DR AMBROSOLI MEMORIAL HOSPITAL, ANNUAL ANALYTICAL REPORT

2020-2021

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ENDORSEMENT OF REPORT

This Annual Analytical Report covering the period of Financial Year 2020-2021 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 annual analytical report for Dr. Ambrosoli Memorial Hospital- Kalongo covering the period **July 1st 2020 to June 30th 2021.**
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,
Archbishop of Gulu Diocese.

Date _____

LIST OF ABBREVIATIONS/ACRONYMS

ACT …… Aids Care & Treatment
AIDS …… Acquired Immuno-Deficiency Syndrome
ALoS …….. Average Length of Stay
ART …… Anti-Retroviral Therapy
BCG …… Bacillus of Calmette-Guérin
BoG …… Board of Governors
BOR …… Bed Occupancy Rate
CEO …… Chief Executive Officer
DPT …… Diphtheria-Pertussis-Tetanus
FSB …….. Fresh Still Birth
FY …… Financial Year
CB-DOTS ……. Community Based Directly Observed Treatment
CHD …… Child Health Day
CO …….. Clinical Officer
C/S ……. Caesarean Section
DHMT …….. District Health Management Team
HC …….. Health Centre
FY …… Financial Year
HIV ……. Human Immunodeficiency Virus
HTS …… HIV Testing Services
HMIS ……. Health Management Information System
HMT …….. Hospital Management Team
HRM …….. Human Resources Manager
HSD …… Health Sub-District
HSSP …….. Health Sector Strategic Plan
IDP …….. Internally Displaced People
ITN …….. Insecticide Treated Nets
LLU …….. Lower-Level Unit
MDRTB …… Multi Drug Resistant Tuberculosis
MTB …… Myco bacterium Tuberculosis
MO …… Medical Officer
MoES …… Ministry of Education and Sports
MoH …… Ministry of Health
NSSF …… National Social Security Fund
NTLP …… National Tuberculosis Leprosy Programme
NIDs …… National Immunization Days
OPD …… Out-Patient Department
PCH …… Primary Health Care

PHCCG ……. Primary Health Care Conditional Grants
eMTCT …… Elimination of Mother to Child Transmission of HIV …… Human Immunodeficiency Virus
PNFP …… Private Not for Profit
SNO …… Senior Nursing Officer
SUO …… Standard Unit of Output
SLIPTA …… Stepwise Laboratory Improvement Process towards Accreditation
SLMPTA …… Stepwise Laboratory Management Process towards Accreditation
TT …… Tetanus Toxoid
UMHCP …… Uganda Minimum Health Care Package
UCMB …… Uganda Catholic Medical Bureau
UEC …… Uganda Episcopal Conference
UNEPI …… Uganda National Expanded Program for Immunization
UNMEB …… Uganda Nurses Midwives Educational Board
HG …… His Grace
UNFPA …… Uganda National Family Planning Association
URMCHIP …….. Uganda Reproductive, Maternal and Child Health Improvement Project.
UPMB LSDA …… Uganda Protestant Medical Bureau Local Service Delivery Activity

ACKNOWLEDGEMENTS

The management 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 2020-2021 and contributed to its sustainability. Notable among them, but not limited to, are the Government of Uganda, Dr Ambrosoli Foundation, Comboni Missionaries, USAID – URC, UPMB LSDA, IDI 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. 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 pealing / not macerated. The foetal death is thought to have occurred within the 24 hours before delivery.

7. ***Post C/S Infection Rate***:
   = (Number of mothers with C/S wounds infected / Total number of mother who had C/S operations in the hospital) x 100.
   = The rate of caesarean section wounds getting infected. It is an indicator of the quality of post-operative wound care as well as pre-operative preparations.

8. ***Recovery Rate***:
   = % of patients admitted who are discharged while classified as “Recovered” on the discharge form or register.
   = (Number of patients discharged as “Recovered” / Total patients who passed through the hospital) x 100

9. ***Maternal Mortality Rate*** (for the hospital):
   = Rate of mothers admitted for delivery who die due to causes related to the delivery
   = (Total deaths of mothers related to delivery **/** Total number of live birth) x 100

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

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

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

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

EXECUTIVE SUMMARY

This Annual Analytical Report presents activities output and interpretation for both Dr. Ambrosoli Memorial Hospital Kalongo and Kalongo Midwifery Training School.
Dr. Ambrosoli Memorial Hospital was founded in 1957 and St. Mary's Midwifery Training School in 1959 by Fr. Dr. Giuseppe Ambrosoli of the Comboni Missionaries. Until now, Kalongo Hospital, being a PNFP, is the only General Hospital in Agago district. It provides both preventive and curative services. Kalongo Town Council currently has a total estimated population of 101,343. Major Key performance indicators are herein summarized as below.

The hospitals' current bed capacity is 286. The total OPD attendance was 31,595 patients, representing an increase of 1.7% from 19/20. Inpatient (IP) admissions were 12,203; a reduction of 27.3% from the previous FY. Malaria followed by injuries, were the leading causes of morbidity in the Inpatient department (IPD), while Malaria followed by Malnutrition 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 66.32%. The number of deaths in the hospital reduced by 8% compared to previous FY, reflecting an overall mortality rate of 2.3% of all patients treated in the hospital. The recovery rate increased (95.85%).

ANC 1st and 4th visits decreased by 2.5% and 27.9% respectively from the previous FY. Total ANC attendance also decreased by 13.5%. Post Natal clinic attendance decreased by 7.9%. Deliveries in the hospital decreased by 4.8% compared to FY 19/20. Caesarean section (total) accounted for 25.12% of all deliveries, out of which 99.23% were emergencies.

The members of the BoG and HMT were 14 and 4 respectively. 15 HMT, 2 Ordinary BoG, and 5 Subcommittee (of BOG) meetings were held during the FY. The agenda for each of these meetings were prepared and circulated in advance to the members.

The total income for the hospital decreased by 14% in 2019/20, while that of the school increased by 8% compared to the previous FY. Expenditure in the hospital and school reduced by 2% and 25% respectively. The SUOop in 20/21 was 264,995; a reduction of 23% from 2019/20. The overall patient satisfaction with quality of services offered improved from 81% in 2019/20 to 83% in 2020/21.

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 maintained at 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 effects of the over two decades of civil war in northern Uganda cannot not be understated. It 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 Uganda poverty status report, 2020 estimates poverty in Acholi sub region (Where Agago is located) at 68%.

The hospital and its' environment

DAMHK is located in Kalongo Town Council (Oret Parish), Agago district. The population of Agago district is estimated at 373,780, out of which, 88% live in rural areas. 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 286 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 and already awaiting the African Society of Laboratory Medicine (ASLM) assessment before accreditation. The HUB supervises up to 11 laboratories across the district and part of the neighboring Pader district.

The health training wing has a Specialized Midwifery training school, which offers both Certificate and Diploma courses. In the long-term 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 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 is still very low (estimated below 30%) 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

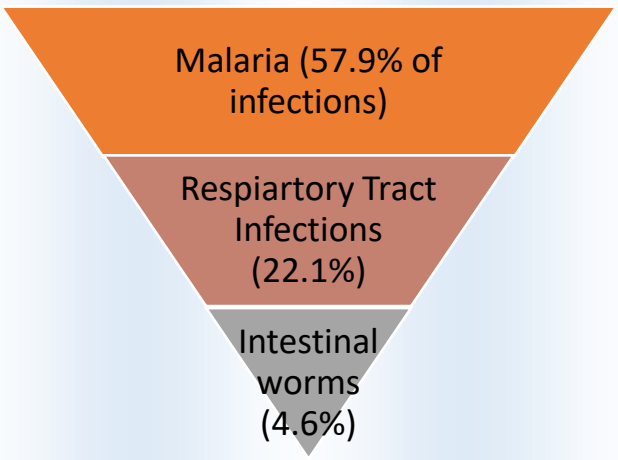
In the FY 2020/2021, the population of Agago district was estimated at 373,780 (Annual Health Sector Report 2020); which is actually the catchment population of the hospital. With the exponential population growth, operational targets increase in both the hospital and the HSD. The hospital contributed significantly to the realization of the district targets projected below for the year 20/21, even with the many challenges posed by the COVID 19 (SARS COV 2) related lockdown measures.

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

Population Group		Formulae	Catchment Area	District
(A)	Total Population	A	101343	373780
(B)	Total expected deliveries (4.85% of population)	(4.85/100) x A	4915.1355	18128.33
(C)	Total Assisted Deliveries in Health Facilities		0	0
(D)	Total Assisted Deliveries as % of expected deliveries	(C/B) x100	0	0
(E)	Children <1 year (4.3%)	(4.3/100) x A	4357.749	16072.54
(F)	Children < 5 years (20.2%)	(20.2/100) x A	20471.286	75503.56
(G)	Women in Child-bearing age (20.2%)	(20.2/100) x A	20471.286	75503.56
(H)	Children under 15 years (46%)	(46/100) x A	46617.78	171938.8
(I)	Orphans (circa 10%)	(10/100) x A	10134.3	37378
(J)	Suspected T.B Cases in the Service Area	(A) x 0.003	304.029	1121.34

Community Health Status

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



Hand washing practiced to control COVID 19 was expected to reduce diarrheal diseases. But this has not been effective.

Public health intervention should target increasing latrine coverage and strengthening the use of hand washing facilities.

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

No.	Causes of Morbidity	FY 2017-18		FY 2018-19		FY 2019-20		FY 2020-21	
		Number	%	Number	%	Number	%	Number	%
1	Malaria	83,933	29.61%	133,109	39.74%	297,061	61.67%	258,474	57.93 %
2	Cough or cold - No pneumonia	107,732	38.01%	96,445	28.80%	109,295	22.69%	98,685	22.12 %
3	Intestinal Worms	18,638	6.58%	21,761	6.50%	17,918	3.72%	20,331	4.56%
4	Diarrhoea – Acute	17,635	6.22%	17,352	5.18%	15,607	3.24%	14,942	3.35%
5	Gastro-Intestinal Disorders (non-Infective)	12,298	4.34%	13,818	4.13%	10,891	2.26%	12,551	2.81%
6	Urinary Tract Infections (UTI)	8,218	2.90%	10,590	3.16%	7,837	1.63%	9,019	2.02%
7	Skin Diseases	8,669	3.06%	11,028	3.29%	10,561	2.19%	7,030	1.58%
8	Malnutrition	952	0.34%	1,572	0.47%	2,354	0.49%	4,680	1.05%
9	Malaria in Pregnancy	2,339	0.83%	3,186	0.95%	4,084	0.85%	4,099	0.92%
10	Epilepsy	1,923	0.68%	2,726	0.81%	3,086	0.64%	3,675	0.82%
	Total attendance	**283,430**		**334,916**		**481,691**		**446,215**	

It is important to observe that the reduced morbidity burden may not necessarily mean absence of disease among the population, rather reflect fear of contracting SARS CoV 2 infection from facilities during the year.

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

Causes of Mortality among Inpatients		FY 2019-20		FY 2020-21	
		Number	Case Fatality Rate	Number	Case Fatality Rate
1	Malaria	214	36.52%	94	18.88%
2	Pneumonia	46	7.85%	33	6.63%
3	Anaemia	10	1.71%	22	4.42%
4	Other Neonatal Conditions	30	5.12%	19	3.82%
5	Other Complications of pregnancy	2	0.34%	17	3.41%
6	Premature baby (as condition that requires mgt)	34	5.80%	15	3.01%
7	Injuries - Trauma due to other causes	21	3.58%	15	3.01%
8	Heart failure	5	0.85%	15	3.01%
9	Malaria in pregnancy	1	0.17%	13	2.61%
10	Septicemia	3	0.51%	12	2.41%
		586		498	

As it has been in the previous FYs, Malaria was the deadliest infection experienced in the HSD (CFR 18.88%). Often, malaria infections are complicated by the acute need for blood products; which remain in shortage across the country. Pneumonia and Anemia followed (CFR 6.63% and 4.42% respectively). Newborn deaths reduced compared to the previous year.

In almost all these mortality causes registered; the common denominator has been the acute need for blood transfusion. Almost routinely, the hospital has had to mobilize emergency blood donations and screening to save critical patients; at a very high sustainability cost for the hospital.

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 2020-2021 by Sub-county

Sub-Counties	Populations	Health units (Level & ownership)	Staffing levels		Staffing gap
	FY 2019-2020		**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 HCIII 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

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.

Support from the Government of Uganda through the PHC conditional grant subsidy continued to come (both in cash and in kind). The PHC amount was revised at the start of the year, upwards by approximately 78%; for which we express gratitude to the GOU. However, the PHC release remain erratic (not in line with indicative planning figures), affecting drugs and other medical consumables supplies.

Health Infrastructure

The project to realize and refurbish the staff accommodation in the hospital quarters is continuing smoothly, and is expected to be completed in the next FY. Unfortunately, the housing needs remain too high that funding availability cannot match these demands. It is expected that living conditions of staff in the quarters is improved; also giving the hospital capacity to accommodate approximately 90% of her core workforce.

The hospital, through its' principal partner; the Ambrosoli Foundation also secured funds towards the reconstruction and refurbishment of the Children's ward from CEI; work is expected to complete in the next FY. The ultimate plan is the realization of a more modern and habitable treatment environment for the children and their caregivers.

Prevention and Health promotion services

The hospital already started the establishment of a dedicated PHC department during the year. The department carried 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. 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) was allocated. In the coming years we expect to scale up our community-based services even more, to promote disease (including NCDs) prevention.

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 projected population of 101,343 (2020). DAMHK continued to carry out immunization in its mobile and static units. Table 2.5 summarizes the out puts in terms of vaccines administered. Patients from all over the district continue to come and access OPD services for up to 15 hours a day/7 day a week.

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	1678	7659	21.91%
TT 2	1100	5076	21.67%
TT 3	13	1598	0.81%
TT 4	5	817	0.61%
TT 5	6	510	1.18%
Non Pregnant women			
TT 1	495	5492	9.01%
TT 2	157	2718	5.78%
TT 3	158	1699	9.30%
TT 4	99	957	10.34%
TT 5	104	705	14.75%
Immunization in school			
TT 1	0	773	0.00%
TT 2	0	333	0.00%
TT 3	0	209	0.00%
TT 4	0	92	0.00%
TT 5	0	27	0.00%
Total TT 2 in all categories	1257	8127	15.47%
Immunization in Children			
BCG	2551	9540	26.74%
Protection at Birth for TT (PAB)	2533	6279	40.34%

Polio 0	2430	9532	25.49%
Polio 1	842	9884	8.52%
Polio 2	816	9243	8.83%
Polio 3	842	9819	8.58%
PCV 1	910	10017	9.08%
PCV 2	863	11292	7.64%
PCV 3	879	9135	9.62%
DPT-HepB+Hib 1	901	9983	9.03%
DPT-HepB+Hib 2	863	9336	9.24%
DPT-HepB+Hib 3	881	9173	9.60%
Measles	616	8960	6.88%
Total Immunisation in Children	15927	122193	13.03%
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 contribution to the district health service delivery continued to remain significant. It is important to note that lockdown measures due to COVID affected the realization of some indicators; for instance, immunization in schools, since school remained closed.

CHAPTER THREE:

GOVERNANCE

The Board of Governors

The Board of Governors (BOG) is the supreme policy making 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 2020-2021 the hospital held two (2) ordinary BOG meetings. The incomplete fulfillment of the meeting requirements was due to the SOPs put in place by the government of Uganda GOU) 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 2020-2021

BOG meetings	Reports presented / Key issues handled / Decision taken	Members present
31st July 2020	Hospital performance review. Budget performance review and approval of new budget.	11
26th February 2021	Writing off bad debts. Review and approval audit financial statements.	09

The Statute enumerates 3 key thematic committees, that are in place; Human Resources &Disciplinary Committee, Finance Committee and School Committee (now known as the governing council). The BOG can appoint additional committees if needed. Their role is to examine in advance reports and proposals from the Management and to present comments and suggestions to the BOG during the plenary meetings.

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

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 • Governing Council of the School • Human Resources& Disciplinary Committee	• 2 • 2 • 2	• 3 • 2 • 0	• 150% • 100% • 0%

Hospital Management

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

The Hospital Management Team collectively shares the task of achieving the strategic objectives and the specific targets decided by the Board of Governors. It is granted operational autonomy within the scope of the hospital strategic plan, approved policies, manuals and procedures. This Team meets at least once every month. In 20/21, management meetings were greatly disrupted by the COVID 19 control requirements. The management still managed to have discussions on line to guide key decisions in the hospital. Small group meetings were

also used more frequently to address key issues of 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 2020-2021

No of planned Management meeting	No. of Management meeting held	Average No. of members present	Reports / key issues handled
20	5 (formal) and 10 (small group meetings)	3 - 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 2020/21. This accreditation entitles the hospital to the full range of services provided by UCMB for the period ending on the 31st December 2021.

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 (near finished)
10	Report on Undertakings & Actions of FY	YES	Regularly observed

Internal Regulatory Documents

DAMHK has in place manuals and guidelines that regulates decisions and practices in both the hospital and the school. These documents include; The employment manual, the finance and material resource manual and the procurement manual. The management continue to ensure that these policies are adhered to. The documents are periodically reviewed to ensure that they remain at pace with the changing needs of the institution.

Advocacy, lobby and negotiation

The Hospital has not yet developed a formal advocacy agenda. The institution ensures that it maintains constant contacts with local leaders, international NGOs, and major donors, e.g. Dr. Ambrosoli Foundation and Comboni Missionaries, according to the needs. The COVID situation made it even more difficult to easily mobilize resources. The management has made it a mandate to tirelessly source for support from different stakeholders towards the sustainability of the hospital. In the future, the community health insurance policy currently being enacted by the government would help very much in bridging some of these funding gaps.

CHAPTER FOUR:

HUMAN RESOURCES

Staff Establishment

Over the years the total number of staffs (clinical and non-clinical) have increased gradually. Currently the hospital is a 286-bed capacity general hospital being run by 156 clinical staff; below the recommended 190 for a 100-bed capacity general hospital by MOH. Qualified clinical staff number, account for 79% of clinical staff.

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

Category		FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
Clinical[1]	Qualified	116	131	136	138	139
	Unqualified	34	17	15	17	17
	Total Clinical	150	148	151	155	156
Not Clinical[2]	Qualified	61	43	42	45	45
	Unqualified	40	62	58	52	31
	Total Non-Clinical	101	105	100	97	76
Total Qualified		177	174	175	183	184
Total Unqualified		74	79	76	69	48
Grand Total		**251**	**253**	**251**	**252**	**232**
% of qualified clinical staff/total staff		**46%**	**52%**	**54%**	**62%**	**79%**

Staff turn-over[1]

Over the years, the hospital has suffered from high turnover rates among the core work force. In the FY 20/21, the turn-over rate among enrolled nurses increased compared to the previous year, 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.

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). It is important to note that the rate of replacement for staff who left did not much with

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

departure rate for clinical staff in 20/21. The reasons were vast; the COVID lockdowns, lack of enough resources to sustain the employment etc.

