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Annual Report 2008

Ndala Hospital

Archdiocese of Tabora

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Introduction

The annual report of 2008 is not much different from previous years. Registration of performance data in MTUHA, the national government registration system, has improved a bit compared to previous years. The collection, compilation and interpretation of hospital data have been done in time because the appointed person to deal with it is quite committed to this task. I sincerely thank him. Although data management in Ndala Hospital is not yet for the full hundred percent correct, I am convinced this report presents a good general picture of the activities of Ndala Hospital.

Dr. Rueben Nyaruga
Ass. Medical Officer in Charge

March-April 2009

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1. General review of the year 2008.

It was a year of adaptation to a new situation: to be without an expatriate Medical Officer in Charge and only three Assistant Medical Officers to continue the patient care, in combination with representing the hospital in several district and regional committees. Fortunately in September two young expatriate doctors, Dr. Wander Kars and his wife Dr. Erica Kars-Koopman with their two little children arrived to join the medical team and help maintain the quality of medical treatment.

Because of the temporary lack of university trained doctors the regular stay of two student doctors for stage periods of 3-4 months from the University of Amsterdam in the Netherlands had been terminated. This had also caused a weakening of the available medical staff for duties at night and during weekend and holydays in MCH, OPD Clinics and Wards. By the end of the year it became clear that student doctors from the University of Groningen in the Netherlands will come for stage periods of 2 months in 2009. This shorter stay might make them less useful for patient care.

Also this year turnover of qualified staff was considerable. 8 Qualified Nurses and 1 Clinical Officer left and only 5 Nurses and 1 Clinical Officer arrived to replace them. A Laboratory and a Pharmaceutical Technician returned form training.

Strict financial management by the Administrator and a much larger number of paying patients eased the financial situation somehow. The new Solar System performed reliably – but not 24 hours - and decreased the fuel expenses considerably. Unfortunately the staff did not profit from this free solar power as was hoped for! The capacity of the solar system is almost always fully consumed by the Hospital and the Convent. Financially there were some large shifts in sources of funding. The contributions of the government are increasing, whilst contributions from donors for running costs decreased. This trend needs to continue further if Ndala Hospital is to survive. Due to financial tightness, many planned activities could again not be carried out. Still progress was made in infrastructural development. The plans for construction of a new theatre are still delayed due to work pressure at CSSC and will possibly start in 2009. The same applies to the construction of the new CTC Clinic by EGPAF and a new Administration Block.

The construction of the new ward for TB patients has been completed, beds that arrived from the Netherlands have been installed but the ward has not yet been opened because of lack of qualified staff.

By all the above-mentioned developments the implementation of the new organogram has been further delayed.

Our sincere gratitude goes to the many friends, benefactors and donor organisations that continue to give professional, moral and financial support to the hospital and its dedicated workers even in times of stress and insecurity about the future. The continuous backing by the Foundation PIUS XII is again highly appreciated.

Our biggest thanks go to all dedicated workers who continue to keep the hospital going for the benefit of our patients. Thank you all!

On behalf of the Hospital Management Team,
Dr. Rueben Nyaruga
Ass. Medical Officer in Charge

2. Hospital and Environment.

Tanzania is a large country measuring 945087 square kilometres in East Africa, much of which consists of a large highland plateau between the eastern and western branches of the rift valley. On this central highland, in Tabora region Ndala Hospital was founded as a dispensary in the early thirties by the Missionary Sisters of Our Lady of Africa, The White Sisters. In 1965 Ndala Hospital was built on the site of the dispensary in the village of Uhemeli. Under the auspices of the Archdiocese of Tabora, the Sisters of Charity of St. Charles Borromeo are responsible for its present management.

Ndala is a Voluntary Agency Hospital and is situated on the border of Nzega District. The small village of Uhemeli relies on the bigger towns of Tabora and Nzega (both approximately 70 km away) for all of its supplies. Both towns are only reachable via mud-roads that are in poor condition during the rainy season. The area around Ndala is very dry and the hospital gets its water from collecting rainwater and from one deep and two shallow wells. When the rainy season is poor, water remains a big problem for the people of Ndala.

Electricity is obtained from 6 large Solar Panels connected to an enormous battery pack, providing – if the sun shines! – almost 24 hours of electric power to the hospital but not to the staff houses. Ndala village is not yet connected to the National Grid of TANESCO.

Communications have improved a lot over the past few years with the arrival of mobile telecommunications in 2003 and the arrival of a satellite disc for broadband Internet and E-mail in 2005. Other communications are still via radio transmitter.

3. Community and Health Status.

3.1 Demographic and economic data.

Tanzania's population is estimated at 37,4 million in 2007, with 44% being under fourteen years of age. Women make up 51% of the population. Tanzania is one of the poorest countries in the world, although some economic progress has been seen in the last couple of years. 36% of the people live below the absolute poverty line. The GDP per capita is estimated at 700 US$ per annum. Industry only contributes 17,2% to the GDP and services 39,6%. Mining is increasing, with natural resources like tin, diamonds, gold, phosphate, zinc and gemstones. With 43%, agriculture is responsible for almost half of the GDP. Agriculture is responsible for 85% of the countries export and it uses 80% of the workforce, although only about 4% of the land is arable. The distribution of incomes and services is highly inequitable with a GINI-coefficient of 0,59. (The GINI coefficient is a measure of income distributions with 0,0 representing absolute income equality and 1,0 sever income inequality. Figures of neighbouring countries: Malawi: 0,62, Zambia 0,44 and Zimbabwe 0,57.)

3.2 Health Indicators.

Health indicators remain poor in Tanzania, although in some areas improvement is seen. Life expectancy is 45 years and falling and infant mortality rate is 96 per 1000 (CIA World Fact book, 2006), largely contributed to

the HIV/AIDS pandemic. Under-five mortality has dropped in the last five years from 147 to 112 deaths per 1000 live births (Tanzanian Demographic and Health Survey 2005), one of the lowest mortality rates in East Africa. Nutritional status of the population is average, with 3% receiving one meal a day, 43% two meals a day and 54% receiving three meals a day. Only 11% of the population has electricity and 52% has access to safe water.

Vaccination coverage is stable with ± 70% of the children having received all recommended vaccinations. However, after about 15 years with only a sporadic case of measles **a small Measles Epidemic occurred in 2008!** No new cases of poliomyelitis and neonatal tetanus have been reported since many years.

Maternal and reproductive health indicators show that Tanzania has one of the highest fertility rates of East Africa, with an average of 5,0 children per woman. More than 25% of the women aged 15-19 years have begun child bearing. (USAID) Family Planning figures show that 72% of the people use no method, 23% uses modern methods and 5% use traditional methods (DHS). Most women receive antenatal care, but many only after the first trimester. More than half of the births in Tanzania occur at home, unassisted by a health professional.

The public health activities in the MCH clinic of Ndala Hospital is supposed to at least cover 16000 people in 2008, of which 608 children under 1 year, 3089 below 5 year and 3039 women between 15 and 49.

3.3 AIDS Pandemic

The devastating effects of the HIV/AIDS pandemic can partly explain the poor health indicators. An estimated 10,9% of the urban population and 5,3% of the rural population has been infected with the virus, making a national prevalence of 7%. 7,7% of the women are infected, compared to 6,3% of the men. The peak of infections occurs at a younger age in women, indicating that women get infected at an earlier age. The prevalence differs greatly between districts, with in general a much higher rate in the south of the country (e.g. Mbeya 13,5%). The prevalence for Tabora region is 7,2%. (DHS) The prevalence in the catchment area of Ndala is probably a bit lower than the regional average; figures obtained from the PMTCT program reaching about 3,3% (percentage of pregnant women that consented to testing and were found positive) , suggests this conclusion.

3.4 Community

Against this background we can place Ndala Hospital in a rural area on the central highlands of Tanzania. The hospital is situated on the boundary of Nzega district in Tabora region. Ndala consists of 5 villages, Uhemeli, Kampala, Wita, Chabutwa and Mabisilo. The ±16.000 people in these villages are directly catered by Ndala Hospital, but its actual catchment area is much bigger, extending up to 7500 square kilometres, inhabited by 300.000 people. The majority belong to the ethnic groups of the Wanyamwezi and Wasukuma, both of Bantu origin. It is a rural area with arid land at an altitude of around 1200 meters, mostly consisting of grassland and bush land savannah. 15% of the land is cultivated and 90% of the people are farmers or cattle herders. Main products are maize, paddle, groundnuts, livestock, tobacco and honey. The average family earns about 600US$ per year by selling their products, which is just enough for subsistence.

4. Health Infrastructure and External Relations.

4.1 Health Infrastructure.

Ndala Hospital is a district hospital on the border of Nzega district. Our official referral hospital is Kitete Regional Referral Hospital in Tabora, about 70 km away via a dirt road, but in reality many patients are referred from Kitete to Ndala instead**.** It was recently learned that the last specialist doctor had left the regional referral hospital. At an equal distance to the north is Nzega District Hospital, the base of the District Medical Officer. About fifty kilometres away is Nkinga Mission Hospital, which has an Ophthalmologist and to which occasionally orthopaedic patients are referred. The main referral option is Bugando Medical Centre in Mwanza, about 330 km to the north. Samples for the pathologist are send there as well as the occasional patient. The great distances involved mean that most problems need to be solved in Ndala itself. Every two months a specialist flying doctor from AMREF visits Ndala Hospital, enabling patients with conditions like VVF, contractures from burns, orthopaedic problems etc. to be helped here. In 2008 a team from Belgium (Medicins Sans Vacance) visited. Three nearby health-centres and dispensaries refer directly to Ndala.
Communication is possible through mobile phone and satellite Internet. Communication with other hospitals still mainly goes via radio, as does communication with AMREF, Nairobi and Flying Medical Services, Arusha.

4.2 External Relations

4.2.1 Archdiocese

The Archdiocese of Tabora is the owner Ndala Hospital, so strictly speaking there are no external relations. The administrator and the AMO-i/c are members of the Archdiocesan Health Board, in which all health facilities under the responsibility of the Archdiocese are represented. Besides Ndala hospital, there are two health centres (Ussongo and Kailua) and five dispensaries (Kipalapala, Ipuli, Igoko, Lububu, Mwanzugi and a new one at Sikonge). The ADHB convened 2 times in 2008. Regrettably funding from Cordaid for the Archdiocesan Health Board had come to an end in January 2006, making it difficult for the Board to function as intended. Fortunately structural support has been received in 2008 from Japanese organisation JOCS (Japanese Overseas Christian Medical Cooperative Service). The organisation posted the very active Public Health nurse Naoko Shimizu in Tabora and a Surgeon, dr. Yoichi, has been helping the hospital for quite some time.

4.2.2 CSSC

The Christian Social Services Commission is the joined body of all church related institutions in Tanzania both for health and education. Ideally CSSC functions as a link between government and mission and should be responsible for the formulation of joint policies. A CSSC officer has occupied the zonal office in Tabora in 2008. This functionary, Mr. Kasoga, will greatly improve communications with CSSC on a variety of subjects like salaries, sponsorship opportunities for upgrading staff, new buildings and in particular the preparation of so called “Service Agreements” between the private health institutions and the (Local) Government.

4.2.3 Government

Ndala Hospital participates in the curative, preventive and promotive health activities of Nzega district. The District (or Council) Health Management Team comes regularly for supervision. The district supplies Ndala hospital with vaccines. Ndala is regularly invited to participate in meetings and seminars organised on district level, although as in previous years invitations often come only a day before.

