The United Republic of

TANZANIA

Ministry of Health & Social Welfare

KIBAHA

District Health Profile Report

2012

TABLE OF CONTENTS

KIBAHA DC DISTRICT HEALTH PROFILE

FOREWORD

The District Health Profile (DHP) is a like mirror that enables the District to know what is prevailing in the area, its causes and what measures can be taken to grab the problems. The profile also allows the District to budget and allocate the resources based on the magnitude of the problem or disease.

DHP is an essential tool for monitoring and evaluating the implementation of programs and knowing the impact of health interventions. Through observing the trend of diseases covered in this DHP document, it will be easy to note the success and failure of the efforts ever tried to alleviate or control the problems prevailing in the entire community.

It is our expectation that planning of health related interventions for the control of diseases as well as health problems other than diseases in Kibaha DC this tool will be used at all levels starting with the community up to Council level. We are also expecting to see more attention in relation to resource allocation be given to health problems seem to have more effects or impact to community health as noted in this document.

Since this is a continuous process, this document will act as a base for the next year planning and assessment of various interventions implemented in the district.

DHP document will also give room for the researchers to look for the causes of the rise and fall of disease trends and recommend on measures to be taken by various levels basing on the findings. The District is therefore expecting to see Development partners to use this DHP document as a guide for their interventions on various health issues found in Kibaha District Council.

ACKNOWLEDGEMENTS

The development of the DHP is a collaborative effort, and the following people and/or organizations are being acknowledged for their direct contribution:

The Ministry of Health and Social welfare for the support in terms of material, financial and guidance during the whole process of preparation, final development of this document.National Institute for Medical Research (NIMR) for their facilitation on Data interpretation during the preparation of this document.

Kibaha District Council Authority for the support in terms of permission to participate in the orientation workshop and relevant information that enabled the development of this District Health Profile document.

University of DSM especially Computer science department for the technical guidance on Report generation by the aid of DHIS2 software,

We acknowledge all individuals who in way or another acted as a resource of ideas and technical support during the compilation and final development of this DHP document. Since it is not possible to mention their individual names and respective contributions we take this opportunity to acknowledge for their valuable inputs.

KIBAHA DC DISTRICT HEALTH PROFILE

EXECUTIVE SUMMARY

This District Health profile covers the introductory information of Kibaha district council i.e. geographical location of the area, size, population, health status and education status. The DHP deeply explains the common health problems dominating the community and the efforts done by the government to alleviate that conditions and diseases. It also covers the data collection and analysis methods and achievements observed in various aspects in meeting the health indicators covered in this DHP.

The Health Indicators included in this DHP fall under the following areas:

A. Health Status of the Population:

   The health status of the population has shown improvement in terms of vaccination coverage, utilization of health services and improvement of health delivery services in health facilities.

B. Health Service Delivery

   OPD attendance rate per capita is above 2% in almost 75% of the facilities in the council. This is an indication of improved health service delivery

C. Health Systems

   In terms of health financing the following have been observed:- PE increased from 43.5% of total health budget to 66.19% this was also seen on Basket fund and OC. Also dependence on other sources decreased from 42.0% to 6.4%

D. Progress in the Health Sector

   -Progress in health financing, increased skilled health workers, progress in health facility coverage, improved referral services and progress in ANC attendance

In this DHP outcomes in relation to control and management of diseases is noted covering:

1. Morbidity
2. Mortality
3. Reproductive health services
4. Immunization
5. Causes of deaths,

6. Causes of Inpatients
7. Human resources for Health
8. Health financing and Availability of medicine
9. Progress in health sector
10. Best practices

ACRONYMS AND KEY TERMS

Table 0-1.ACRONYMS

ACRONYM	LONG NAME
AIDS	Acquired Immunity Defficincy Syndrome
AMO	Assistant Medical Officer
ANC	Antenatal Clinic
ALU	Artimether Lumefantrine
BCG	Bacillus Calmet Guelen
CO	Clinical Office
CYP	Couple Year Protection
DAWASCO	Dar es Salaam Water andSewarage Company
DHIS2	District Health Information System version 2
DC	District Council
DHP	District Health Profile
DNO	District Nurse Officer
DNUtriO	District Nutrition Officer
EHO	Environmental Health Officer
EHP	Essential Health Package
EmoC	Emmergency Obstetric Care
FBO	Faith Based Organisation
HC	Health Centre

HIV	Human Immunodeficiency Virus
HO	Health Officer
IPD	In Patient Department
IPT 2	Intermitent Presamptive Treatment dose 2
ITN	Insecticide Treated Nets
KDC	Kibaha District Council
KMC	Kangaroo Mother Care
LGA	Local Government Authority
MMAM	Mpango wa Maendeleo wa Afya ya Msingi
MCHA	Maternal and Child Health Aider
MOHSW	Ministry of Health and Social Welfare
MO	Medical Officer
MRDT	Malaria Rapid Diagnosis Test
MTHUA	Mfumo wa Takwimu wa Uendeshaji wa Hudumaza Afya
NACTE	National Council for Technical Education
NIMR	National Institute for Medical Research
NO	Nursing Officer
OPD	Out patient Department
OPV	Oral Polio Vaccine
P4P	Pay for performance
PMTCT	Prevention of Mother to Child Transimission
RCH	Reproductive a nd Child Health

TB	Tuberculosis
UDSM	Univesity of Dar es salaam
TANROAD	Tanzania Road Agency Development

Table 0-2. KEY TERMS

TERM	DEFINITION
HEALTH INDICATOR	A measure of the health of people in a community, such as infant mortality rates, rates of obesity, or incidence of diabetes.
CRITICAL HEALTH SERVICES	Services covering Neonatal Health, Child health and Maternal health
MANDATORY INDICATORS	Health Indicators that of paramount important at all levels
OPTIONAL INDICATORS	Health Indcators that are not necessarily important to all but can be optionaly included

1. INTRODUCTION

1.1 MISSION AND VISION

VISION STATEMENT

A world class, vibrant, social economic affordable and progressive council where people feel safe to live, to visit, enjoy their locality and access wealth.

MISSION STATEMENT

To provide high quality services in efficient, courteous manner and to enhance the quality of life through planning and visionary leadership.

