EAST SEPIK PROVINCIAL HEALTH AUTHORITY

ANNUAL REPORT 2017

Marking the new era in health reforms

Table of Contents

EAST SEPIK PROVINCIAL HEALTH AUTHORITY

DEPARTMENT OF HEALTH

Private Mail Bag
WEWAK 531
East Sepik Province
PH: (675) 456 2166, Fax: (675) 456 2767
Email: esphaceo@gmail.com

EAST SEPIK PROVINCIAL HEALTH
FINANCIAL REPORTS FOR MAIN OPERATING ACCOUNT # 6000426476
CASH FLOW FORECAST 2017
MONTHLY EXPENDITURE Vs BUDGET APPROPRIATION AS PER APPROVED BUDGET 2017 FINANCIAL YEAR

Item No.	Description	Total Appropriation 2017	Actual CFC Received to Date	Actual Expediture to Date	2017 Surplus/ (Deficit)	Movement of Funds 2017 Transfer Out	Transfer In	Running Balance	2017 Outstanding Payments	Final Bal Surplus/ (Deficit)
212	Wages	252,000.00	252,034.00	(168,702.95)	83,331.05	(63,468.00)		19,863.05	-	19,863.05
213	Overtime	54,000.00	54,018.00	(54,885.25)	(867.25)		15,757.00	14,889.75	(15,727.26)	(837.51)
214	Leave Fares	221,400.00	221,400.00	(221,512.70)	(112.70)		120,000.00	119,887.30	(117,716.60)	2,170.70
221	Travel & Subsistence	77,800.00	77,844.00	(74,577.40)	3,266.60			3,266.60	-	3,266.60
231	Utilities	400,000.00	-	(139,656.41)	(139,656.41)			(139,656.41)	-	(139,656.41)
223	Office Materials & Supplies	62,300.00	62,300.00	(63,784.84)	(1,484.84)			(1,484.84)	-	(1,484.84)
224	Operational Materials & Supplies	648,000.00	648,000.00	(622,821.88)	25,178.12	(33,000.00)	41,000.00	33,178.12	-	33,178.12
225	Transport & Fuel	105,700.00	105,670.00	(115,073.83)	(9,403.83)		19,000.00	9,596.17	-	9,596.17
226	Administrative Consultancy Fees	150,000.00	150,000.00	(3,440.00)	146,560.00	(46,000.00)		100,560.00	-	100,560.00
232	Rental Of Properties	1,000,000.00	1,000,000.00	(978,912.66)	21,087.34		106,000.00	127,087.34	(101,600.00)	25,487.34
233	Routine Maintenance	82,400.00	82,385.00	(83,194.81)	(809.81)			(809.81)	-	(809.81)
227	Other Operational Supplies	562,000.00	1,075,100.00	(842,671.75)	232,428.25	(163,889.00)		68,539.25	-	68,539.25
228	Education & Training	44,500.00	44,500.00	(59,879.45)	(15,379.45)		40,600.00	25,220.55	(21,927.53)	3,293.02
215	Retirement Benefits	178,600.00	163,674.00	(111,370.14)	52,303.86	(16,000.00)		36,303.86	(14,403.69)	21,900.17
271	Purchase Of Office Equipment	89,900.00	89,901.00	(81,918.14)	7,982.86			7,982.86	-	7,982.86
273	Purchase Of Vehicle	150,000.00	-	-	-			-	-	-
275	Plant Equipment & Machinery	150,000.00	150,000.00	(78,706.70)	71,293.30	(20,000.00)		51,293.30	-	51,293.30
	TOTAL:	4,228,600.00	4,176,826.00	(3,701,108.91)	475,717.09	(342,357.00)	342,357.00	475,717.09	(271,375.08)	204,342.01

Prepared by: _____
Supervisor Finance
Isidore Sirongo

Date: _____

Approved by: _____
Chief Executive Officer
Mark Mauludu

Date: _____

Summary for Project Funds, Operating & Trust Accounts as at 31st December 2017

Balance as per Bank Statement for Operating Account - 31.12.17	7,130,234.99
Book Balance as per Constuction, Renovation & Improvement - 31.12	5,778,935.61
Book Balance as per ESPG Grant - 31.12.17	142,025.55
Book Balance as per Main Operating Account - 31.12.17	1,209,273.83
Less: Unpresented Cheques as at - 31.12.17	(274,815.27)
Available Cash to be spent as at - 31.12.17	934,458.56

DIRECTORATE OF MEDICAL SERVICES

RE - DEVELOPING EAST SEPIK'S PEOPLE HOSPITAL

OVERVIEW

The year 2017 was more challenging in terms of providing continuous specialist medical service at Wewak General Hospital.

The issue of shortage and aging essential workforce at the Hospital.

The hospital continues to be faced with this issue hence impacting the quality of medical service provided to our patients. The current manpower plan at the Hospital was planned taking into consideration a population of less than 300,000 in the early 1980's, however the population in the province has now grown to over half a million (500,000). In addition, the hospital also serves the population in Bogia in Madang province, Nuku Aitape, Lumi and Teleformin in Sandaun province. To improve and maintain the quality of clinical service, the hospital staff strength issue has to be addressed.

The current Hospital Infrastructure rehabilitation had also impacted the clinical services provided at the Hospital. The current plan of Hospital Rehabilitation while at the same time, providing continuous clinical service has impacted the level of Standard of clinical care. The following are contributing factors;

- Space limitation
- Temporary Relocation arrangement
- Increase number of people seeking Medical attention at the Hospital

The current Economic climate that Papua New Guinea is faced with resulting in low cash flow and the National Government had to cut back on budget allocation to the Hospital. Further still the delay in monthly allocation received by the Hospital had overall impacted the clinical service provided by the Hospital.

The issue of drug shortage. It is appreciated that the National Government has prioritized and allocated money to National Department of Health to purchase medicine for the country. However, at the Hospital level we are still experiencing shortage of essential drugs to manage patients. Chemotherapy drugs are not available, Panadol and other anti-hypertensive drugs are inconsistently available impacting patient management by Medical Officers.

East Sepik Provincial Health Authority was officially launched in October 19th, 2017. Combining both the Hospital and the Provincial Health under one Health Authority Board. This process is step in the right direction to assist the primary health care system in East Sepik Province.

There are challenges as the Provincial Health indicators are below national minimum standard for the following;

- Antenatal Booking
- Family planning usage
- Supervised Deliveries
- Immunisation rate
- Outreach Health Activities
- MCH Clinics
- Functional Health Facility

In addition there are many aid post that are closed or non-functional due to no staff or defoliating facility condition, this has caused increase flow of People coming to the Hospital to Seek Medical Service. The Management and Board is well aware of these situations and is working progressively to address the challenges.

Worsening Law and Order in the province has also impacted us at the Hospital. There is already increase number of trauma cases seen at both the Accident and Emergency and Surgical Department. More than 70% of the cases seen at both Departments are trauma related and 90% of them are categorized as Unnecessary Self-Inflicting trauma case. These category of cases use up time, resources and cause unnecessary stress on the limited staff strength at the Hospital.

Staff Accommodation.

This is an issue raised time and time again and has not been addressed as yet. To add value to the service at the Hospital, the staff essential need of accommodation has to be addressed to see improvement in attendance and punctuality. At present Hospital staff look for their own accommodation in settlements and blocks of land bought privately from local land owners. They then had to come to work using PMV and private Vehicle, which at times are not reliable. The management and board should reprioritise this housing need in future and address it to see improvement in quality of service provided at the Hospital.

Hospital Department Annual Report

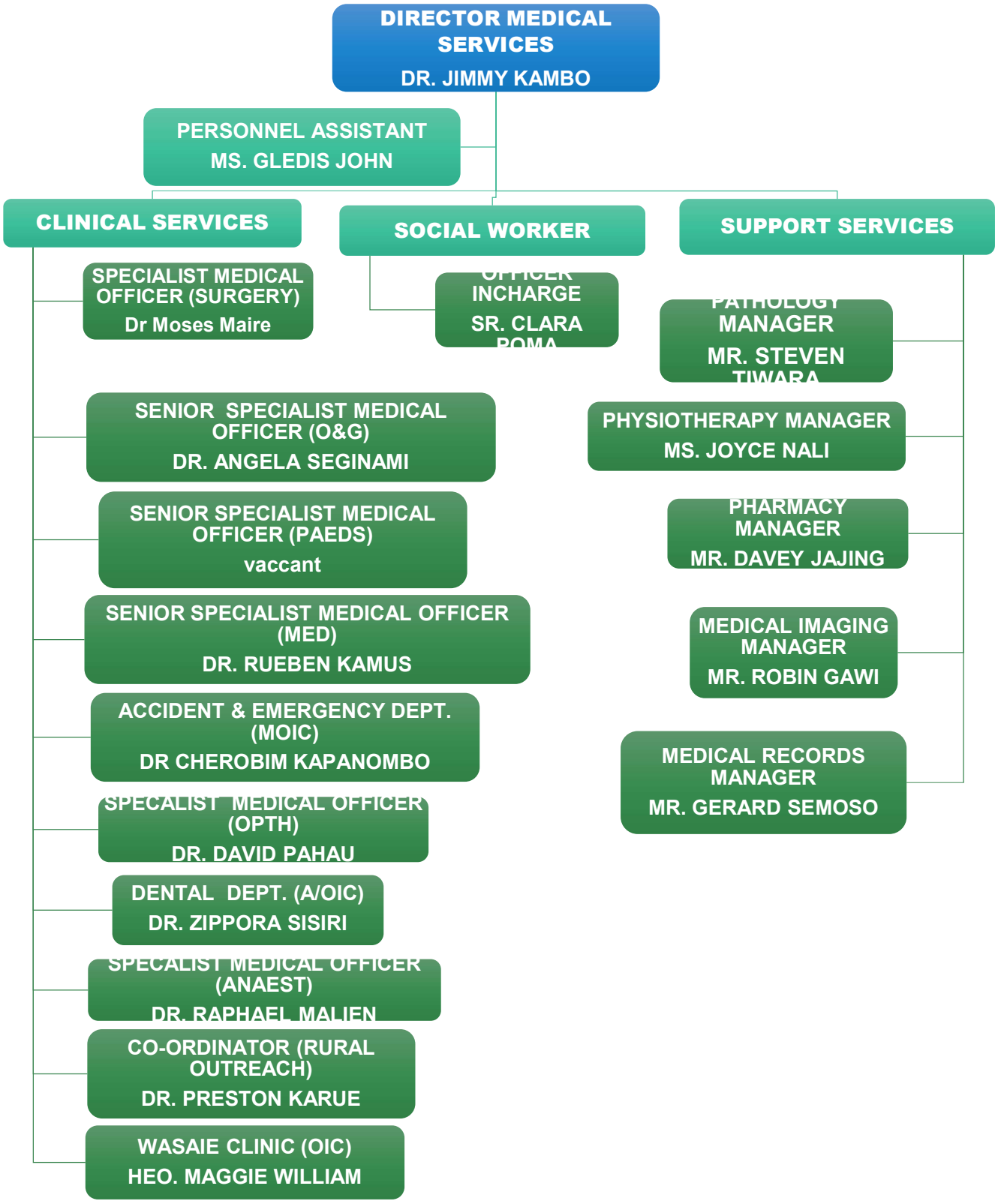
The 2017 Departmental Reports continue to reflect increasing demand for medical service provided at the Hospital. The changing Trend in Infectious and non-Infectious Disease causing new cases of the following;

Resistance and Multi drug Resistance tuberculosis

Increase cases of lifestyle Disease including Complicated Diabetes hypertension, stroke and myocardial Infarctions, Pneumonia, Malnutrition

The breakdown in law and order in the province had been reflected with the Hospital increase statistic at both the Accident and Emergency and Surgical Departments with increased number of cases seen for trauma related Injuries. In both departments 90% of the trauma cases are Self-Inflicting that are Unnecessary and thus imposing work stress on the limited staff and causing unwise use of the limited medical drugs and consumables at the Hospital.

MEDICAL SERVICES DIRECTORATE STRUCTURE



GENERAL STATISTICAL INFORMATION – MEDICAL SERVICES DIRECTORATE

The following table shows Summary of some hospital statistics for the year 2017;

Item	Description	Total Number
1	Total outpatient and Emergency Attendance	20, 359
2	Bush knife is the Commonest cause of Trauma seen at A&E	61% of Trauma cases
3	Alcohol Consumption Related Trauma	55% of trauma cases
4	Total Deliveries	2, 025
5	Total Obstetric and Gynaecological Operation	811 (49%)
6	Total Material Deaths - Total Perinatal Deaths -	8 (395/100,000) 128 (64/1000)
7	Un booked rate	18%
8	Abortion	710
9	Total Operations	1645
10	Total Surgical Operation	834 (51%)
11	No blood as the Commonest Reason for cancellation of Operation	20%
12	Total Admission to Paediatric ward	578
13	TB is the Commonest cause of Admission to Paediatric ward	11%
15	Neonatal is the most common cause of Admission to Special Care Nursery	218 (46%)
16	Birth Asphyxia is the most common cause of Death in Special Care Nursery	22%
14	Total Admission to Special Care Nursery (SCN	477
17	Total Admission to the Medical Ward	-
19	Tuberculosis is the most Common cause of Death in the Medical Ward	
20	Total Eye Cases seen at the Eye Clinic	2, 534
21	Cataract is the most common reason for Eye Consultation	252 (10%)
22	Total Dental Cases seen at the Dental Clinic	2, 756
24	Dental Cases in the most Commonest reason for Dental Consult	566 (42%)

The Hospital continues to see increased number of deaths in 2017. The following are top 10 causes of death recorded at the hospital ranging from highest o least in top ranking. .

1. Tuberculosis Defaulters
2. Malignancy
3. Severe Head Injuries
4. Severe body Injuries with severe loss of blood
5. Severe Pneumonia
6. Motor Vehicle Accident
7. Septicaemia
8. Diabetes with complications
9. Cardio Vascular Accident
10. Unsupervised Delivery with complication

The other department reports issues and statistics are reflected in respective Department reports.

Way Forward

The following are the way forward to adding value and improving quality of health service provided by East Sepik Provincial Hospital;

- National Government to continue and fully fund the Hospital Infrastructure Rehabilitation,
- Provincial Health Authority Office to be including staff Accommodation funded and Constructed
- Restructure of the East Sepik Provincial Health Authority Structure
- Design, Costing and Construction of all Six Districts Hospital
- Fully fund the East Sepik College of Nursing
- Establish One (1) New Community Health training College in East Sepik Province
- Strength and fully fund all Public Health Program in East Sepik Province
- Increase Health Outreach Programs and Activities in the Province
- Improve and Strength Emergency Referral Pathways to East Sepik Provincial Hospital
- Improve and Strengthen Continuing Medical Education and training for Medical and Medical Support Staff

Conclusion

The following staff must be commended for their dedication and commitment to providing Medical Services to the people of East Sepik

- Late Matthias Eremas – TB
- Late Ms Janet Aisir – DMS Secretary
- Dr Godfrey Naboam – SMO O&G
- Dr Linda Tamsen – SMO Public Health
- All 2017 Retirees

ACCIDENT AND EMERGENCY DEPARTMENT

Introduction

Accident and emergency section is the gateway to the hospital. All cases presented here include accidents and emergencies as well as outpatient cases for both adults and children. It is also responsible for receiving all referrals coming in from the peripheral health facilities in East Sepik and parts of West Sepik as well as parts of Manus and Madang provinces.

Section manpower

CADRE OF HEALTH WORKERS AT ACCIDENT AND EMERGENCY	NUMBER
Medical Officers (Doctors)	1
Health Extension Officers (HEOs)	4
Nursing Officers (RNOs)	10
Community Health Workers (CHWs)	10

Accident and Emergency department has been seeing about 60 patients on daily basis in 2017 that amount to total of 20,000 patients seen in 2017. Notably there were total of 24 deaths in OPD/A&E in total. Other notable issues can be identified on the table on the pages. Other figures can be seen in the graphs included below.

This department sees and manage all categories of patients. It operates as Adult Outpatient Department, Children's Outpatient Department, and Obstetrics and Gynaecology Outpatient Department. As well as seeing the general outpatient cases, this place responds to emergencies and casualties as Emergency Department day and night including weekends and public holidays.

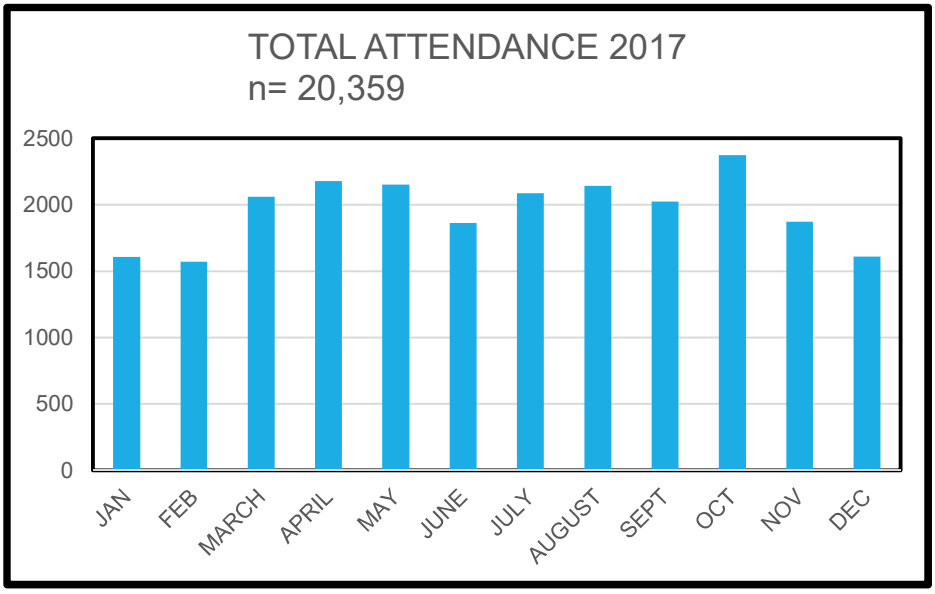
As a result of many accidents and trauma cases seen, this department did design a trauma survey form hence records were kept and are included in this annual report as can be seen in the following pages.

This department has four beds in the two cubicle and three beds in the resuscitation bay. We have a defibrillator, an electrocardiogram and a digital monitor set which include a blood pressure machine, pulse oximetry and a cardiac monitor.

This department has had its share of downfalls, shortages of necessary drugs and equipment, and criticisms both from outside and within the hospital. The staff has also been harassed on occasions especially by drunkards. All these has not compromised its function as a service provider in saving lives.

Department Statistics

Figure 1: Bar graph showing total number of cases seen monthly at the OPD/A&E department of East Sepik Provincial Hospital in 2017.



Total of 20,359 patients were attended to at the OPD and A&E from January to December 2017. One can infer from the graph above that between 1500 and 2500 patients were attended to every month with the average monthly attendance being around 1,697 patients per month. On a weekly basis this department did see 424 patients per week which comes down to 61 patients a day at an average.

Figure 2: Yearly OPD/A&E Attendance in 2017 by gender

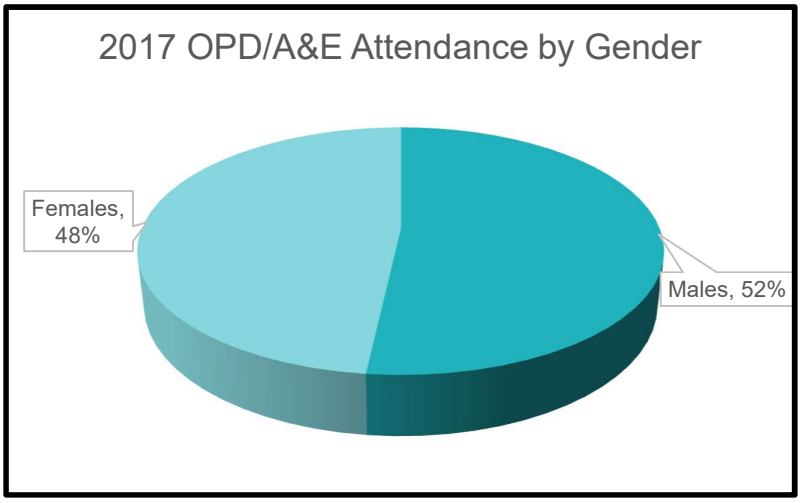
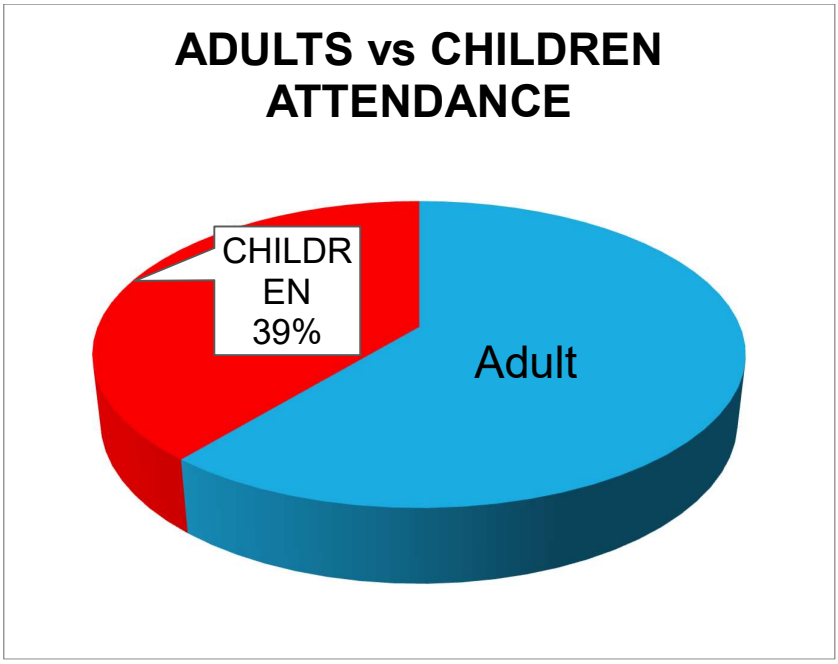


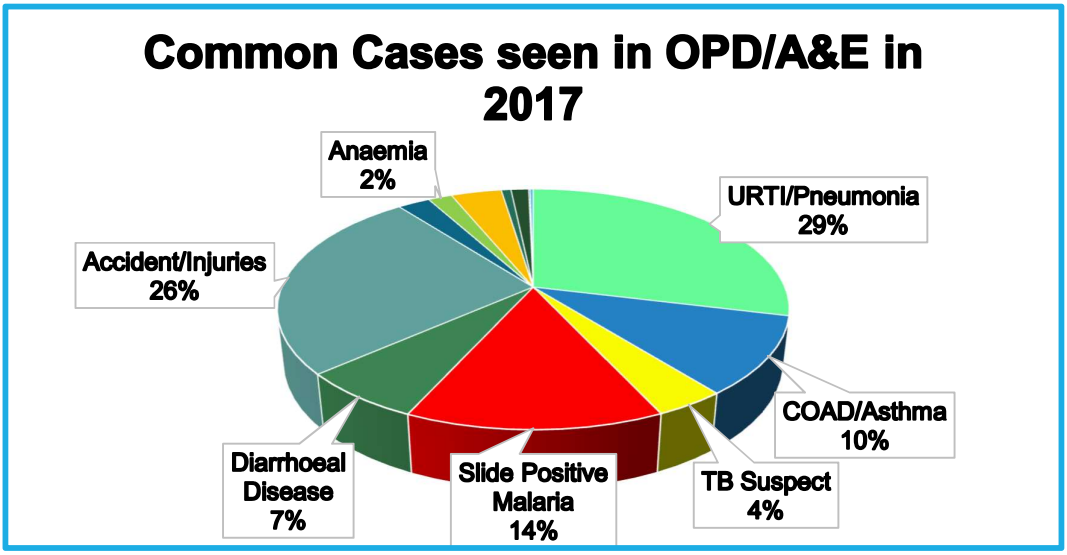
Figure 2 above shows that slightly more males were seen (52%) compared to the females (48%) in general in 2017

Figure 3: Pie Graph showing adults and children seen in 2017 in OPD/A&E



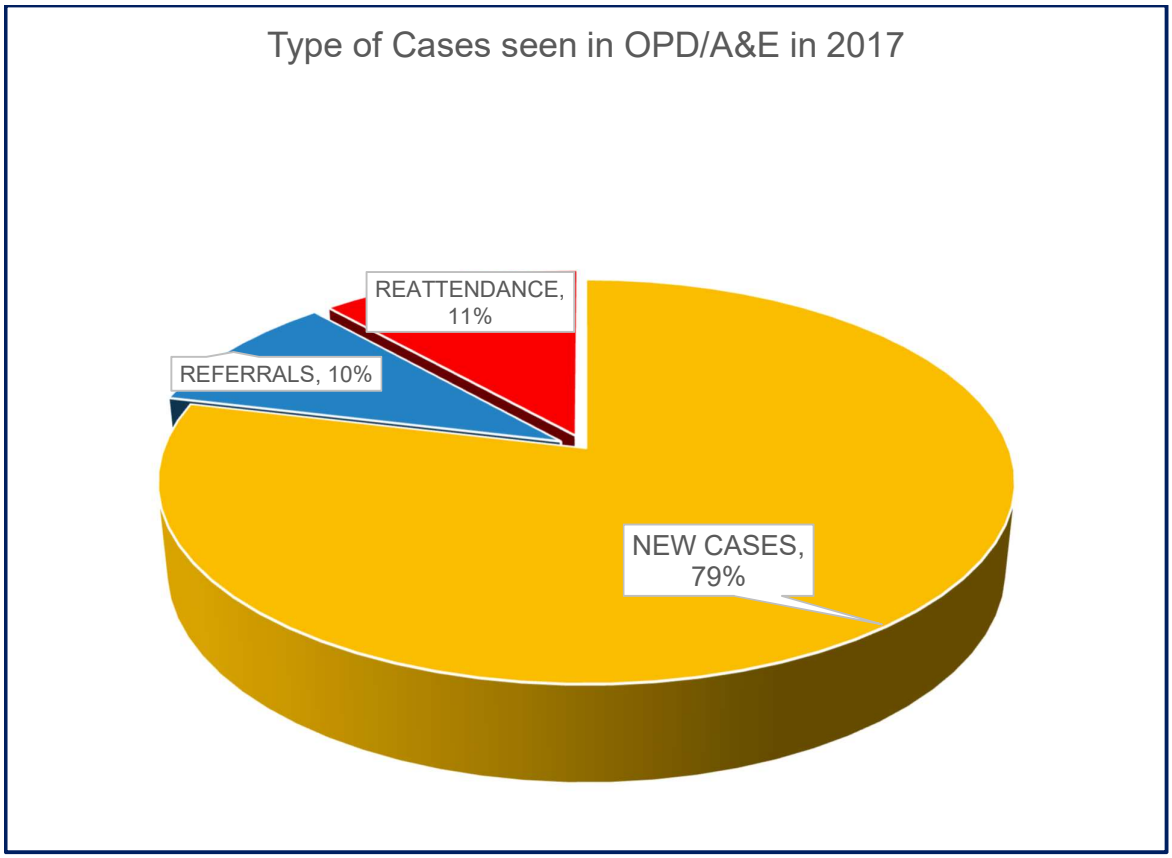
About two thirds of the cases seen were adults compared to children.

Figure 5: Pie Graph showing common diseases seen in OPD/A&E in 2017.



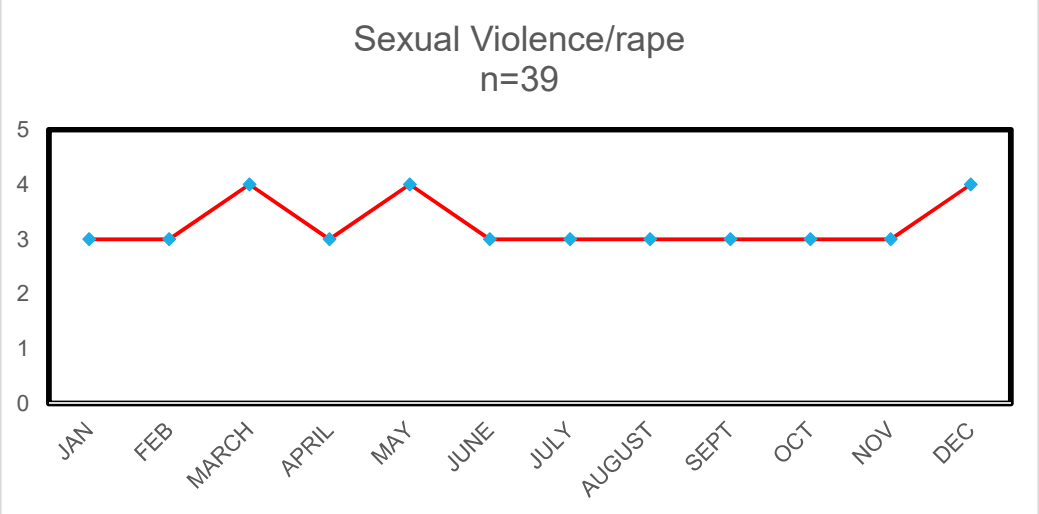
Upper respiratory tract infection (URTI) and Pneumonia were common cases seen followed by Accidents and injuries.

Figure 6: Types of cases seen in 2017 at OPD/A&E



Majority of the cases seen were new cases (79%) compared to Referrals which are only 10%. While the 11% makes up the cases of Re-attendance.. The bulk of the new case are mostly due to non-functioning rural health services which culminate to self-referral by patients themselves creating the influx in the new cases seen at outpatient at the hospital.

Figure 7: Monthly Sexual Violence including Rape cases seen in 2017 at ESPH



OPD/A&E

There were three (3) or more sexual violence case seen each month in 2017, totalling up to 39 cases overall.

Figure 8A: Graph showing Male to Female distribution of trauma cases seen from March to September 2017

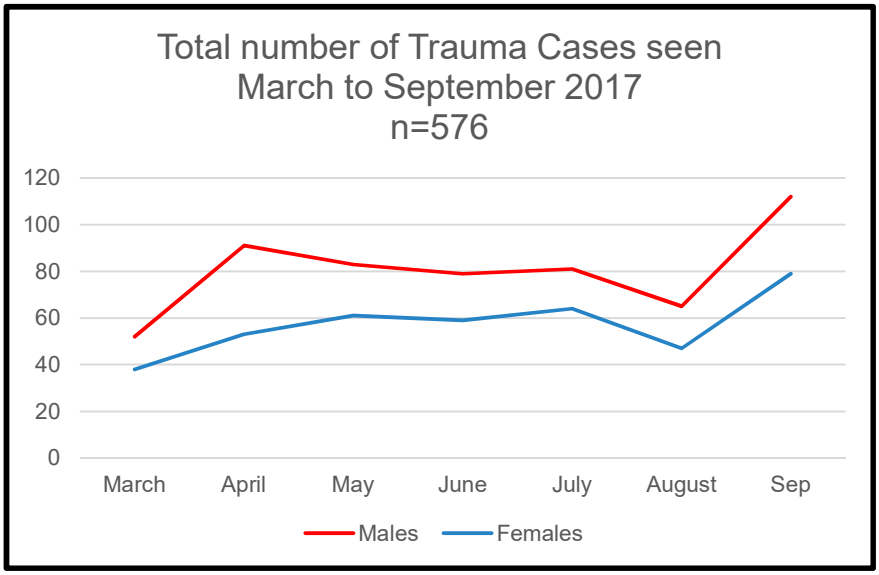
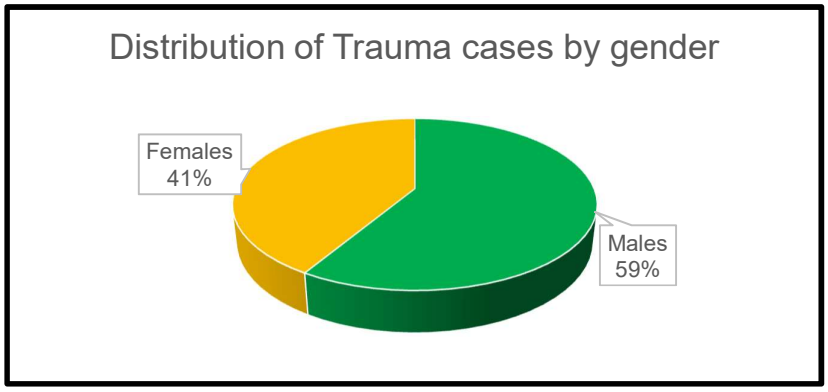
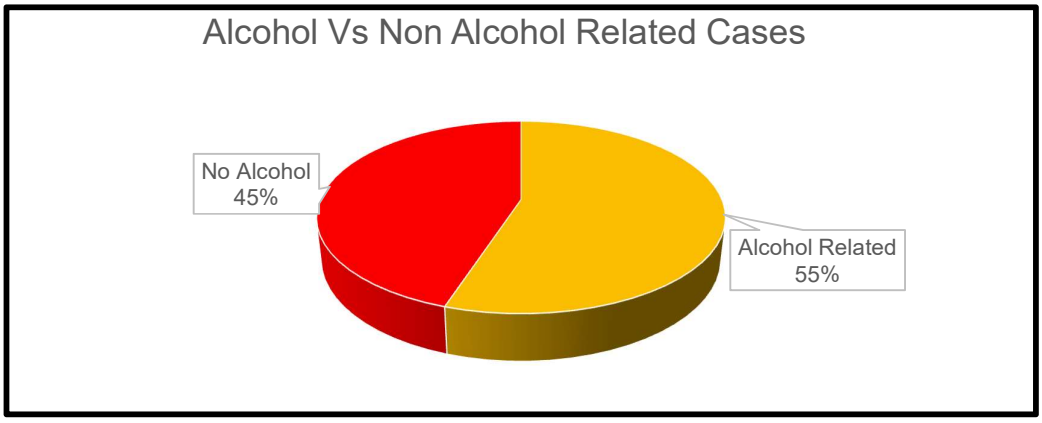


Figure 8B; Graph showing percentage of Males to Females involved in trauma cases



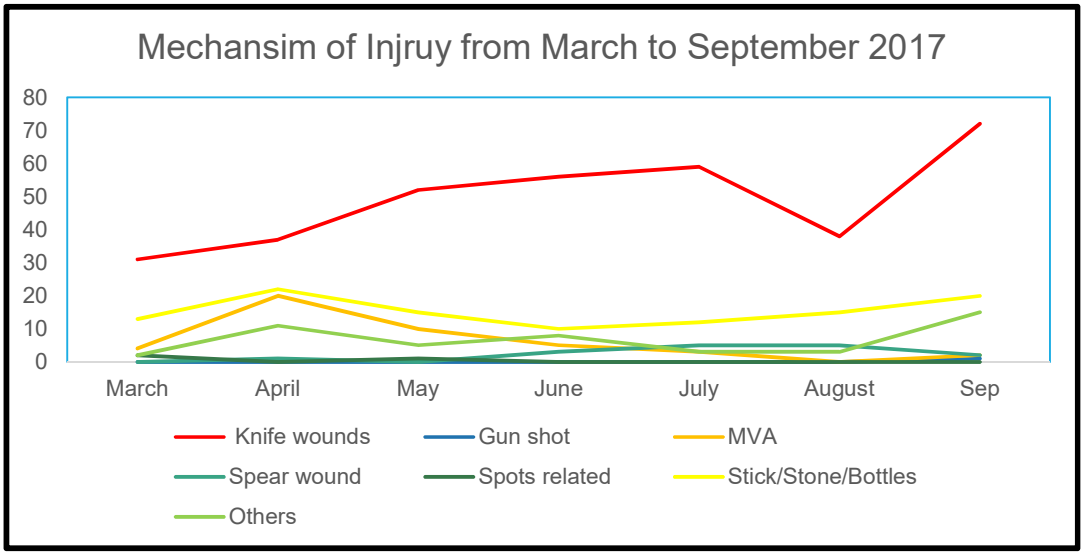
More males (59%) were involved in trauma and accidents compared to females (41%).

Figure 8C: Pie Graph Showing Alcohol Vs Non-Alcohol Related Trauma cases from March to September 2017



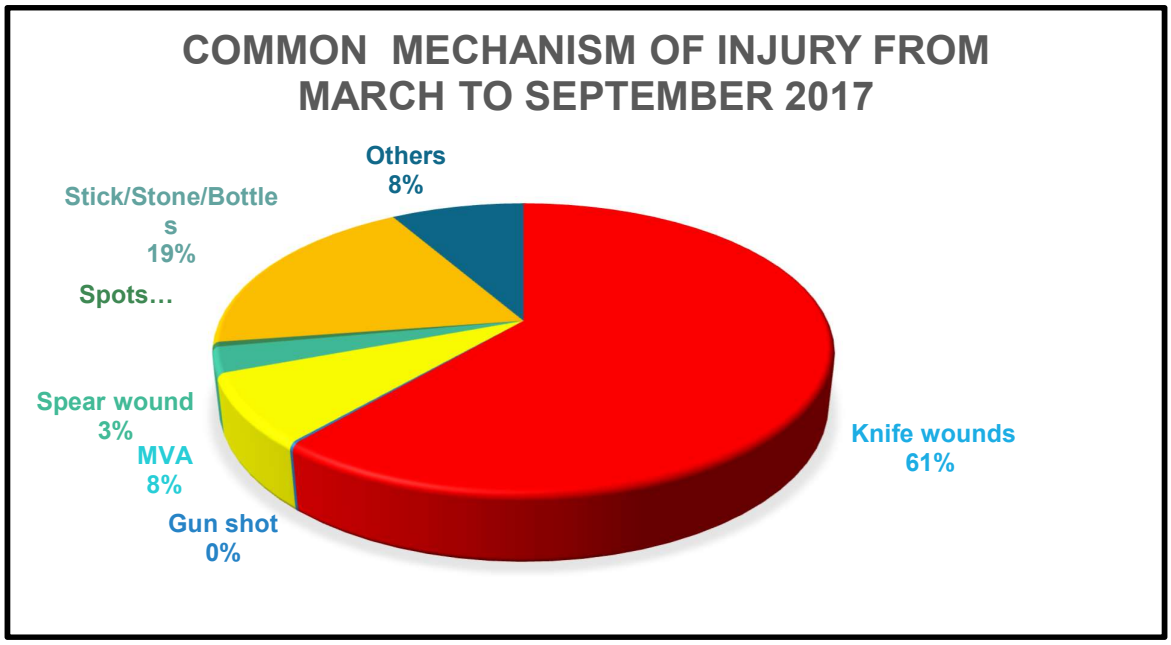
More than half (55%) of trauma cases were related to alcohol consumption.

Figure 8DI: Common Mechanism of Injury as seen from March to September 2017 at Emergency Department of East Sepik Provincial Hospital.



Knives (bush knives, grass knives and kitchen knives) were common weapons (61%) used in inflicting injury, followed by sticks, stones bottles (19%). Motor Vehicle Accident was the third common cause of injury (8%). See below figure 8DII.

Figure 8DII: Common Mechanism of trauma cases seen in 2017 March to September



Discussion of Results.

A total of 20,359 patients were seen and treated at the Outpatient and Accident and Emergency department in 2017. This turns out to be an average of 60 patients seen on a daily basis. Majority of the patients presented with new complains hence recorded as new cases, while 10% of patients were referred in from nearby health facilities. Interestingly a good number of re-attendance cases (11%) were seen a well. About half of the re-attendance cases were for repeat treatment which in my opinion we must do away with.

By gender, there was no big difference between males (52%) and females (48%). Majority of them were adult patients (61%) compared to children (39%). There is therefore, a need for a separate children's outpatient department.

About a quarter (5047) of the patients seen last year got admitted to the wards while the rest were managed and discharged at the OPD as outpatient cases. During the same period this department recorded 24 deaths in 2017.

Common conditions seen in 2017 were respiratory problems with upper respiratory infections and pneumonia (29%) topping the list followed by accidents and injuries (26%). Malaria (14%) was also the third common illness seen followed by COAD and Asthma (9%). Sexual Violence including rape cases though being lower in number, but every month in 2017, about three cases were seen.

Trauma and accidents accounted for the second common reasons for OPD/A&E visitation in 2017. There were more males (59%) than females (41%) involved in accidents or sustained injuries. More than half (55%) of the accidents and injuries were related to alcohol consumption. With the common cause of injury being knife wounds (61%) followed by common assault with sticks, stones, bottles and fists and boots. Interestingly, Motor Vehicle accidents were the third common reason for hospital visit at the Emergency in 2017.

Conclusion

The general outpatient and emergency department in 2017 manned by one Medical Officer, five HEOs, ten nursing officers and ten Community Health Workers. Total of 20,359 were seen in 2017 with a daily average of 60 patients per day. These numbers I believe are under calculated because there are times when the place is busy with limited number of staff that sometimes tallying of patient of the daily attendance is overlooked.

It is recommended that more officers be recruited to fill the staff ceiling in this department. In addition to that emphasis be placed on training a doctor from this hospital to undertake Emergency Medicine. Included in the training should be emergency nursing candidates. It is also compulsory to conduct a refresher course to all clinical staff to regards to data collection and outpatient daily attendance tally sheet.

There were more males (52%) compared to the females (48%) in general in 2017. About two thirds (61) of the cases seen were adults compared to children (31%). There is however a need for a separate COPD to see and manage the children. O&G outpatient should also be a separate unit rather than everyone overcrowding the Emergency area.

Respiratory infections and complications accounted for majority of the cases seen last year at the OPD/Emergency department. Following that were trauma and accidents (26%). Out of the trauma cases, most of the injuries were related to alcohol consumption (55%). Knife was seen as a common weapon of assault (61%) together with use of sticks, bottles and stones. As such some measures be put in place regarding alcohol consumption and purchase and ownership of knives. Carrying knives in public places apart from gardening areas should be completely banned.

Motor Vehicle Accidents cases where the third common causes of trauma and injuries, and as such, attention should be placed also on vehicle registrations and checks, including strict penalties on overloading and drink and driving as well.

Malaria was the third common disease seen in 2017. Thus emphasis be placed on awareness on usage of treated mosquito nets and keeping the homes free of mosquito breeding area should be a public health priority.

Sexual violence including rape though been low on the common types of cases seen in 2017, but an average of three (3) cases of such nature should be of concern to this province. Hence measures must be taken to control and lower the cases of sexual assault and rape.

Though the Emergency and outpatient department had some basic diagnostic tools like electrocardiography machine and defibrillator, this place is still in need of another very handy diagnostic tool, the ultrasound scan machine. Some major urgent medical conditions like pericardial effusion and temponade, ectopic pregnancies, splenic injuries and others can be diagnosed with the aid of this machine. As such it is recommended that an ultrasound machine be placed in OPD/A&E rather than in wards such and Medical wards of surgical wards.

Recommendations

In summary after what the OPD/A&E department experienced on 2017, the following recommendations are made.

1. Separation of Outpatient Departments from Accident and Emergency Department
2. Subdivision of Outpatient departments to AOPD, COPD, and GOPD
3. Recruitment of Clinical Officers (Doctors including Emergency Physician, HEOs, Nurses and CHWs) to complete the staff ceiling to increase man power to this department
4. There is a need for refresher course and training of new recruits by the medical record staff on the basis of Medical Record keeping and daily attendance tally sheet.
5. Training of specialist Emergency Physician, Emergency Nurses and others
6. Do away with **repeat treatments** especially repeat intravenous antibiotics (crystalline penicillin) and intramuscular injections.
7. The Emergency department is need of an ultrasound scan machine that is readily available for use.
8. General Awareness on the trauma statistics be carried out in Wewak Town and other districts as well.
9. Recommendations below are for law makers including Members of Parliament and law enforcers like the Police. Hence I suggest these recommendations be brought forward to proper authorities. Recommendations include;
10. Laws on the use of alcohol and alcohol related injuries be made tougher for offenders.
11. Laws on possession of knives and busk knife and other similar injuries.
12. Tougher penalties must be applied to those involved in sexual assault and rape cases as there is an increasing sexual assault case now.
13. Regular road blocks should be done to check vehicles check for road worthiness and to see if the driver is drunk or not. Safety stickers and registrations should be checked regularly as well. Overloading of vehicles is another area of concern
14. Road safety authority and the traffic should be encouraged to do this.

OPHTHALMOLOGY (OPHAL)

Manpower

Boram Hospital

1. Dr David Pahau – Specialist Medical Officer (SMO)
2. Dr Dennis Likia – Registrar, Medical Officer (MO)
3. Sr Agatha Maru – Nursing Officer (ADEC)
4. Mr Billy Micheal – Nursing Officer (ADEC)
5. Nrs Patricia Joromo – CHW OT Nurse
6. Nrs Stephannie Koriapi – CHW Eye nurse
7. Nrs Stella Asuman – CHW
8. Nrs Janet Labim – CHW
9. Nrs Jeannie Kapasingai - CHW

Provincial Health Office attachments

1. Sr Josephine Kambu – Nursing Officer (PGDEC)
2. Nrs Elizabeth Tobokom – CHW Eye Nurse (PGDEC)

Position Vacancies

Recruited 3 x CHW this year on newly created positions in Ophthalmology, they all went through the Public Service Induction course.

No vacancies available

Meetings /Continuing Education / Training

1. Mr Michael and Sr Maru attended a refresher workshop for a week in March 2017 in Madang (DWU) sponsored by Fred Hollows Foundation NZ.
2. Dr Likia spent 2 weeks in July 2017 for revision classes at The Lions Eye Resource Centre at Medical Faculty UPNG. Travel and Accommodation costs sponsored by Fred Hollows Foundation NZ.
3. Nrs Stephannie Koriapi, HEO Applonia of ESP PHO and Dr Pahau had training for 1 week in Pom in October 2016 on the Rapid Assessment of Avoidable Blindness (RAAB) Survey which was carried out across PNG in February / March 2017.

It is funded by Fred Hollows Australia and Implemented by PNG Eye Care, Brien Holden Vision Institute, University of NSW, University PNG, and National Department of Health.

Infrastructure

1. Minor OT
2. Office Space for Clinic / Consultations
3. No Eye Ward (Admitted patients in Surgical wards)
4. Store room at the Pharmacy being renovated (We allowed Dr Preston Karue (Rural Outreach Coordinator) to use that Office space.

Diagnostic Equipment

New A Scan Probe purchased by the Hospital this year

Surgical Equipment Purchased

No new surgical equipment purchased by the Hospital this year

Eye Care Sub ledger vote

Created within the Trust Account and we were able to know the amount of revenue the Eye Clinic generated for the Hospital

Word of thanks and appreciation on behalf of the East Sepik PHA Management we wish to thank the following partners in Eye Care:

1. Fred Hollows Foundation NZ, PNG Programme in Madang had been donating surgical eye consumables and eye medications to East Sepik PHA.
2. PNG Eye Care Project sponsored by RACS and a lot of help from Dr Booth & Dr Fergus, who had donated to Wewak General Hospital
3. Consumables (Tergaderms, Sterile drapes, Tapes,)
4. spare bulbs for the Scan Optics Microscope (Adelaide)
5. DAK Foundation Australia, Mr Dave Richards, Mrs Kerry Richards, Ms Marnie Richards and Joanne Taig.
6. SICS Cataract Kits from Aurolab
7. Purchased surgical instruments from Iscon Pricon (India)
8. Purchased a new power pack for the Slit Lamp at the Eye Clinic
9. Purchased spare Halogen bulbs for the Scan Optics Portable Microscope.
10. Samaritan Aviation for the support in Eye Care Services in East Sepik Province.
11. YWAM Kona - Pacific Link Donated a lot of surgical accessories, OT caps, sterile gauze, drapes etc

Weekly Activities

- ✓ Mondays – Minor Day Surgery
- ✓ Tuesday – Clinic at Boram – Post OP reviews & new cases.
- ✓ Wednesday – Clinic at Boram – New Cases & Glasses Clinic
- ✓ Thursday – Minor Day Surgery / Booked GA Cases in Main OT.
- ✓ Friday – Clinic at Boram – Post OP reviews & Review cases.

Teaching Sessions

Callan – teaching sessions during the clinic consultations and not been eventuating as due to increase in work load, and the non-availability of proper diagnostic equipment all Callan patients are referred to Boram Eye Clinic.

Clinic teachings to Eye nurses and registrar on interesting cases showing up at the Eye Clinic and CME.

Boram Hospital - Clinical Grand Rounds (All Clinical Disciplines).

Eye Clinic Statistics

New cases: 760	Review cases: 1774	(Total: 2534)
Males: 1342	Females: 1192	(Total: 2534)
Pediatric cases: 148	Adult cases: 2386	(Total: 2534)

Disease Type (New cases only)	#
Orbit (Tumour, Pthysis,Cysts)	19
Lids	8
Trachoma	0
Lacrimal	8
Conjunctivitis (Bact ,Viral, Allergic)	15
Other Conjunctival Growths (granuloma,cysts)	16
Pterygium	47
Episcleritis / Scleritis	18
Corneal Ulcer / Keratitis/ Keratopathy	81
Injuries - Blunt Trauma	53
Corneal Abrasion	26
Penetrating, Rupture	10
Corneal Laceration	1
Uveitis	13
Glaucoma	13
Lens - Cataract	252
Other Lens disorders	10
Diabetic / Hypertensive Retinopathy	15
Other Retinal / Vitreous / Maculopathy	23
Neuro Ophthalmology	15
Refractive Error (Myopia, Hyperopia, Astigmatism)	44
Presbyopia	36
Normal	29
Reviews	1774
Total	**2534**

Surgical Cases

Surgery Type	#
Orbit (growths, CA, Ex Bx)	3
Lacrimal	0
Lids laceration (Suturing)	0
Lids Chalazia (Ix &Cx)	8
Conjunctival granuloma, F/body	5
Pterygium, Pinguecula	40
Corneal / Scleral Laceration, Repair	1
Trabeculectomy	0
SICS / PCIOL	289
SICS / ACIOL	13
SICS / ICCE only	10
Post Op Hyphaema, AC reform	10
Evisceration / Enucleation	9
Others	6
Total	**394**
Males	213

Females	169
Paediatric	7
Adults	375
Local Anaesthesia	370
General Anaesthesia	12

Cancellation of OT Cases

Males	63
Females	51
Adults	114
Children < 10	0
REASONS	
Doctors being ill	24
Nurses being ill	0
Absent	50
High BP	5
Eye Infections	6
Uncooperative Patients	5
Refused	2
Other Systemic Disorders	5
Other Eye Disorders	7
Others eg no guardian	10
Total	**114**

MAJOR EYE PROGRAM SUPORTER IN PNG

Admissions

Diagnosis	Treatment	#
Cataracts (overnight only)	SICS / IOL	2
Congenital & Juvenile Cataract	SICS/Asp/IOL	2
Post Op Complications	AC formation, AC wash out	1
Eye Injuries	EUA / Repair	4
Corneal / Conjunctival	Excision	3
Endophthalmitis / Chronic ACG	Eviseration	5
Intraocular tumours / ruptured globe	Enucleation	2
Childhood Blindness	EUA / Fundoscopy	0
Lacrimal	Probing & Syringing / DCR	0
Glaucoma	ICCE / PI/ Aphakia	0
Orbital (cysts), Tumors	Excision / Exernteration	3
Squint	Squint Surgery	2
Other periorbital Cellulitis	Conservative, IV antibiotics	1
Congenital Glaucoma	Trabeculectomy	0
Head Injury, F/ body/Brain Abscess/ Hemiplegia	Removal, Conservative A/biotics, Mortality	1
Total		**26**

Remarks

As seen from the surgical statistics there were 50 cases cancelled because they were absent from their appointed surgery dates. Transport costs may be the main factor even though they had come earlier for consultations. The next cause of cancellation was OT days where a doctor was ill so cases got cancelled but were rebooked again to another surgery day which they had surgery done eventually.

There was 1 death of a child who fell from a height and landed on a wood which entered his left orbit and into the brain causing primary brain tissue damage, he had EUA, left enucleation done with a large foreign body (piece of wood) removed. He had right sided hemiplegia and was covered on antibiotics, he had continues spiking temperatures and became too sick with reduced consciousness, it is highly likely he had a brain abscess. He passed away into his second week of admission. A CT scan would help to know the extent of damage intra cranially.

Due to the lack of drugs / supplies at the hospital we suspended surgeries for 2 months (June and July 2017).

The reduced number of admissions as seen from the statistics is because of the renovation process of the surgical wards until its opening and there is very limited space for admissions.

Surgery fees are Minor (K15) & Major (K50) like Cataract.

Note: Old poor blind patients had to be done for ½ the price (K25.00) or free as we can't send a treatable blind person away. We have never sent a blind patient away.

Outreach Visits in 2017

These are outreaches done by our Wewak Eye Team in partnerships with other Eye Teams.

Youth with a Mission (YWAM) Medical Ships Kona (USA)

East Sepik Province Outreach (November 2016 – February 2017)

Sponsored by East Sepik Provincial Administration & Partners to YWAM Kona Pacific Link, DTS teams, Samaritan Aviation etc…

Wewak District:

1. Wewak Town,
2. Walis,
3. Tarawai,
4. Karasau,
5. Kairiru,
6. Mushu
7. Uwo

Angoram District:

1. Timbunke,
2. Kanduanum,
3. Moim,
4. Kambaramba,
5. Angoram,
6. Marienberg,
7. Amuk,
8. Singirin,
9. Murik Lakes & Kopar

Other work done by clinic was

Total consultations	**5712**
Total reading glasses dispensed	3492
Total Distance glasses dispensed	941
Total eye surgeries performed	217

External visits done in 2017

Madang Hospital – Madang Province (12/06/17 – 26/06/17)

Sponsored by Fred Hollows Foundation

Consultations – 240

Surgeries – 30

International visits by SMO

Santo – Vanuatu (02/07/17 – 08/07/17)

Fred Hollows Foundation (NZ) & Pacific Eye Institute (Suva Figi) Sponsored. Invitation for Dr Pahau to join the team.

Vanuatu Ministry of Health

Consultations – 250+

Surgery – 100

Other National visits

Madang Hospital – Madang Province (28/08/17 – 02/09/17)

Sponsored by Fred Hollows Foundation

Consultations – 373

Surgery – 79

Rabaul Hospital – East New Britain Province (03/09/17 – 14/09/17)

Sponsored by Fred Hollows Foundation (NZ) & Pacific Eye Institute (Suva Fiji) .Invitation for Dr Pahau to join the team.

East New Britain PHA

Consultations – 600

Surgery – 169

Vanimo – West Sepik Province (23/10/17 – 06/11/17)

Fred Hollows Foundation (NZ) & West Sepik PHA Sponsored. Invitation for Dr Pahau to join the team

Consultations – 662

Surgery – 137

Aitape Raihu Hospital – Sandaun Province (19/11/17 – 27/11/17)

Sponsored by West Sepik PHA

Consultations – 204

Surgery – 70

Kavieng Hospital – New Ireland Province (20/11/1 – 03/10/16)

Sponsored by Fred Hollows Foundation NZ, CBM Goroka, New Ireland Provincial Government and New Ireland PHA.

Dr Pahau & Dr Likia with FHF Madang Team.

Consultations – 734

Surgeries – 127

Further clinical outreach could not be pursued due to funding constraints from our government's after exhausting funding from the donor source (Fred Hollows Foundation NZ) We also provided outreach services with the assistance from East Sepik Province that was paid to YWAM. This was earlier in January 2017.

Staff Training 2017

There were no new candidates from East Sepik sent for the Advanced Diploma in Eye Care training this year at Divine Word University under the Fred Hollows Foundation sponsorship.

Dr Dennis Likia is working as a training registrar and successfully passed his Diploma in Ophthalmology in 2016 and is already a very competent SICS surgeon at his level of training. He has completed his MMed Part 1 this year and will continue his MMed Part 2 in Pom in 2018. Thanks to Fred Hollows Foundation NZ who had sponsored his travel expenses to be in Port Moresby and for the Revision Classes and the duration of the Final MMed 1 Exams.

Problems encountered in 2017

Due to the financial crises across the country in 2017 all government agencies were affected with reduced funding.

On some instances we scaled down services in all sections due to lack of supplies and essential drugs and only attended to emergencies.

The renovation process in the surgical wards is also a factor with very limited admissions due to beds available in the surgical wards.

This will show by the reduced number of Admissions in 2017.

We had problems with the Air Condition at the Eye Clinic and had to scale down services for a short while. Our air condition had been serviced and reinstalled.

General Observation so far

No Eye ward as yet and so patients from far are admitted to the Surgical wards if space is available and they can stay after surgery and be discharged the next day. The patients are normally done under Local Anaesthesia so the relatives can look after them as we don't have nurses to look after them. Patients done under General Anaesthesia are still kept in the new surgical wards.

Most old patients find it difficult to come to Wewak, is it the lack of awareness? Is it transport difficulties? Is it financial constraints? As shown by the statistics, less surgery (10 – 12 cases per week) is done here at the Hospital compared to surgery on outreach about 20+cases per day .Thus we have to deliver services to the rural population meaning more outreach visits. I believe that is the way on service delivery in line with the National Health Plan.

Recommendations

We thank the East Sepik Provincial Administration for

the funding support in the past years for outreach programs.

With East Sepik Provincial Health Authority being launched in October 2017. We should plan to do a lot of Outreaches as we deliver to the rural majority.

We have Callan Disabled Services based here in Wewak and the need for us to work closely in partnership with them. Maprik Callan Services do most screening & awareness in the Central Sepik area and have booked cases listed and awaiting surgery by our team. Support has to be given to them as well from the District Administration and even at the LLG level.

Callan SERC Wewak and Maprik seem to be having similar funding constraints and need more support from Callan Services National Unit (CSNU).

Improvement of the Rural Health Centre Facilities with regards to the availability of electricity as the Optical Microscopes is very expensive and any electrical failure would be very costly for the equipment if it needs repairs. Adequate water supply for use during surgery.

Several Health Centres in the ESP were not operating to full capacity and planned trips had to be cancelled. A setback for rural health service delivery. The ESP PHA and Districts Administrations certainly has a big task ahead to sort these infrastructures. Most Church Health services are really delivering Health Care to the rural majority.

Improvements in the outreach trip logistics organizing in 2018. Plans to do outreaches to Yangoru / Sassoya District, Ambunti / Drekikir District, Wosera / Gawi District and Maprik District. Work closely with District Administrators and DDA's as partners including Samaritan Aviation.

Continue to support West Sepik Provincial Health Authority to continue to deliver Eye Care services to the remote districts of the Sandaun Province. The Sandaun PHA has to purchase eye surgical consumables for use in Sandaun Outreaches.

Thanks to DAK Foundation Australia for your continuous support as well in terms of funding support for surgical consumables and equipment for East Sepik PHA.

We sincerely thank the Visiting Australian Eye teams had donated a lot of consumables to East Sepik PHA that had enabled us to be able to use these supplies on our outreaches. But certainly donated supplies will run out, the hospital needs to buy eye surgical consumables which are not available at the NDoH Pharmaceuticals.

Thanks to Samaritan Aviation as well for their support to the delivery of Eye Care Services in East Sepik Province.

East Sepik PHA provides the Specialist Eye Care Services and we charge K50 for cataract surgery here at the hospital and certainly we can't charge that fee on rural outreach as most old people can't afford and the fees will scare them away. However we have not sent any poor blind patients away they are done free of charge.

I would like to formally thank the East Sepik PHA CEO Mr Mark Mauludu & the Management for the continued support in Eye Care for the people of East Sepik, West Sepik and other Provinces in PNG.

Also extending our help to our smaller Pacific Countries together with our other partners as we help the Blind to see again.

Lastly thanks to our staff: Dr Dennis Likia, Sr Agatha Maru, Mr Billy Micheal, Nrs Patricia Jaromo, Nrs Stephannie Koriapi, Nrs Stella Asuman, Nrs Janet Labim, Nrs Jeanie Kapasingai, for the hard work you have done in the provision of Eye Care Services in ESP and the other Provinces as well.

Also to our 2 nurses from former PHO Sr Josephine Kambu and Nrs Elizabeth Tabokom.

<u>Planning 2017</u>

- Need for a bigger space for the Eye Clinic & Minor Eye Theater
- Need for a Yag Laser, New Surgical Instrument sets.
- Sustainable Cataract Consumables Supply

- Sustainable Readymade Glasses Order that is sustainable
- More Rural Outreach Patrols
- School Screenings
- Training more Primary Eye Nurses
- Need for an Eye Ward

The way forward

Continued support from East Sepik PHA Management

With the National Blindness Prevention Committee in place hopefully we see a difference in the delivery of Eye Care service delivery in PNG in 2018 and beyond.

Joint partnership with other NGO's (e.g...Callan, PNG Eye Care Project, DAK Foundation Australia, Fred Hollows Foundation NZ, Christian Blind Mission, PNG Eye Care, involvement of International Agency for Prevention of Blindness (IAPB) and other Eye Care Service Providers to effectively implement the Vision 2020 Motto and Advocacy.

Continuous support from the East and West PHA with regards to funding as we have to take ownership of health programs and promote delivery of rural health care.

National Department of Health Budgeting / Funding Eye Services at the National level.

SURGICAL UNIT

Introduction

Providing the best surgical services in any place that is of the expected standard is quiet difficult at times. More so very difficult in the poor resource setting countries and places. Wewak has its share of problems and given the extreme of settings the surgical unit faces during the course of providing the much needed services. The surgical team of Wewak General Hospital has managed to provide the necessary and much needed surgical treatment despite the difficulties. It has been a tough year for all of us in the team. It has been more challenging for us also was due to the fact that our 4 wards were under rebuilding and we were providing full services using the 2 paediatric wards. In order to maintain a good turn-over rate for the patients theatre usage was on a daily bases.

We eventually moved in to the new wards in June 2017. Despite the limited bed spaces service was continued as our normal routine.

New Surgical Suit.

Following services were provided.

- ✓ Admissions and ward management of cases
- ✓ Providing surgical interventions
- ✓ Providing surgical consultation clinic
- ✓ Covering and reviewing of general outpatient cases.
- ✓ Reviewing consults from other colleagues with in the hospital
- ✓ Teaching ward rounds
- ✓ Daily ward rounds
- ✓ Surgical rural outreach carried not done due to non-availability of funds.

Staff	Current	Required	Better
Surgeon	1	2	3
Registrars	2	3	4
HEO	-	1	2
RMOs	-	2	3
RHEOs	1	3	3
Nursing officers	11	13	15
CHWs	10	15	20
Ward clerk	1	1	1
Ward Hygiene Officer	1	2	3

Surgical team ready for Friday Morning ward rounds.

Surgical Unit is the first unit to utilise the newly constructed infrastructure under this hospital rehabilitation and redevelopment program. Thanks to CEO and the Government of Papua New Guinea under the Prime Ministership of Peter O'Neil.

WARD 2A	**10 BEDS**
WARD 2B	**10 BEDS**
WARD 2C	**10 BEDS**
WARD 2D	**10 BEDS**

Ward 2A serves as Intensive Care Unit for Surgical patients requiring hourly observations or those on 4th hourly observations under full nursing care. Very critically ill patients are also nursed there.

2B serves as recovery unit with 10 bed space. It mostly caters for stable and dirty cases. On 4th hourly observations with full nursing care.

2C serves as orthopaedic unit with 10 bed space and caters for mostly clean cases. Most are stable on BD observations with full nursing care.

2D serves as palliative unit with 10 bed space mostly for cancer patients, and very dirty wounds. Eye patients and those awaiting to go home also transit in that ward. Full nursing care and BD observations also applies in that ward.

Total of 40 beds and most times the beds are always full.

Staff shortage is a major issue in the surgical unit. It costs a lot for the team providing a full 24 hours coverage. Even though we have reached our full staff strength we still have shortages ,when staff fall sick, go on recreation leave or some don't turn up for work.

Medical cover is always provided for full 24 hours and 7 days. Resident HEOs mostly on call together with the registrars and never allowed on their own.

Nursing cover is a major issue as most times all rostered for the shift do not turn up due to various reasons.

