ST. MARY'S HOSPITAL LACOR

ANNUAL REPORT

FINANCIAL YEAR 2011/2012

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TABLE OF CONTENTS

LIST OF FIGURES AND TABLES

I. FOREWORD BY THE EXECUTIVE DIRECTOR

We thank God for all the support and guidance which has allowed us to successfully complete the FY 2011/2012 despite the many challenges. Indeed, this was a special one. The year ending 30th June 2012 , did not only mark the end of a financial year but it is also the end of the first five-years' strategic plan 2007-2012, which plan was largely successful.

We are grateful to everyone who attended the annual workshop where the performance of the five years' strategic plan was laid out. As you will get from the detail of this report, there has been a lot of challenges and achievements registered. I wish to note that FY 2011/2012 was another particularly difficult year. For instance, the soaring inflation towards the end of FY 2010/2011 seriously affected the hospital and the staff in many ways as it translated in the increase in prices of commodities and the general increase in the cost of living. Compared to the previous year, the Hospital finished the financial year with reduced cash reserves only partially balanced by larger inventories. We have begun the FY 2012/2013 with no clear sign of averting the trend especially now worsened by the recent but general worry of Ugandans about the withdrawal of donors over mismanagement of public funds.

On rather consoling note, despite the many challenges, there were a number of achievements registered in FY 2011/2012. The hospital was able to maintain high volumes of service output and there was general improvement in quality of service as a result of many interventions including functionality of quality improvement committees. The hospital for the first time achieved 100% compliance with the UCMB accreditation program. Stocks out of drugs were greatly minimized and mortality rates reduced. There was also improved performance in the schools (Nursing and Laboratory training schools) with the schools registering 100% passing rate. By coincidence, the Board has deemed it timely and has therefore given its blessings for the schools to host the first ever graduation ceremony slated for 1st March, 2013 to which we warmly open our doors to welcome everyone especially those who were fortunate to have completed their studies from the sister schools right from the inception. I already mentioned in the beginning about the new strategic plan. Yes. The process for the development of the new strategic plan 2012-2017 was successfully concluded and it is now operational. On projects, the new Northern Uganda Health (NU-Health) program has successfully begun implementation both in the hospital and the three heath Centres of Opit, Pabo and Amuru, however the real success of the project calls for maximum cooperation and hard work especially since the project is performance based and highly depend on the quality of work done. Another project that will continue in operation is the ACT (HIV project funded by Uganda Episcopal Conference).

The year also ended with a positive note in as far as staffing is concerned. The work force remained stable since the beginning of the financial year. However, given the looming recruitment and salary increase to the health workers by the government, it is feared that, some of our staff will be attracted to join the public service. Management is proactively looking at strategies to mitigate this effect.

On behalf of the Board, I wish to thank everyone especially our partners, the Corti Foundation, management and all the staff for the cooperation and the commendable work done during the year. We recognize and appreciate all the sacrifices made along the way which enabled us to grow in experience and to reach the end of the year focused to the mission of Christ.

Yours sincerely,
Dr. Cyprian Opira, Executive Director

II. GEOGRAPHICAL LOCATION AND SIZE OF GULU DISTRICT

Figure I.1- Map of Acholi Sub Region in Uganda

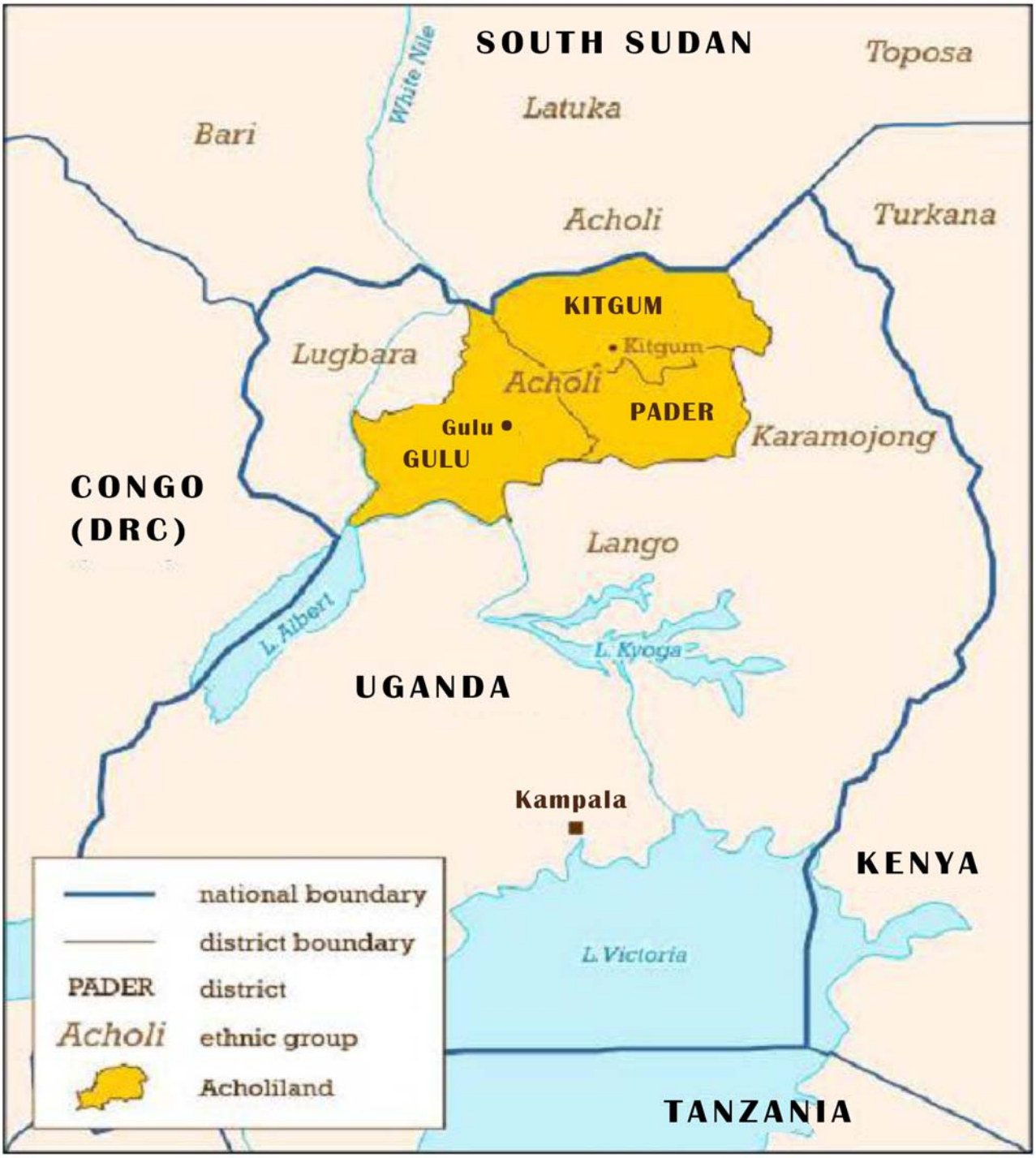
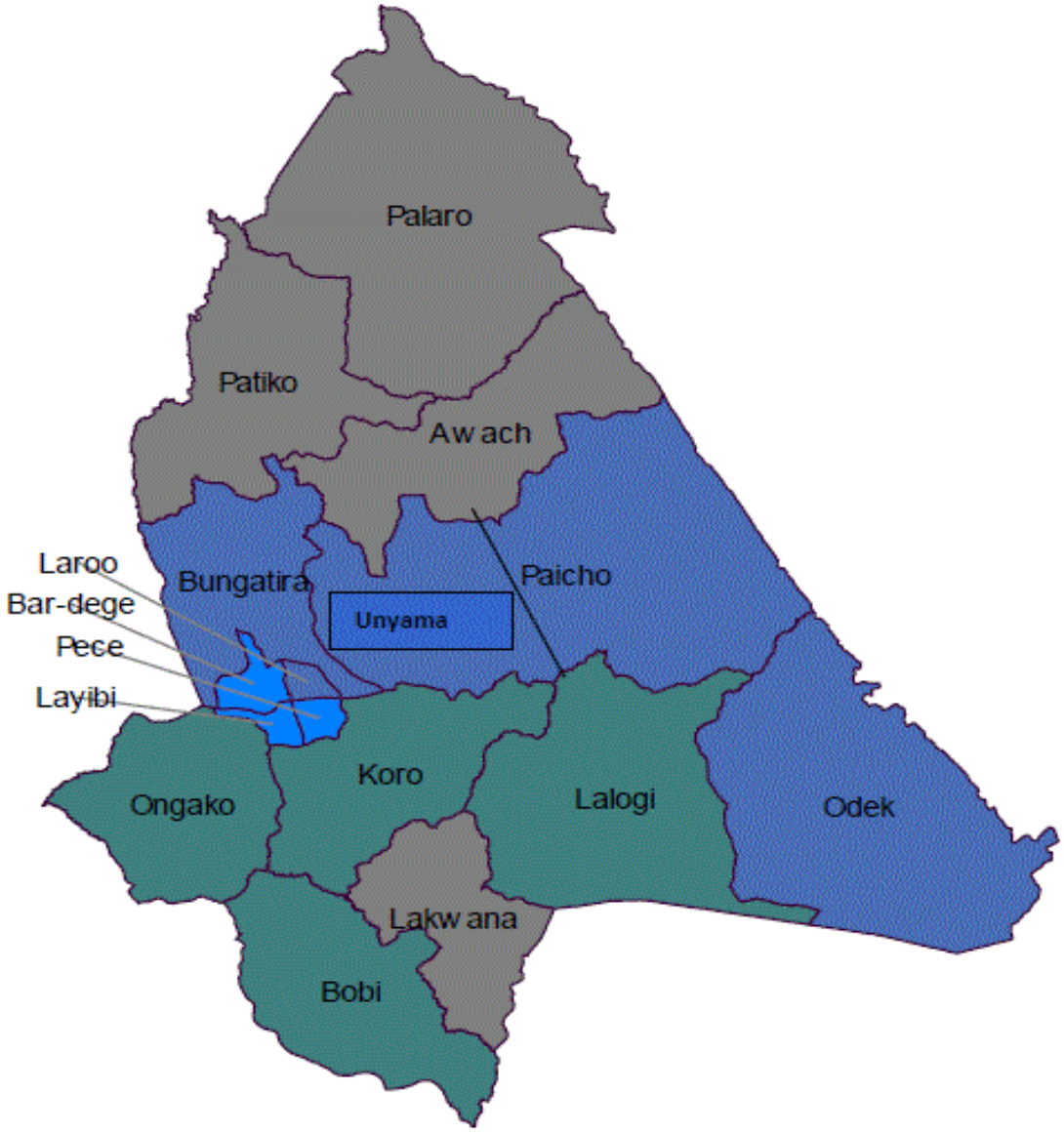


Figure I.2 Map of Gulu District



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 waters and the district headquarters is 332 km by road from Kampala.

III. LIST OF ABBREVIATIONS 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
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
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
VHC	Village Health Committee
YCC	Young Child Clinic

IV. EXECUTIVE SUMMARY

IV. 1 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 50 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 Centres is 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 and its Health Centres accommodate every day on average more than 500 inpatients plus their attendants and receives on average 800 outpatients. There are about 1,000 employees combined with their family members living within the Hospital.

IV. 2 MAJOR ACHIEVEMENTS FY 2011/12

Highlighted below are some selected achievements in the FY 2011/12 in the different areas according to the Hospital plan.

Table IV.1 - Major Achievements – 2011/12

Service output
Total Deliveries Increased by 15.2% of which 39% of these were in the three Health Centres
Total number of contacts increased by 2.3% of which 30% took place in the three Health Centres
Total OPD Attendance increased by 3.3%
High volume of Surgical Operations (5,516 major operations) maintained although with a slight decrease (5,630 in FY 2010/11)
Radiological examinations increased by 8.7%
School of anaesthesia established in collaboration with Mulago Institute of Allied health sciences

Orthopaedic surgery boosted through collaboration with CCM and Corti Foundation. Orthopaedic surgeons visit the hospital four times a year
Quality of service
Bed occupancy (combined Hospital and Health Centres) rates decreased from 98.26% to 96.51%
All hospital committees are fully functional. Hospital Prescription guidelines and Infection control SOPs have been produced
Full compliance with UCMB Accreditation
Nursing supervision and monitoring by the office of the Principal Nursing Officer and Quality control Nurse has been improved and regularised
Nursing process has greatly improved; observations are carried out much better
Patients satisfaction and prescription surveys done yearly and results discussed with the hospital staff
Safety checklist established in theatre and is used routinely before and after every surgery
WHO accreditation process is on course for the laboratory to move from 3 stars to 4 stars
Hospital acquired infection being monitored by Hospital Infection Committee
Rational prescription being monitored by the Hospital Medicines and therapeutic committee
Hospital mortality rates reduced to 3.2%, down from 4.1% last FY
Drug stock out rates minimised
Human resources
Successfully recruited one senior Anaesthesiologist to provide leadership in ICU, Theatre and School of Anaesthesia
Hospital attrition rate has remained below 10% at 9.2%
Two tutors in training for Bachelor of health education
Theatre nurses trained on theatre skills with the help of Canadian team
24 hospital employees are on hospital scholarship for various courses that meets the hospital interest
Patients administration software successfully introduced, linking to the wards awaited
Infrastructure
Software for the laboratory has been completed, for X-Ray still to be developed
New housing block for senior paramedical staff completed
Two new Land cruiser ambulances acquired
New theatre equipments installed
Installation of the Air conditioners in theatre completed and are functional
Institutional capacity
The Hospital NGO registration status renewed for the next five years
Revised hospital statute is in place
The process of the new strategic plan 2012 – 2017 completed and due for printing
Revision of the employment manual completed and is in use
Agreement between the diocese, Corti Foundation and Lacor Hospital renewed for five years
Finance Manual produced
Training schools
New course of certificate in midwifery introduced
Nursing school reverted to training the traditional certificate in enrolled nursing dropping the controversial Enrolled comprehensive course
School of Anaesthesia established in collaboration with Mulago paramedical school
Two classrooms have been created to accommodate the new course
16 Midwifery students and 11 laboratory students have been selected for MOH/DP bursary schemes
Pass rates improved in both laboratory and Nursing schools
Plan to hold the first graduation ceremony is at an advanced stage
Teaching aids received as donation of from visiting USA friends of the nursing school and school of laboratory received assortment of text books from AMREF
Discipline in the school has remained good
Established collaboration with University of Sherbrooke in Canada for training of Family Medicine students
Extended collaboration with Gulu University for the training of Certificate and Diploma in Pharmacy

IV. 3 SERVICE UTILIZATION

There has been a slight increment in the total number of patients served in the hospital this year as shown in the table. However laboratory examinations and immunisation doses dropped.

Table IV.2 - Selected service utilization – 2011/12

Service output	2010/11	2011/2012	Variance (No)	Variance (%)
Total OPD attendance	233,566	241,190	7,624	3.3%
Admissions	35,020	33,584	-1,436	-4.1%
Deliveries	5,348	6,160	812	15.2%%
Major surgical operations	5,630	5,516	-114	-2.0%
Laboratory examinations	252,076	210,845	-41,231	-16.4%
Radiological examinations	42,544	46,261	3,717	8.7%
Immunization doses	71,825	63,541	-8,284	-11.5%

IV. 4 FINANCIAL REPORT

During FY 2011/12 total revenues decreased by 1,222 million UGX (-10%), while total operating costs increased by 3 billion UGX (+25%), thus generating a deficit of 3,949 million UGX.

The decrease in revenue of this year is due to the fact that donations used to cover this year's costs were released by donors in the preceding years in order to ensure stock replenishment and smooth cash flow, while 3,125 million of donations received this financial year have been deferred to next financial year (see Annex 8 for actual cash receipts from donors) in order to fully follow the accrual method recently adopted.

The increase in costs was due to partly to inflation and partly to increase in drug consumption especially in Outpatient Department.

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

Table IV.3 - Financial Report

Profit and Loss (synthesis)	2011/12 UGX '000	2010/11* UGX '000	Differ. UGX ,000	diff. %
Income				
Uganda Government	1,028,083	849,690	+178,393	21%
Donors	5,759,059	8,081,904	-2,322,845	-29%
User fees	2,090,417	1,517,377	+573,040	38%
Other local revenue	206,556	150,682	+55,874	37%
Amortization of deferred capital contributions	2,131,534	1,838,765	+292,769	16%
Total Income	**11,215,649**	**12,438,418**	**-1,222,769**	**-10%**
Cost				
Personnel	5,381,240	4,846,432	+534,808	11%
Medical items and services	5,070,122	3,509,214	+1,560,908	44%
Generic items	1,083,727	705,405	+378,322	54%
Transport expenses	411,767	401,423	+10,344	3%
Administrative expenses	513,614	451,680	+61,934	14%
Property expenditure	774,239	563,929	+210,310	37%
Total recurrent costs	**13,234,709**	**10,478,083**	**+2,756,626**	**26%**
Depreciations	2,131,533	1,838,868	+292,665	16%
Total operating costs	**15,366,242**	**12,316,951**	**+3,049,291**	**25%**
Other gains/(losses)	**200,642**	**449,255**	**-248,613**	**-55%**
RESULT OF THE YEAR	**-3,949,951**	**570,722****	**-4,520,673**	**-792%**

***Compared to last year's financial report comparative figures for FY 2010/11 have been reclassified to ensure consistency with this year's new chart of accounts. Waived fees for around UGX 60 million which last year were included among expenditure have been treated as discounts thus reducing the revenue and costs by the same amount. ****In last year's Annual Report the result was 560,722 due to a typing error.

IV. 5 LOGISTIC AND TECHNICAL SERVICES

Some of the required materials have to be transported from the capital Kampala, about 360 km away. Lacor Hospital has well-organized system for handling logistics and a logistic office in Kampala, from where goods and supplies are transported at least twice every week. This inevitable demand accounts for significant proportion of recurrent expenditure. The Hospital's technical workshop constitutes a vital component of Lacor Hospital. All activities of construction, maintenance of buildings and some equipment, renovations, waste management, water supply and maintaining constant electricity supply, are performed by the workshop.

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 50 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, 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 800 outpatients; 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 Nurse Training and the Laboratory Training schools. Lacor 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.

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 2.1 - 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.

Table 2.2 - Top Ten (10) OPD causes of Morbidity in the district for FY 2011/12

DISEASE CONDITIONS	NUMBERS	%
Malaria	202,839	26
ARI not pneumonia	181,501	23
Intestinal worms	55,948	7
Skin diseases	28,973	4
Diarrhoea diseases	29,420	4
Injuries/Trauma	22,004	3
Urinary Tract Infections	19,608	2
Pneumonia	17,545	2
Gastrointestinal	17,285	2
ENT Conditions	15,674	2
Others	196,394	25
TOTAL	787,191	100

2.1.3 Key Health Indicators of Gulu District

The health indicators provided in the table below portray the poor health status of the people compared to the national status.

Table 2.3 - Key Health Indicators

Key social indicators	District status	National status
Number of health units	76	2.297
Population within 5 km to nearest health facility	72%	79%
Doctor : Patient ratio	1:19,984	1:18,600
Nurse/midwife : Patient ratio	1:2,677	1:2870
OPD utilization/person/year	2.2	0.9
% of TB notified vs expected	92	49
% pregnant mothers received IPT II	65	47
Pit latrine coverage	62	69.7
Infant mortality rate per 1,000 Live Births	40	76
Maternal mortality ratio per 100,000 Live Births	251	435
Child mortality ratio per 1,000 Live Births	177	137
Immunization coverage	110%	76%
Contraceptive prevalence	42%	24%
Adolescent pregnancy	23%	20%
Supervised delivery	70%	33%
HIV Sero-prevalence	11%	6.4%

2.1.4 Health Infrastructure

There are a total of 76 Health Facilities (Public, Private Not for Profit and Private for profit) of which 51 are functional government health facilities (46 local and 5 central governments managed) and about 17 health facilities are run by NGOs. Table 2.5.5.4 shows the status of the facilities and Map 2 gives accessibility to health facilities by sub-county.

Table 2.4 - Health infrastructure by level

HSD	Hospital	Health Centre IVs	Health Centre IIIs	Health Centre IIs	Total
Aswa HSD	0	1	4 (1)	14 (3)	19 (4)
Omoro HSD	0	1	6 (0)	17 (3)	23 (3)
Municipality	4	0	4 (0)	17 (1)	26 (1)
TOTAL	4	2	14 (1)	48 (7)	68 (8)

There are four functional hospitals and two Health Centre IV in Gulu District, 14 Health Centre III are functional with only one under construction, 48 Health Centre II with 7 non-functional. Most of the non-functional facilities are under rehabilitation and construction of health facilities in underserved parishes using funding from PRDP, PHC and donor support.

2.1.5 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.

3. LACOR HOSPITAL HEALTH CARE ACTIVITIES

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

Lacor Hospital had a total consolidated number of annual contacts of 274,774 patients in this FY 2011/12. A total 241,190 (87.8%) were seen as outpatients, while 33,584 (12.2%) patients were treated in the wards. Out of them, 192,068 (69.9%) were seen in the Hospital, while 82,706 (30.1%) clients were attended to at the Health Centres.

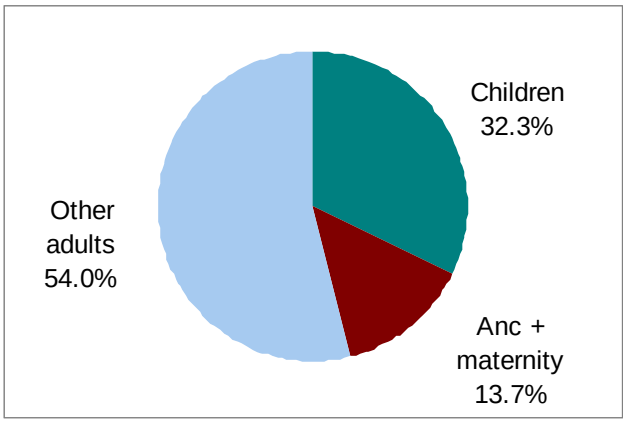
Table 3.1 - Consolidated number of contacts (In and Out patients) – 2011/12

Contacts 2011/12	In-pts children	In-pts Maternity	In-pts other adults	In-pts Total	Out-pts children	ANC	Out-pts other adult	Out-pts Total	Total Contact
Hospital	8,325	6,328	8,936	23,589	39,760	12,014	116,705	168,479	192,068
Amuru	1,272	1,610	551	3,433	13,436	7,865	5,298	26,599	30,032
Opit	960	870	627	2,457	8,244	2,820	8,487	19,551	22,008
Pabo	2,072	1,027	1,006	4,105	14,615	5,225	6,721	26,561	30,666
TOTAL	**12,629**	**9,835**	**11,120**	**33,584**	**76,055**	**27,924**	**137,211**	**241,190**	**274,774**

3.2 ATTENDANCE BY SPECIFIC GROUPS

Children below five made up 32.3% of the total attendance, while pregnant mothers (antenatal clinic and deliveries) attracted an additional 13.7% of the total attendance.

Figure 3.1 - Attendance by specific groups, Hospital & Health Centres - 2011/12



Thus, about half (46%) of all patients served in Lacor Hospital in the last year were children and pregnant women, who continued to benefit of high accessibility to the services of Lacor Hospital in line with the hospital's mission, and due to selective reduction of fees as below.

Table 3.2 - User fees for mothers and children – 2011/12

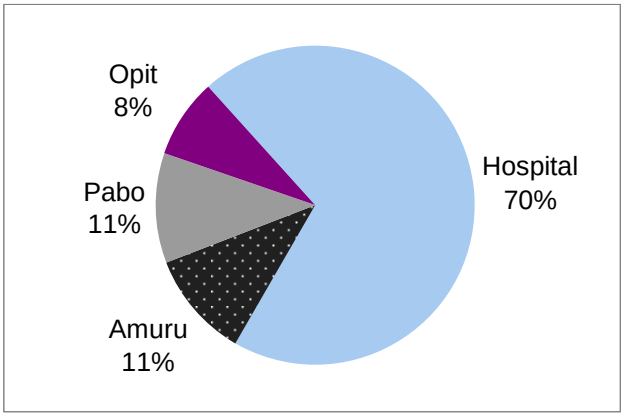
All services related to pregnancy (surgery included)	Free
All service to children in the Health Centres	Free
Admission of children in the Hospital	Free
Young Child Clinic in the Hospital and AIDS clinic (token flat rate all-inclusive)	Shs 1,000

The total average presence of patients in the Hospital and its Health Centres was of 535 in-patients and 804 outpatients for a total average presence of 1,339 patients per day.

3.2.1 Distribution of attendance according to location of the Units

The Hospital attracted 70% of the total attendance, followed by the Health Centre of Pabo, Amuru and Opit in this order.