As a Voluntary Agency Hospital (VAH), Ndala hospital is entitled to receive 10-15% of the ceiling Basket Fund, which can be used for a variety of items like training, infrastructure, medicine and community health activities. The AMO-i/c of Ndala hospital is a member of the District Health Board. He is also involved in the compiling of the CCHP (Comprehensive Council Health Plan) together with the District Health Management Team and the district-planning officer. He is the appointed lead agent for all VAH's (voluntary agency hospitals) in the district. Relations with the region are stable and good. The regional medical officer (RMO) is a member of the BoG of Ndala, and although he had to send someone to represent him at the meeting, communication is regular and easy. The regional laboratory technician visits on a regular basis for supervision. The Ministry of Health (MOH) also supervises regularly and all members of the Hospital Management Team are also regularly visited by the MOH to discuss matters of training, salaries and seconded staff. The Ministry of Health (MOH) supplies Ndala hospital with a staff grant, which assists in the payment of salaries for 38 qualified staff. Ndala hospital has chosen to follow government salary scales as opposed to those of the diocese in order to retain staff more easily. Communication with the MOH concerning all issues is extremely difficult unless visited personally. The government seconds two of the AMO's.

4.2.4 Technical Assistance

In the AMREF Flying Doctor program, 6 visits were made by the following specialists: Urologist 2x, Orthopaedic Surgeon + Lab Technician, ENT Surgeon + Anaesthetist, Reconstructive Surgeon and a Physician + Lab technician, altogether they saw hundreds of patients and did approximately 10% of all the major operations. Lectures and discussions with the medical and nursing staff present during the clinics were very important for improvement of medical practice.

Other specialists and residents visited the hospital on a personal basis, like in previous years, and, together with local staff, attended and operated patients and gave lectures. The hospital has made an agreement with the Belgian organisation Doctors Without Holidays (AZV) for technical assistance. They sent an orthopaedic surgeon, anaesthetist and nurse in October 2008. Dr. Yoichi Myao, surgeon from JOCS assisted in the theatre.

4.2.5 Donors

As in previous years, Ndala Hospital has been only able to continue with the help of numerous friends and donors who helped Ndala in a wide variety of activities. A list of names of all donors is given in appendix 7. All donors generally receive an annual report and individual communication via email and telephone. Donations are received either directly to the hospital euro account or through the motherhouse of the CB-sisters in Maastricht

or via the Stichting Tabora. The **Foundation Pius XII** has been supporting Sengerema Hospital already since a long time and Ndala Hospital since 2004 in a big way, e.g. it paid for the rehabilitation of several staff houses in 2008. The foundation is a close cooperation between the Congregations of Brothers of Johannes de Deo and the Sisters of Charity of St. Carolus Borromeo in the Netherlands.

4.2.6 Miscellaneous

The MOiC together with the Administrator attended the annual meeting of the TCMA in Dar es Salaam. It serves as a platform for church hospitals among themselves and talks with representatives from CSSC, MSD, NHIF and the MOH.

TEC is mostly responsible for the duty free clearing of imported goods and donations from abroad. Cooperation with TEC is difficult and delays in clearance are long.

Good relations exist with neighbouring hospital "Nkinga". Ndala and Nkinga regularly help each other in case of out-of-stock medicines or when technical assistance is needed. Cooperation with Nzega District Hospital on matters of HIV/AIDS is good.

5. Management.

The Catholic Archdiocese of Tabora is the owner of Ndala Hospital. Since 1962 the management of the hospital is in the hands of the Sisters of Charity of St. Charles Borromeo, a congregation with the mother-house in Maastricht in The Netherlands ("Zusters Onder de Bogen"). The Hospital Management Team is the executive power in charge of the hospital. The Hospital Management Team is responsible for the day-to-day management and is supposed to meet every month. In reality of course, members of the daily board meet each other on a daily basis to discuss matters arising. By January 1st, 2007 the former Daily Board was called the Ndala Hospital Management Team and consisted of six people, namely the previously mentioned members and their assistants. The Archdiocese and the Board of Governors did official appointment the new members. However this new situation did not last long because of all the human resource changes that took place during the year. So the situation returned to the past: The Administrator, the AMOi/c and Patron form the Hospital Management Team.

The Board of Governors (BoG) met once in 2008. The aim is to meet a minimum of two times per year. The Board should set policies, approve budgets and generally supervise the activities of the Hospital Management Team. The Board consists of the Archbishop, the Vicar-General of the Archdiocese and also Parish Priest of Ndala, the Regional Medical Officer, the acting medical officer in charge of Sengerema Hospital, who is also a CB sister, the regional superior of the CB sisters, the General Superior of the Congregation of Daughters of Mary, the chairman of Caritas Tabora. Plans have been made and approved to include the District Medical Officer and a representative from the local government in Ndala, but these plans have not yet been implemented. The MOiC in charge is the secretary of the Board. The members of the Hospital Management Team (as it is still called) are no members, but are invited to attend the meetings. The constitution of the BoG, the Organogram, the possible members of a Hospital Advisory Board consisting a.o of representatives of the local community and a representation of the workers are still under discussion.

6. Human Resources.

The Patron mostly does human resource tasks although they are divided between members of the daily board. Financial staffing matters are the responsibility of the administrator. A new 'conditions of service' document was written by the Archdiocese in 2004, but it has not yet been implemented by Ndala Hospital. The government has prescribed a staff establishment for a hospital of the size of Ndala, but the required number of staff is not reached by far. (see Appendix 5)

Staffing levels have improved to some extend. Shortage is especially felt in the administrative and nursing departments, but also in the laboratory and pharmacy. Turnover of staff in these departments is very high, as especially qualified nurses and midwives leave after a short period looking for greener pastures. The reasons for this are not always easy to identify, especially since the hospital follows government salary scales. Government hospitals do generally have better secondary conditions however and combined with the remoteness of Ndala and the lack of facilities like electricity and water, the younger nurses tend to prefer working in bigger towns.

No good written policy is in place for plans and hospital policy concerning Human Resource Management. There are no regular assessment meetings of individual staff members with their heads of sections. New staff has a probation period according to their grade but this period often is not being assessed or confirmation is often not always done in writing.

6.1 Training and upgrading.

It is hospital policy to send staff on training whenever possible and where necessary to improve educational levels of staff. Funds for these trainings are sometimes found through donors or our own resources are being used. Staff should however have been with the department for at least three years and there must be a commitment to stay with the department after completing the course as well. A standard bondage contract is signed between the trainee and the hospital to ensure this.

Appendix 4. Shows the number of staff on training in 2008.

In principle every week a clinical lecture is given by one of the medical staff and the flying doctors often give presentations during their visit as well. The student-doctors program with the University of Amsterdam had been stopped after the departure of university trained medical officers. In 2009 student-doctors from the University of Groningen in the Netherlands most probably will arrive in the first half of the year.

7. Finances

The administrative and accounts department is headed by the administrator. As always the administrative department faced several problems. A severe shortage and high turnover of staff still made it difficult to allocate tasks to specific people. The lack of space in the office furthermore made it impossible to hire more staff. Fortunately with the help of the Pius XII Foundation construction of a completely new and bigger office block will be started in 2009. Mr Ndaki, a senior accountant from Tabora assists for one day a week in keeping the books. The administrator continues modernizing the accounting and financial control systems, but further improvement will only be possible if the staff situation improves. A proper inventory of all the assets of the hospital has been done in 2008. The improvement of this department remains one of the highest priorities of the

hospital. See Appendix 10.6 for details about the financial situation. From these figures it is clear that the overall financial situation has improved in comparison to 2007. There is a positive balance between receipts and payments at the hospital as well as between deposits and payments on the account of the hospital at the NBC branch in Tabora. Very striking is the fact that the contribution of the government has been lacking behind very much. Even compared to 2007!!!!

Income from patient fees had to be increased and reduction of cost had to be achieved to survive. The present administrator, Sr. Reni Ngadi, has achieved these goals with admirable dedication. It has cost her a lot of personal satisfaction because her rigorous measures were not understood nor appreciated by many people inside nor outside the hospital. However, to explain clearly for everybody the necessity of certain measures is not easy. Many cultural barriers have to be overcome to achieve that goal!

7.1 Objectives

The main goal is to keep hospital care accessible to everyone, even for the poorest people. The hospital continues to depend heavily on donations and patient fees. The aim is to achieve as much financial independence as possible. With the continuous rise of salaries this becomes more and more difficult and solutions need to be sought in closer partnership with government, possibly in the form of a **service agreements**. An important proposal of the Government has been put forward in 2008 and has been studied by the voluntary organisations involved in health care (CSSC) in 2008. Major decisions about this major issue will be taken in 2009. The main idea is that the Government 'buys' (pays for all the cost) some of the most important 'services' offered by the hospital (e.g. MCH and Maternity services).

8. Hospital Activities.

8.1 Curative Services.

8.1.1 General OPD.

Attendance at OPD increased somehow in 2008. Again data of the 'old' recording system were used. Because of several reasons the MTUHA (National Hospital Information System) data are underreporting the actual attendance. No firm conclusions can thus be drawn from these data in comparison with previous years.

OPD	2008*	2007*	2006*	2005*	2004	2003
Total new cases OPD	**7,475**	**6,155**	9,560	11,928	13,776 (11,716)	9,948
Re-attendances	**10,342**	**10,782**	10,258	13,423	10,775	5,795
Re-attendances for dressing	**3,935**	**5,668**	5,717	6,633	6,634	5,651
Referrals to other health facilities	**?**	-			81	64
Total OPD patients*	**21,751**	**22,613**	**25,535**	**31,984**	**31,266 (29,206)**	**21,458**
Special OPD Clinics						
Attendance TB/leprosy clinic	**165**	**231**	270	252	209	341
Attendance Eye-Clinic	**333**	**281**	203	274	390	192
Attendance Epilepsy/Mental Clinic	**937**	**953**	881	843	554	0
Attendance Dental Clinic	**125**	**109**	96	114	94	104
Total	(1560)	(1574)				

* The data from the reception were used, **while excluding the children under 5 years (MCH)!** And not the data from MTUHA, the national information system. Data from MTUHA are lower. There are two explanations: in the data from the reception all patients of the OPD are included. In MTUHA patients who are admitted after OPD visit are not registered as Out-patients. Untill 2004 the figures from the reception included all under-five children that visited the MCH clinic. These were therefore counted double in 2004 (both in OPD figures and in MCH figures). Between brackets are shown the corrected 2004 figures without MCH patients. The attendance figures under MCH (see 8.2.3.1) are quite reliable.
NB. These figures make clear that the number of adult patients attending the OPD has stabilized.

8.1.1.1 TB and Leprosy Clinic.

The cure rate in 2008 has decreased to 67% that is below the WHO target of 75%. The cure rate fluctuates a lot over the years and is influenced mostly by the number of defaulters. In reality it is unknown if these patients really defaulted, continued elsewhere or died. As in previous years, the district took care of a continuous supply of drugs. The TB clinic is held every Wednesday and is run by two Clinical Officers. All TB activities and patients are subsidised by the Sonnevanck foundation from the Netherlands, enabling us to provide free services to all patients suffering from TB. The TB ward will be equipped and ready to admit patients in 2009.

