Annual Analytic Report Year 2023/24

Dr. Ambrosoli Memorial Hospital-Kalongo

"Service with Love and Humility"

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Endorsement of Report

This Annual Analytical Report for the Financial Year 2023-2024 has been prepared diligently by the management of Dr. Ambrosoli Memorial Hospital. The report accurately reflects the management's perspective regarding the hospital's performance at the time of the report.

Name: Dr. Okot Godfrey Smart

Signature _____

Chief Executive Officer
Dr. Ambrosoli Memorial Hospital

Date _____

It is with great pleasure that I acknowledge the receipt of the faithfulness to the mission report for Dr. Ambrosoli Memorial Hospital-Kalongo, encompassing the period from July 1st, 2023 to June 30th, 2024.
After thoroughly reviewing the report, I confirm its authenticity and confirm that it accurately reflects the hospital's position during the reporting year.

Name: His Grace Raphael P'Mony Wokorach, MCCJ

Signature _____

Archbishop of Gulu,
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
IDRC ……...…….……... Infectious Disease Research Collaboration
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

TASO-LPHS…….. The AIDS Support Organisation- Local Partner for Health Services

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

Dr. Ambrosoli Memorial Hospital's management wishes to express their sincere gratitude to all staff members for their supremely dedicated and selfless hard work in the provision of excellent care to patients. We extend special thanks to all those who have provided support to the hospital in one way or another and assisted in its sustainability in the Financial Year 2023-2024, such as the government of Uganda, Dr. Ambrosoli Foundation, the Comboni Missionaries, USAID – URC, UCMB, UPMB LSDA, TASO LPHS, IDRC Love One International, SMAART Trials Consortium, as well as our patients.

We are especially grateful to UCMB for their valuable accompaniment and direction, which has played an important role in our success. We also wish to thank H.G. Emeritus Dr. John Baptist Odama, H.G. Raphael P'Mony Wokorach and the whole Board of Governors for their great leadership and wise supervision of the hospital.

Finally, we would like to express our heartfelt gratitude to all members of our hospital staff and school who, regardless of their qualifications or duties, have played critical roles in each success detailed in this report. While the recognition is well-deserved, we believe it will also serve as motivation to continue and even improve our level of commitment in the future.

Important Indicators and Definitions

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

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

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

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

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

   = used bed days/available bed days

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

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

4. **Throughput**

   =Average number of patients utilising one bed in a year

   =Number of patients/ Number of beds

5. **Turn over interval**

   =Number of days between patients

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

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

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

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

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

8. ***Recovery Rate***:

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

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

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

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

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

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

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

EXECUTIVE SUMMARY

This annual analytical report details the performance and insights derived from both Dr. Ambrosoli Memorial Hospital Kalongo and Kalongo Midwifery Training School. Founded in 1957 by Fr. Dr. Giuseppe Ambrosoli of the Comboni Missionaries, the hospital was complemented by the establishment of St. Mary's Midwifery Training School in 1959. Serving as the only general hospital in the Agago district, Kalongo Hospital offers a comprehensive range of curative and preventive healthcare services. DAMHK, a key health institution in the Agago District, Uganda, continues to uphold its mission of providing quality healthcare services with a focus on the poor and vulnerable. Serving as a referral hospital, it supports a catchment area of 13,600 people within a total district population of 262,500. This report outlines the primary Key Performance Indicators, which are summarized in the following sections.

Currently, the hospitals are equipped with 287 beds. There has been an 11% decrease in inpatient admissions compared to the previous fiscal year (FY23/24). In total, there were 12,354 admissions during FY 2023-2024, marking a 7.7% increase from the prior year. The primary causes of morbidity included malaria, pneumonia, and injuries, while the overall mortality rate saw a significant decline of 29.2%, now standing at 1.7%.

The first antenatal care (ANC) attendance experienced a 5.2% drop, mirroring the trend in total ANC attendance. Conversely, there was a 3.5% increase in deliveries, totaling 2,752, indicating a need to enhance maternal health outreach and services in light of the declining ANC attendance. Outpatient department (OPD) attendance rose from 29,444 in FY 2022-23 to 34,524 in FY 2023-24, reflecting a growing demand for outpatient services. Malaria continues to be the leading cause of OPD visits, accounting for 11%, underscoring the necessity for improved community-level prevention initiatives.

In terms of financial performance, the hospital reported a 22.4% increase in income, primarily driven by higher cash donations, project funding, and increased financial sources such as deposit interests. However, expenditures also rose by 17% due to escalating costs associated with human resources, medical supplies, and consumables. The cost recovery rate fell to 9.51% in FY 2023/24, indicating a significant reliance on donations. Conversely, the school faced a 14.6% decrease in income, largely attributed to reduced donor contributions and lower enrollment, while expenditures decreased by 17.6% in response to the decline in income. Overall, the hospital demonstrated a positive income trend but remains heavily dependent on donations, with rising expenditures outpacing local revenue recovery. The school, on the other hand, is experiencing financial challenges due to diminishing donations, highlighting the urgent

need for diversifying income sources. Since its establishment, St. Mary's Midwifery Training School has successfully graduated both diploma and certificate students in midwifery, achieving a remarkable pass rate of 100%.

CHAPTER ONE.

Introduction

Fr. Dr. Giuseppe Ambrosoli of the Comboni Missionaries established Dr. Ambrosoli Memorial Hospital Kalongo (DAMHK) and St. Mary's Midwifery Training School in 1957 and 1959, respectively. This private, non-profit hospital is part of the UCMB's Catholic health facilities network. The Catholic Diocese of Gulu owns the hospital.

This rural hospital serves a remote, impoverished community in northern Uganda that has been devastated by war for the past 20 years. According to UBOS' Uganda Demographic Health Survey of 2022 housing statistics and household population, the Acholi subregion had the highest proportion of women and men with disabilities (unable to function in at least one domain) compared to other regions.

The hospital and its' environment

DAMHK is located in Kalongo Town Council, within Oret Parish of the Agago District. The district is bordered to the west by Pader, to the north by Kitgum, to the east by Kotido and Abim, and to the south by Otuke and Alebtong. It has a population of 373,780 people, with 88% residing in rural areas.

Because several of these surrounding districts lack functional hospitals, DAMHK also serves their people with medical problems that necessitate hospitalization. Agago has one of the worst road networks in the country, with no tarmac and most in poor condition, making it impossible to carry out operations such as transferring patients for emergency care, immunisation programs, supervising LLUs and home visits, and increasing the cost of all transportation activities.

Dr. Ambrosoli Memorial Hospital comprises two main components: the healthcare delivery section and the health training section. The facility is equipped with 286 beds, which are allocated across various departments, including Surgical, Medical, Pediatrics, Obstetrics/Gynecology, and Private Wards. It provides a comprehensive range of general healthcare services, encompassing curative, promotional, preventive, and rehabilitative care, in addition to hosting specialist medical camps organized by the Ministry of Health.

The hospital is currently accommodating the laboratory HUB, which is participating in the Ministry of Health's SLMPTA program and has received a three-star rating from the African Society of Laboratory Medicine (ASLM) during its accreditation process. This HUB is responsible for the management of up to ten laboratories within the district, as well as in certain areas of the adjacent Pader district. A dedicated midwifery training institution that provides

certificate and diploma programs is situated within the Health Training Wing. As part of its strategic plan to evolve into a degree-granting institution, technical consultations are currently underway. This training facility also invites students from various educational backgrounds for practical training, aiming to enhance collaborative efforts over time. The literacy rate among the district's residents is critically low, estimated to be below 30%. Furthermore, a significant portion of the population, particularly women, lacks proficiency in English, both in speaking and writing. The predominant ethnic group in the area is the Acholi, while the Langos represent a minority group in the southern region.

Agriculture serves as the primary economic driver in the region, where most farming operations are small-scale and primarily focused on subsistence. Regrettably, the absence of industrialization and mechanization in agricultural practices has hindered the development of commercial activities.

Demographic Data for the Hospital Catchment area.

DAMHK manages a health sub-district within the Agago district, which encompasses 17 sub-counties. As the sole hospital in the Agago district, it functions as a crucial referral center. In spite of facing economic difficulties, the hospital has played a vital role in achieving the district's targets for the 2023/2024 year.

Table 1.1: Demographic Data of the Hospital and Agago district

Population Group		Formulae	Catchment Area	District
(A)	Total Population	A	28723	262,500
(B)	Total expected deliveries (4.85% of population)	(4.85/100) x A	1393.07	12,731.25
(C)	Total Assisted Deliveries in Health Facilities	(0.12/100)xB	1.67	1527.75
(D)	Total Assisted Deliveries as % of expected deliveries	(C/B) x100	12	12
(E)	Children <1 year (4.3%)	(4.3/100) x A	1235	11,287.5
(F)	Children < 5 years (20.2%)	(20.2/100) x A	5802	53,025
(G)	Women in Child-bearing age (20.2%)	(20.2/100) x A	5802	53,025
(H)	Children under 15 years (46%)	(46/100) x A	13212	120,750
(I)	Orphans (circa 10%)	(10/100) x A	2872	26,250
(J)	Suspected T.B Cases in the Service Area	(A) x 0.003	86	787.5

CHAPTER TWO

Health policy and district health services

The Uganda National Health Policy prioritizes the needs of vulnerable groups, focusing on the early detection and treatment of diseases while enhancing the health sector's capacity to fulfill the objectives of the Uganda Minimum Health Care Package (UMHCP). The Ministry of Health's Strategic Plan for 2020/21 to 2024/25 is aligned with the Human Capital Development Component of the National Development Plan III, establishing a framework for advancing towards Universal Health Coverage. The main goal of health sector policy is to decrease mortality, morbidity, and fertility rates, along with addressing related inequalities.

Dr. Ambrosoli Memorial Hospital actively implements the Uganda National Health Policy (NHP) and the Health Sector Strategic Plan by delivering essential components of the Uganda Minimum Health Care Package. This encompasses comprehensive maternity and child health services, as well as the prevention and treatment of significant communicable and noncommunicable diseases. Additionally, the hospital addresses cross-cutting issues such as health promotion, community health programs, and gender-related health concerns. Furthermore, DAMHK adheres to the standards set by the Uganda Episcopal Conference through the Uganda Catholic Medical Bureau (UCMB) and participates in District Health Management Team (DHMT) meetings, contributing to collaborative efforts outlined in the district health plan.

District Health Services

Health care services are organized within a decentralized system. The district health framework oversees all health facilities within the district, with the exception of Regional Referral Hospitals when they are present. Agago District is administratively divided into one Health Sub-District (HSD) and three counties: Agago North County, Agago County, and Agago West County. Kalongo Hospital, situated in Agago North County, continues to function as a district referral hospital. Additionally, the district is segmented into sixteen sub-counties, with the allocation of health services across these sub-counties detailed in Table 2.1 below.

Table 2.1: Population, health units and staffing in Agago District FY 2023-2024 by Sub-County

Sub-county	Population	Total OPD attendance	Organization unit name	Staffing levels		Staffing gap
				Staffing Norm	No. available	
Adilang	23600	49238	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	7100	18266	Lukole HC III	19	14	5
Arum	13800	13299	Acholpii HC III	19	13	6
Kalongo Town Council	13600	34524	Kalongo Ambrosoli Memorial Hospital	334	253	81
Kotomor	14700	26234	Kotomor HC III	19	14	5
			Odokomit HC II	9	7	2
			Onudapet HC II	9	5	4
Lamiyo	9800	14592	Kwonkic HC II	9	4	5
			Lamiyo HC II	9	8	1
Lapono	25800	44929	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	28000	39580	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	18000	23997	Lapirin HC III	19	9	10
			Olung HC II	9	5	4
			Otumpili HC II	9	5	4
Omiya Pachwa	13600	18707	Layita HC II	9	13	-4
			Omiya Pacwa HC II	9	5	4
Omot	6700	21531	Geregere HC II	9	7	2
			Omot HC II	9	11	-2
Paimol	24500	24411	Kokil HC II	9	6	3
			Paimol HC III	19	15	4

Parabongo	13400	29390	Kabala HC II	9	4	5
			Pacer HC II	9	12	-3
			Pakor HC II	9	5	4
Patongo	12900	13233	Opyelo HC III	19	9	10
Patongo Town Council	13500	27921	Patongo HC III	19	24	-5
			Patongo Prison HC II	9	1	8
Wol	27000	43069	Kuywee HC II	9	6	3
			Okwadoko HC II	9	5	4
			Toroma HC II	9	5	4
			Wol HC III	19	13	6
Total HSD	266000	442921	**40 Govt. and 3 NGO Units**	832	604	228

Access to health services is severely restricted by inadequate health infrastructure. This situation is compounded by a shortage of skilled personnel, high illiteracy rates, and inconsistent community engagement, all of which further diminish the quality of healthcare services provided. These challenges lead to widening healthcare disparities, manifesting in higher rates of maternal and newborn morbidity and mortality, as well as malnutrition. Additionally, the district's poor road conditions worsen an already fragile referral system, making it difficult for ambulances to navigate, and in some cases, rendering roads completely unusable or maintenance costs prohibitively high.

Table 2.2: Structure of the District Health Office team

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

Theatre Assistant	1
Records Assistant/HMIS focal person	1
Office Assistant	1
Grand Total	**13**

Funding

Over 60% of the hospital's ongoing operational funding is sourced from external partners and contributors. As attracting new donors to cover these recurring costs has become more challenging, the hospital is facing a considerable funding shortfall, relying heavily on the limited fees collected from patients. The Ugandan government has maintained its support through the Primary Health Care (PHC) conditional grant subsidy, providing both financial and material assistance. However, the disbursement of PHC funds remains inconsistent and does not align with the anticipated projections, which adversely impacts the availability of medications and other essential medical supplies.

Health Infrastructure

The hospital's requirement for housing to support its workforce continues to be notably elevated. Regrettably, the available financial resources fall short of addressing these needs. As the hospital expands its range of services, the demand for additional staff has intensified, compounding the existing accommodation issues. There is an anticipation that the living conditions for personnel in the housing quarters will enhance, with the goal of accommodating nearly all staff members. Financial support has been secured from the Ambrosoli Foundation; the hospital's main partner involved in the AICS project.

Prevention and Health promotion services

The hospital's Primary Health Care (PHC) department is responsible for managing health education initiatives within the community, offering immunization services, conducting cervical cancer screenings, and providing supervisory support to lower-level health facilities. The PHC department supervises Village Health Teams (VHTs), which are crucial in promoting health and preventing diseases. These teams assist the PHC in managing communicable diseases, particularly focusing on malaria, STI/HIV/AIDS, and tuberculosis, while also advocating for sexual and reproductive health and rights. However, there has been a decline in

the resources allocated to enhance the Health Sub-District's integrated PHC outreach programs. Over time, these outreach efforts have expanded to include a broader range of community-based interventions, particularly in the screening and prevention of noncommunicable diseases.

The HC II function of the hospital

A health center II is designed to cater to a population of several thousand individuals, with the capability to manage prevalent illnesses such as malaria. In line with the health policy established by the Ugandan government, it is mandated that each parish should be equipped with an HC II. The designated catchment area for the HC II services is the Kalongo Town Council. DAMHK has maintained its commitment to providing immunization services through both mobile and stationary units. The outcomes related to the vaccinations administered are detailed in Table 2.5. The outpatient department (OPD) remains accessible to patients from the surrounding region, operating for up to 15 hours daily, seven days a week.

Table 2.3: Hospital contribution to prevention &health promotion services of the District

FY 2023-2024			
Activity: TT to child bearing ages	Hospital	District	Hospital output as % of HSD/District
Pregnant women			
TT 1	1,339	8,180	16.37%
TT 2	1,737	5,164	33.64%
TT 3	35	1,624	2.16%
TT 4	9	849	1.06%
TT 5	2	665	0.30%
Non Pregnant women			
TT 1	913	5,659	16.13%
TT 2	490	2,869	17.08%
TT 3	251	1,637	15.33%
TT 4	117	971	12.05%
TT 5	17	655	2.60%
Immunization in school			

TT 1	94	4,330	2.17%
TT 2	113	2,148	5.26%
TT 3	109	1,045	10.43%
TT 4	4	482	0.83%
TT 5	2	279	0.72%
Total TT 2 in all categories	2,340	10,181	22.98%
Immunization in Children			
BCG	2717	7,750	35.06%
Protection at Birth for TT (PAB)	2696	5,922	45.53%
Polio 0	2717	8,749	31.05%
Polio 1	814	12,609	6.46%
Polio 2	802	12,569	6.38%
Polio 3	835	11,798	7.08%
PCV 1	814	11629	7.00%
PCV 2	800	11247	7.11%
PCV 3	834	11675	7.14%
DPT-HepB+Hib 1	824	11683	7.05%
DPT-HepB+Hib 2	798	11,195	7.13%
DPT-HepB+Hib 3	835	11,723	7.12%
Measles	1000	11,695	8.55%
Total Immunisation in Children	937	11817	7.93%
Total Family Planning attendances	2767	27,682	10.00%
Total ANC attendance	5600	44,886	12.48%
Deworming	14210	168,458	8.44%
Vitamin A Supplementation	6468	70,083	9.23%

The data referenced encompasses the vaccination outputs from UNEPI along with specific outreach metrics. The number of vaccinations has expanded from the conventional six to approximately twelve on the immunization schedule, thanks to the addition of new vaccines,

including the injectable polio vaccine, pneumococcal conjugate vaccine, rotavirus vaccine, HPV vaccine, and measles-rubella vaccine. Additionally, Kalongo Hospital is actively involved in National Immunization Days (NIDs), Family Health Days, and various special immunization programs. Its role in delivering district health services continues to be substantial.

CHAPTER THREE:

Governance

The Board of Governors

The Board of Governors (BOG) serves as the main decision-making and governing entity for Dr. Ambrosoli Memorial Hospital and St. Mary's Midwifery Training School. Nonetheless, the Hospital Management Team retains sole responsibility for the operations of both the hospital and the training school. According to the hospital's Statute, there can be up to two Ordinary BOG meetings and two extraordinary meetings annually. At the beginning of the year 23/24, a new board was constituted for both the hospital and school following the expiration of the terms of office of the previous board.

The board reviewed and deliberated on management reports from the hospital, which underscored critical issues related to both hospital and school operations, as well as various challenges faced. These reports not only pointed out achievements but also identified areas that require further development.