Figure 3.2 - Distribution of Attendance, Health Centres and Hospital - 2011/12

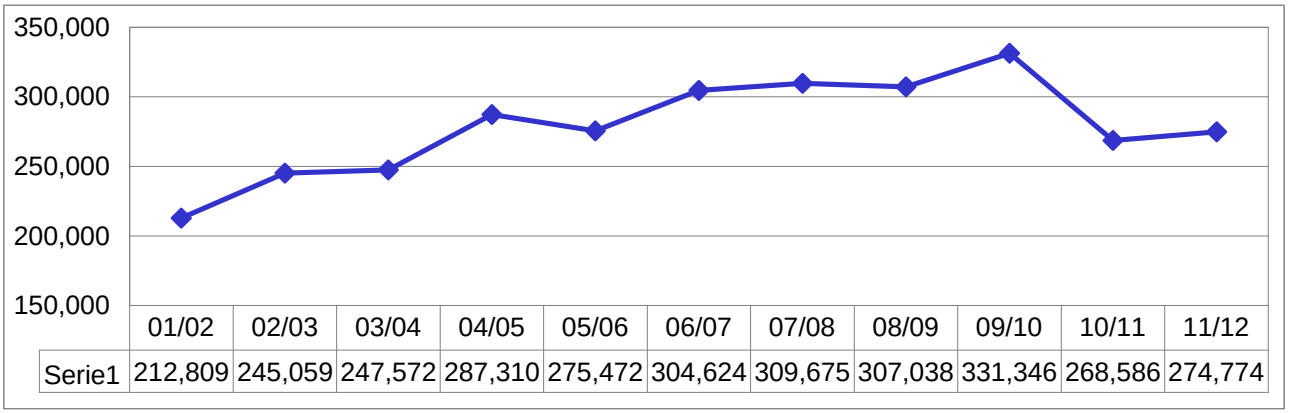


Service delivery in the Health Centres continue being fully integrated with the Hospital, actually they operate as branches of the Hospital, from which they share personnel, supplies and administration. The Hospital also regularly supervises the peripheral units and an ambulance service is maintained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

3.2.2 Trends of attendance

After many years of steady increase the overall service utilization in Lacor Hospital and in its three Health Centres in FY 2010-11 decreased by 19%, after reaching the previous year the ever-highest peak of 331,246 contacts. This year 2011/12 has however registered an overall increment in the total patient contacts of 2.3%.

Figure 3.3 - Trend of Total contacts – 2001/02 to 2011/12



	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
Serie1	212,809	245,059	247,572	287,310	275,472	304,624	309,675	307,038	331,346	268,586	274,774

3.2.3 Group-specific trends

In FY 2011/12 there was still a reduction in number of children services, but more gently than in the previous year. Maternity services and other adults have however recorded an increment.

Table 3.3 - Change in group-specific attendance – 2011/12

Total Attendance	2010/11	2011/12	Variance	Variance %
Children	91,037	88,684	-2,353	-2,6%
ANC and Maternity wards	36,327	37,759	1,432	3.9%
Other Adults	141,222	148,331	7,109	5.0%
TOTAL	**268,586**	**274,774**	**6,188**	**2.3%**

This increment of total attendance was due to an increase of 3.3% in outpatient contacts, while there was a small decline in admissions of 4.1%, compared to the previous FY when admissions declined by up to 30% in only one FY.

Table 3.4 - Trends of admissions compared to out-patient contacts – 2011/12

Total Attendance	2010/11	2011/12	Variance	Variance %
Admissions	35,020	33,584	-1,436	-4.1%
Outpatient contacts	233,566	241,190	7,624	3.3%
TOTAL	**268,586**	**274,774**	**6,188**	**2.3%**

This because in FY 2011/12 admissions of children have stabilized while the admissions in adults have increased.

Table 3.5 - Trends in children's admission and outpatients – 2011/12

Children	2010/11	2011/12	Variance	Variance %
Admissions children	14,289	12,629	-1,660 (-15,023 FY 10/11)	-11.6% (-51% FY 10/11)
Children Outpatients	76,748	76,055	-693 (-50,362 FY 10/11)	-0.9% (-40% FY 10/11)
TOTAL	**91,037**	**88,684**	**-2,353** (-65,385 FY 10/11)	**-2.6%** (-42% FY 10/11)

Actually, there was a marked reduction at the rate of reduction in admission of children from the previous 51% to only 11.6%. Likewise there was a marked reduction at the rate of reduction in the children outpatient attendance from 40% the previous FY to only 0.9% reduction this FY.

3.2.4 Trends by location of the Unit

This FY all the health centres recorded increment in attendance unlike the previous FY when all the health centres had recorded a big reduction in the number of attendance. The highest increment this FY has been recorded at Pabo health centre, which recorded an increment of up to 18.3% from -40% last FY. The main hospital, which last FY had recorded a total reduction of 31,128 contacts, recorded only a reduction of 1,011 contacts.

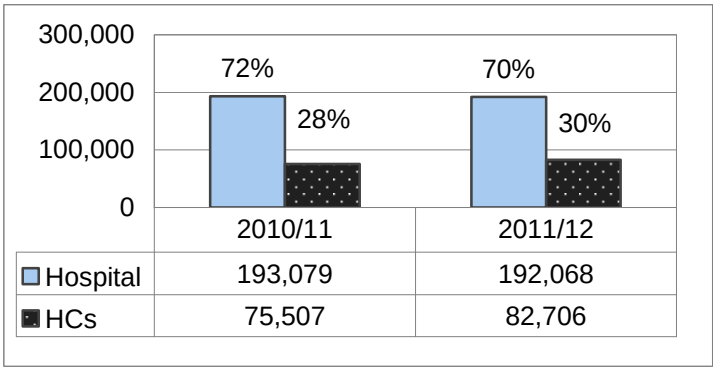
Table 3.6 - Trends of attendance by Location of the Unit – 2011/12

Total Attendance	2010/11	2011/12	Variance	Variance %
Lacor Hospital	193,079	192,068	-1,011 (in FY 10/11 was -31,128)	-0.5% (in FY 10/11 was -14%)
Amuru	28,965	30,032	1,067 (in FY 10/11 was -5,691)	3.7% (in FY 10/11 was -18%)
Opit	20,618	22,008	1,390 (in FY 10/11 was -6,530)	6.7% (in FY 10/11 was -24%)
Pabo	25,924	30,666	4,742 (in FY 10/11 was -19,411)	18.3% (in FY 10/11 was -40%)
TOTAL	**268,586**	**274,774**	**6,188** (in FY 10/11 was -62,760)	**2.3%** (in FY 10/11 was -19%)

3.3 DECENTRALIZATION OF SERVICE

The distribution of service output between the Hospital and its Health Centres (decentralization of service) has increased from 28% FY 2010/11 to 30% this FY 2011/12. This is in line with the last strategic plan of decentralizing 30% of the services to the Health Centres.

Figure 3.4 - Distribution of attendance, Health Centres and Hospital - 2011/12



3.3.1 Interpretation of the trends

The following are postulated reasons for the sharp fall in overall attendance since FY 2010/11 up to the present:

- A general reduction in the cases of malaria which is the leading disease burden in both adults and children. Malaria is a major driver of hospital attendance in Lacor. The following graph shows how drastic was the reduction of malaria cases admitted in the Hospital since august 2010. The MoH strategies of indoor residual spraying with insecticide (IRS), distribution of Long Lasting Insecticide Treated Nets (LLINs), prompt case management using artemisinin combination therapy (ACT) and Intermittent Presumptive Treatment (IPT) for malaria in pregnant women are probably the major contributors to this decline of malaria cases.
- Reduction in the number of severe malnutrition due to generally improved food security among the local population.
- The prompt case management of malaria in the community and the reduction of malnutrition can explain why the decline in the number of admission of children was proportionally higher than their attendance of out-patient services.
- Re-opening and improved functionality of public health facilities in the community.
- General improvement in the living environment of the local population after the disbanding of the Internally Displaced Peoples` camps.
- The relocation of the population from the areas of towns and urban centres to rural areas when the war ended.

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

Table 3.7 - Trend of selected activities – 2011/12

Total Attendance	2010/11	2011/12	Variance	Variance %
Surgical Clinic	9,455	9,784	329	3.5%
Dental Clinic	6,126	5,654	-472	-7.7%
Endoscopy	830	800	-30	-3.6%
Surgical operations	5,630	5,516	-114	-2.0%
ICU	234	250	16	6.8%
Diagnostic imaging	42,544	46,261	3,717	8.7%
Sickle Cell Clinic	2,208	2,328	120	5.4%
Emergency Clinics	7,999	7,629	-370	-4.6%

Dental clinic, Endoscopy, Surgical operations and Emergency clinics all recorded reduction in the outputs while surgical clinics, ICU, diagnostic images and sickle cell clinics have all recorded increments.

Substantial increment of attendance was also recorded in all maternal services, confirming the trend of the previous years.

Table 3.8 - Change in Maternity services – 2011/12

Total Attendance	2010/11	20201/12	Variance	Variance %
Deliveries	5,348	6,160	812	15.2%
Caesarean sections	713	787	74	10.4%
ANC-Obst&Gyn clinics	32,126	47,316	15,190	47.3%

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.

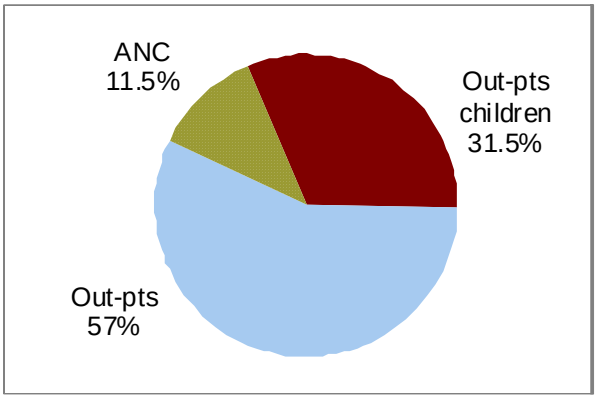
The Hospital also runs the following special clinics on outpatient basis: HIV clinics, Dental clinics, Obstetrics and Gynaecology clinics, Surgical clinics, Sickle Cell clinics, TB outpatient clinics, as well as private clinics.

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 remain opened twenty-four hours a day. On average 562 outpatients are seen in the Hospital daily. Another 242 outpatients are served on average for 6 days a week in the Health Centres.

3.4.1 Outpatient Services by categories of patients (Hospital / Health Centres)

Of the total 241,190 patients seen as outpatients, 137,211 (57%) were seen in the Adult OPD, 76,055 (31.5%) in the YCC, and 27,924 (11.5%) were pregnant women attending the ANC

Figure 3.5 - OPD Attendance by cadre of patients, Hospital & Health Centres – 2011/12

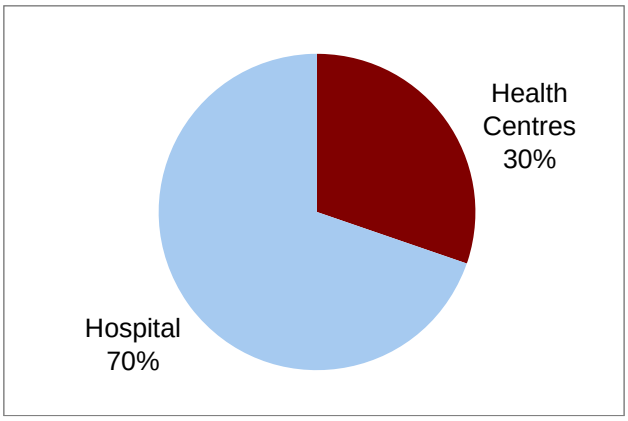


Thus children below 6 years and pregnant women attending ANC comprised 43% of all the hospital outpatient attendance, with 103,979 visits this year. When all women attending OPD are added (94,417), the proportion of women and children outpatients reaches 82% which means outpatient attendance is in line with the hospital mission to care for the most vulnerable groups.

3.4.2 Attendance according to location

Of the total 241,190 outpatients 168,479 (70%) were attended to in the Hospital and 72,711 (30%) were seen in the Health Centres.

Figure 3.6 - OPD Attendance, Hospital & Health Centres



3.4.3 Trend of outpatient attendance (Hospital and Health Centres)

An overview of outpatient attendance in the last 10 years shows a continuous increase until the FY 2009/10) and a sharp drop in FY 2010/11, but there has been a slight rise in attendance this FY.

Compared with last year there was an overall increment by 3.3% in outpatient attendance in this FY 2011/12, although this is still down compared to a total of 280,960 OPD contacts recorded in FY 2009/10.

Figure 3.7 - Trend of OPD Attendance, Hospital & Health Centres – 2002/03 to 2011/12

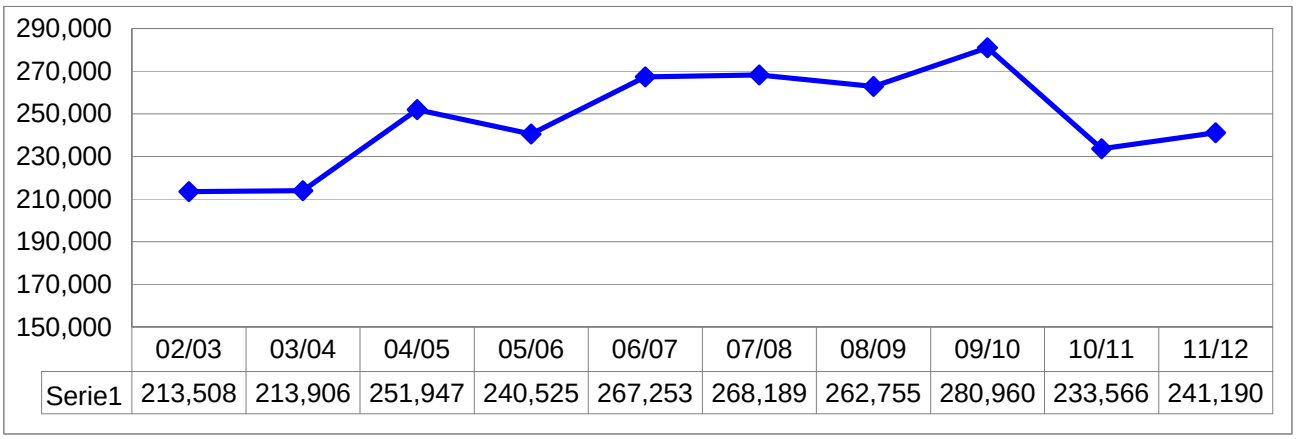


Table 3.9 - OPD Attendance by category of patients – 2011/12

Outpatient contacts	FY 10/11	FY 11/12	Variance	Variance %
Children	76,748	76,055	-693 (in FY 10/11 was 50,362)	-0.9% (in FY 10/11 was -40%)
Mothers	26,748	27,924	1,176 (in FY 10/11 was 1,514)	4.4% (in FY 10/11 was 6%)
Adults	130,070	137,211	7,141 (in FY 10/11 was 1,454)	5.5% (in FY 10/11 was 1%)
TOTAL	**233,566**	**241,190**	**7,624 (in FY 10/11 was -47,394)**	**3.3% (in FY 10/11 was -17%**

Noteworthy is the fact that, whereas the outpatient cases declined for children was by 50,362 (-40%) in FY 2010/11, this FY the decline was by only 693 (-0.9 %), for adults there was a further increment from 1,454 (1%) in FY 2010/11 to 7,141 (5.5%) this FY 2011/12. Also for pregnant women attending ANC there has been further increment in attendance (4.4%).

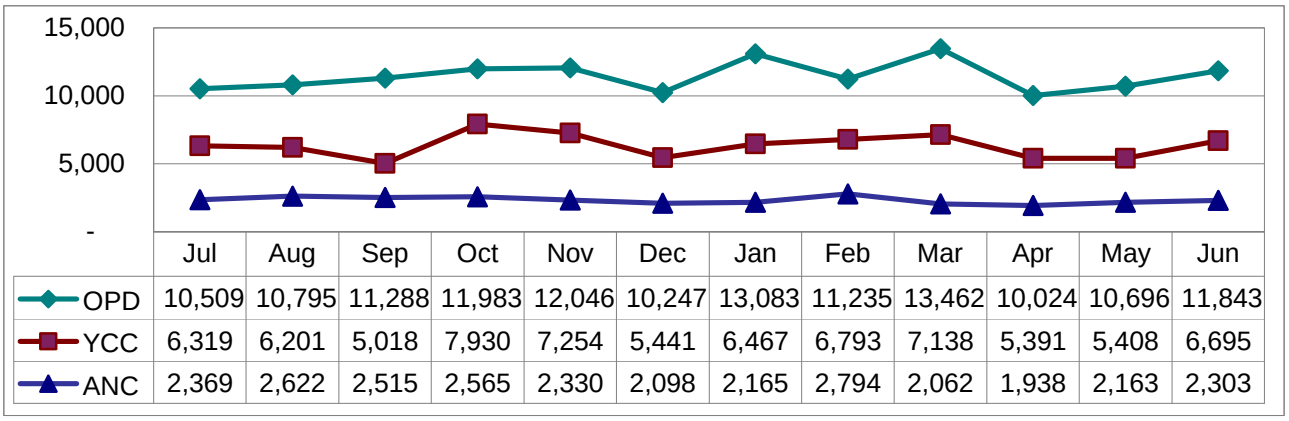
Table 3.10 - OPD Attendance in Hospital and Health Centres – 2011/12

Total Attendance	2010/11	2011/12	Variance	Variance %
Lacor Hospital	166,683	168,479	1,796	1.1%
Health Centres	66,883,	72,711	5,828	8.7%
TOTAL	**233,566**	**241,190**	**7,624**	**3.3%**

Both the Hospital and the three Health Centres recorded increment in OPD attendance this FY as compared to a general reduction the previous FY2010/11.

3.4.4 Trend of out-patients attendance throughout the year

Figure 3.8 - Monthly trends of adult OPD attendance in the Hospital and HCs - 2011/12



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
OPD	10,509	10,795	11,288	11,983	12,046	10,247	13,083	11,235	13,462	10,024	10,696	11,843
YCC	6,319	6,201	5,018	7,930	7,254	5,441	6,467	6,793	7,138	5,391	5,408	6,695
ANC	2,369	2,622	2,515	2,565	2,330	2,098	2,165	2,794	2,062	1,938	2,163	2,303

There was a slight seasonal variation in OPD attendance with all attendance dropping in the month of December which is a festive season while peak attendance were recorded in the months of January, February and March with another dip in attendance being recorded in April.

3.4.5 Outpatient attendance in Health Centres

The OPD attendance in the Health Centres increased by 8.7% this FY from 66,883 FY 2010/11 to 72,711 this year.

Table 3.11 - OPD attendance in Health Centres - 2011/12

Outpatient Attendance	2010/11	2011/12	Variance	Variance %
Opit				
Children	8,867	8,244	-623	-7.0%
ANC	2,695	2,820	125	4.6%
Adults	6,866	8,487	1,621	23.6%
Total Opit	18,428	19,551	1,123	6.1%
Pabo				
Children	13,098	14,615	1,517	11.6%
ANC	4,412	5,225	813	18.4%
Adults	5,310	6,721	1,411	26.6%
Total Pabo	22,820	26,561	3,741	16.4%
Amuru				
Children	13,984	13,436	-548	-3.9%
ANC	5,924	7,865	1,941	32.8%
Adults	5,727	5,298	-429	-7.5%
Total Amuru	25,635	26,599	964	3.8%
TOTAL ALL HCs	**66,883**	**72,711**	**5,828**	**8.7%**

Pabo and Opit Health Centres recorded more than 20% increase in the number of adults attending OPD. While Amuru receive 429 fewer adults compared to the previous year (-7.5%). There was however a 32.8% increase in ANC attendance in Amuru, the highest among the three Health Centres. This big increase in ANC attendance is attributed to the support given by Red Cross to mothers during ANC and deliveries at the Health Centre.

OPD attendance among children although still on a downward trend in Opit and Amuru, the rate of reduction however has stabilized at an average of -5% this year compared to about -40% last FY. As the attendance among children is reducing, the HCs are receiving more and more adults.

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 attending the ANC and all other Adults (both male and female). However in the Hospital bedside the general clinics there are several specialist or condition-specific clinics.

Table 3.12 - Overview of outpatient services and related attendance – 2011/12

Outpatient Attendance	2011/12	% of the total
Services for Adults		
General OPD	32,227	
Emergency Unit	6,327	
Private Clinic	2,631	
Staff Clinic	414	
AIDS Clinic	36,913	
TB Clinic	3,363	
Surgical Clinic	9,784	
Dental Clinic	5,654	
TOTAL services for adults	97,313	62%
Services for Children		
General YCC	33,970	
Emergency	1,302	
AIDS children	749	

TB children	1,411	
Sickle Cell Clinic	2,328	
TOTAL services for children	39,760	22%
Obst and Gyn Services		
ANC	12,014	
Gyn clinic	17,715	
Gyn clinic private	1,677	
TOTAL Obst&Gyn services	31,406	16%
TOTAL HOSPITAL OUTPATIENTS	**168,479**	**100%**

3.4.7 Distribution between general services and specialist/specific services

While more detailed information about specialist clinics or dedicated services for specific condition shall be given below, it is here worth noting that the Hospital's outpatient services attend more patients (87,223) in their specialist or condition-specific units that in the general clinics (81,256).

3.5 DISEASE BURDEN IN THE OUTPATIENTS IN THE HOSPITAL

3.5.1 Leading causes of morbidity among adults attending OPD

Acute respiratory infections, trauma and pneumonia are the leading causes of ill health among adults attending OPD. Malaria was this year the forth cause of ill health among adults unlike in the past years when malaria was the leading cause of ill health. This is due to the preventive measures of Indoor residual sprays which has been consistent for the last three years in northern Uganda.

Table 3.13 - Leading causes of morbidity among adults attending OPD – 2011/12

N.	Disease (multiple diagnoses allowed)	2011/12	Percentage
1	Acute Respiratory Infections	3,836	26.7%
2	Trauma	2,706	18.9%
3	Pneumonia	1,761	12.2%
4	Malaria	1,383	9.6%
5	Urinary Tract Infections	1,339	9.3%
6	Intestinal worms	1,150	8.0%
7	Cardiovascular diseases	815	5.7%
8	Hypertension	505	3.5%
9	Tuberculosis	479	3.3%
10	Skin diseases	407	2.8%
	TOTAL	**14,381**	**100.0%**

3.5.2 Leading causes of morbidity among children attending YCC

Even in children less than six years Malaria is no longer the leading cause of morbidity in the Young Child Clinic. Respiratory tract infections including pneumonia are now the leading causes of morbidity among the children, accounting for 38.9% of the major causes of illness treated in the YCC. The major causes of morbidity in children as seen in the YCC are largely preventable through improvement of general living conditions of the populace. Community based health care services would probably go a long way in reducing the incidences of these conditions.

Table 3.14 - Leading causes of morbidity in children attending YCC - 2011/12

N.	Diagnosis (multiple diagnosis allowed)	2011/12	Percentage
1	Respiratory Tract Infections non pneumonia	9,211	39.35%
2	Pneumonia	3,973	16.97%
3	Malaria	2,724	11.64%
4	Diarrhoeal diseases	2,493	10.65%
5	Skin diseases	1,721	7.35%
6	Ear Nose and Throat (ENT) conditions	952	4.07%
7	Intestinal worms	628	2.68%
8	Urinary Tract Infections	475	2.03%
9	Injuries/Trauma	415	1.77%
10	Anaemia	413	1.76%
11	Eye conditions	217	0.93%
12	Dysentery	187	0.80%
	TOTAL	**23,409**	**100.0%**

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 who seek care from Lacor Hospital. 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, as well as prevention of mother-to-child transmission (PMTCT) programme. Community follow up is done by Comboni Samaritans – another faith-based NGO with vast experience in home-based AIDS care. Lacor-Comboni partnership ensures good adherence to antiretroviral therapy. Safe male circumcision (SMC) was added to the spectrum of activities towards the end of the Financial Year, but specific SMC operations started later. Other interventions for HIV prevention include abstinence and being faithful, and health education.

