

# **DR. AMBROSOLI MEMORIAL HOSPITAL KALONGO ANNUAL ANALYTICAL REPORT**



## **FY 2021-2022**

## Table of Content

Endorsement of Report.....	VI
LIST OF ABBREVIATIONS/ACRONYMS.....	VII
ACKNOWLEDGEMENTS.....	IX
Important Indicators and Definitions.....	X
EXECUTIVE SUMMARY .....	XII
CHAPTER ONE:.....	2
INTRODUCTION .....	2
Background.....	2
The hospital and its' environment .....	2
Demographic data for the hospital catchment area .....	3
CHAPTER TWO:.....	6
HEALTH POLICY AND DISTRICT HEALTH SERVICES .....	6
Health Policy .....	6
District Health Services .....	6
Funding .....	9
Health Infrastructure.....	9
Prevention and Health promotion services .....	9
The HC II function of the hospital.....	10
CHAPTER THREE: .....	12
GOVERNANCE.....	12
The Board of Governors .....	12
Hospital Management.....	13
Statutory commitments compliance .....	13
Internal Regulatory Documents.....	14
Advocacy, lobby and negotiation .....	14
CHAPTER FOUR: .....	16
HUMAN RESOURCES .....	16
Staff Establishment.....	16
Human resources development and career progression .....	17
CHAPTER FIVE: .....	19
FINANCES.....	19
Income .....	19
Expenditure.....	2
CHAPTER SIX: .....	6
SERVICES .....	6
OUT PATIENTS' DEPARTMENT .....	7
ANTENATAL CLINIC.....	9
HIV/AIDS Clinic.....	10
Tuberculosis (TB) treatment.....	15
Orthopaedic Services.....	17
Mental health clinic .....	18
Dental Clinic.....	18
Palliative Care.....	19
INPATIENTS DEPARTMENT .....	19
MEDICAL WARD.....	24
Surgical Ward .....	25
Surgical operation theater.....	28
PEDIATRIC WARD .....	30
Maternity Ward.....	33
TB ward.....	37
Diagnostic services .....	38

IMAGING SERVICES.....	40
X ray and Ultrasonography .....	40
PHARMACY ACTIVITIES.....	41
CHAPTER SEVEN: .....	45
SUPPORT SERVICES .....	45
Pastoral care.....	45
Ambulance services.....	45
Technical services.....	45
DOMESTIC SERVICES .....	46
CHAPTER EIGHT: .....	48
QUALITY OF CARE AND PATIENTS' SAFETY.....	48
QUALITY OF CARE AND PATIENTS' SAFETY .....	48
FAITHFULNESS TO THE MISSION.....	50
CHAPTER NINE: .....	53
ST. MARY'S MIDWIFERY TRAINING SCHOOL .....	53
Human resources management and development .....	53
Staff development.....	53
School Performance.....	54
School Finances .....	54
Income .....	54
Expenditure.....	55
Relation with external partners.....	56
Faithfulness to the Mission.....	56
CHAPTER TEN: .....	58
CONCLUSIONS .....	58
Pending Issues .....	58

## List of Tables and Figures

Table 1.1: Demographic Data of the Hospital, HSD and Agago districtFY2021-2022.....	3
Table 1.2: Top ten causes of morbidity in the HSD OPDs.....	4
Table 1.3: Relative percentage of the top 10 causes of mortality during the last2FYs in the HSD .....	4
Table 2.2: Population, health units and staffing in Agago DistrictFY2021-2022 by Sub- County .....	7
Table2.3: Structure of the District Health Office team .....	8
Table 2.4: Structure of the Health Sub District team at the referral facility.....	9
Table 2.5: Hospital contribution to prevention &health promotion services of the HSD/District .....	10
Table 3.1: Summary of BoG meetings held in the FY2021-2022.....	12
Table 3.2: Table showing functionality of the Board Committees.....	12
Table 3.3: Frequency of HMT meetings FY 2021-2022 .....	13
Table 3.4: Statutory commitments compliance .....	14
Table 4.1: Total number of employees in the hospital in the last 5 FYs .....	16
Table 4.2: Turn-over trends of enrolled cadres <sup>2</sup> in the last3 FYs.....	16
Table 4.3a:Turn-over trends of Clinical Staff in the last3 FYs .....	17
Table 4.3b:Turn-over trends of General Staff .....	17
Table 4.4: Hospital Staff who attended courses in FY2021-2022.....	18
Table 5.1: Trend of Income by source over the last 5 years.....	19
Table 5.2: Trend of Expenditure over the last 5 FYs .....	3
Table 5.3: Trend of average user fees by department in the last5 FYs .....	4
Table 5.4: Trend of Cost Recovery from Fees in the last 5 FYs .....	4
Table 5.5: Trend of indicators of efficiency in utilization of financial resources .....	4
Table 5.6: Sustainability ratio trend without donors and PHCCG funding, in the last 5 FYs.....	5
Table 5.7: Sustainability ratio trend in absence of donor funding but with PHC CG- last 5 FYs	5
Table 6.1: The staff composition in OPD in the FY 2020-21 andFY2021-22 .....	7
Table 6.2: Trend in OPD attendance by gender & age in the last 5 FYs .....	8
Table 6.3: Top ten diagnoses in OPD in the last 2 FYs.....	9
Table 6.4:Antenatal and Postnatal indicators during the last 4 FY .....	9
Table 6.5: Trend of HCT/VCT results in the last 5 FYs .....	11
Table 6.6: HIV test by purpose during FY 2021– 2022 .....	12
Table6.7:Performance Indicators of the PMTCT Programme inFY2021-2022.....	12
Table 6.8: PLHAs eligible for ART and started on ART by age group and gender - last 5 FYs	13
Table 6.9: Number ofPLHAs startedonARVbyagegroupand gender inFY 2021-2022 .....	13
Table 6.10:TB patients registered for treatment in the last 5 FYs.....	15
Table 6.11: MDR/MTB diagnosis during the FY2021-22 .....	16
Table 6.12:Results of TB treatment in the last 4 FYs .....	16
Table 6.13:Results of TB treatment smear positive Pulmonary TB patients in thelast4 FYs .....	17
Table 6.14: Main procedures in orthopaedics andphysiotherapydonein the last5 FYs .....	17
Table 6.15: Mental health cases reviewed in OPD in the last4 FYs .....	18
Table 6.16: Number of Patients who received Palliative Care in the FY2021-22 .....	19
Table 6.17: Summary ofbeds and qualified health personnel per ward .....	20
Table 6.18: Key indicators for the entire hospital in the last 5 FYs .....	20
Table 6.20:Pattern of referrals to and from the hospital in the last5 FYs.....	22
Table 6.21: Top ten causes of admission in all thewards in theFYs 2020-2021&2021-2022.....	22
Table 6.22:Trend in Malaria admissions over the last 5 FY .....	23
Table 6.23:Top ten causes of death among inpatients all wards FY2020-21 and FY2021-22....	23
Table 6.24: Staff Composition in Medical Ward FY2021-2022 .....	24
Table 6.25: Key indicators in Medical Ward in the last5 FYs .....	24
Table 6.26:Top 10 causes of admission in Medical Ward in the last two FYs .....	25



Table 6.27: Top 5 common causes of death in Medical ward in the last two FYs.....	25
Table 6.28: Staff composition in Surgical Ward in the FY2021-2022.....	26
Table 6.29: Key indicators in Surgical Ward in the last 5 FYs .....	27
Table 6.30: Top 10 causes of admissions in Surgical Ward - FYs 2020-2021 & 2021-2022.....	27
Table 6.31: Top 5 common causes of death in Surgical Ward in the current FY .....	28
Table 6.32: Staff Composition in the operating theatre FY 2021-2022 .....	28
Table 6.33: Top major surgical procedures performed in the FY 2021-22.....	29
Table 6.34: Top minor surgical procedures done in FY2021-22 .....	29
Table 6.35: Trend of surgical activities in last 5 FYs.....	29
Table 6.36: Pattern of anesthesia used during the last 5 FYs .....	29
Table 6.37: Personnel assigned to Paediatric Ward in FY2021-22.....	30
Table 6.38a: Paediatric Ward indicators over the last 5 FYs .....	31
Table 6.38b: Neonatal Intensive Care Unit only .....	32
Table 6.39a: Top ten causes of admission in Paediatric Ward-FY2020-21 and FY2021-22.....	32
Table 6.39b: Top ten causes of admission in NICU Ward - FY2020-21 and FY2021-22.....	32
Table 6.40a: Top five causes of death in Paediatric Ward in FY2021-22.....	33
Table 6.40b: Top five causes of death in NICU in FY 2021-22 .....	33
Table 6.41: Staff Composition in Maternity Ward in FY2021-22 .....	34
Table 6.42: Key indicators in Maternity Ward (Obs & Gyn) in the last 5 FYs .....	34
Table 6.43: Maternity Ward Deliveries & Births indicators in the last 5 FYs .....	35
Table 6.44a: Origin of mothers who delivered through C/S in the last 5 FYs <sup>3</sup> .....	36
Table 6.44b Continuation .....	36
Table 6.45: Admissions in Maternity Ward not related to maternity conditions .....	37
Table 6.46: Key indicators in TB Ward in the last 5 FYs .....	38
Table 6.47: Trend of laboratory testing workload in the last 5 FYs.....	38
Table 6.48: Percentage of positive findings per selected examinations in the two last FYs.....	39
Table 6.49: Proportion distribution of blood groups and Rhesus Factor D.....	40
Table 6.50: X-Ray examinations done in the last 5 FYs .....	40
Table 6.51: Ultrasound examinations conducted in the last 3 FYs .....	41
Table 6.52: Staff composition in Pharmacy and General Store in the FY2021-2022.....	41
Table 6.53: Average temperature and humidity recorded in Pharmacy Department FY2021-22 .....	42
Table 6.54: Most used drugs (excluded HIV/AIDS clinic)- FY 2020-2021 and FY2021-2022.....	43
Table 6.55: Consumption of IV fluids in FY2020-2021 & FY2021-2022.....	44
Table 7.1: Activities trend in clinical pastoral care of the sick during the last 5 FYs.....	45
Table 7.2: Consumption of fuel by destination in the last 5 FY.....	46
Table 8.1: Proportion of clinical qualified staff in the hospital in the last 5 FYs.....	48
Table 8.3: Satisfaction levels per core area for the last 5 FYs .....	50
Figure 8.1: Trend of SUOop (do more people come?).....	50
Figure 8.2: Trend of Average Fees per SUO (do people, on average, pay more or less?) .....	51
Figure 8.3: Trend of Average Expenditure per SUO (do we spend more or less to produce our services?) .....	51
Figure 8.4: Trend of Average SUO per staff (with the same resources, do our staff produce more or less?).....	52
Table 9.1: School staff and support staff establishment FY 2021-2022 .....	53
Table 9.2: Work shops and courses attended by the teaching staff.....	54
Table 9.3: Student Enrollment in years 1st-2nd-3rd and success rate in the FY 2021-22 .....	54
Table 9.4: Planned, actual and unrealized income in the FY2021-2022.....	55
Figure 9.1: Income contribution by source.....	55
Table 9.5: Planned, actual expenditure and unspent balance in the FY 2021-2022.....	55
Annex 1. Members of Board of Governors and designation as per 30th June 2022 .....	59
Annex 2. Members of the Management Team and designation as per 30th June 2022 .....	59

## Endorsement of Report

This Annual Analytical Report covering the period of Financial Year 2021-2022 has been prepared by the management of Dr. Ambrosoli Memorial Hospital. I endorse that it represents Management's views on the position of the hospital in the period under report.

Name: Dr. Okot Godfrey Smart

Signature \_\_\_\_\_

Chief Executive Officer

Dr. Ambrosoli Memorial Hospital

Date \_\_\_\_\_

This is to acknowledge that I have received this faithfulness to the mission report for Dr. Ambrosoli Memorial Hospital-Kalongo covering the period **July 1<sup>st</sup> 2021 to June 30<sup>th</sup> 2022.**

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

Name: His Grace John Baptist Odama

Signature \_\_\_\_\_

Chairperson of the Board of Governors

Date \_\_\_\_\_

## LIST OF ABBREVIATIONS/ACRONYMS

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

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



## ACKNOWLEDGEMENTS

The management of Dr. Ambrosoli Memorial Hospital thanks each and every member of staff for their tireless efforts on behalf of patients. We also wish to express our gratitude to everyone who, in a variety of capacities and ways, supported the hospital and contributed to its sustainability during the Financial Year 2021-2022. The government of Uganda, the Dr. Ambrosoli Foundation, the Comboni Missionaries, USAID – URC, UPMB LSDA, IDI, and the patients are notable examples.

We have an extraordinary obligation of thankfulness to UCMB for the constant and valuable technical support and guidance.

We also like to express our gratitude to H.G. Dr. John Baptist Odama and the entire Board of Governors for their leadership and supportive oversight of the hospital.

Last but not least, we want to express our sincere gratitude to all of the hospital staff and of the school, who have been the creators of every accomplishment that is described in this report, at all levels and with various qualifications and responsibilities. This appreciation is surely appropriate, but it also hopes to serve as an encouragement to keep the same spirit in the future and perhaps even strengthen it.

## 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/ (365x No. of beds)

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

**4. Throughput**

=Average number of patients utilizing 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 without the skin not peeling/not macerated. The foetal death is thought to have occurred within the 24 hours before delivery.

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

=(Number of mothers with C/S wounds infected/Total number of mothers who had C/S

Operations in the hospital) x100.

=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.

$$= (\text{Number of patients discharged as “Recovered”} / \text{Total patients who passed through the hospital}) \times 100$$

**9. Maternal Mortality Rate** (for the hospital): = Rate of mothers admitted for delivery who die due to causes related to the delivery

$$= (\text{Total deaths of mothers related to delivery} / \text{Total number of live birth}) \times 100$$

**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, Immunizations, 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 within patients, 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= $\text{Total cases of TB Notified} / \text{Total population} \times 0.003$ .

**13. OPD Utilization** = $\text{Total OPD New attendances in the year} / \text{Total population of the area}$ .

## EXECUTIVE SUMMARY

Both Dr. Ambrosoli Memorial Hospital Kalongo and Kalongo Midwifery Training School's activity output and interpretation are included in this annual analytical report.

Fr. Dr. Giuseppe Ambrosoli of the Comboni Missionaries founded the Dr. Ambrosoli Memorial Hospital in 1957 and St. Mary's Midwifery Training School in 1959. The only general hospital in the Agago district up to this point is Kalongo Hospital, a PNFP. It offers both curative and preventive services. The current estimated population of Kalongo Town Council is 101,343. The major Key performance indicators are compiled here and summarized as follows.

Currently, 287 beds exist at the hospitals. Inpatient (IP) admissions increased by 12.2% from the prior FY20/21 to 27,766. We recorded 362,344 patients visiting the outpatient department in total, a decrease of (18.8%). In the inpatient department (IPD), intestinal worms, coughs or colds without pneumonia, and malaria were the main causes of morbidity. Malaria, injuries and pneumonia were the main causes of mortality in the IPD.

The primary causes of death in the IPD, exactly like in the previous FY20/21, were still malaria and pneumonia. In FY 21/22, the bed occupancy rate dropped by 5.36% to 60.96%. The number of hospital deaths increased by 12.5% as compared to the prior financial year, showing an overall mortality rate of 2.6% of all hospital patients. The recovery rate rose to 96.24%.

When compared to the prior financial year, the first ANC visit dropped by 3.3% while the fourth visit rose by 55.9%. There was a 2.4% increase in overall ANC attendance. Post-natal attendances went up 11.7%. Overall hospital deliveries increased by 12.53% as compared to FY 19/20. Caesarean sections accounted for 23.9% of births overall, 97.4% of which were emergencies.

The members of the BoG and HMT were 14 and 5 respectively. 6 HMT, 1 Ordinary BoG, and 8 Subcommittee (of BOG) meetings were held during the FY. The agenda for each of these meetings were prepared and circulated in advance to the members.

In comparison to the prior FY, the hospital's total income rose by about 12% in FY21/2, but the midwifery school's revenue decreased by around 8%. While expenditure at the hospital decreased by 10%, spending at the school rose by 11%. The SUOop in FY21/22 was 264,712, which is strikingly similar to the SUOop in FY20/21. Patient satisfaction with service quality overall decreased from 83% in 20/21 to 79% in 21/22.



Since its founding, St Marys' Midwifery Training School has graduated 1,521 students. The school's expenditures increased as a result of re-opening of schools following COVID 19 decline. The pass rate for students remained at 100%.

## **CHAPTER ONE:**

### **INTRODUCTION**

#### **Background**

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

This rural hospital serves a remote, poverty-stricken community in northern Uganda that has been deeply impacted by war over the past two decades. The people who rely on this hospital are among the poorest of the poor and live significantly below the country's poverty line; according to 2020's Uganda Poverty Status Report, 68% of Acholi Sub-region (where Agago is located) is impoverished. In addition to this, the sub-region had the highest orphanhood rate at 12% compared to the national average of 8% according to the National Service Delivery survey of 2021.

#### **The hospital and its' environment**

DAMHK is situated in Kalongo Town Council (Oret Parish) of Agago district. It's estimated that 373,780 people live in the district, with 88% of them in rural areas. It's bordered by 6 Districts: Pader to the West, Kitgum to the North, Kotido and Abim to the East and Ouke and Alebtong to the South. With many of these neighboring districts lacking functional hospitals, DAMHK also serves their populations for medical needs requiring hospitalization. Agago has one of the worst road networks in the country-no tarmac roads and most are in terrible condition, making it difficult for activities like transferring patients for emergency care, immunization campaigns, supervising LLUs and home visits and adding extra costs to all transport activities.

Dr. Ambrosoli Memorial Hospital is a complex consisting of the health service delivery wing and the health training wing. It has 286 beds split among Surgical, Medical, Pediatrics, Obstetrics/Gynecology, and Private Wards, providing a range of general health care services such as curative, promotive, preventive and rehabilitative care as well as hosting MOH specialist medical camps. DAMHK also complements the government's initiative in health service provision. The hospital is housing the laboratory HUB which is undergoing MOH

SLMPTA program and awaiting assessment from African Society of Laboratory Medicine (ASLM) before accreditation. The HUB oversees up to 10 labs in the district and parts of neighboring Pader district.

The Health Training Wing has a Specialized Midwifery Training School that provides Certificate and Diploma courses. With the long-term vision of the institution, there is a plan to upgrade this school to a degree-offering institution– technical consultation is already underway. The hospital also opens its doors to students from various educational institutions for training purposes, with the intention of strengthening these collaborations even further in the long run.

