	95.07%

Main causes of caesarian section as follow:

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

Table 6.44: Origin of mothers who delivered through C/S in the last 5 FYs[8]

Sub-County	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Adilang	28	20	28	49	46
Kotomor	14	10	9	16	35
Patongo	32	15	31	52	58
Patongo T.C.		13	12		
Lukole	45	29	38	58	68
Lukole T.C.		4	10	6	
Kalongo T.C.	21	23	35	39	69
Paimol	25	19	20	32	53
Parabongo	14	18	21	46	40
Omot	14	14	17	34	38
Acholpii	11	5	0	4	25
Lamiyo	5	7	2	9	37
Lapono	36	34	34	60	39
Lira Palwo	17	24	20	28	35
Omiya Pacwa	19	12	10	25	41

[8]Note: Data for Patongo town council and Patongo Sub county are not disaggregated; the same applies to Lukole Town Council and Lukole Sub county (source: Kalongo Hospital theatre, operation book FY 18/19)

Wol	30	25	29	40	25
Total	**311**	**272**	**316**	**498**	**609**

Almost all women who underwent C/S in our Hospital comes from Agago district. Patongo HC 4 remains not operational. In Pader district, the private sector has increased activities in the field of assistance to pregnant women, with few referred to Kalongo, almost all of them for complications. Surely one of the motivating factors for mothers to access qualified medical services during pregnancy/delivery and postnatal care has been the Voucher/USAID project. Therefore the foreseen closure of the same, in 2020 presents several challenges. On the medical side, there is a concrete risk that more disadvantaged mothers will be unable to receive proper care. On the financial side, the Hospital will have to cover the gap left by the lack of insurance reimbursements.

Table 6.45 continuation

Outside the Catchment Area of Agago District (distances of 58 km and above)					
District	**FY 2014-15**	**FY 2015-16**	**FY 2016-17**	**FY 2017-18**	**FY 2018-19**
Pader	30	28	18	17	10
Kitgum	8	4	7	10	1
Abim	11	1	4	7	0
Other	9	10	71	23	0
Total	**58**	**43**	**300**	**58**	**11**

Referrals of patients remains one of the biggest challenges of the District. The poor condition of roads, the lack of functioning ambulances and the level of poverty of the majority of the households in Agago, represents a persistent threats for pregnant mothers. The Hospital still maintains a waiting shelter where mothers with identified risk factors can wait until the delivery. Still this means for some women many weeks away from their family with all the understandable related problems.

Gynaecological ward

The lack of a specialist, the presence of young MOs, at their first employment after school can explain the remarkable decrease in admissions, especially for cases requiring surgical interventions. More specialist conditions, like infertility presently do not find treatment in our Hospital. The gynaecological clinic still runs every Monday in OPD.

Table 6.46: Gynaecological morbidity causes

Diagnosis of admission	FY 2013-14	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Pelvic Inflammatory Disease	106	37	44	46	57	52
Urinary Tract Infection	91	57	55	1	64	0
Cancer of cervix	25	10	7	27	19	13
Uterine Fibroid	16	7	10	6	17	3
Ovarian Cyst	12	23	28	31	16	32
Vaginal Candidiasis	6	5	12	2	4	0
Bartolini's Cyst	6	7	0	1	1	0
Peritonitis	2	1	0	0	1	0
Other Gyn conditions				270	124	143
Total	**243**	**147**	**403**	**384**	**303**	**243**

TB WARD

The TB ward is accommodated in the oldest building in the hospital annexed to the Medical Ward main building. Staffs from Medical Ward attend to patients admitted in this unit.

From the data summarizing the activities of the Ward, it has to be noticed a net increase of deaths (from 0.79% to 5.67%) and a reduction of the recovery rate. Comorbidities, especially HIV coinfection, late presentation, malnutrition all contribute to a poor outcome. Other key challenges affecting outcome includes; poor treatment adherence, GBV and excessive alcohol consumption. MDRT cases are referred to Kitgum treatment centre.

With the revised guidelines on testing and treating TB, the hospital has embarked on intensive active case identification through isolating and treating all confirmed cases. Regular follow up of clients on treatment to assess adherence continued in the community.

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

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
No. of beds	18	18	19	18	18
Total Admissions	186	225	219	252	194
Bed days	3,891	4,182	3,345	2,078	2,126
ALoS	20.9	18.6	8.2	8.2	5.8
BOR	59.20%	63.70%	48.2	31.6	32.40%

Throughput	10.3	12.5	11.5	14	10.8
Turnover interval	14.4	10.6	16.4	17.8	22.9
Deaths	8	10	10	2	11
Death Rate	4.30%	4.40%	4.56%	0.79%	5.67%
Recovery Rate	95.70%	95.10%	95.40%	99.20%	94.33%
Self-discharges	0	1	0	0	94.85%

DIAGNOSTIC SERVICES

Laboratory services

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

The hospitals' laboratory is still a part of the MOH accreditation program, and is currently among the selected laboratories in the country in line for the next regional assessment. Workload in Laboratory decreased by more than 50% in 18/19.

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

	Type of Tests	FY 2014-16	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Parasitology	Malaria Microscopy, Malaria RDTs, Other Haemoparasites, Stool Microscopy.	16,178	33,969	36,283	23,320	23,793
Haematology	HB, WBC Total, WBC Differential, Film Comment, ESR, RBC, Bleeding time, Prothrombine time, clotting time, blood transfusion tests, & Others	26,917	102,373	166,984	111,917	23,156
Biochemistry	Urea, Potassium, Sodium, Creatinine, ALT, AST, Albumin, Total protein, Amylase, Glucose, Uric Acid, Others	6,242	11,729	30,335	13,518	2,069

Bacteriology	ZN for AFBs, Gram staining, Indian Ink, Wet Preps, Urine Microscopy	11,141	9,510	8,291	7,262	6,633
Serology	Syphilis Screening, Hepatitis B, Brucella, Pregnancy Test, Vidal Test, Rheumatoid Factor, Crag	21,186	12,111	21,260	13,270	12,845
Immunology	CD4 tests & others	4,432	3,916	5,123	5,080	2,722
HIV tests by purpose	HCT, PMTCT, Quality control and clinical diagnosis	12,897	16,057	26,913	28,211	22,762
	Total tests	98,993	189,665	295,189	202,578	92,141
	Total lab staffs	8	8	11	11	10
	Average tests per Lab staff	12,290	23,708	26,835	18,416	9214.1

During the FY, the laboratory experienced very frequent equipment breakdowns. The regionalization of HIV implementing partners, partly contributed to this. It was very difficult for the current IP to easily award the service contract for equipment in the Laboratory to a service provider (note; the equipment are used a lot to benefit monitoring of PLWH). The hospital had to therefore shoulder both this cost and costs of reagents for these clients, which are often rendered free of cost, consequently raising operational cost on the hospital.

