

St Kizito Hospital Matany

***Annual Report
Financial Year 2003/2004***

***St Kizito Hospital Matany
Moroto Diocese-Karamoja
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Chapter 1: Executive Summary

Introduction

St Kizito Hospital of Matany is a private non-profit institution with social and spiritual aims belonging to the Catholic Diocese of Moroto (Northern Uganda).

It was built at the beginning of the 70's and has since then provided essential medical/health services to the population of the Karamoja Region, an extremely underdeveloped region of the Country.

The Hospital is presently equipped with 226 beds. Various services are provided by the Hospital including: surgery, laboratory, diagnostic imaging, occupational and physiotherapy. The Hospital deals with an average of 10,000 admissions per year, of these, 300 - 400 included major surgical operations and 25-30,000 outpatient consultations. The Hospital ensures regular supervision for the Health Units of Bokora Health Sub-District.

The Hospital operates in accordance with the policy guidelines of the Ministry of Health of the Republic of Uganda and in co-operation with the local Health Authorities.

Within this report the activities will be related to the Government financial year (July to June the following year) which was introduced in the accounting system of the Hospital in 1996. Where possible, the activities of previous financial years will be presented for the sake of comparison.

Services offered and Activities carried out

The health and medical services provided by the Hospital cover a wide spectrum:

- preventive care (vaccinations, ante-natal clinic, growth monitoring and under 5 clinic, epidemiological surveillance)
- curative care (diagnosis and treatment of the most common diseases and of referred cases within and beyond the catchment area, emergency and elective surgery)
- promotive care (health education, training of professional and lay personnel, home based care)
- rehabilitative care (physiotherapy, occupational therapy).

The leading diseases, seen in OPD and in the catchment area, were infectious diseases like malaria, respiratory tract infections, diarrhea and intestinal worms. The overall bed occupancy rate was 101%, the average length of stay was 8 days and the throughput per bed was 42. Recovery rate in the year was 94%, self-discharge rate was 0,3% and death rate 5,7%. More than 400 major surgical operations were performed and 40% of them were emergencies.

About 70% of the infants of the area covered by the Hospital vaccination service received a complete course of vaccinations before the first year of life. In the catchment area nearly half of the pregnant women delivered under the supervision of a qualified midwife or a traditional birth attendants trained by the hospital personnel. Less than 12% of the numerous TB patients abandon treatment. During Financial Year 2003/04 the hospital has registered an increase in the accessibility, equity and quality but a slight decrease in the efficiency.

The Hospital opened a Nurses Training School in 1984 which is recognized by the MoH. Approximately twenty five nurses qualify each year as Enrolled Nurses and fifteen as Registered Nurses every second year. It is the only recognized professional training offered in the entire Region of Karamoja.

A centre for research on health management and for the permanent training of health personnel (Karamoja Human Resources Development Centre for Health) is attached to the Hospital. It is open to all those who wish to utilize it. It began to operate in 1994. This initiative sprang from a double need: the need to provide a structure for ongoing training and health management research and to generate income for the Hospital's recurrent costs. The structure was completed with an additional hostel during the past financial year.

Management and Finance

Since its foundation, the Hospital has relied on the presence of expatriate medical and managing personnel linked to the Italian Co-operation for Development (CUAMM) and to the Comboni Missionary Societies (Sisters, Fathers and Brothers). After years of financial difficulty the Hospital is now more stable due to the release of Delegated Funds (PHC conditional grant) from Government since FY 97/98. Delegated

Funds from Government have increased yearly since their introduction and currently constitute almost 40% of the total expenditure of the Hospital.

Extraordinary expenses (buildings, major equipment, and extraordinary maintenance) are financed exclusively by external aid. Ordinary expenditure (recurrent costs) are covered by patients' fees, recoveries and income generating activities (training centre, workshops, hospital guest house) and Delegated Funds from Government. The remaining costs are covered by donations and aid (from catholic organizations, international aid, NGOs, private benefactors).

Due to the extreme poverty of the population, all attempts at increasing the quota of income generated by fees has resulted in a reduction of the demand for service by the weakest sectors of the population (women, children and the destitute; women and children represent 80% of the admissions). This reached its climax with the introduction of a new fee structure in August 97, when the impact on utilisation was dramatic. Fees were reduced in November 97, after the release of delegated funds and an extraordinary fund raising mission abroad. Further reduction of fees took place in September 1998, July 2000, and July 2002. A further reduction for certain targeted groups (women and children) was implemented also at the beginning of this FY.

The cost of the services offered has been analysed and will be presented in chapter 3. On average the cost of one IP activity unit is now 40,695 Ushs verses the average fee charge of 7,000 Ushs. The cost of one OPD activity unit is 6,782 Ushs verses an average fee charge of 2,200 UShs. Both activities are subsidised with the aim of maintaining the Hospital's accessibility to all strata of the population, thus remaining faithful to its mission statement. The effect of an increase of fees in 1997 was closely monitored and led to a reversal of policy in November 1997 and in September 98, the result being another reduction of user fees. Due to a increased release of delegated funds from Government, a further reduction of user fees was effected in July 2000 and again in July 2002. The financial year 2002/03 closed with a fair situation of the finances of the Hospital. This gives a better outlook to the on-going financial year.

New Achievements

Towards the middle of the FY a new accounting programme sponsored by UCMB was introduced with the aim of tracking and possibly cutting down costs in the various departments. The hospital was further split into more cost centres for the same purpose. New policies and regulations (use of cars, requisition of Materials, Departmental budgeting) were introduced for the same purpose. Starting from the coming FY management should have a proper and more realistic view of how the different departments are performing and costing to the entire institution.

Along with this long term project, during the same year the new Constitution and the new employment manual were approved by the board and implemented. These two very important documents are now the cornerstones for management in its managing and decision making for the Institution.

The 2003/2004 Annual Report

The 2003/2004 annual report compares the activity reports to financial years in order to relate input and output. Therefore the comparison with previous years will be, wherever possible, presented with the activities of the corresponding FY.

The data presented here will be commented on and interpreted. Whenever possible a working hypothesis will be offered to explain data with controversial interpretation. The hypothesis proposed will be, where possible, tested in the course of 2004/05. Policy issues arising from the information presented will be highlighted. Points requiring action will be identified at the end of each chapter and compared with the points of action identified in the previous edition of the report. Therefore it is hoped that all data presented can be placed and viewed in a dynamic perspective, thus making the reading of this report more attractive and enlightening.

Plans for the Coming Year

For the financial sector and management sector, for the coming year, the Hospital should embark in the preparation and approval by the board of the Manual on management of financial and Material resources. A continuous assessment of the performance and reliability of the new accounting programme together with

the remaking of the fixed assets register will be of a paramount importance in this stage for a sound managing of the resources of the Institution.

Chapter 2: The Hospital and its environment

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Enviroment:

Moroto District is located in the north east of Uganda, bordering Kenya to the east side, Lira, Soroti and Kumi to the west side, Mbale and Nakapiripirit to the south side, and Kotido District to the north side. Mainly plain, Moroto District has an average altitude of 900 meters above sea level, with mountains Moroto (3,084 mt) and Kadam (3,068 mt) along east side. Savannah grass is the typical vegetation with thorny bushes and scattered few big trees. The rain usually comes from April to August and in form of torrential down pours which carry away the top soils. During the dry season, lasting from September to March, Moroto District experiences an absolute shortage of water. The temperature ranges from 21 to 36 C under the shadow. Because of the high temperature, the wind and the long dry season the soil, in some areas, has lost its grass cover making it easily accessible to the wind erosion.

Chapter 3: The Community and Health Status

The inhabitants of Moroto District belong to Karimojong ethnic group. They are further divided in the Bokora, Matheniko and Pian Karimojong. In the District there are also other smaller ethnic groups, Tepeth and Kadam, mainly living on the mountains. The Karimojong live in clusters called Manyatta. For security reason each Manyatta has a thorn fence and within the population can reach 400 inhabitants.

The houses are small and short round huts with mud walls and grass thatched roofs. The huts are used mainly for sleeping and during the night up to 10-15 people can fill it. This habit, together with the absence of ventilation, makes easy the spread of communicable diseases, as TB and meningitis.

The Karimojong are mainly cattle keepers; there are anyway some agricultural potentialities, especially around Iriri, where the land is fertile. The main crop cultivated is sorghum. Most of the Karimojong are

used to adopt a nomadic life, searching water and grass for cows especially during dry season. This lifestyle makes difficult health services delivery.

Following are some health indicators of Moroto District: IMR 137/1000, MMR 5/1000, Under 5MR 245/100, access to health services 24%, household latrine coverage 12,6%, rural water coverage 44%. Poor sanitation and harsh living conditions make water-borne and water-washed diseases quite common.

Moroto District has three Health Sub Districts: Bokora, Matheniko and Municipality. Bokora Health Sub District has six Sub-Counties and a total of 22 parishes. The population of the HSD, for the year 2004, is projected to be around 107,501 persons.

Chapter 4: Health Policy and District Health Services

During Financial Year 2003/04 the Hospital has delivered services according to the guidelines of National Health Policy and in the framework of the Uganda Health Sector Strategic Plan (HSSP 2000/1-2004/5).

Matany Hospital and Bokora Health Sub-District health plans have been included in Moroto District Annual Health Work-Plan for Financial Year 2003/04. The highest health authorities of Matany Hospital (Medical Superintendent and In-charge of Bokora Health Sub-District) are members of the District Health Management Team while the Medical Superintendent is also member of the Diocesan Health Commission.

The decentralization policy carried on by the Ministry of Health has lead Matany Hospital to become the referral facility of Bokora Health Sub-District with a central role in planning, supervise and monitoring all health activities in the area. Further information regarding health infrastructures, type and number of health facilities and their main characteristics are given in chapter 8 (PHC Department).

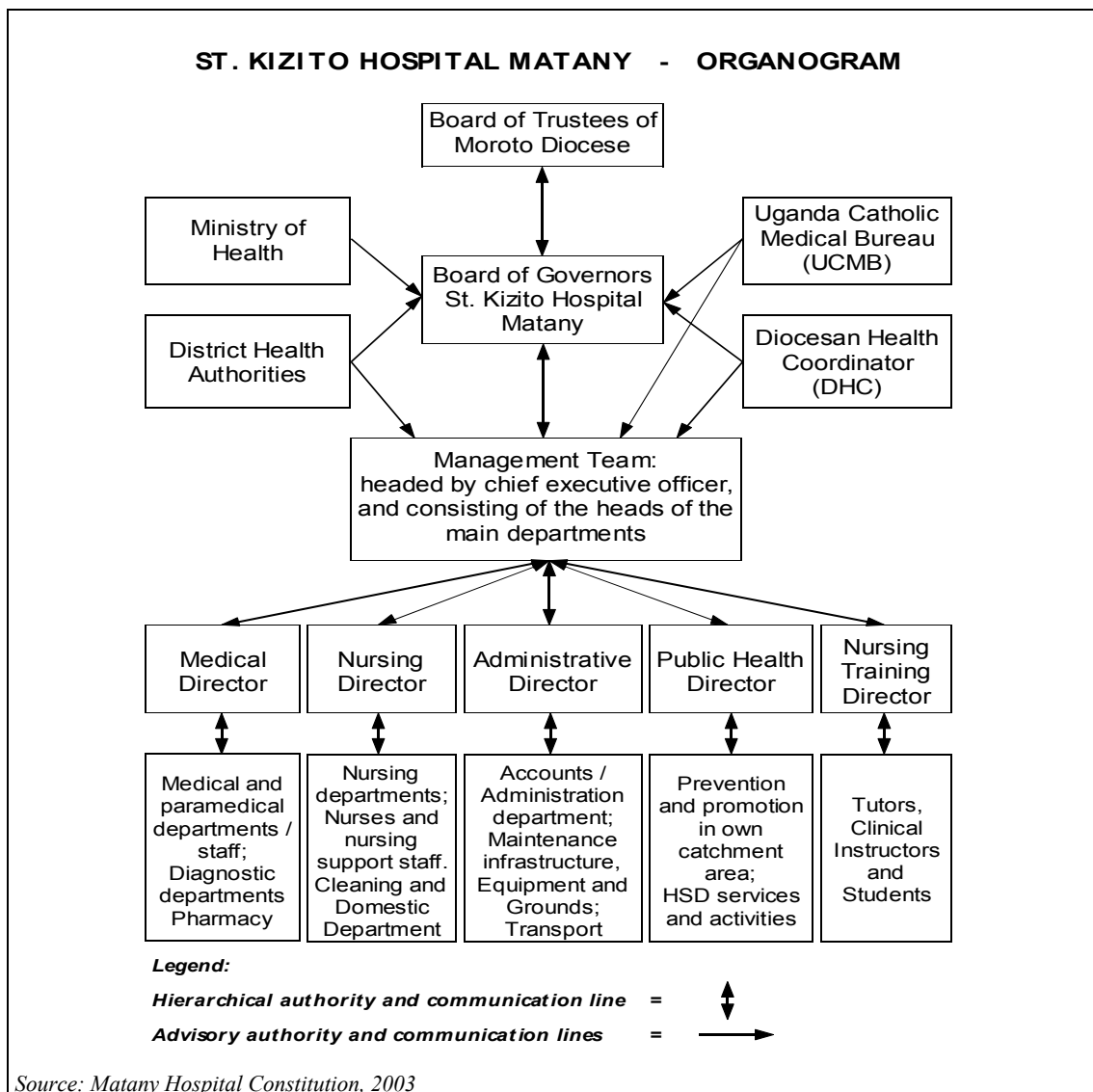
Chapter 5: Management

Management

The Hospital operates under the direction of the Board of Governors (BOG), which takes its mandate from the Board of Trustees of the Diocese through its Chairman, the Bishop. The BOG is held twice during a financial year, as per Constitution that is in June and December.

The Hospital is managed by the Hospital Management Team (HMT) with its executive body, (the daily board), formed jointly by the Administrative Director (AD), the Medical Director (MD) and Nursing Director (ND). This executive body meets daily (in the morning) with the main task of tackling issues arising during the day to day running of the Institution. Issues concerning finance, personnel and implementation of activities are the most common. Contrary to the present arrangement in Government Hospitals, the function of the Chief Executive Officer is not statutorily exercised by the Medical Director. The Chief Executive Officer is at present the Administrative Director. However, the Constitution of the Hospital allows this office to be held by any of the Hospital Officers upon the Bishop's nomination.

GRAPH 5.A – ORGANOGRAM OF ST. KIZITO HOSPITAL MATANY



The Chief Executive Officer has direct access to the Bishop in the event of need and ensures the function of liaison with the Diocesan, District and National Health Authorities.

The Hospital Management Team (HMT) is composed of the executive board together with the PHC Director and Nursing Training Director. The HMT meets regularly once per month and the chairperson is the Chief Executive Officer. The main functions of the HMT are:

- ❖ To ensure the smooth day to day running of the Hospital and Nursing Training School.
- ❖ To ensure the implementation of the Hospital activity plan.
- ❖ To ensure the daily implementation and administration of the HSD activities.

The School Management Team (SMT) is the management of the Nurse Training School and is composed of the Nursing Director who is also the chairperson, the Nursing Training Director who is also the secretary, the Medical Director and the Administrative Director and the tutors. The SMT meets quarterly with the functions of:

- ❖ Ensure smooth running of the School.
- ❖ Prepare reports and proposals for the BOG considerations.
- ❖ Propose the level of school fees to the Board.
- ❖ Decide on intake, schedule lessons and examinations.

- ❖ Authorizes the use of discipline measures for students in breach of school rules.

The Hospital has also established a Disciplinary Committee with the main function of ensuring proper conduct by the staff. The disciplinary committee meets whenever a disciplinary evaluation is urgently in need. The committee is called by the CEO who is the chairperson.

General Staff assemblies are regularly held twice a year that is after the Board of Governors meetings.

As advocated by the UCMB, the BOG during 2003/04 Financial Year has approved the new Hospital Constitution and the Employment Manual. These two documents are the cornerstone where all the decisions taken by the Hospital Management Team are based upon. The next task for the Hospital Management Team for Financial Year 2004/05 is to prepare, make it approved by the BOG and implement the Manual on Management of Financial and Material Resources.

Chapter 6: Human Resources

Introduction

The recruitment of staff and its retention have always represented a serious challenge for the management of the Hospital. The harshness of living conditions in Karamoja, its many years of insecurity, and its remoteness have all rendered work in Matany less than attractive. Therefore, the Hospital failed to have enough Medical Officers which should be ideally six. During FY's 2003/04 an average of 4 Medical Officers were present in the station. Since November 2003 two newly qualified Medical Officers have been contracted for two years. One of them is a Karimojong doctor and hopefully he will remain working in Matany for a long period.

On the side of administrative staff the situation remained stable. Our candidate for a Master degree at Nkozi University in Management and Administration came back in October 2002 and now is acting as the Assistant Administrator.

The opening of the training school for nurses in 1984 has managed to secure the needed qualified nursing staff. A challenge remains for all categories of allied medical professionals (for whom the opportunities of employment in large cities are many and very attractive) and by capable indigenous technical cadres. The technical department still relies on the supervision of one expatriate staff.

An additional problem is posed by the lack of qualified cadres from among the ranks of Karimojong indigenous. Despite the generous investment of the Hospital management in the training of young Karimojong the results are still poor. The low academic standards of schools offered in Karamoja make it more difficult for people here to have access to professional training. Another problem is that staff sponsored by the Hospital, they often did not honor their bonding agreements but leave soon after for more attractive places.

In addition to this, the lack of well established career development schemes and promotional outlets makes the employment in Matany a temporary arrangement for most people who achieve a professional qualification. At present, with the assistance of the UCMB, the Hospital is working toward a scheme which will allow staff to develop and be promoted.

Some initiatives have been put into place so as to provide for the well-being of the staff in general. In 2002, the first Orientation Course was held for newly qualified staff. Since then all new employees are provided with needed information in order to make them feeling more a part of the overall mission of the Hospital. The Annual Staff Christmas Party was also held in 2003. This included staff from all the various departments of the Hospital. It improved the morale of the staff tremendously. There is now, DSTV in place, which provides recreational programmes for the staff to watch. This year the staff was able to view the European Football Cup. There is also a Hospital football team, the White Angels. This team is comprised of students from the Nursing Training School, as well as Hospital employees. They have become quite serious, and often challenge rival teams from the area on weekends. This also provides needed recreation for the staff.

Present situation (June 2004)

The Hospital Management is following the Government Salary scale. At present, thanks to the intervention of government in the form of Delegated Funds, the Hospital Administration has been able to maintain a salary level of 100%. Compared to salaries paid by the private sector and the very attractive employment of NGOs operating in the frame of projects, salaries are still low but according to information given us by Uganda Catholic Medical Bureau our Medical Officers get in average more than the colleagues working in government health facilities while the situation for other cadres in the Hospital is jeopardized with salaries, usually, lower than the ones of public sector.

At the end of June 2004 Government posted Officers were three (one Health Educator, one Health Inspector and one Community Based rehabilitation Officer for the Public Health Department). The expatriate staff includes the Administrator (mccj), the Senior Nursing Officer (cms), the Medical Superintendent (since May 2004), one Technical Supervisor (mccj Lay missionary), the Domestic Officer (cms) and three Medical Officers. The total number of employees is 270, 215 (79%) of whom are Karimojong. The distribution by departments appears in table 1 The number of qualified staff (employees holding a diploma, certificate or degree) is 83 (31%).

Trends

With the exception of nursing, administrative, PHC and the teaching staff, the number of employees decreased in 1995 (graphic A) and increased again in 1996 and 1997. From 1998 onwards there was a marked increase in the overall number of employees, especially Nursing Staff, in order to face the increased demand for health care services. The number of Karimojong Staff (215) is the highest level noted in the last years. The institutional policy of favoring the employment of indigenous personnel is well established as can be seen in the last years. The Technical Department has a rather high Staff level and continues to be a necessary department. This department is essential for the proper running of the Hospital (maintenance and building activities); it also provides services to the public and to projects, generating additional income. Its importance to the hospital economy justifies its size.

In the period covered by the report the hospital has continued promoting the up-grading of staff: more details are given in Table 3.

As mentioned before, salaries paid to the employees are in line with those of public sector.

All employees are covered by NSSF (National Social Security Fund). Employees are paid on a salary basis. The salary is composed of a basic salary to which some incentives are added. This constitutes the basis of calculation for insurance purposes. Other payments (overtime, calls, stand-by allowance and specific tasks related allowances) are considered instead for the purpose of calculation of PAYE. The average salaries paid at the end of the year for the stated categories of staff are indicated in Table 2.