The literacy rate for the population in this district is alarmingly low, estimated to be below 30%. Moreover, the majority of inhabitants, especially women, do not speak or write English. The main ethnic group is Acholi; while Lango is the minority ethnic group in the southern regions. Agriculture forms the core of economic activities in this region with most agricultural production being small scale and intended for house hold consumption. Unfortunately, commercial activities have not taken off due to lack of industrialization and mechanization of agricultural processes.

### **Demographic data for the hospital catchment area**

Agago district has one health sub-district which is headed by DAMHK. The health sub-district serves 17 sub-counties. DAMHK is the only hospital in Agago district and serves as the referral hospital. Despite the difficulty posed by the COVID-19 pandemic related lockdown measures, the hospital made a substantial contribution towards achieving the district targets set for the 21/22 year.

**Table 1.1: Demographic Data of the Hospital, HSD and Agago district FY2021-2022**

Population Group		Formulae	Catchment Area	District
(A)	Total Population	A	101,343.0	373,780.0
(B)	Total expected deliveries (4.85% of population)	$(4.85/100) \times A$	4,915.1	18,128.3
(C)	Total Assisted Deliveries in Health Facilities	$(0.12/100) \times B$	589.8	2,175.4
(D)	Total Assisted Deliveries as % of expected deliveries	$(C/B) \times 100$	12.0	12.0
(E)	Children <1 year (4.3%)	$(4.3/100) \times A$	4,357.7	16,072.5
(F)	Children < 5 years (20.2%)	$(20.2/100) \times A$	20,471.3	75,503.6

(G)	Women in Child-bearing age (20.2%)	$(20.2/100) \times A$	20,471.3	75,503.6
(H)	Children under 15 years (46%)	$(46/100) \times A$	46,617.8	171,938.8
(I)	Orphans (circa 10%)	$(10/100) \times A$	10,134.3	37,378.0
(J)	Suspected T.B Cases in the Service Area	$(A) \times 0.003$	304.0	1,121.3

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

No.	Causes of Morbidity	FY		FY		FY		FY	
		2018-19		2019-20		2020-21		2021-22	
		Number	%	Number	%	Number	%	Number	%
1	Malaria	133,109	39.74%	297,061	61.67%	258,474	57.93%	205,079	56.60%
2	Cough or cold - No pneumonia	96,445	28.80%	109,295	22.69%	98,685	22.12%	83,351	23.00%
3	Intestinal Worms	21,761	6.50%	17,918	3.72%	20,331	4.56%	15,624	4.31%
4	Gastro-Intestinal Disorders (non-Infective)	13,818	4.13%	10,891	2.26%	12,551	2.81%	11,157	3.08%
5	Diarrhoea – Acute	17,352	5.18%	15,607	3.24%	14,942	3.35%	10,381	2.86%
6	Urinary Tract Infections (UTI)	10,590	3.16%	7,837	1.63%	9,019	2.02%	8,130	2.24%
7	Skin Diseases	11,028	3.29%	10,561	2.19%	7,030	1.58%	4,842	1.34%
8	Malaria in Pregnancy	3,186	0.95%	4,084	0.85%	4,099	0.92%	4,054	1.12%
9	Epilepsy	2,726	0.81%	3,086	0.64%	3,675	0.82%	3,721	1.03%
10	Bacterial Conjunctivitis	2,277	0.68%	2,806	0.58%	3,508	0.79%	3,279	0.90%
	OPD All others	36,574	10.92%	13,288	2.76%	27,091	6.07%	22,709	6.27%
<b>Total OPD ATTENDANCE</b>		<b>334,916</b>		<b>481,691</b>		<b>446,215</b>		<b>362,344</b>	

In Agago district, there was an overall reduction in OPD attendances as compared to the previous year. We recorded a total of 362,344 patients attending Outpatient Department. Malaria, cough or cold – no pneumonia, and intestinal worms were the leading causes of ill-health experienced in the area. Low usage of mosquito nets has been identified as a contributing factor to the high prevalence of malaria. Intestinal worms have still remained a big challenge in this community due to low latrine coverage and limited use of hand washing facilities. District authorities should increase the intensity of programs related to water and sanitation.

**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 2020-21			FY 2021-22		
		Cases Admitted	Death	Case Fatality Rate	Cases Admitted	Death	Case Fatality Rate
1	Malaria	8,368	94	1.12%	9,268	54	0.58%
2	Pneumonia	841	33	3.92%	1,264	35	2.77%
3	Injuries	1,328	24	1.81%	1,606	20	1.25%
4	Other Neonatal Conditions	168	19	11.31%	228	17	7.46%
5	SAM	829	7	0.84%	296	15	5.07%



<b>6</b>	Premature baby (as condition that requires mgt)	130	15	11.54%	160	11	6.88%
<b>7</b>	Heart failure	45	9	20.00%	44	10	22.73%
<b>8</b>	Hypertension (old cases)	84	6	7.14%	148	9	6.08%
<b>9</b>	Anaemia	673	22	3.27%	395	9	2.28%
<b>10</b>	Tuberculosis	205	4	1.95%	170	6	3.53%
	All others	1,820	29	1.59%	1,737	26	1.50%
<b>TOTAL (IPD Admission and Death)</b>		<b>24,737</b>	<b>498</b>	<b>2.01%</b>	<b>27,766</b>	<b>525</b>	<b>1.89%</b>

Malaria, pneumonia and injuries have topped the causes of mortality among the in patients. Malaria related complications including severe anemia and renal failure were a big contributor to the causes of malaria related mortalities. Road traffic accidents and gunshot wounds were the primary causes of death related to injuries. Other neonatal related conditions have still remained a major contributor of mortality among the in-patients in the HSD.

## **CHAPTER TWO: HEALTH POLICY AND DISTRICT HEALTH SERVICES**

### **Health Policy**

The Uganda National Health Policy has a strong emphasis on vulnerable populations and early detection and treatment of disease, as well as increasing the ability of the health sector to fulfill the UMHCP.

Reducing mortality, morbidity, and fertility rates as well as their inequities is the main goal of health sector policy. The primary elements of the Uganda Minimum Health Care Package are provided by Dr. Ambrosoli Memorial Hospital as it continues to carry out the Uganda National Health Policy (NHP) and Health Sector Strategic Plan. These elements include integrated maternal and child health services, prevention and control of major communicable and non-communicable diseases and cross-cutting areas of health promotion, community health initiatives and gender health.

DAMHK also adheres to the guidelines set by the Uganda Episcopal Conference through the UCMB. It also participates in the DHMT meetings and the operational plans for the common activities that are incorporated in the district health plan.

### **District Health Services**

Agago District is made up of one (1) HSD and three (3) counties (Agago North County, Agago County, and Agago West County) administratively. Agago North County is home to Kalongo Hospital, which is still used as a district referral hospital. The district includes sixteen (16) sub counties. Table 2.1 below displays the distribution of health services by Sub County.

Poor health infrastructure limits physical access to health services. This, coupled with a Shortage of skilled manpower, further reduces the quality of health services provided. All these challenges add up to widening healthcare gaps such as: increased maternal and infant morbidity and mortality and especially malnutrition. The district's poor road network adds to the already crippled referral system. In some cases, roads can become impassable for ambulances or maintenance costs become 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	15,427	1	0	0	0	1
Omiya Pacwa	17,351	0	0	0	2	2
Paimol	25,188	0	0	1	1	2
Lapono	38,965	0	0	1	5	6
Adilang	31,822	0	0	2	3	4
Patongo	39,531	0	0	1	1	2
Patongo Town council						
Kotomor	20,098	0	0	1	2	3
Omot	9,914	0	0	0	2	2
Arum	22,235	0	0	1	0	1
Lamiyo	19,201	0	0	0	2	2
Lira Palwo	42,329	0	0	1	4	5
Wol	36,108	0	0	1	3	5
Parabongo	18,102	0	0	0	3	3
Lukole	27,026	0	0	0	3	3
Agago Town Council	10,022	0	0	1	0	1
<b>Total for HSD and District</b>	<b>373,319</b>	<b>1</b>	<b>0</b>	<b>10</b>	<b>31</b>	<b>42</b>

**Table 2.2: Population, health units and staffing in Agago DistrictFY2021-2022 by Sub- County**

Sub-county	Population	Total OPD attendance	Organisation unit name	Staffing levels		Staffing gap
				Staffing Norm	No. available	
Adilang	31,822	40,469	Adilang HC III	19	17	2
			Alop HC II	9	5	4
			David Fagerlee's Medical Centre	19	15	4
			Ligiligi HC II	9	6	3
			Orina HC II	9	5	4
Agago Town Council	10,022	13,860	Lukole HC III	19	14	5
Arum	22,235	12,697	Acholpii HC III	19	13	6
Kalongo Town Council	15,427	27,591	Kalongo Ambrosoli Memorial Hospital	334	253	81
Kotomor	20,098	20,986	Kotomor HC III	19	14	5
			Odokomit HC II	9	7	2
			Onudapet HC II	9	5	4
Lamiyo	19,201	10,841	Kwonkic HC II	9	4	5
			Lamiyo HC II	9	8	1

Lapono	38,965	35,532	Abilonino HC II	9	5	4
			Amyel HC II	9	6	3
			Lira Kaket HC II	9	5	4
			Lira Kato HC III	19	15	4
			Ogwang Kamolo HC II	9	5	4
			Ongalo HC II	9	6	3
Lira Palwo	42,329	34,731	Acuru HC II	9	5	4
			Lanyirinyiri HC II	9	5	4
			Lira Palwo HC III	19	16	3
			Obolokome (Lira) HC II	9	5	4
			St. Janani HC II	9	5	4
Lukole	27,026	24,976	Lapirin HC III	19	9	10
			Olung HC II	9	5	4
			Otumpili HC II	9	5	4
Omiya Pachwa	17,351	15,747	Layita HC II	9	13	-4
			Omiya Pacwa HC II	9	5	4
Omot	9,914	18,322	Geregere HC II	9	7	2
			Omot HC II	9	11	-2
Paimol	25,188	21,950	Kokil HC II	9	6	3
			Paimol HC III	19	15	4
Parabongo	18,102	22,006	Kabala HC II	9	4	5
			Pacer HC II	9	12	-3
			Pakor HC II	9	5	4
Patongo	18,896	13,162	Opyelo HC III	19	9	10
Patongo Town Council	20,635	17,485	Patongo HC III	19	24	-5
			Patongo Prison HC II	9	1	8
Wol	36,108	31,989	Kuywee HC II	9	6	3
			Okwadoko HC II	9	5	4
			Toroma HC II	9	5	4
			Wol HC III	19	13	6
<b>Total HSD</b>	<b>373,319</b>	<b>362,344</b>	<b>40 Govt. and 3 NGO Units</b>	<b>832</b>	<b>604</b>	<b>228</b>

**Table2.3: Structure of the District Health Office team**

Human Resources (Cadre)	Current Number
DHO	1
Assistant DHO	1
Biostatistician	1
Environmental Officer	1
EPI FP/Health Assistant	1
Senior Accounts Assistant	1
Office Attendant	1
Health Educator	1
Nursing Officer/MCH	1
Cold Chain Assistant	1
Theatre Assistant	1
Records Assistant/HMIS focal person	1
Office Assistant	1
<b>Grand Total</b>	<b>13</b>



**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 Assistant	1
Guard-0	1
<b>Grand Total</b>	<b>6</b>

## Funding

More than 60% of the hospital's funding requirements for recurrent expenses still come from external sources and partners. There is now a big funding gap and complete reliance on the small user fees paid by patients because it has gotten harder over time to attract contributors to cover recurrent expenses.

The PHC conditional grant subsidy continued to provide assistance from the Ugandan government (both in cash and in kind). Drugs and other medical consumables and supplies are affected by the PHC release, which continues to be unpredictable and out of line with planned estimates.

## Health Infrastructure

The housing needs of the hospital to accommodate her work force is still high. Unfortunately, the funding availability cannot match these needs. Thankfully, in the last financial year, the housing project that was to realize and refurbish the staff accommodation was completed and this enabled to bridge the large gap of housing needs. It is anticipated that the living conditions of the staff in the quarters is improved and more almost all staff accommodated by the hospital.

Through the hospital's principal partner, Ambrosoli Foundation, funds were secured from CEI for the construction and refurbishment of the pediatric ward. This was achieved and a modern, child friendly and hospitable treatment environment for the children and their caretakers was achieved.

## Prevention and Health promotion services

During the last financial year, the hospital established a PHC department to help in coordination Of the health prevention and promotion services. Among the achievements was health education in the community, immunization services including COVID-19 vaccination, cervical cancer screening, and provision of support supervision to the lower-level facilities.

Under the PHC department, there is supervision of Village Health Teams (VHTs) who play a crucial role in health prevention and promotion. These VHTs support the PHC through control of communicable diseases with special emphasis to; malaria, STI/HIV/AIDs and tuberculosis, Integrated management of Childhood illnesses, promotion of sexual and reproductive health and rights among others.

More resources were allocated to strengthen the integrated PHC outreach activities across the HSD. Progressively, the outreach activities will involve more community-based interventions and include screening and prevention of non-communicable diseases.

### The HC II function of the hospital

According to the Ugandan government's health policy, every parish is supposed to have a HC II. The catchment area within which the hospital carries out its' HCII function is Kalongo Town Council. DAMHK continued to carryout immunization in its mobile and static units

The results in terms of administered vaccines are shown in Table 2.5. Up to 15 hours each day, 7 days per week, patients from all across the area continue to come and use OPD services.

**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	1,651	7,183	22.98%
TT 2	1,141	4,914	23.22%
TT 3	28	1,411	1.98%
TT 4	7	745	0.94%
TT 5	5	465	1.08%
Non Pregnant women			
TT 1	781	4,859	16.07%
TT 2	348	2,906	11.98%
TT 3	153	1,705	8.97%
TT 4	98	1,299	7.54%
TT 5	33	648	5.09%
Immunization in school			
TT 1	0	1,313	0.00%
TT 2	0	585	0.00%
TT 3	0	379	0.00%
TT 4	0	156	0.00%
TT 5	0	59	0.00%
Total TT 2 in all categories	1,489	8,405	17.72%
Immunization in Children			
BCG	2,498	9,852	25.36%
Protection at Birth for TT (PAB)	2,563	7,268	35.26%
Polio 0	2,435	10,482	23.23%

Polio 1	810	10,793	7.50%
Polio 2	817	10,421	7.84%
Polio 3	787	10,021	7.85%
PCV 1	869	10,890	7.98%
PCV 2	864	10,446	8.27%
PCV 3	823	10,085	8.16%
DPT-HepB+Hib 1	869	10,887	7.98%
DPT-HepB+Hib 2	862	10,450	8.25%
DPT-HepB+Hib 3	823	10,113	8.14%
Measles	782	10,871	7.19%
Total Immunisation in Children	756	10,327	7.32%
Total Family Planning attendances	406	30,742	1.32%
Total ANC attendance	6,550	44,956	14.57%
Deworming	9,893	196,297	5.04%
Vitamin A Supplementation	5,365	96,549	5.56%

The UNEPI vaccine outputs and certain outreach statistics are included in the aforementioned data. With the advent of additional vaccines, such as the injectable polio vaccine, the pneumococcal conjugate vaccine, the rotavirus vaccine, the HPV vaccine, and the measles-rubella vaccine, vaccinations have grown from the customary six to around twelve on the immunization schedule.

Additionally, Kalongo Hospital takes part in NIDs, Family Health Days, and special immunization efforts. The contribution to the delivery of district health services remained substantial. It is significant to highlight that lockdowns brought on by COVID had an impact on the achievement of several indicators. For example, vaccination rates in schools suffered because of the closure of the schools.

## CHAPTER THREE: GOVERNANCE

### The Board of Governors

The Board of Governors (BOG) is the principal decision-making and governing body of Dr. Ambrosoli Memorial Hospital and of St. Mary's Midwifery Training School. However, the Hospital Management Team continues to be solely in charge of all hospital and school operating matters. A maximum of two (2) Ordinary BOG meetings may be held annually, under the hospital Statute, and two (2) Extra Ordinary meetings. In the FY 21/22, the BOG held one (1) ordinary meeting. The board received and discussed hospital management reports highlighting key issues related to activities and challenges affecting the hospital and school. The reports highlighted areas of achievement and work in progress. It was difficult to fully meet the requirements as stipulated in the statute due to unavoidable circumstances involving more than 50% of the board members. In the subsequent year, arrangements have been made for all members to be able to participate even remotely for meetings.

**Table 3.1: Summary of BoG meetings held in the FY2021-2022**

BoG meetings	Reports presented / Key issues handled /Decision taken	Members present
30 <sup>th</sup> September 2021	Hospital performance report Budget performance report for the hospital and School Draft budget for the hospital and School for the year 21/22 Development of the strategic operational plan	10

The Statute provides for three important thematic committees that are already in place: the school Subcommittee (now known as the Governing Council), the Finance Committee, and the Human Resources and Disciplinary Committee. The BOG can appoint additional committees as and when required. Subcommittee responsibility is to review reports and suggestions from the Management in advance and to offer feedback and recommendations to the BOG during plenary meetings.

**Table 3.2: Table showing functionality of the Board Committees**

Name of committee	Required No. of meetings per year	No.of meetings held	Percentage of required meetings held
Finance Committee	2	2	100%
The School Governing Council	2	4	200%



Human Resources & Disciplinary Committee	2	2	100%
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## 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 Board of Governors'

established strategic goals and targeted outcomes are jointly shared by the Hospital Management Team. It is granted operational autonomy within the scope of the hospital strategic plan, approved policies, manuals and procedures. This Team meets at least once every month. The core members of the Hospital Management Team are:

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

**Table 3.3: Frequency of HMT meetings FY 2021-2022**

No ofplanned Management meeting	No.of Management meeting held	AverageNo. of members present	Reports /key issues handled
12	6	4	Key issues discussed relates to general hospital operations. Minutes of each meeting were prepared and circulated by the CEO

## Statutory commitments compliance

The Hospital complies with all legal requirements established by the government, the ministry of health, and the UCMB, as shown in further detail in Table 3.4 below. The UCMB established an accreditation program for the hospitals of the catholic network. Kalongo hospital satisfied these requirements for the year 2021/22. This accreditation entitles the hospital to the full range of services provided by UCMB for the period ending on the 31st December 2022.

