ST MARY'S HOSPITAL
LACOR

ST. MARY'S HOSPITAL LACOR
ANNUAL REPORT

FINANCIAL YEAR JULY 2015 - JUNE 2016

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FOREWORD BY THE EXECUTIVE DIRECTOR

Dear Stakeholders,

The FY 2015/2016 marked the last year of our second strategic plan. During the annual stakeholders meeting, we updated the members of the achievement, challenges and gaps in the implementation of the plan. Whereas progress was made in many of the areas, reducing the dependence of foreign donation was under mined by malaria epidemic which increased hospital expenditure and generally increased number of patients. The process of producing the third strategic plan has started and we shall involve all stakeholders in order to have a comprehensive document.

Service delivery went on smoothly during the financial year however, we got one major upset, our IT system collapsed and a lot of data was lost. We learnt the hard way and measures are being taken to prevent re-occurrence. The hospital now regularly takes patients and students satisfaction survey to help us improve. The smooth flow of patients, waiting time are still problem. We hope triaging, numbered card will reduce these complaints. The health centre which have delivered about third of the total service output needs more support. They are now in-semi urban areas which mean the demand/needs of the patients are also changing. Request for ambulance for referral are also correspondingly increasing. Social promises a US based NGO has donated an ambulance to the hospital. Our new courses in the Schools are; Diploma in midwifery, certificate in midwifery, theatre assistants, Diploma in laboratory techniques has been accredited. The hospital has installed a high temperature, high volume and high efficiency incinerator which will improve disposal of medical waste. Medical waste management especially segregation is not being strictly adhered to; although continuous effort are being made to have staff adopt the practice .The hospital is in the process of installing digital radiology system which will reduce or eliminate the use of films which we hope will reduce the cost and waiting time. The human resource development program of the hospital is on course. This is the only way we can replace those who have left and also upgrade the others.

Result based funding, initially started by the NU-Health project has now become normal practice and some of our donors have accepted to adopt. The advantage it comes with is the regular external verification which we hope will help us maintain quality of services. The result based performance will be used internally for salary increment .New partners are hard to come by and the CEI, Corti Foundation, Coutou and UEC have maintained steady. Financing the service delivery remain a challenge. The last financial year was a part of the election year so local fund raising activities were not done.

The hospital is trying its level best to meet the expectation of the stake holders despite the serious challenges of bridging the gap between expenditure and income. We are ready to listen to suggestions and therefore implore the stake holders to come forth with ideas for the new strategic plan. To all our partners let us continue to work together for the benefit of our patients.

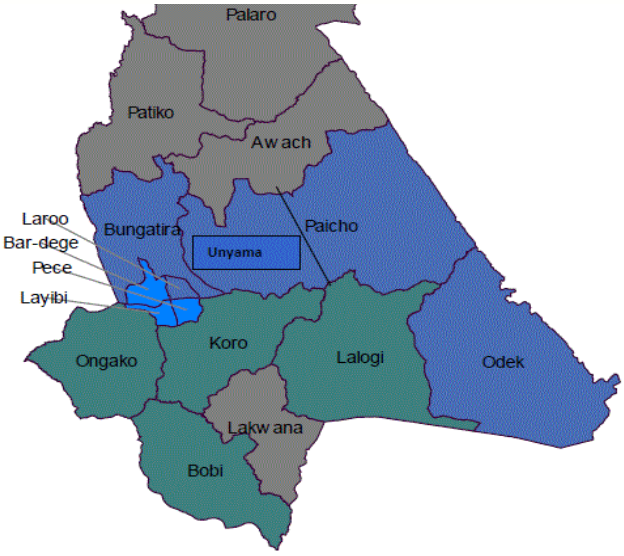
At the governance level the hospital suffered a major catastrophe in that two board members passed on namely; Mr. Vincent Opio Lukone and Dr. Ezaati Isaac Alidria.**(May their souls Rest in peace),** These were dedicated and very active members of the board. We hope that other people will come forward to fill in the gaps left by these members.

We would like to thank all the staff, Government of Uganda, partners the Board of Governors and the patients. The successful conclusion of the year can be attributed to the manual efforts. Challenges will continue to exist.
Let us all be part of the solution.
Yours in service

Dr Opira Cyprian
Executive Director

I: GEOGRAPHICAL LOCATION AND SIZE OF GULU DISTRICT

Figure I. 1: Map of Northern Uganda



Gulu District is located in Northern Uganda between longitude 30-32 degrees East; latitude 02-4 degrees North it is bordered by Amuru District in the West, Lamwo District in the North East, Pader District in the East, Lira District in the South East and Oyam District in the South. The total land area of Gulu District is 3,449.08 sq km (1.44% of the Uganda land size). 96.9 sq km (0.8%) is open water and Gulu Town, the district headquarters, is 332 km by road from Kampala.

III: LIST OF ABBREVIATION AND ACRONYMS

ALOS	Average Length of Stay
ARI	Acute Respiratory tract Infection
BOR	Bed Occupancy Rate
CBHC	Community Based Health Care
CHW	Community Health Worker
CPD	Continuing Professional Development
CRSC	Catholic Relief Services Consortium
DHC	District Health Committee
DHMT	District Health Management Team
DHO	District Health Officer
DHT	District Health Team
DOTS	Directly Observed Therapy Short-course
ECN	Enrolled Comprehensive Nursing
eMTCT	Elimination of Mother to Child Transmission of HIV.
EPI	Expanded Programme of Immunisation
GDHSSP	Gulu District Health Sector Strategic Plan
HMIS	Health Management Information System
HSD	Health Sub-District
HUMC	Heath Unit Management Committee
ICU	Intensive Care Unit
MMR	Maternal Mortality Ratio
MoES	Ministry of Education and Sports
MoH	Ministry of Health
NSSF	National Social Security Fund

OPD	Out-Patient Department
PEPFAR	The President's Emergency Plan For AIDS Relief
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PNFP	Private Not For Profit
PTC	Pharmacy and Therapeutic Committee
QIN	Quality Improvement Nurse
TB	Tuberculosis
TBA	Traditional Birth Attendant
UBOS	Uganda Bureau of Statistics
UCMB	Uganda Catholic Medical Bureau
UDHS	Uganda Demographic Health Survey
UHSSP	Uganda Health Sector Support Programme
UNICEF	United Nations Children's Fund
URN	Uganda Registered Nursing
VCT	Voluntary Counselling and Testing
VHT	Village Health Team
YCC	Young Child Clinic

EXECUTIVE SUMMARY
LACOR HOSPITAL AND ITS ENVIRONMENT

St. Mary's Hospital Lacor is the largest Referral private non-profit catholic based institution in Uganda. It was founded in 1959. It is owned by the Registered Trustees of Gulu Diocese. Lacor Hospital is registered with the National Board for Non-Governmental Organisations and is accredited to Uganda Catholic Medical Bureau. Lacor Hospital activities are in line with Uganda Ministry of Health policies of health care provision. The integration of Lacor Hospital into the Uganda national health system has been in line with national health reform, which was implemented from 1996/1997.

From a small 30-bed Hospital 55 years ago, Lacor Hospital is now a complex with 482 -bed capacity and 3 Peripheral Health Centres - each with 24 beds (Opit, Amuru and Pabo), a Nurse Training School, a Laboratory Training School, Gulu University teaching site for medical school and other training programmes.

The total bed capacity of the hospital complex including the three health centers are therefore 554.

The Hospital is located in Gulu Municipality, about 6 km west of Gulu town along Highway to Sudan. It has been built on land owned by Gulu Catholic Archdiocese. The Christian doctrine of dedication and providing care to the sick is the strong pillar on which Lacor Hospital's identity and performance rests.

Gulu municipality has 149,900 inhabitants, while the total population of Gulu district is 374,700 and that of Amuru district is 220,400. Gulu Government Hospital, about 6 km from Lacor, has 335 beds and is the regional referral Hospital. There are other small private clinics and drug shops for commercial purposes in Gulu town and the suburbs. The approach of Lacor Hospital is to supplement the government's efforts in health service provision.

Lacor Hospital has operated in a very difficult social and economic environment. Insecurity has since 1986 devastated the economy of northern Uganda leaving the population in dire need, suffering and despair. Most of the patients served are among the poorest of the poor, who live well below the poverty line.

Even with the disbanding of the IDP Camps and the local populace accessing their land, it will take more than ten years for the economy of the region to stabilise

The Hospital accommodates every day on average 600 inpatients plus their attendants and receives on average 600 outpatients there are about 1,000 employees combined with their family members living within the Hospital.

SELECTED ACHIEVEMENTS FY 2015/16

Highlighted below are some selected achievements in the FY 2015/16 as well as selected critical issues in the different areas.

- Two new generators with high capacities have been installed in the Hospital.
- Liquid waste treatment plant has been completed.

- The new incinerator is near completion.
- A block of flat composing of 8 apartments for Doctors` accommodation and a students` dormitory at Amuru HC has been completed, thanks for the funding from CEI.
- A new Costa bus for students has been purchased.
- The Hospital received learning visits from St. Benedictine Eye hospital, St. Joseph hospital Kitgum, District Health team from Kasese and Nsambya hospital administrations as understudies.
- The Hospital achieved unconditional Accreditation from UCMB.
- 15 hospital employee salaries have been taken up by USAID (SDS) under the ACT project
- The hospital has been able to replace the personnel who left the hospital in the year.
- Staff development strategy through hospital scholarship has been maintained.
- Diploma in midwifery and certificate in medical theater Assistant courses introduced in our schools
- RBF have been adopted as a funding mechanism by some donors. The hospital has maintained quality scores of above 90%.
- Security at the gate has been strengthened. Regular checks are done on luggage and bags getting out of the hospital. CCTV Cameras is working well.

SELECTED CRITICAL ISSUES 2015/16

- The recurrent cost has continued to escalate in the Hospital.
- The hospital lost a member of Board of Governor, Dr. Ezati Isaac (RIP) who was also the chairman Quality Improvement committee.
- Number of patients have drastically increased, especially in the health centers so does the cost of delivering the services.
- Biomedical equipment's have been used up. The operating theatre beds needs replacement.
- Attrition of critical cadre continues in the Hospital.
- The public Universities have increased their salaries which might attract our specialist to move to the universities.
- The Consultant Pediatrician and Head of department has notified the hospital intending to shift to Gulu University with effect from January 2017.
- Maintenance of digital biomedical equipment's still poses challenges.
- The hospital experienced system failure in its Navision system leading to 2 months of data loss.

SERVICE UTILIZATION

There has been a reduction in the total number of patients served in the hospital and its health centres this year as shown in the table.

Table 1- *Selected service utilization – 2015/16*

Service output	2012/2013	2013/2014	2014/15	2015/16	Variance (%)
Total OPD attendance	216,918	210,801	212,029	232,863	9.9%
Admissions	34,344	32,865	36,021	58,294	61.9%
Deliveries	6,089	6,110	6,380	6,652	4.3%
Major surgical	5,753	5,288	5,266	4,426	-16%
Laboratory	209,671	291,697	320,542	487,181	52%
Radiological	41,721	40,878	38,703	40,069	3.6%
Immunization doses	60,726	59,294	67,199	69,435	3.4%

IV.4 FINANCIAL REPORT

During the FY 2015/16 total revenues increased by 20.6% compared to last year, while total operating costs increased by 20.6 %. The report is therefore balanced.

The increase in costs is due mainly to a UGX 2 billion increase in Medical Item Cost, as well as a general, although more moderate, increment in the other cost items.

This year the financial report was audited by BDO, a leading international audit firm.

Profit and Loss (synthesis)	**2015/16 UGX '000**	**2014/15 UGX '000**	**Difference UGX '000**	**diff. %**
Income				
Uganda Government	1,439,128	1,118,778	320,350	28.6%
Donors	10,918,352	8,485,264	2,433,088	28.7%
User fees	4,444,365	3,729,303	715,062	19.2%
Other Local Revenues	352,775	550,226	-197,451	-35.9%
Amortization of deferred capital contributions	2,177,047	2,148,043	29,004	1.4%
Total Revenue	**19,331,665**	**16,031,615**	**3,300,050**	**20.6%**
Costs				
Personnel	6,803,355	6,411,327	392,028	6.1%
Medical Items and services	7,292,445	5,290,710	2,001,735	37.8%
Generic Items	1,499,824	1,118,644	381,180	34.1%
Transport expenses	561,036	477,150	83,886	17.6%
Administrative expenses	695,792	657,071	38,721	5.9%

Property expenses	456,164	396,627	59,537	15.0%
Total Recurrent Costs	**17,308,616**	**14,351,529**	**2,957,087**	**20.6%**
Depreciations	2,177,047	2,148,043	29,004	1.4%
Total Operating Costs	**19,485,663**	**16,499,572**	**2,986,091**	**18.1%**
Other gains/(losses)	153,998	467,958	-313,960	-67.1%
RESULT OF THE YEAR	**-**	**-**		

CHAPTER 1
INTRODUCTION

1.1 BACKGROUND

St. Mary's Hospital Lacor is a referral PNFP hospital. It is the largest private non-profit catholic based institution in Uganda. It was founded by the Comboni missionaries in 1959. It is owned by the Registered Trustees of Gulu Diocese. Lacor Hospital is registered with the National Board for Non-Governmental Organisations and is accredited to Uganda Catholic Medical Bureau. Lacor Hospital activities are in line with Uganda Ministry of Health policies of health care provision. The integration of Lacor Hospital into the Uganda national health system has been in line with national health reform, which was implemented from 1996/1997.

From a small 30-bed hospital 55 years ago, Lacor Hospital is now a complex with 482-bed capacity and 3 Peripheral Health Centres - each with 24 beds (Opit, Amuru and Pabo), a Nurse and Midwifery Training School, a Laboratory Training School, School of Anaesthesia and Gulu University teaching site for its faculty of medicine.

The total bed capacity of the hospital complex including the three Health Centres are therefore 554. It offers general health care services ranging from curative, promotive, preventive and rehabilitative health care services including specialist services and is a training Centre for different cadres of medical personnel.

The selected specialised services provided includes urology, orthopaedic, paediatric, plastic and Fistula surgeries, treatment of childhood malignancies and detection and treatment of early cervical cancers and endoscopy. The approach of Lacor Hospital is to supplement the government's efforts in health service provision.

Lacor Hospital operates in a very difficult social and economic environment. The over two decades of civil war in the northern part of Uganda devastated the economy of the region leaving the population in dire need, suffering and despair. Most of the patients served are among the poorest of the poor, who live well below the poverty line.

Even with the disbanding of the IDP Camps and the local populace accessing their land, it will take more than ten years for the economy of the region to stabilise.

The Hospital together with its health centres accommodate every day on average more than 500 inpatients plus their attendants and receive on average 600 outpatients on a daily basis; there are about 1,000 employees combined with their family members living within the Hospital.

1.2 THE HOSPITAL AND ITS ENVIRONMENT

Lacor Hospital is a complex institution, comprising of the main Hospital, the three Peripheral Health Centres at Amuru, Opit and Pabo, The training wing includes the Schools of Nursing and Midwifery, the school of medical Laboratory Technology, the School of Anaesthesia and the school of theatre Assistants. The Hospital is also an official teaching site for Gulu University faculty of medicine since its inception in the year 2004.

Lacor Hospital refers to the Hospital complex, the Hospital refers to the main Hospital only and the Health Centres are referred to as Lacor Health Centre III - Amuru, Lacor Health Centre III - Opit and Lacor Health Centre III – Pabo.

The Hospital is located in Gulu Municipality, Bardege division, about 6 km west of Gulu Town along the Highway to the Republic of South Sudan. It has been built on land owned by Gulu Catholic Archdiocese leased to Lacor Hospital. The Christian doctrine of dedication and providing care to the sick is the strong pillar on which Lacor Hospital's identity and performance rests.

Gulu municipality has 149,900 inhabitants, while the total population of Gulu district is 374,700 and that of Amuru district is 220,400. Gulu Government Hospital, about 6 km from Lacor, has 335 beds and is the regional referral Hospital. There are other small private clinics and drug shops for commercial purposes in Gulu Town and the suburbs.

Currently the hospital has a bed capacity of 482 beds offering referral services, primarily serving the population of Gulu, Amuru and the newly created Nwoya districts many patients also come from the other districts of Acholi sub-region including Kitgum, Pader, Agago and Lamwo districts as well as from other parts of Uganda. In order to further improve accessibility of health services to the community, Lacor Hospital constructed three satellite Health Centres in Amuru, Opit and Pabo. Each Health Centre is located about 40 km away from the Lacor Hospital.

Lacor Hospital is mainly funded from three main sources: the delegated funds from government of Uganda, user fees and mostly from foreign donations. A small proportion of revenue (about 1%) is locally generated.

Gulu and Amuru districts, where Lacor Hospital and its Health Centres are located, are bordered by seven districts: Adjumani, Arua and Nebbi to the West; Oyam, and Nwoya to the South and Kitgum and Pader to the East. The northern border of Amuru district borders South Sudan. The two districts have a projected population of 374,700 for Gulu and 220,400 for Amuru. For over 20 years, both districts have had insecurity, which has led to many deaths and disruption of life, with massive displacement of people, most of whom had ended up either in urban areas or in protected camps for the Internally Displaced. The IDP-camps have now been closed. In the Acholi region, almost every people have already returned to their original homes. Normal life, food production, education, health and other social services that had all been disrupted by the insecurity for all this time is slowly returning to normal today. Gulu and Amuru districts have some of the worst health indicators in the Country. Less than 10% of the adult population is formally employed and 75% of households survive on subsistence farming.

CHAPTER 2
DISTRICT HEALTH SERVICES AND HEALTH POLICY

2.1 THE COMMUNITY AND HEALTH STATUS OF GULU DISTRICT

2.1.1 ADMINISTRATIVE UNITS IN GULU DISTRICT

Administratively, Gulu District is composed of three (3) Counties which are equivalent to the 3 HSD of Aswa, Omoro and Gulu Municipality. There are a total of 16 Lower Local Governments (12 Sub-counties and 4 Divisions). There are a total of 70 Parishes (54 parishes in the rural sub counties and 16 wards in the divisions) and 342 villages as in the table below.

Table 2 *Administrative units in Gulu District*

County	**Sub-County**
ASWA	Awach, Bungatira, Paicho, Unyama, Palaro and Patiko
MUNICIPALITY	Bar-dege, Laroo, Layibi and Pece
OMORO	Bobi, Koro, Lakwana, Lalogi, Odek and Ongako

2.1.2 The main health development challenges

Inadequate health infrastructure lowers physical accessibility to health services. This coupled with lack of qualified human resources further lowers the quality of health services provided. Logistics and health supplies are limited and sometimes not regular. Lack of transport and communication affects referral as well as health data management system.

The high level of maternal and child morbidity and mortality rates are partly attributed to the high prevalence of HIV/AIDS/TB, malaria, and other communicable diseases. Reproductive health services (e.g. Emergency Obstetric Care) is generally limited to urban hospitals.

Malnutrition, especially among children under 5, is quite high, with recent survey showing that (30 percent child stunting, 5 percent wasting and 16.7 percent retardation). High level of poor hygiene and sanitation exists at household level.

Gulu district is one of the many districts in northern Uganda who have experienced an upsurge of malaria epidemics since the end of Indoor residual sprays.

DISTRICT HSSIP PERFORMANCE

Mortality	Gulu HMIS 2013/14	Uganda 2011 Survey	HSSIP Targets 2015
MMR	198	438	131
IMR	66	54	41
U5MR	86	90	56

NATIONAL TREND OF MORTALITY

	Uganda DHS 2006	Uganda DHS 2011
MMR/100,000 LB	435	438
IMR/1,000 LB	76	54
U5MR/1,000 LB	137	90

DISTRICT PERFORMANCE FY 2010 – 2013/14

Key Indicators	2010/11	2013/14
Accessibility within 5 km (%)	67	72
Staffing level % filled	72	88
Latrine coverage (%)	62	72
HIV/AIDS Prevalence – ANC (%)	12	07
No stock out of Essential medicines (%)	20	75
Malnutrition (%)	4.2	1.4
Timely Reporting HMIS (%)	67	72
HUMC Functionality (%)	20	50

Health Policy

The focus for the Uganda NHP II 2010 – 2020 is on health promotion, disease prevention and early diagnosis and treatment of disease with emphasis on vulnerable populations.

In addition the NHP is focused on health systems strengthening, specifically:

- Strengthening health systems in line with decentralization through training, mentoring, technical assistance and financial support;
- Re-conceptualizing and organizing supervision and monitoring of health systems at all levels in both public and private health sectors and improving the collection and utilization of data for evidence-based decision-making at all levels;
- Establishing a functional integration within the public and between the public and private sectors in healthcare delivery, training and research;
- Addressing the human resource crisis and re-defining the institutional framework for training health workers, including the mandate of all actors;
- Leadership and coordination mechanisms, with the aim of improving the quantity and quality of health workers production shall also be a priority.

2.1.6 HSSP III 2012 – 2017

The GoU, with the stewardship of the MoH, has also developed the second National Health Policy (NHP II) that covers a ten year period 2010/11-2019/20. The HSSP III has therefore been developed to operationalize the NHP II and the health sector component of the NDP.

The focus is on strengthening health systems' capacity to deliver the UNMHCP including health promotion, environmental health, disease prevention, early diagnosis and treatment.

2.1.7 THE MINIMUM HEALTH CARE PACKAGE

The minimum health care package in Uganda involves the most cost-effective priority healthcare interventions and services addressing the high disease burden that are acceptable and affordable within the total resource envelope of the sector. The package consists of the following clusters:

- Health promotion, environmental health, disease prevention and community health initiatives, including epidemic and disaster preparedness and response;
- Maternal and Child Health;
- Prevention, management and control of communicable diseases;
- Prevention, management and control of non-communicable diseases.

Lacor Hospital continues to implement the Uganda National Health Policy and the Health Sector Strategic Plan by providing the major components of the Uganda Minimum Health Care Package offering in-patient, out-patient and community-based services. The Hospital receives patients referred from all the districts of northern Uganda and beyond. The range of services offered includes diagnostic, therapeutic and preventive services.

With creation of the new district of Amuru, two of the three Health Centres (Lacor Health Centre III-Amuru and Lacor Health Centre III-Pabo) are now located in the new district. The operational plan of each of the health units is incorporated into the overall activity plan of the respective districts.

Each of Lacor Hospital's peripheral health Centres is designated Health Centre III and offers a range of services including maternal and child health care, VCT for HIV/AIDS as well as PHC activities, and other clinical services with maternity component. The Health Centres provide support supervision to the local lower level units within their catchment areas, including the lower level government health units. The Health Centres also serve as points of screening of patients for referral to the Hospital. Ambulance services are available free of charge for referral of patients from the Health Centres to the Hospital.

Lacor Hospital participates in the DHMT and DHC meetings and the operational plans for the common activities are incorporated in the district health plan.

CHAPTER 3
LACOR HOSPITAL HEALTH CARE ACTIVITIES

3.1 CONSOLIDATED NUMBER OF IN/OUT PATIENTS (HOSPITAL & HCS)

The overall number of patients who attended Lacor Hospital and its three health centers this FY was 291,157 which is 1.8% higher than that recorded last FY. A total 232,863 (80%) were seen as outpatients, while 58,294 (20%) patients were treated in the wards. Out of them, 184,069 (63.2%) were treated in the Hospital, while 107,088 (36.8%) clients were attended to at the Health Centres.

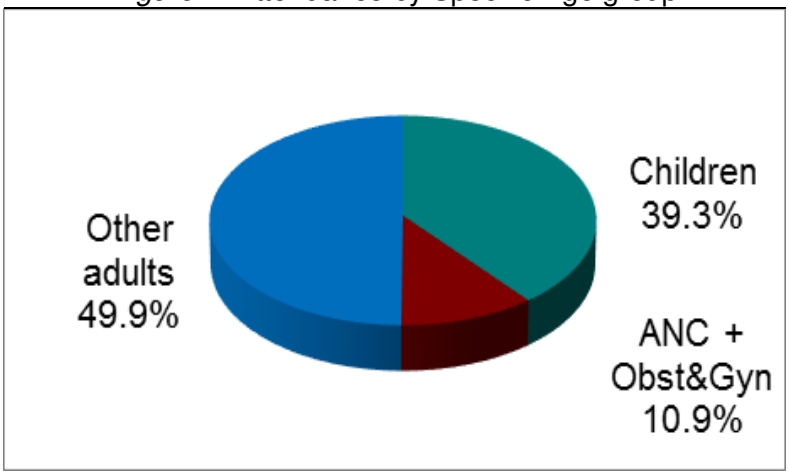
Table 3 *Consolidated number patient contacts – 2015/16*

Contacts 2014/15	In –pts Children	In-Pts Maternity	In-pts Other Adults	In-pts Total	Out-pts Children	ANC	Out-pts Other Adults	Out-pts Total	TOTAL Contacts
Hospital	15,656	7,940	11,004	**34,600**	35,703	9,053	104,713	**149,469**	**184,069**
Amuru	3,960	1,434	1730	**7,124**	17,478	5,471	9,668	**32,617**	**39,741**
Opit	6,277	835	1443	**8,555**	12,635	2,628	8,252	**23,515**	**32,070**
Pabo	5,718	1,011	1286	**8,015**	16,853	3,325	7,084	**27,262**	**35,277**
TOTAL	**31,611**	**11,220**	**15463**	**58,294**	**82,669**	**20,477**	**129,717**	**232,863**	**291,157**

3.2 ATTENDANCE BY SPECIFIC GROUPS

Children five years and below made up 39.3% of the total attendance, while pregnant mothers (antenatal clinic and deliveries) attracted an additional 10.9% of the total attendance. A total of 49.9% of the contacts were other adults as shown in the figure below.

Figure 1: Attendance by Specific Age group



Over 50% of all patients served in Lacor Hospital this FY children and pregnant women, who continued to benefit, in spite of some fee adjustment, of high accessibility to the services of Lacor Hospital in line with the hospital's mission, while 49% of the contacts were other adults.

Table 4 *User fees for mothers and children – 2015/16*

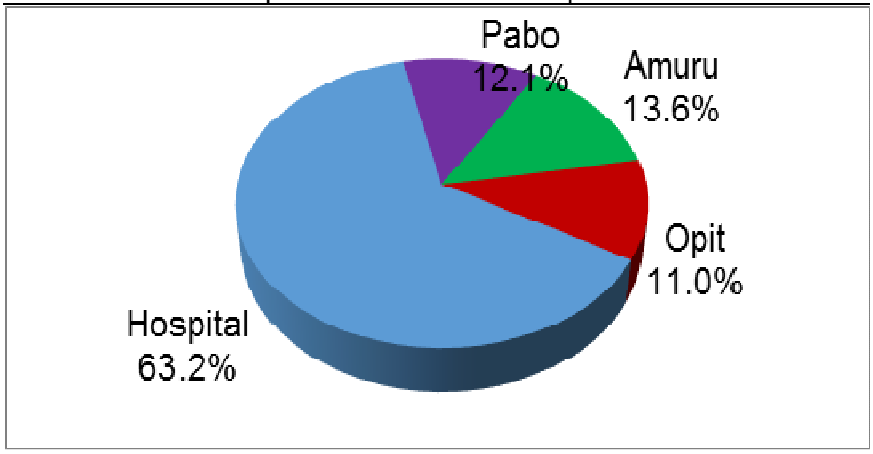
Deliveries and admission of children in HCs (investigations and drugs included)	Free
Young Child Clinic in the HCs (investigations and drugs included)	Shs 1,000
Antenatal Clinic in HCs and Young Child Clinic in Hospital (investigations & drugs included)	Shs 2,000
Adult outpatient (only consultation)	Shs 2,000
AIDS Clinic (investigations and drugs included)	Shs 4,000
Antenatal Clinic and admission of children in the Hospital (investigations and drugs included)	Shs 5,000
Delivery in the Hospital, inclusive of admission fees	Shs 5,000
Admission maternity ward (flat rate)	Shs 5,000
Admission adults through AIDS Clinic (flat rate)	Shs 20,000
Admission adults in other wards (flat rate)	Shs 30,000

The fees for the various services have remained stable, apart from minor adjustments.

3.2.1 DISTRIBUTION OF ATTENDANCE ACCORDING TO LOCATION OF THE UNITS

Out of the total patients contacts, 37% were in the health centres an increase from 33% last FY while the main hospital handled 63% of the total load. This is in line with the hospital strategy of taking service closer to the local community through greater utilisation of its three health centres.