Figure 4.1: Turn-over trends of enrolled cadres[2] in the last 3 FYs

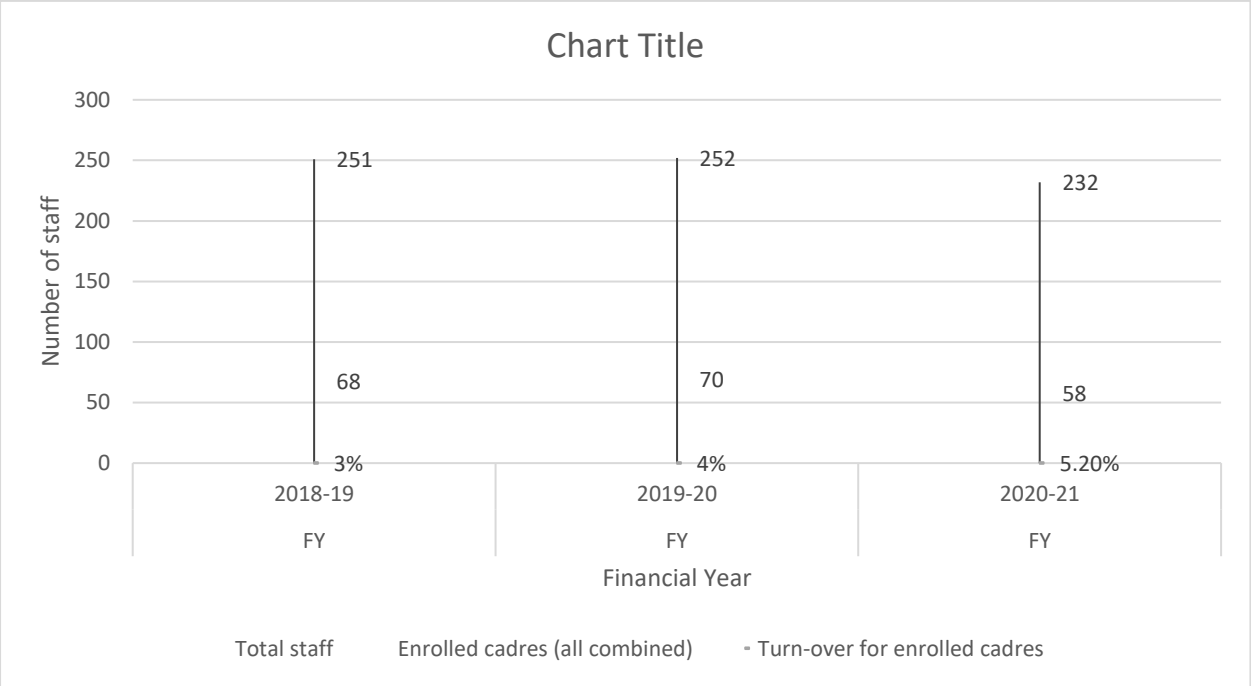


Table 4.2: Turn-over trends of Clinical Staff in the last 3 FYs

Clinical Staff	FY 2018-19	FY 2019-20	FY 2020-21
Total staff	251	252	232
Total arrivals of key health personnel	34	37	18
Total departures of key health personnel	34	35	31
Turn-over rate	14%	14%	17.7%

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

The hospital provides accommodation for a large proportion of its employees (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.

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

Salaries have been regularly paid and any statutory obligations are 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 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 20/21 academic calendar was marred by the COVID 19 pandemic (just like the case of the previous year), 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 4.3: Hospital Staff who attended courses in FY 2020-2021

S/N	Name	Designation	Course	Date of start	Date of End
1	Sr. Acan Santina	Double Trained Nurse	BA in Midwifery (Lira University)	17-Aug	21-Jun
2	Okao Maurice	Medical Officer	MA Paediatrics	Sept, 18	June, 21
3	Sr. Kwena Beatrice	Enrolled Midwife	Diploma in Midwifery	July, 19	Jun-21
4	Lamwaka Charity	Enrolled Midwife	Diploma in Midwifery	July, 19	Jun-21
5	Sr. Ayaka Hellen	Registered Nurse	BA. In Nursing (UCU)	Jan, 2020	Dec, 2023

CHAPTER FIVE:

FINANCES

The total income for the hospital reduced by approximately 14% in the year 20/21. Reductions were marked in user fees and donations in kind and cash. The exchange rate variation in the market was a key contributing factor to reduction in cash donation. The prevailing pandemic has certainly made it stiffer to mobilize financial resources towards recurrent cost support.
On the other hand, PHC conditional grant increased by about 78% from the GOU. This also means the support to PHC line medical consumables increased by the same amount; we extend our gratitude to the government and the MOH for this and pledge to continue supplementing government efforts to promote community health.

Overall, the hospital is still heavily donor dependent; contributing to more than 70% of the recurrent budget. We remain hopeful that community health financing modules currently being advocated for by GOU will supplement sustainability efforts.

The income for the midwifery school increased by approximately 8%. Significant increments were registered from private student's school fees and donations. Despite the lockdown and school closure, the school maintained its' objective capacity enrolment and didn't lose students to drop outs.
The subsequent tables below show the trend of financial statements for the hospital and the school. Additional comments on school finances is made in Chapter 9 of this report.

Income

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

Income Item	Income over the last 5 Years				
	FY 2016-17	FY 2017-2018	FY 2018-19	FY 2019-20	FY 2020-21
HOSPITAL					
User Fees	490,794,376	515,399,441	805,406,207	918,631,455	724,456,625
PHC CG cash	488,334,860	251,159,632	251,159,542	251,159,632	492,117,659
Government donations in kind (Drug/Lab)	243,072,352	346,633,198	294,661,401	279,299,838	469,333,874
Other donations in kind	1,023,496,908	787,210,769	845,619,113	1,410,912,848	1,264,283,983

Donations in cash (including project funding)	3,811,677,210	2,403,785,395	2,626,348,706	3,128,079,686	2,294,082,763
Others Financial sources (Deposit Interests & others)	326,116,116	56,168,380	162,796,288	92,546,915	51,770,039
Technical Department	213,555,605	141,070,362	93,943,603	136,116,992	59,583,590
Sub-Total Hospital	**6,597,047,427**	**4,501,427,177**	**5,079,934,860**	**6,216,747,366**	**5,355,628,533**
SCHOOL					
Fees (private)	182,308,450	236,974,842	336,578,535	160,475,145	235,067,000
PHC CG School/PAF Delegate funds	53,021,152	24,264,900	24,264,900	152,386,215	15,641,098
Donations and other income	317,297,684	187,713,340	245,355,733	312,861,360	428,420,077
Sub-Total School	**552,627,286**	**448,953,082**	**606,199,168**	**625,722,720**	**679,128,175**
HSD					
Sub-Total HSD	60,473,163	-	-		
Grand-Total	**7,210,147,876**	**4,950,380,259**	**5,686,134,028**	**6,842,470,086**	**6,034,756,708**

Expenditure

The overall total expenditure reduced by approximately 2% in the hospital and 25% in the school, in comparison to the year 19/20. The management will continue to galvanise prudent cost control measures that are continuously being tested, to keep expenditures in check. Medical goods and supplies were the major drivers of cost, as it has been in the previous years.

Table 5.2: Trend of Expenditure over the last 5 FYs

Expenditure Item	Expenditures over the Last 5 Years				
	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
HOSPITAL					
Human Resource cost	1,742,346,590	1,670,778,158	1,937,322,775	2,220,512,253	2,281,897,544
Administration & Governance Costs	159,589,078	148,417,998	256,159,365	176,454,730	281,947,329

Medical goods and supplies (included drugs)	1,978,701,042	1,723,605,199	1,564,891,236	2,048,954,822	1,906,084,286
Non-medical goods / supplies	136,173,475	1,126,086,235	481,599,381	237,715,358	95,862,373
Property Costs	268,887,558	311,950,518	342,469,799	277,795,146	263,900,824
PHC	1,235,279,987	235,268,336	287,069,131	408,008,500	212,414,809
Transport & Plant Costs	237,801,122	204,022,401	209,423,206	198,506,748	220,474,884
Capital Development	85,087,450	261,422,729	165,112,516	621,477,605	782,214,141
Hospital Total Expenditure	**5,843,866,302**	**5,681,551,574**	**5,244,047,409**	**6,189,425,162**	**6,044,796,191**

SCHOOL					
Employment	203,568,991	195,750,295	255,244,790	289,320,411	260,168,468
Administration	67,647,686	37,652,900	39,400,393	125,364,301	28,658,219
Students costs	136,801,294	115,564,162	180,483,191	149,127,572	130,125,198
Transport & Travelling	60,641,850	23,987,550	25,463,900	25,901,800	18,872,400
Property, Supplies, Services	9,572,678	48,034,600	31,022,821	16,403,572	29,529,301
Capital Development	-	14,448,597	60,336,306	35,543,000	9,720,500
School Total Expenditure	478,232,499	435,438,104	591,951,401	641,660,656	477,074,086

HSD					
HSD Total Expenditures	60,473,163	-	-		
Grand Total	**6,382,571,964**	**6,116,989,678**	**5,835,998,810**	**6,831,085,818**	**6,521,870,277**

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.

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

	Average Fees				
	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
OPD Adult Male	9,700	11,500	15,000	15,000	15,000
OPD Adult Female	10,500	12,000	16,500	15,000	15,000
OPD Children < 5yrs	4,500	4,500	9,500	9,500	9,500
OPD Children 5-13 yrs	7,000	7,000	12,000	9,500	9,500
IP Medical Male	24,000	25,000	30,000	30,000	30,000
IP Medical Female	24,000	25,000	30,000	30,000	30,000
IP Maternity	16,050	15,850	36,900	35,000	35,000
IP Paediatric < 5 yrs	6,100	8,500	15,500	15,000	15,000
IP Paediatric 5-13 yrs	6,100	9,000	16,000	16,500	16,500
IP Surgical Ward	21,700	23,200	24,000	28,000	28,000

In the FY 20/21, the hospital had 13.8% cost recovery rate, representing a decrease of 2.7% from the previous year. The hospital has over the years continued to invest in the health needs of the patients more than it collects from the patients; a concept that threatens the sustainability of quality services. The gap between donor support and local revenue generation certainly needs to be prudently narrowed over the next years, especially in the face of the growing donor fatigue.

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

	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
Total User fees [a]	490,794,376	515,399,441	805,406,207	918,631,455	724,456,625
Total Recurrent Expenditure (b)[2]	5,757,781,852	5,416,639,845	5,078,934,893	5,567,947,557	5,262,582,049
Cost Recovery Rate = (a/b)x100	8.5%	9.5%	15.9%	16.5%	13.8%

The average cost per bed reduced by 10% in the year 20/21. The cost per in patient per day increased by approximately 22%; as well, the cost per SUOop increased by about 25%. Efficiency in utilisation of resources for the care of patients reduced, highlighting the burden of care upon the hospital to the patients served.

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

Indicator	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
Cost per bed[1]	20,061,958	19,987,601	18,741,457	20,545,932	18,400,637
Cost per IP/day[2]	56,897	56,783	53,243	62,026	76,018
Cost per SUOop	15,904	21,622	16,386	15,854	19,859

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

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

	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
Total User fees (a)	490,794,376	515,399,441	805,406,207	918,631,455	724,456,625
Total Recurrent Expenditure (b)[2]	5,757,781,852	5,416,639,845	5,078,934,893	5,567,947,557	5,262,582,049
Cost Recovery Rate = (a/b)x100	8.5%	9.5%	15.9%	16.5%	13.8%

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

Considering local revenues and Government contributions in the FY 20/21, the hospital was 74% sustainable. This is a 4% increase from the previous year. The rise was because of the increased government in-kind and cash contribution under PHC.

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

	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-201
Total in-country funding (c)	1,518,800,957	4,501,427,177	5,079,935,215	3,907,443,605	3,888,851,326
Total Recurrent Expenditures (d)	5,757,781,852	5,416,639,845	5,078,934,893	5,567,947,557	5,262,582,049
Sustainability Ratio = (c/d)x100	26%	83%	100%	70%	74%

(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 and Specialized Obstetric and Gynecologic Surgery

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

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

Pediatrics & Child Health
Young child clinic
Malnutrition Therapeutic feeding
Neonatal intensive care
Pediatric admissions and care
Immunization and health promotion

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

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

OUT PATIENT DEPARTMENT

Dr. Ambrosoli Memorial 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. In the coming year, we shall be studying to introduce a 24-hour system which was greatly hampered by the pandemic.

Staffing composition

Generally, the OPD staffing norm and level did not change from the past years. OPD was managed by five Clinical Officers, assisted by six (6) enrolled nurses (including midwives), two (2) nursing assistants, two (2) nursing officers 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.

Table 6.1: The staff composition in OPD in the FY 2019-20 and FY 2020-21

Cadre/ Discipline	Qualification	FY 2019-20	FY 2020-21
Clinical officers	Diploma in clinical Medicine	5	5
Pharmacy Assistant	Certificate in Pharmacy	4	2
Double Trained	Diploma in Nursing / Midwifery	1	2
Enrolled Midwife	Certificate in Midwifery	1	1
Enrolled Nurse	Certificate in Nursing	4	2
Enrolled Comprehensive	Certificate in Comprehensive	1	3
Nursing Assistant	Certificate in Nursing Assistance	2	2
Cashier	Diploma in Business Studies	4	2
Nursing Aide	Trained on the job	1	1
Total		**23**	**20**

OPD key indicators

Total OPD attendance slightly increased (1.7%) compared to the previous FY. Under five (5) morbidity (new attendance and re attendance) reduced by 41.6%. The reduced disease burden observed in the under 5s (in the hospital) could be related to increased utilization of OPD services in the lower facilities, due to the fear of contracting the SARS COV 2 virus from the hospital. Patients registered as new attendance were more than re attendance. As routinely observed, women continue to come to the hospital more than their male counter parts.

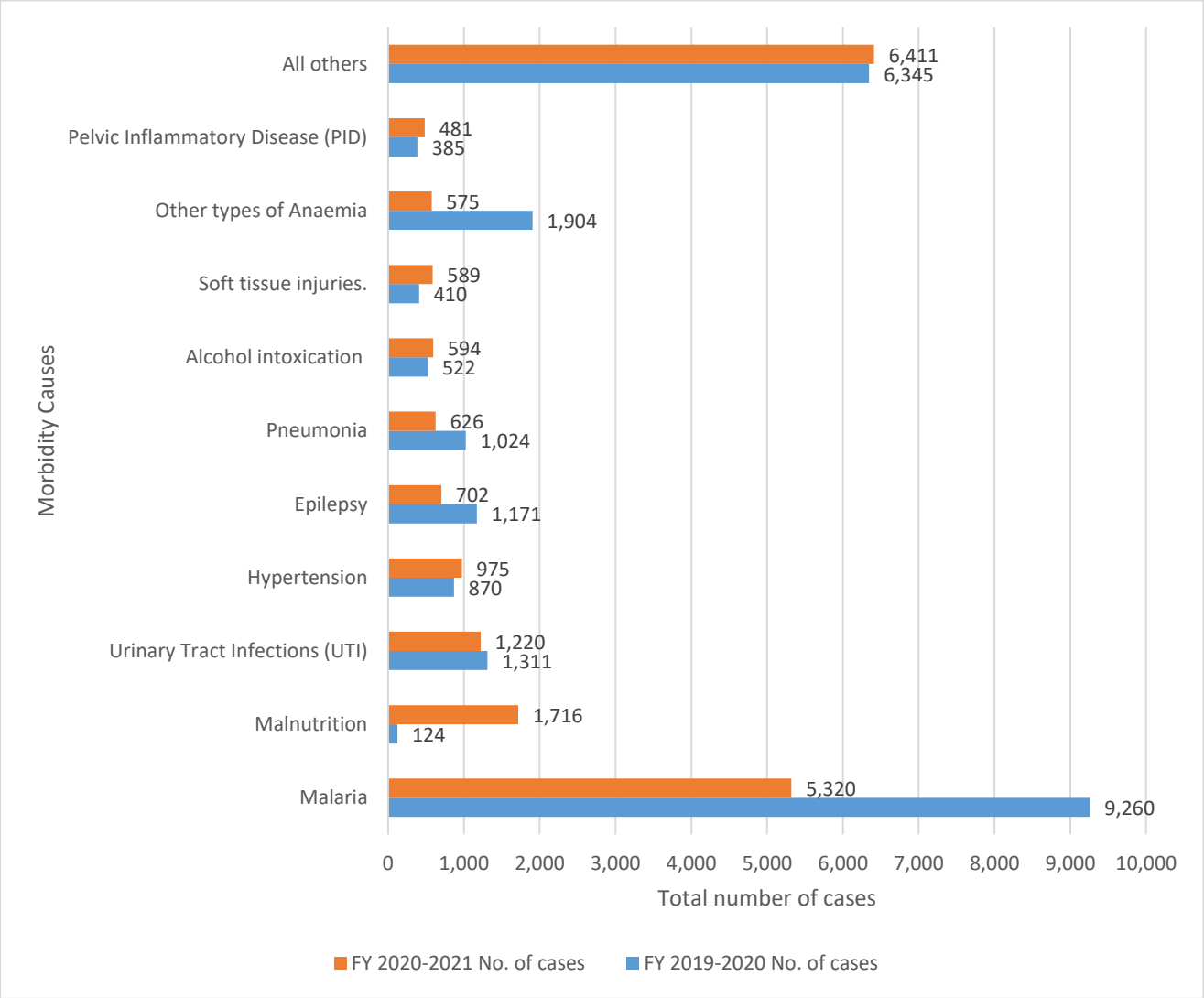
Table 6.2: Trend OPD attendance by gender & age in the last 5 FYs

			FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
FEMALE	New Attendance	0-4 yrs	3,539	2,442	2,037	3,014	1,600
		Over 5 yrs	13,743	11,095	10,835	8,978	9,260
	Re-attendance	0-4 yrs	49	124	129	121	97
		Over 5 yrs	1,738	2,097	1,934	4,097	7,836
MALE	New Attendance	0-4 yrs	3,984	2,720	2,337	2,976	1,818
		Over 5 yrs	7,423	6,121	6,193	8,492	5,631
	Re-attendance	0-4 yrs	78	203	170	118	123
		Over 5 yrs	1,819	2,089	1,987	3,262	5,230
All New Attendances			28,689	22,378	21,402	23,460	18,309
All Re-attendances			3,684	4,513	4,220	7,598	13,286
All Attendances			32,373	26,891	25,622	31,058	31,595

Morbidity Trend in the OPD

Malaria was the leading cause of morbidity in the OPD followed by Malnutrition. Non communicable diseases remain on the rise, contributing to 5.31% of OPD attendance. Malnutrition rates rose drastically during the year. The hospital has seen the number of cases (both SAM and MAM) rise by more than 100%. This is expected to escalate given that intervention programs to address malnutrition challenges in the district are very much inadequate (an area the hospital looks to invest in).

Figure 6.1: Top ten diagnoses in OPD in the last 2 FYs



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.