Tuberculosis	2008	2007	2006	2005	2004	2003
Patients on treatment per 01-01	**36**	60	70	52	55	151
Newly Registered Patients	**111**	130	88	130	112	125
Re-treatment Cases	**5**	13	3	4	9	2
Patients transferred-in	**3**	4	6	12	4	7
Patients Transferred-out	**2**	2	26	5		
Total Registered	**155**	**209**	**193**	**203**	**180**	**285**
Sputum-positive	**69(44,5%)**	82(39,2%)	102 (52.8%)	92(45%)	87(48%)	39%
Sputum-negative	**46(29,7%)**	30(14,3%)	24 (12.4%)	50(25%)	39(22%)	42%
Extra-pulmonary	**40(25,8%)**	97(46.4%)	67 (34.7%)	61(30%)	54(30%)	19%
Tested for HIV (positive)	**81 (32)**	92(32)	14 (2)	-	-	-
Treatment Results						
Completed	**67**	65	78		105	62
Cured (cure-rate)	**45 (67%)**	55(84,6%)	41(53%)	56	82%	40%
Failed	**0**	0	3	0	0	0
Transferred	**2**	-	26	5	2	1
Died	**3**	2	11	5	8	10
Defaulted	**17**	7	9	23	9	26

Leprosy	2008	2007	2006	2005	2004	2003
Patients on treatment per 01-01	**6**	16	5	16	13	30
New Patients	**4**	2	16	27	12	23
Re-treatment Cases	**0**	4	3	3	3	1
Patients transferred-in	**0**	0	0	2	1	2
Patients Transferred-out	**0**	0	4	1		
Total Registered	**10**	**22**	**28**	**49**	**29**	**56**
Pauci-bacillary	**0**	0	0	5(10%)	21%	21%
Multi-bacillary	**10**	22	28(100%)	44(90%)	79%	79%
Treatment Results						
Completed	**6**	4	5	10	17	9
Failed	**0**	0	0	0	0	0
Transferred	**0**	0	4	1	0	0
Died	**0**	0	0	0	0	0
Defaulted	**0**	1	7	2	5	5

8.1.1.2 STD Clinic.

The majority of patients with sexually transmitted disease (STD) are seen in the regular OPD. Therefore this former weekly clinic was closed already in 2007. All patients diagnosed with an STD are encouraged to come with their partners to receive treatment and counselling to the VCT clinic. Like the HIV test kits, all STI drugs are supposed to be donated by government and given to the patient free of charge. Bu the normal STD medicines (not the antiviral) are not supplied free by the government, the patients have to pay for them.

Diagnosis	2008	2007	2006	2005	2004
Genital Discharge Syndrome	-	-	92	45	100
Genital Ulcer Disease	-	-	12	30	16
Pelvic Inflammatory Disease	-	-	121	88	178
RPR/VDRL Positive	-	-	104	208	85
Other STD's	-	-	11	0	17
Total	**-**	**-**	**340**	**371**	**396**

8.1.1.3 Epilepsy and Psychiatry Clinic.

The special clinic for psychiatric and epileptic patients is open every Wednesday and is run by one psychiatric nurse. Ideally, the clinic should open more than once a week, but staffing levels do not allow that at present. The treatment for the patients is free and subsidized by the Tabora Foundation. A total of **937** (2007: 953) patients are receiving treatment. The majority of patients seen are epileptic patients (90%). The main psychiatric problem presented was again schizophrenia. Many psychiatric patients are known not to come to the hospital. Also, many psychiatric diseases like depression are probably not properly recognized at OPD and in the wards, where emphasis is on treating somatic conditions.

8.1.1.4 Eye Clinic.

An ophthalmic nurse runs the eye clinic in the Radiology Department and should be housed better and the equipment is old and needs replacement and modernisation. Better facilities for examination and for cataract operation exist in Nkinga Hospital (55 km). Thus patients are referred to Nkinga Hospital if they need glasses or operation.

Eye Diseases	2008	2007	2006
Conjunctivitis	**67**	67	58
Cataract	**65**	43	41
Trauma	**30**	23	14
Cornea ulcers and scars	**20**	10	7
Foreign body	**24**	17	11
Refractive errors	**14**	10	3
Presbyopia	**14**	29	16
Glaucoma	**18**	24	14
Retina diseases	**7**	7	1
Eye lid / leprosy lesions/ Trachoma	**7**	-	1
Xerophtalmia	**5**	10	3
Trachoma	**2**	-	1
Glaucoma	**18**	11	8
No pathology detected	**10**	8	3
Herpes	**2**		
Others	**32**	22	22
Total	**335**	281	203

8.1.1.5 Dental Clinic.

Two Dental Assistants run the Dental Clinic. One has gone for upgrading and will resume duty in 2008. Until now only tooth extractions are done. A total of **125** extractions were done (in 2007: 109, which is comparable to previous years.

8.1.2 In-Patients.

The hospital essentially has four wards: a male ward, a female ward, a paediatric ward and a maternity ward. There are semi-private rooms in each ward and there is a private wing with a few rooms. In the children department the new ward was completed and furnished in 2005, and has about 10 beds at present. They are not counted as an increase in the total number of beds because they are considered a 'transplant' from the regular wards. The Children ward has five isolation rooms in which patients with meningitis are admitted. Male and female wards do not have separate isolation rooms and a TB ward will be opened in 2009.
The main diagnoses in admitted patients are malaria and non-infectious internal conditions. In CW the main diagnoses were malaria, pneumonia, anaemia and diarrhoea.

In-Patients	**2008**	2007	2006	2005	2004	2003	2002
Total beds	**128**	128	128	128	131*	128	129
Total admissions	**6,048**	6,663	6,570	6,283	6,403	5,860	5,731
Average Length of Stay (ALS)		4,3	4,9	5,3	6.4	6.1	6.4
Bed Occupancy Rate (BOR)		62,7	69,5	71,6	79%	76%	77%
Death cases absolute	**444**	315	398	422	507	432	414
Death rate (/1000 admissions)	**73,4**	47	60,6	67,2	79,2	73.7	72.2

Wards 2008	**Beds**	**Admissions**	**ALS *****	**BOR*****	**Death cases abs.**	**Death rate (/1000 adm)**
Male Ward	**28**	**1110**	**5,1**	**55%**	**91**	**81**
Female Ward	**28**	**1467**	**4,2**	**61%**	**66**	**46**
Children Ward	**45**	**3536**	**3,7**	**79%**	**235**	**66**
Maternity	**20**	**2212****			35*	109*
Prematures (below 2000 gr)	**4**	53			17	
Private Ward	**3**	13			0	

* Excluding maternal mortality: 6 mothers (see text under Obstetrics). Excluding the premature children (< 2000gr) that died, these deaths are mainly newborn children that died after a few days and/or were admitted in the ward for intensive care after being born at home.

** Deliveries (See Obstetric dep.)+ mothers (321) admitted with their newborn that had been born at home some days earlier.

*** Average length of stay (ALS) and bed occupancy rate (BOR) calculations in this ward are not very relevant

General Overview:	2008	2007	2006	2005	2004	2003
Hospital deliveries	1873	1877	1736	1709	1613	1527
Deliveries before arrival	18	37	22	18	22	28
Total deliveries	1891	1914	1758	1727	1635	1555
Abnormal deliveries	243	277	316	259(14,9%)	13%	15%
Caesarean section	203 (10,9%)	193* (10,2%)	191(11%)	174(10%)	11,7%	10,8%
Maternal death (rate per 100.000 birth)	6	5	4	5	10	6

Deliveries 2008:			Complications:	
Spontaneous Vertex Delivery	1648	1637	Ruptured uterus	6
Caesarean section	203	193	Ante partum haemorrhage	3
Breech delivery	27	49	Post partum haemorrhage	8
Multiple pregnancies (twins, triplets, quadruplets)	51x2 1x3	?	Retained placenta	8
Vacuum extraction	13	35	Eclampsia	5

because mothers who deliver without complications stay generally only one day.

8.1.3 Obstetric Department.

The number of deliveries is stable, with an average of 5,2 deliveries per day again over 2008. The percentage of Caesarean Sections and the Maternal Death rate doesn't vary much. The Causes for 6 maternal deaths were:

1. CS was performed on a gravida 1, para 0) because of severe Eclampsia. The mother died during the procedure and the child lived only for a few days.
2. The mother (27 years, gravida 5, para 4) entered the hospital with a ruptured uterus. Mother and child died after emergency CS.
3. Vacuum extraction was done on a macerated foetus on a gravida 3 para 2 of 30 years after prolonged labour The uterus was found to be ruptured. The mother died during an attempt to remove the ruptured uterus.
4. A gravida 2, para 1 of 26 years arrived at the OPD with a ruptured uterus. Mother and child died.
5. A gravida 6, para 5 of 32 years arrived in the hospital with a retained 2nd twin. The mother died apparently from a massive long embolism.
6. CS was done on a gravida 5, para 4 of 31 years because of severe Eclampsia. The child survived..

~~In hospital~~	~~1997~~	~~1877~~	~~1815~~	~~1798~~	~~1665~~	~~1557~~	~~1621~~
Births / Babies born	**2008**	2007	2006	2005	2004	2003	2002

Before arrival	**19**	37	22	18	22	28	18
Total babies	**2016**	1914	1837	1816	1687	1585	1639
Born alive	**1899**	1809	1729	1717	1601	1520	1581
Fresh stillbirth (per 1000 ! newborns)*	**76(38,7)**	51(28,1)	48(26,1)	40(22,0)	(25,5)	(24,0)	(16,5)
Macerated stillbirths	**41**	48	38	41	21	27	31
Multiple pregnancies (neonates)	**51x2 1x3**		76	101	75	60	105

- 53 neonates were recorded with a birthweight below 2000 gram. 17 of them died.
- The percentages of fresh stillbirths has risen and might indicate that the quality of supervision 0f women in labour has decreased and too late a decision to terminate the delivery has been made!

NB. Like in previous years the data collected in the maternity ward differ a little from the data collected in the theatre and at the reception. This human error is difficult to correct in retrospect. Measures have been taken to improve data collection in general.

8.1.4 Theatre

There were three trained nurses in anaesthesia and one nurse returned after a two-year training in theatre management. Four staff members are involved in other activities like the eye-clinic, the psychiatric clinic and the dental room. Most dressings are done in a separate dressing room to avoid contamination, although complicated dressings that require anaesthesia are done in minor theatre.

The number of major operations remained stable at 670 (2007:666) major procedures. The differentiation between ‘elective’ and ‘emergency’ is no longer made, because of the lack of strict criteria. The general distribution of types of procedures remained the same and as in previous years around 10% of the operations were performed by or assisting a visiting specialist. The remainder of the operations are done by the (A)MO’s of Ndala Hospital. Plans to build a new theatre complex have been postponed due to factors beyond control of Ndala Hospital, but construction might start in 2009.