Graphic 1: Levels of Employment at Matany Hospital since 1994

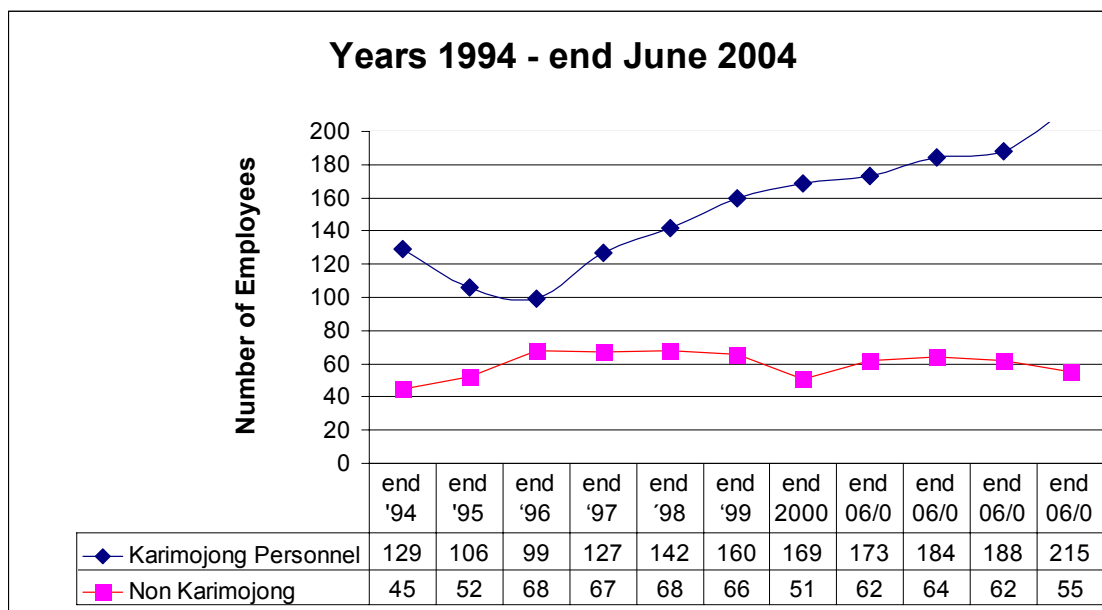


Table 6.1 : Establishment at Matany Hospital – June 1996 - June 2004

	end '97	end '98	end '99	end 2000	end 06/01	end 06/02	end 06/03	end 06/04
MEDICAL OFFICERS	4	6	7	6	4	3	4	7 (1)
ALLIED MEDICAL PROFESSIONS	13 (6)	14 (4)	14 (7)	11(7)	9 (7)	10 (4)	11 (4)	11(4)
NURSING STAFF	42 (19)	57 (22)	53 (27)	56 (31)	65 (34)	64 (33)	66 (37)	74(57)
ADMINISTRATIVE STAFF	8 (1)	11 (4)	11 (7)	11 (8)	11 (7)	11 (6)	11 (10)	14(10)
PHC STAFF	29 (28)	27 (25)	33 (32)	29 (28)	33 (32)	37 (36)	37 (36)	37(36)
TECHNICAL STAFF	43 (28)	42 (38)	54 (43)	50 (41)	55 (41)	56 (41)	53 (38)	57(42)
SUPPORT STAFF	42 (36)	39 (38)	39 (39)	41 (41)	41 (38)	49 (47)	49 (47)	49 (47)
SCHOOL STAFF	11 (7)	12 (9)	11 (8)	10 (7)	12 (9)	14 (11)	15(12)	14(11)
KHRDCH STAFF	2 (2)	2 (2)	4 (4)	6 (6)	5 (5)	6 (6)	4 (4)	7(7)
TOTAL	194	210	226	220	235	247	250	270
<i>(.) = Karimojong Personnel</i>	<i>127</i>	<i>142</i>	<i>160</i>	<i>169</i>	<i>173</i>	<i>184</i>	<i>188</i>	<i>215</i>
Non Karimojong Personnel	67	68	66	51	62	63	62	55

Table 6.2: Average Monthly Salary per Category of Employee

Average Salaries	End '98	06/2001	06/2002	06/2003	06/2004
	Ushs	Ushs	Ushs	Ushs	Ushs
ALL. MEDICAL PROFESSIONS*	200,000	230,000	230,000	270,000	270,000
UEN/MW	130,000	155,000	155,000	200,000	220,000
URN/MW	180,000	220,000	220,000	270,000	270,000
NURSE ASSISTANT	80,000	115,000	115,000	140,000	140,000
ADMINISTRATIVE STAFF	170,000	190,000	190,000	225,000	225,000

PHC STAFF	52,000	60,000	60,000	75,000	75,000
TECHNICAL STAFF*	120,000	140,000	140,000	160,000	160,000
SUPPORT STAFF	65,000	72,000	72,000	80,000	80,000
SCHOOL STAFF*	200,000	300,000	300,000	385,000	385,000
KHRDCH STAFF	120,000	130,000	130,000	150,000	150,000
* qualified cadres					

Table 6.3 : Training of Staff : (* Karimojong)

Type of Training	Institution
Enrolled Midwifery 3 (2*)	St. Mary's Midwifery T.S. Kalongo
Registered Midwifery 2 (1*)	Rubaga School of Midwifery
Registered Midwifery 2 (2*)	Kalongo School of Midwifery
Laboratory Technologist 1 (1*)	Mulago School of Lab. Technologist
Laboratory Technician 1 (1*)	Nsambya School of Laboratory Technician
Laboratory Assistant 1 (1*)	Rubaga School of Lab. Assistant
Health Inspector 2 (2*)	Mbale School of Health Inspectors
Diploma in Pharmacy 1*	MEDS Nairobi
Electrical Installation 1*	BVTPC Tororo
Registered Nursing 1*	Nsambya School of Nursing
Registered Nursing 4 (2*)	Matany School of Nursing
Data Management 1 (1*)	Uganda Management Institute, Kampala
Bachelor in Accounting 1	Nkozi University, Kampala
Enrolled Midwifery 2 (2*)	Kalongo School of Midwifery

Conclusion

The management of human resources with the management of finances remains clearly the main managerial problems of the Hospital. The lack of qualified Karimojong personnel will require more substantial investment in their training. The training will have to be focused in 2004/05 on the development of following cadres as a priority: Senior Accountant, radiographer, midwives, nurses, tutors and other Medical Officers to replace those who will finish their contracts. This conclusion also indicates the points of action for 2004/05.

In addition, the Hospital is planning to increase the salaries of its staff according to government salary scale.

Chapter 7: Finances

Beginning with the Financial Year 1997/98 the Hospital experienced a greater financial stability due to the release of Delegated funds from Government. This allocation has increased annually which helped the institution to cope with the steady increase of expenditures along the years. Moreover, various capital development projects carried out by the technical department of the Hospital have also helped the financial situation to improve.

The FY 2003/2004 has turned out to be a very important year in the life of the Institution. Towards the end of this FY, a new accounting programme was introduced and the hospital as a cost centre was further spited into 18 more cost centres. All these changes are aiming at having a better way of tracking costs per

departments for better analyses and decision making. Some results should already been seen by the next FY.

The FY 2003/2004 ended with a fair surplus. The increased release of Delegated Funds from the Ugandan Government, the ongoing capital development projects, a fairly steady flow of donated funds from benefactors, have permitted us to fulfill Roman Catholic Hospitals' Mission to provide services at accessible levels to the poor.

See the table below for a better understanding of the origin of the various sources of income.

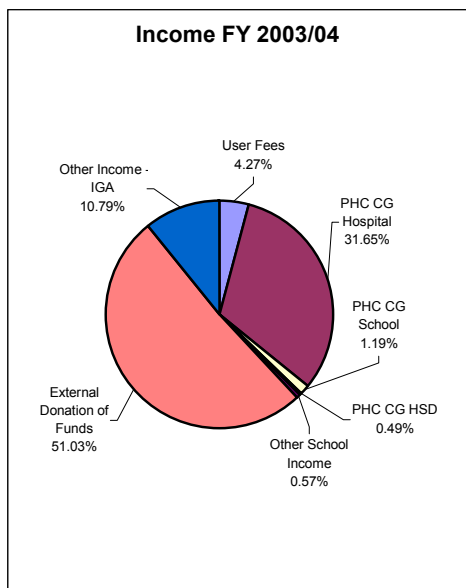
Table 7.1: Various sources of Income for FY 03-04, FY 02-03, FY 01-02, FY 00-01

INCOME	FY 03/04 UGX	FY 02/03 UGX	FY 01/02 UGX	FY 00/01 UGX
User Fees	80,024,005	86,279,440	81,458,321	84,312,854
PHC CG Hospital ^	593,160,676	526,410,542	375,451,467	201,683,221
PHC CG School ^	22,253,901	40,659,610	37,224,212	18,630,989
PHC CG HSD ^	9,244,036	16,342,874	21,828,876	28,942,556
Other School Income	10,771,000	90,482,625	16,323,435	13,620,767
External Donations of Fund §	956,295,663	468,158,100	437,943,358	387,917,480
Other Income – IGA §	202,202,565	230,176,143	294,771,756	267,978,344
TOTAL	1,873,951,846	1,458,509,334	1,265,001,425	1,003,086,211
^ Delegated funds				
§ Various benefactors – unconditional donations in funds				
§ Income from KHRDCH*, Technical Department, various sales, projects				
* KHRDCH = Karamoja Human Resources Development Centre for Health				

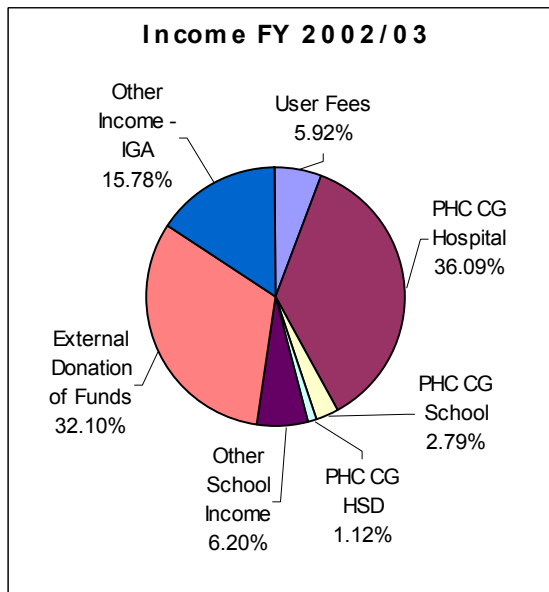
Income

If we compare the percentage allotted to sources of income over the last four financial years (Graph 7.1), it is evident that the External Donation of Funds in FY 2003/04 has sharply increased (almost 20%) compare to the previous three financial years. This is due to the fact that the hospital received a lot of help in forms of funds from different benefactors for projects, payment of salaries, new equipment, sponsorships etc. The Government support, in the form of Delegated Funds for the hospital has slightly increased (seventy million more) though the graphic shows a lower percentage over the whole picture. Meanwhile the Delegated Funds for the School and HSD have experienced a sensitive drop. For Instance the DF for the school was reduced almost to the amount given for FY 2000/01. However, It is important to point out that the hospital received 97% of Hospital DF budgeted for our Institution.

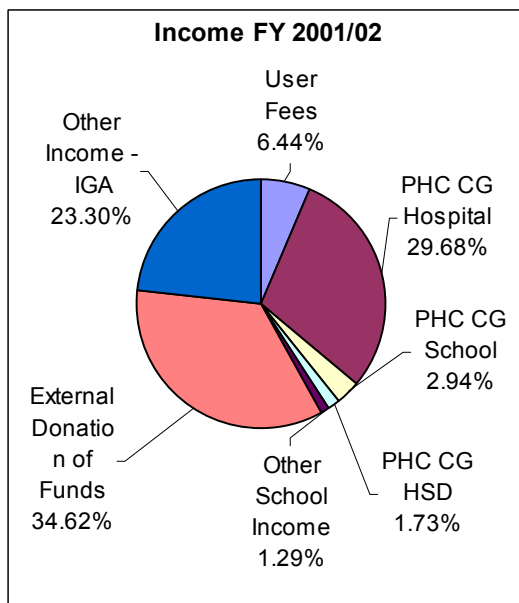
Graph 7.1 – INCOME



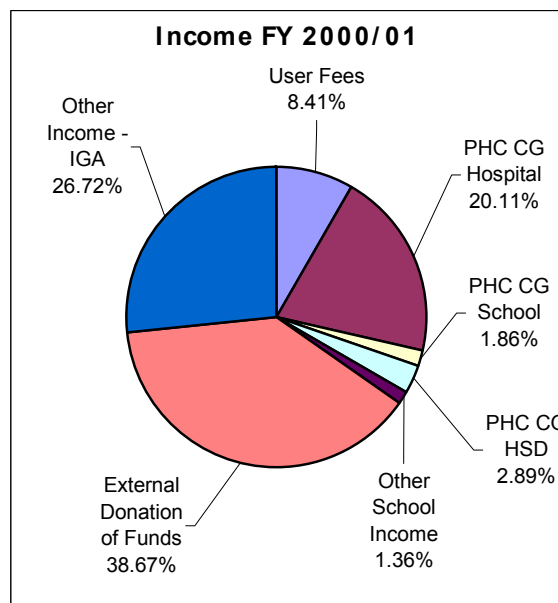
Total: 1,873,951,846/=



Total: 1,458,509,334/=



Total: 1,265,001,425/=



Total: 1,003,086,211/=

Despite the high utilization, the income fees reduced slightly due to the further flattening of charges at the beginning of the FY 2003/04. The NTS school revenue dropped sharply because the funds allocated by Danida/HSSP for the Nursing Training programmes were received only after the close of the FY. For the same reason a higher percentage on the same is expected in the current FY 2004/05. Other income/IGA dropped due to fewer building activities.

Expenditure

From FY 2002-03 to FY 2003-04, the global expenditure shows an increase of approximately 26%. This increase is related mainly to two factors:

- Hospital expenditures due to the increase of salaries, drugs and medical sundries.
- The expenditure for capital development projects, both in terms of Human Resources and buildings which, at the same time are the cause of the increase of income.

Below is the table with the expenditures occurred during the past four years using the Government format.

Item	Description	Budget 2003/04	FY 2003/04	FY 2002/03	FY 2001/02	FY 2000/01
71xx	EMPLOYMENT COSTS					
7101	Staff Salaries and wages	380,000,000	378,971,633	284,358,025	217,642,232	189,478,801
7103	Hous/bic/overtime&other all.	10,500,000	7,780,227	5,018,639	7,008,379	5,249,591
7106	Night/safari all.	7,500,000	6,359,000	6,035,914	3,557,500	3,577,000
7109	Welfare & staff health	10,600,000	11,034,116	12,124,363	3,800,367	3,126,508
7111	Uniforms & prot. clothing	1,000,000	294,000	216,600	923,400	1,146,190
7115	Transport all.					
7116	Workshop/seminars	2,000,000	1,450,000	850,000	700,000	620,000
7120	XXX NSSF XXX	38,000,000	37,778,986	24,353,256	17,556,750	15,354,676
7121	Duty/Resp./Acting all.	54,500,000	46,607,000	46,046,504	41,488,000	36,509,200
7122	Lunch all.					
	Sub Total	504,100,000	490,274,962	379,003,301	292,676,628	255,061,966
72xx	ADMINISTRATION COSTS					
7220	Printing and stationery	15,000,000	20,722,585	12,280,896	6,907,435	7,558,707
7230	Tel./fax./postage/courrier	15,000,000	8,607,252	11,055,555	9,401,557	9,960,715
7231	Bank charges	800,000	1,112,202	530,843	504,100	583,887
7280	Advertising and Public Relations	3,000,000	5,880,900	512,500	2,145,000	1,901,200
7290	Other office expenses	21,500,000	13,391,900	16,386,260	16,659,637	12,920,242
	Sub Total	55,300,000	49,714,839	40,766,054	35,617,729	32,924,751
73xx	PROPERTY COSTS					
7310	Water					
7330	Electricity					
7380	Repairs and upkeep of buildings	51,300,000	22,546,681	44,139,007	43,916,403	41,220,699
	Sub Total	51,300,000	22,546,681	44,139,007	43,916,403	41,220,699
75xx	TRANSPORT AND PLANT COSTS					
7510	Fuel	43,800,000	43,127,617	34,072,356	32,900,041	28,523,557
7520	Maintenance and repairs	1,500,000				
7240	Tyres and spares	23,200,000	19,910,729	21,036,282	15,819,287	11,738,770
7570	Air travel	15,000,000	17,018,907	15,009,815	11,186,490	4,163,800
7580	License/Insurance of vehicles	4,800,000	3,542,683	1,150,347	1,427,084	1,774,490
7590	Operation/maintenance of generators	3,400,000	2,603,677	2,526,700	2,151,424	2,963,887
	Sub Total	91,700,000	86,203,613	73,795,500	63,484,326	49,164,504
76xx	SUPPLIES AND SERVICES COSTS					
7630	Equipment and supplies	33,000,000	56,145,480	26,546,005	32,618,265	23,089,605
7635	Mainten. of equipment and supplies					
7660	Newspapers and publications	2,500,000	2,349,400	1,944,100	2,477,950	2,106,574
	Sub Total	35,500,000	58,494,880	28,490,105	35,096,215	25,196,179

77xx	MEDICAL GOODS AND SERVICES					
7710	Medical drugs	85,000,000	85,338,013	69,657,227	59,641,252	47,554,017
7720	Medical tools and equipment	5,000,000	1,303,148	5,210,410	5,210,410	858,500
7725	Maint. of medical tools and equip.					
7730	Medical supplies	60,000,000	75,310,731	50,777,144	50,274,454	54,156,100
7750	Beds and beddings					
7770	Foodstuff and firewood	51,000,000	66,030,676	54,280,532	31,464,306	35,640,034
7790	Consultancy charges					
	Sub Total	201,000,000	227,982,568	179,925,313	146,590,422	138,208,651
78xx	PRIMARY HEALTH CARE COSTS					
7810	Support Supervision	4,000,000	3,528,000	3,528,000	3,050,000	2,820,000
7820	Outreach services	5,000,000	4,320,000	2,880,000	2,510,000	2,400,000
7830	Drugs and Sundries for LLUs					
7840	Planning and Meetings	700,000	504,000	504,000	400,000	420,000
7850	Training of TBAs	4,000,000	3,480,000	2,610,000	2,500,000	2,500,000
	Hospital Based PHC	95,000,000	93,804,546	49,072,331	46,034,428	45,278,112
	Home Care	115,000,000	114,914,345	22,954,442	53,075,297	48,734,919
	Sub Total	223,700,000	220,550,891	81,548,773	107,569,725	102,153,031
8xxx	CAPITAL DEVELOPMENT COSTS					
8500	Major maint. and upkeep of buildings	30,000,000	23,407,968	12,335,156	16,027,518	13,209,939
8700	Other capital expenditure					
8900	Staff Development	40,000,000	38,862,650	34,489,391	34,116,450	20,089,663
	Sub Total	70,000,000	62,270,618	46,824,547	50,143,968	33,299,602
	TRAINING SCHOOL COSTS	131,550,000	108,052,207	98,168,158	80,390,741	65,390,398
	Exp. For IGA	292,000,000	205,024,129	236,891,160	165,433,136	166,478,443
	GRAND TOTAL EXPENDITURE	1,656,150,000	1,531,115,388	1,209,551,918	1,020,919,293	909,098,224
	BALANCE (Income-Expenditure)		342,836,458	248,957,416	185,082,132	93,987,987

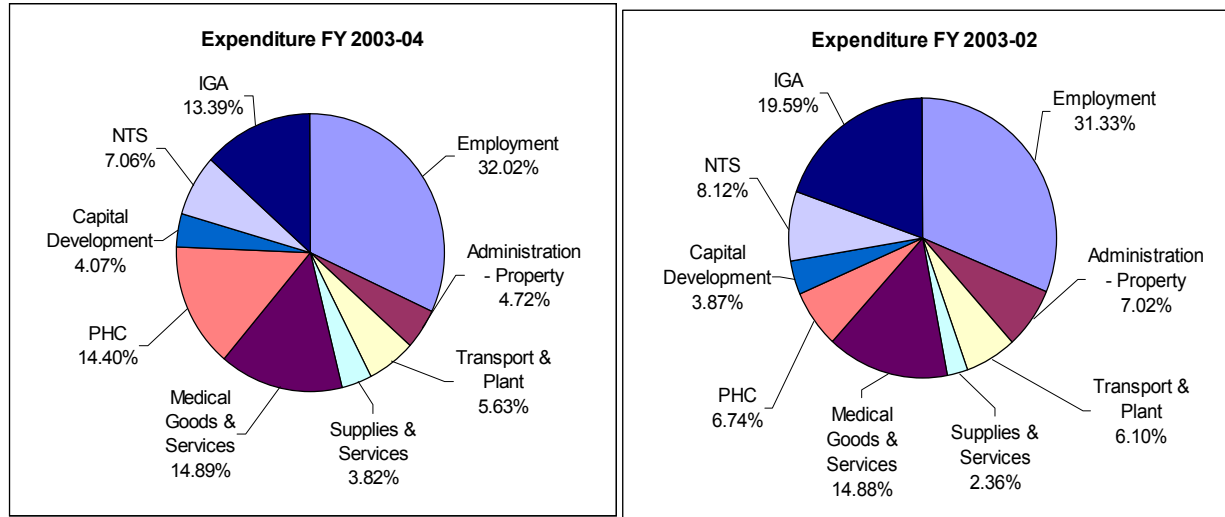
Looking at the different groups of expenditures it is possible to notice that during FY 2003/04 there has been a good increase by 20 to 30% in almost all the groups compared to the previous FY; this is due to the high increase of costs of material and services. Moreover, the following can be made out:

1. For the property costs a reduction of 100% of cost was obtained due to less resource allocated to repairs and upkeep of the hospital buildings.
2. An increase of 100% in the supplies and services cost occurred due to the more supplies used and more equipment bought to furnish the different wards/Departments.
3. The cost for the PHC department had a huge increase (200%) from the previous financial year due to the intervention of the Home Care project from the EU. More money was allocated by the EU for this projects thus more was spent in implementing the same.
4. For the IGA expenditures a reduction of roughly 14% occurred due to the fewer building construction and jobs done for outsiders.

Graphs 7.2 in the next page show the percentage for the different groups of expenditures comparing them with the previous three years. Apart from the PHC (more than double) no remarkable changes are demonstrated for this FY. A slight increase occurred for the employment, supplies and services and capital development costs, while a decrease of expenditure occurred for the administration – property, transport and plant, NTS and IGA costs.

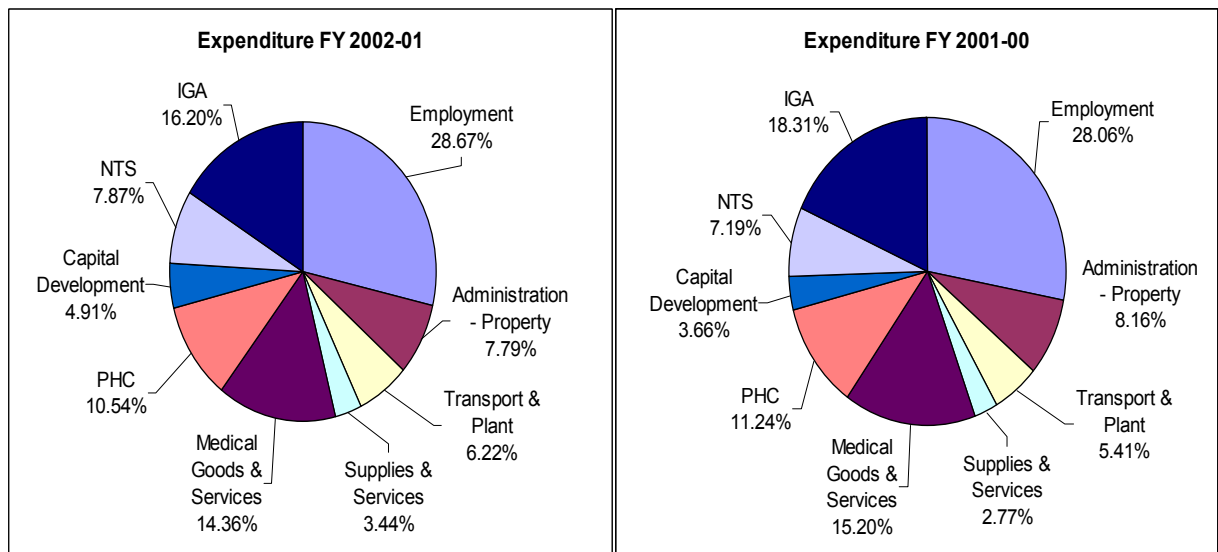
It is important to point out that having an accrued system of accounting the value of material which is indicated it is the actual value consumed and not the stock purchased.