Malaria positivity in 18/19 increased by 73.9%, in as much as fewer samples were tested compared to the FY 17/18. Hepatitis B continues to be a real threat, with a positivity rate of 9.58%

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

Type of Test	FY 2017-2018			FY 2018-2019		
	Total	Positive	% Positive	Total	Positive	% Positive
Malaria (both slide and RDT)	15,967	3,103	19.40%	10,751	3,627	33.74%
VDRL/RPR	4,010	270	6.70%	3,358	270	8.04%
Hepatitis B	4,594	474	10.30%	2,046	196	9.58%
Brucella	799	86	10.80%	199	9	4.52%

The Gulu Regional Blood bank has remained the supplier of blood to the hospital. The regular supply of blood products is significantly hampered by many factors such as; distance from Gulu, poor state of roads during rainy seasons, and availability of blood at the blood bank.

Towards the end of last FY, the country experienced general shortage of blood, leading to severe impacts of anaemia, especially among under 5s. Sometimes in emergency situations, the hospital has had to collect and screen blood from eligible attendants and volunteers in order to save life, further raising operational cost of the laboratory.

Blood group O and A, RH+ have remained the most consumed blood products. In the FY 18/19, the demand for RH- also increased, providing a real challenge since it is not easy to find RH- donors. With the rise in malaria and associated anaemia in children, the demand for specific blood products like packed cells also continue to rise in the hospital.

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

FY 2017-18						FY 2018-2019					
Group A	Group B	Group AB	Group 0	RH +	RH -	Group A	Group B	Group AB	Group 0	RH +	RH -
33.70%	17.30%	3.40%	44.90%	99.40%	0.60%	31.36%	17.98%	4.70%	44.66%	98.75%	1.25%

IMAGING SERVICES

X ray and Ultrasonography

The department functioned with two dark room attendants and a radiographer. The main challenge has been retention of core staff such as radiographers; and as consequently interrupted vital services in the hospital.

The total number of X rays performed in the FY 18/19 increased by 149.75%. Chest X ray remains the mostly performed followed by upper extremities. This has been the same pattern for the last 5 FYs.

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

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Chest	2,974	2,752	2,062	572	1,459
Upper extremities	1,172	1,022	848	458	997

Lower extremities	959	1,160	800	278	710
Vertebral column	314	390	338	83	283
Skull and mandible	269	351	332	53	158
Shoulder and clavicle	234	195	135	69	139
Pelvis and hip	276	258	196	60	153
Abdominal – plain	226	175	130	51	155
Abdominal –contrast	1	1	0	0	2
Screening	0	0	0	0	0
Total	**6,423**	**6,304**	**4,841**	**1,624**	**4,056**

Ultrasound examinations reduced by 15.1% in 18/19. The reduction could be attributed to the departure of the skilled radiographer towards the end of the FY. Gynecological and Abdominal US were the mostly performed examinations. We have continuously motivated and trained all the doctors to be able to do basic diagnostic U/S. In the next FY, there is a plan to start up a training program for U/S, aimed at boosting more sustainable capacity to support such vital services. The existing U/S machines are old and prone to break down. The future plan is to acquire a U/S machine with Doppler capability.

Table 6.51: Ultrasound examinations conducted in the last 2 Fys

	FY 2017-18	FY 2018-19
Obstetrics	728	840
Gynaecology	1,326	1,077
Abdomen	1,344	1,044
Others	336	211
Total	**3,734**	**3,172**

PHARMACY ACTIVITIES

The Pharmacy received great attention from the HMT due to the relevant cost that drugs supplies represent for the hospital budget. The operation of the Pharmacy was split into; in patient, outpatient and ART clinic. This was in a bid to ensure efficiency and ease of controls. All these units were supervised by the central pharmacy.

The Pharmacy continued to implement the Unit Dose System (UDS) of drugs management in the hospital. Emergency drugs are present in specifically designed boxes in all the Wards, under regular check of Pharmacy dispensers.

Table 6.52: Staff composition in Pharmacy and General Store in the FY2018-2019

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

Storage

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

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

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

Table 6.53: Average temperature and humidity recorded in Pharmacy Department FY 2018-19

Reading Time	Temperature	Humidity
8:15 am	24 C	60%
12.00 pm	27 C	44%
5.00 pm	28 C	42%

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

Pharmaceutical supplies

The supplies are mainly ordered from Joint Medical Stores (JMS). Items not available at JMS are bought from Abacus or other open market options. JMS were the main suppliers for the antiretroviral drugs for the HIV Clinic. The supplies for ARVs and Anti TBs, currently handled by JMS hasn't been smooth with frequent out of stock periods.

Procurement system

Drugs and sundries are procured in most cases on a quarterly basis. However, financial constrains have limited the possibility to proceed with big orders and a more fragmented systems has been utilized to cover the pressing requests from the Wards.

Procurement starts at the store level, where buffer stock levels are monitored and orders are made. The orders are expected to come at least one month before the buffer stock is expected to be utilized. Orders are reviewed by the Drug and therapeutic committee before the procurement department takes up for execution.

On a number of occasions, the hospital experienced shortage of some commodities. Mainly because such commodities were not available with suppliers and the country.

Inventory management

There is a manual and computerized inventory system that helps to manage purchase and stock movements. Stock taking is done biannually and physical count monthly to ensure accountability. The management also sanctioned spontaneous stock inventory to monitor effectively real time status.

Distribution and use

The Pharmacy issues drugs to the different wards and departments according to a Unit dose system.