Table 6.3: Antenatal and Postnatal indicators during the last 4 FYs

ANTENATAL	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
ANC 1st Visit	1,874	2,397	1,606	1,566
ANC 4th Visit	1,217	1,648	1,217	878
Total ANC visits new clients + Re-attendances	6,045	8,721	7,388	6,390
ANC Referrals to unit	2	2	0	0
ANC Referrals from unit	0	0	0	0
POSTNATAL				
Post Natal Attendances	952	4,472	3,939	3,629
Number of HIV + mothers followed in PNC	124	164	906	246
Vitamin A supplementation	952	90	0	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 13.5%. Post Natal Care services utilization also decreased by 7.9%. As already anticipated in the previous year, ANC service utilization reduced due to the closure of maternal voucher services in Agago district. Majority of mothers now opt for services in the HCs which are free of charge.

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 the Uganda Protestant Medical Bureau, Local Service Delivery Activity (USAID funded) following transitioning from RHITES-N Acholi. The services offered are substantially integrated into the hospital services. It 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 HIV 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 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, whose policies do not support any structural development needs.

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).

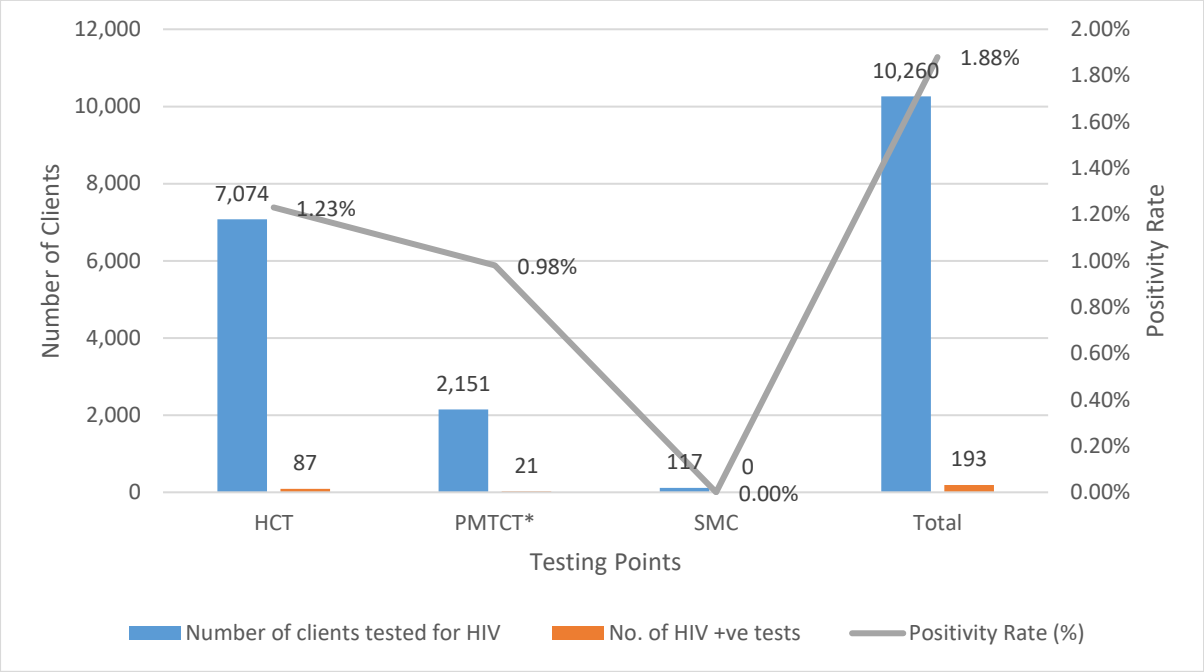
HTS activities currently includes also community-based services. The concept of HTS in the community is based on targeted testing (Targeting the at-risk population).

Table 6.4: Trend of HCT/VCT results in the last 5 FYs

	FY 2016-17	FY 2017-18	FY 2018-2019	FY 2019-20	FY 2020-21
Number Tested					
Male	14,144	10,532	4,736	7,347	4,088
Female	6,478	10,995	6,993	6,721	6,172
TOTAL (Tested)	20,622	21,527	11,729	14,068	10,260
Tested +ve for HIV					
Male	316	386	160	103	86
Female	389	437	222	149	107
TOTAL (+ve Tests)	705	823	382	252	193
Positivity Rates of HCT					
Male	2.20%	3.70%	3.4%	1.4%	2.1%
Female	6.00%	4%	3.2%	2.2%	1.7%
Both sexes	3.40%	3.80%	3.3%	1.8%	1.9%

A total of 10,260 clients accessed HIV counselling & testing services during FY 2020-2021; a reduction of 27% from the previous year. The reduction in testing was related to the effects of the SARS COV 2 pandemic control measures.

Figure 6.2: HIV test by purpose during FY 2020 – 2021



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 6.5: Performance Indicators of the PMTCT Programme in FY 2020-2021

A. Antenatal	No.
A1. Mothers re-tested later in pregnancy, labour or postpartum	967
A2. Mothers testing positive on a retest	7
A3. New pregnant and lactating mothers newly enrolled into psychosocial support groups.	9
A4. HIV positive pregnant women already on HAART before 1st ANC visit /Current pregnancy	123
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	131
A7. HIV positive Pregnant women initiated on Cotrimoxazole	8
A8a. Mothers assessed using CD4	0
A8b. Mothers assessed using WHO clinical staging only	0
A9a. HIV + pregnant women initiated on HART (Option B+) for EMTCT - CD4 >350 or Stage I and 1I (ART-T)	8
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	120
C. Postnatal	
C1. Postnatal mothers newly tested for HIV	7
C2. Postnatal mothers testing HIV positive	2
C3. Postnatal mothers initiating ARVs in PNC period	2
D. Early Infant Diagnosis (EID)	
D1. HIV-exposed infants (<18 months) getting a 2nd DNA PCR	113
D2. HIV-exposed infants initiated on Cotrimoxazole prophylaxis	100
D3a. 1st DNA PCR results returned from lab within 2 weeks of dispatch	107
D3b. 2nd DNA PCR results returned from lab within 2 weeks of dispatch	95
D4a. Total HIV-exposed infants who had a serological/rapid HIV test at 18 months or older.	183
D4b. Positive Number of HIV-exposed infants who had a serological/rapid HIV test at 18 months or older	3
D5. DNA PCR results returned from the lab that are positive	3
D6. HIV-exposed infants whose DNA PCR results were given to caregiver	23
D7. Number of referred HIV positive-infants who enrolled in care at an ART clinic	3

Antiretroviral therapy

Table 6.6: PLHAs eligible for ART and started on ART by age group and gender - last 5 FYs

		FY 2016-17	FY 2017-18	FY 2018-2019	FY 2019-20	FY 2020-21
ELIGIBLE FOR ART						
Male	<5 yrs	0	6	6	4	2
	5-<18 yrs	0	9	8	6	5
	18 and above	5	216	129	96	70
Female	<5 yrs	0	3	6	6	1
	5-<18 yrs	0	8	13	8	7
	18 and above	7	306	221	120	91
TOTAL ELIGIBLE FOR ART		**12**	**553**	**383**	**240**	**176**
STARTED ON ART						
Male	<5 yrs	4	6	6	4	2
	5-<18 yrs	2	9	8	6	5
	18 and above	131	216	129	96	70
Female	<5 yrs	1	3	6	6	1
	5<18 yrs	9	8	13	8	7
	18 and above	201	306	221	120	91

TOTAL STARTED ON ART	**348**	**553**	**383**	**240**	**176**

Total new positives reduced for the year. However, all eligible clients tested were linked and started on care. During the year, there were challenges relating to drop outs and lost to follow up of active clients. These would subsequently be followed and returned to care, or enrolled in one of our community modules of drug distribution.

Table 6.7: Number of PLHAs started on ARV by age group and gender in FY 2020-2021

Data Element	No. of Children < 9yrs		No of Individuals 20–24 yrs		No. of Individuals 25+ yrs		Total
	M	F	M	F	M	F	
Number of new patients enrolled in HIV care at this facility during the year	4	2	15	24	58	73	**176**
Number of pregnant women enrolled into care during the year.				13		11	**24**
Cumulative Number of individuals on ART ever enrolled in HIV care at this facility							**4479**
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	16	18	98	128	163	221	**644**
No. of newly identified positives that are initiated on ART int the same FY	4	2	15	24	58	73	**176**
No. of pregnant & Lactating women started on ART at this facility during the				13		11	**24**

quarter (Subset of HC11)								
No. active on ART screened for TB at last visit in the quarter		37	31	98	147	837	1424	**2574**
No. active on ART with presumptive TB during the quarter		3	1	10	9	41	57	**121**
No. active on ART diagnosed with TB during the quarter		3	1	0	7	33	21	**65**
Net current cohort of people on ART in the cohort completing, 12 months during the year		1	4	3	7	14	21	**50**
Number of clients surviving on ART in the cohort completing, 12 months on ART during the year		1	1	2	4	10	17	**35**
Number of people accessing ARVs for PEP		0	1	13	19	30	29	**92**
No. active on ART on 1st line ARV regimen		26	18	64	102	818	1345	**2373**
No. active on ART on 2nd line ARV regimen		15	18	47	72	137	227	**516**
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	Total Tested	39	34	102	162	820	1431	**2588**
	Suppressed viral load	29	23	78	136	795	1391	**2452**

load test during the past 12 months (most recent test)								
Number active on ART enrolled in DSD approach	FBIM	2	2	14	17	67	87	**189**
	FBG	20	21	54	76	35	195	**401**
	FTDR	6	3	33	51	346	565	**1004**
	CDDP	13	10	10	30	425	607	**1095**
	CCLAD	0	0	1	0	82	118	**201**

Enrollment into community drug distribution modules like the CCLAD, CDDP etc has continued to rise over the last years. The idea is to enroll all eligible clients to service points in one of the modules above, to decongest the facility and improve efficiency and adherence (by taking drugs closer to the clients). In the next year, enrolment of private pharmacies to support drug distribution to eligible clients is expected to start, with the hope that it will reduce stigma and improve compliance.

Tuberculosis (TB) treatment

Dr. Ambrosoli Memorial Hospital offers TB treatment services; integrated into the general medical care activities. TB screening 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.

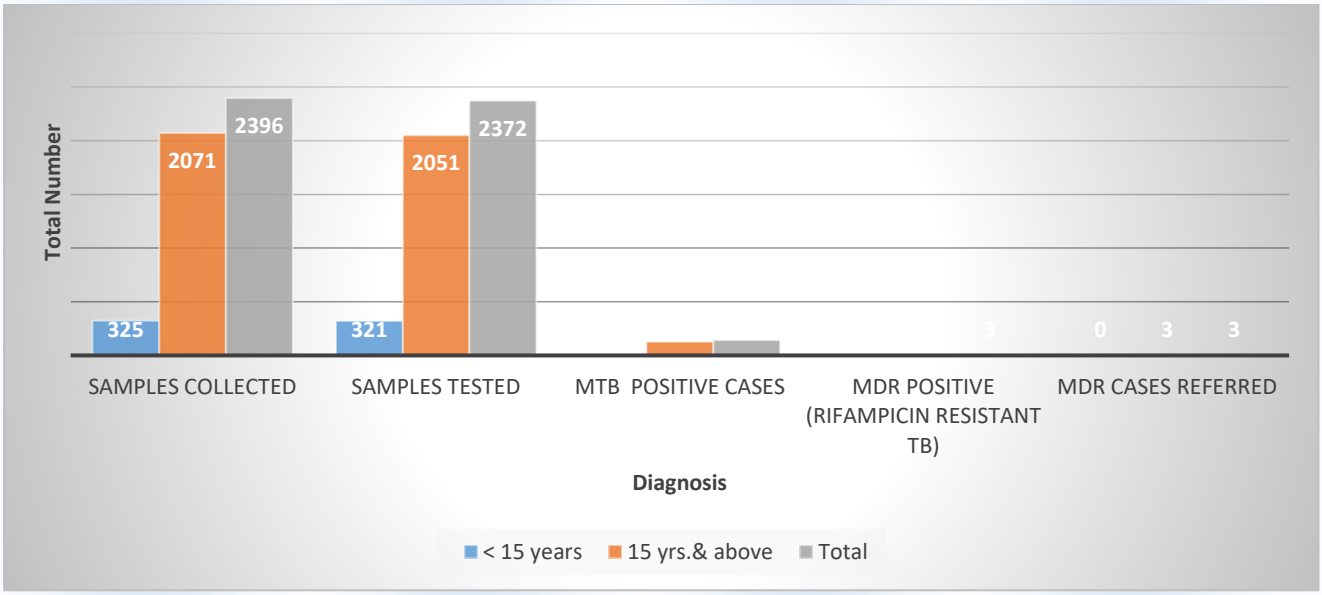
We continue to see high cases of TB among children below 5 years; especially in the malnourished and/or the exposed infant with immunosuppression. TB diagnosis remains a challenge to many health care givers. Therefore, a higher index of suspicion is always employed. Homestead screening and presumptive diagnosis especially among the malnourished admissions is currently being scaled up to improve our case identification rates.

Table 6.8: TB patients registered for treatment in the last 5 FYs

	FY	FY	FY	FY	FY
	2016-17	**2017-18**	**2018-19**	**2019-20**	**2020-21**
No. of patients registered (all)	223	243	196	325	270
Children (< 5 yr.)	4	11	16	38	38
Disaggregation by Disease					
New Pulmonary Positive	175	109	82	84	83
Relapses Pulmonary Positive	4	6	7	10	5
Treatment failure	2	0	1	7	1
Lost to follow up Pulmonary Positive	8	12	10	0	3
New pulmonary Negative	49	99	82	206	167
Relapses Pulmonary Negative	0	1	0	6	7
Default Pulmonary Negative	1	3	0	4	0
Pulmonary no smear done	19	0	0	0	0
Extra Pulmonary	34	16	14	8	4
Disaggregation by Treatment					
New Patients	207	224	198	298	250
Re-treatment	16	22	18	27	20
Other Patients					
Transferred in	0	0	7	0	0

MDR TB still presents a significant public health problem in the surrounding community. The number identified reduced from the last year by about 55% and were referred to the treatment center in Kitgum general hospital. It is important to note that, not all cases are identified (it is possible that there are others still out there). Intense awareness and case identification measures have to be set up.

Figure 6.3: MDR/MTB diagnosis during the FY 2020-21



TB treatment outcome

Mortality among TB patients remains high. Total death increased by approximately 42%. Most of these were associated with HIV co-infection and malnutrition. Patient number certified as cured also increased by 26.3%. Although many patients' complete treatment, they require bacteriological tests to confirm cure. These are not often available and their supply from the National Medical Store is not consistent. Key challenges remain with patients who are lost to follow up; most of who could not be easily traced from their parent community (some of them moved to other locations).

Table 6.9: Results of TB treatment in the last 4 FYs

Outcome of treatment	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21
	Number	Number	Number	Number
Cured	49	53	38	48
Treatment Completed	52	101	126	222
Died	27	28	24	34
Failure	2	2	0	2
Defaulted	13	24	1	0
Transfer out	N/A	36	3	0
Lost to follow Up				5
Not Evaluated				4
Total	**143**	**244**	**192**	**315**

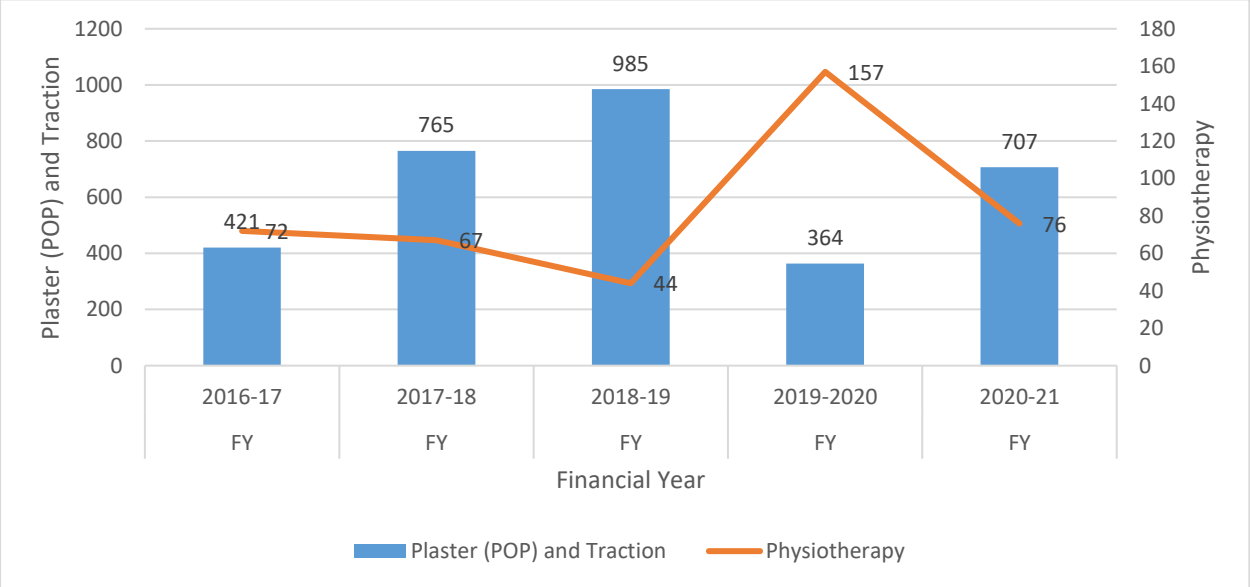
Table 6.10: Results of TB treatment smear positive Pulmonary TB patients in the last 4 FYs

Outcome of treatment	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21
Cured	47	53	36	48
Treatment Completed	14	26	43	33
Died	6	6	10	6
Failure	0	2	0	1
Defaulted	0	9	1	0
Transfer out	N/A	29	2	0
Lost to follow Up				5
Not Evaluated				2
Total	**67**	**125**	**92**	**96**

Orthopaedic Services

Non operative orthopaedic treatment is still the main treatment provided, while surgery is performed during surgical camps occasionally (this wasn't possible with COVID 19). 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, but efforts are underway to have one trained and bonded, following lifting the COVID 19 disruption of trainings.

Figure 6.4: Main procedures in orthopaedics and physiotherapy done in the last 5 FYs



Mental health clinic

In this part of Acholi sub region, access to specialized mental health services is very limited. The hospital still does not have mental health fully integrated into its' core service scopes. However, clinicians continue to review these patients.

