

ANNUAL ANALYTICAL REPORT FY 2019-2020



**DR AMBROSOLI MEMORIAL
HOSPITAL
KALONGO**

Endorsement of Report

This Annual Analytical Report covering the period of Financial Year 2019-2020 has been prepared by the management of Dr. Ambrosoli Memorial Hospital. I endorse that it represents 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 faithfulness to the mission report for Dr. Ambrosoli Memorial Hospital- Kalongo covering the period **July 1st 2019 to June 30th 2020.**

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

Name: His Grace Dr John Baptist Odama

Signature _____

Chairperson of the Board of Governors

Date _____

Table of Contents

ENDORSEMENT OF REPORT	I
LIST OF ABBREVIATIONS/ACRONYMS	IX
ACKNOWLEDGEMENTS.....	XI
IMPORTANT INDICATORS AND DEFINITIONS.....	XII
EXECUTIVE SUMMARY.....	XIV
CHAPTER ONE	XVI
INTRODUCTION	XVI
Background.....	xvi
The hospital and its' environment.....	xvi
Demographic data for the hospital catchment area.....	xvii
Community Health Status	1
CHAPTER TWO.....	3
HEALTH POLICY AND DISTRICT HEALTH SERVICES	3
Health Policy	3
District Health Services	3
Funding	6
Health Infrastructure	6
Prevention and Health promotion services	7
The HC II function of the hospital	7
CHAPTER THREE:	10
GOVERNANCE	10
The Board of Governors.....	10
Hospital Management	11
Statutory commitments compliance	12
Internal Regulatory Documents.....	13
Advocacy, lobby and negotiation.....	13
CHAPTER FOUR:	14
HUMAN RESOURCES.....	14
Staff Establishment	14
Staff turn-over.....	14
Human resources development and career progression	15
CHAPTER FIVE:.....	17

FINANCES	17
Income	17
Expenditure	18
CHAPTER SIX:	22
SERVICES	22
OUT PATIENT DEPARTMENT	2
Staffing composition	2
OPD key indicators	3
Morbidity Trend in the OPD.....	3
ANTENATAL CLINIC	4
HIV/AIDS Clinic	5
HIV Testing Services (HTS)	6
Antiretroviral therapy	8
Tuberculosis (TB) treatment	10
TB treatment outcome	12
Orthopaedic Services	13
Mental health clinic	13
Dental Clinic	14
Palliative Care	14
INPATIENTS DEPARTMENT.....	15
Summary of beds and qualified health personnel.....	15
Utilization indicators	16
Patient Days and Average Length of Stay (ALOS)	16
Bed Occupancy Rate (BOR) and Throughput per Bed.....	17
Number of deaths, Mortality Rate, Recovery Rate and self-discharges.....	17
Inpatient referrals	19
Morbidity causes	19
Mortality causes.....	20
MEDICAL WARD	21
Staff Composition	21
Key Indicators in Medical ward.....	21
Morbidity causes.....	22
Mortality causes.....	22
SURGICAL WARD	23

Staff composition	23
Key Indicators in surgical ward	24
Morbidity causes.....	24
Mortality causes.....	25
SURGICAL OPERATION THEATER.....	26
Surgical Procedures.....	27
PEDIATRIC WARD	28
Staff Composition	28
Key ward indicators.....	29
Morbidity causes.....	29
Mortality causes.....	30
Nutrition unit	31
MARTERNITY WARD	31
Key Indicators.....	32
Birth indicators.....	33
Gynaecological ward.....	35
TB WARD.....	36
DIAGNOSTIC SERVICES.....	37
Laboratory services	37
IMAGING SERVICES	39
X ray and Ultrasonography	39
PHARMACY ACTIVITIES	40
Storage	41
Pharmaceutical supplies	41
Procurement system.....	42
Inventory management	42
Distribution and use.....	42
Intravenous fluid consumption.....	43
CHAPTER SEVEN	44
SUPPORT SERVICES.....	44
Pastoral care	44
Ambulance services	44
Technical services	44
DOMESTIC SERVICES.....	45

Water Supply.....	45
Power Supply	46
Sewage system.....	46
Waste disposal	47
CHAPTER EIGHT	48
QUALITY OF CARE AND PATIENTS' SAFETY	48
Quality indicators:	48
Availability of qualified clinical staffs	48
Quality of care.....	48
Patient satisfaction survey	49
FAITHFULNESS TO THE MISSION	50
Access.....	50
Equity	50
Efficiency	51
Productivity	52
CHAPTER NINE.....	53
ST. MARY'S MIDWIFERY TRAINING SCHOOL.....	53
Introduction	53
Human resources management and development	53
Staff development	54
School Performance	55
School Finances.....	55
Income	55
Expenditure.....	57
Support from Dr. Ambrosoli Memorial Hospital.....	57
Relation with external partners	58
Faithfulness to the Mission.....	58
Access.....	58
Quality	59
Equity	59
Efficiency	59
CHAPTER TEN	61
CONCLUSIONS	61
Pending Issues	62

ANNEXES.....	62
Annex 1. Members of Board of Governors and designation as per 30th June 2020.....	62
Annex 2. Members of the Management Team and designation as per 30th June 2019	62

Table of Figures

Table 1.1: Demographic Data of the Hospital, HSD and Agago district.....	1
Table 1.2: Top ten causes of morbidity in the HSD OPDs.....	1
Table 1.3: Relative percentage of the top 10 causes of mortality during the last 4 FYs in the HSD.....	2
Table 2.1: Distribution of Health Service points by Sub-county.....	4
Table 2.2: Population, health units and staffing in Agago District FY 2018-2019 by Sub-county	4
Table 2.3: Structure of the District Health Office team	5
Table 2.4: Structure of the Health Sub District team at the referral facility	6
Table 2.5: Hospital contribution to prevention & health promotion services of the HSD/District.....	7
Table 3.1: Summary of BoG meetings held in the FY 2019-2020	10
Table 3.2: Table showing functionality of the Board Committees	11
Table 3.3: Frequency of HMT meetings FY 2016-2017	12
Table 3.4: Statutory commitments compliance	12
Table 4.1: Total number of employees in the hospital in the last 5 FYs.....	14
Category.....	14
FY 2015-16	14
FY 2016-17	14
FY 2017-18	14
FY 2018-19	14
FY 2019-20	14
Table 4.2: Turn-over trends of enrolled cadres in the last 3 FYs.....	15
Table 4.3: Turn-over trends of Clinical Staff in the last 3 FYs	15
Table 4.4: Hospital Staff who attended courses in FY 2019-2020.....	16
Table 5.1: Trend of Income by source over the last 5 years.....	17
Table 5.2: Trend of Expenditure over the last 5 FYs.....	18
Table 5.3: Trend of average user fees by department in the last 5 FYs	19
Table 5.4: Trend of Cost Recovery from Fees in the last 5FYs.....	20
Table 5.5: Trend of indicators of efficiency in utilisation of financial resources.....	20
Table 5.6: Sustainability ratio trend without donors and PHC CG funding, in the last 5 FYs ..	21
Table 5.7: Sustainability ratio trend in absence of donor funding but with PHC CG - last 5 FYs	21
Table 6.1: The staff composition in OPD in the FY 2018-19 and FY 2019-20	2
Table 6.2: Trend OPD attendance by gender & age in the last 5 FYs	3
Table 6.3: Top ten diagnoses in OPD in the last 2 FYs	3
Table 6.4: Antenatal and Postnatal indicators during the last 4 FYs	4
Table 6.5: Trend of HCT/VCT results in the last 5 FYs.....	6
Table 6.6: HIV test by purpose during FY 2019 – 2020.....	7

Table 6.7: Performance Indicators of the PMTCT Programme in FY 2019-2020.....	7
Table 6.8: PLHAs eligible for ART and started on ART by age group and gender - last 5 FYs....	8
Table 6.9: Number of PLHAs started on ARV by age group and gender in FY 2019-2020	9
Table 6.10: TB patients registered for treatment in the last 5 FYs.....	11
Table 6.11: MDR/MTB diagnosis during the FY 2019-20	11
Table 6.12: Results of TB treatment in the last 4 FYs	12
Table 6.14: Main procedures in orthopaedics and physiotherapy done in the last 5 FYs	13
Table 6.15: Mental health cases reviewed in OPD in the last 4 FYs	14
Table 6.16: Number of Patients who received Palliative Care in the FY 2019-20	15
Table 6.17: Summary of beds and qualified health personnel per ward	15
Table 6.18: Key indicators for the entire hospital in the last 5 FYs	16
Table 6.19: Key indicators per ward in the last 4 FYs	18
Table 6.20: Pattern of referrals to and from the hospital in the last 5 FYs	19
Table 6.21: Top ten causes of admission in all the wards in the FYs 2017-2018& 2018-2019	19
Table 6.22: Trend in Malaria admissions over the last 5 FYs.....	20
Table 6.23: Top ten causes of death among inpatients all wards FY 2018-19 and FY 2019-20	20
Table 6.24: Staff Composition in Medical Ward FY 2019-2020	21
Table 6.25: Key indicators in Medical Ward in the last 5 FYs	21
Table 6.26: Top 10 causes of admission in Medical Ward in the last two FYs	22
Table 6.27: Top 5 common causes of death in Medical ward in the last two FYs.....	23
Table 6.28: Staff composition in Surgical Ward in the FY 2019-2020	23
Table 6.29: Key indicators in Surgical Ward in the last 5 FYs	24
Table 6.30: Top 10 causes of admissions in Surgical Ward-FYs 2018-2019 & 2019-2020	25
Table 6.31: Top 5 common causes of death in Surgical Ward in the current FY.....	26
Table 6.32: Staff Composition in the operating theatre.....	26
Table 6.33: Top major surgical procedures performed in the FY 2019-20.....	27
Table 6.34: Top minor surgical procedures done in FY 2019-20	27
Table 6.35: Trend of surgical activities in last 5 FYs.....	27
Table 6.36: Pattern of anesthesia used during the last 5FYs.....	28
Table 6.37: Personnel assigned to Paediatric Ward in FY 2019-20	28
Table 6.38: Paediatric Ward indicators over the last 5 FYs	29
Table 6.39: Top ten causes of admission in Paediatric Ward - FY 2018-19 and FY 2019-20...	30
Table 6.40: Top five causes of death in Paediatric Ward in FY 2019-20	31
Table 6.41: Staff Composition in Maternity Ward in FY 2019-20.....	32
Table 6.42: Key indicators in Maternity Ward (Obs & Gyn) in the last 5 FYs	32
Table 6.43: Maternity Ward Deliveries & Births indicators in the last 5 FYs.....	33
Table 6.44: Origin of mothers who delivered through C/S in the last 5 FYs	34
Table 6.45 continuation	35
Table 6.46: Admissions in Maternity Ward not related to pregnancy conditions	35
Table 6.46: Key indicators in TB Ward in the last 5 FYs	36
Table 6.47: Trend of laboratory testing workload in the last 5 FYs.....	37
Table 6.48: Percentage of positive findings per selected examinations in the two last FYs...	38
Table 6.49: Proportion distribution of blood groups and Rhesus Factor D.....	39
Table 6.50: X-Ray examinations done in the last 5 FYs	39
Table 6.51: Ultrasound examinations conducted in the last 2 FYs.....	40
Table 6.52: Staff composition in Pharmacy and General Store in the FY2019-2020	40

Table 6.53: Average temperature and humidity recorded in Pharmacy Department FY2019-20	41
Table 6.54: Most used drugs (excluded HIV/AIDS clinic) - FY 2018-2019 and FY 2019-2020	42
Table 6.55: Consumption of IV fluids in FY 2018-2019 & FY 2019-2020	43
Table 7.1: Activities trend in clinical pastoral care of the sick during the last 5 FYs	44
Table 7.2: Consumption of fuel by destination in the last 5 FYs	45
Table 8.1: Proportion of clinical qualified staff in the hospital in the last 5 FYs	48
Table 8.2: Indicators for the quality and safety measures	48
Table 8.3: Satisfaction levels per core area for the last 5 FYs	49
Figure 8.1: Trend of SUOop (do more people come?).....	50
Figure 8.2: Trend of Average Fees per SUO (do people, on average, pay more or less?)	51
Figure 8.3: Trend of Average Expenditure per SUO (do we spend more or less to produce our services?).....	51
Figure 8.4: Trend of Average SUO per staff (with the same resources, do our staff produce more or less?)	52
Table 9.1: School staff and support staff establishment FY 2019-2020	53
Table 9.2: Workshops and courses attended by the teaching staff	54
Table 9.3: Student Enrollment in years 1 st -2 nd -3 rd and success rate in the FY 2019-20	55
Table 9.4: Planned, actual and unrealized income in the FY 2019-2020.....	56
Table 9.5: Planned, actual expenditure and unspent balance in the FY 2019-2020	57

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 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, supported the hospital during the Financial Year 2019-2020 and contributed to its sustainability. Notable among them, but not limited to, are the Government of Uganda, Dr Ambrosoli Foundation, Comboni Missionaries, USAID – URC, and the patients.

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

We would also like to thank H.G. Archbishop Dr John Baptist Odama and all the members of the Board of Governors for the leadership and encouraging supervision given to the hospital. Last but not least, we extend our utmost appreciation to all the employees of the hospital and of the School who, at all levels and with different qualifications and responsibilities, have been the makers of all achievement that are presented in this report. This acknowledgement is certainly due, but wants to be also an encouragement to maintain and possibly enhance the same spirit in the future.

Important Indicators and Definitions

- 1. Inpatient Day / Nursing Day / Bed days**= days spent by patients admitted to the health facility wards.
- 2. Average Length of stay (ALoS)**
 - = Sum of days spent by all patients/ Number of patients
 - = Average length of days each in-patient spends during each admission. The actual individual days vary.
- 3. Bed Occupancy Rate expressed as %**
 - = used bed days/available bed days
 - = Sum of days spent by all patients/ (365 x No. of beds)
 - =ALOS x Number of patients / (365 x Number of Beds)
- 4. Throughput**
 - =Average number of patients utilising one bed in a year
 - =Number of patients/ Number of beds
- 5. Turn over interval**
 - =Number of days between patients
 - = [(365 x number of beds) – (Occupied bed days)]/number of patients
- 6. FSB (Fresh Still Birth):** This is a baby born with the skin not peeling / not macerated. The foetal death is thought to have occurred within the 24 hours before delivery.
- 7. Post C/S Infection Rate:**
 - = (Number of mothers with C/S wounds infected / Total number of mother who had C/S operations in the hospital) x 100.
 - = The rate of caesarean section wounds getting infected. It is an indicator of the quality of post-operative wound care as well as pre-operative preparations.
- 8. Recovery Rate:**
 - = % of patients admitted who are discharged while classified as “Recovered” on the discharge form or register.

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

9. Maternal Mortality Rate (for the hospital):

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

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

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

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

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

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

Executive Summary

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

Dr. Ambrosoli Memorial Hospital was founded in 1957 and St. Mary's Midwifery Training School in 1959 by Fr. Dr. Giuseppe Ambrosoli of the Comboni Missionaries. Until now, Kalongo Hospital, being a PNFP, is the only General Hospital in Agago district. It provides both preventive and curative services. Kalongo Town Council currently has a total estimated population of 11,667. Major Key performance indicators are herein summarized as below.