**Table 3.4: Statutory commitments compliance**

No	Requirement	Did you achieve? (Yes,Partly,No)	Comment
<b>Government /MOH Requirements</b>			
1	PAYE	Partly	Regularly observed unless if there are no funds
2	NSSF	Partly	Regularly observed unless if there are no funds
3	Local service tax	Yes	Regularly observed
4	Annual operational licence	Yes	Regularly observed
5	Practicing licence for staff	Yes	Regularly observed
6	Monthly HMIS	Yes	Regularly observed
<b>UCMB statutory requirement</b>			
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	
4	Contribution to UCMB for the year	Yes	Regularly observed
5	HMIS 107 PLUS financial report/quality indicators ending FY	Yes	Regularly observed
6	Report Status of staffing as of end of FY	Yes	Regularly observed
7	Manual of Employment (still valid)	Partly	Currently being revised
8	Manual Financial Management (still valid)	No	
9	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. Due to the COVID 19 pandemic, it was very difficult to 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

The number of staff has gradually increased over the years for both clinical and non-clinical staff. Currently, the hospital has a capacity of 286 beds and is staffed by 159 clinical staff, which is less than the MOH's suggested 190 for a facility with a 100-bed capacity. 57.4% of the clinical staff are qualified professionals; slightly lower than last year.

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

Category		FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
Clinical <sup>[1]</sup>	Qualified	131	136	138	139	144
	Unqualified	17	15	17	17	15
	Total Clinical	148	151	155	156	159
Not Clinical <sup>[2]</sup>	Qualified	43	42	45	45	45
	Unqualified	62	58	52	31	47
	Total Non-Clinical	105	100	97	76	92
Total Qualified		174	175	183	184	189
Total Unqualified		79	76	69	48	62
<b>Grand Total</b>		<b>253</b>	<b>251</b>	<b>252</b>	<b>232</b>	<b>251</b>
<b>% of qualified clinical staff/total staff</b>		<b>51.8%</b>	<b>54.2%</b>	<b>54.8%</b>	<b>59.9%</b>	<b>57.4%</b>

### Staff turnover<sup>1</sup>

The hospital has had substantial turnover rates among its core workforce over the years. The turn-over among enrolled cadres has been higher than in the previous FY, 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. This has contributed to the high attrition rate of employees. Other factors that may also have played a role) 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).

**Table 4.2: Turn-over trends of enrolled cadres<sup>2</sup> in the last 3 FYs**

Cadres	FY	FY	FY
	2019-20	2020-21	2021-22
Total staff	252	232	251
Enrolled cadres(all combined)	70	58	66

Turn-overforenrolled cadres	4%	4%	5%
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The working hours of most staff is between 40 to 42 hours a week. The in-charge of the department/ward is responsible for communicating work schedules and shifts on a monthly basis to the responsible personnel in the various departments. The hospital provides accommodation to approximately 62% of staff and their families in the staff quarters. This housing facilitation includes water and electricity. The staff salaries have regularly been paid and any statutory obligations (NSSF and PAYE) are remitted according to the current legislation except when the funds are not available.

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

Clinical Staff	FY	FY	FY
	2019-20	2020-21	2021-22
Total Clinical staff	155	156	159
Total arrivals of key health personnel	26	17	50
Total departures of key health personnel	25	31	28
Turn-over rate	16%	19.87%	17.61%

**Table 4.3b: Turn-over trends of General Staff**

General Staff	FY	FY	FY
	2019-20	2020-21	2021-22
Total staff	252	232	251
Total arrivals of personnel	37	21	64
Total departures of personnel	35	41	45
Turn-over rate	14%	17.67%	17.90%

<sup>1</sup>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 30<sup>th</sup> 2015 + Total staff available on June 30<sup>th</sup> 2016) / 2]

<sup>2</sup>Enrolled Nurses, Enrolled Comprehensive Nurses and Enrolled Midwives

## Human resources development and career progression

By offering capacity development, the hospital kept up with the staff training and development policy. This aims to ensure the institution's future growth and the maintenance of its culture and work ethics. CMEs, brief trainings, on-site mentoring, and advanced courses pertinent to the institution are some of the ways in which this capacity development is accomplished.

Similar to the previous year, the COVID 19 epidemic disrupted all training programs for the FY 21/22. Due to the lack of in-person training for various trainings and workshops, all staff undergoing training turned to online learning. Towards the end of the financial year a few staff managed to attend physical events due to the easing of the restrictions and reduction in the COVID 19 cases in general.



The HMT envisions capacity development as a mode of retention and motivation. We intend to evolve more our training plan through establishing realistic collaboration and ensuring continuity in the training programs. Support to capacity development comes from our key benefactor, the Ambrosoli Foundation; as well as direct contribution from the hospital. Table 4.4 below presents the list of employees who enrolled in training through the hospital's scholarship program in key areas of needs

**Table 4.4: Hospital Staff who attended courses in FY2021-2022**

S/N	Name	Designation	Course	Date of start	Date ofEnd
1	Sr. Ayaka Hellen	RegisteredNurse	BSc. In Nursing (UCU)	Jan,2020	Dec,2023
2	Atto Sunday	Enrolled Midwife	Dip in Midwifery	March, 2021	Jul, 2022
3	Ayoo Rose	Enrolled Midwife	Dip in Midwifery	March, 2021	Jul, 2022
4	Adong Ketty	ClinicalInstructor	Dip in Midwifery	March, 2021	Jul, 2022
5	Ayikoro Lydia	ClinicalInstructor	Dip in Midwifery	March, 2021	Jul, 2022
6	Lalam Paska	Double trained	Dip inOrdinaryUltrasound	Jan,2022	Jul, 2022
7	Oling Francis	Electrician	Dip inBio-medicalEngineering	March, 2022	Feb, 2024
8	Oyet Patrick	MedicalOfficer	MMed Orthopaedics	March, 2022	Jul, 2026

## CHAPTER FIVE: FINANCES

The total income for the hospital slightly increased by approximately 12%. This was realized mainly through the increment in the user fees and donations from the hospital's partners.

Compared to the previous year 2020/21, the PHC condition grant decreased slightly. Nonetheless, the PHC line medical consumables were realized and we still appeal to the government to continuously provide support and increase on the amount of the PHC conditional grant to cover for the daily rising costs of medical consumables. This is in a bid to continuously supplement the government efforts in promoting community health.

Overall, the hospital continues to rely largely on donations, which account for more than 70% of the recurrent budget. We continue to believe that the GOU supported community health funding modules will support sustainability efforts.

The total income for the midwifery school decreased by approximately 8% as compared to the last financial year. Despite an overall increment in the amount collected from private students, there was a great reduction in the donations and other income and PHC conditional grant.

The financial statement trends for the hospital and school are displayed in the tables that follow. In Chapter 9 of this report, additional remarks are made regarding school finances.

### Income

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

Income over the last 5 Years						
Income Item	FY	FY	FY	FY	FY	Variance 2019/20 Vs. 2020/21
	2017-2018	2018-19	2019-20	2020-21	2021-22	
<b>HOSPITAL</b>						
User Fees	515,399,441	805,406,207	918,631,455	724,456,625	1,029,262,390	304,805,765
PHC CG cash	251,159,632	251,159,542	251,159,632	492,117,659	480,809,025	-11,308,634
Government donations in kind (Drug/Lab)	346,633,198	294,661,401	279,299,838	469,333,874	478,592,584	9,258,710
Other donations in kind	787,210,769	845,619,113	1,410,912,848	1,264,283,983	1,332,703,237	68,419,254
Donations in cash (including project funding)	2,403,785,395	2,626,348,706	3,128,079,686	2,294,082,763	2,674,489,300	380,406,537
Others Financial sources (Deposit Interests & others)	56,168,380	162,796,288	92,546,915	51,770,039	99,348,095	47,578,056
Technical Department	141,070,362	93,943,603	136,116,992	59,583,590	54,708,270	-4,875,320
<b>Sub-Total Hospital</b>	<b>4,501,427,177</b>	<b>5,079,934,860</b>	<b>6,216,747,366</b>	<b>5,355,628,533</b>	<b>6,149,912,901</b>	<b>794,284,368</b>
<b>SCHOOL</b>						
Fees (private)	236,974,842	336,578,535	160,475,145	235,067,000	361,495,000	126,428,000
PHC CG School/PAF Delegate funds	24,264,900	24,264,900	152,386,215	15,641,098	-	-15,641,098
Donations and other income	187,713,340	245,355,733	312,861,360	428,420,077	265,325,381	163,094,696
<b>Sub-Total School</b>	<b>448,953,082</b>	<b>606,199,168</b>	<b>625,722,720</b>	<b>679,128,175</b>	<b>626,820,381</b>	<b>-52,307,794</b>
<b>Grand-Total</b>	<b>4,950,380,259</b>	<b>5,686,134,028</b>	<b>6,842,470,086</b>	<b>6,034,756,708</b>	<b>6,776,733,282</b>	<b>807,713,378</b>

## Expenditure

Similarly, like the past financial year, the overall expenditure by the hospital reduced. The reduction in expenditure in FY 21/22 was more, approximately 10% as compared to 2% in FY 20/21. Human resource costs and medical goods and sundries were the main drivers for the hospital expenditure.

However, the school spent more as compared to the previous year by approximately 11%. This expenditure was mainly administrative costs.

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

**Table 5.2: Trend of Expenditure over the last 5 FYs**

<b>Expenditures over the Last 5 Years</b>					
<b>Expenditure Item</b>	<b>FY</b>	<b>FY</b>	<b>FY</b>	<b>FY</b>	<b>FY</b>
	<b>2017-18</b>	<b>2018-19</b>	<b>2019-20</b>	<b>2020-21</b>	<b>2021-22</b>
<b>HOSPITAL</b>					
Human Resource cost	1,670,778,158	1,937,322,775	2,220,512,253	2,281,897,544	2,378,741,751
Administration & Governance Costs	148,417,998	256,159,365	176,454,730	281,947,329	266,260,862
Medical goods and supplies (included drugs)	1,723,605,199	1,564,891,236	2,048,954,822	1,906,084,286	1,638,112,842
Non-medical goods / supplies	1,126,086,235	481,599,381	237,715,358	95,862,373	111,514,065
Property Costs	311,950,518	342,469,799	277,795,146	263,900,824	318,974,217
PHC	235,268,336	287,069,131	408,008,500	212,414,809	168,309,000
Transport & Plant Costs	204,022,401	209,423,206	198,506,748	220,474,884	181,012,623
Capital Development	261,422,729	165,112,516	621,477,605	782,214,141	395,180,275
<b>Hospital Total Expenditure</b>	<b>5,681,551,574</b>	<b>5,244,047,409</b>	<b>6,189,425,162</b>	<b>6,044,796,191</b>	<b>5,458,105,635</b>
<b>SCHOOL</b>					
Employment	195,750,295	255,244,790	289,320,411	260,168,468	241,805,446
Administration	37,652,900	39,400,393	125,364,301	28,658,219	73,641,294
Students costs	115,564,162	180,483,191	149,127,572	130,125,198	159,721,701
Transport & Travelling	23,987,550	25,463,900	25,901,800	18,872,400	24,398,400
Property, Supplies, Services	48,034,600	31,022,821	16,403,572	29,529,301	18,951,990
Capital Development	14,448,597	60,336,306	35,543,000	9,720,500	19,165,000
<b>School Total Expenditure</b>	<b>435,438,104</b>	<b>591,951,401</b>	<b>641,660,656</b>	<b>477,074,086</b>	<b>537,683,831</b>
<b>HSD</b>					
HSD Total Expenditures	-	-			
<b>Grand Total</b>	<b>6,116,989,678</b>	<b>5,835,998,810</b>	<b>6,831,085,818</b>	<b>6,521,870,277</b>	<b>5,995,789,466</b>

For each department, the typical user fee per patient stayed the same. The user fees for the hospital have not changed. However, during the FY, revenue collection efficiency increased. There are still cases where patients leave the hospital without paying user fees; something that the management continues to grapple with given the numerous porous points.

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

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

In the FY 21/22, the cost recovery rate was 17.9%. This represents an increment of 4.1% as compared to the previous year. Over the years, the hospital has continued to spend more on patients' medical needs than it receives from them, a practice that jeopardizes the long-term viability of high-quality services.

Over the coming years, it is unquestionably necessary to wisely close the gap between donor support and local revenue generation, particularly in light of the rising donor fatigue.

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

	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-2021	2021-2022
Total User fees (a)	515,399,441	805,406,207	918,631,455	724,456,625	1,029,262,390
Total Recurrent Expenditure (b) [2]	5,416,639,845	5,078,934,893	5,567,947,557	5,262,582,049	5,754,732,626
Cost Recovery Rate =(a/b)x100	9.5%	15.9%	16.5%	13.8%	17.9%

There was a very minimal increment in the average cost per bed of 1.7% in the FY 21/22. The cost per patient per day as well as the cost per SUOop similarly registered a very minimal increment. Reduced efficiency in the use of resources for patient care highlighted the burden of care placed on the hospital by the patients it served.

**Table 5.5: Trend of indicators of efficiency in utilization of financial resources**

Indicator	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21	2021-2022
Cost per bed [1]	19,987,601	18,741,457	20,545,932	18,400,637	18,081,876



Cost per IP/day[2]	56,783	53,243	62,026	76,018	79,564
Cost per SUOop	21,622	16,386	15,854	19,859	19,173

(NB:  $Total\ SUO_{op} = Total\ OP + 15*IP + 5*Deliveries + 20*Major\ Surgery + 0.5*Total\ ANC + 0.2*Total\ Immunisation$ )

Source: UCMB

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

Without PHC CG	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-2021	2021-2022
Total Local Revenues (a)	4,250,267,545	4,828,775,673	918,631,455	724,456,625	1,029,262,390
Total Recurrent Expenditures(b)	5,416,639,845	5,078,934,893	5,567,947,557	5,262,582,049	5,062,925,360
Sustainability Ratio= (a/b)x100	78.5%	95.1%	16.5%	13.8%	20.3%

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

The hospital was 80% sustainable in the FY 21/22 when local income and government contributions were taken into account. This represents an increase of 6% as compared to the last financial year. The increase was brought about by the local income generation and increased user fees collection.

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

	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-2021	2021-2022
Total in-country funding (c)	4,501,427,177	5,079,935,215	3,907,443,605	3,888,851,326	4,043,280,957
Total Recurrent Expenditures (d)	5,416,639,845	5,078,934,893	5,567,947,557	5,262,582,049	5,062,925,360
Sustainability Ratio = (c/d)x100	83%	100%	70%	74%	80%

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

## CHAPTER SIX:

### SERVICES

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

#### **Obstetrics & Gynecology Services**

Antenatal, Delivery & Postnatal care  
Elimination of MTCT of HIV  
Emergency Obstetrics and Neonatal care  
General and Specialized Obstetrics and Gynecological Surgery

#### **Internal Medicine Care**

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

#### **Pediatrics & Child Health**

Young child clinic  
Inpatient and Outpatient Therapeutic care (ITC and OTC)  
Neonatal intensive care services  
Pediatric admissions and care  
Immunization and health promotion  
Sickle cell Disease care  
Paediatric Outpatient Clinic

#### **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.

#### **General Surgical Services**

Trauma and Emergency Care Surgical  
Outpatient clinic  
Minor Orthopedics services  
Burns care  
Anesthesia  
General surgical operations (minor and major surgery)

#### **Physiotherapy services & rehabilitation**

## OUT PATIENTS' DEPARTMENT

OPD serves as an entry point for patients seeking services from DAMHK. The hospital's main entrance is where you'll find the Out Patients Department (OPD) of Dr. Ambrosoli Memorial Hospital. The OPD is open seven (7) days a week, from 8:00 a.m. to 9:00 p.m. on Monday through Friday and 8:00 a.m. to 8:00 p.m. on Saturdays and Sundays (including public holidays). The OPD time was changed from 2:00 p.m. to 8:00 p.m. over the weekend and public holidays in order to increase utilization of the OPD services by the community. We will be researching the introduction of a 24-hour system in the upcoming year. Good dispensing procedures are maintained since pharmacist assistants manage the OPD pharmacy.

To accommodate variety of client needs, the patient flow and payment system are well established.

The OPD also has improvised an emergency unit from one of the one rooms. The emergency unit/room is run by the clinical officers stationed in OPD and in supported by the medical officers when the need arises.

### Staffing composition

In general, the OPD staffing level and norm remained same from previous years. Five clinical officers managed OPD with the help of five enrolled nurses, three nursing assistants, two nursing officers, and two nursing aides. The staff at OPD frequently welcomes nursing and clinical students from the midwifery school and other educational institutions to join them as they carry out their work.

Following a weekly schedule, medical officers oversee specialized clinics: gynecological clinic on Monday; sickle cell clinic and pediatric outpatient clinic on Tuesday; surgical outpatient clinic on Wednesday; and medical clinic on Thursday.

**Table 6.1: The staff composition in OPD in the FY 2020-21 and FY2021-22**

Cadre/ Discipline	Qualification	FY	FY
		2020-21	2021-22
Clinical officers	Diploma in clinical Medicine	5	5
Pharmacy Assistant	Certificate in Pharmacy	2	2
Registered Nurse/Midwife	Diploma in Nursing / Midwifery	2	2
Enrolled Midwife	Certificate in Midwifery	1	0
Enrolled Nurse	Certificate in Nursing	2	4
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	3	1
Nursing Assistant	Certificate in Nursing Assistance	2	3

Cashier	Diploma in Business Studies	2	2
Nursing Aide	Trained on the job	1	2
Records Assistant	Certificate in Records mgt	1	1
<b>Total</b>		<b>21</b>	<b>22</b>

## OPD key indicators

There was a decrease in the OPD attendance by 14% compared to the previous year. There was a 48.3% decline in the OPD re-attendance. Patients who were listed as new attendees outnumbered those who were re-attendants. The under-five morbidity generally increased. This could be attributed to the rising number of flue like illnesses among this population. As is frequently noted, women continue to visit the hospital more frequently than their male counterparts.