In our OPD, Epilepsy remains the leading psychiatric problem encountered. Alcohol and other substance abuse also rose drastically among the young men (some these present with suicidal tendencies)

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 6.11: Mental health cases reviewed in OPD in the last 4 FYs

Diagnosis	FY 2017-18		FY 2018-19		FY 2019-20		FY 2020-21	
	No.	%	No.	%	No.	%	No.	%
Epilepsy	1,001	88.70%	576	85.30%	1171	84.55%	702	80.78%
Drugs/alcohol abuse	37	3.30%	46	6.80%	3	0.22%	60	6.90%
Depression & post-traumatic stress disorders	28	2.50%	21	3.10%	75	5.42%	31	3.57%
Psychosis (schizophrenia)	6	0.50%	1	0.10%	12	0.87%	7	0.81%
Bipolar affective disorder	36	3.20%	5	0.70%	3	0.22%	8	0.92%
Attempted suicide	2	0.20%	0	0.00%	3	0.22%	16	1.84%
HIV related Psychosis	2	0.20%	3	0.40%	19	1.37%	11	1.27%
Other mental illnesses	16	1.40%	23	3.40%	99	7.15%	34	3.91%
Total	**1,128**		**675**		**1,385**		**869**	

Dental Clinic

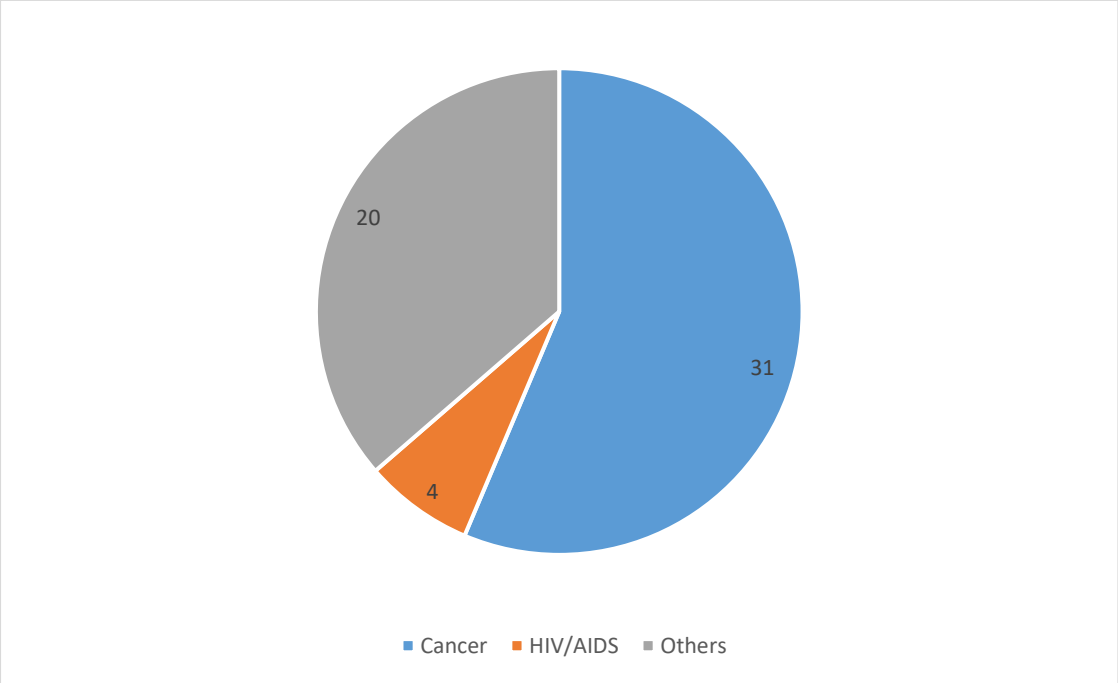
Dental services remain an outstanding unmet need in Agago District. The hospitals' clinic located in the OPD has since closed more than five (5) years ago. The machines and equipment required have either worn out with aging or mechanically broken down.

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. We continue to lobby appeal to available partners for support to revamp the unit.

Palliative Care

Palliative care activities have partly taken shape despite numerous implementation challenges. Lack of funding towards patient follow-up and provision of essential palliative care supplies stills remains a barrier to service delivery. The hospital has integrated palliative care into PHC services, in an effort to curb these challenges. Figure 6.16 summarizes the palliative care services offered in the year 20/21.

Figure 6.4: Number of Patients who received Palliative Care in the FY 2020-21



INPATIENTS DEPARTMENT

Summary of beds and qualified health personnel

The hospitals' bed capacity slightly increased to 286; with the introduction of some new services. In 20/21, five (5) Medical Officers worked in the hospital. There is still 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 of beds to nurse/midwife (7.6) and NICU with the lowest. These indicators are not always constant, given the seasonal variation in disease patterns. Some peak seasons of a particular ailment (e.g., malaria) can give rise to even floor cases; further widening the ratio.

Table 6.11: 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	10	4.1
TB Ward	18			
Surgical Ward	76	1 Surgeon	10	7.6
		1 Medical Officer		
		2 Orthopedic Officer		

		1 Physiotherapist		
Maternity & Gyn Ward	75	1 Medical Officer	14	5.4
Pediatric Ward	61	2 Medical Officers	10	6.1
NICU	15		7	2.
Total	286	1 Specialist Doctor and 5 Medical Officers	51	3.4

Utilization indicators

The total admissions reduced by 27.3%. The overall recovery rate also reduced. Mortality rate reduced by 0.2%. Patients spent slightly longer in the hospital as evidenced by the increased ALOS and turnover interval. The ALOS was higher than the national recommendation of 4.7 days. The number of patients who escape from the hospital more than doubled in the last year (173%). The habit greatly impacts revenue generation (coupled to the already high cost of services and very low fees levied), and reflects the reduced user fees earlier on highlighted. The management has laid down strategies to curb down escapes without payment of fees and hope to reduce this in the coming year.

Table 6.12: Key indicators for the entire hospital in the last 5 FYs

Indicator	FY	FY	FY	FY	FY
	2016-17	**2017-18**	**2018-19**	**2019-20**	**2020-21**
No. of beds	267	271	271	271	286
Total Admissions discharged	20,446	13,460	14,794	16779	12203
Patient days	100,930	68,521	69,329	89761	69228
Average Length of Stay	4.9	5.1	4.7	5.35	5.67
Turn over interval	-0.17	2.26	2.0	0.5	2.9
Throughput per bed	76.6	49.7	54.6	61.9	42.7
BOR	103.60%	69.30%	70.10%	90.75%	66.32%
No. Deaths	204	115	192	373	343
Mortality Rate	1.00%	0.85%	1.3%	2.5%	2.3%
Recovery Rate	98.80%	97.00%	97.09%	97.42%	95.85%
Self-discharges	48	20	67	60	164

Bed Occupancy Rate (BOR) and Throughput per Bed

The hospital Bed Occupancy rate (BOR) was at 66.32%, a reduction of 24.43%. Children ward had the highest BOR (105.6%) followed by Maternity (63.7%). Malaria and its' associated complications were still responsible for the increased BOR observed in the Children's and Maternity wards in the year 20/21. The throughput per bed reduced by 31%; the reduction was experienced across all departments as evidenced by the reduced admissions.

Table 6.13: Key indicators per ward in the last 4 FYs

MEDICAL WARD				
	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
No of beds	41	41	41	41
Total Admissions	2,072	2,237	2,684	1,834
Patients days	11,334	11,310	12,549	7,542
ALOS	5.5	5.1	4.7	6.6
Throughput per bed	50.5	54.6	65.5	44.7
BOR	75.70%	75.60%	83.18	50.40
No of Deaths	63	86	113	140
Mortality rate	3.04%	3.84%	4.21%	7.63%
Recovery rate	95.50%	95.75%	95.45%	89.59%
Self-discharges	4	9	9	51

SURGICAL WARD[1]				
	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
No of beds	76	76	76	76
Total Admissions	2,024	2,055	1,925	1,521
Patients days	17,995	14,721	15,189	13,701
ALOS	8.9	7.2	7.9	9.0
Throughput per bed	26.6	27.0	25.3	20.0
BOR	64.90%	53.10%	56.00%	49.4%
No of Deaths	13	31	32	30
Mortality rate	0.64%	2%	2%	2%
Recovery rate	98.80%	98.49%	98.13%	97.04%
Self-discharges	4		4	15

PAEDIATRIC WARD				
	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
No of beds	61	61	61	76
Total Admissions	3,810	4,143	7,615	4,437
Patients days	19,783	20,188	43,503	29,304
ALOS	5.2	4.87	5.71	6.60
Throughput per bed	62.5	67.9	124.8	58.4
BOR	88.90%	90.70%	195	105.6%
No of Deaths	36	59	217	157
Mortality rate	0.94%	1.42%	2.85%	3.54%
Recovery rate	98.70%	98.58%	96.53%	94.79%
Self-discharges	10		47	74

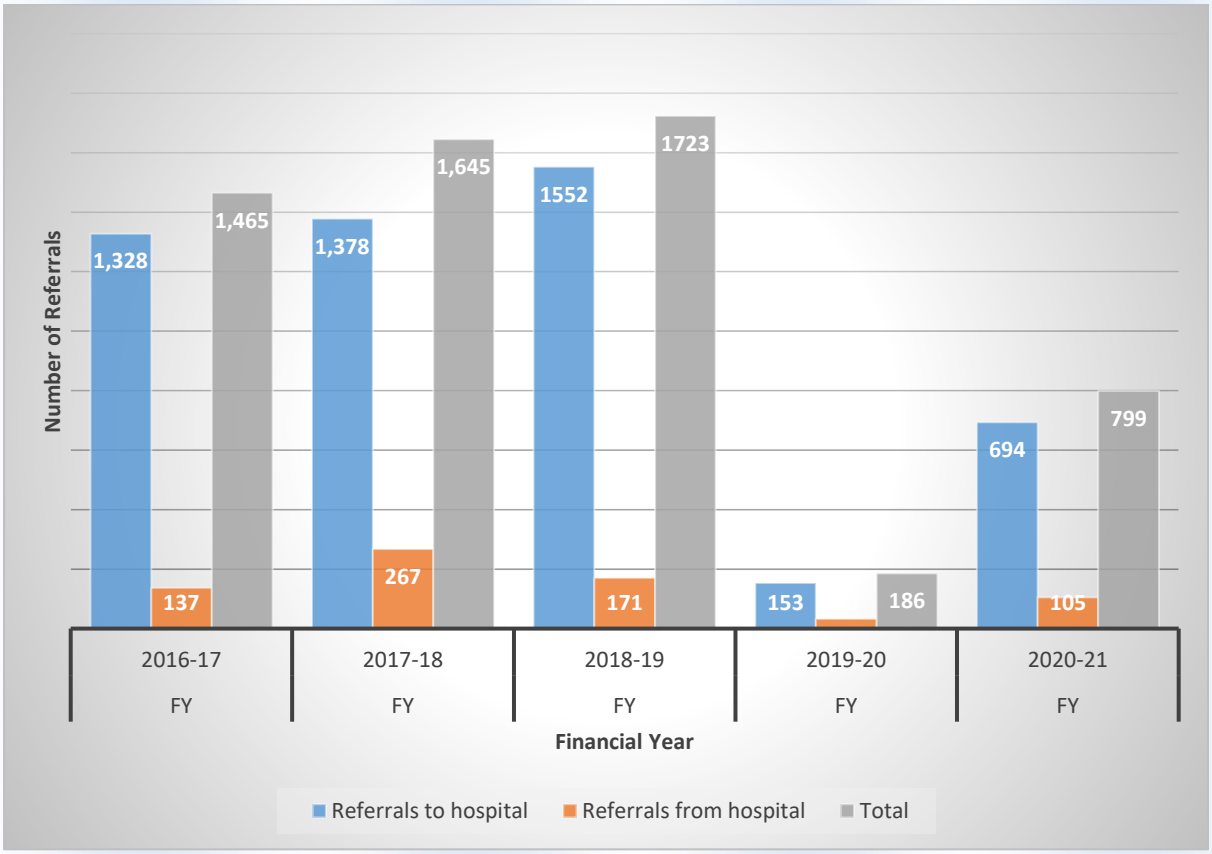
OBSTETRICS& GYNECOLOGY WARD				
	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
No of beds	75	75	75	75
Total Admissions	5,302	6,165	4,226	4,144
Patients days	17,331	20,984	16,519	17,441
ALOS	3.3	3.4	3.9	4.2
Throughput per bed	70.7	82.2	56.35	55.3
BOR	63.30%	76.70%	95.45	63.7%
No of Deaths	1	7	4	11
Mortality rate	0.02%	0.11%	0.09%	0.27%
Recovery rate	99.40%	99.9%	199.9%	299.9%
Self-discharges	0	0	0	20

TB WARD				
	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
No of beds	18	18	18	18
Total Admissions	252	194	329	267
Patients days	2,078	2,126	2,001	1,240
ALOS	8.2	11.0	6.1	4.6
Throughput per bed	14	10.8	18.3	14.8
BOR	31.60%	32.40%	30.45	18.87%
No of Deaths	2	9	7	5
Mortality rate	0.79%	4.64%	2.13%	1.87%
Recovery rate	99.20%	95.36%	97.87%	98.13%
Self-discharges	0	0	0	0

Inpatient referrals

Total hospital referrals increased by 329%. Referrals to and from the hospital increased by 353.6% and 218.2% respectively. The hospital is still the referral facility for Agago and four (4) other neighboring districts. The rapid increase in referrals follows as well the easing of COVID-19 restrictions.

Figure 6.5: Pattern of referrals to and from the hospital in the last 5 FYs



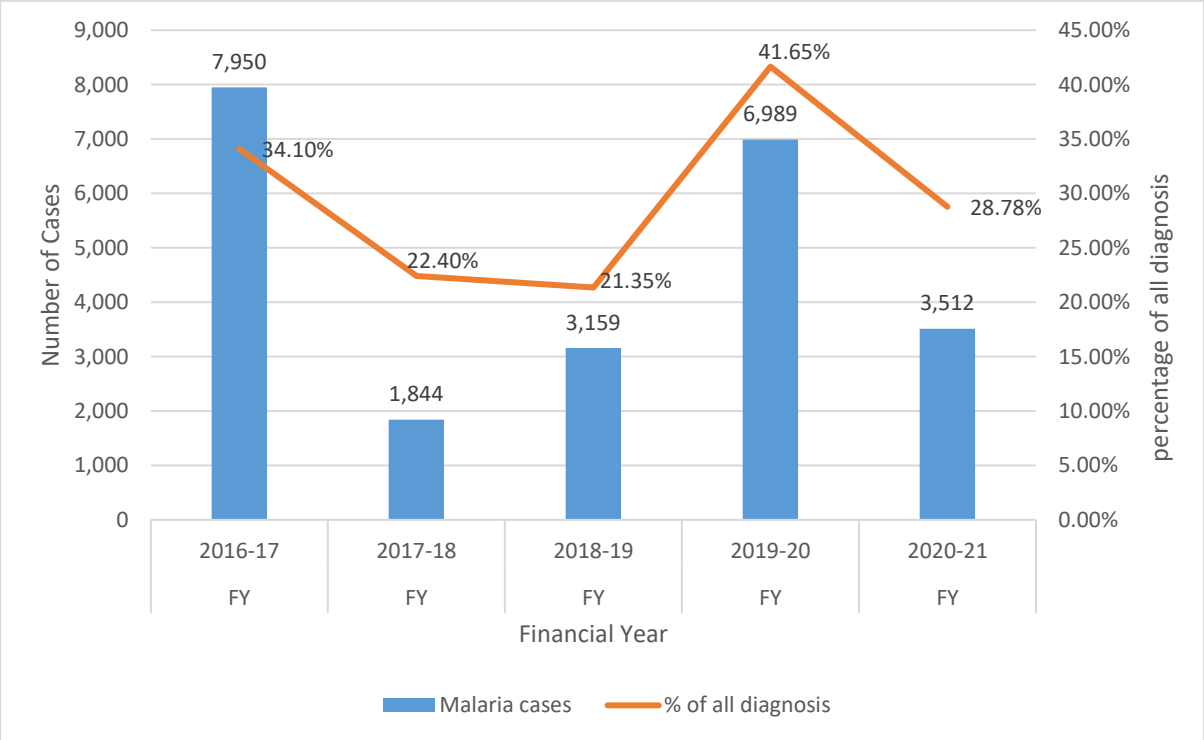
Morbidity causes

Malaria remains the leading morbidity cause (28.78% of all admissions) followed by Injuries (7.99%). 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. Sickle cell disease makes the top 10, showing signs of rising cases yearly. With improved screening modalities, it is expected that identified cases will continue to rise. The hospital is already working on a project to compliment MOH effort in making Hydroxy urea more accessible to eligible patients, to reduce the incidence of complications, and as well, increase access to screening tests.

Table 6.14: Top ten causes of admission in all the wards in the FYs 2019-2020 & 2020-2021

	Causes of Morbidity	FY 2019-20		FY 2020-21	
		No. of cases	**% on all diagnose**	**No. of cases**	**% on all diagnose**
1	Malaria	6,989	41.65%	3,512	28.78%
2	Injuries - Trauma due to other causes	1,426	8.50%	975	7.99%
3	Pneumonia	993	5.92%	618	5.06%
4	Anaemia	384	2.29%	618	5.06%
5	Abortions due to other causes	243	1.45%	495	4.06%
6	Neonatal Sepsis 8-28days	35	0.21%	413	3.38%
7	Malaria in pregnancy	182	1.08%	399	3.27%
8	Septicemia	406	2.42%	397	3.25%
9	Diarrhea - Acute	245	1.46%	240	1.97%
10	Sickle cell disease	195	1.16%	210	1.72%
	All others	601	3.58%	763	6.25%
	Total	**16,779**		**12,203**	

Figure 6.6: Trend in Malaria admissions over the last 5 FYs



Mortality causes

Malaria accounted for the highest number of disease specific deaths (91). Prematurity had the highest CFR 11.54%. Death of neonates continue to be a burden, especially when referrals of neonates from lower facilities is still delayed. Other neonatal conditions had the second highest CFR 11.31%). Anaemia accounted for 22 disease specific deaths; almost directly due to the chronic shortage of blood faced by the hospital and region at large (the nearest blood bank is at least 170 km away, with no assurance of blood availability at any time). On many occasions, the hospital has had to conduct emergency transfusion in an effort to save lives.

Table 6.15: Top ten causes of death among inpatients all wards FY 2019-20 and FY 2020-21

Causes of Mortality among Inpatients		FY 2019-20			FY 2020-21		
		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	191	6,989	2.73%	91	3,512	2.59%
2	Pneumonia	43	993	4.33%	32	618	5.18%
3	Anaemia	10	384	2.60%	22	618	3.56%
4	Other Neonatal Conditions	22	197	11.17%	19	168	11.31%
5	Premature baby (as condition that requires mgt)	27	131	20.61%	15	130	11.54%
6	Injuries - Trauma due to other causes	21	1,426	1.47%	14	975	1.44%
7	Septicemia	2	406	0.49%	12	397	3.02%
8	Heart failure	1	20	5.00%	9	45	20.00%
9	Hypertension (old cases)	2	62	3.23%	6	77	7.79%
10	Other Cardiovascular Diseases	6	195	3.08%	6	64	9.38%
	All others	1	535	0.19%	16	763	2.10%

NCD related deaths are also on the rise. We observed 166% more deaths from hypertension and cardiovascular events than in the previous year. The hospital will continue to educate the mass on the risks of NCD and their prevention.

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

Table 6.16: Staff Composition in Medical Ward FY 2020-2021

Cadre/ Discipline	Qualification	Number
Medical Doctor	Bachelor Degree in Medicine and Surgery	1
Registered Comprehensive Nurse	Diploma in Comprehensive Nursing	4
Enrolled Nurse	Certificate in Nursing	5
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	1
Nursing Assistant	Certificate in Nursing Assistant	2
Nursing Aid	Trained on the Job	0
Total		**13**

Key Indicators in Medical ward

As already highlighted before, the total admissions reduced through the year. The ALoS (4.1) and BOR (50.4%) also reduced. Death rate increased (7.6%). Deaths were mainly due to NCDs and HIV/AIDS related co-morbidities. The reduction in the utilization indicators is also linked to the reduced malaria burden observed, compared to the year before. The Medical ward, is one of the wards where many patients escape. The management will be working closely with the team in the ward to address this problem.