1.2 STRUCTURE OF DISTRICT

Kibaha district council is one of the seven Councils making Coast Region. Other councils are Bagamoyo, Mafia, Kisarawe, Rufiji, Mkuranga and Kibaha Town Council. The district council was inaugurated in September 1978 after portioning part of Bagamoyo and Kisarawe districts. It lies between Latitude 6 – 8 south of equator and Longitudes 38.9 to 39.05 East. It is located 40 km from Dar es Salaam City along Tanzania – Zambia/Malawi Highway.

It experiences typical coastal climatic conditions that have two rainy seasons (the long and short rains). According to 2002 census the district council has a population of about 73,952 and a growth rate is 3.4 per annum.

Kibaha District Council has an area of 880 square Kilometers, which is equal to 76,554 hectors. The District council has 74,552 hectors of arable land, of which 87% (26,794 ha) is under cultivation.

The District council consists of 11 wards namely Soga, Bokomnemela Mlandizi, Kilangalanga, Janga, Ruvu, Kikongo Kwala, Dutumi, Gwata and Magindu. There are 33 registered villages and 82 sub villages.

Table 1-1. Wards And Villages

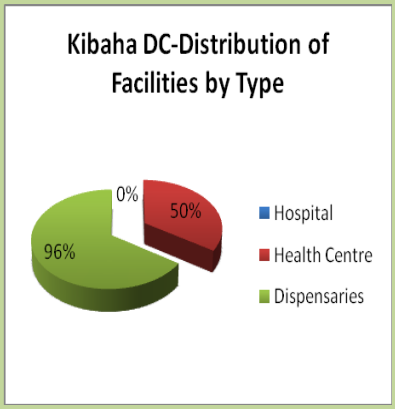
WARD NAMES	MUMBER OF VILLAGES/STREETS
Mlandizi	10
Janga	6
Kilangalanga	4
Magindu	6
Gwata	6
Kwala	3
Dutumi	3
Ruvu	4
Kikongo	4
Soga	4
Boko mnemela	4

1.3 FACILITY DISTRIBUTION

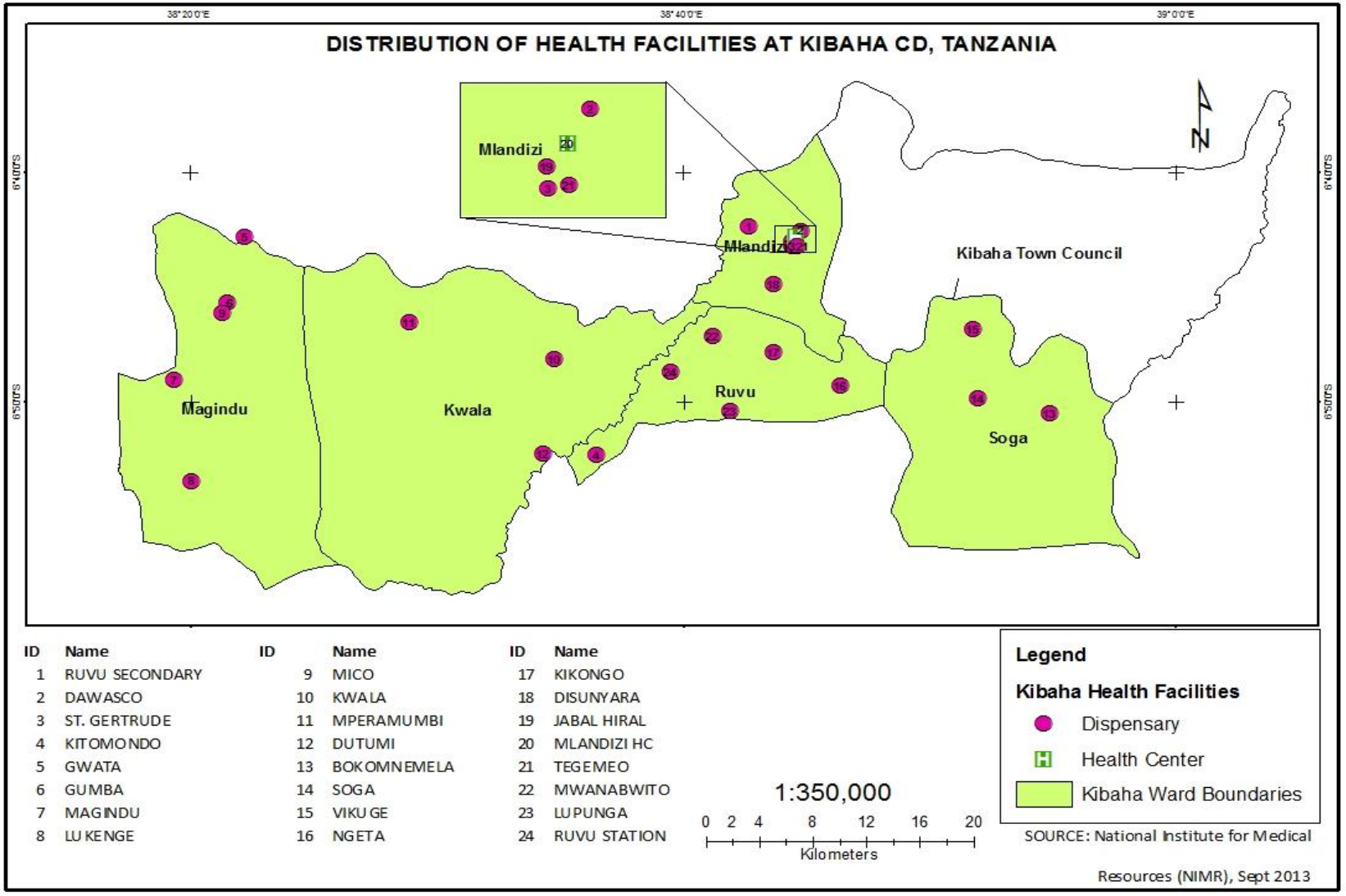
Kibaha District Council has 23 operating Health facilities. Out of them 1 is a health centre owned by Local Government and the rest 22 facilities are dispensaries of which 17 are owned by Local Government Authority, 2 are owned by Parastatal, 2 by Private and 1 is owned by FBO (See theTable below on thus distribution)

Table 1-2. Facility Distribution

TYPE OF FACILITY	NUMBER OF FACILITIES	OWNERSHIP
HOSPITAL	0	-
DISPENSARY	22	17-LGA 2-Private 2-Parastatal 1-FBO
HEALTH CENTER	1	LGA
CLINICS	0	-



KIBAHA DC DISTRICT HEALTH PROFILE



1.4 POPULATION

Kibaha District council Gender based population shows that 36,327 are Females and 37,625 are Males. The age population distribution in the council shows a bigger number in the age group of 15-49 years which is 38,117

Table 1-3. Gender and Age Based Statistics

The council has a Gender and age based population as shown in the table below.