The hospitals current bed capacity is 271. The total OPD attendance was 31,058 patients, representing an increase of 21.2% from 18/19. Inpatient (IP) admissions were 16,779; an increase of 13.4% from the previous FY. Malaria followed by injuries, were the leading causes of morbidity in the Inpatient department (IPD), while Malaria followed by Anaemia were the leading causes in the OPD. Malaria followed by pneumonia, were the leading mortality causes in the IPD. The hospital Bed Occupancy rate (BOR) was 90.75%. The number of deaths in the hospital increased by 94.75% compared to previous FY, reflecting an overall mortality rate of 2.5% (c.f 1.3%) of all patients treated in the hospital. The recovery rate increased (97.42%).

ANC 1st and 4th visits decreased by 33% and 26.2% respectively from the previous FY. Total ANC attendance also decreased by 15.3%. Post Natal clinic attendance decreased by 12%. Deliveries in the hospital decreased by 35.1% compared to FY 18/19. Caesarean section (total) accounted for 20.35% of all deliveries, out of which 94.1% were emergencies.

The members of the BoG and HMT were 14 and 4 respectively. 6 HMT, 2 Ordinary BoG, 1 extra ordinary BoG and 7 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 22.4% in 2019/20, while that of the school increased by 3.2% compared to the previous FY. Expenditure in the hospital increased by 18%

compared with 2018/19. The SUOop in 2019/20 was 343,997; an increment of 11% from 2018/19.

The overall patient satisfaction with quality of services offered improved from 86% in 2018/19 to 81% in 2019/20.

St Marys' Midwifery Training School has qualified a total of 1,513 students since its foundation. The main challenge faced during the year was financial constrains created by the closure of schools due to the pandemic. The students pass rate increased (100%).

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.

The institution is a general rural hospital; serving a remote community 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.

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 SLMPTA program. The HUB supervises up to 11 laboratories across the district.

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 remains 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 2019/2020, the population of Agago district was estimated at 248,900 (Annual Health Sector Report 2019); 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	District
(A)	Total Population	A	11667	248900
(B)	Total expected deliveries (4.85% of population)	$(4.85/100) \times A$	565.8495	12071.65
(C)	Total Assisted Deliveries in Health Facilities		0	0
(D)	Total Assisted Deliveries as % of expected deliveries	$(C/B) \times 100$	0	0
(E)	Children <1 year (4.3%)	$(4.3/100) \times A$	501.681	10702.7
(F)	Children < 5 years (20.2%)	$(20.2/100) \times A$	2356.734	50277.8
(G)	Women in Child-bearing age (20.2%)	$(20.2/100) \times A$	2356.734	50277.8
(H)	Children under 15 years (46%)	$(46/100) \times A$	5366.82	114494
(I)	Orphans (circa 10%)	$(10/100) \times A$	1166.7	24890
(J)	Suspected T.B Cases in the Service Area	$(A) \times 0.003$	35.001	746.7

With the exponential population growth, operational targets increase in both the hospital and the HSD. The hospital contributed significantly to the realization of the district targets projected above for the year 19/20.

Community Health Status

Generally speaking, the burden of morbidity increased among the population of Agago.

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

No	Causes of Morbidity	FY		FY		FY		FY	
		2016-17		2017-18		2018-19		2019-20	
		Number	%	Number	%	Number	%	Number	%
1	Malaria	192,229	51.04%	83,933	29.61%	133,109	39.74%	297,061	61.67%
2	Cough or cold - No pneumonia	124,420	33.04%	107,732	38.01%	96,445	28.80%	109,295	22.69%
3	Intestinal Worms	19,056	5.06%	18,638	6.58%	21,761	6.50%	17,918	3.72%
4	Diarrhoea	20,260	5.38%	17,635	6.22%	17,352	5.18%	15,607	3.24%
5	Gastro-Intestinal Disorders (non-Infective)	12,094	3.21%	12,298	4.34%	13,818	4.13%	10,891	2.26%
6	Skin Diseases	7,023	1.86%	8,669	3.06%	11,028	3.29%	10,561	2.19%
7	Urinary Tract Infections (UTI)	7,321	1.94%	8,218	2.90%	10,590	3.16%	7,837	1.63%
8	Malaria in Pregnancy	3,930	1.04%	2,339	0.83%	3,186	0.95%	4,084	0.85%
9	Pneumonia	4,044	1.07%	3,826	1.35%	3,070	0.92%	3,330	0.69%
10	Other eye conditions	6,205	1.65%	5,779	2.04%	5,725	1.71%	3,295	0.68%
	Total attendance	376,609		283,430		334,916		481,691	

Malaria remained the leading cause of morbidity across the HSD OPDs. The prevalence registered increased by 123.2% in comparison to the year 18/19. In the year 19/20, a number of natural factors may have affected the effectiveness of interventions to combat Malaria. Respiratory Tract Infections were the second leading morbidity causes. The bulk of these morbidities are witnessed among the under 5s. The proportion of pregnant women treated with Malaria in Pregnancy reduced by 22%.

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		FY 2016-17		FY 2017-18		FY 2018-19		FY 2019-20	
		Number	Case Fatality Rate	Number	Case Fatality Rate	Number	Case Fatality Rate	Number	Case Fatality Rate
1	Malaria	46	20.72%	22	13.50%	24	12.00%	214	36.52%
2	Pneumonia	17	7.66%	13	7.98%	13	6.50%	46	7.85%
3	Injuries - Trauma due to other causes	18	8.11%	11	6.75%	16	8.00%	21	3.58%
4	Premature baby (as condition that requires mgt)	5	2.25%	5	3.07%	14	7.00%	34	5.80%
5	Other Neonatal Conditions	4	1.80%	4	2.45%	21	10.50%	30	5.12%
7	Anaemia	16	7.21%	4	2.45%	12	6.00%	10	1.71%
8	Diarrhea - Acute	1	0.45%	2	1.23%	2	1.00%	8	1.37%
9	Liver Cirrhosis	7	3.15%	3	1.84%	2	1.00%	8	1.37%
10	Gastro-intestinal bleeding	3	1.35%	1	0.61%	8	4.00%	7	1.19%
		222		163		200		586	

Malaria continue to be the leading mortality cause. The number of disease specific death due to malaria increased by 792% in the fiscal year 19/20. This dramatic rise in the number of malaria related deaths were a direct consequence of the more severe forms of malaria and reduced response to treatment experienced.

More premature babies died in the year. The increase in the number of premature delivery and their death were related to the increased malaria cases and other factors like; delayed referrals and new born infections. Deaths due to trauma reduced compared to the number in the year 18/19.

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 the 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 three (3) counties (Agago North County, Agago County and Agago West 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 these 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	12739	1	0	0	0	1
Omiya Pacwa	12739	0	0	1	2	2
Paimol	23161	0	0	1	1	2
Lapono	24214	0	0	1	5	6
Adilang	22213	0	0	1	3	4
Patongo	24845	0	0	1	1	1
Patongo Town council						
Kotomor	13896	0	0	1	2	3
Omot	14738	0	0	1	2	2
Arum	12948	0	0	1	0	1
Lamiyo	9369	0	0	0	2	2
Lira Palwo	17896	0	0	1	4	5
Wol	25476	0	0	1	3	4
Parabongo	12528	0	0	1	2	3
Lukole	17160	0	0	1	3	3
Agago Town Council	6632	0	0	1	0	1
Total for HSD and District	248900	1	0	13	30	40

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

Sub-Counties	Populations FY 2019-2020	Health units (Level & ownership)	Staffing levels		Staffing gap
			Staffing Norm	No. available	
Lira Palwo	17,896	Lira Palwo HC III Gov.	19	14	-5
		Acuru HC II Gov.	9	7	-2
		Obolokome HC II Gov.	9	3	-6
		St Janani HC II CoU	9	7	-2
		Lanyirinyiri HC II Gov.	9	3	-6
Omot	14,738	Omot HC III Gov.	9	9	0
		Geregere HC II Gov.	9	7	-2
Adilang	22,213	Adilang HC III Gov.	19	14	-5
		Ligiligi HC II Gov.	9	3	-6
		Alop HC II Gov.	9	4	-5
		Orina HC II Gov.	9	5	-4
Lamiyo	9,369	Kwonkic HC II Gov.	9	5	-4

		Lamiyo HC II Gov.	9	5	-4
Arum	12,948	Acholpii HC III Gov.	19	12	-7
Kotomor	13,896	Kotomor HC III Gov.	19	7	-12
		Odokomit HC II Gov.	9	6	-3
		Onudapet HC II Gov.	9	3	-6
Omiya Pacwa	12,739	Omiya Pacwa HC II Gov.	9	5	-4
		Layita HC III Gov.	9	5	-4
Lapono	24,214	Lira Kato HC III Gov.	19	13	-6
		Lira Kaket HC II Gov.	9	5	-4
		Ongalo HC II Gov.	9	3	-6
		Amyel HC II Gov.	9	4	-5
		Ogwangkamolo HC II Gov.	9	4	-5
		Abilonino HC II Gov.	9	4	-5
Wol	25,476	Wol HC III Gov.	19	9	-10
		Kuywee HC II Gov.	9	4	-5
		Toroma HC II Gov.	9	6	-3
		Okwadoko HC II Gov.	9	2	-7
Paimol	23,161	Paimol HC III Gov.	19	11	-8
		Kokil HC II Gov.	9	4	-5
Parabongo	12,528	Pakor HC II Gov.	9	4	-5
		Pacer HC III Gov.	19	18	-1
		Kabala HC II Gov.	9	5	-4
Lukole	17,160	Lapirin HC III Gov.	9	6	-3
		Olung HC II Gov.	9	7	-2
		Otumpili HC II Gov.	9	3	-6
Agago Town Council	6,632	Lukole HC III Gov.	19	12	-7
Patongo Town Council	24,845	Patongo HC III Gov.	19	25	6
Patongo S/C		Opyelo HC III Gov.	19	7	-12
Kalongo Town Council	12,739	Kalongo Hospital NGO	190	252	62
Total HSD	248,900	38 Govt. and 2 NGO Units	567	491	-128

Table 2.3: Structure of the District Health Office team

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

Cold Chain Assistant	1
Theatre Assistant	1
Records Assistant/HMIS focal person	1
Office Typist	1
Office Assistant	1
Grand Total	14

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

Human Resources (Cadre)	Current Number
Nursing Officer/MCH	1
Cold Chain Assistant	1
Theatre Assistant	1
Records Assistant/HMIS focal person	1
Account Assistant	0
Office Typist	1
Office Assistant	1
Guard-0	1
Grand Total	8

Funding

Health funding has been constant but static for the past years 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.

The hospital remains heavily reliant on external partners for more than 60% of its funding needs towards recurrent cost. Over the years it has become increasingly difficult to find donors to fund recurrent expenditures, leaving a huge gap and total dependence on the meager user fees from patients.

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.

The 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 2019/20, 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 12,739 (2019).

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	1752	7146	24.52%
TT 2	1338	4533	29.52%
TT 3	11	1614	0.68%
TT 4	1	747	0.13%

TT 5	2	391	0.51%
Non Pregnant women			
TT 1	710	4941	14.37%
TT 2	455	2135	21.31%
TT 3	268	1184	22.64%
TT 4	142	768	18.49%
TT 5	121	18109	0.67%
Immunization in school			
TT 1	312	1056	29.55%
TT 2	110	653	16.85%
TT 3	59	368	16.03%
TT 4	16	172	9.30%
TT 5	9	43	20.93%
Total TT 2 in all categories	1903	7321	25.99%
Immunization in Children			
BCG	2706	8766	30.87%
Protection at Birth for TT (PAB)	2475	4807	51.49%
Polio 0	2241	8100	27.67%
Polio 1	951	9286	10.24%
Polio 2	1036	9385	11.04%
Polio 3	944	9241	10.22%
PCV 1	1070	9487	11.28%
PCV 2	984	9314	10.56%
PCV 3	1073	9379	11.44%
DPT-HepB+Hib 1	1072	9582	11.19%
DPT-HepB+Hib 2	979	9346	10.48%
DPT-HepB+Hib 3	1081	9382	11.52%
Measles	883	8471	10.42%
Total Immunisation in Children	17495	114546	15.27%
Total Family Planning attendances	1862	45865	4.06%
Total ANC attendance	7388	33528	22.04%
Deworming	4938	52994	9.32%
Vitamin A Supplementation	2962	29819	9.93%

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.

The total antigens administered to children decreased by 24.2% in 2019/20. The quantity of TT administered to women also reduced by 26.8%. The reduction in coverage directly relates to the lockdown measures instituted by the government in the response against the COVID

19 pandemic. Family planning attendances contributed to 4.06% of the total family planning services offered in the district.

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 2019-2020 the hospital held two (2) ordinary BOG meetings and one (1) Extra Ordinary BOG Meeting. The incomplete fulfillment of the meeting requirements was due to the SOPs put in place by the government of Uganda in the fight against COVID 19.

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 2019-2020

BOG meetings	Reports presented / Key issues handled / Decision taken	Members present
12 th July 2019 1 st Ordinary Meeting	<ul style="list-style-type: none">• Buying shares from Centenary Bank• Cost control measures• Budget performance 18/19 and Budget for 19/20• Bad debts in both the hospital and School	11
29 th November 2019	<ul style="list-style-type: none">• Budget performance review first quarter FY 19/20• External audit review• Human resources and Staff discipline	12
27 th October 2019	<ul style="list-style-type: none">• Human resources and discipline	7

The Statute enumerates 3 key thematic committees, that are in place; 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. In the year 19/20 however, the subcommittees successfully held most of the required meetings. All BOG members are being encouraged to routinely attend and contribute in meetings.

Table 3.2: Table showing functionality of the Board Committees

Name of committee	Required No. of meetings per year	No. of meetings held	Percentage of required meetings held
Finance Committee	2	4	100%
School Committee	2	1	50%
Human Resources& Disciplinary Committee	2	2	100%

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. In 19/20, management meetings were greatly disrupted by the emergence of the COVID 19 pandemic and the subsequent ban on gatherings of more than two (2) people by the government of Uganda from March 2020. The management still managed to have discussions on line to guide key decisions in the hospital.

The core members of the Hospital Management Team are:

- The Chief Executive Officer
- The Medical Director
- The Administrator
- The Senior Nursing Officer

- The Principal Tutor of the School

Table 3.3: Frequency of HMT meetings FY 2016-2017

No of planned Management meeting	No. of Management meeting held	Average No. of members present	Reports / key issues handled
20	6	5	General hospital operations. Minutes of each meeting were prepared and circulated by the CEO

Statutory commitments compliance

The Hospital 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 these 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 2020.

Table 3.4: Statutory commitments compliance

No	Requirement	Did you achieve? (Yes, Partly, No)	Comment
Government / MOH Requirements			
1	PAYE	YES	Regularly observed, except when there are no funds.
2	NSSF	YES	Regularly observed, except when there are no funds.
3	Local service tax	YES	Regularly observed
4	Annual operational licence	YES	Regularly observed
5	Practicing licence for staff	YES	Regularly observed
7	Monthly HMIS	YES	Regularly observed
UCMB statutory requirement			
1	Analytical Report end of FY year	YES	Regularly observed
2	External Audit end of FY year	YES	Regularly observed
3	Charter (still valid)	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 include; 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 are ongoing at the moment. The school fees policy and the rules and regulations for the Midwifery school was reviewed in the last FY, as well as the user fee manual. The management continue 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 need 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 155 clinical staff; below the recommended 190 for a 100 bed capacity general hospital by MOH. Qualified clinical staff number, account for 89% of clinical staff.