Surgical Audit

	Jan	Feb	March	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Total	%
Total admissions	71	77	85	101	104	110	112	122	108	92	100	66	1148	
Total discharges	68	75	82	93	100	103	109	118	104	82	89	58	1081	95%
Trauma	43	43	46	63	60	68	72	64	65	50	75	42	691	60%
Non trauma	28	34	39	38	44	42	40	59	43	42	25	26	460	40%
Total deaths	2	1	1	5	3	2	1	1	2	6	3	3	30	3%
Expected	2	1	1	5	2	1	-	1	1	4	3	3	24	80%
Unexpected	-	-	-	-	1	1	1	-	1	2	-	-	6	20%
Transfers out of province	-	-	1(POM)		1(POM)	-	-	-	1	-	1 (Pom)	-	4	0.3%
Transfers out of ward	-	-	-	-	2	-	-	-	-	-	-	-	2	0.2%
Referral in	18	13	15	20	13	34	25	24	23	25	43	6	259	23%
Absconds	-	1	-	2	-	2	1	2	-	1	2	1	12	1%

Leaving at own risk	1	-	1	-	-	3	1	1	1	3	3	1	15	1.3%
Still in the ward	-	-	-	1	-	-	-	-	-	-	-	3	3	0.3%
No record	-	-	-	-	-	-	-	-	1	-	2	-	3	0.3%

Table 1: Ward situation 2017

CANCER ADMISSIONS TO THE SURGICAL WARD FOR 2017

	Jan	**Feb**	**Mar**	**April**	**May**	**June**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total**
Total	**9**	**12**	**9**	**7**	**10**	**8**	**8**	**7**	**7**	**6**	**8**	**6**	**97**
Cancers													
Breast	1	1	1	1	1	4	1	2	2	3	4	2	23
Mouth /palate/tongue	2	5	4	1	3	1	2	2	-	1	1	-	22
Anal/Colorectal	2	2	2	2	1	2	-	1	1	-	1	1	15
Larynx	-	1	2	-	-	1	1	-	-	1	-	-	5
Penis	1	1	-	-	-	-	-	-	-	-	-	-	2
SCC hand/ limbs	2	-	-	-	-	-	1	1	-	-	-	-	4
Brain (SOL)	-	-	-	-	2	-	-	-	-	-	-	-	2
Bowel /gastric	-	-	-	3	-	-	2	-	2	-	1	1	9

Table showing the common causes of Deaths by diagnosis for 2017

Diagnosis	Expected	Unexpected	Total
Cancer	9	-	9
Severe head injury	6	-	6
Moderate head injury	-	-	-

Sepsis with MOF	7	1	8
Chest injury fail chest	-	2	2
MVA ?pulmonary embolism	1	2	3
High C-spine injury	1		1
MVA multiple injury	1		1
Total	25	5	30

CATERGORY	Jan	Feb	Mar	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Total
Total													
ORTHOPEDIC	**14**	**22**	**21**	**32**	**34**	**30**	**29**	**23**	**22**	**19**	**32**	**13**	**291**
FRACTURES	12	17	16	22	27	20	21	20	20	17	25	9	226
Dislocations		1		3	1	4	1	-	-	-	1	1	12
Amputations		1	1	1	-	1	-	-	1	-	6	1	12
Cut tendons		2		1	-	2	-	-	-	-	-	-	5
Spinal injuries	1		2		1	2	5	1	-	1	-	-	13
C –spine injury	1			1	1	-	1	1	-	1	-	1	7
Congenital/Talipes				2	2	-	-	1	-	-	-	-	5
Implants in-situ		1	1	-	-	-	-	-	1	-	-	1	4
Fracture pelvis			1	2	2	1	1	-	-	-	-	-	7
Neurology associated with fractures	**4**	**5**	**3**	**12**	**5**	**9**	**6**	**4**	**8**	**3**	**5**	**5**	**69**
Head injuries mild	2	3	-	7	2	7	4	2	1	1	2	1	32
Moderate	1	2	1	2	1	2	2	1	3	-	3	1	19
Severe	1		2	3	1		-	1	4	2	-	3	17
Meningoencephalocel					1		-	-	-	-	-		1
GIT	**12**	**11**	**19**	**22**	**23**	**23**	**22**	**22**	**23**	**25**	**9**	**15**	
Acute abdomen	9	8	14	17	11	18	7	13	14	11	6	12	140
Splenic injuries	1	1	-	2	2	-	3	2	-	1	1	2	15
Acute Cholecystitis	-	1	-	-	1	-			-	1	-	-	3
Imperforated anus													
Epigastric mass													
Prolapsed thrombosed piles		1			1	1		1					4
VVF/RVF with colostomy												1	1
Philonodal Sinus													
Obstructive jaundice			1										1

Foreign body in the esophagus							1						1
Millary TB					1								1
Hernias	**2**	**-**	**4**	**3**	**7**	**4**	**11**	**6**	**7**	**12**	**2**	**-**	**58**
RIH	1		1	1	2	4	6	3	3	8	1	-	30
LIH			2	2	5		3	3	2	3	1	-	21
Epigastric							1		1	1	-	-	3
Umbilical	1		1				1		1				4
Rectal injury									2				2
Urology	**3**	**2**											
BPH with Cystitis	2			1		2			2		1	1	9
Fournier's gangrene	1			1				1					3
Fibrosed foreskin							1	2					3
Urethral stricture										1	1		2
Testicular tumour/mass		1											1
Cancer prostate													
Uncircumcised				1									1
UTI													
Orchitis													
Phymosis/Paraphymosis		1											1
Cystitis								1					1
Scrotal laceration /bleeding post home circumcision						1			1				2
Pyelonephritis				1			1						2
Severed ureter													
Neurogenic													
Penile ulcer							1						1
Cystolithiasis							1	1	1				3
Kidney injury							1						1
Cardiothoracic	**3**	**2**	**3**	**4**	**5**	**6**	**2**	**2**	**4**	**6**	**10**	**1**	

Haemopneumothorax	3	2	3	3	4	4	2	2	4	6	7	1	41
Multiple fractured ribs				1	1	2					3		7
Pericardial effusion													
ENT/Head & Neck	**1**	**2**	**4**		**2**	**2**		**4**	**1**		**1**		**17**
Foreign body nose/ear		1	3			1		3			1		9
Thyroid mass						1							1
Submandibular cyst			1						1				2
Tonsillitis	1												1
Laryngitis		1											1
Angiofibroma					1								1
Nasal polyp					1			1					2
Burns	**1**		**1**	**3**	**1**	**2**		**4**	**4**	**1**	**2**	**2**	**21**
Fire				2	1	1			1		1		6
Hot water	1		1					1		1		1	5
Oil													
Petrol									3		1	1	5
Burns contracture			1	1		1		3					6
Bomb blast	1												1
Lumps & Bumps	1	3	2		4		1	7	2	1	1		22
Infections /abscess	3	6	9	4	6	13	5	11	13	6	8	5	89
Osteomyelitis	-			1	1	1		1	2	2		1	9
Lacerations /STI/spear wounds /BKW/GSW/MVA	18	10	13	9	12	12	25	23	21	17	20	14	194
Animal bite	**-**	**1**		**1**			**1**		**1**	**1**			
Pig		1		1			1		1	1			5
Human bite													
MBU	1	1		1			1	1	1			1	7
Diabetes sepsis				1	1		2	1	2	1	2		10
No Diagnosis									1				1

CATERGORY	Jan	Feb	Mar	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Total
Total													
ORTHOPEDIC	**14**	**22**	**21**	**32**	**34**	**30**	**29**	**23**	**22**	**19**	**32**	**13**	**291**
FRACTURES	12	17	16	22	27	20	21	20	20	17	25	9	226
Dislocations		1		3	1	4	1	-	-	-	1	1	12
Amputations		1	1	1	-	1	-	-	1	-	6	1	12
Cut tendons		2		1	-	2	-	-	-	-	-	-	5
Spinal injuries	1		2		1	2	5	1	-	1	-	-	13
C –spine injury	1			1	1	-	1	1	-	1	-	1	7
Congenital/Talipes				2	2	-	-	1	-	-	-	-	5
Implants in-situ		1	1	-	-	-	-	-	1	-	-	1	4
Fracture pelvis			1	2	2	1	1	-	-	-	-	-	7
Neurology associated with fractures	**4**	**5**	**3**	**12**	**5**	**9**	**6**	**4**	**8**	**3**	**5**	**5**	**69**
Head injuries mild	2	3	-	7	2	7	4	2	1	1	2	1	32
Moderate	1	2	1	2	1	2	2	1	3	-	3	1	19
Severe	1		2	3	1		-	1	4	2	-	3	17
Meningoencephalocel					1		-	-	-	-	-		1
GIT	**12**	**11**	**19**	**22**	**23**	**23**	**22**	**22**	**23**	**25**	**9**	**15**	
Acute abdomen	9	8	14	17	11	18	7	13	14	11	6	12	140
Splenic injuries	1	1	-	2	2	-	3	2	-	1	1	2	15
Acute Cholecystitis	-	1	-	-	1	-			-	1	-	-	3
Imperforated anus													
Epigastric mass													
Prolapsed thrombosed piles		1			1	1		1					4
VVF/RVF with colostomy												1	1
Philonodal Sinus													
Obstructive jaundice			1										1

Foreign body in the esophagus							1						1
Millary TB					1								1
Hernias	**2**	**-**	**4**	**3**	**7**	**4**	**11**	**6**	**7**	**12**	**2**	**-**	**58**
RIH	1		1	1	2	4	6	3	3	8	1	-	30
LIH			2	2	5		3	3	2	3	1	-	21
Epigastric							1		1	1	-	-	3
Umbilical	1		1				1		1				4
Rectal injury									2				2
Urology	**3**	**2**											
BPH with Cystitis	2			1		2			2		1	1	9
Fournier's gangrene	1			1				1					3
Fibrosed foreskin							1	2					3
Urethral stricture										1	1		2
Testicular tumour/mass		1											1
Cancer prostate													
Uncircumcised				1									1
UTI													
Orchitis													
Phymosis/Paraphymosis		1											1
Cystitis								1					1
Scrotal laceration /bleeding post home circumcision						1			1				2
Pyelonephritis				1			1						2
Severed ureter													
Neurogenic													
Penile ulcer							1						1
Cystolithiasis							1	1	1				3
Kidney injury							1						1
Cardiothoracic	**3**	**2**	**3**	**4**	**5**	**6**	**2**	**2**	**4**	**6**	**10**	**1**	

Haemopneumothorax	3	2	3	3	4	4	2	2	4	6	7	1	41
Multiple fractured ribs				1	1	2					3		7
Pericardial effusion													
ENT/Head & Neck	**1**	**2**	**4**		**2**	**2**		**4**	**1**		**1**		**17**
Foreign body nose/ear		1	3			1		3			1		9
Thyroid mass						1							1
Submandibular cyst			1						1				2
Tonsillitis	1												1
Laryngitis		1											1
Angiofibroma					1								1
Nasal polyp					1			1					2
Burns	**1**		**1**	**3**	**1**	**2**		**4**	**4**	**1**	**2**	**2**	**21**
Fire				2	1	1			1		1		6
Hot water	1		1					1		1		1	5
Oil													
Petrol									3		1	1	5
Burns contracture			1	1		1		3					6
Bomb blast	1												1
Lumps & Bumps	1	3	2		4		1	7	2	1	1		22
Infections /abscess	3	6	9	4	6	13	5	11	13	6	8	5	89
Osteomyelitis	-			1	1	1		1	2	2		1	9
Lacerations /STI/spear wounds /BKW/GSW/MVA	18	10	13	9	12	12	25	23	21	17	20	14	194
Animal bite	**-**	**1**		**1**			**1**		**1**	**1**			
Pig		1		1			1		1	1			5
Human bite													
MBU	1	1		1			1	1	1			1	7
Diabetes sepsis				1	1		2	1	2	1	2		10
No Diagnosis									1				1

CATERGORY	Jan	Feb	Mar	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Total
Total													
ORTHOPEDIC	**14**	**22**	**21**	**32**	**34**	**30**	**29**	**23**	**22**	**19**	**32**	**13**	**291**
FRACTURES	12	17	16	22	27	20	21	20	20	17	25	9	226
Dislocations		1		3	1	4	1	-	-	-	1	1	12
Amputations		1	1	1	-	1	-	-	1	-	6	1	12
Cut tendons		2		1	-	2	-	-	-	-	-	-	5
Spinal injuries	1		2		1	2	5	1	-	1	-	-	13
C –spine injury	1			1	1	-	1	1	-	1	-	1	7
Congenital/Talipes				2	2	-	-	1	-	-	-	-	5
Implants in-situ		1	1	-	-	-	-	-	1	-	-	1	4
Fracture pelvis			1	2	2	1	1	-	-	-	-	-	7
Neurology associated with fractures	**4**	**5**	**3**	**12**	**5**	**9**	**6**	**4**	**8**	**3**	**5**	**5**	**69**
Head injuries mild	2	3	-	7	2	7	4	2	1	1	2	1	32
Moderate	1	2	1	2	1	2	2	1	3	-	3	1	19
Severe	1		2	3	1		-	1	4	2	-	3	17
Meningoencephalocel					1		-	-	-	-	-		1
GIT	**12**	**11**	**19**	**22**	**23**	**23**	**22**	**22**	**23**	**25**	**9**	**15**	
Acute abdomen	9	8	14	17	11	18	7	13	14	11	6	12	140
Splenic injuries	1	1	-	2	2	-	3	2	-	1	1	2	15
Acute Cholecystitis	-	1	-	-	1	-			-	1	-	-	3
Imperforated anus													
Epigastric mass													
Prolapsed thrombosed piles		1			1	1		1					4
VVF/RVF with colostomy												1	1
Philonodal Sinus													
Obstructive jaundice			1										1

Foreign body in the esophagus							1						1
Millary TB					1								1
Hernias	**2**	**-**	**4**	**3**	**7**	**4**	**11**	**6**	**7**	**12**	**2**	**-**	**58**
RIH	1		1	1	2	4	6	3	3	8	1	-	30
LIH			2	2	5		3	3	2	3	1	-	21
Epigastric							1		1	1	-	-	3
Umbilical	1		1				1		1				4
Rectal injury									2				2
Urology	**3**	**2**											
BPH with Cystitis	2			1		2			2		1	1	9
Fournier's gangrene	1			1				1					3
Fibrosed foreskin							1	2					3
Urethral stricture										1	1		2
Testicular tumour/mass		1											1
Cancer prostate													
Uncircumcised				1									1
UTI													
Orchitis													
Phymosis/Paraphymosis		1											1
Cystitis								1					1
Scrotal laceration /bleeding post home circumcision						1			1				2
Pyelonephritis				1			1						2
Severed ureter													
Neurogenic													
Penile ulcer							1						1
Cystolithiasis							1	1	1				3
Kidney injury							1						1
Cardiothoracic	**3**	**2**	**3**	**4**	**5**	**6**	**2**	**2**	**4**	**6**	**10**	**1**	

Haemopneumothorax	3	2	3	3	4	4	2	2	4	6	7	1	41
Multiple fractured ribs				1	1	2					3		7
Pericardial effusion													
ENT/Head & Neck	**1**	**2**	**4**		**2**	**2**		**4**	**1**		**1**		**17**
Foreign body nose/ear		1	3			1		3			1		9
Thyroid mass						1							1
Submandibular cyst			1						1				2
Tonsillitis	1												1
Laryngitis		1											1
Angiofibroma					1								1
Nasal polyp					1			1					2
Burns	**1**		**1**	**3**	**1**	**2**		**4**	**4**	**1**	**2**	**2**	**21**
Fire				2	1	1			1		1		6
Hot water	1		1					1		1		1	5
Oil													
Petrol									3		1	1	5
Burns contracture			1	1		1		3					6
Bomb blast	1												1
Lumps & Bumps	1	3	2		4		1	7	2	1	1		22
Infections /abscess	3	6	9	4	6	13	5	11	13	6	8	5	89
Osteomyelitis	-			1	1	1		1	2	2		1	9
Lacerations /STI/spear wounds /BKW/GSW/MVA	18	10	13	9	12	12	25	23	21	17	20	14	194
Animal bite	**-**	**1**		**1**			**1**		**1**	**1**			
Pig		1		1			1		1	1			5
Human bite													
MBU	1	1		1			1	1	1			1	7
Diabetes sepsis				1	1		2	1	2	1	2		10
No Diagnosis									1				1

CATERGORY	Jan	Feb	Mar	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Total
Total													
ORTHOPEDIC	**14**	**22**	**21**	**32**	**34**	**30**	**29**	**23**	**22**	**19**	**32**	**13**	**291**
FRACTURES	12	17	16	22	27	20	21	20	20	17	25	9	226
Dislocations		1		3	1	4	1	-	-	-	1	1	12
Amputations		1	1	1	-	1	-	-	1	-	6	1	12
Cut tendons		2		1	-	2	-	-	-	-	-	-	5
Spinal injuries	1		2		1	2	5	1	-	1	-	-	13
C –spine injury	1			1	1	-	1	1	-	1	-	1	7
Congenital/Talipes				2	2	-	-	1	-	-	-	-	5
Implants in-situ		1	1	-	-	-	-	-	1	-	-	1	4
Fracture pelvis			1	2	2	1	1	-	-	-	-	-	7
Neurology associated with fractures	**4**	**5**	**3**	**12**	**5**	**9**	**6**	**4**	**8**	**3**	**5**	**5**	**69**
Head injuries mild	2	3	-	7	2	7	4	2	1	1	2	1	32
Moderate	1	2	1	2	1	2	2	1	3	-	3	1	19
Severe	1		2	3	1		-	1	4	2	-	3	17
Meningoencephalocel					1		-	-	-	-	-		1
GIT	**12**	**11**	**19**	**22**	**23**	**23**	**22**	**22**	**23**	**25**	**9**	**15**	
Acute abdomen	9	8	14	17	11	18	7	13	14	11	6	12	140
Splenic injuries	1	1	-	2	2	-	3	2	-	1	1	2	15
Acute Cholecystitis	-	1	-	-	1	-			-	1	-	-	3
Imperforated anus													
Epigastric mass													
Prolapsed thrombosed piles		1			1	1		1					4
VVF/RVF with colostomy												1	1
Philonodal Sinus													
Obstructive jaundice			1										1

Foreign body in the esophagus							1						1
Millary TB					1								1
Hernias	**2**	**-**	**4**	**3**	**7**	**4**	**11**	**6**	**7**	**12**	**2**	**-**	**58**
RIH	1		1	1	2	4	6	3	3	8	1	-	30
LIH			2	2	5		3	3	2	3	1	-	21
Epigastric							1		1	1	-	-	3
Umbilical	1		1				1		1				4
Rectal injury									2				2
Urology	**3**	**2**											
BPH with Cystitis	2			1		2			2		1	1	9
Fournier's gangrene	1			1				1					3
Fibrosed foreskin							1	2					3
Urethral stricture										1	1		2
Testicular tumour/mass		1											1
Cancer prostate													
Uncircumcised				1									1
UTI													
Orchitis													
Phymosis/Paraphymosis		1											1
Cystitis								1					1
Scrotal laceration /bleeding post home circumcision						1			1				2
Pyelonephritis				1			1						2
Severed ureter													
Neurogenic													
Penile ulcer							1						1
Cystolithiasis							1	1	1				3
Kidney injury							1						1
Cardiothoracic	**3**	**2**	**3**	**4**	**5**	**6**	**2**	**2**	**4**	**6**	**10**	**1**	

Haemopneumothorax	3	2	3	3	4	4	2	2	4	6	7	1	41
Multiple fractured ribs				1	1	2					3		7
Pericardial effusion													
ENT/Head & Neck	**1**	**2**	**4**		**2**	**2**		**4**	**1**		**1**		**17**
Foreign body nose/ear		1	3			1		3			1		9
Thyroid mass						1							1
Submandibular cyst			1						1				2
Tonsillitis	1												1
Laryngitis		1											1
Angiofibroma					1								1
Nasal polyp					1			1					2
Burns	**1**		**1**	**3**	**1**	**2**		**4**	**4**	**1**	**2**	**2**	**21**
Fire				2	1	1			1		1		6
Hot water	1		1					1		1		1	5
Oil													
Petrol									3		1	1	5
Burns contracture			1	1		1		3					6
Bomb blast	1												1
Lumps & Bumps	1	3	2		4		1	7	2	1	1		22
Infections /abscess	3	6	9	4	6	13	5	11	13	6	8	5	89
Osteomyelitis	-			1	1	1		1	2	2		1	9
Lacerations /STI/spear wounds /BKW/GSW/MVA	18	10	13	9	12	12	25	23	21	17	20	14	194
Animal bite	**-**	**1**		**1**			**1**		**1**	**1**			
Pig		1		1			1		1	1			5
Human bite													
MBU	1	1		1			1	1	1			1	7
Diabetes sepsis				1	1		2	1	2	1	2		10
No Diagnosis									1				1

Theatre cases

Entrance to the main operating theatre of Wewak General Hospital

Surgical team at work. It is a team work.

Operations done 2017

Types	Jan	Feb	Mar	April	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total	%
Major	14	21	28	28	22	37	37	47	35	26	32	19	346	41%
Minor	36	30	45	31	53	36	39	72	43	36	39	28	488	59%
Elective	9	20	23	15	17	22	30	59	28	21	27	12	283	34%
Emergency	41	31	50	44	58	51	46	60	50	41	44	35	551	66%

Trauma	34	28	39	35	53	44	55	69	49	34	57	35	532	64%
Non trauma	16	23	34	24	22	29	21	50	29	28	14	12	302	36%
Total	50	51	73	59	75	73	76	119	78	62	71	47	834	100 %

Operations	Jan	Feb	Mar	April	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Total
Total	**50**	**51**	**73**	**59**	**75**	**73**	**76**	**119**	**78**	**62**	**71**	**47**	**834**
Orthopaedics													
MUA/POP/collar /cuff	5	5	8	4	11	8	6	12	11	6	7	1	**41**
Amputations													
Rays		2	2	1		1		1		1	2		**6**
Wrist /forearm	1				2				1		1		**3**
AKA												1	**1**
BKA		1					1		1		3	2	**1**
Above elbow												1	
Tendon repair /nerve repair	1			2		2		2	3	4	2		**5**
Tenotomy				2									**2**
Reduction of dislocation													
shoulder		1											**1**
digits													
hip		1				2							**3**
Elbow				1		1	1						**2**
TMJ													
Ankle				1									**1**
ORIF													
P/S (both double and single)													
K-Wire	5	2	4		1	3	3	7	1	2	2	1	**15**
Rush Pin	2	1	1	1	1	6	4		3	1	9	1	**12**
K-nail									1				
TBW			1	1									**2**
Ex-Fix		1			1		1	3	2	1	3	1	**2**
Skull traction													
Marrow drilling	1												**1**
Tenotomy				2		1							**3**
Removal of implants													
K -wire		4		1		1	2	2	2			1	**6**
Steinmann pin					1		1	1			1		**1**
Plate & screws									1				
K-nail													
Ex-fix		1	2								1	1	**3**
Rush /pin							2		1		1		
Neurosurgery													
Craniotomy				2				1		1			**2**
Excision of Saccrocoxygeal teratoma													
GIT													
Explo-lap	4	5	2	4	4	7	5	5	10	4		7	**26**
Appendectomy	3	4	9	8	4	7	2	6	3	1	3	1	**35**
Splenectomy					1			1					**1**
Colostomy		1	2					3	1	1		1	**3**
Cholecystectomy													
Proptoscopy	1	1	1							1			**3**
APR								1					
Pyloromyotomy					1							1	**1**
Herniorraphy													
Inguinal	2		2	3	3	5	6	6	4	8	2		**15**
Mayo's	1		1	1	1		3		4	1			**4**
Herniotomy						1	1	1	1				**1**

ENT/Head &Neck													
Tracheostomy													
Tracheostomy tube change													
F/B removal nose/ear	1	1	3				1	3			1		**5**
Hemi thyroidectomy								1					
Hemi-glossectomy													
Submandibular cyst excision													
DLA		1											**1**
Cleft lip repair								4					
Polypectomy								1					
Urology													
Circumcision	1	1		1		1		1					**4**
Cystoscopy													
Fibrosed f/skin													
Nephrectomy									1				
EUA -rape													
Open prostatectomy								1					
Fibrosed foreskin flap								1					
Bilateral sub cap orchiectomy													
Cystostomy	2				1						1		**3**
Paraphymosis reduction													
Cystolithiotomy								1					
Cardiothoracic													
UWSD			1		2		1		1				**3**
Thoracotomy		1	1		1								**3**
Mastectomy		1											**1**
Others													
Excision biopsy /lumpectomy		6	5	2	1	4	1	9	7	3	2		**18**
EUA/Suturing/COD/Debridement	17	7	21	23	34	16	27	26	11	21	27	21	**128**
I&D	1		5	1	2	5	2	7	6	3		1	**14**
SSG		3	2		3	2	1	2	1	1		2	**10**
Foreign body removal	2						2						**2**
Spear								1	2	1	2	3	
Z plasty burns								6					

Can be seen 64% of all operations are due to trauma, reflecting the high admission of trauma patients.

ALL OPERATIONS DONE FOR 2017

And so the story continues

(Rt) This is male of 18 years with bush knife wound through the back across both sides .segmented fracture of the left scapula and proximal humerus, all done he went home happy.

Table showing cancellations for 2017

Reasons for cancellation	Total
Bad chest	4
No blood	38
Patient refuse/relatives refuse surgery	3
Patient broke fast	7
Patient not in bed/no show	3
Sterilizer down/no trays	13
No anaesthetists	18
High BP on the table	4
Awaiting SSMO	1
Surgeon sick	8
Team worked till day break	3
Not worked up properly	3
Time factor	29
Improving on treatment	8
No Nurse	3
No water	4
No power	16
Patient reacted to anaesthetic drugs	1
Full ward	2
Low Hb	24
Difficult air way	1

Bar graph showing main reasons for cancellations

Outpatient and consultation clinic cases seen from January to October 2017. Clinic was closed in October due to high Emergency bookings with continuous full ward. After the closure most cases were reviewed out-side the operating theatre.

Out-patient cases are the ones reviewed at the emergency department every day.

There is no record of consults in and consults given out.

	No of cases
Consultation clinic	5432
New	2375
Review	3057
Outpatient cases	3117

Discussion of the audit.

The admissions after the month of October are just emergencies, when we did the shutdown period early due to the increase in trauma burden and we were unable to cater for the elective cases. Only a few special elective cases were entertained.

We were also not doing a lot of major cases due to non -availability of blood for surgeries as reflected in the cancellation table.

After the closure of the consultation clinic Most of our review cases were seen along the corridor and just in front of the main operating theatre.

Other outpatient reviews are seen at the Emergency Department.

Most orthopaedic operations done emergency and a few electives.

We have done a few out of province referrals due to nature of the cases in total 2 as per the table.

Our deaths are mostly cancer, sepsis with multi organ failure and severe head injury. These are very sick patients that are admitted for full nursing and intensive care.

A few deaths we think are un-expectable and their outcome would have been better if we had facilities like ICU and back up laboratory facilities. These will be discussed in detail in the Morbidity and Mortality review.

Most cancer patients are well advanced at time of admission for palliative care. We still do not have chemotherapy drugs since October 2016, histology results still a major problem. As of date none of the results for the last 3 years are back yet.

Most of the other patients would have the benefit of an ICU or a well set up Intensive care unit and full laboratory investigation services.

Continuous Medical Education.

We had a few more formal classes this year with the help of Dr Meron who was here with us for about 5 months and did participate in the hospital grand rounds.

There is bed side teaching taking place during our ward rounds, Mondays, Wednesdays, and Fridays.

This is the area that we need to improve on this year 2018 and on -wards.

Constrains

There are many constrains and I would only high light a few of them.

1. Enough staff strength in all divisions, ward and the operating theatre but most are not performing.
2. The few that continue to work get sick very easily due to always covering up for the ones that continue to have problem coming to duty as per their rooster. Staff need to improve their work attitude.
3. Support services not providing the much need services
4. E.g. Laboratory unable to provide another other test like electrolytes, blood culture, microscopy and others to make patient care easier with constant blood shortage.
5. X-ray machine out for longer periods making diagnosis and appropriate treatment a dilemma.
6. In need of an ICU and a High Dependency unit.
7. Patients staying longer than required due to health centres not functioning and difficulty in transport.
8. Frequent rotation of nurses.
9. Need specialist Surgical and Acute Nurses.

Remarks

Despite all the problems that we have en counted as a unit I Stand proud to say that we the surgical team of Boram General Hospital have managed to provide the best surgical care that we can afford with the limited resources we have available to our people. These is a team effort and I command all for their never failing commitment.

Conclusions

This hospital has a few very valuable assets and these are:

1. Current location very ideal
2. Few old staff who are very committed and very experienced despite any situation they will always step in and they are very good teachers.
3. Variety of cases seen is always a mental challenge.

We have the potential to improve and build our standard up.

Key areas identified to make an impact on the quality of services provided.

Trauma burden in Wewak so huge and uses up most of the resources, need to do awareness, charge a minimum service fee, must pay before they get treated. So that the rate of trauma goes down and we are able to at least do some elective cases.

Regular supply of consumables, due to the high trauma rate, we have a lot of orthopaedic cases. We need an X-ray that is fully functioning at all times. We need a battery operated bone drill. We need bone implants, rush pins, plates and screws, eternal fixators, k-nails and k-wires. And we need to train an Orthopaedic Surgeon. We have to start charging some fees set by the Hospital Management before the operation so it will enable us to keep our stock up dated.

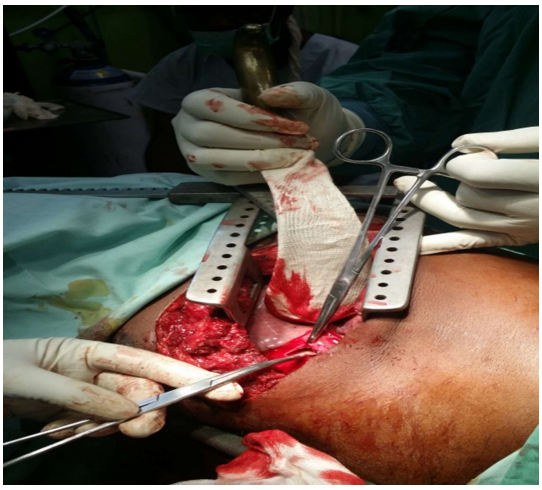
As per our Audit for 2015 deaths due to cancer is quite high, affecting our mortality rate. Most of them present very late and can be referred back to their health centres to be closer to family if the health centres were functioning well. And it also affects our bed occupancy rate.

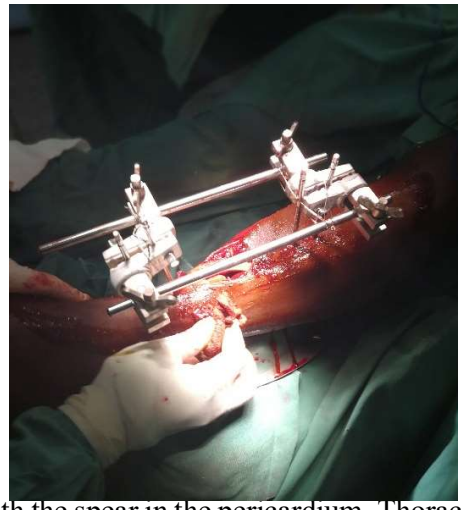
Need to increase the number of surgical nurses and those who are interested should be sent for further training. Need to increase the staff strength. In order to achieve all the above we need a good nursing care.

Need to establish a proper referral system or local visit by our regional chiefs. E.g. ENT, Paediatric, Orthopaedic, Interplast and all other teams, need to have their intended visit dates at the beginning of the years so patients can be prepared or referred appropriately.

One of the recommendations that I would strongly suggestive is introduce a compulsory trauma fee and it must be passed by the Provincial Executive Counsel

Need to train an Orthopaedic Surgeon to set up a Trauma and Orthopaedic centre in Wewak, to cater for the huge demand.

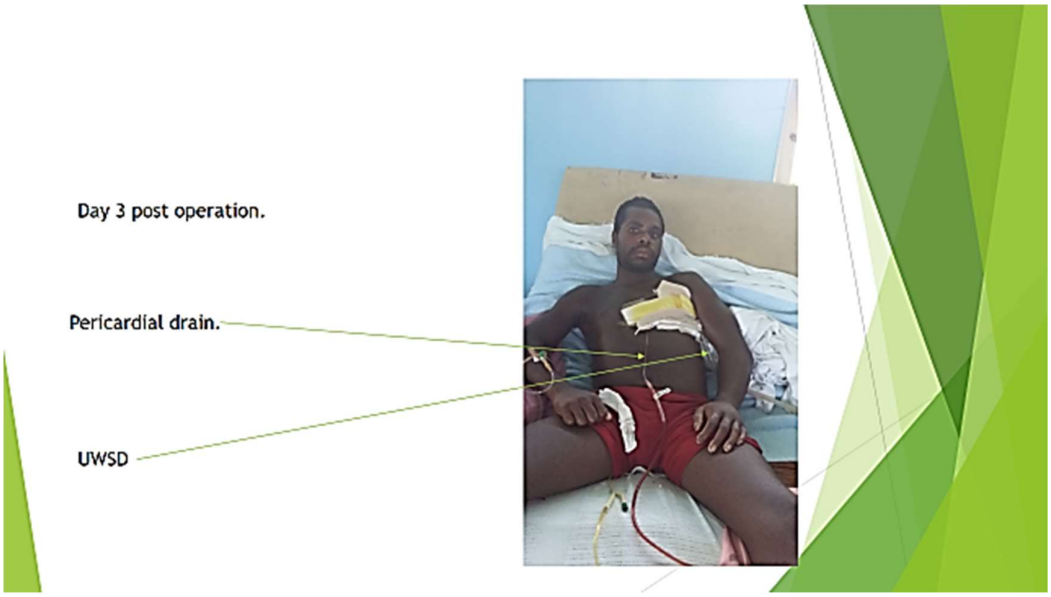




Case of penetrative spear wound to the chest with the spear in the pericardium. Thoracotomy done pericardium opened up and spear removed.

Compound fracture with external fixators not the latest but achieves the aim with good out comes. This apparatus has saved a lot of limbs from being amputated.

Post-operative case of thoracotomy with spear in the pericardium removed. Has appropriate drains as per indicated.



ANAESTHETIC UNIT

INTRODUCTION

In 2017 there were some positive changes taking place within the hospital as compared to the previous years. The new surgical wards were completed and opened by the Health Secretary during the hospital's Annual General Meeting. The public especially surgical inpatients were impressed with the new surgical wards. Even the surgical staffs were pleased with the new working environment.

The launching of East Sepik Provincial Health Authority (ESPHA) was staged at Sir Michael Somare's Stadium in October, in the presence of the Health & HIV Minister, Health Secretary and ESP Governor with other invited guests. This launching signifies the merging of Provincial Health and Wewak General Hospital into one structure (ESPHA), under one new board, the ESPHA Board with a new Chairman and members. The new management of ESPHA was also appointed on acting basis only during ESPHA launching. See Pictures 1 – 2 overleaf.

Picture 1: A/CEO Mr. Mauludu

Picture 2: Governor Bird with Minister Sir Puka Temu

The Anaesthetic Department compliments the services provided by other Departments like Surgery and Obstetric & Gynaecology. Nearly all surgical procedures require some form of anaesthesia. Without anaesthesia having surgical procedures will almost be impossible for both the patients and staff. Not many people are aware of the very important and vital role Anaesthetists and ASOs (or Anaesthetic Nurses) played in any surgical procedures.

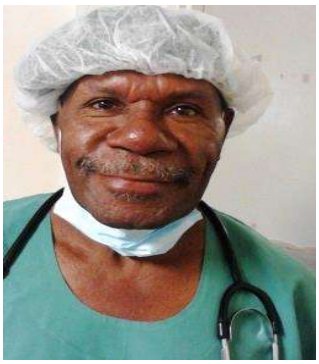
Within our Department we have always strive for better and quality services. There are obvious negativities along the way but as a Department we continued to minimize disturbances or incidents that might have jeopardised our delivery of services. There are incidents which have happened that might have affected other sections as well because of our failures. Such grievances are usually channelled through the office of Acting Director Curative Health (formerly Director Medical Services) for addressing.

- This year's Annual Report will cover the following:
- Staff Strength
- Working Environment
- Equipment and Consumables
- Audit
- Continuing Medical Education
- Constraints
- Recommendation
- Conclusion

Staff Strength

The Department is so fortunate to have total of 10 staff attached in 2017. We got one Anaesthetist, four Anaesthetic Scientific Officers (ASOs) and four Anaesthetic Assistants (AAs). In addition, we have one nurse attached to the Department in preparation to undertake Diploma in Anaesthetic Science (DAS) in 2018. See Staff Pictures below (3 – 11).

Picture 03



Andrew Lahule – Senior ASO

Picture 04

Alfred Sikilimbin – ASO

Picture 05

Elizabeth Waita – ASO

Picture 06

Anton Kalai – Senior AA

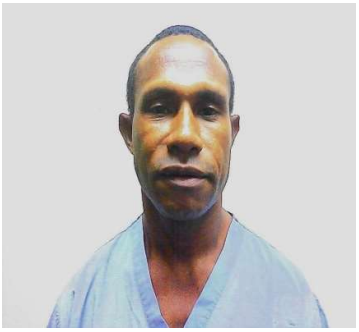
Picture 07

Paul Krufale – Senior AA

Picture 08

Emmanuel Kambu – AA

Picture 09



Lawerence Ali - AA

Picture 10

Samuel Apisai – Trainee

Picture 11

Pouru (left) & RHEO Uri (right) –

NB: Missing in photos – Daniel Singut – Senior ASO (retiree)

There is one SMO position which has been occupied. There is also a vacancy in the Anaesthetic Registrar position but to date no one has applied. Few candidates have shown interest but no one has made a solid commitment. Most registrars that applied here streamlined into other disciplines especially surgery and O&G where greater interest is shown there. Perhaps certain incentives have to be offered to attract registrars to do post graduate training in Anaesthesia. This vacant registrar position has to be repeatedly advertised until an applicant applies and is accepted.

One of our senior ASO, Mr Daniel Singut retired towards end of this year after a long and colourful career with the Health Department. The Department misses him as one of the most experienced and committed staff in our team. Another of our senior ASO, Mr Andrew Lahule, is approaching his retirement as well but the Department has retained him to continue to support the Department. The ESPH will currently focus on ASO training for few years until such time when enough Physician Anaesthetists are trained within the country.

The assistants played a very key role in anaesthetic management of patients undergoing any surgical procedures in the operating theatre. Their presence reduces the risk of any anaesthetic mishap that might occur. Refer to Annual Report of 2016 about the emphasis on having assistants during any anaesthetic procedures.

The Department received four Resident Health Extension Officers on two months rotation each. Throughout the course of their residency programme most have performed well. One of the requirements is performing or assisting to perform most anaesthetic procedures which are then recorded in their log book. There no Resident Medical Officers doing their rotation here in 2017 in anaesthetic.

Working Environment

The duty station of most anaesthetists is based out in the operating theatre and ICU. Unfortunately, this hospital doesn't have a functional ICU. Instead critical patients requiring ICU care are nursed on the acute bay of each respective section. The hospital still uses the same old operating theatre that was first built more than 50 years ago. The plan is now for the hospital to upgrade a new operating theatre and this will take place hopefully by next year which will also include the ICU facility. Figure 1 & 2 below; showed our small office/work station/ change room occupied by five staff at any one time.

Figure 1: Entrance to the small office

Figure 2: One of two seats in the office

At this moment the interior design of the current O/T remains same. The space is simply inadequate to accommodate for PARU and also complicates proper waste disposal. This is the problem we still have to face until a new O/T is constructed. See Figure 3 & 4 below

Refer to Annual Report of 2016.

Figure 3: Is a one way traffic for clean and dirty items

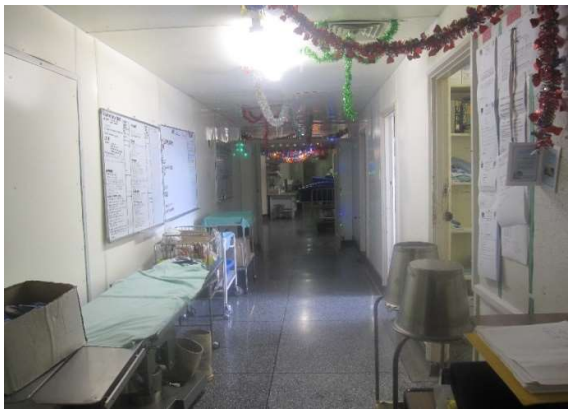


Figure 4: This area serves as both PARU & waiting area

Equipment and Consumables

Equipment

Most of the equipment used in 2015 is still used by the department 2017. These include the mechanical ventilators and the monitors that were bought and received by the hospital in 2015.

Anaesthetic Machines

The department now has 6 functioning anaesthetic machines. Two are being used, with one each in Operating Room One & Two. As mentioned in 2015 report, two of the anaesthetic machines were sent to be used by the district hospitals. The problem with these anaesthetic machines is that, their ventilators are not working even the new ones purchased by the NDOH. The issue was raised with Biomed but to date there is no positive response forth coming.

Once the district hospitals at Maprik and Angoram are functioning normally as a Level 4/5 hospitals only then provision of anaesthetic services will compliment other services. This is when the availability and use of anaesthetic machines will be an integral part of providing anaesthetic services. See Figure 5 & 6

It has been noted that some newer anaesthetic machines purchased by the NDOH for use are not user friendly especially when there is an inbuilt ventilator with both electronic & manual controls. It takes time to get familiar with the various components especially if there are no hands on training. Unfamiliar use of anaesthetic machine can lead to complicated patients outcome.

Figure 5: Showed one of the two new anaesthetic machine purchased in 2015 by NDOH.

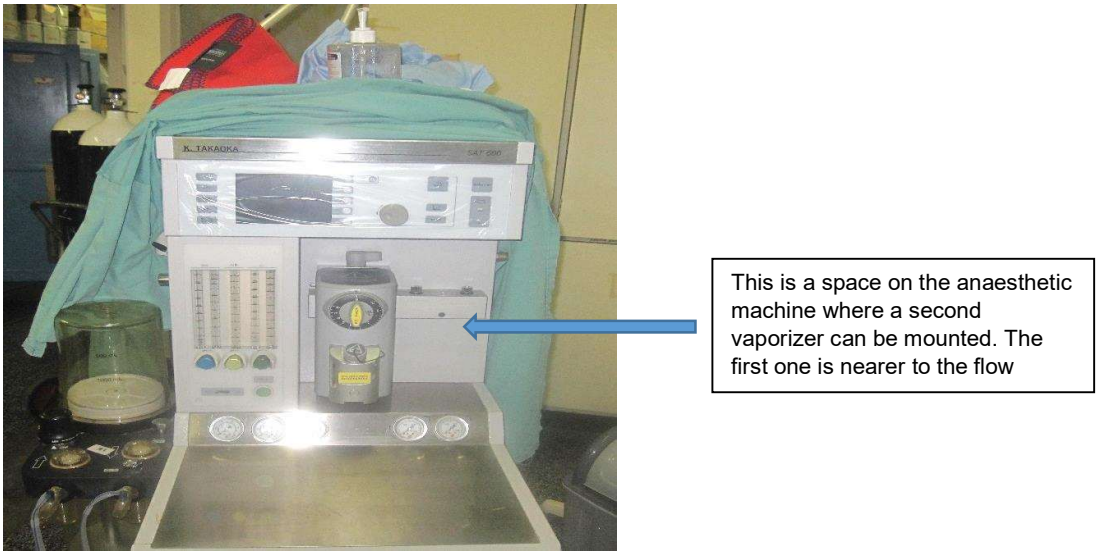


Figure 6: Another of an older version of Ulco Anaesthetic machine

Faulty Equipment & Anaesthetic machine

If the anaesthetic machine ever becomes faulty the report must go directly to the Biomedical Engineers with copies of the report channelled to the management. Persons without necessary experiences should never attempt to fix the faulty machine. Storage space for Anaesthetic machine

We have been facing problems with storing of our consumables including equipment and particularly the Anaesthetic machine. We have limited choice to keep our machines safe. Instead they are put in with other items in a room that is not ideal which can contribute to early break down of various components of Anaesthetic machine.

Mechanical Ventilators

The only mechanical ventilator (for ICU use) that the hospital has is still out of service. The monitor screen was brought to the biomedical company (Premier Biomed) in Port Moresby for repair since 2015. To date the department hasn't received the monitor screen yet despite our numerous follow up. This has affected our ability to manage critical patients effectively and according to required standard. To date the monitor screen is still outstanding despite notifying the Biomedical Engineers of the hospital. The hospital, also do not have a portable ventilator for transportation of patients requiring ventilator support. See Figure 3 below.

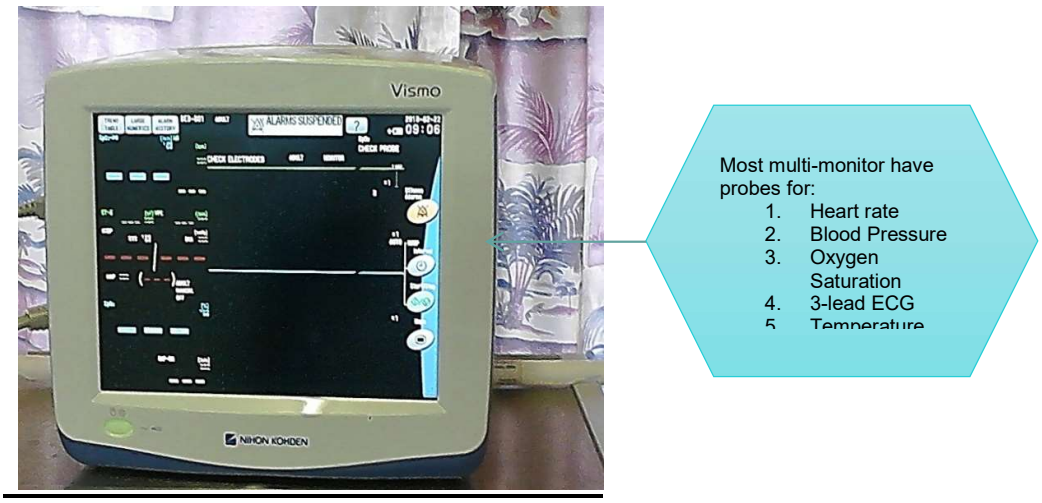
Figure 7: Shows the mechanical ventilator.

There is no screen monitor as seen on this picture

Monitors

The Department has three multi-monitors. There are one each in two operating rooms and one in the PARU section. They are all functioning well except all three lacked carbon dioxide analysis and temperature readings due to unavailability of specific probes. In addition all three lacked neonatal and paediatric blood pressure (BP) cuffs to take BP readings (see Figure 8).

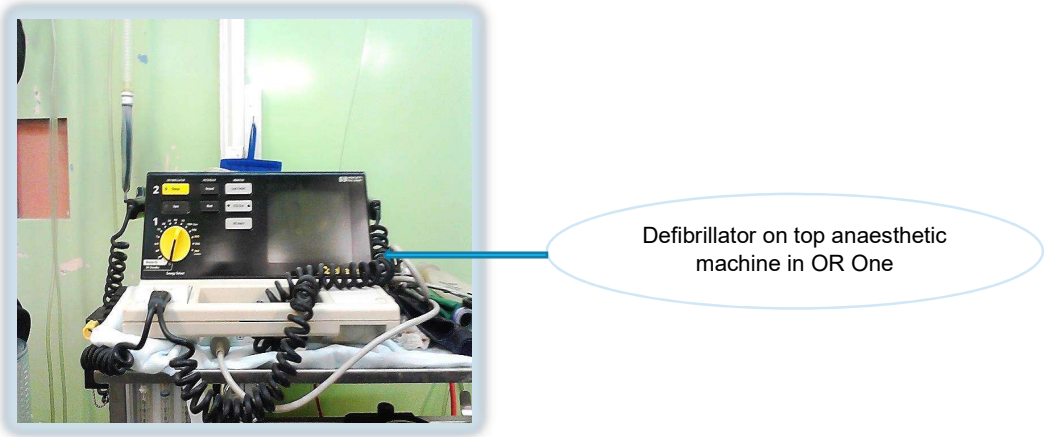
Figure 8: One of the 3 multi monitor stationed at PARU



Defibrillator

There is one Defibrillator in the Operating Theatre which is placed on the Anaesthetic Machine in Operating Room One. It is used rarely since we do not encountered intra-operative cardiac arrest frequently. See Figure 9 below.

Figure 9: Defibrillator



Consumables

Our department do have encountered problems with some consumables shortages at time (see Figure 10). In addition, we have experienced oxygen shortages on few occasions unlike 2016 where it is more frequent. Recently, towards the end of the year we have limited supplies of Nitrous Oxide. We need to purchase extra size G cylinders (at least 6 more) for us the use. The NDOH Medical Supply branch will assist in this regard. A number of times we are faced with poor quality drugs, which doesn't work effectively on patients when we used them (see Figure 11). The problem of opioid shortages like last year is rare this year because the supplies were managed consistently by our Provincial Medical Stores and hospital pharmacy. Frequently, we have encountered expired drugs which again causes problem for us. The drug shortage is a nationwide problem (see Figure 12) which also affected us but whenever there is an urgent need, the department approaches management to purchase some for us to use.

Figure 10: Double lumen tubes

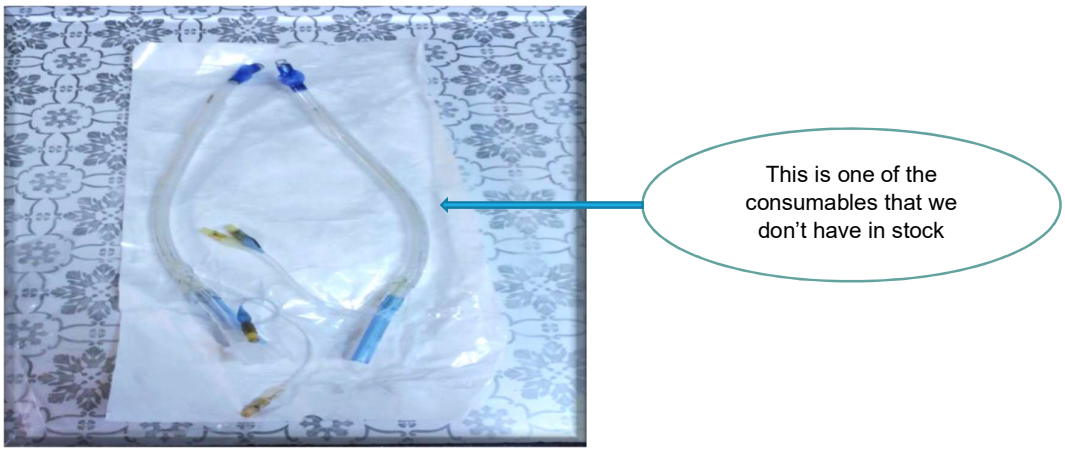


Figure 11: Bupivacaine (Hyperbaric)

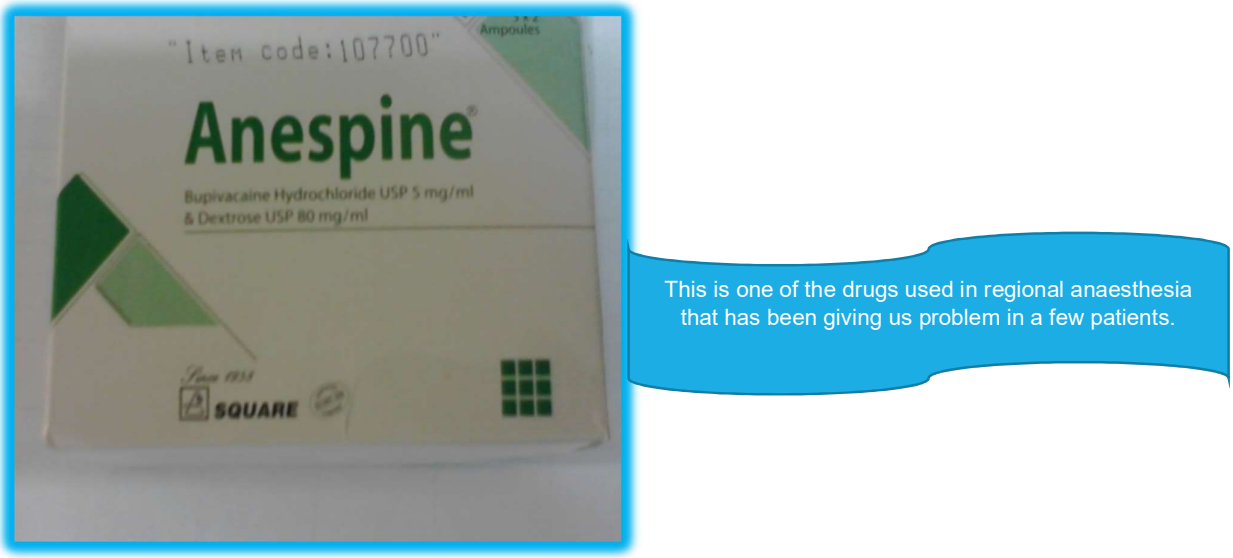


Figure 12: Propofol

Our Department understands the cash flow crisis the country is facing currently. This prompted us to take decisive actions to ensure our services are still maintained regardless. This means cutting down on drug wastages and reserve few important drugs for specific emergencies only. Even despite frequent shortages, our Department continues to ensure our services to the general public is always made available. It is hoped that the medical supplies to rural areas including Provincial Hospitals is continuously maintained so that services can still be offered to those needing it.

Audit

Anaesthetic services is provided on 24/7 basis to two main disciplines – Surgery and O&G. On few occasions the Eye Department relies on Anaesthetic Department to provide anaesthesia especially with General Anaesthetic for some of their cases. Their cases are also recorded in the Surgical Register Book.

Maintaining Anaesthetic Register Book consistently is sometimes a problem when data is not entered correctly. In addition, retrieving data for statistic often becomes difficult and time consuming. The Department needs a computer preferably a desktop where all the data entry can be stored for retrieval at any moment notice.

In addition, having a full time Data Entry Clerk in the O/T is an advantage as the officer can minimize extra workload on clinical staff having to spent time on entering data. Not only that but all the information concerning the daily activities of the O/T can be fully captured by the clerk, for example; reason for cancellation of elective cases for that particular day.

2016 Statistic

Table One: showed a number of cases done in 2016 (from Oct – Dec) which were left out in 2016 Annual Report.

Table 1: Number of cases performed in Surgical Department from Oct – Dec 2016

Variables		
Total cases		276
Sex	Male	157
	Female	69
Urgency	Emergency	113
	Elective	113
Types of anaesthesia	FCGA	51
	LMA	8
	TIVA	0
	Regional	39
	Others (Ket/Sed/LA)	98

NB: 1. Statistics for surgery for 2016 (Oct – Dec)

2. FCGA = full conventional general anaesthesia, TIVA = total intravenous anaesthesia, LMA = laryngeal mask

2017 Statistic

In 2017 we have a total of 1675 patients utilizing the anaesthetic services with 860 cases done by Surgical Department and 815 from O&G Department.

In surgery, most cases predominantly trauma related. Trauma related cases consume a lot of our limited resources since a number of them have to come for repetitive surgery also. In O&, a good number of cases is bilateral tubal ligation (BTL) for Family Completion (F/C) followed by Evacuation of Retained Product Of Conception (ERPOC) for Retained Product Of Conception (RPOC). These figures are captured in respective Departments statistics.

The following pictures are few of the many graphic traumatic cases that were anaesthetized for surgery.

Figure 13: 18 year old girl – Patient A

Figure 14: x-ray of Patient A showing wire

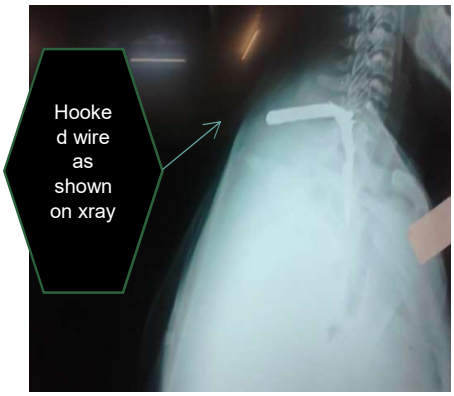


Figure 15: Bush knife wounds to middle and lower (L) chest of M/A – Patient B

Figure 16: Patient B - (R) laterally placed after intubation on prone position

Figure 17: Laparotomy for penetrating left lower abdomen M/A – Patient C

Figure 18: Part for the laparotomy for Patient C

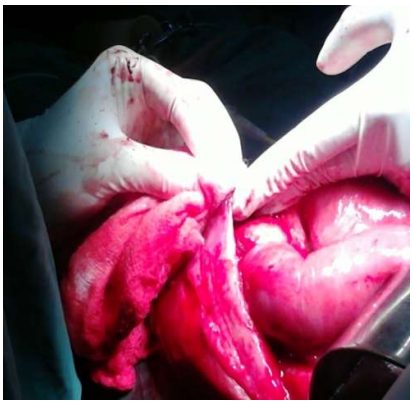


Figure 19: Bush knife wound (L) chest in M/A who is unable to lie totally flat – Patient D

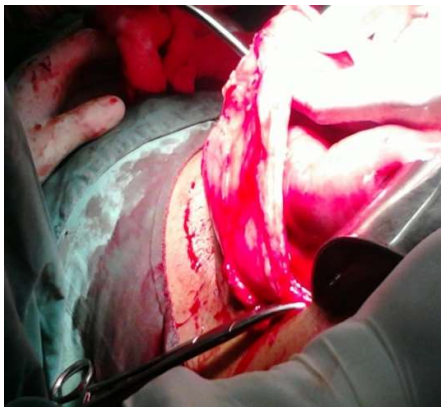
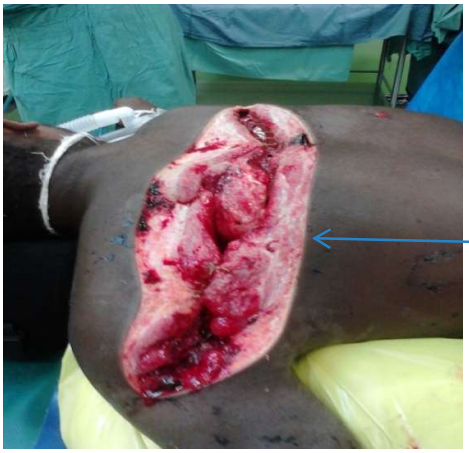


Figure 20: The open left chest wound - Patient D

Figure 20: Bush knife wound across the entire back of the chest M/18 – Patient E



This young male received a massive deep penetrating bush knife wound across the back of his entire chest. Anesthetizing him was challenging and very laborious. He was induced prone then placed supine for intubation then placed prone again for surgery.

Figure 21: Patient F in SCN

This is a week old female infant (Patient F) who was born with imperforated anus. Her intubation proved extremely difficult because her airway was not easily visualized. After more than 12 attempts her surgery was deferred to next day were she was intubated on first attempt. She had colostomy done and is recovering extremely well in Special Care Nursery (SCN). This is her Day One Post-operative photo, were she was actively moving.

Figure 22: Male/30 – Patient G

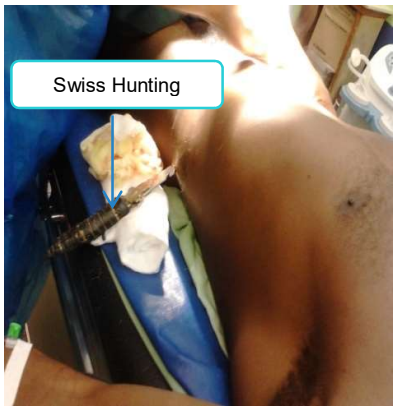


Figure 22 & 23

Patient G, a male 30 years old was referred in from Nuku (WSP) with penetrating knife wound to his left lower abdomen. Was given GA and had laparotomy done. He recovered well post-op.

Figure 23: Male/30 – Patient G

Figure 24: Young male with iron rod catapult his into his right side of the face – Patient H

Airway management including intubation is often complicated when such cases are presented to Operating Theatre for surgery

Figure 24 & 25 are classic examples

Figure 25: Young male with arrow into left cheek – Patient I

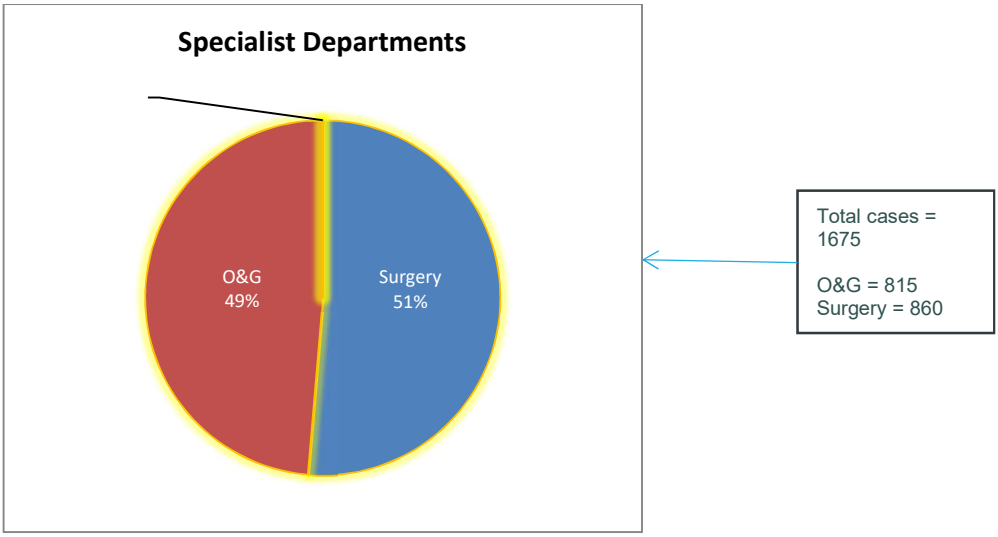
Take note that each specialty will produce its own Annual Report for 2017. Surgery will provide their statistics on various types of admissions and therefore will most likely capture the number trauma related admissions. Likewise, this will be the same for O&G which they required to produce their 2017 Annual Report.

Most of the information provided below reflects quantitative measurements of the data only which the reader can easily relates to and understand. The information is about the Total number of cases anaesthetized and from which specialty done for 2017. The data on Sex distribution, Urgency of cases, ASA Classification (see below), Types of Anaesthetic techniques and the Average Anaesthetic Time is also made available in the report below.

The Anaesthetic Department compliments the services provided by other Departments like Surgery and Obstetrics & Gynaecology. The following showed some statistic for Department for 2017. There were a total of **1675** cases that had surgical procedures under anaesthesia. Almost half of them are from O&G Department. See Figure 26 below.

Specialty Distribution

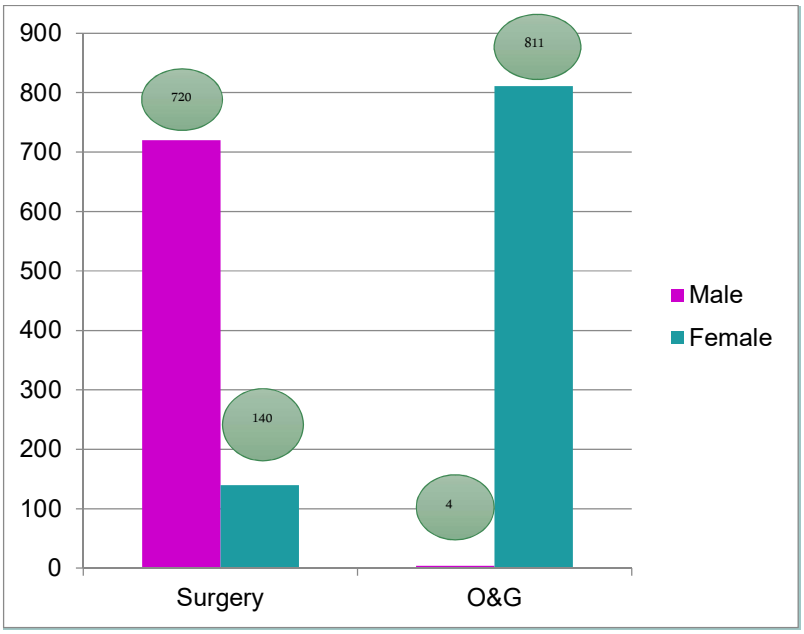
Figure 26: Pie chart showed number of cases between Surgery and O&G



Sex Distribution

In Surgery, the number of males going for surgical operations is higher than the females. In O&G, it is the other way around since this specialty strictly caters for women's business only but occasionally we have males coming in for vasectomies. The figures are almost similar as in 2016. See Figure 27 below.

Figure 27: Column chart showing sex distribution by respective specialty - 2017



In 2016

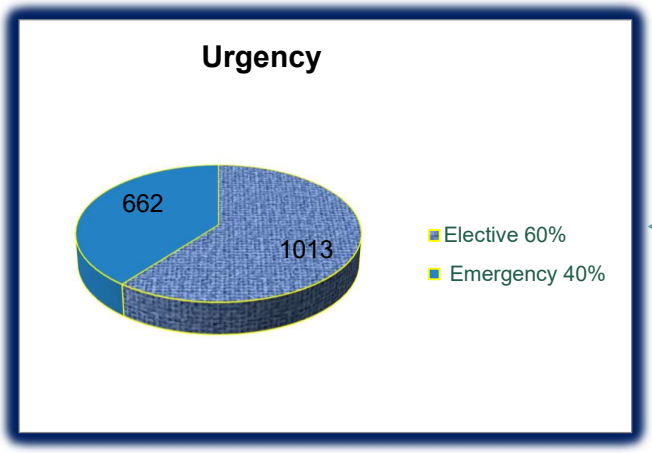
Surgery:
Females = 125
Males = 729

O&G:
Females = 798
Males = 2

Urgency of Operations

Whenever, the cases are booked for operations, it is important to know if they are life threatening and therefore need instant surgical interventions immediately or are non-life threatening which can be operated on at the later stages. For example, a ruptured uterus will always take precedence over a K-nail insertion of a fractured femur. There are many cases that fall between absolute emergencies and elective cases and these are sometimes called semi-emergencies though the term is often used loosely and semi-emergencies are practically emergencies which can be delayed. In this year we have 662 cases being classified and operated as emergencies whilst the rest are treated as electives. See Figure 28 below.

Figure 28: Pie chart showing percentage of electives and emergencies



	Surgery	O&G
Elective	433	580
Emergency	427	235

American Society of Anaesthesiologist Classification (ASA Classification)All patients needing surgical operations need to have a pre-operative clinical assessment done on them prior to surgery. Many countries

have devised their own system of assessment but the commonly used one worldwide is the ASA classification. This classification gives the rough guide to how well a patient can cope with the stress of both anaesthesia and surgery. Normally, ASA I & II is an assessment score given to almost fit and healthy patients going in for surgery whilst ASA III is the average score between very sick and healthy. The score of ASA IV denotes 50-50 chances of surviving the anaesthesia and surgery. The assessment score of V is reserved for those cases that will still die (sick moribund cases) despite anaesthesia and surgical intervention. See Table 2 below.

Table 2: Showed the ASA classification done between surgery and O&G - 2017

ASA Classification	Surgery	O&G
I	765	326
II	95	467
III	14	20
IV	3	2
V	0	0

Morbidity and Mortality

Peri-operative complications include 3 septic shocks, 3 delayed recovery and 1 unfortunate intraoperative death from Pulmonary Embolism as confirmed during autopsy.

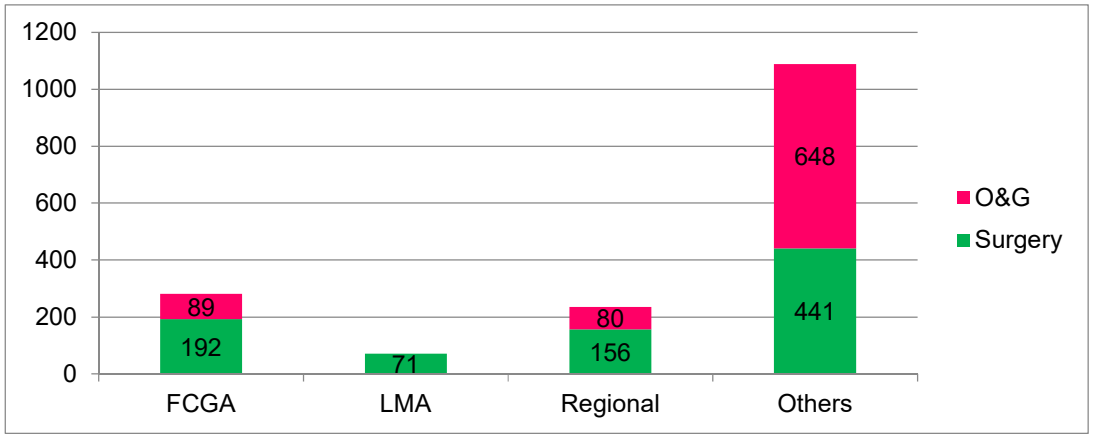
Types of Anaesthesia administered

Patients undergoing any form of surgery will definitely require some form of anaesthetic administered to them. All anaesthetic techniques have some risks associated with them. If there is a choice, patients will be given an opportunity to decide which one they would prefer, after being explained on various risks associated with them. Most often patients may not have any choices, which in this case, the anaesthetist must fully explain to them.

In this hospital, Full Conventional General Anaesthesia (FCGA) is administered usually for major cases requiring muscle relaxation. Various anaesthetic techniques are also administered in this hospital which includes Laryngeal Mask Airway (LMA), Regional Anaesthetic Technique (such as Spinal and Brachial Plexus Block) and Ketamine alone or in combination with other drugs. Local skin infiltrations with Local Anaesthetics (LA) such as Lignocaine for most minor surgical procedures is given alone or in combination with other drugs such as sedatives (e.g. benzodiazepines) including Ketamine. Ketamine is often used to supplement pain relieve in patients who initially received local skin infiltrations but starting to feel pain when the surgical procedure takes longer than anticipated and LA starts wearing off. As such this often complicates how to classify them together as which type of anaesthetic administered (thus they have been combined together as others). See Figure 29 below.

In real practice, we also have to consider different anaesthetic options depending on the availability of drugs and other consumables. For example, if there is very limited supply of certain induction agent (e.g. propofol or thiopentone) for FCGA, we then have to consider giving Spinal for Total Abdominal Hysterectomy instead of FCGA. The reason is, this few induction agents will be used strictly for surgical procedures requiring FCGA with muscle relaxation as well (e.g. laparotomy). During 2017, majority of our cases have been administered with Ketamine alone or in combination with other drugs. We rarely administered Total Intra-Venous Anaesthesia (TIVA) and Epidural Anaesthesia in this hospital except only on two ASA IV/V cases (TIVA with Ketamine infusion) in 2016.

Figure 29: Showed various anaesthetic procedures



Average Anaesthetic Time

Anaesthetic Time generally refers to the time period between the administrations of an anaesthetic to the time they are discharged from PARU. For this year (2017), the average anaesthetic time of most of the cases is just under 30 minutes (about 75%). The rest of cases were done above 30 minutes (about 25%).

Continuing Medical Education

The CME is part of an on-going medical education which all departments within the hospital are expected to participate including attending the presentations and take part in presenting an interesting topic themselves. Every Monday morning is a usual day of the week allocated for seminar or grand round presentations. Our Department itself conducted in-house or hands on training including tutorials to our own staff during our spare time.

In addition, most of our staff (under DMS) didn't attend this years' Annual Medical Symposium conducted by PNG Medical Society. This event was held in Port Moresby which is expensive for most of the staff to attend. It is also an important yearly calendar event where ideas and information concerning health services in the country are presented to health professionals both from within PNG and abroad. To miss out such opportunity is a loss for our hospital (in updating and maintaining our medical knowledge for benefits of patients' care). Other hospitals within PNG have funded the travel for their staff to attend the Medical Symposium in Port Moresby as they have realised its importance and have include it in their annual budget estimation. For next year (2018) Medical Symposium, it will be held in Madang.

Constraints

Below are some of the problems our Department continues to face up to 2017. This is to remind ourselves that we are overdue for some changes in the hospital, especially in our work station which is the Operating Theatre. This is an ongoing issue for the last two consecutive years which still remains. The following are excerpts from 2015 Annual Report which still has not been fully addressed (as highlighted in light blue font below) and hence presented in this report as well.

Lack of ICU

The unavailability of ICU in the hospital is one of the set back the department faced. This compromises specialized critical care that these critical ill patients required especially when ventilator support is needed. This results in these patients being managed in the acute section of their respective units or wards often by nursing staff who lacked ICU experiences and training. See above as well.