Table 3.15 - HIV Services – 2011/12

HIV/AIDS Services	2009/10	2010/11	FY 2011/12
Patients on HIV care			
Children	372	946	978
Adults	9,516	9,567	10,338
TOTAL on general care	**9,888**	**10,513**	**11,316**
Active patients on ART			
Children	136	356	378
Adults	3,216	3,509	3,909
TOTAL on ART	**3,352**	**3,865**	**4,287**

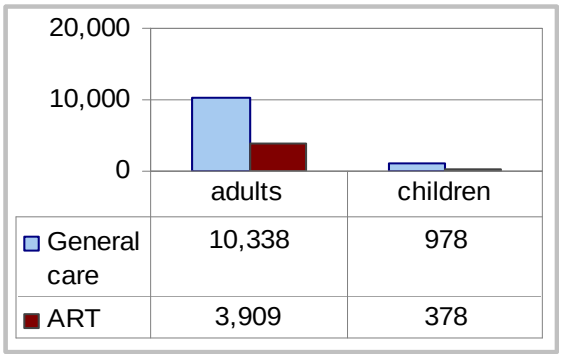
There were 11,316 patients active on HIV care in FY 2011/12. Children aged 14 years and below were 978, while 10,338 were adults. There were 4,287 patients active on ART, of which 378 were children under 15 years. About 10% of the services are provided at the health centres. About half (45%) of the clients seen in the health centres are on ART.

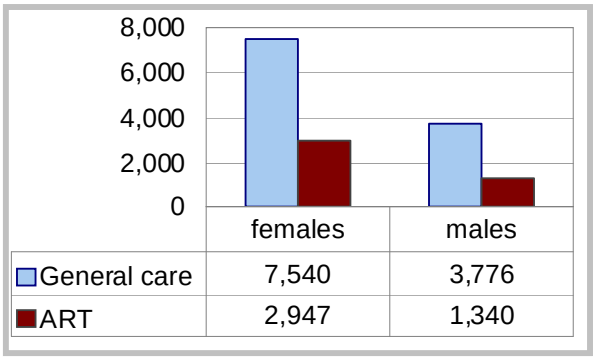
Most of the patients receiving ARVs from Lacor are provided free services under AIDS Care and Treatment (ACT) programme of Uganda Catholic Medical Bureau, Uganda Episcopal Conference, funded by PEPFAR. The number of patients being treated in the AIDS clinic has continued to increase since the introduction of ARV under the AIDS Relief Programme.

On average, a total of 120 patients are treated in the AIDS 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 3.9 – HIV Services by type of care / age and gender - 2011/12



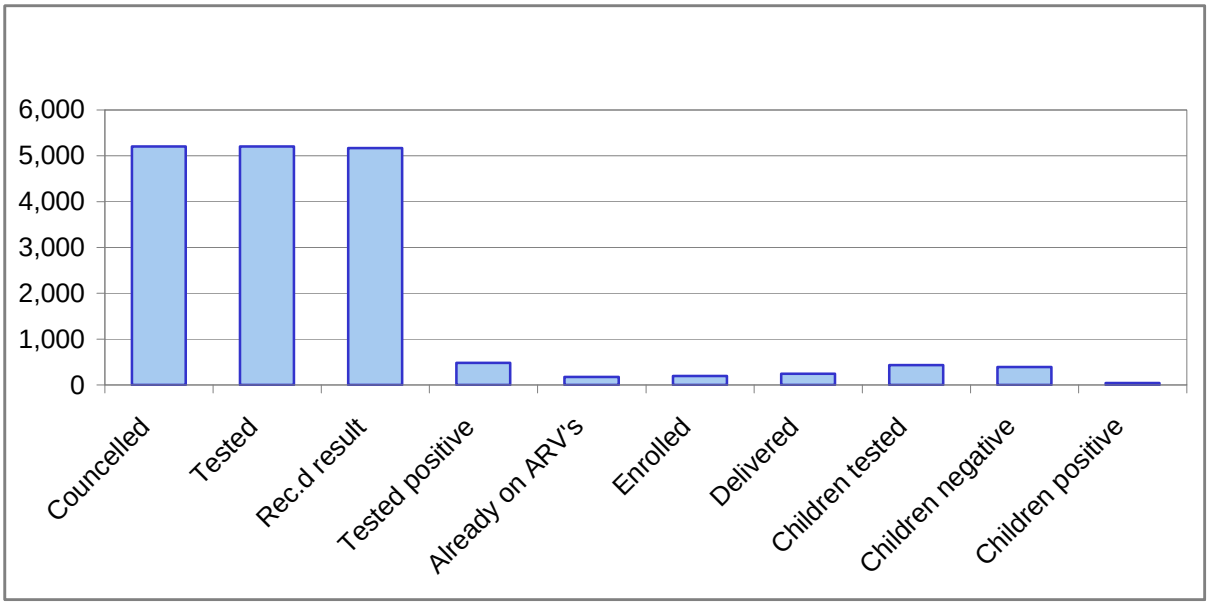


Most of the clients attending the HIV clinic have been females, who comprise 69% of those on ART, and 67% of the total in care. This has been due to the poor health seeking behaviour of males, who tend to come with advanced HIV disease. This trend has not significantly improved since the opening of the clinic.

Table 3.16 - PMTCT activities – 2011/12

PMTCT Activity	2011/12	Percentage
New ANC cases	5,218	-
New ANC cases + others pre-test counselled	5,203	99.7% ANC new cases
Women tested for HIV	5,202	99.7% ANC new cases
Post-test counselled and received HIV result	5,165	99.3% of tested women
Women tested positive for HIV	486	9.3% of tested women
Partners (of HIV tested women) tested for HIV	1409	27.1% of ANC women
Partners positive for HIV	75	5.3% of tested partners
ANC mothers already on ART	175	36.0% of ANC positive women are on ART. Overall 76.75% positive mothers getting ARVs
Enrolled into PMTCT programme (received ARVs/On ART)	198	
HIV positive mothers delivered in the Hospital	247	50.8% of HIV positive women
Children of HIV positive mothers tested for HIV	434	175% of women who delivered in hospital
Children of HIV positive mothers who tested HIV negative	393	90.6% of children tested with results
Children of HIV positive mothers who tested HIV positive	41	9.4% of children

Figure 3.10 - PMTCT Services – 2011/12



The very significant improvement realised in HIV care was the escalation of PMTCT uptake and Early infant diagnosis. Note that 175% percent of children were tested because many came to test long after delivery on realising the more readily available service. 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. A challenge in this is linkage to the ART clinic where the services are provided, and the difference in protocols (the surrounding hospitals and health units still provide Option A).

With more engagement of males, male involvement has increased from 20% in FY 2010/11 to 27% in 2011/12.

3.7 INPATIENT CARE ACTIVITIES: ADMISSIONS

3.7.1 Bed capacity (Hospital and Health Centres)

The bed capacity has not changed in the last year and it still is 482 in the main Hospital and 24 beds in each of the three Health Centres. The total bed capacity of the Hospital complex is therefore 554.

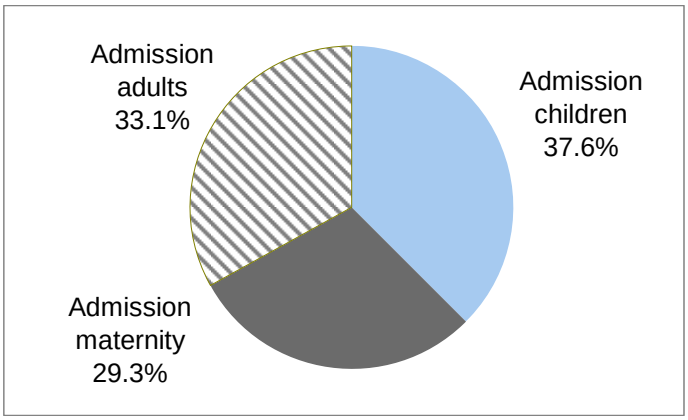
Patients with severe medical and surgical conditions are admitted and treated as inpatient, both in the Hospital and in the three Peripheral Health Centres.

Patients that 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

The total number of admissions in the Hospital and Health Centres was 33,584. Children were still the biggest group with 12,629 admissions, followed by 11,120 adults admitted in all other wards, except 9,835 women admitted in maternity. Admissions in children wards and maternity wards accounted for over 2 thirds (66.9%) of all admissions in the Hospital and in the Health Centres.

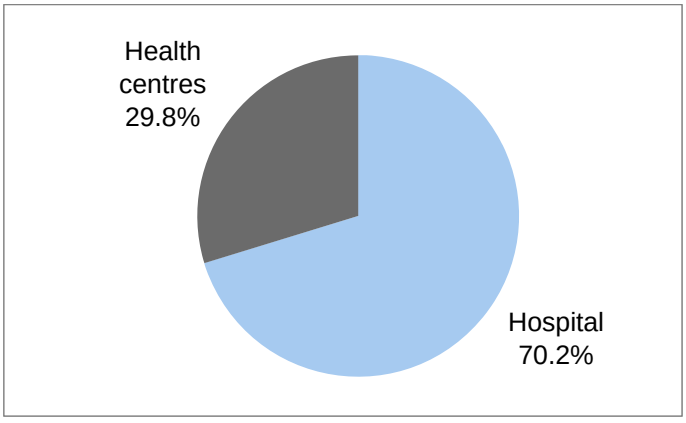
Figure 3.11 - Admissions by specific age groups - 2011/12



3.7.3 Admissions by location

Out of the 33,584 admitted patients, 23,589 (70.2%) were admitted in the Hospital and 9,995 (29.8%) in the three Health Centres.

Figure 3.12 - Admissions by location – 2011/12

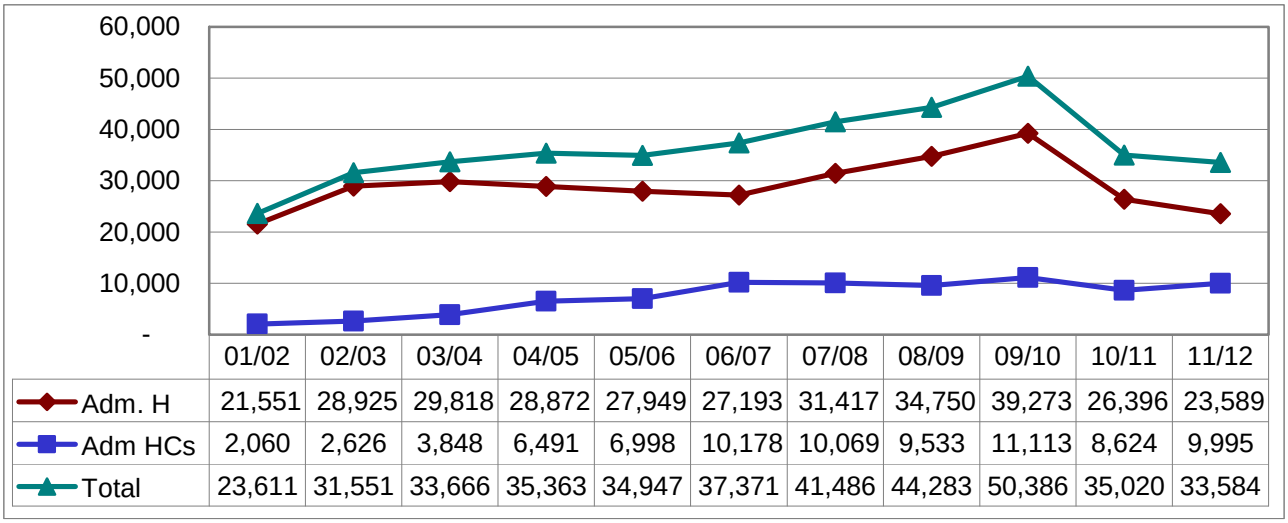


The average number of new patients admitted per day into the hospital wards the FY 2011/12 was 91 patients per day including health Centres, and 65 patients per day for the hospital only, while the average number of patients present in the wards was 452 for 482 beds in the Hospital and 83 for 72 beds in the Health Centres.

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, this FY 2011/12 there has been a further drop in the number of admissions especially in the hospital. Admissions in the three Health Centres have all recorded increment from last FY.

Figure 3.13 - Trends of Admission to the Hospital & Health Centres – 2001/02 to 2011/12



	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
Adm. H	21,551	28,925	29,818	28,872	27,949	27,193	31,417	34,750	39,273	26,396	23,589
Adm HCs	2,060	2,626	3,848	6,491	6,998	10,178	10,069	9,533	11,113	8,624	9,995
Total	23,611	31,551	33,666	35,363	34,947	37,371	41,486	44,283	50,386	35,020	33,584

Compared with the last FY 2010/11 when the drop in admissions was by up to 30%, this FY admission only dropped by 4.1%, which is a much gentler drop.

Table 3.17 - Reduction in admissions to the Hospital & Health Centres - 2010/11

Admissions	2009/10	2010/11	Variance	Variance %
Total admissions children	29,312	14,289	-15,023	-51%
Total admission maternity	9,033	9,579	546	6%
Total admissions adults	12,041	11,152	-889	-7%
TOTAL	**50,386**	**35,020**	**-15,366**	**-30%**

Table 3.18 - Reduction in admissions to the Hospital & Health Centres - 2011/12

Admissions	2010/11	2011/12	Variance	Variance %
Total admission children	14,289	12,629	-1,660	-11.6%
Total admission maternity	9,579	9,835	256	2.7%
Total admission adults	11,152	11,120	-32	-0.3%
TOTAL	**35,020**	**33,584**	**-1,436**	**-4. 1%**

The number of children admitted has decreased by 11.6% this year compared to a reduction of 51% FY 2010/11.

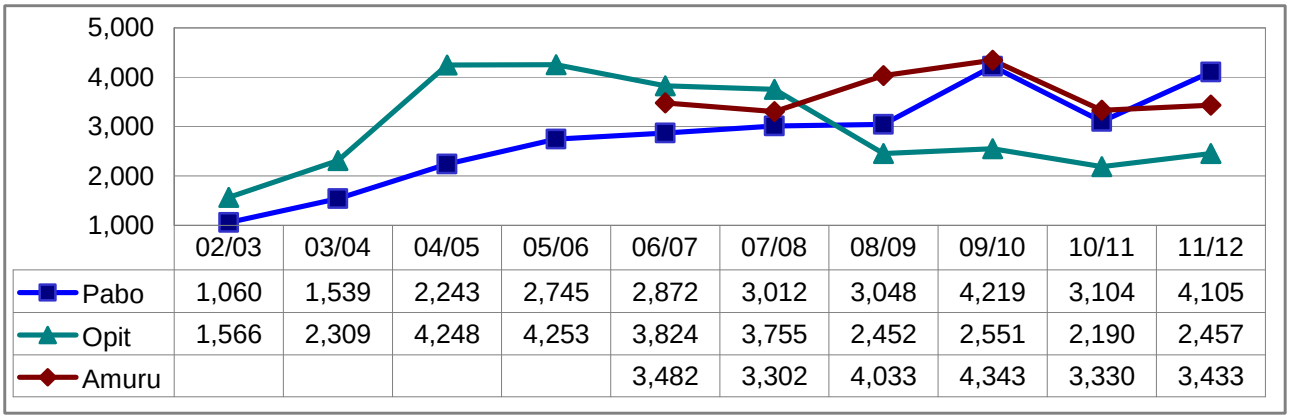
The number of admissions decreased more in the Hospital than in the Health Centres. Actually as shown by the graph above the admissions in the Health Centres have more moderate changes than the Hospital.

3.7.5 Admission to the Health Centres

The number of patients in the individual Health Centre changed overtime because of several factors like swelling 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 first by the district and then by an international NGO (MSF).

Figure 3.14 - Trends of admission to the Health Centres - 2002/03 to 2011/12



	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
Pabo	1,060	1,539	2,243	2,745	2,872	3,012	3,048	4,219	3,104	4,105
Opit	1,566	2,309	4,248	4,253	3,824	3,755	2,452	2,551	2,190	2,457
Amuru					3,482	3,302	4,033	4,343	3,330	3,433

In FY 2010/11 all Health Centres registered decline in admission, the highest being in Pabo, by 26%, followed by Amuru (23%). The least decline in admission was seen in Opit HCIII (14%).

Table 3.19 - Admission to the Health Centres – 2009/10 and 2010/11

Admissions	2009/10	2010/11	Difference	% Variance
Amuru	4,343	3,330	-1,013	-23%
Pabo	4,219	3,104	-1,115	-26%
Opit	2,551	2,190	-361	-14%
TOTAL	**11,113**	**8,624**	**-2,489**	**-22%**

In this FY 2011/12 the admissions in the Health Centres have all increased. Actually, 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 case mixes.

Table 3.20 - Admission to the Health Centres – 2010/11 and 2011/12

Admissions	2009/10	2010/11	Difference	% Variance
Amuru	3,330	3,433	103	3.1%
Pabo	3,104	4,105	1,001	32.2%
Opit	2,190	2,457	267	12.2%
TOTAL	**8,624**	**9,995**	**1,371**	**15.9%**

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 were opened.

Table 3.21 - Departments, Wards and Number of beds in the Hospital - 2011/12

Bed state FY 2011/12	Beds per ward	Total for department
Paediatric Department		152
Nutrition Unit	40	
General Paediatric Ward	106	
Neonatal Unit	6	
Medical Department		134
Medicine Ward	80	
Medicine Private	5	

TB Ward	30	
Isolation Unit	20	
Surgical Department		136
Surgery 1 (Septic Surgery)	62	
Surgery 1 Side Room	2	
Burns Unit	8	
Surgery 2 (Clean Surgery)	47	
Surgery 2 Private	5	
Surgery 2 Private Grade 1	4	
Intensive Care Unit	8	
Obst&Gyn Department		60
Maternity Ward	54	
Maternity Private	6	
TOTAL		**482**

3.7.7 Private Beds

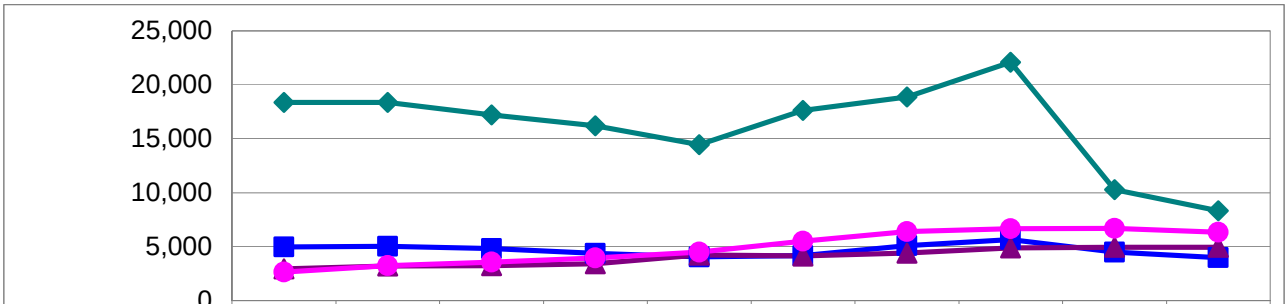
The Hospital has a total of only 19 private beds out of 482. Private rooms have 1 or 2 beds and patients are charged per day and on consumption, while all patients in common room are charged a flat rate of Shs 25,000 everything included, except surgical operations that are charged separately (see below). As already mentioned, children and pregnant women are admitted free of charge and patients registered with the AIDS clinic pay a flat rate of only Shs 10,000.

Table 3.22 - Admissions by Ward to the Hospital - 2011/12

Admissions	FY 2010/11	FY 2011/12	Difference	% Variance
Paediatric Department				
General Paediatric Ward	9,696	8,074	-1,622	-16.7%
Neonatal Unit	127	94	-33	-26.0%
Nutrition Unit	448	157	-291	-65.0%
Total Paediatric Department	10,271	8,325	-1,946	-18.9%
Medical Department				
General Medicine	4,295	3,762	-533	-12.4%
TB Ward	133	104	-29	-21.8%
Isolation Unit	51	129	78	152.9%
Total Medical Department	4,479	3,995	-484	-10.8%
Surgical Department				
Surgery 1	2,025	1,836	-189	-9.3%
Burns Unit	68	91	23	33.8%
Surgery 2	2,620	2,764	144	5.5%
Intensive Care Unit	234	250	16	6.8%
Total Surgical Dept	4,947	4,941	-6	-0.1%
Maternity	6,699	6,328	-371	-5.5%
TOTAL	**26,396**	**23,589**	**-2,807**	**-10.6%**

Nutrition ward recorded the biggest drop in number of admission by 65% while there was a gentle drop in paediatrics by 16.7%. Generally all departments recorded reductions in their admissions. Reduction of transmissible diseases is probably the cause. Actually, most cases of malaria are being treated at home or as outpatients, due the introduction of the more effective ACT based combination therapy.

Figure 3.15 - Trend of admissions to the Hospital by departments – 2002/03 to 2011/12



	02//03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
Paediatrics	18,371	18,361	17,226	16,215	14,437	17,626	18,881	22,097	10,271	8,325
Medicine	4,960	5,018	4,818	4,358	4,041	4,153	5,075	5,641	4,479	3,995
Surgery	2,935	3,208	3,247	3,413	4,232	4,130	4,390	4,863	4,947	4,941
Maternity	2,659	3,231	3,581	3,963	4,483	5,508	6,404	6,672	6,699	6,328

The above graph shows that the number of children admitted in the paediatric department had the biggest drop between 2009/10 and 2010/11; this drop has continued but at a much slower rate this year. There has been for the first time a drop in admission in maternity by 5%.

3.8 LEADING CAUSES OF ADMISSION TO THE HOSPITAL

3.8.1 Admission among children

The four leading causes of admission have remained similar this FY compared to 2010/11, although septicaemia (including bacteraemia) now tops the list at 25.1%, followed by pneumonia, malaria, and acute diarrhoea. Malaria, though rates are falling, still remains a significant cause of morbidity.

Table 3.23 - Leading causes of Admission to the Hospital among Children – 2011/12

N.	Diagnosis (multiple diagnoses allowed)	2011/12	Percentage
1	Septicaemia	4,864	25.1%
2	Pneumonia	3,358	17.4%
3	Malaria	2,606	13.5%
4	Acute diarrhoea	1,702	8.8%
5	Sickle cell disorders	723	3.7%
6	Persistent diarrhoea	522	2.7%
7	Acute Respiratory tract infections	486	2.5%
8	Anaemias	365	1.9%
9	Hernias	266	1.4%
10	Burns	225	1.2%
11	Malnutrition	168	0.9%
12	Phemosis, paraphemosis	167	0.9%
13	Perinatal conditions/asphyxia	160	0.8%
14	Injuries/fractures	150	0.8%
15	Meningitis/bacterial	146	0.8%
16	Cryptococcal meningitis	124	0.6%
17	Tuberculosis	117	0.6%
18	Urinary tract infection	110	0.6%
19	Cellulitis	96	0.5%

20	AIDS	75	0.4%
21	All others	2,869	14.9%
	TOTAL	**19,299**	**100.0%**

3.8.2 Admission among adults

The commonest diseases causing admission in adults (including children 6 years and above) in this FY were malaria, cancers, injuries, AIDS, and TB, when pregnancy and its complications are excluded. It is important to note that there were many snake and animal bites, possibly because of people returning to ancestral homes which were not inhabited for long.

Table 3.24 - Leading causes of Admission to the Hospital among Adults – 2011/12

N.	Diagnosis (multiple diagnoses allowed)	2011/12	Percentage
1	Pregnancy/Deliveries	5,959	20.3%
2	Abortions and Complications of pregnancy	1,874	6.4%
3	Malaria	1,809	6.2%
4	Malignant neoplasm (cancers)	1,619	5.5%
5	Injuries, fractures (excluding burns)	1,296	4.4%
6	AIDS	620	2.1%
7	Tuberculosis	611	2.1%
8	Pneumonias	605	2.1%
9	Septicaemias	588	2.0%
10	Sickle cell disorders	521	1.8%
11	Pelvic inflammatory disease	506	1.7%
12	Hypertensive diseases	492	1.7%
13	Benign neoplasm	469	1.6%
14	Hernias	453	1.5%
15	Diabetes	365	1.2%
16	Anaemias	339	1.2%
17	Diarrhoea	304	1.0%
18	Snake and animal bites	264	0.9%
19	Cellulitis	263	0.9%
20	Others	10,343	35.4%
	TOTAL	**29,300**	**100.0%**

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'.
HIV/AIDS cases are being diagnosed more easily due to the more liberal testing policy of routine testing and counselling being encouraged, and the many outreaches with testing done in collaboration with other community based organisations.