Figure 2: Distribution of patients load in the hospital and the health centers

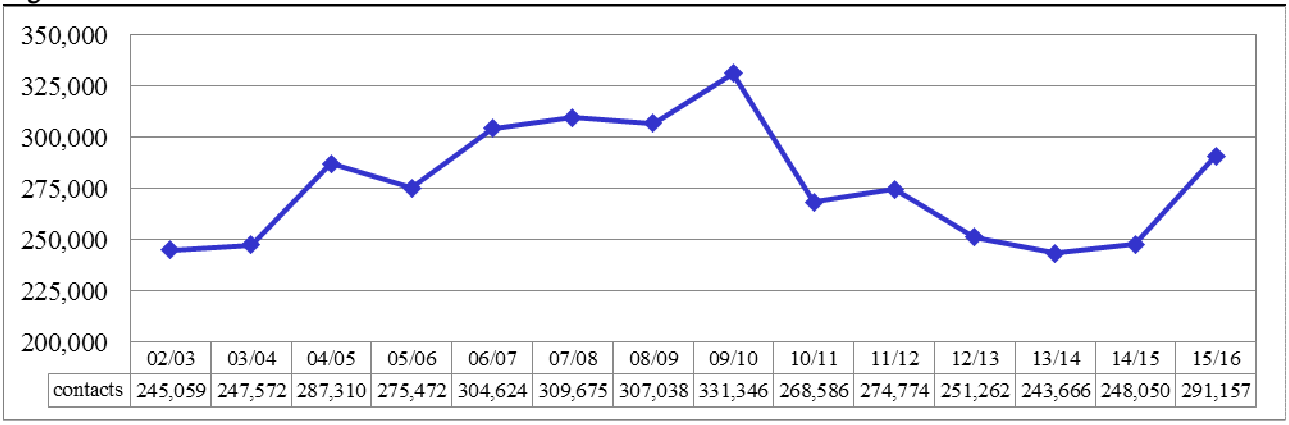


Service delivery in the Health Centres continues being fully integrated with the Hospital. The Health Centres, actually, operate as branches of the Hospital with which they share personnel, supplies and administration. The Hospital also regularly supervises the peripheral units and an ambulance service is maintained between the Health Centres and the Hospital.

3.2.2 TREND OF ATTENDANCE

This FY there has been a big increase in attendance from 248,050 total contact to 291,157 this was the highest number in the last 5 years.

Figure 3: Trend of Total Patient contacts



	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16
contacts	245,059	247,572	287,310	275,472	304,624	309,675	307,038	331,346	268,586	274,774	251,262	243,666	248,050	291,157

3.2.3 GROUP-SPECIFIC TRENDS

In FY 2015/16 the increase in attendance was mostly attributed to by the 45% increase in attendance of children below 6 years, this is mainly due to the resurgence of malaria which has persisted in the region since 2014.

Table 5 :Change in group-specific attendance – 2015/16

Total Attendance	FY 14-15	FY 15-16	Variance	**Variance %**
Children	78,514	114,280	35766	45.6%
ANC & admission Maternity wards	30,381	31,697	1316	4.3%
Other Adults	139,155	145,180	6025	4.3%
TOTAL	248,050	291,157	43107	17.4%

Table 6: Trends of admissions compared to out-patient contacts – 2015/16

TOTAL ATTENDANCE	FY 14-15	FY 15-16	Variance	Variance %
Admissions	36,021	58,294	22,273	61.8%
Outpatients	212,029	232,863	20,834	9.8%
TOTAL	248,050	291,157	43,107	17.4%

The was 22,273 more patients admitted in the hospital this FY this constituted over 61% increase in admission in one FY alone and it's the highest number of patients ever admitted to the hospital since its inception.

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Table 7: *Trends in children and adults admission – 2015/16*

Admissions	FY 14-15	FY 15-16	Variance	**Variance %**
Children	14,596	31,611	17,015	116.6%
Adults	21,425	26,683	5,258	24.5%
TOTAL	36,021	58,294	22,273	61.8%

The increase in admissions was mostly registered in the children which doubled in one year from 14,596 last FY to 31,611 this FY. As explained earlier, Malaria is the major contributory factor to this trend.

3.2.4 Trends of total attendance in the hospital and in the health centers

Table 8*: Trends of attendance by Location of the Unit – 2015/16*

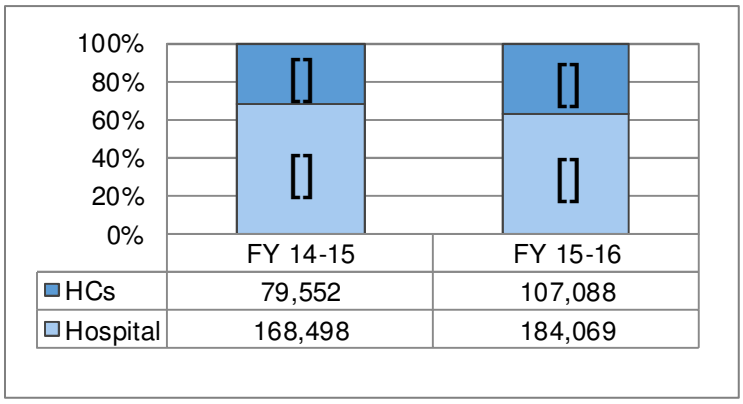
Total Attendance	FY 14-15	FY 15-16	Variance	**Variance %**
Lacor Hospital	168,498	184,069	15,571	9.2%
Amuru	29,734	39,741	10,007	33.7%
Opit	21,391	32,070	10,679	49.9%
Pabo	28,427	35,277	6,850	24.1%
TOTAL	248,050	291,157	43,107	17.4%

There was overall increase in total attendance, all the three health centers of Amuru, Opit and Pabo recorded increment in the number of total contacts by 33.7%, 49.9% and 24.1% respectively. 35.9% of all the total contacts occurred at the health centers with Opit recording the highest increment of 49.9%.

3.3 DECENTRALIZATION OF SERVICE

The contribution of service output in the three Health Centres combined has continued to increase over the years reaching 35.9% this FY up from 30% last FY and 28% recorded in the FY 2013/14. This is in line with the hospital strategy of decentralisation of services to the health centers.

Figure 4: Distribution of attendance, Health Centres and Hospital – 2015/16



3.3.1 INTERPRETATION OF THE TRENDS

This FY 2015/16, we have recorded the highest increase in total attendance, unlike the persistent decline since FY 2009/10. The most likely attribution for the increment is the outbreak of malaria towards the end of the FY 2013/14. There had been a general reduction in cases of malaria since 2009/10 with the Indoor residual spraying exercise, but since the spraying stopped at the beginning of the FY2013/14, we have seen a resurgence. Continued MoH strategies include distribution of Long Lasting Insecticide Treated Nets (LLINs), prompt case management using artemisin in combination therapy (ACT) and Intermittent Presumptive Treatment (IPT) for malaria in pregnant women had probably been the major contributors to the previous decline of malaria cases. Other community based interventions for malaria are being reactivated to combat this outbreak.

Other factors had that caused the long decline in total attendance since 2009 included reduction in the number of severe malnutrition due to generally improved food security among the local population and re-opening and improved functionality of public health facilities in the community. Gulu now has 91 facilities from about 89 in the last FY, mostly functional. There has also been a general improvement in the living environment of the local population after the disbanding of the Internally Displaced Peoples` camps. The population has also relocated from the areas of towns and urban centres to rural areas when the war ended. Many private clinics and drug shops have been established in town but also in smaller centres, that might also be a cause of the reduced outpatient attendance.

The hospital is however receiving more complicated cases that need more costly care, like patients needing surgical operations, anti-cancer treatment, ART therapy or, generally, specialist attention.

Table 9*: Trend of selected activities – 2015/16*

Total Attendance	FY 14-15	FY 15-16	Variance	**Variance %**
Surgical Clinic	9,810	7,984	-1826	-18.6%
Dental Clinic	6,915	5,983	-932	-13.5%
Endoscopy	1,134	1,143	9	0.8%
Surgical operations	5268	4,426	1213	-16.%
ICU	294	392	98	33.3%
Diagnostic imaging	38,703	40,067	1364	3.5%
Sickle Cell Clinic	2,585	2,123	-462	-17.9%
Emergency Clinics	17,407	24,409	7002	40.2%

This FY there has been a reduction in the attendance to the surgical clinics as well as in the dental clinic, a reduction in output was also recorded in the sickle cell clinic while diagnostic imagining as well as attendance in ICU recorded increments. The total number of operations

has reduced by -16% this FY to 4,426 from 5,268 recorded in FY 2014/15. The apparent reduction in HIV clinic attendance is due to a three monthly refill for stable patients.

Table 10*: Change in Maternity services – 2015/16*

Total Attendance	FY 14-15	FY 15-16	Variance	**Variance %**
Deliveries	6,380	6,652	272	4.3%
Caesarean sections	1,105	1,253	148	13.4%
ANC-Obst &Gyn clinics	35,103	33,653	-1450	-4.1%

The number of deliveries has remained on its upward trend that was offset in the previous FY, by 4.3% increase, and the total number of Caesarean sections also continues to rise by13.4%. The Hospital and in its Health Centres have noted a drop for the second year in attendance at the antenatal clinic attendance, due probably to the reactivation of the government health centres in the districts.

3.4 OUTPATIENT SERVICES

The outpatient department is the reception point for most patients receiving services in the Hospital and the Health Centres. In the Hospital, services are delivered through the adult Outpatients Department (OPD) for patients of six years and over, through the Young Child Clinic (YCC) for patients less than six years of age and through the Antenatal Clinic (ANC) for pregnant women.

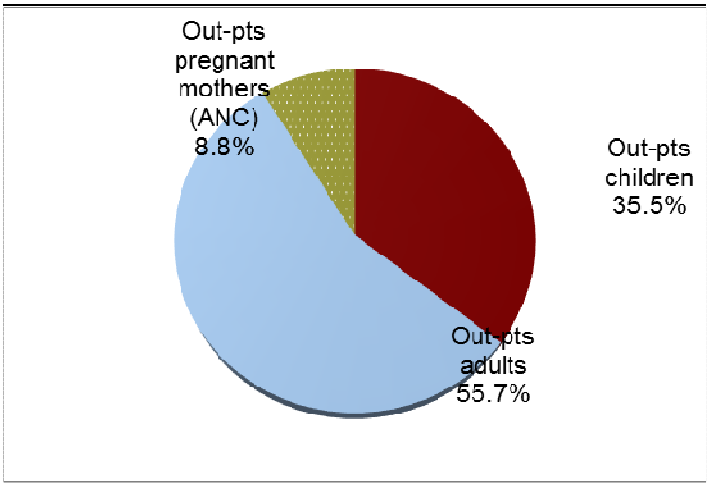
The Hospital also runs the following special clinics on outpatient basis: HIV clinic, Dental clinic, Obstetrics and Gynaecology clinics, surgical clinic, Sickle Cell clinic, TB outpatient clinic, cardiovascular and diabetic clinics, as well as private clinic.

The OPD is open from Monday to Saturday during working hours, Young Child Clinic is also open on Sundays and public holidays to handle emergency cases. The ANC is open 5 days a week. Emergencies that come after hours are served in the respective inpatient wards and/or in the casualty department, which remains open twenty-four hours a day. On average 486 outpatients have been seen in the Hospital daily. Another 221 outpatients were served on average for 6 days a week in the Health Centres.

3.4.1 OUTPATIENT SERVICES BY CATEGORIES OF PATIENTS (HOSPITAL AND HEALTH CENTRES)

Of the total 232,863 outpatients seen, 129,717(55%) were seen in the Adult OPD, 82,669 (35%) were children seen in the YCC, and 20,000 (8.8%) were pregnant women attending the ANC.

Figure 5: OPD Attendance by cadre of patients, Hospital & Health Centres – 2015/16

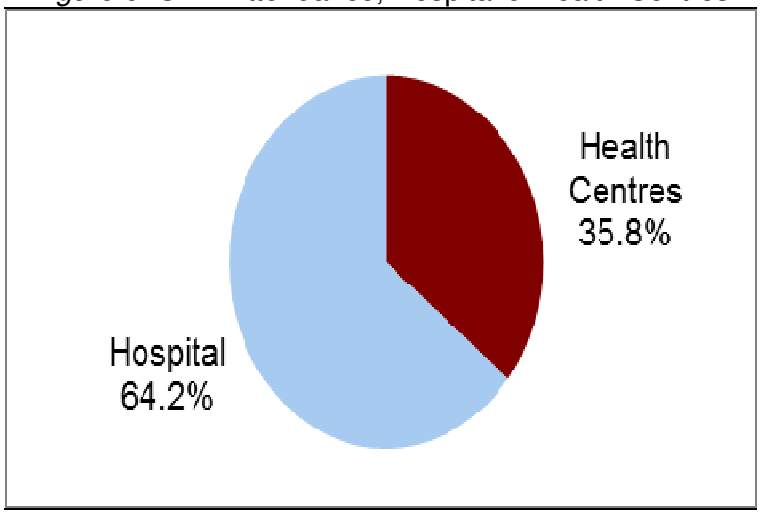


Thus children below 5 years attending YCC and pregnant women attending ANC comprised 45% of all the hospital outpatient attendance. When all women attending OPD are added (103,339), the proportion of women and children cared for as outpatients reaches 79.4% which means outpatient attendance is in line with the hospital mission to care for the most vulnerable groups.

3.4.2 Attendance according to location

Of the total 232,863 outpatients this FY, 149,469 (64.2%) were attended to in the Hospital and 83,394 (35.9%) were seen in the Health Centres. This is an increase from last FY's.

Figure 6: OPD Attendance, Hospital & Health Centres

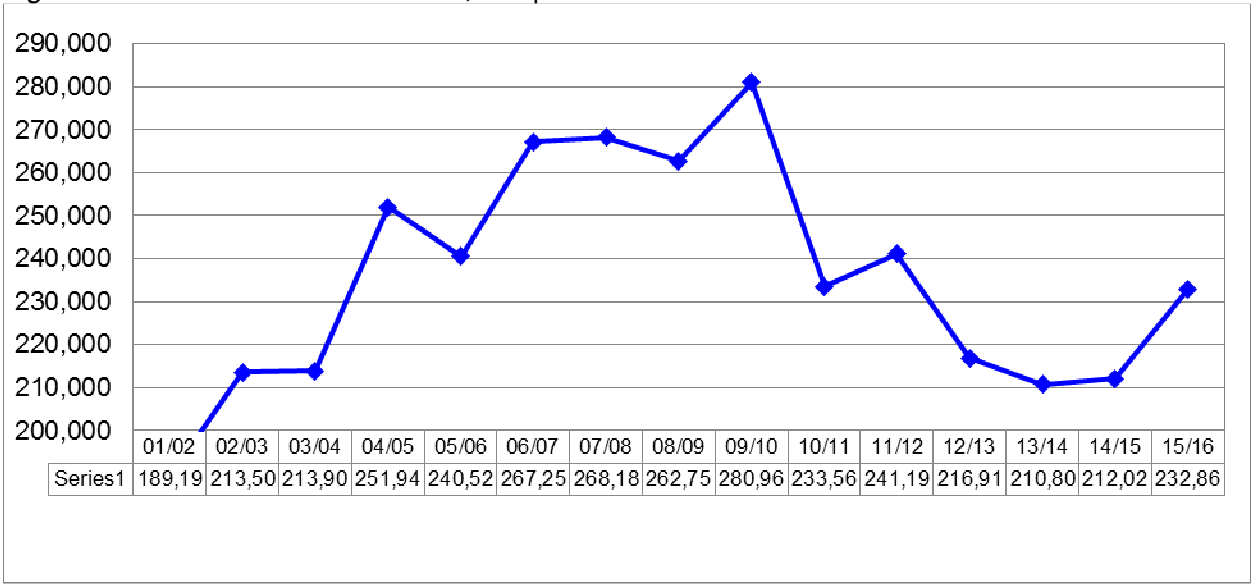


3.4.3 TREND OF OUTPATIENT ATTENDANCE (HOSPITAL AND HEALTH CENTRES)

An overview of outpatient attendance in the last 11 years shows a continuous increase until the FY 2009/10) and a sharp drop in FY 2010/11, a slight rise in attendance in FY 2011/12 and further decline the past two years.

There has however been a sudden increase in total OPD attendance of nearly 10% this FY as shown in the graph below.

Figure 7: Trend of OPD Attendance, Hospital & Health Centres – 2001/02 to 2015/16



	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16
Series1	189,19	213,50	213,90	251,94	240,52	267,25	268,18	262,75	280,96	233,56	241,19	216,91	210,80	212,02	232,86

Table 3: OPD Attendance by category of patients – 2015/16

Outpatient contacts	FY 14-15	FY 15-16	Variance	**Variance %**
Children	63,918	82,669	18,751	29.3%
Mothers	19,981	20,477	496	2.5%
Adults	128,130	129,717	1,587	1.2%
TOTAL	212,029	232,863	20,834	9.8%

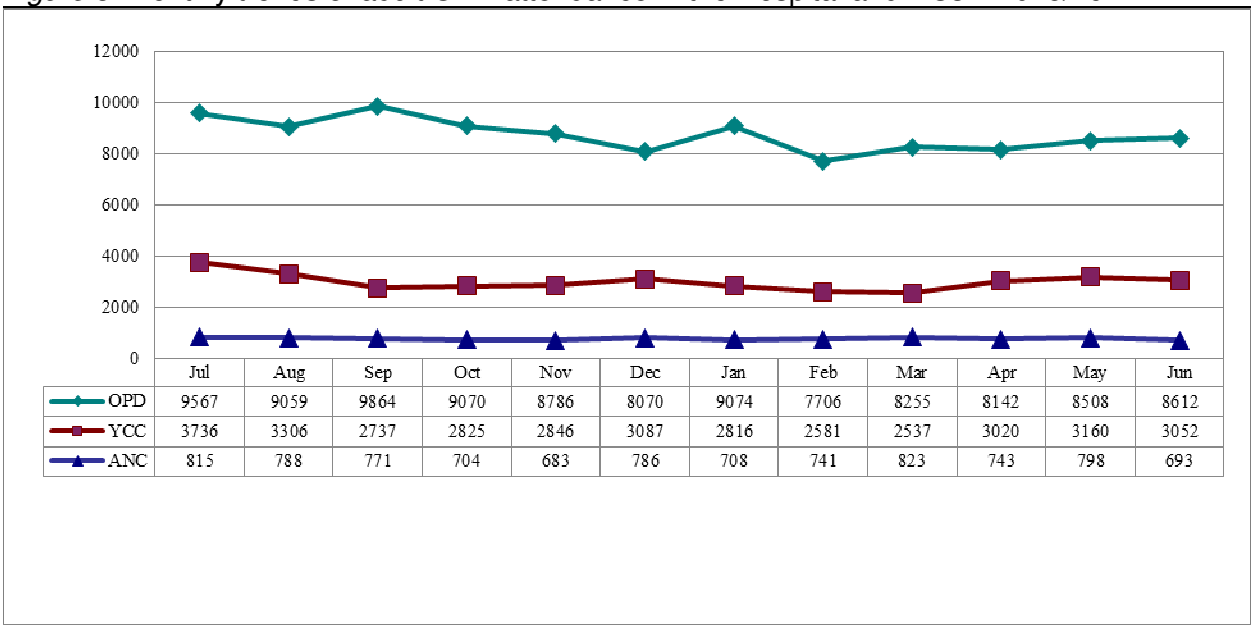
There was an overall increment in OPD contacts by 9,8% this FY. This was due to the increment in children OPD attendance from 63,918 FY 2014/15 to 82,669 this FY.

Table 3: OPD Attendance in Hospital and Health Centres – 2015/16

Total Attendance	FY 14-15	FY 15-16	Variance	**Variance %**
Lacor Hospital	145,568	149,469	3,901	2.7%
Health Centres	66,461	83,394	16,933	25.5%
Total	212,029	232,863	20,834	9.8%

The Hospital recorded a 2.7% increase in OPD attendance while the three Health Centres recorded up to 25.5.7% increment in OPD attendance this FY.

Figure 8: Monthly trends of adult OPD attendance in the Hospital and HCs – 2015/16



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
OPD	9567	9059	9864	9070	8786	8070	9074	7706	8255	8142	8508	8612
YCC	3736	3306	2737	2825	2846	3087	2816	2581	2537	3020	3160	3052
ANC	815	788	771	704	683	786	708	741	823	743	798	693

Children and adults show more uniform number of attendance with a peak in August for the children and a dip in December due to the festive season.

3.4.5 OUTPATIENT ATTENDANCE IN HEALTH CENTRES

The OPD attendance in the Health Centres increased by 25.5% this FY from 66,461 in FY 2014/15 to 83,394 this FY children were the biggest contributors to this increment.

Table 11*: OPD attendance in Health Centres – 2015/16*

Outpatient Attendance	FY 14-15	FY 15-16	Variance	**Variance %**
OPIT				
Children	8,745	12,635	3,890	44.5%
ANC	2,461	2,628	167	6.8%
Adults	7,221	8,252	1,031	14.3%
Total Opit	18,427	23,515	5,088	27.6%
PABO				
Children	12,486	16,853	4,367	35.0%
ANC	4,885	3,325	(1,560)	-31.9%
Adults	6,292	7,084	792	12.6%
Total Pabo	23,663	27,262	3,599	15.2%
AMURU				
Children	11,708	17,478	5,770	49.3%
ANC	4,969	5,471	502	10.1%
Adults	7,694	9,668	1,974	25.7%
Total Amuru	24,371	32,617	8,246	33.8%
TOTAL ALL HCs	66,461	83,394	16,933	25.5%

Two health centers of Amuru and Opit recorded marked increment in the total OPD attendance of 33.8% and 27.6% respectively in the OPD attendance while Pabo recorded a modest 15.5% increment in the OPD.

3.4.6 OUTPATIENT ATTENDANCE IN THE HOSPITAL

The Hospital out-patients services are organized along three lines that reflect, like the Health Centres, the three main groups of patients it serves, i.e. Children, Pregnant Women and all other Adults (both male and female). However in the Hospital bedside the general clinics there are several specialist or condition-specific clinics. Emergency services recorded the highest increment this FY children emergency increasing by 60.7% while adult emergency units recorded 25%increment as shown in the table below.

Table 12*: OPD attendance in the Hospital – 2015/16*

Outpatient Attendance	FY 14-15	FY 15-16	Variance	**Variance %**
Services for Adult Out-patients				
General OPD (incl. Private & staff and >4 seen in YCC, SCD adults)	28,315	32,745	4430	15.6%
Emergency Unit	10,186	12,806	2620	25.7%
AIDS Clinic	34,692	31,081	-3611	-10.4%
TB Clinic	2,567	1,525	-1042	-40.6%
Surgical Clinic	9,810	7,984	-1826	-18.6%
Dental Clinic	6,231	5,396	-835	-13.4%
Total services for adults	91,801	91,537	-264	-0.3%
Services for Children				
General YCC (incl. Dental clinic)	20,896	22,142	1246	6.0%
Emergency	7,221	11,603	4382	60.7%
AIDS children	421	350	-71	-16.9%
TB children	713	309	-404	-56.7%
Sickle Cell Clinic	1,728	1,299	-429	-24.8%
Total services for children	30,979	35,703	4724	15.2%
Obst and Gyn Services				
ANC	7,666	9,053	1387	18.1%
Gyn clinic (incl priv.)	15,122	13,176	-1946	-12.9%
Total Obst&Gyn services	22,788	22,229	-559	-2.5%
TOTAL Hospital Outpatients	145,568	149,469	3901	2.7%
	145,568	149,469	3901	2.7%

3.4.7 DISTRIBUTION BETWEEN GENERAL SERVICES AND SPECIALIST/SPECIFIC SERVICES

While more detailed information about some specialist clinics or dedicated services for specific condition are given below, in 2014/15 the Hospital's outpatient services recorded slightly more patients in their specialist or condition-specific units (88,691) than in the general clinics (56,877). This has shown a 0.2% increment in specialist or condition specific clinics attendance, compared with a 7.0% drop in attendance for general conditions, thus reflecting the increasing complexity of disease conditions presenting here.

3.5 DISEASE BURDEN IN THE HOSPITAL OUTPATIENTS

3.5.1 LEADING CAUSES OF MORBIDITY AMONG ADULT OUTPATIENTS

Malaria, gastrointestinal disorders, urinary tract infections and injuries are the leading causes of consultation among adults attending OPD, followed by cough, Pelvic Inflammatory Diseases (PID) and hypertension. Malaria came back to 1st position after being number 6th position last FY and number 8th in the FY 2013/14.

Table 13*: Leading causes of morbidity among adults attending OPD – 2015/16*

N.	Dioagnosis	Diagnosis Counts	%age
1	Malaria	6,006	9.13
2	Gastro-Intestinal disorders (vomiting, esophagitis, gastritis, enteritis/colitis, rectal and anal conditions, incl. tumors) - non-infective	5,132	7.80
3	Urinary Tract Inf. (UTI) - incl. Pyelonephritis, Cystitits	3,675	5.58
4	Injuries	3,671	5.58
5	No pneumonia - cough or cold (incl. Rinitis, Tonsillitis, Pharingitis, Bronchitis)	3,236	4.92
6	PID	2,701	4.10
7	Hypertension	2,225	3.38
8	Hepatitis	1,564	2.38
9	Anaemia	1,165	1.77
10	Pulpitis	1,059	1.61
11	All others	35,382	53.76

3.5.2 LEADING CAUSES OF MORBIDITY AMONG OUTPATIENT CHILDREN UNDER 5 YEARS

Among children less than 5 years, Malaria has regained its 1st positon followed by respiratory tract infections, diarrhoea, malaria, and pneumonia are now the leading causes of morbidity among the children, accounting for 62% of the major causes of illness treated in the YCC. These are largely preventable through improvement of general living conditions and vaccination of the populace. Community based health care services would probably go a long way in reducing the incidences of these conditions. The recent resurgence of malaria requires an integrated approach.

Table 14*: Leading causes of morbidity in children attending YCC in the hospital – 2015/16*

N.	Diagnosis	Diagnosis Counts	%age
1	Malaria	11,751	27.54
2	Pneumonia	10,878	25.49
3	Diarrhea-Acute (enterocolitis, salmonellosis, enteric fever, paratyphoid fever)	3,651	8.56
4	Bacteremia	2,077	4.87
5	Skin Diseases (incl. warts and cones)	2,010	4.71
6	Anaemia	1,283	3.01
7	Septicemia	1,065	2.50
8	Sickle Cell Disease (SCD) - incl. Painfull crisis	898	2.10
9	Otitis media	816	1.91
10	Urinary Tract Inf. (UTI) - incl. Pyelonephritis, Cystitits	617	1.45
11	All Others	7,625	17.87

3.6 HIV/AIDS CARE SERVICES

The Hospital has a very busy AIDS clinic, which operates daily from Monday to Saturday. Started in 1993, the clinic now offers comprehensive care to HIV infected patients. The package of care includes voluntary counselling and testing (VCT) for HIV, treatment of opportunistic infections, provision of anti-retroviral treatment (ART) with routine clinical, laboratory and community follow up, health education, as well as elimination of mother-to-child transmission (EMTCT) program; Safe male circumcision, and Post exposure prophylaxis. Community follow up is done by Comboni Samaritans – another faith-based NGO experienced in home-based AIDS care. Lacor-Comboni partnership ensures good adherence to antiretroviral therapy and continuity of care. Other interventions for HIV prevention include abstinence and being faithful, and health education at various levels, in collaboration with the district HIV/TB working group.

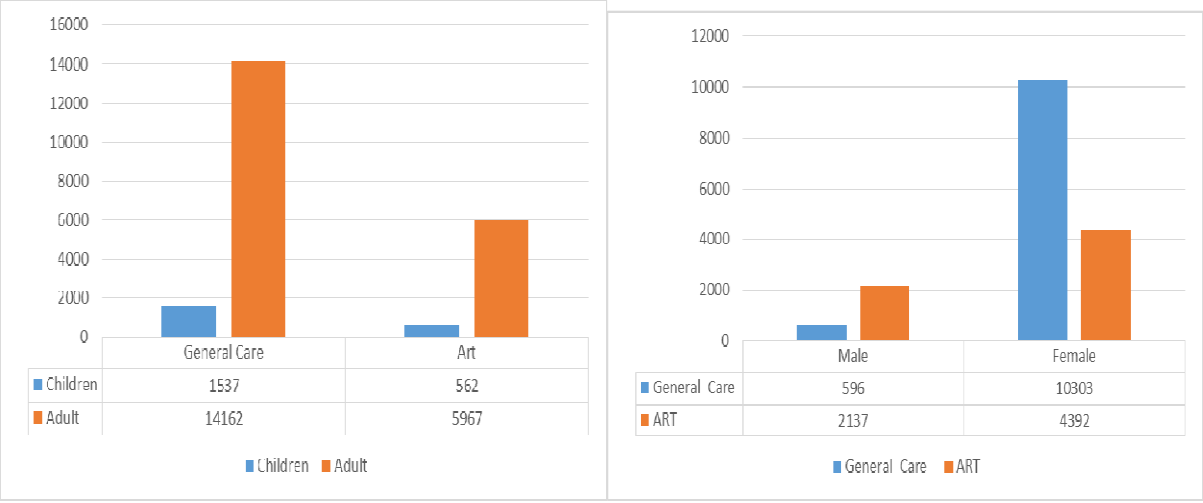
Table 15*: HIV Services – 2014/15*

HIV/AIDS Services	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16
Active patients on HIV care						
Children	946	978	947	1,023	1,467	1537
Adults	9,567	10,338	10,785	11,201	13,459	14162
TOTAL	**10,513**	**11,316**	**11,732**	**12,224**	**14,926**	**15699**
Active patients on ART						
Children	356	378	415	544	510	562
Adults	3,509	3,909	4,504	5,248	5,707	5967
TOTAL on ART	**3,865**	**4,287**	**4,919**	**5,792**	**6,217**	**6529**

There were 15,699 patients active on HIV care in FY 2015/16. Children aged 14 years and below were 1537, while 14,162 were adults. There were 6529 patients active on ART, of which 562 were children under 15 years. About 30% of the services are provided at the health centres. With the update in guidelines requiring all children under 15 years and adults with cd4 under 500 to be initiated on ART, many more clients will be initiated on ART.