Lack of equipment

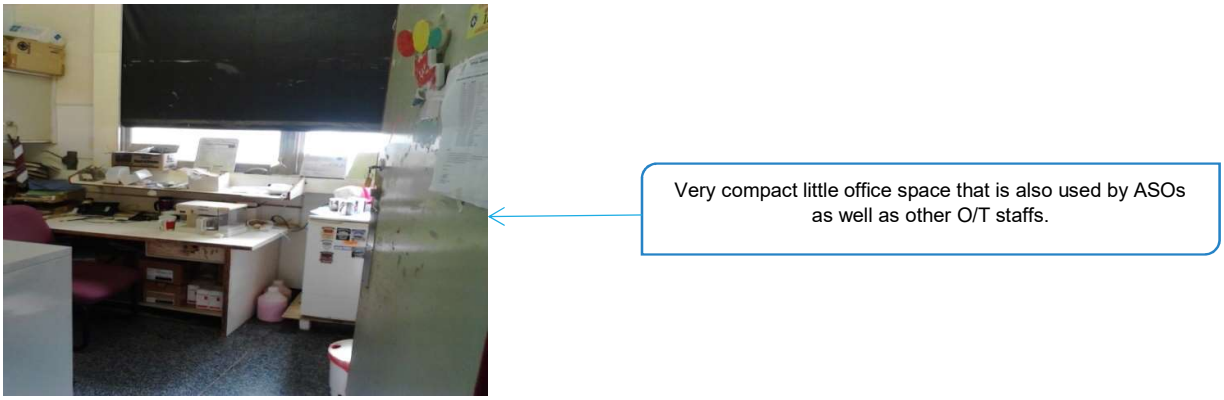
This year the department lacks some basic equipment. Listed below are some of the examples.

1. Lack of Portable pulse oximeters)
2. No infusion pumps
3. No blood warmers
4. No electric blanket except for neonates and babies
5. No nerve stimulators
6. Lack of defibrillators (need 2 extras for OR 2 and PARU)
7. No mechanical ventilators

Lack of office space

This year there is no proper office for the HOD. The one that was supposed to be allocated for use by HOD within the OT is still cramped with various items. It is important to have a secured separate office where items of value including confidential correspondences can be kept without thief and/or sticky beak by non-authorized personals. In addition, there is no extra space within OT that can be utilized as the change room for anaesthetic staff. See Figure 30 below.

Figure 30: Small office used by ASOs in O/T

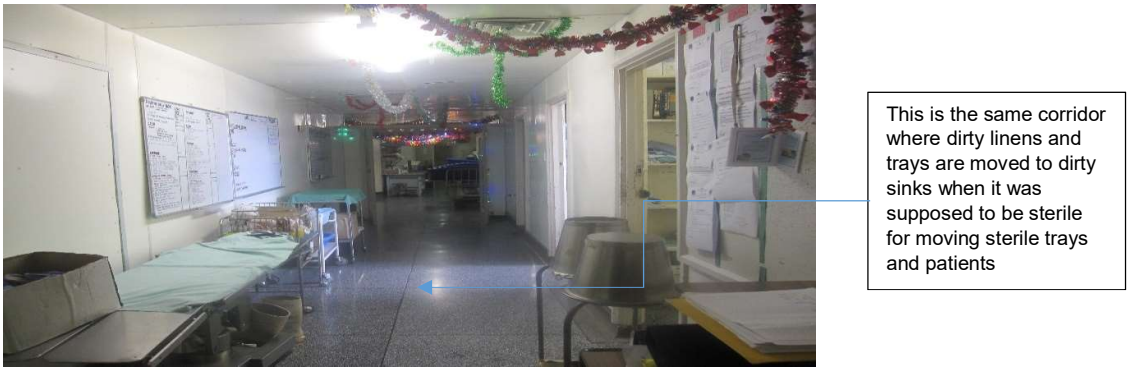


OT lacks adequate space or capacity

1. The current OT interior lacks sufficient space or capacity to accommodate for extra requirements. This caused inconvenience to OT users and breached certain infection control policies and occupational health & safety (OHS) standards. See Figure 31, below.
2. Dirty and soiled linen and trays are brought to the dirty sink along the same corridor which is supposed to be sterile
3. The female and male change rooms are compact with limited capacity for staff to use for attire changes during working hours
4. There is no extra bathroom for the male staff

5. There is no proper common tea room for staff which forces our staff to fetch water from the same sink we used to washed our dirty instruments
6. There is no proper post anaesthetic recovery unit (PARU). Postoperative patients are nursed on the same bay as the preoperative patients
7. The OT also lacks pre-anaesthetic preparation room
8. The scrub room including the design of the taps for ease of hand washing is substandard
9. The OT dirty sink is located within the area where sterile trays are packed and where the CSSD is located.
10. The whole building is rat infested and they chew on food, IV fluids and basically anything that stands in their way
11. The interior of OT is small and compact that there is lack of enough space to store extra items and consumables.

Figure 31: Shows the interior of the OT which was made even narrowed, by items placed along the sides.



Lack of Accommodation for staff

For a number of reasons some of our staff continues to face accommodation crisis. This is often used as an excuse for not coming to work on time or not attending efficiently to on-calls. Our numbers are limited and when this happens it places extra burden on staff who were supposes to have rest on their days off.

The services this Department provides, not only within this hospital but other hospitals as well, are crucial and vital for its status as referral hospital within East Sepik Province (ESP). It is should not be overlooked and ignored by all concerned stakeholders including the management of this hospital.

Outstanding (unpaid) allowances for staff

Some of our staff (ASOs and AAs) has not been properly renumerated whilst doing a lot of work especially after hours, during weekends or public holidays. This is so since despite being in the same Department, they are paid according to their different industrial awards which they come under. To simply put it, our staff are often overworked and underpaid compounded by the fact that the hospital sometimes failed to provide certain incentives to staff to appreciate their work. Some of their grievances are usually addressed in a public forum by the management. See Figure 32 & 33 below.

Figure 32: General Staff Meeting to address problems

Figure 33: Staff listening to the management

Recommendations

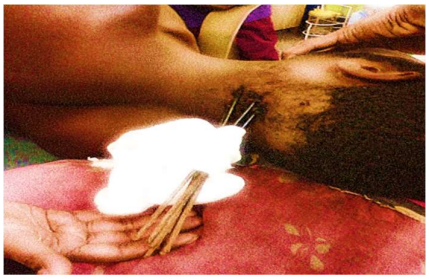
Most of the recommendations relates to addressing these constraints as mentioned above. These problems will continue to remain if outstanding issues are not adequately addressed. I reiterate with the excerpts from 2015 and 2016 Annual Report.

The following is our recommendations for improvement.

1. Allocate space and resources for ICU (which may not happen soon)
2. Purchase new equipment which are not available e.g. drug trolleys
3. Maintain consistency in the supply of anaesthetic consumables
4. Purchase new airway facilities aforementioned
5. Allocate space for HOD's office (currently unavailable)
6. Upgrade OT to reasonable standard complying with current infection control practices and OHS standards
7. Prioritize single quarter allocations for transit to staff taking on-call duties. Staff not taking calls or rarely takes calls at all should vacate a quarter so that a flat/room is reserved for my staff
8. Renumerate outstanding allowances for staff on reasonable time and provide incentives to staff using their (the management) discretion.

Conclusion

This year we have seen some ongoing changes taking place to upgrade current existing facilities. Though this has affected and slow down most the services, emergencies were still managed by the hospital fairly well. This will continue for sometimes until the proposed upgrading is fully achieved. The opening of a 40 beds, 4 wings new surgical wards during launching of 2016 Annual Report is a great blessing that occurred for the hospital. The launching of East Sepik Provincial Authority is another blessing for us. This facilitated the merging of Provincial Health and the hospital which is now under one management. We hope to see further improvement and changes in 2018, one of which will be the Wewak School of Nursing where the work is currently taking place.



OBSTETRICS & GYNAECOLOGY UNIT

The Obstetrics and Gynaecology Unit ESPHA Wewak General Hospital

Introduction

The obstetrics and Gynaecology unit now has complete medical and nursing manpower despite problems encountered beginning and middle of the year.

The maternity unit also will be undergoing demolition and reconstruction next year. We appreciate the Management of ESPHA under Mr M Mauludu and the Donors for the long overdue changes.

Below is the summary for the year 2017 Statistics

Grand overall inpatients admission in 2017		5240
Gynaecology Admission	710	
Antenatal admission	300	
Total Post Natal	2264	

Labour Ward Deliveries

Grand overall labour ward deliveries		2025
Mothers with single child	1966	
Mothers with Twins	57	
Mother with triplets	1	

SUMMARY OF DEATHS

Total cancer deaths	= 5
Ovarian cancer deaths	=2
Cervical cancer deaths	=3
Total maternal deaths	= 8
Maternal mortality rate	= 395/100 000 live births
Total perinatal deaths	= 128
Perinatal death rate	=63.6 per 1000 births
Stillbirths	=96
Stillbirth rate	= 47.4 per 1000 births
Neonatal deaths	=32 per 1000 live births
Neonatal death rate	=17.1 per 1000 live births
Booked mothers perinatal death rates	=43/1000
Unbooked perinatal death rates	=119/1000

High still birth rates 47.4 >/1000 births

High perinatal death rates >63.6/1000 births in the first quarter as compared to PMGH (2015 PMGH 25.1/1000)

ENND Rates=18.1/1000 in the first quarter as compared to PMGH 2015 of 9.8/1000 births.

Maternal mortality rate = 6 deaths (311/100,000) for the whole year

The above mortality ratios are more than double the rates of the Port Moresby

General, these statistics have not improved but worse than last year.

SUMMARY OF OTHER INDICATORS

High Unbooked Rates=18. (PMGH 8%)

High BBA rates= (PMGH 2.5%)

Grand-multip rates =11.5% (PMGH= 2.8%)

The other health indicators such as unbooked rates, grand multi-parous rates and BBA unsupervised delivery rates are also very high.

TOTAL OPERATIONS =811 (172 MAJOR/ 639 MINOR SURGICAL PROCEDURES)

Caesarean section rate) in the beginning of the year as compared to 99/2025 4.8%lower than last year 6% and is also comparable to PMGH at 5%.

ABORTION RATES

Abortion rates= 209/710 =29.4 % of all gynaecology.

Wound infection rates =

High Unbooked Rates=18% (PMGH 8%)

High BBA rates = 6% (PMGH 2.5%)

Grand-multip rates =6.1 (PMGH= 2.8%)

The other health indicators such as unbooked rates, grand multi-parous rates and BBA unsupervised delivery rates are also very high.

GYNAECOLOGICAL CANCERS

There's also an increase in the no of women with cervical cancers followed by ovarian cancers. In 2017 there were 5 cancer deaths 2 from ovarian cancer and three from cervical cancers; there was a total of 5o women with cervical cancer and 4 with ovarian cancers

FAMILY PLANNING

Total family completion operations=375

FAMILY COMPLETION	375
INTERVAL	144

POSTNATAL	186
C/S + BTL	25
ERPOC + BTL	16
VASECTOMY	4
Implant insertion	135
Implant removal	65

We also do family planning in the wards because our family planning clinic is closed.

HIV and VDRL screening for antenatal mothers

No VDRL and HIV test records in charts. Tests not done routinely in the family health clinic, Family Health clinic is closed most Antenatal clinic days due to no air condition and patients end up in the ward to see doctors in the wards. The family health clinic is manned by the Public Health staff and we never assisted them because we are running collateral clinics in the wards

OBSTETRICS AND GYNECOLOGY CLINIC PATIENTS

The antenatal, gynaecology and USS clinics are also done in the wards every Tuesdays and Thursdays and at least 20 patients are seen per clinic day= total of about 1500+ patients seen through the consultation clinic.

FAMILY SEXUAL VIOLENCE CLINICS.

This year we treated 23 victims of rape, child sexual abuse and domestic violence in the maternity ward

CONCLUSION

To conclude the overall maternity ward statistics have not improved from last especially the perinatal statistics have dropped, despite a fully staffed labour ward roster. There was shortage of medical personal at some time in the year and surgical and emergency medical staff has to cover the O&G unit. Thank-you, Dr Tovu and Dr Kapanambo for covering O&G unit in those times of need. Despite everything the O&G team has done well overall given the case load we endure on a daily basis, CONGRADULATIONS EVERYONE and We look forward to a prosperous and successful 2018.

May GOD bless you all in the years ahead.

UNITS OF THE DIVISION

MATERNITY UNIT INFRASTRUCTURE

The Obstetrics and Gynaecology Unit is situated towards the posterior end of the hospital. It consists of special care nursery, four bed Labour ward, 19 postnatal beds, 6 antenatal beds 15 gynaecology beds and two examination beds. Total bed capacity for the ward is 45 beds in total. There is one treatment room, one pantry room and one examination room. There are three nurse managers office room, two SMO office rooms, one registrar's room which is also as the scan and clinic room.

Apart from inpatients the unit conducts outpatient obstetrics and gynaecology clinics including ultra sound clinics on Tuesdays and Thursdays and implant insertion on Mondays

No proper storage areas for extra pharmaceuticals therefore IV fluids are just stored along corridors causing obstruction.

ABLUTION BLOCKS FOR PATIENTS AND STAFF

The unit has three staff toilets and two shower rooms for staff. There is no toilet shower or sludge toilet for labouring mothers in the labour ward.

There is only one functioning toilet and one functioning shower for Postnatal, gynaecology, antenatal, labouring mothers, special care nursery mothers and also the O&G outpatients. They all use only one common shower and toilet. The toilet is situated in closer to gynaecology and antenatal wards and usually smells so much to the patients and staff because the cleaners hardly ever use the right cleaning agents for the toilet. When there is water shortage the toilets just gives off offensive smell into the ward and we always see a rise in wound infection rates.

LABOUR WARD SUITE (4 bed labour ward four baby cots and one neonatal resuscitator)

The labour ward now has four new labour ward beds.

No chairs for labouring mothers.

The Bench top steriliser from ward one now relocated to the labour ward.

Shortage of sterile delivery trays (shortage of equipment) instruments are only washed and reused,

No safety gear for labour ward staff, Labour ward Scrub suites, aprons, gum boots and safety glasses.

No toilet and shower for labouring mothers.

No sludge room

There is now an exit door from labour ward past the waste management area for the labour ward.

Infant warmer and neonatal resuscitation room now in labour ward.

There is now separate nursing roster for labour ward.

No linens for mothers and babies in the labour ward.

GYNAECOLOGY WARD. (15 BED)

The 15 bed gynaecology ward has a unit manager but same nursing officers working in the antenatal and post natal wards. We now have a separate labour ward roster.

Problems in gynaecology ward.

1. Five beds in this ward are too old and rusted old fashioned beds.
2. We now have ten new mattresses donated to us by the Saman Balus Good Samaritan.
3. Dr Seginami bought six new chairs for post-operative patients and Dr Naboam bought six chairs for the conference room.
4. No beddings and proper linen to cover the mattresses, patients bring their own linens or otherwise just sleep on the mattresses without covers.

5. Holes in the floor in the gynae ward despite a number of request forms to the carpenters to mend the holes.
6. The hand washing sink in the gynae ward.
7. No separate Gynae patients' toilets all patients use a common toilet and shower.

POSTNATAL & ANTENATAL WARDS (24 BED WARD) the ward is manned by a nurse unit manager but same staff roster for post natal and gynaecology wards.

Problems in ward

1. Common toilet for all
2. All torn mattresses have been replaced.
3. Dire shortage of linen. Only acute beds have linens.
4. No chairs for post-operative patients. (Chairs bought by Dr Seginami and Sr Trowale last year)

CONSULTATION CLINICS.

1. The doctors consultation clinics and implants insertion are done in the wards.
2. Overcrowding in the corridors is a problem.
3. No prober booking and record of patients are kept.
4. Need for a consultation clinic nurse to be also stationed in the ward.
5. Clerk to be stationed at the front reception of the ward to attend to queries direct traffic and make bookings for clinic consultation.

Wewak hospital and Provincial Health must reopen the family health clinic outside the fence. Need for the authorities concerned to maintain the place and reopen it to cater for all the other Family health Issues such as

- Family planning clinic
- Antenatal clinic
- Gynaecology clinic
- Family and Sexual Violence Clinic.
- Well baby clinic
- Well woman's clinic, (screening for cancers)
- Well men's clinic (vasectomy & circumcision clinics)

OPERATING THEATRE SUITE.

The O&G unit shares the operating theatre with the surgical and the Eye team. Our operating days are on Wednesdays and Fridays. The operating theatre staff have been excellent in organising cases despite limitations.

One issue that needs urgent attention in the operating theatre is a neonatal resuscitator for newborns delivered by operative procedures in the operating theatre.

ULTRASOUND SCAN CLINIC;

The O&G unit is privileged to have two USS machines but the newly acquired ESAOTE brand seemed to be encountering problems if overused. The visiting Green limited Consultants were not able to fix the problem. The other older USS machine (TOSHIBA) brand is still in good condition.

We are always able to scan all our patients provided there are no power blackouts.

Need for new USS machine

OUTREACH CLINICS

No outreach clinics done this year due to logistical issues no money.

POSTGRADUATE TRAINING

THERE WAS NO POST GRADUATE CANDIDATE FOR 2017 BUT WE HOPE TO HAVE ONE OR TWO CANDIDATES FOR 2018.

NO REASEACH TOPICS IDENTIFIED YET. Dr Hacca and Dr Malisa will go into Post Graduate Training in 2018.

MEDICAL, NURSING AND ANCILLARY STAFF OF THE UNIT.

The staff strength is average compared to the patient work load, below is the list of domestic servants, clerks, nurses and doctors in the maternity unit.

Specialist Medical Officers SSMO O & G	2
Medical Officers (Registrars)	2
Midwives Nursing Officers	15
CHWs	17
Clerk Ward	1
Hygiene Officers	2

OBSTETRICS & GYNAECOLGY UNIT PROGRAMMES

The on-call team does labour ward and accidents and emergency rounds at 8am and 4pm daily before attending to other activities and before heading home after 4pm.

DAY	TIME	ACTIVITY
MONDAY	8am –930am	Hospital Grand Round at Hospital Conference Room

	930am—12 noon	Teaching ward round postnatal gynaecology and antenatal wards
	12pm-1pm	Lunch hour
	1pm –4pm	Implant Insertion and removal O&G registrars room
TUESDAY	8am—9.30am	Case presentation by RMOs/RHEOs and registrars in O&G registrar's office
	9.30am—11am	Ward Rounds postnatal, gynaecology & antenatal wards
	11am -12noon	Antenatal & USS clinic
	1-4pm	Antenatal & USS clinic
WEDNESDAY	8 am –9 am	Ward Round all wards
	9 am -4pm	Operations in the operating theatre
THURSDAY	8am –9.30am	Case presentation by RMOs/RHEOs and Registrars in O&G Registrar's office
	9.30am—11am	Ward Rounds postnatal, gynaecology & antenatal wards
	11am –12noon	Gynaecology and USS clinic
	1—4pm	Gynaecology and USS clinic
FRIDAY	8am—9am	Ward round all wards
	9am ---4pm	Operations in the operating theatre

WEWAK GENERAL HOSPITAL

MONTHLY OBSTETRICS STATISTICS 1

MONTH: JANUARY TO DECMBER YEAR: 2017

MOTHERS

	BOOKED	UNBOOKED	REFERRED	TOTAL
NO: (%)	1587 (80.7%)	353 (18%)	26(1.3%)	1966

PARITY DISTRIBUTION BEFORE THIS PREGNANCY

PARITY	0	1-3	4	5 & OVER
(%)	778 (38.%)	966 (49.%)	132(6.7.%)	120 (6.2%)

INFANTS

	A	B	C	STILL BIRTH		D	E	F	G	H
	TOTAL	LIVE BIRTH	TOTAL	MAC	FRESH	SB RATE $\frac{CX1000}{A}$	FIRST WEEK NND	NNDR $\frac{EX1000}{B}$	PNDC&E	PNDR $\frac{(C\&E)X1000}{A}$
Booked	1642	1593	50	25	25	30.4	19	9.7	71	43.1
Unbooked	355	322	32	15	17	90.1	12	37.2	42	119.3
Ref. in labour	28	14	14	6	8	500	2	142.8	16	695.6
TOTAL	2025	1929	96	46	50	47.4	33	17.1	129	63.7
LBW										

500-999gms	17	7	9	5	4	529.4	7	1000	15	882
1000-1499gms	35	27	9	4	5	257	9	333	18	514
1500-2499gms	325	299	26	17	9	80	10	33.4	36	110.7
TOTAL	377	355	44	26	18	116.6	25	70.4	69	183
Macrosomia										
4 kg & more	27	27	0	0	0	0	0	0	0	0
BBA	118	117	1	0	1	8.5	0	0	0	8.5

Multiple Pregnancy		Number	Percent (%)
	Twin	57	2.9%
	Triplet	1	0.05%
	Others	0	0

MONTHLY OBSTETRICS 2

MONTH: January to December YEAR: 2017

METHOD OF DELIVERY	NO	% ALL DEL	PRIMERY INDICATION FOR CAESAREAN SECTION	NO 99 cs	% PER c/s
SPONTANEOUS VERTEX	1788	88%	PREVIOUS C/SECTION	3	3%
ASSISTED BREECH	65	3.2%	CPD/ OBSTRUCTED LABOUR	27	27%
BREECH EXTRACTION			FETAL DISTRESS	25	25%
FACE DELIVERY	1	0.05	Mojar Placenta prae –not in labour	2	2%
VACCUM EXTRACTION	71	3.5	APH - PRAEVIA	11	11%
FORCEPS DELIVERY	1	0.05	Twin/breech	1	1%

CAESAREAN SECTION (TOTAL)	99	4.8%	MALPRESENTATION-BREECH	4	4%
Emergency LUSCS	88	4.3	TVL/ARM PROLAPSE	20	20%
Elective LUSCS	7	0.3%	FACE PRESENTATION	1	1%
Emergency Classical/ inverted "T"	1	0.05	CONGENITAL ANOMALY	1	1%
C/ Hysterectomy	3	0.15	SEVERE PET	1	1%
Vertex			CORD PROLAPSE	3	3%
Breech (+ twin)			CAESAREAN HYSTERECTOMY FOR RAPTURED UTERUS	2	2%
Forceps			3RD STAGE COMPLICATIONS		% per del
TOTAL (all deliveries)	2025		POST PARTUM HAEMORRAGE	61	3.1%
INDUCTION OF LABOUR	29	1.47	RETAINED PLACENTA	30	1.5%
PRIMARY INDICATION			3RD DEGREE TEAR	2	0.17 %
HYPERTENSIVE DISORDERS	7	0.3%	RUPTURED UTERUS	3	0.2%
APH - ADRUPTION			POST PARTUM ECLAMPSIA	1	0.7%
POST MATURITY	5	0.25	ANTENATAL COMPLICATIONS		
Term			ANAEMIA (lowest level during pregnancy)		
FDIU	7	0.3%	Hb 8 – 9.9 g%	103	10.3 %
IUGR without hypertension			Hb less than 8 g%	80	8%
Others			NO RECORD	997	50.7 %
OXYTOCIN INDUC. AFTER SRM	10	0.5%	PRE ECLAMPSIA	27	1.4%

AUG. WITH OXYTOCIN	251	12.7%	ECLAMPSIA	5	0,25 %
PREVIOUS CAESAREAN SECTION	9	0.45%	OTHER HYPERTENSIVE DISEASE	4	0.2%
1 X PREVIOUS SECTION	8	89%	APH - PRAEVIA	13	0.7%
2 X PREVIOUS SECTION	1	1.15%	- ADRUPTION	1	0.1%
NO DELIVERED VAGINALLY	6	66.7%	- INDETERMINE		
NO DELIVERED REPEATED C/SECT.	3	33.35	Teenage Pregnancy	112	5.7%
			DIABETES	0	0
FAMILY COMPLETION	375	19%	PREVIOUS C/ SECTION	9	0.45 %
INTERVAL	144	7.3%	ABNORMAL PRESENTATION	7	0.35
POSTNATAL	186	9.5%	Breech	69	3.5%
C/S + BTL	25	1.3%	VARIABLE LIE		
ERPOC + BTL	16	0.8%	TRIPLETS	1	0.1%
VASECTOMY	4	0.2%	TWINS	57	2.9%
Implant insertion	135	8.3%	POSITIVE VDRL (No rec)	2/5	0
Implant removal	65	3.3			
MATERNAL DEATH	6	311/100 000 LIVE BIRTHS	POSITIVE HIV (No rec)	0/2	0

GYNAECOLOGICAL ADMISSION DIAGNOSIS

MONTH: January to December YEAR: 2017

MENSTRUAL DISORDERS	NO.	ABORTIONS	NO.
Dysfunctional disorders	20	Threatened	6
Peri/Post-menopausal bleeding	6	Incomplete	174

Menorrhagia	1	Inevitable	0
Endometrial hyperplasia	0		
Others	3	Complete	20
BENIGN		Missed	2
Ovarian cyst	37	Septic	7
Fibroid	29	Ectopic pregnancy (ruptured)	18
Cervical polyp	2	Abdominal pregnancy	0
Cervical prolapsed	0	Infertility - Primary	0
Abnormal smear	0	- Secondary	0
Molar pregnancy	9	Postcoital tear	
Endometrial polyp/cyst/hyperplasia	1	- Postpartum	
Others	4	Retained IUD	
MALIGNANCIES		3rd degree tear	
Ovarian cancer	4	Prolapsed Uterus	5
Uterine cancer		RVF	
Cervical cancer	50	UVF	
Choriocarcinoma	1	Secondary Amenorrhoea	
Vulval	2	Endometriosis	2
Others	15	Hormonal Disorders	
INFECTIONS		Admitted for chemotherapy	
PID	33	Terminal illness for repatriation	
Peritonitis – PID	4	Puerpural sepsis	3
- Appendicitis	0	Post partum anaemia	
Pelvic Abscess	3	INTERVAL BTL	152
Bartholin's Abscess	3	Retained Placenta /POCS	24
Wound infection	1	Postpartum pneumonia	
Endometritis		Severe anaemia secondary to Ca Cx	20
Secondary PPH	14	Vulvular haematoma	

Cervicitis/ Vaginitis	3	Wound infection	
Syphilis	0	Thyroid mass	
Donovanosis	1	Cystocele	
Veneral watts	1	Cervical ectropion	
Pelvic Mass	0	Androgen insensitive syndrome	
Malaria	0		
Surgical adhesions	0		
Sexual assault	2		
UTI		TOTAL GYNAE ADMISSION	710

SUMMARY OF ALL ADMISSIONS	
	TOTAL
Admissions	710
Discharges	700
Ref. in as non emergency	59
Ref. in as emergency	104
Transfers in	3
Transfer out to other wards	2
Transfer outside of province	1
Deaths	12
Remaining	84
Abscond	14

ANTENATAL & POSTNATAL ADMISSIONS

MONTH: January to December YEAR: 2017

ANTENATAL	NO.	POSTNATAL	NO.
Anaemia in pregnancy	27	Normal Deliveries	1670
Malaria in pregnancy	11	Birth Before Arrival (BBA)	118
Respiratory Infection in pregnancy	8	Complicated Deliveries	0

TB in pregnancy	2	Breech	65
HIV in pregnancy	0	Face	2
Urinary Tract Infection in pregnancy	42	Instrumental - Vacuum	71
Diabetes in pregnancy	0	- Forceps	1
Intrauterine Growth Retardation (IUGR)	1	Caesarean sections	99
Antepartum Haemorrhage	7	Secondary Postpartum Haemorrhage	3
Breech	0	Primary PPH	21
Unstable Lie	6	Puerperal Sepsis	3
Labour	0	Puerperal Psychosis	2
False Labour	112	Postnatal Tubal Ligation	143
Post Term	2	Retained Placenta	18
Preterm Rupture of Membranes (PROM)	12	Wound infection	4
Pregnancy Induced Hypertension (PIH)	5	Postpartum Anaemia	31
Jaundice in pregnancy	0	Labour Injuries - Nerve Injury	0
Multiple pregnancy – Twins	10	- Pelvic Injury	0
- Triplets	1	- VVF	0
Breast – Mastitis	2	RVF	0
PET	8	Episiotomy	0
Twins with PET	0	First degree tear	0
Oligohydramnious	1	- Second degree tear	5
Polyhydraminous	1	- Third degree tear	4
Hyperemesis Gravidarum	0	Vulva Haematoma	3
High Risk pregnancy for confinement	2	Ruptured Uterus	3
Low Risk pregnancy for confinement	0	Other Postnatal Admissions	2

Foetal Death in Utero (FDIU)	2		
Other antenatal admissions(epilepsy)/gastroenteritis	38		
TOTAL ANTENATAL ADMISSIONS	300	TOTAL POSTNATAL ADMISSIONS	2264

SUMMARY OF ALL ADMISSIONS			
	ANTENATAL	POSTNATAL	TOTAL
Admission	300	2264	2564
Discharges	289	2150	2439
Ref. in as non-emergency	11	57	68
Ref. in as emergency	8	64	72
Transfers In	0	0	0
Transfers out to other wards	0	0	0
Transfers out to other Provinces	0	0	0
Deaths	1	0	1
Remaining	11	114	125
LHAOR/ Abscond	9	20	29

January to December 2017 OPERATIONS

MINOR OPERATIONS		MAJOR OPERATIONS	
OPERATION	NUMBER	OPERATION	NUMBER
Puerperal BTL	186	TAH/BSO	5
ERPOC& BTL	16	TAH/LSO	22
Interval BTL	144	C/SECTION HYSTERCTOMY	3
Vasectomy	4	Elective LUSCS	25
Suction curettage	1	Classical C/Section	2

MROP	22	Emergency LUSCS	67
EUA& DD&C	10	LAPORATOMY	
ERPOC	182	CYST	16
EUA & staging & biopsy	17	ECTOPIC	17
EUA	24	ABCESS	5
Excision Biopsy,warts,granuloma	5	Lap for other pathology	5
EUA & SUTURING	18	Manchester Repair	5
POLYPECTOMY	3		
Sexual assault suturing	2		
Implant removal	1		
Debridement & secondary suturing	2		
TOTAL	639	172	
	811		

Maternal and perinatal death summaries

- ✓ Total maternal deaths = 8
- ✓ Maternal mortality rate= 395/100 000 live births
- ✓ Total deaths from gynaecological cancers=5
- ✓ Deaths from ovarian cancer =2
- ✓ Deaths from cervical cancer = 3
- ✓ Total perinatal deaths = 128
- ✓ Perinatal death rate=63.6 per 1000 births
- ✓ Stillbirths=96
- ✓ Stillbirth rate= 47.4 per 1000 births
- ✓ Neonatal deaths=32 per 1000 live births
- ✓ Neonatal death rate=17.1 per 1000 live births
- ✓ Booked mothers perinatal death rates=43/1000
- ✓ Unbooked perinatal death rates=119/1000
- ✓ Referred cases perinatal death rates=695/1000

SUMMARY OF CAUSES OF DEATHS FOR PERINATAL DEATHS

CAUSES OF EARLY NEONATAL DEATHS FROM LEADING CAUSES

NO	CAUSE OF DEATH	TALLY	PERCENTAGE

1	SEVERE BIRTH ASPHYXIA FROM MEC ASPIRATION	19	57.6%
2	EXTREME LOW BIRTH WEIGHTS.>1500G	10	30.4%
3	CONGENITAL ABNOMALITY	2	6%
4	NEONATAL SEPSIS	2	6%
	TOTAL	33	100%

CAUSES OF STILL BIRTHS FROM THE LEADING CAUSE

NO	CAUSE OF DEATH	TALLY	PERCENTAGE
1	BIRTH ASPHYXIA	29	30.3%
2	VERY LOW BIRTHWEIGHT	14	14.5%
3	TRANSVERSE LIE ARM PROLAPSE/PROLONGED LABOUR-REFERRED CASES	13	13.5%
4	MASCERATED STILL BIRTHS WITH UNKNOWN CAUSES	9	9.5%
5	CONGENITAL ABNORMALITY	9	9.5%
6	OBSTRUCTED LABOUR	4	4.1%
7	SEVERE APH	4	4.1%
8	FOOTLING BREECH WITH CORD	4	4.1%
9	PROLONGED OBSTRUCTED LABOUR VERTEX PX	4	4.1%
10	ECLEMPSIA	3	3.1%
11	RAPTURED UTERUS	3	3.1%
	TOTAL	96	100%

MATERNAL DEATH SUMMARY 8 DEATHS

CAUSES OF DEATHS

NO	CAUSE OF DEATH	NO	PERCERNTAGE
1	APH PPH AND DIC	2 ALL THREE REFERED CASES 2,ANGORAM	40%
2	ADVANCED CHRIOCARCINOMA	1 REFERED FROM NUKU	10%
3	SEVERE PET/CEREBRAL MALARIA WITH END ORGAN FAILURE	1 REFEERED MAPRIK	10%
4	RETAINED PLACENT PPH WITH PNEUMONIA HEART FAILURE	1 REFEREED KAIRURU	10%
5	AMNIOTIC FLUID EMBOLI	1 BOOKED MOEM BARRACKS IN HOUSE CASE. C/SECTION DEATH ON TABLE	10%
6	RAPTURED UTERUS HYPOVULAEMIC WITH SEPTIC SHOCK AND END ORGAN FAILURE	1 REFFERED MAPRIK	10%

DEATHS FROM GYNEACOLOGICAL CANCERS

THERE WERE FIVE DEATHDS FROM GYNECOLOGICAL CANCERS (60%)

THREE WOMEN DIED OF CERVICAL CANCER AND TWO WOMEN DIED OF OVARIAN CANCER (40%)

CASE SUMMARIES OF MATERNAL DEATHS

	Name/AGE	Diagnosis	Treatment	Date of Death	Type of delay
1. 4/1/17	N.Y 28yrs, Para 4g5, referred case from Maprik with raptured uterus ,FDIU	In hypovolumic septicaemic shock- taken in for STAH – bp pulse unrecordable. Slow recovery intra-op	STAH, died in ward from septicaemic shock.	5/1/17	Died of Multiorgan failure=hypovolaemic septicaemic shock. Delay in ICUreceiving care

2. 7/10/17	A.P f/40 p5g6 referred from Kairuru HC with retained placenta,PPH and severe pneumonia with heart failure. Unfit for GA- to stabilise then OT	Was already in multi-organ failure, in severe respiratory distress, no urine output,low sp02,	Given triple antibiotics, oxytocins , lasix and O2 could not get blood no blood in bank	7/10/17	Died of multiorgan failure=ARDS, delay in ICU receiving care
3.	MS, 36 year,p7g8 old referred from Nuku with severe anaemia, Miliary TB,and Advanced choriocarcinoma in Heart Failure	Admitted via ED hb 3.7G% , wcc 17,000 CXRay showed, severe brochocpnemonia ?military TB, ? secondaries to lungs consulted physicians no response	transfused with two units of blood,.given triple antibiotics and lasix 20mg daily- and given FDC but no improvement conditioned deteriorated	Died of multi-organ failure and overwhelming sepsis > fr0m disseminated TB /choriocarcinoma died	Delay in referral, patient advanced choriocarcinoma
4..)18/11/17	G.B, 30yrp1g2 pregnant at 30weeks referred case from Maprik District Hospital with cerebral malaria and severe PET 160/110 with multiorgan failure in coma	Positive PF 120/1. Hb 9.7.wcc 8700 plt normal,	Given MgSO4 and anti-hypertensive and anti-malarials before referral	18/11/17	Needs ICU care and multidisciplinary approach. Unbooked mother no malarial prophylaxis in pregnancy
5...)27/3/17		APH/PPH/DIC			
6..)20/3/17		AMNIOTIC EMBOLI			
7..21/11/17		APH/PPH/DIC			

ANALYSIS OF PROBLEMS ASSOCIATED WITH CARE OF MOTHER AND BABY

Perinatal death audits revealed that more than 50% of the fresh still births and early neonatal deaths were due to birth asphyxia.

The other problems are high unbooked rate of 20%.associated with high perinatal death rate of 119/1000 live births.

Late referral of cases mostly of transverse lie and obstructed labour

Birth asphyxia is related monitoring of a mother in labour- care provided by midwives and doctors working in the antenatal period and during labour in the labour ward, whether routine hourly obs are taken and whether the mother and the baby are monitored on the partogram.

Use of fetal monitoring devices, whether we are using the fetoscope, CTG to monitor babies properly

Proper intrapartum care with low threshold to alert doctors on high risk pregnancies, such as breech, TLV, aph, twins, pet, previous poor obstetric history, meconium stained liqour, 2+ to 3+ mec liqour.

oncall team to start and finish the day in labour ward before going home monitoring every mother in labour,

More than 50% of maternal and perinatal deaths are reffered cases and are reffered too late in labour

No effective communication and refferal pathway in place,

All midwives, pathology, theatre staff and doctors live out of the hospital and responding to emergencies take over an hour before any important oncall staff comes into hospital.

All health workers need inservive on antenatal care, intrapartum care and postpartum care of mother and baby.

Gynaecological problems

- ✓ Increasing no of women comming in with adavnced cancers of the cervix and ovarian cancers.
- ✓ 50 cases of cervical cancer admissions- 3 three died in hospital others sent home to die.
- ✓ 4 cases of ovarian cancer- 2 died already.
- ✓ Need for well womens clinic ie papsmear clinic and
- ✓ Via visual inspection under ascetic acid and cryotherapy
- ✓ High rates of induced abortion,
- ✓ Great need for family planning clinic
- ✓ Adolescent sexual and reproductive health clinics

Achievements

- ✓ New registrar ,HEO and two RHEOS and more midwives
- ✓ New laundry and rubbish bay
- ✓ 6 new delivery beds
- ✓ New CTG machine
- ✓ New scrub gear
- ✓ New jug and cooler for postnatal ward
- ✓ Infection control standards have greatly improved and there is now low rates of neaonatal and puerperal sepsis in the wards.

Recommendations for change.

Construction and establishment of a new ESPHA family health clinic-house a number of other clinics including:

- ✓ Antenatal clinic
- ✓ Gynaecology clinic
- ✓ Family planning clinic
- ✓ Well woman's clinic
- ✓ Well man's clinic
- ✓ Family and sexual violence clinic

Construction of a new maternity wing coming up which will house a number of wards

- ✓ Labour ward
- ✓ Special care nursery
- ✓ Gynaecology ward
- ✓ Antenatal ward
- ✓ Postnatal ward
- ✓ Operating theatre
- ✓ High dependency unit for critically ill and post op patients

Equipment

- ✓ Ultrasound scan machine x2 for clinic and ward
- ✓ Neonatal resucsitoir x2 for labour ward and operating theatre
- ✓ New set of delivery trays x 10, includes instruments like- artery forcepx1, corkers forcepsx2, tissue forceps x2, curves tissue scissors x1, suture scissors x1, kidney dish x1 bowelx1
- ✓ Vacuum extractor set, birds cup and rubber tubingsx4
- ✓ D&C tray x2
- ✓ Destructive tray x1
- ✓ Fetal dopplers x10
- ✓ BP machines and stethoscope x10

Human resource

EOC training for hospital and rural staff one per district this year

CHW midwifery up skilling for all districts to the ESPHA hospital

Attach Marie stopes and living child for family planning outreach and training of rural health workers.

Send at least 5 midwives yearly for training

Train a registrar each year for dgo and masters

Twice weekly in-house CME for hospital staff –ongoing

Send midwives and doctors for nurses and medical symposium and other international conferences such as midwifery conference and pacific society of reproductive health.

Accommodation for essential on call staff

Essential on call staff such as midwives theatre nurses, pathology, anaesthetist and radiology must be given accommodation on site.

Communication logistics for early referral

All health centres, aid posts and district hospitals must be linked to a central communication line through the hospital switch board and the vhf radio.

Hospital must have an internal ambulance to help evacuate emergencies within wewak or other districts linked to Wewak by road in cases of dire emergencies. Hospital is undergoing a reconstruction phase and there is a real need for an internal hospital ambulance

Regular blood bank mobile outreach, to have more blood in the bank all the time.

Establish good support services in the districts such as blood bank pathology and xray.

Upgrade district health centres such as Angoram and Maprik to district hospital status to provide comprehensive emergency

Establishment of a maternal and perinatal task force- to audit maternal and perinatal death and make recommendations for improvement of care.

Acknowledgements

- ✓ The management and board of ESPHA
- ✓ Donors who helped ESPHA O&G unit
- ✓ The maternity unit staff and patients also sincerely appreciates the great help by donors who ensure basic services reach our rural majority.
- ✓ Living child foundation- Jim and Robyn and team, for assisting family health clinics and Angoram district health services.
- ✓ Spacim Pikinini rotary Australia- Wendy stein and team for doing family planning in East Sepik province.
- ✓ Good Samaritan for always evacuating medical emergencies, and donating mattresses and other equipment
- ✓ Ywam ship for outreach to Angoram and Wewak islands.
- ✓ Vamed Internation for the enormous task in rebuilding Wewak hospital a multimillion project which includes the maternity wing.
- ✓ And finally all the team of ESPHA staff who contribute tirelessly to providing family health services for East Sepik province.
- ✓ Paediatric department

PAEDIATRIC WARD

Introduction

As discussed the paediatric division comprises of the following subdivisions under the division with several areas which are covered to provide best paediatric care to the people of East Sepik province and Sandaun province as well.

1. **Neonatology unit (SCN)**

- Neonatal intensive care unit (NICU) regarded as the (clean bay).
- Sepsis bay
- Recovery unit that is the susu-mama rooms.
- Postnatal care
- Delivery wards.

2. Paediatric/children's unit (ward 3) (infants, children & adolescence)

- Paediatric intensive care unit (ICU). Also called acute ward.
- Recovery/ambulatory
- Chronic patients and child abuse.
- Adolescence ward.
- Nutrition ward with tuberculosis/HIV/AIDS

Note: **with the current development the paediatric unit will have an additional adolescence ward. The patients will be aged from 13 years to 17 years.**

Consultation clinics

- ✓ Children outpatient department (COPD)
- ✓ Maternal and child health (immunizations)
- ✓ Radio talk back show – radio ES.

Community Paediatrics E.G.: Rural Outreach Programs

The paediatric division was managed well despite many problems that had been encountered in 2017 by the medical staff and with the assistance accorded by the paediatric division nurses under the supervisions of the paediatrician Dr Kauve Pomat and the ward manageress or the sister in-charges (**SIC**) of each sub divisions and the supervisor sr. Jacinta Sairere of the paediatric division.

This report will discuss the paediatric unit performances during the year, the constraints and the plans to archive the best quality of children's health care service delivery in an integrated manner encompassing the communities and the province as a whole.

The report may reveal any improvements or failures in the general management of the patients. With these results and findings after data analysis a proper plan can be drawn up to improve and better the paediatric services in wewak general hospital and to the whole province under the espha management of the provincial and national health system with series of health services.

THE STAFF STRENGHT OF THE PAEDIATRIC DIVISION

A. The medical Services staff: 4

SSMO	Dr Kauve Pomat
Registrar	Dr Violet R Nagiria/Dr. Stella Malisa
HEO	HEO Serah Wasi
Paediatric Unit supervisor: 1	Sr. Sairere
SIC Ward 3:	Sr. Scholar Kapari/Sr. Daisy Naboam.
Ward 3 nurses	
Nursing officers	8
CHW	6

E. Nutritional Unit	4
NO	2
CHW	2
Paediatric Unit Clerk	1
Cleaner /Hygiene	1
SIC Neonatology Unit:	Sr. Regina Urosombi
SCN nurses	
NO	6
CHW	6
Consultation clinic	
NO	2
CHW	2

PAEDIATRIC SERVICES PROVIDED

- ✓ Accident and Emergency Care.
- ✓ Children Out-Patient.
- ✓ General Paediatric In-Patient Care
- ✓ Neonatal In-Patient Care
- ✓ Weekly outpatient review of discharged nursery patients every Thursday at SCN.
- ✓ Consultation clinics on Thursday's weekly & Nutritional unit review weekly as booked.
- ✓ Immunization services on opportunity based at the wards and during the consultation clinic days.
- ✓ TB/HIV & Child abuse care.
- ✓ Counselling services for PPTCT/Adoption/Nutrition/Hygiene/Family planning etc.
- ✓ Daily patient education & Daily ward round teaching at the patient's bedside.
- ✓ Specialist Rural Out Reach.
- ✓ Medical referrals and reports.
- ✓ Medical Team In house teachings twice weekly.

IMPORTANT NOTE:

The Child Health Policy and Plan recognizes that other areas are important to child health in PNG, including adolescent health, family planning and maternal health.

Adolescent health has been largely neglected by medical services in many countries, including PNG; paediatricians have concentrated on children aged 0-12 years, and adult physicians have focused on those over 18 years of age.

Focus on adolescents is an opportunity to protect children from acute and chronic infections including STDs, HIV/AIDS, lifestyle diseases, chronic non-communicable disease and social problems which result in the majority of the disease burden in adults in PNG. It is also an opportunity to promote good health for future mothers and fathers

A healthy adolescence requires informed and safe choices about risk-taking behaviour such as smoking, alcohol and other drugs, sexual activity, diet and relationships. Adolescence is a time when interventions and healthy choices may reduce the risk of chronic physical illness in adulthood, and reduce the risk of adverse mental health and substance abuse problems.

The programs currently in place to address issues affecting adolescence are very limited. The policy aims in this area are to: Provide appropriate facilities for adolescent health services. Improve human resources for adolescent health. Provide training for a paediatrician in adolescent health, to act as a national resource person for this area. Provide training for other health workers in adolescent health.

Therefore the Paediatric Division of East Sepik Provincial Health at the Wewak Provincial Hospital will accommodate the adolescence Health into the Paediatric Division with the current Paediatric Ward restructure so these population of adolescence in East Sepik will be captured.

Paediatric Division Statistics For 2017

Under this sub heading, there are three topics to be discussed after analysis of the data. These are:

- ✓ NEONATOLOGY UNIT OR THE SPECIAL CARE NURSERY STATISTICS OF 2017.
- ✓ PAEDIATRIC UNIT OR THE INFANT, CHILDREN & ADOLESCENCE STATISTICS OF 2017.
- ✓ THE COMPARISION OF DATAS FROM 2016 AND 2017.

NEONATOLOGY UNIT OR THE SPECIAL CARE NURSERY STATISTICS FOR 2017.

Neonatal care In PNG neonatal mortality makes up 50% of infant mortality, so reducing neonatal mortality is vital to improving child survival.

Two thirds of neonatal deaths are associated with high risk pregnancies, labour and delivery. Although there are many factors, **prematurity**, **low birth weight**, deliveries that are not supervised by skilled health workers, and **neonatal sepsis** account for the majority of deaths in the first month of life in PNG.

Efforts to reduce neonatal mortality are closely linked to safe motherhood programs, including the National

Strategic Action Plan to Reduce Maternal and Newborn Mortalities and the WHO Integrated Management of Pregnancy and Childbirth (IMPAC). Antenatal clinics (ANC) continue to be important to prevent neonatal illness.

The policy aims in neonatal care are to provide the highest possible level of care for newborns in health facilities and within communities: Encourage access to the highest possible quality ANC and delivery care by skilled birth attendants Ensure that Essential Early Newborn Care is provided to all newborns Implement Minimal Standards of Neonatal Care in provincial and district hospitals and health centres Promotion of breast feeding (see also breast feeding, nutrition and micronutrients section of this plan)

Provide understandable information on newborn care available to all mothers

Develop centre of excellence for neonatal care and training at Port Moresby General Hospital and major provincial hospital.

Therefore in Wewak Hospital we try our best with the limited resources to provide the best Neonatal Care. The results of our data collection are as follows with analysis:

Total and Causes of admissions.

Total and Causes of deaths.

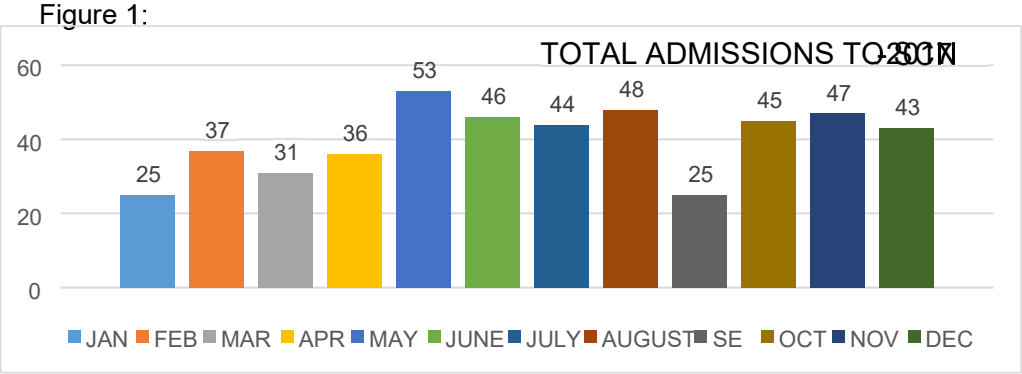
Summary of admissions, discharges, deaths, absconds, LHAOR and transfers in & out. 4) Patients Volume Statistics

Distribution of vaccines

Neonatology Unit or the so called Special Care Nursery is an Intensive Care Unit for sick neonates from birth to 28 days of life with a bed capacity of 32 beds. The average length of stay is from five days to sixteen days. And the ward rounds are done daily from Monday to Friday and on weekends.

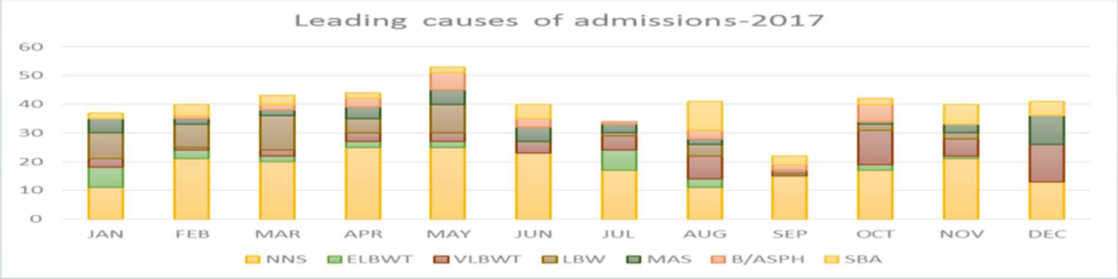
1) The Total Admissions and the Causes of Admissions

Figure 1:



The highest admissions of patients was during the month of May and November with the lowest during January and September as expected due to the Christmas holidays and the Independence Day for PNG.

Figure 2:



The highest number of the patients been seen and admitted In Neonatology Unit was in May (53) and April (44) in 2017. The lowest number of admission to the Nursery was in the month of September with The lowest number of 25 patients been admitted. The majority of these patients were diagnosed with Neonatal Sepsis.

The lowest admission number in September may be due to the Papua New Guinea Independence

Day celebrations which results in transport difficulties and individual families' celebrations therefore parents wait until all celebrations are done before taking their sick neonates to the hospital.

The leading causes of admissions was from **Neonatal Sepsis (NNS) of 219** patients followed by **Birth Asphyxia** than **Very Low Birth weight (VLBW)** of about 61 patients. The 6th cause of admissions to the Neonatology Unit is Extremely Low Birth Weight (ELBW).

The top five (5) leading causes of admissions to the Neonatal Unit of Wewak Hospital are;

1. Neonatal sepsis (219)
2. Birth Asphyxia (72)
3. Very low birth weight (61)
4. Low birth weight (54)
5. Meconium aspiration syndrome (42)
6. Extremely low birth weight (29)

Total number of patients admitted with Birth Asphyxia is about 72.

This total includes mild, moderate and severe birth asphyxia therefore should elevate the status of birth asphyxia to the second most common admissions to the Neonatal Intensive Care Unit This result mean that the following:

Poor delivery room delivering techniques that should be investigated and improved.

The examination and investigations of the pregnant mothers nearing term or with early signs of labour should improve using the ultrasound scan, CTG, fetoscope etc.

Poor Early and proper monitoring and management of pregnant mothers with medical conditions or pregnancy induced complications.

Poor early intervention of babies with problems in the womb when investigated and identified.

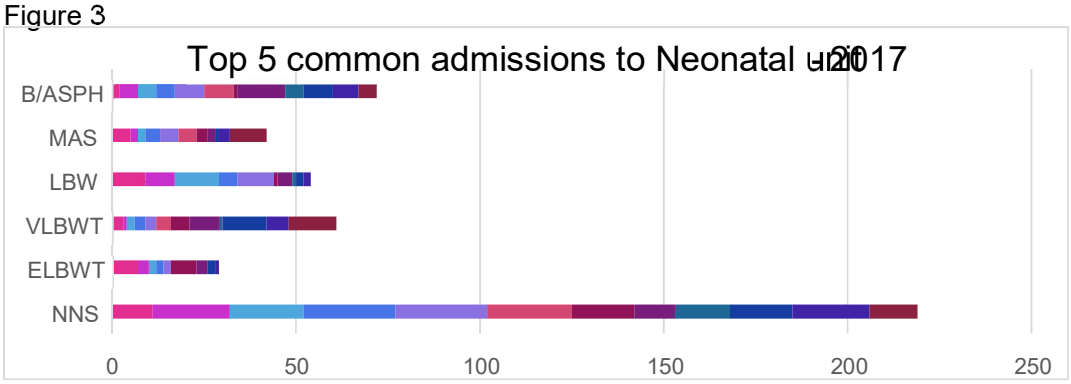
Neonatal resuscitation technique and the Early Neonatal Diagnosis method of care was not sternly applied.

Delayed response to deliver the neonates with complications.

Amnio-infusion not done to meconium stained liquor.

There was no suction or proper suction or clearing of the oropharyngeal airway before the delivery of the baby's shoulders and chest for the first intake of breathe in life.

Figure 3



Important notes:

- ✓ The total number of caesarean section is 22
- ✓ The total number of Congenital Anomalies is 19.

- ✓ Born before arrival babies (BBA) were totalling of 19.
- ✓ Neonatal Meningitis patients admitted were 7.

Top 5 leading Causes of Deaths in Neonatology unit.

In 2017 there were 63 deaths in the Neonatology Unit which composes **11.1%** of the total admissions over the year.

Most of the deaths occurred during the months of July (10), June (8) and October (8). The top five conditions resulting in deaths of the neonatal patients were:

Severe Birth Asphyxia at a total of 16 deaths (22.2% CFR)

Neonatal Sepsis at a total of 14 deaths (6.4% CFR)

Extremely low Birth weight at a total of 14 deaths too.(48.3% CFR)

Very low birth weight (6) – (9.5%CFR)

Meconium aspiration syndrome(5) – (7.9% CFR)

In 2016 the top 5 deaths were prematurity, birth asphyxia, neonatal meningitis, others and neonatal sepsis with a total of crude fatality rate of 5.3%.

The highest case fatality rates of the disease diagnosed in neonatology to the low risk of deaths are;

- ✓ Neonatal meningitis at 57% CFR
- ✓ Extreme Low Birth Weight at 48.3% CFR
- ✓ Severe Birth Asphyxia at 22.2% CFR
- ✓ Congenital abnormalities at 21.1%
- ✓ Meconium aspiration syndrome at 12% CFR -
- ✓ Very Low Birth Weight at 9.8% CFR -
- ✓ Neonatal Sepsis at 6.4% CFR.

The 4 listed with the highest case fatality rate meant that the prognosis were very poor and the final outcome of the patients with the above diagnosis admitted to the Neonatology Unit had died with very few days. The chance of survival of a neonatal patient with Meningitis or ELBW or Birth Asphyxia is minimal.

For example, the total number of patients admitted and diagnosed with Neonatal Meningitis are 100% over the year of which 40% survived and approximately 60% died meaning that Neonatal Meningitis has a very high mortality rate.

COMPARING ALL NEONATOLOGY UNIT DEATHS OVER THE YEAR

Figure 4

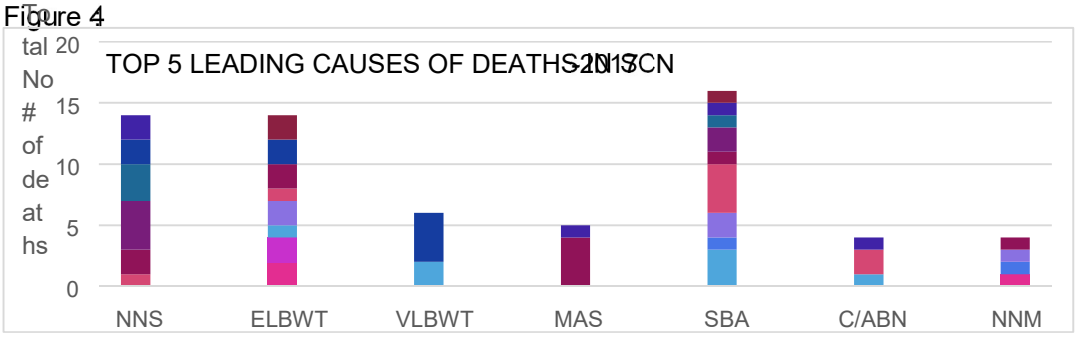
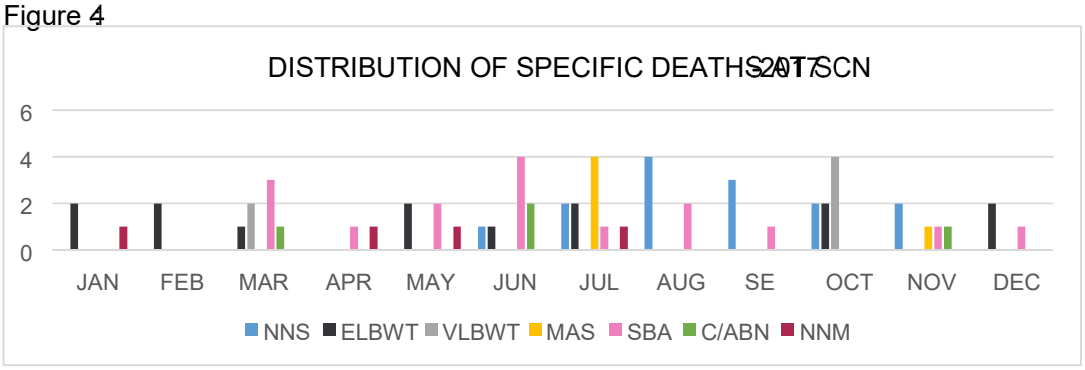


Figure 4



These are the following interpretation of the graphs above (Figure 3 & 4) about the distribution of patient's deaths in the Neonatology Unit over the year 2017:

Severe birth asphyxia deaths was commonest during the months of March and June.

Meconium aspiration syndrome death was the highest in the month of July followed by November.

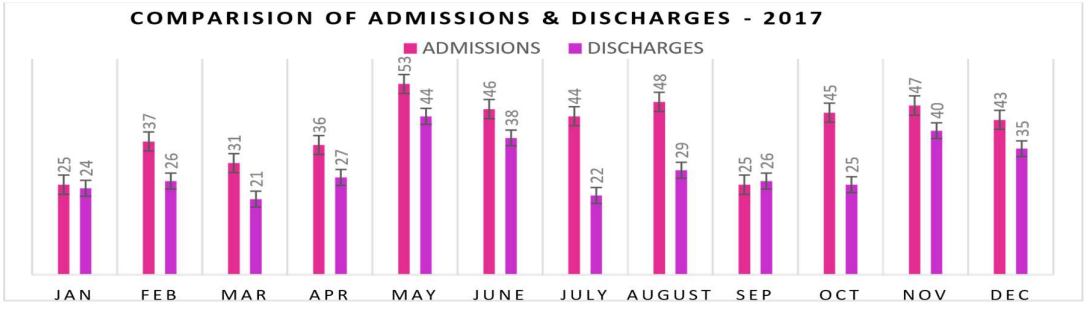
Neonatal sepsis death is the highest in August and September.

Very low birth weight patient dying is at its highest in October.

There were 2 congenital abnormality patients death in June. That was high.

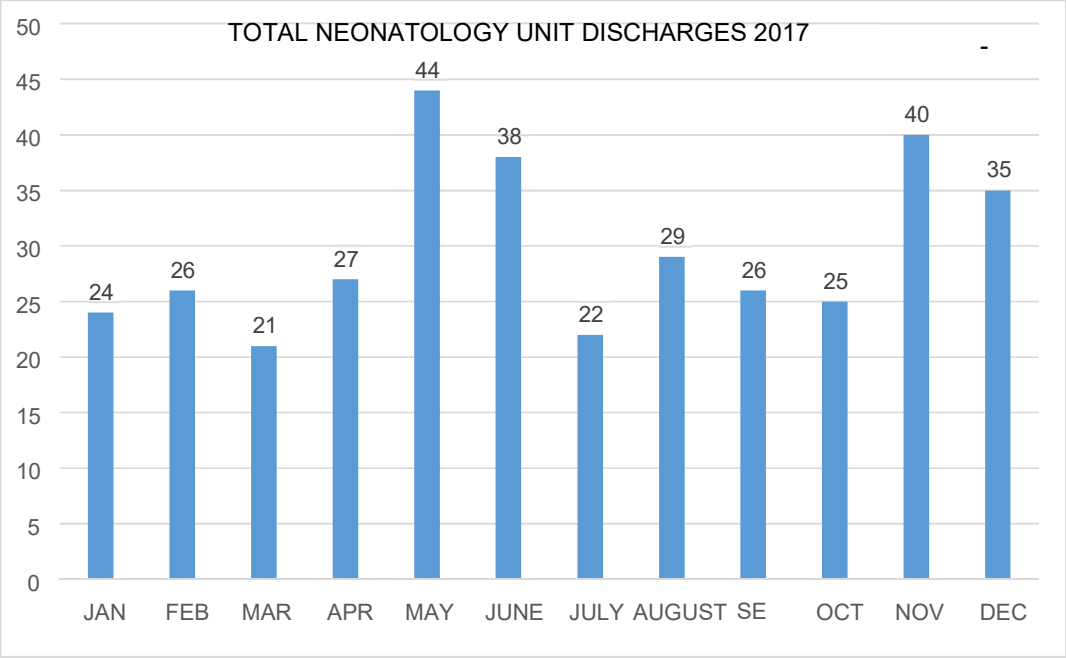
Otherwise the distribution of death in the Extremely Low Birth Weight neonates is evenly spread out over the year. That is normal given the case fatality rate of 48.3%.

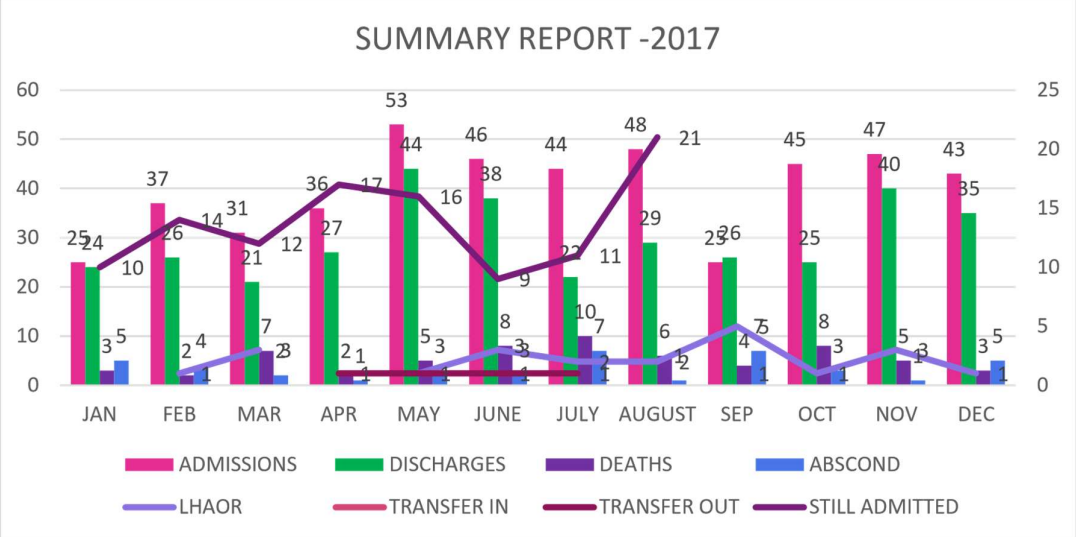
3) Summary Of Admissions, Discharges, Deaths, Absconds, LHAOR, Transfer In & Out.



The discharges are lower than the admissions monthly due to different diagnosis of the patients and the length of stay at the hospital requiring treatment or palliative care.

The highest number of discharges (44 patients) was in May which also corresponds to the high number of patients (53) admitted during that same month.





The following can be depicted from the above graph [Figure 5:]

The highest number of patient been admitted to the SCN over the year was during the month of May, August and November.

Discharges corresponded to the number of admissions.

Most deaths occurred in the month of July.

Most patients absconded in July and September.

Those who left at own risk was commonest in September.

Patients Volume Statistics

	Average length of stay	Average admissions/day	Average discharges/day	Bed occupancy rate (%)	Average daily census (no: of patients)
Jan	9	1	1	34%	11
Feb	8	1	1	28%	9
Mar	9	1	1	28%	9
Apr	12	1	1	25%	8
May	16	2	1	34%	11
June	10	2	1	31%	10
July	7	2	1	44%	14
Aug	7	2	1	38%	12
Sept	5	1	1	16%	5
Oct	10	2	1	50%	16
Nov	8	2	1	34%	11
Dec	13	1	1	41%	13

The longest average number of days a patient had stayed in the ward before being discharged is 16 days. The patient was discharged in May.

This is followed by the month of April (12 days) and December (13 days).

The summary of the whole year are as follows:

- ✓ The average length of stay in Neonatology Unit is: 10 days.
- ✓ The average admissions per day to SCN is: 2 patients
- ✓ The average discharges per day is: 1 patient.
- ✓ The bed occupancy rate is: 34%

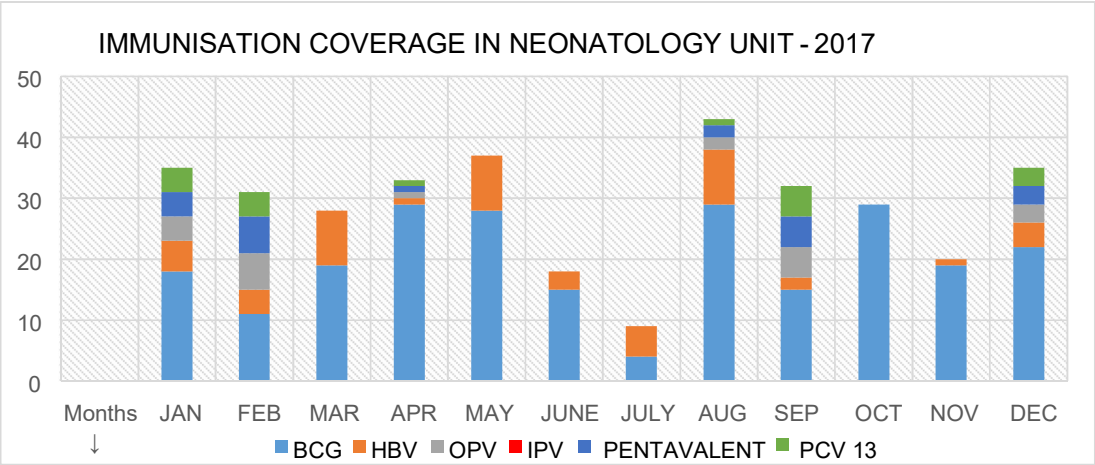
The average daily census of the number of patients: 11 patients. **The Immunisation Coverage of the Neonatology Unit.**

Vaccines → Months ↓	BCG	HBV		OPV	IPV	PENTAVALENT	PCV 13
JAN	18	5		4	0	4	4
FEB	11	4		6	0	6	4

MAR	19	9		0	0	0	0
APR	29	1		1	0	1	1
MAY	28	9		0	0	0	0
JUNE	15	3		0	0	0	0
JULY	4	5		0	0	0	0
AUG	29	9		2	0	2	1
SEPT	15	2		5	0	5	5
OCT	29	0		0	0	0	0
NOV	19	1		0	0	0	0
DEC	22	4		3	0	3	3
TOTAL	238	52		21	0	21	18

The patient who had been followed for weight gain at SCN were given the other vaccines apart from BCG and HBV.