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

Category		FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Clinical ^[1]	Qualified	130	116	131	136	138
	Unqualified	18	34	17	15	17
	Total Clinical	148	150	148	151	155
Not Clinical ^[2]	Qualified	38	61	43	42	45
	Unqualified	59	40	62	58	52
	Total Non-Clinical	97	101	105	100	97
Total Qualified		168	177	174	175	183
Total Unqualified		77	74	79	76	69
Grand Total		245	251	253	251	252
% of qualified clinical staff/total staff		53%	46%	52%	54%	62%

Staff turn-over¹

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. Turnover rate remained at 14% compared to 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).

¹Turn 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 cadres² in the last 3 FYs

Cadres	FY	FY	FY
	2017-18	2018-19	2019-20
Total staff	253	251	252
Enrolled cadres (all combined)	70	68	70
Turn-over for enrolled cadres	9%	3%	4%

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

Clinical Staff	FY	FY	FY
	2017-18	2018-19	2019-20
Total staff	253	251	252
Total arrivals of key health personnel	26	34	37
Total departures of key health personnel	22	34	35
Turn-over rate	9%	14%	14%

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 (156 staff and their families, 62% of the total staff) in the staff quarters located within its premises. This housing facilitation includes also availability of water and electricity. The refurbishment of the houses with funding from the Ambrosoli foundation is still on going, with the sole aim of improving living conditions for all staff in the quarter.

Salaries have been regularly paid and any statutory obligations are regularly remitted (PAYE and NSSF) according to the current legislation, except when funds are not available.

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

²Enrolled Nurses, Enrolled Comprehensive Nurses and Enrolled Midwives.

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 FY 19/20 academic calendar was marred by the COVID 19 pandemic, disrupting all training programs. All staff on training resorted to learning on line; depending on the availability of such provisions at their institutions of learning.

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 hospital's scholarship program in key areas of needs.

Table 4.4: Hospital Staff who attended courses in FY 2019-2020

S/N	Name	Designation	Course	Date of start	Date of End
1	Ojera Alex Latim	Registered Nurse	BSc in Public Health (Lira University)	17-Aug	20-Jun
2	Sr. Acan Santana	Double Trained Nurse	BSc in Midwifery (Lira University)	17-Aug	21-Jun
3	Olanya Richard	Nursing Aide	Certificate in Nursing (St. Joseph Kitgum)	17-Oct	20-Jun
4	Okao Maurice	Medical Officer	MMed Paediatrics	Sept, 18	June, 21
5	Akot Polly	Dep. Principal	MSc Public Health	Feb, 2019	Jan, 2020
6	Sr. Kwena Beatrice	Enrolled Midwife	Diploma in Midwifery	July, 19	Jun-21
7	Lamwaka Charity	Enrolled Midwife	Diploma in Midwifery	July, 19	Jun-21
8	Sr. Ayaka Hellen	Registered Nurse	BSc. In Nursing (UCU)	Jan, 2020	Dec, 2023

Some of the staff will complete shortly when schools reopen (following government closure) and will return to support the workforce in the hospital.

CHAPTER FIVE:

FINANCES

The FY 19/20 saw the hospital and school realise increments in total income received, 22.4% and 3.2% respectively. This came despite of the conditions created by the pandemic. User fee revenue collected increased by 14.1% (accounting for 15% of the total income). The government donation in kind reduced by 5.2%. Donation in cash increased by 19.1%, maintaining the upward trend registered in the previous years (accounting for 50.3% of the total income).

These figures highlight 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 18/19, the hospitals' expenditure increased by 18%. The expenditure was less than the revenue generated by 0.4%. Human resource costs and medical consumables were the major drivers of costs. Key senior positions in the hospital were filled by qualified personnel.

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					
Income Item	FY	FY	FY	FY	FY
	2015-16	2016-17	2017-2018	2018-19	2019-20
HOSPITAL					
User Fees	537,697,285	490,794,376	515,399,441	805,406,207	918,631,455
PHC CG cash	496,440,741	488,334,860	251,159,632	251,159,542	251,159,632
Government donations in kind (Drug/Lab)	251,710,481	243,072,352	346,633,198	294,661,401	279,299,838

Other donations in kind	1,171,239,924	1,023,496,908	787,210,769	845,619,113	1,410,912,848
Donations in cash (including project funding)	1,352,092,200	3,811,677,210	2,403,785,395	2,626,348,706	3,128,079,686
Others Financial sources (Deposit Interests & others)	76,684,887	326,116,116	56,168,380	162,796,288	92,546,915
Technical Department	70,879,020	213,555,605	141,070,362	93,943,603	136,116,992
Sub-Total Hospital	3,956,744,538	6,597,047,427	4,501,427,177	5,079,934,860	6,216,747,366
SCHOOL					
Fees (private)	81,206,100	182,308,450	236,974,842	336,578,535	160,475,145
PHC CG School/PAF Delegate funds	53,939,020	53,021,152	24,264,900	24,264,900	152,386,215
Donations and other income	471,872,451	317,297,684	187,713,340	245,355,733	312,861,360
Sub-Total School	607,017,571	552,627,286	448,953,082	606,199,168	625,722,720
HSD					
Sub-Total HSD	12,401,032	60,473,163	-	-	-
Grand-Total	4,576,163,141	7,210,147,876	4,950,380,259	5,686,134,028	6,842,470,086

Expenditure

Table 5.2: Trend of Expenditure over the last 5 FYs

Expenditures over the Last 5 Years					
Expenditure Item	FY	FY	FY	FY	FY
	2015-16	2016-17	2017-18	2018-19	2019-20
HOSPITAL					
Human Resource cost	1,571,469,625	1,742,346,590	1,670,778,158	1,937,322,775	2,220,512,253
Administration & Governance Costs	95,753,358	159,589,078	148,417,998	256,159,365	176,454,730
Medical goods and supplies (included drugs)	1,937,705,529	1,978,701,042	1,723,605,199	1,564,891,236	2,048,954,822
Non-medical goods / supplies	119,594,489	136,173,475	1,126,086,235	481,599,381	237,715,358
Property Costs	240,980,620	268,887,558	311,950,518	342,469,799	277,795,146
PHC	331,106,130	1,235,279,987	235,268,336	287,069,131	408,008,500
Transport & Plant Costs	140,006,217	237,801,122	204,022,401	209,423,206	198,506,748

Capital Development	-	85,087,450	261,422,729	165,112,516	621,477,605
Hospital Total Expenditure	4,436,615,968	5,843,866,302	5,681,551,574	5,244,047,409	6,189,425,162
SCHOOL					
Employment	200,984,878	203,568,991	195,750,295	255,244,790	289,320,411
Administration	87,858,321	67,647,686	37,652,900	39,400,393	125,364,301
Students costs	148,001,835	136,801,294	115,564,162	180,483,191	149,127,572
Transport & Travelling	71,521,000	60,641,850	23,987,550	25,463,900	25,901,800
Property, Supplies, Services	59,910,050	9,572,678	48,034,600	31,022,821	16,403,572
Capital Development	-	-	14,448,597	60,336,306	35,543,000
School Total Expenditure	568,276,084	478,232,499	435,438,104	591,951,401	641,660,656
HSD					
HSD Total Expenditures	12,401,032	60,473,163	-	-	
Grand Total	5,017,293,084	6,382,571,964	6,116,989,678	5,835,998,810	6,831,085,818

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.

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

	Average Fees				
	FY	FY	FY	FY	FY
	2015-16	2016-17	2017-18	2018-19	2019-20
OPD Adult Male	12,000	9,700	11,500	15,000	15,000
OPD Adult Female	12,000	10,500	12,000	16,500	15,000
OPD Children < 5yrs	4,500	4,500	4,500	9,500	9,500
OPD Children 5-13 yrs	7,000	7,000	7,000	12,000	9,500
IP Medical Male	26,000	24,000	25,000	30,000	30,000
IP Medical Female	26,000	24,000	25,000	30,000	30,000
IP Maternity	20,000	16,050	15,850	36,900	35,000
IP Paediatric < 5 yrs	8,500	6,100	8,500	15,500	15,000
IP Paediatric 5-13 yrs	8,500	6,100	9,000	16,000	16,500

IP Surgical Ward	25,000	21,700	23,200	24,000	28,000
------------------	--------	--------	--------	--------	--------

The average user fee per patient remained the same for every department. The hospitals' user fees have not been revised. However, the efficiency of revenue collection improved during the FY. The amount of user fees collected would have been higher than stated if it wasn't for the disruption of the pandemic. The hospital still continues to have instances when patients escape without paying user fees.

In the FY 19/20, the hospital had 16.5% cost recovery rate, representing an increase of 0.6% 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 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Total User fees (a)	537,697,285	490,794,376	515,399,441	805,406,207	918,631,455
Total Recurrent Expenditure (b)³	4,436,615,968	5,757,781,852	5,416,639,845	5,078,934,893	5,567,947,557
Cost Recovery Rate = (a/b)x100	12.1%	8.5%	9.5%	15.9%	16.5%

The average cost per bed increased by 9.6% in the year 19/20. Meaning the average cost of treating one patient admitted in the hospital per day was higher compared to the previous year. The cost per SUOop reduced by 3.2% from the previous year. Efficiency in utilisation of resources for the care of patients improved.

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

Indicator	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Cost per bed⁴	16,371,277	20,061,958	19,987,601	18,741,457	20,545,932
Cost per IP/day⁵	51,055	56,897	56,783	53,243	62,026
Cost per SUO_{op}	11,527	15,904	21,622	16,386	15,854

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

Source: UCMB

In 19/20, the hospital was 20.6% sustainable in the absence of any sort of donor funding. This also reflects a 0.3% decrease from the year 18/19. The 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 5 years.

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

Without PHC CG	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Total Local Revenues (a)	685,261,192	1,030,466,097	712,638,183	1,062,146,116	1,147,295,362
Total Recurrent Expenditures (b)	4,436,615,968	5,757,781,852	5,420,128,845	5,078,934,893	5,567,947,557
Sustainability Ratio = (a/b)x100	15.4%	17.9%	13.1%	20.9%	20.6%

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

Considering local revenues and Government contributions in the FY 19/20, the hospital was 70.1% sustainable. This is a 38.4% increase from the previous year. The significant rise was because of the increased government in-kind contribution towards malaria and TB management. 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 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Total in-country funding (c)	1,181,701,933	1,518,800,957	1,310,431,013	1,607,967,059	3,907,443,605
Total Recurrent Expenditures (d)	4,436,615,968	5,757,781,852	5,420,128,845	5,078,934,893	5,567,947,557
Sustainability Ratio = (c/d)x100	26.6%	26.4%	24.2%	31.7%	70.1%

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

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 seven (7) days a week from Monday to Friday from 8.00 am to 9.00 pm, and Saturday/Sunday (including public holidays), from 8:00 am to 2:00 pm. The increasing need to streamline access of outpatients to Hospital services demands revision of the existing working hours. A plan for 24 hours activities is presently under evaluation by HMT. The implementation of this plan was delayed due to the prevailing pandemic setbacks.

Staffing composition

OPD was managed by five Clinical Officers. In 19/20, the OPD had six (6) enrolled nurses (including midwives), two (2) 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 join 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 increased in the OPD compared to previous FY.

Table 6.1: The staff composition in OPD in the FY 2018-19 and FY 2019-20

Cadre/ Discipline	Qualification	FY 2018-19	FY 2019-20
Clinical officers	Diploma in clinical Medicine	5	5
Pharmacy Assistant	Certificate in Pharmacy	2	4
Double Trained	Diploma in Nursing / Midwifery	1	1
Enrolled Midwife	Certificate in Midwifery	0	1
Enrolled Nurse	Certificate in Nursing	4	4
Enrolled Comprehensive	Certificate in Comprehensive	2	1
Nursing Assistant	Certificate in Nursing Assistance	3	2
Cashier	Diploma in Business Studies	2	4
Nursing Aide	Trained on the job	1	1
Total		20	23

OPD key indicators

Utilization of OPD increased (21.2%) compared to the previous FY. Under five (5) morbidity (new attendance and re attendance) increased by 33.3%. As already experienced in the previous FYs, women utilized the OPD more. The increased OPD utilization corresponds with the increased malaria burden experienced.

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

			FY	FY	FY	FY	FY
			2015-16	2016-17	2017-18	2018-19	2019-20
FEMALE	New Attendance	0-4 yrs	3,372	3,539	2,442	2,037	3,014
		Over 5 yrs	12,294	13,743	11,095	10,835	8,978
	Re-attendance	0-4 yrs	90	49	124	129	121
		Over 5 yrs	1,077	1,738	2,097	1,934	4,097
MALE	New Attendance	0-4 yrs	3,794	3,984	2,720	2,337	2,976
		Over 5 yrs	6,785	7,423	6,121	6,193	8,492
	Re-attendance	0-4 yrs	97	78	203	170	118
		Over 5 yrs	1,374	1,819	2,089	1,987	3,262
All New Attendances			26,245	28,689	22,378	21,402	23,460
All Re-attendances			2,638	3,684	4,513	4,220	7,598
All Attendances			28,883	32,373	26,891	25,622	31,058

Morbidity Trend in the OPD

Malaria was the leading cause of morbidity in the OPD followed by Anaemia. The malaria surge was experience since the onset of the FY. This reverses the picture seen in the previous FY. Non communicable diseases remain on the rise, contributing to 2.8% of OPD attendance (an increase of 1.29% from the previous year).

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

Causes of Morbidity		FY 2018-2019		FY 2019-2020	
		No. of cases	% on all diagnoses	No. of cases	% on all diagnoses
1	Malaria	2,140	8.35%	9,260	29.82%
2	Other types of Anaemia	215	0.84%	1,904	6.13%
3	Urinary Tract Infections (UTI)	1,845	7.20%	1,311	4.22%
4	Epilepsy	576	2.25%	1,171	3.77%
5	Pneumonia	738	2.88%	1,024	3.30%
6	Skin Diseases	855	3.34%	876	2.82%
7	Hypertension	386	1.51%	870	2.80%

8	Gastro-Intestinal Disorders (non-Infective)	2,538	9.91%	792	2.55%
9	Alcohol use	65	0.25%	522	1.68%
10	Diabetes mellitus	169	0.66%	504	1.62%
	All others	6,080	23.73%	6,345	20.43%
Total OPD attendance		25,622		31,058	

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	FY	FY	FY
	2016-17	2017-18	2018-19	2019-20
ANC 1st Visit	2,041	1,874	2,397	1,606
ANC 4th Visit	1,236	1,217	1,648	1,217
Total ANC visits new clients + Re-attendances	5,883	6,045	8,721	7,388
ANC Referrals to unit	1	2	2	0
ANC Referrals from unit	3	0	0	0
POSTNATAL				
Post Natal Attendances	927	952	4,472	3,939
Number of HIV + mothers followed in PNC	100	124	164	906

Vitamin A supplementation	927	952	90	0
Clients with premalignant conditions for breast	0	0	0	0
Clients with premalignant conditions for cervix	0	0	0	0

Total ANC attendance decreased by 15.3%; so, did 1st and 4th visits by 33% and 26.2% respectively. Post Natal Care services utilization decreased by 12%. Reduction in ANC service utilization is likely to continue into the next FY due to the end of the USAID Voucher plus activity that ensured improved access to services for mothers.

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; conducted every Tuesdays and Thursdays, during working hours. The positivity rate of the screening tests has remained very low among the women of child bearing age. There is a need to expand the activity to reach a broader population, if sustained funding can be realised.