Table 6.17: Key indicators in Medical Ward in the last 5 FYs

	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
No. of beds	41	41	41	41	41
Total Admissions	2,792	2,072	2,237	2,684	1,834
Bed days	14,880	11,334	11,310	12,549	7,542
ALoS	5.5	5.5	5.1	4.7	4.112
BOR	99.40%	75.70%	75.57%	84.29%	50.40%
Throughput	68.1	50.5	54.6	65.5	44.7
Turnover interval	0.03	1.75	1.63	1.36	1.99
Deaths	79	63	86	113	140
Death Rate	2.82%	3.04%	3.84%	4.21%	7.63%
Recovery Rate	97.10%	95.50%	95.75%	95.45%	89.59%
Self-discharges	2	4	9	9	51

Morbidity causes

As experienced in the previous FY, Malaria was the leading cause of admission into the medical ward (accounting for 29.83% of the total admission). This was a reduction of 44.6% from last year. Sepsis followed (accounting for 9.76% of all admissions). Infectious disease remains the big burden of diseases. Hypertension increased by 293.8%; a very significant rise in the number of cases.

Table 6.18: Top 10 causes of admission in Medical Ward in the last two FYs

	Causes of Morbidity in Medical Ward	FY 2019-2020		FY 2020-2021	
		No. of cases admitted	% on all admissions in Medical Ward	No. of cases admitted	% on all admissions in Medical Ward
1	Malaria	988	36.81%	547	29.83%
2	Sepsis	164	6.11%	179	9.76%
3	Acute Gastroenteritis	68	2.53%	114	6.22%
4	Pneumonia	154	5.74%	112	6.11%
5	Anaemia due other cause	105	3.91%	80	4.36%
6	Hypertension	16	0.60%	63	3.44%
7	Alcohol intoxication	28	1.04%	46	2.51%
8	Drug poisoning	68	2.53%	46	2.51%
9	Tuberculosis	46	1.71%	42	2.29%
10	Liver cirrhosis	79	2.94%	33	1.80%

Mortality causes

In the FY 20/21, Pneumonia was the leading cause of death. It accounted for 112 disease specific deaths. Majority of these were community acquired pneumonia compounded by HIV co-infection. Heart failure followed with 15 disease specific deaths and the highest CFR of 34.1%. NCDs have continued to contribute significantly to mortality causation in the ward.

Table 6.19: Top 5 common causes of death in medical ward in the last two FYs

Causes of Mortality in Medical Ward		FY 2019-2020			FY 2020-2021		
		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	Pneumonia	14	154	9.09%	21	112	18.75%
2	Heart failure	2	36	5.56%	15	44	34.09%
3	Malaria	19	988	1.92%	14	547	2.56%
4	Anaemia due to other cause	5	105	4.76%	8	80	10.00%
5	Septicaemia	1	44	2.27%	8	62	12.90%

SURGICAL WARD

Surgical Ward is accommodated in one of the oldest structures in the hospital, with 71 beds.

The ward is one of the oldest in the hospital and is in urgent need of critical renovation. The renovation requirement of the surgical ward extends as well to the furniture (beds, lockers, mattresses etc.), which are in very poor state. 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 MOH Internship program continued, with an average of three Intern doctors attached periodically. Due to the effects of SARS COV 2, it has not been possible to arrange surgical camps by visiting surgeons.

Table 6.20: Staff composition in Surgical Ward in the FY 2020-2021

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	2
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	1
Enrolled Nurse	Certificate in Nursing	7
Nursing Aid	Trained on the job	1
Orthopedic Officer	Diploma in Orthopedic	1
Physiotherapy	Dip. In Physiotherapy	1
Total		**16**

Key Indicators in surgical ward

The total admissions reduced by 21% compared to the previous year, mostly because of the effects of the pandemic and the absence of surgical camps. The ALoS slightly increased. The ALOS was nonetheless high, compared to the national average of 4.5. The BOR reduced by 6.6%. 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. 97% of all patients treated in the surgical ward fully recovered. Mortality rate increased by 0.31%.

Table 6.21: Key indicators in Surgical Ward in the last 5 FYs

	FY	FY	FY	FY	FY
	2016-17	2017-18	2018-19	2019-20	2020-21
No. of beds	71	76	76	76	76
Total Admissions	2,171	2,024	2,055	1925	1521
Bed days	17,833	17,995	14,721	15189	13701
ALoS	16.4	8.9	7.2	8.0	9.0
BOR	68.80%	64.90%	53.07%	56.00%	49.39%
Throughput	30.6	26.6	27.0	25.3	20.0
Turnover interval	3.7	4.8	6.3	6.5	9.2
Deaths	27	13	31	32	30
Death Rate	1.24%	0.64%	1.51%	1.66%	1.97%
Recovery Rate	98.40%	98.80%	98.35%	98.13%	97.04%
Self-discharges	7	4	3	4	15

Morbidity causes

Unlike in the previous years, injuries were the leading morbidity causes on the surgical ward. Fractures accounted for 16.4% of all admissions in the ward, followed by head injury (9.73% of all admissions). Blunt abdominal trauma and burns accounted for 2.7% and 1.6% of all admissions respectively. Over 70% of these injuries were a result of road accident; the others were due to accidental falls, fights etc. Domestic violence, SGBV and alcohol intoxication which still have high prevalence in the community; all played very important roles in injury causation.

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 6.22: Top 10 causes of admissions in Surgical Ward-FYs 2019-2020 & 2020-2021

Causes of Morbidity in Surgical Ward		FY 2019-2020		FY 2020-2021	
		No. of cases admitted	% on all admissions in Surgical Ward	No. of cases admitted	% on all admissions in Surgical Ward
1	Fracture	133	6.43%	250	16.44%
2	Head injury	74	3.58%	148	9.73%
3	Abscess	329	15.91%	134	8.81%
4	Laceration	176	8.51%	98	6.44%
5	Hernia	133	6.43%	68	4.47%
6	Septic wound	117	5.66%	65	4.27%
7	intestinal obstruction	57	2.76%	61	4.01%
8	Cellulitis	82	3.97%	55	3.62%
9	Blunt abdominal trauma	39	1.89%	41	2.70%
10	Burn	46	2.22%	25	1.64%

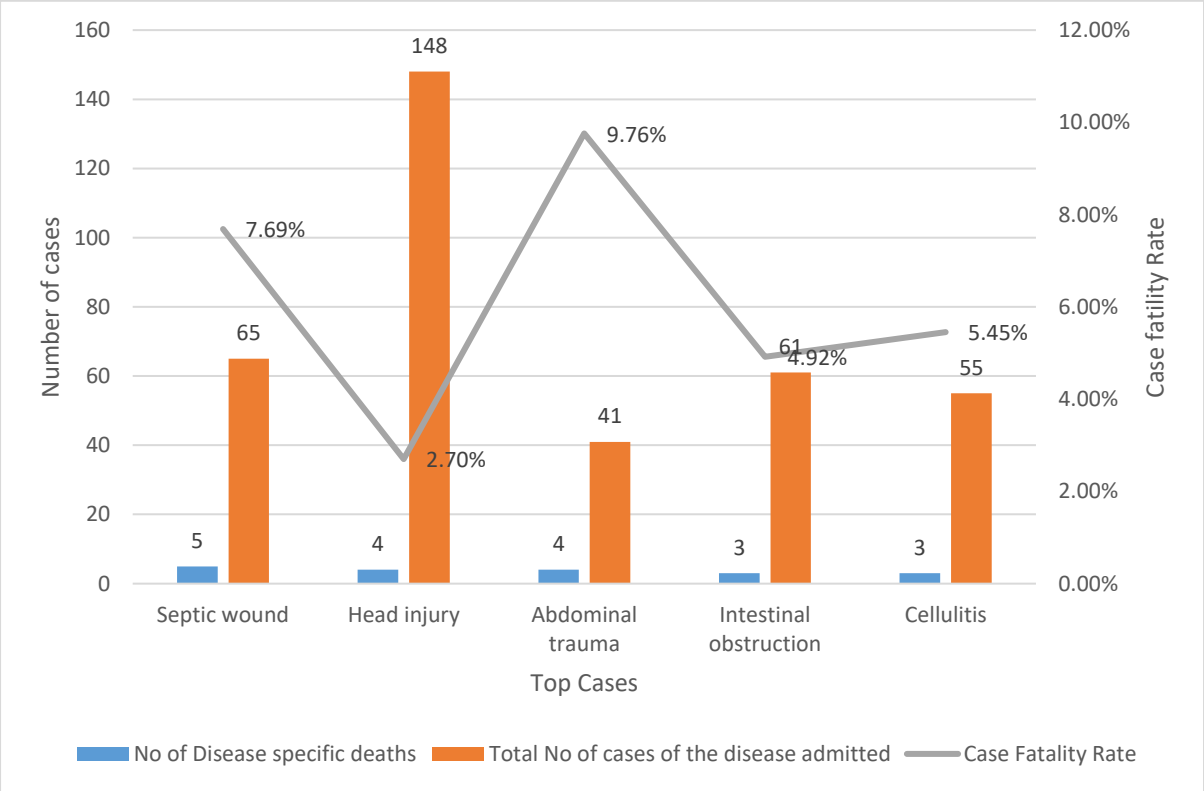
Mortality causes

Overall, trauma presented the highest CFR. Abdominal trauma and head injury had CFRs of 9.8% and 2.7% respectively. Mortality in trauma patients were directly related to severity of the injuries sustained. This was worsened by the total lack of critical care services (ICU) in the hospital to support the very sick and post operative patients. Acholi sub region also still significantly suffer from lack of CT scan services; complicating the care for trauma patients.

Septic wounds contributed to the highest number of disease specific death (5); most of who were elderly patients with other comorbidities (diabetes etc.). The care of patients with

sepsis remains a challenge when there is lack of critical care services. The hospital has since undertaken to look for resources to set up a High Dependence Unit to curb the gap.

Figure 6.7: Top 5 common causes of death in Surgical Ward in the current FY



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 (GGP grants), 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 6.23: Staff Composition in the operating theatre FY 2020-2021

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	2
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	1
Medical Theatre Assistant		2
Nursing Assistant	Certificate in Nursing Assistant	4
Nursing Aid	Trained on the Job	4
Total		**18**

Surgical Procedures

The total number of surgeries performed in the hospital reduced by 38.1% compared to the last year. Major and minor surgeries reduced by 27% and 45.4% respectively. As highlighted above, the pandemic effects and absence of surgical camps were key contributing factors to this.

73% of all the surgeries performed were emergency operations. C/S accounted for 71.7% of major surgeries performed.

Figure 6.8: Top major surgical procedures performed in the FY 2020-21

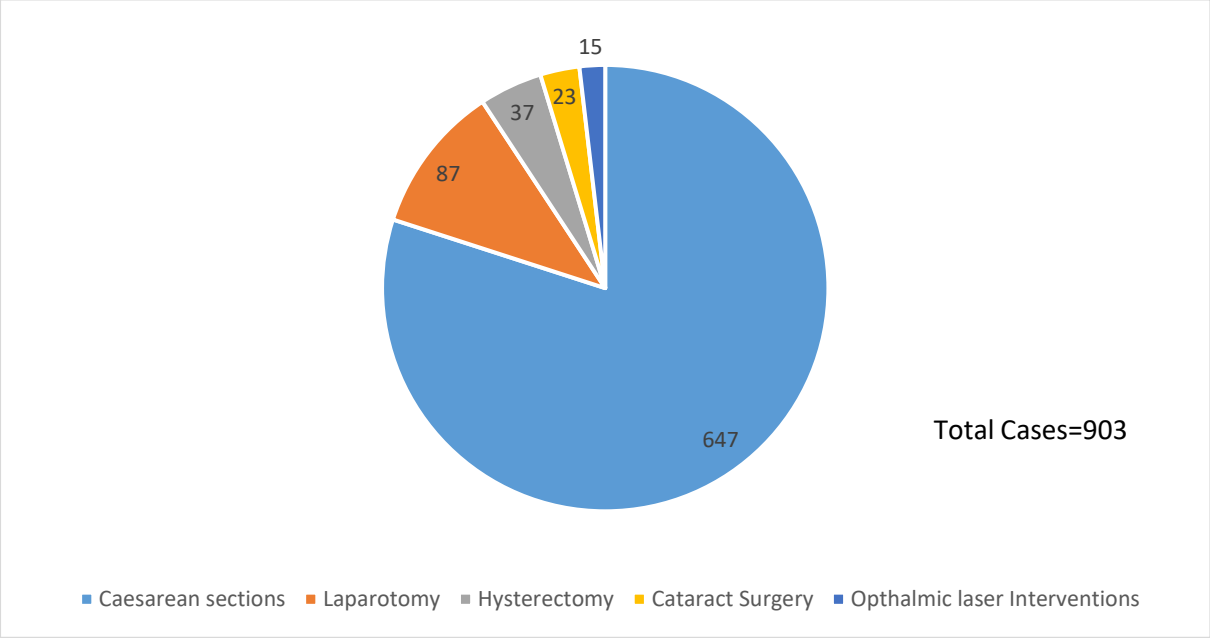


Figure 6.9: Top minor surgical procedures done in FY 2020-2

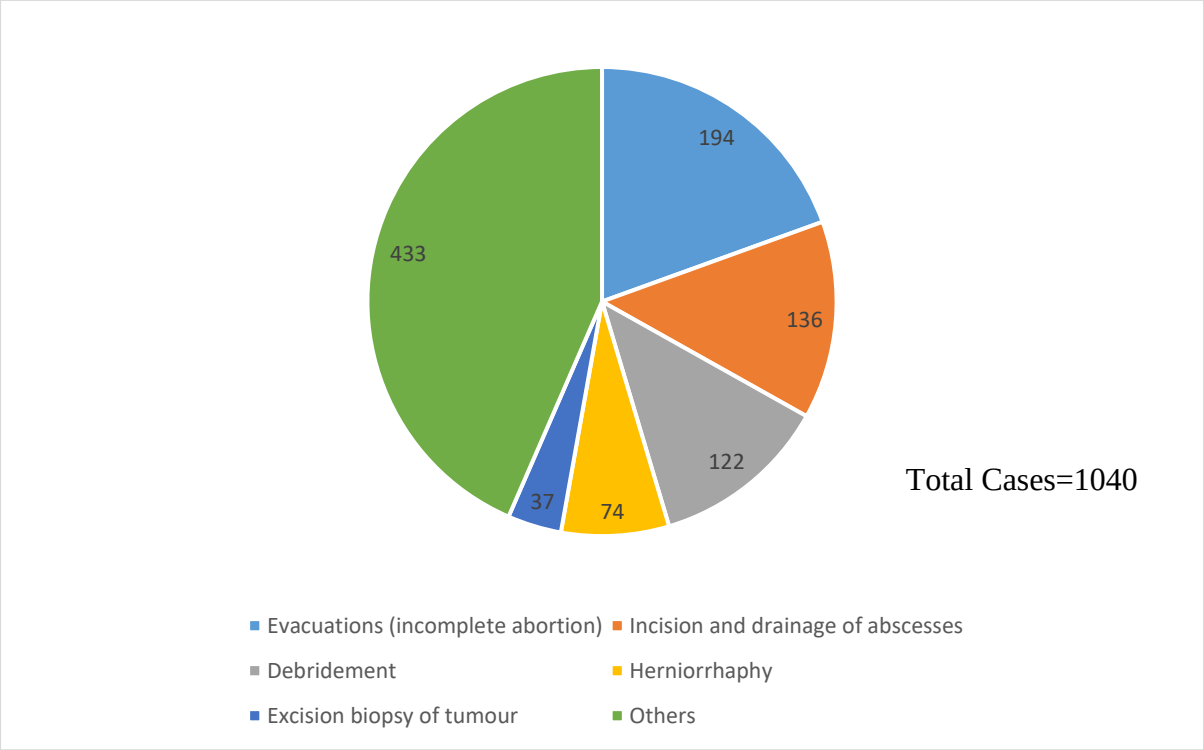


Table 6.24: Trend of surgical activities in last 5 FYs

	FY 2016-17	FY 2017-18	FY 2018-2019	FY 2019-20	FY 2020-2021
Total Operations	2,639	3,425	3,286	3,139	1,652
Major operations (including C/S)	994	1,285	1,314	1,235	963
Minor operations	1,645	2,140	1,972	1,904	589
Emergencies	381	530	585	620	704
Emergencies as % of total major operations	38.30%	41.20%	44.52%	50.20%	73.10%

Table 6.25: Pattern of anesthesia used during the last 5FYs

Type of Anesthesia	FY 2016-2017	FY 2017-2018	FY 2018-2019	FY 2019-2020	FY 2020-2021
Local Anesthesia	269	344	163	146	163
General Anaesthesia with IV Ketamine	1,101	1,175	645	933	731
Spinal Anesthesia	247	262	263	737	678
General Anesthesia with ETT	41	69	65	88	78
General Anesthesia with LMA	0	0	0	13	2
Regional Anaesthesa	0	0	0	1	0
Total	**1,658**	**1,850**	**1136**	**1918**	**1652**

PEDIATRIC WARD

The ward has a capacity of 61 beds, distributed in the general ward, Nutrition and Isolation Units. The refurbishment of the ward that started with funding from CEI is expected to finish in the next FY.

Staff Composition

The ward was run by two MOs, who also supervised activities in the NICU. The number of nursing staff remained stable despite some few nurses leaving for further studies. A visiting volunteer Italian Pediatrician came in periodically to support the activities of the ward during the year.

Table 6.26: Personnel assigned to Pediatric Ward in FY 2020-21

Cadre/ Discipline	Qualification	Number
Medical officers	Bachelor Degree in Medicine and Surgery	2
Enrolled Midwife	Certificate in Midwifery	1
Registered Nurse	Diploma in Nursing	2
Nutritionist	Dip. In Human Diet and Nutrition	1
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 reduced by 41.7%. This significant drop was due to the reduced malaria burden registered in the year. The ALOS increased by 0.9 days and the BOR reduced by 89.3%. The total number of deaths reduced by 27.6% but the death rate increased by 0.7%. The ward also registered the highest number of escaped patients during the year.

Table 6.27: Paediatric Ward indicators over the last 5 FYs

	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
No. of beds	61	61	61	61	76
Total Admissions	9,671	3,810	4,143	7,615	4,437
Bed days	44,765	19,783	11,310	43,503	29,304
ALoS	4.6	5.2	4.9	5.71	6.60
BOR	201.10%	88.90%	90.70%	194.95%	105.64%
Throughput	158.5	62.5	67.9	124.8	58.4
Turnover interval	-2.3	0.65	2.64	-2.79	-0.35
Deaths	83	36	59	217	157

Death Rate	0.85%	0.94%	1.42%	2.85%	3.54%
Recovery Rate	95.40%	98.70%	98.04%	96.53%	94.79%
Self-discharges	0	10	22	47	74

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 53.5% of all cases. This was also a 53.6%% drop in the number of cases from the previous FY. Respiratory Tract Infections followed, accounting for 9.1% of all admissions. The top two causes of morbidity, are easily preventable illnesses with prudent public health interventions. Anemia cases from other causes reduced by 20.4%. Malnutrition continues to be on the rise; typically related to the high poverty levels in the surrounding community.