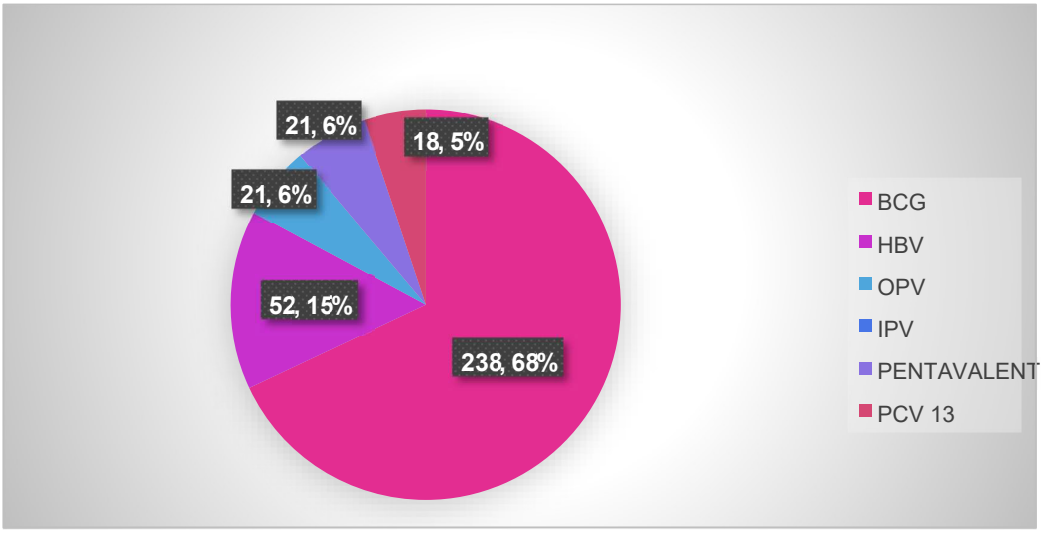
BCG vaccines was in stock when the HBV ran out therefore there is reduced coverage at birth.



The highest immunisation coverage in the Neonatology Unit was in August 2017 and the lowest coverage in July and June. HBV vaccine coverage should be equivalent to the BCg but as analysed the HBV was low due to lack of supply and stock.

The other vaccines been recorded were given to patients who are over one month old. Those were the patients diagnosed with LBW, VLBW and ELBW who were followed up regularly at the Neonatology Unit for weight gain till discharged at weight of 2.5kg and over.

Below are the interpretations of the immunisation coverage over the whole year in the Neonatology Unit in 2017 basing on the above table and the graphs illustrated under the topic.



BCG is the most given vaccines at birth over the year due to availability when HBV actually was out of stock.

The total vaccines given to patients over the year seemed to be equal except for the months of May and June 2017 where the number of patients vaccinated was only 25 and 5% of which the BCG was the major vaccine given then.

The highest admissions and discharges to the Neonatology Unit was around May and June meaning that most of the patients was not immunised before discharged.

Paediatric Unit (Infants, Children and Adolescence Statistics)

The Children's ward currently cater for children under 14 years of age with the exception of the Thalassaemia patients whose age range do sometimes exceed the current age range required for admissions to the wards.

With the current reconstructions of the children's wards the Paediatric Division will have access to 5 subunits for differentiation of the patients according to their diseases and the range of ages to appropriately manage them according to the paediatric codes and regulations ethically.

The paediatric division should have four (4) essential units for the paediatric medical and the nursing team to manage. These are as follows

- ✓ Paediatric Intensive Care Unit (PICU).
- ✓ Paediatric Recovery wards
- ✓ Paediatric chronic wards
- ✓ Paediatric adolescence wards 5. Paediatric Nutrition/TB/HIV wards.

The paediatric adolescence wards should accommodate children age range of 14-16 years old. These are the special group of patients who had missed out on proper patient care and management by the Paediatric Division.

The data presentations and discussions will be as follows:

1) Causes of admission

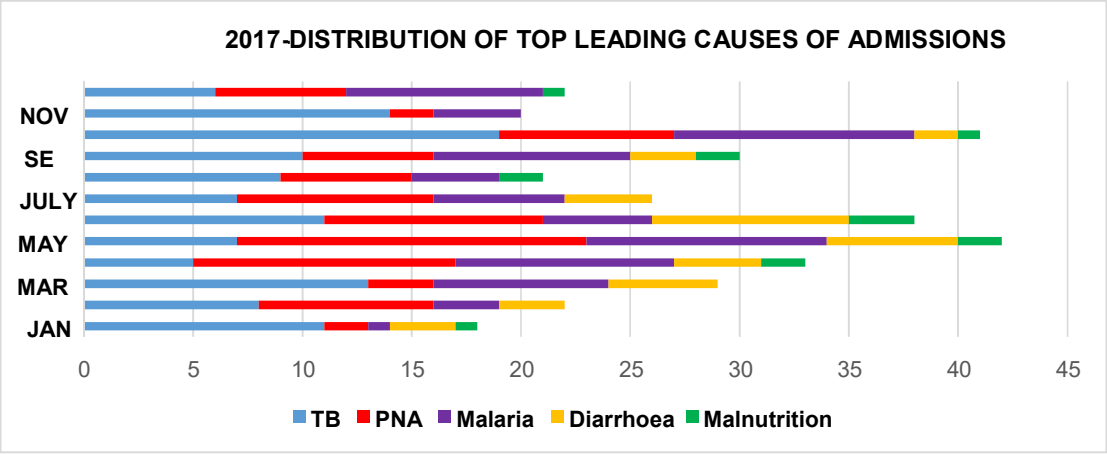
2) Causes of deaths

3) Summary of admissions, discharges, deaths, absconds, LHAOR and transfer in & out.

4) Average length of stay.

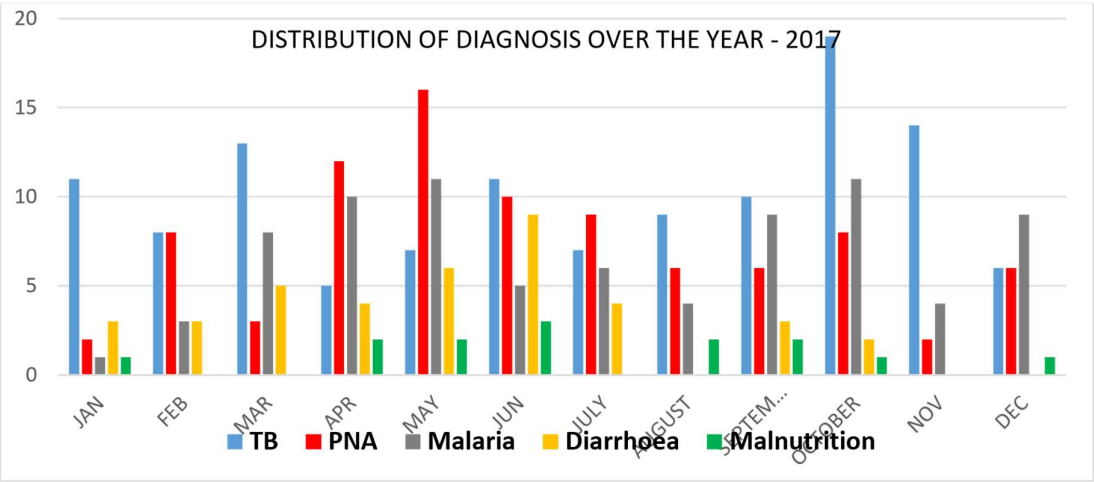
5) Distribution of vaccines

The Top 5 Causes of Admissions to the Children's Wards.



The highest admissions was in May and October 2017 and lowest in the month of January.

Majority of the diagnosis were from TB, Pneumonia, Malaria and Diarrhoea whereas in 2016 was Malaria, Tuberculosis, pneumonia, meningitis and Malnutrition.



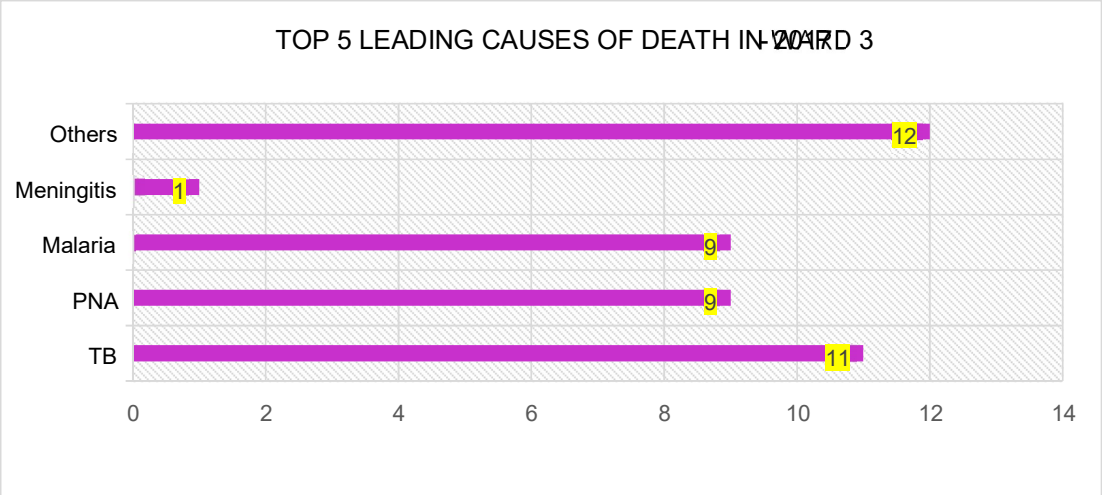
The month of the highest TB patient admissions was in October and November.

Pneumonia cases were the highest in May followed by April of 2017.

High Malaria cases were common in May and October.

The month of June had lots of Diarrhoea cases been admitted.

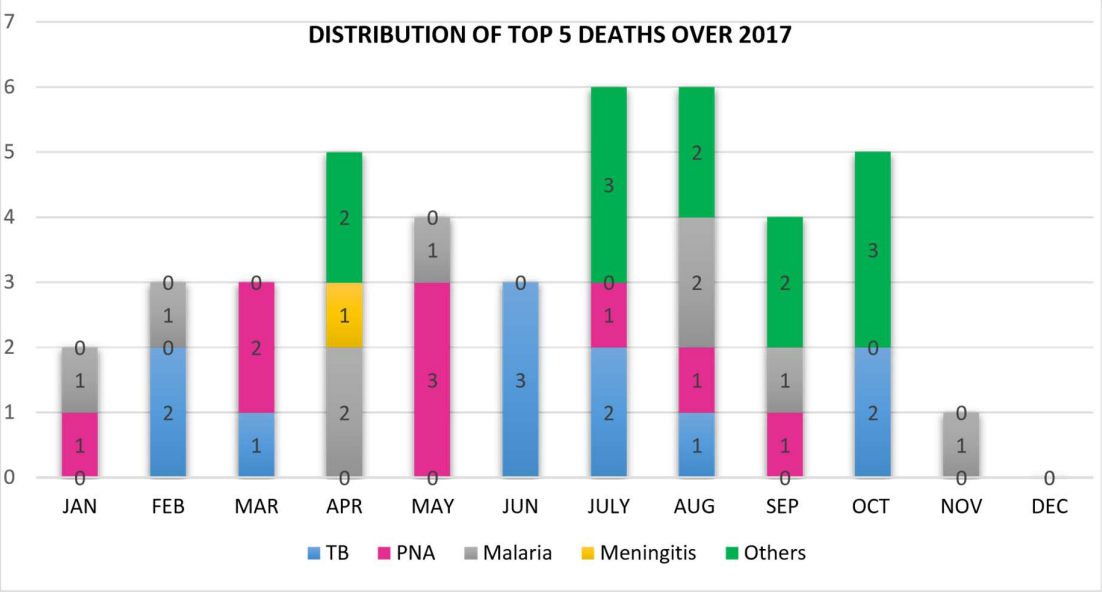
The Top 5 Leading Causes Of Deaths in the Children's Wards



Most of the deaths in the Paediatric Unit is from Tuberculosis followed by Malaria and Pneumonia.

There was only one death from Meningitis.

Others relates to other disease conditions that contributed to death of 12 patients.



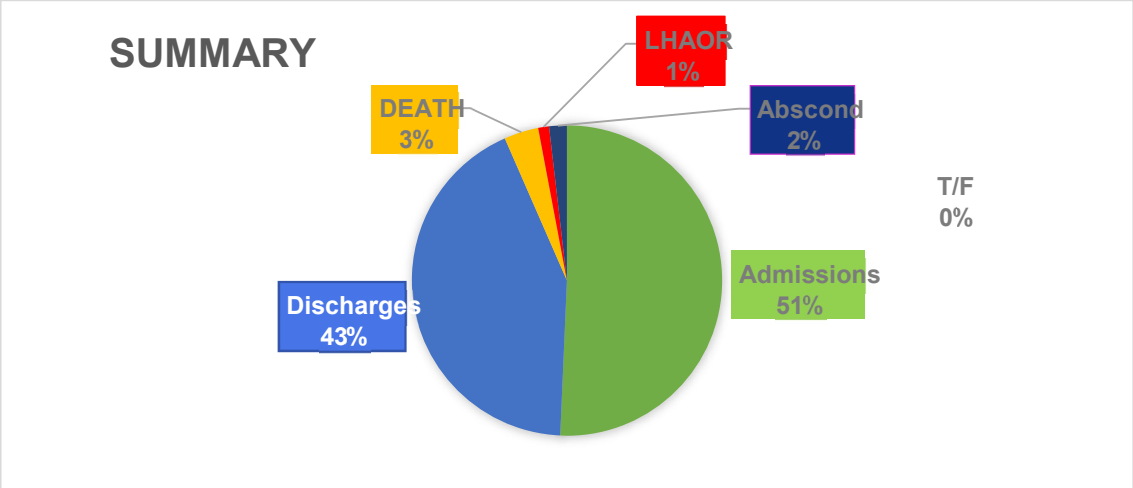
Most of the sick patients died over the month of July and August 2017 and also followed by October and April.

Others include the others diseases apart from the top 5 diseases causing deaths.

Statistics Summary.

51% of the patients that were admitted over the year only 43% had been officially discharged while the other patients either died, absconded or left at own risk by their guardians.

3% died of TB, Pneumonia and Malaria with other diseases.



There are several points to consider interpreting from the above graphs:

Admissions to the unit revealed a fair and about equal number of patients were admitted over the year with the highest numbers in May and October.

The number of Discharges are similar to the number of admissions except more discharges also in June and September too.

Most deaths occurred during the months of July and august of 2017.

Majority of the patients that left the hospital at their own risk (LHAOR) were in December due to the Christmas and New Year Period.

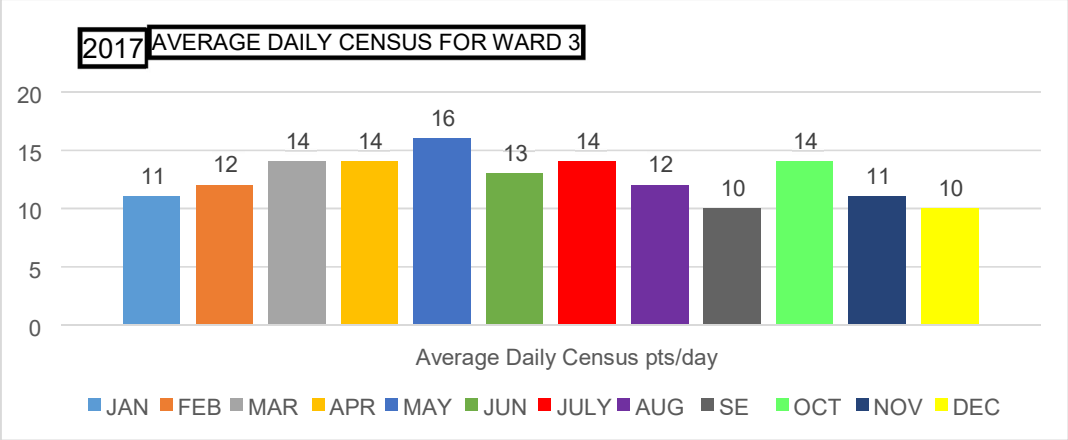
Transfer of the 2 patients happened in July and September.

The Summary of Volume Statistics

Months	Daily Census (pts./day)	Occupancy Rate (%)	Average length of stay (days)	Average admissions (pts./day)	Average Discharges (pts./day)	Mortality Rate (%)	Crude fatality (%)
JAN	11	52	31	1	1	7	15
FEB	12	57	12	2	1	5	6

MAR	14	67	10	1	1	7	7
APR	14	67	12	2	2	10	13
MAY	16	76	8	2	2	8	7
JUNE	13	62	8	2	2	5	6
JULY	14	70%	12	2	1	11%	15%
AUG	2	60%	9	2	1	5%	6%
SEP	10	50%	7	1	2	7%	6%
OCT	14	70%	9	2	1	6%	8%
NOV	11	55%	9	1	1	2%	3%
DEC	10	50%	9	1	1	0%	0%

a) Daily census

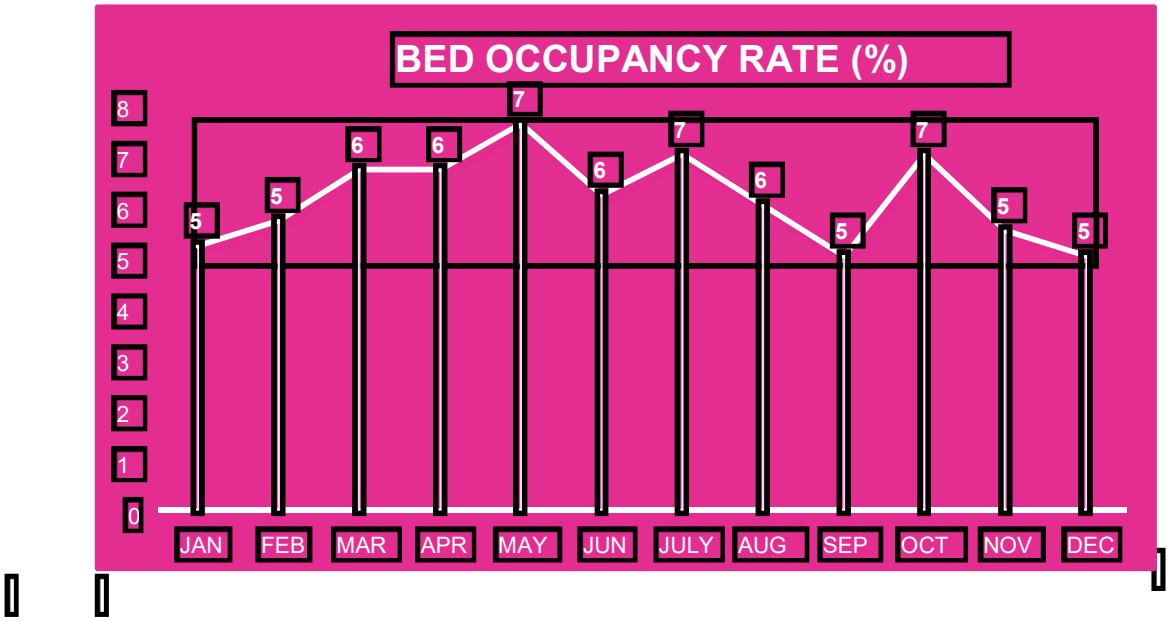


The average daily census over the 12 months is 12 patients per day.

The maximum number of patients in the wards per day for each month is 14 patients followed by 12 patients.

The minimum number of patients in the ward per day is 10.

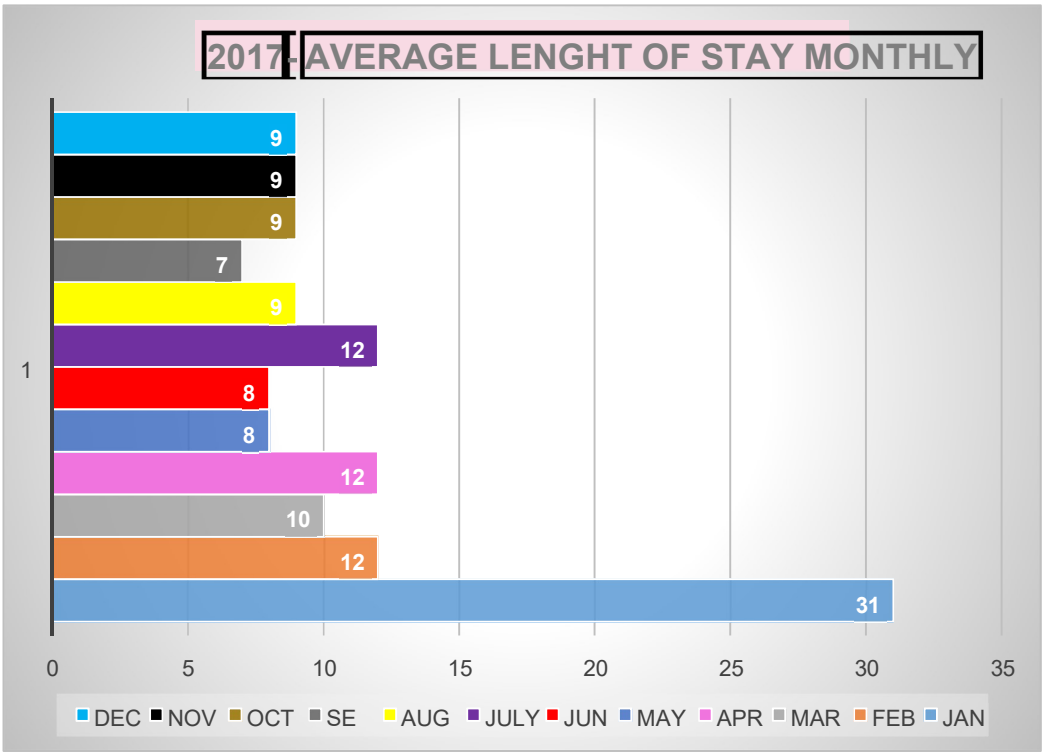
b) Occupancy rate.



The beds in the Paediatric Unit was occupied more than 50% of the time over the year.

The month of May had the highest occupancy rate of 76% followed by July and October at 70%.

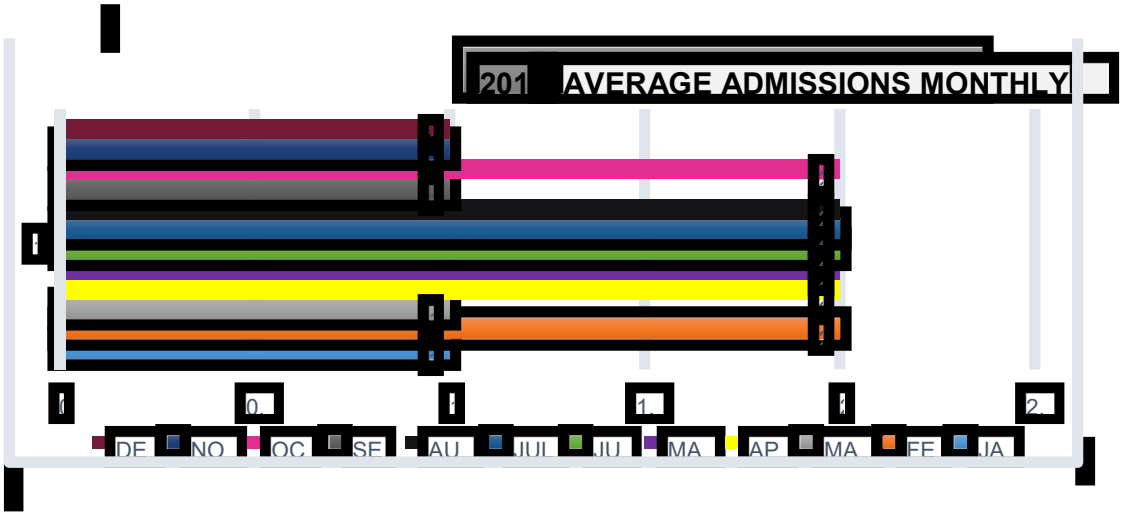
c) Average length of stay.



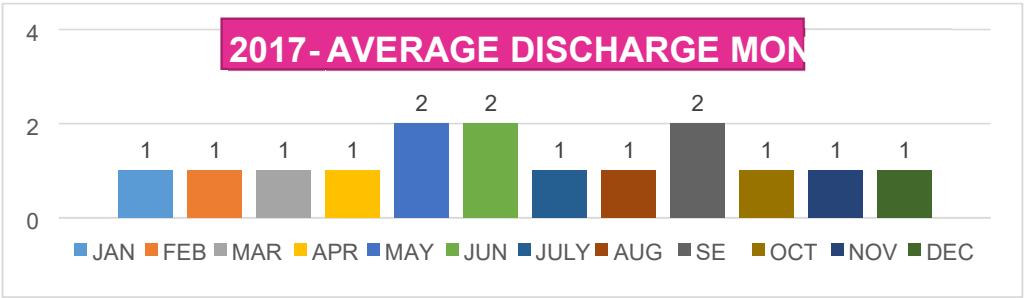
The longest days a patient had resided in the wards awaiting treatment is 31 days and the minimum is 7 days.

The average of length of stay is 11 days in the paediatric Unit in 2017.

Average daily admissions



Average daily Discharge.



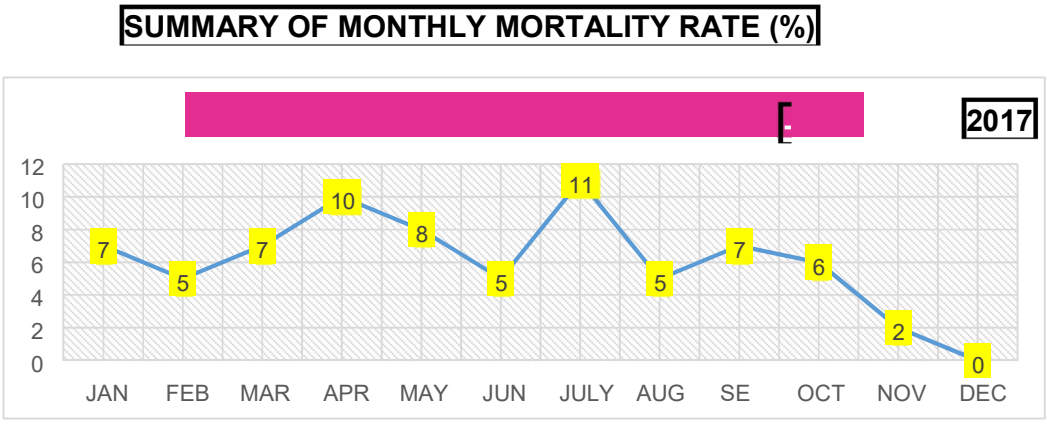
Total number of the discharges is nearly equal to the total admissions.

Most discharges were in September and October. The month of October had the highest admissions therefore it is expected to have a higher number of discharges too.

The September discharges increased due to the Independence Day of PNG.

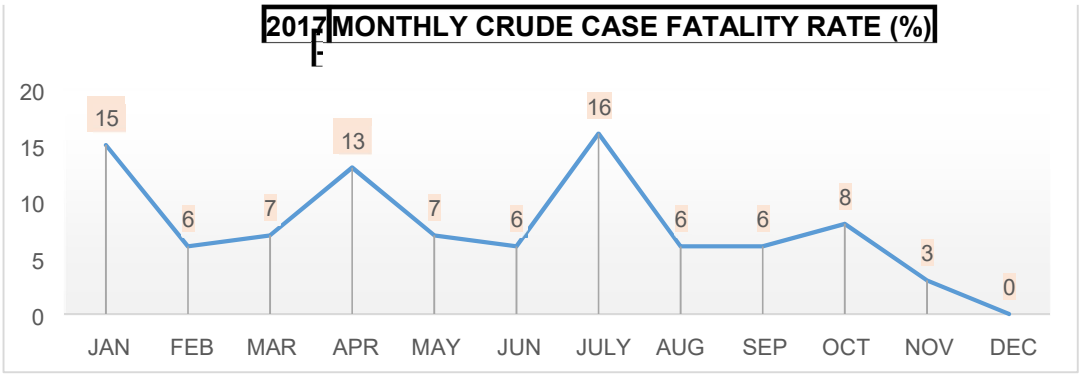
There are more male than female been discharged just similar to the admissions of more males.

Monthly Mortality Rate



The highest MR was in July followed by April with the lowest or no deaths in the month of December 2017.

Monthly Crude Case Fatality Rate (%)



The highest is in July followed by January 2017. It also peaked in April too.

The lowest in December.

Total Crude Fatality rate for 2017 is 4.5% and the year 2016 is 5.3% followed by 2015 by 8.7%.

Transferring Of Patients

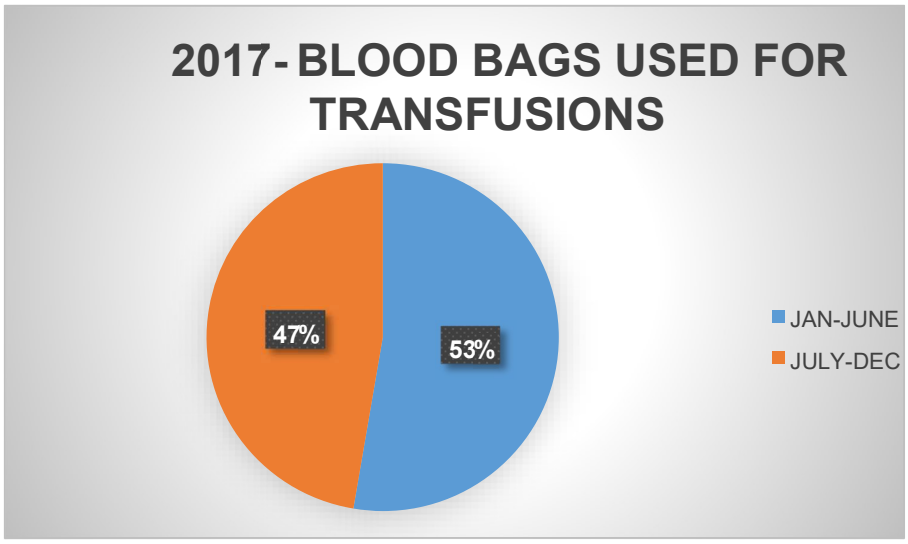
The patients are either transferred to other external hospitals in the country or another medical unit for further management or investigations.

The summary of the Volume statistics are as follows:

- The average length of stay in the wards: 9 days

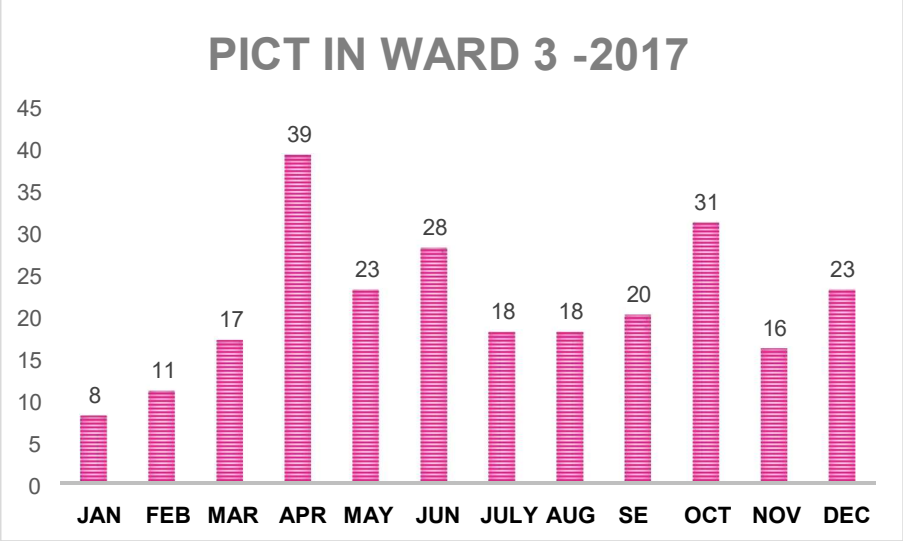
□ The average admissions to the ward 3:	2 patients/day.
□ The average discharges from the ward:	1 patient/day.
□ The mortality rate:	5%
□ The crude fatality rate:	6%

Blood bags used for blood transfusions



Provider Initiated Testing and Counselling for HIV-AIDS

PICT



There were a total of 252 patients been identified as a high risk of possible diagnosis of HIV-AIDs.

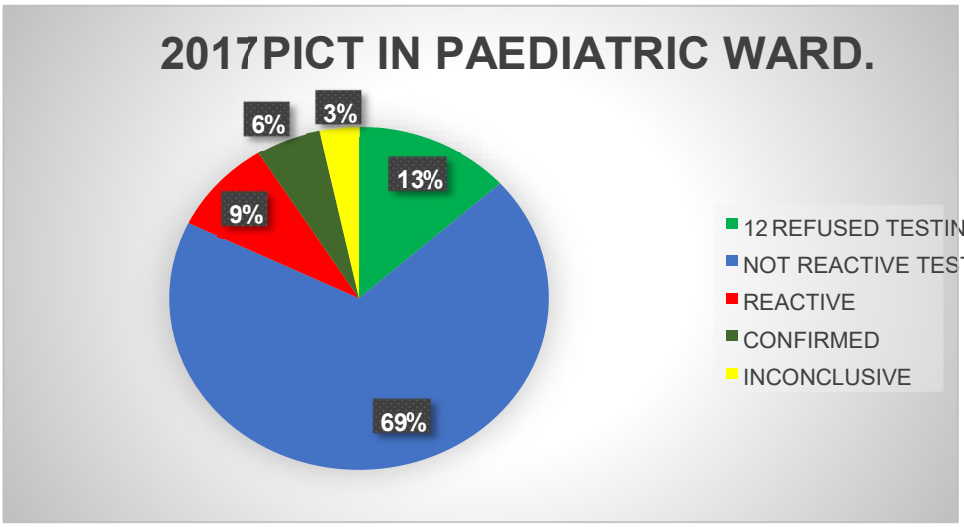
Out of all the patients been counselled only 12 guardians of patients refused testing of the blood for HIV infection.

Of the total 240 patients counselled allowed testing for HIV virus.

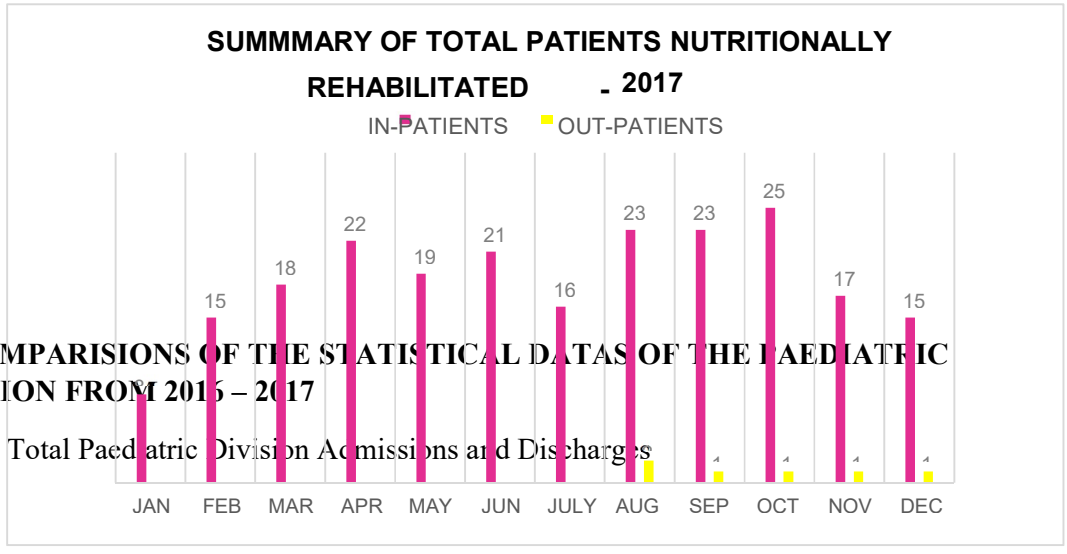
69% of the patients and the guardians tested had Not Reactive Tests. 9% were reactive.

Of the 9% with Reactive blood test on RDT only 6% were confirmed to be positive meaning the patients were infected with HIV via Trans placental route.

3% of the patients had inconclusive results meaning that the test needed to be repeated after 3 months.

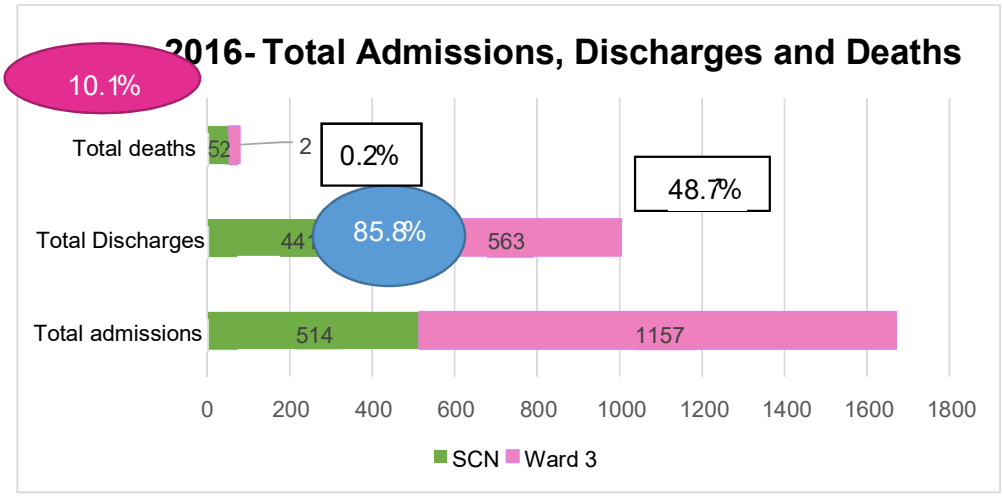


k) NUTRITIONAL REHABILITATION SUB-UNIT (DIET KITCHEN)



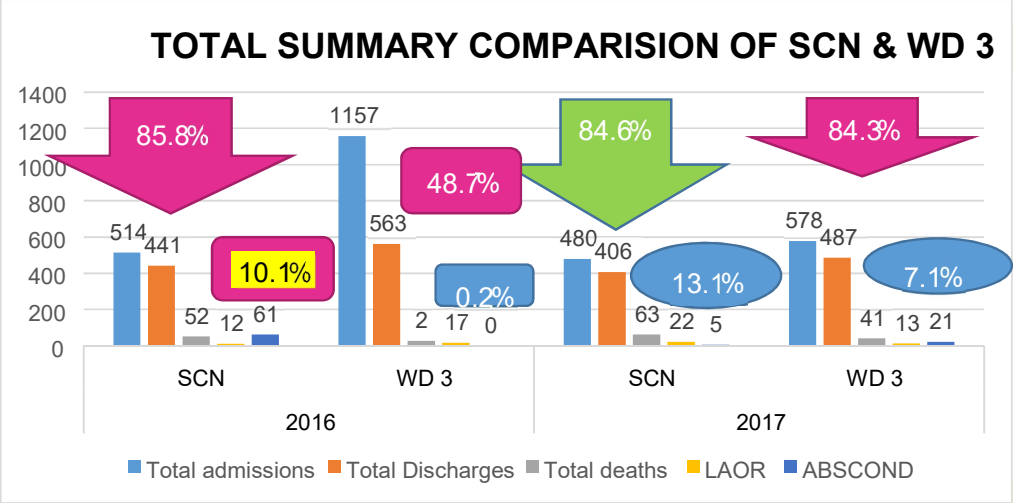
C. COMPARISIONS OF THE STATISTICAL DATAS OF THE PAEDIATRIC DIVISION FROM 2016 – 2017

a) Total Paediatric Division Admissions and Discharges



The above graph established that in 2016 there were more discharges from SCN (85.8%) than WD 3 (48.7%) from the total number of patients admitted to each units.

The deaths in the SCN (10.1%) is the highest recorded than ward 3 with the lowest deaths record of 0.2% during the whole year.



In 2017 there is massive increase in the percentages of deaths in the Neonatology Unit by 63 patients which is about 13.1% and the Paediatric Unit by 7.1% (41 patients).

The total number of admissions and discharges were lower but the death rate was highest with the difference of 3% in SCN and 6.9% in the Paediatric Unit when compared to the year before that is 2016.

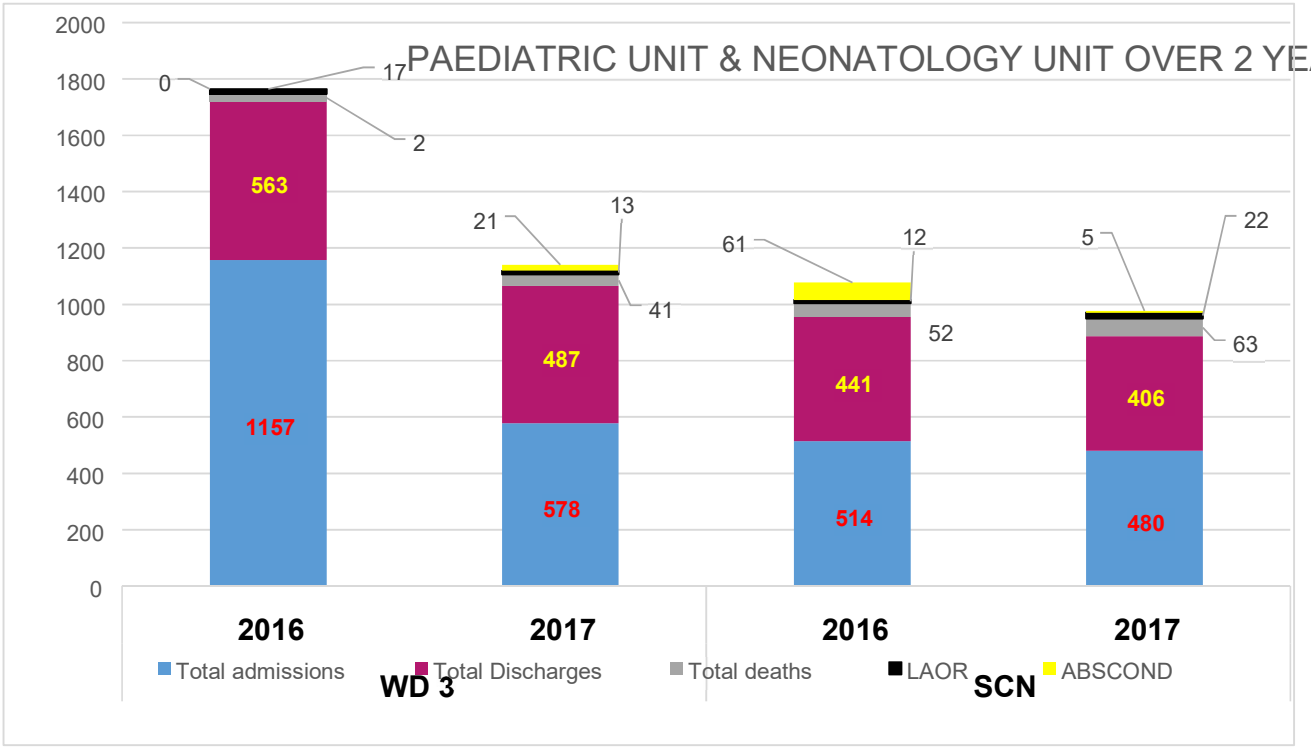
The admission of patients to the Paediatric Unit in 2017 is 50% lower than patients admitted in 2017 of about 578 as compared to 1157 in 2016.

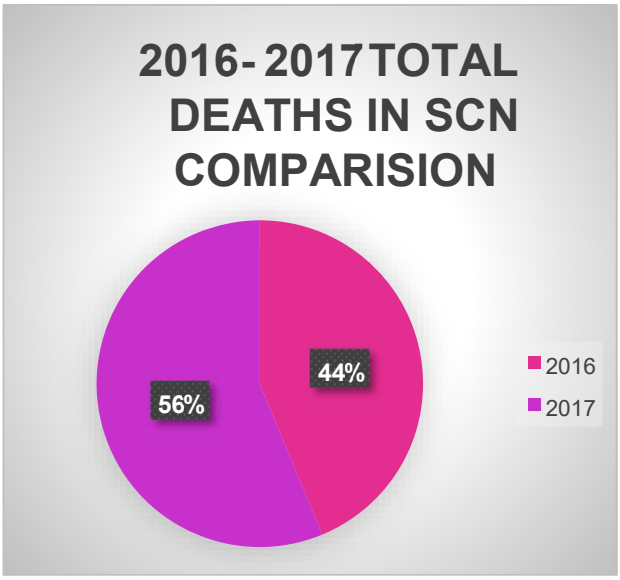
The highest number of patients that left the hospital at own risk (LHAOR) by the guardians was highest in SCN in 2017 with 22 (4.6%) patients.

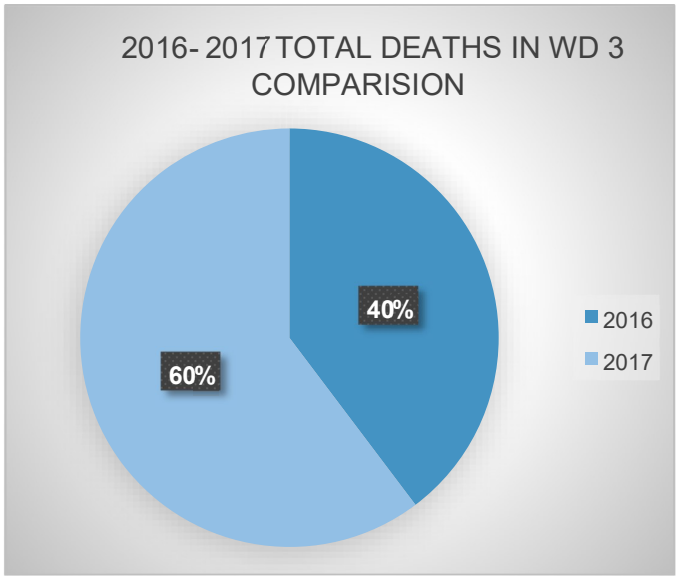
In 2017 the total deaths in the SCN was 13.1%. That is 3% more than 2016.

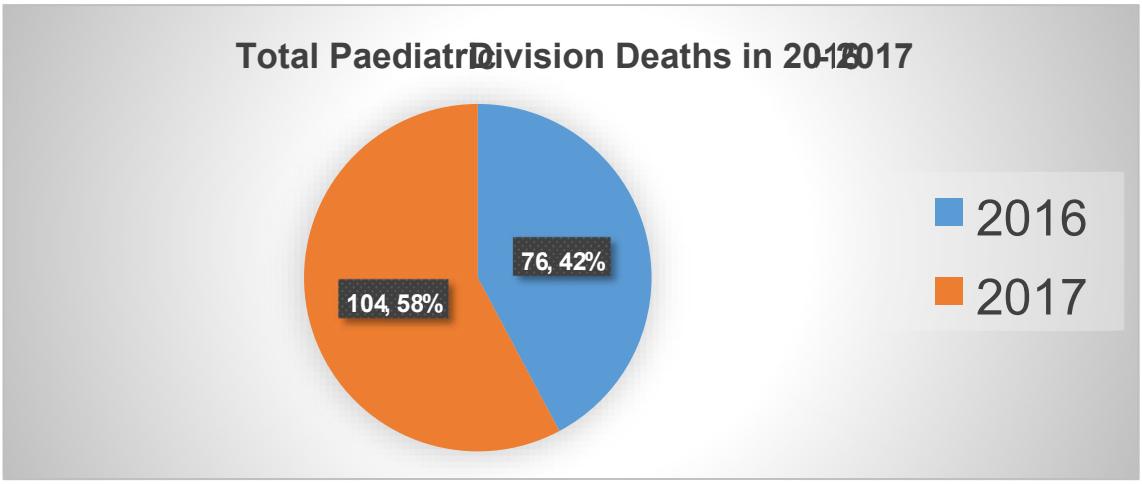
In ward 3 there were 7.1% deaths which corresponds to 6.9% more deaths in the Paediatric Unit too.

In 2016 at the SCN 11.9% of the guardians of the patients absconded from the SCN with the patients whereas in 2017 only 1% absconded.









- There is an obvious increase of deaths over the 2 years

STAFFING

Refer to the above summaries

DAILY ACTIVITIES

1. NURSING ACTIVITIES

Monthly regular unit meetings

Occasional in-service done when need arises

Immunisation rounds four (4) times a week

Provider Initiated Counselling and Testing (PICT) provided by Sr Kauron

Hourly observations for new thalassemia treatment of IV infusion Desferrioxamine

Total of 118 bags of blood transfused from July – December 2017, including thalassemia patients.

2. MEDICAL TEAM ACTIVITIES

Regular daily ward rounds and doing all investigations to diagnose a patient properly so the right treatment can be given.

Daily ward round teaching and patient health education.

Daily ward procedures.

Weekly CME on Mondays.

Weekly BMS lectures

Twice weekly In-house teaching and lectures about paediatric cases.

Consultation clinic attendance by SSMO/MOIC every Thursday to attend to review patients and new cases been booked.

Anytime review of Chronic and known patients with Diabetes, Malnutrition, Epilepsy, Cerebral Palsy, Asthmatics, Rheumatic Fever, and Congenital Anomalies etc.

PITC provided by any of the medical team personal or a Nursing staff.

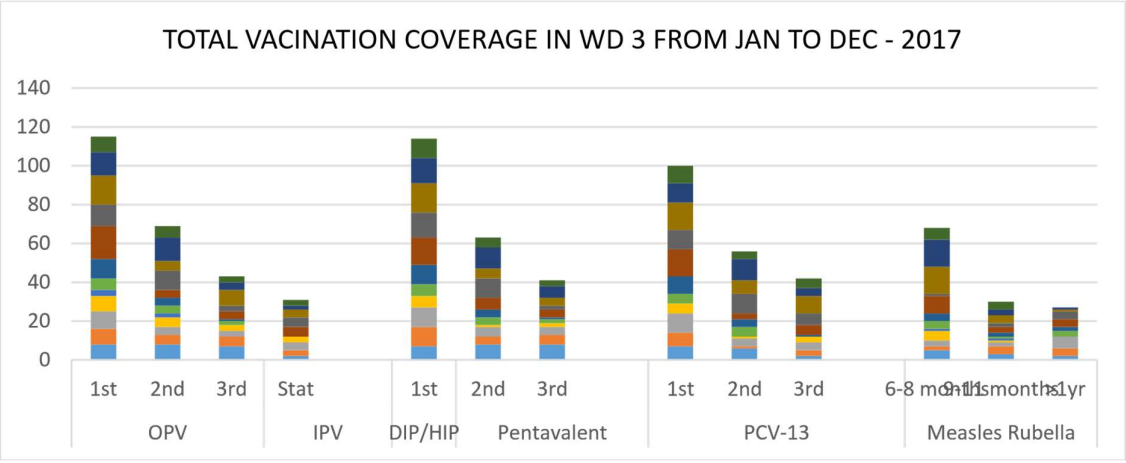
Counselling an abused child, malnourished child, TB etc.

Give Chemotherapy to paediatric cancer patients.

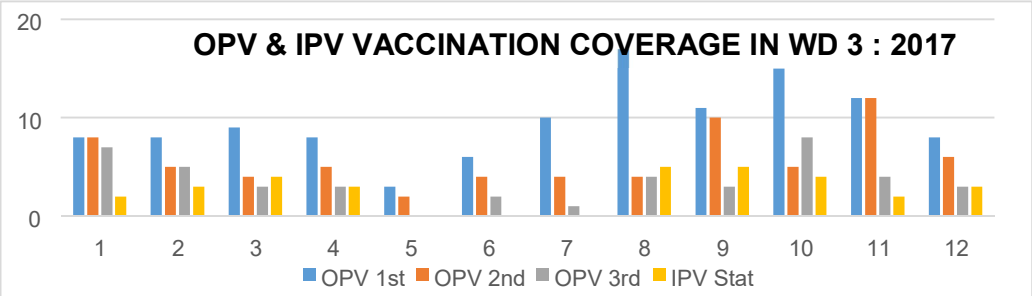
Giving desferoxamide to thalassemic patients after the blood transfusion.

IMMUNSATION

Total Immunisation Coverage From January - December – 2017



OPV VACINATION



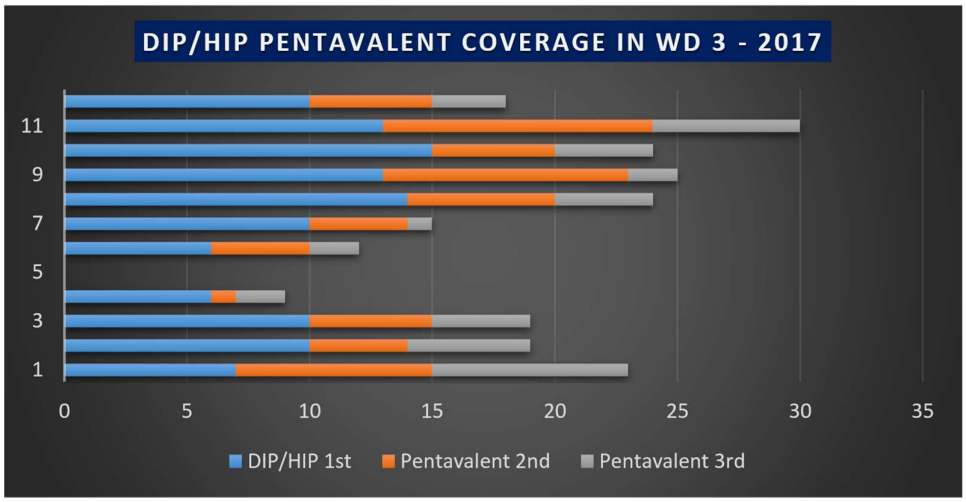
There were more 1ST doses of OPV given than the 2nd and the third doses.

In the month of August and October there had been many children been vaccinated with OPV.

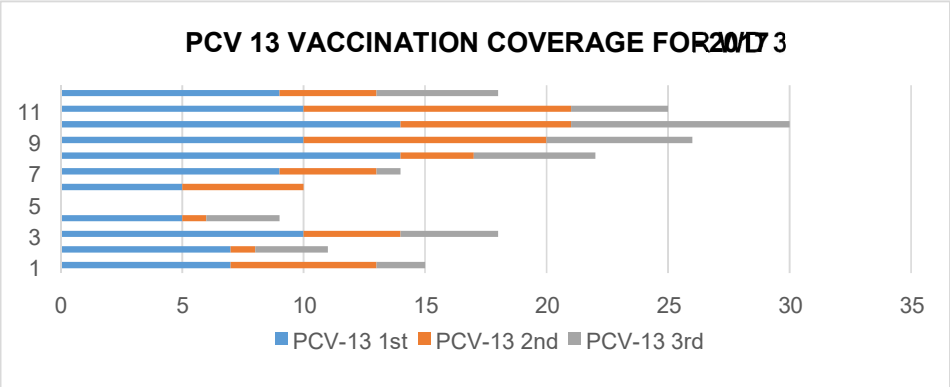
May was the lowest coverage of 1st 2nd dose of OPV

Lowest 3rd dose of OPV was given in July.

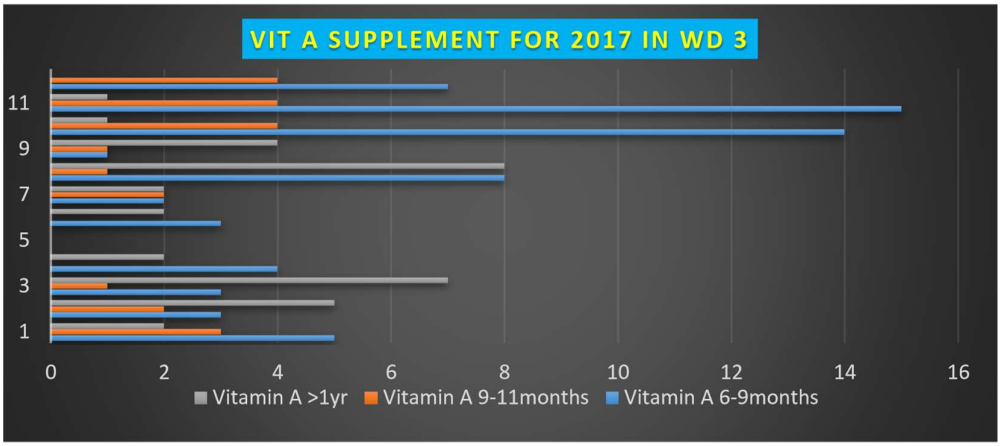
DIP/HIP PENTAVALENT VACINATION COVERAGE



PCV 13 VACINATION COVERAGE



VITAMIN A SUPPLEMENT WI TH VACCINES



7. PAEDIATRIC DIVISION ACTIVITIES

a. Medical activities

- ✓ Attended 5 ward meetings with the Neonatology team.
- ✓ Had 2 medical team meetings with SSMO and MOIC.
- ✓ Weekly in house teaching on Tuesdays with SSMO and MOIC Master's (MMED) training lectures with SSMO on Thursdays weekly Daily ward rounds and ward teachings.
- ✓ Health talks and education of the guardians daily at ward rounds.

b. Nursing activities

- ✓ There were only 5 ward meetings held in 2017.
- ✓ Clinical ward teachings rarely conducted.
- ✓ Health talks and education are usually done upon discharges.

FACILITIES

Special care nursery will be undergoing demolition and renovation under the current development plans for Wewak General Hospital like the other wards undergoing the construction phase.

We have sat with the management teams to discuss the necessary requirements of a Neonatology Unit to the best of our abilities.

Therefore we would like to acknowledge and appreciate the current Hospital management under the stern leadership of HEO and Chief Executive Officer Mr. Mark Malaudu of the changes that is currently taking place and that is yet to be taking place in the hospital facilities and structures.

AUDIT OF MEDICAL EQUIPMENTS

Neonatology unit

The current medical equipment been used by the Neonatology Unit to providing the best care possible for the patients and guardians and the essential medical equipment not available but are essential to delivering the best neonatal services are also listed in the table below

Paediatric Unit equipment's

The Paediatric Unit was fortunate to be involved by the Chief Executive Officer to order the medical equipment's and the necessary logistics for the newly constructed Paediatric Wards which should relieve all the issues of faulty and new machines to diagnose and use for the patients.

ACHIEVEMENTS

Increase in the number of the Medical and Nursing staff strength to both units under the Paediatric Division.

CONSTRAINTS

Shortages of essential medical items, drugs, and equipment are still a major problem in SCN and Ward 3.

- ✓ Overcrowding with not enough storage space to store extra medical items, equipment and drugs.
- ✓ The unavailability of hand hygiene detergents and poor hand washing facilities to maintain hand hygiene practices.
- ✓ The milk preparation room is still exposed to the public with no control of hygiene.
- ✓ Food preparation room is small and limited for cooking but not big enough to do nutritional counselling.
- ✓ Milk expression room not available therefore mothers are expressing the Breast milk in NICU.
- ✓ Mothers are exposed to the NCIU which are contraindicated in the principles of NICU and guidelines.
- ✓ When there is full house of the Neonatal patients. The mothers are been forced to sleep on the floor.
- ✓ Limited investigative equipment's for full investigation of the neonates.
- ✓ There is no resuscitation trolley in the Septic bay and the Operating Theater therefore the patients are all managed in the NCIU thus creating a great risk of cross infections.
- ✓ Also no separate resuscitation for the recovery wards with different treatment trolleys etc..
- ✓ Paediatric ward has no tubing's for the oxygen concentrator.
- ✓ One oxygen flow meter for the oxygen cylinder for multiple emergencies.
- ✓ No portable oxygen for emergency chest x-ray or transfer of very sick neonates from Emergency department, operating theatre or Labour Ward.

- ✓ Not enough medical equipment's to use for patient care and diagnostics.
- ✓ Not having the right logistics for general patient care.

The general view of the wards are in appalling conditions and need major fixing.

THE Adolescences are the lost generation which had not been caught by the Paediatric division therefore in 2018 the Adolescence between the ages of 13 -16 will be captured once the Paediatric Wards have been reconstructed.

SUMMARY

The year 2016 had the lowest rate of deaths compared to 2017 with 58% more deaths combined.

The deaths were mainly from birth asphyxia. Neonatal sepsis, Extreme low birth weight, Meconium aspiration, Tuberculosis, Pneumonia and Malnutrition which also correlates to the PNG nation figures of top 10 disease causing death in PNG.

The total admission was lowest compared to 2016 admissions with equal amount of discharges.

The total admission rate is 50% lower than 2016.

The crude fatality rate of 2017 is at 4.5% which is the lowest compared to 2016 with 5.3% and 2015 with 8.7%.

The death in SCN is 3% more in 2017.

Death of the patients in the Ward 3 is 6.9% more than 2016 deaths.

Most of the deaths occurred around the months of January, April, July, September and October 2017.

Average length of stay in the hospitals by the hospital had increased from 7 days in 2016 to 9 days in 2017.

The occupancy rate daily is 50%.

The immunization coverage of the patients in the Paediatric Division had increased tremendously over the year.

The provider initiator counselling and testing had commenced on a very good note with the identification of 6% of the patients tested to be living with HIV.

The Nutritional rehabilitation sub-unit had increased in the number of patients been seen and are been reviewed weekly for weight gain.

The usage of blood in the Paediatric division had also remain high due to the Thalassemia patients requiring blood nearly every 2-3 weeks.

CONCLUSION

To conclude the overall ward statistics have not improved from last year, the perinatal death rate is still high.

There is worsening of the Paediatric Division Statistics from 2016 to 2017 with increased deaths in the Neonatology Unit and the Paediatric Unit.

The main causes of admissions include neonatal sepsis, birth asphyxia, and preterm and low birth weight with Pneumonia, Tuberculosis, malaria and Malnutrition etc.

The main cause of death in these 12 months are severe birth asphyxia, extreme preterm and extreme low birth weight, Pneumonia, Tuberculosis, Malnutrition, Meningitis etc.

Both the nursing staff and medical staff strength had improved in 2017, however, it is still a problem due to staff taking sick leaves, maternity leaves, recreational leaves and being insubordinate etc.

Shortages and unavailability of essential medical items and drugs is a major problem now in the hospital.

Infection control and cross infection is another major concern in SCN and ward 3. The general hygiene of the Paediatric Division.

The adolescence data were not collected as yet because the Paediatric Division will start admitting the adolescent patients into the newly constructed wards late June or July 2018 therefore the lost generations' data has to be captured as well with the other Paediatric patients.

RECOMMENDATIONS

- ✓ Improve and maintain constant supply of medical items and drugs.
- ✓ The pharmacist to seek advice or have an audience from the Pediatrician for the drugs required to making the purchase order.
- ✓ The pharmacy to make suspensions and other liquid drugs for the Paediatric patients.
- ✓ The pharmacists to allow the dispensing open at lunch hour and on weekends from 8 – 4pm.
- ✓ Need 2 Pediatrician immediately for the Paediatric Division.
- ✓ The Neonatology Unit does need a Pediatrician and its own registrar and nurses yearly for training in pediatrics or maternal and child health.
- ✓ New and functional equipment's to use to diagnose the patients illnesses.
- ✓ Extra cooler for the Blood Bank to store bloods collected from the donors.
- ✓ The OIC Pathology to order reagents for specific tests required ahead so the chronic issues of NO REAGENTS has to stop immediately.
- ✓ OIC Pathology to be inventive and creative to initiate Serology for Blood, Pus, sputum, urine, CSF etc. for culture and Histopathology for tissue sampling here in Wewak General Hospital.
- ✓ The OIC Radiology to order films in advance and stock to avoid the issue of running out.
- ✓ Proper data entry in a computer therefore urgently need a Computer for the Paediatric Division.
- ✓ The Medical record staff to record all statistics from the wards then they should submit the summary at the end of each quarter.
- ✓ The Human resource officers to address all the clinical staff issues therefore it should not affect a staff's absence at work.
- ✓ A qualified and clinically or medically orientated person to be employed in the position of Quality Assurance and infection control.
- ✓ Infection control officer to pay daily ward round visits and address infection control issues in SCN and ward 3.

- ✓ Knowing the difference between the grounds personnel and the Hygiene personnel therefore need educated Hygiene officers to properly train for infection control.
- ✓ Increase the number of protein to the Nutritional Rehabilitation Unit for the patients. The proteins like chicken or beef or fish etc..
- ✓ Senior management to look at the above constraints and address them accordingly.

ACKNOWLEDGEMENT

1. Paediatric Specialist Dr. Kauve Pomat for continuously supporting and mentoring regardless of time.
2. SIC of the Neonatology Unit Sr. Regina Urosombi and Sr. Daisy Naboam for continuous supporting and maintaining the Unit to the best of her ability to making sure all guidelines are followed to the best of her ability with the limited available resources.
3. The Chief Executive Officer to having met majority of our recommendations from last year's report.
4. All SCN nursing & medical staff for your cooperation and hard work in 2017.