Most of the patients receiving ARVs from Lacor are provided free services under AIDS Care and Treatment (ACT) program of Uganda Catholic Medical Bureau, Uganda Episcopal Conference, funded by PEPFAR. The number of patients being treated in the AIDS clinic has continued to increase since the introduction of ARV under the AIDS Relief Program, albeit program funding challenges. On average, a total of 120 patients are treated by the HIV clinic on a daily basis. Lacor Hospital is one of the government-designated 21 national sentinel surveillance sites for monitoring trends of HIV/AIDS epidemic in Uganda. HIV prevalence trends are monitored based on testing all pregnant mothers attending Ante Natal Clinic for the first time.

Figure 9: HIV Services by type of care / age and gender - 2015/16



Most of the clients attending the HIV clinic have been females (68% of those on ART, 66% of the total in care). This has been due to the poor health seeking behaviour of males, who tend to

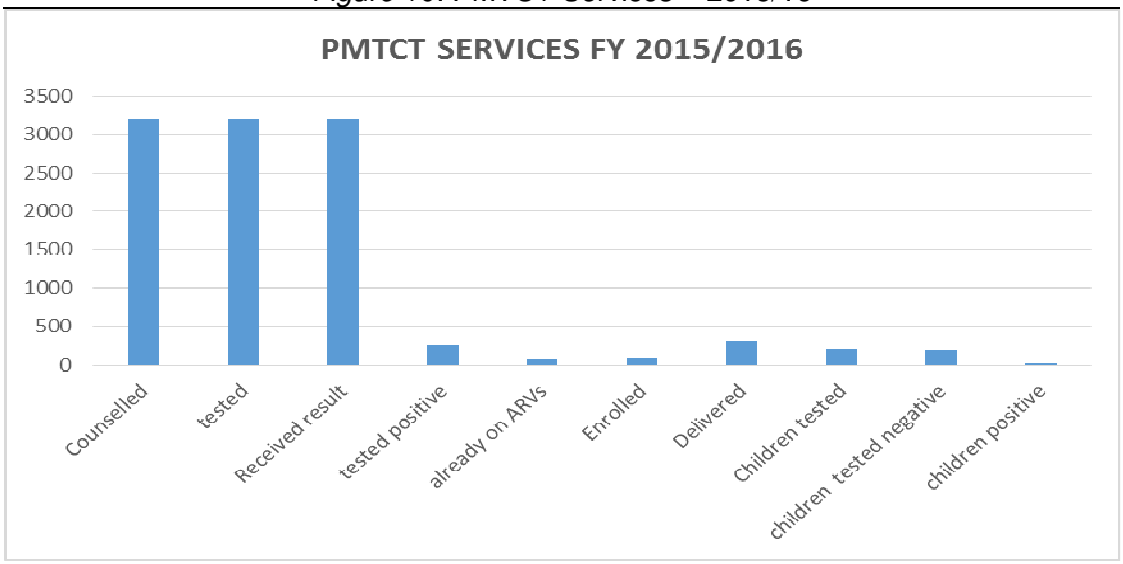
come with advanced HIV disease. This trend has not significantly improved since the opening of the clinic.

Table 16*: PMTCT activities – 2015/16*

PMTCT Activity	2015/16
New ANC cases	3,203
New ANC cases + others pre-test counseled	3,203
Women tested for HIV	3,203
Post-test counselled and received HIV result	3,203
Women tested positive for HIV	263
Partners (of HIV tested women) tested for HIV	1,638
Partners positive for HIV	66
ANC mothers already on ART	169
Enrolled into PMTCT program (received ARVs)	86
HIV positive mothers delivered in the Hospital	312
Children of HIV positive mothers tested for HIV	200
Children of HIV positive mothers who tested HIV negative	191
Children of HIV positive mothers who tested HIV positive	9

Elimination of mother to child transmission of HIV is still a priority. In the Hospital the 263 positive mothers tested positive for HIV were ensured to be on ART for eMTCT (Elimination of Mother to Child Transmission of HIV) for life. Of the 200 infants born, 191 have been tested, and we are proud to report a 4.5% transmission rate, which we hope to bring lower in the coming FY. Lacor Hospital continues providing Option B, to option B **plus,** for eMTCT, where all HIV positive pregnant mothers are to be given antiretroviral therapy, for life.
Lacor is engaging more males in antenatal care, with increasing male partner.

Figure 10: PMTCT Services – 2015/16



The very significant improvement realised in HIV care was the escalation of PMTCT uptake and Early infant diagnosis. Note that 200 of children were tested and 9 tested positive.

Routine counselling and testing is provided at the ANC, and those found positive are linked to the HIV clinic for the PMTCT drugs and lifelong care. Lacor Hospital has in the FY 2011/12 started providing Option B for PMTCT, where all HIV positive pregnant mothers are to be given antiretroviral therapy. Current according to the MOH policy Elimination of Mother to Child Transmission of HIV (eMTCT) services are provided and linked to the ART clinic where the services are provided. We appreciate the government engagement of all health centre III as unit providing Ante retro Viral Therapy (ART)

Cervical cancer screening

Cervical cancer screening was amplified in January 2014, with some equipment, which enabled us to screen 1108 women by visual inspection with acetic acid (VIA), of which 15.7% were HIV positive. The cryotherapy machine has not been very functional, but suspects were investigated appropriately and referred accordingly. All the women also undergo screening for breast cancer.

Table 17*: Cervical cancer screening*

FY 2015/16	VIA	PAP Smear/LEPP	Biopsy	HIV + ve	HIV – ve	Cervical Cancer Suspect	Cryotherapy done
14-49 Years	895	12	33	186	748	485	2
49 Years and	133	0	12	10	191	11	0
TOTAL	**196**	**12**	**45**	**196**	**939**	**496**	**2**

3.7 Inpatient care activities: admissions

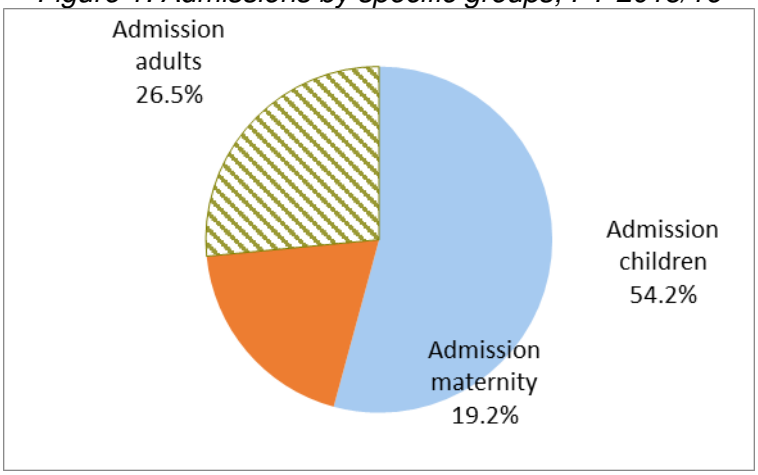
3.7.1 Bed capacity (Hospital and Health Centres)

The main hospital has a bed capacity of 482 beds and there are 24 beds in each of the three Health Centres. The total bed capacity of the Hospital complex is therefore 554.
Patients with severe medical and surgical conditions are admitted and treated as inpatient, both in the Hospital and in the three Peripheral Health Centres.
Patients who require Hospital treatment are referred to the Hospital from the Health Centres through the Hospital ambulance services which is on standby 24 hours a day.

3.7.2 Admissions by specific groups (Hospital and Health Centres)

The total number of admissions in the Hospital and Health Centres was 58,294 this FY, which is 22,273 more patients admitted (61%) increment in admissions from 36,021patients admitted last FY 2014/15, of all these admissions children below 6 years were 31,611 which is more than double the number recorded last FY which was 14,596. Maternity ward admitted 11,220 mothers up from 10,400 recorded last FY and 15,463 were other adults admitted in the various wards of the hospital and the health centers which was also higher than the total number of 11,025 which was admitted the previous FY. Admissions in children wards and maternity ward accounted for over two thirds (73.4%) of all admissions in the Hospital and in the Health Centres.

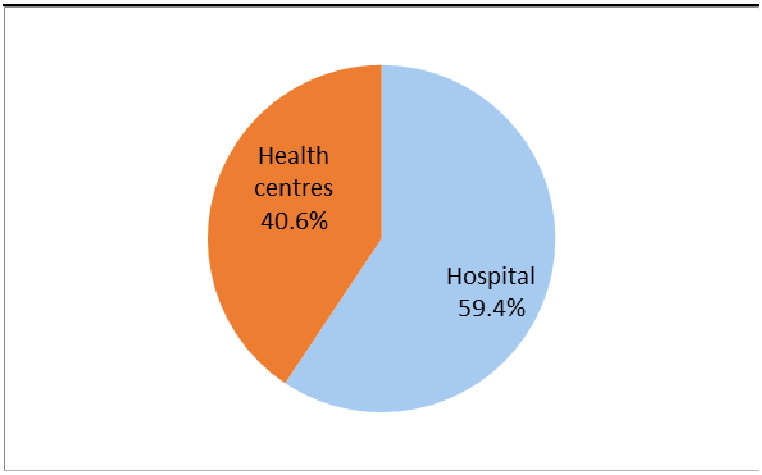
Figure 1: Admissions by specific groups, FY 2015/16



3.7.3 Admissions by location

Out of the 58,294 admitted patients, 34,600 (59.4%) were admitted in the Hospital and 23,694 (40%) in the three Health Centres.

Figure.2: Admissions by location

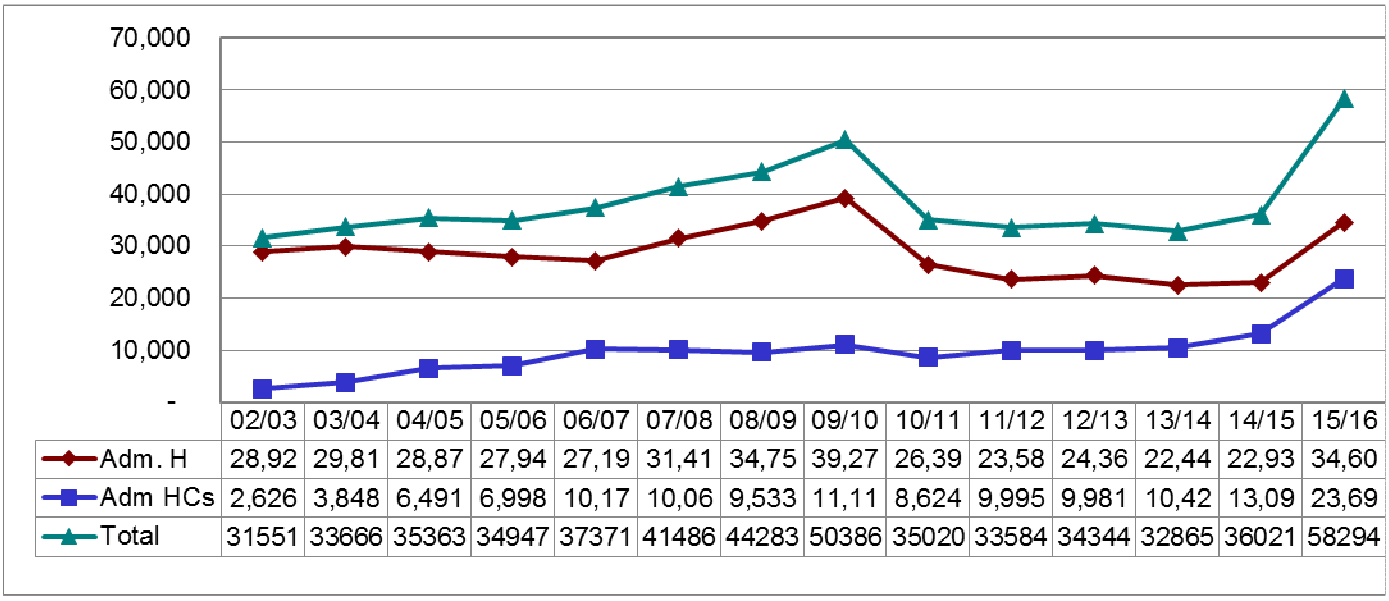


The average number of new patients admitted per day into the hospital wards in FY 2015/16 was more than 200 patients (including the Health Centres), and about 100 admissions for the hospital only, while the average number of patients present in the wards was 472 for the 482 beds in the Hospital.

3.7.4 Trends of Admission to the Hospital & Health Centres

While in FY 2010/11 there was the first significant drop of the number of admissions in 20 years, and a smaller one in FY 2011/12, in this FY 2015/16 there was an exponential increase in the overall number of admission by 61% which is the highest number of admissions ever recorded in the hospital.

Figure 3: Trends of Admission to the Hospital & Health Centres – 2001/02 to 2015/16



	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16
Adm. H	28,92	29,81	28,87	27,94	27,19	31,41	34,75	39,27	26,39	23,58	24,36	22,44	22,93	34,60
Adm HCs	2,626	3,848	6,491	6,998	10,17	10,06	9,533	11,11	8,624	9,995	9,981	10,42	13,09	23,69
Total	31551	33666	35363	34947	37371	41486	44283	50386	35020	33584	34344	32865	36021	58294

Table 18: *Admissions to the Hospital & Health Centres – 2015/16*

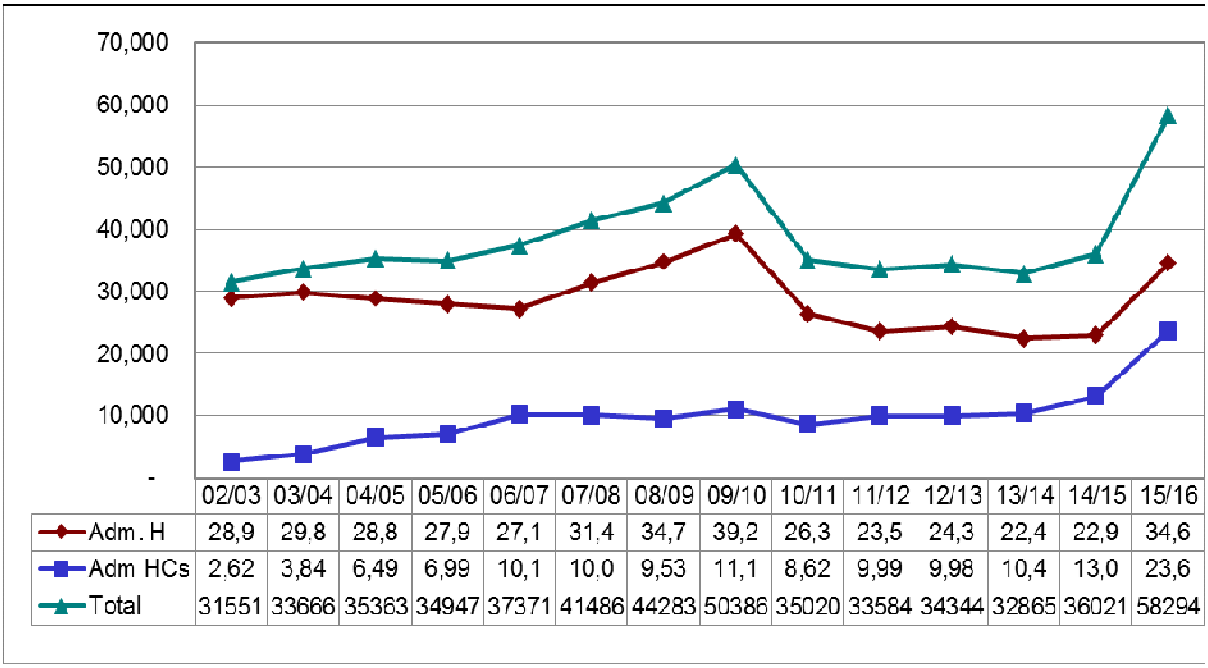
Admissions	FY 14-15	FY 15-16	Variance	**Variance %**
Total admissions children	14,596	31,611	17,015	116.6%
Total admission maternity	10,400	11,220	820	7.9%
Total admissions adults	11,025	15,463	4,438	40.3%
Total	36,021	58,294	22,273	61.8%

The number of children admitted has increased by 116% from last year while the number of admission in both maternity and other adults increased by 7.9% and 40,3% this year. This is possibly due to the ongoing up surge of malaria outbreak since end of the FY 2014/15

3.7.5 Admission to the Health Centres

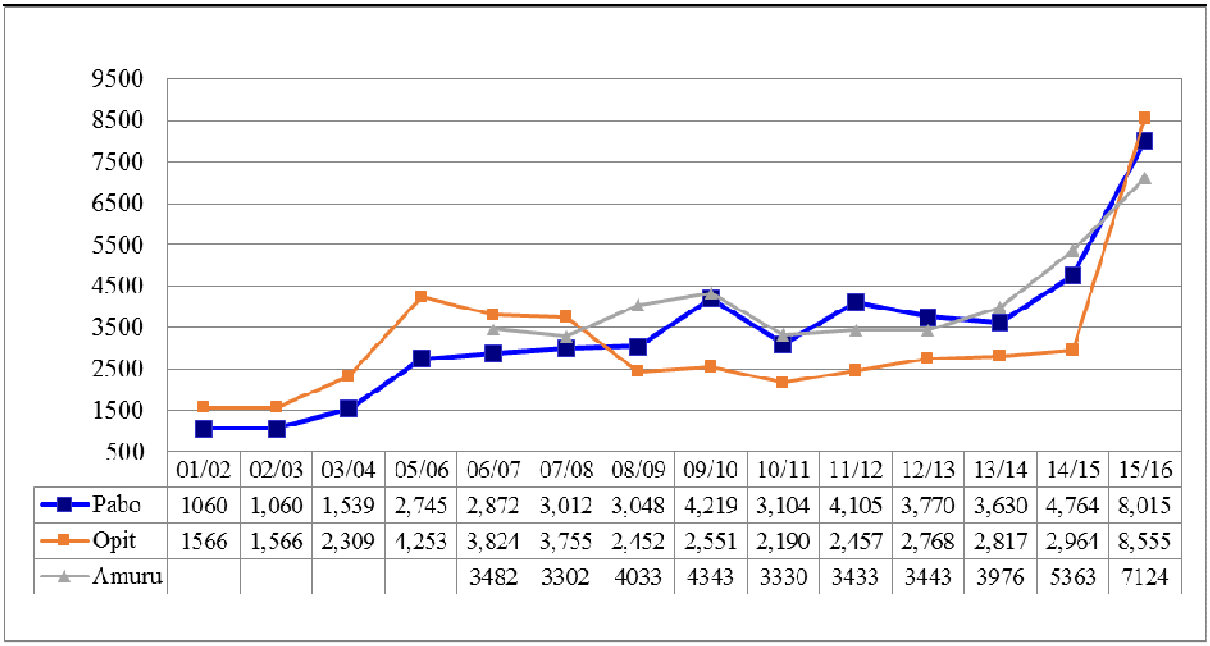
The number of patients in the individual Health Centre changed overtime because of several factors like dismantling of the IDP camp in the vicinity, presence of NGOs providing health services in the area, rehabilitation of District's units. Amuru HC until 2006-2007 was run by the district and then by an international NGO (MSF).

Figure.4: Trend of Admissions in the Hospital and Health Centres, 2001/02 to 2015/16



	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16
Adm. H	28,9	29,8	28,8	27,9	27,1	31,4	34,7	39,2	26,3	23,5	24,3	22,4	22,9	34,6
Adm HCs	2,62	3,84	6,49	6,99	10,1	10,0	9,53	11,1	8,62	9,99	9,98	10,4	13,0	23,6
Total	31551	33666	35363	34947	37371	41486	44283	50386	35020	33584	34344	32865	36021	58294

Figure.5: Trends of admission to the Health Centres - 2001/02 to 2015/16



	01/02	02/03	03/04	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16
Pabo	1060	1,060	1,539	2,745	2,872	3,012	3,048	4,219	3,104	4,105	3,770	3,630	4,764	8,015
Opit	1566	1,566	2,309	1,253	3,821	3,755	2,452	2,551	2,190	2,457	2,768	2,817	2,961	8,555
Amuru					3482	3302	4033	4343	3330	3433	3443	3976	5363	7124

In this FY 2015/16 the admissions in the Health Centres have tremendously increased by 116%, all the three health centres recorded increments. The biggest increment was however recorded at Opit health centre. A possible reason for massive increment could be the outbreak of malaria in the last two years. The hospital has strategically moved to strengthen the Health Centres so that services can be taken nearer to the rural population, improving access to services, but also decongesting the hospital and leaving it for more complex cases.

Table 19: Admission to the Health Centres – 2014/15and 2015/16

Admissions	FY 14/15	FY 15/16	Variance (No)	**Variance (%)**
Amuru	5,363	7,124	1,761	32.8%
Pabo	4,764	8,015	3,251	68.2%
Opit	2,964	8,555	5,591	188.6%
TOTAL	13,091	23,694	10,603	81.0%

3.7.6 Admissions to the Hospital

The Hospital is organised in departments and each department can be comprised of one or more wards. The distribution of beds has not changed since January 2009, when the new neonatal unit was opened, except for the reassignment of the 40 bed Gynaecology ward from Nutrition unit.

Table 20: Departments, Wards and Number of beds in the Hospital – 2015/16

Department/Ward	Beds per Unit/Ward
PAEDIATRIC DEPARTMENT	**112**
1. Nutrition	17
2. General Paediatric.	89
3. Neonatal Unit	6
MEDICAL DEPARTMENT	**134**
1. Medicine	80
2. Medicine Private	4
3. Tb Ward	30
4. Isolation	20
SURGICAL DEPARTMENT	**136**
1. Surgery 1 (Spetic Surgery)	62
2. Surgery 1 Side Room	2
3. Burns Unit	8
4. Surgery 2 (Clean Surgery)	47
5. Surgery 2 Private	5
6. Surgery 2 Private Grade 1	4
7. ICU- Intensive Care Unit	8
OBST&GYN DEPARTMENT	**100**
1. Maternity	54
2. Gynaecology	40
3. Maternity Private	6
Total private beds	**19**
OVERALL TOTAL	**482**

3.7.7 PRIVATE BEDS

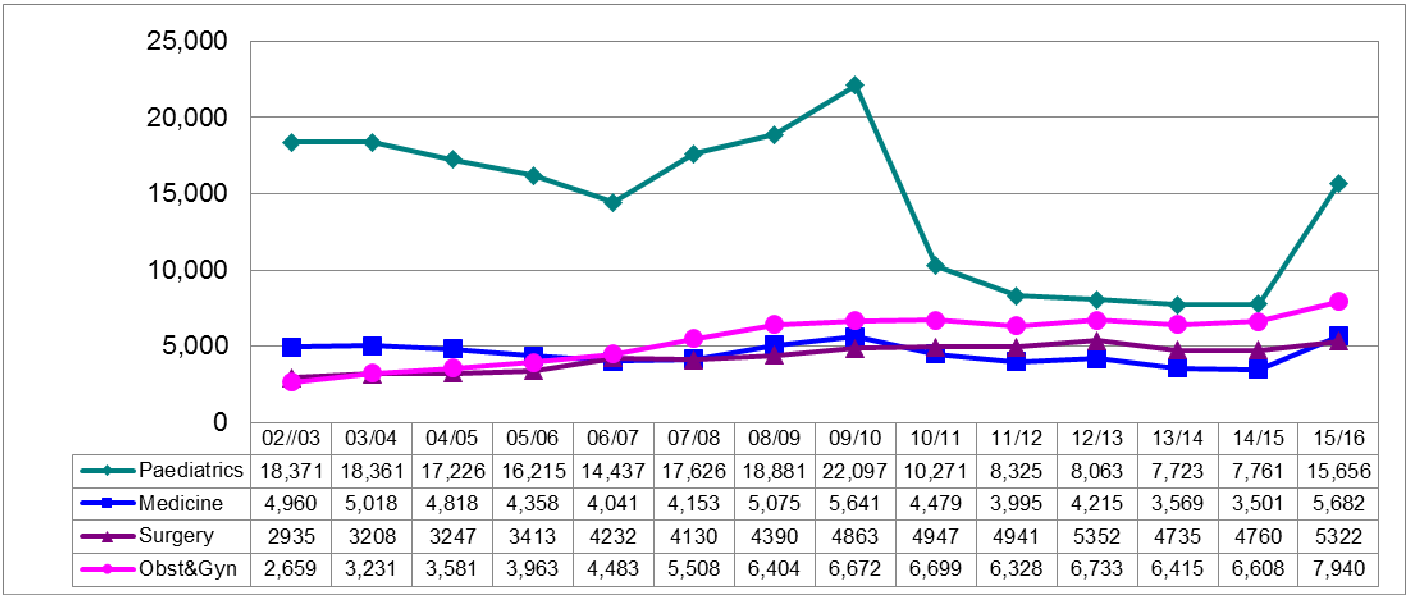
The Hospital has a total of only 19 private beds out of 482. Private rooms have 1 or 2 beds and patients are charged per day and on consumption, while all patients in common room are charged a flat rate of Shs 30,000 everything included, except surgical operations that are charged separately (see below). As already mentioned, children and pregnant women are admitted at a minimal symbolic fee and patients registered with the AIDS clinic pay a flat rate of only Shs 20,000.

Table 21: Admissions by Ward in FY 2014/15 and 2015/16

Admissions	FY 14/15	FY 15/16	Difference	% Variance
Paediatric Department				
Gen Peadiatric and Nutrition	7,358	15,320	7,962	108.2%
Neonatal	403	336	-67	-16.6%
Total Paediatric Dept	7,761	15,656	7895	101.7%
Medical Department				
General Medicine	3,382	5,567	2185	64.6%
Tb	69	66	-3	-4.3%
Isolation	50	49	-1	-2.0%
Total Medical Dept	3,501	5,682	2181	62.3%
Surgical Department				
Surgery 1	1,659	1,800	141	8.5%
Burns	92	74	-18	-19.6%
Surgery 2	2,715	3,056	341	12.6%
ICU	294	392	98	33.3%
Total Surgical Dept	4,760	5,322	562	11.8%
Obsterics and Gynaecology Dept				
Maternity	5,081	5,651	570	11.2%
Gynaecology	1,527	2,289	762	
Total Obst & Gyn	6,608	7,940	1332	20.2%
TOTAL	22,630	34,600	11,970	52.9%

All the major inpatient departments had increments in admissions this FY 2015/16 compared to FY 2014/15, except for TB wards and isolation and Burns wards which recorded some reduction in number of admissions. The highest increment was seen in the medical ward which recorded 64.6% increment in admission this FY. ICU recorded a 33% increment in its admissions, while Burns unit and Isolation wards had reduction in attendance

Figure.6: Trend of admissions to the Hospital by departments – 2002/03 to 2015/16



	02//03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16
Paediatrics	18,371	18,361	17,226	16,215	14,437	17,626	18,881	22,097	10,271	8,325	8,063	7,723	7,761	15,656
Medicine	4,960	5,018	4,818	4,358	4,041	4,153	5,075	5,641	4,479	3,995	4,215	3,569	3,501	5,682
Surgery	2935	3208	3247	3413	4232	4130	4390	4863	4947	4941	5352	4735	4760	5322
Obst&Gyn	2,659	3,231	3,581	3,963	4,483	5,508	6,404	6,672	6,699	6,328	6,733	6,415	6,608	7,940

The above graph shows that the number of children admitted in the paediatric department had the biggest increment from last FY. There was only a marginal increment in total attendance, in both operative departments of Surgery and Obs&Gyn. Medicine ward had more than double in number of admissions. No department recorded any drop in the number of patients admitted to their departments.

3.8 Leading causes of admission to the Hospital

3.8.1 Admission among children

The five leading causes of admission were Malaria, Anaemia and Pneumonia, Diseases and conditions of the new-born, acute Diarrhoea, Anaemias and Septicaemia. Sickle Cell Disease genitourinary diseases follow closely.