Table 6.54: Most used drugs (excluded HIV/AIDS clinic) - FY 2017-2018 and FY 2018-2019

Drug description	FY 2017-2018		FY 2018-2019	
	Quantity issued tablets/vial	Monetary value (UGX)	Quantity issued tablets/vial	Monetary value (UGX)
Paracetamol 500mg	328661	5767977.368	356,038	6,245,806.22
Amoxicillin 250mg	250672	13220069.55	238,994	12,188,843.06
Metronidazole 200mg	166136	3312706.543	251,038	4,964,600.79
Folic acid 5mg	141519	3378439.694	95,679	2,281,493.86
Folic acid + Ferrous Sulphate	70904	3132747.67	157,446	7,129,154.88
Ferrous sulphate 200mg	69240	1890610.191	34,965	1,020,371.71
Cloxacillin 250mg	5941	4163505.728	75,077	5,205,298.32
Ampicillin 500mg	576600	26808959.59	50,272	23,186,402.36
Carbamazepine 200mg	83995	5173245.3	91,950	5,684,252.32
Ibuprofen 200mg	66916	1805158.372	73,383	1,757,929.39
Vitamin B complex	79140	980237.0443	97,455	1,037,405.87
Ampicillin/cloxacillin 500mg	82786	9611356.661	58,108	6,678,067.26
Prednisolone 5mg	65941	2004978.818	72,132	2,277,434.33
Omeprazole 20mg	26866	1081753.975	48,692	2,041,251.02
Ciprofloxacin 500mg	73388	6665495.626	52,523	5,029,871.22
Frusemide 40mg	46684	895993.9999	48,336	927,702.99
Erythromycin 250mg	67989	6890127.337	133,081	12,109,862.71
Benzylpenicillin 1MU	17575	4863827.69	11,153	3,128,938.92
Penicillin V 250mg	83220	5357122.844	53,300	3,436,920.89
Metronidazole 5mg/ml 100ml	5306	4554275.065	10,801	9,633,547.73
Total		**111,558,589.07**		**115,965,155.85**

The consumption of essential medicines remained stable.

Intravenous fluid consumption

The consumption of intravenous fluid slightly decreased in the FY. Overall the amount of fluids procured were also lower than those from the previous FY.

Table 6.55: Consumption of IV fluids in FY 2017-2018 & FY 2018-2019

Fluid Description	Quantity (in bottles) 2017-2018	Value(UGX) for 2017-2018	Quantity (in bottles) 2018-2019	Value(UGX) for 2018-2019
Water for Injection 10 ml	61,140	5,920,709.45	61,371	5,904,036.41
Sodium Chloride 0.9% IV 500 ml	18,418	24,434,842.66	20,063	26,665,755.02
Dextrose 5% IV 500 ml	5,148	6,583,735.14	7,651	970,020.08
Dextrose 5% IV 250 ml	1,952	2,632,896.64	1,656	2,233,645.92
Sodium Lactate Compound IV 500 ml	5,252	6,867,076.87	5,114	6,704,826.93
Dextrose 50% IV 100 ml	1,227	2,648,277.75	1,227	2,649,008.13
Gelatine/polygeline Solution 3.5% IV 500 ml	95	2,738,556.27	171	4,964,825.64
Darrow's Half Strength 500 ml	311	576,124.21	346	641,646.62
Total		**52,402,218.99**		**50,733,764.75**

Drug and therapeutic committee

The Drug and Therapeutic Committee was established with Terms of Reference and a clear mandate to address the various aspects of drug management. The committee sat on a monthly basis. It is represented by staff from different cadres in the hospital.

A roadmap for specific targets has been designed and will be developed during the FY2019-20. Priority identified:

- Revision of essential drug list
- Monitoring of consumptions
- Introduction of adapted guidelines especially concerning use of antibiotics
- Shift to an electronic management of Pharmacy and store

CHAPTER SEVEN

SUPPORT SERVICES

Pastoral care

Pastoral care is provided to all patients in the hospital for free. These services are offered under the Kalongo Catholic Denary by volunteers. The team comprises of a social worker, a catechist and a Priest. In 2018/19, 461 patients accessed pastoral care services, an increase of 1.8%. Hospital staff were also encouraged to benefit from such pastoral services; as a consequence, staff recollection activities were arranged on a number of occasions.

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

Activity / Indicator	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
No. patients visited and counselled	228	243	94	452	454
No. of patients given sacrament of Marriage	0	1	0	0	0
No. of patients anointed	4	3	18	1	7
Total	**232**	**247**	**112**	**453**	**461**

Ambulance services

Ambulance services were offered to patients across the district. The terrible state of roads hinders or delays response to some parts of the district during the raining seasons. Ambulance maintenance is still a big problem due to frequent break downs from the bad roads. The hospital has only one operational Ambulance; the backup got involved in an accident and has not yet been repaired due to financial constraints.

Technical services

The Technical and Maintenance Department (TD) of the hospital is mandated to ensure the ordinary maintenance of all structures and equipment, including vehicles, for both the hospital and the school. It provides also technical assistance and supervision. Extraordinary renovations and bigger scale constructions are contracted out. The TD also carries out some limited income generating activities in order to contribute to the sustainability of the hospital. The function of the TD was greatly hampered by financial challenges and therefore could not fulfill all its' obligations.

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

	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
DIESEL TOTAL	**33,128**	**29,242**	**39,111**	**45,142**	**87648.6**
Board of Governors Fuel Refund to members	417	205	428	315	350
Generators	11,890	8,961	14,222	17,391	38,182.8
Vehicles	19,769	19,265	22,546	26,341	42,599.7
Workshop	26	47	20	10	25
Incinerator	260	750	1,018	1,065	2004
Others	766	60	877	20	4487.1
PETROL TOTAL	**2,709**	**3,474**	**2,905**	**3,054**	**6,917**
Administration	0	0	5	494	315
Donation	0	40	85	0	0
Generators	0	10	78	0	29
Vehicles	15	338	75	0	12.5
Motorcycles	2,275	2,551	2,284	2,335	6,509.5
Workshop	0	37	25	116	32
Others (Sales)	419	499	354	111	19
KEROSENE TOTAL	**105**	**58**	**75**	**36**	**0**
Workshop	78	19	75	25	0
Pharmacy	3	0	0	0	0
Main store	0	5	0	0	0
Others	24	34	15	11	0

In 2018/19, diesel consumption increased by 94.2%. This was mainly because of increased generator use (119.6%) due to frequent power black outs and more vehicle movements (61.7%), as a result increased PHC and outreach activities.