THANK YOU VERY MUCH……SIGNING OFF IS DR. VIOLET REGINA

MEDICAL UNIT

TOTAL ADMISSIONS

STATISTICS FOR MEDICAL WARDS A,B & C 2017

Months	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Admissions	94	99	101	72	97	100	100	101	94	103	84	71	1116

TOTAL ADMISSIONS BY GENDER

Months	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Male	39	48	51	33	44	45	39	48	50	53	40	37	527
Female	55	51	50	39	53	55	61	53	44	50	44	34	589

TOTAL ADMISSIONS BY AGE GROUPS

AGE GROUPS	13 - 20	21 -30	31-40	41 -50	51-60	61+	TOTAL
No.of Patients	128	212	182	209	198	187	1116

TOTAL DISCHARGES

Months	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Discharges	**72**	**73**	**78**	**53**	**71**	**91**	**84**	**90**	**76**	**89**	**70**	**62**	**909**

TOTAL DISCHARGES BY GENDER

Months	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total**
Male	**32**	**37**	**46**	**23**	**45**	**51**	**43**	**49**	**31**	**42**	**32**	**36**	**467**
Female	**40**	**36**	**31**	**30**	**26**	**40**	**41**	**41**	**45**	**47**	**38**	**26**	**442**

TOTAL DEATHS

MONTHS	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total**
DEATHS	**14**	**17**	**15**	**5**	**12**	**6**	**13**	**11**	**5**	**13**	**10**	**16**	**137**

TOTAL DEATHS BY GENDER

MONTHS	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total**
Male	**6**	**10**	**8**	**1**	**9**	**3**	**6**	**6**	**4**	**9**	**3**	**9**	**74**
Female	**8**	**7**	**7**	**4**	**3**	**3**	**7**	**5**	**1**	**4**	**7**	**7**	**63**

TOTAL DEATHS BY AGE GROUPS

AGE GROUPS	**13 -20**	**21-30**	**31 -40**	**41 -50**	**51 -60**	**61+**	**Total**
No.Of Patients	**12**	**26**	**29**	**14**	**24**	**32**	**137**

Total Referrals from other health facilities

Month	Jan	Feb	Mar	Apr	May	June	July	AUG	SEP	Oct	Nov	Dec	Total
Male	8	3	4	5	12	6	12	7	9	10	7	10	93
Female	8	5	4	5	9	10	9	4	6	9	10	9	88
Total	16	8	8	10	21	16	21	11	15	19	17	19	181

Total Absconders per month

Month	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Total
Male	1	2	1	0	0	0	0	0	0	1	1	0	6
Female	2	0	0	1	1	0	0	1	0	0	0	0	5
Total	3	2	1	1	1	0	0	1	0	1	1	0	11

Total left hospital at Own Risk

Month	Jan	Feb	Mar	Apr	May	Jun	July	Aug	SEP	Oct	Nov	Dec	Total
Male	1	1	1	2	0	0	2	0	0	1	0	1	9
Female	2	0	0	2	1	1	1	1	0	1	0	0	10
Total	3	1	1	4	1	1	3	1	0	2	0	0	19

Total Transfer Out to other wards

Month	Jan	Feb	Mar	Apr	May	Jun	July	AUG	SEP	Oct	Nov	Dec	Total
Male	1	1	0	0	0	0	0	1	0	0	0	0	3
Female	1	1	1	0	0	0	0	1	1	1	0	0	6
Total	2	2	1	0	0	0	0	2	1	1	0	0	9

Top 11 Common causes of admissions (2017)

No	Disease	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	**Nov**	De c	**Tot**
1	TB	20	17	15	7	14	13	15	14	32	**2**	15	21	186
2	Anemia	18	7	18	9	12	12	15	21	15	**1**	9	13	150
3	Malaria	19	10	15	8	6	8	18	9	5	**2**	3	2	105
4	Asthma	3	5	2	10	7	3	8	6	2	**1**	2	3	52
5	PNA	4	4	10	6	3	8	3	1	2	**1**	4	5	51
6	COPD	4	7	5	3	4	2	9	5	2	**3**	2	2	47
7	AGE	5	2	2	1	7	2	3	2	2	**2**	3	3	34
8	HIV/AIDS	4	3	2	4	2	2	3	4	0	**1**	1	0	26
9	CVA/HPT N	2	1	4	3	2	2	2	2	2	**2**	1	2	25
10	Liver Cirrhosis	2	3	1	2	4	3	2	1	2	**1**	1	1	23
11	Cancer	2	2	2	1	2	3	2	1	3	**1**	2	0	21
	TOTAL	83	61	76	54	63	58	80	66	67	**17**	43	52	720

TOP 10 CAUSES OF DEATHS (2017)

NO.	DISEASE	NO.OF PATIENTS
1	**Tuberculosis**	**42**
2	**Chronic Obstructive Pulmonary Disease (COPD)**	**15**
3	**HIV Complications**	**12**
4	**Chronic Renal failure**	**10**
5	**Cerebral Vascular Accident (stroke)**	**9**
6	**Acute Bacterial Meningitis**	**7**
7	**Liver Cirrhosis**	**7**
8	**Hepatocellular Carcinoma (HCC)**	**7**
9	**Peptic Ulcer Disease**	**6**
10	**Cerebral Malaria Complications (ARF/Electrolyte imbalance)**	**4**

MAN POWER

Medical

Officers Designation	Current Numbers	Required
SSMO	1	2
SMO	2	2
MO	2	4
Clinical HEO	2	4
RMO	0	4
RHEO	0	4

Nursing

Officers Designation	Current Numbers	Required
Acute Care SNO	**1**	**4**
Cardiac Care SNO	**0**	**4**
HIV Care SNO	**1**	**3**
TB Care SNO	**1**	**4**
Geriatric Care SNO	**0**	**4**
Diabetic Care SNO	**0**	**4**
Dietician SNO	**0**	**4**
Infection Control Care SNO	**0**	**2**
General NO	**7**	**10**
CHW	**11**	**10**

Corporate Support Services

Officers Designation	Current Numbers	Required
Clerks	1	4
Cleaners	1	4

CLINICS

Clinics	Days	**Time**	Infrastructure
General/Respiratory-asthma & COPD	Tuesdays	9:00am-2:00pm	Hospital Cons Clinic
TB/Leprosy	Monday – Fridays (required Building)	9:00am-4:06pm	Office TB ward (Required Stand alone building)
HIV/STI	Monday – Fridays (white house)	9:00am-4:06pm	Wasae Clinic Building
Diabetes/Cardiovascular/Lifestyle disease	Fridays	9:00am-4:00pm	Hospital Cons Clinic (Required Stand alone Clinic)

WARDs

Wards	Activities
6A	Acute section
6B	General
6C	TB
6D	HIV (required)
6E	TB Exclusive Resistant Cases (Required)
6F	Diabetes/Renal /cardiac

WARD ACCESSORIES

Accessories	Available	Required
Fridge	**1**	**6**
Trolleys	**1**	**6**
Emergency Trolleys	**1**	**6**
Bed sheets	**0**	**200**
Pillows	**0**	**200**
Tables	**3**	**6**
Chairs	**4**	**10**
Kidney diseases	**4**	**15**
Bathing Dishes	**5**	**20**
Buckets	**2**	**20**
Bed Pan	**2**	**10**
Urinals	**2**	**10**
Drip Stands	**4**	**20**
Ward Pedestal fans	**3**	**10**
Mattresses	**26**	**200**
Water Urn	**1**	**6**
Beds	**17**	**60**
Curtains	**0**	**50**
Patients Cup Board	**50**	**50**
Patients Gowns	**10**	**100**

MEDICAL EQUIPMENTS

Medical Equipments	Current Status	Required
Ultrasound Scan	2	2
ECG machines	1	2
Cardiac monitor/Defibrillators	1	6
Pulse Oxymeters	1	6
Diagnostic Set	1	6
Patella Hammers	2	6
Stetescopes	3	6
Glucometers	2	4
Urine Dipsticks analysis	0	6
HbA1c machine	0	6
Xray Viewers	2	6
Oxygen Concerntrators	1	6
BP machines (aneroid)	1	4
BP machines Digital	1	4
Thermometers (mercury)	1	4
Thermometers (digital)	1	4
Haematocrit Machine	0	2
Foot weighing Scale	2	4
Nebulisers	1	6
Mechanical ventilator	0	2

CLERICAL ACCESSORIES

Accessories	Current status	Required
Computers	0	2
Printers	0	2
Scanners	0	2
Multimedia	0	1
Laptop	1	1
Mobile Phone	1	4
Ward Radio	1	1

FAILURES (2017)

ACTIVITIES	FAILURES
Monthly Audits (Deaths/Admissions)	Minimal
Unit Monthly General Meetings	Minimal
Rural Outreach programs	Not Done
TB DOTS follow ups	Not Done
HIV Follow ups	Minimal
Health Awareness (Radio/Schools etc)	Minimal
Staff In-house Teachings	Minimal

RECOMMENDATIONS

Management to assist with Medical Wards Renovations.

Management to assist with Medical equipments & accessories.

Management to assist with Manpower.

Staff in medical ward to work on our failures mentioned above.

ACKNOWLEDGMENTS

Our Heavenly GOD for his continous Blessing & Love.

A/CEO of ESPHA and his management Team .

Medical ward staff for your endless clinical care to your patients.

INTERNAL MEDICINE CONSULTATION CLINIC STATISTICS 2017

CLINIC	TYPE
TUESDAYS	RESPIRATORY/GENERAL/MEDICAL EXAMINATIONS
FRIDAYS	LIFE STYLE / DIABETES /CARDIAC/ENDOCRINE/MEDICAL EXAMINATIONS

1. MEDICAL EXAMINATIONS

Months	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEP	OCT	NOV	DEC	TOTAL
Male	60	34	13	2	5	27	51	25	24	12	34	47	334
Female	44	20	11	3	11	38	81	28	11	9	77	47	380
TOTAL	104	54	24	5	16	65	132	53	35	21	111	94	714

2. TUESDAYS CLINICS

2.2 NEW CASES BY GENDER

Months	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Male	0	15	3	14	4	3	5	13	3	4	0	0	64
Female	0	14	7	9	2	2	5	19	8	8	0	0	74
TOTAL	0	29	10	23	6	5	10	32	11	12	0	0	138

2.3 REVIEW CASES BY GENDER

Months	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Male	0	42	27	39	59	26	45	69	49	22	0	0	378
Female	0	48	31	42	42	30	55	91	35	43	0	0	417
TOTAL	0	90	58	81	101	56	100	160	84	65	0	0	795

3. FRIDAYS CLINICS

3.1 New Cases by gender

Months	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Male	**0**	**0**	**4**	**2**	**1**	**0**	**3**	**1**	**0**	**1**	**0**	**0**	**12**
Female	**0**	**0**	**7**	**3**	**0**	**2**	**2**	**1**	**4**	**0**	**0**	**0**	**19**
TOTAL	**0**	**0**	**11**	**5**	**1**	**2**	**5**	**2**	**4**	**1**	**0**	**0**	**31**

3.2 Review Cases by gender

Months	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Male	**0**	**0**	**17**	**44**	**15**	**24**	**16**	**14**	**30**	**37**	**0**	**0**	**197**
Female	**0**	**0**	**22**	**44**	**24**	**34**	**46**	**18**	**42**	**54**	**0**	**0**	**284**
TOTAL	**0**	**0**	**39**	**88**	**39**	**58**	**62**	**32**	**72**	**91**	**0**	**0**	**481**

ACHIEVMENTS

1. We had 2 registrars added to the Medical team to see patients at the 2 clinic days.
2. We also had 2 CHWs added to the nursing team to assist our doctors.

CHALLENGES

1. Adequate medical equipment at the clinic
2. Lack of appropriate date collection
3. Support office equipment such as computer at the clinic

RECOMMENDATIONS

1. Management to assist with providence of the above mentioned resources
2. SSMO to work out statistics standard data for the clinics.

ACKNOWLEDGMENT

1. First and foremost, we acknowledge GOD our heavenly father for the blessings at the clinic
2. A/CEO and his management team for continue care despite lack of many resources
3. Staff of the Consultation Clinic for you clinical care.

Psychiatric Unit

BRIEF INTRODUCTION

Psychiatric Unit was established in the 1960s.It has a female ward and a male ward with 6 beds each plus 2 restraining units.

Had 7 staff with enough medicines and no patients were referred to Laloki.

Currently

Staff strength is 3.

Staff work from 8am -4pm

Admissions of patients are denied

No awareness programs

STATISTICS

Psychiatric Condition		NEW CASES				RE-ATTANDANCE				ADMISSION				TOTAL
SEX		Male		Female		Male		Female		Male		Female		
AGE GROUP		10-35	36-80	10-35	36-80	10-35	36-80	10-35	36-80	10-35	36-80	10-35	36-80	
1	Functional Psychosis	4	4	1	1	82	65	14	5			1		**177**
2	Organic Psychosis	2	1	4		5		5		1		1	1	**20**
3	Maniac Depressive Psychosis		1	1	2	1	5	2	2					**14**
4	Anxiety/Stress	3	2	5	5	2	5	1	8					**36**
5	Depression		1	1	1		1	5	2					**11**
6	Drug/Alcohol Disorder	11	1	1		34	1							**48**
7	Violence		1		1									**2**
8	Epileptic	4		1		13	7	8						**33**
9	Insomnia	2				1	2		1					**6**
10	Situational Crisis	2	2	4	6	1	2	1	4					**22**

	Reactive Reaction													
11	Post traumatic stress disorder	1	1			3	2	4						**11**
12	Other Medical Conditions	5	4	6		1	3	3	4					**34**
TOTAL		**34**	**18**	**24**	**24**	**143**	**88**	**43**	**26**	**1**	**0**	**2**	**1**	**404**

OTHER ACTIVITIES

ACTIVITY	No.of patients
Counselling	19 new cases : Re-attendance 3 cases
CIS Visits	3 visits
Consultation Attended	22 new cases : Re-attendance 1 case
Home Visits	None done

RECOMMENDATION

No	PLAN	ACTIVITIES
1	**Psychiatric Unit**	**Rehabilitation centre – ward with 10 beds: 5 males/5 females** **Consultation room for outpatients** **Staff /Patients toilet & showers** **Staff tea room** **Restraining rooms x2 male/female.** **Doctor/Ward Manager offices x2**
2	**Staff Strength**	**SMO –Psychiatrist** **3 Nursing Officers** **4 CHWs** **1 clerk**
3	**Shift Work**	**Admit patients for 3 shifts work**

4	**Staff Training**	**New Training programme** **Refresher training at Laloki Psychiatric hospital**
5	**Data Entry Equipment**	**Computer/Printer for data entry**

1. ALL TB CASES REGISTERED (2017)

Table 1.1 Pulmonary Sputum Smear Positive

	Previously Treated		
New Cases	Relapses	After failure	After default
37	**8**	**0**	**4**

Table 1.2 New Pulmonary sputum smear negative

0 -4 years	5 -14 years	> 15 years
2	**0**	**37**

Table 1.3 Pulmonary sputum smear not done/not available

0 – 4 years	5 -14 years	> 15 years
27	**26**	**179**

Table 1.4 New extra-pulmonary

0- 4 years	5 -14 years	> 15 years
20	**29**	**120**

Table 1.4 Other previously treated

Others previously treated	All Cases for 2017 (TOTAL)
16	**507**

2. New pulmonary sputum smear positive cases – Age groups

SEX	0-4	5-14	15-24	25-34	35-44	45-54	55-64	> 65	Total
Male	**0**	**0**	**2**	**6**	**2**	**3**	**4**	**0**	**17**
female	**0**	**1**	**7**	**8**	**4**	**4**	**0**	**0**	**24**

3. Laboratory activity – Sputum smear microscopy

No.of TB suspects examined for diagnosis by sputum smear microscopy	No.of TB suspects with positive sputum smear microscopy result.
278	**48**

4. TB/HIV activities

	No.of TB patients referred for voluntary counselling and testing for HIV	No.of TB patients tested for HIV before or during TB treatment	No. Of TB patients who are HIV positive
New sputum smear positive TB	**30**	**17**	**6**
All TB cases (including the above)	**278**	**78**	**11**

5. Report on Sputum Smear Microscopy Conversion

Number of new sputum smear positive cases registered in quarter recorded	**Sputum smear microscopy not done at either 2 or 3 months**	**Sputum smear microscopy at:**	
		2 months	3 months
57	**39**	**4**	**2**
Total converted at 2 or	3 months	**6**	

6. Report on TB treatment Outcome in BMU

6.1 TB treatment outcome

Type of Case	Total number of patients registered during quarter	Treatment Outcomes						Total number evaluated for outcomes
		Cure	Treatment completed	Died	Treatment failure	Default	Transfer out	
New sputum smear positive cases	**49**	**2**	**3**	**0**	**0**	**3**	**3**	**11**
Previously treated sputum smear positive cases (relapse,treatment after failure,treatment after default)	**17**	**0**	**5**	**2**	**0**	**0**	**0**	**7**
All other cases (sputum smear negative,smear not done,EP,other previously treated)	**235**		**46**	**2**	**0**	**2**	**5**	**55**

6.2 TB /HIV activities

	No.TB patients on CPT	No.TB patients on ART
All TB cases	**0**	**8**

TB CLINIC & WARDS MANPOWER

Title	SSMO	SMO	MO	HEO	NO	CHW	**Micropist**
Current	Dr Kamus	Dr Tamsen – (Public Health SMO)	None	HEO Samiak	Sr Wakenro	1.Nrs Ambun 2.Nrs Maniora	Nrs Waraningi
Required	0	1	1	0	1	2	1

TB INFRASTRUCTURES

	WARDS	CLINICS
Current	TB General ward TB-MDR ward	TB Clinic
Required	TB General ward to be renovated. TB – MDR ward to be isolated within TB general ward	TB Clinic to be re-designed and examination rooms, Laboratory room, store rooms and patients clinic room all in one building

TB MEDICAL EQUIPMENTS

	MEDICAL EQUIPMENT
Current	**None**
Required	Emergency trolley for both general ward & MDR ward Gene x-pert machine for diagnosing TB-MDR cases

TB ACHIEVMENTS

We have achieved a TB –MDR ward with patients using it and have completed their 6 months of intensive phase TB-MDR treatment and discharged home with their 5 more months of medicine to be completed. (Monthly TB Clinic visits for supply)

We have now a TB clinic where doctors, HEOs and nurses can see patients free from overcrowding.

We have manpower to carry out TB activities i.e 1HEO,1 NO,2 CHWs.

We have a full time CHW (Micropist) for doing stains for TB

We need a full time clerk to do clerical ward for statistics, recording, monitoring & evaluation.

We need a vehicle for daily follow up of TB patients and awareness programs to the communities within catchment areas.

We need a computer for statistics and programme planning.

RECOMMENDATIONS

1. Management to assist us with our TB Manpower.
2. Management to assist us with TB medical equipment
3. Management to assist us with TB infrastructures
4. Management to assist us with TB challenges that need to be solved.

ACKNOWLEDGMENTS

1. We Thank & Acknowledge
2. Our God Almighty for his endless love to all TB health workers & patients.
3. Our Excellent A/ CEO – Mr Mark Mauludu for the support to TB programme and activities.
4. Dr Jimmy Kambo,Our Good A/ Director Curative for advice and support.
5. Mr Brown Kum,Our Helpful A/Director Public Health.
6. Dr Tamsen – SMO Public Health to for providing her clinical care to our clinics & wards.
7. Our D/Director Nursing – Sr Sak for her nursing support.
8. Our A/Director Corporate – Mr Kabaru.

DENTAL UNIT

Introduction

Oral Health is gradually becoming a recognizable health specialty in East Sepik Province. Through annual oral health outreaches, the community are realizing the importance of their oral health and in addition have become aware that there are oral health services offered in the province. This can be reflected in the increasing number of patient attendance recorded each year to the only dental clinic in the province.

The oral health needs of the entire provincial population is met by five dental clinicians. The only dental facility that provides oral health services is a Dental Clinic found at East Sepik Provincial Hospital in Boram, Wewak.

Aims and Objectives

The aim of the dental staff of East Sepik Provincial Hospital is to provide the best oral health care services in the Province.

The objectives of 2017 were;

1. Attend to the dental needs of all who present to the Clinic
2. Identify districts with the highest number of Oral Health needs and carry out outreaches

3. Revive active oral health promotion/prevention outreach programs, like school dental visits, oral cancer awareness

Dental Manpower

There are five dental clinicians currently providing oral health services in the province.

1. Dr Zipporah Sisiri- Dental Officer/ OIC Dental Clinic, East Sepik Provincial Hospital
2. Dr. Nerida Bun- Dental Officer
3. Mrs Florence Moel- Dental Therapist
4. CHW Elizabeth Kero- Dental Nurse
5. Mr Gabriel Mongonumbo- Dental Technician

- ❖ Dr. Preston Karue is a Dental Officer and is active in reviving or strengthening clinical oral health prevention and promotional activities.

Types of Oral Health Services provided

- ➢ Oral Health Clinical services currently provided at East Sepik Provincial Hospital, Dental Clinic
- ➢ Tooth restorations- Simple fillings, compound fillings, multiple fillings, post crowns, pin restorations, crown re-cementing, endodontics
- ➢ Periodontal Therapy- scaling and root planning, gingivectomies
- ➢ Dental Prosthesis- removal appliances (acrylic partial and full/full dentures), immediate, denture repairs, additions, relines, rebases etc.
- ➢ Minor Oral Surgery- surgical extractions, ridge reconstructions, debridement's, IMFs, Splints, I&D, biopsy's
- ➢ Dental Rural outreach programs, e.g. district outreaches or school dental visits
- ➢ The Dental officers are general Dentists and their knowledge/skills are limited when it comes to dental sub-specialities.
- ➢ The dental clinic is open 8:30 – 3pm every week days.
- ➢

Oral Health Facilities

There is only one dental clinic operating in East Sepik Province, providing oral health services for the entire province and it's located at East Sepik Provincial Hospital, Boram. The five dental clinical manpower listed above staff the dental clinic.

The dental clinic surgery has four dental chairs, two functional, other two needs commissioning. There are two wall mounted dental x-ray machines, one out of order for 2 years. There is one old portable dental x-ray machine that is still being used.

For cleaning dirty instruments, there is a room for cold sterilisation and an old but functional auto clave machine to sterilise the instruments daily.

The clinic also has a prosthetics laboratory managed by the dental technician, who is supervised by the dental officers. The dental laboratory had some new equipment's recently added earlier in the year to increase production of false teeth as it is a demanding dental service in the province.

2017 Highlights...

Few oral health outreaches carried out within the year

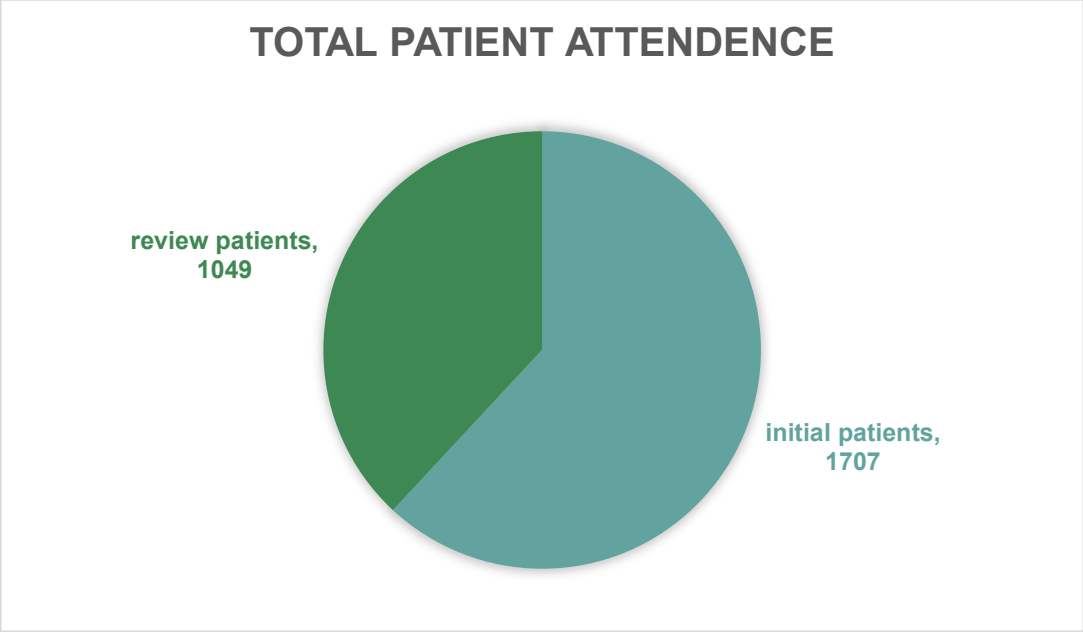
Free Oral health Checks for the Kaindi Community- Dr Karue

Free Oral health screening for the provincial government officers and cooperate employees in Wewak District- Dr Bun and Dr Karue

Couple of school oral health education visits, involving a few town schools, Wewak Primary Schools, Lomad Christian Academy school, Hawaiin Primary school, Wewak International School and Kreer compound elementary school – Dr Karue and Dr Bun

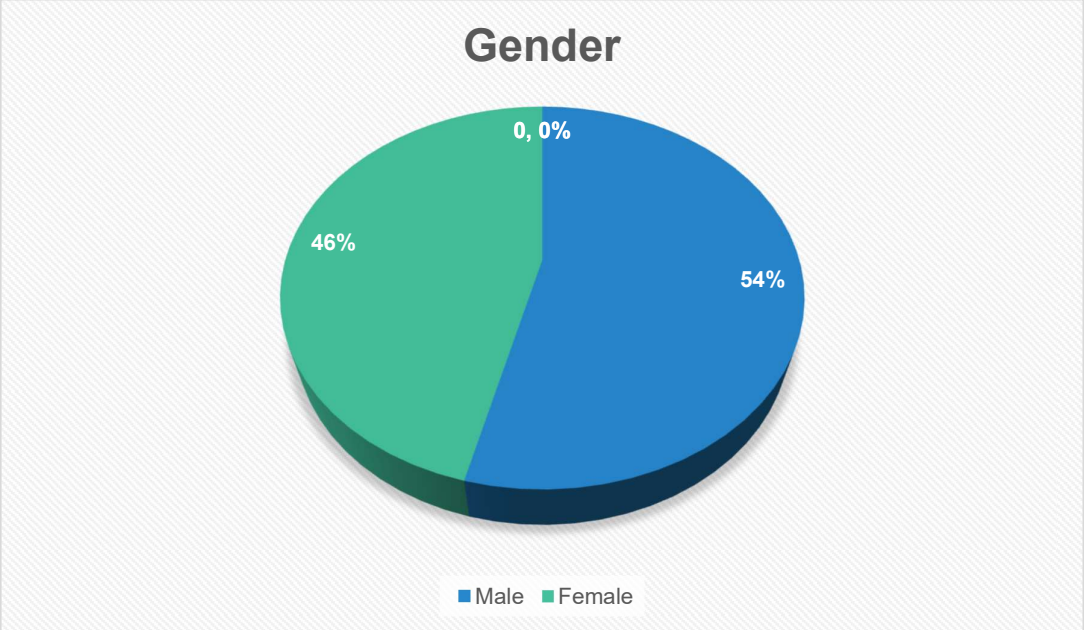
Clinical Statistics

Graph 1: The total number of patient attendance to the Dental Clinic in 2017



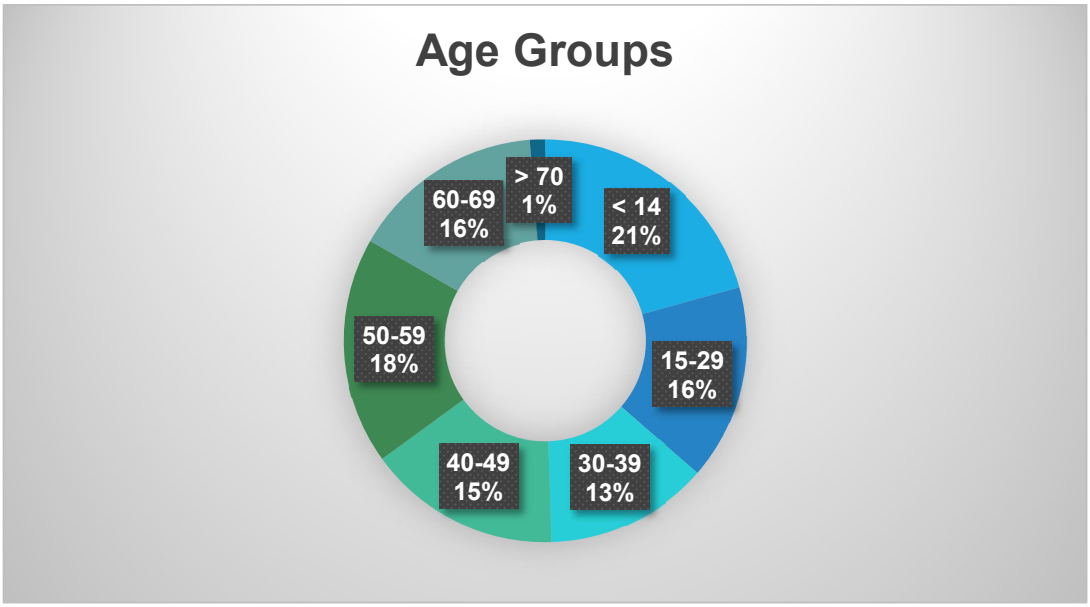
The total patient attendance at the dental clinic was 2,756. There were 1,707 initial patients and 1,049 reviews.

Graph 2: Comparing the percentage of male patients to female patients



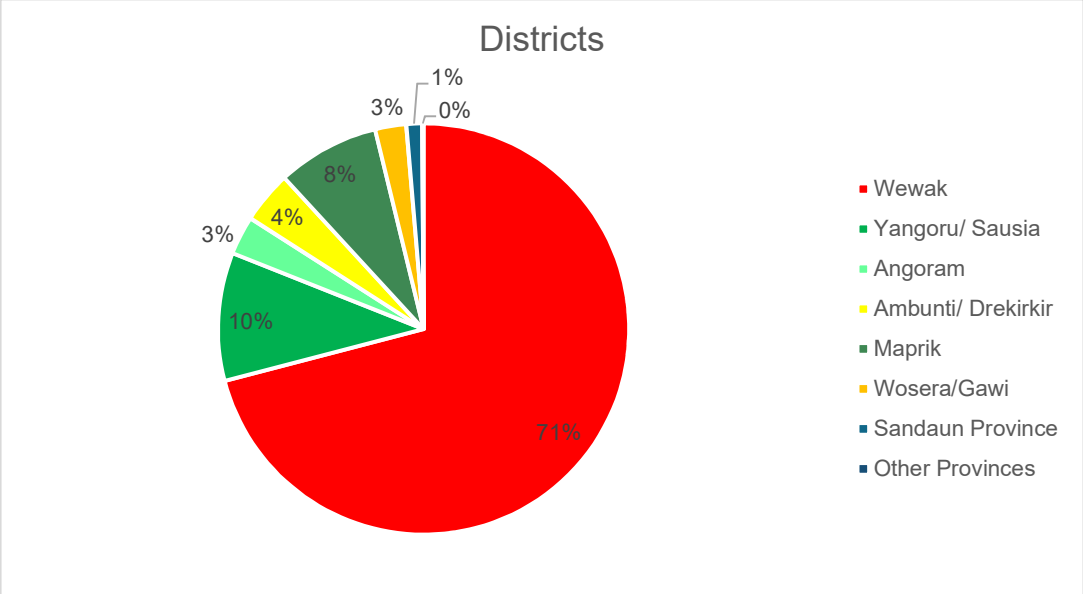
From the 1, 707 initial patients that attended the dental clinic, more than half the patients were Males.

Graph 3: The percentage of the dental patients Different Age groups



The patient's age group ranged from 6 months to 70 + years. The age group with the largest number of attendance at the clinic was the ages 14 and below with 354 in total. The second largest was the age group 50-59 years with 311. The age group with the least number were the patients over 70+.

Graph 4: The number of Dental Patients that attended the clinic from the Different Districts in ESP including outside provinces



Most of the patients came from within Wewak District. Followed by Yangoru/ Sausia and Maprik District. Within the Province, the least number of people came from Wosera/Gawi District. 21 patients came from Sandaun Province.

TABLE 1: Oral Health Disease Condition for ages 15 – 70+ years. Permanent Teeth

ORAL DISEASE CONDITIONS (15-70+ Years)												
Diff Diagnosis	Dental Caries	Periodontitis		Trauma			Oral Pathology		Tooth eruption abnormalities		Missing	others
		Perio	Attrition & Erosion	Traumatised Teeth	Fractured Mandible	TMJ Dysfunction	Oral Lesions	CA of mouth	Impaction	Supernumery		
No of Pts		529	23	60	30	10	12	23	23	7		
	556	552		100			35		30		63	7
%	42	41		7			3		2		5	0
Total Number of Patients Diagnosed: 1, 353												

Discussion

Attendance

The total attendance of patients at the Dental Clinic in year 2017 was 2,756.

There was 1, 707 new patients and 1, 049 reviews. (Refer to graph 1)

Gender

Of the 1, 707 initial patients, 921 were male and 786 were female. It may be interpreted as, either males had more oral health problems than females or they were more mindful of their oral health then females. (Refer to graph 2)

Age groups

The patients were classified under several age groups. The age group of 14 years and less, was the age group with the highest number of attendance to the clinic with 354 from the 1, 707 initial

patients. The second largest age group was the 50- 59 years old at 311. The age group with the lowest number was the 70 years old or older. (Refer to graph 3)

The age group 14 years and younger is of great interest as this is the mixed Dentition Age group. To assess the deciduous dentition, this is the age group to look at. By age 15, all the children would have their baby teeth replaced by permanent dentition. This is also the age group of primary school children.

The greatest number of attendance in this group shows the need for oral health education outreaches in schools.

In addition oral health education programs needs to be initiated at Maternal Child Health clinics, as baby teeth erupts at ages 6 months and the babys teeth is the responsibility of the mother /parents.

Districts

Most of the patients came from within the Wewak District, followed by Yangoru/ Saussia District and then Maprik District. In comparison with the other Districts, these three districts have good road access to seek oral health services in town. About 23 people came from outside the province to sought oral health services. 21 of them from our neighbouring province, Sandaun. The patients that came from Sandaun Province came from Nuku and Aitape/ Lumi Districts. (Refer to graph 4)

Dental Disease condition & Dental Procedures

The dental disease condition and dental procedures were broken up into two age groups depending on the dentition whether deciduous (baby) or permanent teeth. Baby teeth erupts at 6 months and is replaced by the permanent teeth by 15 years of age. Therefore a separate table has been created for ages 14 and below for diagnosis and treatment of baby teeth. (Refer to tables)

The total number of dental procedures done in year 2017 was 2,766.

Permanent Dentition (Adult Teeth)

There were 1,353 dental patients diagnosed with a dental disease condition within the age range 15 – 70+. Most people came with a complaint of dental caries. The second highest being of periodontitis. That is not surprising as these two are the two main oral health diseases. Then followed by Trauma patients which is of concern, 60 patients with traumatised teeth and 30 fractured mandible cases. Also 63 patients were registered with missing teeth and requested for false teeth. (Refer to table 1)

Under oral pathology, there were 23 initial cases of Oral Cancer. Oral Cancer is the second leading cancer in the country and is a public health issue. There is no proper screening clinics or proper referral system for oral cancer patients in place and the Dental clinicians are usually the first line of health workers.

There were 2, 207 dental procedures done in 2017 for patients within the age range 15- 70+ years. Of the total procedures done in this age range, the highest number was for tooth extractions. Then followed by tooth restorations. (Refer to table 2).

136 patients came for dental prosthesis. This would be more if the lab was operational all year. There was material shortage for half the year resulting in closure of dental prosthetic services for some time. There is great demand for dental prosthesis services in the province.

There needs to be more options of saving a tooth than extracting it. More in-depth dental knowledge and skills is required for the dental clinicians.

Mixed Dention (Baby Teeth + Permanent Teeth)

In the mixed dentition ages (<14 years), of the 354 children, most of them were diagnosed as having dental caries. 147 Deciduous teeth and 107 dental caries on Permanent teeth. Permanent teeth have just erupted and to be decayed so quickly is a great cause for concern. (Refer to table 3)

With the treatment in the mixed dentition age, the main procedure done was tooth extraction. Again 53 permanent teeth extracted at a younger age is alarming. Tooth restorations was the second highest procedure done in that age group, with a greater number of permanent teeth being restored. (Refer to table 4)

Short falls/ Constraints

There were several shortfalls or constraints that hindered oral health service delivery in the province in year 2017

Inconsistent dental services due to shortage of materials

Some dental services provided like dental prosthetics lacked materials and service ceased for several months, March – August of 2017. In august materials were purchased but due to a high demand of Dental prosthetics services, materials ran out again in December and dental prosthetic services ceased. It is still closed, awaiting hospital funding for prosthetic materials

Shortage in dental manpower

There are five dental clinicians, two of which are nearing retirement age. The dental nurse and dental technician would be retiring in a year or two and there has been no interest in CHW or Dental technicians graduands wanting to join the Dental team. In addition, there wasn't a lot of Oral Health Promotional/ Prevention outreach programs done in the community in the last two years because of shortage of staff.

Lack of support staff

The dental clinic does not have a cleaner's position. The clinic has a dental surgery room that needs to be cleaned out daily to keep up with infection control standards.

Dental patient's registry not recorded properly because there is no clerk at the clinic. Clinical Statistics has to be kept well for accurate and detailed reporting.

Burning of hospital rubbish disrupts dental clinic operations

The burning of hospital rubbish at boram point every week during morning hours disrupts clinic operations. The putrid fumes that is produced by the burning rubbish gets into the clinic making it impossible for patients and operators to breathe. Most times when this happens the clinic is forced to close.

Recommendations

Several recommendations may be made to improve on the quality and delivery of oral health services in the province

In comparison to the medical doctors the dental doctors do not get much clinical dental continuing professional courses/ workshops/training offered in the country. Therefore if it is offered either within the country or neighbouring countries it should be encouraged by management to attend. This would greatly improve quality of service delivery and expansion of oral health services currently provided.

Dental nurse is a speciality nurse position and should have a high enough pay grade to be attractive for CHWs to apply. At the moment, CHWs do not see the dental nurse position as attractive in comparison to their extra shift allowances that they receive working in the other sections.

There needs to be a dental clinic clerk position for correct book keeping of patient registry. This is so there is complete recording of patients for accurate and detailed monthly/ yearly reports

A cleaner should be assigned to the dental clinic alone. Rubbish should not be left to the next day to be removed. Linens, scrubs and towels should be washed every end of the week.

Burning of hospital rubbish at Boram Point should be done late afternoon or after working hours as during the morning it disrupts the dental clinic operations.

Oral Health Education programs should be greatly encouraged each year, dental school visits revived and awareness carried out in town or wherever there presents an opportunity. Targeting and lowering prevalence in oral cancer and rampant dental caries in school children.

WASAIE CLINIC

INTRODUCTION

This year has brought with it a lot of challenges and problems in terms of limited staff strength with increasing clients' attendance and the shortage of HIV consumables. We were not full team throughout the year because we have officers taking recreational leave, maternity leave and sick leave in between. Due to that we may fail to provide quality services however we always open the clinic's door to those who need our services.

The nationwide stock out of anti-retro viral drugs and HIV testing Kits that we experienced in mid-year with other HIV clinics in the country have caused a big dropped in the HIV testing coverage and have caused patients to missed ART which may lead to ART resistance and deaths in the future. We also experienced an increased in the ART defaulter rate during this period, which indicate the need of putting in more effort to keep patient on ART. The Closure of the ANC clinic in the hospital has forced us to stop providing PPTCT services to anti-natal mothers which is one of our initiatives since 2015. These issues have disallowed us to achieve our set targets for the year 2017.

This report covers staffing, statistics, achievements, problem encountered and recommendations & way forward.

List of abbreviations;

- ✓ VCCT – Voluntarily confidential counselling and testing
- ✓ PICT – Provider Initiated Counselling and Testing
- ✓ PPTCT – Prevention of Parent to child HIV transmission
- ✓ IMAI- Integrated Management of Adult & Adolescence HIV Illnesses
- ✓ ART – Anti-retro Viral Therapy
- ✓ STI – Sexually transmitted infections
- ✓ PLWHA – Person Living with HIV & AIDS
- ✓ EID – Early Infant Diagnosis for HIV Exposed Babies
- ✓ HCT – HIV Counselling and Testing

STAFFING AND TRAINING

Staff Strength

The clinic's staff ceiling has improved as per the current structure; however this is not what we have in the clinic currently. We only have 57% of the staff as indicated in the table below. This means we still have issues of staff shortage in the clinic.

Moreover, this current structure had captured the important positions that are required however; there was no consideration on hygiene and data entry staffs for the clinic.

This is illustrated on the table below.

CATEGORIES OF HCW	STRUCTURE	CURRENT	VACANT
MEDICAL OFFICER	1	0	1
HEALTH EXTENSION OFFICER	1	1	0
NUSRSING OFFICER	2	1	1
COMMUNITY HEALTH WORKER	3	2	1

The vacant Nursing officer and CHW positions are currently being occupied by officers who are working elsewhere

Competency & Training

Wasaie clinic requires officers who are well trained in the field of STI and HIV. These trainings equipped staff with skills and knowledge which will improve their competency to ensued quality work output.

Almost all staffs have attended some training which qualified them to work in the clinic; however training needs still remain.

Staff	Designation	Training Attained	Year Trained	Training Required
Maggie William	Health Extension Officer	PPTCT	2012	PICT
		IMAI	2013	Paediatric ART
		VCCT	2014	STI Syndromic Management
		HIV LOGISTICS SUPPLY CHAIN	2013 and 2015	
		Early Infant Diagnosis of HIV (EID)	2017	
Maryanne Rofunduo	Sister in Charge	PICT	2012	IMAI
		VCCT		Paediatric ART

		Syndromic Management of STIs	2001,2003	PPTCT
		TOT for STI Syndromic Management		HIV Logistics & Supply Chain
		Early Infant Diagnosis		
			2017	
Susan SEP	Community Health Worker	PICT	2014	VCCT
		Introduction to HIV/AIDS	2014	PPTCT
		HIV/AIDS data collectors workshop	2014	Early Infant Diagnosis (EID)
		Community Leadership and Basic HIV/AIDS		Paediatric ART
		IMAI	2009	STI Syndromic Management
		HIV Logistics & Supply Chain		
			2016	
			2017	
Rudolf Auklea		PICT	2014	VCCT
		PPTCT	2014	IMAI
		IMAI	2016	Early Infant Diagnosis (EID)
				Paediatric ART
				STI Syndromic Management
				HIV Logistics and Supply Chain

STATISTICS

The total annual attendance for 2017 is 2,338. These clients attended the clinic due to the following reasons;

STI treatment services,

HIV counselling & testing services (HCT)

HIV Care & treatment services, or

Other medical cases just wanting to get assistance.

They were either referred in by other health facilities, hospital wards or they came by themselves because they know the type of services offered in the clinic. We get clients from everywhere within the province.

For HIV care and treatment services, we do get clients transferring in from other provinces or seeking assistance as passer-by.

Table 1: Showing general attendances with the indication for visit, Wasaie Clinic, 2017.

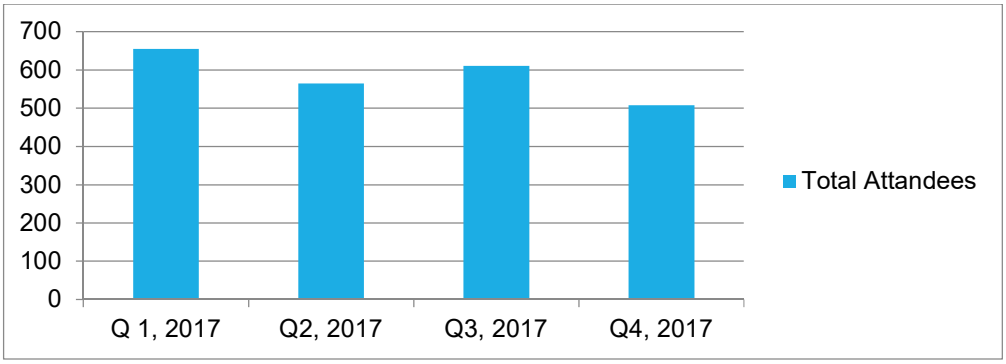
Reason For Visit	Sex	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Total
NEW STIs	M	31	22	44	7	35	26	21	21	32	32	24	15	310
	F	61	53	90	38	72	47	63	63	46	69	40	36	678
VCCT	M	10	8	14	4	3	2	6	8	3	15	5	1	79
	F	9	11	7	5	6	4	7	10	6	5	7	7	84
PICT	M	1	10	8	10	3	3	5	4	5	7	6	1	63
	F	6	10	21	17	10	9	11	5	11	11	10	7	128
PLHWA	M	7	7	13	13	15	15	7	15	19	9	9	7	136
	F	12	8	11	16	11	8	17	14	21	19	9	12	158
STI REVIEW	M	14	12	12	3	9	25	2	12	23	21	8	4	145
	F	37	36	53	33	36	49	33	49	51	48	27	21	473
OTHER CASES	M	1	0	4	4	9	1	1	2	6	4	3	0	35
	F	6	0	6	3	12	2	1	4	6	3	4	2	49
TOTAL		195	177	283	153	221	191	174	207	229	243	152	113	2,338

Table 2: Showing general attendance in different age group, Wasaie Clinic, 2017

Age Group	Gender	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
< 50 YEARS	M	58	49	77	32	65	60	37	56	68	78	44	25	649
	F	114	111	173	90	128	111	121	135	136	146	88	76	1429
50 + YEARS	M	4	8	13	10	8	11	5	7	11	10	7	4	98
	F	15	2	4	15	17	7	8	7	5	8	8	4	100
0 - 7 YEARS	M	2	2	5	1	2	2	3	1	9	0	3	2	32
	F	2	0	5	2	0	0	0	1	0	1	2	1	14
7 YEARS	M	0	3	0	0	0	0	0	0	0	0	0	0	3
	F	0	2	6	3	1	0	0	0	0	0	0	1	13
	TOTAL	195	177	283	153	221	191	174	207	229	243	152	113	2,338

General Attendance Data Analysis

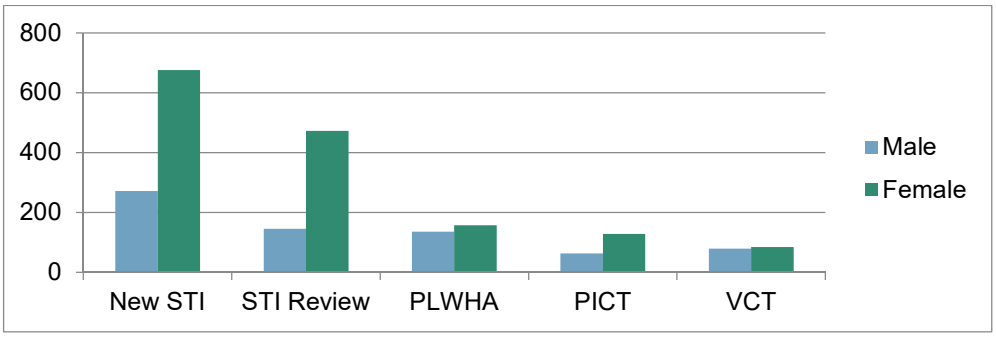
Figure 1: Line graph showing the trend of attendances in the different quarters, Wasaie clinic, 2017.



There is only slight variance in the number of attendees in the four different quarters.

The average number of attendees per quarter is 585.

Figure 2: Graph showing the different reasons for visit, per gender, Wasaie Clinic, 2017.

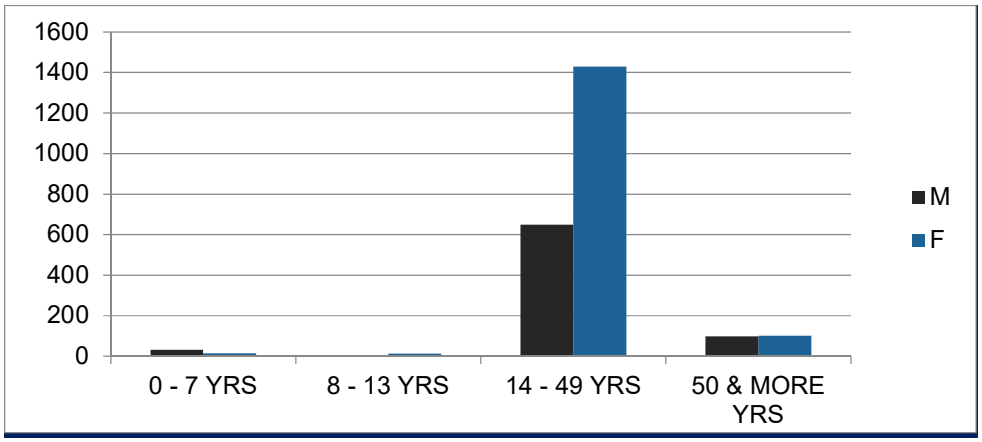


42% of those are newly confirmed STI cases whilst 26% are those who were diagnosed and treated for a STI and have returned to assess treatment outcome.

For HCT services it is either client voluntarily presents with request for HIV testing (VCCT), or they are being referred in for initiation of HIV counselling and testing services (PICT). Of the clients that we saw, PICT accounts for 8% of the cases whilst 7% are VCCT clients. Over all 15% of cases who visited the clinic came for HCT services.

13% are known HIV positives who attended the clinic for ART supply and diagnosis and treatment of HIV opportunistic infections.

Figure 3: Total attendances per gender and age group, Wasaie Clinic, 2017.



Most of the attendees were in the most productive and sexually active age group. Females really dominate the males. Does this mean more women are infected with STI than males or is it because women can attend STI clinic more freely than men.

67% of the attendees are females whilst 33% are males

Children made up only 3% of the attendees. Most of them are PLWHA who came for regular follow up.

Table 3: New STI cases, Wasaie Clinic, 2017.

Type of STI	Sex	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Annual Total
LAPS	F	99	64	81	63	**307**
VDS	F	83	72	71	60	**286**
UDS	M	61	40	56	57	**214**
GUS	M	16	15	10	3	**44**
	F	6	9	9	4	**28**
Latent Syphilis	M	7	1	4	9	**21**
	F	4	3	1	5	**13**
Genital Wart	M	0	0	0	0	**0**
	F	0	1	0	2	**3**
Other STI	M	13	12	4	4	**33**
	F	12	8	10	9	**39**
Total		**301**	**225**	**246**	**216**	**988**

The common type of STIs seen in both gender are Genital Discharge Syndrome. This syndrome accounts for 51% of all STI cases seen during the year. Most common infections causing this syndrome are gonorrhoea, chlamydia, trichomoniasis, candidiasis and bacterial vaginitis. Bacterial vaginitis mostly affects the female and is not an STI.

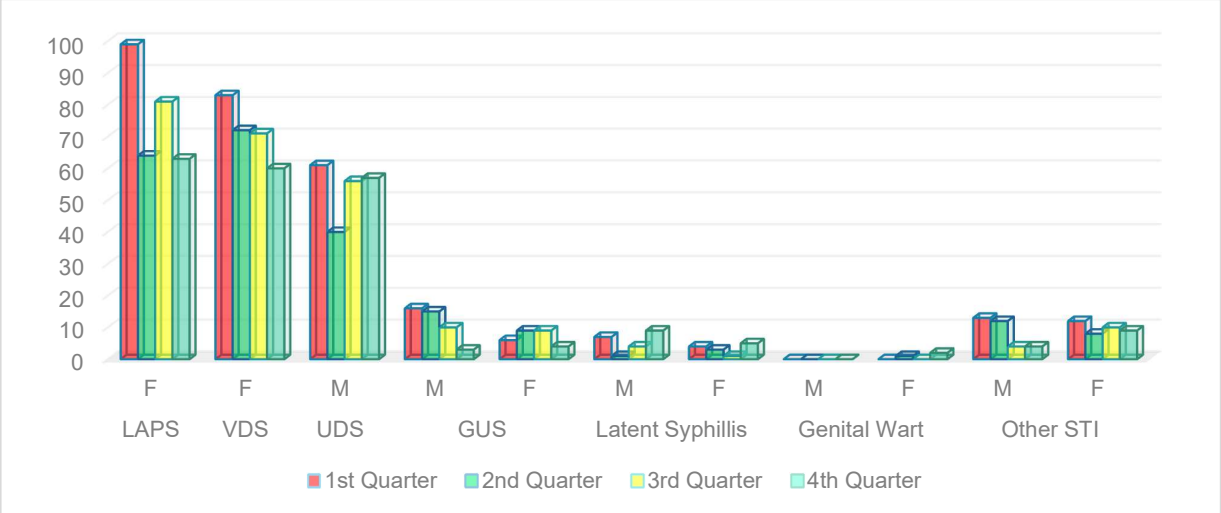
31% of the STI cases are females with LAPS. This is one of the main complications of untreated STI, especially the infections which caused genital discharge syndrome. Women who presented at this stage

Months	Jan		Feb		Mar		Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec	
Age Group/Gender	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
0 -17 months	0	0	0	0	0	0	0	0	0	0	0	2	0	2	3	1	0	0	0	0	0	0	2	1
18m - 4 years	0	0	1	0	1	0	1	1	1	0	1	0	0	0	0	0	2	0	1	0	2	0	2	1
5 - 9 years	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0
10 - 14 years	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15 - 19 years	0	2	0	3	0	3	0	0	1	1	0	2	0	0	0	1	2	3	0	1	0	1	0	2
20 - 24 years	1	2	4	1	2	4	1	4	0	2	2	0	0	7	3	5	1	3	4	3	1	1	1	3
25 - 29 years	7	10	3	7	4	12	1	4	1	2	1	5	3	2	4	12	1	8	0	2	1	5	0	4
30 - 49 years	13	14	8	10	8	10	1	2	0	3	6	4	3	10	11	13	0	13	16	14	2	6	2	8
50 and more years	1	3	2	0	2	0	0	0	0	0	3	3	1	2	2	0	1	1	3	2	0	1	1	0
Unknown Age	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL (sub)	22	31	18	22	17	29	4	11	3	9	13	17	7	23	23	32	7	28	24	22	7	14	8	19
Over all Total	52		40		46		15		12		28		28		51		35		46		21		27	

most times have poor treatment outcome.

15% are other STIs which do not fit into any of the syndromic groups, whilst 3% are those with latent syphilis.

Figure 4: Graph presenting the trend of different STI case seen in each quarter of 2017.



There is only a slight difference in the number of each STI cases in the different quarters quarter of 2017.

HIV TESTING STATISTICS, WASAIE, 2017

Months	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

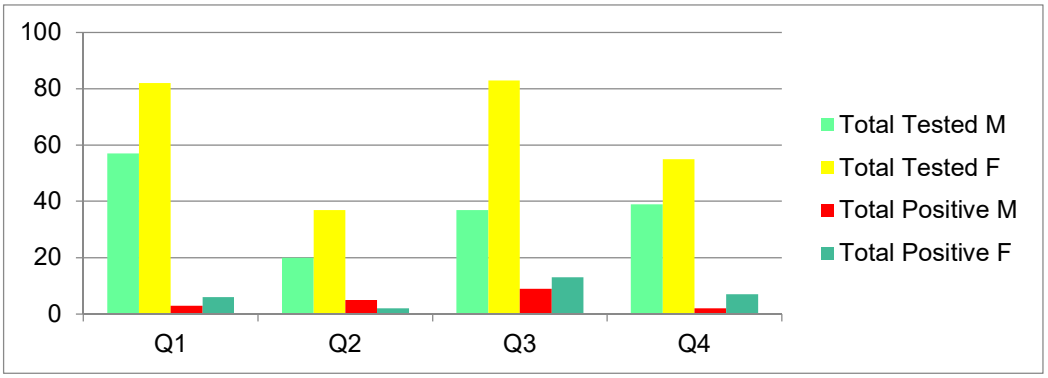
Age group/ Gender	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
0 -17 months	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
18m - 4 years	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0
5 - 9 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
10 - 14 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15 - 19 years	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
20 - 24 years	0	0	0	0	0	0	0	1	0	1	0	0	0	1	0	0	0	0	0	1	0	0	0	0
25 - 29 years	0	1	0	1	0	2	0	0	0	0	1	0	0	1	0	0	0	0	0	1	0	0	0	1
30 - 49 years	1	2	1	0	0	0	0	0	0	0	0	0	0	2	1	1	0	1	0	1	0	1	1	2
50 and more years	0	0	0	0	1	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Unknown Age	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not Reported Previously	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	7	7	0	0	0	0	0	0
SUB TOTAL	**1**	**3**	**1**	**1**	**1**	**2**	**1**	**1**	**1**	**1**	**3**	**0**	**0**	**4**	**1**	**1**	**8**	**8**	**1**	**3**	**0**	**1**	**1**	**3**
OVER ALL TOTAL	**4**		**2**		**3**		**2**		**2**		**6**		**4**		**2**		**16**		**4**		**1**		**4**	

Table 5: New HIV Positive cases per age group and gender, Wasaie, 2017

Table 6 & Figure 5: Showing HIV Testing per quarter by gender and age Wasaie, 2017.

		Q1, 2017	Q2, 2017	Q3, 2017	Q4, 2017	**TOTAL**
Total Tested	M	57	20	37	39	**153**
	F	82	37	83	55	**257**
Total Positive	M	3	5	9	2	**19**
	F	6	2	13	7	**28**

Figure 5:



Total of 410 HIV tests were conducted in the clinic in 2017. This figure has dropped from the previous years due to the stock out of HIV testing kits for some time in the year.

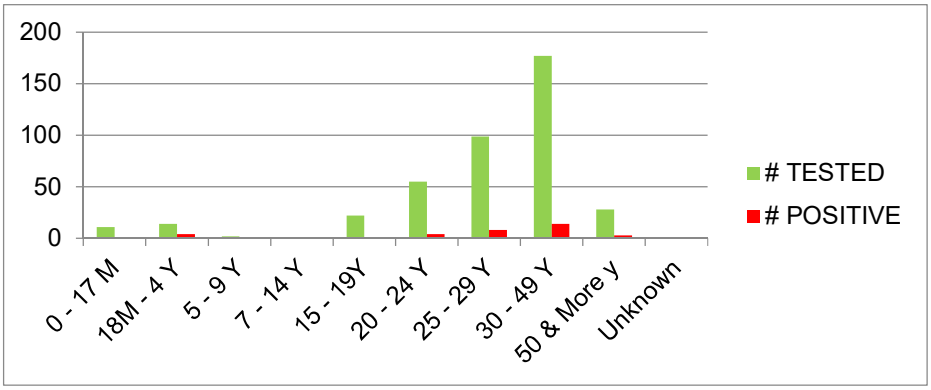
Female accounts for 63% whilst 37% are males. More females are tested than males

47 new HIV positive cases were detected. Again female accounts for the highest percentage which is 60% and males 40%. The over-all HIV prevalence for the clinic in 2017 is 11%.

Table 7 & Figure 6: Total tested for HIV and new HIV positive cases by age group & gender.

AGE GROUP	# TESTED	# POSITIVE
0 - 17 M	11	0
18M - 4 Y	14	4
5 - 9 Y	2	0
7 - 14 Y	1	0
15 - 19Y	22	0
20 - 24 Y	55	4
25 - 29 Y	99	8
30 - 49 Y	177	14
50 & More y	28	3
Unknown	1	0
TOTAL	**410**	**33**

Figure 6:



Most tested were in the age group of 30 – 49 years and this age group also accounts for the highest number of HIV positive cases.

HIV CARE AND TREATMENT STATISTICS

New Registration for HIV care and Treatment, Wasaie, 2017.

ADULT (14 YRS & More) **PAEDS (0 – 13 YRS)**

	Male	Female	Male	Female
New Registration	21	31	4	0
Transfer In	1	1	0	0
Total	22	31	4	0

PLWHA Deaths and Lost to follow up cases, Wasaie, 2017.

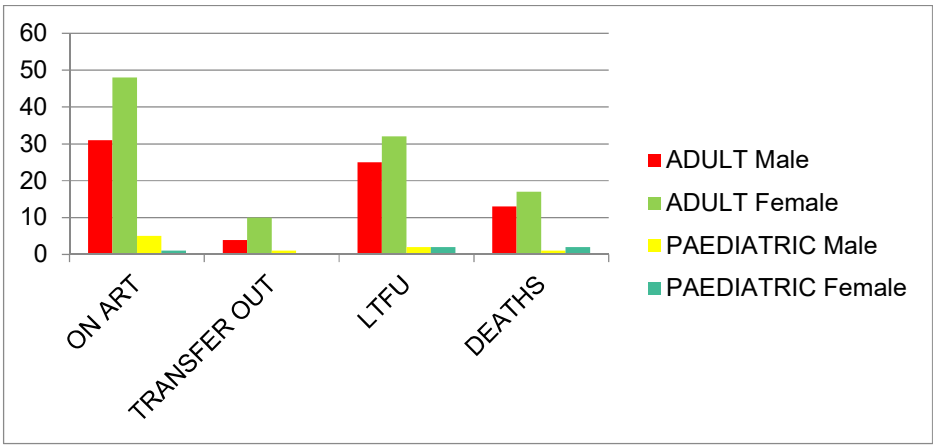
	ADULT (14 YRS & More)		**PEADS (0 – 13 YRS)**		**TOTAL**
	Male	Female	Male	Female	
Recorded Deaths	3	4	0	0	7
LTFU	7	12	2	0	21

Total of 58 PLWHA were registered for care and treatment in 2017. 91 % were adults whilst 9% children**.** Most were females in the adult category.

At the end of 2017 only 28 (50%) remain in care and treatment.36% failed to return for continuation of treatment, 14% were reported deaths.

CUMULATIVE UPDATE OF PLWHA REGISTERED FOR ART.

		ON ART	TRANSFER OUT	LTFU	DEATHS
ADULT	Male	31	4	25	13
	Female	48	10	32	17
PAEDIATRIC	Male	5	1	2	1
	Female	1	0	2	2
Total		85	15	61	33



Total of 194 patients were commenced on ART from 2009 to 2017. This only 60% of total PLWHA registered for care and treatment. 43% remain on treatment whilst 8% transferred out to other ART sites.

31% were lost cases, deaths accounts for 17%.

ACHIEVEMENT

EID Training: Two of the clinic staff, HEO and Nursing Officer has attended the Provincial Early Infant Diagnosis Training (EID) which was conducted in December, 2017. Therefore, the clinic can now provide EID services to babies exposed to HIV. We can now collect DBS sample for HIV DNA PCR test for early detection of HIV infection in children is important to save lives.

PROBLEMS ENCOUNTERED/ CONSTRAINTS

1. HIGH DEFAULTER/ LOST TO FOLLOW UP RATE

The 90/90/90 concept is an ambitious treatment target to help end the AIDS epidemic. That is to identify 90% of people living with HIV, commenced and keep 90% of them on treatment and 90% of those on treatment must have viral suppression.

As per the statistics, there is very high lost to follow up cases. For 2017 alone, we have already lost 50% of these new HIV cases that were put on treatment. Only 50% remained in care and treatment. This may result in continuous transmission of the virus as ART is currently seen as the only effective method for preventing the spread of HIV.

2. DATA ENTRY CLERK

A data entry clerk is required as soon as possible to make sure all data are well recorded and are kept in order to assist with reporting.

3. COMMUNICATION

The clinic has no phone extension or mobile phone. Communicating with other section of the hospital remains a problem. Currently we had to leave the clinic out of our business just for simple things that can be discussed over the phone with other colleagues within the hospital. We also have regular communication with the HIV/STI team at NDOH in-terms of reporting and ordering of HIV/STI

consumables and this is done through our personal mobile phones. Patients especially PLWHA are also communicating with us through our personal phones.

4. INFECTION CONTROL

Hygiene Staff – Thorough cleaning is important for infection control because deposits of dust and microbes on surfaces can transmit infection**.** We don't have hygiene staff that will make sure the clinic is clean and safe for the staff and the patients to use. At the moment the nurses are doing the cleaning up only when there is time available.

Trash Bin – Waste disposal is also important for infection control. We know that different types of waste – general, clinical and pharmaceutical- have different waste management procedures that need to be followed. Currently the clinic has only one yellow bin with the lid all broken and gone. We have no choice but to dispose all types of waste in the same bin. Because there is no lid, every morning we have rubbish being pulled out and thrown everywhere by the dogs. The infection control standard is not in place.

5. STATUS OF THE BUILDING

The roof overhang at the main entrance door is high enough that it usually allowed rain water into the clinic through the main door. During heavy down fall the patients' waiting area and the data room are always filled with rain water. This continuous exposure of the main door and floor tiles may lead to premature siding rot.

-Almost all the doors in the clinic have been damaged by termites. Soon all the consultations rooms will have no doors. That will compromise the patients' privacy.

RECOMMENDATIONS

1. IMPROVE ART COVERAGE

Interventions to improve the ART coverage of patients on ART are important and must be considered seriously by the ESPHA Management. One that I can think of is to roll out the HIV testing and HIV care & Treatment programs to all Health facilities in the province. There is funding available for HIV programs and it would be good if it is utilised in staff capacity building by conducting all the required trainings for health workers in all facilities.

Secondly, HIV is a big public health program; it should have its own vehicle to be used for outreach and awareness programs and to do follow up visits for patients who are not able to come to us.

2. DATA ENTRY CLERK

A data entry clerk must be allocated to the clinic as soon as possible to assist maintaining the clinic's data. This will help us submit reports in a timely manner.

3. COMMUNICATION

A telephone extension has to be in place as soon as possible which will provide adequate communication with the areas concern within the hospital. The clinics also need a mobile phone for communication outside of the hospital.

4. INFECTION CONTROL.

A hygiene staff should be considered for Wasaie clinic sooner to ensure a clean and safe working environment that is friendly to both staffs and patients.

Standard infection control policies are very important and must be put in place. We need new and rubbish bins of required quantity so that wastes are disposed accordingly.

5. STATUS OF THE BUILDING

The carpentry team in the hospital needs to do a thorough visit to identify the problems mentioned. They need to attach an overhang at the entrance door to prevent rain water from entering the clinic.

Also as per their expertise they will consider the best option to help prevent the consultation room doors to fall off.

Most of these problems and recommendations have been repeatedly mentioned in the previous reports but nothing has been considered as yet.

RURAL OUTREACH SERVICE

Introduction

Rural Outreach programs fall under KRA 1 of the GoPNG National Health Plan, to increase access of quality health care to the rural majority and urban disadvantaged. I Dr. Preston Karue am the coordinator and only staff member under Rural Outreach. As the Rural Outreach Coordinator for East Sepik Provincial Hospital my role is to design and manage multidisciplinary clinical outreach programs and report on those programs. 2017 saw several successful outreaches to the rural majority, implementation of public health activities to the urban disadvantaged and health promotion and partnership building.

The Rural Outreach Program is reliant on two core variables; contingent funding and human resources. In 2017, funding was a major obstacle to the successful implementation of a full-scale outreach program. In response, I have focused on cultivating relationships with stakeholders including NGOs, INGOs, and government agencies, to advocate for the important role of Hospital run clinical outreach programs across the Province. These partnerships have proved vital on a number of the 2017 missions and support us both financially and in-kind, often in the form of logistical support.

A second approach to funding shortfalls was the research and application for external grants. In August 2017 I submitted an application for the Community Scheme Grant, administered through Australian Volunteers International (AVI). Whilst the application was unsuccessful, the professional experience gained will be vital for future grant opportunities.

The outreach programs rely on Hospital human resources. Before a discipline can participate, they must have sufficient staffing to ensure that Hospital patient care is not affected. The launch of PHA and the ongoing support of the Human Resource Management Team will work towards filling 100% of vacancies, which will enable all disciplines to participate going forward.

Throughout the 2017 year I maintained my own levels of professional development to ensure that I can continue to grow the role of Rural Outreach Coordinator and the Rural Outreach Program. I attended the Annual National Medical Symposium in Port Moresby. I was invited to attend a gender-mainstreaming workshop in Madang with Hospital Directors. Lastly, I have worked extensively with the Australian Volunteer International Program particularly concentrating on project management and design.

Despite limited available resources for the 2017 financial year, the rural outreach program met its KRA objectives and will continue to work on improving quality of health care to the rural majority and urban disadvantaged in 2018 and beyond.

The Statistics 2017

5 Districts in East Sepik Province were reached with clinical or health promotion activities

3682 individuals were served by the Rural Outreach Program in 2017

26 health workers received training through the Rural Outreach Program in 2017

1. Discussion with SSMOs & SMOs on how rural outreach programs to be coordinated.

Input: Throughout February 2017 I held a series of discussions with one SSMO/SMO from the four major clinical disciplines, and Ophthalmology, Dentistry, Physiotherapy, Wasaie Clinic, and Pathology. The outcomes of these discussions were to determine each team's requirements for rural outreach, including team composition, outreach frequency and duration.

In addition I discussed the outreach program with Director, Medical Services.

2. Designing of rural outreach program.

Input: Based on consultations with relevant stakeholders, as outlined above, the rural outreach plan was designed. In summary the plan dictated quarterly multidisciplinary visits to each district, excluding Wewak District. This plan was finalised in consultation with Director, Medical Services and presented to the CEO for endorsement. The outcome of the rural outreach plan was contingent on Provincial Government funding, which by December 2017 had not been received.

3. Secure funding.

Input: Without recurrent funding for the rural outreach program I actively sought out relevant stakeholders and concentrated efforts on partnership building with private enterprise, INGOs, NGOs and government agencies for potential in-kind as well as financial support.

Outcome: Good working relationships with Provincial Health, District Administrators and members of parliament, INGOs including YWAM, World Vision, and Living Child, NGOs including Spacim Pikini, Outreach International, Samaritan Aviation, and PSI and lastly private enterprise that included Colgate. These relationships will continue to work with the Hospital's Outreach Program where possible and allowed the successful completion of number activities in the 2017 calendar.

4. Outreach program being implemented, one visit per district, and every quarter.

Input: The clinical outreach program was conducted in partnership with stakeholders. In addition the Rural Outreach Coordinator supplemented the program with public health activities, health promotion and general outreach due to lack of funding for purely clinical outreach.

4.1 Clinical Outreach serving the rural majority

3 clinical outreaches conducted

5 districts visited

4.1.1 YWAM Outreach

Two clinical outreaches were conducted aboard the YWAM medical vessel Pacific Link from 6 - 8 February 2017 The program reached nine villages across Angoram District and Samaritan Aviation also provided logistical support to the outreach program.

The first YWAM clinical outreach was conducted on 8 – 21 January 2017. This program included a team of eight Hospital staff consisting of one SMO, two registrars, one nurse, four CHWs that provided dentistry and ophthalmology services as well as insertion of family planning implants.

The second program ran from 23 January – 8 February 2017. This outreach took a five-person team that included one registrar, one nurse, three CHWs performing only ophthalmology services.

Across the two outreach programs a total of:

1886 optometry patients were seen

131 eye surgeries performed

213 dental patients treated

100 implants were provided to women.

Pic 1.A. Dr. Pahau doing postoperative assessment

Pic 1.B. YWAM Team assisting a patient return of a patient at Kambaramba, Angoram home after postoperative assessment.

4.1.2 Spacim Pikinini Outreach Program

The Spacim Pikinini outreach program, supported by Rotary Australia, commenced 6 – 8 February 2017 with training for labor ward staff for family planning implant program. The outreach program itself ran from 19 – 24 February 2017, with logistical support from Samaritan Aviation. Four districts were covered during this outreach; Angoram, Ambunti-Drekikir, Yangoru-Saussia and Wewak. The following results were achieved.