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

			FY	FY	FY	FY	FY
			2017-18	2018-19	2019-20	2020-21	2021-22
FEMALE	New Attendance	0-4 yrs	2,442	2,037	3,014	1,600	1,944
		Over 5 yrs	11,095	10,835	8,978	9,260	10,703
	Re-attendance	0-4 yrs	124	129	121	97	41
		Over 5 yrs	2,097	1,934	4,097	7,836	4,166
MALE	New Attendance	0-4 yrs	2,720	2,337	2,976	1,818	2,446
		Over 5 yrs	6,121	6,193	8,492	5,631	5,623
	Re-attendance	0-4 yrs	203	170	118	123	82
		Over 5 yrs	2,089	1,987	3,262	5,230	2,586
All New Attendances			22,378	21,402	23,460	18,309	20,716
All Re-attendances			4,513	4,220	7,598	13,286	6,875
All Attendances			26,891	25,622	31,058	31,595	27,591

## Morbidity Trend in the OPD

Malaria was the leading cause of morbidity in OPD just like the previous years. Gastro-intestinal disorders (non-infective) was the second top cause of morbidity. The number of G.I disorders rose by 66% as compared to the previous FY 20/21. Anemia still continues to be among the top causes of morbidity. This could be attributed to presence of malaria associated complications and other causes like anemia of chronic disease. Blood availability is still a challenge in Agago District, complicating clinical care for this category of patients.



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

Causes of Morbidity		FY 2020-2021		FY 2021-2022	
		No. of cases	% on all diagnoses	No. of cases	% on all diagnoses
1	Malaria Total	5,320	16.84%	3,994	14.48%
2	Gastro-Intestinal Disorders (non-Infective)	457	1.45%	1,353	4.90%
3	Urinary Tract Infections (UTI)	1,220	3.86%	1,232	4.47%
4	Other types of Anaemia	575	1.82%	1,030	3.73%
5	Hypertension	975	3.09%	984	3.57%
6	Pneumonia	626	1.98%	851	3.08%
7	Soft tissue injuries	589	1.86%	810	2.94%
8	Cough or cold - No pneumonia	392	1.24%	751	2.72%
9	Epilepsy	702	2.22%	745	2.70%
10	Pelvic Inflammatory Disease (PID)	481	1.52%	627	2.27%
	All others	6,411	20.29%	5,070	18.38%
<b>Total OPD attendance</b>		<b>31,595</b>		<b>27,591</b>	

## ANTENATAL CLINIC

The Ante Natal Clinic (ANC) is an outpatient clinic that offers specialized treatments to pregnant women, the unborn infants they are carrying, and childbearing women who are not pregnant. The purpose of antenatal care is to ensure good health in every pregnant woman and her unborn baby by checking for any conditions that may cause a risk either during pregnancy or at birth. The ANC is operational 5 days a week, from Monday to Friday, 8:00 a.m. to 5:00 p.m. The clinic is closed on Saturdays, Sundays and all public holidays. In the ANC clinic, there are EMTCT services. At the ANC, all expectant mothers and their husbands are tested for HIV, and those who test positive are started on option B+ to lessen transmission to the unborn child. These moms are monitored throughout the pregnancy, delivery, and postpartum period. Their exposed infants are enrolled in mother-baby care points where EID is performed, and they are monitored until they are 18 months old, at which point their final HIV status is determined. If they are negative, they are later discharged, and if they are positive, they are enrolled in chronic care at the ART clinic.

**Table 6.4: Antenatal and Postnatal indicators during the last 4 FY**

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



ANC Referrals from unit	0	0	0	12
POSTNATAL				
Post Natal Attendances	4,472	3,939	3,629	4,107
Number of HIV + mothers followed in PNC	164	906	246	243
Vitamin A supplementation	90	0	0	0
Clients with premalignant conditions for breast	0	0	0	0
Clients with premalignant conditions for cervix	0	0	0	0

The total ANC attendance increased by 2.4% in the FY 20/21. The number of referrals to and from the unit also increased compared to the previous years. Post-natal attendances increased by 11.7 % as compared to the last financial year. Following the lifting of the COVID 19 restrictions, the uptake of ANC services was generally increased both in ANC visits and post-natal care services.

Cervical cancer screening services are provided by the hospital in the ANC and are done every day during working hours. Among women of childbearing age, the screening test positive rate has remained low. If ongoing funding can be attained, the activity must be expanded to reach a larger population.

## HIV/AIDS Clinic

In November 2005, the HIV/AIDS clinic was established with the help 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 provided services are largely included 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. A medical officer serves as the clinic's coordinator and oversees all of its operations. Every year, the number of clients who are HIV+ is increasing in the HIV program.

The HIV/AIDS Clinic is housed in a temporary building that is also used for data entry, nursing care, counseling, clinical consultation, file storage, and other information management tasks. Right now, there is an urgent need for expansion in order to handle all of the clinic's necessary activities. Even from the current Implementing partner, whose policies do not support any structural development demands, this demand is addressed despite the ongoing budget constraints. Over the years, the budget support to the clinic has decreased and this in turn affecting the operations of the clinic from reduction of staff to planned activities.

## HIV Testing Services (HTS)

HIV testing services (HTS) are a unique opportunity and a door for those diagnosed with HIV to rapidly initiate lifesaving treatment and for those at higher risk of acquiring the virus to have immediate access to the effective recommended package of prevention services to remain negatives. The first of the United Nations' 95-95-95 targets to end the HIV epidemic is for 95% of people living with HIV to know their HIV status by 2025. HIV testing is therefore essential to achieving "the first 95".

HIV testing services include the full range of services that should be provided together with HIV testing: counselling (pre-test information and post-test counselling); linkage to appropriate HIV prevention, treatment and care services, and other clinical and support services; and coordination with laboratory services to support quality assurance and the delivery of correct results.

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

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

	FY	FY	FY	FY	FY
	2017-18	2018-2019	2019-20	2020-21	2021-22
<b>Number Tested</b>					
Male	10,532	4,736	7,347	4,088	4,498
Female	10,995	6,993	6,721	6,172	5,580
TOTAL (Tested)	21,527	11,729	14,068	10,260	10,078
<b>Tested +ve for HIV</b>					
Male	386	160	103	86	56
Female	437	222	149	107	94
TOTAL (+ve Tests)	823	382	252	193	150
<b>Positivity Rates of HCT</b>					
Male	3.70%	3.4%	1.4%	2.1%	1.2%
Female	4%	3.2%	2.2%	1.7%	1.7%
Both sexes	3.80%	3.3%	1.8%	1.9%	1.5%

In the FY 21/22, a total of 10,078 clients accessed HTS. This represents a reduction in 1.8% from the previous year. This is also reflected in both the total HIV positive tests and the positivity rates. This reduction could also be attributed to the reduction in the activities under the HIV clinic due to budget reductions that are continuous over the years.

**Table 6.6: HIV test by purpose during FY 2021– 2022**

Types of test	HCT	PMTCT*	SMC	Total
Number of clients tested for HIV	7,407	1,830	841	10,078
No. of HIV +ve tests	121	27	2	150
Positivity Rate (%)	1.63%	1.48%	0.24%	1.49%

*The above figure is for total test on epurely for HIV screening & excludes quality control tests done during the FY2019-20. \*Source: Laboratoryrepor*

**Table6.7:Performance Indicators of the PMTCT Programme inFY2021-2022**

A. Antenatal	No.
A1. Mothers re-tested later in pregnancy, labour or postpartum	1958
A2. Mothers testing positive on a retest	68
A3. New pregnant and lactating mothers newly enrolled into psychosocial support groups.	0
A4. HIV positive pregnant women already on HAART before 1st ANC visit /Current pregnancy	412
A5. Pregnant women who received services at the health facility after referral from the community	43
A6. HIV (+) lactating mothers followed up in community for infant feeding, early infant diagnosis, or linkage into chronic care	74
A7. HIV positive Pregnant women initiated on Cotrimoxazole	26
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)	26
A9b. HIV + pregnant women initiated on HART (Option B+) for EMTCT - CD4 <350 or Stage III and IV(ART-T)	0
<b>B. Maternity</b>	
B1. HIV positive deliveries initiating ARVs in Labour	1
<b>C. Postnatal</b>	
C1. Postnatal mothers newly tested for HIV	31
C2. Postnatal mothers testing HIV positive	1
C3. Postnatal mothers initiating ARVs in PNC period	1
<b>D. Early Infant Diagnosis (EID)</b>	
D1. HIV-exposed infants (<18 months) getting a 2nd DNA PCR	124
D2. HIV-exposed infants initiated on Cotrimoxazole prophylaxis	149
D3a. 1st DNA PCR results returned from lab within 2 weeks of dispatch	124
D3b. 2nd DNA PCR results returned from lab within 2 weeks of dispatch	108
D4a. Total HIV-exposed infants who had a serological/rapid HIV test at 18 months or older.	111
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	6
D7. Number of referred HIV positive-infants who enrolled in care at an ART clinic	3

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

		FY	FY	FY	FY	FY
		2017-18	2018-2019	2019-20	2020-21	2021-22
<b>ELIGIBLE FOR ART</b>						
Male	<5 yrs	6	6	4	2	4
	5-<18 yrs	9	8	6	5	3
	18 and above	216	129	96	70	54
Female	<5 yrs	3	6	6	1	3
	5-<18 yrs	8	13	8	7	6
	18 and above	306	221	120	91	85
<b>TOTAL ELIGIBLE FOR ART</b>		<b>553</b>	<b>383</b>	<b>240</b>	<b>176</b>	<b>155</b>
<b>STARTED ON ART</b>						
Male	<5 yrs	6	6	4	2	4
	5-<18 yrs	9	8	6	5	3
	18 and above	216	129	96	70	54
Female	<5 yrs	3	6	6	1	3
	5-<18 yrs	8	13	8	7	6
	18 and above	306	221	120	91	85
<b>TOTAL STARTED ON ART</b>		<b>553</b>	<b>383</b>	<b>240</b>	<b>176</b>	<b>155</b>

There was a reduction in the year's total number of new positives. Nevertheless, links were made and care was started for all tested eligible clients. There were difficulties with dropouts and lost follow-up with active clients throughout the year. These would then be pursued and placed back into care, or enrolled in one of our community drug distribution programs.

**Table 6.9: Number of PLHAs started on ARV by age group and gender in FY 2021-2022**

Data Element	No. of Children < 19yrs		No of Individuals 20-24 yrs		No. of Individuals 25+ yrs		Total
	M	F	M	F	M	F	
Number of new patients enrolled in HIV care at this facility during the year	7	9	9	19	45	66	155
Number of pregnant women enrolled into care during the year.		2		12		17	31
Cumulative Number of individuals on ART ever enrolled in HIV care at this facility							4,445
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		94	111	20	35	163	221	<b>644</b>
No. of newly identified positives that are initiated on ART int the same FY		7	9	9	19	45	66	<b>155</b>
No. of pregnant & Lactating women started on ART at this facility during the quarter (Subset of HC11)			2		12		17	<b>31</b>
No. active on ART screened for TB at last visit in the quarter		110	118	25	60	837	1424	<b>2,574</b>
No. active on ART with presumptive TB during the quarter		22	23	4	7	50	80	<b>186</b>
No. active on ART diagnosed with TB during the quarter		2	2	1	4	12	19	<b>40</b>
Net current cohort of people on ART in the cohort completing, 12 months during the year		6	6	9	18	67	87	<b>193</b>
Number of clients surviving on ART in the cohort completing, 12 months on ART during the year		6	2	3	11	47	61	<b>130</b>
Number of people accessing ARVs for PEP		7	6	9	1	21	8	<b>52</b>
No. active on ART on 1st line ARV regimen		68	78	22	42	818	1345	<b>2,373</b>
No. active on ART on 2nd line ARV regimen		51	51	11	39	137	227	<b>516</b>
No. active on ART on 3rd line or higher ARV regimen		0	0	1	0	0	0	<b>1</b>
Number of clients on ART who had a viral load test	Total Tested	114	124	27	72	820	1431	<b>2,588</b>



during the past 12 months (most recent test)	Suppressed viral load	85	92	22	67	795	1391	2,452
Number active on ART enrolled in DSD approach	FBIM	6	5	10	14	67	87	189
	FBG	68	65	6	32	35	195	401
	FTDR	22	26	17	28	346	565	1,004
	CDDP	23	33	0	7	425	607	1,095
	CCLAD	0	0	1	0	82	118	201

The number of people enrolling in community drug distribution modules like the CCLAD, CDDP, etc. has increased over the past few years. The goal is to enroll all qualified clients in one of the aforementioned modules to reduce facility congestion and increase adherence (by taking drugs closer to the clients). In the coming year, enrollment of private pharmacies to assist drug distribution to qualified clients is anticipated to begin in an effort to lessen stigma and boost compliance.

### Tuberculosis (TB) treatment

The Dr. Ambrosoli Memorial Hospital provides TB treatment services that are integrated into the routine activities of general medical care. The OPD is where TB screening begins, where all coughers are recognized and isolated. Confirmed cases are promptly admitted to the TB treatment unit for the length of the intensive phase of therapy before being released on CB-DOTs. The unit is where all treatment follow-ups are completed. The total number of TB patients registered throughout the last five (5) FYs is shown in Table 6.11.

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

	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21	2021-22
No. of patients registered (all)	243	196	325	270	194
Children (< 5 yr.)	11	16	38	38	32
<b>Disaggregation by Disease</b>					
New Pulmonary Positive	109	82	84	83	145

Relapses Pulmonary Positive	6	7	10	5	7
Failure Pulmonary Positive	0	1	7	1	5
Lost to follow up Pulmonary Positive	12	10	0	3	
New pulmonary Negative	99	82	206	167	31
Relapses Pulmonary Negative	1	0	6	7	4
Default Pulmonary Negative	3	0	4	0	0
Pulmonary no smear done	0	0	0	0	0
Extra Pulmonary	16	14	8	4	2
<b>Disaggregation by Treatment</b>					
New Patients	224	198	298	250	178
Re-treatment	22	18	27	20	11
<b>Other Patients</b>					
Transferred in	0	7	0	0	0

MDR TB still presents a significant public health problem in the surrounding community. The number identified increased from the last year by about 50% and were referred to the treatment center in Kitgum general hospital. It's crucial to remember that not all cases are found (it is possible that there are others still out there). It is necessary to build up mechanisms for intense awareness and case identification.

**Table 6.11: MDR/MTB diagnosis during the FY2021-22**

Age group	Samples Collected	Samples Tested	MTB positive Cases	MDR positive (Rifampicin Resistant TB)	MDR cases referred
< 15 years	350	336	4	0	0
15 yrs.& above	1753	1701	122	6	6
Total	2103	2037	126	6	6

### **TB treatment outcome**

Treatment of TB reduces mortality dramatically and should maximize cure, preventing ongoing transmission and TB sequelae. Mortality among TB patients remains high, although there was a 50% decrease in mortality as compare to the previous year. The majority of these were linked to both malnutrition and co-HIV infection. The number of patients cured decreased by 14.5% as compared to last year. 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 6.12: Results of TB treatment in the last 4 FYs**

Outcome of treatment	FY	FY	FY	FY
	2018-19	2019-20	2020-21	2021-22

	Number	Number	Number	Number
Cured	53	38	48	35
Treatment Completed	101	126	222	201
Died	28	24	34	17
Failure	2	0	2	0
Defaulted	24	1	0	0
Transfer out	36	3	0	0
Lost to follow Up	0	0	5	13
Not Evaluated	0	0	4	5
<b>Total</b>	<b>244</b>	<b>192</b>	<b>315</b>	<b>271</b>

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

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

### Orthopaedic Services

The primary mode of treatment is still non-operative orthopaedic care, while occasionally surgery is done at surgical camps. For cultural and financial reasons, patients from the hospital and the district are still hesitant to be referred. Strengthening the operational treatment is necessary given the large number of orthopaedic patients. Although there isn't an orthopaedic surgeon at the hospital, there is a medical officer in training who will be bonded to the hospital and provide surgical orthopedic care. In addition to this, a “club foot” clinic is run among the orthopaedic services.

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

Procedures	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21	2021-22
Plaster (POP)	765	985	364	707	1434
Physiotherapy	67	44	157	76	814

## Mental health clinic

In Agago district, specialized mental health services are limited due to lack of the required personnel and infrastructure to provide mental health services. The hospital still does not have mental health fully integrated into its' core service scopes. However, clinicians continue to review these patients. Epilepsy still remains the highest contributor of mental ill health in our OPD, followed by depression and alcohol/ substance abuse.

Despite the hospital's best efforts, maintaining staff sustainability is still a significant concern (majority leave for greener pastures). A significant difficulty is the scarcity of mental health medications and beds for these people. The table below 6.15 shows the cases which were reviewed in the OPD during the FY.

**Table 6.15: Mental health cases reviewed in OPD in the last4 FYs**

Diagnosis	FY		FY		FY		FY	
	2018-2019		2019-20		2020-21		2021-22	
	No.	%	No.	%	No.	%	No.	%
Epilepsy	576	85.3%	1,171	84.5 %	702	80.8%	745	76.73 %
Drugs/alcohol abuse	46	6.8%	3	0.2%	60	6.9%	68	7.00%
Depression & post-traumatic stress disorders	21	3.1%	75	5.4%	31	3.6%	99	10.20 %
Psychosis (schizophrenia)	1	0.1%	12	0.9%	7	0.8%	3	0.31%
Bipolar affective disorder	5	0.7%	3	0.2%	8	0.9%	12	1.24%
Attempted suicide	0	0.0%	3	0.2%	16	1.8%	9	0.93%
HIV related Psychosis	3	0.4%	19	1.4%	11	1.3%	1	0.10%
Other mental illnesses	23	3.4%	99	7.1%	34	3.9%	34	3.50%
<b>Total</b>	<b>675</b>		<b>1,385</b>		<b>869</b>		<b>971</b>	

## 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 will continue to advocate and engaging potential partners for support in revamping the unit.

## Palliative Care

Palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to improve quality of life for both the patient and the family.

Despite various implementation challenges, palliative care initiatives are beginning to take shape.

The availability of crucial palliative care supplies and patient follow-up are still hindered by a lack of funds. To address these issues, the hospital has incorporated palliative care into PHC services. The palliative care services provided in the year 21/22 are summarized in Figure 6.16.

**Table 6.16: Number of Patients who received Palliative Care in the FY2021-22**

Clinical Condition	No. of patients that need palliative Care	No. of patients who received palliative Care
Cancer	21	14
HIV/AIDS	0	0
Others	19	7

## INPATIENTS DEPARTMENT

### Summary of beds and qualified health personnel

The hospitals' total bed capacity is to 286. The hospital employed five (5) medical officers in 20/21. The hospital still suffers from a severe shortage of specialists. When financing allows, the management wants to increase the capacity in this area. Currently there are 3 specialists, 2 surgeons and recent addition of a paediatrician. The average number of beds per nurse/midwife has increased to 3.86, a 13.5% increment. Medical ward currently has the highest number of beds per nurse/ midwife and NICU still having the lowest, just like the previous year. There is a variation in these indicators for example during peak seasons with malaria, there are even floor cases and this further widens the ratios.