Graph 7.2 – EXPENDITURE



Total: 1,531,115,388/=

Total: 1,209,551,918/=



Total: 1,020,919,293/=

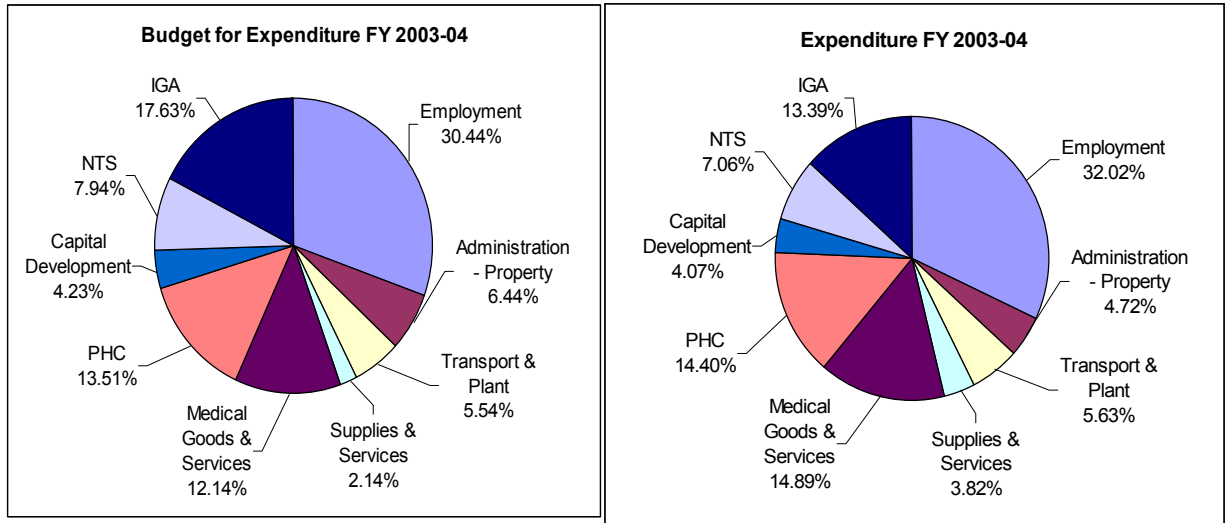
Total: 909,098,224/=

Budget Comparison

Comparing the budget with the expenditures occurred during the Financial Year 2003/04 (see graph 7.3, budget comparison), it is evident that as a whole the expenditures have been within the budget. There was just a slight breaking of the ceiling (between 1.5 to 2.7%) in some areas such as, employment, Supplies and Services, Medical Goods, and PHC due to the increase of costs on Material and human resources. Knowing

this, a big effort was made in containing the costs in other areas in order not to exceed the budget as a whole. The management has the power to shift to priority activities even after the budget approval according to the needs arising, but proper documentation and explanation has to be given to the BOG.

Graph 7.3 – BUDGET COMPARISON



Total: 1,656,150,000/=

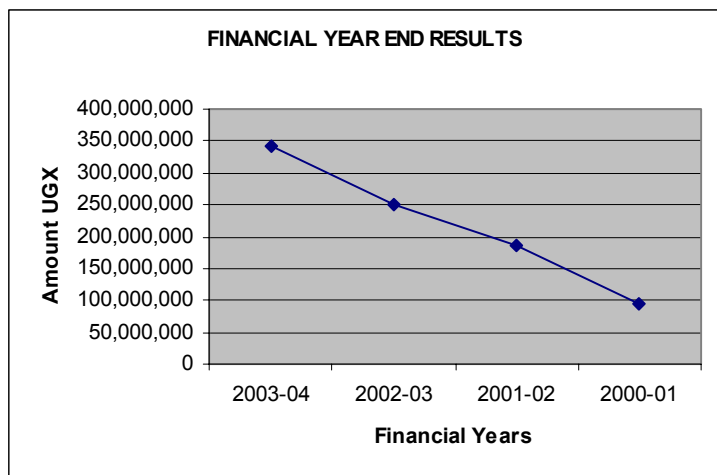
Total: 1,531,115,388/=

Graph 7.4 – FINANCIAL YEAR RESULTS

Financial Year Result

As it was said at the beginning of this chapter the FY 2003-04 ended with a fair surplus of 342,836,458 UGX, (see Graph 7.4). It is already some years that the Hospital is trying to end its financial years with some surplus to be reinvested in the organization.

Slowly by slowly management has become aware that the only way forward is the containment of costs. Some efforts have already been put into this direction especially in the areas of material usage. Management is aware that a lot can be still done in the same and other areas as well. We hope that with the implementation of a new accounting system, the involvement of the heads of department and the people from the different stores, the development of a financial policy manual (to be introduced in the coming FY) more people will become aware of the need of reducing cost for a better utilization of resources at all levels.



Government Intervention

As previously mentioned Government's support to the Hospital has been substantial beginning with FY 97-98 and thereafter. A good working relationship with the District together with the prompt release of Delegated Funds has assisted the Hospital in achieving various objectives and goals.

Appreciation should be given to the Government not only for the financial support itself but also because the level of co-operation has been good. The release of funds by the District Authorities, once received from the centre, has been for the most part very punctual.

Conclusion

Looking at the market trend of the Country it is clear that costs for services and material will substantially increase during the coming Financial Years. It is clear that the only way forward is to contain costs with a proper utilization of resources. More and more resources are limited and the call for a better utilization and savings is more than ever urgent. Taking into account these factors the action plan for the next financial year will focus in the following areas:

- ❖ Continue the dialogue with the Government at District and at National level through the strengthening of co-operation and mutual trust.
- ❖ Monitor usage of material and other resources at departmental levels with more involvement of the staff especially the heads.
- ❖ Reduction of costs at various levels through proper planning and better utilization of resources.
- ❖ Consolidate the new computerized accounting program (FiPro) with proper planning and monitoring of departmental costs.
- ❖ Establishment of the manual on management and material resources.
- ❖ Development and consolidation of reserve schemes and policies.

Chapter 8: Activities

OPD (Out Patient Department activities)

Introduction

The Hospital has a separate OP Department with two wings: one for adults and the another one for children. The Building also hosts the Ophthalmologic and ENT services, the ANC and the Immunization services. Working hours is from 8.00 am to 1.00 pm from Monday to Saturday. The Dental and Private Service, though part of the OPD, are in a separate building. The laboratory and radiological examinations are carried out on the Hospital premises. The arrangement is such that the two premises can be accessed from the Hospital courtyard. Here follow data focused on the curative function of OPD services. The PHC function exercised is reported apart, as a global report for the Health Sub District.

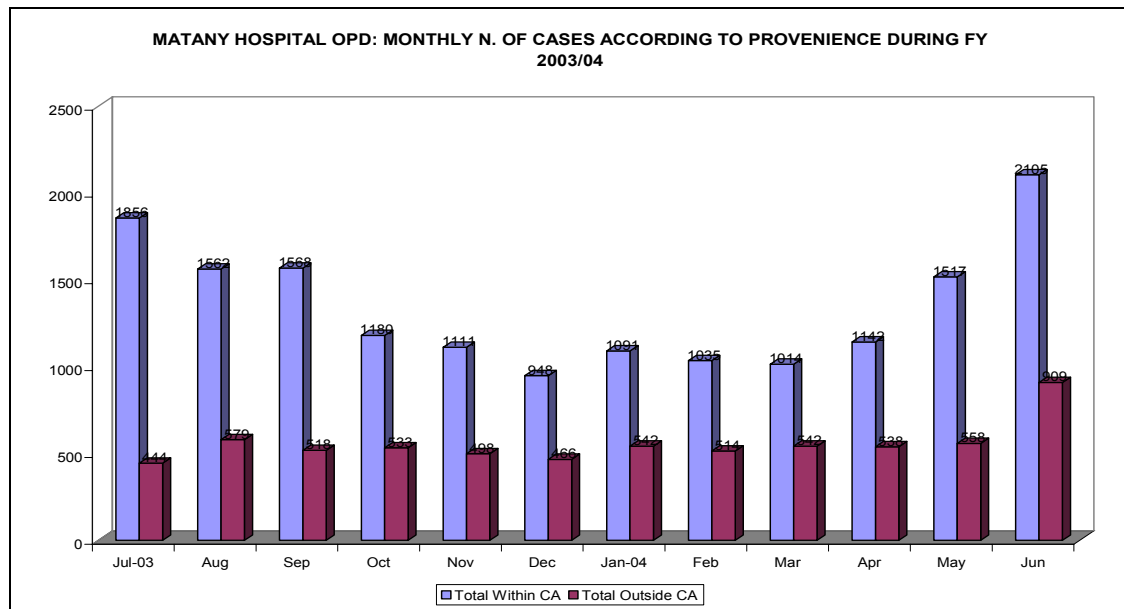
Function of the Hospital OPD

According to its established function in the District Health System, the Hospital should offer to the public outpatient consultations of first contact (exclusively for the immediate catchment area of the hospital), outpatient consultations of referral level (for referred patients only), inpatient and emergency (medical and

surgical) services and a package of preventive and promotive services (for the immediate catchment area = Health Sub District).

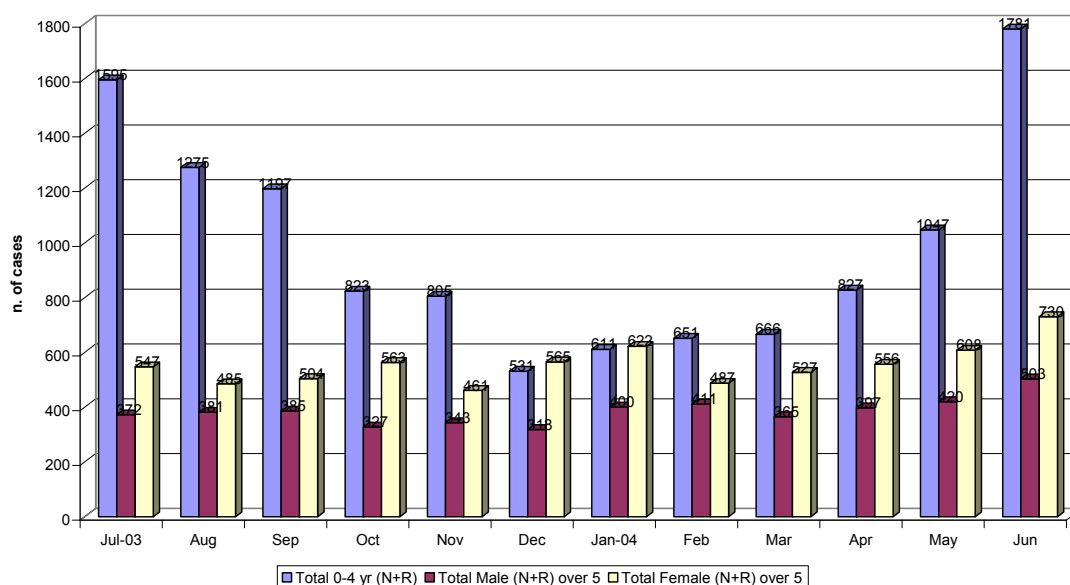
Matany Hospital OPD covers two separate functions. It serves as first contact for the patients of the immediate catchment area (Matany Sub County) and it also serves as a referral centre for patients who have first consulted elsewhere and have either been referred or have reported to the Hospital because their problem was not solved. Sometimes it serves as a first contact level for patients who bypass their first contact unit. The first two functions may be considered in line with proper use of the health system. The third utilization pattern (bypass of first contact near home) goes against a correct and cost-effective utilization of the system. During Financial Year 2003/04 70% of patients were from within catchment area (Health Sub District) while 30% were outside (see graph 8.1). The number of patients attending OPD was changing during the year: the period from May to August was very busy while the period from November to April was quite. The seasonal variations are due to the climatic conditions and the nomadic lifestyle of karimojong (see graph 8.2): the period November-April corresponds to the dry season during which the adults and part of their families escape from Karamoja looking for grass for grazing while the period May-August includes the rain season and coincides with the coming back of shepherds and their herds of cows. The fee structure translated in local language has been displayed to the public in OPD, public board and in all the wards.

Graph 8.1: origin of OPD patients during FY 2003/04



Graph 8.2: seasonal variations in n. of OPD clients during FY 2003/04

MATANY HOSPITAL OPD: MONTHLY N. OF NEW CASES+REATTANDANCES SEEN DURING FY 2003/04



Workload

All OPD workload data from Financial Year 1996/7 onwards is reported in table 8.1. OPD activities were quite high in 1996, and dropped sharply in 1997/98 as a consequence of an increase in user fees because of the financial crisis the Hospital was experiencing at that time. It increased again in FY 1998/99 and remained at an average of 30,000. In FY 2001/02 there was again a sharp drop, which is explained by the opening of the two Health Centres: Lokopo and Lopei. These had an attendance of about 4,000 each during that period. During the FY 2003/04 the number of OPD new cases seen has increased compared to previous year while the total number has dropped down due to reduced number of reattendances. Assuming records have been taken properly, the explanation could be a better assessment done since the beginning by Medical and Clinical Officers in OPD. The fees structure is the same of the last year so the patients have not been discouraged to come because of money factor and also the number of patients admitted in the wards has been almost the same of the FY 2002/03 so the patients have not been switched to the wards. Other explanations could be a decreased burden of diseases in the Health Sub District or an increased utilization of Peripheral Health Units. Looking at the data of Health Sub District (see PHC chapter), the morbidity pattern and the workload of Peripheral Health Units were more or less the same of the previous year. Out of 23,086 visits done in OPD 16,161 (70%) patients were visited by a Clinical Officer while 9,925 (30%) by a Medical Officer.

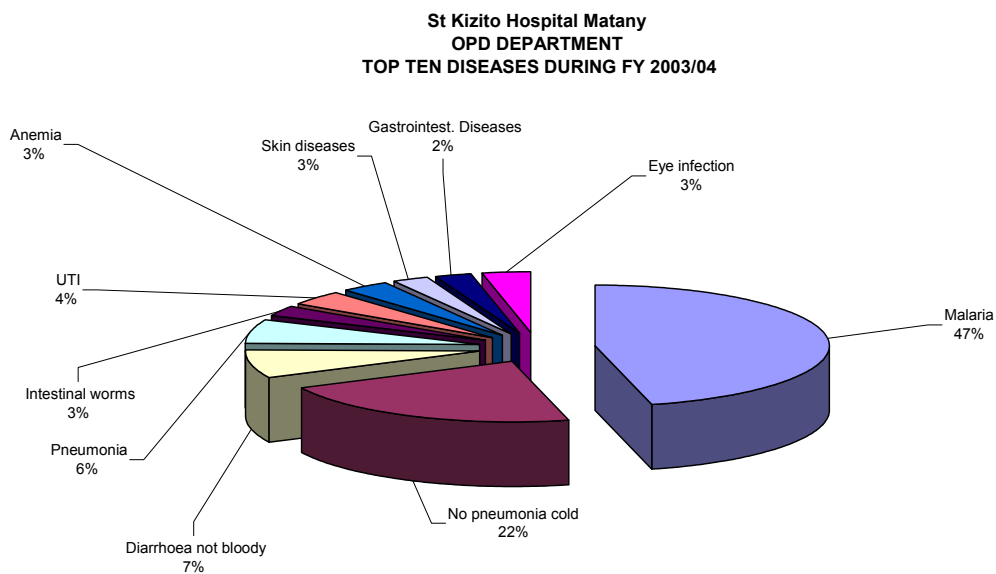
Table 8.1: OPD workload from FY 96/97 to FY 03/04:

OPD Department								
	FY 96/97	FY 97/98	FY 98/99	FY 99/00	FY 00/01	FY 01/02	FY 02/03	FY 03/04
New attendance	21.038	11.102	15.998	13.835	18.182	16,167	18,281	19,792
Adults	8.524	3.757	6.956	4.332	5.037	8,483	9,614	9,197
Children	12.514	7.345	9.042	9.503	13.145	7,684	8,667	10,595
Re-attendance	22.973	11.029	18.511	14.662	14.319	8,606	8,093	3,294
TOTAL	44.011	22.131	34.509	28.497	32.501	24,773	26,374	23,086

Epidemiology

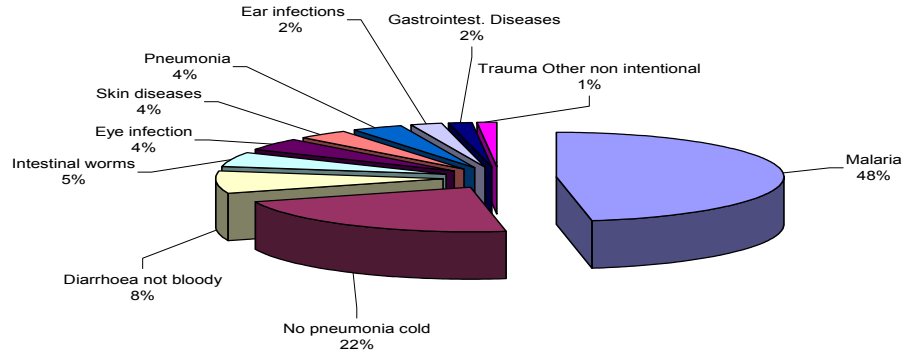
The morbidity pattern, mainly the 10 commonest diseases seen in OPD during FY 2003/04, shows malaria (8,065 episodes) as leading disease. The second most frequent diagnosis is LRTI (3,776 episodes). The third most frequent pathology reported is diarrhea (1,303), followed by pneumonia (1,082) and intestinal worms infections (928). The OPD top ten diseases is indicated in graph 8.3 and compared with the 10 commonest diseases recorded in Bokora Health Sub District (graph 8.4). The pattern is almost the same: the only difference is the fourth cause of disease: pneumonia in Matany against intestinal worms infections in Bokora Health Sub District, due to referral function of Matany Hospital compared with first filter function of peripheral health units.

Graph 8.3: top 10 diseases in OPD during FY 2003/04:



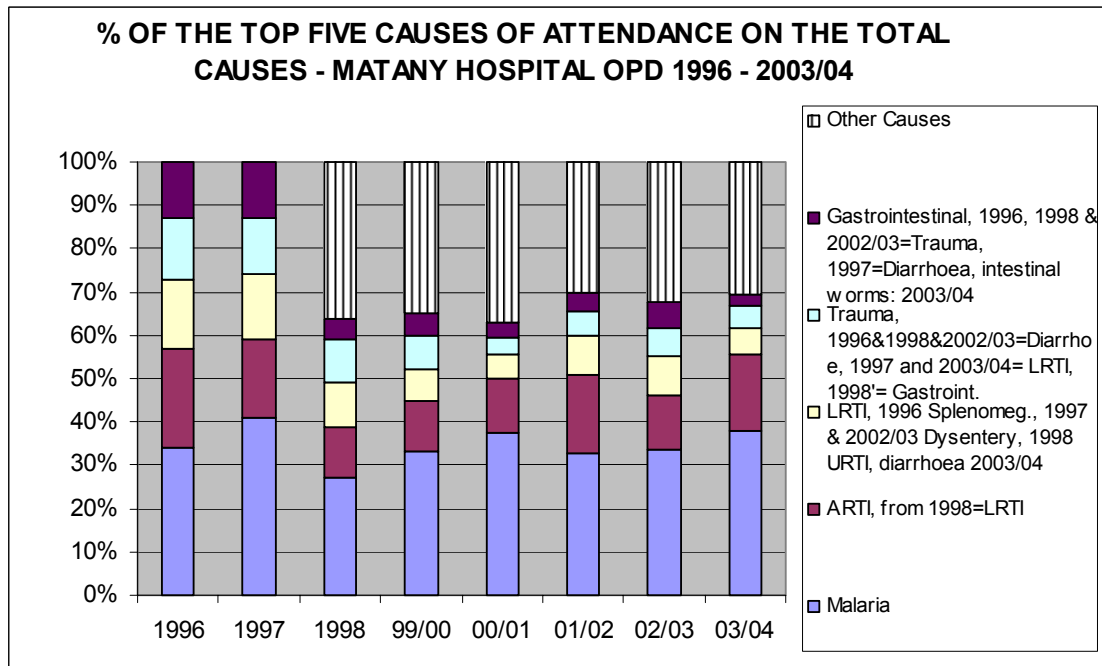
Graph 8.4: top 10 diseases in Bokora Health Sub District during FY 2003/04:

BOKORA HSD: TOP TEN DISEASES DURING FY 2003/04



In the following graph, the percentage of the five top causes of attendance is compared to the previous years.

Graph 8.5: percentage of top five diseases in OPD since 1996:



There are no significant changes in the epidemiological pattern, and the more “obvious” diseases remain to be the five top diseases. Some differences occur in some years concerning the fifth one. This is very difficult to explain. It could be trauma, worms, gastrointestinal diseases or splenomegally.

Surveys

During FY 2003/04 following Uganda Catholic Medical Bureau recommendations, two surveys have been carried out among OPD clients: patients’ satisfaction and drug prescription survey.

In May 2004 a patients' satisfaction survey was carried out among clients of OPD and inpatients. The questionnaire administered included 15 questions concerning the patients' perception on health services provided by Matany Hospital. In particular the areas covered by investigations were: clinical effectiveness and outcomes, humanity of care, organization of care and environment. 100% of inpatients declared they had the impression they improved after treatment given and found the medical staff kind with them but none of them was involved in decisions made about treatment and care. Waiting time for getting treatment was less than ½ hour for OPD and inpatients and all the interviewees expressed to be fully satisfied about the care they received. Only the environment, above all the toilets and the bathrooms, did not satisfy the clients who were asking for more cleanness. The 96,6 % of interviewees declared the care they received was worthy the payment done and all of them were willing to go back to Matany Hospital next time for further care.

The second survey, the Drug prescription one, was done in order to get information on prescription practises in OPD among Medical Officers and Clinical Officers. According to the results of the survey 98,7 % of OPD clients were provided with an outpatient card where history, physical examination, working diagnosis and treatment are supposed to be indicated. In the survey 98,7 % of OPD cards were reporting a full history, a complete physical examination, one or more working diagnosis and consequent treatment. The average of drugs prescribed was 2,4 and the average of diagnosis was 1,25 per patient. The percentage of injectable drugs prescribed and antibiotics was respectively the 7,5% and the 7,10% of the total drugs prescribed. All the drugs prescribed were available in OPD pharmacy and given to the clients. The average fees for adults and children were respectively 1787 and 667 Ushs.

Performance Indicators

Hospital performance can be measured through some indicators developed ad hoc by Uganda Catholic Medical Bureau (UCMB). These indicators are useful to compare different hospitals of same size and workload and to monitor the performance of the same hospital in the years.

Matany Hospital provides several health services to the people and these services can be seen as outputs. The main outputs of a hospital are the no. of patients visited in OPD or admitted in the wards, the no. of pregnant women screened, immunizations done and deliveries conducted. Giving a weight to each of these five outputs against a term of reference (Op = 1 outpatient contact), UCMB has produced an aggregated indicator of outputs called Standard Unit of Output (SUO-op). SUO-op is calculated using the following formula:

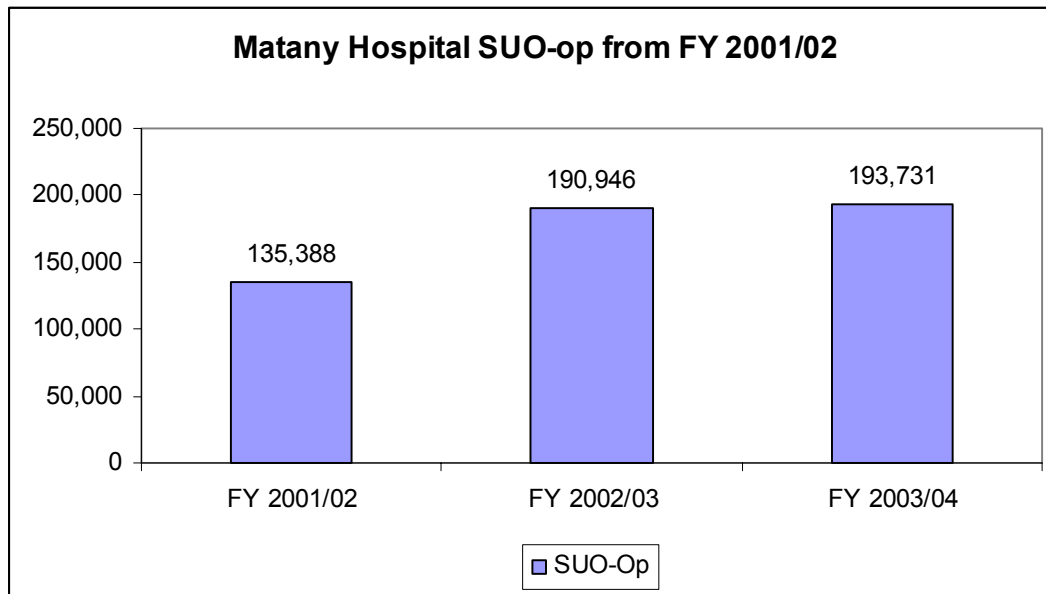
$\text{SUO-op} = (15 \times \text{no. IP}) + (\text{no. OP}) + (5 \times \text{no. deliveries}) + (0,2 \times \text{no. of immunizations given}) + (0,5 \times \text{ANC visits})$
--

In a similar way SUO-ip (Standard Unit of Output per Inpatient) can be calculated.