- 512 women were provided with an implant
- 26 health workers were trained and certified to insert implants
- 8 health facilities were supplied with implants for ongoing insertion

Pic 2.A. Women being registered for Implants.

Pic 2.B. Implant insertion by Rotary Australia Volunteer.

Pic 2.C. Local staff being taught how to insert implants.

5. Health promotion activities

5.1 World TB Day

With the assistance of Wewak District Health Manager Mr.Cletus Bon, I organised a major awareness event for World TB Day. TB is a disease, which is a growing threat to the province due to our high defaulter rate, and so activities to increase awareness on this disease are very important. World TB Day was hosted on 24 March 2017 in Wewak Town at the Square next to ANZ Bank. It was not only a great event for raising awareness to the general public but brought together the various stakeholders of the disease in the province including Provincial Health, Wewak District Health, World Vision and PSI. A live band performance by the Sons Arise Band drew a significant crowd and Wewak Town audience were addressed by speakers including the East Sepik Provincial Health Advisor Mr. Albert Bunat, Provincial Disease Control Officer Mr. Conrad Kambi and Wewak Disease Health Manager Mr.Cletus Bon, among others. The media were also present and took recordings, which were aired both on radio and TV.

5.2 Oral Health Programs

Five oral health promotion programs were conducted in Wewak District to the urban disadvantaged including children, a vulnerable population, from October to November 2017, with support from Colgate Palmolive (PNG) Ltd supplying 3,800 Oral Health Kits.

4 schools visited - Lomet (ET) Exodus Christian Academy, Kreer Compound Elementary School, and Hawaiin Primary School, Wewak International School

1 community visited – Kaindi

840 young people received Oral Health Kit

840 young people received health promotion information

Pic 3.A. Oral health awareness at Hawaiin

Pic 3.B. Colgate tooth brushing kits given to Primary School Students.

5.3 Corporate Lifestyle Disease Program

The Corporate Lifestyle Disease programs were conducted in Wewak Town for the working population who were vulnerable to lifestyle diseases. It involved both the Hospital, Wewak District staff and the PNGDF teams who together conducted tests for blood pressure, blood sugar, BMI, and dental and eye assessments as well as health promotion and consultations. Wewak District Health Manager Mr. Cletus Bon funded the activity and its purpose was not only to screen for lifestyle diseases but also to build relationships with the various corporate organisations in Wewak Town so that they could, in turn, support health programs.

Due to funding limitations however only two programs were done; one for the provincial administration staff and one for the general business community at Wewak International School (statistics not provided as they were not given by partner organisations).

Pic 4.A. Sr Maru performs eye check.

Pic 4.B. Dr Bun providing dental

Pic 4.C. Captain Mary Ako of Moem Barracks providing health consultations

5.4 World AIDs Day

In support of East Sepik Provincial Administration we conducted a day of free health clinics prior to World AIDS Day on 1 December 2017 in partnership with the Sepik Centre of Hope. The clinics were set up at the main town car park and the services offered included immunizations, blood donation drives, B P, BSL and BMI checks.

Pic 5.A. Dr Angela Seginami providing health awareness.

Pic 5.B. MCH team immunizing a child.

Pic 5.C. Locals line up to donate life-giving blood

Pic 5.D. Nrs Ambun checks patient BP

The gender-mainstreaming training was held in Madang from 7 - 11 August 2017. It was attended by myself, the Acting Director for Corporate Affairs, Acting Director for Medical Services and Director for Nursing Services. The mainstreaming training for managers was initiated to sensitize health managers on gender issues so that they could be gender sensitive in their health decisions and advocate for gender and family sexual violence issues.

6.2 Medical Symposium

I attended the Medical Symposium in Port Moresby funded from a personal funding arrangement, as the hospital did not have the funds to support travel. However, in the lead up to it myself and the HR Manager spent a lot of time in discussions with the Provincial Administration to secure funding for the Doctors of the Hospital but this did not eventuate due to the lack of funds. Continuing to build partners to support such activities is vital to the future medical education for ESPHA staff.

7. Funding grant application

With the assistance of Emma Charlston, Australian Volunteer, I applied for funding from Australian Volunteers International for a District Health outreach program but this was not successful as the outreach programs were considered by the grant to be a core function of the Hospital, which the Hospital should fund. I learnt a lot from the experience however and will apply the lessons learnt to future grant applications.

8. Positives

The donation of the Rural Outreach vehicle by the National Gaming Board on 19 May 2017 is a positive step forward. Our CEO Mark Mauludu and the Hospital Board are to be commended for their efforts, which made this a reality.

Pic 6.A. Presentation of the Rural Outreach Vehicle to the CEO.

8. Constraints

Funding was the major constraint for outreach programs this year. I will continue to advocate amongst partners, government agencies and ESPHA for recurrent funding arrangements and seek external grant opportunities.

9. Equipment Requirements

1. Office Space
2. Rural outreach boat
3. Storage Container
4. Printer/Photo copier
5. Laptop
6. Projector
7. 20 x matrasses
8. 2 x tents
9. 10 x foldable chairs
10. 4 x foldable tables
11. 1 x Generator
12. 2 x double gas burner stoves and gas bottles
13. 4 x storage eskies
14. 4 x patrol boxes

Note: this list is not exhaustive and more items will be added as the need arises.

10 Recommendations

1) Rural Outreach programs are very dependent on funding and must be made available by PHA to carry out programs.
2) All clinical vacancies, especially for SSMOs/SMOs and registrars must be filled so there are adequate numbers of staff for outreach programs.
3) All Districts must plan to have transit houses to help house rural outreach staff and reduce outreach costs.
4) All District Health Managers need to conduct primary health care outreaches so that cases can be identified prior and the in the lead up to specialist clinical outreaches.
5) Improve collection of statistics from District health facilities so that there is information available for Rural Outreach Planning.

11 Conclusion

Availability of funding for outreach programs was a major obstacle and so the focus of 2017 was building relationships with the various stakeholders who will support rural outreach programs. The presentation of the Rural Outreach Vehicle by the National Gaming Board is definitely a big boost to outreach programs. Lastly, PHA will unite the health services and resources across the Province, and this will contribute to a successful outreach program in 2018 and beyond.

SOCIAL SERVICE (SOCIAL WORKER)

Introduction

Social Work unit plays a vital role as one of the supporting units in the hospital that provides psychosocial l services for inpatients and their families for their after treatment care and also linking them to other social services within their communities to seek further assistance. The social work unit also work with outpatients on cases of domestic violence and sexual assault. Furthermore, the unit also provides assistance to referred patients of outside centers and clinics and other social services stakeholders such as the Police, Department of Community Development and NGOs.

In the past years social work unit was not properly established in the hospital and a lot of patients and staffs does not understood the roles and responsibilities of a social worker and its importance in contributing to the recovery of patients. The lack of knowledge and awareness of social work services in the hospital has been the major setback for the unit's data collection this year. There is also no proper written records of social work cases in East Sepik Provincial Hospital all these years. Thus, there was no system in place of identification of social work cases and the respective interventions and management plans. For the year 2017, with the recruitment of two new Social Workers under the unit, the social workers were working towards establishing proper records for identified cases, social work interventions and management for an effective delivery of social work services.

This report will be based on the identified social work cases for the year 2017, staffing, client statistics and discussion, achievement, constrains, recommendation and way forward.

Main Programs and Activities currently implemented by Social Work Unit

PROGRAMS	ACTIVITIES
Counselling for Wasaie Clinic and outpatient clients	Provide counselling for sexual assault patients Provide counselling for patients with marital problems and referrals to outside services like; welfare, police, etc.
Repatriation	Assist patients to arrange for transportation to be sent home.
Destitute Cases	Provide counselling to patients Link neglected patients to their relatives.
Awareness	Follow Wasaie Clinic team awareness programs to educate people on social work services provided by the hospital.

IDENTIFIED CASES

The identified social wok cases from January to December 2017 are;

Wasai Clinic and outpatient referrals	Wards (Surgical, Medical, Pediatrics, O&G and Special Care Nursery)
Sexual assault and incest cases	Repatriation
Welfare cases – Deserted Women and Children (maintenance and dissolving of marriage) Note: Case referred to Welfare Office and Police Sexual Violence Unit	Destitute
Domestic Violence	Adoption
Unwanted pregnancy	Psychosocial counselling to patient to accept chronic illnesses

STAFFING

1) 2 social workers
2) Nursing Officer
3) Social Worker

CLIENT STATISTICS

Statistics of Social Work Cases at East Sepik Provincial Hospital from January - November 2017

Month	Domestic Violence	Destitute	Repatriation	Sexual Assault / Incest	Unwanted Pregnancy/ Adoption	Psychosocial Counselling	Deserted Wife and Children	Total Number of Social Work cases
January		1						**1**
February	2	2	1	1	1	1	3	**11**
March		1		2		1	2	**6**
April		2		3		1		**6**
May				2		2	2	**6**
June	2	1		1				**4**
July	1				1	1		**3**
August		2				1		**3**
September								**0**
October	1							**1**
November	4			1		4		**9**
December				1		4		**5**
							Total	**55**

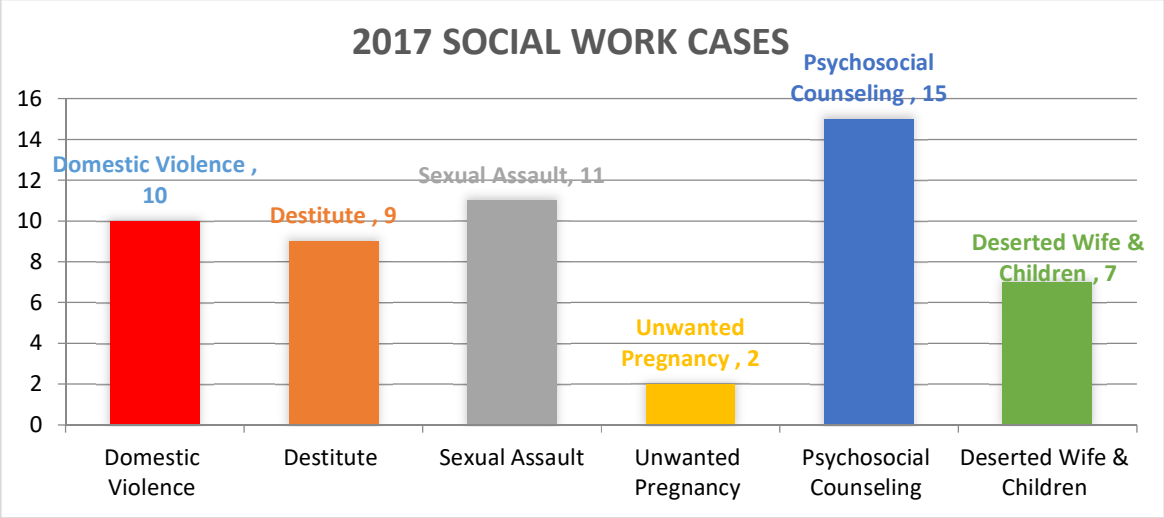


Figure 1: 2017 Social Work Cases at ESPH

DISCUSSION

There were 55 total number of recorded cases being referred and attended to by the social work unit this year, 2017. Domestic violence, destitute cases, repatriation, sexual assault, incest, unwanted pregnancy, welfare and adoption, psychosocial and deserted wife and children cases were identified and interventions were provided. The number of cases seen at Wewak Provincial Hospital in the year 2017 will be presented from the lowest to the highest number of cases.

There was no cases seen in September because there were no referrals to the unit that month. January and November has the second lowest number of recorded cases with only 1 case recorded for each of these two months. For January to have only one case was because the social workers were newly appointed to the positions in late November following the internal

advertisement and the clients were still referred to the psychiatric unit where the previous social worker is now located. However, for October there was only one case being referred to the social workers. July and August has the third lowest number of cases being recorded with the total number of 3 cases being recorded for each of the months. June has the fourth lowest number of case with the total number of 4 cases. December has the fifth lowest number of cases being recorded. March, April and May has the fifth lowest number of case with 6 cases being recorded for each of the months. November has a record of 9 cases been seen and February has the highest number of cases with the record of 11 cases. In February there was a lot of referral from the Wasaie Clinic that was the reason for the unit to have the highest cases.

Figure 1 shows the total number of percentage of social work cases seen in 2017 at East Sepik Provincial Hospital. Psychosocial Counselling cases has the highest percentage of cases seen with a percentage of 28%. Psychosocial counselling covers areas such as inpatient counselling on acceptance of patient health condition and treatment. Sexual Assault has the second highest percentage of cases being recorded for the year 2017 with a percentage of 20%. Sexual assault cases covers areas such as rape, incest and child molesting. Destitute cases the third highest percentage of 17% being recorded. Domestic Violence cases has the fourth highest percentage being recorded with the percentage of 18%. Deserted Wife and Children has a percentage of 13% being recorded for the year. It covers cases such as child maintenance and restraining order. Most of these cases are being referred to the Welfare office and NGOs that provides paralegal services. Unwanted Pregnancy has the lowest number of percentage being recorded with a percentage of 4%. It also covers adoption cases. Adoption cases are being referred to the child protection officer at the Welfare office.

There are three different factors that contributes to the low number of cases seen by the unit in the year 2017. The first factor and the most important that reduces the number of cases seen is lack of awareness for the services social workers provide. Most of the staffs are not aware of the types of services a social worker is supposed to provide in the hospital to contribute to the holistic recovery of a patient. This is because there was no proper awareness being made by the unit. The second factor would be the referral pathway. The hospital does not have a good referral pathway for social work. The lack of awareness of the services social workers should provide contributes to no good referral pathway being established and therefore a lot of the cases were not attended to. The number of cases seen in the year 2017 was determined by the knowledge few staffs had of social work to refer their case for the different psychosocial interventions. The third factor is the office space. Social workers does not have a good office space. We are using the Wasaie Clinic Conference area and therefore we will produce late reports as all their staff also uses the area for break. Most of the cases we see are sensitive cases and thus not being able to have a proper counselling area hinders our services and for the privacy of patients using the HIV and STI clinic will add to stigma and discrimination.

East Sepik Province does not have a Family Sexual Violence Action Committee in place. Thus, we had to create a good working relationship with other government agencies and NGOS who deliver similar services for a good referral pathway for our clients outside of the hospital. This year we have established working partnership with several organisations within the Wewak District and they are; the Family Sexual Violence Unit of RPNGC, Department of Community Development, Community Based Correction Division of Department of Justice and Attorney General, Oxfam PNG, Family for Change, East Sepik Council of Women, Wewak District Council of Women and Mariestellas. Through this partnership with these organizations we can

be able to provide safe houses for our clients as well referring them to the right authorities for legal assistance if needed. These organizations were also able to refer their clients to the hospital to seek medical assistance through this pathway created.

CONSTRAINTS

Data collection

The previous social worker does not have a good record of the cases. The unit does not have log books. We are starting to keep our records and do proper filing.

Referral pathway

A referral pathway for social work services was not established and thus many cases were not referred for social work intervention. We are liaising with Dr. Seginami from Obstetrics and Gynecology Unit to create a referral pathway.

Lack of coordination and support

We are struggling to coordinate our repatriation cases due to lack of funding to support the patients who are asked to be repatriated. We also manage most of the destitute cases with our own money.

Office Space

We are currently placed in Wasaie Clinic's conference room and we are also sharing all their facilities to assist our clients. We need a proper office space to manage our services in the hospital and be able to keep our data properly.

Limited knowledge of functions of social worker in the hospital

We have a graduate social worker and a nursing officer in this unit. The nursing officer lacks certain skills and knowledge about social work therefore short courses and training is required for this officer to improve service delivery in the unit.

RECOMMENDATION

Training

Further training is required in counselling and social work case management in hospitals that we social workers have identified which is important to carry out our work effectively for the following reasons;

General counselling technique is not applicable in other counselling areas in cases like sexual assault, trauma, grief and cancer patient counselling.

In order to understand hospital social work case management a training is required and PNG Famili Inc is running social work case management trainings. Therefore, if we are allowed to those trainings it will boost our work efficiency to produce a satisfactory outcome.

Gender/ Domestic Violence training

Law and justice training specifically on paralegal and juvenile justice training.

Attachment with a Family Support Center in either Port Moresby General Hospital or Angau General Hospital to understand how to manage a FSC when we have ours established.

Short computing courses for the Officer In charge as most of our work and report involves using a computer.

ACHIEVEMENTS FOR SOCIAL WORK UNIT

Established a record book to record our cases for proper filing and reporting.
Awareness on social work services provided with Wasaie Clinic team visits to schools to conduct awareness programs.

WAY FORWARD

Presentations and awareness
A lot of presentations has to be done on the roles and responsibilities of social workers so that the cases are being properly referred. Public awareness on the services that we provide has to be also done.
Proper activity plan to be done for the year 2018
Family Support Center
Proper referral pathway
Proper ward rounds with different units

RADIOLOGY UNIT

Introduction

The Radiology Department of Wewak General Hospital is the only facility providing radiology services to the people of East Sepik Province. Maprik district hospital had x-ray facility before, however, they no longer have it now. Referral patients/clients do come to hospital for Radiology service from neighbouring Raihu and Nuku district hospitals.

This year had been a challenging year with continues break down of x-ray machine. Therefore the statistics of time the x-ray machine was functioning.

Manpower

Currently there are six staff on strength providing x-ray services to the general public in East Sepik Province

- 4 Radiographers
- 1 Darkroom Assistant
- 1 clerk

EQUIPMENT

EQUIPMENT	CONDITION
Fuji Computed Radiography (FCR)	In working Condition
System	Installed on 09.12.2015

Shimadzu UD150L – 30FX with II	Out of Order as of 28.12.2015
Shimadzu Mux – 100 mobile unit	Out of Order
Konica Minolta SXR – 201	Out of Order
Automatic X-ray Film Processor	as of 21.05.2015
Konica Minolta – 101	Out of Order as of 07.09.2017
Automatic X-ray Film processor	Installed on 11.05.2015
Villa Visitor T30 C	In working condition
Mobile X-ray machine	Installed on 21.12.2017
Senegal Mobile Unit	In working condition
	Installed on 08.12.2017

TOTAL NUMBER OF PATIENTS:

Months	Number of in-patients		Number of out-patients		Total
	Adult	Children	Adult	Children	
January	0	0	0	0	0
February	77	9	280	19	385
March	90	22	623	54	789
April	66	18	484	42	610
May	141	15	585	63	804
June	136	24	495	47	702
July	151	37	752	48	988
August	158	44	950	56	1208
September	135	13	413	28	589
October	105	20	341	25	491
November	95	13	407	26	541
December	43	8	25	9	85
Total	1197	223	5355	417	7192

TOTAL NUMBER OF MINATIONS:

Examination/	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEP	OCT	NOV	DEC	TOTAL

Month													
CHEST& RIBS		183	459	362	490	446	684	824	407	294	324	106	9 457
EXTREMITIES		178	234	205	241	219	285	302	238	139	171	65	2277
SKULL		15	31	37	28	3	37	49	29	17	34	18	298
FACIAL BONES		6	3	6	6	2	4	16		2	2		47
NASAL BONES													0
MANDIBLE		2	11	10	12	5	9	10		5	4	2	70
MASTOID													0
T.M.JOINTS													0
SINUSES													0
SPINES		25	82	64	76	63	92	104	40	22	33	21	622
PELVIS & HIPS		19	26	19	36	27	19	40	21	9	16	10	242
ABDOMEN		9	25	23	19	19	28	29	35	24	15	4	230
CYSTO-URETHROGRAM			2	2	1								5
BARIUM SWALLOW		1	3	2									6
BARIUM ENEMA						1							1
INVERTOGRAM					1					1			2
TOTAL	**0**	**438**	**876**	**730**	**910**	**785**	**1158**	**1374**	**770**	**513**	**599**	**226**	**8379**

TOTAL NUMBER OF WET IMAGING FILMS USED:

MONTH/ DESCRIPTION	**35X43CM**		**35X35CM**		**24X30CM**		**18X24CM**		**SUB-TOTAL**		**GRAND TOTAL**
	GOOD FILMS	**REJECT FILMS**	**GOOD FILMS**	**REJECT FILMS**	**GOOD FILMS**	**REJECT FILMS**	**GOOD FILMS**	**REJECT FILMS**	**GOOD FILMS**	**REJECT FILMS**	
JANUARY	0	0	0	0	0	0	0	0	0	0	0
FEBRUARY	69	7	43	4	47	15	6	5	165	31	196

MARCH	216	9	154	12	211	13	41	6	622	40	662
APRIL	56	6	235	8	197	22	173	21	661	57	718
MAY	69	10	342	27	330	20	273	26	1014	83	1097
JUNE	279	17	319	7	313	13	18	16	929	53	982
JULY	45	5	344	10	497	17	380	26	1266	58	1324
AUGUST	57	11	369	28	537	22	383	22	1346	83	1429
SEPTEMBER	0	0	69	3	88	4	62	1	219	8	227
OCTOBER									0	0	0
NOVEMBER									0	0	0
DECEMBER									0	0	0
TOTAL	**791**	**65**	**1875**	**99**	**2220**	**126**	**1336**	**123**	**6222**	**413**	**6635**

TOTAL NUMBER OF DRY IMAGING FILMS:

Month/description	35x43cm	25x30cm	Total
January			**0**
February			**0**
March			**0**
April			**0**
May			**0**
June			**0**
July			**0**
August			**0**
September	366	119	**485**
October	406	134	**540**
November	381	110	**491**
December	200	0	**200**
Total	**1353**	**363**	**1716**

TOTAL NUMBER OF CHEMICALS USED:

Month/chemistry	Developer Replenisher	Fixer Replenisher	Total Number
January	0	0	0
February	1	2	3
March	3	4	7
April	3	5	8
May	4	6	10
June	5	6	11
July	5	6	11
August	7	9	16
September	1	1	2
October	0	0	0
November	0	0	0
December	0	0	0
Total	29	39	68

Constraints

- Breakdown of X-ray machine and x-ray film processor has affected service provision in the year.
- Shortage of dry imaging films due to funding shortfall.
- No personal radiation monitors due to non- payment of accounts.
- Lack of training for staffs.

Achievements

- Two new mobile x-ray machines were installed this year.
- Villa Visitor T30 C mobile x-ray machine was installed on 21.07.2017
- Sedegal mobile x-ray machine was installed on 08.Nov.2017

Discussion

Wewak general hospital is the only facility that provides radiology service in all of East Sepik Province. Also patients/clients from Nuku district do get referred here for x-ray services.

The major x-ray machine broke down in September of 2015 and there is no parts to have it fix so it's going to be dispose off when replacement machine comes. Two new mobile x-ray machines were installed this year and these machines are being in use now.

The Computer Radiography (CR) system was installed in December 2015 and it's in use now after two automatic film processors broke down. With the use of CR system comes the use of dry imaging films. These dry imaging films are non-catalogue items, meaning that it is not available at medical store. The hospital is purchasing it from private companies and it cost more than wet imaging film that is supplied by medical store.

The personal radiation monitors has not being issued to Radiographers and Dentist staff who operates radiation emitting equipments. These monitors are very important because it monitors or records the amount radiation the workers are exposed to in terms of occupational health and safety is concern.

Conclusion

There is zero recording for the month of January because the x-ray machine broke down and there was work in that month. Generally the number of patients/clients has increase due to the increase in population. And below are the general data showing the total number of patients/clients who attended and the total of examinations performed and consumerables used.

General data

	TOTAL
Number of patients:	7192
Number of X-ray Examinations:	8379
Number Wet Imaging Films used:	6635
Number of Dry Imaging Films used:	1716
Number of chemistry: Fixer	39
Developer	29

The demand for Imaging Services has increase over the years. With increase in population growth, the demand for service has increased and definite plans have to be taken to upgrade its facilities and equipment to meet the needs of the province. According to those demands, other imaging modalities have to be taken on board to assist in improving patient care.

RECOMMENDATIONS

1. Major X-ray machine be replaced with digital radiography (DR) system.
2. Mobile X-ray machine with DR system be purchase in the future.
3. Clinical attachment for Radiographers at Pom Gen radiology Department for up skilling
4. Radiographer to undergo ultrasound training

PATHOLOGY

Introduction

Pathology Department of Wewak General Hospital consists of four main operational sections which provide Medical support service in the hospital. These four sections are; 1. Main analysis laboratory 2. Malaria laboratory 3. Blood Transfusion centre and 4. Mortuary. These four sections operates on a daily basis providing specific functions both within normal working days and after hours, public holidays and weekends.

Staff strength

Main laboratory

Currently there are three laboratory scientists and four laboratory assistants were all being promoted to Laboratory technicians in the latest Hospital appointments in the new structure. There is one casual cleaner and one clerk.

Vacancies – one MLA

No	Staff Name	Position	Employment Date
01	Steven Tiwara	Lab Manager/Grd.14	27.11.2000
02	James Oken	MT Gird. 12	08.04.2014
03	Kimberly Mota	MLA	April 2017
04	Belinda TuiJangit	MLA	10.04.2017
05	Hellen Fallan	MLT Grd. 10	12.03.1993 (retirement)
06	Francis Tamalako	MLT Grd. 10	Oct 2009
07	John Sambi	MLT Grd. 10	02.02.1982
08	Alpha Ao	MLT Grd. 10	15.11.1980
09	Leah Urasimbie	Casual Clerk	2011
10	Christophilda Narawafi	Casual Cleaner	2017

Blood bank – currently there is one blood bank laboratory Manageres, two CHWs, one clerk.

Vacancies – one nursing officer.

No	**Staff Name**	**Position**	**Employment Date**
01	Brenda Homiehombo	B/bank Manager	09.02.2012
02	Maureen Nawayap	CHW	2000
03	Jenevie Biatus	CHW	2017
04	Aglea Ivaroa	Clerk	2008
05	Vacant	Nursing Officer	

Malaria laboratory – currently there are three malaria microscopists.

Vacancies – none

No	**Staff Name**	**Position**	**Employment Date**
01	Theresa Mauri	MLT/ OIC	03.08.2005
02	Anslem Masalan	MLA	2016
03	Douglas Tambi	MLA	26.09.2016

Mortuary – currently there are two mortuary personals of which one is a community health worker. The other is a morgue assistant.

Vacancies - None

No	Staff Name	Position	Employment Date
01	Malcolm Wani	OIC/ CHW	2005
02	Bob Wongs	Morgue Assistant	2010

Summary

Total Staff strength: Nineteen (19)

Total vacancies: two (2)

Workload Statistics.

Main Analysis Laboratory

Haematology

Test Done	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	TOTAL
Clinical FBE	318	978	1295	673	1569	736	1295	603	1112	834	959	418	10790
ANC Hb	54	106	96	108	104	269	256	184	164	96	108	178	1723
Donor Hb	123	58	91	107	157	79	166	89	124	32	14	30	1070
												Grand Total	**13,583**

Biochemistry

Tests Done	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
UEC	155	171	168	40	179	0	90	23	65	34	143	0	1068
LFT	76	132	145	75	136	60	65	18	99	29	119	0	954
LIPIDS	51	23	24	30	17	10	9	1	13	15	23	8	224
Blood Sugar	52	56	45	34	18	9	12	1	16	16	10	9	278
Cardiac Enzyme	8	4	4	10	5	4	4	2	8	1	14	3	67
Uric Acid	6	3	9	6	8	4	14	1	11	1	20	0	83
												Grand Total	2674

Serology (Widals)

	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
Total Tests	46	31	42	22	40	94	43	0	0	0	0	0	318
Positives	1	1	5	1	5	29	3	0	0	0	0	0	45

Hepatitis

	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	TOTAL
Clinical	61	49	64	49	62	26	27	73	2	44	7	15	479
Positives	10	3	9	1	4	1	1	9	1	4	0	0	43
Donors	144	128	245	151	171	173	243	244	224	131	114	142	2110
Positives	14	22	34	23	26	27	40	26	27	20	11	20	290

HIV

	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	Total
Clinical	10	8	1	4	3	6	2	25	7	4	2	1	73
React/Pos	2	0	1	0	0	1	0	2	0	1	1	0	8
Donor	144	128	245	151	171	173	243	244	224	131	114	142	2110
React/Pos	0	6	10	1	2	5	4	9	7	3	3	3	53

VDRL/TPHA

	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	Total
Clinical	113	77	106	65	60	50	33	64	42	55	64	46	775
Positive	6	8	10	0	5	1	5	11	4	4	4	5	63
Donor	144	128	245	151	171	173	243	244	224	131	114	142	2110
Positive	13	14	30	3	7	23	31	34	17	10	21	12	205

Microbiology

Urine Analysis

	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	Total
Urin micro	94	64	97	78	99	96	89	137	109	86	69	59	1077
Urin prot	129	70	102	77	99	96	89	137	109	86	69	59	1122
Urin sugar	129	70	102	77	99	96	89	137	109	86	69	59	1122
Preg test	4	5	4	3	3	6	9	18	26	21	18	27	144
Pos	2	0	2	0	0	1	3	8	3	6	7	13	45

CSF & Aspirate Analysis

	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	Total
CSF micro	8	6	5	4	8	8	11	21	10	13	19	2	115
CSF prot	8	6	5	4	8	8	11	21	10	13	3	0	97
CSF sugar	8	6	5	4	8	8	11	21	10	13	3	0	97

Semen Analysis

	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	Total
Wet prep	1	4	2	2	4	3	2	2	3	4	0	0	27
Gram stain	-	-	-	-	-	-	-	-	-	-	-	-	-

Police/Rape Case

	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	Total
Wet prep	0	3	8	1	5	1	1	1	1	2	2	12	37
Gram stain	-	-	-	-	-	-	-	-	-	-	-	-	-

(Tuberculosis Investigation 2015 data)

	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	Total
Total Examined	42	25	61	84	117	97	-	76	60	45	53	58	718
positives	4	3	15	20	16	11	-	9	7	7	7	19	118

Malaria

	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	Total
Total tested	75	100	150	125	200	200	125	125	100	175	149	172	1696
Positives	5	9	5	10	11	12	9	6	6	8	7	11	99
P.falciparum	4	6	3	6	6	7	6	4	3	2	4	9	60
P.vivax	1	1	1	4	5	5	3	2	3	5	2	2	34
P.malariae	-	1	-	-	-	-	-	-	-	1	-	-	2
P.ovale	-	-	-	-	-	-	-	-	-	-	-	-	-
Mixed	-	1	1	-	-	-	-	-	-	-	1	-	3

Blood Banking and Transfusion

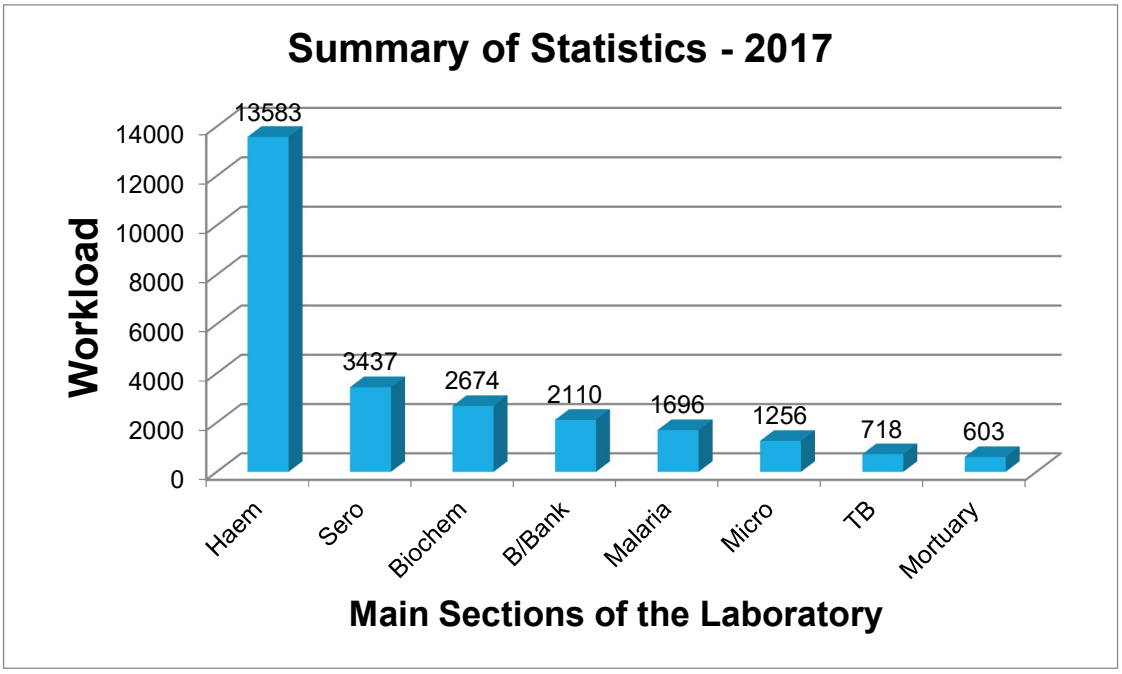
	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	Total
Total blood donors	196	98	231	130	220	166	239	245	197	131	114	142	2110
X-match done	91	74	139	121	130	144	177	126	144	120	80	130	1476

Mortuary

	JAN	FEB	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	Total
No.of bodies stored	25	41	46	45	46	47	49	65	34	53	69	65	603
No. of bodies released	44	29	44	44	56	45	34	49	44	47	91	51	578

Note:

HIV statistics given here are for Wewak Hospital alone thus, does not represent the provincial picture.



Comparison on Average per Month in the Years: 2016 and 2017

Sections	Number on Average per Month	
	Year 2016	Year 2017
Haematology	1357	1132
Serology	758	665
Biochemistry	238	223
Malaria	168	141
Microbiology	149	105
Mortuary Storage	38	50
Mortuary Release	33	48
Blood Bank Donors	198	176
Blood Bank Crossmatch	126	123
TB Investigation	80	60

Costs incurred in running Laboratory Services in the year 2017.

Company Involved	Month	Total Costs	Remarks
Boucher & Muir – Port Moresby	January	12,438.30	
LabChem – Madang	January	20,600.00	
PMS Suppliers – Port Moresby	February	3,066.18	
PMS Suppliers – Port Moresby	April	3,416.32	
Meddent – Port Moresby	May	4,251.00	
LabChem – Madang	May	6,300.00	
PMS Suppliers – Port Moresby	June	7,780.10	
Meddent – Port Moresby	July	13,838.10	
Meddent – Port Moresby	September	4,827.24	

Boucher & Muir – Port Moresby	September	13,235.80	
Meddent – Port Moresby	October	10,968.40	
Meddent – Port Moresby	November	6,817.00	
PMS Suppliers – Port Moresby	November	18,758.45	
Meddent – Port Moresby	December	11,316.10	
TOTAL SPENDING IN 2017. Meddent: 52,017.84			
PMS Pom: 33,021.05			
Boucher & Muir: 25,673.60			
LabChem: 26,900.00			
GRAND TOTAL: K137,612.49			

Please note:

The above information on laboratory spending is for laboratory consumables and was compiled by retrieving all the deposit slips for payment as well as quotations from respective suppliers that were all kept in the Laboratory file.

All consumables that were ordered for 2017 usage were all received and all payments done in full.

ACHIEVEMENTS

- Upgrade of all Laboratory positions.
- Recruitment of two new laboratory staff in April 2017.
- Improvement in procurement of laboratory consumables due to priority funding from the hospital.
- Availability of Hospital Out-Reach vehicle for blood mobile activities.

CONSTRAINTS/DIFFICULTIES

One officer released on compulsory Retirement.

WAY FORMARD

A standalone vehicle for blood bank section to enable effective and proper awareness and blood mobile to be carried out.

PHYSIOTHERAPY

Introduction

Physiotherapy Department is one of the key areas that are providing quality care services to the patients that are handicap and disable. The things to be discussed in this report will cover the staff, objectives (delivering curative, achievements, operational report, statistics 2017, and matter of concern, recommendation, and conclusion). Staff attendance is very good.

Physiotherapy department has total of four staffs namely;

Staff Names	Photo	Designation/Position	Currently
Ms Joyce Nali		Physiotherapist- OIC	Leave (Maternity & Recreational)
Naomi Maiyau		Physiotherapist	Working
Junior Rodney		Physiotherapist	Working
Elvina Sandau		Physiotherapy Aide	Working
Julia Pomat		Resident Physiotherapist Year 2	Working & will be Finishing this year
Magdalene Bakat		Resident Physiotherapist Year 1	Working as Year 2 Resident Physiotherapist

OBJECTIVES

- Delivering curative care for in and out patients
- Achievements

- Operational report
- Internal activities
- External activities
- Quarterly statistics 2017
- Matter of concern
- Recommendation
- Conclusion

Delivering curative care for in and out patients

The physiotherapy staffs provides a daily curative clinical care in close cooperation with the medical and nursing staffs on weekly basis ward rounds conducted by the doctors and nurses. The department opens from Monday to Friday from 8:00am to 4:00pm.

The ward rounds are attended by the staffs according to the time table scheduled for each wards. The ward rounds have teachings with exchanges of clinical information between the medical and paramedical staff as for the patients progresses, reports and feedbacks are reviewed and discussed. The department also has case presentations and discussions as a requirement to review knowledge and skills. Patients are reviewed and feasible working strategies are designed and put in place.

Achievements

The Physiotherapist officer was put on a Physiotherapy Aide position was now on Gr 10 position. Also we are thankful to Dr Kambo, CEO with the management to create and advertised a Gr 11 Physiotherapist position on external advertisement.

Unfortunately one of our Physiotherapy Aide Staff left us because of his absenteeism.

In the first quarter, we were able to conduct one outreached clinic in Comworks with the assistance from the President of Wewak Local Honorable Francis Hevu and his Manager Joe Bernard and a good number of patients were seen, total of 32 patients. In the second quarter, we manage to hold a clinic in Town clinic with the assistance from Ward 10 councilor Mr, Philip Dai and Honorable Charles Malenki. We saw 53 patients altogether including the eye and ear patients with the physical disability patients.

Unfortunately our outreach clinics were stopped because of election periods and we did not complete the program because after the election the country was facing financial crisis also.

Operational report

The operational report consists of the internal and the external report. The internal activity refers to the clinical service done within hospital premises during Mondays to Fridays while the external activity refers to the clinical care done outside from the hospital premises.

Internal Activities

The internal activities are: ward rotation, outpatient clinics and weekly presentation.

Ward Rotations schedule for the first – Fourth Quarter are given below in the table:

WARD S	FIRST	SECOND	THIRD	FOURTH

Medical	Julia Pomat Magdalene Bakat	Magdalene Bakat Elvina Sandau	Naomi Maiyau	Junior Rodney Elvina Sandau
Surgical	Junior Rodney Hubert Mangawe	Junior Rodney Julia Pomat	Julia Pomat Magdalene Bakat	Naomi Maiyau
Pediatric	Naomi Maiyau Elvina Sandau	Naomi Maiyau Hubert Mangawe	Junior Rodney Elvina Sandau	Julia Pomat Magdalene Bakat

Outpatient Clinics

As there are various types of clinical conditions that require physiotherapy, there are different clinics conducted daily to cater for patients that are discharge from the wards as outpatients. These clinics are established because the Physiotherapy Department doesn't have a Rehabilitation Ward to accommodate patients to continue with physical treatment until patients reach independence or near dependent. These clinics are:

Hand Clinics Mondays 11am - 12pm

We see patients that have functional difficulties with their hands as a result of tendon rupture or repair, soft tissue injuries and fractures. This clinic was developed because we see a lot of cases that comes in with hand injuries mainly due to violence.

Neuro Clinic Tuesdays 11am – 12pm

All neurological cases are seen and treated, reviewed and re-assessed. This clinic is held to reinforce home rehabilitation exercises on patients living with disability.

Most common cases seen this year is CVA and Meningitis.

Antenatal Clinic Tuesdays 19am---10am

This clinic was created because most of the patients referred from O&G are the post natal cases with weak pelvic floor muscles, bowel and bladder dysfunction, dislocated hip, sciatica or nerve compression, etc…. This clinic is only for mothers in their 2nd and 3rd trimester only to get them prepare for labour and to prevent after birth complications.

Pikinini Clinic Wednesdays 11am – 12pm

Pikinini clinic is for children living within the town and also from local districts if possible. Most cases seen are cerebral palsy, meningitis, and cerebral malaria are brought to be assessed or reassess and treated with exercises.

Home visits Thursdays 1pm – 4pm

This visit is carried out to help home bound patients who are not able to come to the hospital for exercise. Home environment settings are assessed and appropriate advice is given to aid independency apart from home treatment and advice.

Note: No home visit done this year 2017 due to financial crisis in the hospital. Therefore we didn't manage to see our patients in town area and also in West and East Coast area.

Poseti Clinic Friday 11am – 12pm

Ponsetti Clinic is carried out to help clubfeet children. The clinic is still on today, the officers incharge in Pediatric sections is always responsible for this babies with clubfeet and manage.

External Activities

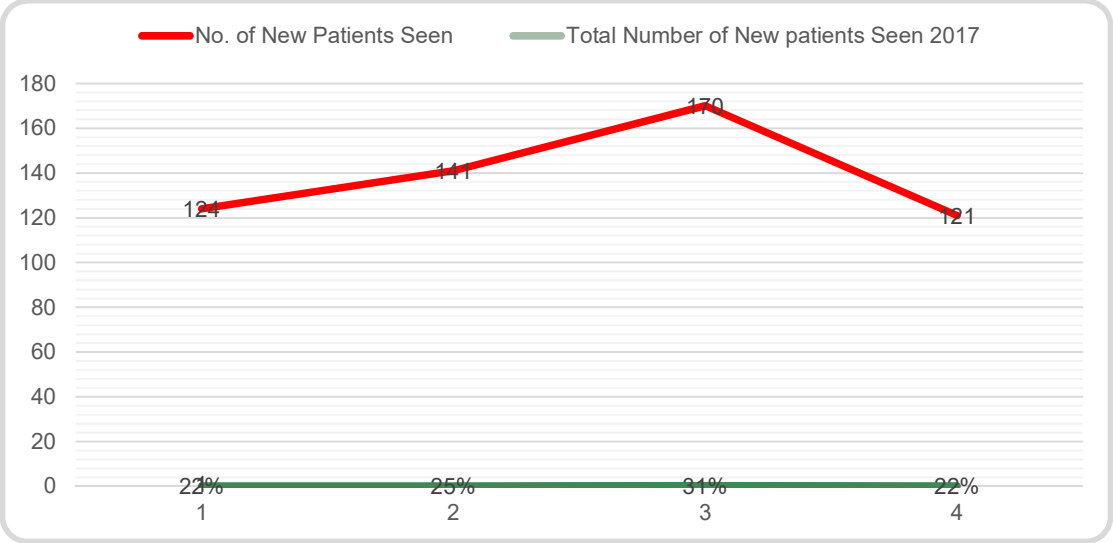
Outreached Visits

The outreached visit starts in February and ends in April. The transports were provided by Wewak Local president Hon. Francis Hevu and town mayor Hon. Charles Malenki. It was a combine clinic with Blood Bank and Callan Service. We were fortunate to held two clinics, one at Comworks and the other at Town Clinic. The rest was discontinued due to election.

Evaluation of statistics

The evaluation of the statistics is given according to the total number of new cases seen within those four quarters. Provided below are the totals for the four quarters in the table. As shown in the table the total patients seen in 2017 altogether was 556 patients.

QUARTER	No. of New Patients Seen	Percentage
First	124	22%
Second	141	25%
Third	170	31%
Fourth	121	22%
Total	556	100%



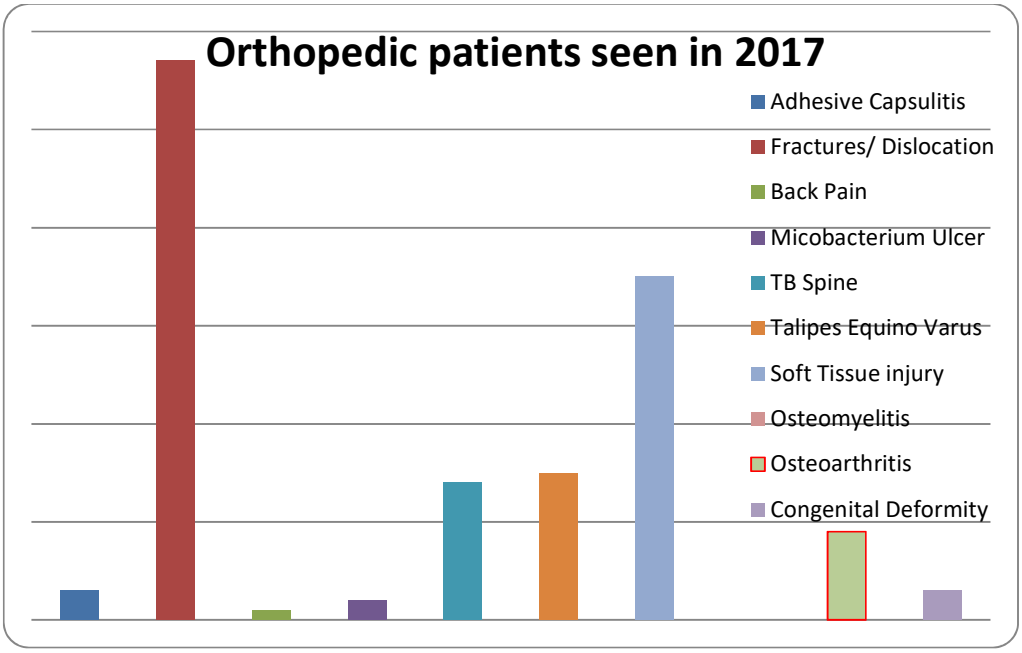
As given in the cone graph above, it shows that from first quarter we have limited number of patients as a result of consultation clinic close for Christmas holiday and then when it opens again, there is a rise in second quarter and then to third quarter it goes up and then drops down again in the fourth quarter because consultation clinic closes again. The statistics consist of the orthopedics, neurology, cardiorespiratory, surgery and other conditions.

Orthopaedics conditions

The Orthopaedic sections consist of ten conditions altogether. The conditions are given in the table below with their totals seen in each month. Below is the bar graph showing the number of patients.

Conditions	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Adhesive Capsulitis	2	0	1	0	3
Fractures/ Dislocation	17	16	21	13	57
Back Pain	0	0	1	0	1
Micobacterium Ulcer	1	1	0	0	2
TB Spine	4	5	5	0	14
Talipes Equino Varus	5	5	4	1	15
Soft Tissue injury	7	10	7	11	35
Osteomyelitis	0	0	0	0	0
Osteoarthritis	1	5	2	1	9
Congenital Deformity	3	0	0	0	3
Totals=	40	42	41	26	129

The cone graph below shows that during the third quarter, fracture and dislocations was the most leading condition in this year 2017 in orthopaedic condition while soft tissue injury is next and the lowest with zero is Osteomyelitis that is out from the total of 129 patients.



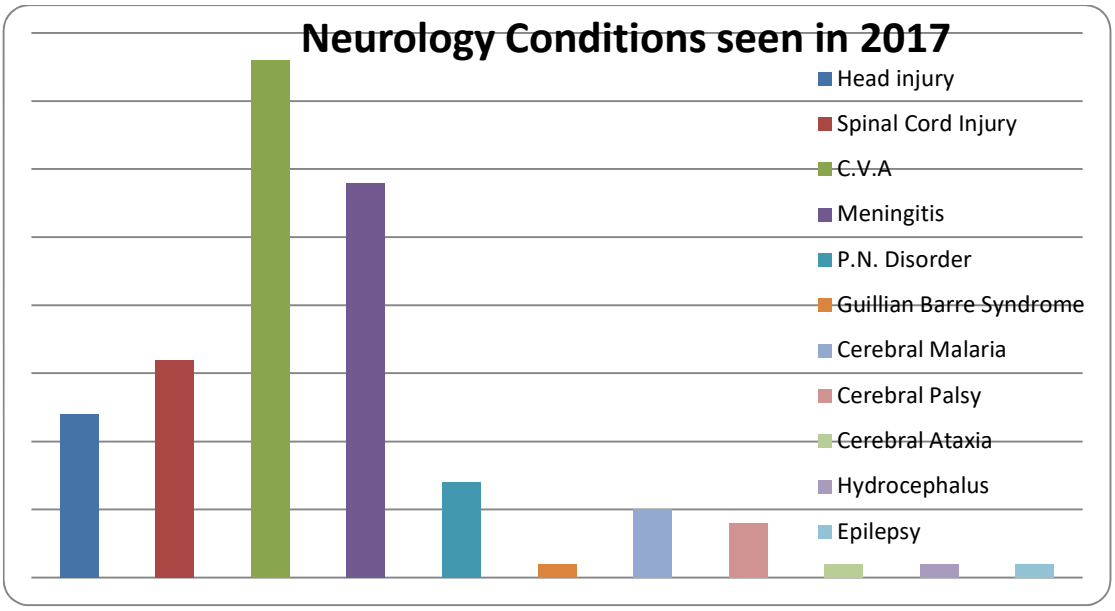
Neurology Conditions

The Neurology section consists of eleven conditions altogether. Below is the table providing the conditions seen in year 2017 and each quarter with their totals given. The total Neurology patients seen in year 2017 were 114 patients altogether.

Head injury	3	4	3	2	12
Spinal Cord Injury	5	3	7	1	16
C.V.A	7	10	8	13	38
Meningitis	10	11	3	5	29

P.N. Disorder	1	2	3	1	7
Guillian Barre Syndrome	1	0	0	0	1
Cerebral Malaria	1	3	1	0	5
Cerebral Palsy	0	0	3	1	4
Cerebral Ataxia	0	0	0	1	1
Hydrocephalus	0	0	1	0	1
Epilepsy	0	1	0	0	1
Totals=	28	33	29	24	114

The cylindrical graph below shows the highest conditions seen in 2017 was CVA with total of 38 patients out from the total of 114 neurology patients and the lowest conditions with one patient and they are GBS, Cerebellar ataxia, hydrocephalus and epilepsy.



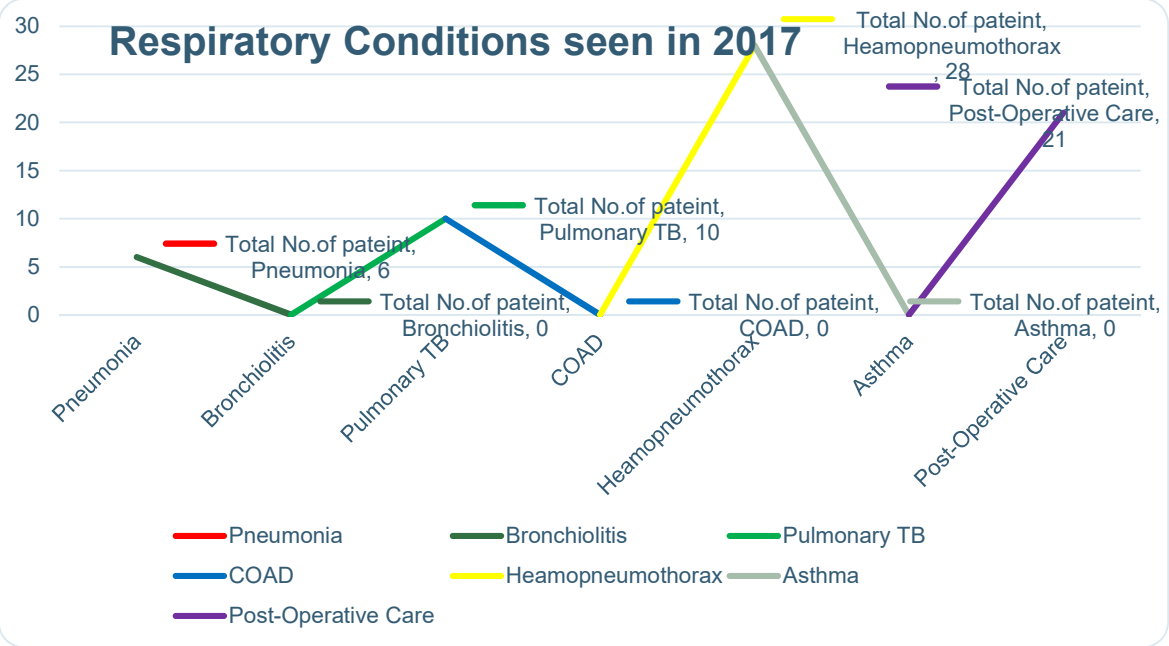
Respiratory Conditions

The respiratory section consists of seven conditions. Below is the table showing the conditions and the total seen in each quarter of the year 2017.

	1st Quarter	2nd Quater	3rd Quarter	4th Quarter	Total
Pneumonia	1	2	1	2	6
Bronchiolitis	0	0	0	0	0
Pulmonary TB	0	5	1	4	10
COAD	0	0	0	0	0
Heamopneumothorax	5	9	6	8	28

Asthma	0	0	0	0	0
Post-Operative Care	6	6	8	1	21
Totals=	12	22	16	15	65

Below is the bar graph showing the highest condition seen in 2017 was Hemopneumotharax with 28 patients out from the total of 65 patients. The lowest with zero patients is bronchiolitis and asthma.

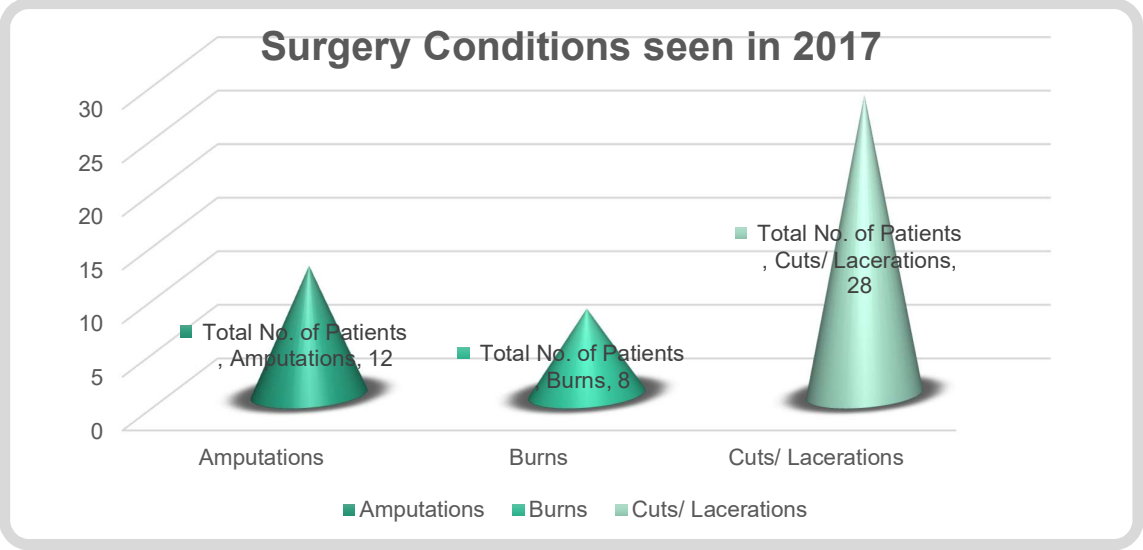


Surgery Conditions

The Surgical Section consists of three conditions. They are given below on the table with the totals seen in each quarter of year 2017 and the totals for each condition.

Amputations	3	2	3	4	12
Burns	1	2	2	3	8
Cuts/ Lacerations	3	5	11	9	28
Total=	7	9	16	16	48

Below is the cone graph showing the highest condition to the lowest. The highest is cuts and lacerations with the total of 28 patients out from the total of 48 patients in year 2017 while burns with the lowest of 8 patients.

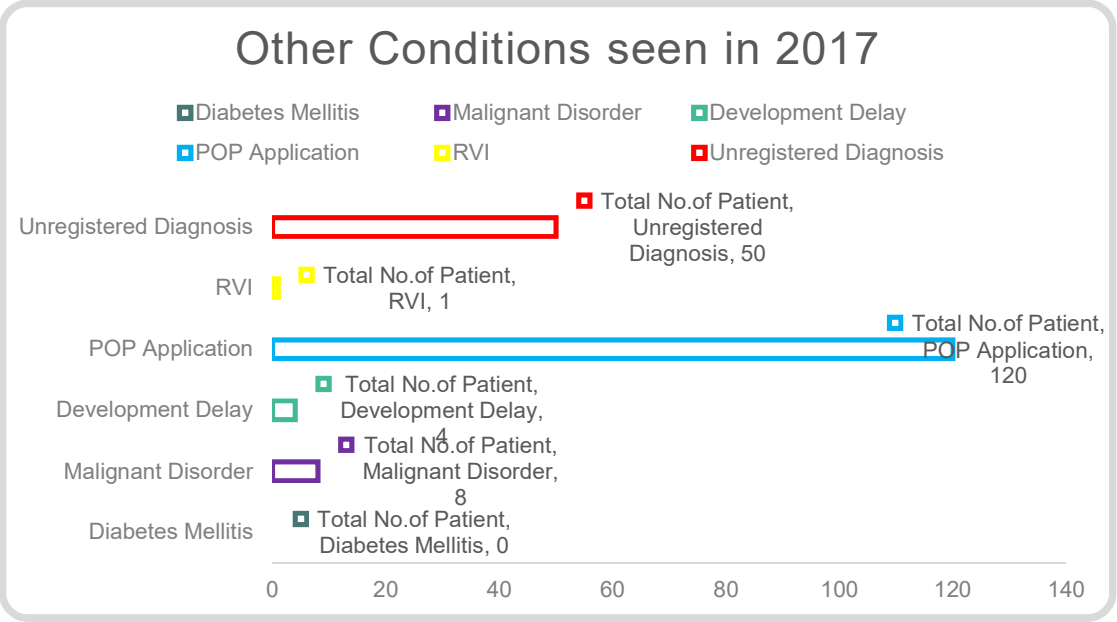


Others Conditions

The other section has six conditions that are not categories under one of the above topics. They are given below in the table with their total seen in each quarter of the year 2017.

Other Conditions	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total
Diabetes Mellitis	0	0	0	0	0
Malignant Disorder	4	2	2	0	8
Development Delay	4	0	0	0	4
POP Application	28	32	39	21	120
RVI	1	0	0	0	1
Unregistered Diagnosis	0	1	27	22	50
Totals=	37	35	68	43	183

Below is the graph showing other conditions. The highest condition seen in 2017 was POP application with the total of 120 patients out from the total of 183 patients. The lowest is Diabetes myelitis with zero.



Matter of concerns

Home visit patients in the communities is still a problem because of unavailability of transport in the hospital. Patients are discharged home and due to factors like, transport, money problems, no guardian, geographical location so visit to the Physiotherapy Unit for regular exercises is denied and eventually the patients die from secondary complications.

Exercise equipments are needed for the treatment of patients. Almost all the equipments in the Physiotherapy Unit are donated from CORDAID through Callan National Unit from 10 to 11years ago.

A rehabilitation ward should be included in the new Physiotherapy building to accommodate patients who need ongoing rehabilitation before discharge. A building design has been done so I hope the management will see to that.

Conclusion

To conclude, all staffs are always punctual during work time and are very committed to their profession. Once again we thank the management to create a grade 11 Physiotherapist position and we are looking forward to have you create more positions for Physiotherapist and Physio Aide under Provincial Health Authority (PHA). This can cater for district hospital that can help extend our services to the disable patients in their respective districts and rural areas.

PHARMACY DEPARTMENT

Introduction

Firstly I would like to take this opportunity to thank all the pharmacy staffs namely Faridah Langlang, Miriam Zitae, Vincent Mali, Nathan Semoso and Lucas Kaboi for the support they put in to get the attention of the hospital management to make funds available to build a proper outpatient dispensing area. I also would like to thank the Chief Executive Office for his never ending support. Not forgetting the Director Medical Services for his input.

On Wednesday 16th November 2016 we fare welled Mr. Nathan Semoso for working with the Pharmacy Department for the last four years.

He has moved to the Records Department as of Wednesday 7th September 2016.

His service to the Pharmacy Department will be treasured.

I tried as much as possible to maintain the same format of reporting for all the quarterly reporting. This final quarter report will give the statistics from the beginning of October to Friday 16th December 2016.

Statistics from Monday 19th December 2016 to the end of March 2017 will be captured under first quarter repot for 2017.

This report is the final report from the series of four quarterly reporting. Reporting has improved from time to time.

This final quarter report will cover the following:

- Staffs
- Storage (formerly titled as shelves)
- Stock Card
- Outpatient Prescription
- Visits
- Meeting
- Outreach
- AMS Wewak Orders
- Dangerous Drug
- Polyvalent Snake Anti-venom
- Oxygen
- Expenses
- Plans
- Constraints
- Achievements

Staffs

Since the last appointment of Pharmacy Staffs to their substantive positions the Pharmacy Department faced a shortage of staff.

According to the Director Medical Services one (1) technician and one (1) assistant will join the Pharmacy Department soon.

The two officers have not started yet. Probably they will join the Pharmacy Team next year, 2017.

It seems that the male staff of the Pharmacy Department is not complying with what I've advised the entire staff to do.

This has put extra work for me and the two female staff to do.

.

Storage

Despite the limited spacing and shelving we tried to store items in such a way that:

Fast moving items are easily accessible

Stock take is done quickly and the

Walk way is clear of obstacles

At the moment the store room is partly empty due to nil stock of items from AMS Wewak.

Come next year, 2017 we will need extra storage spacing as I will order at least twelve (12) months stock of fast moving medical supplies.

This is because we ran out of much needed essential fast moving stocks towards the end of the first quarter of this year.

Stock Cards

When I first rolled out the stock card system on Monday 14th March 2016 staffs had mixed reactions about the system. The stock card system was introduced by the Pharmacy Upgrading Project (PUP) more than 12 years ago. The main purpose of the stock card system was to:

Monitor movement of Medical Supplies

Calculate Average Monthly Consumption Rate of Medical Supplies at all Area Medical Stores and Provincial Hospitals and other health facilities

I introduced the stock card system because there was no form of monitoring mechanism of medical supplies in place before my inception.

In all our unit meetings I had to elaborate the importance of maintaining the stock card system.

Also on daily basis I stress the importance of maintaining a good stock card system.

Since the male staffs did not cooperate by setting up the stock card system I had to do it myself.

I had to take lead and lead by example. Miriam and Faridah were supportive in the initial phase of creating and maintaining the stock card.

I used students from the St. Andrew Community College in the end of the third quarter and the beginning of the fourth quarter to create and maintain the stock cards.

The progress of the stock card roll out on Monday 14th March 2016 is depicted in table 2.

Table 2: Stock card progress report

Section	Description	Staff/s	Progress
1	Drugs and Medicinal Preparations	Miriam Zitae,	Miriam was able to create stock cards and update data on stock cards. Faridah assisted Miriam.
2	Dangerous Drugs	Davey	Dangerous Drug Book was used as a substitute for stock cards so all data was entered.

3	Serological Products	Davey	Stock cards were created and stocks well monitored
4	Dressings	Lucas Kaboi	Did not do anything. I assisted him to create the stock cards but Lucas failed to do the update and maintain the stock card. I had to step in.
5	Hospital Sundries	Vincent Mali	No progress at all so I had to step in. All items now have stock cards and up to date.
5	Medical Gas Cylinder	Davey	Created stock cards on Monday 14th March 2016. All records are up to date and well maintained.
8	Minor Equipment	Faridah Langlang	Created stock cards for each items. But no up to date information received from her yet.

Table 2 clearly indicates that I had to step in to create and maintain the stock cards.

Outpatient Prescription

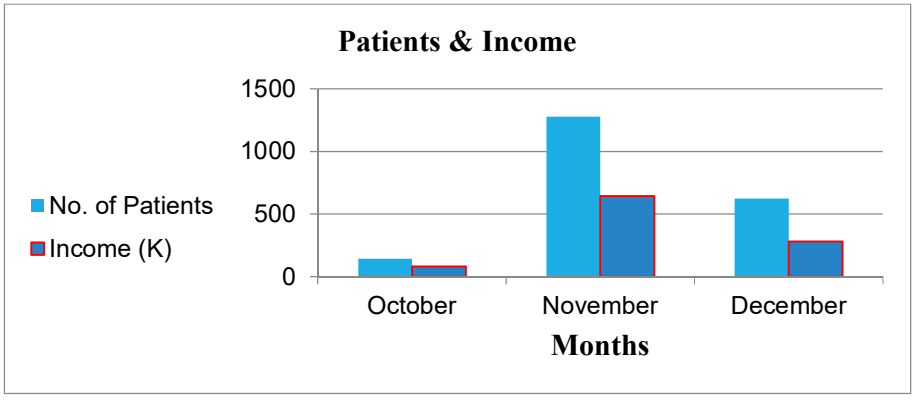
The number of prescription forms collected from the outpatient window each day indicates the number of patients medicines were dispensed to for that particular day.

Table 3 and figure 2 depict the prescription count for the final quarter.

Table 3: Number of patients and the amount of money collected for the final quarter

Month	**No. of Patients**	**Income (K)**
October	145	83
November	1278	645
December	623	282
TOTAL	**2046**	**1010**

Figure 2: Number of Outpatient and Income



According table 3 and figure 2 the month of October had the lowest number of prescription forms and income. This is because we stopped dispensing on Friday 9th September 2016 as staffs were experiencing itchiness from inhaling minute powder particles emitted by the cracks from the asbestos roof.

We started dispensing to the outpatient on Tuesday 25th October 2016.

Between Friday 9th September and Tuesday 25th October Pharmacy staffs were dispensing at the consultation clinic. Discharged inpatients from all wards and outpatients from the Accident & Emergency Department were advised to get their discharged medicine there.

The prescription form count for December ended on Friday 16th December because I had to prepare this report and hand it in before the year ends.

Visits

The M Supply Team visited us on Tuesday 13th December 2016. They took photos of the Outpatient Dispensary Area and promised to return next year (2017) to set up the system.

Meeting

- We had three meetings for this quarter. The dates of the meeting were on:
- Thursday 27th October 2016
- Tuesday 29th November 2016
- Wednesday 14th December 2016
- Thursday 27th October 2016

Duration: 1217 - 1330 Venue: Pharmacy Outpatient Dispensary Room

Chairman: Davey Secretary: Davey

Agendas:

Congratulation to the Pharmacy Staff for their promotion.

Review of last meetings minutes (Tuesday 28th June 2016)

Staff shortage

Progress for renovations

Nathan's Exit Party

Stock Take (If stocks are in order no problem with stock take)

Stock Card

Imprest Order Forms Review and Update (Check Imprest and Imprest Stock Take)

Calculating Average Monthly Consumption Rate for medical supplies issued

Call M Supply Back to Wewak General Hospital to set up the system

Constrains-(Computer, Antivirus, Printers, Fax Machine, Toilet, No air condition in my office, Pharmacy building not up to standard.)

Achievements (Oxygen Concentrator and Pharmacy Outpatient Dispensary Room Constructed)

AOB

Operating hours for the Pharmacy Department

Imprest Stock Take

Increase quantity of Paracetamol Oral Tablets 500mg for Cancer patients

Expired Items to be used. Will have to get advice from Dr. Kigodi (Lecturer UPNG Taurama Campus)

Use SAVE THE CHILDREN'S area to keep excess stocks of items.

On call to be on weekends only. On call for emergency only

Operating Hours for Outpatient Dispensing Window from 9:00 am -12md and 1pm-3pm

Check drug sheets for Ceftriaxone Inj. 1g

Tuesday 29th November 2016

Duration: 1330-1404 Venue: Pharmacy Outpatient Dispensary Room

Chairman: Davey Secretary: Davey

Agenda

Review of last meeting minutes (Thursday 27th October 2016)

State of the AMS Wewak monthly orders

Average Monthly Consumption Rate

Absenteeism

AOB

Other commitment- Free day for Marketing/Shopping

Change roster

Staff Shortage (Faridah will go for recreational leave next year. Miriam might go to school next year, 2017.)

Lucas Kaboi wanted to do outpatient dispensing

Friday 16th December 2016

Time: 1200-1301 Venue: Pharmacy Outpatient Dispensary Room

Chairman: Davey Secretary: Davey

Agenda:

Review of Last Meeting Minutes (Tuesday 29th November 2016)

Purchase of all nil stock of medical supplies will be done by the OIC

Outpatient Window Operating Hours (Open and close on time)

Shut down period

Achievements (Average Monthly Consumption Rate for all the fast moving medical supplies calculated and most of all slow moving items.)