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. There is however a plan to again transition the support to UPMB Local Service Delivery Activity in the next FY. 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 2019/20 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 Coordinator, 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 95 of the UNAIDS 95 95 95 global agenda (to ensure that 95% 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 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Number Tested					
Male	3,251	14,144	10,532	4,736	7,347
Female	5,028	6,478	10,995	6,993	6,721
TOTAL (Tested)	8,279	20,622	21,527	11,729	14,068
Tested +ve for HIV					
Male	243	316	386	160	103
Female	335	389	437	222	149
TOTAL (+ve Tests)	578	705	823	382	252
Positivity Rates of HCT					
Male	7.50%	2.20%	3.70%	3.40%	1.40%

Female	6.70%	6.00%	4%	3.20%	2.22%
Both sexes	7.00%	3.40%	3.80%	3.30%	1.79%

A total of 14,068 clients accessed HIV counselling & testing services during FY 2019-2020; an increase of 19.9% from the previous year. More men accessed HTC compared to the women. Positivity rate was high among women compared to men. This reverses the previous years' trends. One of the core objectives this FY was to raise up male involvement.

The total number of clients tested for HIV (all HTS) was 14,068. Out of these, 252 positive clients (positivity rate of 1.79%) were identified and linked to care.

Table 6.6: HIV test by purpose during FY 2019 – 2020

Types of test	HCT	PMTCT*	SMC	Total
Number of clients tested for HIV	10,017	2,567	1,484	14,068
No. of HIV +ve tests	201	45	6	252
Positivity Rate (%)	2.01%	1.75%	0.40%	1.79%

The above figure is for total test done purely for HIV screening & excludes quality control tests done during the FY 2019-20.

**Source: Laboratory records*

Table 6.7: Performance Indicators of the PMTCT Programme in FY 2019-2020

A. Antenatal	No.
A1. Mothers re-tested later in pregnancy, labour or postpartum	444
A2. Mothers testing positive on a retest	8
A3. New pregnant and lactating mothers newly enrolled into psychosocial support groups.	31
A4. HIV positive pregnant women already on HAART before 1st ANC visit /Current pregnancy	98
A5. Pregnant women who received services at the health facility after referral from the community	0
A6. HIV (+) lactating mothers followed up in community for infant feeding, early infant diagnosis, or linkage into chronic care	250
A7. HIV positive Pregnant women initiated on Cotrimoxazole	14
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 II (ART-T)	14
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	129
C. Postnatal	
C1. Postnatal mothers newly tested for HIV	74
C2. Postnatal mothers testing HIV positive	7
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	116
D2. HIV-exposed infants initiated on Cotrimoxazole prophylaxis	221
D3a. 1st DNA PCR results returned from lab within 2 weeks of dispatch	90
D3b. 2nd DNA PCR results returned from lab within 2 weeks of dispatch	88
D4a. Total HIV-exposed infants who had a serological/rapid HIV test at 18 months or older.	131
D4b. Positive Number of HIV-exposed infants who had a serological/rapid HIV test at 18 months or older	4
D5. DNA PCR results returned from the lab that are positive	4
D6. HIV-exposed infants whose DNA PCR results were given to caregiver	44
D7. Number of referred HIV positive-infants who enrolled in care at an ART clinic	3

The number of mothers initiated on ARVS in labor increased significantly (12,800%) in 19/20.
DNA PCR utilization slightly increased from last year.

Antiretroviral therapy

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

		FY	FY	FY	FY	FY
		2015-16	2016-17	2017-18	2018-2019	2019-20
ELIGIBLE FOR ART						
Male	<5 yrs	0	0	6	6	4
	5-<18 yrs	0	0	9	8	6
	18 and above	10	5	216	129	96
Female	<5 yrs	0	0	3	6	6
	5-<18 yrs	0	0	8	13	8
	18 and above	11	7	306	221	120
TOTAL ELIGIBLE FOR ART		21	12	553	383	240
STARTED ON ART						
Male	<5 yrs	3	4	6	6	4
	5-<18 yrs	5	2	9	8	6
	18 and above	137	131	216	129	96
Female	<5 yrs	9	1	3	6	6
	5-<18 yrs	10	9	8	13	8
	18 and above	90	201	306	221	120

TOTAL STARTED ON ART	254	348	553	383	240
-----------------------------	------------	------------	------------	------------	------------

All clients eligible for HAART were immediately enrolled in care, with no drop outs.

Table 6.9: Number of PLHAs started on ARV by age group and gender in FY 2019-2020

Data Element	No. of Children < 9yrs		No of Individuals 20–24 yrs		No. of Individuals 50+ yrs		Total
	M	F	M	F	M	F	
Number of new patients enrolled in HIV care at this facility during the year	7	7	9	35	90	92	240
Number of pregnant women enrolled into care during the year.				9		22	31
Cumulative Number of individuals on ART ever enrolled in HIV care at this facility							5242
Number of HIV positive patients active on pre-ART Care	0	0	0	0	0	0	0
Number of HIV positive cases who received CPT/Dapson at last visit in the year	8	8	20	41	93	199	369
No. of newly identified positives that are initiated on ART int the same FY	7	7	9	35	90	92	240
No. of pregnant & Lactating women started on ART at this facility during the quarter (Subset of HC11)				9		22	31
No. active on ART screened for TB at last visit in the quarter	46	44	99	176	905	1480	2750
No. active on ART with presumptive TB during the quarter	3	1	5	9	60	67	145
No. active on ART diagnosed with TB during the quarter	1	1	2	2	23	14	43

Net current cohort of people on ART in the cohort completing, 12 months during the year		1	5	6	19	35	42	108
Number of clients surviving on ART in the cohort completing, 12 months on ART during the year		1	4	3	8	26	26	68
Number of people accessing ARVs for PEP		0	0	16	9	29	20	74
No. active on ART on 1st line ARV regimen		20	35	79	174	877	1467	2652
No. active on ART on 2nd line ARV regimen		26	10	24	22	65	83	230
No. active on ART on 3rd line or higher ARV regimen		0	0	1	0	0	0	1
Number of clients on ART who had a viral load test during the past 12 months (most recent test)	Total Tested	37	40	92	160	774	1314	2417
	Suppressed viral load	31	32	73	131	735	1262	2264
Number active on ART enrolled in DSD approach	FBIM	7	8	24	61	255	387	742
	FBG	39	37	61	112	71	223	543
	FTDR			15	21	291	425	752
	CDDP			2	2	291	447	742
	CCLAD			2	0	34	68	104

Tuberculosis (TB) treatment

Dr. Ambrosoli Memorial Hospital offers TB treatment services; 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 increased in 2019/20. 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 must also be scaled up.

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

	FY	FY	FY	FY	FY
	2015-16	2016-17	2017-18	2018-19	2019-20
No. of patients registered (all)	233	223	243	196	325
Children (< 5 yr.)	9	4	11	16	38
Disaggregation by Disease					
New Pulmonary Positive	154	175	109	82	84
Relapses Pulmonary Positive	5	4	6	7	10
Failure Pulmonary Positive	3	2	0	1	7
Default Pulmonary Positive	7	8	12	10	0
New pulmonary Negative	26	49	99	82	206
Relapses Pulmonary Negative	2	0	1	0	6
Default Pulmonary Negative	3	1	3	0	4
Pulmonary no smear done	27	19	0	0	0
Extra Pulmonary	6	34	16	14	8
Disaggregation by Treatment					
New Patients	213	207	224	198	298
Re-treatment	20	16	22	18	27
Other Patients					
Transferred in	3	0	0	7	0

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 2019-20

Age group	Samples Collected	Samples Tested	MTB positive Cases	MDR positive (Rifampicin Resistant TB)	MDR cases referred
< 15 years	197	197	10	0	0
15 yrs.& above	1790	1790	157	7	7
Total	1987	1987	167	7	7

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 a 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 20/21, 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	FY	FY	FY
	2016-17	2017-18	2018-19	2019-20
	Number	Number	Number	Number
Cured	20	49	53	38
Treatment Completed	28	52	101	126
Died	19	27	28	24
Failure	0	2	2	0
Defaulted	7	13	24	1
Transfer out	18	N/A	36	3
Total	92	143	244	192

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

Outcome of treatment	FY	FY	FY	FY
	2016-17	2017-18	2018-19	2019-20
Cured	19	47	53	36
Treatment Completed	24	14	26	43
Died	18	6	6	10
Failure	0	0	2	0
Defaulted	1	0	9	1
Transfer out	2	N/A	29	2
Total	64	67	125	92

Orthopaedic Services

Orthopaedics services was run by an Orthopaedics officer. 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. Orthopaedic services remain a key unmet need of the population, and it is desirous for the hospital to build capacity in this line (surgeon and physiotherapist) if funding permits.

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

Procedures	FY	FY	FY	FY	FY
	2015-16	2016-17	2017-18	2018-19	2019-2020
Plaster (POP)	236	421	765	985	364
Physiotherapy	62	72	67	44	157

Mental health clinic

In this part of Acholi sub region, access to specialized mental health services 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 these patients.

In our OPD, Epilepsy still remain the leading psychiatric problem encountered. We also experienced a rise in the number of post-traumatic stress disorders.

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		FY		FY		FY	
	2016-17		2017-18		2018-19		2019-20	
	No.	%	No.	%	No.	%	No.	%
Epilepsy	238	72.3%	1,001	88.70%	576	85.30%	1171	84.55%
Drugs/alcohol abuse	33	10%	37	3.30%	46	6.80%	3	0.22%
Depression & post-traumatic stress disorders	21	6.4%	28	2.50%	21	3.10%	75	5.42%
Psychosis (schizophrenia)	2	0.6%	6	0.50%	1	0.10%	12	0.87%
Bipolar affective disorder	4	1.2%	36	3.20%	5	0.70%	3	0.22%
Attempted suicide	0	0%	2	0.20%	0	0.00%	3	0.22%
HIV related Psychosis	4	1.2%	2	0.20%	3	0.40%	19	1.37%
Other mental illnesses	27	8.2%	16	1.40%	23	3.40%	99	7.15%
Total	329		1,128		675		1,385	

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.

Dental Clinic

Dental services remain an outstanding unmet need in Agago District. The hospitals’ clinic located in the OPD has since closed more than five (5) years ago. The machines and equipment required have either worn out 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.

Currently palliative care outreaches have been integrated into PHC activities. Table 6.16 summarizes the number of patients (by diagnosis) who accessed palliative care in 19/20.

Table 6.16: Number of Patients who received Palliative Care in the FY 2019-20

Clinical Condition	Number
Hypertension	13
Diabetes	6
Renal Heart Disease	5
Liver Cirrhosis	6
Ascites	3
Congestive Cardiac Failure	3
Chronic obstructive Pulmonary Disease	3
Hep B	4
Others	23

INPATIENTS DEPARTMENT

Summary of beds and qualified health personnel

The hospitals' bed capacity has remained 271. In the FY 19/20, 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 partly. The surgical ward was covered by a Surgeon. Evidently, there is a critical lack of specialists in the hospital. The management intends to build more capacity in this line, when funding permits.

The average number of beds per nurse/midwife has remained at 3.4, with surgical ward being the ward with the highest ratio beds to nurse/midwife (6.9) and Maternity Ward the lowest (3.5).

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

Ward	No. of Beds	Medical Personnel	No. of Nurses & Midwives	No. of beds per Nurse/MW
Medical Ward	41	1 Medical Officer	9	6.5
TB Ward	18			
Surgical Ward	76	1 Surgeon	11	6.9
		1 Medical Officer		

		2 Orthopedic Officer		
Maternity & Gyn Ward	75	1 Medical Officer	21	3.5
Pediatric Ward	61	2 Medical Officers	10	6.1
Total	271	1 Specialist Doctor and 6 Medical Officers	51	3.4

Utilization indicators

The total admissions increased in 2019-20 (13.4%). The overall recovery rate has remained more or less constant at 97.42%. Overall mortality raised to 2.5% from 1.3%. The increased mortality was related to HIV/AIDS, cardiovascular disorders and malaria complications. Patients spent longer in the hospital as evidenced by the increased BOR and ALOS. This also reflects the increased utilization of resources earlier highlighted.

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

Indicator	FY	FY	FY	FY	FY
	2015-16	2016-17	2017-18	2018-19	2019-20
No. of beds	271	267	271	271	271
Total Admissions discharged	22,274	20,446	13,460	14,794	16,779
Patient days	86,898	100,930	68,521	69,329	89,761
Average Length of Stay (ALOS)	3.9	4.9	5.1	4.7	5.35
Turn over interval	0.5	-0.17	2.26	2.0	0.5
Throughput per bed	82.2	76.6	49.7	54.6	61.9
BOR	87.90%	103.60%	69.30%	70.10%	90.75%
No. Deaths	251	204	115	192	373
Mortality Rate	1.10%	1.00%	0.85%	1.3%	2.5%
Recovery Rate	98.00%	98.80%	97.00%	97.09%	97.42%
Self-discharges	14	48	20	67	60

Patient Days and Average Length of Stay (ALOS)

The number of days of inpatient services increased by 29.5% in 19/20. The ALOS increased by 13.8%. The national recommendation for ALOS is 4.5. This increment meant patients spent more days on inpatient treatment, translating into increased cost of treatment and utilization of financial resources.

Bed Occupancy Rate (BOR) and Throughput per Bed

The hospital Bed Occupancy rate (BOR) was at 90.75%. Children ward had the highest BOR (195%) followed by Maternity (95.45%). Surgical Ward registered the lowest BOR (56%). Malaria and its' associated complications were responsible for the increased BOR observed in the Children's and Maternity wards.

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

Overall, the number of deaths in the hospital increased by 94.2% compared to previous FY. This reflects an overall mortality rate of 2.5% (c.f 1.3%) of all patients treated in the hospital. Mortality rate was highest in the medical ward (4.21%) followed by Children's ward (2.82%). This was mainly due to HIV associated comorbidity, non-communicable diseases and malaria.