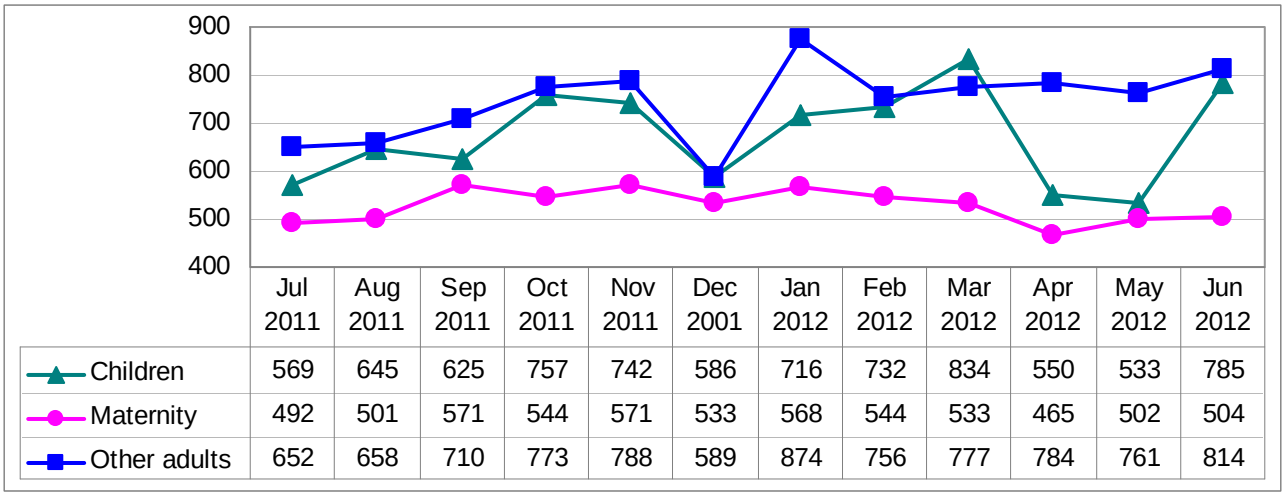
Tuberculosis remains a major problem, coupled with our new ability to detect resistant forms of TB using GeneXpert.

3.8.3 Monthly rates of admission

The rate of admission of children shows seasonal variation. There is a decline in admission during the dry months of December to April, when the incidence of malaria, the major cause of illness in children, is low due to the dry environmental condition unfavourable for breeding of mosquitoes. This year May also recorded very low attendance. Adult admissions dip in December, which is the festive season, but are generally almost stable throughout the year.

On average, the rate of monthly admission to the Hospital is 673 children and 1,272 adults a month. This is a total of 64 admissions in the Hospital on a daily basis, 35% of them being in the children wards.

Figure 3.16 - Monthly rates of admission to the Hospital by wards – 2011/12



	Jul 2011	Aug 2011	Sep 2011	Oct 2011	Nov 2011	Dec 2001	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	Jun 2012
Children	569	645	625	757	742	586	716	732	834	550	533	785
Maternity	492	501	571	544	571	533	568	544	533	465	502	504
Other adults	652	658	710	773	788	589	874	756	777	784	761	814

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

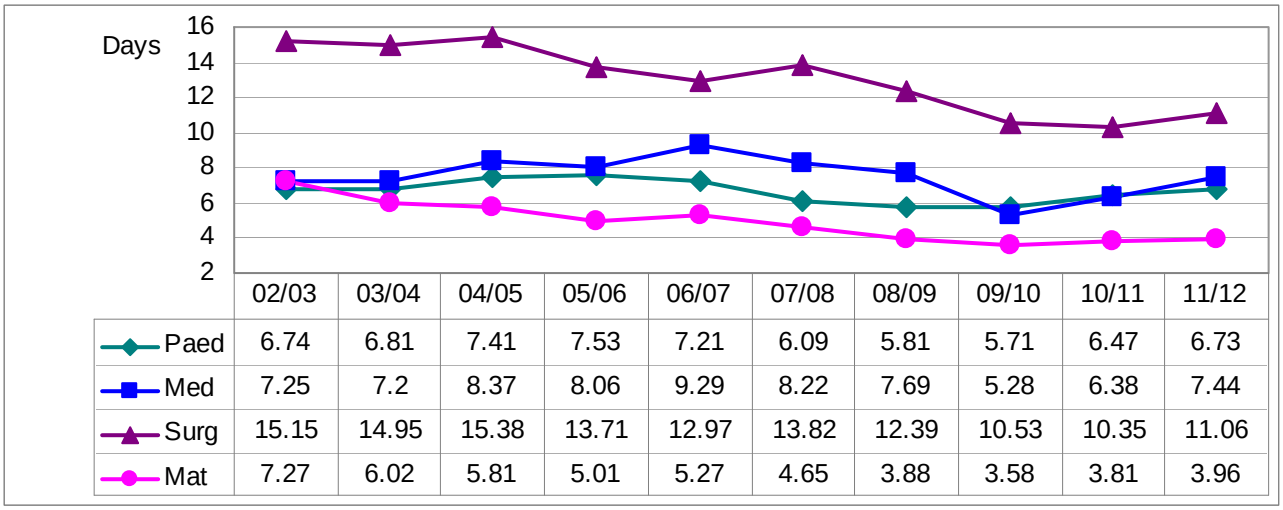
The hospital length of stay in FY 2011/12 was 7.01 days up from 6.50 days in 2010/11 and 5.89 days in the FY 2009/10. This could be attributed in part to declining cases of malaria which takes shorter time to treat, and more complex cases managed.

Table 3.25 - Variations in department specific inpatient ALOS and BOR - 2011/12

Department	Bed Capacity	Admissions	Bed State	ALOS 2011/12	BOR 2011/02
Paediatrics	152	8,325	56,003	6.73	100.67%
Medicine	134	3,995	29,709	7.44	60.58%
Surgery	136	4,941	54,624	11.06	109.74%
Maternity	60	6,328	25,072	3.96	114.17%
TOTAL/AVERAGE	**482**	**23,589**	**165,408**	**7.01**	**93.76%**

The average length of stay varies by ward, with maternity having the lowest ALOS of 3.96, up from 3.81 in the last FY; surgery still has the highest ALOS of 11.06 up from 10.35 days. 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.

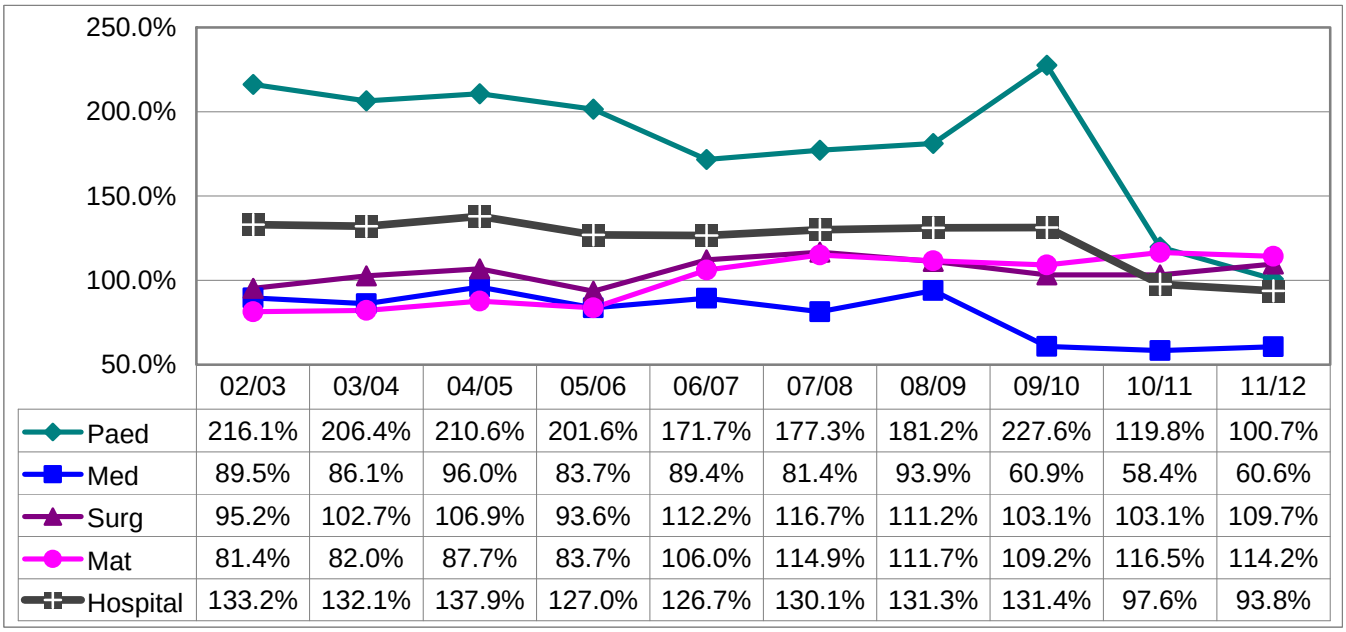
Figure 3.17 - Variations in department specific inpatient ALOS – 2002/03 to 2011/12



	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
Paed	6.74	6.81	7.41	7.53	7.21	6.09	5.81	5.71	6.47	6.73
Med	7.25	7.2	8.37	8.06	9.29	8.22	7.69	5.28	6.38	7.44
Surg	15.15	14.95	15.38	13.71	12.97	13.82	12.39	10.53	10.35	11.06
Mat	7.27	6.02	5.81	5.01	5.27	4.65	3.88	3.58	3.81	3.96

The average length of stay in each ward over the last ten years has shown downward trends until two years ago, when they started to increase.

Figure 3.18 - Variations in department specific BOR – 2002/03 to 2011/12



	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
Paed	216.1%	206.4%	210.6%	201.6%	171.7%	177.3%	181.2%	227.6%	119.8%	100.7%
Med	89.5%	86.1%	96.0%	83.7%	89.4%	81.4%	93.9%	60.9%	58.4%	60.6%
Surg	95.2%	102.7%	106.9%	93.6%	112.2%	116.7%	111.2%	103.1%	103.1%	109.7%
Mat	81.4%	82.0%	87.7%	83.7%	106.0%	114.9%	111.7%	109.2%	116.5%	114.2%
Hospital	133.2%	132.1%	137.9%	127.0%	126.7%	130.1%	131.3%	131.4%	97.6%	93.8%

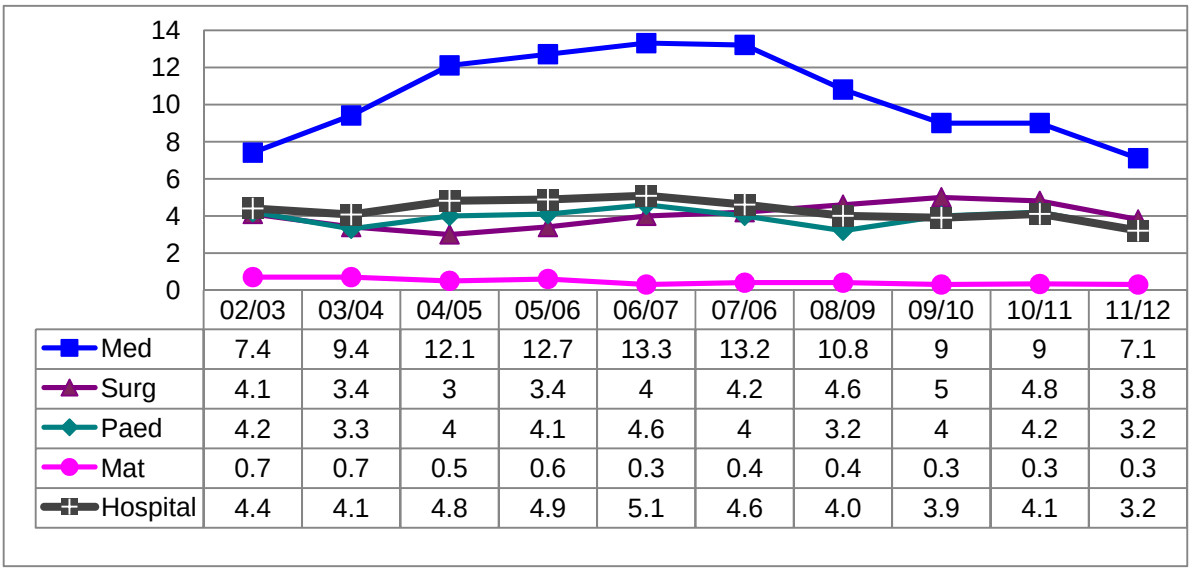
In FY 2010/11 for the first time since many years the BOR for the whole hospital fell below 100% because of the lower BOR of paediatrics. This FY 2011/12 BOR has reduced to 93.8% following a further reduction in paediatrics. The medical department has a low BOR of 60.6%, being comprised of Isolation ward (20 beds) with BOR 17.2%, TB ward (30 beds) with BOR 40.7% and General Medicine (84 beds) with 78.0%.

3.9 INPATIENT MORTALITY RATE IN THE HOSPITAL

The total number of deaths in the Hospital in FY 2011/12 was 755. Mortality rates in the hospital declined to 3.2% this FY, unlike in the last nine years, when it ranged between 4% and 5%. This is in spite of the increasing numbers of critically ill patients being treated in the wards.

High mortality 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 increased complexity of disease conditions and referral of cases from nearby hospitals seem to have minimally affected the mortality rate this year. The neonatal unit which receives very delicate prematures had 36.2% mortality and the Intensive Care Unit which received patients for critical care had mortality of 47.6%.

Figure 3.19 – Variations in department specific Mortality – 2011/12



	02/03	03/04	04/05	05/06	06/07	07/06	08/09	09/10	10/11	11/12
Med	7.4	9.4	12.1	12.7	13.3	13.2	10.8	9	9	7.1
Surg	4.1	3.4	3	3.4	4	4.2	4.6	5	4.8	3.8
Paed	4.2	3.3	4	4.1	4.6	4	3.2	4	4.2	3.2
Mat	0.7	0.7	0.5	0.6	0.3	0.4	0.4	0.3	0.3	0.3
Hospital	4.4	4.1	4.8	4.9	5.1	4.6	4.0	3.9	4.1	3.2

3.9.1 Leading causes of death in children admitted to the Hospital

Neonatal conditions, especially neonatal septicaemia, coupled with pneumonia, septicaemia, burns and meningitis are the leading causes of both death and admissions in children. Other leading causes of death include malaria, diarrhoea, sickle cell disease, malnutrition, AIDS, and neonatal tetanus. A sickle cell clinic is now operational, to improve lives and reduce deaths among sicklers.

Table 3.26 – Leading causes of death in children admitted to the Hospital - 2011/12

	Diagnosis (multiple diagnosis allowed)	N. deaths 2011/12
1	Neonatal conditions including septicaemia	61
2	Pneumonia	57
3	Septicaemia beyond neonatal period	31
4	Burns	21
5	Meningitis	15
6	Malaria	14
7	Diarrhoea	14
8	Sickle cell disease	13
9	Malnutrition	13
10	AIDS	12
11	Tetanus	7

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

Table 3.27 - Case fatality rates for leading causes of death in children admitted to the Hospital – 2011/12

N.	Diagnosis (multiple diagnoses allowed)	Admissions 2011/12	Deaths 2011/12	Case fatality rates
1	Burns	225	21	9.33%
2	Sickle cell disorders	723	13	1.80%
3	Pneumonia	3,358	57	1.70%
4	Septicaemia	4,864	73	1.50%
5	Anaemias	365	3	0.82%
6	Acute diarrhoea	1,702	11	0.65%
7	Acute Respiratory Tract Infections	486	3	0.62%
8	Persistent diarrhoea	522	3	0.57%
9	Malaria	2,606	14	0.54%
10	Hernias	266	0	0.00%

3.9.3 Leading causes of death in adults admitted to the Hospital

HIV/AIDS and TB have remained the two leading causes of death among adults at Lacor Hospital over many years. Cancers septicaemias and pneumonias as well as liver diseases are other major causes of death in the medical wards, followed by malaria, injuries meningitis, and others. Cancers and liver diseases, especially Hepatitis and related cirrhosis, coupled with Hepatocellular carcinoma, are increasingly playing key roles for mortality among adults. The leading causes of death are not significantly changed compared to the last FY 2010/11.

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

Disease conditions with the highest case fatality rates in adults are AIDS (26.13%), tuberculosis (17.35%), septicaemias 12.59%, pneumonias 11.74%. Others include anaemias, diarrhoeal diseases, cancers malaria, and abortions. A high case fatality rate, 6.24% is seen in cancers, combined, but this is worse in specific cancers, like Hepatocellular carcinoma. Generally liver diseases are rampant in this region, with a lot of Hepatitis progressing into Liver cirrhosis and subsequently Hepatocellular carcinoma.

Those dying from meningitis, pneumonia and TB may as well have underlying HIV infections though not all of them are usually tested for HIV. Deaths from TB and HIV result majorly from late reporting. 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.

Table 3.28 - Case fatality rates for leading causes of death in adults admitted to the Hospital - 2011/12

N.	Diagnosis (multiple diagnoses allowed)	Admissions 2011/12	Deaths 2011/12	Case fatality rates
1	AIDS	620	162	26.13%
2	Tuberculosis	611	106	17.35%
3	Septicaemias	588	74	12.59%
4	Pneumonias	605	71	11.74%
5	Anaemias	339	35	10.32%
6	Diarrhoea	304	24	7.89%
7	Malignant neoplasm (cancers)	1,619	101	6.24%
8	Diabetes	365	22	6.03%
9	Injuries, fractures (excluding burns)	1,296	47	3.63%
10	Malaria	1,809	62	3.43%

11	Abortions and Complications of pregnancy	1,874	55	2.93%

Table 3.29 - Summary of Hospital mortality by Ward – 2004/05 to 2011/12

	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Medicine ward (General Med & TB)								
Admissions	4,818	4,358	4,041	4,153	5,075	5,641	4,479	3,995
Total deaths	586	556	537	548	550	502	403	283
Mortality rate	12.16%	12.76%	13.29%	13.20%	10.84%	8.90%	9.00%	7.08%
Paediatric ward (Children ward, Nutrition & Isolation)								
Admissions	17,226	16,215	14,437	17,626	18,881	22,097	10,271	8,325
Total deaths	688	665	664	719	619	792	432	267
Mortality rate	3.99%	4.10%	4.60%	4.08%	3.28%	3.58%	4.21%	3.21%
Surgical ward (Surgery I, II & ICU)								
Admissions	3,247	3,413	4,232	4,130	4,390	4,863	4,947	4,941
Total deaths	98	117	172	177	205	221	238	188
Mortality rate	3.02%	3.43%	4.06%	4.29%	4.67%	4.54%	4.81	3.80%
Maternity ward (Obstetric & Gynaecology)								
Admissions	3,247	3,963	4,483	5,508	6,404	6,672	6,699	6,328
Total deaths	98	25	12	24	32	21	22	17
Mortality rate	3.02%	0.63%	0.27%	0.44%	0.50%	0.31%	0.33%	0.27%
TOTAL all wards								
Admissions	28,872	27,949	27,193	31,417	34,750	39,273	26,396	23,589
Total deaths	1,388	1,363	1,384	1,468	1,406	1,536	1,095	755
Mortality rate	4.81%	4.88%	5.09%	4.67%	4.05%	3.91%	4.15%	3.20%

Table 3.30 - Summary of hospital inpatient statistics/activities – 2011/12

Ward	Medicine	Paediatrics	Maternity	Surgery	Total / average
Number of beds	134	152	60	136	**482**
Admissions	3,995	4,941	6,328	8,325	**23,589**
Bed days	29,709	56,003	25,072	54,624	**165,408**
Occupancy rate	60.58%	100.67%	114.17%	109.74%	**93.76%**
Average length of stay	7.44	6.73	3.96	11.06	**7.01**
Number of deaths	283	267	17	188	**755**
Death rate	7.08%	3.21%	0.27%	3.80%	**3.20%**

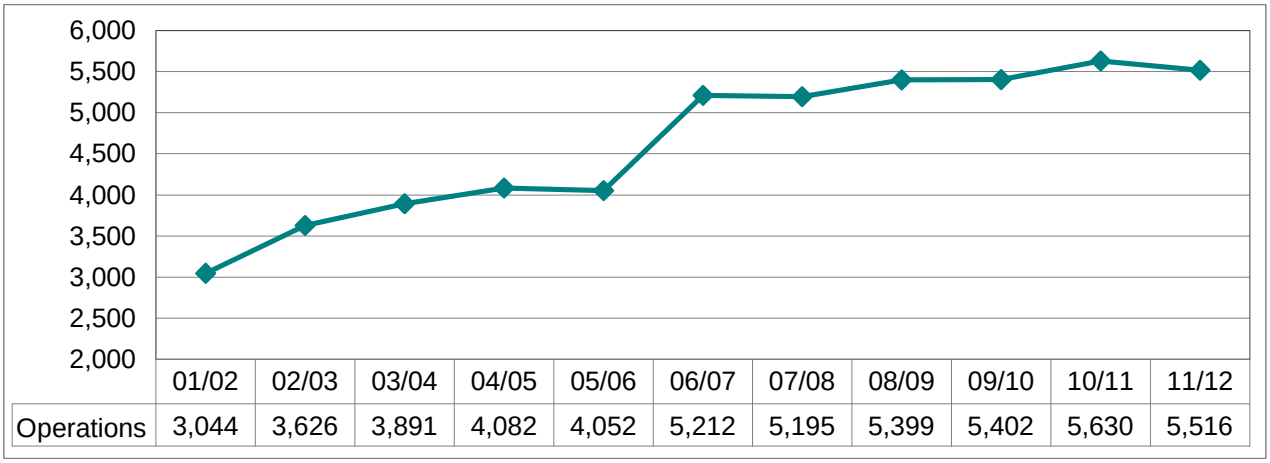
3.10 OTHER CLINICAL ACTIVITIES AND CLINICAL SERVICES

3.10.1 Surgical Operations

The theatres operate everyday 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 remained very high at about 15 major operations being carried out on a daily basis. There were 5,516 major operations performed in the FY 2011/12, of which many were emergency operations. This is a slight reduction from the previous year 2010/11. This number however excludes the many minor procedures done in minor theatres and side rooms of the surgical and gynaecology/obstetric wards.

Figure 3.20 - Trend of major surgical operations – 2001/02 to 2011/12



	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
Operations	3,044	3,626	3,891	4,082	4,052	5,212	5,195	5,399	5,402	5,630	5,516

In addition to the 5,516 major operations, there were a total of 5,023 minor procedures and POPs performed in the hospital.

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

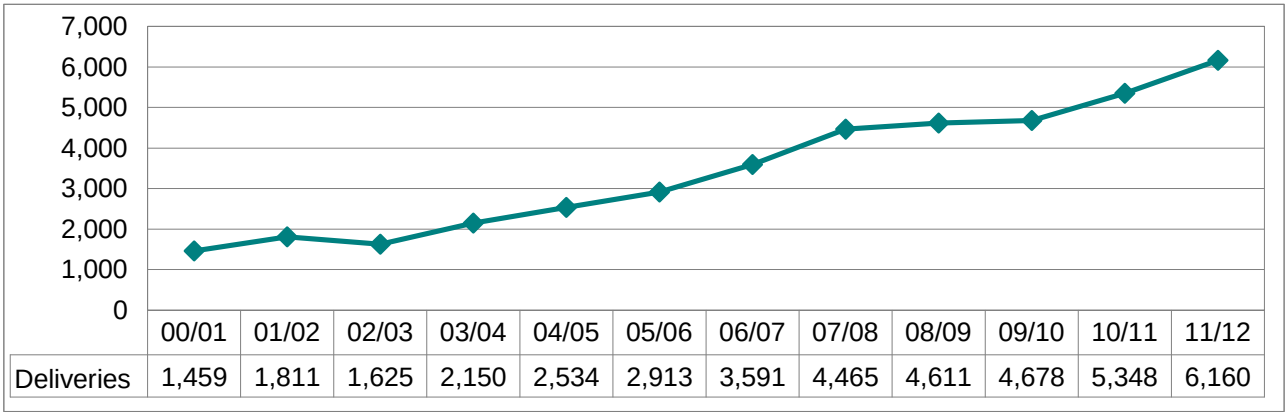
The total number of antenatal visits continued to increase in all the Health Centres especially at Amuru Health Centre where an increment of 32.8% was recorded. The hospital, however, recorded a 12.4% reduction in ANC attendance this year. The highest increment recorded in Amuru HCIII was due o more mothers being attracted to the Health Centre by the project being implemented by the Red Cross, providing Mama Kits and material assistance to pregnant mothers in Amuru.

Table 3.31 - Antenatal care in the Hospital and Health units – 2011/12

ANC	2010/11	2011/12	Difference	% Variance
Hospital	13,717	12,014	-1,703	-12.4%
Amuru	5,924	7,865	1,941	32.8%
Opit	2,695	2,820	125	4.6%
Pabo	4,412	5,225	813	18.4%
TOTAL	**26,748**	**27,924**	**1,176**	**4.4%**

3.10.2.2 Deliveries in the Hospital and Health Centres

Figure 3.21 - Trend of assisted deliveries – 2001/02 to 2011/12



	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
Deliveries	1,459	1,811	1,625	2,150	2,534	2,913	3,591	4,465	4,611	4,678	5,348	6,160

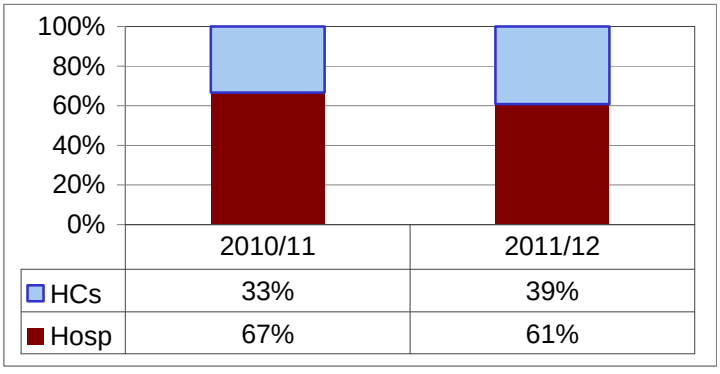
The number of assisted deliveries in the Hospital and the Health Centres has been increasing steadily over the time.