General overview surgery:

THEATRE:	**2008**	2007	2006	2005	2004	2003
Major procedures (emergencies%)	**670**	666 (37%)	751 (46%)	723 (42%)	684 (65%)	637 (42%)
Minor procedures	**1427**	1122	998	1865	1471	1548
Anaesthesia major/minor	**1606 790/816**	1282 659/623	1452	1737	1694	1702

Major procedures:

General		Genito-Urinary	
Release bowel obstruction	-	Prostatectomy transvesical	39
Bowel resection and anastomosis	19	Prostatectomy transurethral	24
Colostomy (closure)	1	Nefrectomy	-
Adhesiolysis	-		
Cleaning abdomen (exploration+drainage)	41	Repair bladder lesion	-
Appendectomy	22	Orchidectomy (uni-/bilateral)	7
Exploration laparotomy non/semi-acute (biopsy)	-	Hydrocelectomy (uni-/bilateral)	16
Gastric outlet obstruction release	1	Urethro-cystoscopy (with procedure)	-
Cholecystectomy	-	Removal Bladder/Urethral Stones	5
Inguinal hernia (uni-/bilateral)	57	Reimplantation Urether	-
Femoral hernia	2	**Obstetrical/Gynaecological**	
Other hernia (incisional, para-umbilical,epigastric,scrotal)	23	Caesarian Section	141
Burst abdomen, tension sutures	-	CS (3rd) and Bilateral Tuba Ligation	27
Splenectomy	-	CS due to foetal distress/placenta praevia	17
Volvulus	2	CS due to placenta praevia	9
		CS due to cord prolapse	11
		Colporaphy	8
Mastectomy/Lumpectomy	2	Bilateral Tuba Ligation	11
Haemorrhoidectomy	7	Abdominal hysterectomy with/without adnexae	54
Fistulectomy	-	Subtotal hysterectomy	30
		Repair 3rd degree tear	1
Abscess I and D	-	Removal ectopic pregancy	25
Excision tumor	18	Ovariectomy and/or Salpingectomy /myomectomy	-
Extensive wounds	1	Pelvic abscess/pyosalpinx	-
Open fracture: cleaning and reposition	2	Repair vesico/recto vaginal fistula	-
Removal foreign body	-	Colporrhaphy	-
Skin grafting	7	**Other Specialities**	-
Necrotomy	1	ENT: nasal polyp / adenoid hypertophy	6
Amputation of leg	3	Enucliation Eye	-
Anal atresia	-	Repair cleft lip/palate	5
Stump repair	-	Tonsillectomy/adenoidectomy	7
Sequestrectomy/scooping	6	Other Plastic Surgery	5
Re-laparotomy (complications)	-	Clubfeet surgery	1
Contracture release	4	Thyreoidectomy	2
other	-	Other Orthopaedic, foot correction	1

Minor Procedures:

General		Orthopedic	
Abscess or septic arthritis I and D	**134**	Reduction dislocated joint/fracture	**66**
Exploration/Aspiration	**48**	Gallows traction	**?**
Cutwound, suturing	**152**	Femur, pin traction	**16**
Contracture release	**1**	Amputation finger/toe	**2**
Woundtoilet/necrotomy (incl. bites)	**150**	Circular POP	**86**
		Back slab POP	**96**
Removal of stitches	**24**	Osteomyelitis: drilling, seqestrectomy, scooping	**4**
Foreign body removal (eye,ear,nose,throat)	**31**	Fistelectomy	**1**
Crep. bandaging	**14**	Armsling	**27**
Excision tumor/ulcer	**35**	Clubfoot	**-**
		Removal POP	**5**
Tongue tie	**5**	**Obstetrical/Gynaecological**	
Biopsy	**4**	Speculum examination	**57**
Aspiration abdomen	**18**	Evacution (incomplete abortion, molar)	**228**
Aspiration chest	**15**	Dilatation and curettage (diagnostic, disfunctional bleeding)	**3**
Insertion thorax drain	**-**	Retained placenta (manual removal)	**4**
Aspiration other	**24**	Cervical and perineal tear repair	**7**
Rectal examination/proctoscopy/fistula	**2**	Opening imperforated hymen/Labia separation	**7**
Anal fissure, dilatation of anus	**3**	**Genito-Urinary**	
Reduction rectal prolaps	**-**	Bugination	**3**
Ear syringing/otoscopy	**13**	Catheterization transurethral (excl. ward)	**79**
		Catheterization suprapubic	**12**
Eye proc. (cornea sutures, evisceration etc.)	**-**	Ochidectomy	**3**
Other procedures	**-**	Circumcision (traditional)	**36**
		Circumcision phimosis/dorsal slit	**12**

Anaesthesia:

Three Anaesthetic nurses are responsible for the anaesthesia and assist in resuscitation throughout the hospital. In the major theatre spinal anaesthesia is most frequently used, followed by ether inhalation anaesthesia. The number of operations in which ether was used decreased, whilst the number of times halothane was used increased. In minor theatre Ketamine is mostly used, with a slight increase in local anaesthesia.

Type	Major				Minor			
Anaesthesia 2008	**Adult**		**Child**		**Adult**		**Child**	
	M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Ether + intubation	**1**	**1**	**-**	**-**	**-**	**-**	**-**	**-**
Halothane + intubation	**19**	**115**	**8**	**9**	**-**	**-**	**-**	**-**
Ketamine (with Diazepam)	**70**	**71**	**15**	**17**	**201**	**124**	**90**	**92**
Diazepam	**-**	**-**	**-**	**-**	**3**	**1**	**-**	**-**
Pethidine	**12**	**4**	**-**	**-**	**4**	**56**	**-**	**-**
Thiopental								
Spinal anaesthesia: Lidocaine in Dextrose	**107**	**280**	**-**	**-**	**-**	**-**	**-**	**-**
Spinal anaesthesia: Bupivacaine	**5**	**5**	**-**	**-**	**-**	**-**	**-**	**-**
Spinal anaesthesia > Lidocaine + Ketamine	**4**	**3**	**-**	**-**	**-**	**-**	**-**	**-**
Saddle block	**9**	**8**		**-**	**-**	**-**	**-**	**-**
Local anaesthesia Lidocaine plain	**3**	**2**	**-**	**-**	**94**	**80**	**35**	**35**
Local anaesthesia Lidocaine + Adrenalin	**2**	**20**	**-**	**-**	**-**	**-**	**-**	**-**
Biers Block	**-**	**-**	**-**	**-**	**1**	**-**	**-**	**-**
Total: 1606	**232**	**509**	**23**	**26**	**303**	**261**	**125**	**127**

8.2 Preventive and health-promotive activities: The Primary Health Care department

All MCH (RCH) activities, in the hospital as well as the mobile clinic, are considered to be primary health care (PHC). The same can be said from the HIV/AIDS and nutrition activities of the hospital. The hospital employs one senior public health nurse who has not been able to focus much on public health due to her other responsibilities for the Aids program (CTC and VTC) starting from January 2007, however, she is in charge of the public health department. The hospital offers a malnutrition program, where mothers are taught to prevent malnutrition and prepare high-energy foods. It also offers several HIV/AIDS related services. In 2008 a community sensitization program for HIV/AIDS as well as training for village health workers was continued. Other community based health care activities are organized by the catholic parish, which organizes seminars on reproductive health and HIV/AIDS. The Tabora Foundation continued its Reproductive Health and Aids Awareness Programme.

NB. Since 2008 the name "Mother & Child Health" (MCH) has been changed in RCH = Reproductive & Child Health!!!!

8.2.1 The Tabora Foundation.

In the absence of a large-scale PHC department, the hospital counts amongst its neighbours the Tabora Foundation ('Stichting Tabora'). Colleagues of former MOiC Dr. George Joosten and his wife Mrs. Gon Joosten-Nienhuys initiated this foundation, based in the Netherlands. The activities of the foundation are in their 9th year and are managed by a local committee of 5 dedicated people and focuses on several goals:

- A Reproductive Health and HIV/AIDS awareness educational programme for 40 primary, 10 secondary schools and one TTC. The program consists of a series of 4 lessons/group discussions. 3500 young people (2800 primary school kids of class 6 and 7) participated in this program in the year under review. In principle school kids follow these lessons 2 times during their primary education. NB: The lower incidence of aids-positive mothers in the catchment area of the hospital might be at least partly due to the teaching of the senior clinical officer, Mr. Theodori Kulinduka since he started in 2000! He continues teaching despite being retired already for some years.
- Support of app. 200 poor households with food, agricultural utensils and medical care.
- Supporting poor (often orphaned) primary schoolchildren (195) and sponsoring promising youths of poor families in different forms of secondary (70) or postgraduate education. (3)
- Incidental donations to support small projects in Ndala Hospital and in the area of the Archdiocese of Tabora. (e.g. A fund for interest free loans to hospital workers, money to repair the borehole, the construction of a water tank and milling and oil extracting machines in Chomachankola etc.)
- In 2008 the foundation started financing the construction of a large dome shaped underground rainwater collecting cistern, catching the water of the roof of the large social hall of the hospital When ready it will contain almost a half million litres of water for use in the hospital.
- The foundation acts as an intermediate to transfer funds from different donors in the Netherlands for training and upgrading hospital staff.

A group of ex-Ndala doctors provides some management support to the hospital via the Tabora foundation.

8.2.2. Mother and Child Health Care (MCH) Now: RCH

8.2.2.1.Under-five and Ante Natal Clinic 2008

Mobile clinics that were stopped in 2007 were started up again in two faraway villages: Misole and Kigandu. They were both visited 6 x during 2008 for during the rainy season and some months afterwards these villages cannot be reached by car. This makes the total number of attendances to the under-five clinic lower and the number of patients that visited Ndala Hospital remained roughly the same. The mobile clinic will hopefully function again in 2008. More than 40% of the MCH clinic attendees are from outside the official service area of Ndala Hospital.

The number of vaccinations is about the same as in 2006 but far better than 2005. After thorough checking, it seams that the figures for 2003-2005 were not correct. Patients coming from outside the catchment area were probably not fully included. The number of malnourished children seen at the MCH was approximately the same as in 2005. The current number of 0,5% severely malnourished children does still not come close to the expected figure of 3% according to district statistics. One explanation could be that the most malnourished children are often also the poorest, unable to afford visiting the hospital. The increase seen compared to 2004 can be explained by disappointing harvests.

MCH / RCH Under-five care	2008		2007	2006	2005	2004
	1st attendance	re-attendance				
In Ndala hospital:	**1,571**	**10,488**	14,049	13,404	13,693	12,975
below 12 months	**1,571**	**7,465**	10,730	10,152		
above 12 months	**0**	**3,023**	3,319	3,252		
Mobile Clinic:					1,777	1,670
below 12 months	**168**	**947**	-			
above 12 months	**0**	**406**				
Total under five visits:	**13,580**		14,049	13,404	15,470	14,276
Malnutrition seen in under fives						
BWT 60-80th percentile	**1,2% ??**		4,6%	6,2%	6,5%	4,1%
BWT below 60th percentile	**0,2% ??**		0,52%	0,5%	0,7%	0,2%
Antenatal Care	**1st attendance**	**re-attendance**				
In Ndala hospital	**3,296**	**3,825**	**6,877**	6,780	6,919	7,353
Before 20 weeks pregnancy	**255**	**3,825**				
After 20 weeks of pregnancy	**3,041**					
Mobile Clinic			**-**	-	463	248
Before 20 weeks pregnancy	**15**	**261**				
After 20 weeks of pregnancy	**141**					
Total antenatal visits	**7538**		**6,877**	6,780	7,382	7,601

Risk factors seen among antenatal visits:						
below 16 yrs	**5,1%**	**7,2%**	4,5%	7,0%	3,2%
above 35 yrs	**3,3%**	**3,9%**	2,3%	4,4%	3,3%
multipara (gravida 5 or more)	**7,4% mobile.:12,7%?**	**8,5%**	5,9%	8,8%	6,6%
Hypertension (>140/90)	**0,14%**	**0,02%**	0,05%	0,2%	0,3%
anaemia (< 60%)	**2,75%**	**2,9%**	4,5%	5,2%	9,9%
TOTAL under five + antenatal visits	**21,118**	**20,926**	20,184	22,852	22,246
Number of outstations	**2**	**-**	-	-	5
Number of visits	**12**	**-**	-	-	18