Seven (7) more people self-discharged from the hospital in 19/20 c.f previous year. 67.2% of these self-discharges were from the CHW, followed by Medical ward, 13.3%. 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 4 FYs

MEDICAL WARD				
	FY	FY	FY	FY
	2016-17	2017-18	2018-19	2019-20
No of beds	41	41	41	41
Total Admissions	2,792	2,072	2,237	2,684
Patients days	14,880	11,334	11,310	12,549
ALOS	5.5	5.5	5.1	4.7
Throughput per bed	68.1	50.5	54.6	65.5
BOR	99.40%	75.70%	75.60%	83.18%
No of Deaths	79	63	86	113
Mortality rate	2.82%	3.04%	3.84%	4.21%
Recovery rate	97.1	95.50%	95.31%	95.45%
Self-discharges	2	4	19	9

SURGICAL WARD[1]				
	FY	FY	FY	FY
	2016-17	2017-18	2018-19	2019-20
No of beds	71	76	76	76
Total Admissions	2,171	2,024	2,055	1,925
Patients days	17,833	17,995	14,721	15,189
ALOS	16.4	8.9	7.2	7.9
Throughput per bed	30.6	26.6	27.0	25.3
BOR	68.80%	64.90%	53.10%	56.00%
No of Deaths	27	13	31	32
Mortality rate	1.24%	0.64%	2%	2%
Recovery rate	98.4	98.80%	98.35%	98.13%
Self-discharges	7	4	3	4

PAEDIATRIC WARD				
	FY	FY	FY	FY
	2016-17	2017-18	2018-19	2019-20
No of beds	61	61	61	61
Total Admissions	9,671	3,810	4,143	7,615
Patients days	44,765	19,783	20,188	43,503
ALOS	4.6	5.2	4.87	5.7
Throughput per bed	158.5	62.5	67.9	124.8
BOR	201.10%	88.90%	90.70%	195%
No of Deaths	83	36	59	217
Mortality rate	0.85%	0.94%	1.42%	2.85%
Recovery rate	99.10%	98.70%	97.51%	96.53%
Self-discharges	2	10	44	47

OBSTETRICS& GYNECOLOGY WARD				
	FY	FY	FY	FY
	2016-17	2017-18	2018-19	2019-20
No of beds	75	75	75	75
Total Admissions	5,593	5,302	6,165	4,226
Patients days	20,107	17,331	20,984	16,519
ALOS	5.1	3.3	3.4	3.9
Throughput per bed	74.6	70.7	82.2	56.35
BOR	73.50%	63.30%	76.70%	95.45%
No of Deaths	6	1	7	4
Mortality rate	0.11%	0.02%	0.11%	0.09%
Recovery rate	99.90%	99.40%	99.9%	99.9%
Self-discharges	1	0	0	0

TB WARD				
	FY	FY	FY	FY
	2016-17	2017-18	2018-19	2019-20
No of beds	19	18	18	18
Total Admissions	219	252	194	329
Patients days	3,345	2,078	2,126	2,001
ALOS	8.2	8.2	11.0	6.1
Throughput per bed	11.5	14	10.8	18.3
BOR	48.20%	31.60%	32.40%	30.45%
No of Deaths	10	2	9	7
Mortality rate	4.56%	0.79%	4.64%	2.13%
Recovery rate	95.40%	99.20%	95.36%	97.87%
Self-discharges	0	0	0	0

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

Inpatient referrals

There was 89.2% decrease in the number of hospital referrals. Referrals to the hospital decreased by 90.1%. The hospital has continued as the referral facility for Agago and four (4) other neighboring districts. The marked reduction in referrals was likely due to the restriction in availability of transport facilities imposed due to COVID 19. Majority of the patients who came to the hospital were self-referrals. Cross boarder movements were not allowed too. In the same vein, the number of referrals out reduced significantly.

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

	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Referrals to hospital	449	1,328	1,378	1552	153
Referrals from hospital	173	137	267	171	33
Total	622	1,465	1,645	1,723	186

Morbidity causes

As it was in 18/19, malaria remained the leading morbidity cause (41.65% of all admissions) followed by Injuries (8.5%). 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.

Table 6.21: Top ten causes of admission in all the wards in the FYs 2017-2018& 2018-2019

Causes of Morbidity		FY 2018-19		FY 2019-20	
		No. of cases	% on all diagnose	No. of cases	% on all diagnose
1	Malaria	3,159	21.35%	6,989	41.65%
2	Injuries: (Trauma due to other causes)	1,623	10.97%	1,426	8.50%
3	Pneumonia	548	3.70%	993	5.92%
4	Severe Malnutrition (SAM): With oedema	109	0.74%	742	4.42%
5	Septicemia	283	1.91%	406	2.42%
6	Anaemia	463	3.13%	384	2.29%
7	New TB cases diagnosed	178	1.20%	298	1.78%
8	Diarrhoea - Acute	278	1.88%	245	1.46%
9	Respiratory Infections (Other)	147	0.99%	241	1.44%
10	Other Neonatal Conditions	203	1.37%	197	1.17%

All others	1,435	9.70%	607	3.62%
Total	14,794		16,779	

The number malaria cases admitted in the hospital increased by 121% from the previous year.

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

	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Malaria cases	9,664	7,950	1,844	3,159	6,989
% of all diagnosis	40.16%	34.10%	22.40%	21.35%	41.65%

Mortality causes

Malaria accounted for the highest number of disease specific deaths (191). Prematurity had the highest CFR 20.61%. Death of neonates continue to be a burden, especially when referrals of neonates from lower facilities is still delayed. Liver cirrhosis had the second highest CFR (12.09%).

Table 6.23: Top ten causes of death among inpatients all wards FY 2018-19 and FY 2019-20

Causes of Mortality among Inpatients		FY 2018-19			FY 2019-20		
		No of disease specific deaths	No of cases admitted in the hospital	Case Fatality Rate	No of disease specific deaths	No of cases admitted in the hospital	Case Fatality Rate
1	Malaria total	19	2,788	0.68%	191	6,989	2.73%
2	Pneumonia	13	534	2.43%	43	993	4.33%
3	Premature baby (as condition that requires mgt)	12	154	7.79%	27	131	20.61%
4	Other Neonatal Conditions	21	182	11.54%	22	197	11.17%
5	Injuries: (Trauma due to other causes)	14	1,623	0.86%	21	1,426	1.47%
6	Liver Cirrhosis	2	22	9.09%	11	91	12.09%
7	Anaemia	12	463	2.59%	10	384	2.60%
8	Diarrhoea - Acute	1	278	0.36%	7	245	2.86%
9	Sickle cell Anaemia	0	64	0.00%	6	195	3.08%
10	Other Cardiovascular Diseases	12	86	13.95%	5	66	7.58%

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 (we continue to solicit for support towards this). The TB ward is annexed to the same structure.

Staff Composition

The ward was run by a Medical Officer and 11 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 2019-2020

Cadre/ Discipline	Qualification	Number
Medical Doctor	Bachelor Degree in Medicine and Surgery	1
Registered Comprehensive Nurse	Diploma in Comprehensive Nursing	2
Enrolled Nurse	Certificate in Nursing	3
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	4
Nursing Assistant	Certificate in Nursing Assistant	2
Nursing Aid	Trained on the Job	0
Total		12

Key Indicators in Medical ward

The total admissions increased by 20%. The ALoS reduced (4.7). The BOR increased by 8.72%. As already mentioned above, these indicators point towards improved utilization of the ward services. The clinical efficiency of the ward remained stable.

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

	FY	FY	FY	FY	FY
	2015-16	2016-17	2017-18	2018-19	2019-20
No. of beds	41	41	41	41	41
Total Admissions	3,088	2,792	2,072	2,237	2,684
Bed days	10,329	14,880	11,334	11,310	12,549
ALoS	3.4	5.5	5.5	5.1	4.7
BOR	69.40%	99.40%	75.70%	75.57%	84.29%

Throughput	75.3	68.1	50.5	54.6	65.5
Turnover interval	1.5	0.03	1.75	1.63	1.36
Deaths	95	79	63	86	113
Death Rate	3.10%	2.82%	3.04%	3.84%	4.21%
Recovery Rate	95.30%	97.10%	95.50%	95.75%	95.45%
Self-discharges	6	2	4	9	9

Morbidity causes

As experienced in the previous FY, Malaria was the leading cause of admission into the medical ward (accounting for 36.81% of the total admission) followed by pneumonia (accounting for 5.74% of all admissions. Infectious disease remains the big burden of diseases. Septicemia increased by 46% during the FY. The overall morbidity burden on the ward increased by 29.2%.

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

Causes of Morbidity in Medical Ward		FY 2018-2019		FY 2019-2020	
		No. of cases admitted	% on all admissions in Medical Ward	No. of cases admitted	% on all admissions in Medical Ward
1	Malaria	651	29.12%	988	36.81%
2	Pneumonia	84	3.76%	154	5.74%
3	Aneamia	85	3.80%	105	3.91%
4	PUD	159	7.11%	101	3.76%
5	Liver cirrhosis	42	1.88%	79	2.94%
6	Sepsis	50	2.24%	73	2.72%
7	Organophosphate poisoning	52	2.32%	68	2.53%
8	Gastritis	80	3.58%	61	2.27%
9	UTI	102	4.56%	57	2.12%
10	Bacteraemia	41	1.83%	53	1.97%

Mortality causes

In the FY 19/20, Tuberculosis was the leading mortality cause (CFR 10.87%). Death due to TB is compounded by HIV comorbidity. This was followed by pneumonia, CFR 9.07%. Malaria however accounted for the highest number of disease specific deaths (19).

NCDs have continued to contribute significantly to mortality causation in the ward. Liver cirrhosis (mostly due to alcohol and other drugs toxicity) was the third leading cause of death (CFR 8.86%). Of late, Liver cirrhosis due to hepatitis B is on the rise.

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

Causes of Mortality in Medical Ward	FY 2018-2019			FY 2019-2020		
	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 Malaria	22	651	3.38%	19	988	1.92%
2 Pneumonia	4	84	4.76%	14	154	9.09%
3 Aneamia	2	85	2.35%	8	105	7.62%
4 Liver cirrhosis	3	42	7.14%	7	79	8.86%
5 T.B	1	19	5.26%	5	46	10.87%

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 2019-2020

Cadre/ Discipline	Qualification	Number
Surgeon	Bachelor Degree in Medicine and Surgery and Master in Surgery	2
Medical Officer	Bachelor Degree in Medicine and Surgery	1
Registered Midwife/Nurse	Diploma in Midwifery and Nursing	3

Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	2
Enrolled Nurse	Certificate in Nursing	5
Nursing Aid	Trained on the job	2
Orthopedic Officer	Diploma in Orthopedic	1
Physiotherapist Assistant	Certificate of Physiotherapist Assistant	0
Total		16

Key Indicators in surgical ward

The total admissions reduced by 6.3% compared to the previous year. The ALoS slightly increased. The ALOS was nonetheless high, compared to the national average of 4.5. The BOR also increased by 5.5%. The overall 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 0.15%.

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

	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
No. of beds	76	71	76	76	76
Total Admissions	2,060	2,171	2,024	2,055	1925
Bed days	16,055	17,833	17,995	14,721	15189
ALoS	7.8	16.4	8.9	7.2	8.0
BOR	57.90%	68.80%	64.90%	53.07%	56.00%
Throughput	27.1	30.6	26.6	27.0	25.3
Turnover interval	5.7	3.7	4.8	6.3	6.5
Deaths	40	27	13	31	32
Death Rate	1.90%	1.24%	0.64%	1.51%	1.66%
Recovery Rate	94.60%	98.40%	98.80%	98.35%	98.13%
Self-discharges	7	7	4	3	4

Morbidity causes

Opposed to last FY, abscess was the leading cause of admission, accounting for 17.09% of admissions, followed by injuries. Injuries due to domestic violence, SGBV and injuries related to alcohol intoxication remain very high. Injuries from RTA accounted for 5.35% of all admissions.

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 presents 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 2018-2019 & 2019-2020

Causes of Morbidity in Surgical Ward		FY 2018-2019		FY 2019-2020	
		No. of cases admitted	% on all admissions in Surgical Ward	No. of cases admitted	% on all admissions in Surgical Ward
1	Abscess	186	9.16%	329	17.09%
2	Injuries due to other causes	1402	69.06%	195	10.13%
3	fracture	225	10.95%	133	6.91%
4	Septic wound	74	3.60%	117	6.08%
5	Hernia	125	6.15%	113	5.87%
6	Injuries due to Road Traffic Accident [RTA]	73	3.59%	103	5.35%
7	Cellulitis	62	3.02%	82	4.26%
8	Hydrocele	55	2.70%	61	3.17%
9	Trauma	69	3.36%	50	2.60%
10	Injuries due to Burn	36	1.77%	46	2.39%

Mortality causes

Injuries from other causes accounted for a greater number of disease specific deaths in the FY. However, burns had the highest CFR (6.52). Diagnostic challenges still make 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. The management plans to set up 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	9	195	4.62%
3	Wound	4	117	3.42%
4	Burn	3	46	6.52%
5	abscess	2	329	0.61%
2	Others	14	161	8.70%

SURGICAL OPERATION 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 are 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	1
Medical Theatre Assistant		4
Nursing Assistant	Certificate in Nursing Assistant	3
Nursing Aid	Trained on the Job	4
Total		18

Surgical Procedures

The total number of surgeries performed in the hospital reduced by 4.5% compared to the last year. The FY 19/20 saw a 6.0% decrease in major surgeries and slight decline (3.4%) in minor surgeries. 50.20% of the surgeries performed were emergency operations. C/S accounted for 44.7% of major surgeries performed. The hospital has continued as the MOH accredited internship center for surgical disciplines.

Table 6.33: Top major surgical procedures performed in the FY 2019-20

No.	Top major surgical procedures	Number of patients	Proportion (%)
1	Caesarian sections	552	44.70%
2	Herniorrhaphy	128	10.36%
3	Orthopedic Surgery	127	10.28%
4	Laparotomy	91	7.37%
5	Plastic/ reconstructive surgery	12	0.97%
6	Other Major procedures	325	26.32%
Total		1,235	

Table 6.34: Top minor surgical procedures done in FY 2019-20

No.	Top minor surgical procedures	Number of Patients	Proportion (%)
1	Minor Orthopedic Surgery	626	32.88%
2	Incision and drainage of abscesses	298	15.65%
3	Debridement and care of wounds and skin grafting	185	9.72%
4	Safe Male Circumcision	6	0.32%
5	Other Minor procedures	789	41.44%
Total		1,904	

No surgical camps were arranged during the FY due to the pandemic. The largest volume of major surgeries performed were Caesarean sections, contributing to 44.70% of procedures. This is 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 is slowly taking shape in the hospital, thanks to the strategic capacity built through the partnership with Njokuty foundation. Both major and minor orthopedic surgeries are currently being performed by the local surgeons (on a case by case basis).

Table 6.35: Trend of surgical activities in last 5 FYs

	FY	FY	FY	FY	FY
--	----	----	----	----	----

	2015-16	2016-17	2017-18	2018-2019	2019-20
Total Operations	1,790	2,639	3,425	3,286	3,139
Major operations (including C/S)	661	994	1,285	1,314	1,235
Minor operations	1,129	1,645	2,140	1,972	1,904
Emergencies	282	381	530	585	620
Emergencies as % of total major operations	42.70%	38.30%	41.20%	44.52%	50.20%

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

Type of Anesthesia	FY	FY	FY	FY	FY
	2015-16	2016-17	2017-18	2018-19	2019-20
Local Anesthesia	276	269	344	163	146
General Anaesthesia with IV Ketamine	1,149	1,101	1,175	645	933
Spinal Anesthesia	335	247	262	263	737
General Anesthesia with ETT	30	41	69	65	88
General Anesthesia with LMA					13
Regional Anaesthesia					1
Total	1,790	1,658	1,850	1,136	1,918

PEDIATRIC WARD

The ward has a capacity of 61 beds, distributed in 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, who also supervise activities in the NICU. The number of nursing staff remained stable despite some few nurses leaving for further studies.

Table 6.37: Personnel assigned to Paediatric Ward in FY 2019-20

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

Registered Comprehensive Nurses		0
Enrolled Nurse	Certificate in Nursing	7
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	2
Nursing Assistant	Certificate in Nursing Assistant	4
Total		18

Key ward indicators

Total admission increased by 83.8%. This significant rise was due to the increased malaria burden registered in the year. The ALOS and BOR increased by 16.3% and 104.3% respectively. The total number of deaths increased significantly by 267.8%. Recovery rate reduced by 1.51%. There was increased utilization of the ward services, translating also into increased cost of treatment in the ward. The average in patient bed days increased. The ward also registered the highest number of escaped patients during the year.