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

Ward	No. of Beds	Medical Personnel	No. of Nurses & Midwives	No. of beds per Nurse/MW
Medical Ward	41	1 Medical Officer	11	4.91
TB Ward	18			
Surgical Ward	76	1 Surgeon	14	4.0
		1 Medical Officer		
		2 Orthopedic Officer		
		1 Physiotherapist		
Maternity & Gyn Ward	75	1 Medical Officer	19	3.75
Pediatric Ward	61	2 Medical Officers	15	3.59
NICU	15		7	1.67
Total	286	3 Specialist Doctor and 5 Medical Officers	66	3.86

**Utilization indicators**

The total number of admissions increased by approximately 5% in the FY 21/22. There was an overall increase in the recovery rate, decreased average length of stay and a decreased number of self-discharges by approximately 40%. The ALOS was higher than the national recommendation of 4.7 days. The management has laid down strategies to further curb down escapes without payment of fees and hope to reduce this even more in the coming year.

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

Indicator	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21	2021-22
No. of beds	271	271	271	286	286
Total Admissions discharged	13,460	14,794	16,779	12,203	12,913
Patient days	68,521	69,329	89,761	69,228	63,633
Average Length of Stay	5.1	4.7	5.35	5.67	4.93
Turn over interval	2.26	2.0	0.5	2.9	3.2
Throughput per bed	49.7	54.6	61.9	42.7	45.2
BOR	69.27	70.09	90.75	66.32	60.96
No. Deaths	115	192	373	343	386
Mortality Rate	0.85%	1.3%	2.5%	2.3%	2.6%
Recovery Rate	97.00%	97.09%	97.42%	95.85%	96.24%
Self-discharges	20	67	60	164	99

### Bed Occupancy Rate (BOR) and Throughput per Bed

The bed occupancy rate decreased by 5.36% to 60.96% in FY 21/22. The paediatrics ward still had the highest BOR (75.56%) just like the previous year followed by the obstetrics and gynecology ward (64.01%). Similarly like in FY 20/21, malaria and its' associated complications were still responsible for the increased BOR observed in the Children's and Maternity wards in the year 21/22. The throughput per bed increased generally slightly by 5.9%. This was experienced in all wards except paediatrics and TB wards.

**Table6.19:Keyindicatorsperwardinthelast4FYs**

MEDICAL WARD				
	FY	FY	FY	FY
	2018-19	2019-20	2020-21	2021-22
No of beds	41	41	41	41
Total Admissions	2,237	2,684	1,834	2,141
Patients days	11,310	12,549	7,542	9,285
ALOS	5.1	4.7	4.1	4.3
Throughput per bed	54.56	65.46	44.73	52.22
BOR	75.60	83.18	50.40	62.04
No of Deaths	86	113	140	142
Mortality rate	3.84%	4.21%	7.63%	6.63%
Recovery rate	95.75%	95.45%	89.59%	92.81%
Self-discharges	9	9	51	12

SURGICAL WARD[1]				
	FY	FY	FY	FY
	2018-19	2019-20	2020-21	2021-22
No of beds	76	76	76	76
Total Admissions	2,055	1,925	1,521	1,584
Patients days	14,721	15,189	13,701	13,776
ALOS	7.16	7.89	9.01	8.70
Throughput per bed	27.04	25.33	20.01	20.84
BOR	53.07	54.75	49.39	49.66
No of Deaths	31	32	30	45
Mortality rate	1.5%	1.7%	2.0%	2.8%
Recovery rate	98.3%	98.1%	97.0%	96.0%
Self-discharges	3	4	15	18

PAEDIATRIC WARD				
	FY	FY	FY	FY
	2018-19	2019-20	2020-21	2021-22
No of beds	61	61	76	76
Total Admissions	4,143	7,615	4,437	4,398
Patients days	20,188	43,503	29,304	20,960
ALOS	4.87	5.71	6.60	4.77
Throughput per bed	67.92	124.84	58.38	57.87
BOR	90.70	195.39	105.64	75.56
No of Deaths	59	217	157	183
Mortality rate	1.42%	2.85%	3.54%	4.16%
Recovery rate	97.51%	96.53%	94.79%	95.52%
Self-discharges	44	47	74	14

OBSTETRICS& GYNECOLOGY WARD				
	FY	FY	FY	FY
	2018-19	2019-20	2020-21	2021-22
No of beds	75	75	75	75
Total Admissions	6,165	4,226	4,144	4,595
Patients days	20,984	16,519	17,441	17,522
ALOS	3.40	3.91	4.21	3.81
Throughput per bed	82.20	56.35	55.25	61.27
BOR	76.70	95.45	0.64	64.01
No of Deaths	7	4	11	5
Mortality rate	0.11%	0.09%	0.27%	0.11%
Recovery rate	99.89%	99.91%	99.3%	98.7%
Self-discharges	0	0	20	55

TB WARD				
	FY	FY	FY	FY
	2018-19	2019-20	2020-21	2021-22
No of beds	18	18	18	18
Total Admissions	194	329	267	195
Patients days	2,126	2,001	1,240	2,090

ALOS	10.96	6.08	4.64	10.72
Throughput per bed	10.78	18.28	14.83	10.83
BOR	32.40	30.46	18.87	31.81
No of Deaths	9	7	5	11
Mortality rate	4.64%	2.13%	1.87%	5.64%
Recovery rate	95.36%	97.87%	98.13%	94.36%
Self-discharges	0	0	0	0

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

### Inpatient referrals

The total hospital referrals decreased by 2.9%. The number of referrals to the hospital remained similar to the previous year while the referrals from the hospital decreased by approximately 2.9%. The hospital continues to serve as the main referral hospital for Agago and four (4) additional nearby districts.

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

	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21	2021-22
Referrals to hospital	1,378	1552	153	694	695
Referrals from hospital	267	171	33	105	81
<b>Total</b>	<b>1,645</b>	<b>1723</b>	<b>186</b>	<b>799</b>	<b>776</b>

### Morbidity causes

The highest causes of morbidity in the wards were malaria (25.14%), injuries (9.15%) and pneumonia (7.17%). These highest causes of morbidity are similar to the previous year. As it is frequently more challenging to manage the problems that occur from malaria infection, it is crucial that more initiatives be oriented towards community prevention of malaria transmission. A combination of community alcohol-related violence and a few traffic accidents made up the observed injury pattern in addition to the insecurity caused by the Karimojong warriors.

**Table 6.21: Top ten causes of admission in all the wards in the FYs 2020-2021 & 2021-2022**

Causes of Morbidity		FY 2020-21		FY 2021-22	
		No. of cases	% on all diagnose	No. of cases	% on all diagnose
1	Malaria	3,512	28.78%	3,246	25.14%
2	Injuries - Trauma due to other causes	975	7.99%	1,182	9.15%
3	Pneumonia	618	5.06%	926	7.17%
4	Abortions due to other causes	495	4.06%	553	4.28%
5	Septicemia	397	3.25%	504	3.90%
6	Malaria in pregnancy	399	3.27%	387	3.00%

7	Other Complications of pregnancy	179	1.47%	354	2.74%
8	Anaemia	618	5.06%	344	2.66%
9	Diarrhea - Acute\$Persistent	240	1.97%	342	2.65%
10	Other Gynaecological conditions	76	0.62%	336	2.60%
	All others	763	6.25%	449	3.48%
<b>Total</b>		<b>12,203</b>		<b>12,913</b>	

**Table 6.22: Trend in Malaria admissions over the last 5 FY**

	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21	2021-22
Malaria cases	1,844	3,159	6,989	3,512	3,246
% of all diagnosis	22.40%	21.35%	41.65%	28.78%	25.14%

### Mortality causes

Malaria and pneumonia accounted for the highest causes of mortality with case fatality rates of 1.51% and 3.78% respectively. The burden of neonatal deaths persists, particularly given the ongoing delay in receiving referrals of newborns from lower-level facilities. The second-highest CFR (7.49%) was associated with other newborn disorders.

**Table 6.23: Top ten causes of death among inpatients all wards FY2020-21 and FY2021-22**

Causes of Mortality among Inpatients		FY 2020-21			FY 2021-22		
		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	91	3,512	2.59%	49	3,246	1.51%
2	Pneumonia	32	618	5.18%	35	926	3.78%
3	Other Neonatal Conditions	19	168	11.31%	17	227	7.49%
4	Injuries - Trauma due to other causes	14	975	1.44%	17	1,182	1.44%
5	Malnutrition	7	297	2.36%	15	227	6.61%
6	Premature baby (as condition that requires mgt)	15	130	11.54%	11	160	6.88%
7	Hypertension	6	77	7.79%	9	141	6.38%
8	Heart failure	9	45	20.00%	9	44	20.45%
9	Anaemia	22	618	3.56%	8	344	2.33%
10	Tuberculosis	4	202	1.98%	6	165	3.64%
	All others	16	763	2.10%	22	449	4.90%

## MEDICAL WARD

The department has both the general ward and an adjacent private wing with a total bed capacity of 41. The private ward has 11 beds of which three are self-contained rooms. The complex is one of the oldest in the hospital and plans for renovation are in the pipeline. The TB ward is annexed to the same structure and its activities run under medical ward.

### Staff composition

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

**Table 6.24: Staff Composition in Medical Ward FY2021-2022**

Cadre/ Discipline	Qualification	Number
Medical Doctor	Bachelor Degree in Medicine and Surgery	1
Registered Nurse/Midwife	Diploma in Comprehensive Nursing	3
Enrolled Nurse	Certificate in Nursing	7
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	1
Nursing Assistant	Certificate in Nursing Assistant	1
Nursing Aid	Trained on the Job	0
<b>Total</b>		<b>13</b>

**Table 6.25: Key indicators in Medical Ward in the last5 FYs**

	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21	2021-22
<b>No. of beds</b>	41	41	41	41	41
<b>Total Admissions</b>	2,072	2,237	2,684	1,834	2141
<b>Bed days</b>	11,334	11,310	12,549	7,542	9285
<b>ALoS</b>	5.5	5.1	4.7	4.112	4.337
<b>BOR</b>	75.70%	75.57%	84.29%	50.40%	62.0
<b>Throughput</b>	50.5	54.6	65.5	44.7	52.2
<b>Turnover interval</b>	1.75	1.63	1.36	1.99	1.71
<b>Deaths</b>	63	86	113	140	142
<b>Death Rate</b>	3.04%	3.84%	4.21%	7.63%	6.63%
<b>Recovery Rate</b>	95.50%	95.75%	95.45%	89.59%	92.81%
<b>Self-discharges</b>	4	9	9	51	12

As noted above, the total admissions increased by 16.7 % compared to the previous year and this can be attributed to improved health seeking behavior following the reduction of COVID 19 disease cases. The ALoS (4.3) and BOR (62.0) both increased with an increase in the total admissions. Death rate decreased by a percentage factor of 1 and this is as a result of improved



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

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

Causes of Morbidity in Medical Ward		FY 2020-2021		FY 2021-2022	
		No. of cases admitted	% on all admissions in Medical Ward	No. of cases admitted	% on all admissions in Medical Ward
1	Malaria	547	29.83%	649	30.31%
2	Sepsis	179	9.76%	238	11.12%
3	Pneumonia	112	6.11%	133	6.21%
4	Poisoning	126	6.87%	95	4.44%
5	Hypertension	63	3.44%	88	4.11%
6	AGE	114	6.22%	86	4.02%
7	Liver disease	33	1.80%	68	3.18%
8	Anaemia	80	4.36%	55	2.57%
9	PUD	36	1.96%	53	2.48%
10	UTI	33	1.80%	53	2.48%
Total Admission		1,834		2,141	

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

Causes of Mortality in Medical Ward		FY 2020-2021			FY 2021-2022		
		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	21	112	18.75%	18	133	13.53%
2	Heart Failure	15	44	34.09%	14	42	33.33%
3	Liver disease	6	33	18.18%	9	68	13.24%
4	Hypertension	1	8	12.50%	7	88	7.95%
5	Covid 19	2	13	15.38%	6	20	30.00%

## Surgical Ward

Surgical Ward is accommodated in one of the oldest structures in the hospital but underwent partial renovation late in 2022. However, a more comprehensive renovation is still needed

involving the structure and the furniture as well (beds, lockers, mattresses etc.) as they are in very poor state. This not only compromise the comfort of the patients but greatly affects staff work and hygiene. The ward accommodates 71 beds with both female and male sides and also has a private wing

#### **Staff composition.**

The total number of staff stood and 19 with the breakdown as below. The Ward is under the headship of a Surgeon and assisted by 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 for their surgical disciplines periodically.

The facility in conjunction with the Njokuti foundation was also able to conduct an orthopaedic surgical camp in which consultation and surgical operations were offered to the population at no cost.

**Table 6.28: Staffcomposition in SurgicalWard in theFY2021-2022**

Cadre/Discipline	Qualification	Number
Surgeon	BachelorDegreeinMedicineand SurgeryandMasterinSurgery	1
Medical Officer	BachelorDegreeinMedicineand Surgery	1
Registered Midwife/Nurse	Diploma in Midwifery andNursing	3
EnrolledComprehensiveNurse	Certificatein ComprehensiveNursing	1
EnrolledNurse	CertificateinNursing	10
NursingAid	Trainedon the job	1
Orthopedic Officer	Diploma in Orthopedic	1
Physiotherapy	Dip.In Physiotherapy	1
<b>Total</b>		<b>19</b>

There was a slight increment in the total admissions by 4% compared to the previous financial year with a proportional increase in the BOR as shown in the table above. The ALoS decreased by 0.3 despite still remaining high with reference to the national average of 4.5. It's the highest when compared to the other wards given the nature of services offered (surgical procedures) and this increases the costs of treatment.

The overall utilization of inpatient services in the surgical ward increased given the increase in the total admission. 97.2% of the total admissions were successfully discharged home while some were referred. Mortality rate stood at 2.8 % with septic wounds having the highest case fatality rate with septic shock as the underlying cause.

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

	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21	2021-22
No. of beds	76	76	76	76	76
Total Admissions	2,024	2,055	1925	1521	1,584
Bed days	17,995	14,721	15189	13701	13,776
ALoS	8.9	7.2	8.0	9.0	8.7
BOR	64.90%	53.07%	56.00%	49.39%	49.66
Throughput	26.6	27.0	25.3	20.0	20.8
Turnover interval	4.8	6.3	6.5	9.2	8.8
Deaths	13	31	32	30	45
Death Rate	0.64%	1.51%	1.66%	1.97%	2.84%
Recovery Rate	98.80%	98.35%	98.13%	97.04%	96.02%
Self-discharges	4	3	4	15	18

**Table 6.30: Top10 causes of admissions in Surgical Ward - FYs 2020-2021 & 2021-2022**

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

**Mortality causes**

Septic wounds had the highest CFR of 12.12% with majority of the cases being elderly people with other underlying co morbid conditions like hypertension and DM which poses management challenges... This was confounded by the total lack of critical care services (ICU) in the hospital to support the very sick and post-operative patients. The hospital is looking at setting up a high dependence unit so as to close this gap.

The Acholi sub region still significantly suffers from lack of CT scan services; complicating the care for trauma patients especially the head injury cases who may need urgent CT scan for timely interventions

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

Top 5 Causes of Mortality among Inpatients		No of Disease specific deaths	Total No of cases of the disease admitted	Case Fatality Rate
1	Head Injury	4	104	3.85%
2	Septic wound	4	33	12.12%
3	Intestinal obstruction	3	40	7.50%
4	Blunt abdominal trauma	2	56	3.57%
5	Abscess	1	113	0.88%

### **Surgical operation theater**

The hospitals' operating theater runs seven (7) days a week, 24 hours a day. The structure was constructed in 2015 with a grant from the Japanese government. The unit has specific elective operation days however emergency procedures run throughout the week 24 hours a day with staff distributed to effectively cover the shifts.

The staffing of the unit is as below with no much change in the cadres however there are now 4 anesthetic officers compared to 3 last years. Retaining of anesthetic staff still remains a challenge as none of the 4 is a full time employee of the hospital since emoluments do not adequately compete with what other institutions offer.

**Table 6.32: Staff Composition in the operating theatre FY 2021-2022**

Cadre/ Discipline	Qualification	Number
Anesthetist Officer	Diploma in Anesthesia	4
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	0
Medical Theatre Assistant		2
Nursing Assistant	Certificate in Nursing Assistant	3
Nursing Aid	Trained on the Job	4
<b>Total</b>		<b>17</b>

### **Surgical Procedures**

The total number of surgeries performed in the hospital increased with the increased number of patients coming to seek health care services. Caesarean section leads the table in terms of major operations and majority of which were emergencies with a few electives. The increased

Caesarean sections is attributed to the high rate of teenage pregnancies following the COVID 19 restrictions which saw many young girls dropping out of school. This also explains the evacuations for incomplete abortions as a leading minor procedure at 16.98% of which some were spontaneous while others were induced.

Overall there was an increase in the number of surgical procedures with bone reconstruction the 5<sup>th</sup> major procedures and this was as a result of the orthopedic surgical camps that were conducted with support from the Njokuti foundation.

**Table 6.33:Top major surgical procedures performed in the FY 2021-22**

No.	Top major surgical procedures	Number of patients	Proportion (%)
1	Caesarean sections	693	70.07%
2	Laparotomy	93	9.40%
3	Herniorrhaphy	84	8.49%
4	Hysterectomy	27	2.73%
5	Bone reconstruction	23	2.33%
<b>Total</b>		<b>989</b>	

**Table 6.34:Top minor surgical procedures done in FY2021-22**

No.	Top minor surgical procedures	Number of patients	Proportion (%)
1	Evacuations (incomplete abortion)	154	16.89%
2	Incision and drainage of abscesses	116	12.72%
3	Debridement	105	11.51%
4	Soft tissue releases	36	3.95%
5	Skin grafting	23	2.52%
	Others	430	47.15%
<b>Total</b>		<b>912</b>	

**Table 6.35:Trend of surgical activities in last 5 FYs**

Surgical activities	FY	FY	FY	FY	FY
	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Total Operations	3,425	3286	3139	<b>1652</b>	<b>1901</b>
Major operations (including C/S)	1,285	1314	1235	<b>963</b>	<b>957</b>
Minor operations	2,140	1,972	1904	<b>689</b>	<b>944</b>
Emergencies	530	585	620	<b>704</b>	<b>765</b>
Emergencies as % of total major operations	<b>41.20%</b>	<b>44.52%</b>	<b>50.20%</b>	<b>73.10%</b>	<b>79.94%</b>

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

Type of Anesthesia	FY	FY	FY	FY	FY
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	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022
Local Anesthesia	344	163	146	163	165
General Anaesthesia with IV Ketamine	1,175	645	933	731	749
Spinal Anesthesia	262	263	737	678	773
General Anesthesia with ETT	69	65	88	78	65
General Anesthesia with LMA	0	0	13	2	21
Regional Anaesthesia	0	0	1	0	12
<b>Total</b>	<b>1,850</b>	<b>1136</b>	<b>1918</b>	<b>1652</b>	<b>1785</b>

## PEDIATRIC WARD

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

The refurbishment of the ward both the structure and furniture with funding from CEI was completed and the department is now the newest in the facility.