AGE RANGE	FEMALE	MALE
<1 YEAR	1453	1505
1-4	7265	7525
5-14	8205	8275
15-49	18519	19598
>50	3706	5563
TOTAL	**36327**	**37625**

1.5 GEOGRAPHY

Physical Features

(i) Topography

Two main features characterize the topography of Kibaha District:

a) The river basin and lowlands
b) The highland areas, which rise from 100 meters to 480 meters above sea level, are mainly dominated by sandy loam, and sandy clay soils.

(ii) Climate

The District Council experiences hot sunny weather throughout the year with maximum temperature of 38˚ C in December and a minimum temperature of 25˚ c in July. There are three pronounced seasons; a dry season of June and two rainy seasons whereby short rains begin from October to December and long rains start in mid-March to June.

(iii) Soils

The soils of Kibaha differ from one part to another within the District. A large part is endowed by loam soils with high permeability with the exception of soils along the Ruvu river basin, which are clay loam.

1.6 TRANSPORTATION AND COMMUNICATION

The road network within Kibaha District Council previously has a total distance of 320 km. Out of this a total distance of 60 km is served by road agency (TANROAD), Coast Region. The rest of 260 km roads are maintained by Kibaha District Council. The District road network is divided into two groups, one is called Collector roads (formally called District roads) and the other is called Feeder roads (Formally called community roads). At this particular moment, only **40%** of the roads are in a good condition is currently motor able by four wheel drive at any time of the year, **45%** which is in fair condition is slightly passable throughout the year or less by normal vehicles during rainy seasons and, **15%** which is in bad or poor condition does not adequately serve the situation and hinders the development in general. 50% of the council area is saved by Public transport but is not reliable especially areas located outside the Morogoro road highway.

1.7 EDUCATION

Kibaha District Council has 37 primary schools all being under LGA. At least each village has one primary school. There are many schools in urban compared to rural areas. There are twelve Secondary schools, 4 of them being privately owned and 8 are public secondary schools. The enrollment in primary schools is 102%

1.8 WATER SUPPLY

The main source of water for Kibaha District residents belong to Dar Es Salaam Water and Sewerage Company (DAWASCO), which contributes 35.6% of water being consumed daily, 10% are piped water under Council schemes, 10.9% are water from dams and the rest 4.5% is contributed by shallow and deep wells owned both privately and by public. Out of total population of KDC, only 61%, have direct access to clean and safe water. The council target is 95% of total population receives clean water by 2016.

2. DATA COLLECTION METHODS AND SOURCES OF DATA

2.1 DATA SOURCES AND THEIR DATA COLLECTION AND ANALYSIS METHODS

Data used in the preparation and final development of this DHP was collected using HMIS whereby the main source was Health facilities and some data are from the community. The data are of health issues (diseases and services) i.e. Curative and Preventive from each facility and community. The data are analyzed by the aid of DHIS 2 software at district level. Also there some data which are collected through vertical programs, surveys and census. These data are used in preparation of various reports and interventions plans such as CCHP and Council strategic plan. Also these data have been used in preparation of this DHP.

2.2 MANDATORY HEALTH INDICATORS

The following is a list of the standard health indicators that the district will assess from over time:

- *The health status of the **Kibaha district council** population.*
- *The status of the **Kibaha District council** health system.*
- *The status of health service delivery in **Kibaha district council**.*
- *Progress that has been made in the **Kibaha district council** health sector.*

Table 2-1. MANDATORY DHP HEALTH INDICATORS

HEALTH STATUS OF THE DISTRICT POPULATION
Maternal, Newborn and Child Health
❖ Nutritional Status
❖ Neonatal, infant, and under 5 mortality rates
Diseases
❖ Incidence of Malaria

- HIV/AIDs prevalence
- Top 10 causes of admission
- Top 10 causes of death

DISTRICT HEALTH SYSTEMS

Health Financing

- Total GOT and donor (budget and off-budget) allocation to health per capita
- Number of training institutions with full NACTE accreditation
- MO and AMO per 10,000 population
- Nurse-midwives per 10,000 population
- Pharmacists and pharm tech per 10,000 population
- Health Offices per 10,000 population (modified to include Environmental Health Officer (EHO)
- Laboratory staff per 10,000 population

DISTRICT HEALTH SERVICE DELIVERY

General

- **OPD Attendance**
- **Vaccination**
- **Proportion of children under 1 vaccinated against measles**

- **Proportion of under 1 3rd Polio (OPV3)**
- **Proportion of under 1 BCG dose**

Reproduction Health

- **Percentage of health centers and dispensaries that can provide EmOC as defined in EHP**
- **Proportion of pregnant women starting ANC before 12 or 16 weeks gestation**

Infectious Diseases and Non-Communicable Diseases

- **Proportion of mothers who received two doses of preventative intermittent treatment for malaria during last pregnancy**
- **Proportion of vulnerable groups sleeping under ITN the previous night**
- **Proportion of laboratory confirmed malaria cases among all OPD visits**
- **TB notification rate per 100,000 population**

PROGRESS IN THE HEALTH SECTOR

Progress in district health financing

- **Overall Health Financing**
- **Expansions in Health spending**

Progress in district health services

- **Increases in skilled health workers**
- **Progress in human resource availability by cadre over a period of time**

Progress in district neonatal health

- **Low birth weight**

Progress in district health facility coverage

- **Expansions in facility coverage across districts**

Progress in district health facility performance

- **Expansions in critical health services**
- **Improvements in referral hospital performance**
- **Progress in ANC Attendance**
- **Progress in health facility reporting rates**
- **Timeliness and completeness of data**

Progress in district health services

- **Social welfare and protection for vulnerable populations**
- **Vaccination coverage**
- **Environmental Health Service Safe Water Initiatives**

Progress against milestones from previous year

- **Progress against milestones set by the technical review of the joint annual**

health service sector review from previous year

2.3 HEALTH INDICATORS IMPORTANT TO KIBAHA DISTRICT COUNCIL

Kibaha district council is embarked in reduction of maternal and child deaths through strengthening of Health delivery services by ensuring close vicinity of the community to health delivery services and availability of essential supplies in the health facilities. The council is implementing MMAM and P4P programs towards achieving the goals for the reduction of health problems such as maternal, neonatal and child morbidity and mortality facing the community and increasing staff commitment to deliver promptly health care services.