Table 6.38: Paediatric Ward indicators over the last 5 FYs

	FY	FY	FY	FY	FY
	2015-16	2016-17	2017-18	2018-19	2019-20
No. of beds	61	61	61	61	61
Total Admissions	10,706	9,671	3,810	4,143	7,615
Bed days	33,596	44,765	19,783	11,310	43,503
ALoS	3.1	4.6	5.2	4.9	5.71
BOR	150.90%	201.10%	88.90%	90.70%	194.95%
Throughput	175.5	158.5	62.5	67.9	124.8
Turnover interval	-1.1	-2.3	0.65	2.64	-2.79
Deaths	102	83	36	59	217
Death Rate	1%	0.85%	0.94%	1.42%	2.85%
Recovery Rate	98.60%	95.40%	98.70%	98.04%	96.53%
Self-discharges	0	0	10	22	47

Morbidity causes

Communicable diseases represent a major morbidity burden in the pediatric age, in Agago district. Malaria was the leading cause of admissions, accounting for 67.18% of all cases. This was also a 99.8% increase in the number from the previous FY. Pneumonia followed, accounting for 7.91% of all admissions. The top two causes of morbidity, are easily

preventable illnesses with prudent public health interventions. Anemia increased by 111.7%, a direct consequence of the increased malaria cases.

Malnutrition continues to be on the rise; typically related to the high poverty levels in the surrounding community.

Table 6.39: Top ten causes of admission in Paediatric Ward - FY 2018-19 and FY 2019-20

Causes of Morbidity		FY 2018-2019		FY 2019-2020	
		No. of cases admitted	% on all admissions	No. of cases admitted	% on all admissions
1	Malaria	2561	50.03%	5116	67.18%
2	Pneumonia	455	8.89%	602	7.91%
3	Anaemia	197	3.85%	417	5.48%
4	Septicaemia	167	3.65%	233	3.06%
5	Sepsis	85	1.66%	178	2.34%
6	Gastroenteritis / diarrhea	499	9.75%	157	2.06%
7	Malnutrition	75	1.81%	153	2.01%
8	Bacteraemia	104	2.03%	92	1.21%
9	Respiratory Tract Infection - (Not Pneumonia)	78	1.52%	90	1.18%
10	measles	3	0.07%	73	0.96%

Mortality causes

Malaria was responsible for the highest number of disease specific deaths in 19/20. However, anemia and malnutrition, were the deadliest illnesses (CFR; 15.59% and 11.11% respectively). These conditions were compounded by the lack of intensive care services with adequate oxygen support for the children. Anemia was mostly a result of malaria infections. Unfortunately supply to and access to safe blood products continue to be a major challenge, since the nearest blood bank is more than 160 kms away. Even then blood is not readily available in the bank. The hospital has had to dig into her pocket to save lives of children and mothers during numerous life-threatening emergencies. This however is not sustainable, given the many financial crisis the hospital faces.

Table 6.40: Top five causes of death in Paediatric Ward in FY 2019-20

Causes of Mortality		No of disease-specific deaths	No of cases of the disease admitted in Paediatric Ward	Case Fatality Rate
1	Malaria	84	5116	1.64%
2	Anaemia	65	417	15.59%
3	Pneumonia	19	602	3.16%
4	SAM	17	153	11.11%
5	Sepsis	6	178	3.37%

Nutrition unit

The nutrition unit is an annex of the pediatric ward, sharing both doctors and nurses. Malnutrition remains a significant threat to the lives of the children in the district. The cases admitted continue to rise. In 19/20, malnutrition had the second highest CFR (11.1%) of all cases managed in the Pediatrics ward. 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 in order to meet malnutrition needs in the district.

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 2019-20

Cadre/ Discipline	Qualification	Number
Medical officer	Bachelor Degree in Medicine and Surgery	2
Clinical Officer	Dip. In Clinical Med & Community Health	1
Registered Midwife/Nurse	Diploma in Midwifery and Nursing	1
Registered Midwife	Diploma in Midwifery	6
Enrolled Midwife	Certificate in Midwifery	16
Total		26

Key Indicators

The total admissions decreased by 31.5%. The ALOS remained stable with a significant rise in the BOR, by 18.8%. The maternal death rate improved. As it has been before, maternal deaths in the district are a consequence of delay in referrals in most instances. 99.9% of all admitted patients recovered and were discharged. Overall, the efficiency of the ward (clinically and economically) improved.

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

	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
No. of beds	75	75	75	75	75
Total Admissions	6,195	5,593	5,302	6,165	4,226
Bed days	22,673	20,107	17,331	20,984	16,519
ALoS	3.6	5.1	3.3	3.4	3.9
BOR	82.80%	73.50%	63.30%	76.65%	95.45%
Throughput	82.6	74.6	70.7	82.2	56.4
Turnover interval	0.8	1.3	1.9	1.04	2.57
No. Deaths	4	6	1	7	4
Death Rate	0.06%	0.11%	0.02%	0.11%	0.09%
Recovery Rate	99.60%	99.90%	99.40%	99.9%	99.9%
Self-discharges	0	1	0	0	0

Birth indicators

Total deliveries in the hospital reduced by 35.1%. Reduction in deliveries was likely due to the abrupt end to the USAID Voucher plus activity in the district compounded by the restrictions put in place due to the pandemic. Caesarean section accounted for 20.35% of total deliveries in 19/20. This was above the MOH recommendation of not more than 15%. 94.1% 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 42.03% 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 reduced by 25%. 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	FY	FY	FY	FY
	2015-16	2016-17	2017-18	2018-19	2019-20
Total deliveries	3,465	3,453	3,547	4,169	2,707
Normal deliveries in unit	3,111	2,918	2,977	3,617	2,187
Abnormal deliveries (incl. C/S)	354	535	570	529	552
Live birth in units	3,445	3,340	3,499	4,142	2,654
Babies born with low birth weight	443	652	577	732	517
Fresh Still births in unit	20	20	18	24	23
Macerated still births in unit	26	22	16	35	46
New-born deaths (0-7 days)	34	27	14	69	59
Maternal Deaths	4	6	1	9	5
Live Births					
Full term normal weight	2813	2,925	2977	3,384	2,084
Full term low birth weight	572	606	577	601	451
Premature cases	60	101	90	157	223
Caesarean Sections					
Elective C/S	26	24	26	30	33
Emergency C/S	292	392	530	579	519
Caesarean Sections total	318	416	556	609	552
C/S as % of total deliveries	9.20%	12.00%	15.70%	14.61%	20.39%
Emergency C/S as % of all C/S	91.80%	94.20%	95.30%	95.07%	94.02%

The main causes of caesarian section haven't changed from those experienced in the previous years:

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

Table 6.44: Origin of mothers who delivered through C/S in the last 5 FYs³

Sub-County	FY	FY	FY	FY	FY
	2015-16	2016-17	2017-18	2018-19	2019-20
Adilang	20	28	49	46	37
Kotomor	10	9	16	35	25
Patongo	15	31	52	58	53
Patongo T.C.	13	12			
Lukole	29	38	58	68	51
Lukole T.C.	4	10	6		
Kalongo T.C.	23	35	39	69	69
Paimol	19	20	32	53	50
Parabongo	18	21	46	40	40
Omot	14	17	34	38	26
Acholpii	5	0	4	25	21
Lamiyo	7	2	9	37	29
Lapono	34	34	60	39	41
Lira Palwo	24	20	28	35	35
Omiya Pacwa	12	10	25	41	33
Wol	25	29	40	25	27
Total	272	316	498	609	537

Almost all women who underwent C/S in our Hospital comes from Agago district. Patongo HC IV remains not operational. Surely one of the motivating factors for mothers to access

³Note: Data for Patongo town council and Patongo Sub county are not disaggregated; the same applies to Lukole Town Council and Lukole Sub county (source: Kalongo Hospital theatre, operation book FY 2011-2012 to FY 2015-2016)

qualified medical services during pregnancy/delivery and postnatal care has been the Voucher/USAID project. Its closure has left serious gap in access to services by vulnerable mothers. Financially, the Hospital has suffered 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	FY	FY	FY	FY
	2015-16	2016-17	2017-18	2018-19	2019-20
Pader	28	18	17	10	8
Kitgum	4	7	10	1	2
Abim	1	4	7	0	5
Other	10	71	23	0	0
Total	43	300	58	11	15

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 threat for pregnant mothers. The hospital still maintains a waiting shelter where mothers with identified risk factors can wait until the delivery.

Gynaecological ward

The lack of specialised obstetrics and gynaecological service still present a challenge in care. Attracting and retaining such cadres has proved very hard for the hospital. All gynaecological conditions are attended to by the Mos who also run the weekly clinic every Monday in OPD. Urinary tract infections presented the heaviest morbidity burden in the FY.

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

Diagnosis of admission	FY	FY	FY	FY	FY
	2015-16	2016-17	2017-18	2018-19	2019-20
Pelvic Inflammatory Disease	44	46	57	52	4
Urinary Tract Infection	55	1	64	0	108
Cancer of cervix	7	27	19	13	1
Uterine Fibroid	10	6	17	3	8
Ovarian Cyst	28	31	16	32	23
Vaginal Candidiasis	12	2	4	0	4

Bartolini's Cyst	0	1	1	0	3
Peritonitis	0	0	1	0	1
Other Gyn conditions	0	270	124	143	117
Total	403	384	303	243	269

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.

The total admissions in the TB ward increased significantly by 69.6%. the increase is related in part to improved active case identification and notification, due to the changes in policy and improved screening modalities. The death rate in the ward reduced (2.13%). 97.87% of all the patients managed improved. TB treatment outcome is greatly influenced by a number of factors; 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.

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

	FY	FY	FY	FY	FY
	2015-16	2016-17	2017-18	2018-19	2019-20
No. of beds	18	19	18	18	18
Total Admissions	225	219	252	194	329
Bed days	4,182	3,345	2,078	2,126	2,001
ALoS	18.6	8.2	8.2	5.8	6.08
BOR	63.70%	48.2	31.6	32.40%	30.45%
Throughput	12.5	11.5	14	10.8	18.3
Turnover interval	10.6	16.4	17.8	22.9	13.9
Deaths	10	10	2	11	7
Death Rate	4.40%	4.56%	0.79%	5.67%	2.13%
Recovery Rate	95.10%	95.40%	99.20%	94.33%	97.87%
Self-discharges	1	0	0	0	0

DIAGNOSTIC SERVICES

Laboratory services

The hospital laboratory is a HUB that serves a total of ten (10) lower-level facilities in Agago and Pader districts. 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 increased by more than 50% in 19/20.

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

	Type of Tests	FY	FY	FY	FY	FY
		2015-16	2016-17	2017-18	2018-19	2019-20
Parasitology	Malaria Microscopy, Malaria RDTs, Other Haemoparasites, Stool Microscopy.	33,969	36,283	23,320	23,793	28,676
Haematology	HB, WBC Total, WBC Differential, Film Comment, ESR, RBC, Bleeding time, Prothrombine time, clotting time, blood transfusion tests, & Others	102,373	166,984	111,917	23,156	28,456
Biochemistry	Urea, Calcium, Potassium, Sodium, Creatinine, ALT, AST, Albumin, Total protein, Triglycerides, Cholesterol, CK,LDH, AlkalinePhos, Amylase, Glucose, Uric Acid, Lactate, Others	11,729	30,335	13,518	2,069	2,504
Bacteriology	ZN for AFBs, Cultures and Sensitivities, Gram, Indian Ink, Wet Preps, Urine Microscopy	9,510	8,291	7,262	6,633	15,327
Serology	VDRL IRPR, TPHA, Shigella Dysentery, Syphilis Screening, Hepatitis B, Brucella, Pregnancy Test, Vidal Test, Rheumatoid Factor	12,111	21,260	13,270	12,845	9,989

Immunology	CD4 tests & others	3,916	5,123	5,080	2,722	4,847
HIV tests by purpose	HCT, PMTCT, Quality control and clinical diagnosis	16,057	26,913	28,211	22,762	20,691
	Total tests	189,665	295,189	202,578	92,141	110,490
	Total lab staffs	8	11	11	10	10
	Average tests per Lab staff	23,708	26,835	18,416	9214.1	11049

Malaria positivity in 19/20 increased. The total number of malaria tests carried out also increased. Hepatitis B continues to be a real threat, with a positivity rate of 10.9%. The hospital rolled out a vaccination campaign for babies born to Hep. B positive mothers with support from the Ambrosoli Foundation.

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

Type of Test	FY			FY		
	2018-2019			2019-2020		
	Total	Positive	% Positive	Total	Positive	% Positive
Malaria (both slide and RDT)	10,751	3,627	33.74%	28,385	14,329	50.48%
VDRL/RPR	3,358	270	8.04%	5,722	582	10.17%
Hepatitis B	2,046	196	9.58%	3,258	355	10.90%
Brucella	199	9	4.52%	221	6	2.71%

The Gulu Regional Blood bank is 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.

The region continues to experience general shortage of blood (worsened by the pandemic conditions), 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 19/20, 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						FY					
2018-2019						2019-2020					
Group A	Group B	Group AB	Group O	RH +	RH -	Group A	Group B	Group AB	Group O	RH +	RH -
31.36%	17.98%	4.70%	44.66%	98.75%	1.25%	31.13%	20.26%	5.12%	41.54%	98.06%	1.94%

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 has consequently interrupted vital services in the hospital.

The total number of X rays performed in the FY 19/20 increased by 15.1%. Chest X ray remains the most performed followed by upper extremities. This has been the same pattern for the last 5 FYs. Plain Abdominal X rays increased in 19/20 by 31%, due to the increased cases of abdominal surgical emergencies treated in the ward.

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

	FY	FY	FY	FY	FY
	2015-16	2016-17	2017-18	2018-19	2019-20
Chest	2,752	2,062	572	1,459	2,009
Upper extremities	1,022	848	458	997	877
Lower extremities	1,160	800	278	710	735
Vertebral column	390	338	83	283	335
Skull and mandible	351	332	53	158	150
Shoulder and clavicle	195	135	69	139	178
Pelvis and hip	258	196	60	153	176
Abdominal – plain	175	130	51	155	203
Abdominal -contrast	1	0	0	2	0
Screening	0	0	0	0	5
Total	6,304	4,841	1,624	4,056	4,668

Ultrasound examinations reduced by 87% in 19/20. The reduction is attributed to the departure of the skilled radiographer during the FY. Sustainability of radiographers have always proven an issue. Abdominal and Obstetrics 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	FY
	2018-19	2019-20
Obstetrics	840	99
Gynaecology	1,077	50
Abdomen	1,044	239
Others	211	24
Total	3,172	412

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; inpatient, 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 FY2019-2020

Cadre/ Discipline	Qualification	Number
Pharmacy Technician	Diploma in Pharmacy	2
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		8

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 pharmacy obviously needs air conditioners to be installed to ensure optimal temperature control even during the dry seasons.