Petrol consumption increased by 126.5%. Despite petrol, mainly reserved for only motorcycle activities, its' use increased by 178.8%. The use of motorcycles for activities surely calls for great attention.

DOMESTIC SERVICES

Water Supply

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

a total capacity of 90,000 litres. All the buildings are provided with reserve tanks of different capacities.

The chlorination system was successfully install with support from the Ambrosoli Foundation. This is expected to help fight contamination from the environment and the worn out pipes.

The process of gradually replacing some worn out pipes and extending water points to all the staff quarters started during the last FY and completed in 18/19. Staff from all quarters now have full tome access to clean water.

Power Supply

The hospital receives power from the national electricity grid. However, this supply line is unstable and often times the institution has had to rely on backup generators for power supply. Electricity is provided to all the staffs within the hospital premises at a subsidized cost. The management introduced a cost sharing scheme, whereby the hospital obligates up to 15 units of electricity and staff borne any extra units consumed. The hospital also uses backup generators. They are however very costly in terms of fuel consumption.

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

Sewage system

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

Since its rehabilitation in 2014, with funding from *Wamba Anthena Onlus-Caripao*; we realized a more efficient and environmentally friendly sewage system. The latrine coverage of the institution is being improved too.

Access to the sewage system was expanded to other staff quarters following construction of the 'pour flash' toilet system (as part of the construction of staff quarters), with funding from the Ambrosoli Foundation.

Waste disposal

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

Intercom telecommunication and Wi-Fi systems

The hospitals' intercom system even faced more challenges in 18/19. Majority of the lines gradually died following the lightning incident in 2014. This has posed serious challenges in locating doctors and communication across the hospital. We are currently exploring ways to optimize the existing Wi-Fi system to support as well telecommunication within the hospital.

CHAPTER EIGHT

QUALITY OF CARE AND PATIENTS' SAFETY

Quality indicators:

The hospital was able to engage in continuous quality improvement reviews and activities. The quality improvement team was fully active during the FY and took part in a couple of activities aimed at quality improvement in the hospital.

Availability of qualified clinical staffs

The total number of clinical staff increased by 3.4% in 2018/19. The proportion of clinical qualified staff over the total hospital staff also increased by 6.1%.

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

Indicators	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Total No. of employees	239	245	251	253	251
Qualified staff[9]	194	168	177	174	196
Clinical qualified staff[10]	108	130	116	131	138
Total Clinical staff[11]	126	148	150	148	153
Proportion of clinical qualified staff over all qualified staff	55.7%	77.4%	65.5%	75.3%	70.41%
Proportion of clinical qualified staff over all clinical staff	85.7%	87.8%	77.3%	88.5%	90.20%
Proportion of clinical qualified staff over the total hospital staff	45.2%	53.1%	46.2%	51.8%	54.98%

[9]Qualified staff includes all staff with a degree in line with their role in the hospital.
[10]Clinical Qualified Staffincludes: Medical Doctors, Paramedics, Nurses and Midwifes.
[11]Clinical Staff includes: Medical Doctors, Paramedics, Nurses, Midwifes, and Nursing Assistants.

Quality of care

The recovery rate on discharge slightly increased by 0.08%. The maternal death rate also increased. The increased maternal death rate was related to mostly delay referrals from LLUs. Early neonatal death rate increased to 1.22%. During the FY, the NICU received even more referrals of premature new-borns from the LLUs. Unfortunately most of these referrals come in late without any intervention having been done within the golden minute. Post caesarean section infection rate was at reduced significantly to 0.82%.

Table 8.2: Indicators for the quality and safety measures

Indicators	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	Explanation
Recovery rate on discharge	97.80%	98.10%	98.80%	97.01%	97.09%	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	0.06%	0.10%	0.17%	0.02%	0.15%	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	0.99%	0.58%	0.58%	0.51%	58.00%	Fresh still birth rate: Fresh Still births have intact, smooth and not macerated skin,
Caesarean sections infection rate	ND	1.27%	ND	5.58%	0.82%	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	0.86%	0.89%	0.78%	0.39%	1.22%	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.

Patient satisfaction survey

The overall patient satisfaction about the quality of services increased in the FY (86% from 81.10% in the previous FY). The waiting time/organization of care in the OPD remained

constant. The Quality Assurance Committee has put in place clear strategies for implementation in the new FY; towards improving quality of patient care with particular attention to reducing patient waiting time in the OPD and optimizing clinical outcome of interventions.

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

Financial Year	FY 2014-15	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
Clinical outcomes	94%	100.00%	93%	88.30%	64%
Humanity of care	85%	85.10%	98%	98.90%	92%
Organization of the care / waiting time (OPD)	56%	50.00%	85%	46.10%	46%
The healthcare environment	99%	99.20%	98%	98.90%	98%
Overall score	79.30%	75.20%	79.70%	81.10%	86%

FAITHFULNESS TO THE MISSION

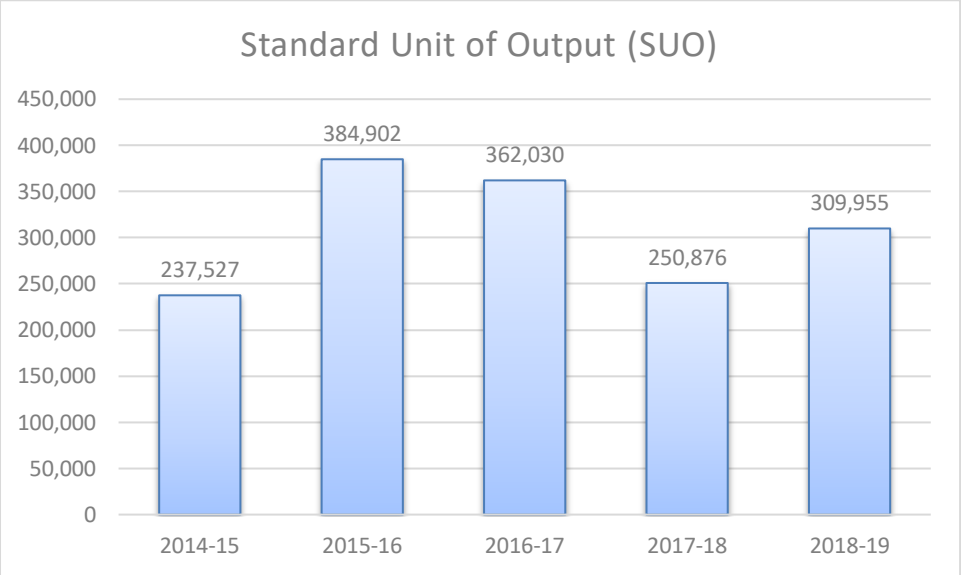
Access

There was 23.5% increase in the Standard Unit of Output (SUO) in 18/19. The increased malaria trend and increased utilization of MCH services, likely contributed to this. Access increased in 2018/19.