Table 3.32- Distribution of assisted deliveries by location – 2011/12

Deliveries	FY 2011/12	FY 2011/12	Difference	% Variance
Hospital	3,564	3,748	184	5.2%
Health Centres				
Amuru	854	1,245	391	45.8%
Opit	551	658	107	19.4%
Pabo	379	509	130	34.3%
Total Health Centres	1,784	2,412	628	35.2%
TOTAL HOSP. & HCs	**5,348**	**6,160**	**812**	**15.2%**

39% of all the deliveries this FY took place in the three Health Centres. Thanks to the remarkable increase of deliveries in Amuru and Pabo and also Opit Health Centres. This is a further decentralization of this vital service.

Figure 3.22 - Deliveries in the Hospital and Health Centres – 2011/12



	2010/11	2011/12
HCs	33%	39%
Hosp	67%	61%

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 in FY 2011-12 is at 438 per 100,000 live births. The next table and figure present the trends of maternity services in Lacor Hospital.

Table 3.33 - Summary of Maternity services – 2004/05 to 2011/12

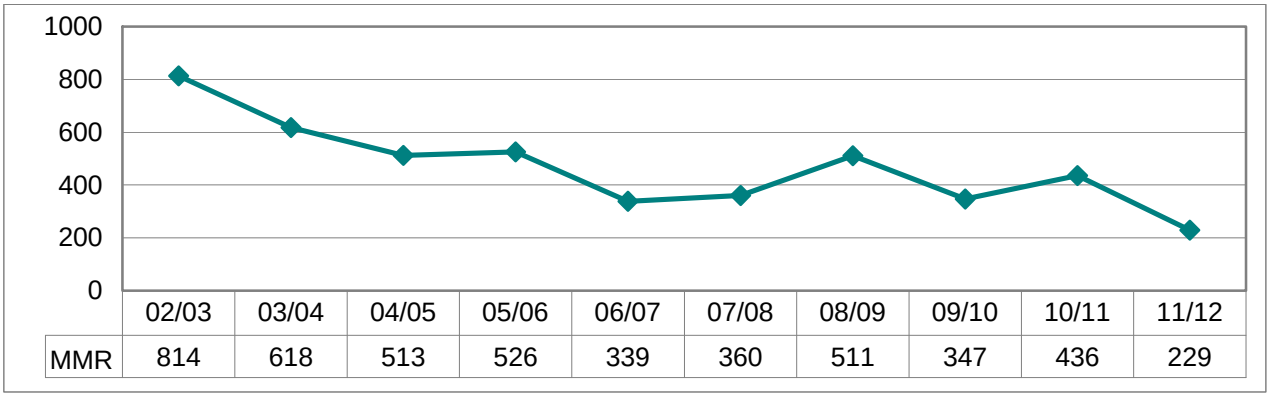
Services	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Total deliveries	2,534	2,913	3,591	4,465	4,611	4,678	5,343	6,160
Deliveries in HCs	626	730	1,065	1,260	1,178	1,291	1,784	2,412
N. C/Sections	280	283	382	635	772	640	713	787
C/Section rates	11.0%	9.7%	10.6%	14.2%	16.7%	13.7%	13.3%	12.8%
N. Maternal deaths	13	15	12	16	23	16	23	14
MMR	513	526	339	360	511	346	436	229
N. live births	2,536	2,854	3,538	4,445	4,502	4,617	5,276	6,101
N. still births	56	112	78	25	167	161	172	110
Still birth rate	22	39	22	6	37	35	33	18

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 2011/12 the MMR is at its lowest 229/100,000 LB.

The continuous improvement is attributed to the general improvement in the obstetric care in the district as well as the improvement in the referral system, both by Government heath units and NGO run heath units allowing patients to reach the Hospital and receive more timely interventions.

The still birth rates this year has also gone down further to 18/1000 live birth from 33/1000 live births last year, while caesarean section rates have remained the same at around 13%. 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 80% of all caesarean sections in Gulu, Amuru and Nwoya districts.

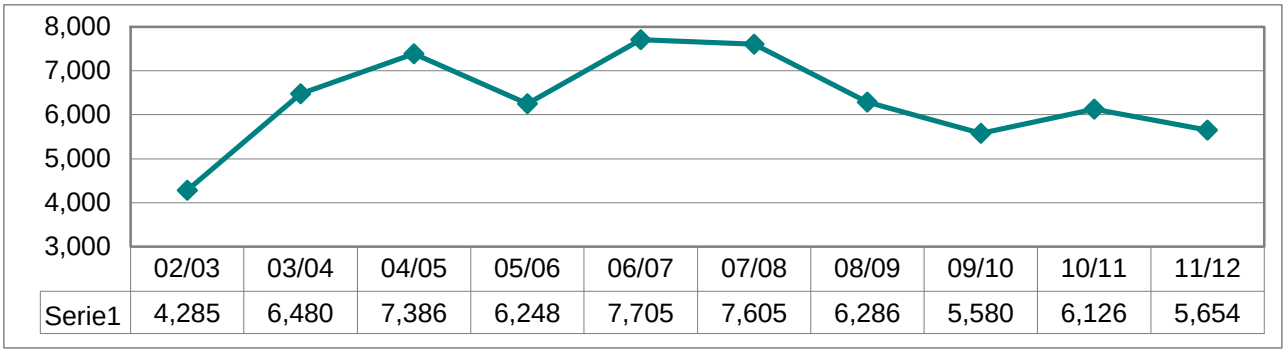
Figure 3.23 - Trend in Maternal Mortality Ratio



3.11 DENTAL SERVICES

After a steady decrease in the number of patients receiving dental treatment in the previous three years, the number of patients rose from 5,880 in FY 2009/10 to 6,126 FY 2010/2011 but this year there has again been a reduction in the number of dental service to 5,654. The services include conservative dentistry, tooth extractions, as well as other emergency dental treatment.

Figure 3.24 - Trend of dental services – 2002/03 to 2011/12



3.12 LABORATORY SERVICES

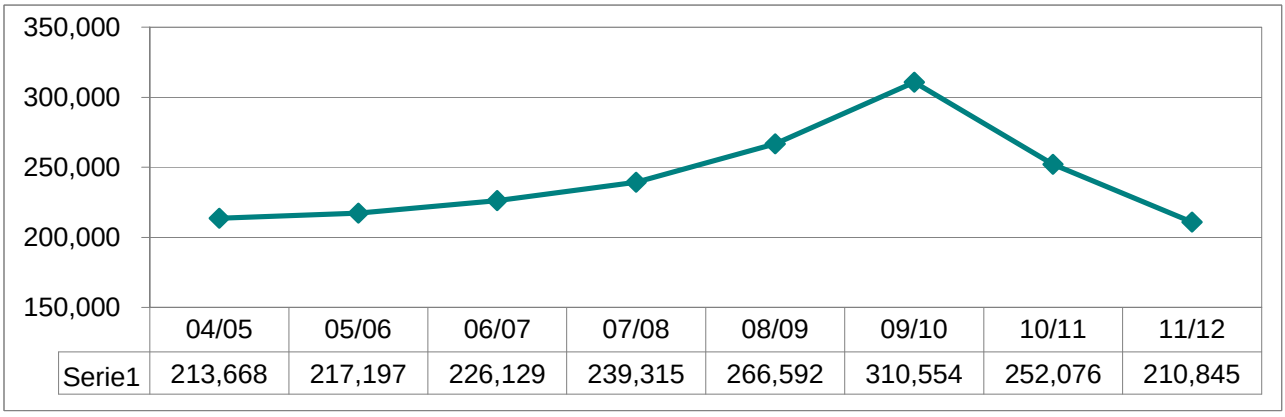
Clinical/diagnostic laboratory examinations are routines in both Lacor Hospital and the three Health Centres. The laboratory tests performed at the Health Centres are basic microscopy and haematological tests, while the types of laboratory investigations performed at the Hospital ranges from the basic 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 four years.

Table 3.34 - Number of Laboratory tests performed – 2004/05 to 2011/12

	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Hospital	193,715	199,939	198,655	212,809	233,492	263,358	214,956	171,688
HCs	19,953	17,258	27,474	26,506	33,100	47,196	37,120	39,157
TOTAL	**213,668**	**217,197**	**226,129**	**239,315**	**266,592**	**310,554**	**252,076**	**210,845**

A general fall in the number of tests performed by 16.4% from 252,076 in FY 2010/11 to 210,845 this FY may correspond to the reduced attendance, and probably because of less suspected cases of malaria. Malaria test is the most commonly performed laboratory test. However the general increase in disease complexity also requires more complicated lab tests, some of which we lack.

Figure 3.25 - Trend of total number of laboratory tests – 2004/05 to 2011/12



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 3.35 - Trends of Radiological examinations – 2003/04 to 2011/12

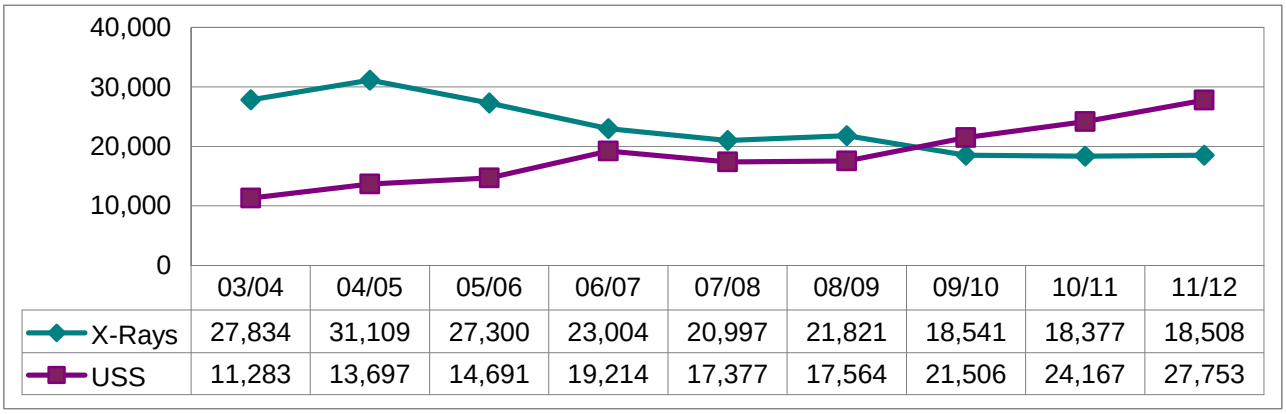
Exam	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
X-Rays	27,834	31,109	27,300	23,004	20,997	21,821	18,541	18,377	18,508
USS	11,283	13,697	14,691	19,214	17,377	17,564	21,506	24,167	27,753
TOTAL	**39,117**	**44,806**	**41,991**	**42,218**	**38,374**	**39,385**	**40,047**	**42,544**	**46,261**

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

This FY 2011/12 Radiology department recorded the highest number of patients ever, reaching 46,261, an increment of 3,717 patients (8.7%) from the FY 2010/11.

The figure below shows steady increments in Ultrasound performed over the years. 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.

Figure 3.26 - Trends of radiological examinations – 2003/04 to 2011/12

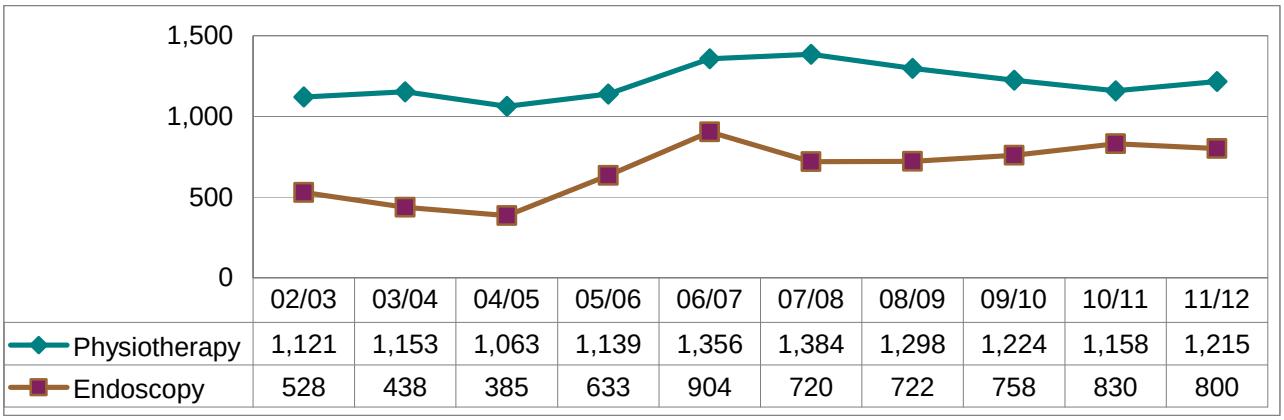


	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
X-Rays	27,834	31,109	27,300	23,004	20,997	21,821	18,541	18,377	18,508
USS	11,283	13,697	14,691	19,214	17,377	17,564	21,506	24,167	27,753

3.14 PHYSIOTHERAPY AND ENDOSCOPY SERVICES

Endoscopy and physiotherapy are two other specialized services offered by the hospital. This FY 2010/11, 800 endoscopic examinations were performed and 1,215 physiotherapy sessions were carried out.

Figure 3.27 - Trends of Physiotherapy and Endoscopy



	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12
Physiotherapy	1,121	1,153	1,063	1,139	1,356	1,384	1,298	1,224	1,158	1,215
Endoscopy	528	438	385	633	904	720	722	758	830	800

Both physiotherapy and endoscopy are performed on both outpatients and inpatients. There has been a slight decline in endoscopy performed this FY, this reflects the general decline in the number of patients in the hospital. Physiotherapy remained stable.

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 and Amuru.

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 3.36 - Health Centres service output for selected services – 2011/12

Service output 2011/12	Amuru HC	Opit HC	Pabo HC	Total
OPD adults	5,298	8,487	6,721	20,506
YCC	13,436	8,244	14,615	36,295
ANC	7,865	2,820	5,225	15,910
Admissions children	1,272	960	2,072	4,304
Admissions maternity*	1,610	870	1,027	3,507

Admissions adults	551	627	1,006	2,184
TOTAL	**30,032**	**22,008**	**30,666**	**82,706**
Deliveries*	1,245	658	509	2,412

* Already included in the total number of contacts.

All the three Health Centres also recorded general increment in attendance, by 9.50%, up from 75,507 contacts in the last FY. The Health Centres contributed 30% of all the total hospital complex contacts. Deliveries in the Health Centres have increased by 35%, possibly due to improved handling of mothers, and better health education in the communities.

Children under 6 years comprised 49% of the total attendance, and children together with pregnant women comprised 60,016 contacts, i.e. 73% of the total 82,705. This concurs with the hospital mission to provide health care to the vulnerable and most needy.

The Health Centres continue to offer free medical care to children below six years and pregnant women, 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 3.37 – Administered vaccines – 2007/08 to 2011/12

Antigen	2007/08	2008/09	2009/10	2010/11	2011/12
BCG	7,352	8,246	8,562	9,444	8,193
Polio	20,784	22,263	22,439	25,552	23,068
DPT	15,550	17,262	18,305	19,196	16,813
Measles	4,343	4,862	5,057	5,788	5,102
Tetanus toxoid	14,013	9,819	9,824	11,845	10,365
TOTAL	**62,042**	**62,452**	**64,187**	**71,825**	**63,541**

The above data include only the routine UNEPI vaccination outputs, but Lacor Hospital also participates in the NIDs. The number of routine vaccines given reduces by 8,284 (11.5%) compared to the last fiscal year. This is possibly due to more functional government health centres 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.

Table 3.38 – Service delivered to paralyzed patients – 2011/12

Service delivery to paralyzed patients	2011/12
Community based care	43
OPD care in Hospital	46
Admissions	59

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 a total of 657 VHTs (vaccinators inclusive) in the subcounties of Lakwana, Amuru, and Pabo.

Table 3.39 – PHC Outreach Activities – 2011/12

Primary Health Care Outreach activities	FY 2011/12
Immunizations	74
Home visits	48
School health	30
Health education within the hospital	7,013
Voluntary Counselling and Testing (VCT)	16
Others	28

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 800 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 DHO. In FY 2010/2011, Lacor actively participated in the verification investigations and management of Nodding Syndrome in Gulu and Amuru, and epidemic preparedness for VHF's like Marburg (Kibale).

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.

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.

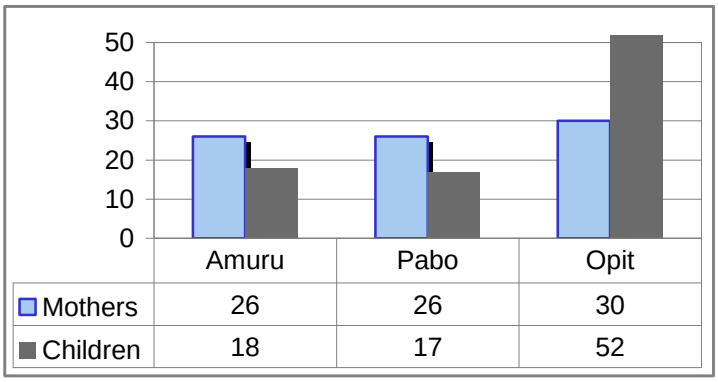
3.15.3 Ambulance Services

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. The number of ambulance services doubled from 187 in FY 2010/11 to 392 in FY 2011/12. 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 3.40 –Ambulance service – 2011/12

Services	Amuru	Pabo	Opit	Community	Total
Mothers	26	26	30	5	87
Children	18	17	52		87
Others	41	49	75	36	201
Referral to Mulago					17
TOTAL	**85**	**92**	**157**	**41**	**392**

Figure 3.28 – Ambulance services for mothers and children – 2011/12



The figure shows that the highest number of calls for the ambulance this year was from Opit, a significant increase from 46 calls in FY 2010-11 to 82 calls this FY. Pabo had the lowest number of calls this FY.

Most of the ambulance services were for mothers and children; even most 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.

3.16 QUALITY AND PATIENT SAFETY IMPROVEMENT

Lacor Hospital has made strides in the improvement of quality of care. A quality improvement team suggested by the board has now been constituted 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 institutionalisation of quality improvement principles in the hospital. Alongside this team are functional the Infection Control Committee, and the Medicines and Therapeutics Committee.

Activities include:

- Compilation of routine quality checklist: the QIN moves around wards every month checking five aspects, for good practices and noncompliances. The Matron's Office then checks these interventions;
- Joint internal support supervision;
- Hospital Acquired Infections surveys have been performed annually, and a 50% reduction in HAI noted in from 28%[1] in 2010/11 to 14% in 2011/12[2], as done by an independent external auditor;
- Monitoring of prescription practices: serial surveys of drug administration showed a reduction of missed doses from 31% in 2010/11 to 22% in 2011/12.

[1] D. Greco and I. Magombe, Hospital Acquired Infections in a large North Ugandan hospital, J Prev Med Hyg 2011, 52:55-58.
[2] D. Greco et al, Report on Hospital Acquired Infection Survey, Lacor Hospital, November 2011.

Future activities:
- Joint internal support supervision instituted;
- Clinical chart audits, death reviews, and maternal death audits. We shall have a more routine hospital acquired infections survey by the Infection Control Committee.
- Interdepartmental meetings.

Table 3.41 - Satisfaction level of patients in different areas – 2008/09 to 2011/12

Year	Satisfaction rates			
	2008/09	2009/10	2010/11	2011/12
Clinical outcomes (Patients who felt they improved definitely)*	83.1%	83.0%	89.7%	70%
Humanity of care (Patients were well received and respected)	90%	90%	88%	96%
Patients felt Health care environment was clean	83%	75%	88%	95%
Waiting before treatment				
a) clients waited for long	50%	54%	47%	38%
b) clients waited to some extent	18%	24%	41%	22%
c) clients did not wait long	32%	22%	12%	40%

*Here an adjusted rate was used, to exclude those who are not applicable.

Overall, there was a paradoxical decline in clinical outcome, yet all other parameters seem to be improving. Note that up to 30% of clients were not eligible for this question because they were coming for the first time.

More patients felt they were treated humanely: well received and respected, an 8% increment from the previous year's marks. This corresponds to the many 'communicate well with patients' campaigns that the hospital has embarked on.

More patients also felt that the hospital environment was clean, with a gradual rise from the previous years. Two % felt the hospital was not clean, and 3% thought the hospital environment was clean to some extent. This is thanks to the compound workers and cleaners who have scheduled cleaning times.

In terms of waiting before treatment, less patients felt they were waiting for a long time before getting treatment (38% from 54%), whereas in another question, more clients thought they did not wait for long before getting treatment (40% up from 12% in FY 2010/11). This is well elaborated in a response which shows that only 3% of clients waited for over 3 hours before getting treatment.

The drug prescription practices in Lacor are monitored. Overall, 2.6 drugs were prescribed per patient. Of these, Injectable drugs were prescribed for 3.75 percent of the patients, and antibiotics were prescribed for 66.25% of our clients. This is a high figure, above our targeted 40%. For those prescribed antibiotics, the average was 1.8 antibiotics.

Table 3.42 – Workplan for quality improvement activities / Interventions

Workplan for quality improvement activities Activity/Interventions	Key action steps	Proposed Commencement / completion date	Person(s) responsible
Joint internal support supervision	Perform joint visits to Medicine, Paediatric, Surgical, and ObsGyn Wards	Commenced November 2012, ongoing	Secretary Quality Improvement Team
Systematic clinical chart audits	Clinical chart audits before visits	November 2012	Quality Improvement Team chair, specialists
Patient satisfaction and	Recruit, train interview	March-May 2013	Head records office

drug surveys	team, perform survey		
Continued quality audits		Monthly to whole hospital	Quality Improvement Team nurse
Spearhead meeting of quality/safety related teams	Meeting with PTC, ICC		Quality Improvement Team
Quality meetings		Monthly	Quality Improvement Team

3.16.1 Safety

Lacor acknowledges many risks involved in provision of health care, ranging from possible harm to patients, health care providers, 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.

3.16.2 Pastoral, palliative and social care

3.16.2.1 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 counselling. The pastoral care nurse has routine ward counselling sessions in the afternoons. The Chaplaincy is available 24 hours on call for emergency sacraments/consultation. On Sundays mass is offered within the hospital.

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 (119 patients visited/counselled, 124 baptized, 7 confirmed, 289 anointed).

3.16.2.2 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.

Palliative care output in Lacor Hospital: 205 patients were enrolled since 2010 (both out and in patients) with pain and other symptoms associated with cancer and HIV/AIDS have received holistic care from the palliative care team. Common cancers include hepatocellular carcinoma (40%), Kaposi's sarcoma (20%), gynaecological cancers (20%) and GIT malignancies (15%).

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.

3.16.2.3 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 Comboni Samaritans of Gulu, a community based organization. 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.

4. HEALTH TRAINING INSTITUTIONS

4.1 BACKGROUND INFORMATION

As the name suggests, Lacor Nursing and Laboratory Schools are sister institutions belonging to St. Mary's Hospital Lacor. The Schools were started in 1973 and 1979 respectively. 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.

4.2 LACOR NURSING SCHOOL

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 a first group of 22 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.

From 1973 to date, student's enrolment has been on the increase yearly. The main objective of the school is to provide training opportunity to disadvantaged students in order to enable them to offer "quality health care to the needy and disadvantage community". The goal is to train quality and competent nurses who are able to love and serve the needy without segregation.

Currently the school has four courses, *Enrolled Comprehensive Nursing and Enrolled Nursing* (which are 2½ years each), *Diploma Nursing* (1½ years) and *Enrolled Midwifery* (2½ years). Most of the trainees are from within the Country but some few come from other countries, like Kenya, Sudan, Congo, Rwanda and Tanzania.

The school at the moment has six classrooms which can accommodate fifty (50) students each, plus a demonstration/skill's lab. At the end of FY 2011/12 the total number of students in the school was two hundred thirty four (234) comprising of (66) male and (168) female trainees. The facilities available are able to accommodate the total number of the students both in classes and hostels.

The Lacor Nursing School is headed by the Principal Tutor who is supported by 5 qualified full time tutors, 4 part time instructors, and 3 full time clinical instructors.