Vaccinations 2008	**2008**	**2007**	**2006**	**2005**	**2004**	
TETANUS Toxoid (Antenatal)						
I	**1968**	1794	1,778	2,208	1,802	
II	**1096**	926	1,033	1,259	792	
III	**226**	280	157	153	90	
IV	**153**	151	148	163	129	
V	**105**	95	96	148	131	
BCG						
at birth	**997**	1252	1075	230	415	
at a later time	**1308**	821	1101	497	772	
POLIO						
at birth	**1204**	1467	1251	362	447	
I	**1879**	1502	1406	962	841	
II	**1828**	1385	1317	831	759	
III	**1314**	924	1000	734	683	
DTP						
I	**1789**	1,223	1430	984	910	
II	**1486**	1,063	1482	910	867	
III	**1133**	854	1030	708	932	
Measles	**1088**	932	881	697	697	
Total vaccinations	**17,574**	14,669	15,185	10,846	11,878	
patients allocated to Ndala	**7632**	8537	7,110			

	hospital						
	patients officially allocated elsewhere	**53%**	46%	53%		56%	
Vitamin A supplement		-				552	
Family Planning							
	New attendances				34	28	
	Total visits	**269**	515			106	

8.2.3 HIV/AIDS Control

As Aids continues to grow as a problem, the AIDS control program aims at prevention of transmission as well as care for the already affected patients. The National Aids Control Programme is a government programme, which aims at servicing all government and private/mission hospitals in the country. Ndala Hospital is so far depending on the DHO to receive supplies of HIV test kits, STI drugs and Family planning products, but supplies are erratic. In 2006 Ndala Hospital started supplying ARV treatment to HIV positive patients in its catchment area. It then also started providing PMTCT services.

8.2.3.1 Voluntary Counselling and Testing (VCT).

One important way to increase awareness and promote prevention is through free Voluntary Counselling and Testing (V.C.T.). In 2005 the hospital established a full time VCT office. Although in general patients did not have to pay for these services, as was the case in previous years, supplies from the district were still very irregular. In contrast to 2006 The PMCTC program regularly borrowed supplies from the VCT room to ensure continuity. In 2007 4 counsellors were trained, one works full time and three part-time. There is a stable shift from provider initiated counselling towards patient initiated counselling.

VCT	**Male clients counselled**	**Female clients counselled**	**Total**	**HIV+**		**HIV-**	
				M	**F**	**M**	**F**
2005	123	89	212	71(58%)	45(50%)	43(35%)	36(40%)
2006	229	297	526	85(37%)	127(43%)	144(63%)	170(57%)
2007	1632	1628	3260	230(14%)	246(15%)	1402	1382
2008	**1069**	**1000**	**2069**	**261(24%)**	**224(22%)**	**798**	**766**
(1% of tested were inconclusive in 2008)				**485 (23,4%**		**1564 (75,6%)**	

age group:	**< 14 y.**		**15 – 24 y.**		**25 - 34**		**35 - 49**		**> 50 y.**		**2008**
gender distr:	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**	**Total**
councelled & tested	**50**	**94**	**221**	**292**	**326**	**256**	**302**	**239**	**170**	**119**	**2069**
positive HIV	**9 18%**	**14 15%**	**8 36%**	**28 9,6%**	**69 21,2%**	**63 24,6%**	**135 44,7%**	**92 38,5%**	**40 23,5%**	**27 22,7%**	**485 23,5%**

NB. The VCT outreach program did reach 5 villages and the Teacher Training College (TTC) between June and December 2007 !:

Total Population	Counselled/Tested	Male	Female	Hiv+ male	Hiv+ female
16,292	1228	641	587	19 (2,9%)	25 (4,2%)
				44 (3.6%)	

8.2.4.2 Care and Treatment Clinic (CTC)

As part of the national program to provide care and treatment to patients living with HIV/AIDS, Ndala Hospital opened a CTC clinic in August 2006, providing counselling and antiretroviral treatment. Government supplies all drugs as well as training and recording materials. The Elizabeth Glacer Pediatric Aids Foundation is assisting the government in implementing the program in Tabora region. Attendance to the clinic and the ARV-drugs are free of charge. Unfortunately, we still have to charge fees for treatment of opportunistic infections, but a proposal for funding of these drugs as well equipment, community sensitization programmes and training of staff has been submitted to EGPAF and has been partly implemented 2007.

Once enrolled in the clinic, patients are staged according to the WHO stages for HIV/AIDS, since no CD4 counter is available. If patients are eligible they will start ARV-treatment after receiving a minimum of three counselling sessions together with a treatment partner (usually a relative) and after showing good understanding. If patients are not yet eligible, they will be seen every two to three months until eligible. Counselling is ongoing. At present there are two clinicians, three nurses, two counsellors, one laboratory assistant and one home based care nurse trained to work in the CTC.

HIV + Care (PEPFAR report)	**M0-1**	**M2-4**	**M5-15**	**M 15-24**	**M > 25**	**F -1**	**F 2-4**	**F 5-15**	**F 15-24**	**F >25**	**TOTAL**
Cumulative number enrolled in HIV care by the start of period	7	16	11	4	212	4	12	12	26	278	**602**
New enrollees in HIV care during the period	1	3	6	3	162	2	4	4	29	203	**417**
Cumulative number enrolled in HIV care by the end of the period	8	19	17	7	374	6	16	16	75	481	**1019**
Total number who received HIV care during the period	1	7	11	4	231	4	6	9	46	325	**644**

Nr. in HIV care during period +eligible for ART, but not on ART at end of period.											**107**

ART Care (PEPFAR report)	**M0-1**	**M2-4**	**M5-15**	**M 15-24**	**M >25**	**F -1**	**F 2-4**	**F 5-15**	**F 15-24**	**F>25**	**TOTAL**
Cumulative number started on ART by the start of period	0	1	5	2	51	0	2	4	5	97	**167**
Number started on ART during the period (New and transferred in on ART)	0	2	2	0	63	1	2	3	6	75	**154**
Cumulative number started on ART by the end of the period	0	3	7	2	114	1	4	7	11	172	**321**
Number started on ART during the period (New only)	0	2	2	0	61	1	2	3	6	72	**149**
Number started on ART during the period (Transferred in on ART only)	0	0	0	0	2	0	0	0	0	3	**5**
Nr on ART as of the end of the period (visited during the period and still on ART on most recent visit during the period and had a status of "Attending this clinic" as of end of period)	0	3	6	1	84	1	3	4	11	134	**247**

ART Care Follow-Up (PEPFAR report)	**M0-1**	**M2-4**	**M5-15**	**M 15-24**	**M >25**	**F -1**	**F 2-4**	**F 5-15**	**F 15-24**	**F>25**	**TOTAL**
Cumulative number started on ART by the end of period who had stopped ART as of the end of period.	0	0	0	0	0	0	0	0	0	0	**0**

Care for Chronically ill patients visited in 2008 under CTC:

Chronical ill patients are visited by Village Health Workers and Volunteers (who received 24 bicycles) visited many chronicall ill patients.

Monthly meetings were held regularly with PLHA and VHW/Volunteers. The latter were able to trace back 35 adult patients and 22 exposed children! The death of three adults was reported by them. Five wards (Uhemeli, Budushi, Puge, Tongi and Isikizya/Mtakuja) received training on HIV, Prevention, ART, and Nutrition to Ward Committee Members. In Tongi orientation trainings were organised for VHW,s , TBA's , Traditional Healers and Sub-village leaders in which 50 people attended.

On 1st October advocacy to community was conducted. Primary and Secondary School teachers, staff of nearby health facilities, local government representatives and Provincial Health Authorities attended. Orientation trainings to groups already mentioned above, were also held in the 4 other wards, in which 176 people attended.

Chron. sick	**Jan**	**Febr**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug.**	**Sept**	**Oct**	**Nov**	**Dec**	**Tot**
Visits	100	119	159	158	176	191	141	140	196	182	229	237	**2028**
Hiv/Aids	35	30	56	50	65	72	55	55	70	67	97	102	**754**

8.2.4.3 Prevention of Mother To Child Transmission (PMTCT).

The PMTCT program in Ndala Hospital started in March 2006 as part of the national program. It is funded by EGPAF, through the District Health Office. 16 people mostly from MCH and Maternity have been trained and provide PMTCT services on a daily basis. 2 members of staff have been trained as TOT and regularly give trainings elsewhere in the country. Every morning a health education talk is given to all pregnant mothers attending MCH. The mothers can then opt in or out for counselling. If tested HIV positive, mothers receive a single dose of Niverapine when labour starts and the children get a single dose of Niverapine syrup within 72 hours after birth. The majority of women agree to be tested. Of those tested, (88 van 2644 tested in 2008) 3,3% is HIV positive, which might be a good indication of the HIV/AIDS prevalence in our catchment area. This is considerably lower than the regional average of 7,2%. This is probably because the hospital stands in a rural area. Ideally, all positive women are referred to the CTC to assess if they are eligible for full scale ARV treatment. In reality however only a minority arrives. This is probably due to the fact the CTC only has two clinic days a week. Other problems faced are the low number of babies receiving NVP. This is mostly because, in spite of counselling, many mothers end up delivering at home. All HIV positive pregnant women get their NVP during antenatal check up, so they can take the medicine at home. For children this is not possible, because the syrup has to be stored in a cool place. Follow-up of babies born from positive mothers is in general poor.

Diagnosis	2006 (March-December)	2007	**2008**
Pregnant mothers counselled	2377	3314	**3422**
Pregnant mothers tested (accepted%)	2267 (95,4%)	2616 (79%)	**2644 (77%)**
Total mothers HIV positive (%)	86 (3,8%)	114 (4,3%)	**88 (3,33%)**
Mothers received NVP	75	114	**88**

Babies received NVP	31	35	**30**
Babies coming for follow up	5	72	**46**

8.3 Supporting Services

8.3.1 Laboratory

The laboratory remains one of the busiest departments in the hospital. For Hb measurements fortunately standard reagents were obtained and the calorimeter was used again, improving the reliability of the tests. Biochemistry was not done in 2008 due to malfunctioning of the water bath for incubation and due to shortage of staff. It is expected that liver and kidney function tests will be frequently done in 2009 because all patients attending the CTC will need baseline examinations. One laboratory assistant had been sent for further studies as a lab-technician in 2005 returned in 2008.