KIBAHA DISTRICT SPECIFIC INDICATORS
1. Percentage of facilities with skilled personnel on Kangaroo Mather Care (KMC)
2. Progress in implementation of P4P program
3. Percentage of Health facilities with CHF scheme

2.4 KEY MESSAGES ABOUT HEALTH INDICATORS

- Kangaroo mother care skills have been introduced in all 18 dispensaries with RCH services and a special ward set for the service at Mlandizi HC
- Implementation of P4P program is in all 18 public facilities that provide RCH services
- Referral services have been strengthened by providing Ambulances to 3 wards (Magindu, Mlandizi and Kwala)

HEALTH STATUS OF THE DISTRICT POPULATION

3.1 MATERNAL, NEWBORN AND CHILD HEALTH

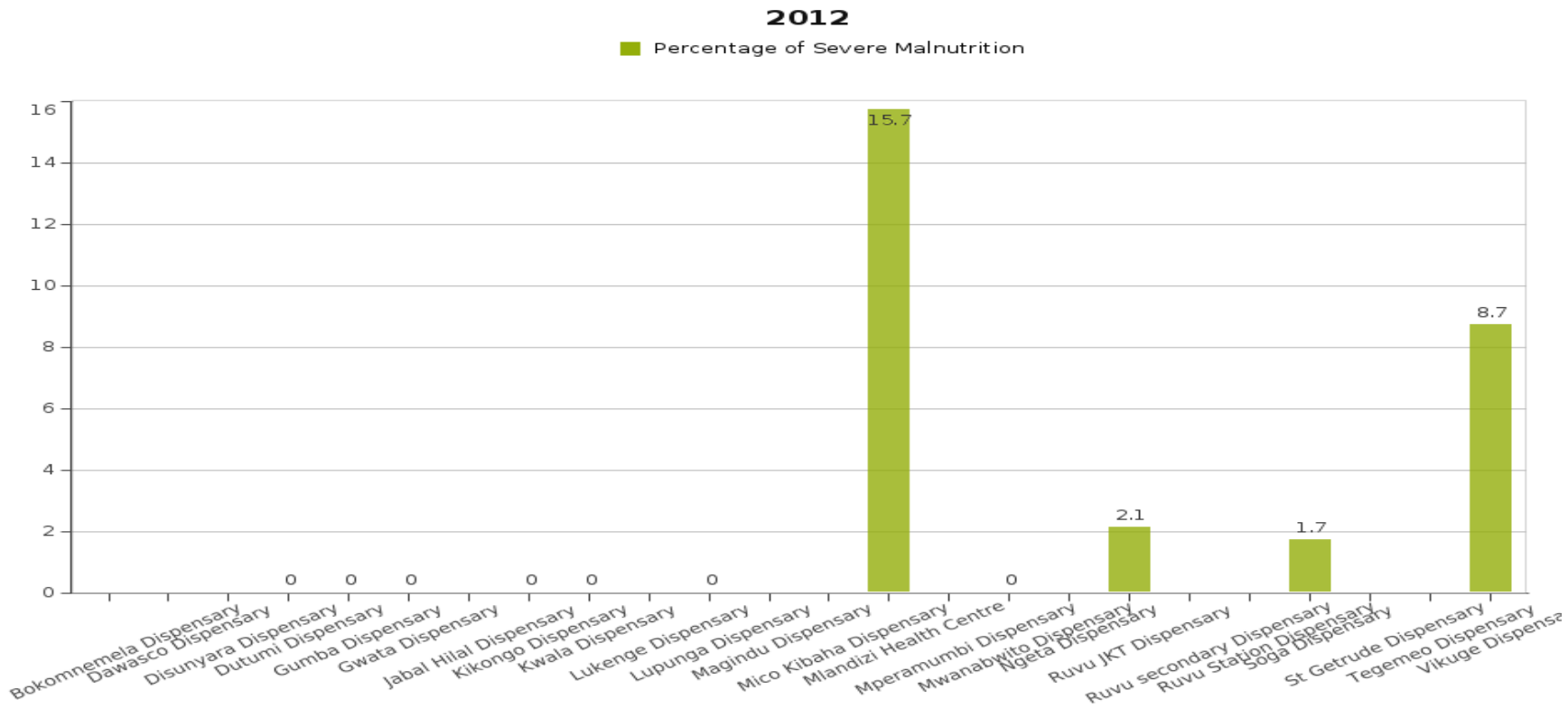
3.1.1 NURTRITIONAL STATUS: LOW BIRTH WEIGHT

Kibaha District Council is one of the districts that experienced low malnutrition rate. During the period of 2012 a total of 7257 children were measured for their nutritional status by using Weight for Age (H|A) technique. Among these 98% were above 80% (>- 2SD), 2% were between 60% - 80% (- 2SD up to -3SD) and 0.2% were below 60% (< - 3SD). However in the 2012 the children with malnutrition were 171 (2%) and 0.2% had severe malnutrition. The opportunities that the district has in regard to nutrition is that the majority of their residences are farmers and livestock keepers.

All the available data on nutrition were obtained through under five clinic visits, no any scientific research on nutrition had been conducted to proof the situation at the district.

The issue of low birth weight in Kibaha DC is not a major issue as explained in the above statements.

Figure 3-1. Nutritonal Status: Low Birth Weight



3.1.2 NEONATAL, INFANT, AND UNDER 5 MORTALITY RATES

In the year 2012 there was a total of 10 neonatal deaths, 5 under five deaths, 18 FSB and 31 MSB.

Accessibility of health facilities in most of the district villages, trained health staffs in such health facilities together with three ambulances to facilitate referral to near health centre and referral hospital and through motivating health staffs under the P4P scheme assisted to reduce neonatal and under five deaths.