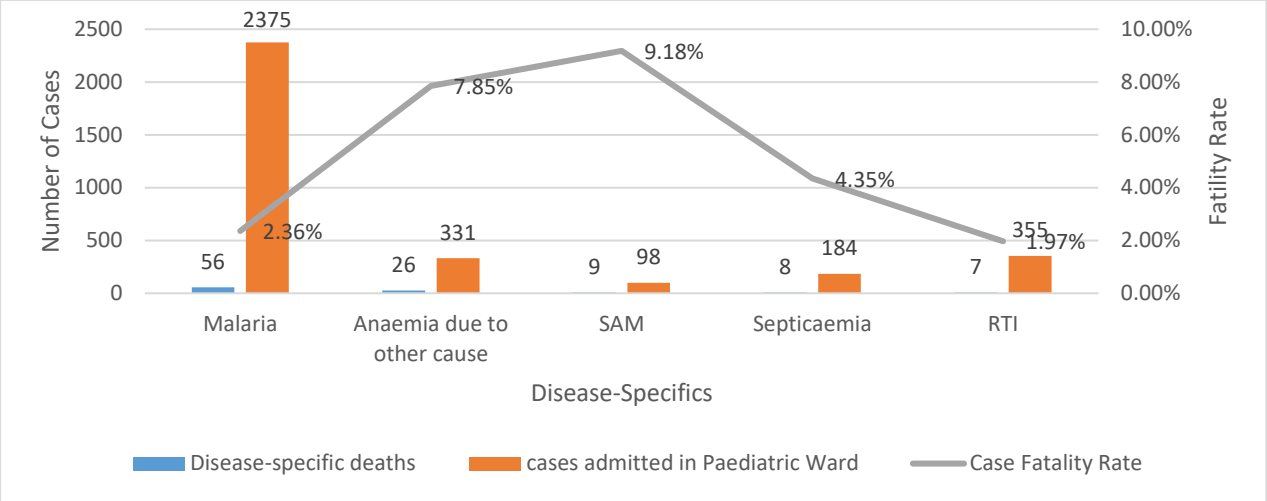
Table 6.28: Top ten causes of admission in Paediatric Ward - FY 2019-20 and FY 2020-21

Causes of Morbidity		FY 2019-2020		FY 2020-2021	
		No. of cases admitted	**% on all admissions**	**No. of cases admitted**	**% on all admissions**
1	Malaria	5,116	67.18%	2,376	53.55%
2	RTI	692	9.09%	404	9.11%
3	Anaemia due to other causes	417	5.48%	332	7.48%
4	Sepsis	503	6.61%	334	7.53%
5	diarrhoea	157	2.06%	190	4.28%
6	SAM	153	2.01%	98	2.21%
7	SCD	63	0.83%	36	0.81%
8	Epilepsy	12	0.16%	10	0.23%
9	UTI	13	0.17%	9	0.20%
10	Heart disease	5	0.07%	7	0.16%

Mortality causes

Malaria was responsible for the highest number of disease specific deaths in 20/21, followed by Anemia from other causes. However, Malnutrition and Anemia due to other causes, were the deadliest illnesses (CFR; 9.18% and 7.85% respectively). The prevailing poverty is compounded by the very low literacy levels (less than 40%) in the district and the currently experienced climate change. This is expected to worsen malnutrition conditions in the district. Anemia will still continue to be a huge threat given the chronic lack of blood products that is currently experienced across the country. The need to mobilize for local emergency blood donations is often very expensive on the hospital and is not in any way sustainable without an extra ordinary support.

Figure 6.10: Top five causes of death in Paediatric Ward in FY 2020-21



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, nurse in-charge office, duty room, private rooms and isolation unit.

This ward was run by 1 Medical Officer 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. The ward participated directly in the World bank funded MOH RBF program which strengthens the URMCHIP intervention.

Table 6.29: Staff Composition in Maternity Ward in FY 2020-21

Cadre/ Discipline	Qualification	Number
Medical officer	Bachelor Degree in Medicine and Surgery	1
Clinical Officer	Dip. In Clinical Mentoring/Nursing/Midwifery	1
Registered Midwife/Nurse	Diploma in Midwifery and Nursing	1
Registered Midwife	Diploma in Midwifery	2
Enrolled Midwife	Certificate in Midwifery	10
Nursing Aide	Primary Leaving Examination (P.L.E)	1
Total		**16**

Key Indicators

The total admissions reduced by 1.9%. The ALOS remained stable with a significant drop in the BOR, by 31.74%. The maternal death rate increased by 0.18%. As it has been before, maternal deaths in the district are a consequence of delay in referrals in most instances; however, we also experienced a rise in the number hypertensive crises in pregnancy as a direct contributor to maternal deaths. 99.2% of all admitted patients recovered and were discharged.

Table 6.30: Key indicators in Maternity Ward (Obs & Gyn) in the last 5 FYs

	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
No. of beds	75	75	75	75	75
Total Admissions	5,593	5,302	6,165	4,226	4,144
Bed days	20,107	17,331	20,984	16,519	17,441
ALoS	5.1	3.3	3.4	3.9	4
BOR	73.50%	63.30%	76.65%	95.45%	63.71%
Throughput	74.6	70.7	82.2	56.3	55.3
Turnover interval	1.3	1.9	1.04	2.57	2.40
No. Deaths	6	1	7	4	11
Death Rate	0.11%	0.02%	0.11%	0.09%	0.27%
Recovery Rate	99.90%	99.40%	99.9%	99.9%	99.2%
Self-discharges	1	0	0	0	24

Birth indicators

Total deliveries in the hospital reduced by 4.8%. Reduction in deliveries was likely due to the end of maternal voucher services in the district compounded by the restrictions put in place due to the pandemic. Caesarean section accounted for 25.12% of total deliveries. 99.23% of the C/S done were emergencies, most of which are a direct consequence of late referrals from LLUs.

Premature delivery was certainly a big burden. The hospital registered 95% increase in cases. 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 20.8%. Low birth weight in our catchment area seems to be directly related to maternal nutritional status, which are often poor.

Table 6.31: Maternity Ward Deliveries & Births indicators in the last 5 FYs

	FY	FY	FY	FY	FY
	2016-17	2017-18	2018-19	2019-20	2020-21
Total deliveries	3,453	3,547	4,169	2,707	2,576
Normal deliveries in unit	2,918	2,977	3,617	2,187	2,576
Abnormal deliveries (incl. C/S)	535	570	529	552	647
Live birth in units	3,340	3,499	4,142	2,654	2,486
Babies born with low birth weight	652	577	732	517	504
Fresh Still births in unit	20	18	24	23	30
Macerated still births in unit	22	16	35	46	31
New-born deaths (0-7 days)	27	14	69	59	55
Maternal Deaths	6	1	9	5	10
Live Births					
Full term normal weight	2,925	2977	3,384	2,084	1,694
Full term low birth weight	606	577	601	451	357
Premature cases	101	90	157	223	435
Caesarean Sections					
Elective C/S	24	26	30	33	5
Emergency C/S	392	530	579	519	642
Caesarean Sections total	416	556	609	552	647
C/S as % of total deliveries	12.00%	15.70%	14.61%	20.39%	25.12%
Emergency C/S as % of all C/S	94.20%	95.30%	95.07%	94.02%	99.23%

Table 6.32: Origin of mothers who delivered through C/S in the last 5 FYs[3]

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

Sub-County	FY	FY	FY	FY	FY
	2016-17	**2017-18**	**2018-19**	**2019-20**	**2020-21**
Adilang	28	49	46	37	41
Kotomor	9	16	35	25	20
Patongo	31	52	58	53	63
Patongo T.C.	12				
Lukole	38	58	68	51	72
Lukole T.C.	10	6			
Kalongo T.C.	35	39	69	69	52
Paimol	20	32	53	50	27
Parabongo	21	46	40	40	40
Omot	17	34	38	26	28

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

Acholpii	0	4	25	21	13
Lamiyo	2	9	37	29	8
Lapono	34	60	39	41	51
Lira Palwo	20	28	35	35	114
Omiya Pacwa	10	25	41	33	13
Wol	29	40	25	27	37
Total	**316**	**498**	**609**	**537**	**579**

Table 6.33 continuation

Outside the Catchment Area of Agago District (distances of 58 km and above)					
District	**FY**	**FY**	**FY**	**FY**	**FY**
	2016-17	**2017-18**	**2018-19**	**2019-20**	**2020-21**
Pader	18	17	10	8	42
Kitgum	7	10	1	2	4
Abim	4	7	0	5	16
Other	71	23	0	0	6
Total	**300**	**58**	**11**	**15**	**68**

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 were attended to by the MOs who also managed the weekly clinics every Monday in OPD. Urinary tract infections presented the heaviest morbidity burden in the FY.

In 20/21 Abortion was the leading cause of admission in the Gynaecological ward, followed by Malaria and UTI in pregnancy. Most abortion cases encountered were spontaneous following hard labor. However, criminal abortion was also observed to be on the rise; often from the immediate communities surrounding the hospital.

Table 6.34: Admissions in Maternity Ward not related to maternity conditions

	Diagnosis of admission	No. of cases admitted	% on all admissions in Surgical Ward
1	Abortion	513	32.72%
2	Malaria in pregnancy	367	23.41%
3	UTI in pregnancy	98	6.25%
4	Puerperal sepsis	44	2.81%
5	Anaemia in pregnancy	33	2.10%
6	Preterm rapture of membranes	32	2.04%
7	False labour	30	1.91%
8	pelvic inflamatory disease	30	1.91%
9	post partum hemorrhage	21	1.34%
10	Preterm labor	9	0.57%
	Total	**1568**	

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 as well to patients admitted in this unit.

The total admissions in the TB ward reduced by 20.1%. In the next year, we anticipate a rise in the number of cases given the intense case identification strategy put in place. ALOS and BOR reduced by 1.48 days and 11.58% respectively. The death rate in the ward reduced by 0.26%. 98% of all the patients managed recovered. TB treatment outcome is often complicated by the presence of comorbidities such as HIV coinfection and malnutrition, as well as the patients' ability to adhere to medication schedules.

Table 6.35: Key indicators in TB Ward in the last 5 FYs

	FY	FY	FY	FY	FY
	2016-17	**2017-18**	**2018-19**	**2019-20**	**2020-21**
No. of beds	19	18	18	18	18
Total Admissions	219	252	194	329	267
Bed days	3,345	2,078	2,126	2,001	1,240
ALoS	8.2	8.2	5.8	6.08	4.6
BOR	48.2	31.6	32.40%	30.45%	18.87%

Throughput	11.5	14	10.8	18.3	14.8
Turnover interval	16.4	17.8	22.9	13.9	20.0
Deaths	10	2	11	7	5
Death Rate	4.56%	0.79%	5.67%	2.13%	1.87%
Recovery Rate	95.40%	99.20%	94.33%	97.87%	98.13%
Self-discharges	0	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.

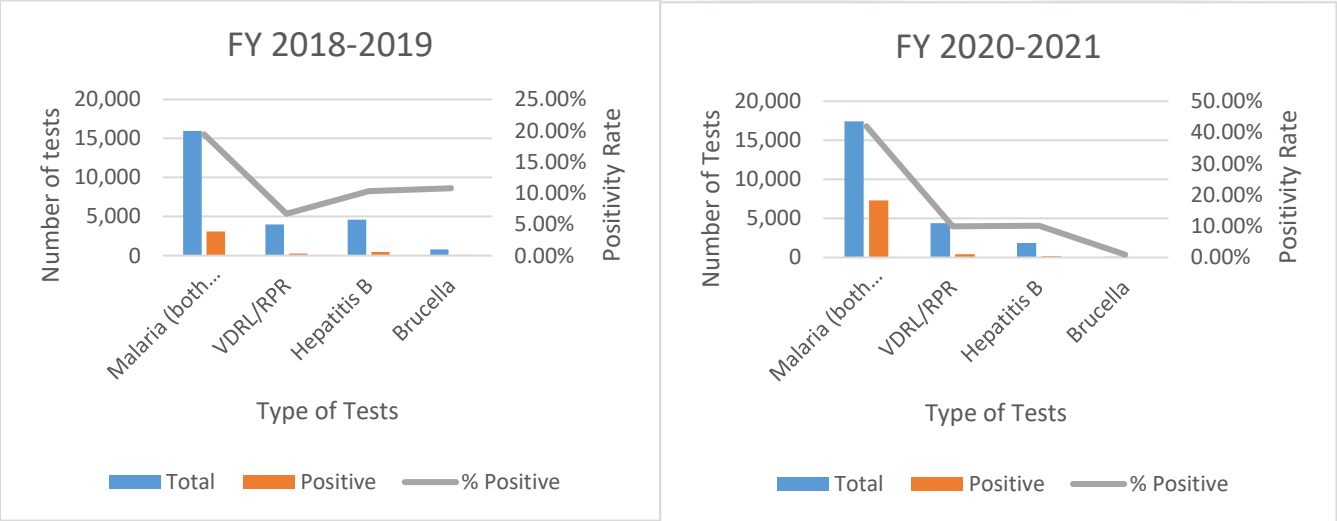
Table 6.36: Trend of laboratory testing workload in the last 5 FYs

	Type of Tests	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
Parasitology	Malaria Microscopy, Malaria RDTs, Other Haemoparasites, Stool Microscopy.	36,283	23,320	23,793	28,676	17,513
Haematology	HB, WBC Total, WBC Differential, Film Comment, ESR, RBC, Bleeding time, Prothrombine time, clotting time, blood transfusion tests, & Others	166,984	111,917	23,156	28,456	20,989
Biochemistry	Urea, Calcium, Potassium, Sodium, Creatinine, ALT, AST, Albumin, Total protein, Triglycerides, Cholesterol, CK,LDH, AlkalinePhos, Amylase, Glucose, Uric Acid, Lactate, Others	30,335	13,518	2,069	2,504	1,243
Bacteriology	ZN for AFBs, Cultures and Sensitivities, Gram, Indian Ink, Wet Preps, Urine Microscopy	8,291	7,262	6,633	15,327	15,619

Serology	VDRL lRPR, TPHA, Shigella Dysentery, Syphilis Screening, Hepatitis B, Brucella, Pregnancy Test, Vidal Test, Rheumatoid Factor	21,260	13,270	12,845	9,989	7,174
Immunology	CD4 tests & others	5,123	5,080	2,722	4,847	3,554
HIV tests by purpose	HCT, PMTCT, Quality control and clinical diagnosis	26,913	28,211	22,762	20,691	14,414
	Total tests	295,189	202,578	92,141	110,490	80,506
	Total lab staffs	11	11	10	10	10
	Average tests per Lab staff	26,835	18,416	9214.1	11049	8,051

The total number of tests conducted per staff in the laboratory reduced, in line with the reduced total number of patients in the hospital during the year.

Figure 6.11: Percentage of positive findings per selected examinations in the two last FYs



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 continued 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 20/21, the demand for RH- also increased, providing a real challenge since it is not easy to

find RH- donors. With the rise in malaria cases and associated anaemia in children, the demand for specific blood products like packed cells also continue to increase in the hospital; but this remains a difficult challenge to solve due to the lack of specific blood products from the regional bank.

Table 6.37: Proportion distribution of blood groups and Rhesus Factor D

FY						FY					
2019-2020						**2020-2021**					
Group A	Group B	Group AB	Group 0	RH +	RH -	Group A	Group B	Group AB	Group 0	RH +	RH -
31.13%	20.26%	5.12%	41.54%	98.06%	1.94%	33.80%	16.80%	4.00%	44.60%	99.20%	0.80%

IMAGING SERVICES

X ray and Ultrasonography

The department functioned with only two dark room attendants and a radiographer who left shortly into the year. 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 20/21 reduced by 6%. Chest X ray remains the most performed followed by upper extremities. This has been the same pattern for the last 5 FYs. The hospital is currently using a digital X ray machine, with images digitally transmitted to the clinicians for a quick review. The challenge has been providing a printed copy to the patients since the digital cassettes are very expensive. We plan to start printing digital images on DVDs and give to the patients for custody in order to cut this operational cost.

Table 6.38: X-Ray examinations done in the last 5 FYs

	FY 2016-17	**FY** 2017-18	**FY** 2018-19	**FY** 2019-20	**FY** 2020-21
Chest	2,062	572	1,459	2,009	1,849
Upper extremities	848	458	997	877	1,013
Lower extremities	800	278	710	735	821
Vertebral column	338	83	283	335	291
Skull and mandible	332	53	158	150	137
Shoulder and clavicle	135	69	139	178	0
Pelvis and hip	196	60	153	176	81
Abdominal – plain	130	51	155	203	198

Abdominal -contrast	0	0	2	0	0
Screening	0	0	0	5	0
Total	**4,841**	**1,624**	**4,056**	**4,668**	**4,390**

Abdominal U/S was not performed by a radiographer and therefore not recorded. Most U/S were performed by the medical officers on the bedside to aid real time diagnosis. In the next year, the management undertakes to recruit and try as much to retain this cadres in the hospital.

Table 6.39: Ultrasound examinations conducted in the last 2 FYs

	FY	FY
	2019-20	**2020-21**
Obstetrics	99	0
Gynaecology	50	0
Abdomen	239	0
Others	24	0
Total	**412**	**0**

PHARMACY ACTIVITIES

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 6.40: 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	3
Nursing Aide	Trained on the Job	1
Store Assistant	Diploma in Store Management	1
Store Attendant	Trained on the Job	2
Total		**9**

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 6.41: Average temperature and humidity recorded in Pharmacy Department FY2020-21

Reading Time	Temperature	Humidity
8:15 am	22.3	56%
12.00 pm	26.8	48%
5.00 pm	27.2	43%

Pharmaceutical supplies

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

Procurement system

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

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

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

Inventory management

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

Distribution and use

The Pharmacy issues drugs to the different wards and departments according to a Unit dose. The quantities of drugs issued has continued to improve in the unit dose system. Drugs are issued following prescription. This has reduced on wastage of drugs.