Table 3.1: Summary of BOG meetings held in the FY2023-2024

BoG meetings	Reports presented / Key issues handled / Decision taken	Members present
2 Ordinary BOG Meetings	• Constitution of a new BOG and taking oath of office • Constitution of a new Governing Council and taking oath of office • Budget reviews and approvals • Review of audit reports • Review and approval of subcommittee reports • Review of MOU between a key partner and Archdiocese of Gulu/Hospital • Review and approval of a revised user fee scheme	12 out of 13 members (for each meeting)
1 Extra Ordinary BOG Meetings	• Approval of MOU between key a partner and the Archdiocese of Gulu/Hospital. • Approval of Debt repayment plan/the sources of funds.	8 out of 13 members

The Governing Council, previously referred to as the school Subcommittee, along with the Finance Committee and the Human Resources and Disciplinary Committee, has been established in accordance with the Statute. The role of the subcommittee involves reviewing Management reports and proposals beforehand, enabling them to offer insights and recommendations to the BOG during their plenary sessions.

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%
Governing Council	2	2	100%
Human Resources& Disciplinary	2	2	100%

Hospital Management

The Hospital Management Team, under the leadership of the Chief Executive Officer, is responsible for overseeing decision-making processes related to both the hospital and the affiliated school. This team aligns its efforts with the strategic goals and desired outcomes set forth by the Board of Governors. Operating with a degree of autonomy, the team functions within the guidelines of the hospital's strategic plan, as well as established policies, manuals, and procedures. Regular meetings are held at least once a month to ensure effective collaboration and progress. The primary members of the Hospital Management Team include:

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

Table 3.3: Frequency of HMT meetings FY 2023-2024

No of planned Top Management meeting	No. of Management meeting held	Average No. of members present	Reports / key issues handled
12	8	5	• Timely report submission to partners • Review of hospital policy documents • Improvement of local revenue generation • Development of a new 5 year strategic plan • Implementation of the revised user fee approved by the board. • Staff training and development • Measures to curb theft in the hospital. • Plan to conduct a cost study in the hospital.

Statutory commitments compliance

The Hospital complies with all legal standards established by the government, the ministry of health, and the UCMB, as detailed in Table 3.4 below. The UCMB established an accrediting program for the Catholic network's hospitals. Kalongo Hospital met these requirements for the financial year 2023/24.

Table 3.4: Statutory commitments compliance

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

Internal Regulatory Documents

DAMHK has established a set of manuals and guidelines that govern decision-making and practices within both the hospital and the school. These documents encompass the employment manual, the finance and material resource manual, and the procurement manual. Management is committed to ensuring compliance with these policies. Additionally, these documents undergo regular reviews to ensure they align with the evolving requirements of the institution.

Advocacy, lobby and negotiation

The Hospital has yet to establish a formal advocacy strategy. In response to its needs, the institution maintains regular communication with local leaders, international NGOs, and significant funding organizations, including the Dr. Ambrosoli Foundation and Comboni Missionaries. The management of the hospital prioritizes collaboration with all stakeholders to secure the institution's sustainability over the long term. Looking ahead, the community health insurance policy being implemented by the government is expected to significantly address some of the existing funding shortfalls.

CHAPTER FOUR:

Human resources

Over the years, there has been a steady rise in the number of personnel, encompassing both clinical and non-clinical roles. At present, the hospital operates with a capacity of 286 beds and employs 169 clinical staff members, which falls short of the Ministry of Health's recommendation of 190 for a facility of this size. Among the staff, 58.33% are qualified clinical staff /professionals, reflecting a constant number just like the previous year.

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

Category		FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Clinical[1]	Qualified	138	139	144	153	154
	Unqualified	17	17	15	15	15
	Total Clinical	155	156	159	168	169
Not Clinical[2]	Qualified	45	45	45	46	47
	Unqualified	52	31	47	48	48
	Total Non-Clinical	97	76	92	94	95
Total Qualified		183	184	189	199	201
Total Unqualified		69	48	62	63	63
Grand Total		**252**	**232**	251	262	264
% of qualified clinical staff/total staff		**55%**	**60%**	**57%**	**58%**	58.33%

Staff turn-over

The hospital has witnessed considerable turnover within its essential staff over the years. There was an increase in the FY 23/24 as compared to the previous year.

The hospital has experienced significant turnover among its critical staff over the years, although it remains lower than that of government and other local entities. This situation has led to a notable employee turnover rate in recent years. However, several initiatives have been implemented to mitigate this issue, such as offering capacity-building opportunities through training programs and providing scholarships for eligible staff members.

Table 4.2: Turn-over trends of enrolled cadres in the last3 FYs

Cadres	FY 2021-22	FY 2022-23	FY 2023-24
Total staff	251	262	264
Enrolled cadres (all combined)	66	72	65
Turn-over for enrolled cadres	5%	1.52%	3.03%

Most employees typically work between 40 and 42 hours each week. The head of each department or ward is tasked with the responsibility of informing relevant personnel about work schedules and shifts on a monthly basis across different departments. The hospital offers housing accommodations to around 62% of its staff and their families within the staff quarters, which also includes access to water and electricity as part of the housing benefits. Employee salaries are consistently disbursed, and all statutory obligations, such as NSSF and PAYE, are fulfilled in accordance with current laws, except in instances where funds are unavailable.

Table 4.3a: Turn-over trends of Clinical Staff in the last3 FYs

Clinical Staff	FY 2021-22	FY 2022-23	FY 2023-24
Total Clinical staff	159	168	169
Total arrivals of key health personnel	50	10	21
Total departures of key health personnel	28	18	21
Turn-over rate	17.61%	10.71%	7.90%

Table 4.3b: Turn-over trends of General Staff

General Staff	FY 2021-22	FY 2022-23	FY 2023-24
Total staff	251	262	264
Total arrivals of personnel	64	15	25
Total departures of personnel	45	26	23
Turn-over rate	17.90%	5.72%	8.71%

Human resources development and career progression

The hospital is committed to its personnel training and development policy by focusing on capacity building. This initiative aims to ensure the institution's future growth while

safeguarding its cultural values and work ethics. Various methods are employed to enhance capacity building, including Continuing Medical Education (CMEs), brief training sessions, on-site mentorships, and advanced courses tailored to the institution's needs. Currently, most employees participating in training are utilizing online learning platforms. With the easing of restrictions, a select number of employees were able to attend in-person events towards the end of the financial year.

The Hospital Management Team (HMT) views capacity development as a crucial strategy for employee retention and motivation. We are dedicated to refining our training approach by fostering realistic collaborations and ensuring the continuity of programs.
Both the Ambrosoli Foundation and the hospital play a direct role in supporting capacity development initiatives. A detailed list of personnel who have enrolled in training through the hospital's scholarship program, focusing on key areas of need, is provided in Table 4.4 below.

Table 4.4: Hospital Staff who attended courses in FY 2023-2024

S/N	Name	Designation	Course	Date of start	Date of End
1	Sr. Ayaka Hellen	Registered Nurse	BSc. In Nursing (UCU)	Jan, 2020	October, 2024
2	Oyet Patrick	Medical Officer	MMOR	March, 2022	Jul, 2026
3	Oling Francis	Electrician	Dip in Bio-medical Engineering	March, 2022	Feb, 2024
4	Alezuyo Agnes	Enrolled Midwife	Dip in Midwifery	January, 2023	July, 2024
5	Akello Jacinta	Enrolled Midwife	Dip in Midwifery	January, 2023	July, 2024
6	Lakot Sunday	Enrolled Midwife	Dip in Midwifery	January, 2023	July, 2024
7	Anywar Oscar	Enrolled Nurse	Dip in Clinical Ophthamology	January, 2023	Dec, 2025
8	Apilla Thomas	Enrolled Nurse	Dip in Clinical Psychiatry	March, 2021	Dec, 2025
9	Okot Galdino	Enrolled Nurse	Dip in Clinical Psychiatry	Jan, 2022	Dec, 2025
10	Sr. Anek Christine	Nursing Officer	BSc. In Nursing (UMU)	Jan, 2021	October, 2025
11	Akol Janet	Enrolled Midwife	Dip in Midwifery	January, 2024	July, 2025
12	Atem Irene James	Enrolled Midwife	Dip in Midwifery	January, 2024	July, 2025
13	Auma Vicky	Enrolled Midwife	Dip in Midwifery	January, 2024	July, 2025
14	Lamwaka Monica	Enrolled Midwife	Dip in Midwifery	January, 2024	July, 2025
15	Lalango Monica	Enrolled Midwife	Dip in Midwifery	January, 2024	July, 2025

16	Ajwang Maureen F	Enrolled Midwife	Dip in Midwifery	January, 2024	July, 2025
17	Apio Innocent Hope	Enrolled Midwife	Dip in Midwifery	January, 2024	July, 2025
18	Ayiko Robina Adyee	Enrolled Midwife	Dip in Midwifery	January, 2024	July, 2025

CHAPTER FIVE:

Finances

Dr. Ambrosoli Memorial Hospital and St. Mary's Midwifery Training School maintain separate financial management systems. Additionally, their financial statements undergo independent audits. There was an increase in the total income of the hospital in the FY2023/2024 by 22.3%. This increment was attributed to by the increase in donations in cash including projects and other financial sources including deposit interests. Due to a decrease in ministry of health budget, there was a general decrease in the government contributions in terms of PHC conditional grant. There was a slight reduction in user fees, along with a decline in in-kind donations from both government sources and other contributors during the same timeframe. We persist in advocating for the government to maintain its support and increase the funding for the PHC conditional grant in order to alleviate the escalating daily expenses associated with medical supplies. This initiative aims to bolster the government's commitment to advancing community health. The hospital largely relies on donations, which constitute over 70% of its ongoing budget. We maintain the view that the Government of Uganda's enhanced community health financing initiatives will aid in promoting sustainability efforts.

The midwifery school's total income experienced a decline of approximately 8% in comparison to the previous financial year. This reduction was primarily attributed to a general drop in the amount received from donations.

The subsequent tables present the financial statement patterns for both the hospital and the school. Additional insights regarding the financial aspects of the school are provided in Chapter 9 of this report.

Income

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

Income Item	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	Variance 2022/23 Vs. 2023/24
HOSPITAL						
User Fees	918,631,455	724,456,625	1,029,262,390	643,655,130	639,030,182	-4,624,948
PHC CG cash	251,159,632	492,117,659	480,809,025	490,609,362	488,852,488	-1,756,874

Government donations in kind (Drug/Lab)	279,299,838	469,333,874	478,592,584	449,326,867	377,354,737	-71,972,130
Other donations in kind	1,410,912,848	1,264,283,983	1,332,703,237	1,582,167,736	1,449,882,200	-132,285,536
Donations in cash (including project funding)	3,128,079,686	2,294,082,763	2,674,489,300	2,686,929,206	3,120,099,223	433,170,017
Others Financial sources (Deposit Interests & others)	92,546,915	51,770,039	99,348,095	126,852,620	1,260,681,166	1,133,828,546
Technical Department	136,116,992	59,583,590	54,708,270	75,511,057	70,957,375	-4,553,682
Sub-Total Hospital	**6,216,747,366**	**5,355,628,533**	**6,149,912,901**	**6,055,051,978**	**7,406,857,372**	**1,351,805,394**
SCHOOL						
Fees (private)	160,475,145	235,067,000	360,800,000	377,503,000	528,601,000	151,098,000
Donations and other income	312,861,360	428,420,077	254,770,381	336,954,015	81,554,600	-255,399,415
Sub-Total School	**625,722,720**	**679,128,175**	**615,570,381**	**714,457,015**	**610,155,600**	**-104,301,415**
HSD						
Sub-Total HSD						
Grand-Total	**6,842,470,086**	**6,034,756,708**	**6,765,483,282**	**6,769,508,993**	**8,017,012,971**	**1,247,503,978**

In contrast to the previous fiscal year, the fiscal year 2023/2024 experienced a 17% rise in the hospital's overall expenditures. This increase was primarily attributed to costs associated with human resources as well as medical supplies and consumables. The main components of these expenditures included employment costs, capital development, and medical drugs and sundries. To manage these rising costs effectively, the management will persist in implementing suitable cost-control strategies that are subject to ongoing assessment.

Table 5.2: Trend of Expenditure over the last 5 FYs

Expenditure Item	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
HOSPITAL					
Human Resource cost	2,220,512,253	2,281,897,544	2,378,741,751	2,868,550,900	3,176,537,216
Administration & Governance Costs	176,454,730	281,947,329	266,260,862	225,490,408	270,334,427
Medical goods and supplies (included drugs)	2,048,954,822	1,906,084,286	1,638,112,842	1,905,551,941	2,300,881,498
Non-medical goods / supplies	237,715,358	95,862,373	111,514,065	102,370,339	95,696,986
Property Costs	277,795,146	263,900,824	318,974,217	315,222,125	397,617,937
PHC	408,008,500	212,414,809	168,309,000	260,488,126	260,897,326
Transport & Plant Costs	198,506,748	220,474,884	181,012,623	192,833,154	215,241,774
Capital Development	621,477,605	782,214,141	395,180,275	379,499,268	619,336,178
Hospital Total Expenditure	**6,189,425,162**	**6,044,796,191**	**5,458,105,635**	**6,250,006,262**	**7,336,543,342**
SCHOOL					
Employment	289,320,411	260,168,468	233,134,106	320,109,976	**333,039,320**
Administration	125,364,301	28,658,219	54,572,994	99,087,299	**130,535,081**
Students costs	149,127,572	130,125,198	159,721,701	93,609,001	**74,055,751**
Transport & Travelling	25,901,800	18,872,400	24,398,400	30,948,900	**30,109,760**
Property, Supplies, Services	16,403,572	29,529,301	38,020,290	57,117,917	**24,729,436**
Capital Development	35,543,000	9,720,500	27,836,340	165,751,628	**29,188,989**
School Total Expenditure	641,660,656	477,074,086	537,683,831	766,624,721	**621,658,337**
HSD					
HSD Total Expenditures					
Grand Total	**6,831,085,818**	**6,521,870,277**	**5,995,789,466**		

The fees imposed on patients for each department have remained unchanged, and there have been no alterations to the hospital's user fee structure. However, the hospital has experienced enhanced efficiency in revenue collection over the financial year. Despite this progress, there are still cases where patients leave the hospital without settling their user fees, presenting an ongoing challenge for management, particularly due to various vulnerabilities surrounding the hospital's perimeter.

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

	Average Fees						
	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
OPD Adult Male	11,500	15,000	15,000	15,000	15,000	15,000	15,000
OPD Adult Female	12,000	16,500	15,000	15,000	15,000	15,000	15,000
OPD Children < 5yrs	4,500	9,500	9,500	9,500	9,500	9,500	9,500
OPD Children 5-13 yrs	7,000	12,000	9,500	9,500	9,500	9,500	9,500
IP Medical Male	25,000	30,000	30,000	30,000	30,000	30,000	30,000
IP Medical Female	25,000	30,000	30,000	30,000	30,000	30,000	30,000
IP Maternity	15,850	36,900	35,000	35,000	35,000	35,000	35,000
IP Paediatric < 5 yrs	8,500	15,500	15,000	15,000	15,000	15,000	15,000
IP Paediatric 5-13 yrs	9,000	16,000	16,500	16,500	16,500	16,500	16,500
IP Surgical Ward	23,200	24,000	28,000	28,000	28,000	28,000	28,000

In the fiscal year 23/24, the hospital recorded a cost recovery rate of 9.51%, reflecting a decline of 10.96% compared to the prior year. This trend indicates that the hospital has persistently incurred higher expenses for patient care than the revenue generated from those services, jeopardizing the sustainability of its high-quality offerings. To secure the hospital's future, it is essential to successfully reconcile the disparity between donor contributions and local revenue streams, particularly in light of the increasing phenomenon of donor fatigue.

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

Income Item	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
HOSPITAL					
User Fees (a)	918,631,455	724,456,625	1,029,262,390	643,655,130	639,030,182
Total Recurrent Expenditure (b)[2]	5,567,947,557	5,262,582,049	5,062,925,360	5,870,506,994	6,717,207,164
Cost Recovery Rate= (a/b)x100	16.50%	13.77%	20.30%	10.96%	9.51%

In the fiscal year 2023/2024, the average cost per bed rose by 14.42%. Concurrently, there was a notable increase in the cost per SUOop, while the daily cost per patient experienced a decline. This situation underscores the strain that patient care imposes on the hospital, indicating a decrease in the efficiency of resource utilization for patient services.

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

Indicator	FY 2019-20	FY 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024
Cost per bed [1]	20,545,932	18,400,637	18,081,876	20,526,248.23	23,486,738.34
Cost per IP/day [2]	62,026	76,018	79,564.46	112,120.30	89,580.68
Cost per SUOop	15,854	19,859	19,173	23,821	26,103

In the fiscal year 2023/2024, the hospital achieved a sustainability rate of 86% when accounting for local revenue and government support. This figure mirrors that of the prior financial year, largely due to a rise in local income and contributions from donors.

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

Without PHC CG	FY 2019-20	FY 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024
Total Local Revenues (a)	918,631,455	724,456,625	1,029,262,390	846,018,807	930,196,799

Total Recurrent Expenditures (b)	5,567,947,557	5,262,582,049	5,062,925,360	5,870,506,994	6,717,207,164
Sustainability Ratio = (a/b)x100	16.50%	13.80%	20.30%	14.41%	13.85%

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

	FY 2019-20	FY 2020-2021	FY 2021-2022	FY 2022-2023	FY 2023-2024
Total in-country funding (c)	3,907,443,605	3,888,851,326	4,043,280,957	4,192,447,265	4,348,758,149
Total Recurrent Expenditures (d)	5,567,947,557	5,262,582,049	5,062,925,360	5,870,506,994	6,717,207,164
Sustainability Ratio = (c/d)x100	0.7	0.74	0.8	0.71	0.65

CHAPTER SIX:

Services

The hospital provides a comprehensive range of services that align with the government's longstanding recommendations for general hospitals. This consistent offering includes a variety of essential medical care options below:

Obstetrics & Gynecology Services

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

General Surgical Services

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

Internal Medical Care

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

Pediatrics & Child Health

Young child clinic
staff in the area of discipline.
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

Ophthalmic Services

Eye disease screening
Minor surgery
Ophthalmic OPD and IPD services

Physiotherapy services & rehabilitation

Physiotherapy clinic and rehabilitation

Mental Health Services

Diagnosis and treatment of mental health conditions.