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)

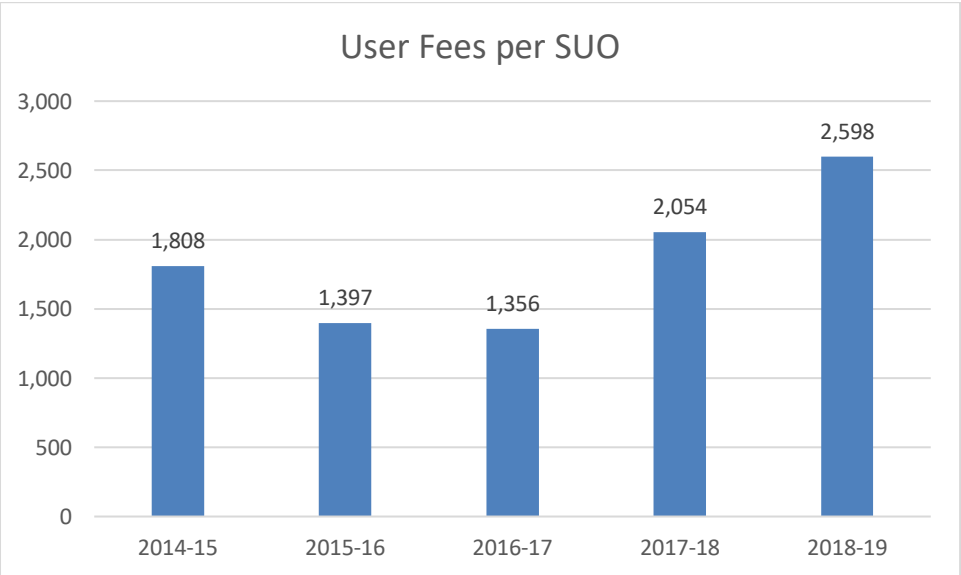
Figure 8.1: Trend of SUOop (do more people come?)



Equity

The average user fees per SUO increased by 26.5%. Even with this, our user fee remains one of the lowest of all the UCMB facilities in the country. The management reviewed and improved efficiency in revenue collection, as well as selective price reviews were conducted. Overall, equity decreased slightly in the FY.

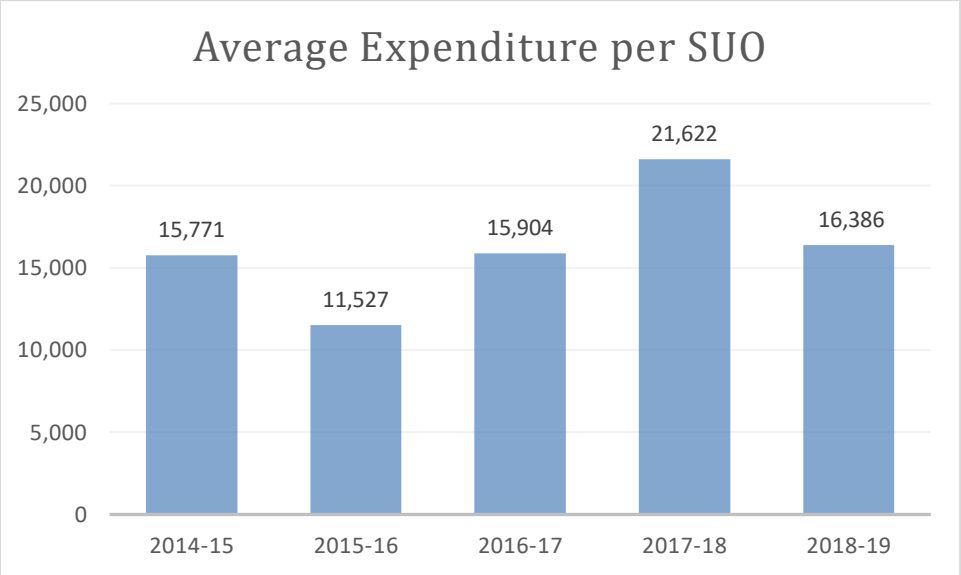
Figure 8.2: Trend of Average Fees per SUO (do people, on average, pay more or less?)



Efficiency

The hospital's economic efficiency improved by 24.2%. The key cost containment measure being focused on is reduction of wastage. The cost of producing one SUO reduced to 16,386 in 18/19.

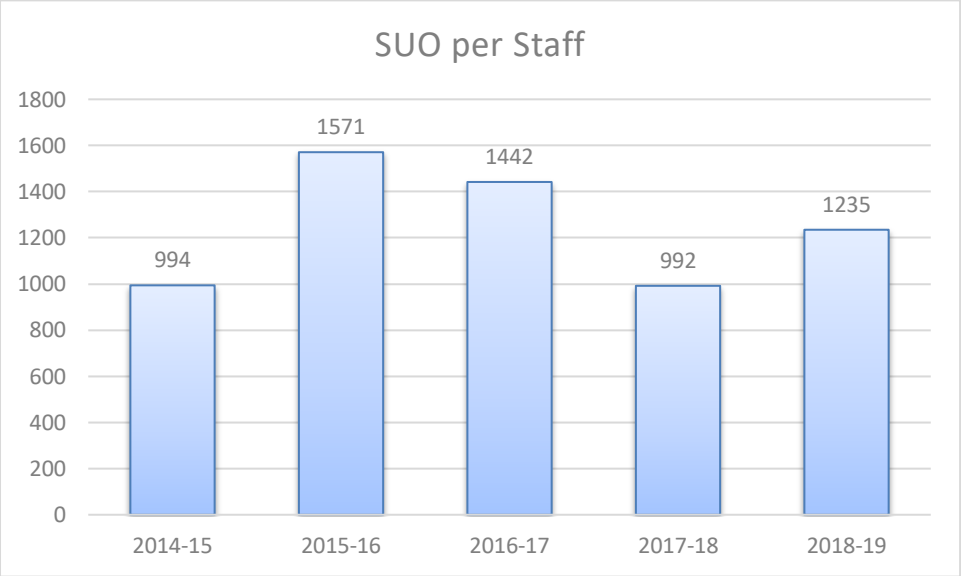
Figure 8.3: Trend of Average Expenditure per SUO (do we spend more or less to produce our services?)