	2008	**Total**	**Positive**		**Total**	**Positive**
Parasitology				Hematology		
Bloodslide (thick droplet)		**11272**		Hb in % or in g/dl (below 50% or 7 g/dl = "positive"))	**4228**	**1752**
	Malaria		**6079**	White Blood Cell count (above 10.000/mm)	**67**	
	Borrelia		**1**	WBC differentiation	**134**	
Stool		**1133**		Platelet count (below 40.000/mm)	**-**	
	Hookworm		**181**	Bleeding time	**-**	
	Ascaris		**1**	Red Blood Cell Morfology	**26**	
	Giardia Lamblia		**9**	ESR	**603**	
	Entamoeba Histolytica		**19**	Sickle Cell Test	**215**	**56**
	Strongyloides Stercolaria		**2**			
	Schistosoma Mansoni		**4**	Biochemical tests		
				SGOT	**-**	
				Cholesterol	**-**	
				Bilirubin (total)	**-**	
Urine		**2274**		Glucose blood (>10 mmol/l)	**112**	
	Schistosoma Haematobium		**15**	Glucose urine (dipstick)	**59**	
	Trichomonas Vaginalis		**13**	Albumen urine (dipstick)	**81**	
	Granular casts		**10**	Pregnancy test urine	**209**	
Bacteriology						
Ziehl-Neelsen colorization for AFB				Other		
	Sputum (Tuberculosis)	**489**	**61**	Spermanalysis	**7**	
	Skin smear (Leprosy)	**18**	**3**	Analysis other body fluids	**59**	**4**
Gramstain						
Cervix/urethral smear		**84**				
	Gonococci		**25**	Bloodgrouping and donation	**	
	Candida Albicans			Bloodgrouping	**960**	
	T. Vaginalis			Screening of donors (HIV, X-match)		
Liquor / CSF		**258**		relative of patient	**	
	Meningococci		**2***	voluntary donor	**	
	Pneumococci		**10***	HIV positive (donors)	**	
	Haemophilus influenzae		**33***	Number of units transfused	**960**	**('07: 1217)**
	Cryptococci		**-**	children	**780**	
	total bact. meningitis		**45**	adults	**180**	
Serology						
PRP (Syphilis)		**535**	**64**	Cytology Burkitt's lymfoma	**-**	
PITC for diagnosis HIV		**21*****	**13**			
Widal		**124**	**17**			

* Positive results based on gram stain only, not on culture.

** Since 2007 all the donor blood taken and given goes via the new zonal blood bank in Tabora and is tested for HIV, hepatitis and malaria etc.

*** HIV testing after counselling is done in the specific programs: PMTCT and VCT.

8.3.2 Pharmacy and IV fluid production unit.

The pharmacy attendant that was sent for training in 2005 returned from training as Pharmacy Technician. A branch MSD (the privatized national Medical Supplies Department) is the first supplier but many essential items are often unavailable and have to be purchased elsewhere in smaller pharmaceutical companies in Tabora or Mwanza (320km). The regular supply of essential medicines remains a hot item.

The IV unit made 4801 bottles (1579 ltrs) of different sterile fluids. The production is restricted by the availability of bottles and ingredients needed, so ready-made bottles or bags with IV fluids were more often bought than in 2007. The local production of IV fluids is not cheap because of the very high electricity consumption of the distilling and sterilization process. (in total ± 15 KW/h !!!), exceeding the capacity of the solar installation.

-

IV	UNIT	Normal Saline 0,9%	Dextrose 5%	ACD solution for blood collection (till Sept. only)	Saline Irrigation	Dextrose 50%	Other	TOTAL
2008	**Total bottles**	**1891**	**2269**			**641**		**4801**
	Total litres	**893**	**686**			**10,6**		**1579**
2007	Total bottles	3,789	3,125	637	-	333	?	7884
	Total litres	1,718	864	39	1898	7,4	?	
2006	Total bottles	5,315	4,060	1,030	-	157	2.5	
	Total litres	2,682	1,023	71	1920	4.6	4.6	

8.3.3 Radiology

The radiology department is responsible for making x-rays during electricity hours and occasionally on emergency indication. A radiology attendant operates the machine. A radiology assistant is presently being trained to become a fully qualified radiographer in Mbeya and will be available only in 2010. The equipment consists of a rather new Philips installation that has been out of order since 2006 and an old mobile x-ray machine that has some voltage problems, which makes the quality differ. Fortunately the machine has been repaired at the end of the year by the provision of new batteries! Results of the thermo luminescent dosimeters remained good throughout the year, indicating that the radiology-room functions well within safety limits. Unavailability of staff with enough qualifications contributed to the absence of barium contrastt x-rays and HSG's.1046 Films were used in 2008.

The total number of Utrasound examinations rose again slightly, because the number of staff able to use the ultrasound has increased again with the arrival of two doctors in September.

X-Rays	**2008**	2007	2006	2005
Chest	**339**	239	289	517
Lower and Upper extremities	**446**	387	445	527
Skull	**25**	7	13	27
Shoulder	**40**	34	29	34
Pelvis and hip	**98**	68	75	98
Vertebral Column	**42**	17	38	62
Plain Abdomen	**3**	12	19	39
Barium meal	**-**	-	0	3
Barium Swallow	**-**	-	4	2
Hystero-Salpingography	**-**	-	3	29
Intravenous Urography	**-**	-	1	1
Ureterogram	**-**	3		
Others	**=**	-	7	1
Totals	**993**	767	923	1340
Films used	**1046**	789		

Ultrasound scans:	**2008**	2007	2006	2005
Obstetrical	**110**	68	196	201

Gynaecological (incl. ectopic/abortion)	**127**	111	224	175
Abdominal (liver, spleen, gallbladder, bladder, tumor eci)	**83**	98	245	200
Urologic	**36**	33	33	33
Heart	**-**	3	3	7
Other	**-**	2	6	18
Total	**356 Male/Fem 58/298**	299	707	634

8.3.4 Administration

The Administrator, her assistant, two assisting sisters and several clerical staff are responsible for the finances and control. The General Office is small and not sufficient for the hospital. Plans to build a new office block have been postponed till 2009. Most of the work is still done manually although financial reports our now made on the computer. The first steps have been made for a more professional bookkeeping system with annual auditing.

8.3.5 Medical Records and Statistics

A medical records office is located in the general office and several of the clerical staff works partly in the medical records archive. The medical records clerk falls under the MOiC, and is responsible for statistics. Because the clerical staffs also have reception and financial responsibilities, the office and archive are severely understaffed. Medical data are collected on a monthly basis and send to the District Health office. Two systems are used: the national health information system “MTUHA” and some data are still collected in the old recording system. Each patient gets his or her personal file and identification number. The files are stored in an archive behind the reception room.

8.3.6 Technical Department and Transport

The TD is supervised by one of the sisters who are supervised by the administrator. It is responsible for general maintenance of the hospital buildings, staff houses and equipment as well as the hospital vehicles. The level of staff remained the same compared to previous years. A terrible fire accident happened to the senior and experienced Technician Mr. Constantino Salun that cost him the normal use of his right arm for a long time. Extensive hospital treatment and plastic surgery was needed to reduce the damage. By the end of 2008 he had not sufficiently recovered to be able te resume his duties.

The installation of the solar energy that had started in February 2007 has been functioning continuously during the year. A considerable reduction in the consumption of diesel has already been achieved. The most effective and efficient use of the system requires a very disciplined use of the sterilizers, boilers and distillation equipment in Theatre and IV-fluids department. It is still necessary to learn how to take full advantage of the

power provided by the sun! It is very a pity that the hospital staff has not profited of this free electricity. They still receive 3 hours (17.00 – 22.00) per day from the small generator at the entrance of the hospital.
The hospital owns three vehicles, two Landcruisers with a hard top and one Landrover pick-up, which is mostly used for local transports of goods. Of the two Landcruisers, the engine of the old one has been overhauled and will need to be replaced in the near future. All vehicles are mostly used for transport of goods, supplies and staff. Occasionally a car is used for the referral of patients, although since referral hospitals are far a way, patients can usually not afford to hire the car. The hospital has also started offering the Landrover to relatives for the transport of deceased patients.
The hospital employs two drivers who are also working in the Technical Department.

8.3.7 Domestic Department

This department is responsible for the storage of all non-pharmaceutical goods, laundry, day labourers, the bicycle shed and the guesthouse. This guesthouse is frequently used to accommodate visitors like medical specialists, consultants, donors and friends of the hospital. A continuous group of day labourers takes care of the compound, giving the hospital its pleasant and green appearance.

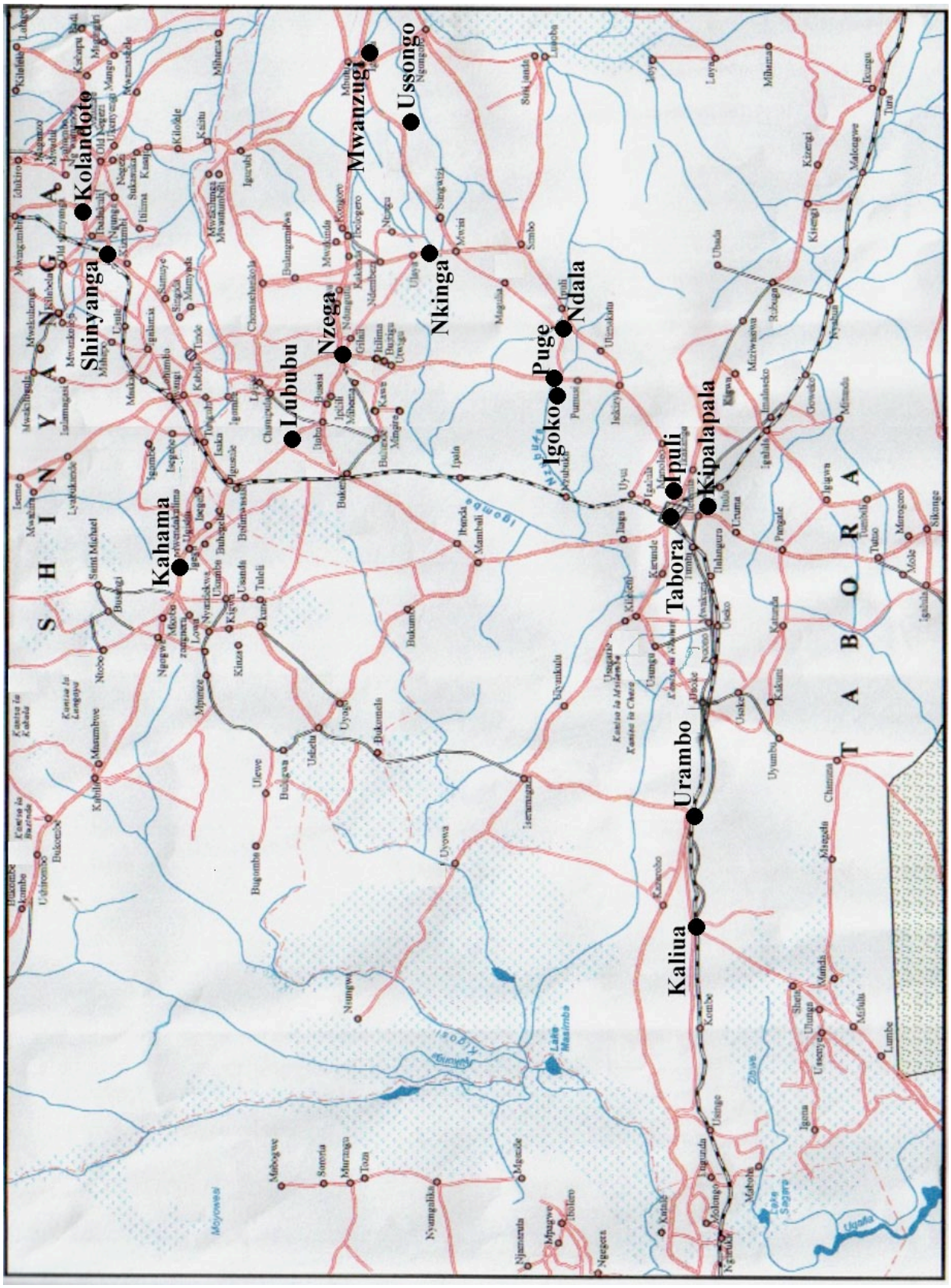
9.Planning for the future.