Table 6.53: Average temperature and humidity recorded in Pharmacy Department FY2019-20

Reading Time	Temperature	Humidity
8:15 am	24.5 C	56%
12.00 pm	28.6 C	55%
5.00 pm	27.5 C	55%

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 constraints have limited the possibility to proceed with big orders and a more fragmented system 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 2018-2019 and FY 2019-2020

Drug description	FY		FY	
	2018-2019		2019-2020	
	Quantity issued tablets/vial	Monetary value (UGX)	Quantity issued tablets/vial	Monetary value (UGX)
Paracetamol 500mg	356,038	6,245,806.22	343,299	6,720,644.03
Amoxicillin 250mg	238,994	12,188,843.06	210,325	12,718,414.57
Metronidazole 200mg	251,038	4,964,600.79	196,579	4,368,595.09
Folic acid 5mg	95,679	2,281,493.86	142,574	2,166,496.99

Folic acid + Ferrous Sulphate	157,446	7,129,154.88	121,644	5,349,318.13
Ferrous sulphate 200mg	34,965	1,020,371.71	63,839	1,862,822.02
Cloxacillin 250mg	75,077	5,205,298.32	83,121	5,898,909.32
Ampicillin 500mg	50,272	23,186,402.36	29,961	14,914,034.34
Carbamazepine 200mg	91,950	5,684,252.32	92,644	5,762,377.83
Ibuprofen 200mg	73,383	1,757,929.39	61,221	2,120,347.26
Vitamin B complex	97,455	1,037,405.87	80,352	827,365.73
Ampicillin/cloxacillin 500mg	58,108	6,678,067.26	16,741	2,679,940.34
Prednisolone 5mg	72,132	2,277,434.33	67,650	1,741,137.53
Omeprazole 20mg	48,692	2,041,251.02	38,781	1,399,964.46
Ciprofloxacin 500mg	52,523	5,029,871.22	46,061	4,352,460.22
Frusemide 40mg	48,336	927,702.99	44,081	810,887.23
Erythromycin 250mg	133,081	12,109,862.71	91,845	9,801,720.71
Benzylpenicillin 1MU	11,153	3,128,938.92	34,362	9,948,571.55
Penicillin V 250mg	53,300	3,436,920.89	72,720	4,630,921.83
Metronidazole 5mg/ml 100ml	10,801	9,633,547.73	8,417	8,231,909.88
Total		115,965,155.85		102,443,524.27

Intravenous fluid consumption

The consumption of intravenous fluid increased by 18%. Fluid consumption (just like drugs) continue to be a heavy cost. The challenge is compounded by the very low-cost recovery on fluids, since they are used to aid many aspects of care for a patient.

Table 6.55: Consumption of IV fluids in FY 2018-2019 & FY 2019-2020

Fluid Description	Quantity (in bottles) 2018-2019	Value(UGX) for 2018-2019	Quantity (in bottles) 2019-2020	Value(UGX) for 2019-2020
Water for Injection 10 ml	61,371	5,904,036.41	60,203	5,893,384.37
Sodium Chloride 0.9% IV 500 ml	20,063	26,665,755.02	15,887	20,293,259.16
Dextrose 5% IV 500 ml	7,651	970,020.08	11,588	15,259,400.90
Dextrose 5% IV 250 ml	1,656	2,233,645.92	432	582,768.00
Sodium Lactate Compound IV 500 ml	5,114	6,704,826.93	6,573	8,443,990.78
Dextrose 50% IV 100 ml	1,227	2,649,008.13	1,570	4,073,390.36
Gelatine/polygeline Solution 3.5% IV 500 ml	171	4,964,825.64	173	5,022,893.78
Darrow's Half Strength 500 ml	346	641,646.62	263	398,442.30
Total		50,733,764.75		59,967,529.65

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 2019/20, 171 patients accessed pastoral care services, a reduction of 63%. This reduction was due to the ban on worships put in place by the government.

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

Activity / Indicator	FY	FY	FY	FY	FY
	2015-16	2016-17	2017-18	2018-2019	2019-2020
No. patients visited and counselled	243	94	452	454	161
No. of patients given sacrament of Marriage	1	0	0	0	0
No. of patients anointed	3	18	1	7	9
Total	247	112	453	461	171

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 had only one operational Ambulance; the backup got involved in an accident and was 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	FY	FY	FY	FY
	2015-16	2016-17	2017-18	2018-19	2019-20
DIESEL TOTAL	29,242	39,111	45,142	87,648.6	55,835
Board of Governors Fuel Refund to members	205	428	315	350	180
Generators	8,961	14,222	17,391	38,182.8	29,946
Vehicles	19,265	22,546	26,341	42,599.7	19,133
Workshop	47	20	10	25	24
Incinerator	750	1,018	1,065	2004	655
Others	60	877	20	4,487.10	5,897
PETROL TOTAL	3,474	2,905	3,054	6,917	3,179.5
Administration	0	5	494	315	57
Donation	40	85	0	0	70
Generators	10	78	0	29	0
Vehicles	338	75	0	12.5	0
Motorcycles	2,551	2,284	2,335	6,509.5	2,969.5
Workshop	37	25	116	32	20
Others (Sales)	499	354	111	19	63
KEROSENE TOTAL	58	75	36	0	
Workshop	19	75	25	0	0
Pharmacy	0	0	0	0	0
Main store	5	0	0	0	0
Others	34	15	11	0	0

In 2019/20, diesel consumption reduced by 36.3%. Generator remains the highest consumer due to the rampant power blackouts from the national grid. Overall, diesel use efficiency improved. Petrol consumption decreased by 54%. Motorcycle use was well regulated owing to the reduced activities that required their movements.

DOMESTIC SERVICES

Water Supply

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

The chlorination system was successfully installed 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 completed in 18/19. Staff from all quarters now have full time access to clean water.

The water pumps frequently breakdown requiring very expensive replacements, often not very well sustained by the hospitals' budget. The existing wells run low in water during the dry seasons, creating serious water shortages during the dry season.

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.

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; 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 flush' toilet system (as part of the construction of staff quarters).

Waste disposal

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

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 remained the same like the previous FY. The proportion of clinical qualified staff over the total hospital staff also remained more less the same.

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

Indicators	FY	FY	FY	FY	FY
	2015-16	2016-17	2017-18	2018-19	2019-20
Total No. of employees	245	251	253	251	252
Qualified staff	168	177	174	196	183
Clinical qualified staff	130	116	131	138	138
Total Clinical staff	148	150	148	153	155
Proportion of clinical qualified staff over all qualified staff	77.40%	65.50%	75.30%	77.71%	84.69%
Proportion of clinical qualified staff over all clinical staff	87.80%	77.30%	88.50%	90.06%	89.03%
Proportion of clinical qualified staff over the total hospital staff	53.10%	46.20%	51.80%	54.18%	54.76%

Quality of care

Overall, the recovery rate on discharge increased by 2.55%. The maternal death rate reduced. Caesarean infection rate continued to improve. Early neonatal death rate increased by 0.96%. 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.

Table 8.2: Indicators for the quality and safety measures

	FY	FY	FY	FY	FY	Explanation
	2015-16	2016-17	2017-18	2018-19	2019-20	

Recovery rate on discharge	98.10%	98.80%	97.01%	97.09%	99.64%	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	0.10%	0.17%	0.02%	0.15%	0.02%	Maternal death rates: it is not the population based maternal mortality rate or ratio that is generally used by statisticians. It is a hospital indicator.
Fresh still birth rate	0.58%	0.58%	0.51%	0.58%	0.85%	Fresh still birth rate: Fresh Still births have intact, smooth and not macerated skin,
Caesarean sections infection rate	1.27%	ND	5.58%	0.82%	1.27%	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	0.89%	0.78%	0.39%	1.22%	2.18%	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 reduced in the FY (81% from 86% in the previous FY). The waiting time/organization of care in the OPD improved significantly. The Quality Assurance Committee have 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	FY	FY	FY	FY
	2015-16	2016-17	2017-18	2018-19	2019-20
Clinical outcomes	100.00%	93%	88.30%	64%	90%
Humanity of care	85.10%	98%	98.90%	92%	88%
Organization of the care / waiting time (OPD)	50.00%	85%	46.10%	46%	71%
The healthcare environment	99.20%	98%	98.90%	98%	88%
Overall score	75.20%	79.70%	81.10%	86%	81%

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

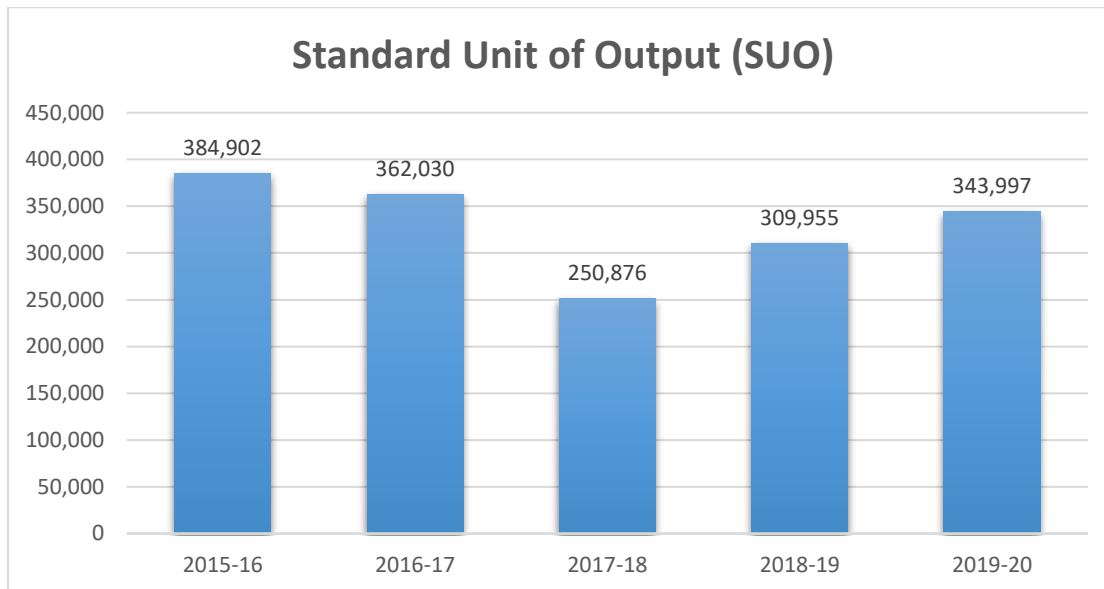
1 SUOop = 1*Outpatients contacts + 15*Inpatients + 5*Deliveries + 0.2*Immunizations in children + 0.5*(ANC+Post Natal Attendance + FamilyPlanning clients) + 20*Major Sugerv

FAITHFULNESS TO THE MISSION

Access

There was 11% increase in the Standard Unit of Output (SUO) in 19/20. The increased malaria trend likely contributed to this. Access increased in 2019/20.

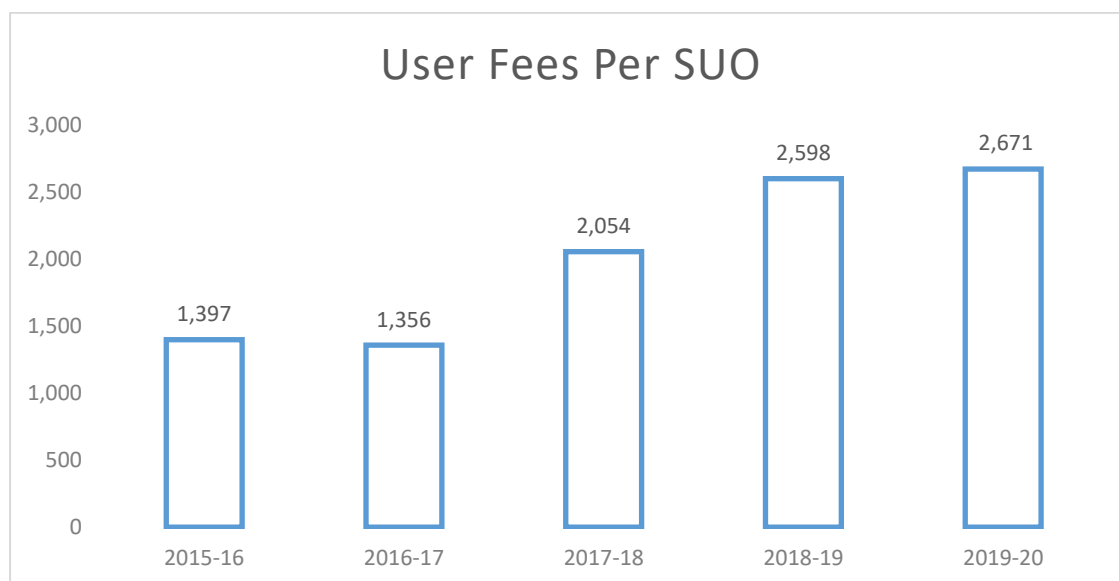
Figure 8.1: Trend of SUOop (do more people come?)



Equity

The average user fees per SUO increased by 2.8%. 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.

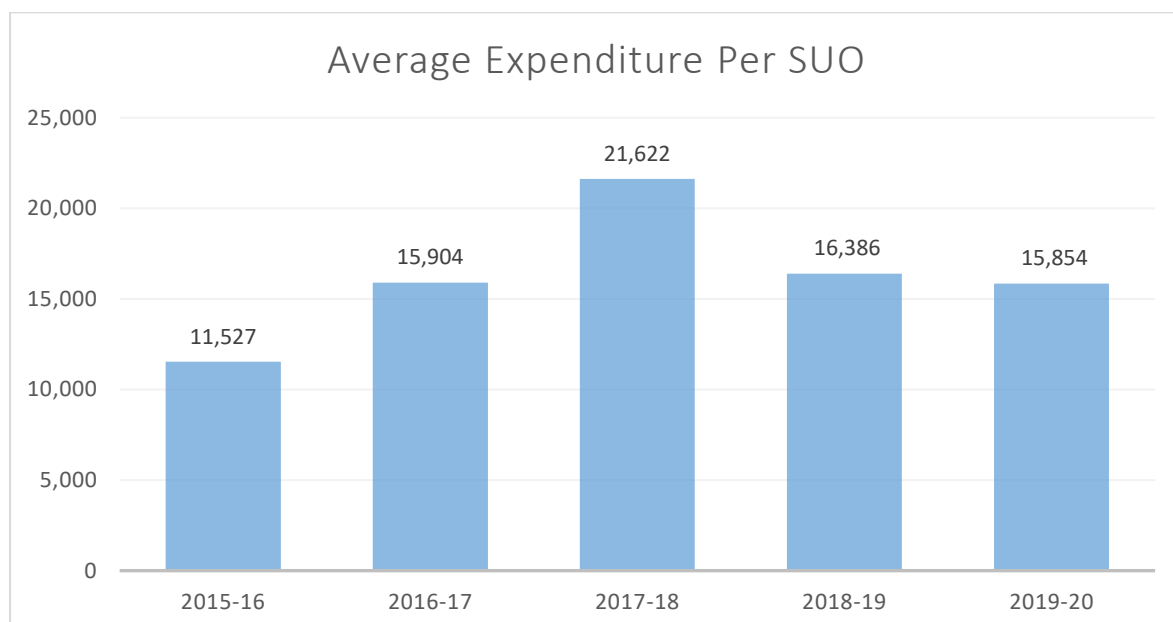
Figure 8.2: Trend of Average Fees per SUO (do people, on average, pay more or less?)



Efficiency

The hospital's economic efficiency improved by 3.2%. The key cost containment measure being focused on is reduction of wastage. The cost of producing one SUO reduced to 15,854 in 19/20.