Starting from SUO-op/ip and knowing the total expenditure of the hospital, the income from patients user fees, the number of qualified staff, the bed capacity, the workload of OPD, PHC Department and wards, it is possible to calculate other indicators called SUO-op per staff, cost per SUO-op, cost per SUO-ip, median user fee fees per SUO-op, median user fees per SUO-ip. These indicators can be used to measure the accessibility, the equity, the efficiency and the quality of Matany Hospital.

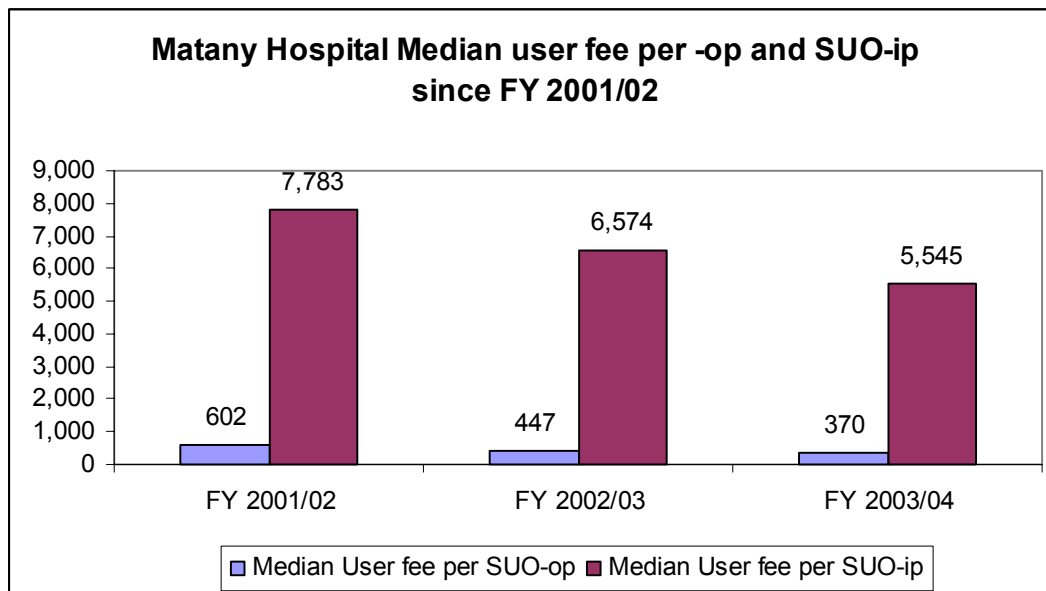
Hospital accessibility is measured looking at its utilization and therefore SUO-op is the best indicator. More people have got health services from Matany Hospital, more accessible it is. As indicated in graph 8.6, the SUO-op has increased from FY 2001/02.

Graph 8.6: SUO-op as measure of accessibility:



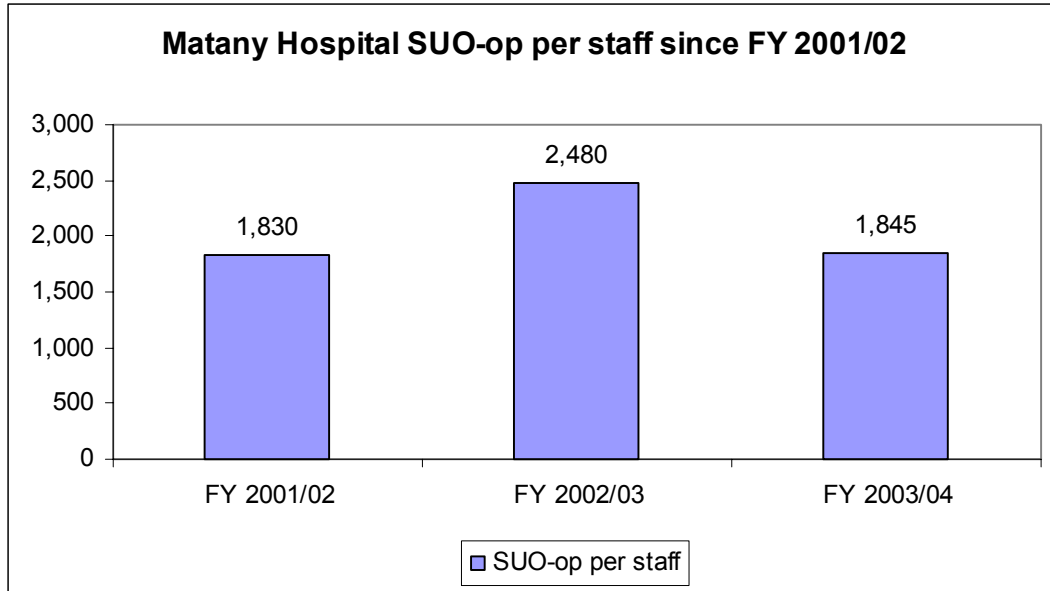
To measure equity, (a hospital is equitable when people who are really in need, i.e. vulnerable groups: children, pregnant women, are served more and more) three indicators are used: median user fees per SUO-op, utilization of services by pregnant women and immunizations given to the population. Graph 8.7 indicates median user fee per SUO-op in the previous three years while no. of immunizations given and Ante Natal Care Clinic workload are discussed in PHC chapter (both of them have increased).

Graph 8.7: median user fee per SUO-op and SUO-ip, indicators of equity:

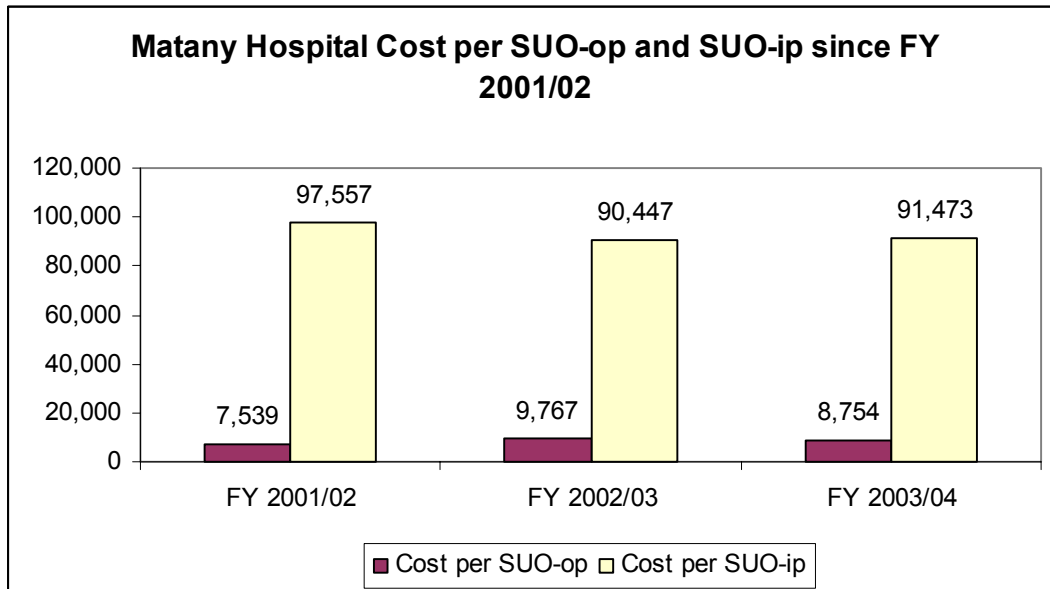


Considering no. of qualified staff and total cost of the hospital, two others indicators, measuring the efficiency, SUO-op per staff and Cost per SUO-op, can be calculated. Graphs 8.8 and 8.9 indicate respectively SUO-op per staff and cost per SUO-op/ip since FY 2001/02. The picture is not clear: SUO-op per staff has decreased compared to last year but has increased compared to FY 2001/02. Cost per SUO-op has decreased compared to FY 2002/03, meaning gain of efficiency, but Cost per SUO-ip has increased from one year to another.

Graph 8.8: SUO-op per staff as measure of efficiency



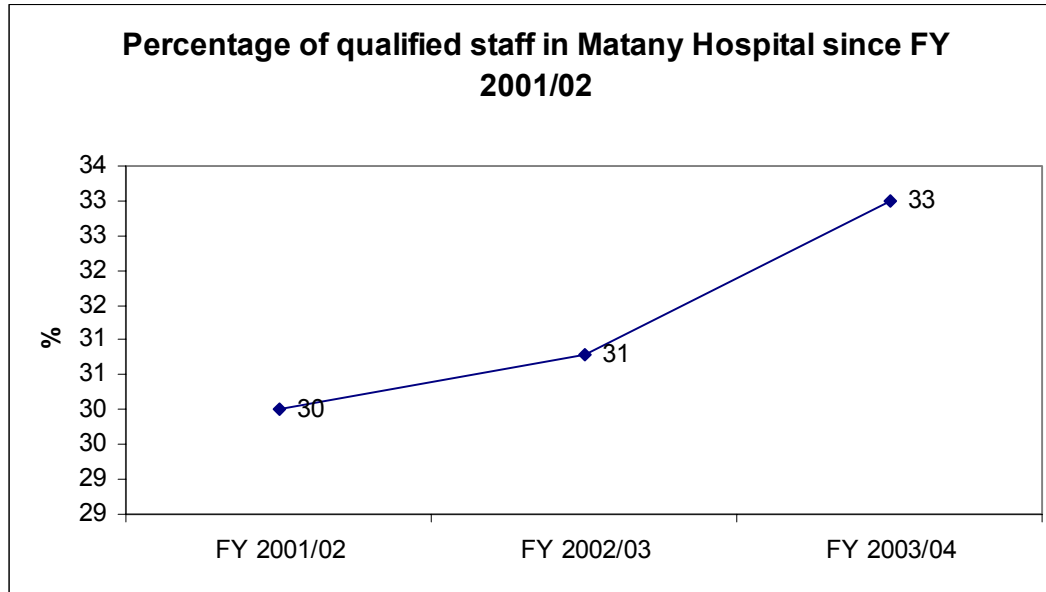
Graph 8.9: cost per SUO-op and SUO-ip (staff productivity indicators).



Quality of services provided by a health facility is difficult to measure but an indicator can be the percentage of qualified staff. Assuming that good The current qualified staff rate is the highest rate never

reached in Matany Hospital before. Quality of drugs' prescription and patients' satisfaction surveys are two others tools, which results have been already presented, to measure quality of health services provided. Inpatients recovery rate, maternal mortality rate, still birth rate and Caesarian infection rate are others quality indicators presented in following chapters.

Graph 8.10: qualified staff rate



OPD Special Services

Some special services are offered as part of the OPD, and are run by trained personnel (table 8.2): primary ophthalmology, primary ENT, and primary dentistry. A private service is also offered for the religious of the diocese and VIP's, it does not generate income. For the first group the Hospital Management has introduced a pre-payment scheme with the diocese of Moroto.

Table 8.2: workload of special outpatient services:

Special outpatient services										
Patients examined	1995	1996	1997	1998	FY 98/99	FY 99/00	FY 00/01	FY 01/02	FY 02/03	FY 03/04
P. Ophthalmology	494	139	812	859	990	892	749	688	654	659
P. Dentistry	267	95	92	74	126	146	130	235	349	376
P. E.N.T	814	884	693	765	679	1,067	1,228	481	307	335
Private Service	166	149	61	122	96	68	84	82	19	19

Points of Action

- Strength the use of UCG 2003 guidelines for diagnosis and treatment.
- Construction of a shelter for ANC clients (suggestion coming from patients' satisfaction survey)
- Waiting time survey
- Extension of OPD working time (from 8.00 am to 6.00 pm)

Wards: Inpatient services

Introduction

Matany Hospital in-patient service functions as a referral service for the District and also for a wider functional catchment area for emergency referral surgery. The Hospital bed strength at the end of the year was 226 beds distributed over 5 Wards: Male Ward and Female Ward with 41 beds each (medical and surgical mixed together), Maternity Ward with 31 beds (ante-natal, post-natal, isolation patients and 6 for premature intensive care), Pediatric Ward with 55 beds including 10 isolation beds, TB Ward with 58 beds. A Medical Officer does the ward round on daily basis. As in OPD, the utilization of the Hospital In-patient service dropped in FY 97/98 while an increase was registered overall in FY 98/99, due to decrease of fees. During the following years the utilization went back to its average coverage. From FY 2002/03 however a remarkable increase of inpatients was experienced and always following another reduction of applied fees. The global bed occupancy rate for FY 2003/04 was 101% and the throughout per bed was 42.

- **Workload**

INPATIENT WORKLOAD MATANY HOSPITAL

Table 8.3 (workload of years 1997-'04) shows the inpatient workload up to June 2004. 1998/99 was a year with a very high workload and the following years have gone back to the average of the past years and has increased again up to its highest level in FY 2002/03. The number of major surgery has increased while minor surgery has decreased. Matany Hospital has been without a permanent surgeon up to June 2003 when Horizon 3000, an Austrian NGO, has contracted one surgeon for 2 years.

Table 8.3: inpatient wards workload from FY 1997/98 to FY 2003/04:

INPATIENT	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04 (admitted)
WARDS							
Male ward (41beds)	731	1.005	921	859	1.014	1,123	1,171
Female ward (41 beds)	806	1.057	816	811	1.007	1,157	1,183
Children ward (55 beds) (with Isol. + 6 Nutrition Unit)	2.321	4.313	3.936	3.780	3,878	6,982	6,939
Isolation ward (with CW since '96)	137	184					
Maternity ward (25+6 beds)	518	838	723	787	753	1,168	1,016
TB Adult ward (58 beds)	193	225	187	145	232	177	256
TB Paed. Ward (with CW since '96)	94	108	137	119	178	114	
TOTAL (226)	4.800	7.730	6.720	6.501	7,062	10,607	10,565
SURGERY							
Major	336	411	361	286	399	354	447

Emergencies (%)	32.4%	24.1%	35.7%	55.6%	38%	49%	64%
Minor	1.904	1.474	1.156	1.032	1.194	2.414	536
MATERNITY							
Deliveries (Total)	364	548	505	549	537	662	490
Deliveries (Abnormal)	85(23.4%)	111 (20%)	103 (20%)	88 (16%)	79 (14.7%)	172 (26%)	122 (25%)
Caesarean Sections		87	96	69	71	113	112
Live births	340	525	501	541	526	644	672
Premature	25	43	33	44	37	22	25

Utilisation Indicators:

All utilization indicators (Bed Occupancy Rate, Turnover Interval and Throughput per Bed) have been calculated on the number of discharged patients. The following formulas were used:

Bed Occupancy rate = $\frac{\text{Dur. n of stay (all pts)}}{\text{No. of beds} \times 365}$	Throughput per bed = $\frac{\text{No. pts. Discharged}}{\text{No. of beds}}$	Turnover Interval = $\frac{(\text{N. Beds} \times 365) - \text{Dur. n of stay}}{\text{No. of pts. Discharged}}$
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INPATIENT UTILISATION from FY 1997/98 to FY 2003/04

Male WARD (41 Beds)	99/00	00/01	01/02	02/03	03/04	Female WARD (41 Beds)	99/00	00/01	01/02	02/03	03/04
Patients Discharged	921	859	1,014	1,123	1,063	Patients Discharged	816	811	1,007	1,157	1,091
Duration of stay (No. of days)	12,190	10,250	12,503	10,012	10,244	Duration of stay (No. of days)	10,726	8,247	8,365	8,442	9,714
Avg. duration of stay (No. of days)	13	12	12	9	9,6	Avg. duration of stay (No. of days)	13	10	8	7.3	8,9
Bed Occupancy Rate (%)	81%	68%	83.5%	67%	68,5%	Bed Occupancy Rate (%)	72%	55%	56%	56%	64,9%
Turnover Interval (No. of days)	3	5	2.4	4.4	4,4	Turnover Interval (No. of days)	5	8	6.5	5.6	4,8
Throughput per Bed (No. of patients)	22	21	25	27	26	Throughput per Bed (No. of patients)	20	20	25	28	26,6
Paediatric WARD (55 Beds)	99/00	00/01	01/02	02/03	03/04	Maternity WARD (25 Beds)	99/00	00/01	01/02	02/03	03/04
Patients Discharged	4,073	3,899	4,081	6,982	6,509	Patients Discharged	723	787	753	1,168	882
Duration of stay (No. of days)	34,859	34,326	35,479	41,801	47,757	Duration of stay (No. of days)	4,850	4,795	5,215	7,701	7,050
Avg. duration of stay (No. of days)	9	9	9	6	7,3	Avg. duration of stay (No. of days)	7	6	7	7	8
Bed Occupancy Rate (%)	174%	171%	177%	188%	237,9%	Bed Occupancy Rate (%)	53%	53%	57%	84%	77,3%

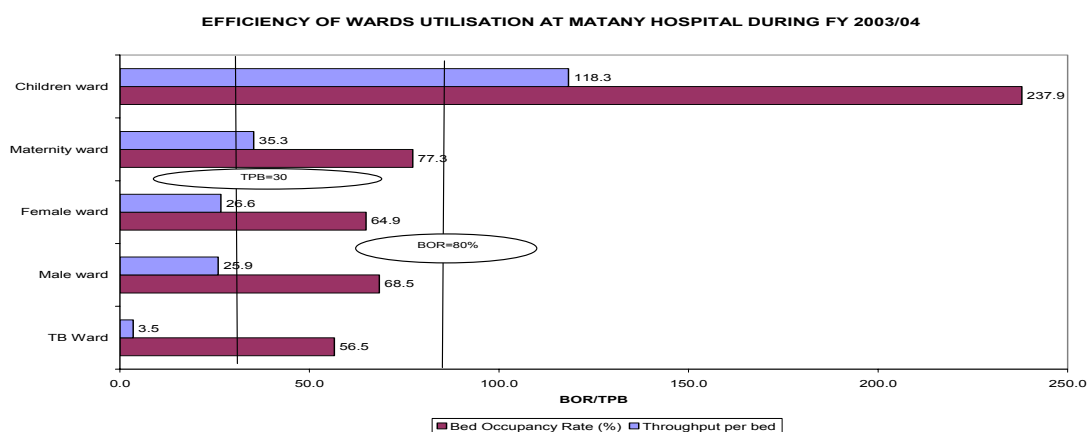
Turnover Interval (No. of days)	-4	-4	-4	-3	-4,3	Turnover Interval (No. of days)	6	6	5	1.2	2,4
Throughput per Bed (No. of patients)	74	71	74	114	118	Throughput per Bed (No. of patients)	29	31	30	47	35,3
T.B Adults WARD (58 Beds)	99/00	00/01	01/02	02/03	03/04	OVERALL indicators	99/00	00/01	01/02	02/03	03/04
Patients Discharged	187	145	232	177	201	Overall B.O.R	93%	83%	94%	95%	101%
Duration of stay (No. of days)	11,877	8,857	14,097	10,117	11,968	Turnover interval	0.9	2.1	0.7	0.4	- 0,66
Avg. duration of stay (No. of days)	63	61	60	57	59,5	Throughput per bed	31	30	32	47	42
Bed Occupancy Rate (%)	56%	42%	67%	48%	56,5%	Average Duration of stay	21	19	11	7,4	8,1
Turnover Interval (No. of days)	50	85	30	62	45,8	Total Inpatients Days	-	-	75,659	78,073	86,733
Throughput per Bed (No. of patients)	3	2.5	4	3	3,5						

The figures for FY 2003/04 show, for all the wards except TB ward, a reduction in the number of patients discharged due to an increased stay in the Hospital.

The overall indicators show for FY 2003/04 a good efficiency of the utilization of the Hospital with an overall B.O.R. of 101 % and a throughput per bed of 42 patients (if we consider “good” when BOR>=80% and throughput per bed >=30).

The following graph 8.11 shows that there were some significant differences between the Wards. While Children Ward and Maternity were beyond a throughput per bed of 30 and B.O.R of 80%, the B.O.R. and throughout per bed for Male and Female Ward were lower than 80% and 30 due to a longer duration of stay. Many adult patients (143, 112 male, 31 female) were gunshot and their permanence was quite long so influencing the overall indicators for Male and Female Wards. Children’s ward is clearly on the other side but too far from the average, which means that the ward is over-loaded and there is a risk of compromising the quality of care and the outcome. TB Ward had the lowest rate of throughput per bed and B.O.R. due to the long stay of TB patients in the hospital.

Graph 8.11



The ten commonest causes of admission in Matany Hospital during FY 2003/04 are listed below according to diagnosis codes list used in the Hospital. The top 10 causes of admission perfectly match with the morbidity pattern in the HSD.

Top 10 causes of admission during FY 2003/04 (all patients with known diagnosis were 6,399):

	No. of cases	Percentage
1. Malaria	2,866	44.7
2. Respiratory System diseases (URTI, LRTI, asthma,)	909	14.2
3. Intestinal Infectious Diseases (typhus, amoebiasis, diarrhoeal dis....)	527	8.3
4. Complication of pregnancy	470	7.3
5. TB	246	3.9
6. Viral diseases with exanthema	200	3.1
7. Injuries including gunshot wounded	160	2.5
8. Nutritional deficiencies (marasmus, kwashiorkor ...)	127	2.0
9. Genitourinary System diseases (UTI, genitourinary organs diseases...)	125	2.0
10. Skin diseases	124	2.0
11. Others	645	10

Quality Indicators

Few quality indicators are available. Those available are based on the outcome of the patient's admission and classified as follows:

- Recovery rate (patients improved or recovered on discharge)
- Death rate (patients who died in the course of the admission)
- Self discharge rate (patients who leave the ward after admission, assuming that they did so because they were dissatisfied with the service given)
- Maternal Deaths
- Fresh Stillbirth rates (the proportion of fresh stillborn over the total number of intra-hospital deliveries; it is assumed that no fresh stillbirth will occur if proper care is delivered). Medical audit takes place for all fresh stillbirths. This was initiated in July 98. Evaluation of this is presently under the quality assurance paragraph. The comparison with previous years raises the question of the accuracy of the data collected before the auditing exercise started.