4.3 LACOR LABORATORY SCHOOL

The School started in 1979 as a result of the high demand for the laboratory services. 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 school is headed by the Principal Tutor who is supported by other full time tutor colleagues and some part-time instructors. The school offers two years' *Laboratory Assistant Course* leading to the award of a *Certificate in Medical Laboratory Techniques*.

The school has two classrooms which can accommodate forty (40) students each. At the end of FY 2011/2012 there were sixty-four (64) students in the school. The availability of the skill and computer laboratories, present an important opportunity for the students as it exposes them to more practical skills.

In August, 2011, the school received with appreciation a donation of books from AMREF to facilitate teaching/learning process. Now computers lessons are being conducted and demonstration rooms adequately utilized.

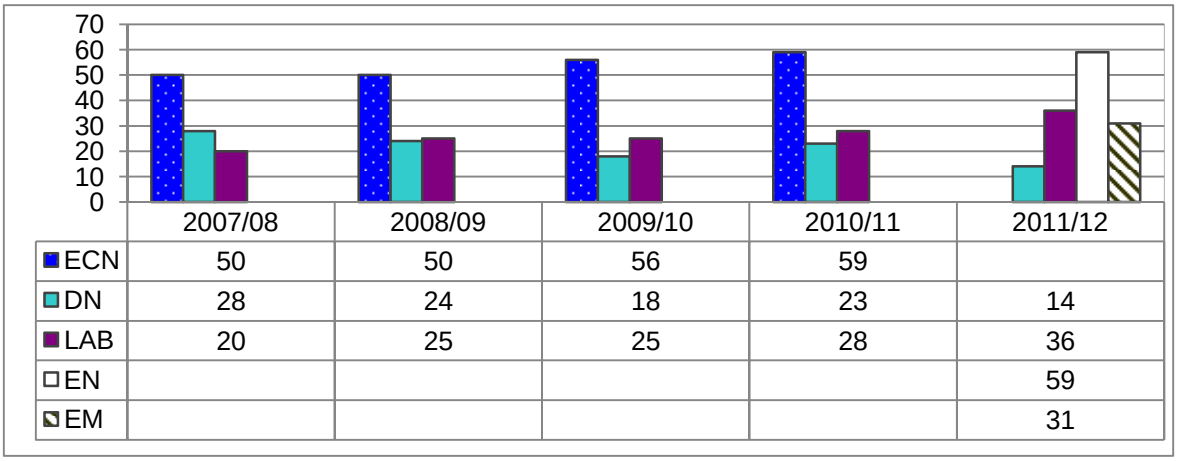
4.4 LACOR NURSING AND LABORATORY SCHOOLS' OBJECTIVE CAPACITY

The new official objective capacity for the two schools for all courses as revised by the Board on 23rd June 2012 is 380 students. At the end of FY 2011/12 the Schools had a total of 298 students, both male and female, with Nursing school having 234 students, while Laboratory school had 64, translating into a 78% capacity utilization rate, but a new group of laboratory students was due for recruitment in July 2012. The utilization gap was as a consequence of the reservation for the RN students. This category are currently exhausted in the market, as a consequence the school ended up recruiting and filling less than the planned capacity.

4.5 STUDENTS' ENROLMENT IN THE FY 2011/12

This year, the nursing school recruited 59 EN, 14 RN and 31 EM as compared to 59 ECN and 23 RN applicants recruited the previous year.

Figure 4.1 - Nursing and Laboratory student enrolment over the past years



	2007/08	2008/09	2009/10	2010/11	2011/12
ECN	50	50	56	59	
DN	28	24	18	23	14
LAB	20	25	25	28	36
EN					59
EM					31

As reported earlier, at the end of this year there were 59 EN students in first year, 56 ECN in year two and 51 ECN students in their third year. For Diploma Nursing there were 14 students in first year and 23 in year two. In the first year of the Enrolled midwife course the students were 31. The Laboratory students comprised of 36 in year one and 28 in year two sitting for their final exam in June 2012. The clear trend emerging from the enrolment figures confirm that there has been constant increase in the students' enrolment at least for the Certificate Courses and the Lab. Assistant trainees. While for the DN students there were fluctuations.

4.6 STUDENT PERFORMANCE

Fortysix (46) Enrolled Comprehensive Nursing candidates were presented for the National Examination in November 2011 and all 46 successfully passed their exams. For Diploma Nursing 18 candidates were presented and 16 passed, with a success rate of 86%. For the Lab students, 28 sat for the final exams in June 2012 and 28 passed, while none failed.

The table below shows the performance of students in the two schools for the last five years (FY 2007/08 to 2011/12).

Table 4.1 - Student Enrolment and Performance over the past years

Course	FY 2007/08	FY 2208/09	FY 2009/10	FY 2010/11	FY 2011/12
ECN	**Set VI**	**Set VII**	**Set VIII**	**Set IX**	
Enrolment	May-08	May-09	May-10	May-11	
Enrolled	50	50	56	59	
Lost (until June 12)	10	4	5	3	

Finalists	40	46	50		
Final exam	May-11	Nov-11	Nov-12	Nov-13	
Succeeded at first attempt	40	46			
Success rate	100%	100%			
DIPLOMA NURSING	**Set XIII**	**Set XIV**	**Set XV**	**Set XVI**	**Set XVII**
Enrolment	May-08	May-09	May-10	May-11	May-12
Enrolled	28	24	18	23	14
Lost (until June 12)	0	0	0	0	0
Finalists	28	24	18		
Final exam	Nov-09	Nov-10	Nov-11	Nov-12	Nov-13
Succeeded at first attempt	15	18	16		
Success rate	54%	75%	89%		
EN					**Set XXXI**
Enrolment					May-12
Enrolled					59
Lost (until June 12)					0
Finalists					
Final exam					Nov-14
Succeeded at first attempt					
Success rate					
EM					**Set I**
Enrolment					May-12
Enrolled					31
Lost (until June 12)					0
Finalists					
Final exam					Nov-14
Succeeded at first attempt					
Success rate					
LAB.	**SE VII**	**Set VIII**	**Set IX**	**Set X**	**Set XI**
Enrolment	Jul-07	Jul-08	Jul-09	Jul-10	Jul-11
Enrolled	20	25	25	28	36
Lost (until June 12)	0	0	1	0	0
Finalists	20	25	24	28	
Final exam	Jun-09	Jun-10	Jun-11	Jun-12	Jun-13
Succeeded at first attempt	15	22	20	28	
Success rate	75%	88%	83%	100%	

Source: Primary data

From the table above, in terms of trends in the success rate, the last two years achieved 100% with improvement in the quality of the passes for the ECN students. For DN students, we are starting to see a positive trend in performance with success rate improving to 89% up from 54% in three years. The Lab school, on the other hand, has registered a significant improvement in the success rate this year, with 100% pass, up from 83% the previous year.

4.7 QUALITY IMPROVEMENT PLANS AND STRATEGIES

To improve the quality of the training, more emphasis has been put in a number of areas:

a. Clinical placement of students: The tutors/ in-charges' meetings have been introduced to improve the quality in the clinical practice/skills.
b. The hospital management identified 2 in-charges who were sent for mentorship course in Uganda Martyrs University.

c. To improve theoretical aspect, planned examinations and set targets have been put in place. End of semester examination is done for all the students and the pass mark was elevated from 50% to 60%. Class attendance of below 75% persistently will lead to referral.
d. Class attendance and monitoring of tutors is calculated according to the timetable and a target of 80%. The tutor who does not achieve the target is tasked to ensure full compensation.
e. To improve Tutors/student ratio, a Clinical Instructor was sent to tutors college Mulago for Training.

4.8 COLLABORATION WITH GULU UNIVERSITY

Lacor Hospital in FY 2003/4 became an official University Teaching Site for Gulu University Faculty of Medicine. A second renewed Memorandum of Understanding was signed with Gulu University authorities in June 2007 spelling areas of cooperation in terms of infrastructure, services and technical needs. Specialist doctors and Medical Officers from Lacor Hospital are involved in the teaching of medical students. They are also members of Gulu University Medical Faculty Board, which plans the operations of the faculty. Lacor Medical Director is designated as the Honorary Faculty Dean and is responsible for coordinating the university activities within Lacor Hospital. The first medical students have qualified in June 2009 with 7 admitted for their internship at Lacor.

A new teaching block to be used by Gulu University for teaching purposes has been constructed by Lacor Hospital and it has been handed over to authorities of Gulu University free use.

Table 4.2 - Gulu University Faculty of Medicine student population – 2011/12

Gulu University student population	Males	Females	Total FY 2011/12
Year III	49	15	64
Year IV	56	12	68
Year V	46	15	61

4.9 TRAINING PROGRAMME FOR INTERN DOCTORS

In this year 21 doctors and 2 pharmacists completed their internship in Lacor Hospital. Further 21 doctors and 3 pharmacists were still on training at the end of the year.

Table 4.3 - Internships – 2011/12

Gulu University student population	Males	Females	Total FY 2011/12
Completed internship			
Doctors	14	7	21
Pharmacists	2		2
total	16	7	23
Still on training			
Doctors	14	7	21
Pharmacists	2	1	3
total	16	8	24

4.10 TRAINING PROGRAMME FOR DIPLOMA IN ANAESTHESIA

Since August 2011 Lacor Hospital is a training site also for the students of diploma in anaesthesia of Mulago. In that month 8 students started their training, due to end in August 2013. A second group is supposed to join them in August 2012.

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 fairly high 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 2011/12, making the attrition rate 9.2%, and the Hospital recruited 97 new staff.

Table 5.1 - Number of employees over the past years

Cadres	FY2007/08	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Total Staff	**542**	**563**	**570**	**591***	**629**

* Correction on previous year's report (erroneously reported total staff 600)

The above figures include also the employees, who are away on hospital sponsorship for further studies, but do not include interns and casual workers.

In order to support the computerization of the OPD two cadres of staff were created, data clerk and receptionists, leading to more staff recruitment and adjustment in the hospital establishment.

At the end of FY 2011/12 the hospital has gaps in the field of Pathologist, Radiologist, and Anaesthesiologist. There is also need for another Paediatrician, and a Records Officer.

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 yrs 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 5.2 - Staff movements – 2011/12

Movement of Staff by cadres of staff 2011/12	Total Lost by 30/06/2012	Total Recruited by 30/06/2012	Total as at 30/06/2012
Medical specialist and consultant	1	0	12
Medical officers and dental surgeons, pharmacists	6	7	11
Tutors and clinical instructors	1	2	12
Clinical, pub health, dental, orthopaedic officers	2	4	20
Anaesthetic officer, radiographer, occupational therapists	3	2	14
Lab technologist and technicians	2	3	09
Lab assistant and attendant	0	0	09
Registered nurse and midwives	6	1	53
Enrolled nurse and midwives	21	55	118
Nursing assistant and physiotherapists assistants	1	0	45
Nursing aides	2	8	102
Administrative staffs, pharmaceutical assistant	2	11	51
Technical staffs	2	1	32
Others	9	2	117
Staff on study leave on hospital sponsorship			24
TOTAL	**58**	**96**	**629**

- The total above is exclusive of interns (24) & casual workers (26). Otherwise, total number of employees as at the end of June 2012 stands at 655, when those on study leave are not considered.
- The total number of nurses include 1 theatre assistant.
- Staff on study leave as at end of June 2012 do not form part of Total on payroll.
- 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 housing subsidy for those who are not accommodated.

All Hospital employees are enrolled with NSSF.

The Hospital employees can obtain loans from their own credit cooperative 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. The progress made so far is that the proposed new chief executive officer and his team are in place and fully operational, course on managerial roles successfully carried out and trained in-charges formally appointed, attrition rate for the FY 2011/12 is 9.2%, 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 5.3 - Hospital sponsorship as of 30th June 2012

Course	Cadre of staff	Duration of training	No. sent for training
Masters in medicine	Medical officers	3.0	3
Bachelor of Nursing	Registered nurses/tutor	2.0	1
Bachelor medical laboratory sciences	Laboratory Technologist	3.0	1
Bachelor of medical education/tutorship	Reg. midwife / laboratory technician	2.0	2
Diploma comprehensive nursing	Enrolled comprehensive nurses	1.5	2
Diploma midwifery	Enrolled midwives	1.5	3
Diploma nursing	Enrolled nurses	1.5	5
Diploma anaesthesia	Registered nurses /midwives	2.0	2
Diploma medical lab. technology	Laboratory assistants	2.0	3
Theatre assistant	Nursing assistant	2.0	1
Diploma water engineering	plumber	1.0	1
TOTAL			**24**

6. TECHNICAL SERVICES

6.1 TECHNICAL DEPARTMENT

The technical department is an established department of the Hospital dealing with the maintenance of all utilities supply (water, electricity), repair of Hospital structures (buildings, doors, furniture), maintenance of biomedical devices (all medical equipments), maintaining the Hospital vehicles and mechanical plants (like generators, compressors) management of waste (incineration and waste water treatment plant) and constructions in case of new buildings. The number of employed staff in the department is: 35 (3 in-charges plus 5 masons, 4 carpenters, 2 mechanics, 2 welders, 2 painters, 1 plumber, 2 storekeepers, 6 electricians/medical equipment technicians, 7 drivers, 1 truck driver assistants). Occasionally, few porters are employed on contractual basis.

6.1.1 Activities in FY 2011/12

The technical department has been implementing various projects in this year:

- Building of staff quarter blocks: 16 apartments in four blocks for senior staff completed and now in use.
- Constructions and repairs in Amuru Health Centre: Construction of stores for medicines, construction of kitchen for the patient attendants, building the gate-keepers' house construction of placenta pit, building a workshop for bicycles (*Bikes not bombs* project for support of the village health team), extension of protective chain link and completion of staff quarters residence in Amuru Health Centre, also expected to be completed by the end of 2011.
- Air Conditioning system with air exchangers has been installed for the operating theatres and is now commissioned and fully operational.
- Internal Restructuring/modification of buildings carried out:
  - Main Laboratories reception, TB Laboratory, OPD Laboratories and billing, sections.
  - Aids clinic and OPD Pharmacy.
  - Restructuring of the staff quarters (for the nursing aids and assistance).
  - Clearing the former IDP camp for use as a ply ground for the Nurse, Midwife and Laboratory schools.
  - Restructuring of buildings to use as classrooms for the Schools of Nursing and midwifery.
- Medical Equipment Maintenance: more than 560 interventions on biomedical equipments were carried out.
- In Opit Health Centre, the water pipe lines were replaced from the old galvanized one to new PE pipes for better efficiency.

6.1.2 Technical information

6.1.2.1 Surface area

Surface area of the Hospital inside the perimeter wall: 122,909 m^2.
Buildings: the total surface area of all existing buildings is 44,850 m2, including the just completed new staff quarters.

6.1.2.2 Water supply

The Hospital has three supply systems for water.

6.1.2.3 Electrical water pumps

The hospital has acquired permits from the Directorate of water Resource management 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 (there is a reduced yield from one of the boreholes due to the ground water level).

- 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. Judes orphanage depth 70m, 3.5 km from the Hospital supplying 16,000 litres/hour.

The water from the electrical pumps is conveyed in 2 tanks of 75,000 litres each, refilled approximately 2 times a day.

6.1.2.4 Average daily consumption

Average daily consumption is about 320,000 litres a day. The tanks include a reserve for fire of 25,000 litres. An additional reserve for fire is linked to the swimming pool.

6.1.2.5 Hand pumps

Water is pumped manually from 3 underground boreholes within the hospital compound for use by patient attendants and staff of the hospital (three hand pumps are currently in use).

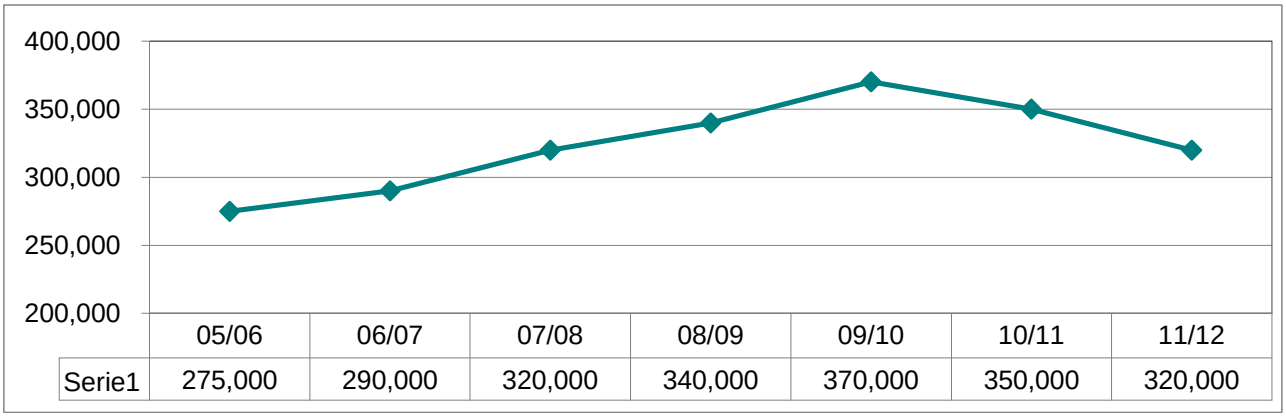
6.1.2.6 Rainwater tanks

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 litres.

6.1.2.7 Consumption of water from the storage tanks in the past years

The main water tanks (2 tanks of 75 m^3 each) were installed in 2004. The consumption of water is as indicated above. The water consumption shot up in 2010 due to construction activities within the hospital. There is a gradual reduction in water use due to less construction works and measures being undertaken for saving water. This usage is for all hospital and residential water needs, flush toilets, washing sinks, laundry, and domestic use: cooking, bathing etc.

Figure 6.1 - Average daily water consumption within the Hospital (m^3) – 2005/06 to 2011/12



	05/06	06/07	07/08	08/09	09/10	10/11	11/12
Serie1	275,000	290,000	320,000	340,000	370,000	350,000	320,000

A review of water and waste water system is ongoing to check on the supply, consumption and waste water disposal.

6.1.2.8 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.

6.1.3 Electricity supply

Four main power supplies 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.

6.1.3.1 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 two big 250kVA generators, which can take over most of the loads when the national network is not available. The medium sized generator (120kVA) and a smaller generator of 80kVA have become too small for the hospital loads; the smaller one is now used for water pumping. However, the generators are not able to supply the whole Hospital compound; when there is a high energy demand in the Hospital buildings, the residences have to be disconnected. The main supply lines are 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.

Due to the prospect of power line upgrade by the supplying authority (Umeme), change from 11kV grid supply to 33kV supply. Studies are underway to acquire a new transformer to fit the new supplies arrangement.

6.1.4 Power consumption

In the overview below, it can be clearly seen that the Hospital has a very high demand of electrical energy determining very high costs.

Table 6.1 - Overview of power consumption and production (main Hospital)

Power consumption 2011/12	Percentage	[KWh]	Costs [UGX]
Total electricity consumed		731,856	473,205,523
UMEME (National Grid bill)	73.1%	535,092	227,418,752
Diesel generators	26,9%	196,764	245,786,771
Alternative energy	Solar mainly used for lighting and emergency power in ICU, pediatrics, laboratory and theatre. To a smaller scale used for lighting in some staff quarters about 4% of power consumed		
Electricity consumption / day		**1,999.61**	**1,292,911**

Note: The average costs for UMEME was 425 UGX/kWh and for the generator 1250 UGX per kWh UGX/kWh. The costs were calculated based on consumption of UMEME and recurrent cost of generator fuel.

The total costs the hospital paid to the power provider (Umeme) was: UGX 227,418,752, in which 4,848,356 was Opit Health Centre and UGX 13,131,607 for water pumping and UGX 209,438,789 for the main hospital.

Table 6.2 - 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	89.7%
2005/06	474,480	161,772	636,252	74.6%
2006/07	543,420	98,424	641,844	84.7%
2007/08	510,768	79,140	589,908	86.6%
2008/09	549,620	163,155	712,775	77.1%
2009/10	542,448	141,744	684,192	79.3%
2010/11	678,267	136,529	759,988	83.2%
2011/12	535,092	196,764	731,856	73.1%

6.1.4.1 Reliability of the Grid and power consumption

Figure 6.2 – Trend of reliability of the grid during 2011/12

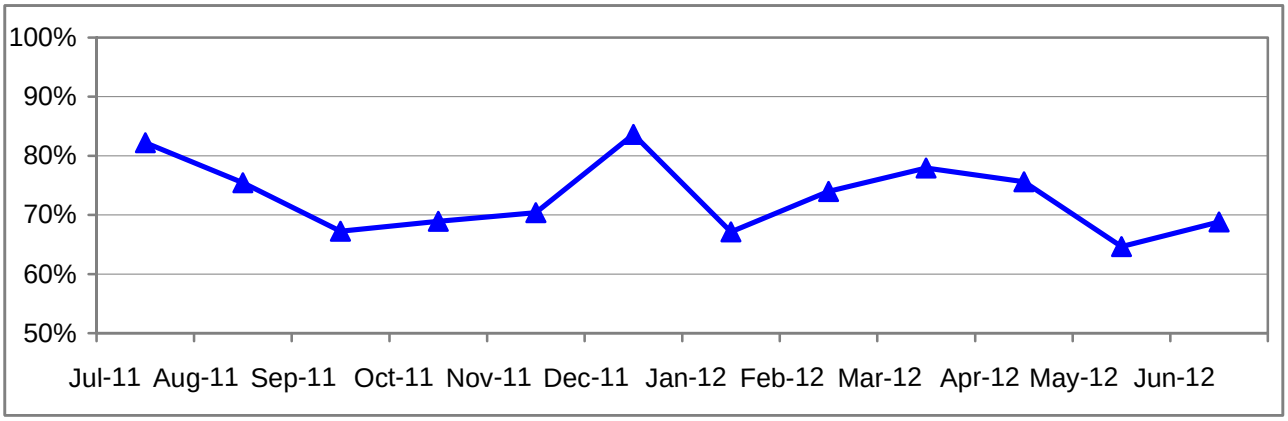


Figure 6.3 - Trend of power consumption over the past years

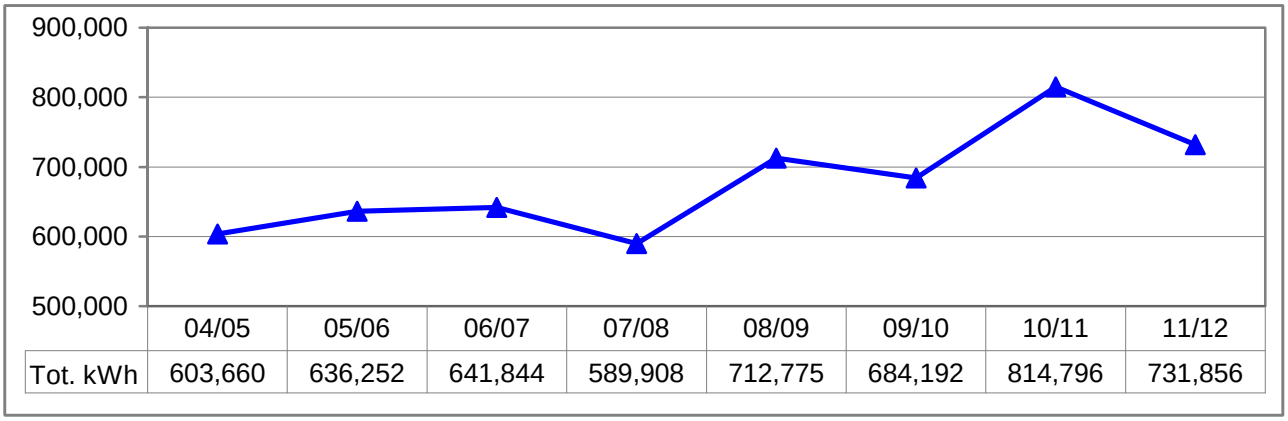


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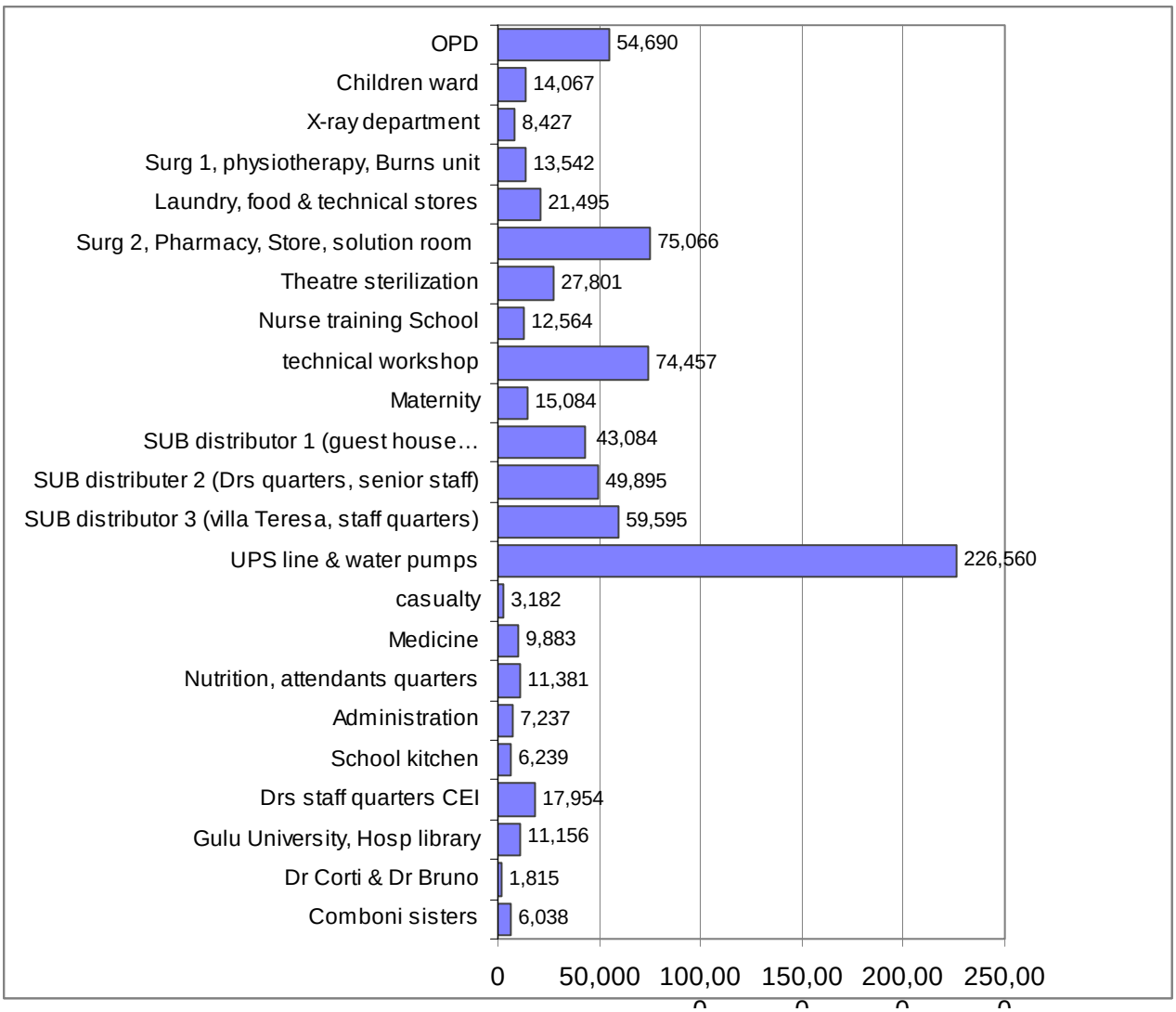
Figure 6.4 - Electricity consumption by the departments – 2011/12



From the graph it is evident that the UPS line is the highest consumer. This maintains the battery charged and supplies all the emergency areas of the hospital all the time. For this reason the hospital is studying ways to reduce on the cost by introducing grid solar inverters to supply the hospital loads during the day.