OUT PATIENTS' DEPARTMENT

The Out Patients Department (OPD) at Dr. Ambrosoli Memorial Hospital acts as the initial point of contact for individuals seeking services from DAMHK. Conveniently situated near the main entrance of the hospital, the OPD operates every day of the week, with hours extending from 8:00 a.m. to 9:00 p.m. on weekdays and from 8:00 a.m. to 8:00 p.m. during weekends and public holidays. In the upcoming year, we aim to explore the possibility of establishing a 24-hour service. Our pharmacy is efficiently managed by pharmacist assistants who ensure adherence to proper dispensing protocols.

To meet the varied needs of our clients, we have developed a comprehensive patient flow and payment system. Additionally, the OPD has adapted one of its rooms to function as an emergency area. This Emergency Department is staffed by clinical personnel from the OPD, with additional support from other medical staff as required.

Table 6.1: The staff composition in OPD in the FY 2022-23 and FY 2023-24

Cadre/ Discipline	Qualification	FY 2022-23	FY 2023-24
Clinical officers	Diploma in clinical Medicine	5	5
Ophthalmic Clinical officers	Diploma in clinical Ophtalmology	1	1
Ophthalmic Assistant	Cert. in Nursing / Cert.in Ophtalmology	1	1
Pharmacy Assistant	Certificate in Pharmacy	2	2
Registered Nurse/Midwife	Diploma in Nursing / Midwifery	2	2
Enrolled Midwife	Certificate in Midwifery	0	0
Enrolled Nurse	Certificate in Nursing	3	5

Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	1	0
Nursing Assistant	Certificate in Nursing Assistance	3	3
Cashier	Diploma in Business Studies	2	2
Nursing Aide	Trained on the job	2	2
Records Assistant	Certificate in Records mgt	1	1
Total		23	24

The overall trend shows an increase in attendance across most categories in FY 2023-24 compared to FY 2022-23, with significant growth in re-attendances for both females and males, particularly in the "Over 5 years" category for females.

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

			FY	FY	FY	FY	FY
			2019-20	2020-21	2021-22	2022-23	2023-2024
FEMALE	New Attendance	0-4 yrs	3,014	1,600	1,944	2,189	2334
		Over 5 yrs	8,978	9,260	10,703	10,412	12996
	Re-attendance	0-4 yrs	121	97	41	179	208
		Over 5 yrs	4,097	7,836	4,166	4,461	6807
MALE	New Attendance	0-4 yrs	2,976	1,818	2,446	2,615	2674
		Over 5 yrs	8,492	5,631	5,623	6,151	6281
	Re-attendance	0-4 yrs	118	123	82	163	251
		Over 5 yrs	3,262	5,230	2,586	3,274	2973
All New Attendances			23,460	18,309	20,716	21,367	24285
All Re-attendances			7,598	13,286	6,875	8,077	10239
All Attendances			31,058	31,595	27,591	29,444	34,524

Causes of Morbidity

Malaria remains the leading cause, though cases like cough/cold and diarrhea declined. Increased cases of UTIs and diabetes mellitus suggest emerging priorities in healthcare.

Overall rise in OPD attendance by 17.2% indicates increased community reliance on the facility for healthcare services. Malaria cases increased by 9%, though its share of diagnoses slightly declined. The **"All Others"** category declined significantly. This reflects better specificity in diagnosis or reduced prevalence of other conditions.

Table 6.3 showing the causes of morbidity in OPD for previous and current financial year

	Causes of Morbidity	FY 2022-2023		FY 2023-2024	
		No. of cases	% on all diagnoses	No. of cases	% on all diagnoses
1	Malaria	3450	11.72%	3761	11%
2	Cough or cold no Pneumonia	2225	7.56%	1604	5%
3	Other types of Anaemia	888	3.02%	691	2%
4	DIARRHEA ACUTE	484	1.64%	478	1%
5	Urinary Tract Infections (UTI)	753	2.56%	1048	3%
6	Gastro-Intestinal Disorders (non-Infective)	701	2.38%	616	2%
7	DIARRHEA ACUTE	484	1.64%	478	1%
8	Pneumonia	448	1.52%	488	1%
9	PELVIC INFLAMMATORY DISEASE	437	1.26%	437	1%
10	Diabetes Mellitus	559	1.11%	579	2%
	All others	6270	21.29%	4674	14%
	Total OPD attendance	**29444**		**34,524**	

Antenatal clinic

Antenatal care serves as the initial point of contact for women to engage with formal healthcare services, facilitating the connection of those experiencing pregnancy complications to a referral network. This care encompasses education, screening, counseling, treatment for minor ailments, and immunization services. The antenatal clinic operates five days a week, from 8:00 a.m. to 5:00 p.m., Monday through Friday, and remains closed on Saturdays, Sundays, and public holidays.

At the antenatal clinic, EMTCT services are provided, ensuring that all expectant mothers and their partners undergo HIV testing. Those who receive a positive result are placed on option B+ to minimize the risk of transmission to their unborn child. These mothers are monitored closely throughout their pregnancy, during delivery, and in the postpartum period. Their infants, who are at risk, are enrolled in mother-baby care centers where early infant diagnosis (EID) is conducted, and they are followed until they reach 18 months of age, at which point

their HIV status is confirmed. If the infants test negative, they are discharged, while those who test positive are transitioned to chronic care at the ART clinic.

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

ANTENATAL	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
ANC 1st Visit	1,606	1,566	1,515	1,376	1305
ANC 4th Visit	1,217	878	1,990	842	755
Total ANC visits new clients + Re-attendances	7,388	6,390	6,550	5,874	5600
ANC Referrals to unit	0	0	31	110	331
ANC Referrals from unit	0	0	12	110	0
POSTNATAL					
Post Natal Attendances	3,939	3,629	4,107	3,836	3780
Number of HIV + mothers followed in PNC	906	246	243	221	216
Vitamin A supplementation	0	0	0	0	0
Clients with premalignant conditions for breast	0	0	0	0	18
Clients with premalignant conditions for cervix	0	0	0	0	52

The overall attendance at antenatal care (ANC) sessions saw a decline of 4.6% compared to the previous fiscal year, while referrals experienced a significant increase of nearly 200%. This shift can be attributed to the heightened initiatives undertaken by implementing partners in collaboration with the Ministry of Health, emphasizing the critical nature of referrals from lower-level facilities to higher-level centres to reduce maternal mortality rates. The hospital offers cervical cancer screening services during ANC visits on a daily basis within regular working hours. However, the rate of positive screening results among women of reproductive age has remained relatively low. Should continuous funding be secured, there is a pressing need to expand this initiative to encompass a larger population.

HIV/AIDS clinic

Dr. Ambrosoli Memorial Hospital Kalongo operates as a Private Not for Profit (PNFP) organization, dedicated to delivering extensive HIV/AIDS care and treatment services. Since October 2020, the hospital has been funded and supported by the Local Service Delivery for HIV/AIDS Activity in collaboration with the Uganda Protestant Medical Bureau, following a transition from the RHITES-N Acholi program. The facility provides a wide range of services,

including HIV Testing Services, timely initiation of Antiretroviral Therapy (ART), Differentiated Service Delivery (DSD), and prevention and treatment for Tuberculosis. Additional offerings encompass Voluntary Male Medical Circumcision (VMMC), the elimination of Mother-to-Child Transmission (eMTCT), home visits, cervical cancer screening, and services addressing Sexual and Gender-Based Violence (SGBV), along with Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP).

The clinic's operations are overseen by a medical officer, and the number of clients living with HIV continues to increase annually. Currently, the HIV/AIDS Clinic is situated in a temporary facility that also functions as a data entry point, nursing care area, counseling space, and clinical consultation room, among other administrative tasks. There is an urgent need for expansion to accommodate the growing demands of the clinic's services. Despite ongoing budgetary challenges, the current implementing partner has been unable to support structural development requests, leading to a gradual decline in budget assistance. This reduction has adversely affected the clinic's operations, resulting in staff cuts and limitations on planned activities.

HIV Testing Services (HTS)

HIV testing services (HTS) represent a crucial strategy in HIV prevention, offering individuals the opportunity to ascertain their HIV status. Those who test negative receive essential health education on preventive measures and are connected to additional services, such as voluntary medical male circumcision (VMMC) and adolescent-friendly health services. Conversely, individuals who test positive are promptly initiated on treatment and linked to comprehensive care. High-risk populations are provided with a tailored package of prevention services designed to help them maintain their negative status. The HTS framework in communities relies on targeted testing approaches, employing various modalities such as community-based HTS, Assisted Partner Notification, Social Network Strategies, and index client testing, which are implemented both in community settings and healthcare facilities, including outpatient departments and inpatient wards.

The United Nations' first target in the 95-95-95 initiative aims for 95% of individuals living with HIV to be aware of their status by 2025, making HIV testing a fundamental component in achieving this goal. Effective HIV testing services encompass a comprehensive array of support, including pre-test and post-test counseling, referrals to appropriate prevention, treatment, and care services, as well as coordination with laboratory services to ensure quality assurance and accurate results. Recent data indicates a significant increase in the number of individuals accessing HTS, rising from 12,323 in the previous fiscal year to 14,148 in the

current fiscal year, reflecting a 14.8% increase. Additionally, there has been a 4% rise in the identification of HIV-positive individuals, attributed to enhanced HTS activities that prioritize high-yield testing modalities such as Assisted Partner Notification, Index Client Testing, and Social Network Strategies.

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

	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Number Tested					
Male	7,347	4,088	4,498	4,533	6,012
Female	6,721	6,172	5,580	7,790	8,136
TOTAL (Tested)	14,068	10,260	10,078	12,323	14,148
Tested +ve for HIV					
Male	103	86	56	82	78
Female	149	107	94	89	100
TOTAL (+ve Tests)	252	193	150	171	178
Positivity Rates of HCT					
Male	1.40%	2.10%	1.20%	1.80%	1.30%
Female	2.20%	1.70%	1.70%	1.10%	1.23%
Both sexes	1.80%	1.90%	1.50%	1.40%	1.26%

Table 6.6: HIV test by purpose during FY 2023– 2024

Types of test	**HCT**	**PMTCT**	**SMC**	**Total**
Number of clients tested for HIV	8,904	5,244	739	14,148
No. of HIV +ve tests	165	13	0	178
Positivity Rate (%)	1.85%	0.25%	0.00%	1.26%

PMTCT/EID services

There has been a noticeable decrease in the performance of first antenatal care (ANC) visits, particularly among those attending during the first trimester, which falls short of the anticipated targets. Specifically, there is a 5.2% reduction in the number of first ANC visits compared to the previous financial year. This decline can be attributed to the limited availability of lower-level health facilities that can provide similar services to mothers, except for those with pregnancy-related complications who require referrals for specialized care.

Acknowledgment is due to the Ministry of Health and its implementing partners for their efforts in strengthening these lower health facilities to deliver ANC services effectively. They have

also emphasized the importance of referrals from these centers to higher-level facilities to prevent maternal mortality. Continuous efforts are being made to screen all women of childbearing age at various entry points within the facilities to ensure timely pregnancy diagnoses and subsequent referrals for ANC services. Additionally, primary healthcare services are being utilized effectively, with strong community mobilization to offer integrated services, including ANC, at the community level.

Table 6.7: Performance Indicators of the PMTCT Program in FY2023-2024

	2019-20	**2020-21**	**2021-22**	**2022-23**	**2023-24**
A. Antenatal					
A1. Mothers re-tested later in pregnancy, labour or postpartum	444	285	1958	1074	1812
A2. Mothers testing positive on a retest	8	2	68	4	10
A3. New pregnant and lactating mothers newly enrolled into psychosocial support groups.	31	8	0	0	0
A4. HIV positive pregnant women already on HAART before 1st ANC visit /Current pregnancy	98	123	412	104	85
A5. Pregnant women who received services at the health facility after referral from the community	0	0	43	110	331
A6. HIV (+) lactating mothers followed up in community for infant feeding, early infant diagnosis, or linkage into chronic care	250		74	118	125
A7. HIV positive Pregnant women initiated on Cotrimoxazole	14	15	26	16	12
A8a. Mothers assessed using CD4	0	0	0	0	0
A8b. Mothers assessed using WHO clinical staging only	0	0	0	0	0
A9a. HIV + pregnant women initiated on HART (Option B+) for EMTCT - CD4 >350 or Stage I and 1I (ART-T)	14	15	26	16	12
A9b. HIV + pregnant women initiated on HART (Option B+) for EMTCT - CD4 <350 or Stage III and IV(ART-T)	0	0	0	3	0
B. Maternity			0		
B1. HIV positive deliveries initiating ARVs in Labour	129	3	1	4	4
C. Postnatal					
C1. Postnatal mothers newly tested for HIV	74	85	31	784	805
C2. Postnatal mothers testing HIV positive	7	1	1	6	6
C3. Postnatal mothers initiating ARVs in PNC period	8	1	1	6	6
D. Early Infant Diagnosis (EID)					
D1. HIV-exposed infants (<18 months) getting a 2nd DNA PCR	116	113	124	132	139
D2. HIV-exposed infants initiated on Cotrimoxazole prophylaxis	121	100	149	124	139
D3a. 1st DNA PCR results returned from lab within 2 weeks of dispatch	90	118	124	118	122

D3b. 2nd DNA PCR results returned from lab within 2 weeks of dispatch	88	99	108	110	96
D4a. Total HIV-exposed infants who had a serological/rapid HIV test at 18 months or older.	131		111	134	124
D4b. Positive Number of HIV-exposed infants who had a serological/rapid HIV test at 18 months or older	4		3	7	4
D5. DNA PCR results returned from the lab that are positive	4		3	7	4
D6. HIV-exposed infants whose DNA PCR results were given to caregiver	44		6	14	36
D7. Number of referred HIV positive-infants who enrolled in care at an ART clinic	3		3	7	4

ART enrolment

All newly identified clients who test positive for HIV are promptly connected to care services. Upon enrolment, they undergo screening for advanced HIV disease, along with a recency test, as part of the comprehensive care package. This information is instrumental in informing the team's health testing services (HTS) activity work plans, including initiatives such as Active Partner Notification (APN), Social Network Strategy (SNS), and Index Client Testing (ICT).

The implementation of Differentiated Service Delivery Models (DSDM) is in accordance with established guidelines, with a significant number of clients utilizing the Community Drug Distribution Point (CDDP) model. Additional strategies being employed include Community Client-led ART Delivery (CCLAD), Fast Track Drug Refill (FTDR), Facility Based Group (FBG), and Facility Based Individual Management (FBIM). The overarching aim is to enroll all eligible clients in one of these models to reduce congestion at facilities and enhance treatment adherence. Comprehensive services are available at both facility and community levels, encompassing drug refills, viral load testing, Integrated Adherence Counseling (IAC), provision of Tuberculosis Preventive Therapy (TPT), distribution of Pre-Exposure Prophylaxis (PrEP) for discordant couples, and cervical cancer screenings. Most clients now receive a six-month drug refill, following new guidelines that advocate for a six-month prescription for all eligible clients participating in Multi Month Dispensing (MMD), which has significantly improved adherence rates.

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

		FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
ELIGIBLE FOR ART						
Male	<5 yrs	4	2	4	4	1
	5-<18 yrs	6	5	3	7	3
	18 and above	96	70	54	64	74
Female	<5 yrs	6	1	3	3	5
	5-<18 yrs	8	7	6	3	6
	18 and above	120	91	85	84	89
TOTAL ELIGIBLE FOR ART		**240**	**176**	**155**	**165**	**178**
STARTED ON ART						
Male	<5 yrs	4	2	4	4	1
	5-<18 yrs	6	5	3	7	3
	18 and above	96	70	54	64	74
Female	<5 yrs	6	1	3	3	5
	5<18 yrs	8	7	6	3	6
	18 and above	120	91	85	84	89
TOTAL STARTED ON ART		**240**	**176**	**155**	**165**	**178**

Table 6.9: Number of PLHAs started on ARV by age group and gender in FY 2023-2024

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	4	11	4	18	70	71	**178**
Number of pregnant women enrolled into care during the year.		0		11		13	**24**
Cumulative Number of individuals on ART ever enrolled in HIV care at this facility							**6350**
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		252	209	32	83	378	535	**1489**
No. of newly identified positives that are initiated on ART int the same FY		4	11	4	18	70	71	**178**
No. of pregnant & Lactating women started on ART at this facility during the quarter (Subset of HC11)			0		11		13	**24**
No. active on ART screened for TB at last visit in the quarter		114	106	32	83	1040	1708	**3083**
No. active on ART with presumptive TB during the quarter		3	2	0	1	11	23	**40**
No. active on ART diagnosed with TB during the quarter		0	0	0	0	6	2	**8**
Net current cohort of people on ART in the cohort completing, 12 months during the year		5	5	5	1	149	202	**367**
Number of clients surviving on ART in the cohort completing, 12 months on ART during the year		5	5	5	1	145	192	**353**
Number of people accessing ARVs for PEP		2	5	6	14	25	8	**60**
No. active on ART on 1st line ARV regimen		99	96	30	80	1005	1677	**2987**
No. active on ART on 2nd line ARV regimen		15	10	2	3	35	31	**96**
No. active on ART on 3rd line or higher ARV regimen		2	1	0	0	1	0	**4**
Number of clients on ART who had a viral load test during the past 12 months (most recent test)	Total Tested	108	97	21	60	782	1441	**2509**
	Suppressed viral load	80	65	20	48	751	1393	**2357**
	FBIM			5	13	77	90	**185**
	FBG	71	69	0	31	0	341	**512**

Number active on ART enrolled in DSD approach	FTDR	0	0	23	29	512	526	**1,090**
	CDDP	45	38	4	10	381	649	**1,127**
	CCLAD	0	0	0	0	71	102	**173**

Tuberculosis (TB) treatment

The Dr. Ambrosoli Memorial Hospital integrates tuberculosis treatment into its standard medical services, ensuring comprehensive care for patients. TB screening is conducted at all hospital entry points, including the Antenatal Care (ANC) and Antiretroviral Therapy (ART) clinics. All individuals suspected of having TB are required to undergo the GeneXpert test available at the laboratory. To enhance access to drug-sensitive testing for TB patients, the Ministry of Health and the National Tuberculosis and Leprosy Program (MOH/NTLP) have initiated the GET TB National Quality Improvement collaborative, aiming for 100% access to GeneXpert testing for all presumptive cases. Positive TB cases are promptly initiated on treatment, with efforts made to trace and follow up on their contacts through collaboration with community linkage facilitators and local health structures.