AOB

ID card and

Department Photo

Outreach

We did not do any outreach as yet.

Area Medical Store (AMS) Wewak Order

In the final quarter of this year despite seeing an increase in percentage of items received there is still nil stock of much needed essential medical supplies.

Table 4 depicts quantity of items ordered and received.

Table 4: Quantity of items ordered and received from AMS Wewak.

MONTH	Item		Percentage (%)
	Quantity Ordered	Quantity Received	
October	281	24	8.540925267
November	237	33	13.92405063

The orders for December will be captured in the first quarter report for 2017.

This year I followed the protocol by ordering supplies that will last us for one (1) month.

The reasons why I ordered items that will last only one (1) month were:

To prevent overstocking

Mindful of storage spacing and

Minimise waste

AMS Wewak caters for East and West Sepik Provinces. From experience we have learnt that we must quickly grab essential fast moving stocks available at the AMS before they run out.

Therefore in my December order I started ordering essential fast moving items that will last at least twelve (12) months. I will continue ordering twelve (12) month's supply in 2017.

Dangerous Drugs

All the dangerous drugs available in the pharmacy are narcotic analgesics.

Dangerous drugs have become the substance of abuse in PNG and other countries.

Therefore strict monitoring is imposed when receiving, storing and issuing of these medicines.

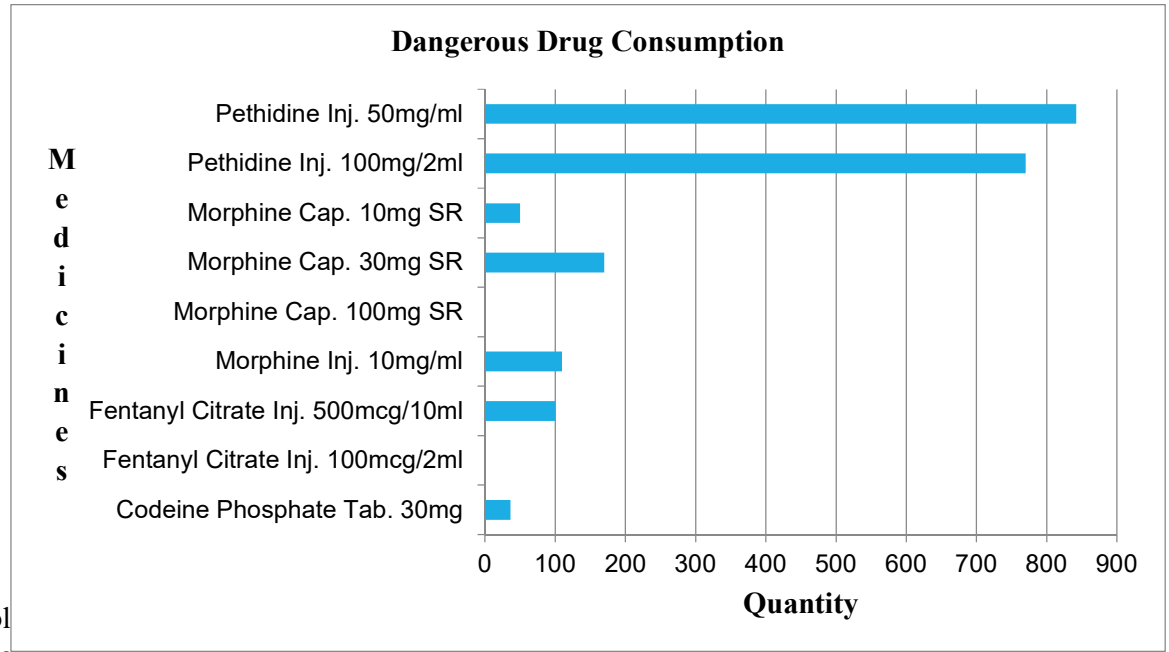
Table 5 and figure 3 depict the consumption of Dangerous Drugs in the final quarter.

Table 5: Consumption of Dangerous Drugs for the final quarter of 2016

(Medicines not included in the table are out of stock since October 2016.)

Catalogue #	Medicine	Consumption
2002	Codeine Phosphate Tab. 30mg	36
2003	Fentanyl Citrate Inj. 100mcg/2ml	0
2004	Fentanyl Citrate Inj. 500mcg/10ml	100
2006	Morphine Inj. 10mg/ml	110
2007	Morphine Cap. 100mg SR	0
2008	Morphine Cap. 30mg SR	170
2009	Morphine Cap. 10mg SR	50
2011	Pethidine Inj. 100mg/2ml	770
2012	Pethidine Inj. 50mg/ml	842

Figure 3: Quantity of Dangerous Drugs used



Tabl
dangerous drug followed by Pethidine Injection 50mg/ml. 2ml and so on for the final quarter of 2016. Fentanyl Inj. 100mcg/2ml and Morphine Cap/Tab. 100mg SR. were not dispensed or used.

Not much of Morphine Cap/Tab. 10mg SR was dispensed because we received only 50 tablets from AMS Wewak on Wednesday 2nd November 2016.

Polyvalent

The hospital did not purchase any polyvalent in the fourth quarter as the two polyvalent vials bought in the third quarter were not used.

On Friday 2nd December 2016 I went to the A&E and the Medical Ward to check if the polyvalent snake antivenom were used or not. This was the last routine check for this year.

Since the vials of polyvalent are very expensive I will do a routine check every month next year as done this year.

CCTC is still waiting for NDoH and CSL to sign their agreement. As soon the agreement is signed CCTC will start distributing the death adder and polyvalent anti-venoms.

Oxygen

In the fourth quarter the hospital did not spend any money for the refill of oxygen cylinders from Tang Mow.

We only received oxygen cylinders from AMS Wewak as delivered by LD Logistics.

Table 6 and 7 on the next page depict the movement of Oxygen Size G and Oxygen Size E Cylinders.

Table 6: Movement of size G oxygen cylinders for the 4th quarter of 2016.

Date	Full Cylinder Received	Empty Cylinder Returned	Waiting Time (Days)
12.10.16		12	
20.10.16		4	
20.10.16	5		30
20.10.16		3	
31.10.16	15		11
31.10.16		1	
05.12.16		15	
09.12.16	10		49
Total	**30**	**35**	**90**

Table 7: Movement of Size E oxygen cylinders for the 4th quarter of 2016

Date	Full Cylinder Received	Empty Cylinder Returned	Waiting Time (Days)
12.10.16		3	
31.10.16	6		41
05.12.16		5	
Total	**6**	**8**	**41**

(Please note that the waiting time is calculated from the last date of delivery of full oxygen cylinder to the current delivery dates)

According to table 6 we returned a total 35 size G cylinders and received 30 cylinders.

This is 5 cylinders less for what we returned.

The hospital had to wait for a total of 90 days to receive a total of 30 size G oxygen cylinders.

According to my record we were supposed to receive a minimum of 39 size G oxygen cylinders in 3 months.

According to table 7 we received 6 size E cylinders instead of 8 cylinders. This is 2 less than what we should have received.

The hospital had to wait for a total of 41 days to receive a total of 6 size E oxygen cylinders.

According to my record we were supposed to receive a minimum of 24 size E oxygen cylinders in 3 months.

The LD Logistics only do the deliveries. AMS Wewak amends our orders and supply us the amended quantity.

Table 6 and 7 illustrated that LD Logistics was very slow in delivering oxygen cylinders.

Rental

In my third quarter repot I stated that the hospital was charged K5, 668.30 for the rental of both industrial and medical gas cylinders for the month of April to July 2016. According to my record the charges were excessive for medical oxygen cylinders.

Since I had a good record of medical gas cylinder I was able to verify the rental charges and prove that the rental charges were not correctly done.

I verbally advised Hicks not to make any payment for both medical and industrial gas cylinder rentals to BOC as BOC's Credit Office in Lae are yet to make corrections to their invoices.

Despite emails, faxes and phone calls made by me to BOC's Credit Office I never got a favorable response.

Our landline phones were disconnected in early December so I was not able to follow up. I will continue to follow up next year.

Expenditure

In the fourth quarter the hospital spent a total of **K45, 815.00** on nil stock items.

There was no expenditure for oxygen cylinders and polyvalent snake antivenom.

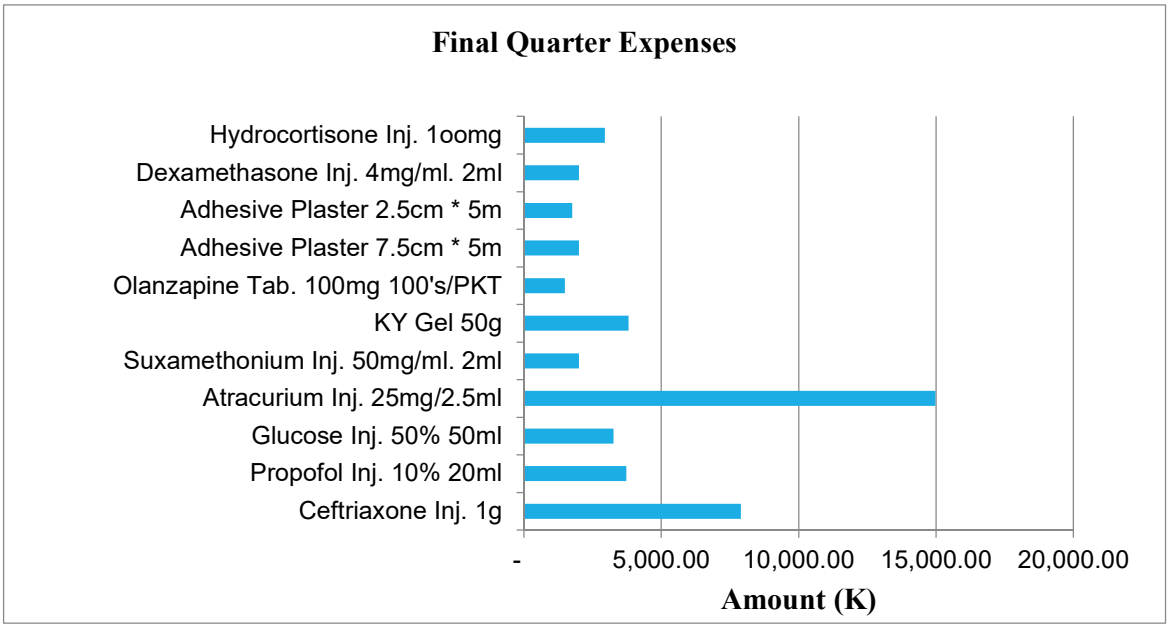
Table 8 and figure 4 depict the expenditure for the final quarter.

Table 8: Expenses for the final quarter of 2016

Date	Item	Issue Unit	Price	Quantity	Total Cost (K)	Company

14.11.16	Ceftriaxone Inj. 1g	Vial	3.95	2,000	7,900.00	Sesago
22.11.16	Propofol Inj. 10% 20ml	Vial	18.60	200	3,720.00	Sesago
30.11.16	Glucose Inj. 50% 50ml	Vial	6.50	500	3,250.00	Indent
30.11.16	Atracurium Inj. 25mg/2.5ml	Amp	29.95	500	14,975.00	Sesago
30.11.16	Suxamethonium Inj. 50mg/ml. 2ml	Amp	9.95	200	1,990.00	Sesago
16.12.16	KY Gel 50g	Tube	19	200	3,800.00	CPL
19.12.16	Olanzapine Tab. 100mg 100's/PKT	pkt	14.9	100	1,490.00	Sesago
19.12.16	Adhesive Plaster 7.5cm * 5m	Roll	9.95	200	1,990.00	Sesago
19.12.16	Adhesive Plaster 2.5cm * 5m	Roll	3.50	500	1,750.00	Sesago
19.12.16	Dexamethasone Inj. 4mg/ml. 2ml	Amp	2.00	1,000	2,000.00	Sesago
19.12.16	Hydrocortisone Inj. 1oomg	Vial	2.95	1,000	2,950.00	Sesago
TOTAL:						**45,815.00**

Figure 4: Final quarter expenses



Our plan for the third quarter has not been achieved due to one (1) single problem and that is the unavailability of a desk top computer. Despite my request for a computer for the Pharmacy Department nothing has been done.

The outstanding plan that was not implemented was the Review of all Imprest Forms.

All other plans were implemented.

Constraints

The constraints for the year that have not been rectified yet are**:**

- ✓ Computer
- ✓ Computer Anti-virus
- ✓ Fax Machine
- ✓ Toilet
- ✓ No Air Condition in the OIC's Office
- ✓ Pharmacy Building not up to standard
- ✓ Staff shortage

The seven constraints still remains as stated in my third quarter report.
On Tuesday 20th December 2016 Hicks gave us a printer. The printer was one of our constraints stated in the third quarter report.

Achievement

M Supply
The M Supply people responded to our call. They came and saw the new look Outpatient Dispensary Area, took photos and promised to return next year and set up the system.

Conclusion

In all of our monthly meetings we have identified that our main constrain was the unavailability of a computer set. The key factor that is dramatically affecting our work. We did progress well in other areas that didn't require the need of a computer. The unavailability of a common desk top computer has forced me to do a lot of work using my own lap top computer. Other staffs were not able to assist me with tasks that required the use of a computer.

The nil stock of medical supplies has really affected the patients and staffs of this hospital as well.

Thank you to the hospital management for doing its best to address this issue.

This is the final report for this year.

MEDICAL RECORDS UNIT

Introduction.

Medical Records Section is derived from its own name that signifies the term **Medical Records,** a place where all the clinical records are safely kept for medical or clinical references. It is a place where records are stored, monitored and managed for the purpose of patient care. It is also a section that create statistics and transmits them to appropriate authorities so that all are collected and subsequently summarised with the other sections to effectively

Determine the Health performances of the organisation such as East Sepik Provincial hospital and East Sepik Province as a whole.

The activities has now broaden out to the rural health centres and this is a massive Challenge that we now take on board to ensure this section assist and operate as a team to ensure that reports are done and sent to NDOH monitoring branch on time.

Manpower.

This section currently has a staff ceiling of six (6) personals, with a new permanent officer

Assisting us in the office. He is awaiting the completion of the new settings so that he will take up his permanent job as a time keeper. The Provincial Health Information officer has

Also moved into the office and is now working with us and it is a plus for this section and

and the hospital as well, which means that we have a complete team that is ready to ensure that reports are collectively summarised, registered and sent to Port Moresby on a monthly basis unlike before where reports were delayed for so many months.

Our current Manpower are as listed below:-

- ✓ Gerard Semoso - Manager Medical Records.
- ✓ Joan Lapim - Medical Records Officer (Assistant).
- ✓ Nathan Semoso - Death Registry Officer.
- ✓ Julius Wangama - IT Specialist
- ✓ Manasha Tapi - Officer assisting on a temporary basis.
- ✓ Augustine Aiyow - Health Information Officer (Provincial).

Constraints.

We urgently require a place to properly store the charts as the charts are coming in from the wards in hundreds every month. We had requested for a container to be completed with shelves so that we could file away charts neatly in months, wards, years so that it can easily be accessed by the medical officers for medical reports and other purposes. The request was not approved and that is a problem as the charts are placed in the container with no space thus creating a massive problem retrieving charts requested by MOs and other health professionals for patients' references. Medical Records should have a space for archiving to keep the charts for future references, e.g. - files that are legally implicated and etc….

All the charts pass on to three stages before it is destroyed.

1. Current or active stage
2. Retention stage
3. Archiving stage &
4. Disposing stage, where charts are incinerated.

This cannot be done due to no space, but we hope that as soon as the new buildings are up the section will by then have enough space. Currently we are keeping the 2017 & 2018 in the current office to ensure that medical officers have access to the files should they need them for clinical decisions.

Infrastructure.

We are happy to have moved into the new office and we thanked the management for their support in ensuring that we work in the proper office beefed up with air-condition and good spaces. We now need shelves to neatly file the incoming charts as mentioned earlier on.

Equipment

We acknowledge the SEMs support in approving our request for a desktop, which we received last year plus a printer. It is now easy for us to do our admin work and reports as well. I have talked to the a/NHIS Technical Advisor at NDOH in relation the computer programmed with the **FOXPRO database software** so that we can easily do the data entry using the software. He has assured us that they will advise us if they have one in place. We also urgently need a big photo copier machine to do copies as the section will do photocopies of NHIS discharges and other forms for all rural health centres as well.

Recommendation.

Some recommendations:-

1. SEM to approve the purchase for 1 Photocopier/Printer/scanner to
2. Run and print new forms with the PHA logo, as this will cut down on the expenses.
3. Approval of temporary shelves to be erected in the current office to neatly file charts for 2018.

Conclusion

I conclude by saying that Medical Records has a massive task at hand to ensure that all the other rural health centres are beefed up with monthly outpatients tally books, NHIS forms, discharges, admission books and other forms to do their monthly report and as such we are bound by this responsibilities to ensure that we have enough forms and books in place to supply to the health centres and this facility as well. I will be writing to the appropriate officers in this hospital **so** that they can provide us with the lists of forms and books that they need, so that we can liaise with our IT to design the forms and books, so that we can forward these forms and books to the management for their approval for printing and later distribute them to the Aid posts and H/centres.

I now take this golden opportunity to thank everyone who have and still continues to assist this section in one way or another for the past 12 months and hope that we will see that help is still coming our way in future for the betterment for the mission at hand –

"QUALITY PATIENT CARE".

Health Centre Annual Summary- 2017

MEDICAL RECORDS SECTION

Province	Health Facil	District	Month	Year
EAST SEPIK	BORAM PROV H	WEWAK	January- December	17

Aidpost
No. of aidposts open

OUTPATIENT

ALL WARDS

Outpatients		Male	Female
Measles (suspected)		0	0
Pertusis		0	2
Simple cough		932	786
Pneumonia	< 1yr	338	170
	1-4yrs	362	259
	5yrs	410	457
Chr. Obst. Pulmon. Dis.		79	102
Asthma		463	568

Inpatients	Discharges		Deaths	
	Male	Female	Male	Female
Diptheria				
Neonatal Tetanus	4	2	0	0
Acute Flaccid Parralysis	1	0	0	0
Measles (suspected)	0	0	0	0
Pertussis	0	1	0	0
Neonatal Sepsis	42	38	1	0
Pneumonia < 1yr	33	23	4	0

Malaria diagnosis

Microscopy

Male	0-4yrs	5-14yrs	15yrs+
P. falciparum	2	3	21
P.vivax	5	7	9
P.malariae	0	0	0
Mixed	0	1	0
No. of slides examined	166	113	451

Female	0-4yrs	5-14yrs	15yrs+
P.falciparum	2	3	24
P.vivax	3	3	8
P.malariae	0	0	1
Mixed	1	0	0
No. of slides examined	130	79	543

Rapid Diagnostic Test (RDT)

Male	0-4yrs	5-14yrs	15yrs+
P. faciparum	66	107	26
Non PF	25	23	45
Mixed	55	109	28
Failed	661	508	1,008
Total No. Tested	802	747	1,497

Female	0-4yrs	5-14yrs	15yrs+
P. falciparum	61	88	194
Non PF	22	30	69
Mixed	69	83	215
Failed	524	427	886
Total No. Tested	666	628	1,364

No. of Artemisinin combination (ACT) courses commenced (outpatient)	4,100
No. of Artemisinin combination (ACT) courses commenced (inpatient)	

0

Leprosy

	PB	MB
Total new cases		
Child <15yrs new case		
Disability Gr. 2 new case		
Female new cases		

Treatment Outcomes		
Treatment Completed		
Defaulters		
Died		
Relapse		
Transferred out		
Total registered cases		Angoram

HIV Testing

	Tested		**HIV+**		**Referred Treatn**	
	Male	Female	Male	Female	Male	Female
Antenatal	0	242	0	0	3	16
0-4yrs	8	2	7	0	2	0
VCT	115	148	3	10	5	52
Donor	122	0	0	0	3	4
STI	354	619	9	10	45	80
TB	57	68	16	4	2	6
Others	37	57	0	1	0	2

General:

STI clinic attendance 0 - 7yrs 45

8 - 50yrs+ 2,430

Trauma c
Other Dise

No. of patients currently on HIV

	Male	Female
<5yrs	36	27
5-14yrs	2	2
15-25yrs	19	26
>25yrs	225	391

Tuberculosis

No. of new TB patients of all types detected in the month	
No. of retreatment TB patients of all types detected in the month	

If the facility has any TB patients' be sure to complete the TB reporting each quarter

	Kubalia	372	TB/ Confinement, Malaria Cancer, Other Diseases Knife wounds/Nns
	Maprik	432	Nns, Self-amputation, TB Spleenic injury, Septic abort, & other Diseases.

DIRECTORATE OF NURSING SERVICES

DIRECTORATE OF NURSING SERVICES ANNUAL REPORT 2017

INTRODUCTION

Nursing Services condition of participation in a hospital is as outline. The hospital must have a nursing service that provides twenty – four (24) nursing services. The nursing services must be supervised by registered experienced nurse administrator.

The Nursing Directorate Report consists of all the wards and sections where patient safety and care is being given plus additional nursing activities such as their work plan as required by their job descriptions. Nurse's work output is measured through bi-annual appraisals system whereby weaknesses are identified, and measures taken to improvement, corrective actions such training are under taken to ensure safety of patients and optimum care is universally provided.

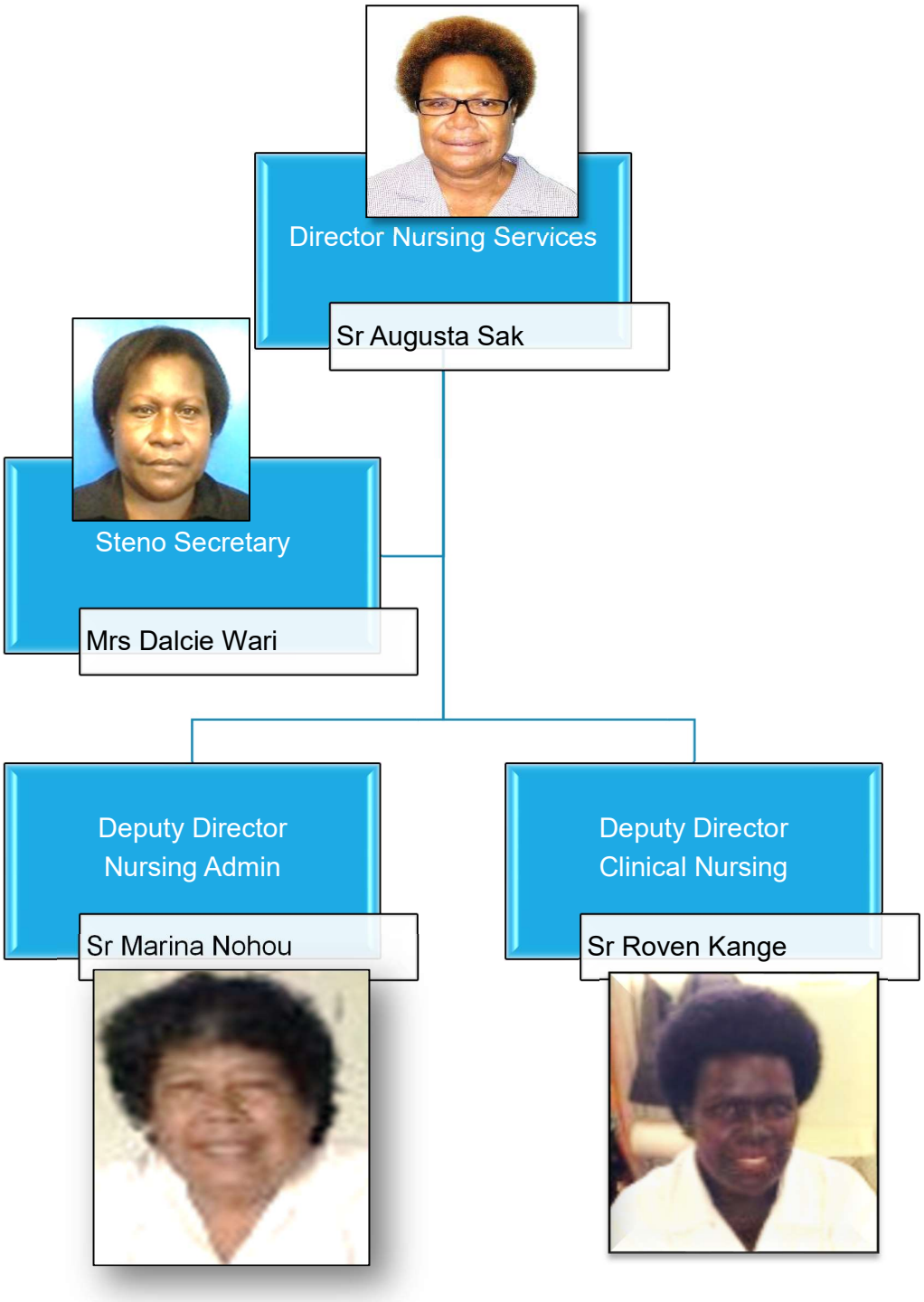
Nursing work is regulated by Papua New Guinea Nursing Council by way of Standards for Professional Nursing Practice and Community Health Worker by the Medical Board of Papua New Guinea.

Directorate of nursing services have been consistent all year-round day in and day out with patient care services. It is managing and lead by Director Nursing Services, the two deputies, seven clinical supervisors (five-unit supervisors and two evening and night supervisors) and sixteen ward managers.

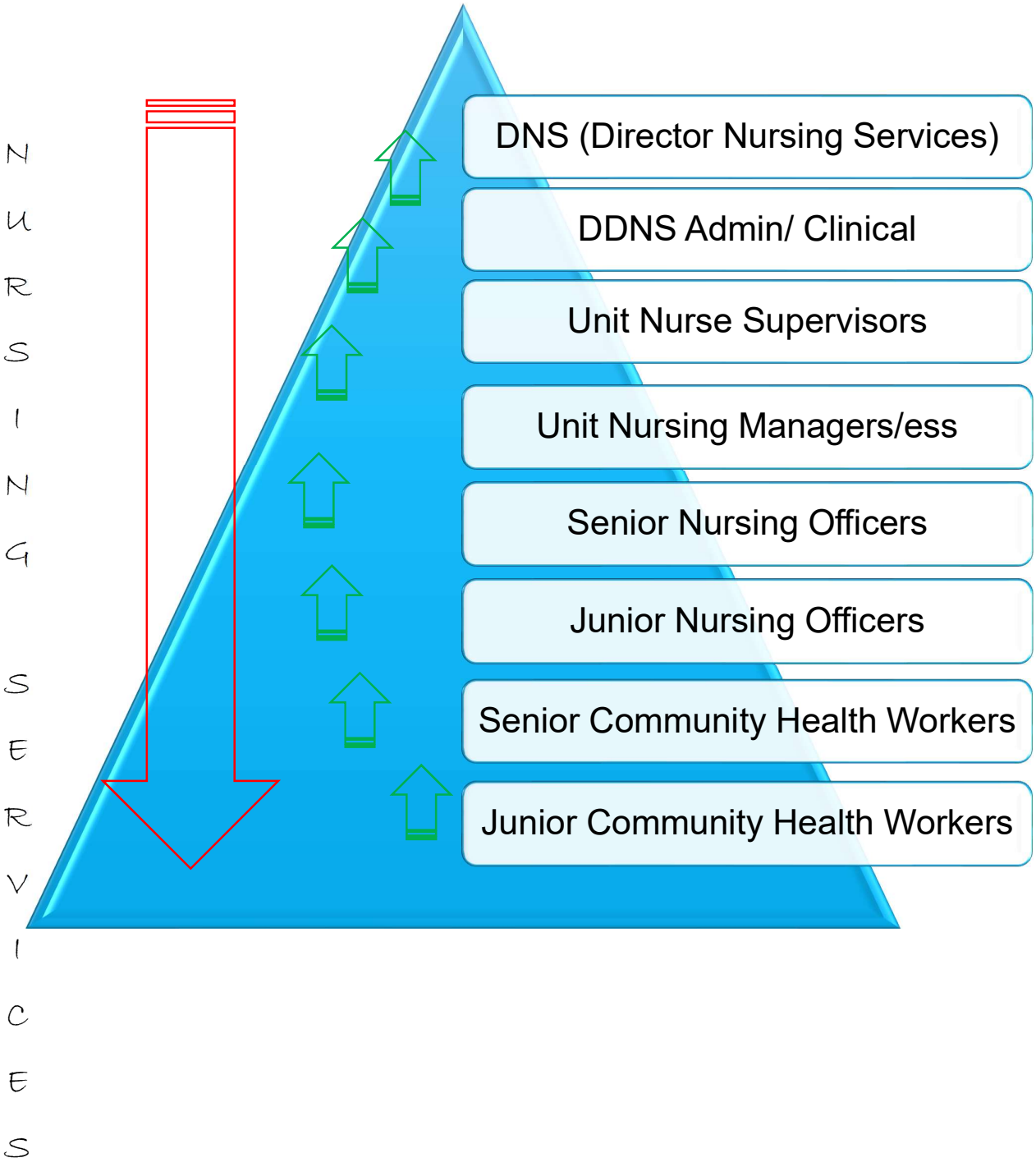
The purpose of this report is to inform the senior executive management of the nursing work in a hospital setting. This report is a contribution of all nurses of Boram General Hospital.

A tribute to them all plus the Director Nursing Services Personal Assistant and other health cadre who has supported nursing in the past, now and beyond.

ADMINISTRATIVE HEADS OF NURSING SERVICES



FLOW OF NURSING SERVICES



Unit Supervisors

Nursing Administration Team 2016

Nursing ceiling is 171 positions, including the steno secretary, 170 are all nursing personnel. Nursing Officers 100 and CHWs 70. All positions are filled by Nursing Officers and Community Health Worker in the Appointment of October of 2016. Nursing personnel are now confirm to their positions. There are no more arrest plan nursing personnel.

Senior Nursing Management

Director Nursing Services – Sr. Augusta Sak

Deputy Director Nursing Administration – Sr. Marina Nouhou

Deputy Direct Nursing Clinical – Sr. Roven Kangei

Middle Nursing Management

Unit Managers

Medical Unit – Sr. Lome Likia

Surgical Unit – Sr. Elizabeth Pararovai

Paediatric Unit – Sr. Jacinta Sairere

Obstetrics & Gynaecology Unit – Sr. Lorain Batek

Accident & Emergency Unit – Sr. Louisa Raeleo

Evening Supervisor – Mr. Graham Sapak

Night Supervisor – Sr. Priscilla Kerek

Ward Managers/ ess

Sr. Hilda Amos – Medical Ward

Sr. Helen Vakenro – Tuberculosis Ward

Sr. Juliana Koris – Intermediate Ward

Mr. Lucas Misan – Psychiatric Ward

Sr. Schola Kapari – Paediaric Ward

Sr. Daisy Naboam – Children's Outpatient

Sr. Regina Urosombi – Special Care Nursery

Sr. Geyac Singut – Surgical Ward

Sr. Joan Ale – Operating Theatre

Sr. Maria Latu – Central Sterilizing Department

Mr. Mark Muriki – Accident & Emergency Department

Sr. Bibiana Yuanis – Intensive Care Ward

Sr. Northy Sapak – Labour Ward

Sr. Patricia Kombari – Gynaecology Ward

Sr. Janet Luma – Post Natal

Sr. Cecilia Sililai – Consultation Clinic

General Nursing Officers and Community Health Workers by Grades: N/O: 100 and CHW: 61

Grade 18x 1

Grade 16 x 2

Grade 14 x 7

Grade 13 x 16

Grade 11x 39

Grade 10 x 12

Grade 09x 02

Grade 08 x 20

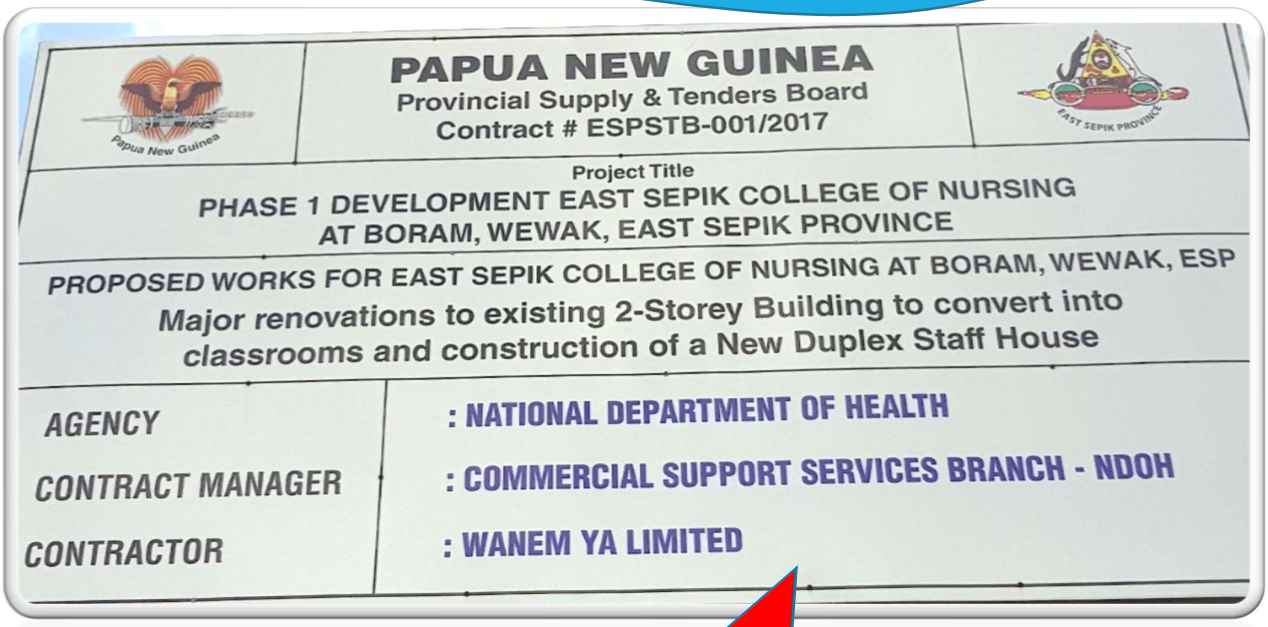
Grade 07x 10

Grade 06 x 12

Grade 05 x 20

Grade 04 x 29

WANEM YA LIMITED



COMMITTED TO BUILD
EAST SEPIK COLLEGE
OF NURSING

As planned since 2007, each ward areas is to have four (4) specialist nurses to cover each of the three shifts for the twenty – four (24) hours period. Way forwards is to ensure patients receive optimum care. Most of the wards rarely have specialist nurses in evening and night shift except O&G Unit, which has full coverage of midwives. In other wards we continue to train for ICU nurses, A&E nurses and Paediatric nurses because specialist nurses we train transfer out of the province and we need to train year in and year out. According to our training plan 5 specialists were to be train each year. The applications forms forwarded to the universities have been unsuccessful, due to universities selections. Hence, we manage the four shifts duties in those wards with either one specialist or with an experienced senior general nurse.

2017 retirement exercise had two senior CHW Gr. 7 retire and so we have two vacant positions. These two positions should be filled now to allow amalgamation of hospital and provincial health to Public Health Authority structure.

Retrenchment exercise is now pending three medical checks from the doctors.

The wards below will need further discussions for more man power to staff the wards into the future restructure, as indicated in 2015 report but for the purpose of reporting it is included here because they are still pending issues. They are;

Post Natal & Gynaecology Wards still has combine staff to one roster due to shortage of nurses. We hope in the near future to have separate roaster for these two wards.

Gynaecology Ward has a Ward Manager - need 5 more Nursing Officer and 5 more CHW.

Tuberculosis Ward, for the first time has a Ward Manager - Need to employ 5 N/O and 5 more CHW.

Children's Outpatient has a Manager- need to 5 more N/O and 5 more CHW.

Intermediate Ward has a Ward Manager, this area will require multi – skill staff for private patient use. Bed capacity is 4 - 2 N/O Midwife, 2 ICU N/O, 2 Paediatric N/O, 4 General N/O and 6 CHWs.

Mental Health Ward will need – 2 more N/O and 3 more CHW

CSSD will need 2 more N/O and 3 more CHW. CSSD is currently operating in the operating theatre.

Nutrition Ward – 2 N/O and 2 CHW

ICU is the intensive care unit for all types of patient use and hence will require skill mix of specialist nurses - 3 Midwives, 4 ICU, 3 Paediatric N/O and 7 CHWs

Eye Clinic – requires 3 N/O and 3 CHW

Wasaie Clinic– 3 N/O and 3 CHW

Specialist Nurses by number:

Midwives: 16, 2 of the staff doing administrative duties

Paediatric Nurses: 8, 1 Administrator- 6 more require in special care nursery as it is the intensive care unit for the neonates.

Acute Operating Theatre: 7, 3 staff doing administrative duties, to train 3 more. Sr. Joan Ale has completed her Masters in perioperative room nursing and to commence work in January of 2018. We hope to see some changes in perioperative nursing.

Acute Accident & Emergency: Two A&E specialist nurses. 1-A&E unit manager, Sr Louisa Raeleo. Now we have Sr. Lyneth Yawi who graduated in April of 2017. Need to train 4 more. To care for three shifts.

Intensive Care Nurse: Two ICU Nurses.1, Sr. Geyac Singut, Ward Manager of Surgical ward. We have another ICU nurse, Sr. Hilda Amos the Ward Manager of Medical Ward Need to train 4 more to cater for three shifts.

Mental Health Nurse: Three mental health nurses, 1appointed to Social work, other as Medical Unit Clinical Supervisor. Sr Schola Jeramie working in Mental Health ward. Need to train 2 more.

Eye Nurse Specialist: One eye specialist nurse. Need to train 2 more.

Nurse Administrators: 2016 – achieve 1, Sr Lome Likia. 2016. Need to equip ward managers with nursing administration and managerial knowledge skill and attitude so they be able to plan, control, implement, and monitor and evaluate staff progress and patient care to the expected standard.

Wards that need to train Ward Managers to Nursing Administration will be; Post Natal – Sr Janet Luma,

Additional man power skill mix that will be included in future restructure is in the directorate of nursing report 2015, p,158, table (1); Need 65 specialist nurses, 49 general nurses and 71 community health workers. An increase of 185 nursing personnel.

Wards according to Patient Type and nursing skill mix distributions

Monthly scheduling of ward rosters by way of nursing personnel distribution to each ward is by skill mix nurses so that the patients are given optimum care. Most of the wards now have average of seven 7N/O's and 7 CHW's on monthly roster schedules since October this year. This is because of the appointments in contrast to the past years. However, we still lacked the ceiling in some wards to match the nurse patient ratio as indicated above.

It is important that I repeat this quote again in this report to remind us of the staffing plan:

Similar practice, and responsibilities of nursing personnel, skill mix is important when determining staff needs because it affects the quality of patients care and it should apply to all areas of the wards for the patients best interest, Lippincott Williams & Wilkins, (2003), p.218.

Deputy Director Nursing Clinical

Main tasks: in consultant and liaison with Director Nursing Services, manage and coordinate all clinical matters in the Nursing Services by ensuring there are safe, effective and efficient clinical management and practices in nursing standards and to achieve optimum patient care services.

Recommend staff for training purposes either in-house or external through clinical reports on direct and in direct observations/monitoring and performances appraisal system. Does monthly staff roster

schedules, meet with unit managers and ward managers, identify staff strength and weaknesses and plan in house and external training. Plan programmes are replan to enable and mentor problem orientated nursing task, novice tenure and junior staff. Ensure all new and general practising nurses are competent in the wards they schedule to work.

Follow up and ensure staffs are inducted to become permanent public servants. Facilitate to ensure nursing staff are fully registered with Papua New Guinea Nursing Council and Medical Board each year.

Achievements; coordination with Clinical Supervisors and Ward Managers had new nurses competent in skill application in respective patient type nursing.

Registration of nurses sent to Port Moresby for registration and completion of appraisal nurses.

Coordinate with Sr. Elizabeth Pararovai, Surgical Unit Supervisor for the 2017 in house Programmes were good, despite interruption with surgical ward surgical reconstruction.

Weaknesses; only one multimedia in the hospital which many times cause in convenience to nursing learning in clinical sessions.

Recommendation; nursing directorate to have a multimedia so it does not cause hindrance to learn.

Projects for year 2017:

Registration for all new graduates from nursing colleges

Create standard procedure log books with checklists

Audit nursing practices

Infection control checklist and implementation in the wards

Create nursing policies

Create tasks under new job descriptions

Staff appraisal yearly

Cardiac Pulmonary Resuscitation (CPR) training

All projects above to be continued

DEPUTY DIRECTOR NURSING ADMINISTRATION

Main Tasks: in consultant and liaison with Director Nursing Services; manage and coordinate the administration services of nursing in human resource issues regarding staff pay, plan and scheduling staff recreation leaves, plan and monitor nurses working resources which are used to use on patients day to day activities, such as stationary, snow white, soap, beddings; and requestions to administration office of the same. Monitor and report ill function medical equipment's and general housekeeping of the ward facilities.

Achievements:

Most of the nursing officer's awards have been awarded. Outstanding issues are the Refinements of sixteen nursing officer's 2016 Restructure. Most nurses have received their outstanding warrants for 2015 and 2016. \

Weakness identified:

Lacked ward working resources such as stationaries, snow white and soap. A lot of nurse's absenteeism for leaves without pay as staff movement advice (SMAs) sent to HRM were not actioned. Staff continue to be absent. HRM need to issue nurses pay slip to Deputy Director Admin, so that nurses pay can be audited for correct measures to be action.

Outstanding payments still pending:

1. HRM still to address outstanding nurses pay issues of 2009 – 2011.
2. Outstanding payments for casual hire Nurses and CHW Allowances from 2013 to 2 014 and 2015 to 2016 **still in HRM files**.
3. 2016 Restructure refinements for nursing officers still pending.

Recommendation;

Timely issuing of recreation leave warrants. HRM to fast tract outstanding issues of 2009 to 2011, Nurses and CHW Casual Hires Allowance for 2013 to 2014 and 2015 to 2016. Timely issuing of stationary and patient's hygiene resources to make nursing work complete as standard and for the comfort for all patients to Wewak General Hospital.

Fortnightly nurse's payslip to DNS office for audit purposes.

Projects for year 2017:

Analyse recreation leave schedules and replan

Develop checklist of ward inventory

Analyse staff pay if under pay and take corrective measures

Checklist monthly store and stationary orders of the wards

Create admin policies

NIGHT MANAGER

Main task is to manage and supervise nursing staff with nursing care activities during the night between 10pm and 7am. Ensure nurses do patients and guardian midnight statements. Patients and staff safety is monitored. Patient receive optimum care.

EVENING MANAGER

Main task is to manage and supervise nursing staff with nursing care activities from 2pm to 10pm. Assist nurses in areas of patient care to ensure they receive optimum care.

OBSTETRIC AND GYNAECOLOGY UNIT

Labour ward has its own staff roster now for the first time in more than 20 years. Its staff with 7 midwifes and 5 CHW's. Has 5 beds but ended up having 3 beds, other 2 beds needs replacement. Same services provided as indicated in 2016 report. Obstetric total admission = 2362, 6 patients per day. Discharges – 2315, 6 patients per day as well. Referred cases – 228 (10%). Death – 4 (0.16%). Average length of stay is 2 days, average daily census of 15 patient, percentage of bed occupancy was 74%. Total births – 2285 registered, 6 per day. 99 times each bed changed occupants in the whole year. Staff total absents (include sick leave)= 509 days, 491 (96%), authorized and 18 (4%) unauthorized. Post Natal beds and Antenatal – 25.

2 midwives & CHW in Labour ward preparing for birthing

Obstetric Ward preparing patients to Operating Theatre.

Recommendation: Need 5 new beds, proper hand wash stations, regular supply of alcohol hand sanitizers and paper towel. Regular supply of cleaning agents and stationaries by the ration store. Multimedia Projector for Nursing Directorate, to use especially for in-house training.

Gynae Clinic

Main activities of the unit;

Daily ward rounds

Surgery on Wednesdays and Fridays weekly;

Tuba ligations, non-scapple vasectomy twice weekly on surgery days

Depo Povera injections given to inpatient and out patients as prescribed

Implants on Monday

Health education each morning

Provide essential and comprehensive obstetrics care

Antenatal care to pregnant women with normal labour and complication associated with pregnancy we care for women who are admitted with Gynaecology problems

We give immunizations to new born babies as well as those who are more than a week old

Supervise and mentor newly employed nurses and student HEOs to be skilled in obstetric care

Assist constantans with specialist clinics on Tuesdays and Thursdays every week

Have their meetings as planned.

Weaknesses; absenteeism, unwilling to adapt and change and poor communication problems and aging.

Area for improvement: Unit Supervisors and Ward Managers advice to interview staff and come up with date lines to correct the problems.

Recommendation; plan for training of the above concerns.

PAEDIATRIC UNIT

Paediatric acute ward has been relocated to intermediate ward of 4 beds and stable and recovery children in ward 3 B. The two wards of 3A and 3C are used by surgical wards because of current new surgical wards being built. Bed capacity of 48 has been reduce to 20 due new ward construction.

Same paediatric care services as indicated in 2015.Top leading cause of admission are; malaria, tuberculosis, pneumonia, meningitis and malnutrition. Top leading causes of death; malaria, tuberculosis, meningitis and malnutrition. Nursing staff ready for ward round.

Average length of stay is 3 – 5 days, bed occupancy is 3 – 5 days.

Special Care Nursery is the intensive Care of the neonates under 28 days. Nursing care services as indicated in 2015 report. CHWs attending to a neonate.

Nutrition ward continue to provide meals to malnourish children less than 5 years old. In future will need a bigger space for meal preparation and its own staffing. CHW preparing the meal for the malnourish children.

Immunisation is given on opportunity base. CHW preparing to give immunization.

SURGICAL UNIT

New forty beds build. Staff are happy to work in new facility.

Operating theatre continue to provide same patient services. From time to time operating theatres has power problems due to old wiring. Same with air-condition which need cleaning and maintenance from time to time. So does the autoclave.

Central sterilizing department still in the operating theatre awaiting new structure.

MEDICAL UNIT

Medical ward still has bed capacity of 30. Patient care services are the same as indicated in 2015 report. Patient average length of stay is 3 – 5 days. Bed occupancy 3 – 5 days.

Tuberculosis ward continue to provide same patient care services in 2015. Bed capacity of 18.

TB sputum examination

Mental health continues to provide same patient care services as in 2015. Bed capacity of 7.

Mental Health Staff in counselling session

Wasaie clinic continue to provide same patient services as 2015.

Intermediate ward services has been taken up by paediatric acute ward due to surgical ward movements.

Eye clinic continue to provide same services.

ACCIDENT AND EMERGENCY DEPARTMENT

Continue to provide same patient services as in 2015 including adult, children outpatients and A&E services. Average outpatient cases seen in 24 hours is 50 – 70. Most trauma cases are alcohol related with knife wounds. Patient still staying here for more than 4 hours. Most health centres and Aid post are not functioning and hence patients are coming to Boram General Hospitals. Waiting time is more than one hour. All clinical domains to meet to see way forward to reduce waiting time to less than an hour. Per attendance is approximately 30 minutes.

A&E staff preparing for morning shift

Triage patient

Consultation clinic continue to provide the same services as in 2015. Patient seeking specialist's advice by way of booking or referral from outpatients or the wards.

Consultation Clinic staff with Stakeholder

Intensive care unit will be in for new structure by 6 beds.

CHW nursing patient in bed

Nursing Activities

Patient care plan and care services is the core business of this hospital which the nurses provide. The three shift is provided in the 24 hour period; 7am, 2pm, 10 pm and 7.45am for nurse administrators. Senior specialist nurse ensure adequate supervision and evaluation of the clinical activities. Nursing staff must develop, and keep current, a nursing care plan for each patient.

Weaknesses identified in nursing areas and work:

Poor communication skills

Not punctuality

Ignorance

Not easily adapt to change or accept changes

Aging

Areas for improvement: in-service training.

Variables that affect nursing roster

1. Aging work force
2. High sick leave rate
3. Non-payment of entitlements
4. Work load / work stress
5. High turnover rate
6. Absenteeism
7. Recreation leaves
8. Compassionate leaves

The above variables gabs are filled at times though it can be stressful when 2 or 3 ward rosters have a nurse each sick or absent at the same time.

Training

External training 2017; all went to UPNG, School of Medicine & Health Sciences, Sr. Lyneth Yawi – Acute Accident & Emergency, Sr. Hilda Amos - Acute Intensive Care and Sr. Lome Likia – Nursing Administration. All have done well.

In house training

The weaknesses identified above is similar to all wards. Hence, it will be plan for in house training to improve staff knowledge and attitude towards work. These also includes areas of infection control by nurses and hygiene staff who are ward station.

All wards conduct their own training in the wards. Overall weekly nursing clinical session was not as effective due to unavailability of multimedia and new ward construction

RECOMMENDATION

- Nursing directorate to have its own multimedia for clinical sessions.

YEARLY CALENDAR WORK PLAN SCHEDULE:

Scheduling of yearly calendar meetings in November of each year continues.
Senior nursing management monthly meeting, middle management and ward meeting continues. Every Monday week – hand over report of the week – end patients report continues.
Daily reporting of Evening and Night Supervisors continues.
Monthly ward meetings, ward manager with staff and the ward doctors, second week of the month. Quarterly nursing staff general meeting, fourth week ending quarter of the month continues. Training plan review March of each year continues. Annual budget in March of each year continues. Annual directorate report of each year to the Chief Executive Officer of December each year continues. Weekly work schedule plan of senior level and middle level nursing to be review as whenever necessary. Quarterly reports of all nursing section due each quarter continues. Clinical audit, patient care audit including death audit with ward doctors every month- needs improvement in this area by holding regular ward meetings.
Problems orientated training and in-service each month. Due to construction of new facilities this year, 2016 has cause some hindrance, however that did not stop inwards learning activities.

New approach research and case studies to be applied to improve services and patient care. This area needs more attention to improve patient care by way of patient case studies, especially of new staff and orientated problems day in and day out. Corporate plan review has been accomplished in 2015 Structure reviews March each year. Appointment has been completed in 2016. Daily/Weekly activity plan, review end of each quarter continues.

STRATEGIC PRIORITIES

Five year cooperate plan was achieve this year. It is the guide that we implement and monitor our activities each year.

Priority Focus Areas

2017 - Going into Provincial Health Authority

Rebuilding Strategies

Areas of weaknesses have been identified by the wards as indicated in their reports of this year 2017. This we will organize senior specialist nurses to plan and run training of; infection control standards, poor communication skills and not easily adapt to change, work stress and overloaded with work. As reported in 2015 report we plan to increase nursing ceiling in the next restructure and each shift reviewing of patient care plan, monitor and correct discrepancies in staff pay and building of accommodations which will increase staff morale and job satisfaction.

Implementation

All nursing personnel are now aiming to achieve the next two years of corporate plan by working as team in collaboration with all other health disciplines and stake holders.

Drive

Drive to develop policies and guidelines not yet develop to complement nursing procedure manuals, embark on case studies/research, again as way forward to improve patient care services and practice. Train 5 CHWs on short courses for the next two years. Train 5 specialist nursing officers for the next two years and review. Each ward is to have at least 4 nursing personnel on each shift.

Monitoring & Evaluating

Challenges

These will be done through clinical audit of patient care, meetings, direct and in direct assessment of staff, patient's complaints/concerns, staff Performance Appraisals and quarterly and annual staff report.

Accommodations, non – timely payment of remunerations and other concerns etc…as indicated in 2015 report.

Way forward

The best thing we could do now is to improve staff morale and job satisfaction and we will see more output from nurses. Build staff accommodations and others as indicated in 2015 annual report.

DIRECTORATE OF CORPORATE SERVICES

Corporate Services Division play a key role as an enabling service and provides a wide range of services covering all aspects of Finance and Administration, Human Resource Management (HRM), Operations and Facilities and Information Communication Technology (ICT) Executive Services and CEO's Office, Curative Health, and Public Health services within the East Sepik Provincial Authority. The Division also provides direct administrative support to PHA Board along with a number of front line services to the general public as external customers and to staff and patients as internal customers.

FINANCE AND ADMINISTRATION

Finance & Administration had its share of challenges. And to make mention of some impact projects implemented throughout the 2017 financial year which were challenges and projects for 2016.

Finance and Accounts

Firstly, we would like to thank the O'Neill-Dion Government for having granted our PIP submission and for providing East Sepik Provincial Hospital the much-needed funds to rehabilitate the hospital. We have seen 4 surgical wards, 2A to 2D pulled down and reconstructed. These rehabilitation projects were funded from the Development Budget worth K3.5million in 2016. The Hospital was given another K3.0 million to continue the rehabilitation program in 2017. This will see the next four wards demolished and reconstructed. The budget figure for the year 2018 has been released. The government is expected to provide additional funds for further hospital rehabilitation.

The hospitals financial Statements for the fiscal year ending December 31st, 2015 has been audited by the Auditor General. Attempts to get the audit team to audit 2016 Financials were hampered by the cash flow situation. However, it is hope that both 2016 and 2017 can be audited at the simultaneously when funding is available. The little funds that the government assisted the hospital by way of CFC has been well managed. Credit should be accorded to the following finance team: Mr. Christopher Kabaru, Director Corporate Services, Mr. Hicks Kuarughin, Manager Finance and Administration; and Mr. Isidore Sirongo, Finance Supervisor who are well versed with accounting and financial Management aspects. These officers are business graduates with a degree in accounting from the Divine Word University.

It is also worth crediting our CEO, Mr. Mark Mauludu who has done exceptionally well in providing the required strategic leadership and direction for the hospital to a whole new level with the guidance from the Almighty God.

The Accounts team is intact, all officers on the ground are fired up and geared to see all the books of accounts are maintained at the highest standard of transparency and accountability to support the overall goals of the organisation in providing the best health care services to the people of East Sepik. We have a total of 8 accounts team members who qualified with respective diplomas and degrees for the jobs recruited for and they maintain the accounts section under the supervision of the Finance Supervisor. They are young and energetic, equipped with vim, vigour and vitality to pen their mark for a quality change in finance.

REVENUE

This hospital's internal revenue section is the only source of income for the hospital apart from the Government grants. This section is managed by OIC Revenue. The sectional staffs collect patients' fees from all departments to help subsidise the operations of the hospital. The figures below show how much has been collected per department and the total. The management is determined to do better in fees collection come 2017.

INTERNAL REVENUE INCOME – USER PAY FEES (Comparative)

DEPARTMENT	TAKINGS PER SECTION		
	2016	2017	PERCENTAGE
D-1-AOPD	0.00	0.00	
D-2-PHC	7,234.10	10,194.19	41% increase
D-3 A& E	58,421.80	74,922.90	28% increase
D-4 CONS	1,718.00	1,578.00	8% increase
D-5 PATH	2,041.00	3,109.00	52% increase
D-6 XRAY	1,476.00	4,638.50	214% increase
D-7 IN-PTN	18,927.00	20,064.00	6% increase
D-8 INTER-M	0.00	18,582.00	
D-9 DENTAL	19,045.00		
D-10 DRINKS	19,210.00	66,620.00	247% increase
D-11 MED RPT	11,944.70	20,681.00	73% increase
D-12 H/BOOKS	5,035.50	5,856.50	16% increase
D-13 ADMIN	9,154.00	41,210.00	35% increase
D-14 GIFT-DON	-	0.00	
D-15 EYE CLINIC	6,529.05	14,865.05	128% increase
TOTAL USER FEES K	**160,736.15**	**307,377.54**	**TOTAL AVERAGE 9725% increase**

D-1 AOPD:

The (AOPD) is the outpatient department which has nil users fee collection because these fees are collected and reported under D-3 (A&E) Accident and Emergency.

D-2 PHC:
The dispensary section user fees are charged under this department. In 2017, a total of K10, 194.09 was collected.

D-3 A&E

The hospital Accident & Emergency section made a total of K74, 922.90. This is highest compared to other departments or section with the hospital user pay.

D-4 CONS

The consultation clinic of the hospital made a total of K1, 578.00 for the year.

D-5 PATH

The pathology section of the hospital collected a total for K3, 109.00 this year. There is a need to improve on user fees collections. The proposed fees may be too low to generate bigger revenue in this section.

D-6 XRAY

The X-ray department collected a total of K4, 638.50 for the year. The proposed fee of K2.00 per X-ray is too low therefore we are unable make much money.

D-7 IN –PTN

The impatient department collected a total of K20, 064.00 for year.

D-8 FLEX & BISCUITS

There was no Intermediate Ward so this department was used to record sales of flex and biscuit sales. For the 2017 financial year, K25, 056.50 was collected.

D-9 DENTAL

The dental section of the hospital recorded a total of K18, 582.00 collected for the year end 2017.

D-10 DRINKS

The sale of drinks in 2017 recorded a total income of K66, 620.00. This main item was sold to support revenue generation of the hospital.

D-11 MED-PRT

The total fees collected for the medical reports done by the hospital was K20, 681.00.

D-12 H/BOOKS

The total fees collected for the sale of Health books was only K5, 856.50. This figure shows that we were selling limited books. We should increase the purchase and sell more.

D-13 ADMIN

The Administration Section of the hospital recorded only K4, 210.00 income made during the year. This shows that certain fees like morgue fees collection has to be monitored well and control measures are established to effectively strengthen collection and eradication of mismanagement anomalies.

D-14 GIFT-DON

This section recorded nil collection of user fees.

D-15 EYE CLINIC

The department under Eye Clinic recorded only K14, 865.05. This section has been providing vital Eye Care Service for the hospital. The total fees collected under this department are looking good. However, more control measures need to be established to ensure collection points are properly monitored.

In Summary, the Revenue Section of the hospital has improved generally, however, more needs to be done to further improve on all aspects of revenue generation streams of the hospital. It is also recommended that the hospital kiosk must be immediately erected and made operational.

Administration

The Administration section looks after other small sections like Switchboard operations, Drivers, Escort Securities and Transport. There were challenges in all these areas as other sections. It is important to note that the management did well in negotiating with DPM and NDoH to have the three sections mentioned above have their payroll codes configured for them to receive shift allowances to substitute for manual overtime payments when worked extra hours. This is believed to be the first of its kind in all health facilities in the country. These areas are the most troublesome wherein drivers, switch board operators, and escort guards often raised their complaints, especially the overtime claims. The management has effectively addressed this concern by paying shift allowances with their salaries. Unnecessary complaints have decreased since. The outstanding issue of hospital uniforms and boots is currently being addressed.

All our staff members are active, except for two employees, Benjamin Rom (cook) who passed away in the middle of 2017 and Balthazar Mariju (driver) who retired from active driving duties.

Transport

In our report for 2016, we had a rundown fleet of vehicle. This which cost the hospital where more funds were spent on maintenance and fuel. The report has provided a clear picture of what should be improved going forward.

The hospital's initial plan was to get rid of the two aged administrative vehicles. In implementing that plan, the division decided to sell by tender our two vehicles for combined tender proceeds of K125, 000. One was sold for K70, 000. The other was sold for K55, 000. The hospital Board approved the balance of K343, 749. This made it possible to purchase two new 10-seater land-cruisers from Ela Motors to replace the ageing vehicles. The hospital also bought an Isuzu Dyna to help the grounds men dispose rubbish as well as carry rations from the local supplier in town to the hospital. It also helped the carpentry section in transporting materials for the rehabilitation maintenance work.

Security wire windscreens are fitted on to the pick-up/drop-off vehicles to safeguard staff and drivers from flying missiles. The hospital management is grateful to the East Sepik Governor, **Hon. Allan Bird**, who was the former Hospital Board Chairman. He negotiated another brand new 10-seater, land-cruiser donated by the National Gaming Control Board for the rural clinical outreach programs.

Plans are underway to purchase another Toyota Land cruiser (10-seater) for the blood bank team to assist them travel out to collect blood for patient blood transfusions. Currently, the East Sepik Provincial Health Authority has 6 vehicles transferred from East Sepik Provincial Hospital.

Fuel

The budgetary allocations for transport and fuel have been very excessive for the last two years as well as this year. Management of these funds have been a challenge and will remain so come 2018.

The lifesaving funds from the East Sepik Provincial Administration health grants have been problematic to access under the Authority largely due to bureaucratic red-tape. However, the Acting Provincial Administrator, Mr. Richard Kombo has been good all along, and we believe an understanding will be reached soon on how best we could collaborate to advance ESPHA for the people of East Sepik.

General and Rations Store

The hospital general and patient rational store has been an area where records were not kept well as noted by the internal audit team. There has been a lot of discrepancies in records of stocks kept in books and physical count. Rations run low in no time. There were a lot of outstanding back orders. Goods ordered and paid were not in stock. These issues had crippled rations store. We have put in quite a number of control measures like: -

1. Stock in, Stock out register
2. Accounts Supervisor to follow up on last payment made, availability of stock received.
3. Stock take done every Friday and follow up on outstanding issues on previous stock take date.
4. Accounts Payable staff, Namely Lydia Ferihembi relocated to rations store on acting appointment (OIC Rations)
5. Whilst there, to follow up on all outstanding issues, keep up to-date the Receiving and Issuing Register, issue rations on properly signed goods request docket, do reconciliation on all invoices with back orders and substitute it for other most needed items with approval from the Manager Finance.
6. Orders to be made from reputable companies only.
7. One month's stock allowance to be kept at all times before next order

Thus, we hope to see better handling of store items once the internal control is implemented.

Laundry Services

There has been a couple of issues in this section brought forward from previous years which we could not manage due to financial constraints. This is largely due to the fact that the 2010 king tide which destroyed all the heavy-duty laundry machines and dryers where the hospital was forced to buy light

machines while waiting for sufficient funds to purchase new ones of the same kind. It managed to revive one or two of these laundry machines by ordering spare parts and having them installed. It is hoped that the rehabilitation projects once completed would the remaining funds will be used to address the outstanding issues in this section.

Patients' Mess

Patients Mess is another area where the king tide also did a lot of damage. Because both the laundry and the patients' mess were directly facing the sea, they were severely affected. As a result cooking equipment fell apart from sea corrosion. Additional utensils bought and shipped from NDoH Facilities Section were lying idle due to aged electrical wires in accommodating the large amount of electric currents needed by these heavy catering equipment. The machines were totally switched off when attempts were made to connect the switch. It is expected that this will be resolved through the rehabilitation project by Vamed Health Products.

This section has also seen a near mishap, when one of the kitchen crews nearly got burned from flames busting out from rusted old burner. Burners which fit the fittings were not available in the country to be purchased and replaced. We have finally settled the issue when a special order is placed from Bishop Brothers Engineering in Lae. We had to wait for 4 months to finally receive the order and have it replaced.

Apart from all these issues, the mess crews have been told to religiously adhere to hygiene rules as well as to pray over meals before dispatching to the patients. The staff have been told to leave household problems behind and come to work with a positive mind, which is to serve the patients. All the problems facing this section will have gone come February 2018, when Vamed settles in to put up a new messing facility.

We also want to thank the O'Neil-Abel government for facilitating funding arrangements regarding Vamed's engagement as the contractor, and its conclusion over the last few weeks. The people of East Sepik Province will now see a new state of the art modern hospital which the biggest infrastructure development for people of East Sepik would be.

Note that Vamed Health Product is a company based in Vienna, Austria specialized in building state of the art hospital infrastructure in the 21st century. The same company built the Goroka Base Hospital, Eastern Highlands Province on the same financial arrangement with the European Union and the Government of Papua New Guinea.

Challenges for 2016 were comfortably managed in 2017 through: -

- ✓ Wheeler bins paid for and delivered
- ✓ Stamp not erected due to change of plan in hospital rehabilitation program
- ✓ Bruch cutter paid for and are in use by the grounds team
- ✓ Incinerator finally installed with few minor fittings fitted before use
- ✓ 2105 Audit done and hope for 2016 and 2107 to be done in 2018
- ✓ Revenue, Switch Board Operators, Drivers and Escort Security now on 15% shift Allowance solving the problem of manually processed overtime.

HUMAN RESOURCE MANAGEMENT

We have delivered the Human Resource Management and advisory service for the Provincial Hospital in a good note this year 2017. This office has undertaken numerous tasks to improve HR capacity by providing the best HRM practice in this organisation for the year. Hospital is witnessing a massive improvement with its infrastructure development and it is a challenge for us to move with these changes by providing the best HRM advice to the organisation. The major activities of HRM functions performance are linked to the overall goals and objectives of the organisation.

With a qualified and experienced HR team, our performance is above required level because of individual commitment and work output. A lot of improvement on HR Business Practice in the past months has motivated overall staff's performance as a result of a good management and leadership. We are looking forward to the challenge in 2018.

In the 2014 structure, the Human Resource Management Team is comprised of four sub units/sections with a manpower establishment ceiling of ten (10) positions and nine staff on strength. The HR units are comprised of Personnel Administration, Payroll Administration, Staff Development & Training and General Administration.

1. Structure & Manpower

With the manpower establishment of 417 positions, 34 are vacant, 13 unattached, and we have officers attached to 81 vacant positions. Actual staff on Ascender Payroll is 396 on full salary and three (03) casual staffs awaiting confirmation.

We are in the process of filing up all the position vacancies in the hospital establishment through our advertisement and selection which will be completed in January 2018.

Manpower Establishment

Current Manpower Establishment Summary

MANPOWER SUMMARY	
SOS	383
VAC	34
UA	13
UA Retirement	03
F/Ceiling	**417**
A/Headcount	396
A/Payroll	396
Casual	03
Staff Establishment	**417**

Above table showing total Hospital Staffing

2. Staff Development & Training

Training could not be facilitated this year (2017) because of shortage of funds to cater for short or long term training for staff in various training courses. However, we were fortunate to be included on the AUSAID sponsored training for Future Leaders Program which Mrs. Rebecca Bandi was the first to attend and she will be graduating in March 2018.

Another six (6) staff have submitted their application to DPM for the same training which might take effect in 2018. This office will be informed as soon as the candidates for the training program are selected.

2.1 CONTRACT MANAGEMENT

- Sixty-one (61) contract officers' gratuity and allowances due for 2017 payment have been settled on pay 25 & 26, of 2017.
- Contract Document for Five (5) Doctors attached to a position will be facilitated once their employment status are confirmed.

2.2 JOB DESCRIPTION

Developing and editing of Job Description was at snail's pace because most of the supervisors could not provide the information required to complete the Job Descriptions per the positions in each directorates. Managers and Supervisors are responsible for the subordinate staffs' positions under their respective unit/sections and their contribution in developing a good Job Description is important.

Table 1:

No.	Directorates	JDs Submitted	JDs Pending	Total
01	Corporate	102	24	126
02	Curative	73	39	112
03	Nursing	76	95	171
04	Executive	02	06	08
		254	**164**	**417**

By first quarter of 2018 all Job Description shall be completed in preparation for the East Sepik Provincial Health Authority Merged Structure.

3. Personnel Administration

This unit mainly deals with salary calculation of allowances, leave administration, simple deductions for personal loans and etc., annual increment (PBSS) and other salary matters are ongoing task for this section. Most allowances and increments were paid on pay 26/2017 and there will be no carry over in 2018. Officers due for recreational leave in 2017 did not receive their travel warrant because of the financial situation we have at the moment.

There are good number of staffs who have not received their travel warrants and other payments. This is an issue for the staff and should be given priority to settle these outstanding payments as soon as our account is healthy.

3.1 Retirement

We have 29 staffs confirmed for retirement under two categories,

(a) Compulsory
- 13 staffs on compulsory retirement have received their final entitlement cheques on the 14/12/2017.

(b) Normal Retirement.
- 16 officers on normal retirement will be retired as soon as funds for this purpose are released to DPM by Department of Treasury in early 2018.

Compulsory retirees were terminated from the payroll on pay 26 pay date 20/12/2017.

4. Payroll Administration

Having the Ascender HR Payroll System has improved the staff's salary matters in compliance with the pay cycle of every pay day. Data inputs are done internally in consultation with officers from Management Information Service (MIS) at DPM and NDoH for compliance purposes.

Ascender payroll system provides information on personnel emoluments expenditure and year to date reports (FINOF3/FINOF4). The system provides up to date reports on the manpower establishment for decision making.

Four (4) HR officers have attended the Concept Training on Alesco payroll and are well versed with the system in terms of data entry and reporting. These officers have to attend the module II of the concept training to equip them with the knowledge and skills required of the system because we are now merged in to one health system (ESPHA).