The available data which are reported in table 8.4 are self explanatory:

Male WARD	97/98	98/99	99/2000	2000/01	2001/02	2002/03	2003/04
			0				
Recovery Rate	79.3	77.8	87.3	88.1	76.8	83.7	94.8
Death Rate	8.6	7.6	8.4	7.3	9.4	9.1	5.7
Self Discharge Rate	1.6	2.6	4.3	4.6	2.8	3.4	0.3
Pediatric WARD							
Recovery Rate	96	85.4	86	83.6	87.7	87.2	94.2
Death Rate	7.2	9.2	11.2	12.9	7.1	7.8	5.5
Self Discharge Rate	1.4	2.4	2.8	3.5	1.5	1.3	0.3
TB Adults WARD							
Recovery Rate	88.6	85.7	89.7	92.6	90	89	91.4

Death Rate	8.8	11.1	9.8	7.4	4.3	5.2	8.2
Self Discharge Rate	2	-	0.5	-	2	2	0.4
Female WARD							
Recovery Rate	84	84	91.7	89.4	80	87	95.9
Death Rate	5.9	3.8	6.3	9.1	6.9	6.8	3.7
Self Discharge Rate	0.6	0.5	2	1.5	1.5	1.4	0.4
Maternity WARD							
Fresh Stillbirth Rate* (%)	6	1.2	2.2	0.8	0.4	0.31	0.44
Maternal Deaths	2	4	2	5	3	3	1
Self Discharge Rates	-	0.1	0.1	0.25	0.2	0.1	0
ALL WARDS							
Recovery Rate	87.7	85.6	87.1	85.7	84.5	87.2	94
Death Rate	6.5	7.5	8.2	8.8	7.3	7.7	5.7
Self Discharge Rate	1.1	1.9	2.6	3.1	1.8	1.6	0.3

Maternal Child Health - Quality Assurance

In 2002, a study was carried out among the community in the catchment area of Matany, which highlighted some of the barriers to Hospital delivery care for high-risk pregnant women. There are factors in the community as well as in the Hospital which may prevent Hospital deliveries. In the community there are strong traditional and cultural influences/beliefs about pregnancy, labour and delivery. Some of these stress home deliveries over Hospital deliveries. Some also believe that procedures performed in the Hospital may render a woman infertile. Women themselves are often unaware of their EDD (expected date of delivery), and therefore are not able to plan for the delivery. They find the cost of a Hospital delivery high. In response to this in January 2003 the Hospital flattened the fees for all deliveries to 2,000/= UGShs. TBAs themselves were unaware in many cases of referral criteria, and therefore also not able to identify obstetric risks. As for Hospital barriers, these included: the distance of the Hospital from the homes, bad attitudes of some midwives towards pregnant women and poor relationship between the midwives and the TBAs. Taking in consideration these conclusions during the year under review the TBAs were met on monthly basis, provided with some basic equipment and refreshed on elementary elements of obstetrics. From July 2003 to June 2004, 55 mothers were referred from the peripheral units for follow – up.

As far as the child health is concerned, perinatal mortality (graph 8.12 and table 8.5) has increased somewhat since the last FY 2003/04. For the most part, a delay in referral of patients has been responsible for this increase, as well as an increased incidence of premature deliveries. The reasons for an increase in premature deliveries is not well documented, but may be correlated to the antenatal mother's lack of knowledge regarding the requirements necessary for a healthy ante-partum period (i.e. the need for rest, improved nutrition, compliance in taking needed iron supplements, early treatment of infections). Some of the impediments to a healthy ante-partum period may also be culturally conditioned, as women continue to work hard throughout the ante-partum period. Therefore an approach which will target belief systems of families in the child-bearing age seems vital to improving the overall health of mothers before, during and after delivery.

Graph 8.12: Perinatal Mortality Death Rate since FY 1988/89:

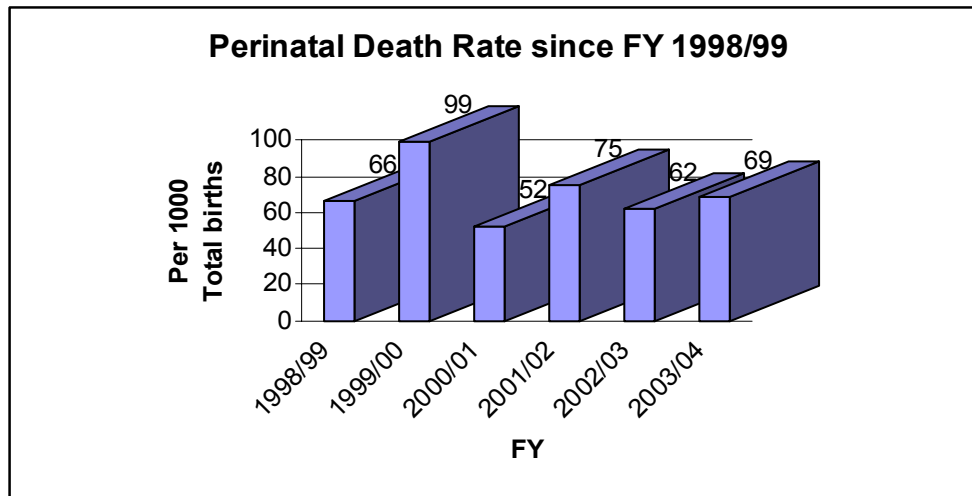


Table 8.5 : Perinatal Causes of Death since FY 1999/00:

Causes of perinatal death	Early neonatal deaths*					Stillbirths				
	1999/00	2000/01	2001/02	2002/03	2003/04	1999/00	2000/01	2001/02	2002/03	2003/04
Birth trauma and stress asphyxia	3	2	1	4	1	2	1	3	6	6
Ante partum haemorrhage	1	3	6	1	0	2	-	4	-	1
Maternal disease (2003/04: placenta insufficiency)	2	4	9	2	2	3	1	10	5	16
Foetal abnormality	3	2	0	2	1	1	1	1	2	3
Cord Prolapse	0	3	5	2	0	3	2	3	1	2
Prematurity (cause unknown)	18	7	0	10	12	5	1	0	4	2
Other**	-	-	0	2	2	7	2	0	3	2
Total	27	21	21	23	18	23	8	21	21	32

*= A death occurring within the first 28 days of life

**= Infections, Rh and ABO incompatibilities, neonatal tetanus, macerated stillbirths, etc...

Medical audits were completed on all neonatal deaths. Table above represents a five year recording of statistics of in-patient infant mortality. The still birth rate calculated as the number of stillbirths/total of live births and stillbirths x 1000 is 44,2%. This is higher than last year's figure of 31,6 %. It should be noted however, at this time that over 60% of the stillbirths registered as having occurred in the Hospital were from outside the catchment area and referred from other centers. Prolonged labour with its associated fetal distress featured as one of the main causes of infant mortality. The accuracy of keeping records can also be a cause in the increased stillbirth rate and decreased early neonatal death rate.

Caesarean Sections

During last FY a total of 112 (18,6% of total deliveries) Caesarean sections were performed. The main reasons for CS were: obstructed labour 39%, Cephalo-pelvic disproportion 25%, two previous scars 15%, transverse lie 5%, placenta praevia 10%, cord prolapse 5%, twins 1%.

Points of action for next FY:

- To continue the collaboration between community and Matany Hospital, to familiarize the midwives with cultural practices and beliefs and to sensitize the community to the importance of certain procedures done in the maternity ward, which improve infant survival rates.
- TBA refresher courses regarding high risk pregnancies and benefit of a safe delivery
- Awareness sessions directed toward women regarding the possible risks during pregnancy, labour and delivery through IEC (Information, Education, Communication materials)
- Improve attitudes on the part of midwives toward both TBAs' and women during delivery in order to promote referrals as well as Hospital deliveries
- Continuing IEC for Field Health Workers on the benefits of safe deliveries
- Introduction of a new delivery room register and a new neonatology registers to keep more appropriate data regarding maternal morbidity and infant mortality

Supportive Services

Introduction

The hospital activity is supported by a series of services. They can be categorized as clinical support, general support and training.

Clinical Support Services

The six main clinical support services are the theatre, the laboratory and blood bank, the diagnostic imaging department, the pharmacy, the physiotherapy unit, the dental department, Counselling, and the Chaplaincy. Other clinical support services are the fluid production unit, non-sterile production unit and the central sterile supply department.

Surgical Theatre, FPU, CSSD, NSPU (table 8.6)

The theatre is well staffed and equipped. It can operate at any given time for emergency requirements. Only major operations are carried out in the theatre; biopsies and surgical debridements are performed in most cases on the Wards. Since May 98 the theatre has a solar power supply that makes it independent from the Hospital generator. Surgery is extremely expensive and all attempts are made to reduce it to strictly necessary interventions, though the proportion of emergency surgeries is high. The sterilisation services (centralised since the beginning of the AIDS epidemic to ensure quality), and the IV fluid production unit are attached to the theatre. One unit (standard 500 ml bottle) of fluid produced in Matany is costed at about 1,250 Ushs (including depreciation costs of equipment) and of about 800 Ushs without such costs, with a production of about 20,000 500ml unit/equivalent. The Hospital purchases IV fluids from outside only for emergency situations.

In the following table 8.6 the surgery activities are presented.

Table 8.6: Major Surgery Performed FY 2001/02 to June 2004						
	FY2001/2002		FY2002/2003		FY2003/2004	
	Elective	Emergency	Elective	Emergency	Elective	Emergency
Caesarean Section	32	39	12	111	14	98

Pelvic Surgery	41	2	33	3	31	3
Laparotomy:						
- For peritonitis	9	28	14	21	17	23
- For intestinal obstruction	9	13	3	7	9	2
- For hemoperitoneum	17	12	5	14	10	5
Hernia Repairs	38	2	34	1	43	3
Hydrocelectomy	9		15		17	1
Operations on the limbs:						
- Amputation	9	2	8	2	14	16
- External and internal fixation	5		4		13	2
- Osteomyelitis	38		12		11	0
- Others		23	40	14	5	23
3rd Degree Tears, RVF, VVF	4		1		8	0
Others	36	31			74	2
Total	247	152 (38%)	181	173 (49%)	269	178 (41%)
Grand Total	399		354		447	

Laboratory - Blood Bank

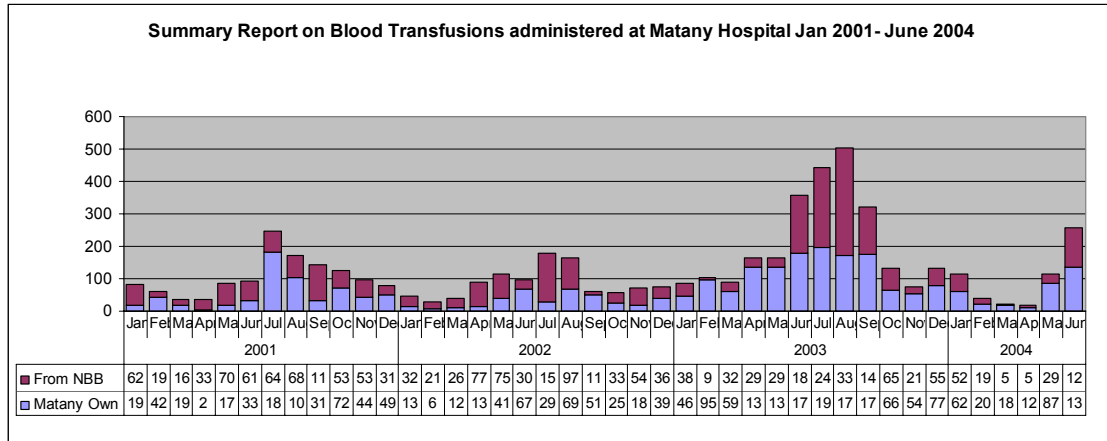
At the end of June 2004 laboratory staff includes two laboratory technicians, one qualified laboratory assistant and two unqualified laboratory assistants, who were trained on the job. The staff coped with the workload, especially with the increased demand for blood transfusions. They maintained a 24-hour on call service throughout the year.

In table 8.7 the laboratory tests performed are compared over the years.

Year	1999	2000	FY 2001/02	FY 2002/03	FY 2003/04
Blood smear for Malaria parasites	9,343	7,930	7,505	11,528	9,210
Blood smear for other purposes	36	76	5	10	94
WBC Count (total and differential)	3,302	4,154	3,448	1,490	1,836
Sputum smears (specific MT/a specific)	2,085	2,059	2,444	2,573	2,632
Urethra and vaginal smears	297	314	70	48	83
Haemoglobin estimations	5,642	4,761	5,285	4,079	4,244
PCV	11	5	1	-	44
Sickling Test	40	63	47	35	42
ESR	443	1,352	1,879	668	1,072
Blood grouping and X-Matching	4,581	4,019	3,929	3,969	6,059
Urine examination	956	1,292	1,413	1,356	1,024
CSF examination	494	606	281	293	59
Other body fluid examinations	117	106	52	24	53
Stool examinations	1,618	2,020	1,502	1,128	1,132
Widal test	18	99	484	734	1,532
VDRL	313	273	657	430	1,870
Serum Creatinine	21	53	86	27	147
Blood Glucose	31	120	803	436	574
Pregnancy test	98	107	125	185	250
HIV test	660	563	940	928	660
Hepatitis B	256	447	556	262	1,296
SGOT	50	111	90	16	107

SGPT	50	111	90	16	109
Other	551	907	818	610	1,600
TOTAL	31,013	31,548	32,510	30,845	35,729

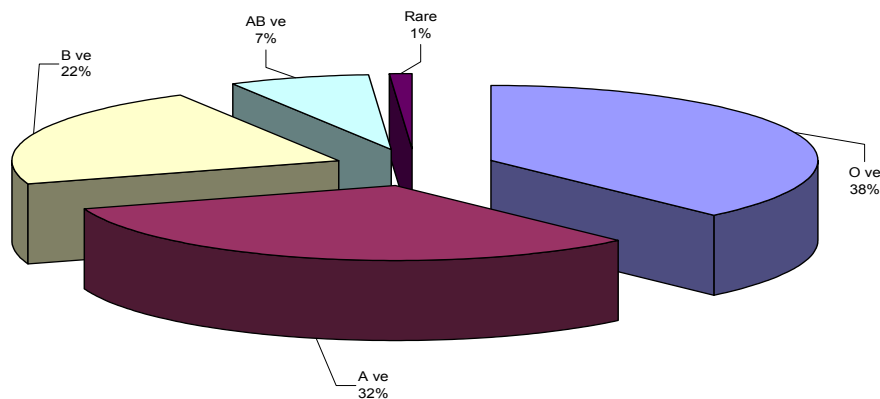
Graph 8.13: distribution of blood transfusion since January 2001



Nakasero continued to supply blood every 3-4 weeks by the MAF plane. Holding sufficient levels of blood proved difficult at periods throughout the year. A total of 210 Blood transfusions (mostly children with severe malaria in conjunction with anaemia) were administered in 1995, 732 in 1996, 781 in 1997, 1726 in 1998, 1815 in 1999, 1481 in 2000, 1242 in 2001, 1,025 in 2002, 2,308 in 2003 and already 513 in the first six months of 2004 (Graph 8.13). To better understand the situation of blood transfusion in order to react to the shortage of blood in the Hospital, in April 2004 a study was carried out and showed in annex 1. The results indicated clearly that there is a seasonal variation in the demand of blood and central supplier like Nakasero Blood Bank and local collection in Matany are not able to satisfy the needs. A plan of action was set up including the collection of blood outside the Hospital, in a Secondary School and in a Seminar. The experience has been very successfully and during the first 8 months of FY 2004/05 blood for transfusion was always available.

The distribution of blood subgroups is indicated in the pie char below:

Distribution of blood subgroups transfused in FY 2003/04

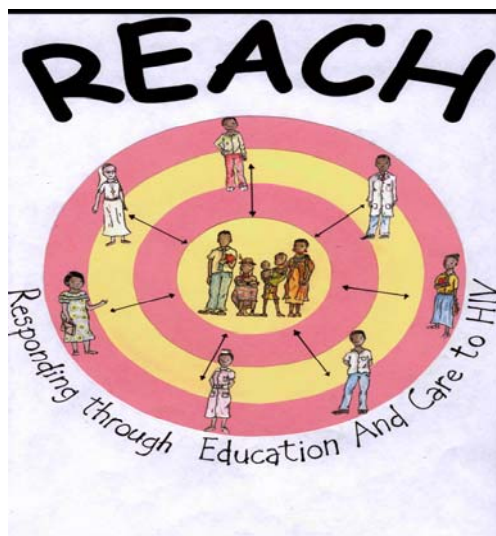


The main reasons of severe anaemia requiring blood transfusion were malaria and intestinal worms infections both in children than in adults. Other causes in adults were anaemia related to pregnancy/delivery and blood loss in gunshot wounded.

In the following table 8.8 the HIV and hepatitis B seroprevalence on replacement Blood Donors is shown:

	1997	1998	1999/00	2000/01	2001/02	2002/03	2003/04
HIV seroprevalence	2%	4.2%	7.1%	8.3%	8.7%	8.3%	4.7%
HBs Ag +	6.6%	19.7%	16.7%	16.3%	16.7%	17.2%	8.2%

The REACH Programme *Responding through Education and Care to HIV*



In the last years there has been a steady increase in the prevalence of HIV in Karamoja. Although numbers are still small, relative to other parts of Uganda, the trend is cause for concern. Indeed, it has been an obvious fact to anybody working in health service provision in the region that the numbers of patients presenting with HIV-related conditions have greatly increased.

In May 2001, Matany Hospital formed a partnership with The European Union and the Government of Uganda to instigate a project primarily aimed at alleviating the economic and social burden of the disease for those affected. The project, entitled *Improving Sexual and Reproductive Health (ISRH)*, targets the north of Uganda and is being carried out in conjunction with other agencies with expertise in the field of AIDS/HIV. The Matany Hospital project also includes a component based out of St. Joseph's TB and Leprosy Centre, Morulem. The project covers the Health Sub-Districts of Bokora and Labwor.

Early on in the implementation of the ISRH project it became apparent that the scope of the project was limited in some ways. For example, very little attention was paid to prevention of the spread of the disease. The project team decided a multi-faceted approach was needed if the project was to prove successful. Thus, the REACH programme was inaugurated at the beginning of 2002. REACH stands for Responding through Education and Care to HIV: it is an all-encompassing programme with the dual focus of prevention and care.

Under the 'care' aspect of the programme, the Primary Health Care Departments of Matany Hospital and St. Joseph's Health Centre now provide regular outreach visits to the homes of clients. Through our networks of Traditional Birth Attendants and Field Health Workers, as well as a specialist team of counsellors and professional medical personnel, basic foodstuffs are distributed together with medical care and attention. Hospital care has been made free of charge for those on the 'Home-Care' register and help with transport to and from hospital has also been made available. A Voluntary Counselling and Testing (VCT) service has also started at Matany Hospital.

The preventive activities of the REACH Programme are now being consolidated through the setting up of three working groups to be co-ordinated by a full-time community worker: a drama group, a teachers' group and a community support group.

Although too early to see any concrete results, it is an imperative that curative and preventative activities enter the mainstream work of Matany Hospital. The cultural isolation which has prevented the Karimojong from contracting AIDS/HIV in the past is the very reason why the Karimojong could be vulnerable in the future; the prevention messages which enter the national psyche through the mass media do not penetrate the indigenous Karimojong culture. It is intended that the REACH programme marks the beginning of a concerted effort on behalf of Matany Hospital to address this problem head-on. It marks a desire for the culture of medical professionalism in Matany hospital to be enhanced with an increased awareness of the HIV/AIDS pandemic and an increased understanding of the needs of people living with AIDS/HIV.

The following are some statistics of the programme that were collected regarding the activities of the REACH Programme during the last financial year. The programme has enabled the Hospital to have a fully functioning Counselling Service.

Activity	Number
Clients Counselling	604
Clients who received material support: food, medical care, transport (no. of units)	1,324
Clients who died	26
Workshop/Training Sessions	18
Drama group performances	19
Creation of a sharing group among the terminally ill	1

Points of Action for the next FY:

Address the stigma created by HIV/AIDS in the community through:

- Discussion groups
- Use of drama/IEC materials
- Education of basic facts about HIV/AIDS
- Use of Radio Karamoja to spread message

Diagnostic Imaging (table 8.9)

The diagnostic imaging service of the Hospital is equipped with X Ray machines as well as an Ultrasound scanner. Two radiographers trained on the job operate the X-ray machines. Medical Officers scan for the ultrasound investigations. The service is available on a 24-hr basis, though its utilisation outside duty hours is tentatively minimised.

Table 8.9: Activity of Diagnostic Imaging Department:

Year	99/00	00/01	01/02	02/03	03/04
Radiology					
Chest	2,102	2,023	1,738	1,717	2,102
Plain Abdomen	97	92	72	63	44
Barium Enema	2	0	1	0	2
Barium Meal	9	5	5	5	9
Traumatology	1,147	987	868	1,096	1,615
Skeletal	685	549	443	348	227

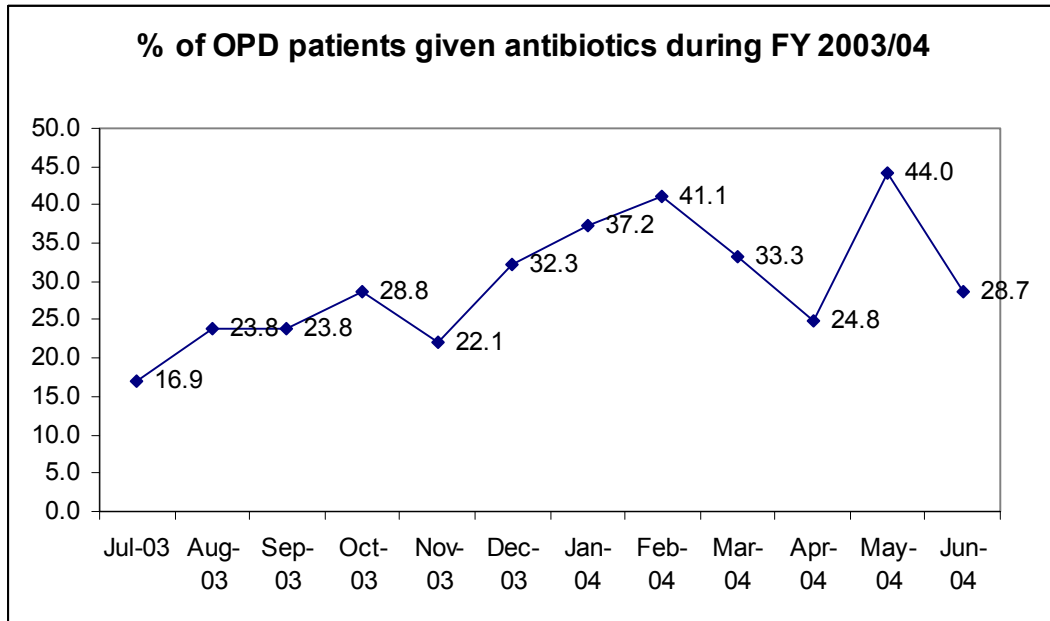
Urogenital	6	3	0	0	5
TOTAL	4,048	3,659	3,127	3,229	4,004
No. Of Patients	3,842	3,618	3,017	3,213	3,445
Chest Screening	5	174			
Ultrasound Scanning					
Obstetric	484	532	270	487	620
Gynaecologic	403	413	241	333	465
Liver, Pancreas, Spleen	1,033	1,028	137	60	235
Abdomen	349	340	533	999	473
Urogenital Organs	234	244	62	27	111
Heart	343	346	84	94	195
Tissue	210	208	55	15	18
TOTAL	3,056	3,111	1,382	2,015	2,117
No. Of Patients	2,505	2,357	1,349	1,854	1,914

Pharmacy

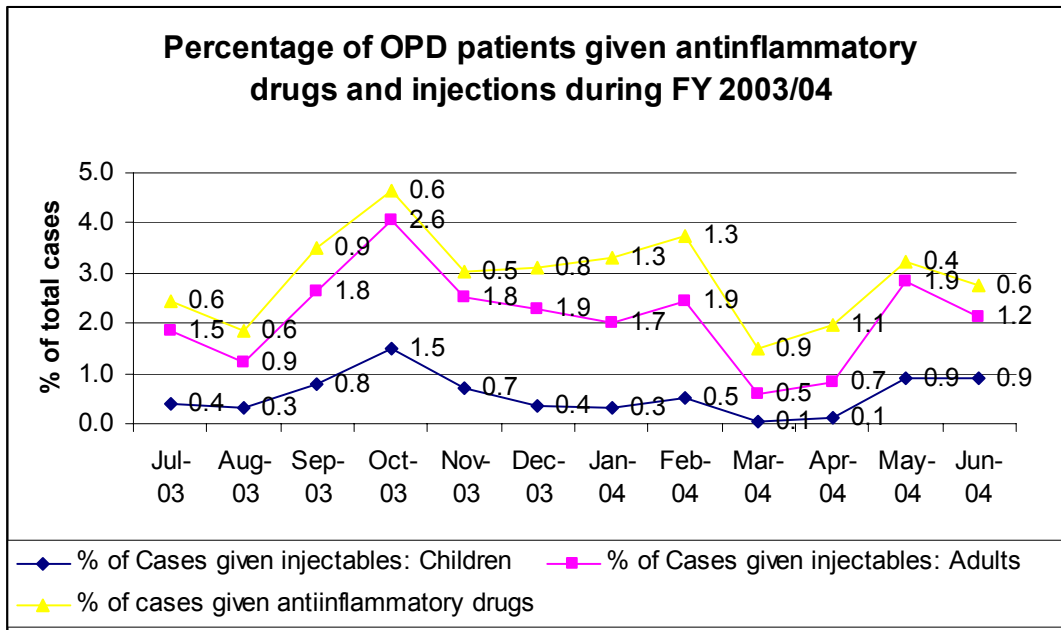
Following last year's restructuring of the pharmacy, drugs have been safely stored and protected. This store is also being utilised for laboratory reagents, while non-perishable items are now stored in the main Hospital store. A pharmaceutical assistant trained in Kenya is now managing both the main pharmacy and out-patient pharmacy. UCMB has created for Roman Catholic Church Hospitals a new computer programme, called FIPRO (FInancial PROgramme for Budgeting, Accounting and Planning). FIPRO has been introduced with current FY the monthly consumption of drugs over a one year period has been calculated. From this information, we are now able to determine the minimum stock needed in the pharmacy to avoid stock outs. There is now a dual system (stock cards/computer) of recording drugs in place in the pharmacy.