Despite a general decline in TB case identification, there has been an increase in the number of children under five years diagnosed with TB. This rise can be attributed to improved diagnostic practices, including the use of GeneXpert on stool samples, which was not previously implemented. A district-led training session facilitated by UPMB/LSDA has further supported this initiative. Additionally, there has been a notable reduction in the number of TB patients lost to follow-up, thanks to targeted community activities aimed at re-engaging these clients. The restructuring of TB services, moving from the medical ward to the ART clinic, aligns with the Ministry of Health's guidelines for a one-stop-shop approach recommended by the WHO and Global Fund. This strategic shift has led to better management of co-infected patients and has positively impacted treatment success and cure rates through improved documentation and timely monitoring of patients undergoing treatment.

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

	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
No. of patients registered (all)	325	270	194	210	150
Children (< 5 yr)	38	38	32	19	28
Disaggregation by Disease					
New Pulmonary Positive	84	83	145	145	127
Relapses Pulmonary Positive	10	5	7	2	11
Failure Pulmonary Positive	7	1	5	0	2
Lost to follow up Pulmonary Positive	0	3	0	8	2
New pulmonary Negative	206	167	31	52	
Relapses Pulmonary Negative	6	7	4	1	
Default Pulmonary Negative	4	0	0	0	0
Pulmonary no smear done	0	0	0	0	0
Extra Pulmonary	8	4	2	2	7
Disaggregation by Treatment					
New Patients	298	250	178	199	123
Re-treatment	27	20	11	11	11
Other Patients					
Transferred in	0	0	0	0	0

Table 6.10b: MDR/MTB diagnosis during the FY 2023-24

Age group	Samples Collected	Samples Tested	MTB positive Cases	MDR positive (Rifampicin Resistant TB)	MDR cases referred
< 15 years	602	602	14	0	0
15 yrs.& above	1733	1707	132	1	1
Total	2335	2309	146	1	1

Table 6.10c : Results of TB treatment in the last 5 FYs

Outcome of treatment	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
	Number	Number	Number	Number	Number
Cured	38	48	35	59	43
Treatment Completed	126	222	201	79	115
Died	24	34	17	24	24
Failure	0	2	0	1	0

Defaulted	1	0	0	0	0
Transfer out	3	0	0	0	0
Lost to follow Up		5	13	13	10
Not Evaluated		4	5	16	7
Total	**192**	**315**	**271**	**192**	**199**

Table 6.10d: Results of TB treatment smear positive Pulmonary TB patients in the last 5 FYs

Outcome of treatment	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Cured	36	48	33	59	43
Treatment Completed	43	33	37	50	76
Died	10	6	8	17	17
Failure	0	1	0	1	0
Defaulted	1	0	0	0	0
Transfer out	2	0	0	0	0
Lost to follow Up		6	5	10	7
Not Evaluated		2	3	14	4
Total	**92**	**96**	**86**	**151**	**147**

Orthopaedic Services

The primary approach to treatment remains non-operative orthopedic care, with surgical interventions being conducted occasionally during surgical camps. Cultural and financial factors continue to deter patients from the hospital and surrounding district from being referred for surgery. With a significant volume of orthopedic cases, it is essential to enhance the availability of surgical treatment options.

Although the hospital currently lacks a dedicated orthopedic surgeon, there is a medical officer in training who will be assigned to the facility to deliver surgical orthopedic services. Additionally, the hospital offers a specialized clinic for "club foot" among its orthopedic services, further addressing the needs of patients in the community.

Of importance, there has been a significant increase in the number of patients who received physiotherapy by 126.5% while those who had POP reduced by 28.9%.

Table 6.11: Main procedures in orthopedics and physiotherapy done in the last 5 FYs

Procedures	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Plaster (POP)	364	707	1434	844	600
Physiotherapy	157	76	814	538	1219

Mental health clinic

The availability of specialized mental health treatments in the Agago district has significantly improved, thanks to the presence of qualified professionals and the necessary infrastructure to provide comprehensive mental health care. Mental health services are now fully incorporated into the hospital's core offerings. However, when patient numbers exceed manageable levels, other healthcare providers are called upon to assist in the treatment of these individuals. Currently, epilepsy remains the predominant cause of mental health issues observed in our outpatient department, followed closely by cases of depression and substance abuse.

Despite the hospital's commitment to enhancing mental health services, the challenge of staff retention persists, as many professionals seek opportunities elsewhere. Additionally, the shortage of essential mental health medications and the limited availability of inpatient beds for patients continue to pose significant obstacles in delivering effective care. Addressing these issues is crucial for sustaining the progress made in mental health treatment within the community. There was a steep rise in the number of patients diagnosed with depression and PTSD as compared to the previous financial year by 2121% while the number of those who were diagnosed with alcohol use disorder decreased.

The table below 6.11 displays the cases reviewed in the OPD during the fiscal year.

Table 6.12: Mental health cases reviewed in OPD in the last 5 FYs

Diagnosis	FY 2019-20		FY 2020-21		FY 2021-22		FY 2022-23		FY 2023-24	
	No.	%	No.	%	No.	%	No.	%	No.	%
Epilepsy	1,171	84.50%	702	80.80%	745	76.73%	728	83.20%	729	78.05%
Drugs/alcohol abuse	3	0.20%	60	6.90%	68	7.00%	35	4.00%	14	1.50%
Depression & post-traumatic stress disorders	75	5.40%	31	3.60%	99	10.20%	47	5.37%	147	15.74%
Psychosis (schizophrenia)	12	0.90%	7	0.80%	3	0.31%	0	0.00%	4	0.43%
Bipolar affective disorder	3	0.20%	8	0.90%	12	1.24%	26	2.97%	25	2.68%
Attempted suicide	3	0.20%	16	1.80%	9	0.93%	0	0.00%	0	0.00%

HIV related Psychosis	19	1.40%	11	1.30%	1	0.10%	15	1.71%	0	0.00%
Other mental illnesses	99	7.10%	34	3.90%	34	3.50%	24	2.74%	15	1.61%
Total	**1,385**		**869**		**971**		**875**		**934**	

Palliative Care

Palliative care is a specialized form of medical support designed for individuals facing terminal illnesses. This approach prioritizes alleviating the symptoms and emotional distress associated with the condition, aiming to enhance the overall quality of life for both patients and their families. Although there are several challenges in implementing palliative care, progress is being made. However, a lack of funding remains a significant barrier to providing essential palliative care resources and ensuring proper patient follow-up. To tackle these issues, the hospital has integrated palliative care into its primary health care initiatives and has also taken steps to recruit a social worker. The number of patients receiving palliative care services has remained the same just like the previous financial year. Figure 6.16 summarizes the palliative care services given in the fiscal year 23/24.

Table 6.13: Number of Patients who received Palliative Care in the FY2023-24

Clinical Condition	No. of patients that need palliative Care	No. of patients who received palliative Care
Cancer	16	13
HIV/AIDS	60	48
Sickle cell	0	0
Others	120	118

Inpatients department

The total bed capacity across the hospitals stands at 286. During the fiscal year 22/23, the hospital employed five medical officers. However, the institution is still grappling with a significant shortage of specialists. Management plans to enhance its capabilities in this regard as funding permits. At present, there are four specialists on staff, comprising two surgeons, a paediatrician, and a recently appointed obstetrician. The average ratio of beds to nurses and midwives has remained relatively stable. The medical ward presently accommodates the highest number of beds per nurse or midwife, whereas the NICU continues to have the lowest, consistent with the previous year's data. These statistics fluctuate, particularly during peak malaria seasons, when there is a notable increase in cases, thereby exacerbating the ratios.

Table 6.14: 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	7	8
TB Ward	18			
Surgical Ward	76	2 Surgeon 1 Medical Officer 1 Orthopedic Officer 1 Physiotherapist	14	5
Maternity & Gyn Ward	75	1 Medical Officer	19	4
		1 Gynecologist		
Pediatric Ward	76		13	3
NICU	10	1 Medical Officers	10	
		1 Paediatrician		
Total	286		49	

Utilization indicators

In the fiscal year 2023/2024, there was a notable increase of 7.7% in the total number of admissions. Additionally, the overall recovery rate saw an improvement of 1.3%, while the average length of stay rose by 11%. Conversely, the incidence of self-discharges experienced a significant decline of nearly 31.3%. The average length of stay exceeded the national benchmark of 4.7 days. The BOR increased by 19% to about 60 while the overall mortality rate greatly decreased by 29.2%.

In response to these trends, management has implemented strategies aimed at further reducing instances of fee-free discharges and is optimistic about achieving additional reductions in the upcoming year.

Table 6.15: Key indicators for the entire hospital in the last 5 FYs

Indicator	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
No. of beds	271	286	286	286	286
Total Admissions discharged	16,779	12,203	12,913	11,473	12354
Patient days	89,761	69,228	63,633	52,359	62631
Average Length of Stay	5.35	5.67	4.93	4.56	5.07
Turn over interval	0.5	2.9	3.2	4.5	3.4
Throughput per bed	61.9	42.7	45.2	40.1	43.2

BOR	90.75	66.32	60.96	50.16	60.00
No. Deaths	373	343	386	352	248
Mortality Rate	2.5%	2.3%	2.6%	2.4%	1.7%
Recovery Rate	97.42%	95.85%	96.24%	96.49%	97.71%
Self-discharges	60	164	99	51	35

Bed Occupancy Rate (BOR) and Throughput per Bed

The bed occupancy rate rose by 3.4% to 60.00 in fiscal year 23/24. The pediatric ward had the highest BOR (77.53), much as the year before, followed by the medical ward (72.98). As in FY 22/23, malaria and its effects continued to be the cause of the rising BOR observed in the pediatric and medical wards in FY 23/24. Overall, throughput per bed rose to 43.2 from 40.1 in FY 22/23.

MEDICAL WARD					
	FY 2019-20	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**
No of beds	41	41	41	41	41
Total Admissions	2,684	1,834	2,141	1,713	1900
Patients days	12,549	7,542	9,285	7,886	10922
ALOS	4.7	4.1	4.3	4.6	5.75
Throughput per bed	65.46	44.73	52.22	41.78	46.34
BOR	83.18	50.40	62.04	52.70	72.98
No of Deaths	113	140	142	140	70
Mortality rate	4.21%	7.63%	6.63%	8.17%	3.7%
Recovery rate	95.45%	89.59%	92.81%	91.24%	95.5%
Self-discharges	9	51	12	10	16

SURGICAL WARD[1]					
	FY 2019-20	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**
No of beds	76	76	76	76	76
Total Admissions	1,925	1,521	1,584	1,577	1462
Patients days	15,189	13,701	13,776	8,830	10771
ALOS	7.89	9.01	8.70	5.60	7.37
Throughput per bed	25.33	20.01	20.84	20.75	19.24
BOR	54.75	49.39	49.66	31.83	38.83
No of Deaths	32	30	45	38	16
Mortality rate	1.7%	2.0%	2.8%	2.4%	1.09%
Recovery rate	98.1%	97.0%	96.0%	96.3%	98.4%
Self-discharges	4	15	18	20	8

PAEDIATRIC WARD					
	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
No of beds	61	76	76	76	76
Total Admissions	7,615	4,437	4,398	3,819	4512
Patients days	43,503	29,304	20,960	17,103	21507
ALOS	5.71	6.60	4.77	4.48	4.77
Throughput per bed	124.84	58.38	57.87	50.25	59.37
BOR	195.39	105.64	75.56	61.65	77.53
No of Deaths	217	157	183	158	148
Mortality rate	2.85 %	3.54 %	4.16 %	4.14 %	3.28 %
Recovery rate	96.53 %	94.79 %	95.52 %	95.78 %	96.6 %
Self-discharges	47	74	14	3	5

OBSTETRICS& GYNECOLOGY WARD					
	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
No of beds	75	75	75	75	75
Total Admissions	4,226	4,144	4,595	4,154	4144
Patients days	16,519	17,441	17,522	16,728	16925
ALOS	3.91	4.21	3.81	4.03	4.08
Throughput per bed	56.35	55.25	61.27	55.39	55.25
BOR	95.45	0.64	64.01	61.11	61.83
No of Deaths	4	11	5	7	5
Mortality rate	0.09 %	0.27 %	0.11 %	0.17 %	0.12 %
Recovery rate	99.91 %	99.3 %	98.7 %	99.4 %	99.6 %
Self-discharges	0	20	55	18	10

TB WARD					
	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
No of beds	18	18	18	18	18
Total Admissions	329	267	195	210	157
Patients days	2,001	1,240	2,090	1,812	1036
ALOS	6.08	4.64	10.72	8.63	6.6
Throughput per bed	18.28	14.83	10.83	11.67	8.72
BOR	30.46	18.87	31.81	27.58	15.77
No of Deaths	7	5	11	9	5
Mortality rate	2.13 %	1.87 %	5.64 %	4.29 %	3.18 %
Recovery rate	97.87 %	98.13 %	94.36 %	95.71 %	96.8 %
Self-discharges	0	0	0	0	0

Inpatient referrals

The hospital is the main referral hospital for Agago district and neighboring districts. In the financial year of 23/34, the total number of referrals slightly increased by 4%. The number of referrals to the hospital decreased while the referrals out of the hospital slightly increased.

Table 6.15: Pattern of referrals to and from the hospital in the last 5 FYs

	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Referrals to hospital	153	694	695	783	756
Referrals from hospital	33	105	81	138	208
Total	**186**	**799**	**776**	**921**	**964**

Morbidity causes

Malaria, accounting for 28.12% of cases, followed by injuries at 6.07% and pneumonia at 5.3%, emerged as the primary contributors to morbidity within the wards. These leading causes of illness show a similarity to the data from the previous year. Given the complexities involved in managing complications arising from malaria infections, it is essential to enhance community-focused initiatives aimed at preventing malaria transmission. The pattern of injuries noted was primarily influenced by incidents related to alcohol-fueled violence within the community, alongside a few traffic-related accidents, compounded by the ongoing insecurity associated with the activities of the Karimojong warriors, which remains a persistent issue.

Table 6.17: Top ten causes of admission in all the wards in the FYs 2022-2023&2023-2024

Causes of Morbidity		FY 2021-22		FY 2022-23		FY 2023-24	
		No. of cases	% on all diagnose	No. of cases	% on all diagnose	No. of cases	% on all diagnose
1	Malaria	3,246	25.14%	2,938	25.61%	3,474	28.12%
2	Injuries: (Trauma due to other causes)	1,182	9.15%	1,001	8.72%	750	6.07%
3	Pneumonia	926	7.17%	710	6.19%	662	5.36%
4	Abortion due to other causes	553	4.28%	529	4.61%	469	3.80%
5	Septicemia	504	3.90%	535	4.66%	394	3.19%

6	Anaemia	344	2.66%	384	3.35%	240	1.94%
7	Malaria in pregnancy	165	1.28%	210	1.83%	467	3.78%
8	Diarrhoea - Acute	342	2.65%	373	3.25%	409	3.31%
9	Other complication in pregnancy	354	2.74%	452	3.94%	244	1.98%
10	Other Neonatal Conditions	227	1.76%	244	2.13%	217	1.76%
	All others	449	3.48%	708	6.17%	1022	8.27%
	Total	**12,913**		**11,473**		**12,354**	

Table 6.18: Trend in Malaria admissions over the last 5 FY

	FY 2019-20	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**
Malaria cases	3,159	6,989	3246	2938	3,474
% of all diagnosis	21.35%	41.65%	25.14%	25.61%	28.12%

Mortality causes

Table 6.19: Top ten causes of death among inpatients all wards FY2022-23 and FY2023-24

Causes of Mortality among Inpatients		**FY 2022-23**			**FY 2023-24**		
		No of disease specific deaths	No of cases admitted in the hospital	Case Fatality Rate	No of disease specific deaths	No of cases admitted in the hospital	Case Fatality Rate
1	Malaria total	52	2,938	1.77%	38	3,474	1.09%
2	Pneumonia	32	710	4.51%	15	662	2.27%
3	Other Neonatal Conditions	20	244	8.20%	26	217	11.98%
4	Injuries - Trauma due to other causes	12	1,001	1.20%	5	750	0.67%
5	Malnutrition	7	127	5.51%	7	284	2.46%
6	Premature baby (as condition that requires mgt)	16	128	12.50%	33	193	17.10%
7	Hypertension	5	95	5.26%	4	124	3.23%
8	Heart failure	8	25	32.00%	4	29	13.79%
9	Anaemia	13	384	3.39%	7	240	2.92%
10	Irritable Bowel Syndrome	8	210	8.00%	8	182	4.40%
	All others	27	681	3.96%	16	1022	1.57%

MEDICAL WARD

The department has the capacity to serve a total of 41 patients, distributed between its primary ward and the adjacent private wing. Within the private ward, there are 11 beds available, including three designated as private rooms. Renovation plans are currently being developed for this facility, which is among the oldest complexes within the hospital. The operations of the tuberculosis ward are overseen by the medical ward and are integrated within the same structure.

Staff composition

The ward is managed by a Medical Officer along with a team of 10 nursing and supportive staff members. The Medical Officer, with the assistance of the Nursing in charge, holds the primary responsibility for the ward's operations. Additionally, the ward benefits from the support of visiting volunteers from Italy, coordinated by IDEA onlus in collaboration with the Ambrosoli Foundation.

Table 6.20: Staff Composition in Medical Ward FY2023-2024

Cadre/ Discipline	Qualification	Number
Medical Doctor	Bachelor Degree in Medicine and Surgery	1
Registered Nurse/Midwife	Diploma in Comprehensive Nursing	2
Enrolled Nurse	Certificate in Nursing	5
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	1
Nursing Assistant	Certificate in Nursing Assistant	1
Nursing Aid	Trained on the Job	0
Total		**10**

In the fiscal year 2023/2024, there was a notable increase in admissions, rising by 10.9% to a total of 1,900. This growth can be attributed to the enhanced operational capabilities of the nearby health centers, which have improved their ability to make timely referrals to the hospital. Nevertheless, there was a slight uptick in the average length of stay, while the bed occupancy rate experienced a significant rise of 25%. Conversely, the mortality rate saw a substantial decline of 54%, largely due to the prompt referrals of critically ill patients from the health centers. Additionally, there was a minor increase in the number of self-discharges, which

can be linked to the multiple unsecured entry points in the hospital's perimeter, complicating the staff's ability to monitor patients who have not settled their bills.