Table 22: Leading causes of admission in children (hospital only) in FY 2015/16

N	Diagnosis	Counts	%age
1	Malaria	8,000	51.42
2	Anaemia	1,390	8.93
3	Pneumonia	1,167	7.50
4	Bacteraemia/Blood stream infection/Septicemia/Sepsis (unspecified)	971	6.24
5	Early neonatal sepsis/Neonatal sepsis (0-7 days)	698	4.49
6	Acute Diarrhoea/Acute Watery Diarrhoea (AWD)/Gastroenteritis/Enteritis (unspecified)	503	3.23
7	Premature baby (preterm)	05	1.96
8	Malnutrition severe/Protein Energy Malnutrition type (PEM) - Severe Acute Malnutrition (SAM)	159	1.02
9	Abscess/Cellulitis/soft tissue infection (site unspecified)	156	1.00
10	Burns	153	0.98
11	All Others	2057	13.22
	Total Diagnoses	15,559	100

3.8.2 Admission among adults

Pregnancy and delivery are still the most common causes of admission this is followed by complications of pregnancy. The third commonest cause of admissions is malaria, followed by Anaemia, gastrointestinal disorders, benign neoplasms, anaemias, and injuries.

The commonest causes of injuries were road traffic accidents, which have become more common due to the increased number of vehicles and motorcycle taxis locally referred to as 'boda-boda' as well as the road reconstruction works on the Gulu-Nimule road.

HIV/AIDS cases are being diagnosed more easily due to the liberal testing policy of routine testing and counselling being encouraged, and the many outreaches with testing done in collaboration with other community based organisations. CD4 cut-off for initiation was raised to 500, ensuring a more healthy HIV positive population.

Snake bite was a particular problem this FY, possibly due to people returning going to previously uninhabited places in the villages.

Table 23: Leading causes of Admissions in Adults (hospital only) in FY 2015/16

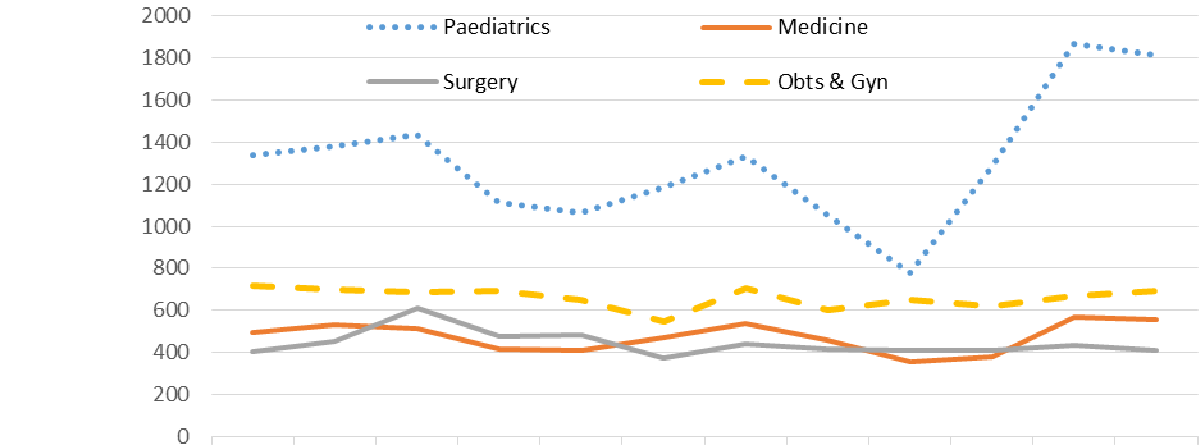
N	Diagnosis	Counts	%age
1	Malaria(incl. Malaria in Pregnancy)	3,822	19.57
2	Active labour (incl. Deliveries)	3,087	15.80
3	Pregnancy related Complications(Latent/prolonged/obstructed labour/poor progress (all causes)	2,368	12.12
4	Injuries	1,002	5.13
5	Anemia	998	5.11
6	Bacteraemia/Blood stream infection/Septicaemia/Sepsis (unspecified)	423	2.17
7	Abscess/Cellulitis/soft tissue infection (site unspecified)	367	1.88
8	Painful crisis/crisis in SCD	266	1.36
9	Bronchopneumonia/Pneumonia/Lobar pneumonia	251	1.28
10	Sickle Cell Disease (SCD) new/known case	179	0.92
11	All Others	6,771	34.66
	Total Diagnosis	**19,534**	**100**

3.8.3 Monthly rates of admission

Since FY 2014/15 Northern Uganda experienced a new outbreak of malaria, starting in April 2015. This led to a significant rise in admission, especially of children

On average, the rate of monthly admission to the Hospital is over 1,200 children and 500 adults a month. This is a total of 63 admissions in the Hospital on a daily basis, 34% of them being in the children wards, and 30% being in the Obstetrics and Gynaecology wards.

Figure.7: Monthly rates of admission to the Hospital by wards – 2015/16



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Paediatrics	1336	1380	1436	1116	1066	1189	1335	1050	781	1283	1870	1814
Medicine	492	531	511	415	412	473	536	456	353	381	568	554
Surgery	405	451	611	478	485	374	440	416	408	408	434	412
Obts & Gyn	719	702	684	695	651	548	707	600	650	620	669	695

3.8.4 Hospital Average Length of Stay (ALOS) and Bed Occupancy Rate (BOR)

The hospital length of stay in FY 2015/16 dropped to 5.0 from 6.70 days the previous FY. This Improvements could be attributed in part to increased cases of malaria which takes shorter time to treat, and more complex cases managed.

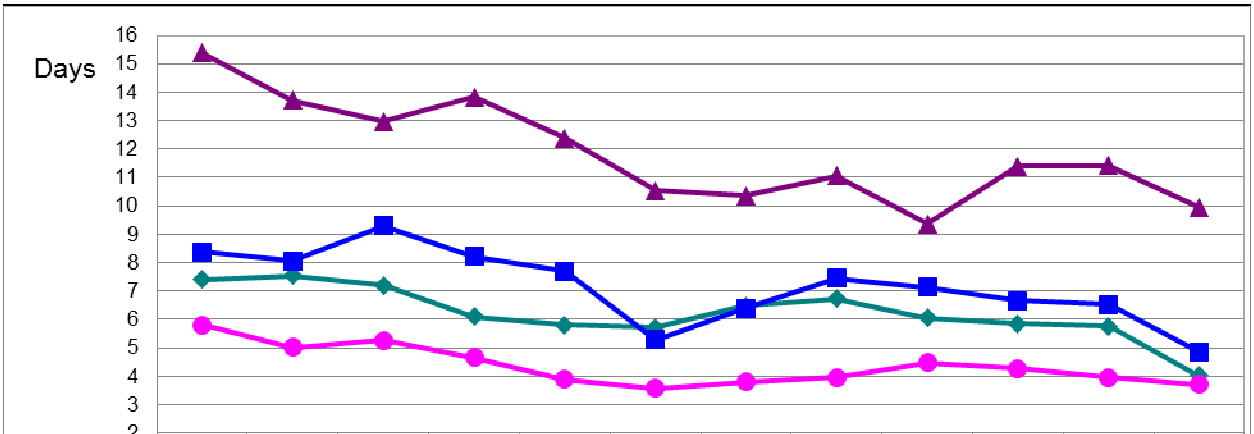
Hospital ALOS and BOR by ward – 2015/16

Table 24: Leading causes of Admissions in Adults

Department	Bed Capacity	Admissions	Bed State	ALOS	BOR
Peadiatrics	112	15,656	63005	4.02	154.12%
Medicine	134	5,682	27547	4.85	56.32%
Surgery	136	5,322	52913	9.94	106.59%
Obst&Gyn	100	7,940	29369	3.70	80.46%
Total/Average	482	34,600	172834	5.00	98.24%

The average length of stay varied by ward, with maternity and gynaecology wards having the lowest ALOS of 3.70 days, Surgery still has the highest ALOS of 9.94% but is lower than last FY which was 11.4%.The variations in ALOS correspond to the different case mixes treated in the various wards. Trauma and conditions requiring operations treated in the surgical wards take longer to recuperate, while the cases treated in the maternity ward, like normal deliveries, tend to recover faster.

Figure.8: Variations in department specific inpatient ALOS – 2003/04 to 2015/16



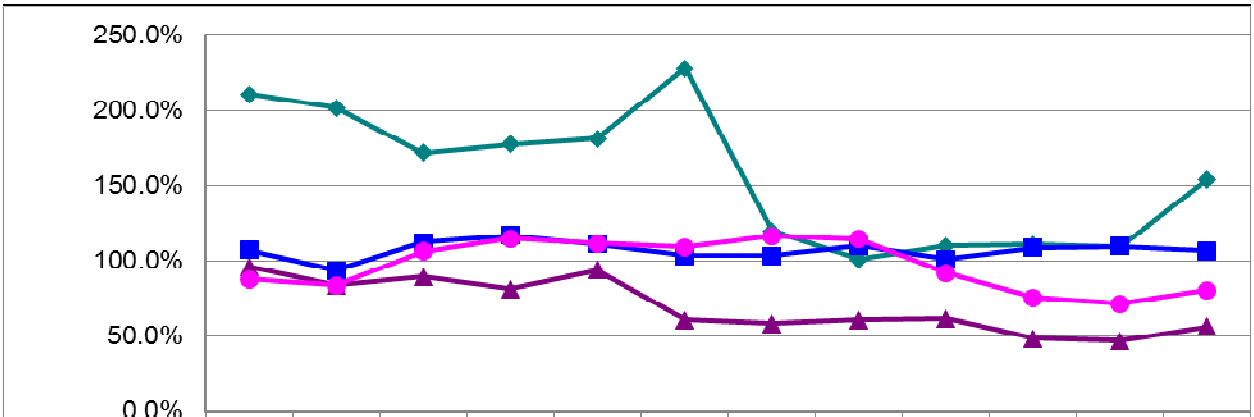
	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16
Paed	7.41	7.53	7.21	6.09	5.81	5.71	6.47	6.73	6.06	5.86	5.77	4.02
Med	8.37	8.06	9.29	8.22	7.69	5.28	6.38	7.44	7.13	6.65	6.52	4.85
Surg	15	14	13	14	12	11	10	11	9	11	11	9.94
O&G	5.81	5.01	5.27	4.65	3.88	3.58	3.81	3.96	4.48	4.28	3.96	3.70

The average length of stay in each ward over the last ten years has shown downward trends until three years ago, when they started to increase, although with a downturn in the last year, except Surgery, which depends on the complexity of cases and operations performed.

BED OCCUPANCY RATES (BOR)

The next Figure shows the Bed Occupancy Rate (BOR) in the last 11 years. The highest BOR for the whole Hospital (131.4%) was reached in FY 2009/10. In FY 2012/13 the BOR was at its lowest with 85.5% for the whole Hospital. This FY 2015/16 the BOR was at 97.9% for the whole hospital. This figure is the result of very different level of occupancy in the different departments. Paediatrics has the highest BOR of 153.7% while Medicine, for example, is as low as 56%, but this is because of the very low occupancy rate in Isolation ward (4.97 %) and in TB wards (19.61%).

Figure.9: Variations in department specific BOR – 2002/03 to 2015/16

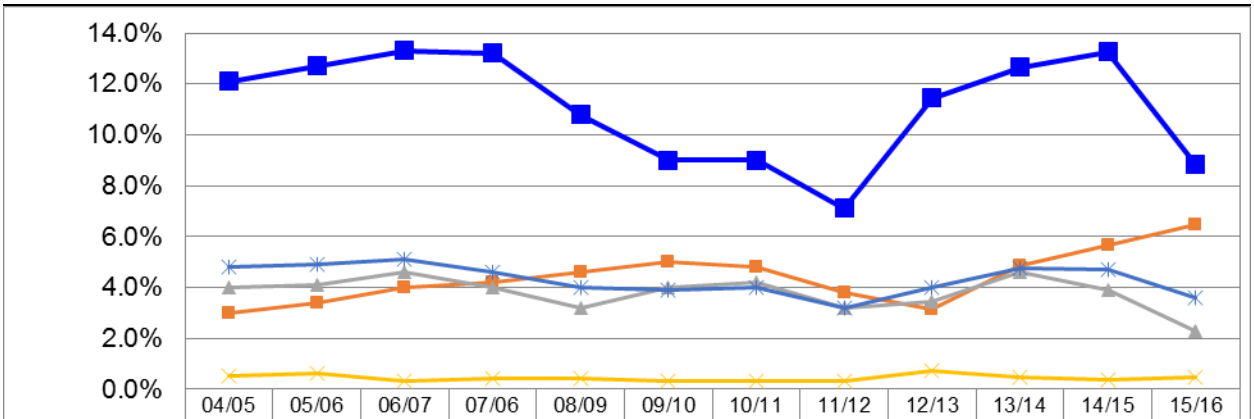


	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16
Paed	210.6%	201.6%	171.7%	177.3%	181.2%	227.6%	119.8%	100.7%	109.7%	110.7%	109.5%	154.1%
Med	96.0%	83.7%	89.4%	81.4%	93.9%	60.9%	58.4%	60.6%	61.4%	48.5%	46.7%	56.3%
Surg	107%	94%	112%	117%	111%	103%	103%	110%	101%	109%	109%	107%
Obst&Gyn	87.7%	83.7%	106.0%	114.9%	111.7%	109.2%	116.5%	114.2%	91.8%	75.3%	71.6%	80.5%

3.9 Inpatient Mortality Rate in the Hospital

The total number of deaths in the Hospital in FY 2015/16 was 1059. After the dip in FY 2011/12, the mortality rate this year (3.6%) was the lowest in the last 10 years. Higher mortality seen in the medical wards is largely attributed to HIV, and its association with TB. Many such patients present at terminal stages of their illness. The neonatal unit which receives very delicate premature babies had 34.7% mortality and the Intensive Care Unit, which received patients for critical care, had mortality of 33.1%.

Figure.10: Variations in department specific Mortality – 2015/16



	04/05	05/06	06/07	07/06	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16
Med	12.1%	12.7%	13.3%	13.2%	10.8%	9.0%	9.0%	7.1%	11.4%	12.7%	13.3%	8.8%
Surg	3.0%	3.4%	4.0%	4.2%	4.6%	5.0%	4.8%	3.8%	3.2%	4.9%	5.7%	6.5%
Paed	0	0	0	0	0	0	0	0	0	0	0	2.3%
Mat	0.5%	0.6%	0.3%	0.4%	0.4%	0.3%	0.3%	0.3%	0.7%	0.5%	0.3%	0.5%
Hospital	4.8%	4.9%	5.1%	4.6%	4.0%	3.9%	4.0%	3.2%	4.0%	4.8%	4.7%	3.6%

3.9.1 Leading causes of death in children admitted to the Hospital

Like in the previous FY 2014/15, neonatal conditions, especially neonatal septicaemia and prematurity related conditions, was the major cause of death among children. This is followed by malaria, anaemia, pneumonia and birth asphyxia and burns. Other leading causes of death include septicaemia, and meningitis. Death from anaemias is worsened by routine lack of blood for transfusion, and the outbreak of malaria stretched this limited resource severely this year.

Table 25: Leading causes of death in children FY2015/16

No	Diagnosis(Multiple Diagnosis allowed)	No of Deaths	%age
1	Premature baby (preterm)	83	19.12
2	Malaria	63	14.52
3	Anemia	47	10.83
4	Pneumonia	34	7.83
5	Birth Asphyxia/apnoea of the newborn	29	6.68
6	Burns due to RTA and other causes	31	7.14
7	Early neonatal sepsis/Neonatal sepsis (0-7 days)	30	6.91
8	Bacteraemia/Blood stream infection/Septicaemia/Sepsis (unspecified)	13	3.00
9	Gastroschisis (congenital)	12	2.76
10	Acute Diarrhoea/Acute Watery Diarrhoea (AWD)/Gastroenteritis/Enteritis (unspecified)	9	2.07
11	All Others	83	19.12
	Grand Total	434	100

3.9.2 Case fatality rates for leading causes of death in children admitted to Hospital

In this FY 2015/16, the highest case fatality rates was due to congenital abnormality called Gastrischesisi with a Case fatality rate of 70.59%. This was followed by birth asphyxia wit 27.88 case fatality rates. Respiratory distress syndrome, especially coupled by prematurity had 27.21% case fatality rate. Others included burns, severe malnutrition, meningitis, and sepsis. Malaria had the lowest case fatality rate of 0.9% a reduction from 1.3% case fatality rate recorded last FY.

Table 26: Case fatality rates for leading causes of death in children

N.	Diagnosis (multiple diagnoses allowed)	No of deaths	Number admitted	Fatality rates
1	Gastroschisis (congenital)	17	12	70.59
2	Birth Asphyxia/apnoea of the newborn	104	29	27.88
3	Premature baby (preterm)	305	83	27.21
4	Burns due to RTA and other causes	153	31	20.26
5	Early neonatal sepsis/Neonatal sepsis (0-7 days)	698	30	4.30
6	Anemia	1,390	47	3.38
7	Pneumonia	1,167	34	2.91
8	Acute Diarrhoea/Acute Watery Diarrhoea (AWD)/Gastroenteritis/Enteritis (unspecified)	503	9	1.79
9	Bacteraemia/Blood stream infection/Septicaemia/Sepsis (unspecified)	971	13	1.34
10	Malaria	8,000	63	0.79

3.9.3 Leading causes of death in adults admitted to the Hospital

Injuries were the leading cause of deaths among adults this FY. This was followed by Malaria, anaemia and pneumonia. Cardiovascular conditions especially hearth failure were the 5 leading cause of deaths among adults. Liver related deaths were among the top 10 leading causes of death. Others include cancers, meningitis, stroke, and HIV/AIDS related conditions. Cancers are particularly problematic because treatment options for many cancers are limited. Liver cirrhosis, hepatitis and injuries are some causes of death among adults that deserve special mention, because more could be done in the community to prevent deaths from them.

Table 27*: Most frequent causes of death in adults, FY 2015/16(multi-diagnoses allowed)*

No	Diagnosis (Multiple Diagnosis allowed)	No of Deaths	%age
1	Injuries	84	10.40
2	Malaria	56	6.93
3	Anemia	55	6.81
4	Pneumonia	40	4.95
5	Heart Failure/Congestive Heart Failure (CHF)/Congestive Cardiac Failure (CCF)/Congestive Cardiomyopathy (CCM)	36	4.46
6	Bacteraemia/Septicemia	32	3.96
7	Bacterial/pyogenic Meningitis	19	2.35
8	Abscess/Cellulitis/soft tissue infection (site unspecified)	16	1.98
9	Liver cirrhosis (also decompensated)	16	1.98
10	Partial Intestinal Obstruction	15	1.86
11	All others	439	54.33
	Grand Total	**808**	**100**

3.9.4 Case fatality rates for leading causes of death in adults admitted to the Hospital

This FY bacterial meningitis had the highest case fatality among adults with 27.9% fatality rates. Heart failure as well as liver conditions also have high case fatality. HIV associated conditions, meningitis, among others.

Table 28: Case fatality rates for leading causes of death in adults admitted to the Hospital – 2015/16

N.	Diagnosis (multiple diagnoses allowed)	No of deaths	Number admitted	Case fatality ratio
1	Bacterial/pyogenic Meningitis	68	19	27.94
2	Heart Failure/Congestive Heart Failure (CHF)/Congestive Cardiac Failure (CCF)/Congestive Cardiomyopathy (CCM)	144	36	25.00
3	Liver cirrhosis (also decompensated)	89	16	17.98
4	Pneumonia	251	40	15.94
5	Partial Intestinal Obstruction	97	15	15.46
6	Injuries	1002	84	8.38
7	Bacteremia/Septicemia	423	32	7.57
8	Anemia	998	55	5.51
9	Abscess/Cellulitis/soft tissue infection (site unspecified)	367	16	4.36
10	Malaria	3822	56	1.47

Those dying from meningitis, pneumonia and TB may as well have underlying HIV infections though not all of them are usually documented, due to multiple diagnoses. It is important to note that only the major causes of morbidity and mortality were considered in this analysis, hence it is not the absolute rank of case fatality rates.

9.5 Summary of Hospital Mortality by Ward

Table 29: Summary of Hospital mortality by Ward – 2004/05 to 2015/16

	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Medicine ward (General Med, TB & Isolation)											
Admissions	4,358	4041	4,153	5,075	5,641	4,479	3,995	4,215	3,569	3,501	5,682
Total deaths	556	537	548	550	502	403	283	482	452	464	501
Mortality rate	12.76%	0	13.20%	10.84%	8.90%	9.00%	7.08%	11.44%	12.66%	13.25%	8.82%
Paediatric ward (Children ward, Nutrition & Neronatal)											
Admissions	16,215	14437	17,626	18,881	22,097	10,271	8,325	8,063	7,723	7,761	15,656
Total deaths	665	664	719	619	792	432	267	277	354	302	359
Mortality rate	4.10%	0	4.08%	3.28%	3.58%	4.21%	3.21%	3.44%	4.58%	3.89%	2.29%
Surgical ward (Surgery I, II & ICU)											
Admissions	3,413	4232	4,130	4,390	4,863	4,947	4,941	5,352	4,735	4,760	5,322
Total deaths	117	172	177	205	221	238	188	169	230	270	345
Mortality rate	3.43%	0	4.29%	4.67%	4.54%	4.81%	3.80%	3.16%	4.86%	5.67%	6.48%
Maternity ward (Obstetric & Gynaecology)											
Admissions	3,963	4483	5,508	6,404	6,672	6,699	6,328	6,733	6,415	6,608	7,940
Total deaths	25	12	24	32	21	22	17	47	31	23	38
Mortality rate	0.63%	0	0.44%	0.50%	0.31%	0.33%	0.27%	0.70%	0.48%	0.35%	0.48%
All wards											
Admissions	27,949	27193	31,417	34,750	39,273	26,396	23,589	24,363	22,442	22,630	34,600
Total deaths	1,363	1384	1,468	1,406	1,536	1,095	755	975	1067	1059	1243
Mortality rate	4.88%	0	4.67%	4.05%	3.91%	4.15%	3.20%	4.00%	4.75%	4.68%	3.59%

3.9.6 Summary of Hospital inpatient statistics

Table 30: Summary of hospital inpatient statistics/activities, FY 2015/16

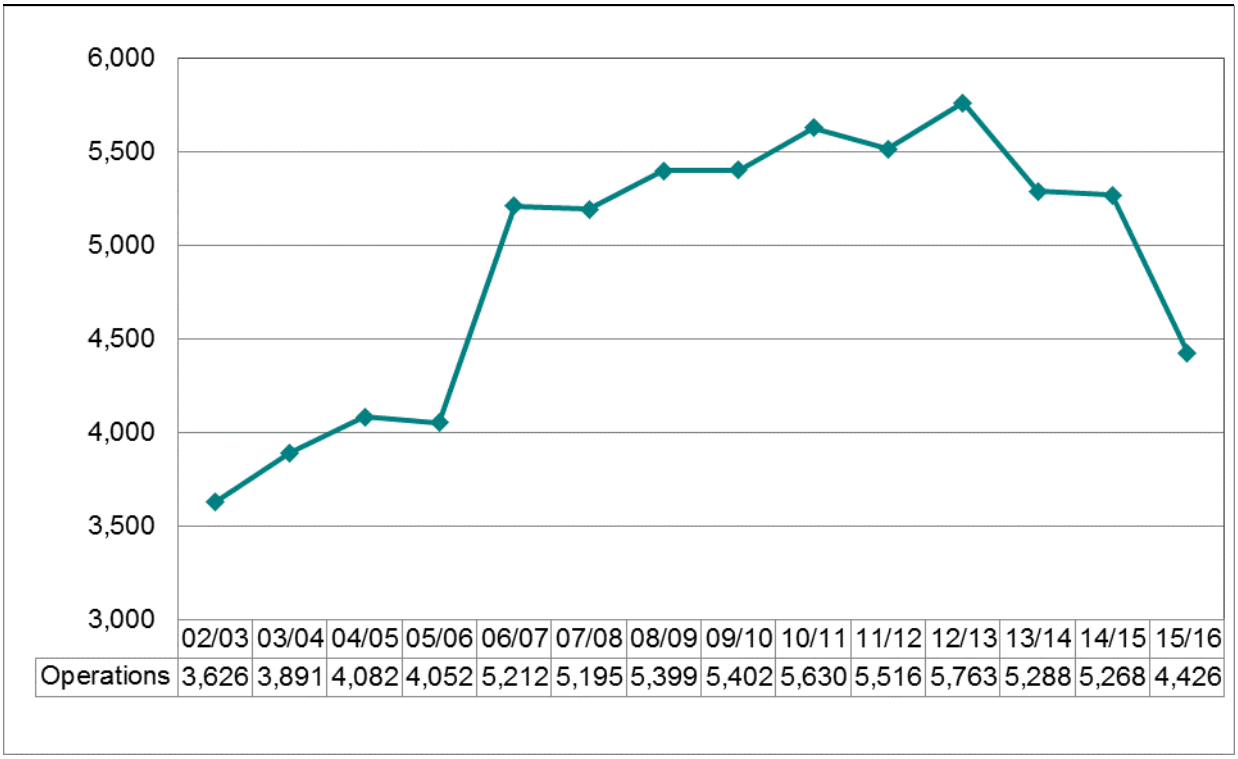
Ward	Medicine	Paediatrics	Obst & Gyn	Surgery	Total / average
Number of beds	134	122	90	136	**482**
Admissions	5,682	15,656	7940	5,322	**34,600**
Bed days	27,547	63,005	29369	52,913	**172,834**
Occupancy rate	56.32%	141.49%	1	106.59%	**98.24%**
Average length of stay	4.85	4.02	4	9.94	**5.00**
Number of deaths	501	359	38	345	**1,243**
Death rate	8.82%	2.29%	0.48%	6.48%	**3.59%**

OTHER CLINICAL ACTIVITIES AND CLINICAL SERVICES

3.10.1 Surgical Operations

The theatres operate every day for emergency surgical procedures and from Mondays to Fridays for elective cases. There are six operating theatres which open on a 24 hour basis.
The major operations include general surgery, orthopaedic surgery, and obstetric and gynaecological procedures. The volume of major surgical operations has been decreasing since FY 2012/13 when it was at 5,900 to this FY when it has dropped to 4,426 major operations being carried out in one year. There were 5,268 major operations performed in the FY 2014/15, down from a peak of 5763 in FY 2012/13, of which many were emergency operations. This decrease in the trend of operations however excludes the many minor procedures done in minor theatres and side rooms of the surgical and gynaecology/obstetric wards.

Figure.11: Trend of major surgical operations – 2001/02 to 2015/16



	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16
Operations	3,626	3,891	4,082	4,052	5,212	5,195	5,399	5,402	5,630	5,516	5,763	5,288	5,268	4,426

In addition to the 4,426 major operations, there were a total of 1,250 POPs performed in the hospital, not to mention the many other minor procedures.

3.10.2 Maternity services

The three health Centres provide basic emergency obstetric care, while the hospital provides all the comprehensive emergency obstetric care. Antenatal care is provided at the three health Centres and the hospital on a daily basis with the exception of weekends.

3.10.2.1 ANTENATAL care

The total number of antenatal visits increased in the Hospital and in Opit and Amuru Health Centres from 19,981 last year to 20,477 this FY. There was a 31.9% reduction in the ANC attendance at Pabo health centre this year. Both Pabo and Amuru health centres recorded increments in this FY 2015/16.

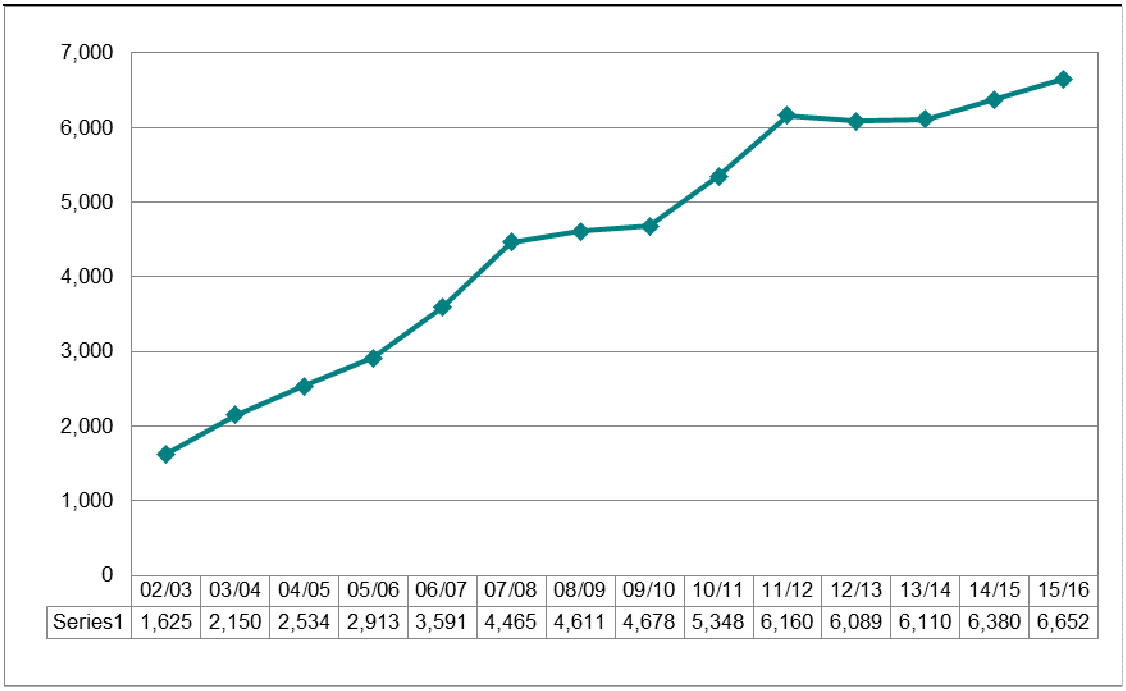
Table 31: Antenatal care in the Hospital and Health units in FY 2013/14 and 2015/16

ANC	2014/15	2015/16	Difference	% Variance
Hospital	7,666	9,053	1387	18.1%
Amuru	4,969	5,471	502	10.1%
Opit	2,461	2,628	167	6.8%
Pabo	4,885	3,325	-1560	-31.9%
Total	**19,981**	**20,477**	**496**	**2.5%**

3.10.2.2 DELIVERIES in the Hospital and Health Centres

The number of assisted deliveries in the Hospital and the Health Centres has been increasing steadily over the time as shown in the graph below.