Productivity

Each clinical staff produced 1,235 SUOop in 2018/19; an increase of 24.5% from the previous FY. This reflects significant increase in the clinical staff productivity.

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



CHAPTER NINE

ST. MARY'S MIDWIFERY TRAINING SCHOOL

Introduction

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

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

The total capacity of 150 students has been maintained. Since its beginning, the school has qualified so far a total of 1,465 competent staff serving in various parts of the country as well as outside Uganda:

- 1,173 Enrolled/Certificate Midwives (EM/CM),
- 252 Registered/Diploma Midwives (RM/DM),
- 40 Enrolled Comprehensive Nurses/Certificate Comprehensive Nurse (ECN/CCN)

Human resources management and development

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

Table 9.1: School staff and support staff establishment FY 2018-2019

No	Cadre	Established target	Actual	Shortage	Surplus
1	Tutors	6	4	2	
2	Untrained clinical instructors	0	3	0	3
3	Accountant	1	1	0	
4	Account Assistant	1	1	0	
5	Cashier	1	1	0	
6	Record Assistant	1	1	0	
7	Store Assistant	1	1	0	
8	Office Attendant	1	1	0	
9	Cooks	6	5	1	

10	Driver	1	1	0	
11	Watchmen	2	2	0	
	Total	**21**	**21**	**3**	**3**
	Trained clinical mentor	10 in the hospital	2 in the hospital	8	

Staff Attrition

In 2018/19, the attrition rate among the qualified teaching staffs was 0%. The tutor who had gone back to school for up grading returned successfully and resumed work. There is however still a strong need to recruit more tutors to support training of the students.

Table 9.2: Staff Advent and attrition

Staff Categories/Indicators	**2014/2015**	**2015/2016**	**2016/2017**	**2017/2018**	**2018/2019**
Qualified Tutors	5	5	5	5	5
Qualified Clinical Instructors / mentor	0	1	5	5	2
No of qualified teaching staff lost during the year	0	0	1	0	0
Attrition rate Qualified teaching staff	0	0	20%	0	0
No of qualified teaching staff recruited during the year.	0	0	0	0	1
No of unqualified teaching staff recruited during the year.	0	1	0	0	2
Attrition rate unqualified teaching staff	5	0	0	0	0
No. of support staff	12	11	11	11	10
No. of hospital staff members providing lectures in HTI	4 (when requested)	4 (when requested)	4 (when requested)	3 (when needed)	7 (when needed)
Ratio Part-Time verses Full-Time qualified Tutors	3:4	4:5	4:4	3:5	1:1
Ratio qualified teaching staff-unqualified staff	1:5	1:5	1:4	3:5	1:1

Staff development

One nursing officer, who has been sponsored for tutorship and completed in June 2018, was taken to the Hospital as Senior Nursing officer (SNO) after the demise of the former SNO. The Clinical Mentor who was also sent for tutorship completed in June 2019. A tutor was sent for Master in Public Health and will complete in December 2019. This is an attempt to improve tutor-student ratio both in the school and in the practicum sites. It is also one way of motivating the staff in their career development to limit staff attrition. Above all the development of the staff is to implement the strategic plan in view of starting Degree in Midwifery. Other workshops or meetings organized by the following organizations: UNMEB, MOH, MOES UCMB, and UNFPA were attended by the different staff in rotation as shown below.

Table 9.3: Workshops and courses attended by the teaching staff

S/N	Workshop	Organized by	Number of staff	Duration
1	Students Online Registration	UNMEB	1 Tutor and Record Officer	2 days
2	Continuous assessment and Log book	UNMEB	2	3
3	Curriculum	INTRAHEALTH	2 tutors	1 week
4	Making teachers guide	INTRAHEALTH	2 tutors	
5	IMCI	MOH-UNICEF	1 Tutor And I Clinical	5 Days
6	Nutrition	UNICEF	I Tutor	1 Week

School Performance

The enrollment of students in the school was driven by the actual capacity of the school.

The passing rate for the certificate students decreased from 100% in the previous FY to 98% for C/M and 92% for D/M in 2018/19. Some students could not sufficiently balance their papers, leading to the performance. All students were able to pass.

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

Table 9.4: Student Enrollment in years 1st -2nd -3rd and success rate in the FY 2018-19

Course	Students Enrolled in the year	Students in 1st year	Students in 2nd year	Students in 3rd year	Number of students currently	Students who sat for final exams	Students who pass final exams	Success rate
C/M	54	39	52	43	**188**	45	44	98%
D/M	14	13	0	0	**27**	14	14	92%
Total	**68**	**52**	**52**	**43**	**215**	**59**	**57**	

School Finances

St. Mary's Midwifery training school is a cost center in Dr. Ambrosoli Memorial Hospital.
All the school's accounts are being controlled by the Principal Tutor of the school and she is one of the signatories of some of the bank accounts. She is the overall controller of the school's activities and she reports to the CEO. Each financial year the school's prepares its own budget and year plan. The hospital engages an external auditor for both the hospital and the school and provides two separate audited financial statements.