Infant mortality rate in the district differs across facilities due to their geographical location and community set up. The health facility with higher infant mortality had 62 deaths and the lowest were had 5 deaths.

Immigration of some communities especially masai and mang'ati tribe in the district aid to increase number of targeted indicator due to their low education on maternal health.

Figure 3-2. Neonatal Mortality Rates

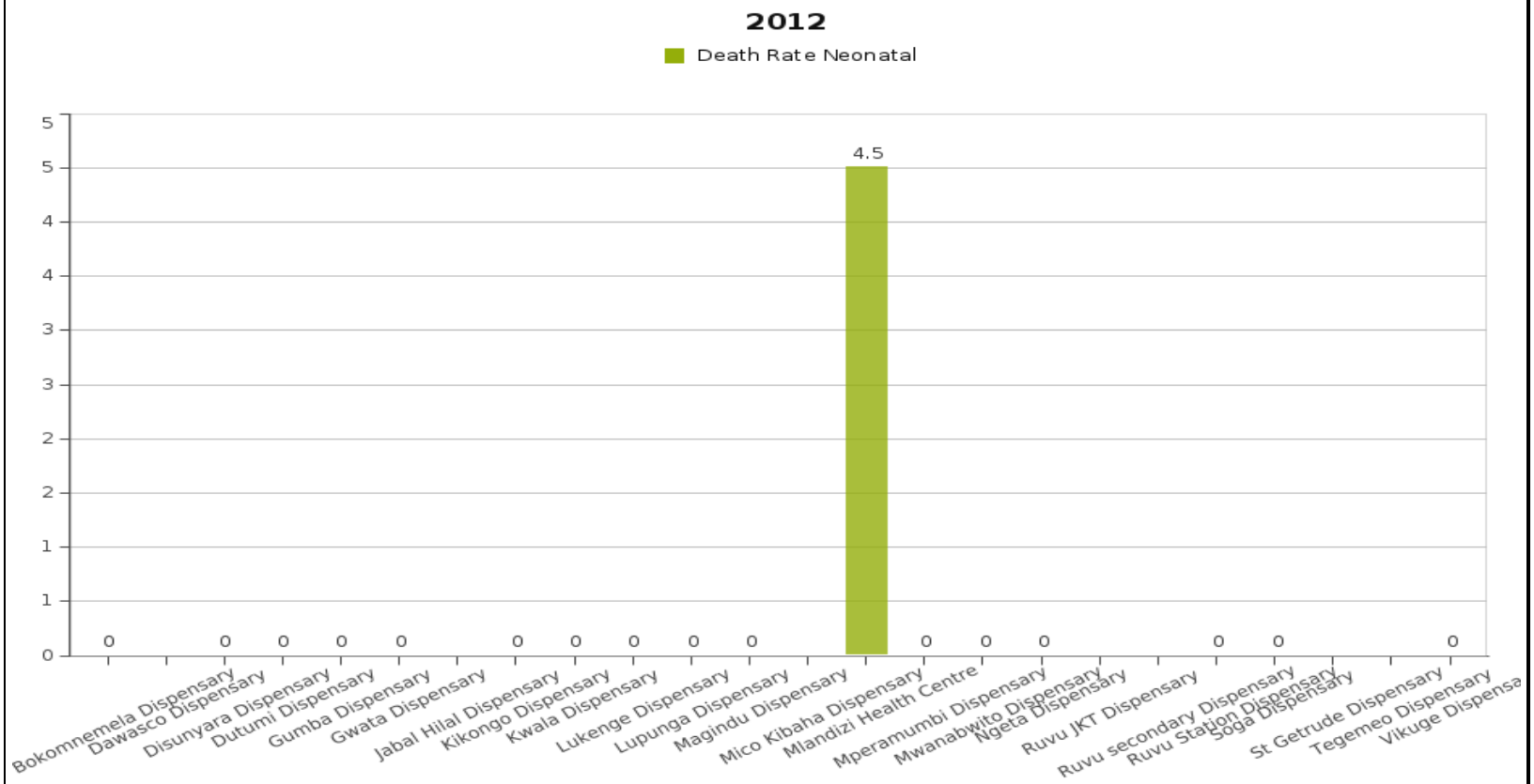


Figure 3-3. Infant Mortality Rate

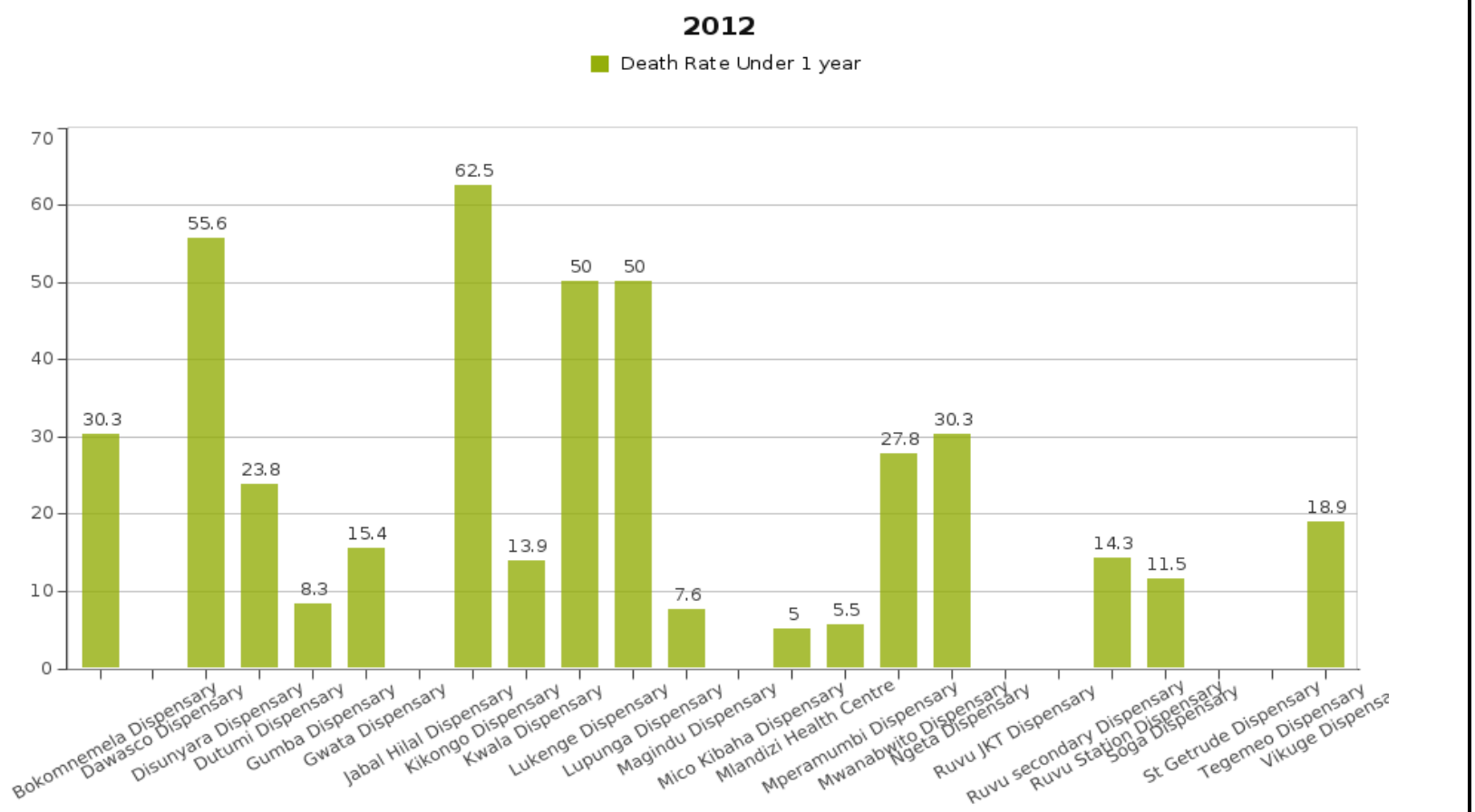
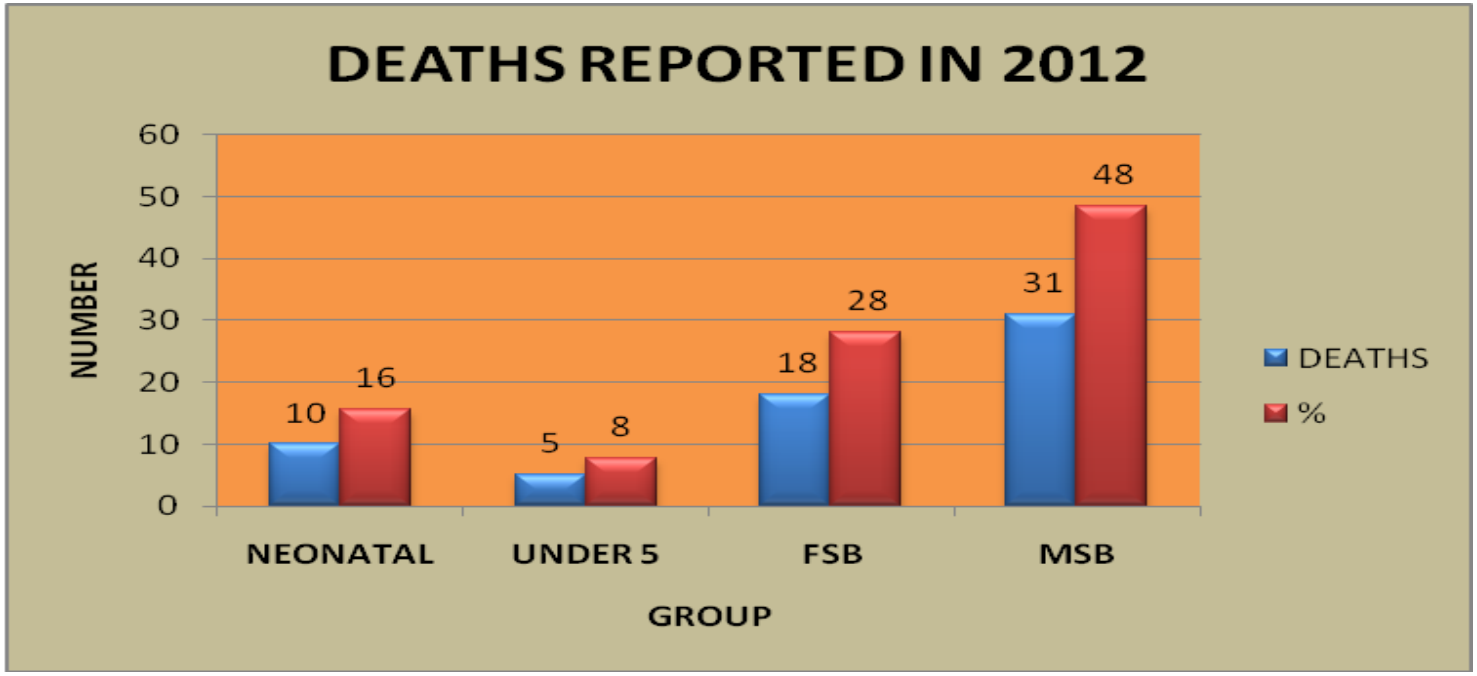


Figure 3-3. Under 5 Mortality Rate



NB: Kibaha DC population is less than 100,000 thus we opted to use number of deaths instead of rate so as to show the magnitude of Under 5 deaths in an overall number of reported deaths