Figure.12: Trend of assisted deliveries – 2001/02 to 2015/16



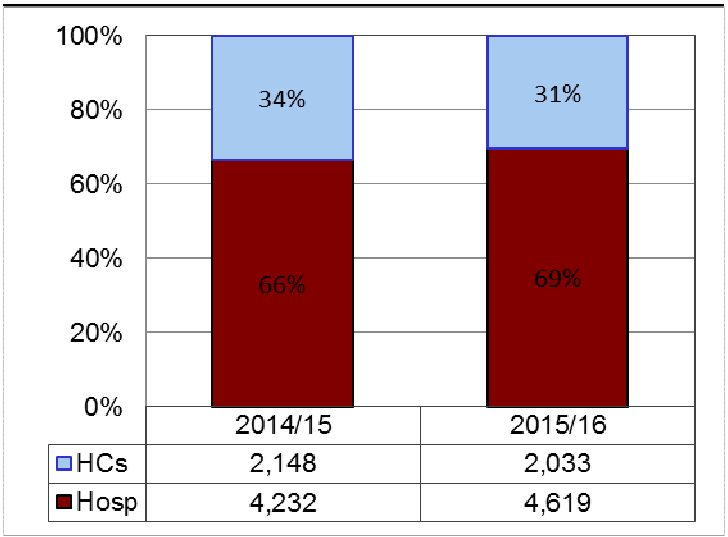
This FY there has been further increment from 6,380 in FY 2014/15 to 6,652 this FY 2015/16. We know that probably there are now more rehabilitated peripheral health units which can cater for delivering mothers near their home and there is improved health seeking behaviours among women in the sub-region in general.

Table 32: Distribution of assisted deliveries by location in 2014/15 and 2015/16

Deliveries	2014/15	2015/16	Difference	% Variance
Hospital	4,232	4,619	387	9.1%
Health Centres				
Amuru	967	934	-33	-3.4%
Opit	561	563	2	0.4%
Pabo	620	536	-84	-13.5%
Total Health Centres	2,148	2,033	-115	-5.4%
Total	6,380	6,652	272	4.3%

30% of all the deliveries this FY took place in the three Health Centres, this is lower than last FY when 34% of all the deliveries were in the health centers. There is therefore a continued decentralisation of this type of service, as far as Lacor Hospital is concerned, but, as already mentioned it probably just means that the patients find assistance just nearer home and must no more travel to Lacor's Health Centre.

Figure.13: Deliveries in the Hospital and in the Health Centres – 2015/16



3.10.2.3 Maternal mortality ratio, still birth ratio and Caesarean section rate

The new National Health policy and the Health Sector Strategic and Investment Plans both prioritise the reduction of maternal mortality and perinatal mortality. The National Maternal mortality ratio is at 438 per 100,000 live births[1]. The next table and figure present the trends of maternity services in Lacor Hospital.

[1] MINISTRY OF HEALTH, Annual Health Sector Performance Report, Financial Year 2013 / 2014

Table 33: Summary of Maternity services, FY 2007/8 to 2015/16

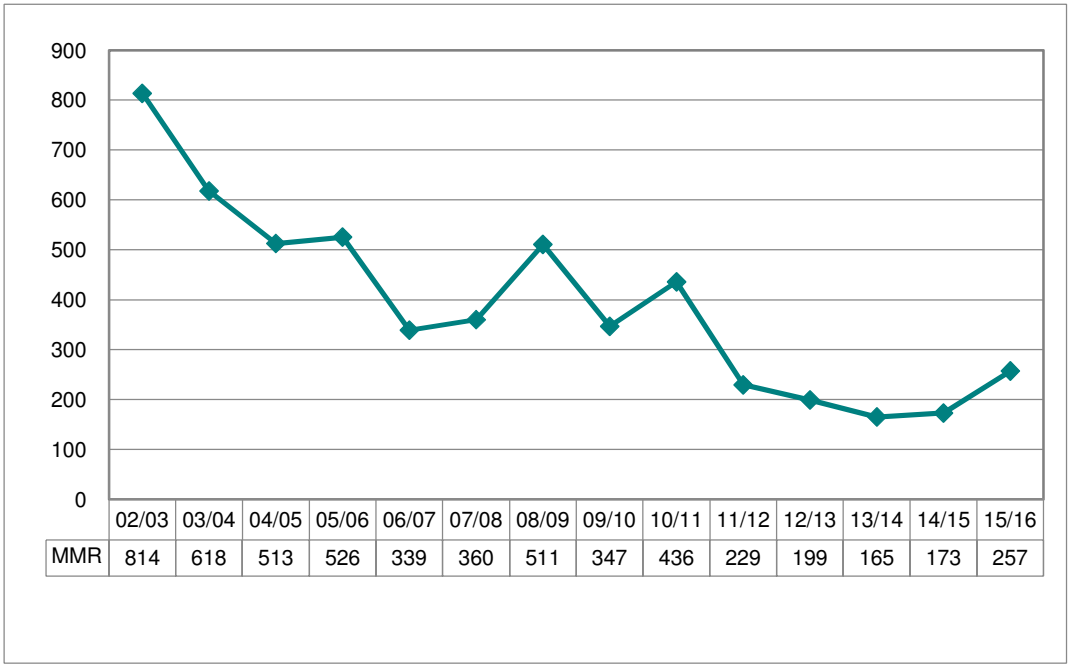
Services	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Total deliveries	4611	4,678	5,343	6,160	6,089	6,110	6,380	6,652
Deliveries in HCs	1178	1,291	1,784	2,412	2,178	2,195	2,148	2,033
N. C/Sections	772	640	713	787	886	1,003	1,105	1,253
C/Section rates	0	13.7%	13.3%	12.8%	14.6%	16.4%	17.3%	18.8%
N. Maternal deaths	23	16	23	14	12	10	11	17
Maternal Mortality Rate (:100,000)	511	346.5	435.9	229.5	199.1	165.6	173.0	257.3
N. live births	4502	4,617	5,276	6,101	6,027	6,038	6,357	6,607
N. still births	167	161	172	110	130	173	163	154
Still birth rate (:1000)	37	34.9	32.6	18.0	21.6	28.7	25.6	23.3

The Hospital maternal mortality rate has been declining in the past years from 513/100,000 live births in 2004/05 to 339/100,000 live births in FY 2006/07 but there has been an increase in the MMR in 2008/09. This year, FY 2015/16 the MMR went up to 257.3/100,000 LB.

The recent increase in hospital MMR is attributed to many referrals from other health facilities being done late when the mothers are in dying stages. We encourage all Government heath units and NGO run heath units to allow patients to reach the Hospital and receive more timely interventions.

The still birth rates this year declined from 28.7/1000 Live Births in 2013/14 to 25.6 this FY 2014/15, while caesarean section rate has increased from 16.4% in FY 2013/14 to 17.3% in this FY 2014/15. The high caesarean section rate is due to a large number of complicated pregnancies being referred to Lacor Hospital from the many health Centres in the districts. Lacor Hospital performs more than 70% of all caesarean sections in Gulu, Amuru and Nwoya districts.

Figure.14: Trends of MMR 2003/04 to 2015/16

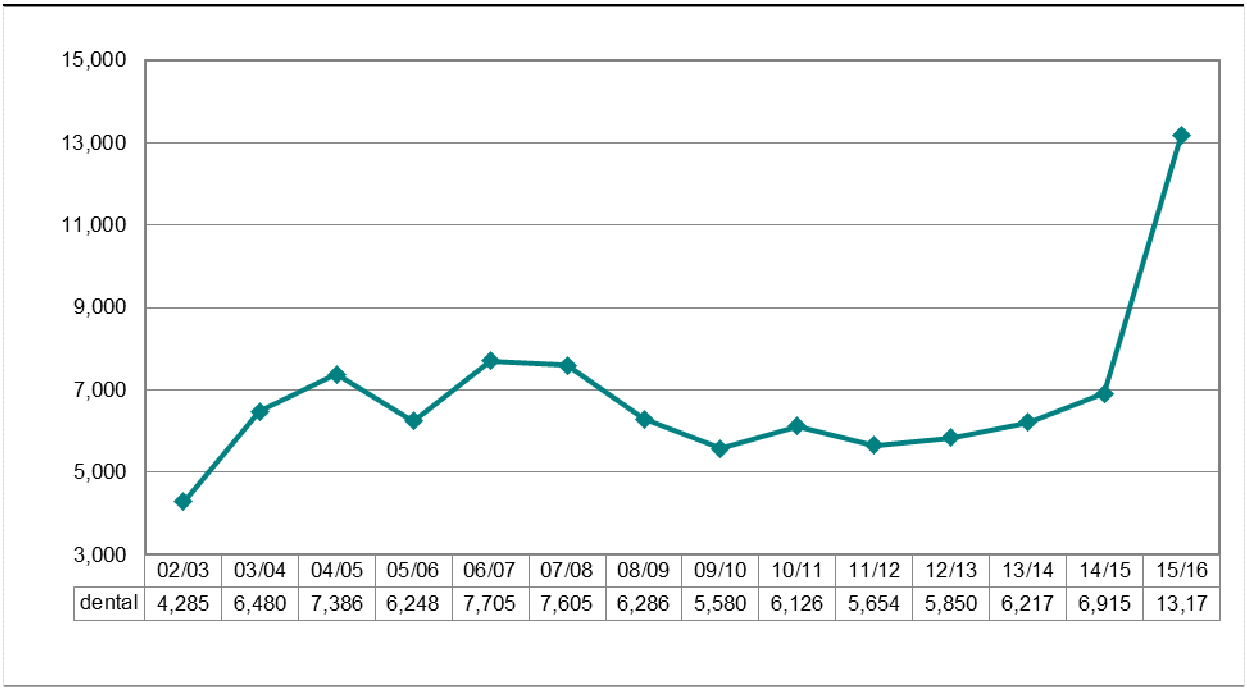


	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16
MMR	814	618	513	526	339	360	511	347	436	229	199	165	173	257

3.11 Dental services

After a steady decrease in the number of patients receiving dental treatment between FY 07/08 and FY 09/10, the number of patients is increasing again, but at a slow pace and with some fluctuations. The services include conservative dentistry, tooth extractions, as well as other emergency dental treatment, totalling to 6,915 interventions this FY 2014/15.

Figure.15: Trends of dental treatment 2002/03 to 2014/15



	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16
dental	4,285	6,480	7,386	6,248	7,705	7,605	6,286	5,580	6,126	5,654	5,850	6,217	6,915	13,17

3.12 Laboratory services

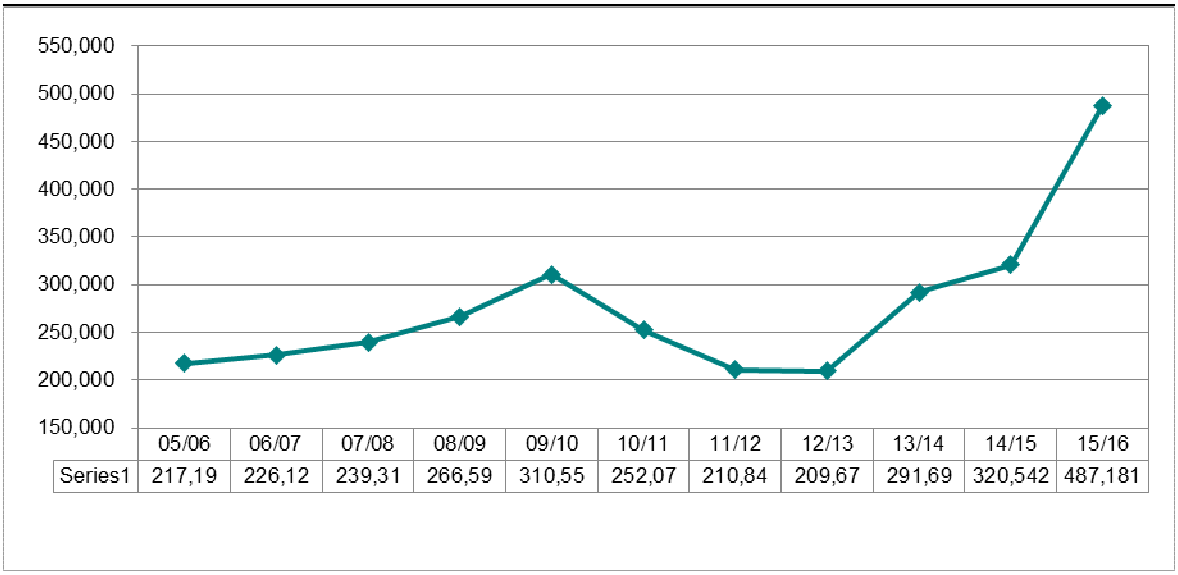
Clinical/diagnostic laboratory examinations are routines in both Lacor Hospital and the three Health Centres. The laboratory tests performed at the Health Centres are basic microscopy and haematological tests, while the types of laboratory investigations performed at the Hospital ranges from the basic microscopy to more complex serological tests, CD4 counts as well as viral load tests. Histopathological specimens are analysed at the pathology section of the laboratory mainly by visiting pathologists who have been constant at the Hospital for the last five years.

Table 34: Number of Laboratory tests performed FY 2008/09 to 2014/15

FY	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Hospital	233,492	263,358	214,956	171,688	172,300	237,506	244039	384642
HCs	33,100	47,196	37,120	39157	37371	54188	76503	102539
Total	**266,592**	**310,554**	**252,076**	**210,845**	**209,671**	**291,694**	**320,542**	**487,181**

After the significant fall (-16.4%) in the number of tests performed by in FY 2011/12, this year there was a significant rise by 9.9% in the number of tests done, possibly reflecting the reorganisation towards International accreditation that the laboratory is undergoing and the malaria outbreak.

Figure.16: Trends of laboratory tests 2005/06 to 2014/15



3.13 Radiological services

3.13.1 Trend of Radiological examinations

The department provides both diagnostic and interventional services. The routine diagnostic procedures include X-rays and ultrasound examinations

Table 35: Trends of Radiological examinations FY 2008/2009 to 2015/16

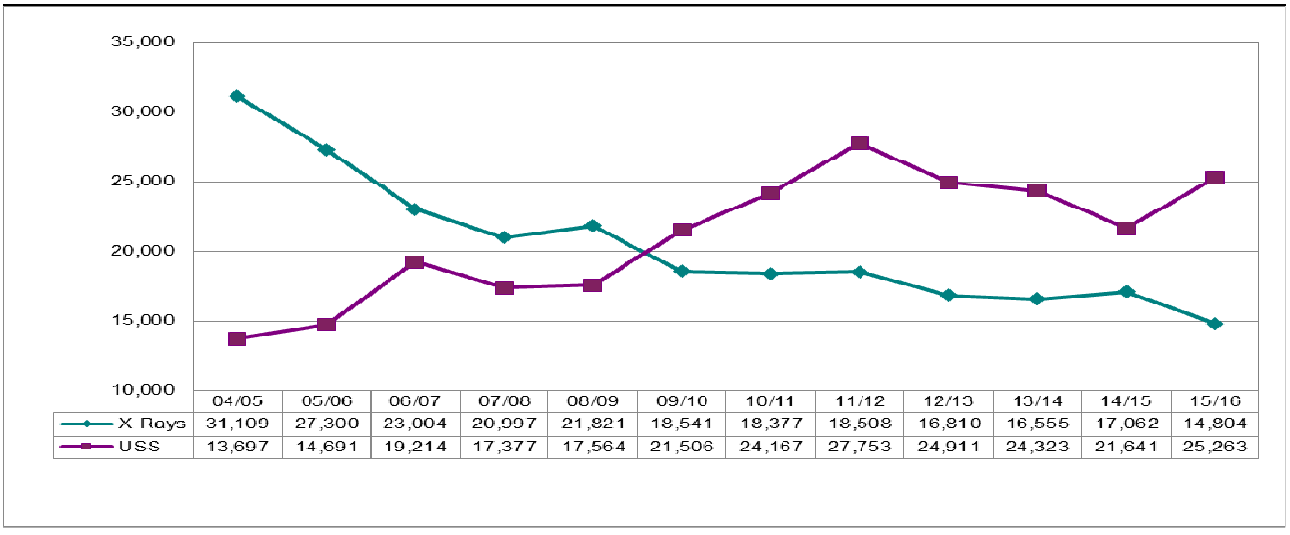
Exam	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
X-Rays	21,821	18,541	18,377	18,508	16,810	16,555	17062	14804
USS	17,564	21,506	24,167	27,753	24,911	24,323	21641	25263
Total	**39,385**	**40,047**	**42,544**	**46,261**	**41,721**	**40,878**	**38,703**	**40,067**

The Radiology department receives many direct referrals from neighbouring hospitals for radiological examinations.

This FY 2014/15 Radiology department recorded a further decrease (-5.3%) of attendance, continuing the downward trend after the 2011/12. This could correspond to the technical challenges with some radiological machines.

The figure below shows steady increments in Ultrasound performed over the years till a peak in FY 2011/12 and subsequent reduction, which continues in 2014/15. While the number of X-Rays being performed has been declining, the number of ultrasonography has been increasing. Now there are more ultrasound being performed than the X-Rays as shown in the figure below. This increase may be attributed to increased attendance of pregnant women, and the big number of people with abdominal problems, notably hepatitis as well as many patients being referred from nearby health facilities for radiological examinations. X-ray recorded a mild increment this FY.

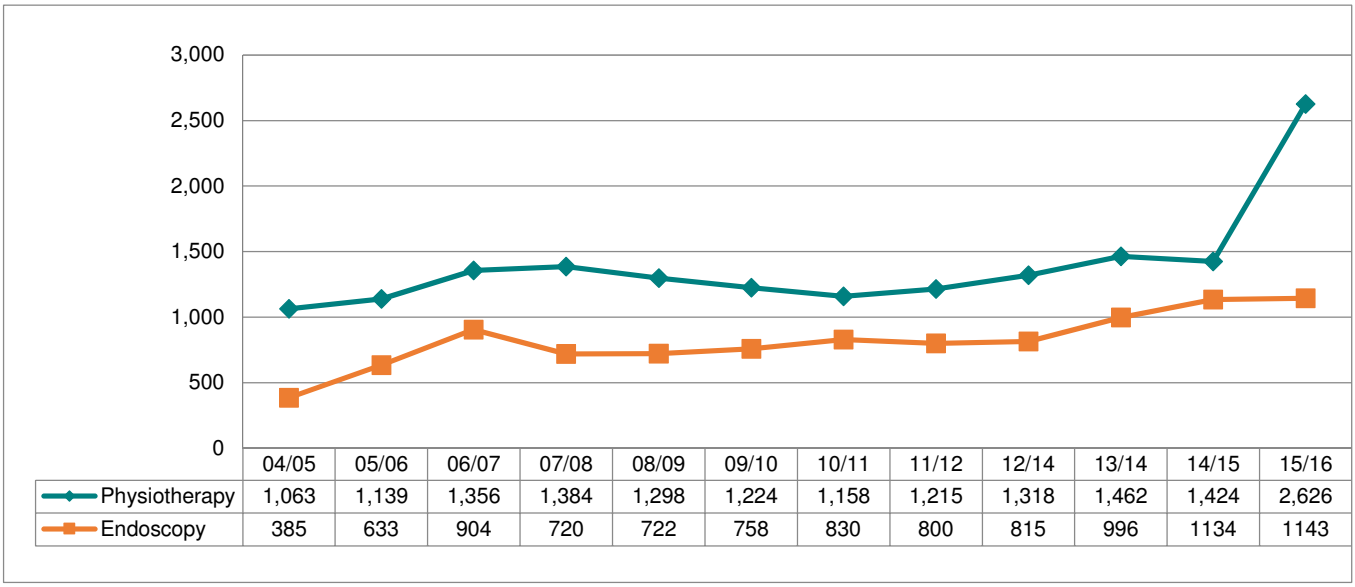
Figure.17: Trends of Radiological examinations 2004/05 to 2015/16



3.14 Physiotherapy and endoscopy services

Endoscopy and physiotherapy are two other specialized services offered by the hospital. This FY 2014/15, 996 endoscopic examinations were performed and 1,462 physiotherapy sessions were carried out.

Figure 3.18: Trends of Physiotherapy and Endoscopy 2004/05 to 2015/16



	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/14	13/14	14/15	15/16
Physiotherapy	1,063	1,139	1,356	1,384	1,298	1,224	1,158	1,215	1,318	1,462	1,424	2,626
Endoscopy	385	633	904	720	722	758	830	800	815	996	1134	1143

Both physiotherapy and endoscopy are performed on both outpatients and inpatients. There has been slight decline (-2.9%) in physiotherapy and a significant increase in endoscopy (+13.9%) performed this FY 2014/15.

3.15 Primary health care activities

3.15.1 The Hospital's Health Centres: Amuru, Opit, and Pabo

The three Health Centres of Lacor, i.e. Amuru, Opit and Pabo Health Centres, are designated Health Centres III. They are located where large IDP camps created during the years of conflict are now closed. Many of the camp residents are just relocating nearby. Each Health Centre has 24 beds and provides both clinical and preventive services. Clinical services offered include treatment of common ailments within outpatient and inpatient settings with maternity services (ANC, conducting normal deliveries, identification and referral of complicated cases to the Hospital). There is a free ambulance system to refer critically ill patients to Lacor Hospital. Among the preventive services offered are immunisation, routine health education in the Health Centres and the nearby communities including schools, VCT for HIV/AIDS. Antiretroviral refill and treatment for opportunistic infections are now provided at Opit, Amuru and Pabo.

After the birth of Amuru district from Gulu district, Amuru and Pabo Health Centres are now located in Amuru district and function under the district health services of Amuru district, while Opit Health Centre is still located and functions under Gulu district health services just like the Hospital itself. Each Health Centre has a management committee with representation from the

local community leaders. Staff for the Health Centres are drawn from Lacor Hospital through a rotation system. The senior staffs of Lacor Hospital, on routine and emergency basis, provide support and supervision. Routine support supervision occurs once in a month for each Health Centre, while emergency supervision is whenever needed. The Health Centres are fully incorporated into the district health system. Pabo Health Centre is under Kilak Health Sub-district, while Opit is under Omoro Health sub-district and Amuru Health Centre is under Kilak health sub-district. They are answerable to Lacor Hospital but supervised by both Lacor Hospital and Gulu district and Amuru district health office.

Table 36: Health Centres service output for selected services, FY 2015/16

Services	Amuru HC	Opit HC	Pabo HC	Total
OPD adults	9,668	8,252	7084	25,004
YCC	17,478	12,635	16853	46,966
ANC	5,471	2,628	3325	11,424
Admissions children	3,960	6,277	5718	15,955
Admission maternity	1,434	835	1011	3,280
Admissions other adults	1,730	1,443	1286	4,459
Total contacts	**39,741**	**32,070**	**35277**	**107,088**
Deliveries*	934	563	536	2,033
previous year	26,037	19,020	26489	71,546
difference	13,704	13,050	8788	35,542
difference	52.6%	68.6%	33.2%	49.7%

**Already included in the total number of contacts.*

All the three Health Centres combined recorded general increment in attendance, by 11.2%, up from 71,546 contacts in the previous FY. The Health Centres contributed 32.1% of all the total hospital complex contacts, an increment from last FY's 29%. Deliveries in the Health Centres remained stable at 2148, a 2.1% decline from 2195 in FY 2013/14.

Children under 6 years comprised 50% of the total attendance, and children together with pregnant women comprised 55,581 contacts, i.e. 70% of the total attendance of 79,552. This concurs with the hospital mission to provide health care to the vulnerable and neediest.

The Health Centres continue to offer admission for children below six years and for pregnant women on delivery free of charge, which improves accessibility to health services to these groups.

3.15.1.1 Immunisation activities

Lacor Hospital continues to carry out immunization in its mobile and static centres. The table below summarises the output in terms of vaccines administered.

Table 37: Trends of Immunization activities 2007/08 to 2015/16

Antigen	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
BCG	7,352	8,246	8562	9,444	8,193	7,370	6,704	6,646	7,883
Polio	20,784	22,263	22439	25,552	23,068	19,897	18,550	21,020	23,326
DPT	15,550	17,262	18305	19,196	16,813	13,810	12,487	15,037	16,940
Measles	4,343	4,862	5057	5,788	5,102	4,734	3,688	3,555	4,911
Tetanus toxoid	14,013	9,819	9824	11,845	10,365	14,915	17,865	20,941	16,375
Total	**62,042**	**62,452**	**64187**	**71,825**	**63,541**	**60,726**	**59,294**	**67,199**	**69,435**

The above data include the routine UNEPI vaccination outputs, and some of the outreach figures. Lacor Hospital also participates in the NIDs and family health days, as well as special immunisation drives. The number of routine vaccines given increased slightly by 7,905 (11.3%) compared to the last fiscal year. This is possibly due to introduction of pneumococcal vaccine. However, more functional government health centres are also providing immunization services.

3.15.1.2 CARE for the paralyzed patients

The hospital has been caring for paralysed patients since 2008, with both hospital-based and home-based care to these patients. The occupational therapist, nurse and community-based rehabilitative workers do 2-3 visits weekly to the community, and per visit they see about 5 patients each. The reduction in this number corresponds to the reducing financial support for it.

Table 38: Services delivered to paralysed patients in FY 2013/14 and 2015/16

	2013/14	2014/15	2015/16
Community based care	58	44	46
OPD care in Hospital	74	63	58
Admissions	67	79	50
Home/community visits	1,919	1,287	1,482

3.15.1.3 PHC and Outreach Activities

Primary Health Care outreaches carried out by the hospital included immunisation outreaches, home visits for TB and VHT meetings, school health programs VCT outreaches and support supervision to lower level units. Significantly, Lacor Hospital now works with over of 100 VHTs (vaccinators inclusive) in the sub counties of Lakwana, Amuru, and Pabo.

Table 39: PHC Outreach activities in FY 2013/14 to 2015/16

	2013/14	2014/15	2015/16
Immunizations outreaches	78	81	74
Home visits	58	58	98
School health	31	32	32
Health education within the Hospital	10,422	9,584	10,018
Voluntary counselling and testing (VCT) outreaches	31	40	36

In the last year there was an increase in PHC activities, totalling to 10,018, up from 9,584 sessions in FY 2014/15. This does not include the 1215 health education sessions in the community.

3.15.2 Epidemic preparedness and response to epidemics

Lacor Hospital continues to play crucial roles in detection and control of disease epidemics. Lacor Hospital has functional and active epidemic detection and rapid response systems. There is an epidemiologist, and a small isolation unit, with a public health team ready to swing into action. Because of Lacor Hospital's large service area covering most parts of northern Uganda, with over 600 outpatient contacts daily, the Hospital is in ideal position to detect disease epidemics promptly.

It is the norm to work together with and provide technical support to the Gulu District Epidemic Response team chaired by the District LCV Chairperson. In FY 2014/2015, Lacor actively participated in the epidemic response for the outbreak of Malaria, and preparedness for VHF's after the news of the Ebola outbreak in West Africa.

Lacor uniquely has an Epidemic Preparedness Plan which involves daily routine surveillance for epidemic-prone and 'strange' diseases in all the departments, including the laboratories. Suspicious cases are immediately isolated in a special isolation ward for further investigation. An infection control committee is in place to mitigate spread of infections within the hospital, with a documented Infection control manual.

In October 2000, Lacor Hospital detected the outbreak of a 'strange' disease that turned out to be the largest Ebola epidemic in the world. Although the Hospital paid a high price in controlling the Ebola outbreak by losing 12 of its experienced staff members, the epidemic prevention, detection and response mechanisms have been greatly strengthened after the outbreak. Lacor Hospital community health department conducts PHC activities in Layibi and Bardege sub-counties and offers CBHC services in 18 parishes within Gulu and Amuru district.

3.15.3 Ambulance Services

The hospital provides ambulance services from the Health Centres of Amuru, Pabo and Opit, and to the community along the way to these Health Centres, and in the Gulu Municipality. The hospital ambulances also respond to accidents when alerted. Most of the calls came from our three Health Centres, some surrounding community, as well as from the district in some cases of mass accidents requiring immediate evacuation of victims. Most of the referrals to Mulago National Referral Hospital were related to foreign bodies or airway problems, for services which are not currently available in Gulu.