Income

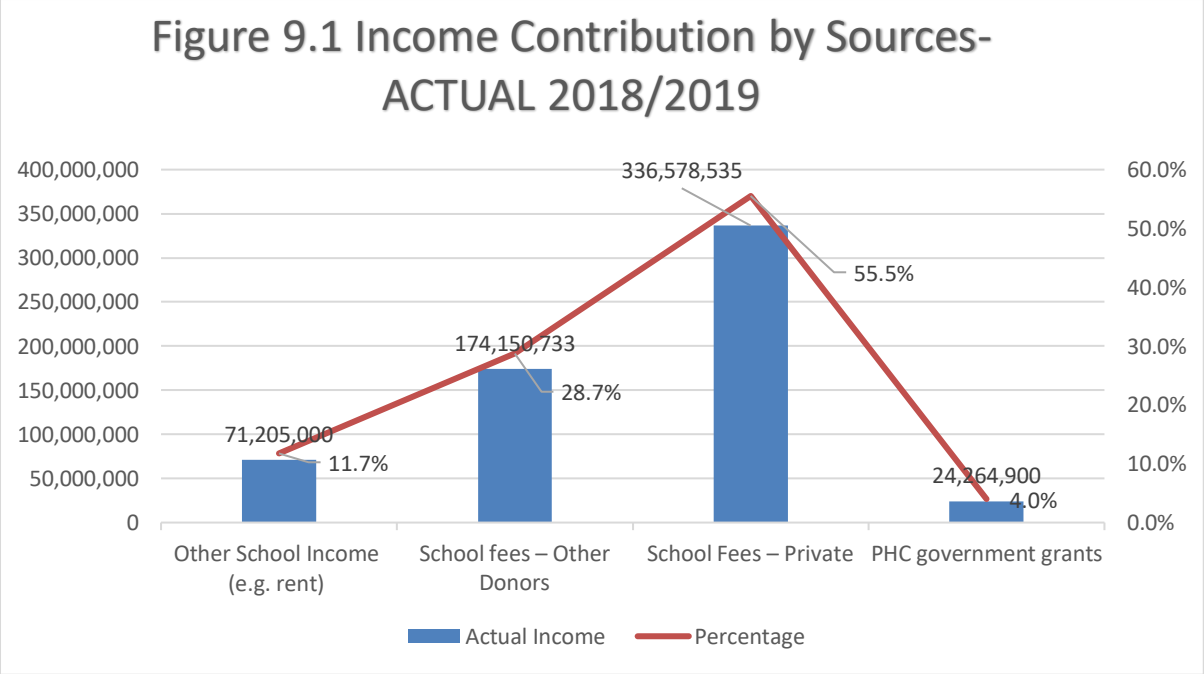
The actual realization from school fees and donors still represents the main source of funding. This donor dependency is posing a major challenge as some donors support is diminishing and sustainability is seriously threatened.
Support for school fees came from UNFPA, Copeland Foundation, Straight talk foundation, Gretta foundation, Dr. Ambrosoli Foundation, and Intra Health.

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

Table 9.5: Planned, actual and unrealized income in the FY 2018-2019

Income Sources	Planned Income (UGX)	Actual Income (UGX)	Budget Gap (UGX)	Variance Comment Surplus/Deficit
Other School Income (e.g. rent)	164,322,000	71,205,000	93,117,000	Deficit
School fees – Other Donors	121,398,012	174,150,733	(52,752,721)	Surplus
School Fees – Private	391,375,363	336,578,535	54,796,828	Deficit
PHC government grants	24,264,900	24,264,900	0	
TOTAL	**701,360,275**	**606,199,168**	**95,161,107**	**Deficit**

Figure 9.1: Income contribution by Sources FY 2018/2019



Expenditure

In the FY 2018/19, the school managed to control its expenditure such that a bigger margin was realized between the planned and the actual expenditure.

Table 9.5: Planned, actual expenditure and unspent balance in the FY 2018-2019

CATEGORY	BUDGET ESTIMATE	ACTUAL EXPENDITURE	UNSPENT ESTIMATE
EMPLOYMENT COST	279,640,534	241,981,598	32,990,544
ADMINISTRATION COST	38,632,000	32,840,785	4,533,215
PROPERTY COST	11,080,000	8,599,000	2,481,000
TEACHING GOODS AND SERVICES	193,513,000	196,841,991	1,976,609
PROFESSIONAL CONSULTANCY SERVICES	2,000,000	0	2,000,000
INSURANCE AND LISCENCE	500,000	0	500,000
TRAVEL AND TRANSPORT	29,660,000	25,463,900	4,196,100
SUPPLIES AND SERVICES	65,634,741	17,874,321	47,760,420
CAPITAL DEVELOPMENT	41,500,000	50,775,861	(9,275,861)
STAFF DEVELOPMENT COST	39,200,000	17,573,945	21,626,055
TOTAL	**701,360,275**	**591,951,401**	**109,408,874**

Support from Dr. Ambrosoli Memorial Hospital

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

Relation with external partners

The external partners continued to play vital roles in the evaluation and performance improvement of the school in terms of financial support through sponsoring of students, technical assistant, donation of teaching and learning materials, and training of staff. In

addition, the more the partners involved themselves, the more staff are exposed to new information and networking that they can transfer to their colleagues with the new knowledge acquired during the weekly CME.

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

PHC activities

Just like in the previous FY, the school carried out PHC activities mainly targeting mental health and parenting.
These workshops were organized for the community leaders and Village Health Team (VHT) from 5 different counties within Kalongo.

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

Faithfulness to the Mission

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

Access

$$\frac{\text{The Total number of students at present}}{\text{Total Capacity of the School}} = \frac{147}{150} \times 100\% = \mathbf{98\%}$$

Comparing the past financial year 2017/2018 and this year 2018-2019, there has been an increase of 5%, in the access.