6.1.4.2 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: 196,764.00 kWh. The cost of running a generator (fuel only excluding service and spares) is currently about 3 times the cost of the gird (Umeme) the presence of the grid during FY2011/2012 was only 73% this means the remaining 27% was supplied by the diesel generators.

The total fuel used for generators (hospital main line) was about: 73,174 litres with a total cost of 245,876,771.80 UGX, which gives an average rate of about 3360 UGX per litre..

The challenges of relying on the generator comes into force when there is fuel shortage (as was the case when there was political problems in Kenya). For this reason an emergency supply is inevitable and plans are to make it better.

6.1.4.3 Emergency supply

The emergency line is backed up with a battery bank of 396V DC and 250Ah. The DC voltage is converted with a UPS system of 40kVA to a 3 phase 400V AC system. The safe line also starts from the main distribution house and is a closed ring system. The underground power cable runs from one ward to the next ward. The residence areas do not have a safe line connection. The battery bank is backed up with a small generator of 63kVA which starts automatically when the battery needs to be re-charged. This generator also powers the water pumps. The battery bank UPS and distribution network was installed in 2003. After 8 years some components are due for replacement.

This central emergency supply system (batteries, inverter and its charging generator) have of recent been overloaded due to additional loads on the system. Plans are underway to acquire bigger emergency supply systems to replace this old one.

The emergency supply (charging) and use, is the highest consumer of energy in the hospital.

Three independent solar supply systems is mainly used for lighting and emergency power in ICU, paediatrics, laboratory and theatre. To a smaller scale used for lighting in some staff quarters.

6.1.4.4 Electrical supply to the Health Centres

Of the three Health Centres, only Opit has grid power, therefore it has a small backup on batteries 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 only by a solar system of 2080Wp capacity charging batteries of 24V 1500Ah for all the Hospital lights and laboratory services.

6.1.4.5 Photovoltaic systems

Solar energy 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.
- Heating of water in the Hospital laundry.
- 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 for the laboratory/children ward, theatre and intensive care unit.

6.1.5 Waste management

6.1.5.1 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. Having been made already 12 years ago, the hospital has already made consultations for the improvement program of the lagoons.

Solid waste Normal 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 with 1 tractor trip a day.

Human tissues are deposited in sealed placenta pits.

7. HOSPITAL FINANCIAL MANAGEMENT REPORT

7.1 BACKGROUND TO LACOR HOSPITAL FINANCIAL REPORT

The Financial Report of the Hospital has been externally audited by a new firm (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.

7.2 EXPENDITURES: RECURRENT COSTS

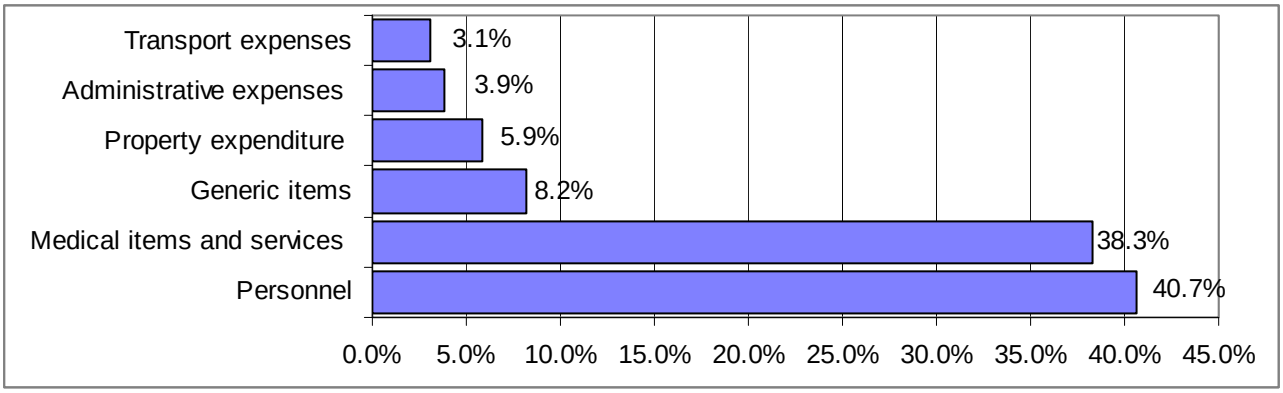
The total operating costs for FY 2011/12 reached UGX15, 366 million compared to UGX 12,316 of the previous year, representing an increase by UGX 3 billion (+ 25%).

Table 7.1 – Lacor Hospital Operating Costs

Costs	2011/12 (UGX '000)	2010/11* (UGX '000)	Difference	Diff. %
Personnel	5,381,240	4,846,432	+534,808	+11%
Medical items and services	5,070,122	3,509,214	+1,560,908	+44%
Generic items	1,083,727	705,405	+378,322	+54%
Transport expenses	411,767	401,423	+10,344	+3%
Administrative expenses	513,614	451,680	+61,934	+14%
Property expenditure	774,239	563,929	+210,310	+37%
TOTAL recurrent costs	**13,234,709**	**10,478,083**	**+2,756,626**	**+26%**
Depreciations	2,131,533	1,838,868	+292,665	+16%
TOTAL operating costs	**15,366,242**	**12,316,951**	**+3,049,291**	**+25%**

***** Compared to last year's financial report comparative figures for FY 10-11 have been reclassified to ensure consistency with this year's new chart of accounts. Waived fees for around UGX 60 million which last year were included among expenditure have been treated as discounts thus reducing revenue and costs by the same amount.

Figure 7.1 - Breakdown of recurrent costs – 2011/12



As shown above, personnel costs remain the highest expenditure in percentage terms (40.7%), although medical items and services reached 38.3%. The major increases in expenditures were due to increase of costs for medical items and services, which increased by 1,560 million UGX (+44%). Generic items increased by 54%, and property expenditures by 37%.

The increased costs for medical items were due partly to the 23.5% yearly inflation (source: Bank of Uganda), and partly to increased consumption of drugs especially in the Outpatients department, including medical items donated in kind to the Hospital for specific programs.

Other expenditures were also influenced by rising inflation, in particular property expenditure by rising costs for fuel and utilities, as well as by frequent blackouts of the national Electric Company (UMEME) that forced the hospital to rely more on its generators, which are more expensive.

7.3 CAPITAL DEVELOPMENT COSTS

The hospital invested 1,854 million in Capital development costs, which constitute a 280 million increase compared to previous year. Of these, around 410 million were spent to complete the works for the new staff quarters and rehabilitation of old nursing aide quarters, which are now functional. Other relevant investments were 760 million to strengthen the Internal Electricity Supply system, mainly to continue ensuring uninterrupted power supplies to the Hospital departments, through new batteries for the UPS system and new distribution boards. Approximate 140 million were spent to complete the installation of the Theatre Air Conditioning system, while 114 million were invested in a new Ambulance.

1,754 million of the above investments were funded by Capital Contributions in cash received by donors, while the remaining 113 million were fixed assets donated in kind by donors.

7.4 LACOR HOSPITAL INCOME (FINANCING OF RECURRENT COST, FY 2011/12)

The total revenue of the year was 11,216 million UGX compared with 12,438 million the previous year that is 1.2 billion less (-10%).

Table 7.2 – Income – 2011/2012

Income of the year	2011/12 UGX '000	2010/11 UGX '000	Differ. UGX ,000	Diff. %
Uganda Government	1,028,083	849,690	+178,393	+21%
Donors	5,759,059	8,081,904	-2,322,845	-29%
TOTAL DONATIONS	**6,787,142**	**8,931,594**	**-2,144,452**	**-24%**
User fees	2,090,417	1,517,377	+573,040	+38%
Other local revenue	206,556	150,682	+55,874	+37%
Amortization of deferred capital contributions	2,131,534	1,838,765	+292,769	+16%
TOTAL INCOME	**11,215,649**	**12,438,418**	**-1,222,769**	**-10%**

Total donations decreased from 8,932 million UGX to 6,787 million UGX (-24%), despite an increase by 21% in contributions from the Government of Uganda, because of a decrease by 29% in other donations. The decrease in other donations is due to the fact that donations used to cover this year's costs were released by donors in the preceding years in order to ensure stock replenishment and smooth cash flow, while 3,125 million of donations received this financial year have been deferred to next financial year (see Annex 8 for actual cash receipts from donors). In this way the Hospital fully follows the accrual method recently adopted. For this reason the result of the year is significantly negative.

User fees and other local revenue increased significantly, by 38% and 37% respectively. This increase is due to change in case mix with increase in services with higher fees as well as improved collection from patients and students.

Amortization of deferred capital contributions showed an increase of 16% from last year. This represents the amortization over the years of the Capital Contributions received in the past to finance capital development. The amortization of the Contributions follows the amortization of the costs (represented by the Depreciations).

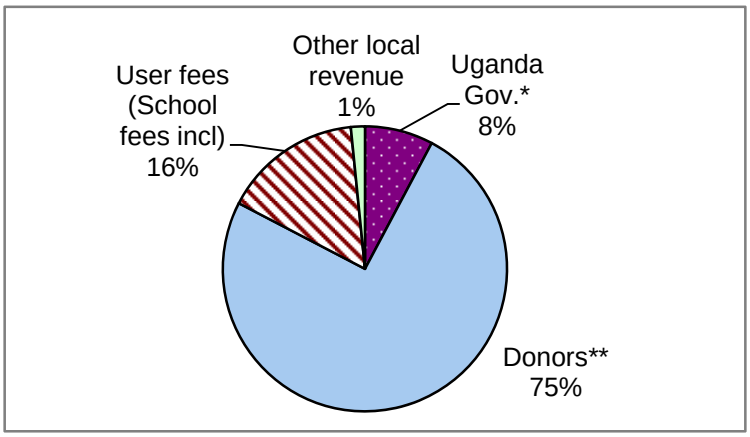
Following the accrual accounting system adopted by the Hospital, the total revenue does not include income and capital contributions received.

Table 7.3 - Source of funds for recurrent costs – 2011/12

Financing of recurrent costs	2011/12 (UGX '000)	%
Uganda Government*	1,028,083	7.8%
Donors**	9,909,653	74.9%
User fees (School fees included)	2,090,417	15.8%
Other local revenue	206,556	1.6%
TOTAL	**13,234,709**	**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.
**See Annex 8 for details on the donors.

Figure 7.2 - Financing of recurrent costs – 2011/12



As shown above, Lacor Hospital covers 75% of its running costs with donations from abroad. This is a direct consequence of the poor economic environment in which the Hospital operates that does not allow higher revenue from user fees. In Lacor Hospital there was no general increase of fees since 2003; rather there was reduction or waiving of fees for vulnerable groups, in spite of the regular yearly increments of costs (especially personnel and supplies). In financial year 06/07, fees for antenatal clinic, admission of children and pregnant women were scrapped off, in line with the hospital mission of increasing access to all, especially the vulnerable groups.

The increase in the fee revenue reflects the higher service output in the services where a fee, tough subsidized, is still maintained, as well as an improved collection from patients and students.

Patients with chronic diseases pay reduced fees and patients in destitute financial position are enrolled in a free-treatment scheme or have their fees waived off as necessary.

Compared to the previous FY, the proportional contribution to the sources of income by the user fees increased slightly from 15% to 16%. During FY 2011/12 the Hospital maintained fee waivers in antenatal clinic, as well as for admitted pregnant mothers and children. In spite of the increase of recurrent costs, globally the fees paid by the hospital users (students in the schools included) in FY 2011/12 fees have been subsidised to a tune of 84%.

Table 7.4 - Sustainability ratio in absence of donor funding but with PHC CG over the past years

	2007/08	2008/09	2009/10	2010/11	2011/12
Total Local Revenues* (c)	1,958,370	2,164,242	3,005,517	2,578,095	3,325,056
Total Recurrent Expenditures (d)	6,117,051	7,358,342	9,082,724	10,538,784	13,234,709
Sustainability Ratio = (c/d)x100	32%	29%	33%	24%	25%

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

7.5 ASSURANCE: AUDITING AND PROCUREMENT

The External Audit of the Hospital has been carried out this year by BDO, a major international accounting firm. The main finding that has been highlighted by the Auditors are related to the accuracy of the opening balance of the inventory. The issue is partly a legacy from the challenges of the transition to the accrual system and to the new Administrative software and is being addressed by the management.

Other identified improvements areas were mainly related to:
- reconciliation between general ledger and corresponding sub ledgers (fixed asset register and payroll), which sometimes show discrepancies due mostly to manual entries;
- filing of personnel related documentation which sometimes is filed together with minutes and a copy is not included in the file of each affected staff thus making it difficult to retrieve;
- lack of internet connection in the Laboratory school;
- low segregation of duties in peripheral Health Centres often due to lack of personnel;
- alternative procurement procedures used by the Hospital for non-standard purchases are not sufficiently documented;
- IT disaster recovery plan not being formalized although disaster prevention measures in terms of back up are present and fully functioning;
- while the Internal Auditor is formally independent, it was noted that he sometimes participated in decisions about general ledger entries and according to the External Auditors this should be avoided.

The management letter has been presented by BDO during the Financial Committee of the Board and each issue has been discussed and responded to by Management who has agreed to address most of the issues although it recognized that some will only be solved over a longer period of time since they require review of IT system or of major internal processes.

The Hospital has an Internal Audit functions which reports directly to the Executive Directors and to the Board of Governors through its Committees. During the Finance Committee of the Board the Internal Auditor has presented his report which has been discussed and the Management has responded to each of them. The major recommendations of the Internal Auditors were related to:
- inventory issues which were partly similar to those highlighted by the External Auditor;
- strengthening the procurement process in order to further promote segregation of duties and controls;
- improving the management and monitoring of cash receipts in the Information System, especially for Donations and Institutional Organizations which sponsor patients.

The Hospital has a procurement Office, which is manned with 2 procurement officers, 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, 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.

Items without official local suppliers are obtained by direct procurement. 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.

8. HOSPITAL GOVERNANCE AND MANAGEMENT

8.1 LACOR HOSPITAL GOVERNANCE AND MANAGEMENT

8.1.1 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.

8.1.2 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.

8.2 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.

8.3 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 a month. 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, he 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.

8.4 COMPLIANCE WITH STATUTORY REQUIREMENTS

The hospital was fully compliant with the statutory requirements for accreditation with the UCMB yet again this FY 2011/12 with a score of 100%. The hospital was therefore accredited without any condition.

9. PERFORMANCE OF THE HOSPITAL STRATEGIC PLAN 2007 - 2012

St. Mary`s Hospital Lacor has successfully implemented its first strategic plan 2007 – 2012. Below is the overview of the performance of the strategic plan over the five years period. The new strategic plan 2012 – 2017 shall be implemented from July 2012 to June 2017.

The last strategic plan had eight objectives, four Service Delivery Objectives (SDO) and four Capacity Building Objectives (CBO) which were implemented concurrently over the five years.

9.1 PERFORMANCE REVIEW OF SERVICE DELIVERY OBJECTIVES OF 1ST SP

9.1.1 SDO 1 - Consolidate core areas of in- and outpatients services

Table 9.1 - Achievements as of FY 2011/12 - SDO1

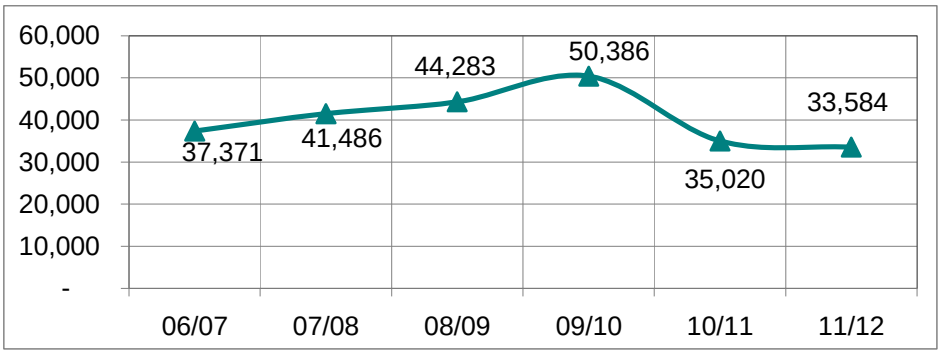
Performance Indicators	Achievements as of FY 2011/12	Comments
Admission in Medical ward stabilized at 4,041 patients yearly	**3,995 Admitted**	**This Target was met.** HIV/AIDS patients have now stabilized on ART and therefore do not require frequent admissions anymore. The Malaria cases went down due to preventive intervention of IRS. Community TB DOT is being encouraged most TB patients are therefore treated at home. However, more complicated patients are being admitted in the medical wards as referrals from other hospitals.
Admission in children ward decreased by 30% from 14,041 to 10,971 per year	**8,185 Admitted**	**Admission decreased by up to 42%** **Target met** way above the target. There has been a reduction in cases of severe malaria. There has been a reduction in cases of severe malnutrition. Public health facilities have become more functional after end of the war. Conservative Target.
Admission in surgery Increased by 30%. From 4,232 to 5,237 per year	**4,865 Admitted**	**There was a 15% increment in admission** **Target nearly met.** There has been a reduction in war injuries over the period of peace, Fewer surgical camps were organized in the hospital More complicated surgical referrals were received. The target was over ambitious.
Admission in Maternity increased by 30%. From 4,483 to 5,558 per year	**6,353 Admitted**	**This Target was met Well above target by 39%.** There has been a better health seeking behaviour among the women. There is better quality of care + EMOC attracted more patients. Many referrals for Obs & Gynae surgeries were received. This target was a conservative target.
Number of Deliveries increased by 30%. From 3,591 to 4,453 year	**6,192 Deliveries (72% increase)**	**This Target was met Well above target by 39%.** There was an Increased ANC attendance. There was Increased facility based deliveries The Ability to offer comp. EMOC attracts more women to deliver at our units.

		There has been Improved quality of care. Improved ambulance services to the Health Centres for transfer of emergencies has attracted more deliveries in the Health Centres. This target was conservative.

9.1.1.1 Trend of Admission over last 5 years

The total admissions in the hospital increased from 37,371 in 2006/07 in the first three years of the strategic plan, reaching a maximum number ever of 50,386 total admissions in 2009/10 before falling to 33,584 in 2011/12 as shown in the figure below.

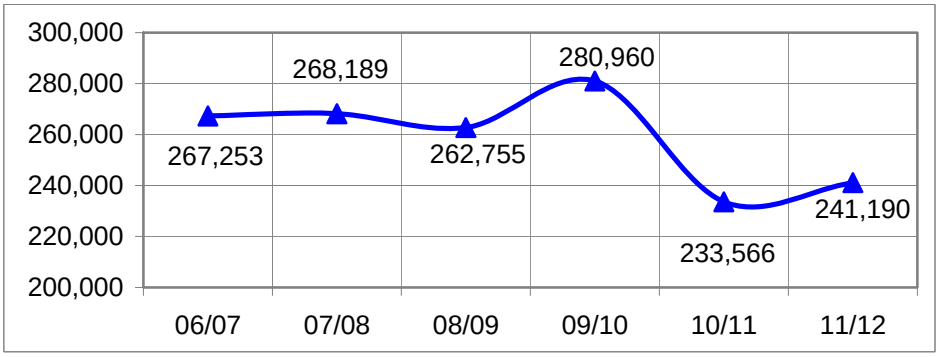
Figure 9.1 - Trend of Admissions over the last 5 years



9.1.1.2 Trend of OPD Attendance

The total OPD Attendance has shown a gentle decrease from 267,253 in 2006/07 FY to 241,190 in the final year of the strategic plan 20011/12 as shown in the figure below.

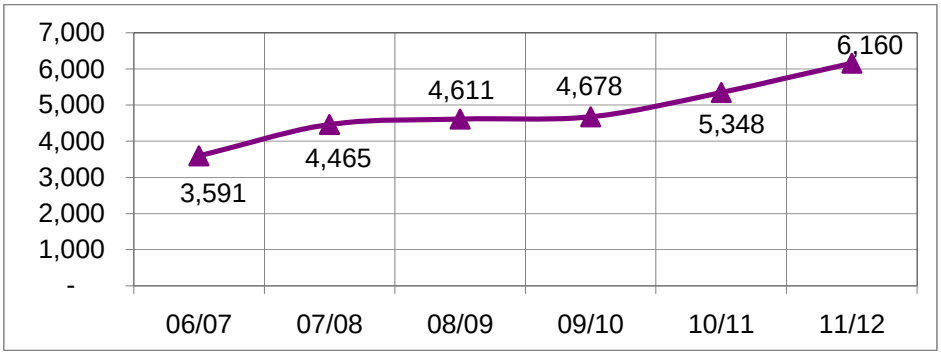
Figure 9.2 - Trend of OPD Attendance over the last 5 years



9.1.1.3 Trend of total Hospital Deliveries

The total number of Deliveries in the Hospital and in the three Health Centres has continued to increase throughout the last five years, increasing from 3,591 at the start of the strategic plan in 2006/07 reaching a maximum number of 6,160 this FY 2011/12. This gives a 72% increment during the last five year of the strategic plan. This is shown in the figure below.