The department has a number of projects running including the RBF and Sickle cell projects with support from the foundation and ISP respectively and all this is with the aim of improving quality services we are offering to the community.

### Staff Composition

The ward is under the leadership of a pediatrician since March 2022 who also doubles as the Medical Director of the hospital. The daily ward activities are however run by one MO who also oversees activities in the NICU. Despite a few nurses leaving for various reasons, the number of nursing staff members remained steady. Over the course of the year, the ward received support from a visiting Italian pediatrician volunteer.

**Table 6.37: Personnel assigned to Paediatric Ward in FY2021-22**

Cadre/ Discipline	Qualification	Number
Medical officers	Bachelor Degree in Medicine and Surgery	1
Enrolled Midwife	Certificate in Midwifery	3
Registered Nurse	Diploma in Nursing	2
Nutritionist	Dip. In Human Diet and Nutrition	1
Enrolled Nurse	Certificate in Nursing	6
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	2
Nursing Assistant	Certificate in Nursing Assistant	3
<b>Total</b>		<b>18</b>

### Key ward indicators

The total admissions remained almost steady when compared to the previous year as majority seek treatment from VHTs, lower Health centers or even private clinics before coming to the hospital. Despite the decrease in the overall malaria cases, it's still the leading cause of

admissions in the department with pneumonia and sepsis next in line respectively. There was a significant decrease in both the BOR and the ALOS which improves the quality of services offered.

Malnutrition continues to be on the rise; typically related to the high poverty levels and low levels of literacy in the surrounding community

Prematurity was the top leading cause of admissions in the NICU given the high rates of teenage pregnancies coupled with poor ANC attendance.

### **Mortality causes**

Mortality rate however increased by 0.62 with SAM having the highest case fatality rate at 4.41% followed by malaria. Majority of these who died often presented late after seeking care from private clinics or health centers in addition to the wide catchment area. Thus they present in critical condition coupled with the shortage of blood products for those with severe anemia requiring very urgent blood transfusion. Emergency blood services are in place to curb some of these deaths though some end up succumbing as it's a process. In addition, it's a costly venture hence raises issues of sustainability given the fact the hospital is a PNFP.

Given the widespread, chronic shortage of blood products that exists right now, anemia will still pose a serious challenge in management of cases of severe anemia.

Among the neonates, pneumonia had the highest case fatality rate followed by birth asphyxia which is associated with prematurity then other complications of prematurity.

Equipment in the NICU are not adequate as sometimes the number of admissions can be overwhelming.

**Table 6.38a: Paediatric Ward indicators over the last 5FYs**

	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21	2021-22
<b>No. of beds</b>	61	61	61	76	76
<b>Total Admissions</b>	3,810	4,143	7,615	4,437	4,398
<b>Bed days</b>	19,783	11,310	43,503	29,304	20,960
<b>ALoS</b>	5.2	4.9	5.71	6.60	4.77
<b>BOR</b>	88.85	50.80	195.39	105.64	75.56
<b>Throughput</b>	62.5	67.9	124.8	58.4	57.9
<b>Turnover interval</b>	0.65	2.64	-2.79	-0.35	1.54
<b>Deaths</b>	36	59	217	157	183
<b>Death Rate</b>	0.94%	1.42%	2.85%	3.54%	4.16%
<b>Recovery Rate</b>	98.70%	98.04%	96.53%	94.79%	95.52%
<b>Self-discharges</b>	10	22	47	74	14

**Table 6.38b: Neonatal Intensive Care Unit only**

	FY 2020-21	FY 2021-22
	NICU	NICU
No. of beds	15	15
Total Admissions	472	589
Bed days	3,116	3,884
ALoS	6.60	6.59
BOR	57%	136
Throughput	31	39
Turnover interval	5	3
Deaths	46	89
Death Rate	8.05%	15.1%
Recovery Rate	91.95%	84.89%
Self-discharges	-	-

**Table 6.39a: Top ten causes of admission in Paediatric Ward- FY2020-21 and FY2021-22**

Causes of Morbidity		FY 2020-2021		FY 2021-2022	
		No. of cases admitted	% on all admissions	No. of cases admitted	% on all admissions
1	Malaria	2,376	53.55%	2,183	56.82%
2	Pneumonia	355	8.00%	399	10.39%
3	Sepsis	334	7.53%	358	9.32%
4	Anaemia due to other causes	332	7.48%	174	4.53%
5	Diarrhoea	190	4.28%	169	4.40%
6	SAM	98	2.21%	136	3.54%
7	SCD	36	0.81%	100	2.60%
8	RTI	49	1.10%	61	1.59%
9	Bronchiolitis	7	0.16%	48	1.25%
10	UTI	9	0.20%	18	0.47%

**Table 6.39b: Top ten causes of admission in NICU Ward - FY2020-21 and FY2021-22**

Causes of Morbidity		FY 2020-2021		FY 2021-2022	
		No. of cases admitted	% on all admissions	No. of cases admitted	% on all admissions
1	Prematurity	139	29.45%	196	33.28%
2	Neonatal sepsis	131	27.75%	128	21.73%
3	Birth asphyxia	100	21.19%	114	19.35%
4	Respiratory Distress Syndrome	0	0.00%	66	11.21%
5	Pneumonia	34	7.20%	19	3.23%
6	Meconium Aspiration Syndrome	0	0.00%	16	2.72%
7	Malaria	0	0.00%	4	0.68%

8	Neonatal Jaundice	7	1.48%	4	0.68%
9	Gastroschisis	1	0.21%	3	0.51%
10	Transient tachypnea of the new born	15	3.18%	3	0.51%
<b>Total Admission</b>		<b>472</b>		<b>589</b>	

**Table 6.40a: Top five causes of death in Paediatric Ward in FY2021-22**

<b>Causes of Mortality</b>	<b>No of disease-specific deaths</b>	<b>No of cases of the disease admitted in Paediatric Ward</b>	<b>Case Fatality Rate</b>
Malaria	35	2,183	1.60%
Pneumonia	13	399	3.26%
SAM	6	136	4.41%
Anemia	4	174	2.30%
Sepsis	4	358	1.12%

**Table 6.40b: Top five causes of death in NICU in FY 2021-22**

<b>Causes of Mortality (NICU)</b>		<b>No of disease-specific deaths</b>	<b>No of cases of the disease admitted in NICU</b>	<b>Case Fatality Rate</b>
1	Prematurity	32	196	16.33%
2	Birth asphyxia	24	114	21.05%
3	Respiratory Distress Syndrome	9	66	13.64%
4	Pneumonia	8	19	42.11%
5	Neonatal sepsis	4	128	3.13%

## **Maternity Ward**

With a capacity of 75 beds, the maternity unit is the hospital's biggest ward. It has an admission room, first stage room, PET room, and labor suite in the pre-delivery area. Postnatal, post-Caesarian, and gynecology make up the IPD area. A doctors' office, nurse in charge office, duty room, private rooms, and isolation unit are all included in the ward's arrangement.

One medical officer supported by intern doctors who are in the facility every six months for their surgical rotations with obstetrics and gynecology as their minor rotation as the facility didn't have a specialist but efforts are underway to employ one. The composition of the nursing and midwives is as shown in the table below and this team is directly in charge of overseeing the care of all admitted patients, ran this unit.

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

The ward participated directly in the World bank funded MOH RBF program which strengthens the URMCHIP intervention, this however has come to a conclusion. This may however contribute to poor pregnancy outcomes as maternal and under 5 referrals ambulance services were being offered at no cost to the patients.

**Table 6.41: Staff Composition in Maternity Ward in FY2021-22**

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	2
Registered Midwife	Diploma in Midwifery	4
Enrolled Midwife	Certificate in Midwifery	19
Nursing Aide	Primary Leaving Examination (P.L.E)	1
<b>Total</b>		<b>28</b>

### Key Indicators

Admissions overall increased by 10.89% compared to last year although there was a decline in the ALOS TO 3.8 compared to 4.2 last year. The BOR remained stable at 64.01 hence the facility is able to accommodate variations in health service demand with effective patient flow.

The rate of maternal deaths stood at 0.11 %, 0.16 lower than the previous year and this is as a result of the improved staffing levels with improved quality of services. In addition, the regular audit of deaths both maternal and neonatal help the team to identify missed opportunities timely so as to avoid similar occurrences.

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

	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21	2021-22
No. of beds	75	75	75	75	75
Total Admissions	5,302	6,165	4,226	4,144	4,595
Bed days	17,331	20,984	16,519	17,441	17,522
ALoS	3.3	3.4	3.9	4.2	3.8
BOR	63.31	76.65	60.34	63.71	64.01
Throughput	70.7	82.2	56.35	55.25	61.27
Turnover interval	1.9	1.04	2.57	2.40	2.14
No. Deaths	1	7	4	11	5
Death Rate	0.02%	0.11%	0.09%	0.27%	0.11%
Recovery Rate	99.40%	99.9%	99.9%	99.2%	98.7%
Self-discharges	0	0	0	24	55



### Birth indicators

Hospital deliveries increased overall by 12.53% and this increase in deliveries was probably as a result of the increased teenage pregnancies due to increased school dropout rate following the COVID 19 restrictions. 23.9% of all births were through Caesarean section compared to 25.12 % last year and of the total C/S performed, 97.4% were emergencies, which are a direct result of LLUs making late referrals

2.3% of the deliveries were still births with 51.5% of these being macerated still births and is still attributed to poor ANC attendance with the majority of pregnant mothers starting the ANC visits after the first trimester. This is still coupled with late referrals from LLU and this will be get worse with the conclusion of the free ambulance services that came with the RBF project enabling swift transfer of mothers from the LLUs

Premature deliveries still undoubtedly remained a heavy burden as even seen in the NICU admissions. The high premature deliveries were linked to infections like malaria and UTI, hard labor by mothers and the increased number of teenage pregnancies. The hospital's Neonatal Intensive Care Unit took care of these premature newborns as well as others who were referred by LLUs though the unit occasionally gets overwhelmed with the high number of admissions.

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

	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21	2021-22
<b>Total deliveries</b>	3,547	4,169	2,707	2,576	2,899
<b>Normal deliveries in unit</b>	2,977	3,617	2,187	2,576	2,200
<b>Abnormal deliveries (incl. C/S)</b>	570	529	552	647	699
<b>Live birth in units</b>	3,499	4,142	2,654	2,486	2,886
<b>Babies born with low birth weight</b>	577	732	517	504	175
<b>Fresh Still births in unit</b>	18	24	23	30	33
<b>Macerated still births in unit</b>	16	35	46	31	35
<b>New-born deaths (0-7 days)</b>	14	69	59	55	75
<b>Maternal Deaths</b>	1	9	5	10	5
<b>Live Births</b>					
<b>Full term normal weight</b>	2977	3,384	2,084	1,694	2,124
<b>Full term low birth weight</b>	577	601	451	357	437
<b>Premature cases</b>	90	157	223	435	325
<b>Caesarean Sections</b>					
<b>Elective C/S</b>	26	30	33	5	18
<b>Emergency C/S</b>	530	579	519	642	675
<b>Caesarean Sections total</b>	556	609	552	647	693
<b>C/S as % of total deliveries</b>	15.70%	14.61%	20.39%	25.12%	23.90%
<b>Emergency C/S as % of all C/S</b>	95.30%	95.07%	94.02%	99.23%	97.40%

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

**Table 6.44a: Origin of mothers who delivered through C/S in the last 5 FYs<sup>3</sup>**

Sub-County	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21	2021-22
Adilang	49	46	37	41	59
Kotomor	16	35	25	20	17
Patongo	52	58	53	63	86
Patongo T.C.					
Lukole	58	68	51	72	79
Lukole T.C.	6				
Kalongo T.C.	39	69	69	52	47
Paimol	32	53	50	27	30
Parabongo	46	40	40	40	42
Omot	34	38	26	28	14
Acholpii	4	25	21	13	13
Lamiyo	9	37	29	8	11
Lapono	60	39	41	51	69
Lira Palwo	28	35	35	114	54
Omiya Pacwa	25	41	33	13	20
Wol	40	25	27	37	55
<b>Total</b>	<b>498</b>	<b>609</b>	<b>537</b>	<b>579</b>	<b>596</b>

<sup>3</sup>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 2017-2018 to FY 2021-2022)

**Table 6.44b Continuation**

Outside the Catchment Area of Agago District (distances of 58 km and above)					
District	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21	2021-22
Pader	17	10	8	42	48
Kitgum	10	1	2	4	6
Abim	7	0	5	16	18
Other	23	0	0	6	25
<b>Total</b>	<b>58</b>	<b>11</b>	<b>15</b>	<b>68</b>	<b>97</b>

Referrals of patients remains one of the biggest challenges of the district. The poor condition of roads, the lack of functioning ambulances, the level of poverty of the majority of the households coupled with the wide catchment area of the hospital, presents a persistent threat for pregnant mothers. The hospital still maintains a waiting shelter where high risk mothers can wait until their time of delivery.

### Gynecological ward

Gynecological services have been made more difficult by the absence of specialized obstetrics and gynecological services. For the hospital, attracting and keeping such cadres has proven to be difficult given the fact that the facility is in a rural setting.

The MOs who also o ran the weekly gynecologic clinics every Monday in OPD, treated all gynecological conditions and those that prove to be challenging are often referred for specialist services.

Abortions were the leading cause of admission of which majority were spontaneous abortions followed by malaria in pregnancy then other pregnancy related complications.

**Table 6.45: Admissions in Maternity Ward not related to maternity conditions**

Diagnosis of admission		No. of cases admitted	% on all admissions in Surgical Ward
1	Abortions	554	30.2%
2	Malaria in pregnancy	387	21.1%
3	Other Complications of pregnancy	354	19.3%
4	Other Gynaecological conditions	336	18.3%
5	Haemorrhage related to pregnancy (APH or PPH)	61	3.3%
6	Sepsis related to pregnancy	45	2.5%
7	Obstructed labour	32	1.7%
8	Pelvic Inflammatory Disease (PID)	32	1.7%
9	Cancer of the cervix(newly diagnosed cases)	22	1.2%
10	Tubal Ovarian mass/cancer	5	0.3%
Total		1834	

### TB ward

The TB ward is annexed to the Medical Ward main building and its activities are also overseen by the medical ward team. Despite TB being a major public concern in the district of Agago, the total admissions decreased by 26.9% compared to last year which could be attributed to poor health seeking behavior. TB cast campaign was conducted in conjunction with the district in which screening for TB in the community was done which unmasked the unmet screening need. Following this finding, it's been programmed that the cast campaign will be conducted twice next year and with screening at all entry points strengthened. With this, we expect the case detection rate to increase next year.

ALOS and BOR both increased by 6.1 and 12.94 respectively given the increased number of bacteriologically confirmed TB cases The death rate significantly increased and this was majorly among HIV co infected individuals who also had poor ART adherence hence advanced

HIV disease High default rates still remains a problem despite efforts to follow up clients in the community being in place but this is not sufficient.

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

	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
No. of beds	18	18	18	18	18
Total Admissions	252	194	329	267	195
Bed days	2,078	2,126	2,001	1,240	2090
ALoS	8.2	5.8	6.08	4.6	10.7
BOR	31.63	32.36	30.46	18.87	31.81
Throughput	14	10.8	18.3	14.83	10.83
Turnover interval	17.8	22.9	13.9	20.0	23.0
Deaths	2	11	7	5	9
Death Rate	0.79%	5.67%	2.13%	1.87%	4.62%
Recovery Rate	99.20%	94.33%	97.87%	98.13%	95.38%
Self-discharges	0	0	0	0	0

## Diagnostic services

### Laboratory services

A HUB system that provides services to ten (10) lower-level facilities in the Agago and Pader areas is the hospital laboratory. Throughout the FY, the hub's operations ran smoothly. Providing laboratory testing services to all samples of HIV positive individuals from LLUs, organizing hub coordination meetings, managing all of the level laboratories, sending samples for tests that couldn't be conducted to the Central Public Health Laboratory, and promptly updating the district on all Laboratory activities

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

Type of Tests		FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22
Parasitology	Malaria Microscopy, Malaria RDTs, Other Haemoparasites, Stool Microscopy.	23,320	23,793	28,676	17,513	24,446
Haematology	HB, WBC Total, WBC Differential, Film Comment, ESR, RBC, Bleeding time, Prothrombine time, clotting time, blood transfusion tests, & Others	111,917	23,156	28,456	20,989	27,055

Biochemistry	Urea, Calcium, Potassium, Sodium, Creatinine, ALT, AST, Albumin, Total protein, Triglycerides, Cholesterol, CK, LDH, Alkaline Phos, Amylase, Glucose, Uric Acid, Lactate, Others	13,518	2,069	2,504	1,243	1,851
Bacteriology	ZN for AFBs, Cultures and Sensitivities, Gram, Indian Ink, Wet Preps, Urine Microscopy	7,262	6,633	15,327	15,619	12,569
Serology	VDRL IRPR, TPHA, Shigella Dysentery, Syphilis Screening, Hepatitis B, Brucella, Pregnancy Test, Vidal Test, Rheumatoid Factor	13,270	12,845	9,989	7,174	9,981
Immunology	CD4 tests & others	5,080	2,722	4,847	3,554	2,684
HIV tests by purpose	HCT, PMTCT, Quality control and clinical diagnosis	28,211	22,762	20,691	14,414	14,212
<b>Total tests</b>		<b>202,578</b>	<b>92,141</b>	<b>110,490</b>	<b>80,506</b>	<b>92,798</b>
<b>Total lab staffs</b>		<b>11</b>	<b>10</b>	<b>10</b>	<b>10</b>	<b>10</b>
<b>Average tests per Lab staff</b>		<b>18,416</b>	<b>9,214.1</b>	<b>11,049.0</b>	<b>8,051.0</b>	<b>9,279.8</b>

In the laboratory, the total number of tests performed per employee increased by 15.26% along with the overall number of hospital patients during the year compared to last year with the number of employees remaining constant.