Improving the secondary working conditions of the workers to retain good workers.

- Increase loan facilities (support St. Tabora)
- Support secondary education of children of staff (support ??)
- Rehabilitation of staff houses (support St. Pius XII)
- Increasing supply of electricity to staff houses. (Connection to the National Grid o TANESCO will improve this situation)

Construction of the Administration Block. (PIUS XII Foundation 2009)
Continue improvement of financial administration and management
Using the TB Ward and complete the fencing. (Support Sonnevanck Foundation)
Recruitment of more qualified staff.
Make more optimal use of the solar system. (Power saving)
Recruiting at least one Tanzanian Medical Officer
Relocating the Incinerator to a less dangerous site.
Start construction of a new theatre complex and mortuary (by CSSC)
Construction of CTC Clinic complex (by EGPAF)
Consider the construction of new sewage system.
Implementation of the new organogram
.

10.1 Appendix 1 Map



10.2 Appendix 2 Management

MEMBERS OF THE BOARD OF GOVERNORS IN DECEMBER 2008

His Grace Paulo Ruzoka	Chairman	Archbishop Tabora Archdiocese
Rev. Sr. Regina Sumiyatni CB	Member	Regional Superior Sisters of CB
Rev. Sister Eustella Josaphat	Member	General Superior Mabinti wa Maria
Rev. Fr. Daniel Malingumu	Vice Chairman	Parish Priest Ndala / Vicar General
Rev. Fr. Cleophas Mabula	Member	Treasurer Archdiocese Tabora
Regional Medical Officer	Member	Regional Medical Officer.
Mr. Festo Ndonde	Member	Caritas Tabora
Sr. Dr. Marie José Voeten CB	Member	Acting MOiC Sengerema Hospital
Dr Reuben Nyaruga AMOic	Secretary (no member)	Medical Officer in Charge Ndala

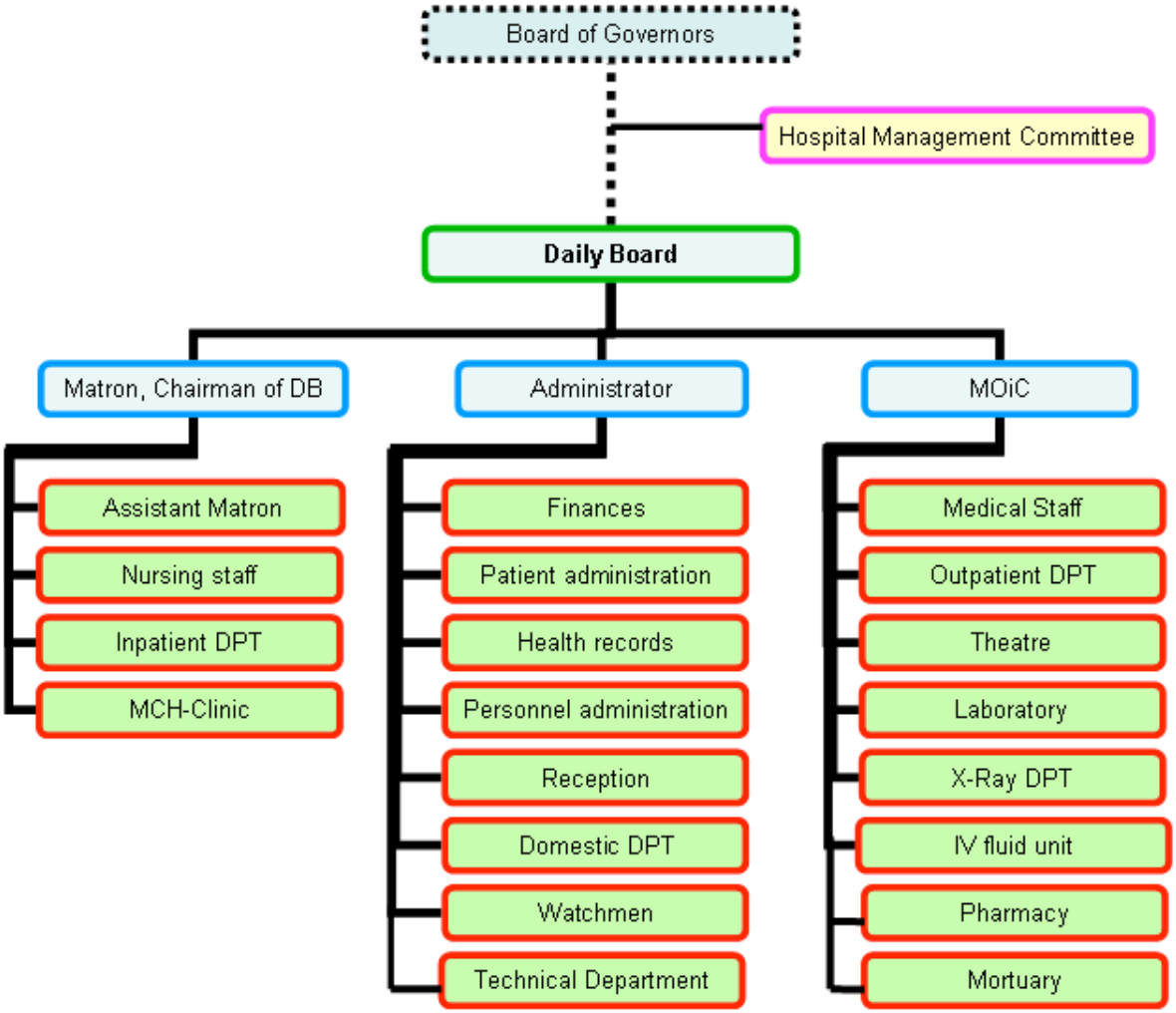
MEMBERS OF THE HOSPITAL MANAGEMENT TEAM DECEMBER 2008

Sr. Reni, Ngadi CB	Administrator Chairperson
Dr. Rueben Nyaruga AMO	Assistant Medical Officer in Charge
Mr. Thomas Mtilimbanya NO	Patron

IN CHARGE POSITIONS DECEMBER 2008

Medical Officer i/c	Dr. Rueben Nyaruga, A.M.O.
Patron	Mr. Thomas Mtilimbanya, R.N.
Administrator	Rev. Sr. Reni Ngadi CB
In Charge domestic dpt.	Rev. Sr. Felicita Joachim CB
In Charge compound/technical dpt.	Rev. Sr. Gemma Shayo CB
In Charge Male Ward	Mr. Rashid Abdallah E.N. (acting)
In Charge Female Ward	Rev. Sr. Claudia Msaki E.N (acting)
In Charge Maternity/Labour Ward	Mrs. Neema Malembeke E.N (acting)
In Charge Children Ward	Mr. Obed Edward E.N.
In Charge Laboratory	Mr. Elisha Maige , Laboratory Technician
In Charge OPD	Mrs. Dorothy Massy, R.N.
In Charge Pharmacy	Mr. Solomon Kitundu, Pharmacy Technician
In Charge Theatre	Mrs. Grace Mlay, R.N.
In Charge Radiology	(Peter Katinda in training))
In Charge Clinical Officers	Mr. Patrick Chubwa, C.O.
In Charge CTC	Dr. Joseph Lugumila, A.M.O.
In Charge VCT	Mrs. Symphorose Crispin R.N.
In Charge PMTCT	Mr. Thomas Mtilibanya . R.N.
In Charge Health Records Dept.	Mr. Godfrey Silas (acting)
In Charge Walinzi /Security	Mr. Adriano Daudi
In Charge Laundry	Mr. Ernesto Daudi
In Charge MCH Clinic	Mrs. Mariama Mtamu E.N.
Chairman Tughe	Mr. Matthew Ndungulu.

10.3 Appendix 3 Organogram



10.4 Appendix 4 Staff Mutations 2008

Staff who joined in 2008:

Name	Designation	Department
1. Letitia Stephen E.N.	Nurse / Midwife	
2. Rashid Abdallah E.N.	Nurse / Midwife	
3. Aron Anthony E.N.	Nurse / Midwife	
4. Theresia L. Mboje E.N.	Nurse / Midwife	
5. Thobias Bolen C.O.	Clinical Officer	Medical staff
6. Dr. Wander Kars MD	Medical Officer	Medical staff
7. Dr. Erica Kars-Koopman MD	Medical Officer	Medical staff
8. James Zachayo	Nursing Officer (back from training)	Theatre
9. Elisha Maige	Laboratory Technician (back from training)	Laboratory
10. Solomon Kitunda	Pharmaceutical Technician (back from training)	Pharmacy
11. Leah Minzi	Nursing Assistant (1 year course)	
12. Godwin Sepetu	Nursing Assistant (1 year course)	

Staff who left in 2008:

Name	Designation	Department	Reason
1. Joyce Joseph E.N.	Nurse / Midwife		
2. Sr. Lucretia Njau E.N.	Nursing Officer		to Sengerema
3. Aron Anthony E.N.	Nurse / Midwife		
4. Raphael Michael R.N.	Nursing Officer		
5. Sr. Veneranda C.O.	Clinical officer		to Dar es Salaam
6. Waydael Sanke R.N.	Nursing Officer		
7. Juliana Masanja R.N.	Nursing Officer		
8. Esther Thadeo R.N.	Nursing Officer		
9. Niite Kifutumo R.N.	Nursing Officer		

Staff on training / upgrading 2008

Name	Qualification	Traning Institute	Sponsor	available
1. George Mgalega	Medical Officer	Kariuki College DSM	Nolet Foundation	2011
2. Sr. Christina CB	Medical Officer	Kariuki College DSM	Srs of Charity of St. Charles Borromeo	2012
3. Sr. Peter Katinda	Radiographer	Muhimbili Universit	JOCS	2010
4. Gertruda Emmanuel	Nurse / Midwife	Nkinga Dipl nursing	PORTICUS	2009
5. Sharifa Shabani	MD	Bugando University	CORDAID	2013
6. Fabian Maganga	Dental Therapist	Tanga Dental Sch.	CSSC + Nolet F.	2011
7. Paulina Christopher	Lab Assitant	Nkinga Lab.School	Fam Lips	2010
8. Merius Ordas	Ass. Medical Off.	Ifakara Med. Sch.	Tabora Foundation	2010
9. Monica Andrea	Nursing Officer	Kolandoto Hospital	CSSC + Nolet F.	2011
10. Teddy Calpophore	Nursing Officer	Tanga Sch. Dipl. Nurs.	CSSC + PORTICUS	2010
11. Thomas Madimilo	Human resources management	Msumbe Tr. College	GEON > Tab. F.	2010