Table 6.42: Most used drugs (excluded HIV/AIDS clinic) - FY 2019-2020 and FY 2020-2021

Drug description	FY		FY	
	2019-2020		2020-2021	
	Quantity issued tablets/vial	Monetary value (UGX)	Quantity issued tablets/vial	Monetary value (UGX)
Amoxicillin 250mg	210,325	12,718,414.57	112,699	7,822,437.59
Ampicillin 500mg	29,961	14,914,034.34	17,175	7,203,305.00
Ampicillin/cloxacillin 500mg	16,741	2,679,940.34	31,693	5,324,316.24
Benzylpenicillin 1MU	34,362	9,948,571.55	15,502	4,730,435.30
Paracetamol 500mg	343,299	6,720,644.03	208,846	4,423,093.38
Erythromycin 250mg	91,845	9,801,720.71	36,031	3,983,536.28
Metronidazole 5mg/ml 100ml	8,417	8,231,909.88	3,717	3,915,354.76
Cloxacillin 250mg	83,121	5,898,909.32	51,141	3,878,725.31
Ciprofloxacin 500mg	46,061	4,352,460.22	29,418	3,239,331.24
Metronidazole 200mg	196,579	4,368,595.09	130,742	3,079,222.20
Ibuprofen 200mg	61,221	2,120,347.26	57,830	2,129,164.83
Penicillin V 250mg	72,720	4,630,921.83	28,074	1,996,078.56
Carbamazepine 200mg	92,644	5,762,377.83	26,618	1,788,244.07
Omeprazole 20mg	38,781	1,399,964.46	41,306	1,679,501.96
Folic acid 5mg	142,574	2,166,496.99	102,798	1,494,257.09
Ferrous sulphate 200mg	63,839	1,862,822.02	55,735	1,308,657.80

Folic acid + Ferrous Sulphate	121,644	5,349,318.13	28,023	1,271,716.29
Prednisolone 5mg	67,650	1,741,137.53	41,456	1,134,703.00
Frusemide 40mg	44,081	810,887.23	45,720	947,121.96
Vitamin B complex	80,352	827,365.73	48,743	548,358.75
Total		**102,443,524.27**		**61,897,561.61**

Intravenous fluid consumption

The consumption of intravenous fluid reduced by 29.4%. Just like with drugs, IV fluids have also been very closely regulated to control wastage.

Table 6.43: Consumption of IV fluids in FY 2018-2019 & FY 2020-2021

Fluid Description	Quantity (in bottles) 2019-2020	Value(UGX) for 2019-2020	Quantity (in bottles) 2020-21	Value(UGX) for 2020-21
Sodium Chloride 0.9% IV 500 ml	15,887	20,293,259.16	10,341	15,071,516.88
Dextrose 5% IV 500 ml	11,588	15,259,400.90	8,228	11,744,441.07
Sodium Lactate Compound IV 500 ml	6,573	8,443,990.78	5,885	8,483,612.78
Dextrose 50% IV 100 ml	1,570	4,073,390.36	11,006	2,953,829.39
Water for Injection 10 ml	60,203	5,893,384.37	27,689	2,912,812.22
Darrow's Half Strength 500 ml	263	398,442.30	394	730,168.68
Gelatine/polygeline Solution 3.5% IV 500 ml	173	5,022,893.78	17	465,904.38
Dextrose 5% IV 250 ml	432	582,768.00	0	0.00
Total		**59,967,529.65**		**42,362,285.40**

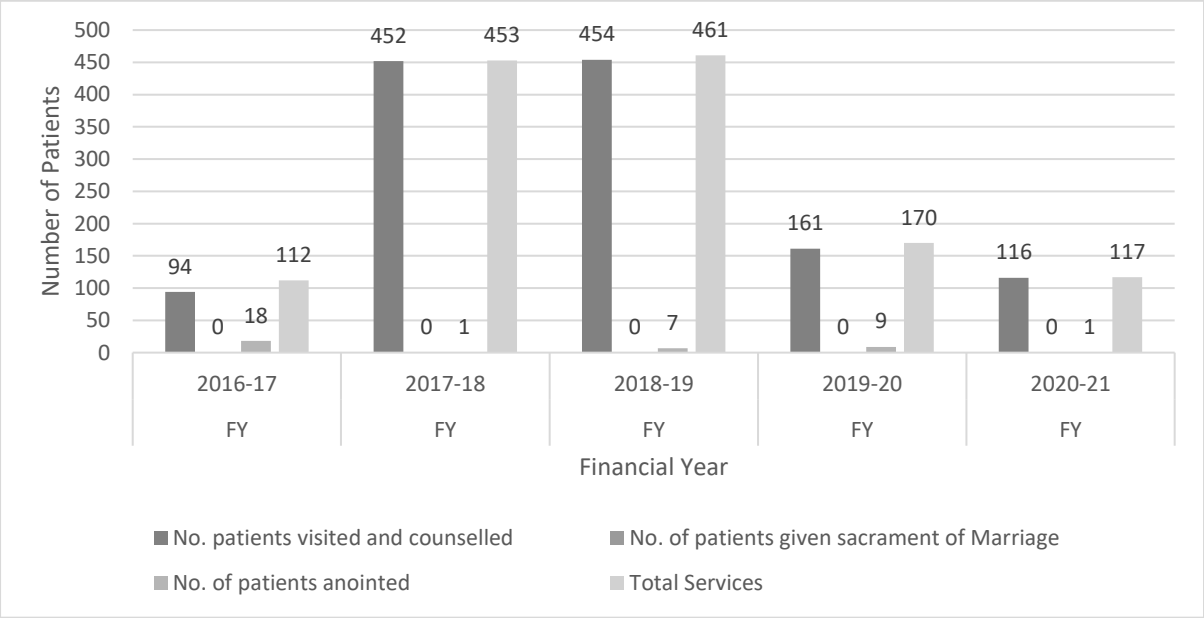
CHAPTER SEVEN

SUPPORT SERVICES

Pastoral care

Pastoral care forms an essential aspect of the holistic care package provided to patients. Shortly before the COVID 19 pandemic, the services had been extended to staff (as recollection) to provide emotional as well as spiritual support. These services are offered under the Kalongo Catholic Denary by volunteers. The team comprises of a social worker, a catechist and a Priest. During the year, 171 patients accessed pastoral care services, a reduction of 31%. Patients and/or their care givers are encouraged to freely request through their respective wards for the services.

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



Ambulance services

Ambulance services were offered to patients across the district and beyond. 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 existing ambulances are very old and prone to break downs. The hospital is therefore in need of a new fully fledged ambulance; and continues to lobby for any support in that direction.

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. In the next year, there is a plan to revamp the revenue generation functions of the department.

Monitoring and regulating fuel usage in the hospital, is a duty charged to the TD under the supervision of the Administrator. In 20/21, fuel usage increased by 4.3%. Diesel consumption increased by 4.9%, while petrol consumption reduced by 6.3%. The increased diesel use was due to the very frequent power black outs experienced on the national grid. Most times, the hospital relies on the generator to meet demands. Motor vehicle fuel consumption reduced. Most field activities have been geographically aligned to reduce on vehicle field movements. Some activities are assigned motorcycles to cut down on the more expensive cost.

Table 7.1: Consumption of fuel by destination in the last 5 FYs

	FY	FY	FY	FY	FY
	2016-17	2017-18	2018-19	2019-20	2020-21
DIESEL TOTAL	**39,111**	**45,142**	**87,648.6**	**55,835**	**58,598**
Board of Governors Fuel Refund to members	428	315	350	180	265
Generators	14,222	17,391	38,182.8	29,946	39,133
Vehicles	22,546	26,341	42,599.7	19,133	18,462
Workshop	20	10	25	24	20
Incinerator	1,018	1,065	2004	655	618
Others	877	20	4,487.10	5,897	100
PETROL TOTAL	**2,905**	**3,054**	**6,917**	**3,179.5**	**2,978.0**
Administration	5	494	315	57	25
Donation	85	0	0	70	0
Generators	78	0	29	0	0
Vehicles	75	0	12.5	0	0
Motorcycles	2,284	2,335	6,509.5	2,969.5	2,885.0
Workshop	25	116	32	20	68
Others (Sales)	354	111	19	63	0
KEROSENE TOTAL	**75**	**36**	**0**	**0**	**0**
Workshop	75	25	0	0	0
Pharmacy	0	0	0	0	0
Main store	0	0	0	0	0
Others	15	11	0	0	0

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 meters from the hospital. The water is pumped to two main tanks with a total capacity of 90,000 liters. All the buildings are provided with reserve tanks of different capacities.

Due to the very heavy workload to meet this enormous demand, the 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. There is a growing need for the neighboring institutions to supplement their water needs from the national water supply line, to relieve the extreme burden on the hospital.

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. In 20/21, the national line supply was very unstable pushing the hospital to consume much more diesel than actually projected.
Having functional photovoltaic systems would significantly reduce this cost. The hospital has attempted (and continues to do so) to lobby for projects that would realize such energy efficient solar systems.

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.

The sewage system has remained functional since its' rehabilitation in 2014. Routine maintenance is the major challenge, in the face of constant vandalism from some members of the community. There is a strong need to refurbish the fence surrounding the sewage lagoon system to protect it from encroachment.

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. The infection prevention and control team have embarked on training to build local capacity on proper waste segregation. They are also planning to start work on how to recycle some of the domestic wastes generated.

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. The key parameters used to examine quality outputs are summarized below.

Availability of qualified clinical staffs

The proportion of qualified clinical staff improved in the hospital. The biggest challenge has been retaining these cadres, since the hospital does not offer very competitive salary packages.

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

Indicators	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
Total No. of employees	251	253	251	252	232
Qualified staff[1]	177	174	196	183	184
Clinical qualified staff[2]	116	131	138	138	153
Total Clinical staff[3]	150	148	153	155	127
Proportion of clinical qualified staff over all qualified staff	65.50%	75.30%	70.41%	75.41%	83.15%
Proportion of clinical qualified staff over all clinical staff	77.30%	88.50%	90.20%	89.03%	120.47%
Proportion of clinical qualified staff over the total hospital staff	46.20%	51.80%	54.98%	54.76%	65.95%

Quality of care

Overall, the recovery rate on discharge reduced by 4.81%. The maternal death rate increased. Late referrals and hypertensive crisis in pregnancy played key roles in the cause of maternal deaths. Key interventions have been drafted and now being implemented to curb this. Early neonatal death rate increased. The rate of premature delivery remains high in the entire district, in the face high teen age pregnancy. During the FY, the NICU received even more referrals of premature new-borns from the LLUs. The timing of referrals and interventions are key factors in saving the new born.

Table 8.2: Indicators for the quality and safety measures

Indicators	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	Explanation
Recovery rate on discharge	98.80%	97.01%	97.09%	99.64%	94.83%	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	0.17%	0.02%	0.15%	0.02%	0.26%	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%	0.51%	0.58%	0.85%	1.21%	Fresh still birth rate: Fresh Still births have intact, smooth and not macerated skin,
Caesarean sections infection rate	ND	5.58%	0.82%	1.27%	2.78%	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	0.78%	0.39%	1.22%	2.18%	2.21%	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

In an annual survey conducted involving randomly selected patients (sample size 100) from the hospital; using standardized tools designed by the UCMB (and adopted by MOH), the patients' impression towards the clinical outcome experienced and the humanity of care improved during the year. We continue to engage our staff towards a client-oriented model of care amidst the numerous difficulties.

The main challenge was the overwhelmingly increased patient waiting time reported by the patients. Our quality improvement team have done a root cause analysis and set standards to address the causes; notwithstanding causes that can't be easily negated like, turnaround time for tests requested by clinicians. The overall patient perception towards quality of care in the hospital improved in 20/21.

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

Financial Year	FY	FY	FY	FY	FY
	2016-17	**2017-18**	**2018-19**	**2019-20**	**2020-21**
Clinical outcomes	93%	88.30%	64%	90%	94%
Humanity of care	98%	98.90%	92%	88%	91%
Organization of the care / waiting time (OPD)	85%	46.10%	46%	71%	58%
The healthcare environment	98%	98.90%	98%	88%	80%
Overall score	79.70%	81.10%	86%	81%	83%

FAITHFULNESS TO THE MISSION

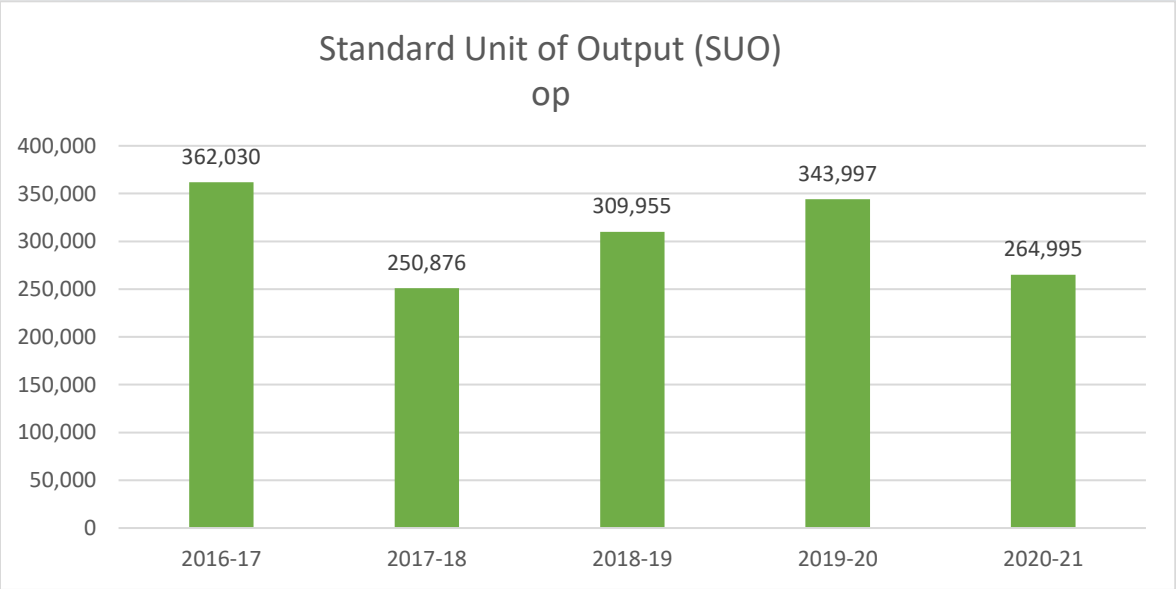
Access

The SUOop reduced by 23%. Factors like; the reduced malaria burden and lockdown measures to fight the pandemic could have contributed to this. Overall, the hospital has still been accessible.

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 Surgery

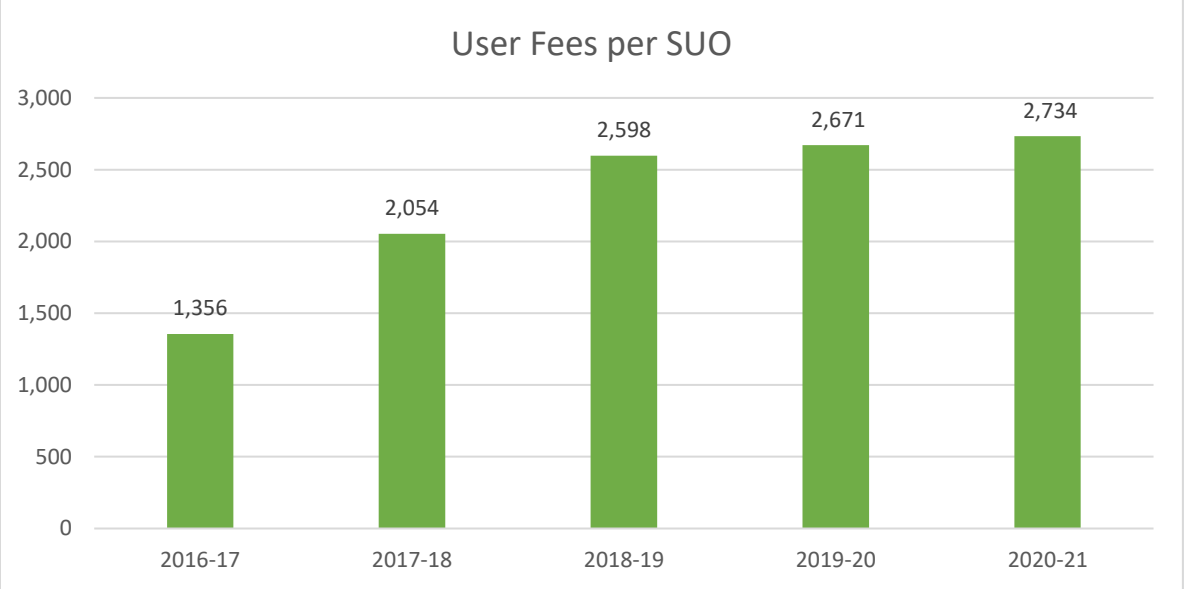
Figure 8.1: Trend of SUOop (do more people come?)



Equity

The average user fees per SUO increased by 2.4%. The hospitals' user fees are still one of the lowest in the UCMB network. The efficiency of revenue collection improved, but this does not counter the increased operational costs. The net outcome is an increased average user fee per SUO.

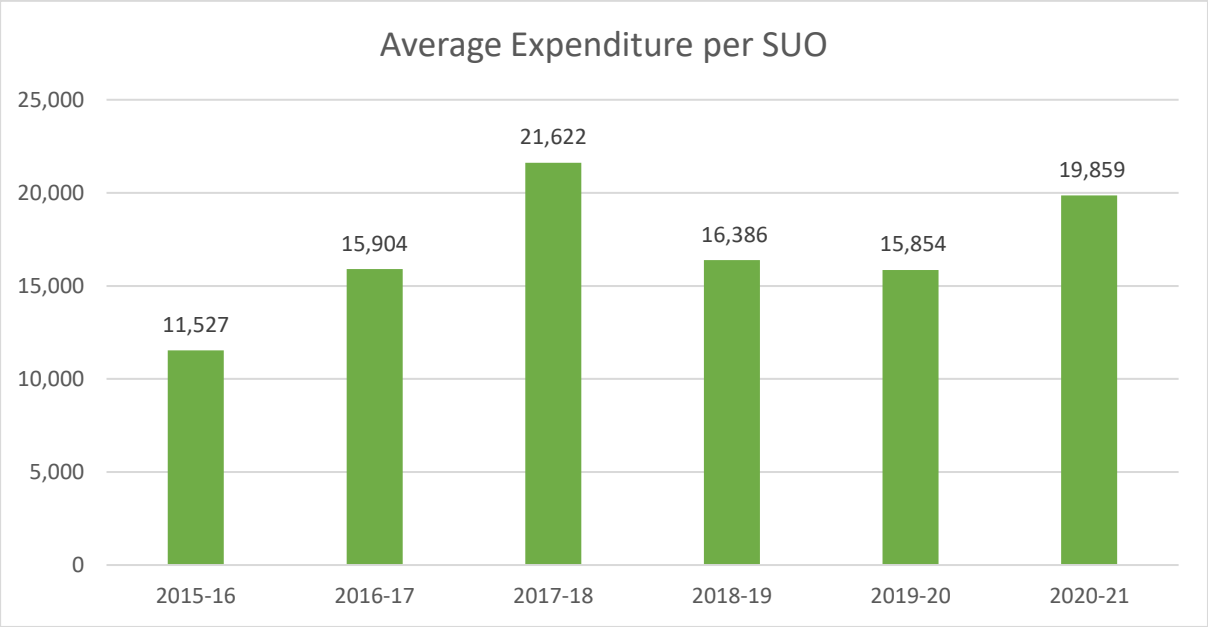
Figure 8.2: Trend of Average Fees per SUO (do people, on average, pay more or less?)