Graph 8.14 below represents the percentages of patients given antibiotics, and injectables during the year under review in the Out-Patient Department. The National Standard Figure is the target the Hospital must work toward. From December 2003 there was a steady increase in the number of cases given antibiotics with a peak in September. As in previous years, an over prescription of antibiotics was responsible for this. This problem was discussed in the daily medical meeting, and a decline in such practices was immediately apparent, as shown in a decline on the graph. There was another peak in May 2004 and same reaction of previous time was taken with similar effect.

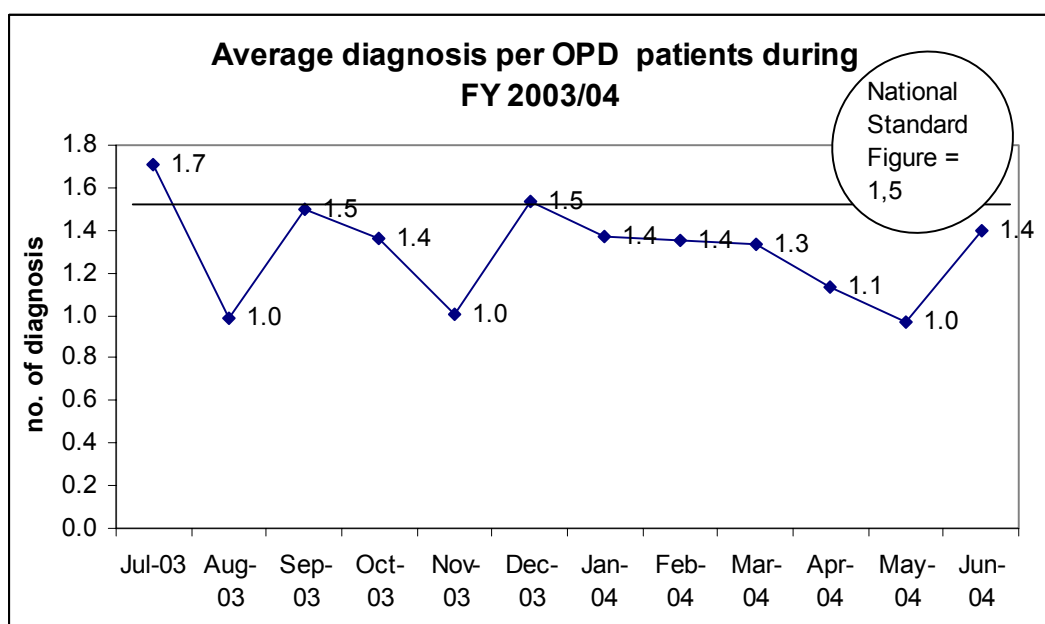
Graph 8.14 shows the percentage of OPD patients getting an antibiotic. National standard figure suggests 20% as maximum percentage.



Graph 8.15 below shows the % of OPD patients given FANS and injection broken down in children and adults.



Graph 8.16 below shows the average no. of diagnosis per OPD patient. As indicated National Standard Figure is 1,5.

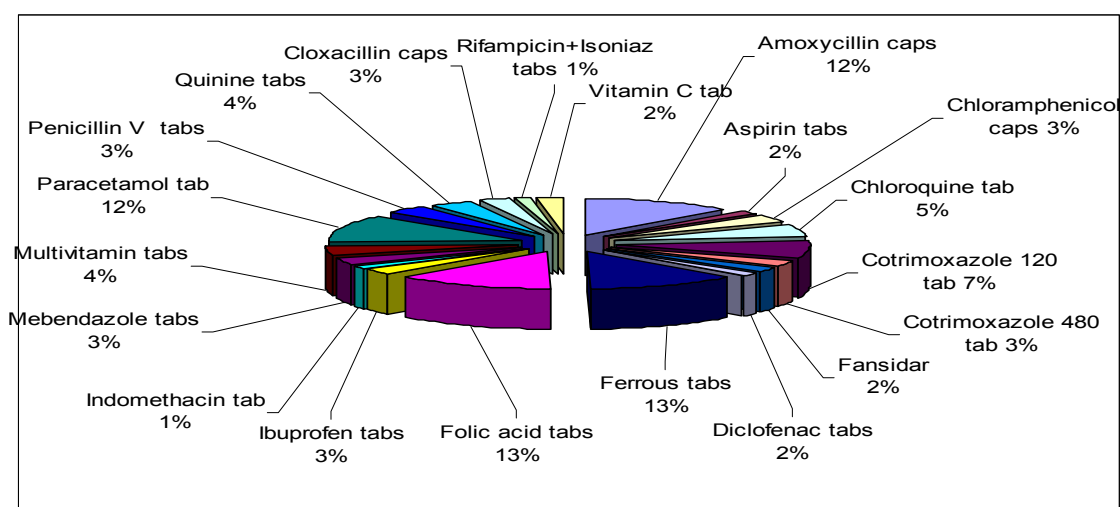


The commonest drugs used in Matany Hospital during last financial year compared with FY 2002/03 and their costs are listed in table 8.17. Hospital spent about 113,900,000 Ushs for drugs procurement (including laboratory reagents and X ray films).

Drug	FY 02/03	FY 03/04	Percentage %	Cost per Unit	Total Cost
Amoxicillin 250 mg caps	191000	234000	22.51	31.980	7,483,320.00
Aspirin 300 mg tabs	92200	37825	-58.98	2.200	83,215.00
Chloramphenicol 250 mg caps	40000	62000	55.00	17.065	1,058,030.00
Chloroquine 150 mg tab	97000	100000	3.09	12.100	1,210,000.00
Chlorpheniramine 4 mg tab	13798	12546	-9.07	1.485	18,630.81
Ciprofloxacin 250 mg tab	24560	16700	-32.00	33.000	551,100.00
Cloxacillin 250 mg caps	32000	46955	46.73	29.700	1,394,563.50
Cotrimoxazole 120 mg tab	56000	140508	150.91	7.955	1,117,741.14
Cotrimoxazole 480 mg tab	44000	52000	18.18	12.550	652,600.00
Crystalline Penicilline vials	9550	21120	121.15		0.00
Diclofenac 50 mg tabs	38600	32100	-16.84	9.350	300,135.00
Doxycycline 100 mg tab	1229	13557	1003.09	16.560	224,503.92
Erythromycin 250 mg tab	18500	18500	0.00	52.825	977,262.50
Fansidar	50298	39000	-22.46	40.150	1,565,850.00
Ferrous sulphate 200 mg tabs	201000	237000	17.91	5.250	1,244,250.00
Folic acid 5 mg tabs	208000	245000	17.79	3.505	858,725.00
Furosemide 40 mg tabs	9070	15659	72.65	7.150	111,961.85
Ibuprofen 200 mg tabs	50500	53500	5.94	6.465	345,877.50
Indomethacin 25 mg tab	25000	25000	0.00	4.510	112,750.00
Mebendazole 100 mg tabs	36000	59000	63.89	4.515	266,385.00
Multivitamin tabs	45100	83000	84.04	4.485	372,255.00
Paracetamol 500 mg tabs	145000	225030	55.19	4.800	1,080,144.00
Penicillin V (Phenoxymethylpen.) 250 mg tabs	51100	65000	27.20	23.170	1,506,050.00
Phenobarbitone 30 mg tabs	19000	23000	21.05	7.485	172,155.00

Phenytoin 100 mg tabs	9958	11408	14.56	11.195	127,712.56
Prednisolone 5 mg tabs	17117	16778	-1.98	14.320	240,260.96
Quinine 300 mg tabs	35200	69058	96.19	52.800	3,646,262.40
Quinine injectable 600 mg amps	1660	3628	118.55		0.00
Rifampicin+Isoniazid 150+100 mg tabs	25000	24300	-2.80	137.150	3,332,745.00
Salbutamol 4 mg tabs	9800	16900	72.45	94.145	1,591,050.50
Vitamin B complex tabs	0	11703	0.00	2.790	32,651.37
Vitamin C (Ascorbic Acid)	0	44000	0.00	4.950	217,800.00
					31,895,988.01

The top 20 are indicated in percentage in the graph below:



IV Fluid Production Unit

During last Financial Year a total of 17, 624 bottles of IV fluids have been produced in Matany while 2,880 were bought in Joint Medical store in Kampala.

	NormoSaline 500 ml	DextroSaline 500 ml	Dextrose 5% 100 ml	RingerLactate 500 ml
Produced in Matany	6,966	4,128	6,530	0
Bought in JMS	1,340			1,540
TOTAL	8,306	4,128	6,530	1,540

Physiotherapy Unit

The physiotherapy unit is run by a qualified physiotherapist and an occupational therapist. A new site was allocated for the unit in May 2002 and new equipment has been made available to enable the team to carry out their work efficiently. The physiotherapy aids are comprised of plinths, floor mats, wall bars, crutches, walking frames, wheelchairs, a rowing machine, parallel bars, toys, etc. The nature of services provided includes: plaster casting, ambulation, massage, ice therapy, counseling, use of support devices (corner seats, crutches, walking frame, prosthesis), bandaging, tractions, reductions, exercises, minor operations (scrubbing).

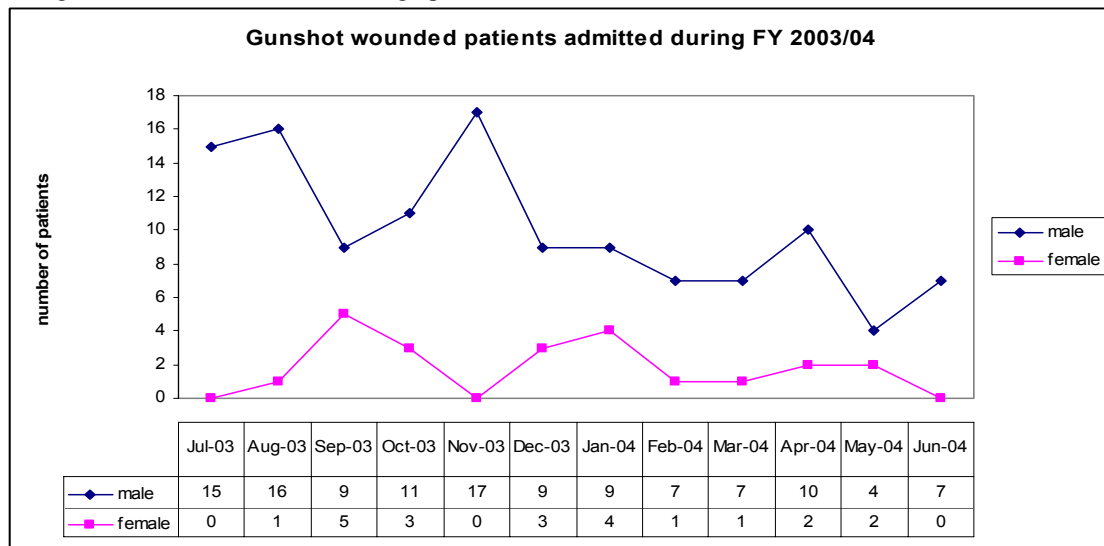
Table 8.18: Physiotherapy unit activity data since 1994:

	1994	1995	1996	1997	1998	1999	2000	FY 2001/02	FY 2002/03	FY 2003/04
Patients treated	48	40	15	n.r.	57	n.r.	51	120	334	256
No. of sessions	161	218	-	-	238	-	197	960	1,397	1,259

During FY 2003/04 the unit registered a great number of cases especially with gunshot wound fractures and trauma to the lower and upper limbs. However other cases were also registered as seen in the table below:

Condition	Number of patients
Fracture Tibia and Fibula	33
Fracture Femur	42
Fracture Upper Limbs	91
Children – malnutrition - fractures and others	32
Paralysed patients	11
Contractures and burns	2
Amputees	3
Club Foot (congenital deformity)	0
Others	42
Total:	256

The total of gunshot wounded patients admitted at St. Kizito Hospital Matany during FY 2003/04 was 143 with its peaks in August and November 2003, due to heavy cattle raids in the region. The distribution during FY 2003/04 is indicated in the graph 8.17 below.



Chaplaincy

The spiritual support of the patients is of paramount importance. During FY 2003/04 the Hospital sent one of its staff for a refresher Course in Clinical Pastoral Care, organized by the UCMB. She assists greatly the priest of Matany Parish as he can avail himself only for a restricted time, due to other commitments.

Regular services for the RCC take place in the Chapel. The premises of the Hospital are made available to other Christian denominations for their worship on Sundays.

Points for Action for 2004/05

- The laboratory unit needs to improve further the quality and type of investigations including cytodiagnostic services.
- The X-Ray department needs a new qualified radiographer to replace the one who left in June 1999. Due to failure to identify one so far, the current two radiographer assistants, trained on the job, will be sent to Lachor Hospital for a refresher course.
- Laboratory and X-Ray Department need to be working from 8.00 am to 8.00 pm

General Support Services

Other services supporting the Hospital running are: the ambulance service, the mortuary and burial service, the domestic service, the administration, the medical record and archive, the technical department, the distribution of food from General Store. Baseline information is given on all these in 1994 edition of this report. Here follows some updated information.

Domestic Service

The domestic service comprises catering and domestic store keeping, food preparation and supply, laundry, tailoring, compound and ward cleaning, waste disposal and wastewater treatment.

The domestic services of the Guest House and the Teaching Centre have become quite burdensome due to the increase of workshops and seminars. At the same time they generate additional income. For this reason the employment of a full time domestic officer became necessary and one has since been trained in catering services.

The water supply remains adequate: it is provided by two bore-holes (one about 1500 m west of the hospital, with one submersible pump linked to the hospital mains by an underground cable, another within the hospital compound, with a solar panel operated submersible pump, donated in 1995 by Grundfos and installed by LWF.) With the introduction of a new sewage system, it was found that the main water supply system of the Hospital (30 years old) was leaking and that a considerable amount of safe water was being wasted along the pipes underground. The pipes were completely replaced this FY, through financing by DANIDA.

Administration, Medical Records and Archive

The Administration is strong at the moment with a full-time administrator (a Comboni Brother) and the assistant administrator who completed his master course at Nkozi University in November 2002. There are 2 cashiers, and 3 accountants. The office clerk was trained to deal with some of the most basic data processing; he is able to computerize the routine hospital data and now is working in PHC Department. UCMB organized in conjunction with UMI (Uganda Management Institute) a three weeks course "The spreadsheets and health management information systems", which was attended by the Office Clerk and by a new record assistant. Later the record assistant went for "The Basic Medical Records Management Course" (3 week, May-June 2003), followed by a Certificate Course in Records and Information Management (7 weeks, July-August 2003) and Diploma in Records and Information Management (6 months, January-June 2004), all organized by UCMB/UMI. Currently the record assistant is responsible for keeping record of the hospital. The Administrator does the analysis of the financial data, while the Medical Superintendent completes the analysis of the epidemiological data.

General Store and distribution of food

The Hospital provides food for all the patients admitted and special feeding programme are in place for malnourished children, TB inpatients, PLWHs (people living with HIV/AIDS), breast-feeding mothers and EVIs (extremely vulnerable individuals, i.e. very poor, elderly and disabled people, leprosy patients...). The food is provided mainly by WFP (World Food Programme) and partially purchased by the Hospital itself.

The total food consumption is indicated in the table below.

Food	Amount distributed during FY 2003/04
Beans	18200 kg
Maize	33271 kg
Cormeal	20800 kg
Soya Corn Blend	21900 kg
Vegetable Oil	6406 liters
Sugar	6050 kg
Dry Skimmed Milk	2075 kg
Groundnuts	85 kg
Cowpeas	16550 kg
Salt	1110 kg

Technical Department

The hospital workshops (carpentry, mechanic, electric workshop and building unit) provide most of the current maintenance, renovation and rehabilitation that takes place in the Hospital. Besides the ordinary routine maintenance and repair of equipment and buildings, the works carried out in 2003/04 were: construction of four buildings of six apartments for single staff, construction of one staff house of four apartments for family staff (each apartment has 3 rooms), construction of underground water tank and connection with hospital rain water catchment system, construction of one twelve doors latrine and one twelve doors bathroom for staff, construction of a water collection system with 120 meters of gutters and two plastic water tanks for NTS. Other works include: fencing to a part of the hospital, extension of tree plantation, maintenance work of Hospital buildings, vehicles, airstrip, etc. , personnel support to building projects of Matany and Kangole parishes, Kanawat and Morulem HC's as well as the production of building blocks, school benches, desks, gates, doors, etc. These were part of the 'income generating activities' of the Hospital.

Points of action for 2004/05

- Complete the rain water catchment project
- Building of a multipurpose hall for NTS
- Completion of 2 staff houses for NTS personnel
- Construction of one staff house and completion of another one for hospital staff
- Completion of latrine and bathroom
- Construction of a shelter for ANC clients

Preventive and Promotive Services

PHC Department

A) Catchment area

The Health Sub-District comprises 6 sub-counties of Bokora County (i.e. Matany, Iriiri, Lokopo, Lopei, Ngoleriet, and Lotome) , with eight Peripheral Health Units. These are respectively, Iriir HC III, Kangole HC III, Lokopo HC II, Lopei HC II, Lorengechora HC II, Lotome HC III, Ngoleriet HC II and Matany Hospital.

Table 8.19 Population figures for year 2004 (Bokora HSD population projected from Census 2002, growth rate= 4,85%, total population= 107,489) :

Age group	% of the population	Target Population	Remarks
Infants < 1 Yr.	4.3%	4,623	For DPT-HEPB+Hib, measles polio coverage
Children < 5 Yrs	20,5%	22,036	For Polio campaign (NIDs)
Women 15 to 49 Yrs	17.8%	19,134	For TT coverage
Pregnant Women	5.0%	5,375	For TT coverage
6 months to 15 years	50.4%	54,175	For measles campaign
1 year to 15 years	45.4%	48,800	
< 15 years	49%	52,670	

B) Personnel/Staffing

Matany Hospital Primary Health Care Department

The Primary Health Care Department (PHC) is strong with 8 established staff (1 Clinical Officer/Enrolled Midwife, 1 EPI focal person (Health Assistant), 1 Health Inspector, 1 primary ophthalmic assistant, 1 Community Based Rehabilitation Officer, 2 Nursing Aides and 1 clerk) and a Medical Officer officer who supervises the department. At the community level there are 33 field health workers (FHWs) who are supervised by the PHC team. The FHWs carry out PHC activities at community level. The activities include health education on common diseases, immunization, guinea worm eradication activities, TB case finding, contact tracing and follow up of malnourished, people with disabilities case finding and follow up.

Peripheral Health Units and staffing levels.

58 % of personnel are non-professional/unqualified staff.

Table 8.19 Personnel by qualification in Bokora HSD Peripheral Health Units as 30/6/2004:

HEALTH UNIT (OWNERSHIP)	Clinical Officer	Registered Nurse	Enrolled Nurse	Enrolled Midwife	Health Assistant	TB/LP assistant	Nurse Assistants	Nurse aides	Lab. Assistants	TOTAL	% of professionals
IRIIR HC III (Govt)	0	1	0	1	1	1	3	0	1	8	50%
KANGOLE HC III (Catholic Church)	0	1	0	1	0	0	3	2	0	7	28%
LOKOPO HC II (Govt)	0	1	0	0	0	0	2	0	0	3	33%
LOPEI HC II (Govt)	0	0	1	0	0	0	1	0	0	2	50%
LORENGECHORA HC II (Govt)	0	0	1	0	0	0	2	1	0	4	25%
LOTOME HC III (Govt)	0	1	0	1	1	1	3	0	0	7	57%
NGOLERJET HC II (Govt)	0	1	0	0	1	0	4	1	0	7	28%

TOTAL	0	5	2	3	3	2	17	4	1	38	39%
Qualified Staffing Gap	3	2	5	0	1	0	0	0	0	11	42%

C) Activities/Achievements

The PHC Department conducts regular supervision for the 8 peripheral health units of Bokora Health Sub District and offers a package of service to the community. Community activities offered are in line with the concept of PHC: MCH/FP/TBA, UNEPI, TBLCP, GWEP, CBR, EDMP, school health, dental care and primary eye care activities. Integration, community participation and multidisciplinary approach are the basis of PHC team activities.

Activity areas include the following:

Support supervision to peripheral health units (Govt. & Non Govt.) and supply of logistics.

A medical officer visits each of the 8 units once a month. Supervision is done with the aim of ensuring correct patient management and continuous quality assurance improvement. The activities supervised include clinical assessments and prescription habits to ensure rational drug use (EDMP), HMIS monitoring, UNEPI cold chain maintenance, supervision of Maternal and child related activities and generally quality of services offered at the health units. Problems identified by the unit staffs or the supervisor are discussed at the end of the working day and possible solutions (which form the basis for subsequent supervision) are suggested and agreed upon for implementation. A report on monthly basis is compiled and submitted to Moroto District Director of Health Services.