Quality

Total number of students who passed = 44 x 100% = **98%**
Total Number of Students who sat 45

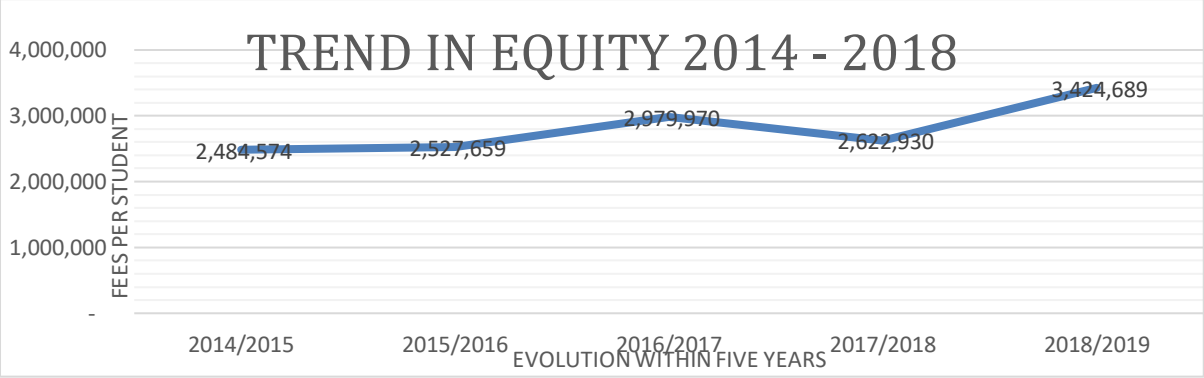
In this financial year 2018/2019, two student midwives failed state final examinations. One from Certificate class and one from Diploma class there by reducing the pass rate to 98%.

Equity

Total fees Collected 503,429,268/= 3,424,688/=

Total number of students 147

Figure 9.2: Trend in equity 2013-2018



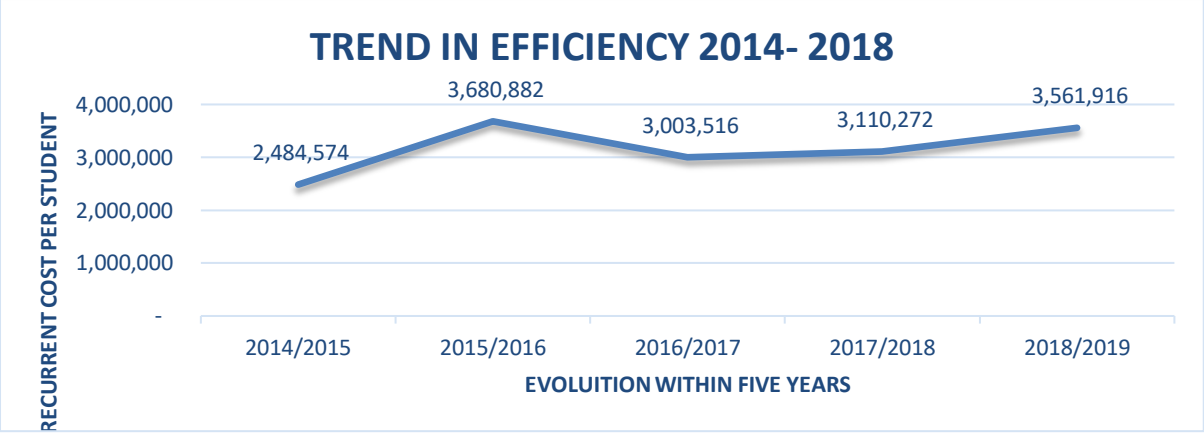
Equity increased in 2018/19. There was an upward adjustment of the school fees to match the rising cost of maintenance and living in the previous FY. The dropped in the average user fee per student is caused by the dropped in the number of students enrolled during the FY.

Efficiency

Total Recurrent Costs	523,601,595	=	**3,561,916/=**
Total number of students	147		

There was 14.5% increase in the average cost per student in 2018/19. Market trend for prices continue to spiral for both training goods and feeding requirement for students. However, the school still managed to contain costs to within realistic limits. The school was economically efficient in 2018/19.

Figure 9.3: Trend in Efficiency 2014-2018



CHAPTER TEN

CONCLUSIONS

Sustainability is still at the center of all activities and initiatives that the Hospital will implement or introduce. In order to meet all these challenges the Hospital must continue to strengthen its governance bodies and its managerial capacity and embark in substantial reorganizational efforts.

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

We are grateful to the MOH and Government of Uganda for the PHC conditional grant which accounted for approximately 12% of the total revenue. The amount of the grant has however remained stagnant over many years despite rising costs of medical goods and services.

The management devised and adopted stringent revenue collection mechanisms which helped to reduce on moneys lost to patients who escape. Selective price reviews was also undertaken after a thorough analysis of costs of those services. The management further instituted price discrimination, but setting up the private services user fee scheme.

The hospital continued to be faithful to its mission and was accredited by the UCMB. It has been accessible. Clinical productivity and financial efficiency increased. We were ranked tenth (10) out of the 132 general hospitals in the country (Annual Health Sector performance report).

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

Pending Issues

- The hospital complex has very old structures, and therefore most of the wards require major renovations. The lobbying plan for funds to renovate this structures remain a priority in the next FYs.
- The perimeter fence around the institution also needs a complete overhaul. During the FY, we had multiple security threats due to the many porous points in the fence.

ANNEXES

Annex 1. Members of Board of Governors and designation as per 30th June 2019

	Name	Designation	Title
1	H.G. John Baptist Odama	Chairperson	Archbishop of Gulu
2	Sr. Liberata Amito	Member	Diocesan Health Coordinator Gulu
3	Msgr. Matthew Odong	Member	Vicar General Gulu
4	Ms. Giovanna Ambrosoli	Member	Representative Ambrosoli Foundation
5	Fr. Achilles Kiwanuka Kasozi	Member	Provincial Superior Comboni Missionaries
6	Fr. Guido Miotti	Member	Parish Priest Kalongo
7	Mr. Louis Odongo	Member	Lawyer - P.O. Box 800, Gulu
9	Mr. Anywar John Kennedy	Member	District Local Councillor 5 - Kalongo T.C
10	Ms. Rose Ogaba	Member	Representative of the Local Community
11	Dr. Emmanuel Otto	Member	DHO Agago District
12	Sr. Susan Deezo 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	Dr. Nicholas Gregory Okello	Member	Senior Lecturer, Gulu University

Annex 2. Members of the Management Team and designation as per 30th June 2019

	Name	Title
1	Dr. Okot Godfrey Smart	Chief Executive Officer/Ag. Medical Director
2	Dr. Carmen Orlotti	Clinical Programs Manager
3	Sr. Carmel Abwot	Principal Tutor
4	Sr. Hellen Ogwal Alobo	Senior Nursing Officer