Efficiency

The hospital's economic efficiency reduced by 25.3%. We used more to produce one SUO compared to the previous year. Wastage is still a challenge we continue to fight; but overall market trends have also gone high for all medical and non-medical consumables. Efficiency reduced in 20/21.

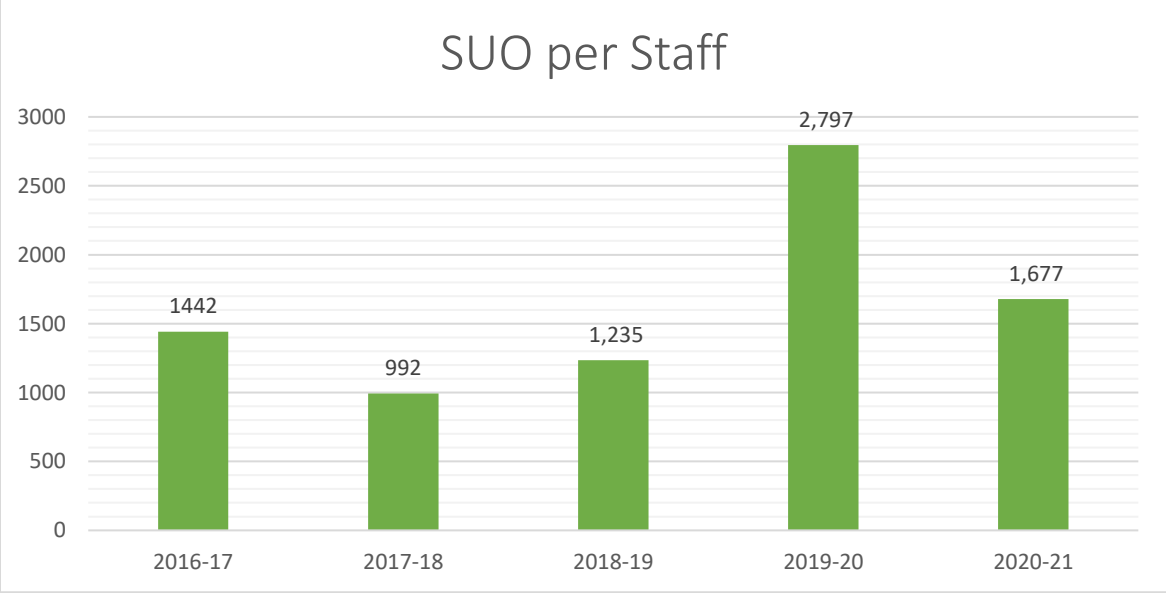
Figure 8.3: Trend of Average Expenditure per SUO (do we spend more or less to produce our services?)



Productivity

Given the same resources, our staff produced 40% less than did in the previous year. Even with the pandemic, and reduced utilization of services, the number of staff remained the same (we did not downsize). We shall continue to engage our staff realistically in order 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, however by June 30th 2021, the total number was 15% less; the COVID 19 situation could not allow enrollment of more students. Since its beginning, the school has qualified so far,

- 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 staff remains a major challenge of the training school. Given the remote location of the school, staff attrition is a key concern. The school continues to engage hospital staff on a part time basis to support in teaching subjects in their professional line.

Table 9.1: School staff and support staff establishment FY 2020-2021

No	Cadre	Established target	Actual	Shortage	Surplus
1	Tutors	6	4	2	
2	Untrained clinical instructors	3	3	0	**3**
3	Trained clinical mentor	10 in the hospital	1	7	
4	Accountant	1	1	0	
5	Account Assistant	1	1	0	
6	Cashier	1	1	0	
7	Record Assistant	1	1	0	
8	Store Assistant	1	1	0	
9	Office Attendant	1	1	0	
10	Cooks	6	6	0	
11	Driver	1	1	0	
12	Watchmen	2	2	0	
	Total	24	23	9	3

Staff development

In line with the strategic plan of the school, staff development is given priority.
Unfortunately, school closure disrupted completion of training for the staff at school. All workshops and seminars were attended by staff virtually due to restrictions of COVID 19.

Table 9.2: Workshops and courses attended by the teaching staff

S/N	Workshop	Organized by	Number of staff	Duration
1	Covid 19 Management	MOH	4	5 days
2	Prevention of Covid 19 in schools	MOES	1	2 days
3	Performance management & Appraisal	UCMB	3	2 days

School Performance

The enrollment of students in the school was driven by the actual capacity of the school; this was however affected by the COVID 19 restrictions.

The passing rate for both the certificate and diploma students have been maintained at 100%.

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 2020-21

Course	Students Enrolled in the year	Students in 1st year	Students in 2nd year	Students in 3rd year	Number of students currently	Students who sat for final exams	Students who pass final exams	Success rate
C/M	208	112	52	44	**208**	94	94	100%
D/M	28	15	13	0	**28**	13	13	100%
Total	**236**	**127**	**65**	**44**	**236**	**107**	**107**	

School Finances

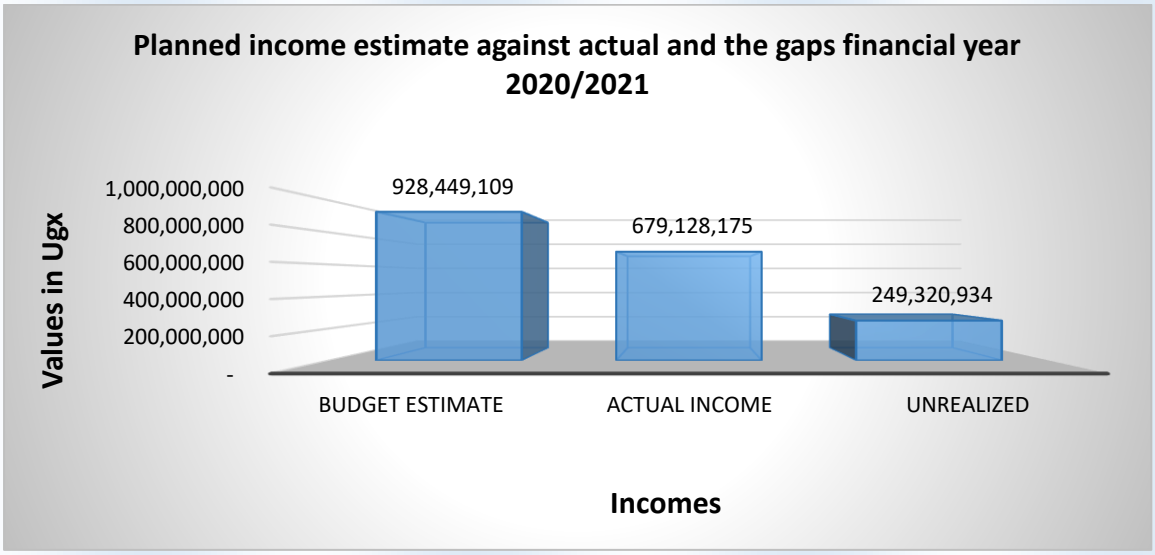
St. Mary's Midwifery training school is a semi-autonomous institution affiliated to Dr. Ambrosoli Memorial Hospital; her mother hospital.
All the school's accounts are being controlled by the principal of the school and she is one of the signatories to the bank accounts. She is the overall controller 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.

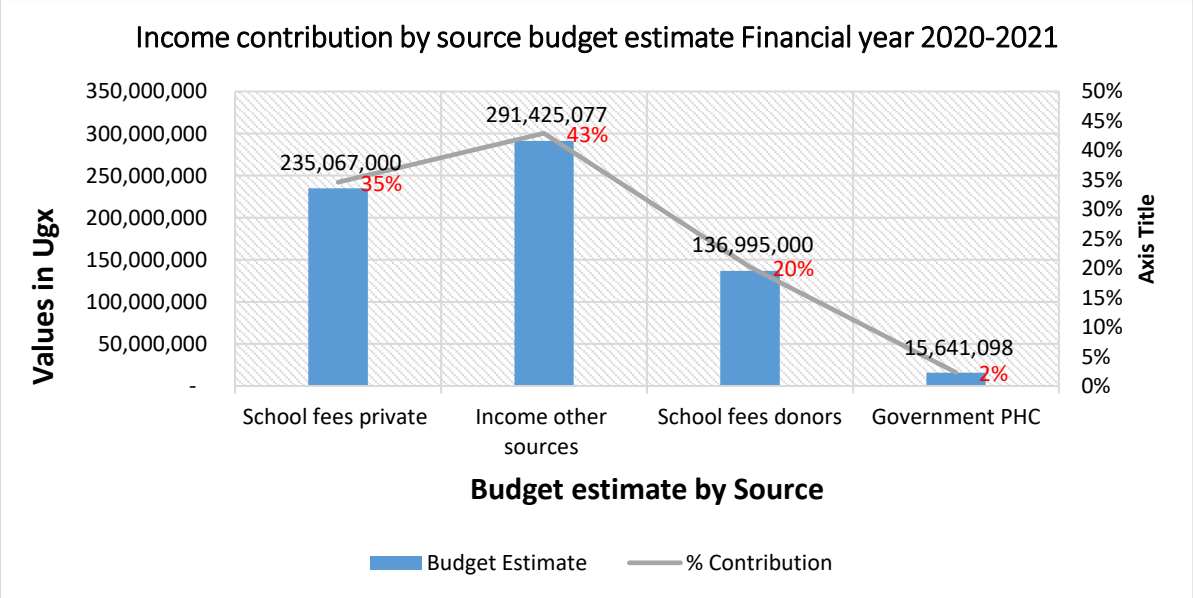
Income

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. COVID 19 completely hampered school fees collection from the private students.
Support for school fees came from UNFPA, Copeland Foundation, Straight talk foundation, Gretta foundation, Dr. Ambrosoli Foundation and Fondazione Ceresio.

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.

Figure: Planned, actual and unrealized income in the FY 20/21





Expenditure

The expenditure in the school was limited by the school closure due to COVID 19. Many activities could not be carried out. When situation normalize, the expenditure could suppass what is presented herein.

Table 9.5: Planned, actual expenditure and unspent balance in the FY 2020-2021

CATEGORY	BUDGET 2020-2021	ACTUAL 2020-2021	DIFFERENCE
EMPLOYMENT COST	342,695,700	253,995,169	88,700,531
ADMINISTRATION COST	103,251,400	28,658,219	74,593,181
PROPERTY COST	13,020,000	5,110,350	7,909,650
TEACHING GOODS AND SERVICES	235,484,000	108,995,798	126,488,202
PROFESSIONAL CONSULTANCY SERVICES	45,000,000	21,129,400	23,870,600
INSURANCE AND LICENCE	1,000,000	-	1,000,000
TRAVEL AND TRANSPORT	29,200,000	18,872,400	10,327,600
SUPPLIES AND SERVICES	65,789,000	24,418,951	41,370,049
CAPITAL DEVELOPMENTR, BUILDING MAINTENANCE	58,976,169	9,720,500	49,255,669
STAFF DEVT COSTS	34,032,840	6,173,299	27,859,541
TOTAL	**928,449,109**	**477,074,086**	**451,375,023**

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, UCMB, UNFPA, MOEs 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

$$\frac{\text{The Total number of students at present}}{\text{Total Capacity of the School}} = \frac{127}{150} \times 100\% = \mathbf{84.7\%}$$

Given the fact that the school was closed for most of 20/21 and only partially reopened, the school has been accessible.

Quality

$$\frac{\text{Total number of students who passed}}{\text{Total Number of Students who sat}} = \frac{107}{107} \times 100\% = \mathbf{100\%}$$

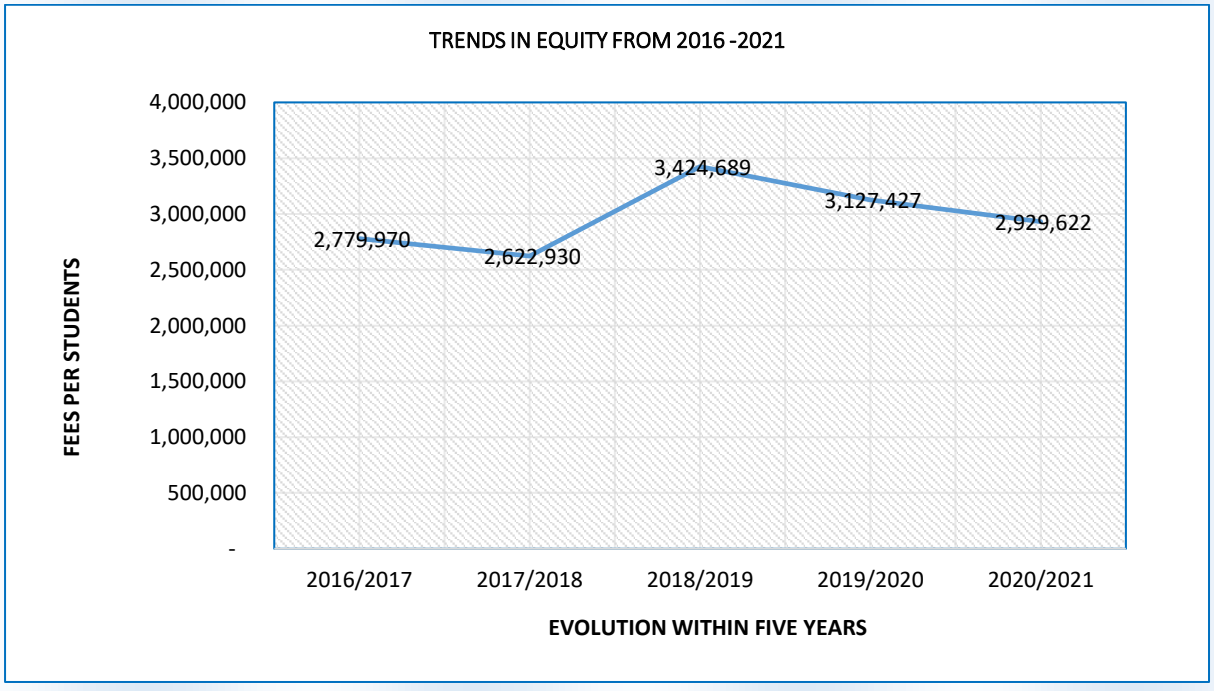
The quality of passing has been maintained at 100%, just like the case of the previous year.

Equity

Total fees Collected 372,062,000/= 2,929,622/=

Total number of students 127

Average school fees paid per student reduced. Our school fees remain one of the lowest of all the HTIs in the UCMB network. Equity increased in 20/21.

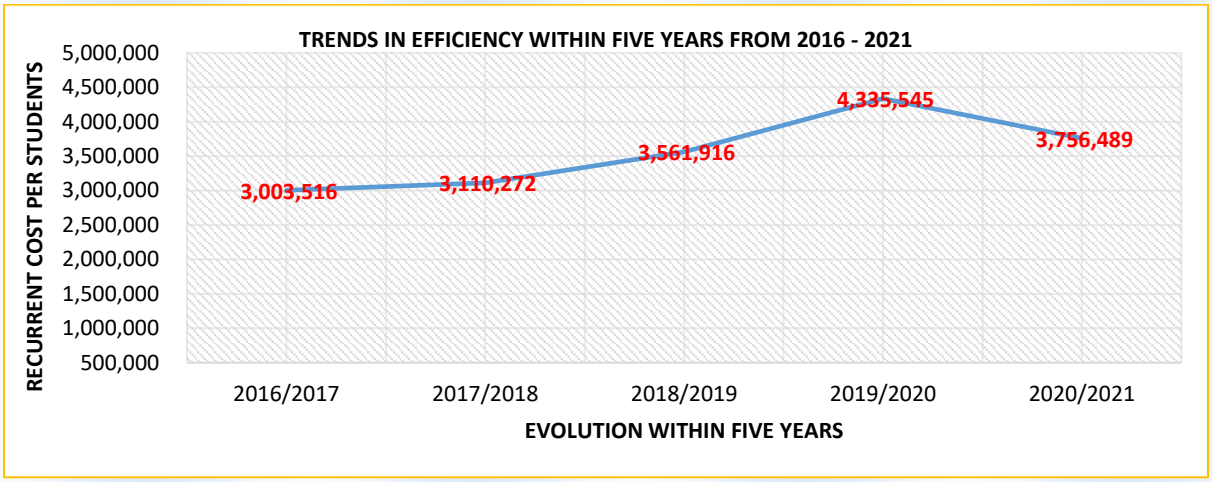


Efficiency

Total Recurrent Costs 477,074,085 /= **3,756,489/=**

Total number of students 127

Compared to last year, efficiency improved. But this was largely due to the fact that schools were closed and costs were controlled. Operational costs have been constantly rising over the past 5 years.



CHAPTER TEN

CONCLUSIONS

Just like the previous year, 20/21 was dominated by a number of 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. The local revenue generated is only a drop in the ocean and not nearly sufficient to meet operational needs.

East Acholi do not currently have access to MCH voucher services (to vulnerable pregnant women and under-fives), unlike our West Acholi counter parts (supported by the Belgian Enable group). This coupled with the already existing crippled referral network only makes worse the circumstances to save lives. The ongoing World Bank funded MOH Results Based Financing activity is set to stop at the end of the year. The project attempted to bridge the gaps in referrals and improve access to services for pregnant women in emergency conditions. We therefore continue to appeal to the GOU to again allow extension of such projects (MCH biased projects) to East Acholi to bridge this much needed service gaps.

We extend our utmost appreciation to our major donors of the FY (The Ambrosoli Foundation, The Comboni Missionaries, and UPMB – LSDA); 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 review which accounted for approximately 15% of the total revenue.

The hospital continued to be faithful to its mission and was accredited by the UCMB. It has been accessible amidst the numerous challenges cited. We look to galvanize the strong points and improve on the weak areas.

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 remain a priority in the next FYs.
- The perimeter fence around the institution also needs a complete overhaul. During the FY, we had multiple security threats due to the many porous points in the fence.

ANNEXES

Annex 1. Members of Board of Governors and designation as per 30th June 2021

	Name	Designation	Title
1	H.G. Dr. John Baptist Odama	Chairperson	Archbishop of Gulu
2	Sr. Liberata Amito	Member	Diocesan Health Coordinator Gulu
3	Msgr. Matthew Odong	Member	Vicar General Gulu
4	Ms. Giovanna Ambrosoli	Member	Representative Ambrosoli Foundation
5	Fr. Achilles Kiwanuka Kasozi	Member	Provincial Superior Comboni Missionaries
6	Fr. Guido Miotti	Member	Parish Priest Kalongo
7	Mr. Louis Odongo	Member	Lawyer - P.O. Box 800, Gulu
9	Mr. Anywar John Kennedy	Member	Representative of the local community
10	Ms. Rose Ogaba	Member	Representative of the Local Community
11	Dr. Emmanuel Otto	Member	DHO Agago District
12	Sr. Susan Deezo Clare	Member	Superior General LSMIG
13	Dr. Okot Godfrey Smart	Secretary	Chief Executive Officer
14	Dr. Pamela Atim	Member	Med. Sup. St Joseph's Hospital – Kitgum
15	Dr. Nicholas Gregory Okello	Member	Senior Lecturer, Gulu University

Annex 2. Members of the Management Team and designation as per 30th June 2021

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

Annex 3. Our vision and mission statement.

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

Mission statement

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