There was a reduction in the malaria cases as reported by the laboratory and also reflected in the reduced malaria admissions reflected in the inpatient data.

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

Type of Test	FY 2020-2021			FY 2021-2022		
	Total	Positive	% Positive	Total	Positive	% Positive
Malaria (both slide and RDT)	17,421	7,316	42.00%	24,246	8,501	35.06%
VDRL/RPR	4,406	437	9.92%	4,816	460	9.55%
Hepatitis B	1,853	188	10.15%	3,092	289	9.35%
Brucella	110	1	0.91%	12	0	0.00%

The Gulu Regional Blood bank provides blood to the hospital. The consistent flow and availability of blood products is severely restricted by numerous circumstances, including inadequate stock at the blood bank, road conditions in wet seasons coupled with the long distances.



The overall blood shortage in the area, has persisted, with severe consequences for anemia, especially in children under the age of five. On occasional basis, in order to save lives in emergency situations, the hospital has had to do local blood donation from qualified visitors and volunteers following the necessary screening tests which has increased the laboratory's operating costs.

RH+ blood products for blood groups O and A continue to be the most utilized as shown in the table below. Since it is difficult to find RH- donors, the demand for RH- also grew in FY 20/21, posing a significant difficulty. Demand for specialized blood products like platelet concentrates, fresh frozen plasma still remains a problem and difficult to resolve because the regional bank does not supply these blood products.

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

FY						FY					
2020-2021						2021-2022					
Group A	Group B	Group AB	Group O	RH +	RH -	Group A	Group B	Group AB	Group O	RH +	RH -
33.80%	16.80%	4.00%	44.60%	99.20%	0.80%	32.70%	16.52%	4.56%	44.40%	98.18%	1.82%

## IMAGING SERVICES

### X ray and Ultrasonography

The department still suffers the lack of a fully qualified radiographer with it being run by one dark room attendant following the exit of his colleague. Emergency ultrasound scans were being done by some of the Mos with background knowledge and skill in offering the services, however others were referred to do these investigations.

Maintaining core employees, such radiographers still a challenge which has therefore disrupted critical medical services however the hospital devised a means of sending one of its employees to do a short course to temporarily close this gap.

The total number of X rays done still reduced like in the previous year with chest x-rays still being the most frequently done with the commonest indications being trauma and also to r/o associated complications of respiratory infections and as a screening test for TB infection. A digital X-ray machine is currently in use at the hospital, and images are digitally relayed to the clinicians for speedy review. Given the high cost of digital cassettes, it has been difficult to give patients a printed copy.

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

	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21	2021-22
Chest	572	1,459	2,009	1,849	1,461

Upper extremities	458	997	877	1,013	714
Lower extremities	278	710	735	821	676
Vertebral column	83	283	335	291	323
Skull and mandible	53	158	150	137	235
Shoulder and clavicle	69	139	178	0	152
Pelvis and hip	60	153	176	81	176
Abdominal – plain	51	155	203	198	143
Abdominal -contrast	0	2	0	0	0
Screening	0	0	5	0	0
<b>Total</b>	<b>1,624</b>	<b>4,056</b>	<b>4,668</b>	<b>4,390</b>	<b>3,880</b>

**Table 6.51: Ultrasound examinations conducted in the last 3 FYs**

	FY	FY	FY
	2019-20	2020-21	2021-22
<b>Obstetrics</b>	99	0	176
<b>Gynaecology</b>	50	0	281
<b>Abdomen</b>	239	0	238
<b>Others</b>	24	0	43
<b>Total</b>	<b>412</b>	<b>0</b>	<b>738</b>

## PHARMACY ACTIVITIES

The Unit Dose System (UDS) for managing medications in the hospital has remained functional with much improvement seen in its implementation and also yielding results. All of the Wards have emergency medications in specially built boxes under routine pharmacy dispenser inspection.

Following a training on the MTC organized by MOH and UPMB that was attended by 3 hospital staff with the pharmacist inclusive, efforts are underway to fully functionalize the already existent hospital MTC. This team will oversee the efficient and cost-effective utilization of pharmaceuticals in the hospital;

**Table 6.52: Staff composition in Pharmacy and General Store in the FY 2021-2022**

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
<b>Total</b>		<b>9</b>

## 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.

Due to fluctuations during the day, the readings for the room are taken three times daily. At the conclusion of the month, an average value is determined. The temperature frequently rises beyond 30°C starting in the afternoon, which poses many risks and challenges for the safe storage of medications. It is apparent that the pharmacy needs air conditioners installed to maintain the ideal temperature even during the dry seasons.

**Table 6.53: Average temperature and humidity recorded in Pharmacy Department FY2021-22**

Reading Time	Temperature	Humidity
8:15 am	25.6	52%
12.00 pm	32.5	48%
5.00 pm	30.8	43%

## Pharmaceutical supplies

Supplies are primarily ordered through Joint Medical Stores, as in prior years (JMS). The open market or Abacus are used to purchase goods that JMS does not carry. The HIV Clinic's primary antiretroviral medicine and TB commodities also supplied by JMS with once in a while stock out of some commodities like isoniazid. Mechanisms of monitoring stock levels are however in place to address such issues before they arise.

## Procurement system

The majority of the time, drugs and other items are purchased every three months. However, due to financial limitations, it has become necessary to use a more fragmented structure in order to handle the urgent requests from the Wards.

Orders are placed and buffer stock levels are tracked at the store level, where procurement begins. At least a month before the buffer stock is anticipated to be used up, the orders are anticipated. Prior to being submitted to the procurement department for execution, orders are vetted by the Drug and Therapeutic Committee.

The hospital had a number of times where certain supplies were in short supply. primarily because neither the country nor its suppliers have access to such commodities.

### Inventory management

The management of purchases and stock movements is assisted by a manual and digital inventory system. To guarantee accountability, physical counts are performed every month and stock taking

every two years. In order to efficiently monitor real-time status, the management also approved spontaneous stock inventories

### Distribution and use

Following the implementation of a Unit dosage system, the Pharmacy distributes medications to the various wards and departments. After a prescription, medications are given out and this has resulted in less medication is being wasted

**Table 6.54: Most used drugs (excluded HIV/AIDS clinic)- FY 2020-2021 and FY2021-2022**

Drug description	FY		FY	
	2020-2021		2021-2022	
	Quantity issued tablets/vial	Monetary value (UGX)	Quantity issued tablets/vial	Monetary value (UGX)
Paracetamol 500mg	17,175	7,203,305.00	26,383	28,443,885.20
Amoxicillin 250mg	15,502	4,730,435.30	17,463	15,800,898.41
Metronidazole 200mg	112,699	7,822,437.59	137,118	9,648,001.66
Folic acid 5mg	36,031	3,983,536.28	55,053	6,964,628.51
Folic acid + Ferrous Sulphate	3,717	3,915,354.76	5,124	5,347,854.24
Ferrous sulphate 200mg	208,846	4,423,093.38	206,174	4,973,382.87
Cloxacillin 250mg	26,618	1,788,244.07	43,514	4,152,681.04
Ampicillin 500mg	51,141	3,878,725.31	37,198	3,856,191.43
Carbamazepine 200mg	130,742	3,079,222.20	127,377	3,706,786.12
Ibuprofen 200mg	29,418	3,239,331.24	27,394	3,235,953.92
Vitamin B complex	31,693	5,324,316.24	22,349	3,086,444.67
Ampicillin/cloxacillin 500mg	57,830	2,129,164.83	59,182	2,608,232.53
Prednisolone 5mg	28,023	1,271,716.29	58,748	2,321,316.40
Omeprazole 20mg	102,798	1,494,257.09	122,736	1,945,159.85
Ciprofloxacin 500mg	41,306	1,679,501.96	34,300	1,763,917.57
Frusemide 40mg	55,735	1,308,657.80	53,309	1,523,126.49
Erythromycin 250mg	28,074	1,996,078.56	15,804	1,231,572.36
Benzylpenicillin 1MU	45,720	947,121.96	33,440	995,325.32
Penicillin V 250mg	41,456	1,134,703.00	30,968	914,950.89
Metronidazole 5mg/ml 100ml	48,743	548,358.75	60,202	680,227.63
<b>Total</b>		<b>2,630,183.71</b>		<b>2,590,503.84</b>

### Intravenous fluid consumption

This year saw an increase in the consumption of intravenous fluids by over 4 million Ugandan shillings in terms of hospital costs which could be attributed to the increased number of patients attending services at the facility.

**Table 6.55: Consumption of IV fluids in FY2020-2021 & FY2021-2022**

Fluid Description	Quantity (in bottles) 2020-21	Value(UGX) for 2020-21	Quantity (in bottles) 2021-22	Value(UGX) for 2021-22
Sodium Chloride 0.9% IV 500 ml	10,341	15,071,516.88	11,041	16,826,917.71
Sodium Lactate Compound IV 500 ml	5,885	8,483,612.78	8,153	12,350,760.18
Dextrose 5% IV 500 ml	8,228	11,744,441.07	6,514	9,791,213.64
Water for Injection 10 ml	27,689	2,912,812.22	40,511	4,882,608.48
Dextrose 50% IV 100 ml	11,006	2,953,829.39	798	2,128,620.36
Darrow's Half Strength 500 ml	394	730,168.68	435	1,032,575.67
Gelatine/polygeline Solution 3.5% IV 500 ml	17	465,904.38	0	0.00
Dextrose 5% IV 250 ml	0	0	0	0
Total		<b>42,362,285.40</b>		<b>47,012,696.04</b>



## CHAPTER SEVEN: SUPPORT SERVICES

### Pastoral care

A vital component of the comprehensive care plan offered to patients is pastoral care. The services were continued for personnel to provide both emotional and spiritual support even after the COVID 19 epidemic. These services are provided by volunteers on behalf of the Kalongo Catholic Denary. A social worker, a catechist, and a priest make up the team.

During the year, 402 patients accessed pastoral care services, an increment of 243.6%. This was as a result of post COVID psychosocial stressors that needed the intervention of spiritual leaders. Patients and/or their care givers are encouraged to freely request through their respective wards for the services.

**Table7.1: Activities trend in clinical pastoral care of the sick during the last5 FYs**

Activity / Indicator	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21	2021-22
No. patients visited and counseled	452	454	161	116	396
No. of patients given sacrament of Marriage	0	0	0	0	2
No. of patients anointed	1	7	9	1	4
<b>Total</b>	<b>453</b>	<b>461</b>	<b>170</b>	<b>117</b>	<b>402</b>

### Ambulance services

Patients accessed ambulance services throughout the district and beyond. In several areas of the district, response times are hampered or delayed during the rainy season due to the poor condition of the roads. Due to frequent breakdowns from the poor roads, ambulance maintenance is still a significant issue.

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 hospital's Technical and Maintenance Department (TD) is in charge of making sure that all buildings and machinery, including the vehicles used by the hospital and the school, are routinely maintained.

Additionally, it offers technical support and oversight. Construction projects of greater scope and extraordinary renovations are contracted out. The TD also engages in a few meager income-generating initiatives to help ensure the hospital's long-term viability. Financial difficulties severely limited the TD's ability to perform its duties, hence it was unable to accomplish them. The department's revenue generation operations will be updated in the upcoming year.

Monitoring and regulating fuel usage in the hospital, is a duty charged to the TD under the supervision of the Administrator. Overall, the consumption of both diesel and petrol decreased in the FY 21/22. Diesel usage decreased by 17.2% while that of petrol was 11.7%. during the previous year, the diesel usage was mainly for the use in the generator due to the frequent power blackouts. The power was more stable this year but still is usually a challenge during rainy days and stormy days that caused damaged to the main transformer supplying the hospital. Just like last year, in the FY 21/22, the majority of field activities have been spatially coordinated to minimize vehicle movements to reduce fuel consumption by motor vehicles. Some activities are assigned motorcycles to cut down on the more expensive cost.

**Table 7.2: Consumption offuel by destination in the last5 FY**

	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21	2021-22
<b>DIESEL TOTAL</b>	<b>45,142</b>	<b>87,648.6</b>	<b>55,835</b>	<b>58,598</b>	<b>48,499</b>
Board of Governors Fuel Refund to members	315	350	180	265	270
Generators	17,391	38,182.8	29,946	39,133	29,040
Vehicles	26,341	42,599.7	19,133	18,462	18,460
Workshop	10	25	24	20	0
Incinerator	1,065	2004	655	618	624
Others	20	4,487.10	5,897	100	105
<b>PETROL TOTAL</b>	<b>3,054</b>	<b>6,917</b>	<b>3,179.5</b>	<b>2,978.0</b>	<b>2,630.0</b>
Administration	494	315	57	25	0
Donation	0	0	70	0	50
Generators	0	29	0	0	0
Vehicles	0	12.5	0	0	0
Motorcycles	2,335	6,509.5	2,969.5	2,885.0	2,507.0
Workshop	116	32	20	68	63
Others (Sales)	111	19	63	0	10
<b>KEROSENE TOTAL</b>	<b>36</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
Workshop	25	0	0	0	0
Pharmacy	0	0	0	0	0
Main store	0	0	0	0	0
Others	11	0	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 distance between the hospital and the wells is about 1,300 meters. Two large tanks with a combined 90,000-liter capacity are where the water is pumped. There are various-sized reserve tanks available in each building. The pumps frequently break down and require highly expensive replacements, which

are frequently not fully supported by the hospitals' budget due to the extremely heavy workload required to satisfy this large demand.

During the dry seasons, the existing wells run dry, leading to severe water shortages. To lessen the enormous pressure on the hospital, it is becoming increasingly necessary for the nearby institutions to supplement their water needs from the national water supply line.

### **Power Supply**

The national electrical grid supplies energy to the hospital. The institution has frequently had to rely on backup generators for power because this supply line is problematic. On the hospital grounds, all staff members receive discounted electricity.

A functioning photovoltaic system would greatly lower this expense. The hospital has tried to advocate for initiatives that would implement such energy-efficient solar systems, and it still does so.

### **Sewage system**

The entire hospital, St. Mary's Midwifery Training School, the staff housing, the neighborhood parish, and convents are all served by the sewage system. About 600 meters from the hospital, a lagoon is used to dispose of all sewage.

Since its rehabilitation in 2014, the sewage system has continued to operate. The biggest difficulty arises from routine maintenance due to persistent vandalism from some community members. To prevent encroachment, it is imperative to rebuild the fence enclosing the sewage lagoon system.

### **Waste disposal**

The facility still produces enormous volumes of waste, both medical and otherwise. Because the support staff working in the incinerator lacks enough training on medical waste management, proper waste segregation and management remains a significant difficulty. The team in charge of infection prevention and control has started a training program to increase local knowledge of correct waste segregation. Additionally, they intend to begin exploring options for recycling some of the household waste produced.

## CHAPTER EIGHT: QUALITY OF CARE AND PATIENTS' SAFETY

### QUALITY OF CARE AND PATIENTS' SAFETY

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

#### Quality indicators:

The hospital was able to conduct evaluations and other procedures for ongoing quality improvement. Throughout the FY, the quality improvement team was fully engaged and participated in a few initiatives to improve hospital quality. Below is a summary of the important criteria used to assess the quality of outputs.

#### Availability of qualified clinical staffs

In the hospital, the percentage of clinically qualified staff increased. The hospital does not offer extremely competitive wage packages, thus keeping these cadres has been the largest issue.

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

Indicators	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21	2021-22
Total No. of employees	253	251	252	232	251
Qualified staff[1]	174	196	183	184	189
Clinical qualified staff[2]	131	138	138	127	144
Total Clinical staff[3]	148	153	155	141	159
Proportion of clinical qualified staff over all qualified staff	75.29%	70.41%	75.41%	69.02%	76.19%
Proportion of clinical qualified staff over all clinical staff	88.51%	90.20%	89.03%	90.07%	90.57%
Proportion of clinical qualified staff over the total hospital staff	51.78%	54.98%	54.76%	54.74%	57.37%

#### Quality of care

The recovery rate after discharge went up overall by 4.37%. The rate of maternal deaths dropped by 0.15 percent. Similar to the previous year, maternal deaths were primarily caused by delayed referrals and hypertensive crises during pregnancy. To stop this, important interventions have been created and are currently being implemented.

The rate of early newborn deaths rose. Despite a high proportion of teen pregnancy, the district as a whole continues to have a high rate of premature births. The NICU received significantly more referrals of preterm newborns from the LLUs in FY 21/22. The effectiveness of referrals and interventions depends heavily on when they are made.

**Table 8.2: Indicators for the quality and safety measures**

Indicators	FY	FY	FY	FY	FY	Explanation
	2017-18	2018-19	2019-20	2020-21	2021-22	
Recovery rate on discharge	97.01%	97.09%	99.64%	94.83%	99.20%	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	0.02%	0.15%	0.02%	0.26%	0.11%	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	0.51%	0.58%	0.85%	1.21%	1.14%	Fresh still birth rate: Fresh Still births have intact, smooth and not macerated skin,
Caesarean sections infection rate	5.58%	0.82%	1.27%	2.78%	2.02%	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	0.39%	1.22%	2.18%	2.21%	2.59%	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' perception of the clinical outcome they experienced declined greatly by 38% and while the humanity of the care they received during the year was the same like last year. The perception of clinical outcomes declined due to long

waiting times and occasional drug shortages. Despite all the challenges, we nevertheless encourage our team to follow a client-centered approach of treatment.

Similar to last year, the huge increase in patient waiting times that patients experienced was the main issue. Our quality improvement team has conducted a root cause analysis and established standards to address the causes, despite factors like



turnaround time for tests required by doctors that are difficult to change. The

overall patient perception towards quality of care in the hospital declined in 21/22.