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

MEDICAL WARD					
	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
No of beds	41	41	41	41	41
Total Admissions	2,684	1,834	2,141	1,713	1900
Patients days	12,549	7,542	9,285	7,886	10922
ALOS	4.7	4.1	4.3	4.6	5.75
Throughput per bed	65.46	44.73	52.22	41.78	46.34
BOR	83.18	50.40	62.04	52.70	72.98
No of Deaths	113	140	142	140	70
Mortality rate	4.21%	7.63%	6.63%	8.17%	3.7%
Recovery rate	95.45%	89.59%	92.81%	91.24%	95.5%
Self-discharges	9	51	12	10	16

Morbidity Causes

Non-communicable diseases (NCDs) continue to be the primary cause of death in the medical ward, predominantly affecting patients with pre-existing conditions, while only a small number are newly diagnosed cases. A significant challenge faced is the failure of patients to attend scheduled appointments, despite the availability of a weekly outpatient clinic, which often results in the presentation of complications. Additionally, the rise in utilization indicators is correlated with an increased incidence of malaria compared to the previous year. The medical ward is also noted for a high rate of patient absconding. To tackle this issue, management will collaborate closely with the ward team to implement effective solutions.

Table 6.22: Top 10 causes of admission in Medical Ward in the last 3 FYs

Causes of Morbidity in Medical Ward		FY 2021-2022		FY 2022-2023		FY 2023-2024	
		No. of cases admitted	% on all admissions in Medical Ward	No. of cases admitted	% on all admissions in Medical Ward	No. of cases admitted	% on all admissions in Medical Ward
1	Malaria	649	30.31%	584	34.09%	680	35.79%
2	Sepsis	238	11.12%	274	16.00%	138	7.26%
3	Pneumonia	133	6.21%	114	6.65%	108	5.68%

4	Poisoning	95	4.44%	27	1.58%	36	1.89%
5	Hypertension	88	4.11%	93	5.43%	101	5.32%
6	Acute Gastritis	86	4.02%	107	6.25%	218	11.47%
7	Liver disease	68	3.18%	63	3.68%	60	3.16%
8	Anaemia	55	2.57%	242	14.13%	174	9.16%
9	PUD	53	2.48%	59	3.44%	80	4.21%
10	UTI	53	2.48%	67	3.91%	78	4.11%
Total Admission		**2,141**		**1,713**		**1,900**	

Mortality Causes

Pneumonia and anemia emerged as the primary contributors to mortality within the medical ward. This situation was largely due to insufficient equipment available for delivering respiratory support to patients suffering from acute respiratory issues. Additionally, the persistent shortage of blood supplies continues to pose significant challenges, making the management of anemia cases particularly difficult.

Table 6.23: Top 5 common causes of death in Medical ward

Causes of Mortality in Medical Ward				
		No. of disease specific deaths	**No. of cases admitted**	**Case Fatality Rate**
1	malaria	7	680	1.03%
2	Anaemia	7	174	4.02%
3	Pneumonia	6	108	5.56%
4	Hypertension	4	101	3.96%
5	Liver disease	5	60	8.33%

Surgical Ward

The Surgical Ward is located within one of the hospital's oldest buildings, which underwent partial renovations in late 2022. Nevertheless, a more comprehensive overhaul is necessary, addressing both the infrastructure and the furnishings, including beds, lockers, and mattresses, all of which are in a state of disrepair. This situation not only compromises patient comfort but also adversely affects staff efficiency and hygiene standards. The ward accommodates 71 beds, divided into sections for female and male patients, and includes a private wing that is currently not operational. Additionally, a High

Dependency Unit (HDU) has been established from the surgical ward to cater to critically ill patients. The HDU plays a vital role in providing specialized care.

Staff composition

The total workforce comprised 20 employees, as detailed below. The Ward is directed by a Surgeon, who is supported by a Medical Officer. They are also responsible for overseeing the operation theater. The MOH Internship program continued to function, with an average of four Intern doctors consistently allocated to their respective surgical specialties.

Table 6.24: Staff composition in Surgical Ward in the FY2023-2024

Cadre/ Discipline	Qualification	Number
Surgeon	Bachelor Degree in Medicine and Surgery and Master in Surgery	2
Medical Officer	Bachelor Degree in Medicine and Surgery	1
Bachelor Nurse	Bachelor Degree in Nursing	1
Registered Midwife/Nurse	Diploma in Midwifery and Nursing	2
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	0
Enrolled Nurse	Certificate in Nursing	11
Nursing Aid	Trained on the job	1
Orthopedic Officer	Diploma in Orthopaedics	1
Physiotherapy	Dip. In Physiotherapy	1
Total		**20**

As indicated in the table below, there was a marginal decline in total admissions relative to the previous fiscal year, accompanied by a corresponding reduction in the Bed Occupancy Rate (BOR). Although the Average Length of Stay (ALoS) remains elevated compared to the national average of 4.5, it has increased by 2. This figure is notably the highest among the various wards, primarily due to the nature of the services rendered, specifically surgical operations, which consequently elevates treatment costs.

In light of the decrease in total admissions, the overall utilization of inpatient services within the surgical ward has diminished. While some patients were referred elsewhere, an impressive 98.4% of all admissions were successfully discharged to their homes. Similar to the previous year, fractures continued to exhibit the highest fatality rate.

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

SURGICAL WARD[1]					
	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
No of beds	76	76	76	76	76
Total Admissions	1,925	1,521	1,584	1,577	1462
Patients days	15,189	13,701	13,776	8,830	10771
ALOS	7.89	9.01	8.70	5.60	7.37
Throughput per bed	25.33	20.01	20.84	20.75	19.24
BOR	54.75	49.39	49.66	31.83	38.83
No of Deaths	32	30	45	38	16
Mortality rate	1.7%	2.0%	2.8%	2.4%	1.09%
Recovery rate	98.1%	97.0%	96.0%	96.3%	98.4%
Self-discharges	4	15	18	20	8

Table 6.26: Top10 causes of admissions in Surgical Ward - FYs 2022-2023& 2023-2024

Causes of Morbidity in Surgical Ward		FY 2022-2023		FY 2023-2024	
		No. of cases admitted	% on all admissions in Surgical Ward	No. of cases admitted	% on all admissions in Surgical Ward
1	Fracture	295	19.88%	293	20.08%
2	Laceration	56	3.77%	50	3.43%
3	Abscess	132	8.89%	139	9.53%
4	Head injury	125	8.42%	98	6.72%
5	Hernia	80	5.39%	77	5.28%
6	Cellulitis	57	3.84%	67	4.59%
7	Blunt abdominal trauma	48	3.23%	64	4.39%
8	Intestinal Obstruction	16	1.08%	29	1.99%
9	Septic wound	47	3.17%	33	2.26%
10	Snake bite	21	1.42%	30	2.06%
11	**Total**			**1459**	

Table 6.27: Top 5 common causes of death in Surgical Ward in the current FY

	Top 4 Causes of Mortality among Inpatients	No of Disease specific deaths	Total No of cases of the disease admitted	Case Fatality Rate
1	Fracture	1	293	0.003413
2	Intestinal obstruction	2	29	0.068966
3	Head injury	1	98	0.010204
4	Burns	2	25	0.08

Surgical operation theatre

The hospital's operating theatre is accessible every day of the week, operating continuously for 24 hours. Established in 2015 with funding from the Japanese government, the facility designates specific days for elective surgeries. However, emergency procedures are conducted around the clock, with personnel assigned to ensure comprehensive shift coverage.

The current staffing structure remains largely unchanged, with four anesthetic officers, consistent with the previous year. The retention of anesthetic staff continues to pose a challenge, as none of the four are full-time employees of the hospital due to the inability of the hospital's wages to compete with those offered by other institutions.

Table 6.28: Staff Composition in the operating theatre FY 2023-2024

Cadre/ Discipline	Qualification	Number
Anesthetist Officer	Diploma in Anesthesia	4
Registered Nurse	Diploma in Nursing	1
Enrolled Midwife	Certificate in Midwifery	0
Enrolled Nurse	Certificate in Nursing	0
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	0
Medical Theatre Assistant	Certificate in Theatre Techniques	4
Nursing Assistant	Certificate in Nursing Assistant	3
Nursing Aid	Trained on the Job	4
Total		**16**

Surgical Procedures

The total volume of procedures performed at the hospital experienced a slight decline, correlating with a reduction in the number of patients seeking medical care. Among major surgical interventions, Caesarean sections are predominant, with the majority classified as emergencies and only a limited number being elective. The significant incidence of teenage pregnancies is attributed to the prevalence of Caesarean sections. In summary, there has been a decrease in the overall number of surgical procedures.

Table 6.29: Top major surgical procedures performed in the FY 2023-24

No.	Top major surgical procedures	Number of Patients	Proportion (%)
1	Caesarian sections	623	52.27%
2	Herniorrhaphy	86	7.21%
3	Orthopedic Surgery	93	7.80%

4	Laparotomy	77	6.46%
5	Plastic/ reconstructive surgery	48	4.03%
6	Other Major procedures	265	22.23%
	Total	**1192**	

Table 6.30: Top minor surgical procedures done in FY2023-24

No.	Top minor surgical procedures	Number of Patients	Proportion (%)
1	Minor Orthopedic Surgery	564	40.37%
2	Incision and drainage of abscesses	126	9.01%
3	Debridement and care of wounds and skin grafting	167	11.95%
4	Safe Male Circumcision	33	2.36%
5	Other Minor procedures	507	36.29%
	Total	**1397**	

Table 6.31: Trend of surgical activities in last 5 FYs

	FY 2019-20	FY **2020-2021**	FY **2021-2022**	FY **2022-2023**	FY **2023-2024**
Total Operations	3139	1652	1901	1759	2589
Major operations (including C/S)	1235	963	989	1105	1192
Minor operations	1904	689	912	654	1397
Emergencies	620	704	765	104	434
Emergencies as % of total major operations	**50.20%**	**73.10%**	**77.35%**	**9.41%**	**36.41%**

Table 6.32: Pattern of anesthesia used during the last 5FYs

Type of Anesthesia	**FY 2019-20**	**FY 2020-2021**	**FY 2021-2022**	**FY 2022-2023**	**FY 2023-2024**
Local Anesthesia	146	163	165	135	177
General Anaesthesia with IV Ketamine	933	731	749	708	846
Spinal Anesthesia	737	678	773	828	690
General Anesthesia with ETT	88	78	65	49	49
General Anesthesia with LMA	13	2	21	19	6
Regional Anaesthesa	1	0	12	0	0
Total	1918	**1652**	**1785**	**1739**	**1768**

Paediatrics Ward

The ward accommodates a total of 76 beds, organized into various sections: a general ward that includes areas for acute and subacute care, private rooms, and a designated space for stable children, along with Nutrition and Isolation units. This facility provides a comprehensive array of healthcare services for pediatric patients, addressing common childhood ailments, infections, malnutrition, and more complex conditions that necessitate specialized care. In alignment with the hospital's mission, the Pediatric Ward frequently adopts a holistic approach, focusing on the physical health of the child while also considering their emotional, mental, and spiritual well-being.

The department is currently engaged in several projects, including the RBF and Sickle Cell initiatives, which receive support from the foundation and ISP, respectively. These efforts are directed towards enhancing the quality of services provided to the community. Additionally, towards the end of the fiscal year 22/23, the pediatrics department participated in a research project focused on investigating severe malaria in children.

Staff Composition

The ward is under the leadership of a pediatrician who additionally holds the position of Medical Director for the hospital. Daily operations within the ward are managed by a single Medical Officer (MO), who is also responsible for overseeing activities in the Neonatal Intensive Care Unit (NICU). The MO is assisted by a clinical officer. Although there were some departures among the nursing staff for various reasons, the overall nursing workforce has remained stable. Throughout the year, the ward benefited from the support of a visiting pediatrician volunteer from Italy, along with other resident volunteers.

Table 6.33: Personnel assigned to Paediatric Ward in FY2023-24

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

Enrolled Nurse	Certificate in Nursing	5
Enrolled Comprehensive Nurse	Certificate in Comprehensive Nursing	2
Nursing Assistant	Certificate in Nursing Assistant	3
Total		**19**

Key ward indicators

The overall admissions in the pediatrics ward saw an increase of 693, representing an 18.1% rise in the fiscal year 2023-24. This surge can be attributed to a higher number of referrals from nearby health centers within the district. Additionally, the average length of stay (ALOS) rose by 0.29 days, or 6.5%, primarily due to the referral of more severely ill children suffering from malaria-related complications. There has been a notable rise in malaria cases, which continues to be the leading cause of admissions in the department, followed by pneumonia and sepsis in the second and third positions, respectively.

Malnutrition remains a significant issue frequently associated with elevated poverty rates and low literacy levels within the community. The prevalence of teenage pregnancies and inadequate attendance at antenatal care (ANC) services has resulted in prematurity being the primary reason for hospitalizations in the Neonatal Intensive Care Unit (NICU).

Table 6.34: Peadiatric Ward indicators over the last 5FYs

PAEDIATRIC WARD					
	FY 2019-20	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**
No of beds	61	76	76	76	76
Total Admissions	7,615	4,437	4,398	3,819	4512
Patients days	43,503	29,304	20,960	17,103	21507
ALOS	5.71	6.60	4.77	4.48	4.77
Throughput per bed	124.84	58.38	57.87	50.25	59.37
BOR	195.39	105.64	75.56	61.65	77.53
No of Deaths	217	157	183	158	148
Mortality rate	2.85%	3.54%	4.16%	4.14%	3.28%
Recovery rate	96.53%	94.79%	95.52%	95.78%	96.6%
Self-discharges	47	74	14	3	5

Table 6.34a: Top ten causes of admission in PaediatricWard-FY2022-23 and FY2023-24

Causes of Morbidity		FY 2022-2023		FY 2023-2024	
		No. of cases admitted	% on all admissions	No. of cases admitted	% on all admissions
1	Malaria	1,554	46.70%	2,580	65.67%
2	Pneumonia	418	12.60%	432	11.00%
3	Diarrhoea	250	7.50%	299	7.61%
5	Sepsis	228	6.90%	568	14.46%
4	SCD	202	6.10%	147	3.74%
6	SAM	101	3.00%	181	4.61%
7	RTI	82	2.50%	188	4.78%
8	Anaemia	66	2.00%	1061	27.00%
9	Bronchiolitis	59	1.80%	61	1.55%
10	UTI	48	1.40%	45	1.15%
		3,326		3,929	

Table 6.34b: Top ten causes of admission in NICU Ward - FY2022-23 and FY2023-24

Causes of Morbidity in NICU		FY 2022-2023		FY 2023-2024	
		No. of cases admitted	% on all admissions	No. of cases admitted	% on all admissions
1	Prematurity	142	28.80%	222	37.82%
2	Neonatal sepsis	103	20.89%	118	20.10%
3	Birth asphyxia	70	14.20%	72	12.27%
4	Respiratory Distress Syndrome	89	18.05%	108	18.40%
5	Pneumonia	11	2.23%	14	2.39%
6	Meconium Aspiration	2	0.41%	3	0.51%
7	Malaria	4	0.81%	1	0.17%
8	Neonatal Jaundice	21	4.26%	17	2.90%
9	Gastroschisis	2	0.41%	2	0.34%
10	Dehydration	0	0.00%	25	4.26%
Total Admission		**493**		**587**	

Table 6.35a: Top five causes of death in Peadiatric Ward in FY2023-24

	Causes of Mortality in Peadiatric ward	No of disease-specific deaths	No of cases of the disease admitted in Paediatric Ward	Case Fatality Rate
1	Malaria	2580	43	1.7%
2	Pneumonia	432	11	34.4%
3	SAM	181	6	3.3%
4	SCD	147	7	4.8%
5	Sepsis	568	13	2.3%

Table 6.35b: Top five causes of death in NICU in FY 2023-24

Causes of Mortality (NICU)		No of disease-specific deaths	No of cases of the disease admitted in NICU	Case Fatality Rate
1	Prematurity	222	45	20.27%
2	Birth asphyxia	72	8	11.1%
3	Respiratory Distress Syndrome	108	30	3.6%
4	Neonatal Jaundice	17	3	5.67%
5	Neonatal sepsis	118	6	5.08%

Mortality causes

The leading cause of mortality within the ward was identified as malaria, with pneumonia and severe acute malnutrition (SAM) following closely behind. A significant factor contributing to this high mortality rate is the extensive catchment area, coupled with the tendency of many patients to arrive late after initially seeking care at private clinics or other medical facilities. Consequently, these individuals often present in critical condition, exacerbated by a lack of available blood supplies for those suffering from severe anemia who urgently need blood transfusions. While emergency blood services are established to mitigate some of these fatalities, there remains a risk that some patients will not survive as the situation unfolds. Additionally, the hospital operates as a private not-for-profit entity, which incurs substantial costs and raises important questions regarding the long-term sustainability of its services.

In the Neonatal Intensive Care Unit (NICU), the primary contributors to mortality include complications arising from prematurity and birth asphyxia. Nevertheless, initiatives have been implemented to prevent these fatalities. Supported by funding from the AICS project via the

Ambrosoli Foundation, various training programs and related activities focused on newborn care have been established.

Maternity Ward

The maternity unit stands as the largest ward within the hospital, featuring 75 beds. It encompasses various areas, including an admission room, a first stage room, a PET room, and a labor suite in the pre-delivery section. The inpatient department caters to postnatal care, post-Caesarian recovery, and gynecological services. The layout of the ward is designed to include a doctors' office, an office for the nurse in charge, a duty room, private patient rooms, and an isolation unit. An obstetrician and a medical officer oversee the unit, supported by intern doctors who rotate through the ward every six months for their surgical training, with obstetrics and gynecology as their minor focus.