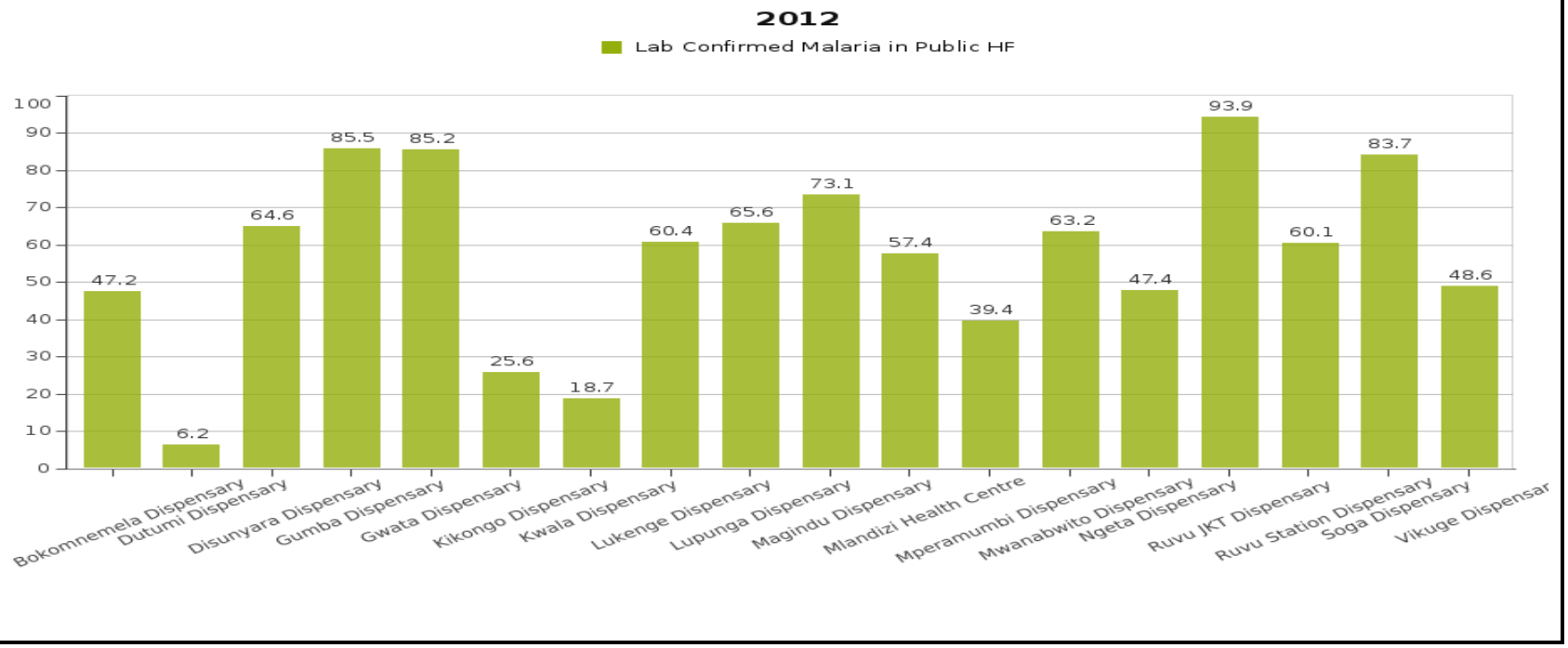
3.2 MORBIDITY

3.2.1 Malaria Incidence

In the year 2012 Malaria maintained to be the main cause of morbidity in many facilities. The detection of Malaria cases was facilitated by the introduction of Rapid Malaria testing algorithm by aid of MRDT. The testing technique is implied in all Health facilities (Public and Private)

Laboratory confirmed cases of Malaria for the year 2012 is as shown in the figure below:

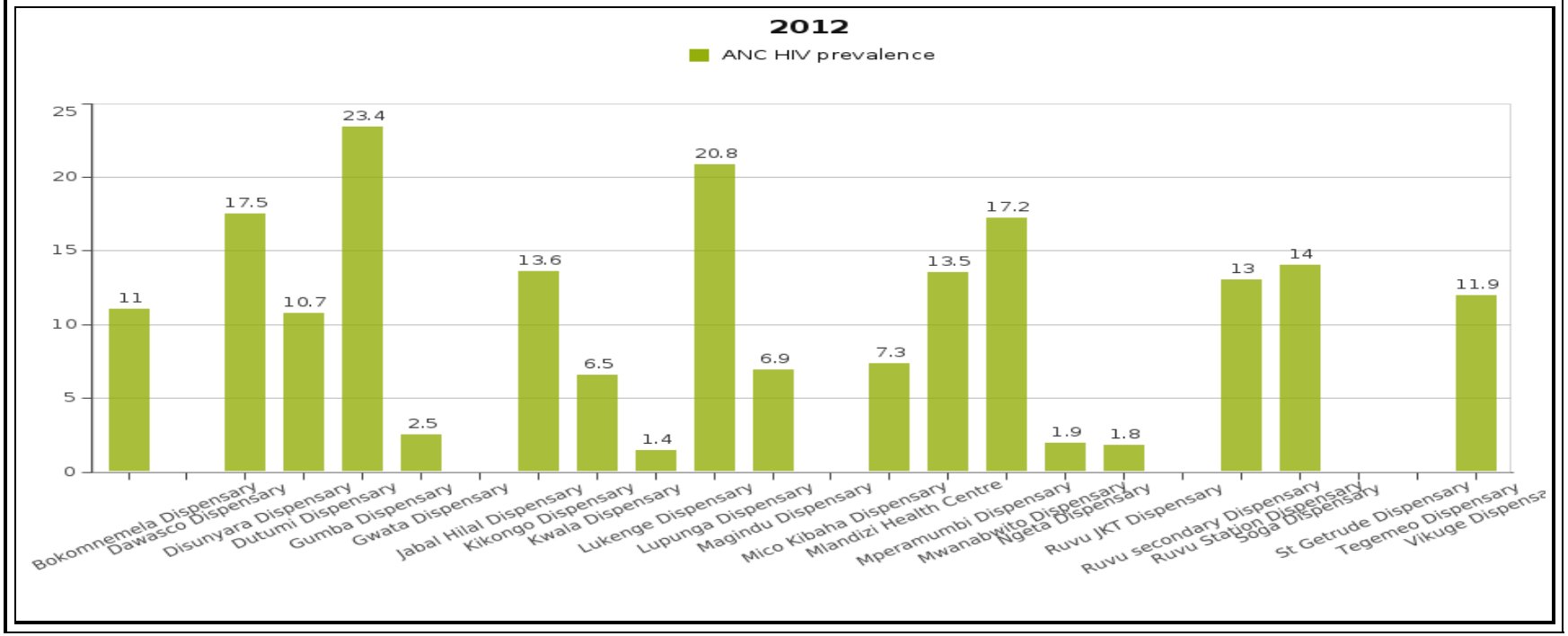
Figure 3-3. Laboratory Confirmed Malaria Cases



3.2.2 HIV/AIDS PREVALENCE

In the year 2012 a total number of 4985 (M=1933, F=3052) clients tested for HIV in different setting of Health delivery system including OPD, IPD, RCH, Laboratory and CTC. Out of this number 286 (M=92,F=194) were tested positive for HIV. This amount is equivalent to 5.7%. The prevalence of HIV in amongst ANC clients in all Health facilities with RCH services.