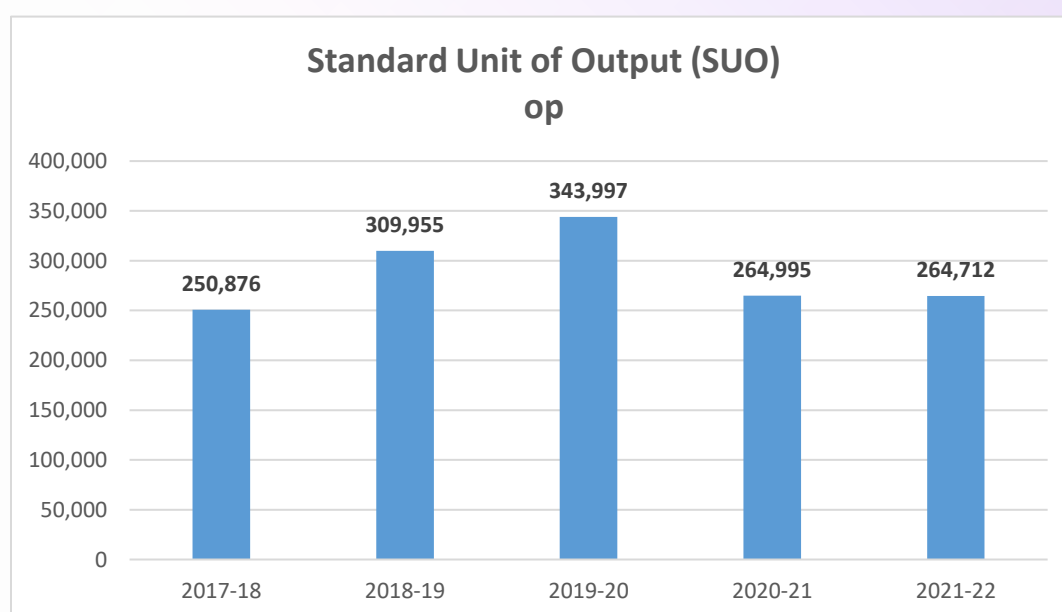
**Table 8.3: Satisfaction levels per core area for the last 5 FYs**

Financial Year	FY	FY	FY	FY	FY
	2017-18	2018-19	2019-20	2020-21	2021-22
Clinical outcomes	88.30%	64%	90%	94%	56%
Humanity of care	98.90%	92%	88%	91%	91%
Organization of the care / waiting time (OPD)	46.10%	46%	71%	58%	74%
The healthcare environment	98.90%	98%	88%	80%	96%
Overall score	81.10%	86%	81%	83%	79%

## FAITHFULNESS TO THE MISSION

### Access

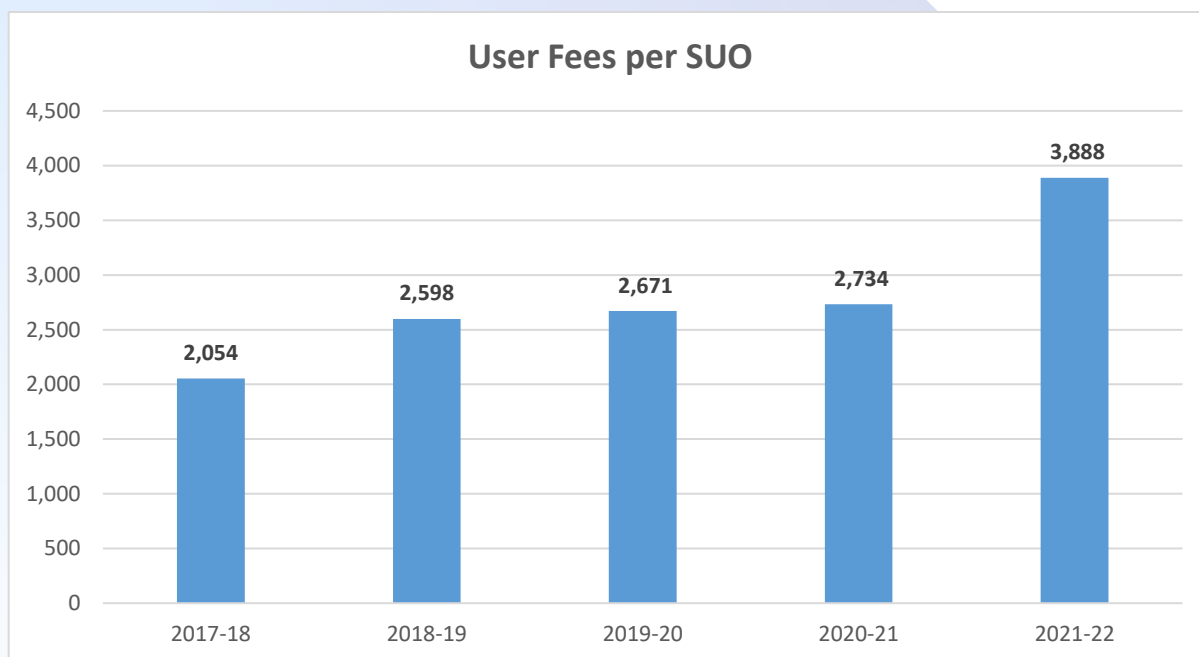
The SUOop remained similar like in the FY 20/21. Overall, the hospital has still been accessible.



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

### Equity

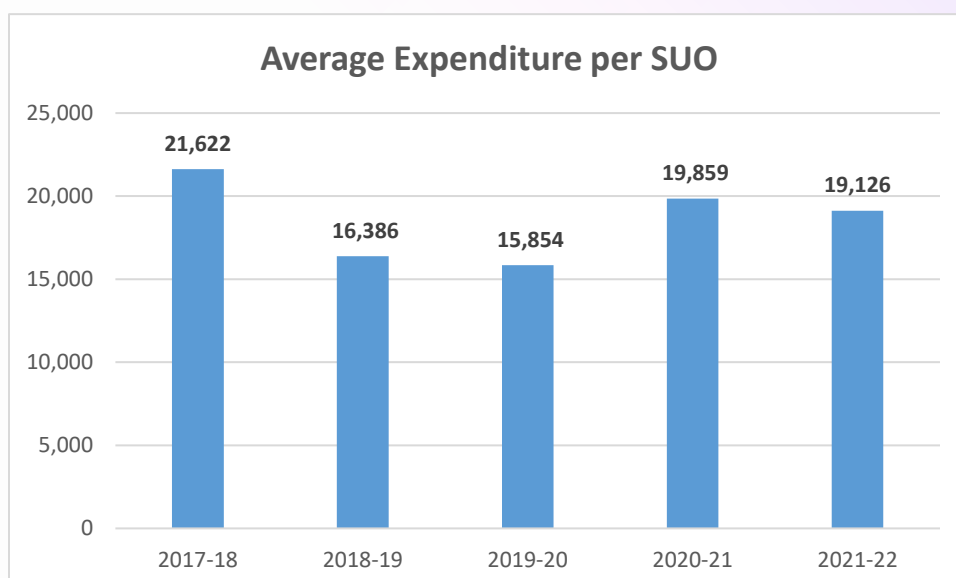
The average user fees per SUO increased. The hospitals' user fees are still one of the lowest in the UCMB network. The efficiency of revenue collection improved, but this does not counter the increased operational costs. The net outcome is an increased average user fee per SUO.



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

### Efficiency

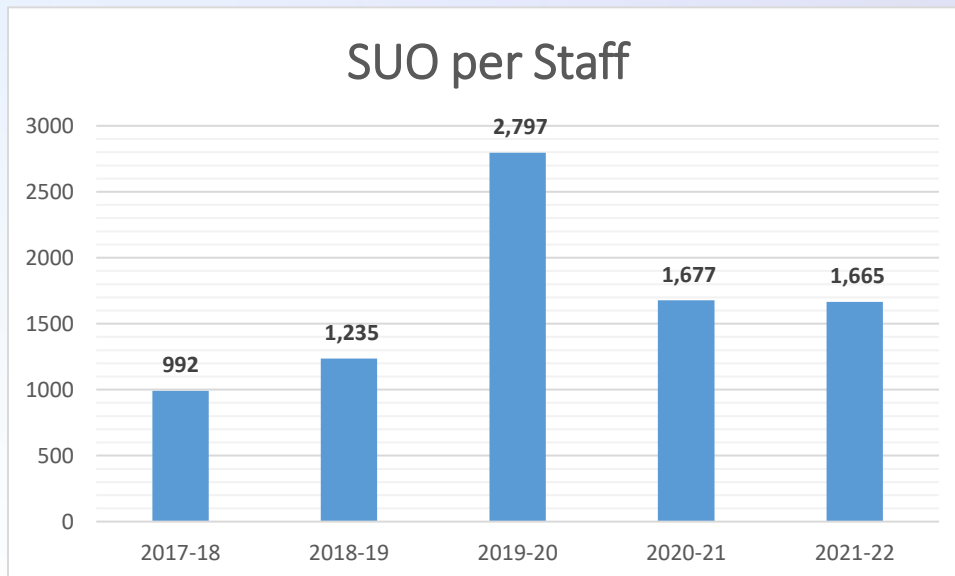
The hospital's financial efficiency somewhat improved. Compared to the prior year, we used slightly less to create one SUO. Even with a slightly increased efficiency, wastage is still a problem we have to deal with, but overall market trends have increased for all consumables, both medical and non-medical. In 21/22, efficiency increased tiny bit.



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

## Productivity

With the same resources, our staff's output was comparable to previous year's. The number of personnel stayed constant despite the pandemic's decline and the rise in service demand. In order to get the most out of our staff, we'll keep engaging them realistically.



**Figure8.4: 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

St. Mary's Midwifery Training School, is part of Dr. Ambrosoli Memorial Hospital. Fr. Dr. Giuseppe Ambrosoli founded the institution in 1959 as an enrolled midwifery school. The institution offers specialized courses in midwifery training, including;

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

### Human resources management and development

The training school continues to face significant difficulties finding qualified teaching staff. Staff attrition is a major concern because of the school's remote location. Hospital employees are still employed by the school on a part-time basis to assist in teaching subjects that relate to their field of work.

**Table 9.1: School staff and support staff establishment FY 2021-2022**

S/No	Cadre	Established	Actual	Shortage	Surplus
1	Tutors	5	4	1	0
2	Untrained clinical instructors	4	5	0	1
3	Accountant	1	1	0	0
4	Account Assistant	1	1	0	0
5	Cashier	1	0	1	0
6	Record Assistant	1	1	0	0
7	Trained clinical mentor (Hospital)	4	2	2	0
8	Store Assistant/Library Attendant	1	0	1	0
9	Office Attendant	1	1	0	0
10	Cooks	5	4	1	0
11	Driver	1	1	0	0
12	Watchmen	4	4	0	0
<b>Qualified Staff</b>		<b>13</b>	<b>12</b>	<b>2</b>	<b>1</b>
<b>Support Staff</b>		<b>12</b>	<b>10</b>	<b>2</b>	<b>0</b>
<b>Total School Staff</b>		<b>25</b>	<b>22</b>	<b>0</b>	<b>0</b>

### Staff development

Keeping with the school's strategic plan, staff development is prioritized. With the easing of the lock down restrictions, a number of trainings have been conducted. The trainings involved both virtual and physical trainings.

**Table 9.2: Work shops 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. 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 2021-22**

Course	Students Enrolled in the year	Students in 1 <sup>st</sup> year	Students in 2 <sup>nd</sup> year	Students in 3 <sup>rd</sup> year	Number of students currently	Students who sat for final exams	Students who pass final exams	Success rate
C/M	158	51	69	38	158	3	3	100%
D/M	27	12	15	0	27	15	15	100%
<b>Total</b>	<b>185</b>	<b>63</b>	<b>84</b>	<b>38</b>	<b>185</b>	<b>18</b>	<b>18</b>	

### 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 creates its own budget and year plan. The hospital engages external auditor to provide two distinct audited financial statements for the school and the hospital.

### Income

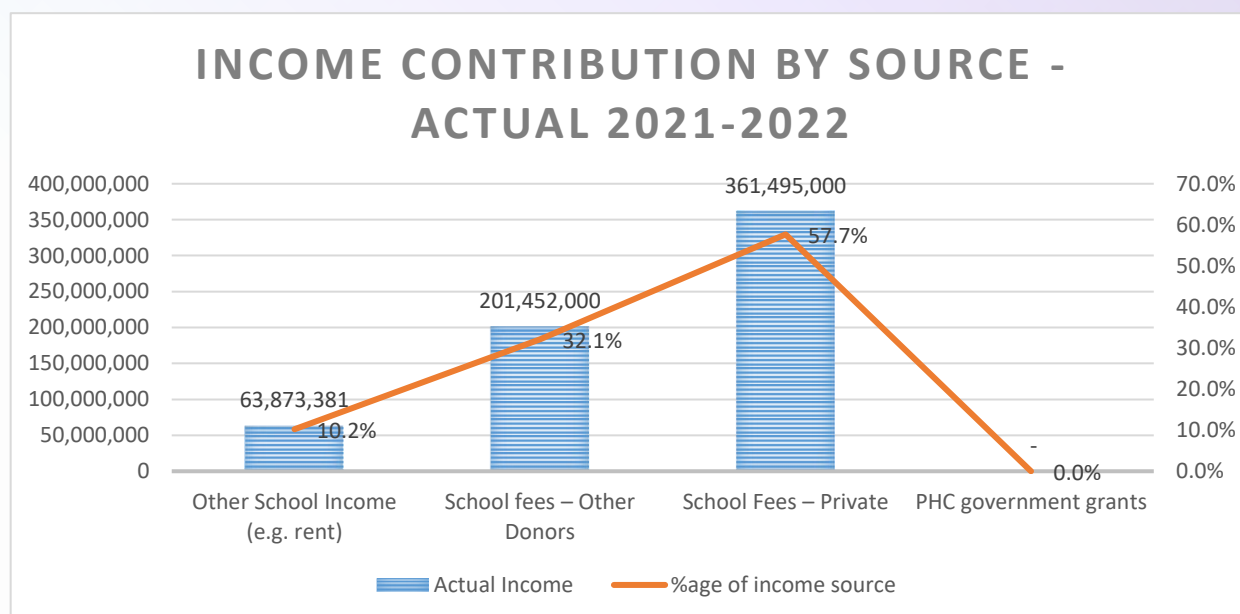
The primary source of funding continues to be the actual revenue from school fees and donations. Given that certain donors' support is waning and sustainability is gravely in jeopardy, this donor dependence is posing a significant issue. School fees collection has not been realized fully like in the previous year that was affected by COVID 19. Support for school fees came from UNFPA, Copeland Foundation, Straight talk foundation, Gretta foundation, Dr. Ambrosoli Foundation and Fondazione Ceresio.

The school realized 98.8% of its budget. There was an improvement in the school fess collection as compared to the previous financial year.



**Table 9.4: Planned, actual and unrealized income in the FY2021-2022**

Income Sources	Planned Income	Actual Income	Budget Gap	Variance Comment
	(UGX)	(UGX)	(UGX)	Surplus/Deficit
Other School Income (e.g. rent)	226,602,676	63,873,381	162,729,295	Surplus
School fees – Other Donors	175,323,864	201,452,000	-26,128,136	Deficit
School Fees – Private	232,423,800	361,495,000	-129,071,200	Deficit
PHC government grants	-	-	-	-
<b>TOTAL</b>	<b>634,350,340</b>	<b>626,820,381</b>	<b>7,529,959</b>	<b>Surplus</b>



**Figure 9.1: Income contribution by source**

### Expenditure

Due to the easing of the COVID 19 restrictions and school resumption, the school's expenditure was achieved by 84.5%. A number of activities were resumed.

**Table 9.5: Planned, actual expenditure and unspent balance in the FY 2021-2022**

PLANNED EXPENDITURE	ACTUAL EXPENDITURE	UNSPENT BALANCE
634,350,340	537,683,831	96,666,509

## Relation with external partners

In terms of financial assistance through student sponsorship, technical assistance, donations of teaching and learning resources, and staff training, the external partners continued to play critical roles in the evaluation and performance improvement of the school. Additionally, the more partners participate, the more staff are exposed to new information and networking opportunities, which they can pass along to their coworkers along with the new information they learn during the weekly CME.

The partners that the school closely related within 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

The Total number of students at present =  $185 \times 100\% = 123\%$

Total Capacity of the School 150

The capacity of the school was exceeded by 23% due to the enrollment of a combined group during COVID period and one intake delayed.

### Quality

Total number of students who passed =  $18 \times 100\% = 100\%$

Total Number of Students who sat 18

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

### Equity

Total fees Collected =  $\frac{372,062,000}{185} = \underline{\underline{2,011,146/=}}$

Total number of students 185

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 21/22.

### Efficiency

Total Recurrent Costs  $\frac{477,074,085}{185} = 2,578,779/=$

Total number of students 185

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**

Similar to the previous year, a number of exceptional circumstances dominated FY 21/22. The hospital and school were still under a significant financial load. Sustainability continues to be at the forefront of all actions and initiatives that the Hospital will carry out or launch.

The hospital continues to rely significantly on donations. Unfortunately, despite the COVID 19 pandemic's fall, the hospital and school's core supporters and benefactors are still under pressure. Although local revenue has grown, it is still paltry and far from enough to cover operational demands.

Just like the previous year, the access to MCH services is still lacking in East Acholi. This is worsened by the weak state of the referral network. In addition to this, the MOH Results-Based Financing activity posed a challenge due to the reduction in the funding and this translated to reduction in ambulance services for pregnant mothers and children under 5 years in emergency situations. Therefore, we keep appealing with the GOU once again to facilitate the resumption of such projects (MCH-biased initiatives) with bigger funding capacity to East Acholi in order to fill in these critically needed service gaps.

The Ambrosoli Foundation, Comboni Missionaries, and UPMB - LSDA, who together contributed close to 80% of the hospitals' yearly budget, are deserving of our deepest gratitude. We kindly ask them to continue providing this crucial assistance.

We appreciate the MOH and the Government of Uganda's provision of the PHC conditional grant, which contributed to the hospital's income to about 15%.

The hospital maintained its commitment to its mission and received UCMB accreditation. Even with all the aforementioned difficulties, it has remained accessible. We seek to strengthen the positive aspects while addressing the negative ones.

### **Pending Issues**

- The majority of the hospital wards need significant renovations because the hospital complex's structures are extremely old. The next financial years will still be devoted to lobbying for funds to refurbish these buildings.
- Just like last year, 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 2022

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

### Annex 2. Members of the Management Team and designation as per 30th June 2022

	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 Aloba	Senior Nursing Officer
5	Mr. Samuele Tognetti	Administrator



**Annex 3.**  
**Our vision and mission statement.**

**Vision**

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

**Mission statement**

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