The nursing and midwifery team, detailed in the accompanying table, is responsible for the comprehensive care of all patients admitted to this unit. Additionally, St. Mary's Midwifery students utilize the maternity ward as their primary site for practical training, where they also provide guidance and supervision to fellow students.

Table 6.36: Staff Composition in Maternity Ward in FY2023-24

Cadre/ Discipline	Qualification	Number
Gynecologist	M.MED Obys & Gyn	1
Medical officer	Bachelor Degree in Medicine and Surgery	1
Registered Midwife/Nurse	Diploma in Midwifery and Nursing	0
Registered Midwife	Diploma in Midwifery	7
Enrolled Midwife	Certificate in Midwifery	21
Nursing Aide	Primary Leaving Examination (P.L.E)	1
Total		**31**

Key Indicators

In the fiscal year 2023-24, there was a minor decline of 10 admissions, representing a decrease of 0.24%, indicating a relatively stable patient intake. Additionally, the average length of stay (ALOS) experienced a slight uptick of 0.05 days, or 1.2%, which may suggest minor adjustments in patient care or recovery requirements. Furthermore, there was a 0.72% rise in bed occupancy rates (BOR), reflecting a slight enhancement in the utilization of the ward's bed

capacity. Notably, there was a significant reduction of 28.6% in the number of deaths, which may point to advancements in patient care and a decrease in severe complications during delivery. The team conducts regular audits of maternal and neonatal fatalities to identify missed opportunities for improvement, aiming to prevent similar incidents in the future.

The Maternity Ward in FY 2023-24 showed some positive trends, with improvements in patient outcomes (recovery and mortality rates) and better bed occupancy utilization. While admissions and patient days were stable, the slight increase in ALOS and bed occupancy indicates higher care demands. The reduction in self-discharges and deaths are indicative of improved healthcare delivery. Overall, the ward performed well in FY 2023-24, with some marginal improvements compared to the previous year.

Table 6.37: Key indicators in Maternity Ward (Obs &Gyn) in the last 5 FYs

OBSTETRICS& GYNECOLOGY WARD					
	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
No of beds	75	75	75	75	75
Total Admissions	4,226	4,144	4,595	4,154	4144
Patients days	16,519	17,441	17,522	16,728	16925
ALOS	3.91	4.21	3.81	4.03	4.08
Throughput per bed	56.35	55.25	61.27	55.39	55.25
BOR	95.45	0.64	64.01	61.11	61.83
No of Deaths	4	11	5	7	5
Mortality rate	0.09%	0.27%	0.11%	0.17%	0.12%
Recovery rate	99.91%	99.3%	98.7%	99.4%	99.6%
Self-discharges	0	20	55	18	10

Birth indicators

A 3.5% rise in total deliveries from FY 2022-23 to FY 2023-24 reflects an increase in the volume of cases managed by the maternity ward during FY 2023-24. Notably, there was a 7.8% uptick in normal deliveries within the unit, indicating a favourable trend where more patients experienced uncomplicated deliveries under the ward's care. Conversely, there was an 8.2% decline in abnormal deliveries, which may suggest enhanced management of high-risk pregnancies or a reduction in complications, as fewer patients required surgical or other interventions. Additionally, a 3.8% increase in live births aligns with the overall growth in total deliveries. However, there was a concerning 40% rise in fresh stillbirths and a 6.7%

increase in macerated stillbirths, primarily linked to malaria and low antenatal care service uptake.

The total number of C-sections remained stable, indicating consistent rates of surgical interventions for obstetric deliveries. Encouragingly, there were reductions in both maternal and newborn mortality rates, signifying advancements in care and outcomes for mothers and infants alike. The fiscal year 2023-24 demonstrated overall enhancements across several critical indicators, including an increase in full-term normal weight live births, a decrease in premature births, and lower maternal and newborn mortality rates. Nonetheless, the rise in low-birth-weight infants and stillbirths, along with the increase in elective C-sections, should be prioritized for future efforts aimed at improving maternal and foetal health management.

Table 6.37: Maternity Ward Deliveries & Births indicators in the last 5 FYs

	FY 2019-20	**FY 2020-21**	**FY 2021-22**	FY 2022-23	FY 2023-24
Total deliveries	2,707	2,576	2,899	2,659	2787
Normal deliveries in unit	2,187	2,576	2,200	1,941	2164
Abnormal deliveries (incl. C/S)	552	647	693	718	623
Live birth in units	2,654	2,486	2,886	2,622	2756
Babies born with low birth weight	517	504	175	361	406
Fresh Still births in unit	23	30	33	25	35
Macerated still births in unit	46	31	35	45	48
New-born deaths (0-7 days)	59	55	75	55	53
Maternal Deaths	5	10	5	6	5
Live Births					
Full term normal weight	2,084	1,694	2,124	2,169	2285
Full term low birth weight	451	357	437	33	286
Premature cases	223	435	325	490	437
Caesarean Sections					
Elective C/S	33	5	18	28	60
Emergency C/S	519	642	675	631	563
Caesarean Sections total	552	647	693	659	623
C/S as % of total deliveries	20.39%	25.12%	23.90%	24.78%	22.35%
Emergency C/S as % of all C/S	94.02%	99.23%	97.40%	95.75%	90.37%

Table 6.38.1a: Origin of mothers who delivered through C/S in the last5 FYs
Within the Catchment Area of Agago District (distances of 2 km to < 58 km)

Sub-County	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Adilang	37	41	59	64	58
Kotomor	25	20	17	25	16
Patongo	53	63	86	62	61
Lukole	51	72	79	76	76
Kalongo T.C.	69	52	47	49	57
Paimol	50	27	30	44	50
Parabongo	40	40	42	44	41
Omot	26	28	14	11	11
Acholpii	21	13	13	13	13
Lamiyo	29	8	11	10	5
Lapono	41	51	69	64	52
Lira Palwo	35	114	54	59	25
Omiya Pacwa	33	13	20	22	16
Wol	27	37	55	60	35
Total	**537**	**579**	**596**	**603**	516

Referring patients remains one of the most challenging responsibilities for the district. The inadequate state of the roads, the scarcity of functioning ambulances, and the prevalent poverty among most households, coupled with the extensive catchment area of the hospital, create a persistent risk for expectant mothers. Nevertheless, the hospital provides a waiting shelter where high-risk pregnant women can reside until they reach their delivery date.

Table 6.38a Continuation

Outside the Catchment Area of Agago District (distances of 58 km and above)						
District	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Pader	10	8	42	48	33	20
Kitgum	1	2	4	6	7	6
Abim	0	5	16	18	5	9
Other	0	0	6	25	11	5
Total	**11**	**15**	**68**	**97**	**56**	**40**

Gynecological Ward

The accessibility of specialized obstetric and gynecological care has facilitated the provision of gynecological services. However, due to the hospital's rural location, attracting and keeping qualified professionals has been challenging, prompting the implementation of strategies aimed at retaining those who join the team. The gynecologist, along with a medical officer, conducted weekly gynecological clinics in the outpatient department every Monday, addressing a wide range of gynecological conditions, while more complex cases were often referred to other facilities for additional care. The primary reason for patient admissions was abortion, predominantly spontaneous abortions, followed by cases of malaria during pregnancy and various other pregnancy-related complications.

Table 6.39: Admissions in Maternity Ward not related to maternity conditions

Diagnosis of admission	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Pelvic Inflammatory Disease	4	30	7	41	66
Urinary Tract Infection	108	4	126	2	4
Cancer of cervix	1	0	0	23	14
Uterine Fibroid	8	7	3	14	8
Ovarian Cyst	23	3	5	9	10
Vaginal Candidiasis	4	1	7	0	2
Bartolini’s Cyst	3	0	0	1	2
Endometritis	0	2	0	0	17
Other Gyn conditions	117	43	42	60	64
Total	**269**	**90**	**190**	**150**	**187**

TB ward

The TB ward is integrated with the main Medical Ward, and its operations are managed by the medical ward team. In the Agago district, where tuberculosis remains a significant public health issue, there has been a notable 25.4% decline in admissions for the fiscal year 2023-24 compared to the previous year. Additionally, patient days have decreased by 42.8%, indicating that individuals are spending less time in the ward, which may be attributed to a growing emphasis on outpatient care. The average length of stay (ALOS) has also dropped by 23.5%, suggesting that patients are being discharged more promptly, potentially due to enhanced treatment protocols and fewer complications. Furthermore, there has been a substantial reduction of 11.81 percentage points in bed occupancy rates, indicating a significant decline in the utilization of beds within the TB ward during FY 2023-24. The reduction in mortality rates

by 44.4% points to improved patient outcomes, while a 1.1 percentage point rise in the recovery rate reflects better treatment efficacy. Of note, there was no TB CAST campaign carried out this year.

Overall, the TB ward's performance in FY 2023-24 demonstrates marked improvements in patient outcomes, highlighted by lower mortality rates, higher recovery rates, and fewer deaths. These encouraging developments suggest enhancements in patient care within the ward, despite the observed decreases in both admissions and bed occupancy. The reductions in average length of stay and bed throughput may indicate more effective management strategies or a transition towards outpatient treatment models for tuberculosis patients.

Table 6.40: Key indicators in TB Ward in the last 5 FYs

TB WARD					
	FY 2019-20	**FY 2020-21**	**FY 2021-22**	**FY 2022-23**	**FY 2023-24**
No of beds	18	18	18	18	18
Total Admissions	329	267	195	210	157
Patients days	2,001	1,240	2,090	1,812	1036
ALOS	6.08	4.64	10.72	8.63	6.6
Throughput per bed	18.28	14.83	10.83	11.67	8.72
BOR	30.46	18.87	31.81	27.58	15.77
No of Deaths	7	5	11	9	5
Mortality rate	2.13%	1.87%	5.64%	4.29%	3.18%
Recovery rate	97.87%	98.13%	94.36%	95.71%	96.8%
Self-discharges	0	0	0	0	0

Diagnostic services

The hospital laboratory operates as a central hub that provides services to ten lower-level facilities located in the Agago and Pader districts. Throughout the fiscal year, the hub has effectively carried out its functions. This includes offering laboratory testing services for all samples collected from HIV-positive individuals at the lower-level units, facilitating coordination meetings for the hub, overseeing the operations of laboratories at all levels, dispatching samples for tests that are beyond the hub's capabilities to the Central Public Health Laboratory, and ensuring that the district remains informed about all laboratory-related activities.

Table 6.41: Trend of laboratory testing workload in the last 5 FYs

	Type of Tests	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2022-24
Parasitology	Malaria Microscopy, Malaria RDTs, Other Haemoparasites, Stool Microscopy.	28,676	17,513	24,446	24,703	34579
Haematology	HB, WBC Total, WBC Differential, Film Comment, ESR, RBC, Bleeding time, Prothrombine time, clotting time, blood transfusion tests, & Others	28,456	20,989	27,055	23,641	32114
Biochemistry	Urea, Calcium, Potassium, Sodium, Creatinine, ALT, AST, Albumin, Total protein, Triglycerides, Cholesterol, CK,LDH, AlkalinePhos, Amylase, Glucose, Uric Acid, Lactate, Others	2,504	1,243	1,851	2,817	3066
Bacteriology	ZN for AFBs, Cultures and Sensitivities, Gram, Indian Ink, Wet Preps, Urine Microscopy	15,327	15,619	12,569	9,547	14202
Serology	VDRL lRPR, TPHA, Shigella Dysentery, Syphilis Screening, Hepatitis B, Brucella, Pregnancy Test, Vidal Test, Rheumatoid Factor	9,989	7,174	9,981	11,526	9236
Immunology	CD4 tests & others	4,847	3,554	2,684	1,931	1386
HIV tests by purpose	HCT, PMTCT, Quality control and clinical diagnosis	20,691	14,414	14,212	14,408	17521

	Total tests	110,490	80,506	92,798	88,573	112104
	Total lab staffs	10	10	10	10	11
	Average tests per Lab staff	11,049.00	8,051.00	9,279.80	8857.3	10191.27

In the laboratory, the total number of tests performed per employee increased by 15.1% over the year compared to the previous year, although the number of staff remained almost unchanged.

Table 6.42: Percentage of positive findings per selected examinations in the two last FYs

Type of Test	**FY 2022-2023**			**FY 2022-2024**		
	Total	Positive	% Positive	Total	Positive	% Positive
Malaria (both slide and RDT)	24,402	8,168	33.47%	32580	12614	38.7%
VDRL/RPR/TPHA	4,895	573	11.70%	4084	546	13.4%
Hepatitis B	2,205	202	9.16%	2409	203	8.4%
Brucella	225	11	4.89%	265	12	4.5%

The hospital obtains blood supplies from the Gulu Regional Blood Bank. However, several challenges hinder the steady supply and accessibility of blood products, such as inadequate inventory at the blood bank, transportation issues during rainy seasons, and the considerable distances involved.

The persistent blood shortage in the region has led to significant cases of anemia, especially among children under five years old. To address life-threatening emergencies, the hospital has intermittently relied on local blood donations from eligible staff and volunteers, following necessary screening procedures, which has consequently increased the operational expenses of the laboratory. Blood products from RH+ groups O and A remain the most frequently utilized, as indicated in the accompanying table. However, the ongoing demand for specialized blood products, including platelet concentrates and fresh frozen plasma, remains a challenging issue, primarily due to the regional blood bank's inability to provide these essential supplies.

Table 6.43: Proportion distribution of blood groups and Rhesus Factor D

FY 2022-2023						FY 2023-2024					
Group A	Group B	Group AB	Group 0	RH +	RH -	Group A	Group B	Group AB	Group 0	RH +	RH -
34.06%	15.90 %	4.47 %	45.57 %	99.01 %	0.99 %	31.00 %	21.95 %	6.91 %	39.96 %	97.87 %	2.12 %

Imaging services

X ray and Ultrasonography

The department is currently staffed by one medical imaging technologist, one sonographer, and a dark room attendant, following the recruitment of a part-time radiographer. Some medical officers with relevant expertise have been conducting emergency ultrasound scans to support the service. The retention of core staff, particularly radiographers, continues to pose challenges, impacting essential medical services. However, the hospital has implemented a temporary solution by enrolling one of its employees in a short training course, who has recently returned to assist. The total number of X-rays conducted has increased compared to the previous year, with chest X-rays being the most frequently performed. The primary reasons for these scans include trauma assessment, ruling out complications from respiratory infections, and screening for tuberculosis. The hospital has adopted a digital X-ray system, allowing for rapid transmission of images to clinicians for prompt evaluation. Nonetheless, the high expense associated with digital cassettes has made it difficult to provide patients with printed copies of their images.

Table 6.44: X-Ray examinations done in the last 5 FYs

	FY 2018-19	**FY 2019-20**	**FY 2020-21**	**FY 2021-22**	FY 2022-23	FY 2023-24
Chest	1,459	2,009	1,849	1,461	1,556	1532
Upper extremities	997	877	1,013	714	885	792
Lower extremities	710	735	821	676	716	744
Vertebral column	283	335	291	323	359	348
Skull and mandible	158	150	137	235	282	278
Shoulder and clavicle	139	178	0	152	125	128
Pelvis and hip	153	176	81	176	169	184
Abdominal – plain	155	203	198	143	179	190
Abdominal -contrast	2	0	0	0	0	0
Screening	0	5	0	0	0	0
Total	**4,056**	**4,668**	**4,390**	**3,880**	**4,271**	**4068**

Table 6.45: Ultrasound examinations conducted in the last 4 FYs

	FY 2020-21	FY 2021-22	FY 2022-2023	FY 2023-2024
Obstetrics	0	176	807	983
Gynaecology	0	281	214	495
Abdomen	0	238	942	1180
Others	0	43	144	465
Total	**0**	**738**	**2,107**	**3123**

Pharmacy activities

The Unit Dose System (UDS) for managing medications within the hospital continues to function effectively, showcasing notable enhancements in both its execution and overall performance. Each ward is equipped with emergency medications stored in specially designed boxes, which are regularly checked by pharmacy dispensers to ensure compliance and safety. Three staff members from the hospital, including a pharmacist, participated in routine MTC training sessions organized by the Ministry of Health and UPMB. These initiatives have led to the successful operationalization of the hospital's existing MTC, with this team responsible for promoting the efficient and cost-effective use of medications throughout the facility.

Table 6.46: Staff composition in Pharmacy and General Store in theFY2023-2024

Cadre/ Discipline	Qualification	Number
Pharmacist	Bsc.in Pharmacy	1
Pharmacy Technician	Diploma in Pharmacy	2
Pharmacy Assistant	Certificate in Medical Pharmacy	3
Nursing Aide	Trained on the Job	2
Store Assistant	Diploma in Store Management	0
Store Attendant	Trained on the Job	2
Total		**10**

Storage

Drugs are organized on shelves, with heavier items positioned on floor pallets. Tablets and capsules share the same shelving, while parenteral solutions, oral liquids, and topical creams and liquids are stored separately. To minimize losses due to expiration, the first expiry, first out (FEFO) method is implemented. Items requiring cold storage are kept in a refrigerator, with daily temperature checks to ensure compliance within the specified range of 2°C to 8°C. Room temperature readings are taken three times a day to account for fluctuations, and an average is calculated at the end of each month. However, temperatures often exceed 30°C in the afternoon, which presents significant risks to the safe storage of pharmaceuticals. It is evident that the pharmacy would benefit from the installation of air conditioning systems to maintain appropriate temperatures, particularly during dry seasons.