Table 8.21: Support supervision visits to peripheral health units in Bokora Health Sub-District (including Matany OPD/AI clinic).

Health Units' Supervision	1995	1996	1997	1998*	98/99**	99/00**	00/01**	01/02**	02/03	03/04	Target
No. of visits to Government units	13	10	17	18	31	31	44	44	38	76	84
No. of visits to Diocesan units	17	22	4	4	8	6	11	12	5	12	12
Total visits to all the units	30	32	21	22	39	37	55	56	43	88	96
Total no. of the units	n.r.	n.r.	n.r.	n.r.	6	6	6	6	8	8	6 (8) “
Average visits per unit	n.r.	n.r.	n.r.	n.r.	3.7	6.5	6.1	9.2	9.3	11	12

Nota Bene. Up to 1997, supervision visits included Kotido and Moroto Diocesan units. NR= not reported.

For the year 1998, supervisory visits concentrated in Bokora Health Sub District only.

* 1998 = period from January to December 1998

** = period from July to June the following year

“ = eight health units starting from FY 2001/02

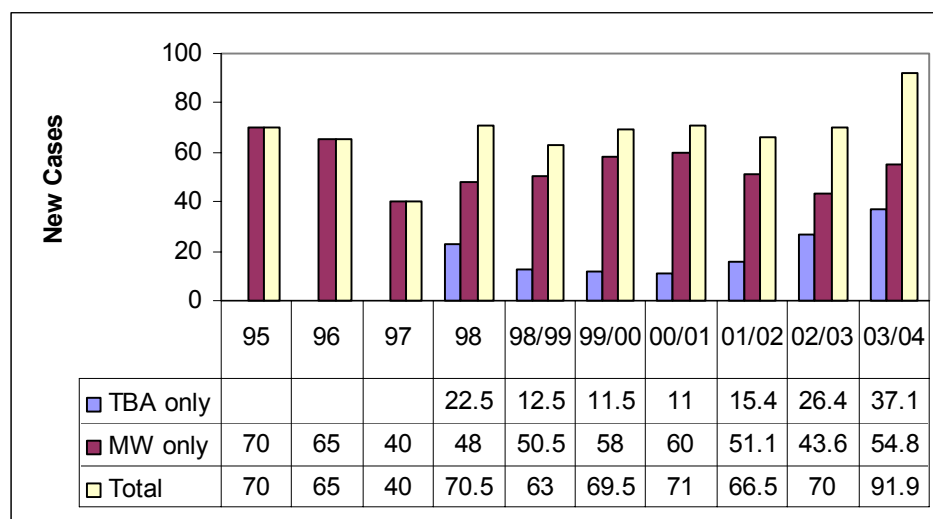
The target for supervision visits was not met due to insecurity in the region, leading to isolation of Iriiri and Lorengechora in some instances.

Maternal and Child Health

A double trained registered nurse- midwife (URM/URN/TBA trainer), supervised by a Medical Officer, is responsible for the “training and supervision” of TBAs and the delivery of ANC activities in the zone. All the sub-counties have trained TBAs (total 206) and they are supervised once every month at Sub-County level. Six ANC outreaches every month and three times per week static hospital ANC services are done in Bokora HSD. As demonstrated in Graph 818 below, the declining trend in ANC coverage observed from 1995 to 1997 has reversed. The coverage improved by 30% from 1997 to 1998 probably due to the intensive community mobilization, increased number of out reach services, training and supervision of TBA's carried out in 1998. The 5% drop in the year 98/99 could be explained by the rampant waves of insecurity which affected mobilization hence low turn-up. FY 99/2000 and 2000/01 reached again coverage of about 70%. The last

financial year the TBA ANC coverage reached 37.7% (1,897 first attendances) and midwives coverage of 54,8 % (2,804 first attendances), totaling to an ANC coverage of 91.9 %.

Graph 8.18 Antenatal Care new attendances in Bokora Health Sub District since 1995



Workload of qualified midwives and Traditional Birth Attendants is indicated in the following tables. Table 8.22 and table 8.23 shows the ANC workload (first visits, deliveries, referrals and average no. of contacts per pregnant woman) of respectively TBAs and qualified midwives.

Table 8.22: TBAs workload in Bokora HSD since Financial Year 1998/99

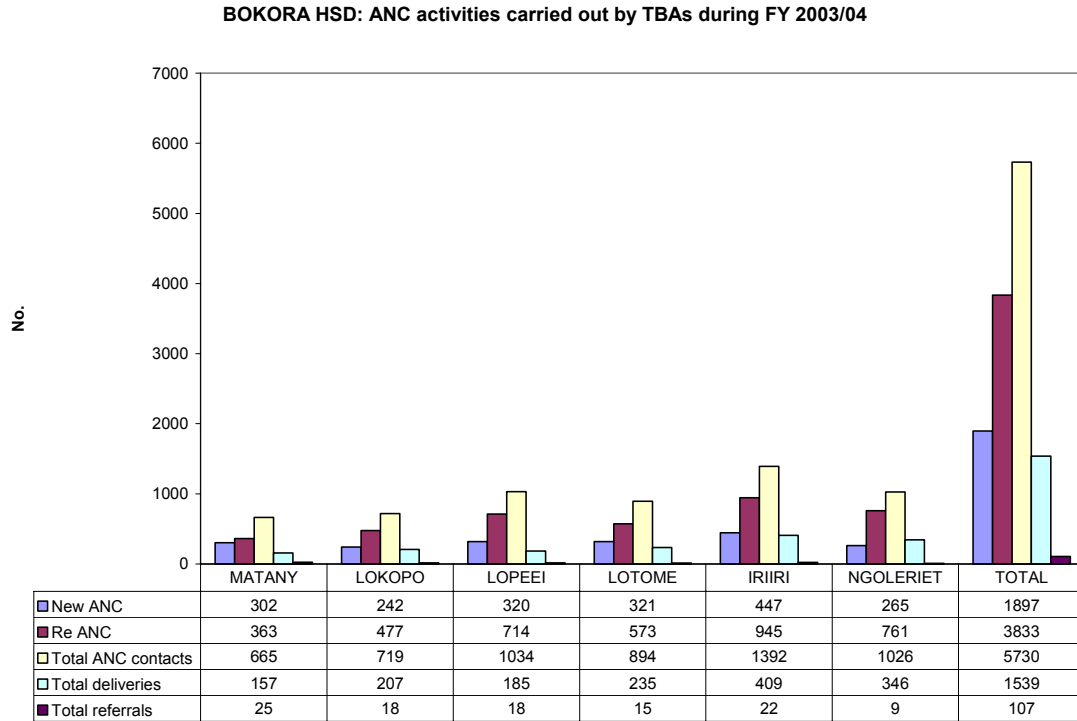
<i>Activities carried out by TBAs in Bokora HSD since 1998: ANC coverage (new cases), delivery coverage, % of women referred, average no. of contacts</i>						
Year	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04
Antenatal care	14%	13.30%	10.20%	15.40%	26.40%	37.10%
Deliveries	11.40%	9.10%	7.20%	13.80%	15.50%	30.10%
Referral to Hospital	0.70%	1%	0.40%	1.60%	3%	2.10%
Average number of contacts per pregnancy	2.7	3.5	4.1	4.2	1.9	1.1

Table 8.23: Qualified midwives workload in the last FY:

<i>Activities carried out by MWs in Bokora HSD during FY 2003/04: ANC coverage (new cases), delivery coverage, average no. of visits</i>	
Year	2003/04
Antenatal care	54.8%
Deliveries	13.8%
Average number of contacts per pregnancy	1.1

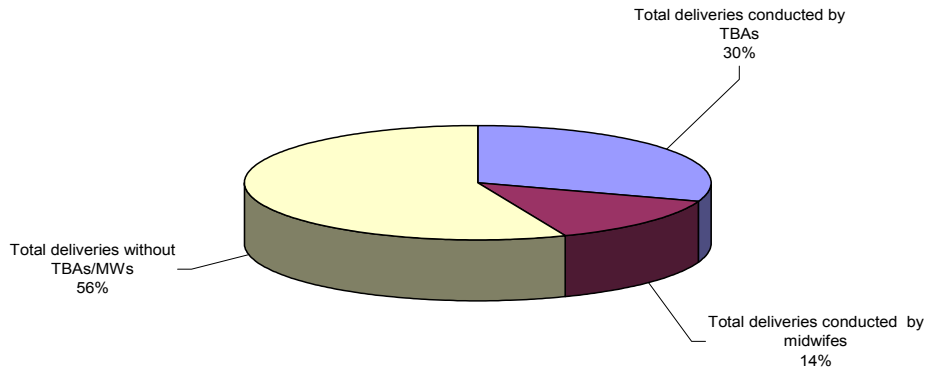
NB: indicators are expressed as new cases/target population x 100%, and total attendance/new attendance for average number of contacts.

Graphics 8.19 shows the ANC workload carried out by TBAs according to the Sub-County during the last financial year.



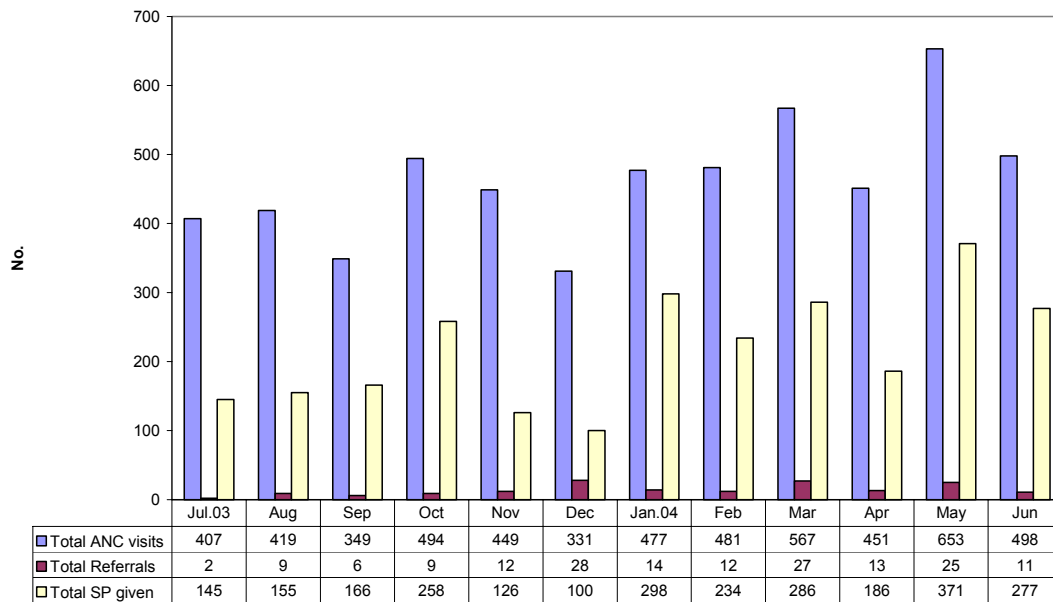
Graphic 8.20 indicates the percentage of deliveries supervised by qualified midwives and TBAs in the last FY in Bokora HSD.

BOKORA HSD
Percentage of deliveries supervised by MWs, TBAs and without supervision during FY
2003/04

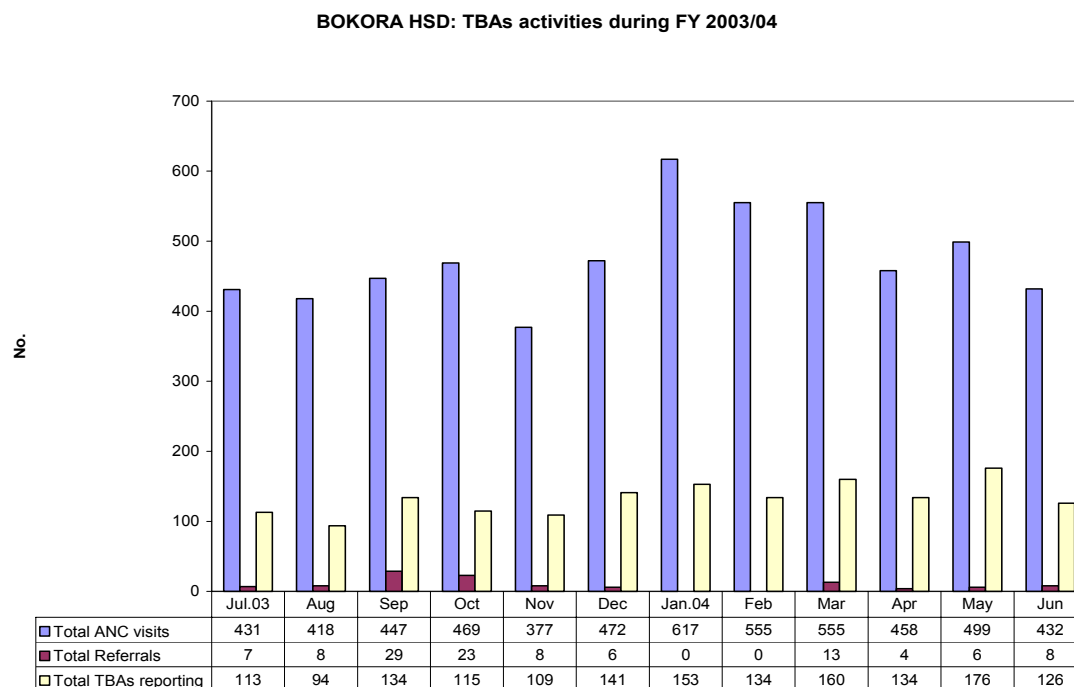


Graphics 8.21 and 8.22 respectively show the monthly distribution of ANC activities conducted by qualified midwives and TBAs, during the financial year 2003/04.

BOKORA HSD: ANC ACTIVITIES CARRIED OUT BY QUALIFIED MIDWIFES DURING FY
2003/04



Graph 8.22:



In 2003/04 the TBA's successfully conducted 1539 (31,1 %) normal deliveries, referred 107 (2,1%) high-risk pregnant mothers to the Hospital and carried out ANC 1897 (37,1%) first attendance and 3833 re-attendances. Compared with previous FYs there was a very great improvement.

During FY 2003/04, the proportion of pregnant mothers who delivered under supervision of trained personnel (qualified midwives and TBA's) has been the highest never recorded (44%). Still the majority (56%) of deliveries in Bokora may not be clean and safe.

Uganda National Expanded Programme of Immunizations (UNEPI)

Bokora County has 8 static units (corresponding to the number of health units supervised by the Primary Health Care Department) and 30 outreach posts distributed all over the county. Each sub-county has on average 5 outreach posts run by the field health workers and health unit staff attached to Matany Hospital and Peripheral Health Units respectively.

Table 8.24 Immunization coverage by antigen for the six killer diseases in Bokora Health Sub-District

Antigen	Coverage 1998-99	Coverage 1999/00	Coverage 2000/01	Coverage 2001/02	Coverage 2002/03	Coverage 2003/04	National Target
BCG	100%	88%	82.4%	86.2%	77%	72.1%	100%
POLIO ₃	102%	109%	89.6%	101.4%	81%	79.9%	85%
DPT3	102%	109%	89.6%	101.4%	81%	80%	85%
MEASLES	92%	106%	92%	89.9%	83.1%	73.1%	90%
TT ₂₊ P	25%	23,4%	35.8%	40.8%	39.4%	27.7%	50%
TT ₂₊ NP	10%	30%	50.9%	38.9%	85.5%	62%	50%

Coverage for all the antigens apart from Non pregnant TT was below target. BCG, DPT3 and OPV3 coverage registered a slight decrease while measles and Pregnant women TT coverage have had a sharp decrease compared with previous FY. The low coverage for pregnant women TT does not match with the barely reported incidence of neonatal tetanus in Bokora HSD. Nevertheless a lot of effort has to be put to revitalize the EPI activities.

TBLCP

Although TB case finding is predominantly passive, Matany Field Health Workers (FHWs) actively seek, identify and refer all cases with chronic cough to the hospital for free TB screening. To achieve high case holding rate, the FHWs follow up TB patients discharged from the 2 months of intensive treatment to ensure treatment compliance and to supply more drugs to patients on maintenance phase. TB DOTS is almost to be introduced in the District.

The expected number of sputum positive cases (Case finding) for the period 01/07/03 to 30/06/04 was estimated using the formula $(55 \times \text{Annual rate of infection} \times \text{Population}/100000) = 202$ new cases smear positive.

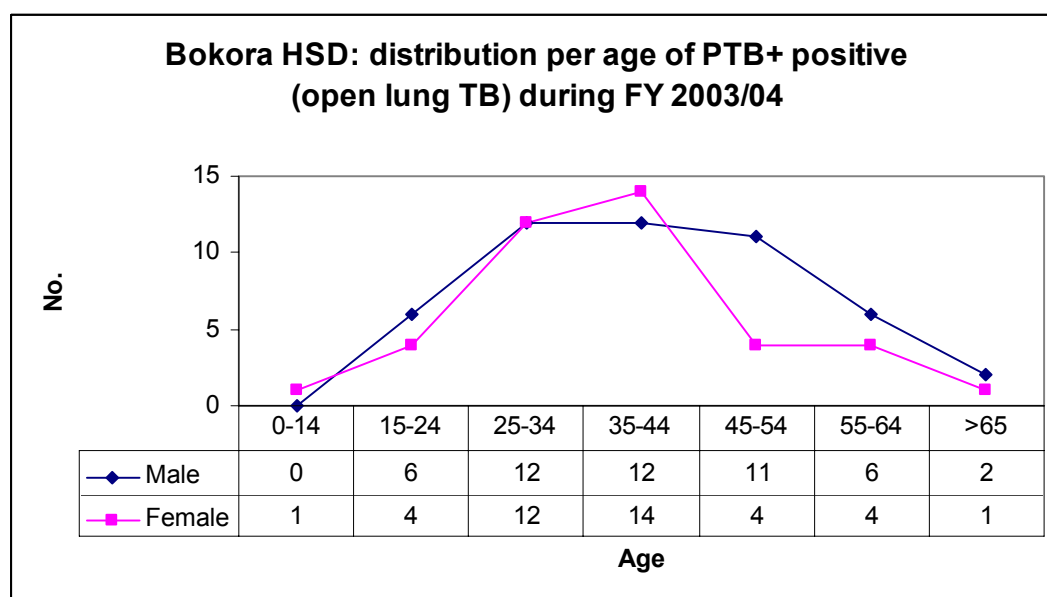
Actual sputum positive cases found were 83 patients from Bokora Health Sub District giving a case finding rate = 41% (48.4% in 2001/02, 37% in 2002/03). We were not able to reach the WHO target. There is need to re-examine our policy on case finding and to strengthen supervision of the FHWs and unit staffs.

Table 8.25 TB control indicators for sputum positive cases in Bokora Health Sub District since FY 1997/98

Indicators (WHO target)	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03	2003/04
No. M+ cases identified (target)	38 (147)	55 (149)	65 (153)	81 (157)	78 (161)	74 (198)	83 (202)
Case finding rate* (target 70%)	26%	37%	42%	52%	48.4%	37%	41%
Sputum conversion rate (target = 85%)	89.5%	100%	100%	100%	100%	100 %	98,8 %
Case holding rate * (target =100%)	60.5% (100%)	NR	NR	NR	NR	75%	75%
Cure rate * (target 85%)	58%	NR	47%	51%	64%	62%	65%
Transferred out rate *	5.3%	NR	NR	NR	3%	12%	10%
Defaulting rate * (target <10%)	23.7%	NR	NR	NR	23%	20%	12%
Death rate *	10.5%	NR	10 %	10 %	10 %	5%	8%
Failure rate* (target= <4%)	2.6%	NR	NR	NR	0%	0%	0%

Nota Bene: * The rates are computed on the cohort sputum positive. NR = not reported.

Graph 8.23 Age distribution of sputum positive tuberculosis in Bokora HSD during FY 2003/04



Open lung TB is more prevalent in the age group 25-34 and 35-44 years in Bokora County. This age group is sexually active hence prone to HIV/AIDS with the associated Tuberculosis. The same age group often socialises through sharing of local brew (kutu-kuto) where everybody drinks from the same pot including those with prolonged cough. Interventions like active case search will be intensified for these age groups and health education on prevention and control of TB targeted for all age groups.

PRIMARY EYE CARE

The PHC Department has a primary ophthalmic assistant who conducts health education on primary prevention of eye problems and carries out treatment of simple eye problems on daily basis. Complicated eye cases are referred or booked for the eye surgeon team coming from Lira. From 5th to 7th June 2004, Lira Team has operated a total of 38 patients (27 cataract with intraocular lens, 8 entropion correction, 3 enucleation) in Matany Hospital. Seventy-eight outreach services, integrated with other activities, have been carried out in Bokora Health Sub-District on scheduled basis.

Table 8.26 Primary Eye Care

	1999/2000	2000/01	2001/02	2002/03	2003/04
No. of uncomplicated cases treated	919	830	688	849	92
No. of cases booked and operated	2	84	83	148	146
No. of cases referred	9	4	5	9	4

Table 8.27 PHC Department: Ophthalmic Assistant Workload during last Financial Year:

Ophthalmic Assistant Workload during FY 2003/04 including static clinic and outreaches					
<i>Eye disease</i>	<i>No.</i>	<i>Eye disease</i>	<i>No.</i>	<i>Eye Surgery</i>	<i>No.</i>
Normal eyes	11	Active trachoma	156	LID Rotation	42
Allergic eyes	261	Non active trachoma	13	CAT	50
Acute red eyes	15	Ocular trauma	35	TRAB	6

Cataract	139	Refractive errors	29	Enucleation	6
Glaucoma	46	Other diseases	212	TOTAL	108
Corneal scars	75	TOTAL	992	Outreaches	78

GWEP

Bokora is the most highly endemic county for guinea worm disease in Moroto District. With the establishment of active surveillance, Bokora has achieved a high case containment (meaning cases identified, treated, prevented from contaminating water and verified by Sub-county/District supervisor within 24 hrs of worm emerging from the blister). This was maintained throughout the reporting year to interrupt the transmission cycle. During the Financial Year 2003/04, two suspected new cases have been notified to local and national authorities.

SURVEILLANCE of Epidemic Potentially Diseases

Surveillance reports have been collected on weekly basis from all the Peripheral Health Units of Bokora Health Sub-District throughout the Financial Year 2003/04. The table below shows a summary of cases reported since FY 2001/02.

Table 8.27 Notifiable Diseases since FY 2001/02:

Disease	FY 2001/02		FY 2002/03		FY 2003/04	
	Cases reported	Deaths	Cases reported	Deaths	Cases reported	Deaths
Cholera	0	0	0	0	0	0
Bacillary Dysentery	899	0	1766	0	1153	6
Measles	19	0	118	0	118	12
AFP/Polio	0	0	0	0	0	0
Meningitis	59	3	64	2	41	8
Malaria	18,900	43	34,515	123	34,555	145
Neonatal tetanus	1	0	0	0	0	0
Plague	0	0	0	0	0	0
Typhoid	51	1	56	0	303	13
Yellow fever	0	0	0	0	0	0
VHF	0	0	0	0	0	0
Guinea Worm	0	0	0	0	0	0
Animal bites/ suspected rabies	121	1	195	0	138	0

HEALTH EDUCATION

Health education, a public health intervention cutting across all areas, is conducted at individual, family, community, institutions (schools) and Health Units level. Hospital staffs, students, and Field Health Workers carry out the activity using various methods and tools to facilitate learning through voluntary adaptation of knowledge, attitude, behavior, and practices for disease prevention, control and health promotion.