Table 40: Ambulance service – 2015/16

Ambulance Service FY 2015/16						
Trips Covered	No of Trips Amuru	No of Trips Pabo	No of Trips Obit	No of Trips Community	No of Trips To Mulago	Total
Mothers	45	30	23			
Children	39	32	19			
Adult	27	26	15			
Others				30	7	
Total	111	88	57	30	7	293

The figure shows that the highest number of calls for the ambulance this year was from Amuru followed by Opit, and Pabo. However this figure does not show the actual number of patients transported since many times even when the vehicle goes for routine activities, it comes back to the hospital with many referrals.
Most of the ambulance services were for mothers and children; even most of the other calls from the community were for transferring pregnant mothers to the hospital for emergency obstetric care.
A major hindrance to this service has been the very bad roads which sometimes become impassable in the rainy season.

3.15.4 Maternity Waiting Home, 'Gang pa Min Atim'

A maternity waiting home was established at Lacor hospital in September 2013 with the aim of allowing the mothers who come from far away yet are at high risk pregnancy to be within the hospital, easily able to access care. This has attracted 137 mothers who were provided with health education and some health monitoring. Most of them have had safe delivery in the hospital. Below is the Figure for mothers attended services from waiting home during FY 2015-2016.

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
Admitted waiting	19	9	9	4	7	3	15	10	2	1	3	3	85
Delivered	15	5	4	3	5	3	13	7	1	1	2	3	62

From above total of 73% of mother delivered while waiting from Gang Pa Min Atim, 27% went back home before their delivery.

CHAPTER 4
QUALITY AND PATIENT SAFETY IMPROVEMENT

4.1 QUALITY

Lacor Hospital has made strides in the improvement of quality of care. A quality improvement is functional with, amongst others, a quality improvement clinician, a nurse, the medical director, the matron, the pharmacist, the internal auditor, a member from technical department. They have regular meetings and carry out other quality activities. Some members of the team have had specific quality improvement trainings.

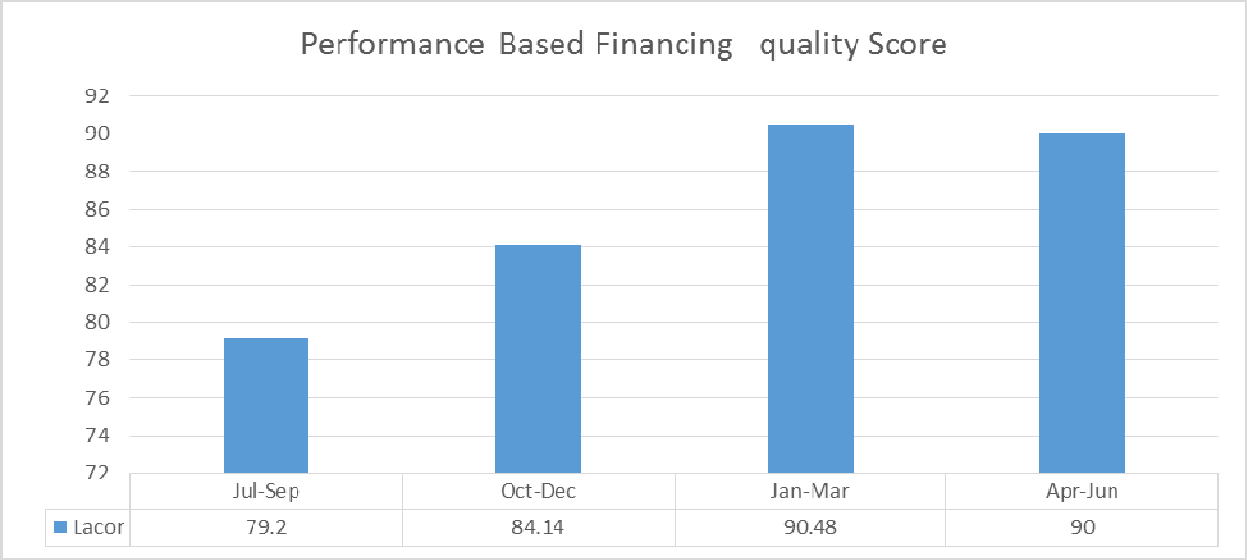
The team carries out meetings, and has embarked on institutionalization of quality improvement principles in the hospital. Alongside this team are functional the Infection Control Committee, and the Medicines and Therapeutics Committee.

Northern Uganda Health or NU Health is a quasi-experimental, controlled trial designed to assess the costs and benefits of Results-Based Financing (RBF) relative to traditional Input-Based Financing (IBF) in delivering quality health care to vulnerable populations. As part of the UK aid funded Post-Conflict Development Program in Northern Uganda and running from 2011-2015, NU Health is among efforts that aim to generate evidence on how to strengthen local and national mechanisms for governance and accountability and to improve access to health and other social services, the verifier spend time with facility staff.

- undertaking a thorough review of critical services delivered,
- Analyzing bottlenecks to improve quality,
- Discussing in a constructive way with HF staff how to address problems found, and,
- Proficiency in the use of the newly rolled out DHIS2.

The program ended on 31st July 2015 with health centre of Amuru and Pabo in Amuru district. Having successfully been implemented and reports with other partners. Teasdale Corti Foundation Canada and their donor took the interest after having shared the NU-Health report, this boosted the improvement quality team of the hospital, tasking them to repeated measures of quality, and rewarding the hospital for good quality health care provision.

The graph below showing the Percentage Quality score Year one Jul 2015 to June 2016



Activities include the following:

Compilation of routine quality checklist: the Quality Improvement Nurse moves around wards every month checking five aspects, for good practices and non-compliances. The Matron's Office then checks these interventions;

Future activities:

Joint internal support supervision continued;

Clinical chart audits, death reviews, and maternal death audits. We shall continue to have routine hospital acquired infections survey by the Infection Control Committee, nurse's audits, and result based funding quality audits.

Interdepartmental meetings and peer reviews.

Formation of smaller quality improvement teams at departmental levels.

Table 41 satisfaction level of patients in satisfaction rate different areas 2008/2009 to 2015/2016.

Year	**2008/2009**	**2009/2010**	**2010/2011**	**2011/2012**	**2012/2013**	**2013/2014**	**2014/2015**	**2015/2016**
Clinical outcome (Patients who felt they improved definitely	83.1%	83.0 %	89.7%	70%	83%	92%	83%	77.1%
Humanity of care (patients were well received and respected	90%	90%	88%	96%	95%	97%	97%	98.5%
Patients felt received care in clean environment	83%	75%	88%	95%	88%	75%	91%	99.4%
Waiting before treatment	50	54%	47%	38%	4%	46%	21%	43.%
a)Clients waited for long								
b)Clients waited to some extent	18%	24%	41%	22%	36%	34%	35%	17%
c) Clients did not wait for long	32%	22%	12%	40%	21%	20%	44%	40%

Table 42: Work Plan for quality improvement activities / Interventions

Work plan for quality improvement activities	Key action steps	Proposed Commencement / completion date	Person(s) responsible
Joint internal support supervision	Perform joint visits to Medicine, Paediatric, Surgical, and ObsGyn Wards	Quarterly ongoing	Chair and Secretary Quality Improvement Team
Systematic clinical chart audits	Clinical chart audits before visits	Jan-March Quarter 2017	Quality Improvement Team chair, specialists
Patient satisfaction and drug surveys	Recruit, train interview team, perform survey	November 2016, May 2017	Records officer, hospital secretary
Continued quality audits		Monthly to whole hospital	Quality Improvement Team nurse
Spearhead meeting of quality/safety related teams	Meeting with PTC, ICC	November 2016, May 2017	Quality Improvement Team
Quality meetings	Discuss salient issues, audit reports	Bimonthly	Quality Improvement Team
Nurses quality audits	Peer audit of quality	Bimonthly	Matron's office
HAI surveys	HAI prevalence survey	Feb-March 2017	Infection control committee
Ward based quality teams functionalized	Wards/unit teams have meetings and projects Report to Head of dept and Hospital quality team	Monthly, throughout 2017	Heads of departments
RBF mock and final quality assessments	Assess different departments on the known quality indicators	Quarterly: October, January, April, July	Quality Improvement

4.1 Safety

Lacor acknowledges many risks involved in provision of health care, ranging from possible harm to patients, health care providers, and patient attendants and even to the general community. The hospital has drafted a Risk Assessment Manual as part of quality control framework, individuating the potential risks that could lead to failure of achieving the strategic plan, and includes key controls in place, gaps in control/assurance and actions to close the gaps.

Supervision of nursing, clinical, surgical and investigative activities have been improved. There are plans to introduce joint internal support supervision. Nurses, specialists, laboratory, pharmacy, and technical department now carry out intensified supervision.

Continued professional development is highly treasured and provided to nurses, clinicians and carried out at departmental level.

Error reporting has been encouraged, and post-exposure prophylaxis for HIV is provided for health workers and community members alike who are exposed to HIV. A fire hazards manual is being drafted, and some sections of the hospital have undergone training in fire response.

4.3 PASTORAL, PALLIATIVE AND SOCIAL CARE

4.3.1 Pastoral Care

Lacor Hospital has a strong and trained team for pastoral care, which comprises of the hospital chaplain, catechist, lay women and a pastoral care nun. Pastoral care started with the hospital, but was strengthened in 2001 with the training of people from the hospital. The team works hand in hand with the palliative care team. They do a round of all hospital units in the morning with the Blessed Sacrament and two other rounds later in the day for consultation and counseling. The pastoral care nurse has routine ward counseling sessions in the afternoons. The Chaplaincy is available 24 hours on call for emergency sacraments/consultation. On Sundays and feast days mass is offered within the hospital with the patients.

The intensification of pastoral care has greatly increased a sense of faith-based assistance among patients and health care workers alike. Many patients and caretakers are very much satisfied with the care, and some came back to the sacraments after many years. One challenge is the need for training of more people to provide pastoral care to patients.

4.3.2 Palliative care in Lacor

Palliative care in Lacor Hospital started in 2001 when UCMB recommended the training of pastoral care advisors. In 2008, a clinical palliative care nurse was trained, giving holistic care to in-patients with cancer and HIV/AIDS. In 2011 a Specialist Palliative care Clinician and Nurse were trained, and they run both in and out patient palliative care clinics. Their role has since expanded to include the management of complex pains as well.

Student nurses and medical students have been mentored in palliative care both in clinic and in class. Clinical audits and research in palliative care were conducted and results shared with the clinicians in Lacor and other palliative care sites.

Outcome of palliative care in Lacor Hospital:

- Both patients and their relatives receive holistic care for pain and other symptoms improving their quality of life;
- Terminally ill patients receive end of life care and are prepared to write their will to avoid family differences or disputes after the death of a breadwinner;
- More than 96% of patients given bad news through advanced therapeutic communication by palliative care specialists choose to die at home while taking WHO step 3 analgesics instead of staying in the hospital;
- Myths and misconceptions about oral morphine are dispelled and more clinicians are comfortable prescribing oral morphine in the right route, dose, frequency and duration without fear of addiction or respiratory depression.

Challenges of palliative care in Lacor:

- Palliative care clinician/nurses perform other duties with less than 30% of their time dedicated to palliative care because of commitment in the primary duties;
- Palliative care outreach services have not yet been institutionalized;
- Data capturing and reporting tools not standardized, no current system for capturing routine visits/consultations.

4.3.3 SOCIAL CARE

The Hospital attempts to provide social care to patients, mainly in the form of counseling, for which many nurses have been trained (beyond HCT). There is however no qualified social medical worker, but plans are in place to get one. The matron's office handles care for the needy or desolate in the hospital.

However for HIV patients, community follow up is done in collaboration with engagement of Village Health team (VHT). This entails home visits, community meetings and engagement of HIV patients, families, and community leaders.

For paralysed patients, there is also limited follow up at home subject to funding availability. They are provided with physiotherapy and occupational therapy services, including the teaching of their care providers.

CHAPTER 5
HOSPITAL HUMAN RESOURCES

5.1 LACOR HOSPITAL STAFFING

Uganda, like many developing countries, is experiencing a human resource for health crisis. Uganda is ranked (WHO Report 2006) among the 57 countries with a critical shortage of health service providers. Staffing is unstable at Lacor Hospital as workers leave to join positions with other NGOs and public sector. The staff demand by the other health institutions is high. Due to moderate staff turnover, Lacor Hospital routinely up-dates staffing levels. Staffs are recruited on regular basis to replace those who leave. A total of 55 staff left In FY 2015/16, making the attrition rate 9.0%, and the Hospital recruited 55 new staff.

Table 43: Number of employees over the past years

Cadres	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16
Total Staff	542	563	570	591	629	583	605	590	609

The above figures includes those working in the three health centres, and also the employees, who are away on hospital sponsorship for further studies, but do not include the 25 Interns (doctors and pharmacists), and the 45 casual workers.

5.2 HUMAN RESOURCE MANAGEMENT

Given the scarcity of health-workers in the Country as well as Lacor Hospital being an equal opportunity employer, opportunities are open to competent and interested persons whenever needs arise. The presence of training institutions within the Hospital allows it to source interested candidates more easily. Admittedly, there is a 'silent'/deliberate effort to source those from the nearby community as a way of improving retention from among the interested.

As stipulated in the Hospital Employment Manual, working hours for all staff shall not exceed 45hrs per week. The doctors do not fit into this category snugly as they periodically do night calls on rotational basis. The hospital has an Employment Manual that is used to guide Management on how to handle employee-related issues. This is used alongside the Employment Act of Uganda in case any contradiction arises. Lacor Hospital has a fairly good range of incentives for its staff as a retention measure. First and foremost there is the strict adherence and compliance to employment and other related laws that ensure continuity of employment. Other pertinent incentives include provision of accommodation to key personnel within the Hospital or payment of a housing subsidy for those commuting from outside, access to free water for those accommodated as well as highly subsidized electricity and a stand-by generator for lighting in case of power outage.

There are also prospects for sponsorship in relevant fields, Continuous Professional Development for all medical personnel, prompt payment of salaries with access to 30% of the salary as an advance, access to heavily subsidized healthcare to the staff, spouse, parents, children and dependents up to 5 and below 12 years of age.

Besides the above, the Hospital also has a cooperative society from which subscribed members can get soft loans for personal development; there is diligent remittance of member savings to NSSF and regular departmental meetings through which staff can air their grievances.
The Hospital does not engage in exchange of employees with other healthcare institutions, however, Lacor being one of the teaching institutions of Gulu University Medical school, most of the doctors are engaged in teaching of the students. Private practice is strictly forbidden by the Employment Manual.

Table 44: Staff movements – 2015/16

Movement of Staff by cadres of staff 2015/16	Total Lost by 30/06/2016	Total Recruited by 30/06/2016	Total as at 30/06/2016
Medical specialist and consultant, Medical officers and dental surgeons, pharmacists	05	04	31
Tutors and clinical instructors	00	00	16
Clinical, pub health, dental, orthopaedic officers	05	05	18
Anaesthetic officer, radiographer, occupational	03	01	10
Lab technologist and technicians	02	01	13
Lab assistant and attendant	01	00	03
Registered nurse and midwives	03	03	57
Enrolled nurses, midwives, Theatre Assistants &	27	33	117
Nursing assistants and physiotherapy assistants	01	00	54
Nursing aides	01	00	79
Administrative staffs, pharmaceutical assistant	03	04	69
Technical staffs	00	00	38
Others	04	01	104
Staff on study leave on hospital sponsorship	00	00	27
TOTAL	**55**	**53**	**609**

- *The total above is exclusive of interns (19) & casual workers (44).*
- *The SNOs are part of Administration staff.*

The cadres of staff with the highest movement are the medical officers and the enrolled nurses. The more senior cadres like registered nurses and medical specialists tend to be more stable.

5.3 COMPREHENSIVE PACKAGES OFFERED TO LACOR HOSPITAL STAFF

Staff retention strategies, among others, include sharing of Lacor Hospital's vision with all the categories of staff, prompt and commensurate monthly salaries with access to salary advances whenever the staff needs, training opportunities including CME, provision of loans, free medical care to all the staff and their immediate relatives. For all its staff, Lacor Hospital either provides free housing within the Hospital quarters (i.e. for staff who work on night shifts or need to be available 24 hours a day), or pays a housing subsidy for those who are not accommodated.
All Hospital employees are enrolled with National Social Security Fund, NSSF.
The Hospital employees can obtain loans from their own credit cooperative society that the Hospital has helped establish.

5.4 HUMAN RESOURCE DEVELOPMENT

In the Hospital Strategic Plan 2007-2012, Capacity Building objective (2) focused on recruitment and retention of a sufficient number of qualified, satisfied and committed personnel. This was to be achieved through several action points. This focus continues in the Strategic plan 2012-2017. Managerial formation of middle managers focussing on Specialists and nursing In-charges has been ongoing since 2014/15. The attrition rate for the FY 2015/16 is 9.0%, the safety and security, infection control and quality assurance committees have been duly instituted and are operational.

5.4.1 STAFF ON HOSPITAL SPONSORSHIP

The Hospital has continued to offer scholarship for further training to its employees in relevant fields that will help enhance the services in the Hospital. It is also aimed at retaining these employees after the completion of their training.

Table 45: Hospital sponsorship as of 30th June 2016

Course	Cadre of staff	Duration of training	No. sent for training
Master in Medicine Surgery	Medical officers	3	2
Master in Pharmacy	Pharmacist	2	1
Master in Orthopaedic Surgery	Medical Officer	2	1
Bachelor of Science Nursing	Nursing Officer-	3	1
Bachelor of Medical Education	Laboratory Technologist	3	7
Bachelor in Science human Nutrition and Clinical Dietetic	Register Nurse	3	1
Diploma In Counselling Psychology	Register Nurse	3	1
Diploma in Anaesthesia	Nursing Officer-	2	4
Diploma in Nursing/midwives	Enrolled	1.5	5
Diploma in Medical Records	Nurse-Aid (“A”	3	1
Diploma in Physiotherapy	Nurse-Aid (“A”	3	1
Diploma in Radiography	Nurse-Aid (“A”	3	1
Diploma in Pharmacy	Nurse-Aid (“A”	3	1
TOTAL			**27**

Those who joined Schools in FY 2015/2016 are 13 the total number on study leave is a cumulative other are on internship or doing their research and are not officially on duty.

CHAPTER 6
LACOR HEATH TRAINING INSTITUTIONS

6.0 BACKGROUND INFORMATION

Lacor School of Nursing and Laboratory Training School are sister institutions belonging to St.Mary's Hospital Lacor, located within the hospital premises. Lacor Hospital is approximately five kilometres west of Gulu town, along Juba Road in the Catholic Archdiocese of Gulu (Gulu District). The Schools were started in 1973 and 1979 respectively, thanks to the visionary leadership of the founders, the late Drs. Piero Corti and Teasdale Lucille. From the beginning to date, the two schools have been under separate management but under same Governance and ownership of Lacor Hospital, more or less as two training departments of the Hospital.

6.1 Lacor School of Nursing & Midwifery

In 1973 the school was started with few students (10) then in 1974, twenty two (22) enrolled nurses were recruited for a course of 2 years by then. Registration in nursing was started in 1992 for a period of 18 months (1½ years). In 2004 the School enrolled 22 first groups of students to be trained as Enrolled Comprehensive Nurses' training under MOES supervision. The Registered Nurses' programme was upgraded to Diploma in Nursing in 2006. The Enrolled Midwifery course was started in May 2012 and the Enrolled Nursing course was reinstituted in May 2012. Currently the school has three courses, Diploma Nursing, Enrolled Nursing and Enrolled Midwifery. Most of the trainees are from within the country but some few come from other countries, like Kenya and Sudan.

From 1973 to date, student's enrolment has been on the increase yearly for the last 3 years as shown in the table below.

Table 46: ***Students enrolment from FY 2012/13 to date***

CATEGORY	2012/13	2013/14	2014/15	2015/16
CN	60	70	70	75
CM	30	40	43	58
DN	14	16	24	22
TOTAL	**104**	**126**	**137**	**155**

The main objective of the school is to provide training opportunity to disadvantaged students in order to enable them offer "quality health care" to the needy and disadvantage community". The goal is to produce quality and competent nurses who are able to love and serve the needy without segregation.

The school at the moment has six classrooms which can accommodate fifty (50) students each plus a demonstration/skill's lab. Currently the total number of students in the school is three

hundred twenty three [323] comprising of (80) male and (243) female trainees. The facilities available are able to accommodate the total number of the students both in classes and hostels.

Currently, Lacor School of Nursing is headed by the Principal Tutor who is supported by 4 qualified tutors, 2 clinical instructors (full time) and 2 part time instructors. The school is offering 3 courses i.e. Certificate in Nursing, Certificate in Midwifery and Diploma Nursing which is 2½ and 1½ years respectively.

6.2 LACOR LABORATORY TRAINING SCHOOL

The School started in 1979 with one senior Laboratory technologist, Mr. Augustine Mwoc (RIP) being the first Instructor with the authorization from MoH. The school started as a result of the high demand for the laboratory services. At the time there were a lot of laboratory investigations to be done yet there were few qualified laboratory staff, hence overwhelming work load on the few staff. Therefore the school set to achieve one major objective; to provide training opportunity to students and therefore empower the trainees to be able to provide the much needed quality medical laboratory services to the community in line with the hospital mission and vision. Laboratory training school is headed by the Principal Tutor who is supported by two full time tutor colleagues', four part time instructors and six clinical mentors. The school offers two years' Laboratory Assistant Course leading to the award of a certificate in Medical Laboratory techniques and Diploma Technician Course leading to award in Diploma in Medical Laboratory Technology which commenced with the first intake in August, 2013.

License for Diploma Program

In May 2015 the school has been granted provisional license by ministry of Education & Sports valid for two (2) years. Application for re- inspection will be made for next year May 2016; this will now leads to acquisition of a permanent license as required by Ministry of Education & Sports.

School capacity and courses: The Laboratory School had 136 students (73% male and 27% female) who were pursuing courses in certificate in medical Laboratory techniques (CLT) and Diploma in medical Laboratory technology (MLT) as reported in the table below:

Table 47: ***Student population at Lacor Lab. Training School***

Programs	Males	Females	Total Nº of students
CMLT I	27	14	41
CMLT II	29	11	40
MLT I	35	10	45
MLT II	08	02	10
Total	**99**	**37**	**136**

The old approved objective capacity stood at 80 students. Given the increase in number of students and the improved infrastructure there was need for a corresponding adjust of the capacity. The new **capacity was raised by Board in the meeting of the 16th May, 2015 to 100 for the lab school.**

6.2 Students' performance School of Nursing and Midwifery

The school presented 26 EM for the first time in November 2014, for state final examination and registered 100% pass rate with 2 distinctions and the rest with credits.

Forty (51) Enrolled Nursing candidates were presented for the National Examination in November 2013, out of which 50 successfully passed their exams and 1 failed. For the Lab students, 36 sat for the final exams in June 2014 and all passed. While for School of Nursing, 16 student Diploma Nurses sat for State Final Examination in November 2014 and 13 passed with credits and 3 with a pass.

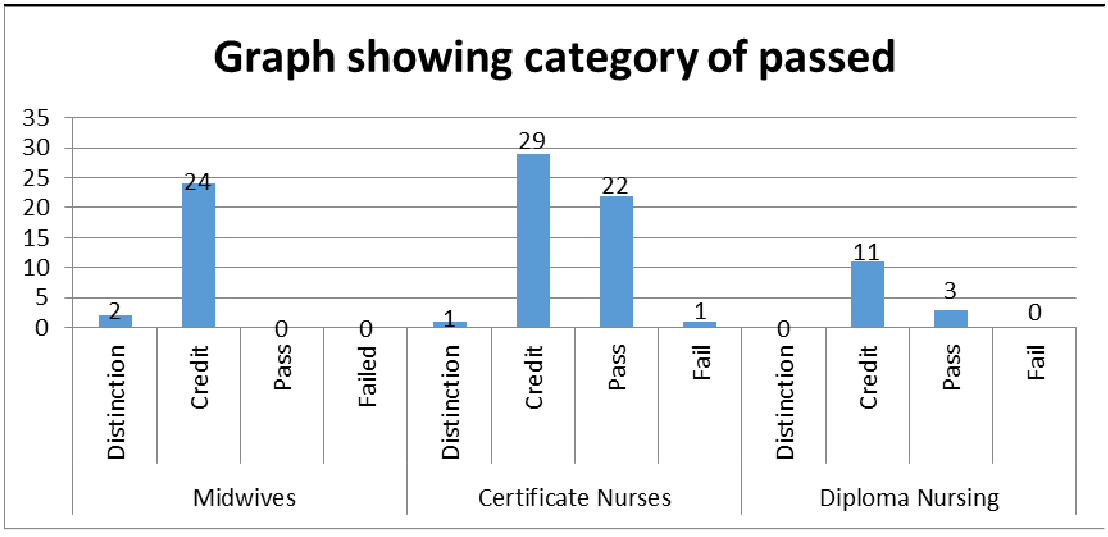
6.3 Academic Programs and performance:

The teaching, examination, assessment and other activities ran on as per Work Plan. Promotional Examination set by Uganda Nurses and Midwives Examination Board (UNMEB) took place in March 2015, where 214 students were presented and results are as follows.

The school presented 94 students for State Final Examination (UNMEB) last November 2014 and out of 94 students presented, 93 passed and only one student failed, translating into 99% pass rate.

The table below shows the quality of passes by category as below:

Fig.3.1 Classification of passes for midwifery, certificate nursing and diploma nursing students



6.4. Students Performance Laboratory School

End of second semester examinations were conducted in June this year. The school registered 40 CMLT finalists, 39 CMLT continuing students and 45 continuing diploma students and 10 DMLT finalists 2015. All sat for the UAHEB national exams and results are as shown in the table below:-

Table 48: ***Performance table, Lacor Lab School***

Program	**Total No of candidates**	**Number passed exams**	**Number with retakes**
CMLT II (Finalist)	40	38	02
CMLT I (Continuing)	40	40	00
DMLT I(Continuing)	45	30	15
DMLT (finalist)	10	07	03

6.5 Human Resource in the Schools

Introduction

The schools , being part and parcel of the hospital fully implements the Human resource and personnel policies enshrined in the Hospital employment manual (Revised version 2010).The Manual clearly spells out policies and regulations relating to staff recruitment, reward management, training and development, organisational hierarchy and reporting channels ,grievance handling as well as issues relating to termination/exit strategies.

Lacor Nursing School's staffing status

Lacor School of Nursing is headed by the Principal Tutor who is supported by 4 qualified tutors (full time), 2 part time Instructors, 2 clinical instructors (fulltime), 1 secretary/librarian and eight (8) support staff (cooks). Currently, the tutor/students ratio stands at 1: 30 short of the recommended ration of 1:20. As part of the implementation of the ongoing Human Resource strategic plan, the school benefited by sending 3 qualified staff for further training. Out of the two staff who were sent to Health Tutors' college Mulago, one has completed and is fully engaged in the routine duty of the school. One staff is still for another one year in Tutor's College and another in Uganda Christian University Mukono. The school therefore had 7 teaching staff and 9 support staff as illustrated in the table below:

*Table 49**: Current staffing level in Nursing School***

Category	**Male**	**Female**	**Total**
Principal	00	01	01
Tutors	02	02	04
Clinical Instructor	01	01	02
	03	**04**	**07**
SUPPORT STAFF			
Secretary/Librarian	00	01	01
Cooks	02	06	08
	02	**07**	**09**

Review of the objective capacity and staff establishment: The old objective capacity for the two schools was 380 (FY 2013/14).Due to the introduction of the Diploma midwifery, Theatre Assistant course, the upgrade of the Laboratory Assistant training certificate course to Laboratory Technician Diploma Course and the improved infrastructure there was need to review both the objective capacity and staff establishment. The Board in its meeting of 16th May 2015 by Min.7 (8), revised the capacity to 550 as follows:

*Table 50**: Approved objective capacity 2015***

	Staff Category/Cadre	**Old Capacity**	**Revised**
1	Nursing and Midwifery School	300	450
2	Laboratory School	80	100
	Total students	**380**	**550**

*Table 51: **Approved Staff Establishment,2015:***
Lacor School of Nursing

	Staff Category/Cadre	Actual Number of Staff	Establishment
1	Principal tutor	1	1
2	Tutors	4	8
3	Clinical Instructors	5	5
4	Mentors	1	5
5	Accountant/Bursar/Project Officer	0	1
6	Part-timers	1	0
7	Cooks	7	5
8	Secretary	1	1
9	Librarian	0	1
10	Compound/Askari	0	0
	Total Staffing	**20**	**27**

Lacor Laboratory Training School

	Staff Category/Cadre	Actual Number of Staff	Establishment
1	Principal tutor	1	1
2	Tutors/Registrar	2	3
3	Clinical Instructors	3	0
4	Mentors	1	2
5	Accountant/Bursar/Project Officer*	0	0
6	Part-timers	2	3
7	Cooks*	0	0
8	Secretary*	0	0
9	Librarian*	0	0
10	Compound/Askari*	0	0
	Total Staffing	**09**	**09**

Lacor Laboratory School's staffing status

Lacor Laboratory School has 3 qualified full time tutors and 4 part-timers. The part timers participate both in the class and in supervisory work, during examination and interviews. Part-time tutors/instructors are paid based on the lessons taught in terms of hours per month. The tutor/student ratio stands at 1:34. The staff sent to Tutors' college in 2011 completed his studies in July 2014 and joined teaching in the school

CHAPTER 7
TECHNICAL SERVICES

7.1 TECHNICAL DEPARTMENT DUTIES

The hospital has an established department under direct management of the head of technical department and overseen by the hospital administrator.
The technical department has the following functions:
 Utilities management: Electrical system, and water supplies.
 Civil works and repairs of hospital structures and furniture.
 Maintenance and management of mechanical plants: generators, compressors, air conditioning systems, laundry equipment.
 The Transport and mobility managements; mechanical works to repair ambulances, and drivers
 Waste management system including the incineration of medical waste and management of waste water treatment plants

7.2 PERSONNEL

The number of employed staff in the department is: 35 (3 in-charges ,3masons, 4 carpenters, 2 mechanics, 4welders, 2 painters, 3 plumber, 2 storekeepers, 6 electricians/medical equipment technicians, 7 drivers, 2 truck driver assistants and 3 sanitation personnel. For the projects of construction (in Amuru HC and the doctor's quarter) more 126 construction staff were hired.