Table 6.47: Average temperature and humidity recorded in Pharmacy Department FY2023-24

Reading Time	Temperature	Humidity
8:15 AM	22.5°C	57%
12.00 pm	26.9 °C	49%
5.00 pm	27.3 °C	44%

Table 6.48: Most used drugs (excluded HIV/AIDS clinic) FY 2022-2023 and FY2023-2024

Drug description	FY 2022-2023		FY 2023-2024	
	Quantity issued tablets/vial	**Monetary value (UGX)**	**Quantity issued tablets/vial**	**Monetary value (UGX)**
Paracetamol 500mg	238,494	5,485,362.00	315,750	7,262,250.00
Amoxicillin 250mg	117,497	8,812,275.00	136,300	10,222,500.00
Metronidazole 200mg	129,256	3,748,424.00	658,350	19,092,150.00
Folic acid 5mg	119,480	1,792,200.00	140,400	2,106,000.00
Folic acid + Ferrous Sulphate	34,796	1,217,860.00	110,300	3,860,500.00
Ferrous sulphate 200mg	25,437	686,799.00	29,100	785,700.00
Cloxacillin 250mg	34,796	2,609,700.00	30,600	2,295,000.00
Ampicillin 500mg	25,437	29,099,928.00	25,270	28,908,880.00
Carbamazepine 200mg	47,375	3,363,625.00	70,400	4,998,400.00
Ibuprofen 200mg	38,014	1,672,616.00	59,200	2,604,800.00
Vitamin B complex	63,752	828,776.00	125,400	1,630,200.00
Ampicillin/cloxacillin 500mg	15,795	2,542,995.00	40,200	6,472,200.00
Prednisolone 5mg	32,670	1,045,440.00	47,800	1,529,600.00
Omeprazole 20mg	28,693	1,262,492.00	36,900	1,623,600.00
Ciprofloxacin 500mg	22,325	3,125,500.00	45,800	6,412,000.00
Frusemide 40mg	31,061	1,025,013.00	34,000	1,122,000.00
Erythromycin 250mg	61,900	7,428,000.00	47,700	5,724,000.00
Benzylpenicillin 1MU	6,216	5,109,552.00	4,850	3,986,700.00
Penicillin V 250mg	18,894	1,454,838.00	24,500	1,886,500.00
Metronidazole 5mg/ml 100ml	7,831	9,600,806.00	9,666	11,850,516.00
Total		**91,912,201.00**		**124,373,496.00**

Pharmaceutical supplies

In line with established practices from previous years, supplies are primarily procured through Joint Medical Stores (JMS). For items not available in JMS's inventory, purchases are made

through the open market or Abacus. JMS is responsible for providing the main antiretroviral medications and tuberculosis (TB) supplies for the HIV Clinic, although certain items, like isoniazid, may experience occasional shortages. To mitigate these challenges, effective stock level monitoring systems have been implemented to address potential issues proactively.

Procurement system

Medications and various supplies are typically acquired on a quarterly basis. However, financial limitations have necessitated a shift towards a more segmented approach to meet the urgent needs of the Wards. At the initial stage of procurement, which occurs at the store level, orders are generated and the levels of buffer stock are monitored closely. It is essential that orders are placed at least one month prior to the anticipated depletion of the buffer stock. The Drug and Therapeutic Committee evaluates these orders before they are forwarded to the procurement department for processing. The hospital has frequently experienced shortages of certain essential items. Notably, both the nation and its suppliers lack access to these critical goods.

Inventory management

A combination of manual and digital inventory systems facilitates the oversight of purchasing activities and inventory flow. Monthly physical counts are conducted to maintain accountability, while comprehensive stock assessments occur biennially. Additionally, management has authorized unplanned stock audits to effectively track the current status of inventory in real time.

Distribution and use

The Pharmacy provides medications to different wards and departments through the implementation of a Unit Dose system. This method of distribution is based on prescriptions, which leads to a reduction in medication waste.

CHAPTER SEVEN:

Support services

Pastoral care

Pastoral care involves the attentive support that a pastor provides to address the emotional, physical, and spiritual needs of their congregation. This form of care is an essential element of the holistic care plan available to patients. Ongoing services are maintained to ensure that personnel can offer both emotional and spiritual assistance. The pastoral team's capacity to engage with patients and their families, navigating a spectrum of complex emotions such as frustration, fear, guilt, grief, and various expressions of love, is of utmost importance. These services are delivered by volunteers representing the Kalongo Catholic deaconry, with the team consisting of a social worker, a catechist, and a priest.

The number of patients who accessed pastoral services increased by 30% as compared to the previous year.

Table 7.1: Activities trend in clinical pastoral care of the sick during the last5 FYs

Activity / Indicator	**FY 2019-2020**	**FY 2020-21**	**FY 2021-22**	FY 2022-23	FY 2023-24
No. patients visited and counselled	161	116	396	376	490
No. of patients given sacrament of Marriage	0	0	2	0	0
No. of patients anointed	9	1	4	5	6
Total	**170**	**117**	**402**	381	496

Ambulance services

Ambulance services have been provided to patients across the district and its surrounding areas. However, during the rainy season, response times in various parts of the district are often hindered or delayed due to poor road conditions. Additionally, the maintenance of ambulances remains a significant challenge, as frequent breakdowns are attributed to these adverse road conditions. Last year, the hospital received a new ambulance, thanks to the assistance of AICS through the Ambrosoli Foundation aimed at replacing the outdated and unreliable vehicles. Furthermore, the increasing cost of fuel complicates the referral process for many patients, as they struggle to cover the associated expenses.

Technical services

The Technical and Maintenance Department (TD) of the hospital is responsible for the regular upkeep of all facilities and equipment, which includes vehicles used by both the hospital and the school. In addition to maintenance, the department offers technical support and oversight. Major construction initiatives and significant renovations are typically outsourced to external contractors. To support the hospital's sustainability, the TD also participates in several small-scale revenue-generating activities. However, financial limitations have significantly hindered the department's capacity to fulfill its responsibilities, resulting in incomplete tasks. Plans to enhance the department's revenue-generating efforts are set for the upcoming year. Furthermore, the TD oversees the monitoring and management of fuel consumption within the hospital, a function that falls under the purview of the Administrator. The use of diesel saw a significant rise of 20.8% compared to the previous year, whereas petrol consumption remained relatively stable. Consistent with the prior year, generators continued to be the primary consumers of diesel, largely due to the erratic power supply in the district. Meanwhile, petrol usage did not change notably, with a predominant application in motorcycles rather than cars for short-distance travel.

Table 7.2: Consumption of fuel by destination in the last5 FY

	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-2023	FY 2023-2024
DIESEL TOTAL	**55,835**	**58,598**	**48,499**	**39,965**	**48,284**
Board of Governors Fuel Refund to members	180	265	270	0	0
Generators	29,946	39,133	29,040	20,869	30,147
Vehicles	19,133	18,462	18,460	17,007	17,133
Workshop	24	20	0	0	0
Incinerator	655	618	624	624	1004
Others	5,897	100	105	1,465	0
PETROL TOTAL	**3,179.5**	**2,978.0**	**2,630.0**	**3,751.5**	**3,730.5**
Administration	57	25	0	8	61
Donation	70	0	50	30	130
Generators	0	0	0	25	0
Vehicles	0	0	0	50	0
Motorcycles	2,969.5	2,885.0	2,507.0	3,538.0	3,473.0
Workshop	20	68	63	50.5	66.5
Others (Sales)	63	0	10	50	0
KEROSENE TOTAL	**0**	**0**	**0**	**0**	**0**
Workshop	0	0	0	0	0
Pharmacy	0	0	0	0	0
Main store	0	0	0	0	0

Others	0	0	0	0	0

Domestic services

The hospital's water supply is sourced from three wells that also serve the School, the Comboni Fathers, and the Convent of the Little Sisters of Mary Immaculate. Located approximately 1,300 meters from the wells, the hospital relies on two large tanks with a combined capacity of 90,000 liters to store the water. Each facility is equipped with various reserve tanks of different sizes. However, the pumps frequently malfunction, leading to expensive replacements that are often not fully funded by the hospital's budget, which is already strained by the high demand for water. During dry seasons, the wells can run dry, causing significant water shortages. To ease the burden on the hospital, nearby institutions are increasingly turning to the national water supply to meet their water requirements.

Power Supply

The hospital relies on the national electrical grid for its power supply. However, due to the issues associated with this connection, the facility often depends on backup generators to meet its energy needs. Employees of the hospital benefit from discounted electricity while on the premises. Implementing a functional photovoltaic (PV) system could greatly lower these energy expenses. The hospital has actively pursued and continues to support initiatives aimed at installing these energy-efficient solar systems.

Sewage system

The drainage infrastructure supports the entire hospital, St. Mary's Midwifery Training School, staff housing, the local parish, and nearby convents. A lagoon located approximately 600 meters from the hospital is designated for sewage disposal. This sewage system has been in operation since its renovation in 2014. One of the primary difficulties faced is the ongoing maintenance, which is hindered by frequent vandalism from certain individuals in the community. To mitigate encroachment issues, it is essential to reconstruct the fence surrounding the sewage lagoon system.

Waste disposal

The organization persists in producing significant quantities of waste, encompassing both medical and non-medical types. The inefficiency in waste segregation and management is largely attributed to the insufficient training of the incinerator's support staff in handling medical waste. In response, the infection prevention and control committee has initiated a

training program aimed at enhancing local expertise in effective waste segregation practices. Additionally, they are exploring options for recycling certain types of household waste generated by the institution.

CHAPTER EIGHT:

Quality of care and patients' safety

Quality of care refers to the degree to which health services for individuals and populations improve desired health outcomes.

Quality indicators:

The hospital received authorization to conduct reviews and engage in various quality enhancement initiatives. The quality improvement committee played an integral role, actively participating in several projects aimed at elevating the hospital's standards throughout the fiscal year. Below is a summary of the primary criteria employed to assess the quality of outputs.

There has been a rise in the percentage of clinically qualified personnel within the hospital. However, retaining these professionals has proven to be a significant challenge, primarily due to the hospital's less competitive compensation packages.

The discharge recovery rate has improved compared to the previous financial year, although there has been a slight rise in the maternal death rate. Additionally, both the fresh stillbirth rate and the infection rate associated with Caesarean sections have seen an increase. Conversely, there has been a significant decrease in the early neonatal death rate. Overall, while there has been a modest enhancement in the quality of care, several challenges persist, particularly regarding the availability of medications and the presence of adequately qualified staff.

Table 8.1: Indicators for Quality and safety measures

Indicators	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24	Explanation
Recovery rate on discharge	99.64%	94.83%	99.20%	95.60%	97.71%	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%	0.26%	0.11%	0.14%	0.18%	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	0.85%	1.21%	1.14%	0.94%	1.29%	Fresh still birth rate: Fresh Still births have intact, smooth and not macerated skin,

Caesarean sections infection rate	1.27%	2.78%	2.02%	0.46%	0.96%	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	2.18%	2.21%	2.59%	2.07%	1.95%	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.

Notably, improvements have been recorded in the Humanity of Care category, which saw an increase of 5%, as well as in the Healthcare Environment, which improved by 17%. These changes underscore a commitment to more patient-centered care and superior facilities. Conversely, there has been a 15% decrease in satisfaction regarding the Organization of Care and Waiting Time, indicating potential inefficiencies or delays within outpatient services. The overall satisfaction score has risen from 80% to 84%, reflecting a positive trend in patient satisfaction for the fiscal year 2023-24 when compared to the previous fiscal year 2022-23.

Table 8.2: Satisfaction levels per core area for the last 5 FYs

Financial Year	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Clinical outcomes	90%	94%	56%	93%	91%
Humanity of care	88%	91%	91%	75%	80%
Organization of the care / waiting time (OPD)	71%	58%	74%	79%	64%
The healthcare environment	88%	80%	96%	73%	90%
Overall score	81%	83%	79%	80%	84%

FAITHFULNESS TO THE MISSION

Being "faithful to the mission" signifies a commitment to the fundamental values and principles that are grounded in Catholic teachings and the essence of Christ's healing ministry. This mission embodies a devotion to the example set by Christ, emphasizing healing, compassion, and love.

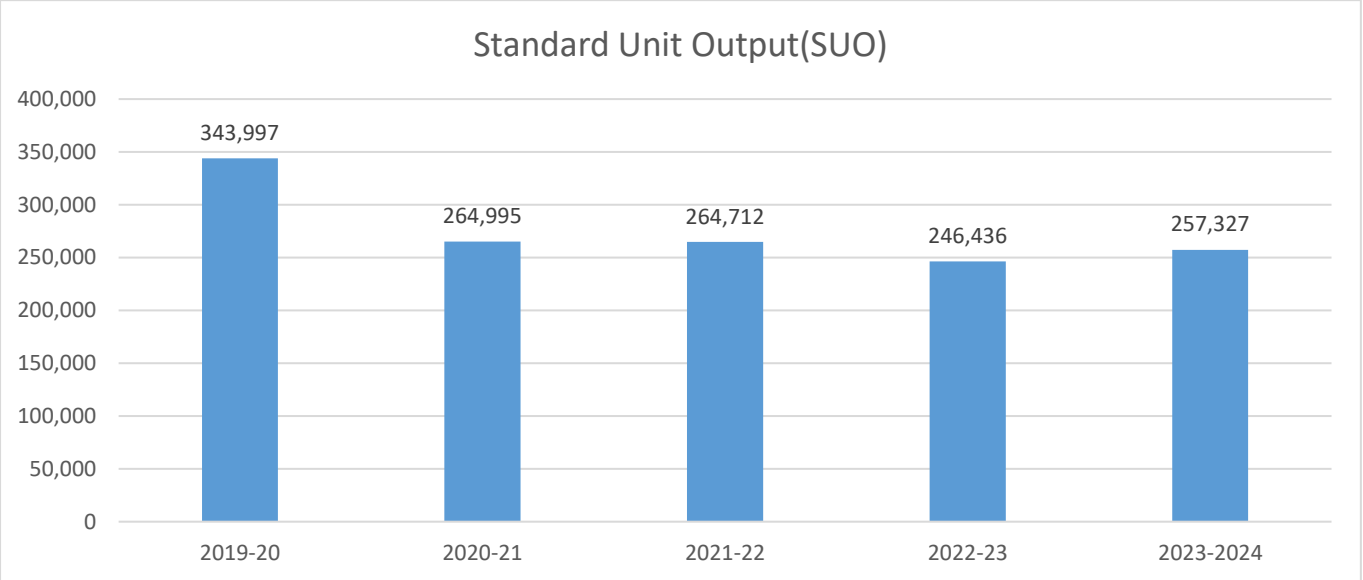
Standard Unit of Output op (SUOop)

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

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

The SUOop increased slightly in the FY 23/24 as compared to the previous year. This meant better utilization of resources and greater access to care for patients. Overall, the hospital has remained accessible.

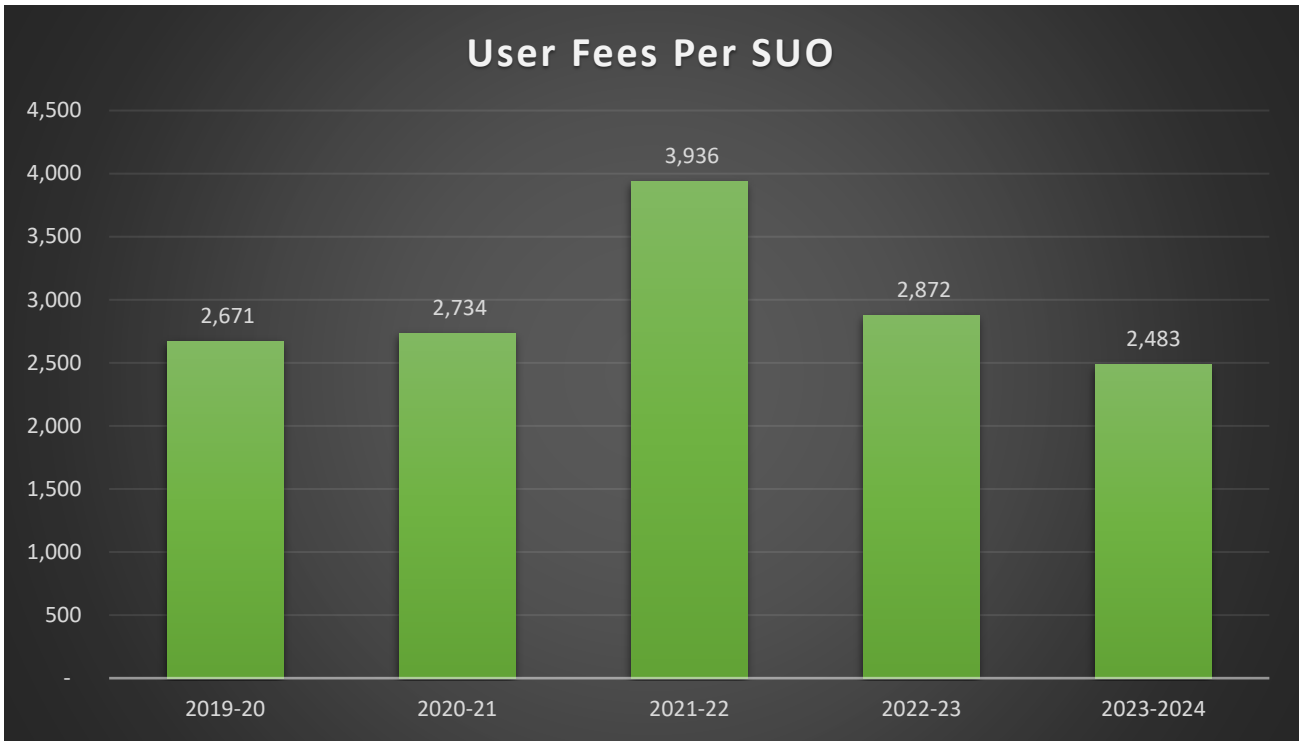
Figure 8.3: Trend of SUO op (do more people come?)



Equity

The typical user fee for SUO has seen a reduction. Within the UCMB network, the user fees charged by hospitals rank among the lowest. While there has been an enhancement in revenue collection efficiency, this improvement does not offset the increasing operational expenses. Consequently, the average user fee for each SUO has diminished.