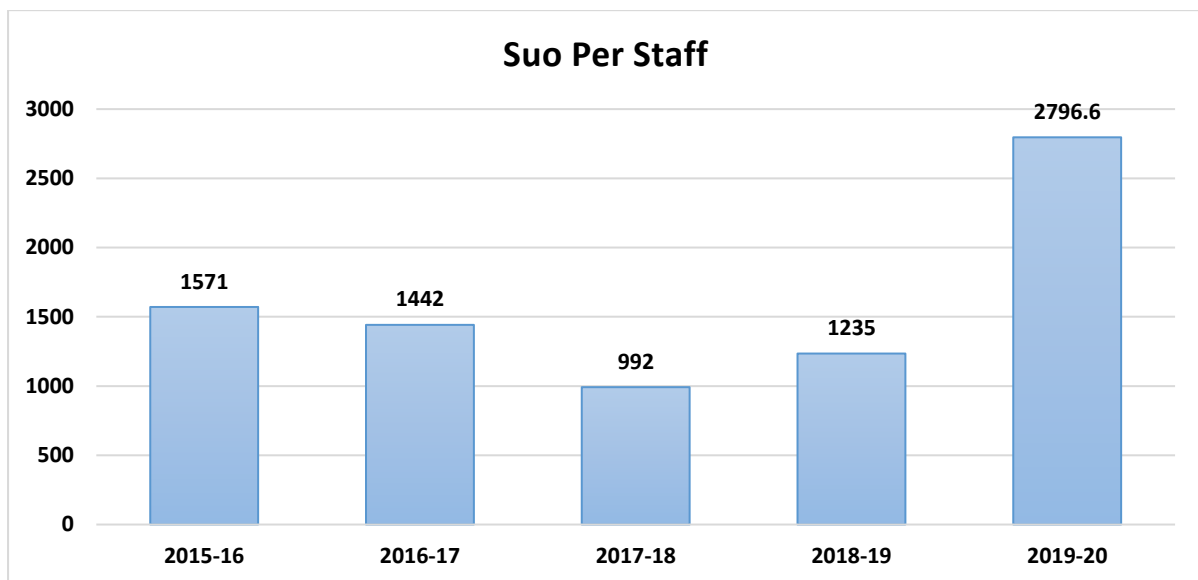
Figure 8.3: Trend of Average Expenditure per SUO (do we spend more or less to produce our services?)



Productivity

Each clinical staff produced 2,796 SUOOp in 2019/20; an increase of 126.4% from the previous FY. This reflects significant increase in the clinical staff productivity. We continue to engage our staff realistically to maximize performance.

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:

- 1,207 Enrolled/Certificate Midwives (EM/CM),
- 266 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 2019-2020

Qualified Staff	Established	Actual	Shortage	Surplus
Tutors	5	4	1	0
Untrained clinical instructors	4	2	2	0
Accountant	1	0	1	0
Account Assistant	1	1	0	0
Cashier	1	0	1	0
Record Assistant	1	1	0	0
Total Qualified Staff	13	8	7	0

Trained clinical mentor (Hospital)	7	4	3	0
Support Staff	Established	Actual	Shortage	Surplus
Store Assistant/Library Attendant	2	2	0	0
Office Attendant	1	1	0	0
Cooks	5	6	0	1
Driver	1	1	0	0
Watchmen	2	3	0	1
Total Support Staff	11	13	0	2
Total School Staff	22	25	3	2

Staff development

In line with the strategic plan of the school, staff development is given priority. One staff was sent for Master in Public Health and was due to complete in May 2020, but was disrupted by COVID 19. Staff development has motivated the school staff to double their efforts to help students in their learning experiences and this is also one of the retention mechanisms. This development has also improved tutor-student ratio in the school.

Other staff continuously had rotation in professional refresher courses in different subjects organized by different stake holders. They always used this information received from these seminars or workshop for teaching or updating other staff during Continuous Medical/Professional Education (CME/CPD). Other workshops or meetings organized by the following organizations: UNMEB, MOH, MOES UCMB, and UNFPA were attended by the different staff in rotation.

Table 9.2: 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 1 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 increased from 98% in the previous FY to 100% for both C/M and D/M in 2019/20.

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

Table 9.3: Student Enrollment in years 1st -2nd -3rd and success rate in the FY 2019-20

Course	Students Enrolled in the year	Students in 1 st year	Students in 2 nd year	Students in 3 rd year	Number of students currently	Students who sat for final exams	Students who pass final exams	Success rate
C/M	41	41	54	42	135	1	1	100%
D/M	13	13	13	0	13	14	14	100%
Total	54	54	57	42	148	15	15	

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 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

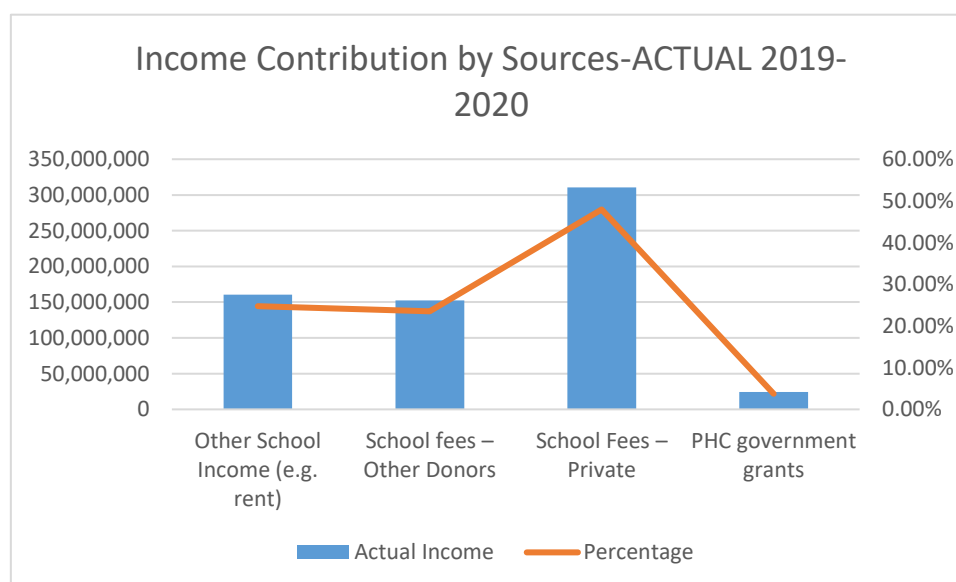
The actual realization from school fees and donors still represents the main source of funding. This donor dependency is posing a major challenge as some donor's support is diminishing and sustainability is seriously threatened.

Support for school fees came from UNFPA, Copeland Foundation, Straight talk foundation, Gretta foundation, and Dr. Ambrosoli Foundation.

The school realized 73% of its planned budget. However, the school could have realized more than this percentage because the collection of school fees had improved. This implies that the school administration needs to remind parents constantly. But this was not possible since the school was closed in March 2020, the mid semester due to COVID 19 lock down when some of the students had not yet made full payment of their fees.

Table 9.4: Planned, actual and unrealized income in the FY 2019-2020

Income Sources	Planned Income	Actual Income	Budget Gap	Variance Comment
	(UGX)	(UGX)	(UGX)	Surplus/Deficit
Other School Income (e.g. rent)	253,982,000	160,475,145	93,506,855	Deficit
School fees – Other Donors	154,384,737	152,386,215	1,998,522	Surplus
School Fees – Private	459,569,692	310,472,950	149,096,742	Deficit
PHC government grants	24,264,900	24,264,900	0	
TOTAL	892,201,329	647,599,210	244,602,119	Deficit



Expenditure

In the FY 2019/20, the school managed to control its expenditure within planned targets. In comparison with the actual income; the schools' expenditure realized a surplus of UGX 5,938,554/=

Table 9.5: Planned, actual expenditure and unspent balance in the FY 2019-2020

CATEGORY	BUDGET ESTIMATE	ACTUAL EXPENDITURE	UNSPENT ESTIMATE
EMPLOYMENT COST	340,818,056	277,543,861	63,274,195
ADMINISTRATION COST	112,869,921	125,364,301	(12,494,380)
PROPERTY COST	13,080,000	11,523,387	1,556,613
TEACHING GOODS AND SERVICES	194,701,000	149,127,572	45,573,428
PROFESSIONAL CONSULTANCY SERVICES	14,312,908	0	14,312,908
INSURANCE AND LICENCE	500,000	0	500,000
TRAVEL AND TRANSPORT	29,660,000	25,901,800	3,758,200
SUPPLIES AND SERVICES	56,802,384	4,880,185	51,922,199
CAPITAL DEVELOPMENT	103,444,400	35,543,000	67,901,400
STAFF DEVELOPMENT COST	26,012,660	11,776,550	14,236,110
TOTAL	892,201,329	641,660,656	250,540,673

Support from Dr. Ambrosoli Memorial Hospital

- The Hospital and School shares the following committee:
 - The Board of Governors (BoG)
 - The Hospital/ School Management team, (HMT/SMT).
 - The disciplinary, financial and quality assurance committees.
 - The signatories to the school account, CEO and Administrator.
 - Supporting the school with logistics e.g. vehicles
 - Ward departments for clinical practice.

- Appointment of a doctor for students
- Formation of Task force for COVID 19, academic committee, by including staff from the hospital and school.
- Some part time teachers come from the hospital.
- Free testing of students for COVID 19
- Supervision of students in the wards is a joint effort by the hospital and school
- Rotation of staff is done where by some hospital staff can be posted to work in the school.

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 involve 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.

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

$$\frac{\text{The Total number of students at present}}{\text{Total Capacity of the School}} = \frac{148}{150} \times 100\% = 99\%$$

Comparing the past financial year 2018/2019, there has been an increase of 1%, in the access.

Quality

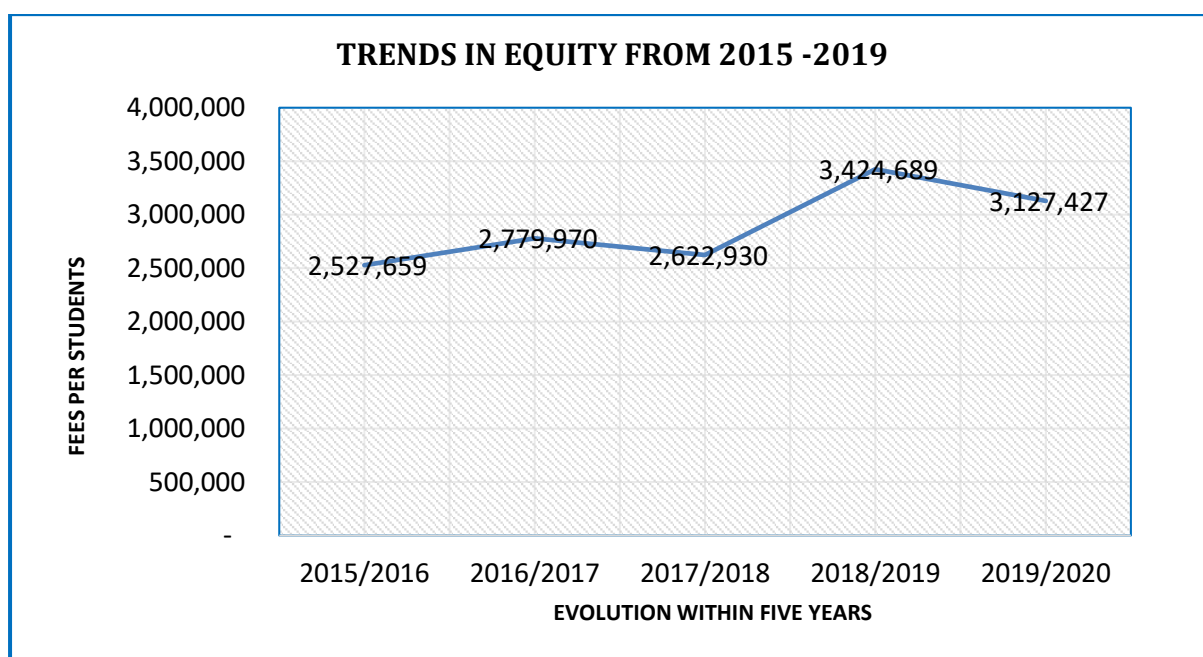
$$\frac{\text{Total number of students who passed}}{\text{Total Number of Students who sat}} = \frac{61}{61} \times 100\% = 100\%$$

In this financial year 2019/2020, all the students who attempted the state final examinations passed.

Equity

$$\frac{\text{Total fees Collected}}{\text{Total number of students}} = \frac{462,859,165/=}{148} = 3,127,427/=$$

This computation shows that the school fees fall within the agreed school fees structure and parents are encourage to pay installment for those who cannot pay the full amount in a semester but should be completed before the next semester.

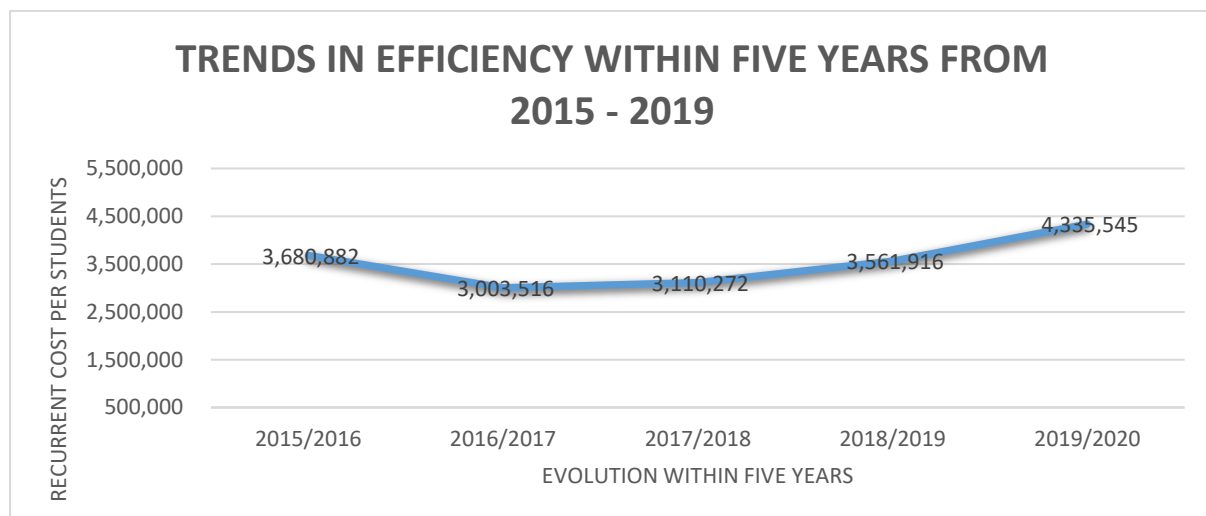


Efficiency

$$\frac{\text{Total Recurrent Costs}}{\text{Total number of students}} = \frac{641,660,656}{148} = 4,335,545/=$$

There was 21.7% increase in the average cost per student in 2019/20. Market trend for prices continue to spiral for both training goods and feeding requirement for students, compounded

by the final challenges brought in place by COVID. However, the school still managed to contain costs to within realistic limits. The school was economically efficient in 2019/20.



CHAPTER TEN

CONCLUSIONS

The year 19/20 was like no other, due to the many unique circumstances. COVID 19 posed (and still poses) a huge financial burden on the hospital and School. In all these; sustainability is still at the center of all activities and initiatives that the Hospital will implement or introduce.

The hospital is still heavily reliant on donations. Unfortunately, the prevailing pandemic has strained the core donors and benefactors even more; putting in question their tireless capacity to sustain the level of support rendered to the hospital. A core project; the USAID Voucher Plus ended during the year, significantly impacting access to MCH for vulnerable mothers in the district, as well as denying the hospital the much-needed financial support. We continue to appeal to the GOU to again allow extension of such projects to East Acholi to bridge this much needed service gap, well aware of the excellent work being done in West Acholi by the Belgian Enable group.

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 hospital continued to be faithful to its mission and was accredited by the UCMB. It has been accessible. Clinical productivity and financial efficiency increased.

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 these structures remains 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 2020

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