7.3 ACTIVITIES REPORT IN FY 2015/16

The technical department has been implementing various projects in this year:
 here are the list of construction that took place in the year 2015-2016
completion New Drs Residence (specialists) funded by Italian Episcopal Conference (CEI)
 Construction of incinerator house by hospital,
construction of perimeter wall Amuru Health centre 1 km,
construction of student dorm, kitchen, toilet at Amuru health centre,
 Grid solar system installed of a capacity of 45kWp and connected to the hospital grid
 General maintenance in the fields of carpentry, plumbing, electrical installation, waste water systems and technical support to the three health centers of Opit, Pabo and Amuru
 More than 400 interventions on medical equipment repairs
 Mechanical service of generators, and plants, and general electrical and safety
 Fire responses for fire around the Hospital surroundings and the annual safety and burns prevention campaign in the surrounding schools by the Fire team in collaboration with the Medical Missions (USA) and Kansas Fire Department.

7.3.1 Technical Information

7.3.1.1 Surface area

Surface area of the Hospital inside the perimeter wall: 122,909 square meters with total surface area of the all existing buildings is 44,850 square meters.

7.3.1.2 Water supply

The Hospital has three supply systems for water.

7.3.1.3 Electrical water pumps

The hospital has acquired permits from the Directorate of water Resource management of Ugandan Government to abstract water from underground. Water is pumped electrically from 5 underground boreholes to the storage tanks for general use in the hospital and residences

– 2 wells: depth 50m (each with a pump) 2.5 Km from the Hospital at St Joseph's Cathedral, supplying together 6,000 litres/hour.

– 1 well: depth 50m, within the Hospital at Doctor's quarters, supplying 3,500 litres/ hour.

– 1 well: depth 30m, within the Hospital at former refugee camp, supplying 4,000 litres/hour.

– 1 water well at St. Jude's orphanage depth 70m, 3.5 km from the Hospital supplying 14,000 liters/hour.

7.3.1.4 Rainwater tanks

Rainwater is harvested from rooftops for use by the patient attendants and the staff. It is used only as a supplement for washing utensils and clothing, no purification process done. Additional use is as 'soft' water for the sterilizers. Total rainwater tanks: approx. 295,000 liters.

With the Water project this year, two more underground storage tanks (each 50,000 litres: one supplying laundry and another supplying the Sterilization units) shall be in use by next financial year.

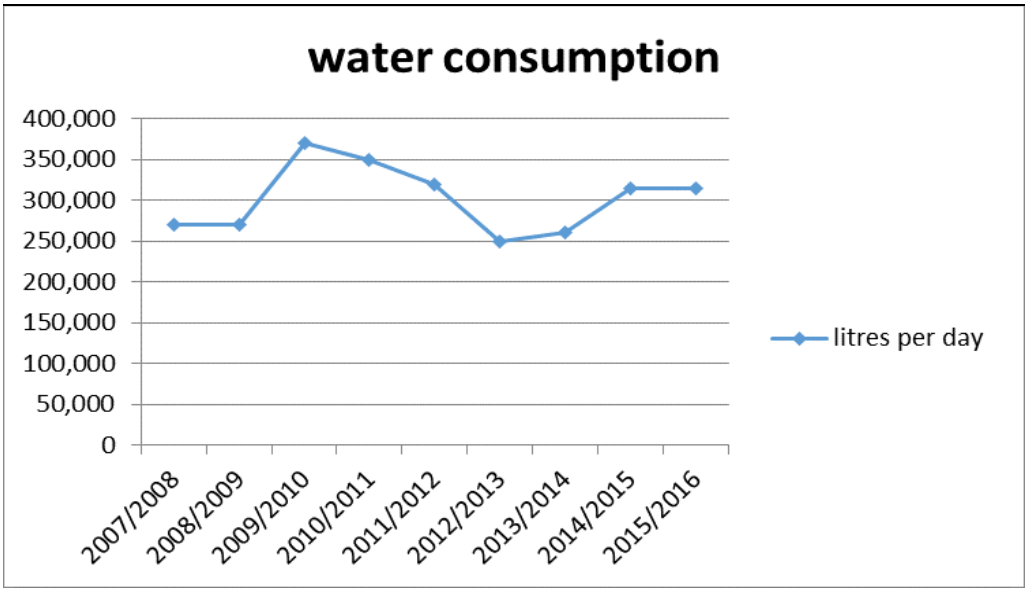
7.3.1.5 Water consumption

Average daily consumption for this year increased to about 315,000 litres a day. This usage is for all hospital and residential water needs, flush toilets, washing sinks, laundry, and domestic use: cooking, bathing etc.

Table showing trend of daily water consumption from FY 2007/08 to 2015/2016

Year	Litres per day
2007/2008	270,000
2008/2009	270,000
2009/2010	370,000
2010/2011	350,000
2011/2012	320,000
2012/2013	250,000
2013/2014	260,000
2014/2015	305,000
2015/2016	**314,000**

Table showing trend of Water Consumption in liters per day 2007-2016



The main water tanks (2 tanks of 75 m3 each) were installed in 2004. The tanks include a reserve for fire of 25,000 litres. An additional reserve for fire is linked to the swimming pool. The consumption of water is as indicated above. The water consumption has increased from the previous year due to construction activities within the hospital.
Additional rainwater tanks (2 tanks of 50,000 litres each) were constructed to supply water to the laundry machine and the sterilization machine.

7.3.1.6 Water supply to the Health Centres

The three Health Centres of Opit, Pabo and Amuru each have one motorized water pump and one hand pump. The motorized pumps of Amuru and Pabo are driven by solar power and each deliver into a 10,000 litres capacity tank. The motorized pump in Opit can use grid power as well solar power, and also delivers into a 10,000 litres capacity tank.

7.3.1.7 Electricity supply

Five power supply systems are available for the Hospital:
– The national grid;
– Generators to supply the Hospital when the national network is not available;
– Uninterruptible power supply (UPS) supplying the emergency lines to the Hospital's critical areas like the ICU, theatre, patients on oxygen and night lights during absence of any other power supply;
– Additional stand-alone solar systems for selected locations: one for the laboratory and children ward, one for the theatre and another for ICU.
– Grid connected solar inverters, installed to supply power directly to the hospital grid.

7.3.1.8 National grid (UMEME), generators and main supply

The Hospital is connected to the 11kV line of UMEME. The Hospital uses its own 1MVA three phase step down transformer to supply the Hospital.
As a backup the Hospital has four big diesel generators: two recently acquired: 500KVA and 350kVA and two older ones, 250kVA which can take over most of the loads when the national network is not available. The main electrical distribution is in star-system from the main distribution house with a network of 16,000m of underground cables. The more remote places are supplied from four sub distributors (e.g. residence buildings).
The transformer, generator, main distributor and distribution network were installed in 2003. Since then extensions have been made to the new constructions of school, staff and doctor's residences, and the Theatre Air conditioning systems

7.3.1.9 Power consumption

The Hospital has a very high demand of electrical energy.
Average daily consumption for this financial year was **2,443**kWh/day Cumulative in both the Grid and Diesel generators use

Three grid connected solar systems are now in use, one of capacity 15kW peak and produces an average of 30kWh of solar energy per day, the second one is of capacity 47.5kW peak and produces 170kWh per day. The third system installed is also of capacity 47.5kWpeak and has produced so far an average of 140kWh per day
All these power is connected directly to the hospital grid. The total power produced and used by the installed solar system during this financial year was: **106,468 kWh,** this is a saving of **UGX 4,258,720** per month.

Note: The average power cost costs for all supplies (UMEME, Generators and solar) was 480 UGX/kWh consumed. For the generator alone was 1,235 UGX per kWh. The total costs the hospital paid to the power provider UMEME was UGX **323,260,311**.

Table 52: Overview of power consumption over the past years

Year	Umeme consumption (kWh)	Generator consumption (kWh)	Total consumption (kWh)	% UMEME
2004/05	541,332	62,328	603,660	90%
2005/06	474,480	161,772	636,252	75%
2006/07	543,420	98,424	641,844	85%
2007/08	510,768	79,140	589,908	87%
2008/09	549,620	163,155	712,775	77%
2009/10	542,448	141,744	684,192	79%
2010/11	678,267	136,529	759,988	83%
2011/12	535,092	196,764	731,856	73%
2012/13	630,024	144,720	774,744	81%
2013/14	587,544	142,416	729,960	81%
2014/15	687,988	101,838	789,826	87%
2015/16	**644,436**	**84,600**	**729,036**	**88%**

7.3.2 Diesel Generator Use

During the absence of the grid, a big generator is run from 8am to 10pm. The Total power supplied by generator was: 84,600kWh. This cost UGX **104,474,700**. The cost per kWh of running a generator (fuels excluding service and spares) is currently about 3 times the cost of the grid (Umeme). The presence of the grid during FY2015/2016 was only 88% this means the remaining 12% was supplied by the diesel generators.

The total fuel used for generators (hospital main line) was **31,659** litres.

The challenges of relying on the generator come into force when there is fuel shortage. For this reason an emergency supply is inevitable.

7.3.3 Emergency supply

The emergency line is backed up with a battery bank of 480V DC 1350Ah (240 industrial Batteries). The DC voltage is converted with a UPS system of 160kVA to a 3 phase 400V AC system. The safe line is distributed from the main distribution house and is a closed ring system to all the hospital departments and connected to vital equipment for patients, lights and computer network.
The residence areas do not have a safe line connection.
The battery bank is backed up with a generator of 120kVA which starts automatically when the battery needs to be re-charged in the absence of the main line. This generator also powers the water pumps.
The emergency supply (charging) and use, is the highest consumer of energy in the hospital. **(134,200kWh) in this financial year**

7.3.4 Electrical supply to the Health Centres

All the health centers have been connected to the Grid, of the three Health Centres, only Opit has a smaller solar grid power with batteries of 24V, 100Ah with an inverter of 3,000VA, charged by the grid or 120 Wp solar panels. The power supplies of Pabo and Amuru are boosted by a bigger solar system of 2080Wp capacity charging batteries of 24V 1500Ah for all the Hospital lights and laboratory services. The average monthly consumption of the health centres from the grid is as follows: Opit: 595kWh, Amuru 253kWh, and Pabo 253kWh per month, supplemented by the Solar system.

7.3.5 Solar systems

Two types of solar systems are used in the hospital
Solar Hot water system used for heating of water in the Hospital laundry and in five other departments including the incubation room for neonatal.
Photovoltaic Solar system is used for:
– General lighting of the Hospital and residences in case there is no electricity from the national grid or the generators are off.

– Powering of water pumps in Opit and Pabo Health Centres.
There are three independent photovoltaic systems with 5200Wp solar array, 15kW of inverter and storage batteries of 3000Ah capacity and the units are used as a backup for the laboratory/children ward, theatre and intensive care unit. These independent photovoltaic systems will be transformed to be grid connected systems during the next year.

7.3.6 Grid connected Photovoltaic systems

Three photovoltaic plants are installed connected to the grid.
First system 2013 solar power of 15.6kWp installed covering 130m^{2} so far produced 42MWh of energy saving UGX **22,885,800** and average daily production of 30kWh per day

Second system in 2014: The solar panels with total peak power of 48.5kWp, solar grid inverters this system has so far produced **125.816MWh** of energy equivalent to **UGX 68,557,138** Average daily production is 170 **kWh** per day

Third system 2015: The 198 panels with peak power of 48.5 kWp and solar grid inverters of 45kVA; the area covered by panels is 200 square meters. The system has so far produced **48.011 MWh** equivalent to **UGX 26,161,194**. Average daily production is **140 kWh per day**

The hospital is embarking on the expansion of the grid connected systems in the next years to supply to the hospital grid and save on the cost from the grid and diesel.

The total production by solar systems was **106,468kWh** saving a total of **UGX 51,104,640**

7.3.7 Waste management

7.3.7.1 Liquid waste

This includes drainage from sinks, washing basins, showers, w/c, and rain water from gutters. Within the Hospital compound there are about 4,000m of drainage pipes inside the Hospital with 776 inspection chambers. An additional 120 meters of drainage pipes and 9 inspection chambers were added for the new university campus building. The system continues outside the compound with 1,600m of drainage pipes to the waste water treatment plant with 1 filter and 61 inspection chambers.
The waste water treatment plant includes a lagoon connected to 4 stabilization ponds with a total capacity of 6,750,000 litres (6,750m3) receiving 250,000 litres per day. After the lagoon, a 200 mm underground drainage pipe takes the treated waste water 1,050m to an artificial wetland filter, which in turn is connected to a natural wetland.
The work on the improvement of the waste water treatment was completed this financial year. It involved: creating a Pre-treatment Unit (PTU) for the sludge before the main lagoons, with a sludge drying bed besides it, cleaning the lagoon ponds, and constructing an artificial wetland after the lagoon ponds to filter the treated water. The waste affluent from our treatment plant is conforming to the Uganda national standards for waste water.

7.3.7.2 Solid waste

Organic and domestic waste is disposed off in pits with 4 trips of tractor a day, each about 3m^3. Special waste (medical) is burned in an incinerator. The medical waste weighs about 600 kilograms per day. Human tissues are deposited in sealed placenta pits.

7.3.7.3 Incinerator

The medical waste incinerator is small and needs to be expanded and improved; a new one has already been procured and works are underway to have it installed during the next financial year

CHAPTER 8
HOSPITAL FINANCIAL MANAGEMENT REPORT

8.1 Background.

The Financial Report of the Hospital has been externally audited by BDO East Africa. In the following pages revenue, expenditures and capital development costs will be illustrated and briefly analyzed. For a more detailed exposition of the Income Statement, Balance Sheet and the main donors, please refer to Annex 8.

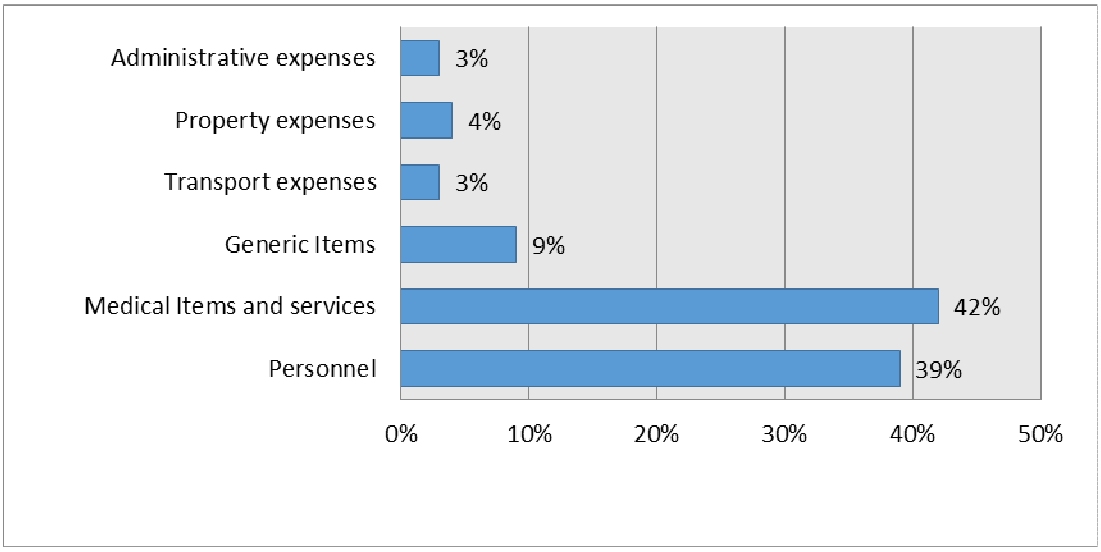
8.2 Expenditures: Recurrent costs

The total operating costs for FY 2015/16 increased from UGX 16,499 billion to 19,485 billion, representing an increase of UGX 2,986 billion (+ 18%).

Table 53: Operating Costs comparing FY 2014/15 and FY 2015/16

Costs	2014/15 UGX '000	2015/16 UGX '000	Difference UGX '000	Diff. %
Personnel	6,411,327	6,803,355	392,028	6.1%
Medical Items and services	5,290,710	7,292,445	2,001,735	38%
Generic Items	1,118,644	1,499,824	381,180	34.1%
Transport expenses	477,150	561,036	83,886	18%
Property expenses	657,071	695,792	38,721	6%
Administrative expenses	396,627	456,164	59,537	15%
Total Recurrent Costs	**14,351,529**	**17,308,616**	**2,957,087**	**21%**
Depreciations	2,148,043	2,177,047	29,004	1.4%
Total Operating Costs	**16,499,572**	**19,485,663**	**2,986,091**	**18.1%**

Figure 8.: Breakdown of recurrent costs



As shown above, medical items and services remains the highest expenditure in percentage terms (42%), followed by personnel costs, which increased from 36.9% to 39%.

The 21% increase in recurrent costs is due mainly to the increase in medical items and services (UGX +2,001 billion, + 38%), Generic items, (UGX + 381 million, +34.1%), as well as by increase in Personnel (UGX +392 million, +6.1%). The increase in medical items is due mainly to the Malaria outbreak, as well as to the use of more expensive drugs for treating malaria. The increase in generic items is due to inflation as well as increase in the number of students and thus the cost for food. Finally, the increase in Personnel Costs is due to the employment of new staff.

8.3. Capital development costs

The hospital invested UGX 1,882 billion in Capital development costs, which constitute an increase by around UGX 942 million compared to previous year. The hospital had major infrastructural development projects like the state-of-the-art incinerator, solar systems, residences for university lecturers and transportation vehicles for students (coaster bus) and patients (ambulance). These are broken down as follows; 23 million were invested in buildings, 817 million UGX were invested in hospital and Clinical Equipment, 204 million were invested in office equipment and furniture, 63 million in motor vehicle. Meanwhile 772 million were still work in progress at the end of the financial year for the construction of residences and incinerator.

8.4. Lacor Hospital Income (Financing of recurrent cost, FY 2015/16)

The total revenue of the year was 19,331 billion UGX compared with total operating costs for 19,485 billion UGX.

Table 54: Income, FY 2014/15 to 2015/16

	21014/15 (UGX '000)	**2015/16 (UGX '000)**	**Difference**	**Diff. %**
Uganda Government	1,118,778	1,439,128	320,350	+28.6%
Donors*	8,485,264	10,918,352	2,433,088	28.7%
TOTAL DONATIONS	**9,604,042**	**12,357,480**	**2,753,438**	**28.7%**
User fees	3,729,303	4,444,365	715,062	19.2%
Other Local Revenues	550,226	352,775	-197,451	-35.9%
Amortization of deferred capital contributions	2,148,043	2,177,047	29,004	1.4%
TOTAL INCOME	**16,031,615**	**19,331,667**	**3,300,052**	**20.6%**

**See Annex 8 for details on the donors*

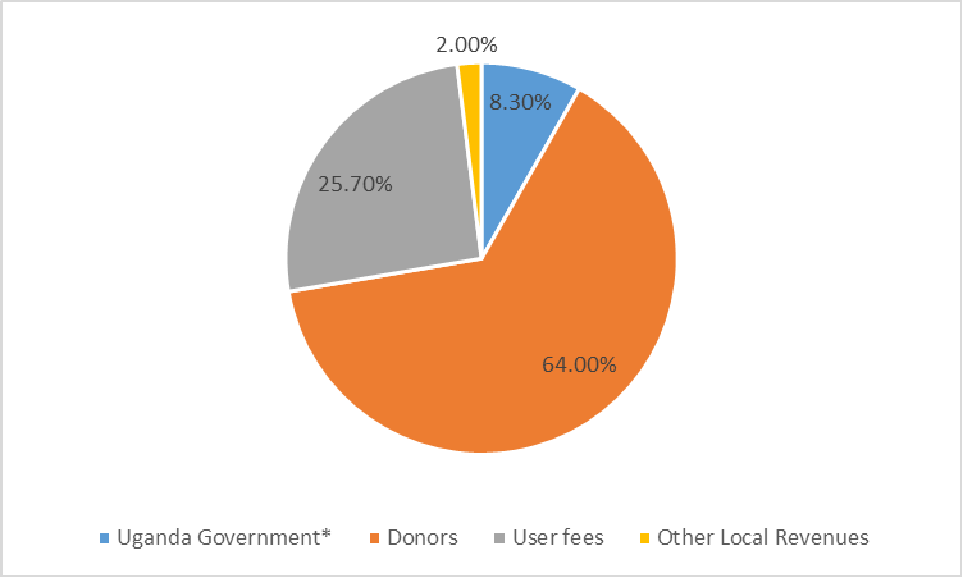
Total donations increased from UGX 9.6 billion, to UGX 12.3 billion, + 29 %). User fees increased by UGX 715 million (+ 19.2%), reaching 4.4 billion. Amortization of deferred capital contributions were stable compared to last year (+1.4%). Amortization of deferred capital contributions represents the distribution over the years of all Capital Contributions received this year and in the past to finance capital development. The amortization of the Contributions follows the amortization of the costs (represented by the depreciations). Following the accrual accounting system adopted by the Hospital, the total revenue does not include capital contributions received during the year, but only the portion that is amortized.

Table 55: Source of funds for recurrent costs

Financing of recurrent costs	2015/16(UGX '000)	%
Uganda Government*	1,439,128	8.3%
Donors	11,072,348	64.0%
User fees	4,444,365	25.7%
Other Local Revenues	352,775	2.0%
	17,308,616	100.0%

**Includes Primary Health Care conditional Grant and salaries for intern doctors and pharmacist; however, it does not include the salaries of the four seconded doctors.*Includes Primary Health Care conditional Grant and salaries for intern doctors and pharmacist; however, it does not include the salaries of the four seconded doctors.*

Figure 11 *Financing of recurrent costs*



As shown above, Lacor Hospital covers 63.6% of its running costs with donations from abroad. The continuous high reliance on donations from abroad is the direct consequence of the poor economic environment in which the Hospital operates that does not allow higher revenue from user fees. Compared to the previous year, the proportional contribution to cover the recurrent costs by the user fees increased slightly. As a consequence, the fees paid by the patients are now still subsidized at a tune of 72%.

Patients with chronic diseases continue to pay reduced fees, those in destitute financial position have their fees waived off as necessary.

Table 56: Trend of hospital sustainability ratio in absence of donor funding but with PHC CG in the last 6 years

FY	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Total Local Revenues* (c)	2,578,095	3,325,056	4,522,696	4,887,402	5,398,307	6,236,268
Total Recurrent Expend.(d)	10,538,784	13,234,709	12,565,547	13,696,478	14,351,529	17,154,620
Sustainability Ratio = (c/d)x100	24%	25%	36%	36%	38%	36.4%

**Local Revenues refers to "in-country funding" and therefore includes user fees, PHC CG, Local Govt contributions, IGAs, etc.*

8.5 Insurance auditing and procurement

The External Audit of the Hospital has been carried out by BDO, a major international accounting firm. The audit was clean and the opinion was not qualified.

The Auditors presented the management letter during the Financial Committee of the Board, highlighting the following issues that should be addressed by management to strengthen assurance and internal controls:

- Variances between the stock balances during the stock count and stock balances as per the stock ledgers resulting to over statement of stock
- Receivables should be monitored and followed up more timely.
- The Administrative Software, Navision, system is extremely slow making it almost impossible to use and access information when needed.

The auditors highlighted that the above finding pose a low risk. Each issue has been discussed and responded to by Management who has agreed to address the identified issues. BDO also highlighted that all other findings from last year had been successfully addressed.

The Hospital has a procurement Office, which is manned with 2 staffs, as well as a Procurement and Disposal Committee, a procurement manual and strict procurement guidelines which are regularly audited by the Internal Auditor.

The Procurement policy requires quotations from at least 3 suppliers and segregation of duties in all the procurement phases (requisitions, quotation, ordering, and receipts of goods, invoicing and payment). The whole process is traced in the Administrative Software and all Local Purchasing Orders are signed by the Administrator or Directors. All cheque payments require two signatures out of 4 signatories from Executive Board Members.

Cash purchases or items that are not easily available on the market are purchased by the Procurement department and verified by Administrator and Director.

Very low value procurements or disposals are carried out by the Procurement Office or by the Technical Department with non-competitive procedures. The Administrator, the Chief accountant and the Internal Auditor verifies regularly that the value of procurement or disposal does not justify a competitive procedure.

CHAPTER 9
HOSPITAL GOVERNANCE AND MANAGEMENT

9.1 LACOR HOSPITAL GOVERNANCE AND MANAGEMENT

9.1.1 THE HOSPITAL STATUTE

The hospital identity, mission statement, ownership and legal status together with institutional organization and government are clearly stipulated in the hospital statute which was recently reviewed and approved by the hospital Board of Governors.

9.1.2 The NGO status

The Hospital is incorporated as a registered NGO under the Non-Governmental Organizations Registration (Amendment) Act, 2006.
Pursuant to the deed dated 21/05/2008, the legal owner has granted the Hospital a semi-autonomous status to operate with its own separate management and administration and with full and absolute control of its assets and liabilities.

9.2 The Hospital Board of Governors

The Hospital Board is the supreme governing body of the hospital, including the training schools and the 3 health Centres of Opit, Pabo and Amuru. The Board of Governors, headed by the Archbishop of Gulu Roman Catholic Archdiocese, is the major policy decision-making body of Lacor Hospital. The Training schools have a standing committee; (School Board) that oversees the operations of the schools.

9.3 The Hospital Management

The Executive Director is the Chief Executive Officer. Two other Directors, Institutional Director and the Medical Director, work hand in hand with the Executive Director but with clearly defined responsibilities. The Executive Committee, with the Hospital Management Team having an advisory role, makes the day-to-day operational decisions. The Hospital Director heads the Executive Committee (comprising the three Directors, the Administrator, the Hospital Secretary and the Senior Nursing Officer) and is responsible for the operations of Lacor Hospital. The Executive Committee meets every two weeks, but may convene meetings as and when the situation demands for a meeting. The Hospital Management Team (comprising all heads of departments and clinical and administrative services) is the main link between the top management and Hospital staff, and meets once in two months. The Medical Director is the overseer of all the medical services and the Institutional Director is responsible for legal and institutional matters, including human resource management and financial matters. The non-medical and administrative issues are the responsibilities of the Hospital Administrator. The Hospital Matron and her assistants are responsible for all nursing matters supervised by the Medical Director. The training schools are headed by the Principal tutors and are supervised by the Executive Director who also is the secretary to the Board of Directors. The heads of departments and the ward in-charges are responsible for planning and supervising the

departmental services/activities. The departments hold routine meetings where performance reviews and subsequent remedial plans are devised. Key decisions made at departmental level are fed back to the management through the Hospital management team.
Besides the Executive and Management Committees, there are other specialised committees e.g. the Disciplinary Committee, the Medicines and Therapeutic Committee (MTC), The Infection control committee, the Quality committee, the Promotion and Training Committee and the Staff Welfare and Housing Committee.
Each Health Centre has its Management Team headed by the Executive Director (Lacor HC Pabo), the Institutional Director (Lacor HC Amuru) and the Medical Director (Lacor HC Opit).
The Management Team meets quarterly. The committee assists the Directors in the decision making process on all relevant matters regarding the Health Centres.

9.4 Compliance with statutory requirements

The hospital was fully compliant with the statutory requirements for accreditation with the UCMB yet again this FY 2015/16 with a score of 100%. The hospital was therefore accredited without any condition.