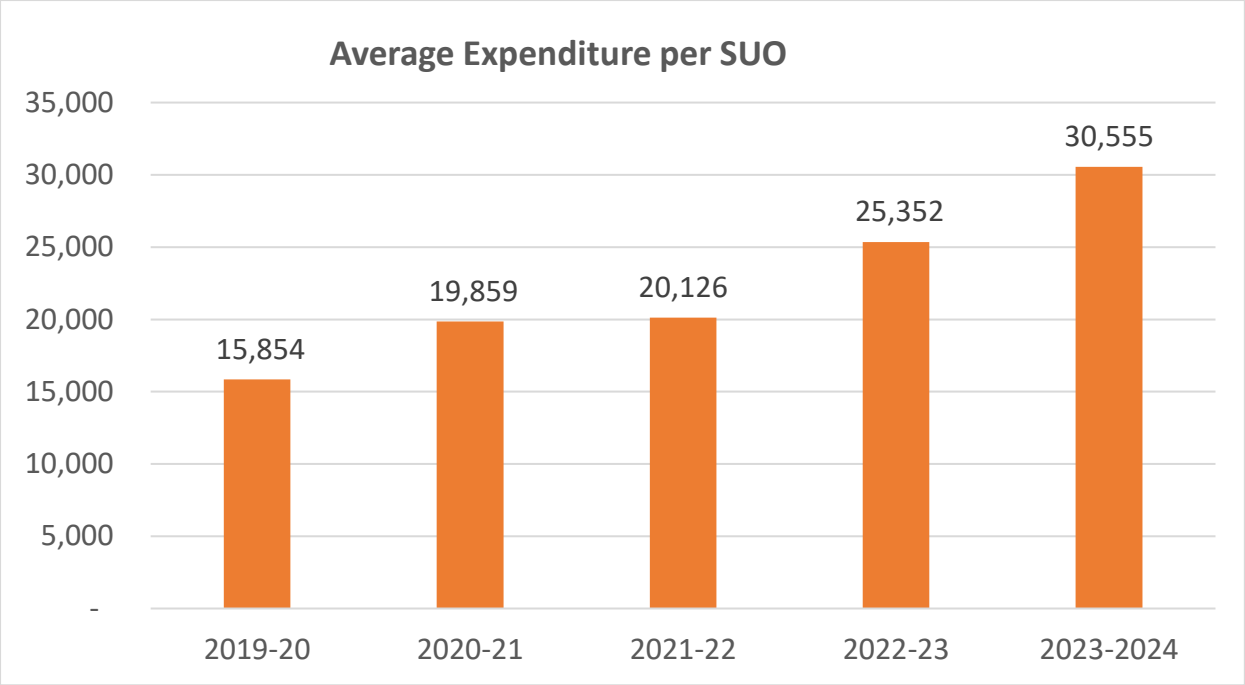
Figure 8.4: Trend of Average Fees per SUO (do people, on average, pay more or less?)



Efficiency

The financial efficiency of the hospital experienced a slight decline. Compared to the prior year, there was a modest increase in expenditures for producing one SUO. Despite a slight enhancement in efficiency, concerns regarding waste persist, although there have been overall positive trends in the market for all types of consumables, including both medical and non-medical items. Efficiency saw a downturn in the 2023-2024 period.

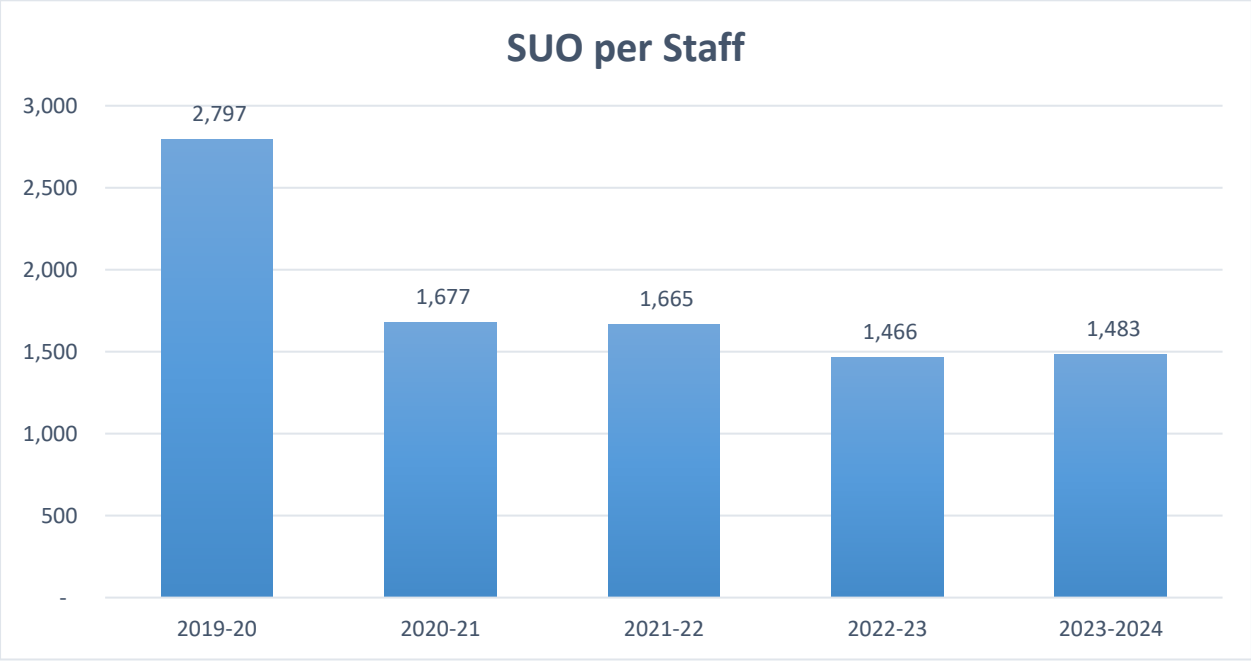
Figure 8.5: Trend of Average Expenditure per SUO (do we spend more or less to produce our services?)



Productivity

The productivity of our team has remained consistent with that of the previous year, despite utilizing the same resources. Even with the decline of the pandemic and a rise in service demand, our workforce size has not changed. We will continue to engage our employees in a realistic manner to maximize their potential.

Figure 8.6: Trend of Average SUO per staff (with the same resources, do our staff produce more or less?)



CHAPTER NINE:

St. Mary's midwifery training school

Dr. Ambrosoli Memorial Hospital houses St. Mary's Midwifery Training School, which was founded by Fr. Dr. Giuseppe Ambrosoli in 1959 as an accredited institution for midwifery education. The school offers a range of specialized training programs in midwifery, including a Diploma in Midwifery (D/M) and a Certificate in Midwifery (C/M).

Human resources management and development

The training institution continues to face challenges in recruiting qualified educators. The remote setting of the school exacerbates issues related to staff turnover, making it a significant concern. To address this, the school employs hospital personnel on a part-time basis to help instruct courses pertinent to their professional expertise.

Table 9.1: School staff and support staff establishment FY 2023-2024

Qualified Staff	**Established**	**Actual**	**Shortage**	**Surplus**
Tutors	6	7	0	1
Untrained clinical instructors	4	4	0	0
Accountant	1	1	0	0
Account Assistant	1	1	0	0
Cashier	1	0	1	0
Record Assistant	1	1	0	0
Total Qualified Staff	**14**	**14**	**1**	**1**
Trained clinical mentor (Hospital)	7	2	5	0
Support Staff	**Established**	**Actual**	**Shortage**	**Surplus**
Store Assistant/Library Attendant	1	1	0	0
Office Attendant	1	0	1	0
Farm Assistant	1	1	0	0
Cooks	4	4	0	0
Driver	1	1	0	0
Watchmen	4	4	0	0
Total Support Staff	**12**	**11**	**1**	**0**
Total School Staff	**26**	**25**	**2**	**1**

Staff development

Staff development is a key focus aligned with the school's strategic plan. Several training sessions have been conducted since then, encompassing both virtual and in-person formats.

Table 9.2: Workshops and courses attended by the teaching staff FY 2023-2024

S/N	Workshop	Organized by	Number of staff	Duration
1	Mental Health	Butabika NRG	4	1 week
2	Research Supervision	UNMEB/UCM	2	1 week
3	Diabetes	Uganda Diabetes Association	2	1 week

The number of students enrolled in the school was dictated by the actual capacity of the institution. The success rate for students pursuing both certificates and diplomas has consistently stood at 100%. The administration and faculty of the school have maintained their commitment to supporting students, addressing not only their academic needs but also various aspects of their lives that influence their overall performance.

Table 9.3: Student Enrolment in years 1st -2nd -3rd and success rate in the FY 2023-24

Course	Students Enrolled in the year	Students in 1st year	Students in 2nd year	Students in 3rd year	Number of students currently	Students who sat for final exams	Students who pass final exams	Success rate
C/M	76	54	52	68	**135**	68	68	100%
D/M	7	7	12	Nil	**10**	12	12	100%
Total	**83**	**61**	**64**	**68**	**145**	**80**	**80**	

School Finances

St. Mary's Midwifery Training School operates as a semi-autonomous entity affiliated with its parent institution, Dr. Ambrosoli Memorial Hospital. The principal of the school manages all financial accounts and serves as one of the authorized signatories for the bank accounts. In her role as the overall supervisor of the school's activities, she reports directly to the CEO. Annually, the school formulates its own budget and operational plan. To ensure financial transparency, the hospital engages an external auditor to conduct audits for both the school and the hospital.

Income

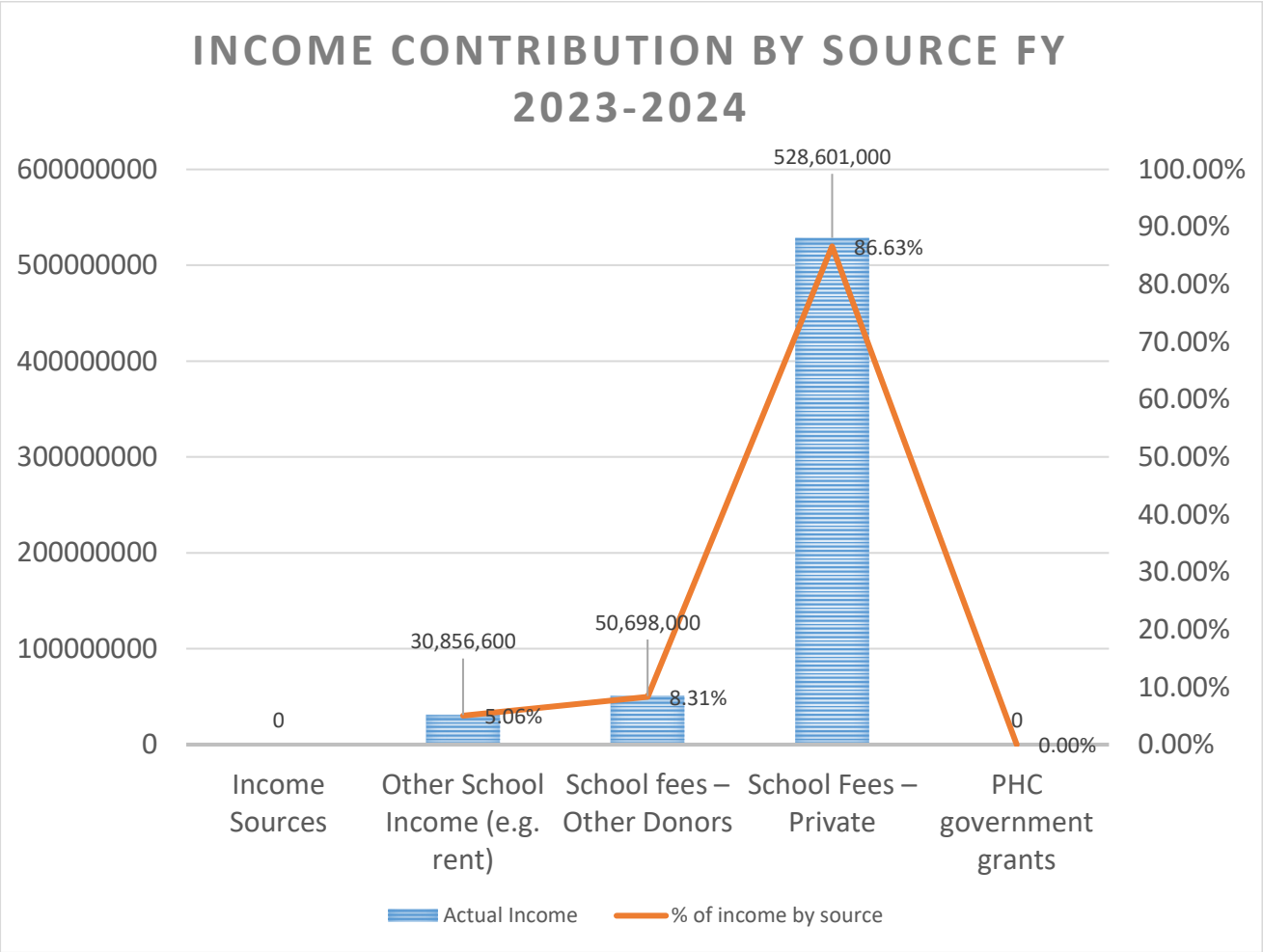
The primary source of funding continues to be the revenue generated from school fees and contributions. As the support from certain donors declines, the sustainability of this funding model is increasingly at risk, highlighting a significant concern regarding reliance on external contributions. Financial assistance for school fees has been provided by organizations such as UNFPA, the Copeland Foundation, the Straight Talk Foundation, the Gretta Foundation, the Dr. Ambrosoli Foundation, and Fondazione Ceresio.

The school achieved 70% of its budget in the FY 23/24.

Table 9.4: Planned, actual and unrealized income in the FY 2023-2024

Income Sources	Planned Income	Actual Income	Budget Gap	Variance Comment
	(UGX)	(UGX)	(UGX)	Surplus/Deficit
Other School Income (e.g. rent)	120,300,000	30,856,600	89,443,400	Donations both for capital and recurrent expenditure was not received as anticipated
School fees – Other Donors	110,930,448	50,698,000	60,232,448	Other donors withdrew from offering schorlarships
School Fees – Private	648,093,804	528,601,000	119,492,804	Fewer students enrolled than anticipated
PHC government grants	0	0		
TOTAL	**879,324,252**	**610,155,600**	269,168,652	

Figure 9.5: Income contribution by source



Expenditure

The school spent about 70% of its budget.

Table 9.6: Planned, actual expenditure and unspent balance in the FY 2023-2024

PLANNED EXPENDITURE	ACTUAL EXPENDITURE	UNSPENT BALANCE
879,324,252	631,658,337	247,665,915

Relation with external partners

External partners have maintained a crucial presence in the evaluation and enhancement of the school's performance by offering financial support through student sponsorship, delivering technical assistance, supplying teaching and learning resources, and facilitating staff training. Additionally, an increase in the number of engaged partners leads to greater exposure for staff to fresh insights and networking possibilities, which they can disseminate among their colleagues, complementing the new knowledge acquired during the weekly Continuing Medical Education sessions.

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 = 145 x 100% = **96.7%**
Total Capacity of the School 150

The total capacity of the school was above 90 %. The school remained accessible to students who needed to pursue their education.

Quality

Total number of students who passed = 80 x 100% = **100%**
Total Number of Students who sat 80

The passing quality has remained consistently at 100%, mirroring the performance observed in the previous year.

Equity

Total fees Collected = 579,299,000 = **3,995,166/=**
Total number of students 145

Average school fees paid per student increased. Our school fees remain one of the lowest of all the HTIs in the UCMB network. Equity reduced in FY 23/24.

Efficiency

Total Recurrent Costs 631,658,337= **4,356,264/=**

Total number of students 145

Compared to last year, efficiency increased.

CHAPTER TEN:

Conclusions

Throughout the fiscal year 23/24, several remarkable circumstances prevailed, mirroring those of the prior year. Both the hospital and the school continued to face significant financial challenges. Sustainability continues to be a primary focus in all initiatives and projects initiated by the hospital. The institution remains largely dependent on donations, and while there has been a rise in local revenue, it remains inadequate to fulfill operational commitments.

Access to maternal and child health (MCH) services in East Acholi remains constrained, mirroring the situation from the previous year. This challenge is further intensified by the weaknesses in the referral network. Additionally, the conclusion of the Ministry of Health's Results-Based Financing initiatives has posed significant challenges due to budget cuts, leading to a decrease in ambulance services for pregnant women and children under five during emergencies. Consequently, we persist in urging the Government of Uganda to reinstate these MCH-focused programs with enhanced financial support for East Acholi to address these critical service deficiencies.

We extend our sincere gratitude to the Ambrosoli Foundation, Comboni Missionaries, and UPMB - LSDA for their generous contributions, which account for nearly 80% of the hospitals' annual budget. We earnestly hope that they will continue to offer this essential support in the future.

Our appreciation also goes to the Ministry of Health and the Government of Uganda for their backing of the Primary Health Care conditional grant, which has provided around 15% of the hospital's revenue. The hospital has upheld its dedication to its mission and has successfully achieved UCMB accreditation. Despite the challenges mentioned, it has remained accessible to the community. We aim to highlight the positive aspects while also acknowledging the areas that require improvement.

Pending Issues

The hospital complex's aging infrastructure necessitates significant upgrades across most of its wards. In the upcoming financial years, efforts will be focused on securing funding to facilitate the renovation of these essential facilities.

Additionally, the perimeter fence surrounding the institution requires a thorough overhaul, similar to the needs identified last year. The presence of multiple vulnerable sections in the fence has led to various security challenges throughout the financial year.

ANNEXES

Annex 1. Members of Board of Governors and designation as per 30th June 2024

	Name	Designation	Title
1	H.G. John Baptist Odama	Chairperson (Emeritus)	Archbishop Emeritus of Gulu
2	Msgr. Matthew Odong	Member	Vicar General Gulu
3	Ms. Giovanna Ambrosoli	Member	Representative Ambrosoli Foundation
4	Fr. Anthony Kibira	Member	Provincial Superior Comboni Missionaries
5	Br. Gunther Neirich	Member	Matany Hospital Administrator
6	Mr. Louis Odongo	Member	Lawyer - P.O. Box 800, Gulu
7	Mr. Thomas Odong	Member	Community Representative
8	Dr Nicholas Gregory Okello (RIP)	Member	Lecturer Gulu University
11	Dr. George William Pariyo	Member	Retired Prof. of Public Health (MAK)
12	Sr. Lucy Achiro	Member	Superior General LSMIG
13	Dr. Okot Godfrey Smart	Secretary/Ex Officio Member	Chief Executive Officer
14	Dr. Pamela Atim	Member	Med. Sup. St Joseph's Hospital – Kitgum

Annex 2. Members of the Management Team and designation as per 30th June 2023

	Name	Title
1	Dr. Okot Godfrey Smart	Chief Executive Officer
2	Mr. Lokong Joseph Adaktar	Administrator
3	Mr. Alex Ojera	Prinicpal Nursing Officer
4	Dr. OkaoMaurice	Medical Director
5	Sr. Carmel Abwot	Principal
6	Sr. Ogwal Hellen Alobo	Senior Nursing Officer

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.