Figure 9.3 - Trend of Hospital Deliveries over the last 5 years



9.1.2 SDO 2 - Bring services closer to the community

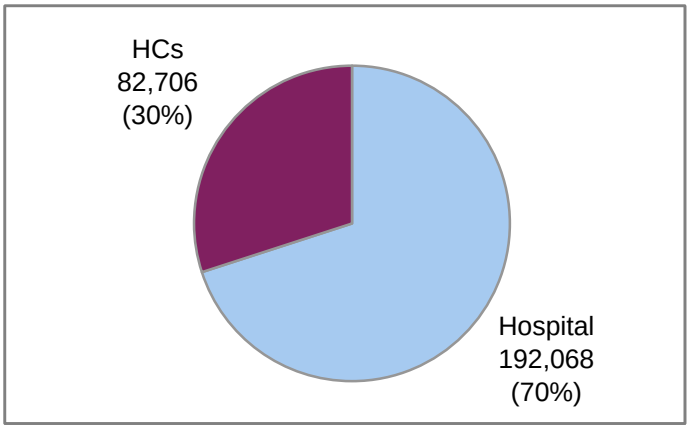
Table 9.2 - Achievements as of FY 2011/12 - SDO2

Performance Indicators	Achievements FY 2011/2012	Comments
Proportion of patients treated from Health Centres increased from 20% to 40%	**30% of patients were treated in the three Health Centres**	**This target was nearly met.** Progress was made towards meeting the target except that resettlement of IDPs affected the number of patients being treated at the Health Centres. More public health facilities also started to become functional after the war serving some of the patients who would come to our Health Centres. There has also been a general reduction in the number of malaria cases following a prevention strategy of IRS.
Number of facility based deliveries in the Health Centres increased from 1,063 to 1,712	**2,412 deliveries were recorded in the three Health Centres**	**This target was met way above the set target.** There were more women who attended ANC. There was an improvement in the capacity of personnel including those at the Health Centres. There was improved support supervision from the hospital to the Health Centres. The ambulance services to the Health Centres Improved. The target was conservative.
DPT3 Coverage of immunisation in catchment areas to reach at least 95% Target 4,056	**5,555 children had DPT3 vaccination**	**Target met.** There is a well defined activity areas of PHC activities for both the hospital and the three Health Centres. There has also been more outreaches especially in Health Centres. A better use of VHTs and community mobilisers for vaccinations.
Increase TB detection rate to 70% Target of 211 (70% of estimated TB cases)	**217 cases of TB were detected**	**This target was met.** However, there is need for more community sensitization on TB signs and symptoms and health seeking behaviours, and on training of personnel on TB detection and reporting.
Receive monthly report from the HCs	**Monthly report being submitted**	**This target was met.** There are regular integrated support supervision by teams from the main hospital including that on record keeping being carried out.

9.1.2.1 Proportion of total number of patients treated at the Health Centres

Of the total number of patients treated in both the hospital and in the three Health Centres, up to 30% were treated from the Health Centres. This is in line with the hospital strategy of decentralising services closer to the community by encouraging more and more patients to access services from the peripheral Health Centres. This is depicted in the figure below.

Figure 9.4 - Proportion of patient contacts in HCs - 2011/12



9.1.3 SDO 3 - Consolidate & introduce select specialised services

Table 9.3 - Achievements as of FY 2011/12 - SDO3

Performance Indicators	Achievements as of FY 2011/12	Comments
New specialized services introduced	**New selected specialized services were introduced**	**This target was met.** Burns unit, Neonatal unit, Sickle cell clinic were introduced and are all functional. Cervical cancer screening, colposcopy & treatment early cervical lesions were also introduced and are functional.
Number of major surgical operations increased by 30% Target: 6,775operations per year Baseline: 5,212	**5,516 major surgical operations were performed**	**Only 5.8% increase was realized in five years. This target was not achieved.** Return of peace in northern Uganda led to a general reduction in number of war related injuries. There was also a delay in establishing orthopaedic surgery. Fewer surgical camps were organized during this period.
At least 100 paralyzed patients handled yearly	**105 patients were treated**	**This target was met.** This service has been left in the hands of Lacor Hospital alone since AVSI and TDH projects have closed. Support from donors very much required here.
At least 50 Obstetrics fistulae (VVF) repaired yearly	**48 VVF repair performed this year**	**The target was met.** However this is a preventable condition with good obstetric care in the community. The less the number seen the better. No other Centre performs this delicate surgery. No more visiting surgeon from AMREF Kenya. Most patients are from districts outside Acholi sub region.

		Improved obstetric care in the region thanks to the DHOs.
No. of children < 12 yrs treated for lymphoma	**85 new young patients treated in 2011/2012 for lymphomas and 34 for other tumours**	**The target was achieved.** Collaborating with EMBLEM in a special research project on Burkitt`s Lymphoma. It involves community mobilisation, improved case detection and better treatment outcomes.

9.1.4 SDO 4 - Reinforce learning and teaching

Table 9.4 Achievements as of FY 2011/12 - SDO4

Performance Indicators	Achievements as of FY 2011/12	Comments
ECN yearly Intake maintained at 50 / year	**50 students were admitted in FY 07/08 and 08/09, 56 in 09/10 and 59 in 10/11; this was the last intake for ECN course before reverting in 2012 to traditional EN course, for which 59 students were admitted. Certificate in midwifery introduced in May 2012 with 31 students.**	**The target has been met.** There is a very high demand for nurse training in this region. The school has good infrastructural capacity. The ECN Training is being phased out from the school with effect from 2011. The school has reintroduced the training of the traditional nurses with effect from 2012. There were 31 pioneer certificate in midwifery students admitted this year as a new cadre to be trained at the school of nursing.
Yearly intake of Diploma Nurses maintained at 30	**28 Diploma students were admitted in FY 07/08, 24 in 08/09, 18 in 09/10, 23 in 10/11 and 14 in 11/12**	**The target was nearly met.** There are fewer candidates who qualify for this course at the moment since the certificate in Enrolled Comprehensive course commenced in 2004. Training of 2 tutors on hospital scholarship for degree courses is going on.
Yearly intake of students for Lab. Assist. increased to 20 every year	**20 students were admitted in FY 07/08, 25 in 08/09, 24 in 09/10, 28 in 10/11 and 36 in 11/12**	**Target met.** There is a very high demand for training. There is adequate space for the training but only two qualified tutors are in place. One tutor is currently in training sponsored by the hospital.
Number of publications monitored	**4 publications made**	**The target was met.** Research and publications is encouraged in the hospital. Many research proposals were approved during the five years.
Number of research projects accomplished	**Regular clinical audits being done IRB formed Research is encouraged**	**The target was met.** Formal registration of the IRB with the Uganda National Councils of science and Technology is in progress. External audits by external assessors were carried out twice in the last five years.

Number of students rotation for clinical practice is monitored	**Student rotations in the hospital are monitored yearly**	Appropriate form has been designed to be filled by visiting students. Register of medical students from Gulu University is kept.

9.2 PERFORMANCE REVIEW OF CAPACITY BUILDING OBJECTIVES OF 1ST SP

9.2.1 CBO 1 - Re-orient activities towards quality of service & humanity of care

Table 9.5 - Achievements as of FY 2011/12 - CBO1

Performance Indicators	Achievements as of FY 2011/12	Comments
Waiting time and processing time in OPD reduced to 3 hrs	**64% seen within 3 hours, according to UCMB survey.**	Partially implemented but measures have been put in place to address it. The remedy being put in place is computerizing most of patient administration and drug dispensing in order to shorten this waiting time further.
Annual Bed occupancy not exceeding 100% in all wards and 150% in Children's ward	**BOR average 93.76% in all wards of the hospital and 100.67% in children's wards.**	Objective fully achieved. This achievement has been attributed to improved health care in the community due to opening of many government health facilities which were closed during war and public health interventions targeting malaria control. Also the improved food security as the populations settled and began food production that reduced the number of malnourished especially children.
Monitor recovery rates, prescription practices, antibiotic rates and completeness of medical records	**Use UCMB format and follow trends. Patient satisfaction remains at 84% at the end of the first Strategic Plan.**	Fully achieved. UCMB format is being followed and there is positive trend and improvement in all parameters including quality indicators. Challenges still remain in the areas of patient satisfaction which deserves constant monitoring.
Carry out Monthly clinical Audits	**Monthly clinical audits**	Target fully achieved with more emphasis in maternal mortality which is monitored by the district as well as ministry of health. To augment this process there is a quality control committee in place. Also a quality control nurse to routine check up to identify gaps and areas of improvement.
Stock out kept at 0%	**Occasional stock outs still occur.**	Partially met as some stock out still occur because of delays on the side of suppliers otherwise computerization of pharmacy is almost complete.
Monitor caesarean wound infections rates	**Caesarian section infection rates monitored**	Fully achieved. The FSB rates and c/section rates are being monitored and remedies put in place to tackle challenges and gaps. The hospital as also instituted the infection control committee and well as the medicine and therapeutic committee.

9.2.2 CBO 2 - Secure & retain a sufficient n. of qualified, satisfied & committed personnel

Table 9.6 - Achievements as of FY 2011/12 - CBO2

Performance Indicators	Achievements as of FY 2011/12	Comments
Proportion of posts filled with qualified persons	**Almost all posts are filled with qualified staff**	New establishment is largely in place and daily monitoring of personnel presence has been instituted.
Staff attrition rate below baseline Baseline: 8.39%	**Attrition rate fluctuating, in 2011/12 at 9.2%**	The highest rate (16) was in 2009/10 due to restructuring of technical department, otherwise between 7% and 10%.
Monitor staff performance and patient satisfaction Baseline: 85%	**Patient satisfaction at 84%**	Analysis of staff performance has begun. UCMB survey revealed level of satisfaction at 84%, not sure at 5% while 11% were not satisfied. Measures are being put in place to address this. Most of these cited waiting time and overcrowding as the major cause of dissatisfaction.
Annual refresher course carried out on managerial roles	**Several refresher courses carried out**	Fully achieved. Staff training on managerial role (baseline training) for in-charges done and appointment done to substantive position. This is to be followed by training of heads of departments, more nurses, and principal tutors of the school. Five training sessions of managers in Health Service Management HSM done.
Appoint New Hospital Chief Executive Officer	**Executive Director appointed**	Fully achieved. Appointment done on 28th Feb 2008.

9.2.3 CBO 3 - Enhance knowledge management and communication capacity

Table 9.7 - Achievements as of FY 2011/12 - CBO3

Performance Indicators	Achievements as of FY 2011/12	Comments
Computerize bookkeeping, invoicing, stores, pharmacies, lab, radiology and admissions	**Computerization of the various departments**	Partially achieved but on track. Accounts, patient admission, stores, OPD and main pharmacy are now fully computerized. Lab, Radiology, Operation theatre and patients records computerization are at various stages of completion. Meanwhile networking (backbone) of the hospital is now complete.
Communications and network strategy in place	**Communication strategy document now in place**	Partially achieved. Communication strategy document is now being functionalized.
Public Relation Officer in post	**Communication officer appointed in 2008, however in the fifth year of the SPI, the office fell vacant.**	Search for a new communication officer continues.

9.2.4 CBO 4 - Secure funding at a sustainable level

Table 9.8 - Achievements as of FY 2011/12 - CBO4

Performance Indicators	Achievements as of FY 2011/12	Comments
Safeguard current level of funding to meet operational cost	**Funds received**	Fully achieved. This is being maintained thanks to external development partners/donors see attached list. Local fund-raising is still a big challenge considering the rampant poverty in northern Uganda (65% live below poverty level). External funding is however reducing due the current global crisis and strategies is being laid out to tackle this challenge.
75% of funds required for investment activities secured	**Investment fund received versus budget**	This has not yet been attained but the Hospital is in contact with various donors to achieve this necessary development fund.
Hospital continues to receive clean audit	**Yearly external audit**	Audit done by PWC until FY 2010/2011 inclusive; for FY 2011/12 there has been a rotation and audit was performed by BDO.

9.3 MAJOR CHALLENGES OF THE FIRST FIVE YEAR STRATEGIC PLAN

Table 9.9 - Challenges as of FY 2011/12

Objective/activity	Challenge
Design and implement Comprehensive Human Resource Strategy	While this strategy is on tract, routine performance evaluation analysis is not yet firmly in place.
Upgrade ICT to facilitate: data capture and retrieval (HIMS), communications with HC, training, teaching and professional development	The ICT back bone has been laid and running well in the area of accounts and patient administration. However, reports still do not come out automatically and electronic medical record has not been achieved. Use of ICT for professional development is still minimal while communication with the peripheral units remains a big challenge. Remedies have been put in place and personnel is being strengthened.
Carry out detailed cost analysis	The hospital is able to carry out cost analysis but not to the details that we desire, work still remains to be accomplished in this area.
Develop resource mobilization strategy, lobbying, advocacy, fundraising	This remains a big challenge, efforts in this direction has been minimal mainly curtailed by the nature of the situation the hospital was operating in during the time of war, the major concern was to handle the various emergencies.
Develop hospital's capacity to respond to national and international call	Attempts have been made with minimal success. Training in this area is ongoing and the hope is that a unit dealing with this response shall be set up.
Transforming the hospital technical department into income generating Centre	No attempt was made as this venture require a feasibility study and formation of a new company which is allowed to make profit as compared to the hospital which is a not for profit organization.
Explore merits of expanding private wing as a mechanism for revenue generation	The study has not been done but remains one of the objectives of the hospital.

10. 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 general 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
Dr. Emintone A. Odong	Medical Director and Chairman
Dr. Martin Ogwang	Institutional Director
Dr Antony Muyingo	Head, medicine department
Dr. Okello Moses	Head, dental/oral surgery department
Dr. Richard Nyeko	Head, paediatrics department
Dr. Bayo Pontius	Head, obstetrics and gynaecology department
Dr. Opira Cyprian	Head, radiology
Dr. Okello Tom Richard	Head, surgery department
Dr. Emmanuel Ochola	Head, HIV, Research & Documentation department
Ms. Betty Justine Anyiri	Ag. Principal Lacor Nurse Training School
Mr. Topiny Marino	Principal Lacor Laboratory School
Sr. Millie Among	Matron
Sr. Josephine Oyella	Head, pharmacy
Mr. Okello Calvin	Head, Laboratory department
Mr. Kenneth Oketayot	Representative of paramedical staff
Bro. Elio Croce	Head, technical department
Mr. Roberto Gestri	Administrator
Mrs. Caroline Okello	Personnel officer
Mr. Pier Paul Ocaya	Hospital secretary
Mr Henry Omal	Chief accountant
Mr. Ojok Geoffrey p'kingston	In-charge Lacor Health Centre III Amuru
Mr. Opira Godfrey	In-charge Lacor Health Centre III Opit
Mr. Otii Benedict	In charge Lacor Health Centre III Pabo

Annex 4 Internal Board

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

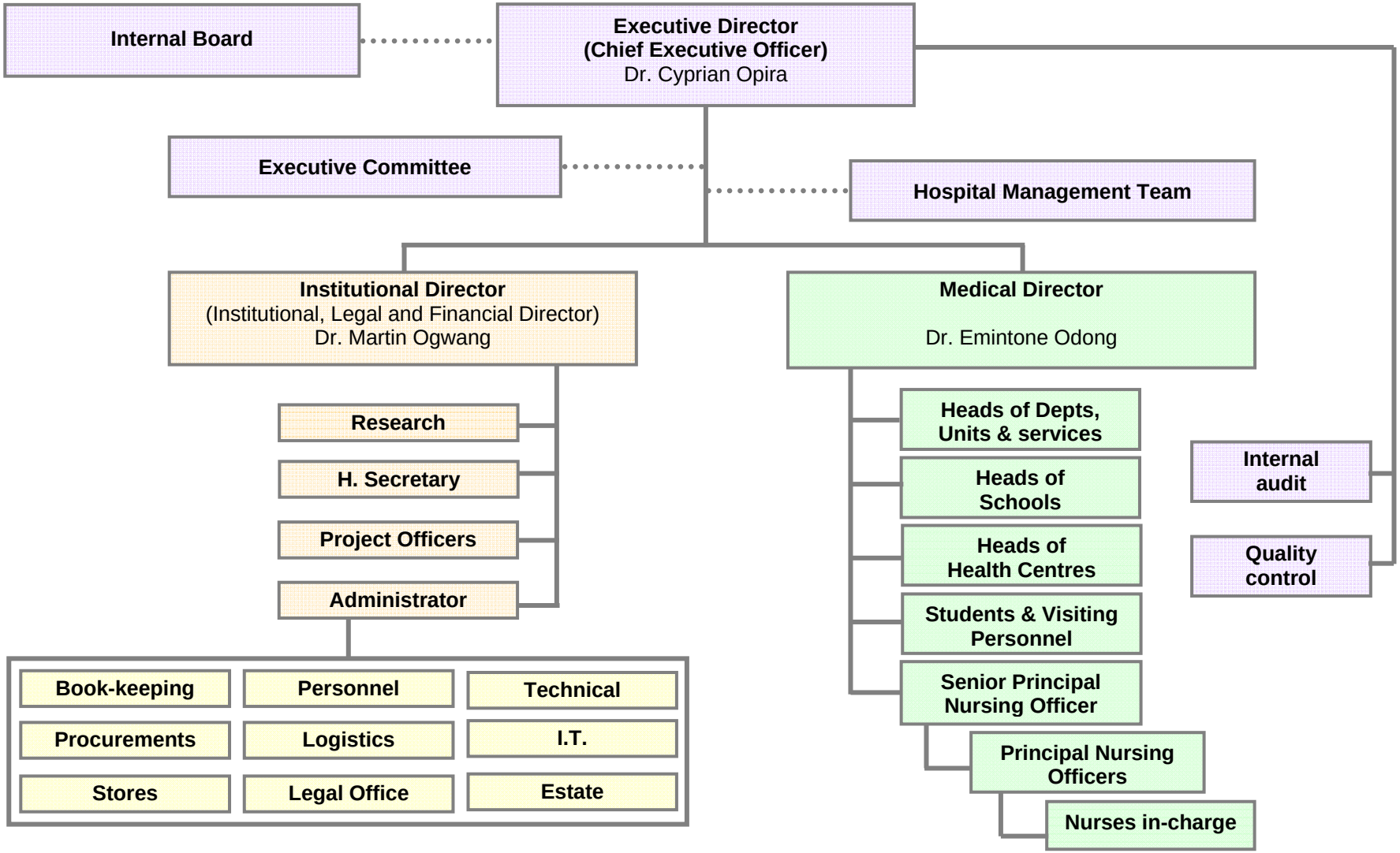
Annex 5 Hospital Executive Committee

Name	Position in the Hospital
Dr. Cyprian Opira	Executive Director
Dr. Martin Ogwang	Institutional Director
Dr. Emintone A. Odong	Medical Director
Mr. Roberto Gestri	Administrator
Mr. Pier Paul Ocaya	Hospital Secretary
Sr. Milly Among	Matron (senior nursing officer)
Mr. Thomas Molteni	Human Resources Advisor

Annex 6 Board of Governors

Name	Personal position	Board position
HG. John Baptist Odama	Archbishop Gulu RC 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. Fillipo Curtale	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 Private Bank, Kampala	Non-Exec. Member
Dr. Isaac Ezati Alidria	Director Planning and Development MOH	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. Roberto Gestri	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 30/06/2012

Profit and Loss	FY 2011/12 UGX'000
REVENUE	
Donations	4,233,281
Donations in kind	2,553,861
Patient charges	1,634,751
Hospital school fees	455,666
Other local revenues	206,556
Amortisation of deferred capital contributions	2,131,534
Total revenue	**11,215,648**
EXPENSES	
Personnel	
Salaries and wages	(3,945,948)
NSSF Hospital contribution	(386,253)
Insurance	(115,585)
Other staff costs	(933,454)
	(5,381,240)
Medical items and services	
Medical drugs	(3,366,600)
Laboratory and radiology items	(443,838)
Medical sundries	(1,259,684)
	(5,070,122)
Generic items	
Food supplies (includes food for students)	(310,074)
Printing and stationery	(313,658)
General supplies	(459,995)
	(1,083,727)
Transport expenses	
Cargo clearing fees	(28,684)
Fuel for ambulances and other vehicles	(217,609)
Insurance ambulances and other vehicles	(47,860)
Vehicle maintenance	(51,062)
Other transportation expenses	(66,552)
	(411,767)
Property expenditure	
Electricity*	(534,492)
Repairs and maintenance	(201,432)
Other utilities	(419)
Other property expenses	(37,896)
	(774,239)

(continuation 1 of Annex 8 Financial Statement for the year ended 30/06/2012)

Administrative expenses	
Professional fees	(322,321)
Communication	(68,330)
Bank charges	(32,923)
Office equipment and software maintenance	(32,228)
Other administrative expenses	(57,812)
	(513,614)
Total recurrent costs	**13,234,709**
Depreciation and amortisation	(2,131,533)
Total operating expenditure	**(15,366,242)**
Operating income	**(4,150,594)**
Other gains and losses**	**200,642**
Total comprehensive (deficit)/surplus for the year	**(3,949,952)**

**Electricity includes fuel for generator and Electricity bills from UMEME
**Other gains and losses includes non operating expenses, mainly foreign exchange differences, as well as re-evaluation of inventory.

(continuation 2 of annex 8 - Financial Statement for the year ended 30/06/2012)

Balance Sheet	2012 UShs'000	2011 UShs'000
ASSETS		
Current assets		
Cash and bank	1,023,352	2,688,497
Trade and other receivables	786,241	1,116,862
Inventories	2,497,505	1,973,952
Total current assets	**4,307,098**	**5,779,311**
Non current assets		
Property and Equipment		
- Buildings	26,832,544	26,560,417
- Hospital and clinic equipment	7,790,440	7,727,424
- Computer equipment	442,052	474,896
- Furniture and fittings	494,150	619,993
- Motor vehicles	488,640	450,342
- Work in progress		458,830
Total property and equipment	36,047,826	36,291,902
Prepaid operating lease rentals*	4,593	4,694
Intangible assets	219,857	249,347
Total non current assets	**36,272,276**	**36,545,943**
TOTAL ASSETS	**40,579,374**	**42,325,254**
LIABILITIES		
Current liabilities		
Trade and other payables	289,935	599,183
Deferred income	3,125,300	481,012
Total current liabilities	**3,415,235**	**1,080,195**
Non current Liabilities		
Capital contributions not yet amortized**	**36,410,281**	**36,541,249**
Net Assets		
Operating fund	4,703,810	4,133,088
Result of the year	(3.949,952)	570,722
Total Net Assets	**753,858**	**4,703,810**
TOTAL LIABILITIES AND NET ASSETS	**40,579,374**	**42,325,254**

*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.

(continuation 3 of annex 8 - Financial Statement for the year ended 30/06/2012)

Cash receipts from Donors (includes Capital Contributions)	2012 UShs'000	2011 UShs'000
Foundation Piero and Lucille Corti Italy	5,178,714	3,274,943
Italian Episcopal Conference	1,584,000	1,715,235
Government of Uganda	820,723	738,665
Catholic Relief Services (CRS)	586,464	707,439
Foundation Teasdale Lucille Canada	462,050	219,708
Ugandan Catholic Medical Bureau (UCMB) and Uganda Episcopal Conference	290,155	
RTI EMBLEM	191,538	38,323
Terres des Hommes Holland	122,625	218,090
Province of Bolzano	100,697	
International Network of Cancer Treatment and Research (INCTR)	64,618	30,686
Bikes not bombs	32,735	
Infectious Diseases Institute (IDI)	15,630	
Archdiocese of Gulu	13,057	
World Health Organisation	11,901	
East African Laboratory Network	9,145	
Centers for Disease Control and Prevention (CDC)	5,478	
Private donations	3,006	409,222
Malaria Consortium	4,349	55,264
The African Medical And Research Foundation (AMREF)	2,878	8,361
Argia Corti		42,215
Edus Educazione		63,460
Associazione Italiana per la Solidarietà tra i Popoli (AISPO)		57,323
Total cash receipts	9,499,763	7,578,934

Cash receipts in FY 11.12 do not include 803 million UShs pertaining to this financial year but not received during this financial year. They include 3,125 million Ushs released in this financial year but pertaining to the next financial years, 669 million pertaining to the previous year, 407 million UShs transferred to other project partners, 1,888 million Ushs of Capital Contributions which are accumulated in the Balance sheet and amortized over the years, as well as 21 million of exchange difference

Annex 8 (continuation)

Donations in kind (includes fixed assets donated in kind)	2012 UShs'000	2011 UShs'000
Catholic Relief Services (CRS)	1,309,055	1,924,505
Ugandan Catholic Medical Bureau	826,069	
Government of Uganda Credit line	207,360	111,027
Foundation Piero and Lucille Corti Italy*	128,310	231,855
Private donations	84,917	
International Network of Cancer Treatment and Research (INCTR)	64,271	3,734
NPS D.O.O. Software	29,353	
Health Partners	7,200	
Centro Cardiologico Monzino	4,032	
UNICEF	4,000	1,348
World Food Programme	1,608	9,754
Bikes not bombs	469	
Private Donors		18,774
Italian Cooperation		330,816
AISPO		211,738
Total	2,666,644	2,843,551

*83 million Ushs donated by Corti Foundation in FY 11/12 as well as the 29 million from NPS D.O.O. are fixed assets and are not included among the revenues in the Profit and Loss but accumulated in the Balance sheet and amortized over the years.