Table 8.28 Health education sessions by Field Health Workers (FHWs)

	1996	1997	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04
In the field	3,126	3,445	2,415	2,767	2,412	3,376	3,623	4,096
In the Hospital	n.r.	119	52	48	49	49	60	65
In the institutions and Trading Centers	n.r.	n.r.	n.r.	n.r.	n.r.	n.r.	n.r.	145

Workshops

In the last Financial Year only one workshop was conducted from 26th to 29th June 2004. This was Expanded Programme of Immunizations (EPI) refresher workshop for all the personnel involved in such activities in Bokora Health Sub District mainly Field Health Workers and extension staffs. The participants were 42 and the workshop was aimed at empowering skills and knowledge for planning and monitoring EPI activities, teaching basic cold chain preventive and maintenance practices, passing messages on vaccines management and strategies for improving EPI coverage and for increasing social mobilization.

Problems/Constraints

- Insecurity due to road ambushes and cattle rustling
- Prolonged drought associated with migration to neighboring districts in search of water and pasture
- New settlements

Plan for next Financial Year 2004/05

- *Continue with support supervision to peripheral health units*
- *Continue delivering an integrated MCH/FP/TBA, UNEPI, TBLCP, GWEP, EDMP, school health, dental care and primary eye care activities.*
- *Continue with epidemiological surveillance of epidemic potentially diseases (cholera, AFP, Measles, ...) .*
- *Continue TBAs' facilitation and supervision at Sub-County level.*
- *Increase of four the no. of Immunization out reaches*
- *Strengthen and supervise mobilization for PHC activities*
- *Strengthen the Community Based Rehabilitation activities*

CHAPTER 9: Training

Training has always been given a priority by the Management, from the beginning, when training for aide nurses and field health workers was taking place in an informal yet effective way. As time went by the need for a more formal training for nurses emerged, and therefore a School was founded for this purpose. A teaching centre was opened to facilitate the ongoing training for the region, as no easily accessible and well-equipped structure existed. The centre is to be used more for activity development in the District. A summary of training activities which took place in Matany Hospital in the past financial year are indicated below.

Karamoja Human Resources Development Centre for Health (KHRDC, table 9.1)

The Centre, established in 1994, was structurally completed during FY 2001/02. Its first building was the tuition block. A dining hall and hostel were built in 1997 with funds from Manos Unidas. In the year 2001 a facilitator's house was built, financed by Manos Unidas. A second hostel was constructed in 2001/02 thanks to support from Danida.

In 2003/04 it hosted eight residential courses. The goal of the Hospital management is that of establishing a centre for training with the aim of addressing the local needs. It is envisioned that it will also build up, in the process, a team of skilled and experienced officers capable of analyzing the performance of the local health system and identifying areas requiring correction. It should at the same time provide for the on-going formation of local health personnel (and their basic formation) identifying corrective actions. The Centre,

together with the Nursing School, would thus, become a health reform oriented complex. This is a highly needed resource in the fast changing social environment.

Table 9.1: activities (trainings, seminars, workshops...) held on KHRDC during FY 2003/04

Date	Activity	No. of participants
July, 7 th -8 th 2003	TBA Workshop	40
September, 8 th -13 th 2003	Solar Energy Follow up Work-shop	15
September, 23 rd -24 th 2003	ACET Teachers' Meeting	10
October, 1 st -4 th 2003	Sanitation and Water Workshop	15
March, 12 th -18 th 2004	Counselling Workshop/Dioces of Moroto	40
March, 19 th -24 th 2004	Counselling Workop for Religious	6
May, 20 th 2004	Womem's Group/Ryamiriam	40
June, 14 th -15 th 2004	Sanitation and Water Workshop	15

Continuing Medical Education (CME) (table 9.2)

During the financial year 2003/04 sixteen CME sessions were held and the following topics presented to the Hospital staff and NTS students.

Table 9.2: CME sessions held during FY 2003/04.

Date	Topic	Presenter	Participants
August 13 th , 2003	Typhoid fever/Safe water	NTS representative	53
August 27 th , 2003	Violence in the workplace	Sr Cathy	39
September 10 th , 2003	Fluid balance	Dr Bob	86
October 8 th , 2003	Dental conditions	R. Chandia	46
October 22 nd , 2003	Data Collection	Lokiru	58
November 5 th , 2003	Meningitis	Dr Bob	61
December 3 rd , 2003	Counseling	Angelline	52
January 21 st , 2004	Counseling	Angelline	52
February 4 th , 2004	Fractures	F. Opiga	51
February 18 th , 2004	PMTCT	D. Ogwang	57
March 3 rd , 2004	Obstructed labour	Dr James	48
March 17 th , 2004	Mental retardation	G. Okello	54
April 7 th , 2004	Conducting meetings	M. Awor	45
April 21 st , 2004	Laboratory investigations	A. Angella	51
May 19 th , 2004	Community Based rehabilitation Activities	M. Ngiro	45
June 30 th , 2004	Pneumonia	O. Bosco	54

Other Training Initiatives (table 9.3)

The Hospital has directly funded or obtained funds for the training of its personnel in other institutions. During 2003/04 23 employees were on or started long term training (see chapter 6 table.3 human resources) while others attended short courses, workshops and seminars on specific issues.

Table 9.3: Training opportunities for Hospital employees

Date	Course	Participants	Place
2003, Jul 17 th – 19 th	ENT	1 Staff	Mbale Hospital
Jul 28 th – Aug 3 rd	Leprosy/TB, activity workshop	1 Staff	Kumi Hospital
Sep 22 nd – Oct 25 th	Pastoral Care Course	1 Staff	St. Augustine, Kampala
Nov 4 th – 10 th	Telemedicine workshop	6 Staff	Moroto
Nov 12 th – 16 th	UNEPI workshop	10 Staff	Matany KHRDCH
Nov 18 th – Dec 14 th	Clinical Instructor's Course	2 Staff	Mbale, MHD-Centre
Nov 18 th – Dec 6 th	UMI Spread sheet Workshop	2 Staff	UMI Kampala
Nov 25 th – 29 th	TASO, Module IV	2 Staff	TASO / Kampala
Dec 10 th – 14 th	Sentinel Surveillance workshop	2 Staff	Viral Research Centre Entebbe
2004, Feb 17 th – 21 st	TASO, Final Module	2 Staff	TASO / Kampala
Feb 27 th – 3 rd Mar	HIV/AIDS workshop for Lab Tec	1 Staff	Mildmay Kampala
Mar 10 th – 14 th	Eye Workshop	1 Staff	Masaka Hospital
April 7 th – 9 th	Workshop for tutors	2 Staff	Kampala
May 19 th – 23 rd	Occupational Therapy Training workshop	1 Staff	Kampala
Jun 26 th – Aug 1 st	Course for Data Management	1 Staff	UMI Kampala

The major problem identified for sponsored students is their retention at the end of the course. Once higher skills are acquired it becomes easy to find better employment and higher remuneration outside Karamoja. This phenomenon has to be expected and does not discourage the Hospital management. All students sign a bonding contract at the beginning of their course, though compliance with the stipulated terms has never been pursued in a court of law.

St. Kizito Nurses' Training School

The School, established in 1984 has since qualified 365 nurses: UEN (306) and URN (59). The teaching personnel have been stable for years and have managed to keep teaching standards high. At present there are 5 Tutors but one, the acting Principal tutor will retire in August 2004 and another one is going to attend a Health Management Course at Nkozi University starting from August 2004 and lasting one year. Effort to recruit replacements is to take place. During FY 2003/04 DANIDA funded the construction of another semidetached tutors' house and paid sponsorships for 29 nurses.

Table 9.4: Matany Nurses' Training School activity data:

	'91	'92	'93	'94	'95	'96	'97	'98	'99	'00	'01	'02	'03
Admitted to Enrolment Course	26	29	20	25	26	25	26	26	24	30	28	26	26
Admitted to Registration Course			6	-	11	-	14	-	15	-	15	-	16
Reported for E.C.	26	29	20	22	26	25	26	26	24	30	28		23
Reported for R.C.			6	-	11	-	14	-	15	-	15	-	16
Qualified as EN	18	13	20	17	22	14	22	20	23	25	21	23	23
Qualified as RN				5	-	11	-	13	-	15	-	15	-
Dropped out E.C.	-	1	1	1	n.r.	2	3	3	2	1	3	2	4
Dropped out R.C.				1	-	-	1	-	-	-	-	-	-
Sponsored candidates EN					7	2	12	6	21	11	20	17	17
Sponsored candidates RN					7	-	8	-	10	-	6	-	11

Chapter 10: Planning for the future

For the financial sector and management sector, for the coming year, the Hospital should embark in the preparation and approval by the board of the Manual on management of financial and Material resources. A continuous assessment of the performance and reliability of the new accounting programme together with the remaking of the fixed assets register will be of a paramount importance in this stage for a sound managing of the resources of the Institution.

As far as the health activities are concerned, the hospital should increase its own productivity, efficiency, accessibility and quality. OPD, Laboratory and X-ray Department will be working from morning to evening without interruption. A new duty roster for Nurses will be put in place to optimize the work of qualified personnel and make it harmonious with the one of medical doctors. Monitor usage of material and other resources at departmental level with more involvement of the staff, a proper planning and the introduction/strengthening of new/available guidelines in drugs prescription and patients' assessment should reduce the cost. Big emphasis will be given to human resource sector through improvement of staff welfare (salary, allowances, accommodation), capacity building (mainly nurses, allied health professionals)

Chapter 11: Acknowledgements

The Hospital Management team on behalf of the Board of Governors of Matany Hospital wish first of all to thank all the Hospital employees for the demanding and often unrewarding work without which all what was achieved and described in this report would have not been possible.

Alessandro	Casagrande(Bro)	Adm. incoming	Namer	Grace	O/A	Nyangan	Philip	porter
Nährich	Günther (Bro.)	Adm. outgoing	Namuzungu	Grace	N/A	Ochan	James	plumber
Catherine	Maynard(Sr)	SNO outgoing	Oryekot	Augustine	C/O	Odeke	Simon	s.mason
M. Teresa	Ronchi (Sr)	SNO acting/P.Tutor	Risa	A. Manang	s/keeper	Okello	Jildo	storekeep.
Luigina	Frison (Sr)	SNO incoming	Rubangaomia	Kevin	E/N	Okiror	Matthew	mason
Kababa	Lubaya	MS outgoing	Yeno	Maria	N/A	Okuda	Cecerino	cas.w.
Stefano	Vicentini	MS incoming	Olee	Alphones	E/N	Okure	Simon	porter
Galimberti	Fausta (Sr)	Caterer	Atim	Christine	E/N	Omalla	Wilbroad O.	mechanic
Lokong	Joseph	Adm.	Akello	Esther	N/A	Ongom	Pasquale	plumber
Orlotti	Carmen	Surgeon	Akongo	Catherine	N/A	Onnax	Felix	s.carp.
Lemukol	James	M/O	Apalia	Monica	N/A	Onyait	Christopher	mason
Obayo	Sirajii	M/O	Ayago	Florence	N/A	Onyanga	James	driver
Lorenzo	Mecocci	M/O	Nayolo	Clementina	N/A	Opuuno	Kenneth	j.mason
Domini	Erik	Obs Consultant	Okiror	Thomas	N/A	Otyang	Paul	electr.
Ogwang	Daniel	CO	Okuda	Matthew	N/A	Sagal	Eliya	driver
Okello	Bosco	CO	Amaese	Mary	N/A	Sagal	Michael	app.carp.
Regina	Öttle	Phar	Angella	Simon Peter	PHC	Edieru	Peter	mechanic
Achia	Deborah	R/N-R/M	Kokor	Magdalena	RN/M	Abura	Anna	H/E
Obiru	Cyprian	Tutor	Locham	Justine	O/A	Adome	Benedict	H/E
Ikabat	James	Tutor	Lowoto	Catherine	PHC	Akol	Barnabas	H/E
Awor	Magdalen	Tutor	Otim	Stephen	PHC	Aleper	John	H/E
Owiny	Charles	Tutor	Adiaka	Margaret	cook	Ditekol	Massimino	H/E
Auma	Anna Grace	E/N-EM	Akol	Alice	cook	Emong	Betty	TBA
Anyiko	Catherine	E/M	Akol	Martha	cook	Irwata	Albert	H/E
Dengel	Mary	E/N	Amuron	Hellen	Cook	Kiyonga	Antony	H/E
Atekit	Hellen	R/N	Angella	Lucy Keem	G/H	Loburo	Simon Peter	H/E
			Angella	Magdalen	G/H	Logiel	Elijah	H/E
			Apiding	Christine	Cook G/H	Lokoru	Philip	H/E

Omara	Florence	E/N	Chero	Anna	clean.	Lokwi	Mark	H/E
Ajaro	Hellen	E/N	Lokoryo	Dorothy	cleaner	Lomilo	Paul	H/E
Amito	Anna	E/N	Lotukei	Margaret	cook	Lomuria	Matthew	H/E
Kagwera	Eugenie	RCN	Nabok	Veronica	cook	Longole	Philip	H/E
Lomonyang	Rose	E/N	Naduk	Alice	Cook	Longoli	Mathew	H/E
Apolot	Florence	E/N	Nake	Cecilia	cleaner	Lopuka	Michael	H/E
Ochen	Patrick	E/N	Nauga	Cecilia	cook	Lorita	Joseph	H/E
Aituk	Dorothy	E/N	Neno	Betty	clean	Lotukei	John	H/E
Apuun	Regina	E/N	Ojao	Angelline	cook	Lotukei	Simon Peter	H/E
Lakot	Caroline	E/N	Sagal	Anna	clean	Louga	Paolo	H/E
Echaat	Anna	RN/M	Aboka	Agnese	clean.	Moru	Abiba	TBA
Agan	Betty	E/M	Aboka	Angello	comp	Nangiro	Rosemary	H/E
Agasiru	Juliet	E/M	Abura	Paul	W/M	Otyang	Zakaria	H/E
Aigo	Rose	R/N	Achia	Giovanna	cleaner	Sagal	John	H/E
Aketch	Nantaviene	E/N	Achilla	Maria	clean.	Teko	Zachary	H/E
Akech	Santina	R/N	Adiaka	Andrew	comp.	Akol	Jermano	H/E
Akol	Anna	N/A	Adome	Gabriel	W/M	Kinei	Michael	H/E
Akumu	Lucy	N/A	Aguma	Thomas	W/M	Adio	Peter	H/E
Akol	Agnes	E/N	Aisu	Anna	storekeeper	Apalia	John	H/E
Alero	Winifred	E/N	Ajilo	Agnes	storekeeper	Namoe	Veronica	H/E
Amodoi	Josephine	N/A	Akung	Betty	clean.	Apuun	Paul	carp.
Among	Mary	R/N	Aleper	Peter	W/M	Atogo	Daniel	s.porter
Amwola	Anna	E/N	Aleper	Philip	comp.	Awok	Domenic	carp.
Amuge	Jane	R/N	Areman	Margret	cleaner	Baraza	Joseph	electr.
Anasho	Lillian	E/N	Atim	Magdalen	store	Bob	Charles	carp.
Aneno	Jenifer	E/N	Awas	Casimiro	W/M	Moru	Christine	N/A
Angolere	Clementina	N/Ass	Chila	Agnes	cook	Apio	Albina	N/A
Asio	Betty	N/A	Epur	Andrew	Watchman	Oyepa	Felix Alex.	N/A
Anyodo	Annet Grace	R/N	Keem	Valeria	cleaner	Logiro	Domenic	W/M
Arao	Caroline	C/O	Kiyonga	Agnes	Cleaner	Akullu	Agnes	N/A
Atukoit	Polly	E/N	Lakawa	Rebecca	cook	Pulkol	Christopher	W/M
Awor	Fiona	E/M	Lochap	Paolo	comp	Anyakun	Moses	Cashier
Ayepa	Alfonse	T/A	Lochoro	Margaret	cleaner	Okot	John Bosco	N/A
Iyango	Hellen	R/N	Logiel	Agnes	clean.	Aruk	Joseph	D/att
Chandia	Robert	D/A	Logwala	Philip	laundry	Moru	Andrew	N/A
Ikiror	Hellen	E/N	Lokirus	Raphael	laundry	Jaka	Valentine	N/A
Kongai	Catherine	E/N	Lokodos	Joseph	Comp.	Nangiro	Stella	N/A
Ikabat	Hellen	L/A	Lokonya	Joseph	comp.	Lochole	David	H/E
Logono	Zachary	Phar	Lokut	Marko	comp	Lokol	Norah	Cleaner
Lokiru	John	GenOffice	Lolem	Lucia	tailor	Teko	Raymond	W/M
Lomilo	Paul	D/A	Loma	Alice	tailor	Lokoru	Mark	porter
Keema	John	N/A	Lomeri	John	comp	Lokut	Galdino	plumber
Kolibi	Bernadette	N/A	Lomudu	Samuel	W/M	Lomer	Mark	mason
Komol	Magdalen	R/N	Longole	Peter	comp	Lomuudu	Michael Muya	storekeep.
Longeth	Magdalen	R/N	Longorok	Sussan	clean.	Loruko	Mike	porter
Longoli	Lucy	E/N	Lote	Joseph	W/M	Lotimong	Christopher	wetlands
Lochap	Simon	GenOffice	Lotukei	Anyese	cleaner	Loukai	Joseph	s.porter
Lojore	Maria Gina	N/A	Munyes	Martha	Cleaner	Menya	Kizito	j. carp.
Lomma	Martha	N/A	Nachuge	Joyce	cleaner	Moru	Rafael	j driver
Nakiru	Magdalen	GenOffice	Nakiru	Hellen	Cook	Mubakye	Patrick	carp.
Nariang	Rebecca	E/N	Namilo	Lucia	comp	Ngorok	Eliya	porter
Ogwang	Samuel	A/C Dep	Nangiro	Paul	clean.	Ngorok	Zakaria	porter
Okello	Bosco	N/A	Napeyok	Lucy	cleaner	Korobe	Federico	carp.

Loumo	Jacinta	E/N	Nate	Catherine	Cleaner	Laalany	Felix	s.electr.
Lowanyang	Lucy	R/N	Pedo	Pia	G/S	Lochugai	David	porter
Mudong	Martina	N/A	Pulkol	John	laundry	Lochuu	Mark	cas.w.
Nachuge	Sakina	E/M	Gandolfi	Roberto	Tec.Dept.	Logono	Andrew	mason
Nachuwa	Mary	N/A	Abol	Thomas	porter	Logono	Peter	wetlands
Okiring	Bernadette	E/N	Agan	Mario	app.carp.	Lokiru	Peter	s.porter
Nawal	Angeline	Counsell.	Aleper	Gabriel	j.plumber	Lokiyo	James	met.work.
Nayolo	Lucy	E/M	Angella	Gabriel	storekeep.	Lomongin	J. Bosco	H/A
Ngorok	Magdalen	Cash.	Apurio	Eliya	s.porter	Iiko	Daudi	mason
Okumu	James	L/T	Etap	Betty	N/A	Ikara	Stephen	carp.
Olee	David	R/N	Liakori	Rose Mary	N/A	Omara	Bruno	A/C Dep
Oula	Alex	C/O	Chero	Paul	porter	Opiga	Fred	Phy
Idilla	Simon	carp.	Lorot	Catherine	L/T	Iryama	Paul Lorot	N/A
Echopu	Joseph	s.driver	Eliau	Julius	electr.	Imalany	Rose	Sec

Conclusion

We would like to thank God our Almighty Father for having graced us with yet another year to serve him in caring for the sick people of Karamoja. He has given us the strength, courage and wisdom to carry out our healing service in fidelity to His call. We would also like to take this opportunity to thank all those who have assisted us in our mandate to make known the healing love of Christ during the past year. In a special way, we would like to thank Sr Catherine Maynard for her tireless efforts during the last five years in quality of SNO.

We hope that this report, and the contents herein will help to inform, all those who are together with us, about our activities in our mission for the sick here in Karamoja.

They are:

- the Board of Governors of St. Kizito Hospital - Matany
- the Health Authorities of the District and the Country
- the Local Government
- the Diocesan Authorities

We thank them for having entrusted us with the task of serving the people of Karamoja and of Bokora Health Sub District in particular.

We would also like to remember all those who support us from near and far (our benefactors) with spiritual and material resources. In particular we thank the two Italian Matany supporting groups: Gruppo di Appoggio dell'Ospedale di Matany-ONLUS Milano and Associazione Toyai – Onlus: without their contribution, and trust in us, we would not have been able to accomplish what we have in the past year. We thank those involved in making policy decisions in favour of the smooth running of our Institution. A special thanks to the Uganda Catholic Medical Bureau, for all its support and encouragement over the past year. And once again a special vote of gratitude to the numerous patients who have availed us with an opportunity to follow in the footsteps of Christ, to bring healing to the sick and suffering. We thank all our staff, our students, our expatriates and all the Ugandans who continue to make St. Kizito Hospital a model for others to follow.

We rejoice with and for all those who have encountered the Lord within the walls of the Hospital; we know that often we have made this encounter more difficult with our shortcomings and fragility: we ask forgiveness for it. Above everything else, we desire to remain faithful to the task, entrusted to us by the Church, of serving the sick: we are grateful to all those who made and who will make this task possible.

Matany, 5th November 2004

Bro. Alessandro Casagrande
Administrator/CEO

Dr Stefano Vicentini
Medical Superintendent

Sr. Luigina Frison
Senior Nursing Officer

Chapter 12: Annexes

Annex 1:

Members Board of Governors:

With Voting Power:

1. Fr. Achia Thomas, Chairman, representative of the Bishop
2. Mr. Aleper Mark, Member of the employees
3. Fr. Damiano Guzzetti, Matany Catholic Church Parish Priest
4. Fr. Pietro Premarini, Member of the Comboni Missionaries
5. Sr. Aldina Viliotti, Member of the Comboni Missionary Sisters
6. Sr. Dinavence, DHC Moroto Diocese
7. Mrs. Zea Wepukhulu, Representing the DDHS Moroto District
8. Mr. Terence Achia, Member of the District Council
9. Mr. Paulino Lukiro, Representing the LC III
10. Mr. David Harold Owiny, Sub County Administration
11. Mrs. Caroline Arao Oola, Member of the Health Unit Management Committee
12. Dr. Fr. Tocalli Egidio, Medical Superintendent of a Sister Hospital
13. Dr. Orlotti Carmen, A Member of the NGO's working in the Hospital

Without Voting Power:

14. Br. Casagrande Alessandro, Administrative Director, Secretary
15. Dr. Vicentini Stefano, Medical Director
16. Sr. Luigina Frison, Nursing Director
17. Mr James Ikabat, Member of the NTS
18. Dr. Dominique Kababa Lubaya, Head of the Public Health Department

Annex 2:

Members of the Hospital Management Team

Br. Casagrande Alessandro, Administrative Director
Dr. Vicentini Stefano, Medical Director
Sr. Luigina Frison, Nursing Director
Sr Maria teresa Ronchi, Principal Tutor NTS
Dr. Dominique Kababa Lubaya, Head of Public Health Department