Care delivery: Adapt level of core services to changing pattern of need and to national priorities in the ncial sustainability.						
	Expected trend	Baseline FY 11/12	2014/15	2015-16	Alert	Comments
ynaecology (Reproductive Health Care)						
	increased	**27,924**	**19,981**	**20,477**		Stabilized, most health unit in the district govt. inclusive now conduct deliveries, however, most complicated cases are referred to Lacor by these units as well as hospitals within the districts
	increased	**6,160**	**6,380**	**6652**		Marginal increase, there is still capacity to accommodate more deliveries.
	stabilised	**50**	**31**	**31**		Decreased, reflecting good obstetric care in catchment area
	Increased	**787**	**1105**	**1252**		The hospital continue to be the major referral centre for Complications in pregnancy
	increased	**0**	**1215**	**1040**		Established practice and demand is high
	increased	**420**	**304**	**280**		Slight decrease, probable reason is that most health units are now offering PMTCT
	started	**0**	**1215**	**1040**		Being carried out together with cervical cancer screening
	increased	**5,516**	**5268**	**4426**		Continue to decrease especially general surgical cases. Reason is not very clear, Probably due to more complex operation being done therefore constituting less cases and drop in emergency cases over the period of the strategic plan.
	increased	**100**	**111**	**111**		Marginal increase however visit by consultants form Italy is now routine

Paralysed patient admitted for acute care	maintained	**100**	**144**	**56**		Number of patients increased this year compared to last fy(67) many of these patients are referrals, but the team still maintain community outreach within the municipality of Gulu
Early detection and referral of cancer prostate increased	**Started**	**0**	**333**	**114**		The demand for this test is low; numbers decreased because the machine was in state of disrepair.
Early Detection of colon cancer	started	**0**	**0**	**0**		Not yet started, number of colon cancer continue to be low in our set up.
Medicine						
Admission in medical ward	reduced	**3762**	**3501**	**5682**		Increasing trend; majority of admitted patients have chronic illnesses, However occupancy in this ward is still low 56.17% due to low occupancy in Isolation and TB ward
HIV patient on ARV	increased	**4287**	**6448**	**6410**		The AIDS clinic is fully functional and able to enrol patients who need care and treatment.
A'Clinic total contact	increased	**36,913**	**34691**	**31,431**		Patients enrolment is stable and follow up is regular and on appointment.
Hypertension Clinic Attendance(Numbers Enrolled)	increased	**505**	**1229**	**2231**		On the increase as anticipated, a dedicated clinic now runs routinely on Thursdays.
Diabetic clinic Attendance (Numbers Enrolled)	increased	**279**	**280**	**365**		Trend on target and routine clinic runs every Wednesday.
Paediatrics						
Admission in General Pead. Ward	reduced	**8,074**	**7647**	**15,656**		Double the number for previous year because of Malaria Epidemic

Admission Nutrition Unit	reduced			**Xxx**		Ward closed 2 years ago and now a section in the paediatric ward
Admission Neonatal Unit	increased	**94**	**403**	**336**		Stabilized, Emphasis now is now on improving survival.
Sickle cell clinic attendance	increased	**2,328**	**2,695**	**2,123**		Well established clinic running twice a week, the number captured are regular patients most of whom are on Hydroxyurea. Major challenge is the cost of these drugs and high maintenance cost of the electrophoresis machine.
Burkitt Lymphoma patient treated	stabilised	**112**	**66**	**60**		Stabilized though most patients come in late disease state
Wilms tumor treated increased	**Stabilized**	**40**	**24**	**23**		Numbers have stabilized
Pead. Diabetic clinic registered patients	Increased	**8**	**21**	**21**		Numbers have stabilized
	Outpatient services in the Hospital					
OPD adult contact in Hospital	Increased	**116,705**	**106,929**	**104,713**		Stabilized, though most patients have chronic illness.
YCC Contacts in Hospital	Decreased	**39,760**	**30,973**	**35,703**		Trend is upward, mainly due to Malaria resurgence
Emergency Contacts (adults, except maternity and paediatrics)	Increased	**6,327**	**10,171**	**12,733**		Slight increase mainly due to medical emergencies (Diabetes, Asthma, respiratory emergencies)
	Community Health					
Admissions in the	stable/red	**9,995**	**13,901**	**23,694**		Increasing, depicting increased utilization of Lacor

3 health centres	uced					health centre services by patients with complications especially Malaria, note Lacor health centres also act as a point for other health centres within its catchment area to access referrals to the hospital
Deliveries in the three health centres	increased	**2,412**	**2148**	**2033**		Slight decrease probably due to reopening of government health centres
OPD Attendance in the 3 h-centres(ANC included)	stable	**72,711**	**66461**	**71,970**		Marked increase due resurgence of Malaria.
VHT supervised and submitting reports		**657**	**584**	**584**		The VHT of Amuru are well organised and trained while those of other health centres still need trainings. Major complaints is lack of monetary facilitation.
Donor support for operational cost reduced from 75% to 50%		75%	69.2%	71.8%		Not achieved as local income is still low with only slight increase in fees despite increasing expenditures.. Local fundraising has not picked up. Selective increase of user fees (School and operation fees) was carried out in Sept 16
Reduction of specific dependence of Corti foundation to the contractual amount of Euro 1,000,000 (Annual)		Euro 1,000,000 Ugx 3,600,000 million	2,389, 507	5,357,763 Euro 1.448 mil		This is above contractual amount. Board has considered it in agreed with the foundation to increase the funding
Slow down/ reverse upward trend of operational cost		12,565,547 million	14,351 ,529 million	17,496,409 million		The costs for running recurrent expenditure has increased in all areas of expenditure from personnel costs, medical supplies, property cost, transport cost

					and administrative costs.
Reduced external funding achieved due to increase in income from(fees) and cost control	6,787,142 m (2,296,973 m)	9,604, 042 million (3,963, 145m)	12,561,751.00 (4,934,658)		Positive trend but not able to catch up with increasing expenditure thus making hospital mainly donor dependant.
Study on other IGA carried out					Private OPD now fully functional other income generating activities not yet studied but Hospital garden project is underway. IDRC funded project aimed at building capacity in resource mobilization did not achieve it intended objective mainly because the officer employed took on political activities besides the obvious lack of Local capacity to fundraise..
Presence of free treatment Policy					Free treatment policy in place (VVF, Epidemic outbreak, paralysed, staff and dependants). Waiver also given to PATIENTS in distress
Option of starting public saving Scheme for fee payment considered and decision taken					No action but we are keenly following progress of National Social Health insurance. There is renewed attempt by donor communities to convince the government to have insurance in place or start the Result based financing
Continued Engagement of partners					We continue to engage partners and look for new ones USAID funded Voucher plus for maternal health is coming on board and training is ongoing

Fully Fledged Private wing					Fully fledged Private Outpatient started Feb 2015 after completion of Remodelling of the existing space, numbers of attendance is increasing Ultrasound and Laboratory function in this section now fully operational.
Annual Improvements in external audit and internal quality controls Running					Infection control committee in place Nursing Quality audit is carried out regularly Health centre quarterly quality audit is now routine Joint support supervision is now done routinely Hospital now need to solve any identified gap as soon as it is known
HAI Rate at 12 or below	14%	13.6%			Last HAI at 13.6%,which is below target continued effort to support infection control and waste management is in place
Incident reporting system instituted					Incident reporting is now done routinely though minor incidences are not being reported, though minor cases are missed out.
Clinical effectiveness compliance promoted					This is carried out under joint support supervision and Nursing Quality Audit, while MTC looks at drugs usage and prescription
At least one guideline implemented for each of the 4 clinical discipline per year					An integrated guideline developed under the hospital Formulary. Emergency protocols are in place in all departments and new identified Standard Operation Procedures (SOP) are developed as needs arises

Clinical chart audits Carried out at least 3 times a year					This is done under the nursing quality audit, joint support supervision, quarterly quality audit and the Medicine and therapeutic committee survey.
Compliance audit program developed for existing guidelines and SOP					Under review, update given by the internal Audit department
Prescription surveys carried out at least once a year					Carried out annually
Patient experience improved Patient satisfaction survey carried out twice a year Patient complaints registered, analysed and acted upon Patient satisfaction consistently above 90%	>90%	94.7%			Patient satisfaction survey is now carried out biannually starting fy 13-14 Complaints are being acted upon Patient satisfaction has improved but pertinent complaints about queue and communication between patients and health workers still persist.
Quality assurance Quality related committee (QIC, MTC, ICC) meet every 2 month and jointly at least 3 times a year Quality assurance processes					QIC, MTC ICC Meets regularly but Joint meeting only took place once. Quality improvement programs of MOH and UCMB being implemented together with RBF program and East Africa Public health Laboratory networking project.

to be yearly audited Continuous active engagement with MoH and UCMB on quality improvement programs and initiatives					
Service Output (Passing Rate) Diploma Nurses Certificate Nurses number ECN (pass rate) Certificate in Midwifery Lab certificate number Finalist Lab Diploma Finalist Anaesthetic students, Number (Pass Rate) NOTE: Last national semester results used as a measure for pass rate.	 >90% >90% >90% >90% >90%	 75% 96% 88% 95.1% 70% 100%			Nurse Training and Laboratory school training has been fluctuating except for anaesthesia Reason being mainly managerial especially for Lab. School School of anaesthesia is running well but still as a satellite of Mulago allied health and management institute
Possibility of desegregating schools' cost from hospital consolidated accounts					Work in progress; segregation is done but administrative cost is apportioned.
Progressive phasing out of					Being carried out gradually. Next step is to calculate accurately administrative cost apportioned to school as

subsidy to school					well as expenditure incurred by students during ward attachment.
MOU with Gulu University renewed and signed					Done
Operational research					Continuous process, 2 operational research are ongoing, The Lacor Hospital Institutional and research ethics is fully accredited and renewing and monitoring most research carried out in Northern Uganda.
HRM All middle management trained					Training of middle management is almost complete, The new training is now concentrated in the school, laboratory and specialists.
Job description in Place for middle management					Job description in place and updated for all middle management staff, heads of departments and specialists who have undergone training.
Performance Evaluation result reviewed yearly					This is now routine for all hospital staff, analysis however, is not routinely carried out
Report of staff deployment reviewed monthly					Routine clocking is now in place and done by everyone.
Time and attendance software integrated with payroll					Time and attendance software in place but not yet integrated into the payroll though presence of individual staff are monitored routinely. This process is rather

					difficult due to the many shifts
Induction provided for all newly employed staff					Being done but needs standardization.
Financial MANAGEMENT Interim statement produced and closed monthly after reconciliation					Trial balance can now be produced but the income-expenditure statement is not yet being produced automatically. Work to upgrade the system is now complete. There was a system failure in June and remedies for better back up is being looked into
Analytical accountability fully integrated into general accountability and routinely reconciled					Work in progress, some reports are however generated by NAVISION accounting package in use
Cost centres for main hospital department established					Done, however, data still not used in budgetary process
Cost per major group diseases established and updated					Not yet accomplished because the Diagnostic Related Groups classification has not yet been defined. This is still under discussion
Real-time tracing of drugs consumption extended at least to OPD					The system is now able to detect stock outs Instances of discrepancy between physical stock and stock in the system still occurs.

Need of stock adjustment reduced in frequency , size and value					Quarterly stock inventory being done regularly but challenges are still many though the amount involve has markedly reduced.
Revised procurement procedures adopted and implemented					Under Review together with the financial manual. Draft procurement manual awaits approval by Ex. Committee
Strategic Management Improve record management					Intense training of personnel and recruitment of basic staff accomplished, program was disrupted by departure of the record officer but new people have been recruited
Progressively define standard report to be produce regularly with information of Service Output, Finance and HR Define standard report for committee of the Board					We are still using performance matrix to report service output, quality improvement matrix and quarterly budget performance to report to the board. For HR we use monthly update which is automatically generated. There is need though to refine these format
ICT Integrate patient administration and financial IT system so that costs and income can be related to Service Output					Patient administration in place but not fully integrated. Computerisation of radiology Department is complete. The Lab computerisation failed as personnel in the ICT section could not train the Lab staff because the person who designed the program had left. A process of reviewing the entire ICT is ongoing and might require big investment.

Extend range of financial and service output that can be automatically produced					Trial Balance List of Debtors HR produced electronically and HIMS available on Dhis2
Transparency and Accountability Produce, adopt and circulate detailed policy document					Is being integrated into the new financial policy document and integrated into internal Audit manual as well. Also in the offing is the whistle blowing policy
Produce strategic plan for water supply					Study has been done but no consensus yet
Liquid hospital waste management					Process for upgrade of hospital waste in place and completed
Power					Upgrade to grid tie in progress, [2] phases has been completed and soon the technical department has embarked on third phase, thanks to funding from Bolzano province
Solid waste disposal					Incinerator fully installed and functional. There is however, ongoing adjustments to improve its efficiency.
Supply, maintenance and logistics					Integrated into NAVISION Soft ware
Produce specific project proposal for possible					

investment by donors					Ongoing project CEI ; Faculty accommodation completed Dormitory for students Amuru; completed Purchase of bus for transporting students: Complete Anaesthesia student dormitory: construction: ongoing Tutors accommodation construction in health centre: :ongoing Installation of solar water pump Opit; Ongoing Next year: Intern/postgraduate block Paving the road

11. ANNEXES

ANNEX 1 - THE MISSION

The Mission of the Hospital is to provide health care to the needy and to fight diseases and poverty, thus witnessing the maternal concern of the Church for every sick person regardless of ethnic origin, social status, religious or political affiliation.

The Hospital wants to promote the access to health care of the weakest social groups, like women, children, people in destitute financial conditions, and people affected by chronic diseases who are unable to provide for themselves offering to all of them a quality medical service. The Hospital advocates a comprehensive, integrated and sustainable action on health, which includes treatment, prevention and training of health workers.

In fulfilling its mandate, the Hospital shall always follow the medical ethics and the moral teaching of the Roman Catholic Church and shall follow the Mission Statement and Policy of the Catholic Health Services in Uganda, as approved by the Bishops' Conference in June 1999.

The Hospital will deliver its services in accordance with the stated Policies and directives of the Ministry of Health.

The Hospital management and all employees shall adhere to the principles of the Mission Statement of the Hospital and, since the person is at the Centre of all activities of Lacor Hospital, a basic attitude of respect for human dignity and of compassion for the sick and needy shall be the guideline for all.

ANNEX 2 - THE VISION

- St. Mary's Hospital Lacor has the vision of being a referral PNFP Hospital serving the population of northern Uganda. It will offer:
- The highest standards of affordable and quality in-patient service.
- The highest standards of affordable and quality in-patient and out-patient care, provided with humanity, in the field of medicine, general surgery, paediatrics and maternity that respond to the health needs of the population and which complement the services of other health care providers in northern Uganda.
- A limited number of specialized services for which it will strive to become a Centre of excellence, that correspond to the priority needs of the population and that build on existing competency and comparative advantage.
- Primary health care and outreach services through its existing network of Health Centres as well, as the work of the Hospital in Layibi and Bardege, in line with the minimum health care package recommended by MoH in the HSSP II.
- Training and teaching facilities for student doctors, nurses and laboratory assistants that contribute to the implementation of the Government's (forthcoming) national strategy for human resources development for health, and to the development of Gulu University's medical faculty.
- Opportunities for research that can contribute to more effective functioning of the Hospital, to new knowledge on tropical disease and health care provision, and to the further advancement of staff knowledge and expertise.

ANNEX 3 - HOSPITAL MANAGEMENT TEAM

	Name	Position in the Hospital
1	Dr. Emintone A. Odong	Medical Director and Chairman
2	Dr. Martin Ogwang	Institutional Director
3	Dr Kansiime Jackson	Head, Medicine department
4	Dr. Joses Komakech	Head, Dental/Oral surgery department
5	Dr. Valeria Calbi	Head, Paediatrics department
6	Dr. Buga Paul	Head, obstetrics and gynaecology department
7	Dr. Opira Cyprian	Head, Radiology
8	Dr. Okello Tom Richard	Head, Surgery department
9	Dr. Emmanuel Ochola	Head, HIV, Research & Documentation department
10	Dr. Mary Auma Alai	Head, Adult Outpatient Department
11	Ms. Betty Justine Anyiri	Ag. Principal Lacor Nurse Training School
12	Mr. Olara Walter	Principal Lacor Laboratory School
13	Sr. Millie Among	Senior Nursing Officer
14	Sr. Josephine Oyella	Head, pharmacy
15	Mr. Ocakacon Robert	Head, Laboratory department
16	Mr. Ojok Geoffrey P'kingstone	Representative of Paramedical staff
17	Bro. Elio Croce	Head, Technical department
18	Mr. Thomas Alessandro Molteni	Administrator
19	Mr. Pier Paul Ocaya	Hospital secretary
20	Mr Henry Omal	Chief Accountant
21	Mr. Francis Okello	In-charge Lacor Health Centre III Amuru
22	Ms Olga Lanyero	In-charge Lacor Health Centre III Opit
23	Mr. Otii Benedict	In charge Lacor Health Centre III Pabo
25	Dr Kisembo Lule	Head of Anaesthesia/School of Anaesthesia
26	Mrs. Caroline Okello	Personnel officer- Secretary management committee

ANNEX 4 - INTERNAL BOARD

Composed of Executive Director, Medical Director and the Institutional Director; meets weekly.

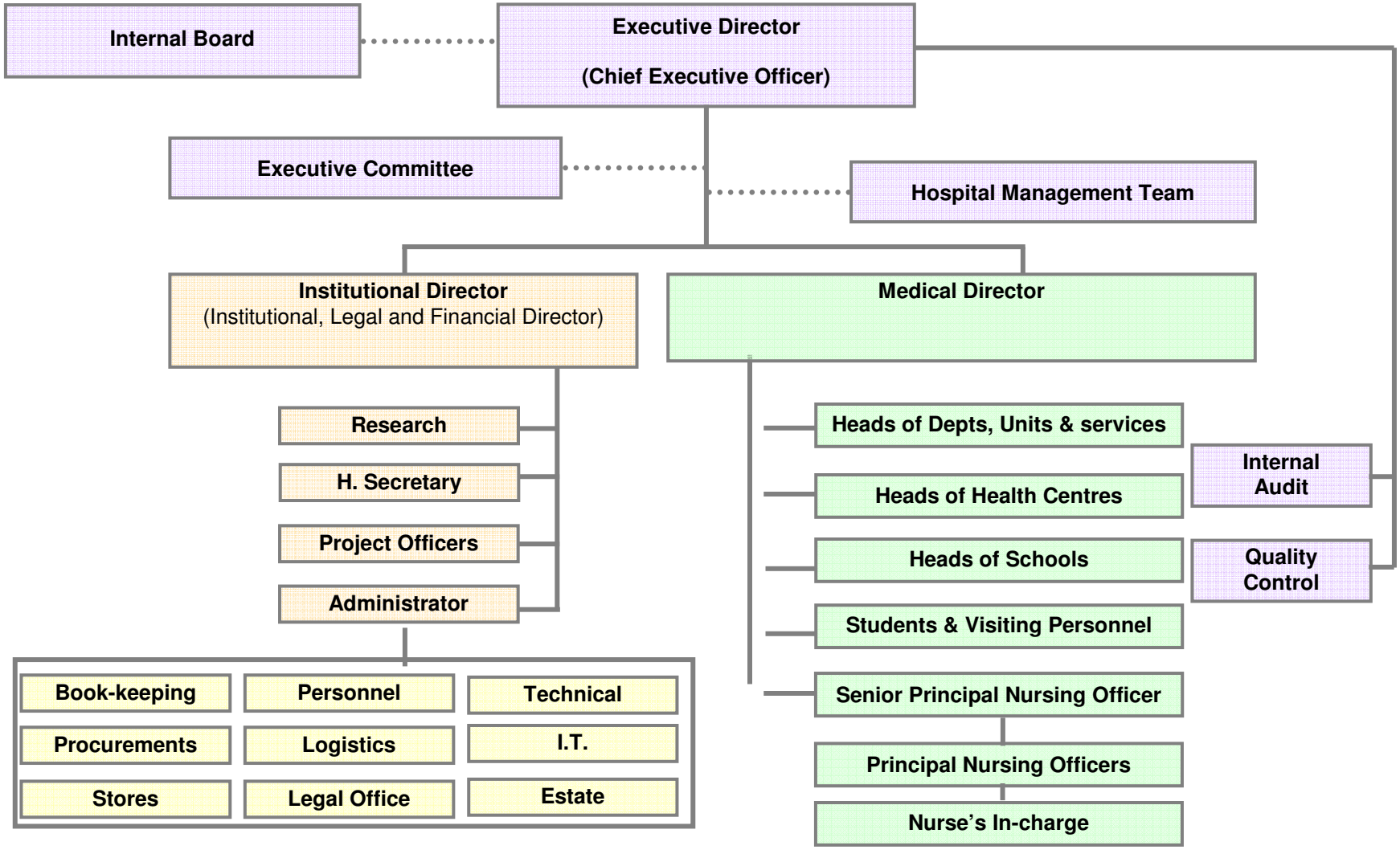
ANNEX 5 - HOSPITAL EXECUTIVE COMMITTEE

S/N	Name	Position
1	Dr. Cyprian Opira	Executive Director- Chairman
2	Dr. Martin Ogwang	Institutional Director
3	Dr. Emintone A. Odong	Medical Director
4	Sr. Milly Among	Matron (senior nursing officer)
5	Mr. Thomas Alessandro Molteni	Administrator
6	Mr. Pier Paul Ocaya	Hospital Secretary- Secretary

ANNEX 6 - BOARD OF GOVERNORS

Name	Personal position	Board position
HG. John Baptist Odama	Archbishop Gulu Roman Catholic church Archdiocese	Chairman
Mr. Opio Lukone	Permanent Secretary to the Cabinet	Non-Exec. Member
Justice Galdino Okello	Judge of the Supreme Court of Uganda	Non-Exec. Member
Dr. Paolo Giambelli	Representative Italian Cooperation	Non-Exec. Member
Dr. Dominique Corti	President Corti Foundation, Milan	Non-Exec. Member
Mr. Guido Coppadoro	2nd representative of Corti Foundation	Non-Exec. Member
Mr. Okema Akena Achellis	Retired General Manager Banking, Bank of Uganda, Manager	Non-Exec. Member
Dr. Isaac Ezati Alidria **(RIP August)**	Director Planning and Development MoH	Non-Exec. Member
Dr. Paul A. Onek	DHO Gulu	Non-Exec. Member
Dr. Cyprian Opira	Executive Director, Lacor Hospital	Executive Member
Dr. Emintone A. Odong	Medical Director, Lacor Hospital	Executive Member
Dr. Martin Ogwang	Institutional Director, Lacor Hospital	Executive Member
Mr. Thomas Alessandro Molteni	Hospital Administrator	Executive Member
Mr. Pier Paul Ocaya	Hospital Secretary	Executive Member

ANNEX 7 - LACOR HOSPITAL ORGANOGRAM



ANNEX 8 - FINANCIAL STATEMENT FOR THE YEAR ENDED 30/06/2016

Profit and Loss	2015/16
REVENUE	
Donations	**9,236,319**
Donations in kind	**3,121,161**
Patient charges	**3,102,168**
Hospital school fees	**1,342,197**
Other local revenues	**352,775**
Amortization of deferred capital contributions	**2,177,047**
Total Revenue	**19,331,665**
EXPENSES	
Personnel	
Salaries and wages	**4,871,529**
NSSF Hospital contribution	**460,885**
School sponsorships	**317,358**
Insurance	**136,853**
Other staff costs	**1,016,730**
Total	**6,803,355**
MEDICAL ITEMS AND SERVICES	
Medical drugs	**5,108,713**
Laboratory and radiology items	**804,105**
Medical sundries	**1,379,627**
Total	**7,292,445**
GENERIC ITEMS	
Food supplies (includes food for students)	**538,742**
Printing and stationery	**398,022**
General supplies	**563,060**
Total	**1,499,824**
TRANSPORT EXPENSES	
Cargo clearing fees	**103,930**
Fuel for ambulances and other vehicles	**241,327**
Insurance - ambulances and other vehicles	**8,000**
Vehicle maintenance	**80,268**
Other transportation expenses	**127,511**
	561,036
PROPERTY EXPENDITURE	
Electricity (metered and generator)	**509,769**
Repairs and maintenance	**107,617**
Other utilities	**39,100**
Other property expenses	**39,306**
	695,792
ADMINISTRATIVE EXPENSES	

Profit and Loss	2015/16
Professional fees	**115,190**
Communication	**72,958**
Bank charges	**36,435**
Office equipment and software maintenance	**73,199**
Other administrative expenses	**158,382**
	456,164
Total recurrent costs	**17,308,616**
Depreciation and amortization	**2,177,047**
Total operating expenditure	**19,485,663**
Operating income	**-**
Other gains/losses*	**(153,998)**
Total comprehensive (deficit)/surplus for the year	**-**

ANNEX 9- BALANCE SHEET

BALANCE SHEET	FY 2015/16 Shs'000	FY 2014/15 Shs'000
ASSETS		
Current assets		
Inventories	3,782,662	4,669,431
Trade and other receivables	2,351,078	1,211,003
Cash and bank	2,541,534	4,324,422
	8,675,274	**10,204,856**
Non-current assets		
Property and equipment		
- Buildings	24,570,007	*25,198,920*
- Hospital and clinic equipment	4,967,812	*5,432,060*
- Computer equipment	487,812	*371,951*
- Furniture and fittings	157,187	*201,871*
- Motor vehicles	202,946	*230,288*
- Work in progress	915,742	*143,445*
Total property and equipment	31,301,506	31,578,535
Prepaid operating lease rentals *	**4,181**	4,285
Intangible assets	**38,866**	54,504
Total non-current assets	**31,344,553**	**31,637,324**
TOTAL ASSETS	**40,019,827**	**41,842,180**
LIABILITIES		
Current liabilities		
Trade and other payables	592,282	935,570
Deferred income	7,616,110	7,889,363
Total current liabilities	**8,208,392**	**8,824,933**
Non-current liabilities		
Capital Contributions not yet amortized**	31,309,206	32,515,018
Net Assets		
Operating fund	502,229	502,228
Result of the year		1
Total Net Assets	**502,229**	**502,229**
TOTAL LIABILITIES AND NET ASSETS	**40,019,827**	**41,842,180**

*Operating lease prepayment comprises 49 years' leasehold on land on which Lacor Hospital is situated

**Capital Contributions not yet amortized represent the total Capital Contributions received over the years to purchase fixed assets. They are amortized among the Hospital revenue over time, along with the depreciation period of the fixed assets to which they are related.

Cash receipts from donors (includes Capital Contributions)	FY 2015/16 Shs'000	FY 2014/15 Shs'000
Foundation Piero and Lucille Corti - Italy	5,357,763	2,389,507
Italian Episcopal Conference	-	1,260,621
Government of Uganda	918,998	1,029,323
Foundation Teasdale Lucille - Canada	1,733,452	259,127
Ugandan Catholic Medical Bureau (UCMB) and Uganda Episcopal Conference	734,127	544,794
RTI-EMBLEM	174,540	167,085
Province of Bolzano	156,742	129,408
International Network of Cancer Treatment and Research (INCTR)	78,965	111,266
Soleterre Strategie Di Pace Onlus	32,286	18,500
Social Promise	158,930	20,264
African Cancer Registry Network (AFCRN)		11,896
African Medical and Research Foundation (AMREF)		8,000
Intra Health International Uganda		18,500
Associazione Theotokos		5,211
World Health Organization	89,587	
Associazione Help-3	2,111	
African Cancer Registry Network	6,775	
International Educators for Africa (IEFA)		1,661
International Development Research Centre	130,000	
UKAid Department for International Development (DFID)	240,002	2,864,942
East African Public Laboratory Networking Project	3,454	19,178
Conrad N. Hilton Fund for sisters	107,322	
Other cash donations	5,649	
Total cash receipts	**9,930,703**	**8,859,286**

* Following accrual accounting and the International Accounting Standards (IFRS), only cash receipts that are meant to cover costs of the year are recognized among the revenue of the year.

ANNEX: 10 CAPITAL DEVELOPMENT CONTRIBUTION

Donations in kind (includes Capital Contributions in kind)	FY 2015/16 Shs'000	FY 2014/15 Shs'000
Ugandan Catholic Medical Bureau	2,231,180	2,286,407
Foundation Teasdale Lucille - Canada	277,539	540,978
UKAid Credit line (NU Health)	33,160	363,346
Government of Uganda - Credit line	520,130	273,130
Foundation Piero and Lucille Corti - Italy	29,880	80,152
World Health Organization	7,116	
Associazione Help-3	9,931	
Human Diagnostics	11,063	
The AIDS Support Organization (TASO)	952	
Joint Medical Store (JMS)		1,870
UHMG		10,500
Other donations	210	26,225
	3,121,161	**3,582,608**

ANNEX: 11 ACKNOWLEDGMENT

We would like to acknowledge the contribution of the Staff of Lacor including the health centres, their commitment in provision of the health care services to the people. We are grateful to Records office team for the collection of raw data. We also would like to acknowledge the contribution of all donors for their support that made the hospital able to provide the services in the period being reported, we appeal for your continues support so that hospital provide quality health care to most vulnerable people of Uganda and far beyond.


ST.MARY'S HOSPITAL


ST. MARY'S HOSPITAL
1959