Alesco Human Resource Management System Monthly Budget Report as at Pay 25 & 26 in Pay Year 2017 is as shown on the below tables.

Pay Period	Annual Budget	PTD Budget	YTD Expense	YTD Variation
Pay 25	11,538,493	11,094,261	16,8,23,950	5,729,689
Total	**11,538,493**	**11,094,261**	**16,823,950**	**5,729,689**

The report shows that we have exceeded our year to date (YTD) expense for pay 25 at the rate of 145.81% from the YTD variation as a result of payment of allowances (PBSS, Contract Gratuity and etc.).

Pay Period	Annual Budget	PTD Budget	YTD Expense	YTD Variation
Pay 26	11,538,493	11,538,493	16,8,23,950	5,729,689
Total	**11,538,493**	**11,538,493**	**17,514,766**	**5,976,273**

In pay 26 our YTD expense exceeded by 151.79% on the variation because most of the allowances were captured on that pay period.

Our Actual Budget Estimate is K19.5million as per the approved manpower ceiling and not K11.5million as per the FINOF 04 report of pay 26/2017. From observation we have not exceeded our

YTD expense as reported but because DPM and DoF are in control over the personnel emoluments budget, consequently they are providing the budget ceiling for us to comply with. Otherwise they must present a realistic monthly and YTD reports based on our budget estimate.

5. Advertisement of Vacant Funded Positions

This office has facilitated two separate advertisements of position vacancies;

(i) External Advertisement

- 25 Position vacancies were advertised on the National Newspaper.

(ii) Internal Advertisement

- Advertisement of 81 positions were placed on the local public noticeboards and also distributed to each sections in the three (3) directorates. Employees attached to these positions were advised to apply for confirmation on those positions to formalise their employment status.

We are now in preparation of the selection of candidates for these positions both the external and internal advertisement. The selection date now is differed to second quarter of 2018.

6. East Sepik Provincial Health Authority

The Merged Structure is at DPM for compliance and vetting for Department of Finance to allocate funding. This is a long process and we have to communicate and follow up to see that action must be taken by these two National agencies so that these positions are given approval for loading. Once it is loaded we can advertise the Top Management position and prepare for ESPHA restructure.

Table 1. Existing Positions from the two establishments merged to establish the East Sepik Provincial Health Authority structure is as shown on the table below.

No	Current Organisation	Public Servants	New Creation	Total
01	DPM Approved Positions (Executive Management)	0	4	4
02	Wewak General Hospital	419	0	419
03	ESPA Health Division Positions	339	37	376
04	**Total**	**758**	**41**	**799**

These positions merged into one structure (ESPHA) will report under four (4) new Executive Management positions that were approved by Department of Personnel Management (DPM) on the 12th of August 2014. The merged structure will therefore have a total of 799 positions as shown in the table above.

Way Forward

Human Resources Management team is focusing on improving performance of all HR functions to accommodate the merged changes in 2018 and beyond. We have the capabilities to provide effective and efficient client service and advisory role to the management and the staff of the East Sepik Provincial Health Authority. With a total of 799 positions it is a big challenge for HR staff to provide the best HRM practice according to the PS Business process.

OPERATIONS AND FACILITIES

This report covers the following sections of the provincial hospital operation

1 Kitchen
2 Laundry
3 General service
4 Ration stores
5 Carpentry
6 Electrical
7 Plumbing & welding
8 Biomedical Engineering

This year 2017 has been a very challenging year, unlike the past years of East Sepik provincial hospital, formally known as Wewak general hospital. In the light of current physical changes that are occurring today in the provincial hospital. The operation section is at the forefront in assisting the contractors with the implementation of the infrastructure development of this hospital and we certainly have the vision and passion to move on to bring about the good changes that are needed by our clients who are seeking quality health care services from the East Sepik provincial hospital.

1. Kitchen

The patients' kitchen section of the operations is always under its commitment with its staff to provide the best possible kitchen service to the sick in regard to meals delivery. There are eight staff members including the supervisor who are always on daily schedule to carry out the task of cooking and serving the sick.

The supervisor is responsible for duty roaster for food preparation as well as going out to the main market to buy greens and vegetables daily.

According to the catering supervisor, there are only two meals served per day, breakfast and dinner due to financial constraints.

Problems faced are:

(a) The building itself is an old building and the kitchen utensils are not sufficient to carry out proper cooking. There are urgent need for Kumu, Rice and stirred sago pots, etc.

(b) Having problem with the boiler stand and gas burners when dealing with one gas company system only would be more appropriate. Unfortunately, both Boral and Origen gas fittings are in use and this is causing inconvenience in connections of joints that make uncertain whether the safety is reliable or not, we are not sure how safe it is for us to use the two different LPG company system.

(c) There are no uniform for the kitchen staff and always in their civilian dress when cooking and serving the sick patient and guidance.

(d) The kitchen itself is a rundown building with faulty electrical wiring as a result of that, the installation of new kitchen equipment were never properly installed and commissioned. The hospital has bought an electrical tester from Brian Bell for the rectification of the electrical fault in the kitchen and the equipment is still with the Health Facilities branch officer Mr Ben Elias. Number of times attempts have been made for delivery of the kitchen equipment which should have been delivered immediately, but due to increased freight charges not included, the delivery was delayed. However, we are expecting it to arrive in the coming days when Mr Ben Elias returned for the commissioning of the incinerator, then the electrical fault can be rectified.

(e) Defreeze not functioning awaiting the air-condition freezer mechanic to repair.

2. Laundry

Laundry service is maintained by 3 staff including the Officer in Charge. There are number of heavy duty laundry machines installed by a contractor, Spic and Span engaged by NDoH Facilities Branch, and not yet commissioned for use. Only one of the machine is operational that is the dryer.

The other 4 machines (2x washers, 1x dryer and 1x ironing machine) are yet to be installed to be fully operational and are lying idle at the laundry house.

This year has a very busy year for the staff in the laundry section who were heavily involved in tailoring of Material for the replenishment of the newly built four (4) surgical wards.

According to the OIC Laundry there is great need for the following to make work to progress smoothly and more effective viz:-

One (1) more washer similar to the existing one. One (1) more industrial sewing machine. Two (2) proper sewing chairs. Eight (8) wheely bins and a hot water system. The laundry house itself is not spacious and with the new infrastructure development taken situation should change in 2018.

3. General Services

There about nine (9) hygiene staff (male) and couple of female including the supervisor Mr Albert Kumasan who were assign to carry out responsibilities of waste management and disposal, ward cleaning, general clean-up and other general service activities and responsibilities like grass cutting etc.

They are grouped and schedule in different responsibilities and task as stated above and two days every week are assign for transporting rubbish to the disposal sites for burning and burying.

These hygiene staff are very hard working regardless of how others treat them as the least by the general attitude of the staff in the hospital. The have beautiful hands to handle medical and solid wastes which we must appreciate, who have kept the hospital environment clean daily.

Challenges currently facing are:

(a) Shortage of staff, there are 5 staff already retired and we are in need of replacement of these staff.

(b) There is no office space for the general service supervisor and computer for administrative correspondence, reporting's, recording etc.
(c) Safety is another issues in this section where there is great need for safety gears like yaka clothing, boots and glasses.
(d) As we go into PHA there is a need for training on health and safety for the section to make an emphasis on how to use chemical, how can a chemical become an hazard to human lives and other safety issues that need to be address for the safety of the staff and the public

4. Rations Stores

There are 3 officers including the supervisor in charge of the ration stores that are responsible of ordering and issuing of items needed for different directorates' sections of the hospital like food to the kitchen, stationaries to the administration offices and wards, also printing is done for the clinical ward services for patient documentation.

Daily task was to register all daily distribution of store items to registry book then transfer to inventory monitoring leger in the computer so that information are kept for reference and monitoring purpose to delivery of service.

Another recommended idea is to make bulk order to all goods from primary suppliers in Port Moresby and Lae instead of going hard wares in here which is expensive.

The other initiative is that the order of sago and kaukau has to be done only two times a month. One week early the order has to be registered before the delivery of the item. Unlike the other past years, where no proper arrangement made before delivery of sago and kaukau as a result food wasted and money waste.

5 Carpentry and Painting

This year 2017 has been a very busy year for this section with the men power of eight (8) actively involved with the current rehabilitation maintenance exercise in the provincial hospital.

These are some of the tasks carried out throughout the year:

(a) Completed the maintenance of the whole dispensary building plus replacing of iron roof
(b) Completion of TB Shutout wards
(c) Completion of TB clinic beside medical ward
(d) Worked on new ward curtain rods for replenishment.
(e) Patient cupboards x 40
(f) Boiler house maintenance commenced, still going and replacement of ion roof completed
(g) Daily minor on-call maintenance services also been carried out through the years.
(h) Full renovation of transit house, old late Mr Sail's residence.
(i) Renovation of physiotherapy to paediatric ward.

Painting is integral part of the building team, the painters do their part in every maintenance or construction work as part of the undivided team to provide service

With more infrastructure rehabilitation now in progress, it needs more manpower to progress many minor works that is shooting up every now and then whilst working also side major infrastructure development to be carried out by Vamed Health Products.

5. Electrical Section

This section also is committed to carry out all the electrical maintenance work required to be carried out. At most time the electrical section always in collaboration with the building section, wherever there's a maintenance program going on by the carpenters, electrician team are there also to do their part. However, there is only one electrician with a volunteer electrician.

This year we have all the security lights been installed in the darker corner of the hospital.

This year we have struggled throughout the year with the sewerage system. There is problem with our sewerage pump. The impellor part of the pump was out and cannot pump the waste out into the sea.

It was found out later after so many attempts to isolate the problem. The real cause of the weakening in the pump system was the broken down impellor. While waiting for the maintenance to the main pump, a smaller size pump was used for temporary pumping into the sea at a short distance.

There are two sewerage pump one is damaged and no longer can be used and the only one is the one that needs to be confirmed that the impellor is faulty otherwise if the Vamed construction team are not here quickly with their new system, we need to order a new main pump for the smooth running of the sewerage system.

7. Plumbing and Welding

There are three (3) plumbers daily scheduled for plumbing duties. This provincial hospital is very old and being close to the sea creates and ongoing water leakage due to old water pipes rusted and bust anywhere. The plumbers are there to attend to the leakages and one attend most is a soon to be retired Mr. Herman Samup who is always the busiest person without complaining in the whole hospital attending to these leakages daily.

When there is a leakage from the main pipe specialist from Water PNG are engaged to solve our problem. This year we have been doing that a couple of times due leakages cause by construction machinery.

8. Biomedical Engineering

There are two biomedical equipment technicians in charge of the workshop one being the senior and other being the junior. Their duty is to manage care repair, service and do routine inspection to all medical equipment of the hospital and also keep inventory for medical equipment.

The standard of the workshop has drop to a very low level compare to 15 years back, when AUSAID first set up the workshop. It was the state of the art workshop in the whole of the hospital
The first computer with email system was installed in the workshop so the direct communication with the outside world was a reality and standard of biomedical workshop matched the training facilitated through the AUSAID sponsorship for the biomedical technicians who attended.

Then in 2011 the king tide wave swept through the hospital causing damage to all the facilities. One of them was the biomedical workshop. The brand new workshop was destroyed to ruin with all the tools, test equipment's and printers and computer lost. As the years go by without any restoration, even attempts were made to restore it was never the same again. The once state of the art workshop is only a story to tell, nothing good in it anymore, only keeping old equipment, No more computer for inventory, email communication, reporting and keeping of data, no tools and test equipment to boost the biomedical engineering section.

Despite this situation, the workshop is still functioning but not to its full capacity as it should operate. As long as the minimum essential services are still being maintained from the workshop to provide for biomedical equipment back up services to the sick.

9. Recommendations

1) The office of the operations manager should have a computer to serve its purpose
   As it is there was no computer on the table of the operations manager since appointed.
   It is necessary for the office to have desktop computer for office use for smooth planning, organising, leading, control and monitoring of the Operations and Facilities Section.

2) The biomedical equipment workshop should be maintained and upgraded to meet the major developments now on the horizon to service the new state of the art modern provincial hospital for East Sepik people.

INFORMATION COMMUNICATION TECHNOLOGY (ICT) SERVICES

Introduction

The I.C.T Services department, which was established some years back, under the Directorate of Corporate Services of former Wewak General Hospital, has many things to accomplish. It is new and as such, there are many hindrances and setback encountered so far. In any organization, I.C.T department is the heart of the organization and in the case of East Sepik Provincial Hospital, we want to achieve that as well, to be the leading provincial hospital in the country in terms of Information Technology and the infrastructure development associated with it.

The function of the ICT section is to establish and operate a backbone data network, that is a Local Area Network (LAN) for the organization and since East Sepik Provincial Hospital does not have any I.T infrastructure in place, although there are computers, to achieve this would be a mammoth task. And as such, only minor computer service, maintenance and repair for both hardware and software are done.

As the I.T Administrator, overseeing the I.C.T Services Department of the hospital to oversee and ensure all I.C.T equipment and devices are fully functional and are operating efficiently as intended, I hereby present the I.C.T Section annual report for the section for the period, January to December, 2017, for your perusal. Though there are huddles and setback in achieving the ICT section's goals, in terms of implementing the I.C.T solution for the hospital, however the I.T section still thrives.

The report is focused mainly on minor service and repair of computers, computer accessories and printers undertaken so far by the I.T section since January 2017, secondly the designing of the hospital's Local Area Network (LAN), thirdly procurement of computers, computer hardware and IT accessories initiated by the I.C.T section. Further, a brief presentation of a province-wide wide area network (WAN) that is being planned to be designed and implemented to enable communication from the rural health posts and district health facilities within the province.

Aims

To provide an innovative, efficient and cost-effective I.C.T services in terms of I.C.T infrastructure development for the East Sepik Provincial Hospital and East Sepik Provincial Health Authority to improve patient and health care services, likewise achieving the National Health Plan.

Objectives

Use innovative Information and Communication Technology solutions to deliver accurate and timely information to the management for planning and decision making.

- Review, strengthen and integrate the different hospital management information systems.
- Improve capacity of unit and sectional managers to compile, analyze and use information.
- Establish a common hospital patient information management system, which will be linked to the national patient master index.
- Build the capacity of the hospital's Medical Records officers to compile, analyze and provide quality information for hospital management.
- Build the management of the hospital to specify, acquire, implement and manage major I.T systems, both clinical and reporting.
- Implement a hospital-wide Local Area Network (LAN) and a province-wide wide area network (WAN) that connects all units, sections and offices as well as all rural health posts and district health facilities to provide an integrated, efficient and effective communication and data services.

Major Functions and Performance Rating

The major function of the I.C.T section is to provide an efficient and cost effective I.C.T solution for the provincial hospital and East Sepik Provincial Health Authority. The I.C.T section was established to implement, operate and manage the I.C.T infrastructure of the hospital.

However, to date the I.C.T section's performance is not to expectations. Due to lack of resources and/ or unavailability of resources, thus, ICT section was not able to carry out most of each intended program.

Although minor programs have been achieved, the scale with which the programs were carried out is at a minimum, especially updating of computer programs and antivirus programs, scanning and cleaning of computers from viruses infections as well as minor service and repair of computer hardware, UPS's and installation and configuration of computer software and hardware.

Staffing

The I.C.T Services section of the hospital is the smallest section in the hospital with a staff strength of two (2) full time officers.

The full time personnel is the I.T Administrator, who oversees, manages and co-ordinate the ICT section while the I.T Support Officer provides I.T support for computers and computer users, likewise servicing and maintaining both computer software and hardware, and printers.

Discussions are underway to absorb the hospital's Switchboard section into the I.C.T section from Finance and Administration section; however this will require management's endorsement and approval.

Similarly, a Printery Section is proposed to be established as this is also the most vital area. If and when this section is established, it will oversee all the printers and photocopiers of the hospital as well as printing and photocopying demands and needs for the hospital as well as the organization as a whole.

Narration of Functions and Statistics (as per Key Performance Indicators)

In line with the National Health Plan 2011 – 2020, Key Result Area 3, Strengthen Health Systems and Governance, specifically Objective 3.4 clearly states the need for health sector to proactively identify and use innovative and evolving I.C.T solutions to deliver accurate and timely information for planning and decision making.

Since East Sepik Provincial Hospital is a Health service provider, grasping the technological revolution will immensely change the way health service is delivered, likewise improve the way data is collected, analyzed and compiled and is made available to decision makers.

The main function of the I.C.T section is to provide the best I.C.T solution for the provincial hospital and ESPHA as a whole, in terms of an effective, efficient and reliable Local Area Network (LAN) infrastructure. Purchase of computers alone as well as minor service and repair works that has been done on computers and printers is not the only function.

If change is to happen, focus and priority must be given to this section. Regardless of how much it will cost the organization but if we are serious, the only way forward is to grasp the technological revolution and utilize it to its full potential.

In doing so will transform the way the business of patient and health care is provided and the delivery of health care services will be improved.

Operating Procedures

The operating procedures for I.C.T section is not as complex as it seems. It is basic with all I.T related issues, especially computer hardware and software are being handled by the I.C.T department. The IT Administrator, who is the manager ICT, reports to the Director – Corporate Services whilst the IT Support officer reports to the IT Administrator.

However when procuring new computers, computer hardware or computer accessories, the I.C.T manager makes the recommendation, justifying the procurement to seek management's approval for funding to purchase the computer, computer hardware or accessories. This is to ensure transparency is maintained, likewise when purchasing the I.T equipment, the I.C.T asset registry is updated.

Challenges

I.C.T section on its own cannot achieve its intended programs, likewise it cannot provide the best I.C.T solution for the organization as a whole. The ICT section needs collective support and full backing from all stakeholders.

In terms of delivery of the best I.C.T solution for the organization, funding will be the greatest challenge, likewise the current state of the provincial hospital. Whilst on the other hand, since the hospital does not have an operational I.C.T infrastructure in place, that is a Local Area Network (LAN), hence the challenge is enormous.

Even to implement the Local Area Network (LAN) for the whole organization with ESPHA now coming into play is a big challenge. Although computers are there, however regular updates of computer programs as well as antivirus programs cannot be done on a regular basis.

Internet access from Alesco Payroll office is not an option since it was purposely installed for Concept Payroll use alone.

Achievements

Computer and Printers Service and Repair

Firstly, with the state of the computers, the I.C.T section is ill-equipped and does not have sufficient resources to carry out its tasks and/ or programs. The computers and printers that are currently in the I.C.T office are all beyond repair, however they are still kept to get parts out if there is a need when an operational computer and/ or printer needs servicing and repair.

Since Wewak is a small centre, purchasing of computer parts from local suppliers is not always possible as most local suppliers do not have a backup warranty for the IT products they sell.

With the computers, computer monitors and printers that are currently in the I.C.T office, some of them needs parts replacement while others are beyond repair. Those that needed replacement of parts cannot be done because the local suppliers do not have spares available that can be purchased and replaced. While those that are beyond repair are retained to get parts from to repair the computers and printers that are currently operational.

While on the other hand, the two heavy duty hospital printers were also serviced with the assistance from Remington Technologies. However this was not done thoroughly to rectify the faults with the printers, hence an arrangement was done with a local supplier, Dajon Photoserv to be the company to service the hospital printers.

This arrangement was done because the service and maintenance fee for services done by Remington is too costly with the issue still there.

Computers and Printers Purchased

So far since building the I.C.T Asset registry, sections have been identified that requires a computer. However, due to funding constraints as well as poor quality of computers supplied by the local suppliers, purchase of computers for these priority sections were not done. For this year, the I.C.T

section have initiated purchase of a Desktop and a colour printer for Operations Supervisor as well as computers and printers for other sections within the hospital.

Whilst also, a quote from Alpha Network Solutions in Madang was sought for the purchase of DELL computers which was approved and purchase was done. However since the supplier does not have all that was requested, only a laptop, two (2) external hard disk drive (HDD), two mouse and keyboard as well as eight (8) pen drives were supplied. Since not all of the items requested were supplied, the balance of the purchase was reimbursed and deposited into the hospital's bank account.

There was also a DELL computer purchased for Asset Officer to replace the previous computer he was using due to the computer's power pack and system board being unrepairable. There was also a color laser jet printer was also purchased for the office of Director – Curative Health Services.

Likewise there was also purchase of three DELL computers with one of the computers issued to the Office of the Director – Curative Health, whilst the second one was issued to Deputy Director – Nursing Services. The third computer will be given to Anaesthetic section once all configurations are done.

And then there was a purchase of a new heavy duty printer/ photocopier for the Office of the CEO. This was purchased to replace the previous aging printer/ photocopier. It was configured and installed by the supplier and is in operation.

Other than that, there were no more purchases done but will be done if and when there are funds available to purchase computers for the priority sections in the hospital.

Printing of Staff ID Cards

Printing of staff identification cards has been completed with all staff being issued an official work ID card. Almost 99% of staff have already received a valid ID card, whilst only 1% are yet to have their photo taken for the processing of their ID card.

Although the quality of the staff ID cards are not up to standard, however at least there is a form of identification available for staff to use for identification purposes.

Those that have lost their ID cards and have requested for a new ID card were advised to pay K15.00 in Revenue and produce the receipt at ICT office to have a new ID card processed

I.T Accessories

Apart from the purchase of computers, there will also be computer parts and accessories as well as tools that will be purchased for use by the I.T office to ensure that all computers are operating efficiently.

There were purchases of few accessories and replacement items that are available locally. As stated in *Annex B – ICT Expenditures*, these were a few purchases initiated by the ICT section in 2017.

Currently there are no computer accessories, only irreparable computers and printers are in the I.C.T office awaiting replacement of parts and/ or disposal.

Local Area Network Design

The design of the provincial hospital-wide Local Area Network (LAN) is partly done and is complete. The completed design is for the main administration building that is the CEO's office, the Accounts office, the HR office and the DCS office, the DMS office and the Revenue office.

The design has been segmented, with one part wired, meaning the computers will be connected through physical network cables while the other segment of the network will be connected through wireless terminals which will be mounted on roof tops of buildings that are identified.

From the design, materials to be used to implement this project has been derived and the material list is finalized and will be sent to possible suppliers, both within the province and outside to request for quotations.

The project design will cover the entire hospital, however in actually implementing the project; it will be done in phases.

The first phase of the LAN project will be implemented in the main administration building, through a wired network, connecting the CEO's office, Accounts office and the HR office. Then a wireless network will be installed and deployed to the Director – Corporate Services office, the Director – Medical Services office, Revenue office and the other offices within the range of the wireless network signal.

After this is done, the main file server will be configured to serve its intended purpose of centrally managing and storing of work files, programs and resources. With the configuration of the main file server, it will be configured to accommodate the users, files and network resources such as printers and external storage devices for backup of files and documents.

With the design of the local area network, it only accommodates the computers and printers and does not include the medical equipment. Although medical equipment are most important and are also part of the project, they are not included in the design as they will be accommodated in the redevelopment program of the hospital.

Further, there is a plan in place to have a province-wide wide area network for East Sepik Provincial Health Authority. With this, the plan is to have all rural health posts and district health centers to have a small local area network for communication as well as submitting of reports to the provincial health headquarter.

It is only in its planning stage, it has not been design as yet because there has not been a site visit to all districts within the province to identify the requirements of each rural health facilities and do up a scope of works for the design of the network to be implemented.

Installation and Configuration of mSupply

The installation and configuration of the mSupply software was done on the 31st of October, 2017. With the installation of this program, it was installed and configured by World Vision – PNG. They have purchased three (3) computers and installed mSupply in them to be used by the Pharmacy section for drug ordering, dispensing, inventory, and reporting.

They have also purchased a wireless internet access device from Telikom (PNG) to be used by the mSupply program as it requires internet access for it to be fully used. They have also created a small 3-computer local area network, thus enabling sharing of resources, especially printers for efficiency in operation.

They have also installed specialized label printer that will be used for printing of drug labels when dispensing of drugs. All the devices as well as the software are a package that was funded and provided by World Vision – PNG.

Short-Medium Term Plans (Way Forward)

Minor service and repair works for computers, computer peripherals and accessories, printers and UPS's as well as updating of computer software and antivirus software will be done using our only internet access in the Alesco Payroll office. This will be done after hours upon approval from the Director – Corporate Services.

Since there is no Local Area Network (LAN) infrastructure in place for the computers to have access to the internet and do automatic update, they will be removed from their offices and will be updated manually on a quarterly basis to ensure the antivirus program installed is effective to protect the computers against virus infection.

Likewise UPS's will be checked to ensure their battery can sustain the computers during power blackouts or power surges. If the batteries are faulty, a new battery will be installed rather than buying a new UPS.

Furthermore, since the hospital will be undergoing a major redevelopment for the next two to three years, the ICT section has in place a plan to do a site survey and inspection in all district health facilities and rural health posts within the province.

During the site survey or inspection, there will be discussions with the district health managers as well as health center O.I.C's to gauge their views as to how communication in terms of internet access and voice communication can be implemented in these rural health posts and district health facilities.

With that there will also be survey conducted for the installation of two-way radio communication in all rural health posts and district health facilities. Rural health posts will be identified as well as district health facilities for the installation of two-way radio communication devices.

Once after the site survey and/ or inspection or scoping is done, the communication network will be designed, for both data and voice communication. After the design, quotations will be requested from

reputable suppliers for both voice and data communication. Only then the cost of implementing this project will be known.

Conclusions

Since most of these computers are of different makes and models and are purchased from various local suppliers, for I.C.T section to repair them is a daunting task. Technology changes as time goes by, and what was available 3 to 5 years ago is no longer available in the market today. And with the software, there is no exception as well.

Likewise, most of the local suppliers are not reputable I.T companies. They do not have a backup service warranty for the products (computers) they sell. Therefore it's very difficult to get replacement parts or spares from them.

The main cause for most of the hardware failures encountered by the computers are due to power surges, power fluctuations and power outages. On the other hand, there were outdated antivirus programs due to inaccessibility to internet for regular updates. This would make the computers more vulnerable to virus infestations and attacks as the defensive system of the computer is weak in performing its intended purpose. More so, it will cause hardware failure, especially the hard disk drives and eventually the computer will crash and not be functional.

.

FINANCIAL REPORT

EAST SEPIK PROVINCIAL HEALTH AUTHORITY

DEPARTMENT OF HEALTH

Private Mail Bag
WEWAK 531
East Sepik Province
PH: (675) 456 2166, Fax: (675) 456 2767
Email: esphaceo@gmail.com

EAST SEPIK PROVINCIAL HEALTH
FINANCIAL REPORTS FOR MAIN OPERATING ACCOUNT # 6000426476
CASH FLOW FORECAST 2017
MONTHLY EXPENDITURE Vs BUDGET APPROPRIATION AS PER APPROVED BUDGET 2017 FINANCIAL YEAR

Item No.	Description	Total Appropriation 2017	Actual CFC Received to Date	Actual Expediture to Date	2017 Surplus/ (Deficit)	Movement of Funds 2017 Transfer Out	Transfer In	Running Balance	2017 Outstanding Payments	Final Bal Surplus/ (Deficit)
212	Wages	252,000.00	252,034.00	(168,702.95)	83,331.05	(63,468.00)		19,863.05	-	19,863.05
213	Overtime	54,000.00	54,018.00	(54,885.25)	(867.25)		15,757.00	14,889.75	(15,727.26)	(837.51)
214	Leave Fares	221,400.00	221,400.00	(221,512.70)	(112.70)		120,000.00	119,887.30	(117,716.60)	2,170.70
221	Travel & Subsistence	77,800.00	77,844.00	(74,577.40)	3,266.60			3,266.60	-	3,266.60
231	Utilities	400,000.00	-	(139,656.41)	(139,656.41)			(139,656.41)	-	(139,656.41)
223	Office Materials & Supplies	62,300.00	62,300.00	(63,784.84)	(1,484.84)			(1,484.84)	-	(1,484.84)
224	Operational Materials & Supplies	648,000.00	648,000.00	(622,821.88)	25,178.12	(33,000.00)	41,000.00	33,178.12	-	33,178.12
225	Transport & Fuel	105,700.00	105,670.00	(115,073.83)	(9,403.83)		19,000.00	9,596.17	-	9,596.17
226	Administrative Consultancy Fees	150,000.00	150,000.00	(3,440.00)	146,560.00	(46,000.00)		100,560.00	-	100,560.00
232	Rental Of Properties	1,000,000.00	1,000,000.00	(978,912.66)	21,087.34		106,000.00	127,087.34	(101,600.00)	25,487.34
233	Routine Maintenance	82,400.00	82,385.00	(83,194.81)	(809.81)			(809.81)	-	(809.81)
227	Other Operational Supplies	562,000.00	1,075,100.00	(842,671.75)	232,428.25	(163,889.00)		68,539.25	-	68,539.25
228	Education & Training	44,500.00	44,500.00	(59,879.45)	(15,379.45)		40,600.00	25,220.55	(21,927.53)	3,293.02
215	Retirement Benefits	178,600.00	163,674.00	(111,370.14)	52,303.86	(16,000.00)		36,303.86	(14,403.69)	21,900.17
271	Purchase Of Office Equipment	89,900.00	89,901.00	(81,918.14)	7,982.86			7,982.86	-	7,982.86
273	Purchase Of Vehicle	150,000.00	-	-	-			-	-	-
275	Plant Equipment & Machinery	150,000.00	150,000.00	(78,706.70)	71,293.30	(20,000.00)		51,293.30	-	51,293.30
	TOTAL:	4,228,600.00	4,176,826.00	(3,701,108.91)	475,717.09	(342,357.00)	342,357.00	475,717.09	(271,375.08)	204,342.01

Prepared by: _____
Supervisor Finance
Isidore Sirongo

Date: _____

Approved by: _____
Chief Executive Officer
Mark Mauludu

Date: _____

Summary for Project Funds, Operating & Trust Accounts as at 31st December 2017

Balance as per Bank Statement for Operating Account - 31.12.17	7,130,234.99
Book Balance as per Constuction, Renovation & Improvement - 31.12	5,778,935.61
Book Balance as per ESPG Grant - 31.12.17	142,025.55
Book Balance as per Main Operating Account - 31.12.17	1,209,273.83
Less: Unpresented Cheques as at - 31.12.17	(274,815.27)
Available Cash to be spent as at - 31.12.17	934,458.56

EAST SEPIK PROVINCIAL HEALTH AUTHORITY

DEPARTMENT OF HEALTH

Private Mail Bag
WEWAK 531
East Sepik Province
PH: (675) 456 2166, Fax: (675) 456 2767
Email: esphaceo@gmail.com

EAST SEPIK PROVINCIAL HEALTH
FINANCIAL REPORTS FOR MAIN OPERATING ACCOUNT # 6000426476
CASH FLOW FORECAST 2017
MONTHLY EXPENDITURE Vs BUDGET APPROPRIATION AS PER APPROVED BUDGET 2017 FINANCIAL YEAR

Item No.	Description	Total Appropriation 2017	Actual CFC Received to Date	Actual Expediture to Date	2017 Surplus/ (Deficit)	Movement of Funds 2017 Transfer Out	Transfer In	Running Balance	2017 Outstanding Payments	Final Bal Surplus/ (Deficit)
212	Wages	252,000.00	252,034.00	(168,702.95)	83,331.05	(63,468.00)		19,863.05	-	19,863.05
213	Overtime	54,000.00	54,018.00	(54,885.25)	(867.25)		15,757.00	14,889.75	(15,727.26)	(837.51)
214	Leave Fares	221,400.00	221,400.00	(221,512.70)	(112.70)		120,000.00	119,887.30	(117,716.60)	2,170.70
221	Travel & Subsistence	77,800.00	77,844.00	(74,577.40)	3,266.60			3,266.60	-	3,266.60
231	Utilities	400,000.00	-	(139,656.41)	(139,656.41)			(139,656.41)	-	(139,656.41)
223	Office Materials & Supplies	62,300.00	62,300.00	(63,784.84)	(1,484.84)			(1,484.84)	-	(1,484.84)
224	Operational Materials & Supplies	648,000.00	648,000.00	(622,821.88)	25,178.12	(33,000.00)	41,000.00	33,178.12	-	33,178.12
225	Transport & Fuel	105,700.00	105,670.00	(115,073.83)	(9,403.83)		19,000.00	9,596.17	-	9,596.17
226	Administrative Consultancy Fees	150,000.00	150,000.00	(3,440.00)	146,560.00	(46,000.00)		100,560.00	-	100,560.00
232	Rental Of Properties	1,000,000.00	1,000,000.00	(978,912.66)	21,087.34		106,000.00	127,087.34	(101,600.00)	25,487.34
233	Routine Maintenance	82,400.00	82,385.00	(83,194.81)	(809.81)			(809.81)	-	(809.81)
227	Other Operational Supplies	562,000.00	1,075,100.00	(842,671.75)	232,428.25	(163,889.00)		68,539.25	-	68,539.25
228	Education & Training	44,500.00	44,500.00	(59,879.45)	(15,379.45)		40,600.00	25,220.55	(21,927.53)	3,293.02
215	Retirement Benefits	178,600.00	163,674.00	(111,370.14)	52,303.86	(16,000.00)		36,303.86	(14,403.69)	21,900.17
271	Purchase Of Office Equipment	89,900.00	89,901.00	(81,918.14)	7,982.86			7,982.86	-	7,982.86
273	Purchase Of Vehicle	150,000.00	-	-	-			-	-	-
275	Plant Equipment & Machinery	150,000.00	150,000.00	(78,706.70)	71,293.30	(20,000.00)		51,293.30	-	51,293.30
	TOTAL:	4,228,600.00	4,176,826.00	(3,701,108.91)	475,717.09	(342,357.00)	342,357.00	475,717.09	(271,375.08)	204,342.01

Prepared by: _____
Supervisor Finance
Isidore Sirongo

Date: _____

Approved by: _____
Chief Executive Officer
Mark Mauludu

Date: _____

Summary for Project Funds, Operating & Trust Accounts as at 31st December 2017

Balance as per Bank Statement for Operating Account - 31.12.17	7,130,234.99
Book Balance as per Constuction, Renovation & Improvement - 31.12	5,778,935.61
Book Balance as per ESPG Grant - 31.12.17	142,025.55
Book Balance as per Main Operating Account - 31.12.17	1,209,273.83
Less: Unpresented Cheques as at - 31.12.17	(274,815.27)
Available Cash to be spent as at - 31.12.17	934,458.56

EAST SEPIK PROVINCIAL HEALTH AUTHORITY

DEPARTMENT OF HEALTH

Private Mail Bag
WEWAK 531
East Sepik Province
PH: (675) 456 2166, Fax: (675) 456 2767
Email: esphaceo@gmail.com

EAST SEPIK PROVINCIAL HEALTH
FINANCIAL REPORTS FOR MAIN OPERATING ACCOUNT # 6000426476
CASH FLOW FORECAST 2017
MONTHLY EXPENDITURE Vs BUDGET APPROPRIATION AS PER APPROVED BUDGET 2017 FINANCIAL YEAR

Item No.	Description	Total Appropriation 2017	Actual CFC Received to Date	Actual Expediture to Date	2017 Surplus/ (Deficit)	Movement of Funds 2017 Transfer Out	Transfer In	Running Balance	2017 Outstanding Payments	Final Bal Surplus/ (Deficit)
212	Wages	252,000.00	252,034.00	(168,702.95)	83,331.05	(63,468.00)		19,863.05	-	19,863.05
213	Overtime	54,000.00	54,018.00	(54,885.25)	(867.25)		15,757.00	14,889.75	(15,727.26)	(837.51)
214	Leave Fares	221,400.00	221,400.00	(221,512.70)	(112.70)		120,000.00	119,887.30	(117,716.60)	2,170.70
221	Travel & Subsistence	77,800.00	77,844.00	(74,577.40)	3,266.60			3,266.60	-	3,266.60
231	Utilities	400,000.00	-	(139,656.41)	(139,656.41)			(139,656.41)	-	(139,656.41)
223	Office Materials & Supplies	62,300.00	62,300.00	(63,784.84)	(1,484.84)			(1,484.84)	-	(1,484.84)
224	Operational Materials & Supplies	648,000.00	648,000.00	(622,821.88)	25,178.12	(33,000.00)	41,000.00	33,178.12	-	33,178.12
225	Transport & Fuel	105,700.00	105,670.00	(115,073.83)	(9,403.83)		19,000.00	9,596.17	-	9,596.17
226	Administrative Consultancy Fees	150,000.00	150,000.00	(3,440.00)	146,560.00	(46,000.00)		100,560.00	-	100,560.00
232	Rental Of Properties	1,000,000.00	1,000,000.00	(978,912.66)	21,087.34		106,000.00	127,087.34	(101,600.00)	25,487.34
233	Routine Maintenance	82,400.00	82,385.00	(83,194.81)	(809.81)			(809.81)	-	(809.81)
227	Other Operational Supplies	562,000.00	1,075,100.00	(842,671.75)	232,428.25	(163,889.00)		68,539.25	-	68,539.25
228	Education & Training	44,500.00	44,500.00	(59,879.45)	(15,379.45)		40,600.00	25,220.55	(21,927.53)	3,293.02
215	Retirement Benefits	178,600.00	163,674.00	(111,370.14)	52,303.86	(16,000.00)		36,303.86	(14,403.69)	21,900.17
271	Purchase Of Office Equipment	89,900.00	89,901.00	(81,918.14)	7,982.86			7,982.86	-	7,982.86
273	Purchase Of Vehicle	150,000.00	-	-	-			-	-	-
275	Plant Equipment & Machinery	150,000.00	150,000.00	(78,706.70)	71,293.30	(20,000.00)		51,293.30	-	51,293.30
	TOTAL:	4,228,600.00	4,176,826.00	(3,701,108.91)	475,717.09	(342,357.00)	342,357.00	475,717.09	(271,375.08)	204,342.01

Summary for Project Funds, Operating & Trust Accounts as at 31st December 2017	
Balance as per Bank Statement for Operating Account - 31.12.17	7,130,234.99
Book Balance as per Constuction, Renovation & Improvement - 31.12	5,778,935.61
Book Balance as per ESPG Grant - 31.12.17	142,025.55
Book Balance as per Main Operating Account - 31.12.17	1,209,273.83
Less: Unpresented Cheques as at - 31.12.17	(274,815.27)
Available Cash to be spent as at - 31.12.17	934,458.56

Prepared by: _____
Supervisor Finance
Isidore Sirongo

Date: _____

Approved by: _____
Chief Executive Officer
Mark Mauludu

Date: _____

WEWAK (BORAM) GENERAL HOSPITAL			
Comparative Receipts and Payments Statement for the Year Ended 31st December 2017 & 2016			
Operating Account			
Year		**2017**	**2016**
	Notes		
Opening Cash Book Balance		6,984,426	3,934,125
Add: Receipts			
Public Servants Salaries & Allowances		17,514,766	13,652,325
Government Grant - CFC		5,106,914	4,685,655
Dept of Health (Rehabilitation Funds)		3,000,000	5,000,000
Others		75,822	75,822
Total Recepts		**25,697,502**	**23,413,802**
Less: Payments			
Salaries & Allowances		*17,514,766*	13,652,325
Casual Wages		169,864	411,489
Overtime		55,244	50,907
Leave Fares		221,513	161,008
Travel & Subsistence		80,210	91,197
Utilities		139,656	1,012,953
Office Materials & Supplies		66,102	61,782
Operational Materials & Supplies		696,165	776,904
Transport & Fuel		113,424	200,583
Administration & Consultancy fees		3,440	-
Rental of properties		1,042,413	818,900
Routine Maintenance		57,472	118,658
Other Operating Expenses		1,221,282	902,188
Education & Training		49,364	135,967
Retirement benefits & Gratuity & Pension		131,212	11,756
Office Furniture & Equipment			34,499
Purchase of Vehicle			-
Plant Equipment & Machinery		47,052	111,819
Construction, Renovation, & Improvements		3,916,710	1,810,564
Total Payments		**25,525,889**	**20,363,501**
Surplus +/(Deficit) - of Receipts over Payments		171,613	**3,050,301**
Balance C/Forward		**7,156,037**	**6,984,426**

WEWAK (BORAM) GENERAL HOSPITAL			
Comparative Receipts and Payments Statement for the Year Ended 31st December, 2017 & 2016			
Trust Account			
Year		**2017**	**2016**
	Notes		
Opening Cash Book Balance		172,355	90,990
Add: Receipts			
User pay fees		307,190	168,387
Others		273,033	163,870
Total Recepts		**580,223**	**332,257**
Less: Payments			
Wages			-
Overtime			-
Leave Fares			-
Travel & Subsistence		78,766	20,216
Utilities			
Office Materials & Supplies			-
Operational Materials & Supplies		495,265	-
Transport & Fuel		35,637	-
Administration & Consultancy fees			
Rental of properties			-
Routine Maintenance		11,125	-
Other Operating Expenses		2,322	230,680
Education & Training			-
Retirement benefits & Gratuity & Pension			-
Office Furniture & Equipment			-
Plant Equipment & Machinery			-
Purchase of Vehicle		103,674	-
Total Payments		**726,789**	**250,896**
Surplus + /(Deficit) - of Receipts over Payments		**(146,553)**	**81,361**
Balance C/Forward		**25,802**	**172,355**

WEWAK (BORAM) GENERAL HOSPITAL			
Consolidated Statement of Accumulated Funds for the Year Ending 31st December 2017 & 2016			
Operating & Trust Accounts			
Year		**2017**	**2016**
	Notes		
Operating Account (Main)			
Accumulated Funds as at January		6,984,426	3,934,125
Excess of Receipts Over Payments		171,613	3,050,301
Closing Balance as at 31st December		**7,156,037**	**6,984,426**
Trust Account			
Accumulated Funds as at January		172,355	90,994
Excess of Receipts Over Payments		(146,553)	81,361
Closing Balance as at 31st December		**25,802**	**172,355**
Presented by:			
Cash at Bank - Operating Account		7,130,235	**6,984,426**
Cash at Bank - Trust Account		25,802.00	**172,355**
Total Asset (Equity)		**7,156,037**	**7,156,781**

WEWAK (BORAM) GENERAL HOSPITAL			
Consolidated Statement of Receipts & Payments			
For period ended 31st December, 2017			
	Operating	**Trust**	**Consolidated**
	Account	**Account**	
Opening Cash Book Balance	**6,984,426**	**172,355**	**7,156,781**
Receipts			
Salaries & Allowances	*17,514,766*	-	17,514,766
Casual Wages	252,000	-	252,000
Overtime	54,000	-	54,000
Leave Fares	221,400	-	221,400
Travel & Subsistence	77,800	-	77,800
Utilities	926,382	-	926,382
Office Materials & Supplies	66,102	-	66,102
Operational Materials & Supplies	648,000	-	648,000
Transport & Fuel	105,670	-	105,670
Administration & Consultancy fees	150,000	-	150,000
Rental of properties	1,000,000	-	1,000,000
Routine Maintenance	82,385	-	82,385
Other Operating Expenses	1,075,100	-	1,075,100
Education & Training	44,500	-	44,500
Retirement benefits & Gratuity & Pension	163,674	-	163,674
Office Furniture & Equipment	89,901	-	89,901
Purchase of Vehicle		-	-
Plant Equipment & Machinery	150,000	-	150,000
Construction, Renovation, & Improvements	3,000,000	-	3,000,000
	25,621,680	-	**25,621,680**
PHA funds		-	-
Other	75,822		75,822
Total Grants & Other Receipts	**25,697,502**	**-**	**25,697,502**
User Fees			

To be continued ….

Continued from previous page

Outpatient - Adult	-	-	-
Pharmacy Fee	-	10,184	10,184
Accident & Emergency	-	74,908	74,908
Consultation	-	1,578	1,578
Pathology	-	3,105	3,105
X-Ray	-	4,639	4,639
Public Inpatient	-	20,024	20,024
Inter-Med	-	25,057	25,057
Dental	-	18,532	18,532
Eye Clinic	-	14,863	14,863
Soft Drinks	-	66,458	66,458
Med-Practioner	-	20,681	20,681
Clinic Books	-	5,857	5,857
Administration	-	41,210	41,210
Donations	-	97	97
Others	-	273,033	273,033
	-	**580,226**	**580,226**
Total Grants, Others & User Fees	**25,697,502**	**580,226**	**26,277,728**
Payments			
Salaries & Allowances	*17,514,766*	-	17,514,766
Casual Wages	169,864	-	169,864
Overtime	55,244	-	55,244
Leave Fares	221,513	-	221,513
Travel & Subsistence	80,210	78,766	158,976
Utilities	139,656	-	139,656
Office Materials & Supplies	66,102	-	66,102
Operational Materials & Supplies	696,165	495,265	1,191,430
Transport & Fuel	113,424	35,637	149,061
Administration & Consultancy fees	3,440	-	3,440
Rental of properties	1,042,413	-	1,042,413
Routine Maintenance	57,472	11,125	68,597
Other Operating Expenses	1,221,282	2,322	1,223,604
Education & Training	49,364	-	49,364
Retirement benefits & Gratuity & Pension	131,212	-	131,212
Office Furniture & Equipment		-	-
Purchase of Vehicle		103,674	103,674
Plant Equipment & Machinery	47,052	-	47,052
Construction, Renovation, & Improvements	3,916,710	-	3,916,710
Total Payments	**25,525,891**	**726,789**	**26,252,680**
			-
Surplus +/(Deficit) - of Receipts over Payments	171,611	(146,563)	25,048
Balance C/Forward	**7,156,037**	**25,792**	**7,181,829**

PUBLIC INVESTMENT EXPENDITURE

		EXPENDITURE REPORT FOR ITEM CODE 228 - CONST, RENOVATION & IMPROVEMENT FROM JANUARY TO DECEMBEI				PROJECT FUNDS
DATE	CHQ #	PAYEE	PARTICULARS	EXPENDITURES	RECEIPTS/	BAL B/F - 31/12/15
		EXPENDITURE REPORT FOR ITEM CODE 276 - CONST, RENOVATION & IMPROVEMENT FROM JANUARY TO DECEMBER 2017				
01.01.17		Bal B/F - 31/12/16			8,500,000.00	6,689,435.60
09.01.17	12619	Cash	T/A for officer attending project steering meeting	(943.00)		6,688,492.60
16.01.17	12630	Department of Work	Pmt for preparation of new morgue site for WGH	(15,260.00)		6,673,232.60
16.01.17	12636	Apiran L Ltd	Design & full costing for 20 men dormitory building for hospital staff accom	(7,000.00)		6,666,232.60
20.01.17	12656	Apiran L Ltd	Design documentation for TB,Phsiotheraphy,cafeteria & 20 men dormitory build	(38,000.00)		6,628,232.60
26.01.17	12660	Dept of Works	Additional Site Preparation to new site for new Morgue	(16,230.50)		6,612,002.10
01.02.17	12665	Westpac Bank	Airfares for officer from Pom for Project Steering Meeting	(6,752.60)		6,605,249.50
01.02.17	12666	Cash	TA for officers attending project steering meeting	(2,590.00)		6,602,659.50
08.02.17	12667	Elite Travel Ltd	Airfares for officer attending Project steering meeting	(906.90)		6,601,752.60
08.02.17	12668	Village Inn Ltd	Hire of confrence room for Project steering meeting	(1,740.00)		6,600,012.60
08.02.17	12669	Village Inn Ltd	Pmt for accommodation for officers attending Project steering meeting	(6,930.00)		6,593,082.60
08.02.17	12670	Ela Motors	Pmt for 2 x new land cruiser (ten seater) for WGH	(343,748.98)		6,249,333.62
08.02.17	12672	Kuntila Co No 4 Ltd	Pmt of cotton drill plain white and gabardise 1.5m white for new surgical ward	(4,382.86)		6,244,950.76
08.02.17	12684	Global Travel Centre	Airfares for officers attending project steering meeting	(3,358.80)		6,241,591.96
08.02.17	12685	Cash	T/A for officers attending project steering meeting	(1,276.00)		6,240,315.96
08.02.17	12686	Village Inn Ltd	Accom for officers attending project steering meeting	(1,980.00)		6,238,335.96
21.02.17	12687	Cash	Costing for Staging of Project Steering Meeting	(3,000.00)		6,235,335.96
20.01.17	12688	Premier Biomedical	Pmt for new x-ray digital unit for x-ray Department	(291,391.00)		5,943,944.96
21.02.17	12690	Department of Work	Pmt for additional work done to hospital new morgue site	(269,335.00)		5,674,609.96
28.02.17		Numbo Build	Cancelled Cheque	0.00		5,674,609.96
03.03.17	12754	Ela Motors	Pmt for fit on x3 window protections for x3 new vehicles for WGH	(26,132.40)		5,648,477.56
13.03.17	12759	Francis Meno	Pmt for GST and customs broker services fee for imported goods	(27,190.65)		5,621,286.91

15.03.17	12794	Ludwig Maliha	Pmt for Toporaphy survey for WGH Project	(17,122.00)		5,604,164.91
17.03.17	12822	Express Freight Man	Transporting of hospital imported goods from Lae to Wewak	(15,000.00)		5,589,164.91
17.03.17	12823	Express Freight Man	Wharfage fees for hospital overseas imported goods	(7,498.75)		5,581,666.16
20.03.17	12842	Cash	Costing for Staging of Project Steering Meeting	(2,000.00)		5,579,666.16
20.03.17	12843	Village Inn Limited	Accommodation for Officers attending Project Steering Meeting	(6,600.00)		5,573,066.16
21.03.17	12847	Michael Vee	Charges forremoval asbestos from hospital quarters contaminated materials	(8,920.80)		5,564,145.36
21.03.17	12850	Cash	T/A for Officers attending Project Steering Meeting	(2,744.00)		5,561,401.36
23.03.17	12861	Global Travel Centre	Airfares for officers attending Project Steering Meeting	(6,717.60)		5,554,683.76
29.03.17	12997	Wewak General Hos	Costing for Staging of Project Steering Meeting	(1,000.00)		5,553,683.76
30.03.17	13000	Department of Works	Pmt for excavation works-Rehabilitation Project	(24,200.00)		5,529,483.76
06.04.17	13064	Express Freight Man	Freight from Lae to Wwk for hospital imported goods	(13,007.50)		5,516,476.26
10.04.17	13072	Michael Vee	Removal of Abestos from WGH dispensary	(25,245.00)		5,491,231.26
13.04.17	13094	PNG Ports Corporati	Being for storage charge for hospital containers	(2,443.00)		5,488,788.26
18.04.17	13096	Department of Works	64 DCP Tests carries out on project site	(12,672.00)		5,476,116.26
21.04.17	13102	Gold Bell Constructi	Pmt for 6th progress claim for constraction work at WGH Project	(755,914.53)		4,720,201.73
24.04.17	13106	Department of Works	Pmt for third DCP tests on recently filled new morgue building	(5,940.00)		4,714,261.73
24.04.17	13107	Department of Works	Pmt for 6 DCP tests on site for new excarvation & back fill works on new x-ray	(1,188.00)		4,713,073.73
25.04.17	13145	Ludwig Maliha	Pmt of progress claim 2 for the DTM survey on VAMED project site-WGH	(6,000.00)		4,707,073.73
25.04.17	13147	Bismark Maritime Lt	Delivery charges for hospital container from Lae wharf	(759.00)		4,706,314.73
16.05.17	13192	Department of Works	Pmt of land cleaning removal work done for new 20 men building	(62,484.98)		4,643,829.75
16.05.17	13196	Department of Works	Twelve (12) tests carried out on old residential quarters	(2,376.00)		4,641,453.75
30.05.17	13240	Ludwig Maliha	Pmt of data processing & plan line drawing of final plans-WGH VAMED Project	(5,000.00)		4,636,453.75
02.06.17	13272	Leon Enterprises	Pmt of office table arm less plastic chairs for new surgical wards	(4,390.10)		4,632,063.65
	13273	TangMow Ltd	Pmt of equipment for new surgical ward	(18,686.95)		4,613,376.70
02.06.17	13275	TangMow Ltd	Pmt of cleaning items for hospital new surgical ward	(2,962.00)		4,610,414.70

06.06.17	13287	Cash	T/A for officers attending Project Steering Meeting	(4,802.00)		4,605,612.70
08.06.17	13293	Village Inn	Pmt of accommodation for project steering committee meeting	(8,505.00)		4,597,107.70
08.06.17	13294	Westpac Bank	Airfares for officers attending Project Steering Meeting	(12,244.40)		4,584,863.30
08.06.17	13303	Cash	Pmt for curtain material size 109 & 64 for use at new surgical ward	(751.00)		4,584,112.30
09.06.17	13311	The South Pacific	Pmt of advertisement of tender No WGH-ESPSTB 006/2017	(6,514.11)		4,577,598.19
09.06.17	13312	Pacific Star Limited	Pmt of advertisement of tender No WGH-ESPSTB 006/2017	(7,840.80)		4,569,757.39
13.06.17	13335	Cash	Pmt of costs of Project Steering Committee Meeting	(1,200.00)		4,568,557.39
20.06.17	13343	Garamut Enterprises	Pmt of materials for construcdtion of bed side cupboard for new surgical ward	(8,012.13)		4,560,545.26
30.06.17	13384	TangMow Ltd	Pmt of curtain rod & copper tee for construction of patients privacy room	(1,671.00)		4,558,874.26
30.06.17	13386	TangMow Ltd	Pmt of curtain rod & copper tee for construction of patients privacy room	(4,180.50)		4,554,693.76
30.06.17	13387	Garamut Enterprises	Pmt of curtain rod & copper tee for construction of patients privacy room	(5,780.38)		4,548,913.38
30.06.17		Deposit	Deposit from Dept of Planning & Monitoring (DPM)		3,000,000.00	4,548,913.38
07.07.17	13392	Gold Bell Constructi	Pmt of the construction of 4 new surgical wards 2A,B,C & D for WGH	(154,043.93)		4,394,869.45
07.07.17	13393	Cash	Pmt of curtain materials for dressing of 4 new surgical wards opening on 14/07	(1,358.10)		4,393,511.35
12.07.17	13428	Department of Work	Pmt of curtain rod & copper tee for construction of pat+D65im	(198,187.94)		4,195,323.41
13.07.17	13429	Village Inn Ltd	Pmt of accommodation for officers attending Project meeting	(1,540.00)		4,193,783.41
13.07.17	13430	Cash	T/A for officers from Department of Health to attend Project Steering Meeting	(2,084.00)		4,191,699.41
25.07.17	13456	Cash	T/A for officer attending Project Steering Meeting	(743.00)		4,190,956.41
01.08.17	13483	PNG Power Ltd	Pmt to PNG Power for new power lines & Power poles	(320,650.00)		3,870,306.41
08.08.17	13493	Michael Vee	Pmt for land purchase for WGH asbestos roofing burail	(30,036.00)		3,840,270.41
08.08.17	13494	Michael Vee	Pmt of civil works ,tomb construction material costs & osbestos burial at dump	(130,983.90)		3,709,286.51
14.08.17	13536	Leon Enterprises Ltd	Pmt of electrical materials for work at sister transit house (Ex Issac Sali Res)	(515.90)		3,708,770.61
14.08.17	13537	TangMow Ltd	Pmt of carpentry materials for work at sister transit house (Ex Issac Sali Res)	(4,405.70)		3,704,364.91
14.08.17	13538	Hardware Haus Ltd	Pmt of plumbing materials for work at sister transit house (Ex Issac Sali Res)	(568.35)		3,703,796.56
21.08.17	13554	Leon Enterprises Ltd	Pmt of materials for maintenance work at ward 3 (tempory ward & physio)	(1,149.06)		3,702,647.50

21.08.17	13555	TangMow Ltd	Pmt for materials plumbing for maintenance work @ ward 3 abluion block	(1,444.00)		3,701,203.50
21.08.17	13556	Garamut Enterprise	Pmt of hardware materials for operation section to complete renovation work	(63,663.75)		3,637,539.75
21.08.17	13557	Garamut Enterprise	Pmt of timber and assort building materials for operation section	(28,508.01)		3,609,031.74
21.08.17	13558	Garamut Enterprise	Pmt of electrical materials for operation section to complete renovation work	(25,620.02)		3,583,411.72
21.08.17	13559	Greenhill Investmen	Pmt of ready mix concrete for opertion renovation section	(16,500.00)		3,566,911.72
21.08.17	13560	TangMow Ltd	Pmt of painting materials for office renovation for operation section	(11,849.80)		3,555,061.92
21.08.17	13561	Kwanjikai Auto Parts	Pmt of brick blocks for office renovation for operation section	(3,850.00)		3,551,211.92
21.08.17	13562	Cash	Pmt of 3 x load of gravel operation section renovation	(750.00)		3,550,461.92
21.08.17	13565	Michael Vee	Pmt of labour cost for removal of abestos at boiler house building	(41,872.00)		3,508,589.92
22.08.17	13574	Department of	Pmt of 02nd additional civil works for 20 men building	(45,581.25)		3,463,008.67
01.09.17	13638	TangMow Ltd	Pmt for additional materials for construct shelves at dispensary	(6,650.90)		3,456,357.77
07.09.17	13642	Nicholas Matui	Being pmt of DTM survey & building profile pegging for PHA building	(5,500.00)		3,450,857.77
07.09.17	13645	Village Inn	Pmt of accommodation for officer attending Project Steering Meeting	(870.00)		3,449,987.77
07.09.17	13646	Cash	T/A for officer attending Project Steering Meeting	(486.00)		3,449,501.77
07.09.17	13651	Westpac Bank(Air	Pmt for airfares for Officer attending Project Steering Meeting	(1,771.90)		3,447,729.87
07.09.17	13675	Garamut	Pmt for final materials list of associated materials for sister's transit house	(455.20)		3,447,274.67
07.09.17	13676	Garamut	Pmt for final materials list of associated materials for sister's transit house	(2,406.25)		3,444,868.42
07.09.17	13677	Garamut	Pmt of additional wheels for new surgical ward bed side cupboard	(162.80)		3,444,705.62
27.09.17+(	13721	Niugini Electrical	Being for led security lights for WGH	(14,812.94)		3,429,892.68
27.09.17		Deposit	East sepik College of nursing reimbursement	2,817.00		3,432,709.68
29.09.17	13728	Westpac Bank(Air	Pmt for airfares for Officer attending Project Steering Meeting	(1,806.90)		3,430,902.78
29.09.17	13729	Westpac Bank(Air	Pmt for airfares for Officer attending Project Steering Meeting	(1,806.90)		3,429,095.88
02.10.17	13732	Cash	T/A for officer attending Project Steering Meeting	(983.00)		3,428,112.88
02.10.17	13733	Cash	T/A for officer attending Project Steering Meeting	(543.00)		3,427,569.88
02.10.17	13734	Cash	T/A for officer attending Project Steering Meeting	(663.00)		3,426,906.88

02.10.17	13735	Nationwide Rent A	T/A for officer attending Project Steering Meeting	(2,938.96)		3,423,967.92
02.10.17	13736	Elite Travel Ltd	Airfares for officer attending Project Steering Meeting	(7,088.00)		3,416,879.92
04.10.17	13750	Noko Motel	Accommodation for officer attending Project Steering Meeting	(580.00)	13740	3,416,299.92
16.1.0.17	13758	Leon Enterprise Ltd	Pmt of temporary fence for ward 3A-3D for construction to commence	(2,896.00)		3,413,403.92
18.10.17	13780	Westpac Bank (Air	Airfares for project steering committees attending Project Meeting	(14,210.20)		3,399,193.72
24.10.71	13827	Cash	T/A for officers attending Project Steering Committee Meeting	(4,344.00)		3,394,849.72
24.10.17	13828	Village Inn Ltd	Accommodation for officers attending Project Steering Committee Meeting	(6,390.00)		3,388,459.72
26.10.17	13829	Cash	Costing for Staging of Project Steering Meeting	(2,000.00)		3,386,459.72
31.10.17	13837	Michael Vee	Removal of asbestos from old laundry building for new construction	(49,648.00)		3,336,811.72
31.10.17	13838	Michael Vee	Removal of asbestos from old 3A-3D wards for new contruction	(210,623.69)		3,126,188.03
01.11.17		Deposit			574.00	3,126,188.03
01.11.17		Deposit			543.00	3,126,188.03
01.11.17		Deposit			543.00	3,126,188.03
02.11.17	13849	Gold Bell	Pmt for construction of new wards 2A-2D and Utility blocks	(126,666.89)		2,999,521.14
03.11.17	13857	Department of	Balance payment of cost estimate for stop backfilled area	(66,660.00)		2,932,861.14
10.11.17	13861	Village Inn	Accommodation for NDOH staff for Project Steering	(9,660.00)		2,923,201.14
13.11.17	13865	Cash(Ali Kunua)	T/A for NDOH officer for Project Steering	(1,438.00)		2,921,763.14
13.11.17	13866	Cash(Kelly Kalo)	T/A for NDOH officer for Project Steering	(1,438.00)		2,920,325.14
13.11.17	13867	Cash(Moses Alois)	T/A for NDOH officer for Project Steering	(1,438.00)		2,918,887.14
13.11.17	13868	Cash(Ben Elias)	T/A for NDOH officer for Project Steering	(1,438.00)		2,917,449.14

13.11.17		Deposit			310.00	2,917,449.14
14.11.17	13878	Westpac Bank(Air	Airfares for NDOH officers for Project Steering	(7,122.60)		2,910,326.54
24.11.17	13896	Arman Larmer	Topographical survey of recreational area,Vamed hospital redevelopment	(54,721.46)		2,855,605.08
24.11.17	13898	Sepik Coastal	Being pmt for additional hire of 7 tone crane for work at inceneration	(343.20)		2,855,261.88
27.11.17	13899	Dingsha Trading	Hardwood timbers for construction of temporary office for ESPHA Office	(20,689.50)		2,834,572.38
28.11.17	13900	Cash(Joseph)	12 x loads river gravel for slaps at boiler house renovation work	(3,000.00)		2,831,572.38
01.12.17	13906	Garamut Enterprise	Pmt of building materials for temporary PHA Office Building	(42,813.96)		2,788,758.42
01.12.17	13907	TangMow Ltd	Pmt of assorted electrical materials for temporary PHA Office Building	(15,795.30)		2,772,963.12
20.12.17	13996	Bishop Brothers	Pmt of parts for incinerator	(684.31)		2,772,278.81
20.12.17	13997	Bishop Brothers	Pmt of parts for incinerator	(629.20)		2,771,649.61
			BALANCE AS AT 31ST DECEMBER 2017	(3,917,785.99)	11,515,710.00	7,597,924.01
			Year to date Expendire totals			
			Total Funds received from Department of National Planning & Monitoring			
			RUNNING BALANCE TO DATE AS AT 31ST JULY 2018			
			Prepared by: _____			
			Manager-Finance - 30/06/18			
			Hicks Kuarughin			
			Approved by: _____			
			Chief Executive Officer -30/06/18			
			Mark Mauludu			
			Notes			
			1. Balance brought forward as of 31/12/2015 = K3 500 000.00			
			2. On 16/12/2016 received K5, 000, 000. 00			
			3. On 22/12/2016 Running balance = K8, 500, 000.00			
			4. On 30/06/2017 received another K3, 000, 000.00			
			5. As of 20/12/2017 total commitment = K5, 724, 457.29			
			6. Running balance as at 20/12/2017 = K5, 559, 781.19			

From these fundings we have done the following,

- Construcion of 4 x surgical wards and its amenities
- Site preparation for construction of residential accomodation
- Renovation of exiting buildings;
    a. Construction of TB isolation ward
    b. Physiotheraphy unit relocation
    c. Upgrading of pharmacy
    d. Upgrading boiler house into rations and office spaces
    e. Upgrading new site for new ,morgue and physiotherpahy unit.
    f. Upgrading of site for temprorary set up of hospital services
    g. Upgrading of IFMS system
    h. Removal of asbestos on top of hospital building's roof
- Construction of x 4 paediatirc wards and amenities
- Rehabiliation and construction of East Sepik College of Nursing buidlings
- Feasibility study for constrcution of sea wall around the hospital.

Recommendations

Recommendations stated below are the best options. These are cost effective and efficient when it comes to implementing them. Adjustments and amendments will still be made to ensure that what will be provided is of the highest standard and quality.

a) Uniformity of computers, all computers purchased must be of the same makes and models so when it comes to servicing and repairing of these computers, parts can be easily sought, or if there is one that is beyond repair, parts can be taken out from the old ones or the non-repairable computers and replace them to save us cost and also we can enquire with one supplier to get the spare parts, either a new one or an old one but functioning.

   However, with the current computers we have that are of different makes and models, servicing and repairing of them is very difficult in terms of sourcing of spare parts for the hardware and software programs to enable these computers to operate efficiently.

b) Implementation of a Local Area Network will greatly improve how we do our work, likewise minimizing costs. With the implementation of a local area network (LAN) and a wide area network (WAN), management of resources such as printers will be much easier and use of inks, toners and papers will be controlled and cost minimised.

c) There has to be a consistent and reliable internet access so that computer programs and antivirus programs will be updated regularly to be effective in performing its function whilst prolonging the life-span of the computers.

d) There has to be consistent power supply without surges or fluctuations and/ or blackouts. Inconsistent power supply can cause the computers to deteriorate overtime

and eventually may crash resulting in the user losing all the information stored in the computer's hard disk drive (HDD).

e) Management of the mSupply system that was installed in the dispensary section to be under ICT section. This is to ensure that the system is fully functional and serves its intended purpose.

f) Implement a province-wide wide area network (WAN) that will link all rural health posts and district health facilities to the provincial headquarter. When this is done, there will be efficiency in terms of communication as communication is the most vital tool that will enable accessibility to services.

g) A rural site visit by the ICT section to all rural health posts and district health facilities within the province to discuss with the district health managers and O.I.C's to gauge their views and opinions as to what their requirements are in terms of implementation of a province-wide wide area network (WAN).

   Likewise, the ICT section will see firsthand what ICT equipment are available and are in use in the facilities. With that, mobile communication coverage will also be measured to see if it will be possible when implementing a local area network within the health facility.

h) Site survey for the two-way radio communication will also be done in the rural health facilities to identify if it is possible to implement a two-way radio communication in the rural health posts and district health facilities.

i) To improve the delivery of health services to the people and an improved patient care services, communication is the most vital tool to achieve that. Without a good, reliable, consistent and cost-effective communication systems in place, delivery of quality health care services within the Province will never be successful

WAY FORWARD

There will be number of activities that both the board and staff will focus in 2019 and onwards.

Following are the areas of focus;

a) Improving Governance
b) Mass Immunization of children 5 years against immunizable diseases such as polio, whooping cough, tetanus etc…
c) Continuous Rehabilitation Program of facilities at both East Sepik Provincial Hospital and Rural Health facilities and
d) Development of Corporate Plan 2019 -2022

a. Improving Governance

Both the Board and Senior Executive Management will continue to apply process in improving governance.

From the board, we are meeting on quarterly basis and in between, we are having special meetings.

Staff are now appointed through the normal selection and appointment practises sanctioned by the Department of Personnel Management.

We are now observing Financial Management Act in commitment of all expenditures.

b. Mass Immunization of Children Under 5 Years

There routine Immunizations were done poorly over the last (4) four years or so. As a result, us under 5 year's population are now vulnerable from attacks from immunizable diseases. From the National Health Department assessment on our performance all of our six (6) districts are colour coded as RED. Meaning we will expect, outbreaks of immunizable diseases outbreak such as whooping cough, polio and others.

We will therefore be conducting mass immunization to all under five (5) years population.

This will commence towards the end of 2018 and run into 2019.

After that, we will ensure that routine immunizations are carried out on monthly basis right across the province.

c. Continuous Rehabilitation Program

We will continue to see that East Sepik Provincial Hospital's rehabilitation program continues on both clinical buildings as well as staff housing in the coming years.

From 2019, we will start on rehabilitation on some of the rural health facilities, eg; Drekikier Health Centre, Kubalia Health Centre, Angoram District Hospital, Ambunti Health Centre, etc.

d. Development of Corporate Plan

East Sepik Provincial Health Authority has already put together Five-Year Services Strategic Plans – Volumes 1 & 2

We will now from 2019, put together Corporate Plan to capture this plan.

From this Corporate Plan, number of projects such as, Development of new PHA staff structure, putting together PNG Incentive Fund proposal, seeking additional support to fund some needed projects, explore ways to construct sea wall around the hospital, construction of number of District Hospitals and Community Health Posts etc, will be addressed.

Michael McCulley
Chairman
East Sepik Provincial Health Authority