10.5 Appendix 5. Staff Establishment.

Staff establishment per August 2008

	2008			2007	2006	2005
	Present	**Required**	**Deficit**			
Medical Officer	**2 (expat)**	2	0	-	2 (expat)	2 (expat)
Assistant Medical Officer	**3**	3	0	2	3 (2 sec.)	3 (2 sec)
Clinical Officer	**5**	7	2	6	7	6
Nursing Officer	**12**	14	2	12	19	14
Nurse/Midwife	**13**	15	2	8	8	9
Trained Nurse	**-**	-	-	3	3	3
Nurse Assistant (1yr course)	**23**	25	2	22	19	22
Nurse Assistant (no tr.)	**21**	21	0	22	19	20
MCH-Aid	**-**	-	-	1	1	1
Laboratory Technician	**1**	2	1			
Lab-assistant (2 yr course)	**2**	3	1	2	5	6 (
Lab-attendant (1 yr course)	**3**	4	1	4	3	3
Pharmaceutical Technician	**1**	1	0	-	1	1
Pharmaceutical Assistant	**0**	1	1			
Radiographer	**0**	1	1			
Radiographic assistant	**0**	1	1	1	1	1
Administrator	**1 (expat)**	1	0	1 (expat)	1 (expat)	1 (expat)
Ass. Administrator	**0**	1	1	-	1	1
Hospital Secretary	**0**	1	1			
Health Recorder	**0**	1	1	1	1	1
Office attendant	**4**	4	0	3	3	4
Receptionist	**-**	-	-	3	3	2
Domestic dpt.	**10**	13	3	11 (expat)	11 (1 expat)	12 (1 expat)
Driver/Technician	**4**	4	0	4	3	4
Security Guards	**11**	11	0	11	11	11
TOTAL	**116**	**136**	**20**	**117**	**125**	**125**
in training/upgrading	**10**			9	6	2

10.6 Appendix 6. Income and Expenditure.

ACTUALS	DETAILS	ACTUALS
	INCOME	
2008		**2007**
1.	**Income from Patients**	
214,322,235	Payments from In-Patients	178,471,005
71,683,750	Payment from Out-Patients	
21,258,800	Payments at the reception	
	NHIF	11,491,909
	NSSF	1,166,592
307,264,785	**Subtotal:**	**191,129,506**
2.	**Contributions from Government**	
	Bed grant	1,955,907
	Staff grant	179,154,033
79,000,000	Basket Funding	13,300,000
79,000,000	**Subtotal:**	**194,409,940**
3.	**Donations**	
19,116,294	For Study/Training	-
41,201,009	For Special Groups of Patients	-
17,280,744	Fund for non-paying patients	-
77,598,047	**Subtotal:**	**107,961,772**
4.	**Income Generating Projects**	
4,758,500	Renting out Car	
1,990,825	Renting out Hall	
414,000	Canteen/Guesthouse	
7,163,325	**Subtotal:**	**5,119,218**
5.	**Other Income**	
4,964,628	'other sources': house rent etc.	
2,736,400	Refunds /Loan Interest	
606,820	miscellaneous	
12,288,827	From Bankaccount etc	
20,596,675	**Subtotal:**	**5,137,077**
491,622,832	**TOTAL INCOME**	**503,757,513**

EXPENDITURE

2008		2007
1.	**Salary and Adjacent Costs**	
203,570,842	Salary, allowances	301,749,003
	NSSF Contribution	19,453,785
3,213,483	Medical Treatment (staff)	3,035,328
617,630	Terminal benefits !!!!!	56,413,613
207,990,627	**Subtotal:**	**380,651,729**
2.	**Medical Supplies**	
86,920,600	Medicines	50,515,050
11,281,650	Medical Supplies	6,166,000
98,202,250	**Subtotal:**	**56,681,050**
3.	**Other Materials**	
35,552,350	Non-Pharmaceutical Medical materials (Basket Fund)	5,164,425
5,296,900	Technical Department	2,838,710
5,585,550	Domestic Department (Food, Textiles)	3,588,050
7,122,300	Office supplies/stationary/Administration	6,927,270
159,500	refund	
53,716,600	**Subtotal**	**18,518,455**
4.	**Transport**	
2,511,000	Transport	
1,053,900	Accomodation	
3,564,900	**Subtotal:**	**1,032,000**
5.	**Water/Power/Light/Commun.**	
	Water Supply	-
2,669,618	Communication	-
12,067,000	Costs Solar /Gener. System	-
12,896,900	Diesel for Generator/Car	15,037,695
1,161,150	Kerosene	2,597,500
28,794,668	**Subtotal**	**17,635,195**
6.	**Maintenance**	
261,000	Airstrip	-
4,934,065	Hospital Car	13,707,800
3,689,450	Buildings/ equipment	1,199,000
2,581,950	IGP (cost)	-
11,466,465	**Subtotal:**	**14,906,800**
7.	**Upgrading Infrastructure and Equipment**	
9,291,300	Renovation staffhouses (PIUS XII)	
5,055,600	New buildings (TB ward)	21,189,360
1,910,900	Equipment (Pump)	-
16,257,800	**Subtotal:**	**21,189,360**

8.	**Training and Upgrading of Staff**	
21,583,103	Training and Education/Study	12,993,880
21,583,103	**Subtotal:**	**12,993,880**
9.	**Contributions and Charity**	
122,000	CSSC/TEC	
876,400	X-mas presents	
2,674.770	Gifts	
6,232,730	misc. Worker Day etc.	
695,150	debts of patients	
2,638,850	EGPAF	
7,007,170	**Subtotal:**	-
10.	**expenses unaccounted for**	
2,312,615	**Petty cash**	**985,450**
456,540,256		524,593,919
456,540,256	**TOTAL EXPENDITURE**	**524,593,919**
BALANCE (INCOME - EXPENDITURE) 2008:	**+ 40,726,634**	
11.	**Depreciations***	
161,800,000	Buildings	161,800,000
27,390,000	Installations	27,390,000
3,800,000	Means of Transport	3,800,000
4,000,000	Generator	4,000,000
196,990,000	**Subtotal:**	**196,990,000**

*The depreciations are not included in these balance sheets. The has been no new assessment in 2008. It is reasonable to include the same values as 2007 as a guide for 2008.

Receipts and payments at the hospital 2008 January – December

Receipts	2008	2007
Balance B/F	18,452,908	
In-patients	214,322,235	
Out-Patients	71,683,750	
Reception	21,258,800	
Other Receipt	6,015,648	
Income Generating Projects	7,112,325	
Cash drawings	20,146,628	
Donation / Loan	59,403,664	
Refund / Study	12,679,784	
Basket Fund	79,000,000	
TOTAL in	510,075,741	
Payments	**2008**	**2007**
Staff cost	203,159,992	
Medicines	98,202,250	
Administration Cost	90,466,598	
Study	21,583,103	
Terminal Benefits	1,028,480	
B/F	35,552,350	
Miscellaneous	-	
TOTAL out	449,992,773	
Balance:	60,082,986	

Bank Deposits and Payments 2008, January – December

DEPOSITS	2008	2007
Balance B/F	61,282,846	
NIFB	16,524,063	
Ministry Salaries	185,560,826	
Bedgrant	3,547,868	
NSSF	588,672	
TMP	75,200	
Sonnevanck	29,063,700	
Deposit temporary	64,985,702	
Refund	93,018	
TOTAL DEPOSITS	361,721,895	
PAYMENTS	2008	2007
Staff salary	83,949,509	
NSSF	44,204,568	
TRA	16,261,838	
Draw from Bank	811,700	
Bank charges	691,059	
TMP	7,570,000	
Deposit temporary	64,985,702	
Staff Loans	10,981,604	
Bank statements	2,400	
Lake Printing	11,232,000	
Kayonza	1,250,000	
J & K Medicks	1,686,250	
NHIF cancelled payments	659,112	
Fortes Mwanza	1,710,000	
Dosaji	5,310,000	
TOTAL PAYMENTS	+251,287,742	
Balance:	110,434,153	

10.7 Appendix 7. Donations 2008

NO	
1	Stichting PIUS XII
2	Congregation of CB Sisters General Board Maastricht
3	The Sonnevanck Foundation
4	Congregation of CB Sisters, regional office Tanzania
5	Dr. Daniel Gans, Rotterdam
5	G.W.M. Haverkamp, Arnhem
6	Rentebestemming Zr. Guido Kooter CB
7	Universiteit Amsterdam
8	Mrs. G.A.W. Berndt, Haren
9	Stichting Steunfonds St.Joseph, Maastricht
10	G.J. Knijn, Venhuizen via sr. Jeanne d'Arc
11	Stichting Missie-Zending.
12	J.A. Oosterhuis, Naarden
13	Fam. van de Kar- Kortman
14	Normbeheer Ommen BV. Ommen
15	Gemeente Loon op Zand (Mej. A.P. Zwaans)
16	Dr. G. van der Ley, Schiedam
17	Stichting Geon (Fam. Dr van Boven)
18	Stichting Porticus
19	Stichting Nolet, Schiedam
20	Family Dr. Lips
21	Stichting Tabora (many individual donors)
22	Stichting Franje (Fam. Van Bossum, via Stichting Tabora)
23	Mrs. R. Polderman-Kortekaas, Amsterdam
24	Dr. H. Drewes (via Stichting Tabora)
25	Family Dr. Slenter
26	Mr. and Mrs. C.J.J. Pieters, Domburg (Via Stichting Tabora)
27	Caritas Parochie Ommen
28	Liliane Fonds for the handicapped (three children helped)
29	Fam. Dijkman – Thomkins, Hoenderloo
29	Werkgroep Ontwikkelingssamenwerking Veere (W.O.V) (via Stichting Tabora)
30	L.van Thijn, Heemstede
31	"Dokters zonder vacantie", Antwerp, Belgium

10.8 Appendix 8. Abbreviations

AD	Archdiocese	MTUHA	National Hospital Administration System
ADHB	Archdiocesan Health Board	MW	Male Ward
AFB	Acid Fast Bacilli	NHIF	National Health Insurance Fund
AIDS	Acquired Immuno-Deficiency Syndrome	NMW	Nurse Midwife
ALS	Average Length of Stay	NO	Nursing Officer
APH	Ante-Partum Haemorrhage	OPD	OutPatients Department
AMO	Assistant Medical Officer	PHC	Primary Health Care
ARV	Anti-RetroViral	PLHA	
ART	Anti-Retroviral Therapy/Treatment	PMTCT	Prevention of Mother To Child Transmission (of HIV)
BCG	Bacille Calmette-Guérin	POP	Plaster of Paris
BoG	Board of Governors	PPH	Post-Partum Haemorrhage
BOR	Bed Occupancy Rate	RMO	Regional Medical Officer
BTL	Bilateral Tuba Ligation	STI	Sexually Transmitted Infections
BWT	Bodyweight	TB	Tuberculosis
CB	Charles Borromeo	TBA	Traditional birth Attendant
CCHP	Comprehensive Council Health Plan	TCMA	Tanzanian Christian Medical Association
CO	Clinical Officer	Tsh	Tanzanian Shilling
CS	Caesarean Section	TT	Tetanus Toxoïd
CSSC	Christian Social Services Commission	TTC	Teachers Training College
CW	Children's Ward	UvA	University of Amsterdam
D&C	Dilatation and Curettage	VAH	Voluntary Agency Hospital
DB	Daily Board	VCT	Voluntary Counselling and Testing
DHS	Tanzanian Demographic and Health Survey 2005	VHW	Village Health Worker
DTP	Diphtheria, Tetanus, Pertussis	VVF	Vesico-Vaginal Fistula
ENT	Ear-Nose-Throat	WDC	
Expat.	Expatriate	WHO	World Health Organisation
FW	Female Ward		
Hb	Haemoglobin		
I&D	Incision and Drainage		
IV	Intravenous		
MCH	Mother and Child Health		
MEMS	Mission for Essential Medical Supplies		
MO	Medical Officer		
MOH	Ministry Of Health		
MOiC	Medical Officer in Charge		
MSD	Medical Stores Department		