Figure 3-4. HIV/AIDS Prevalence



3.2.3 Top 10 Causes of Admission/Inpatient Diagnosis

During the year 2012 the top ten causes of admission were as shown in the table below. In brief malaria and pneumonia ranked first and second in the list. Other diseases in the list are as shown in the table below

Table 3-1.Top 10 Causes of Admission/Inpatient Diagnosis

Na.	IPD	Under 1 Month	1 Month - < 1 Year	1 Year –< 5 Years	5 Years - > 5 Years
1	Uncomplicated Malaria	1	10	27	114
2	Pneumonia	3	28	27	65
3	Severe / Complicated Malaria	2	6	26	33
4	Neonatal Infections (Septicaemia, Local infections)	44	0	0	0
5	Hypertension	0	0	0	54
6	Other gynaecological diseases	0	0	0	43
7	Burns	0	17	12	10
8	Other non-infectious Gastrointestinal diseases	0	7	1	27
9	Snake and Insect Bites	0	0	2	30
10	Other Cardiovascular Disorders	0	0	0	23

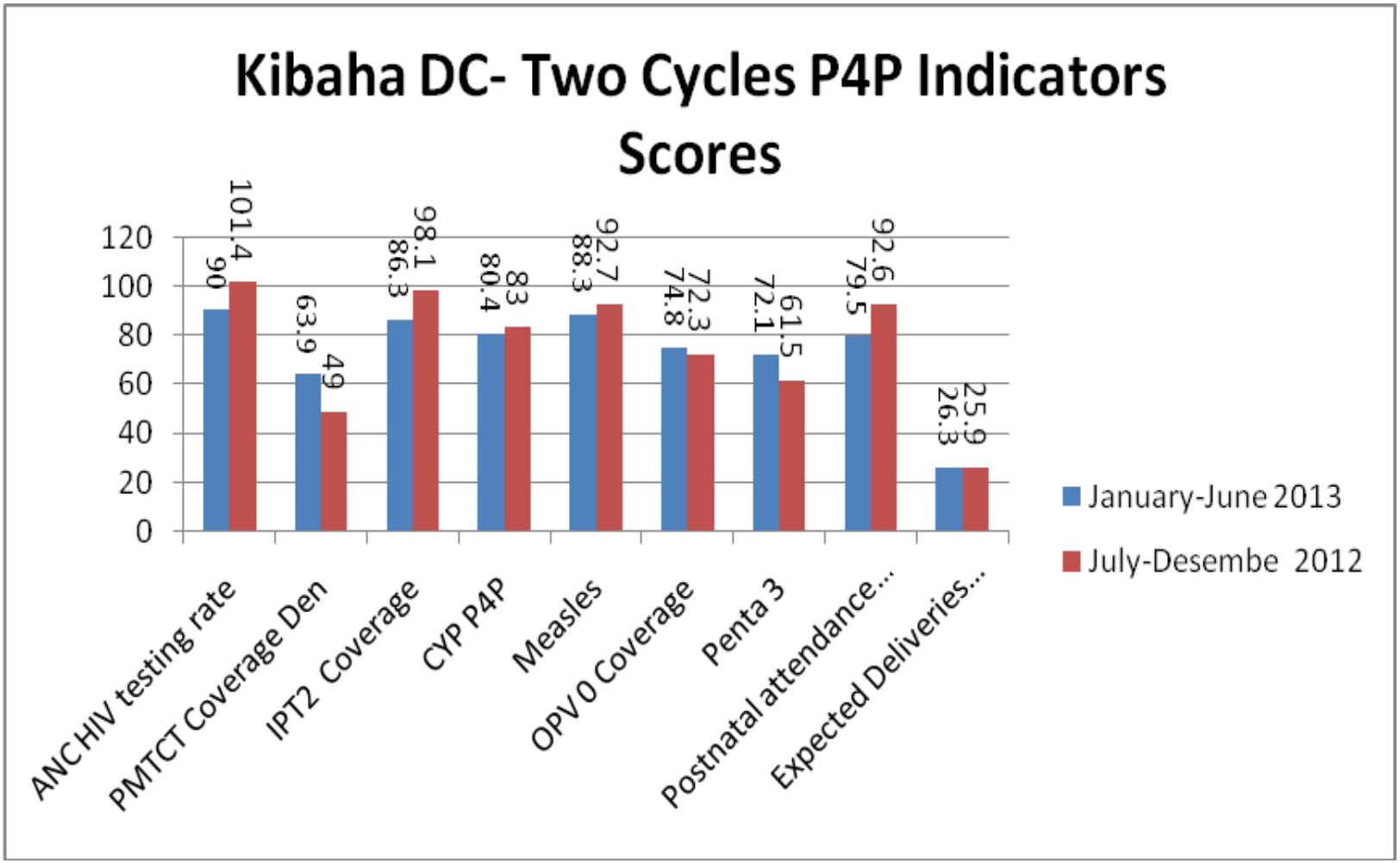
3.3 MORTALITY

Table 3-2. Top 10 Causes of Death

	Causes of Death	Under 1 Month	1 Month - < 1 Year	1 Year –< 5 Years	5 Years - > 5 Years	Total
1	Severe / Complicated Malaria	6	2	32	3	43
2	Pneumonia	2	8	5	14	29
3	Other gynaecological diseases				25	25
4	Other Cardiovascular Disorders				21	21
5	Hypertension, Severe	0	0	1	17	18
6	Gastrointestinal diseases, Other Non-infectious	0	2	5	10	17
7	Neonatal Infections (Septicaemia, Local infections)	16				16
8	Mild / Moderate Anaemia	1	2	6	7	16
9	Symptomatic HIV infection				16	16
10	Liver diseases, Non-infectious	0	2	5	7	14

3.4 OPTIONAL HEALTH STATUS OF THE DISTRICT POPULATION INDICATORS

Kibaha is one of the district implementing P4P program; the performance on P4P indicators in the two cycles in 2012 is shown in the graphs below.



3.5 DISTRICT HEALTH STATUS CONCLUSIONS, RECOMMENDATIONS AND WAY FORWARD

This profile comes up with the fact that although the nutrition status in the district is low but generally the entire community lack knowledge on nutrition education. Low income of the household contributes to poor health status of the community and that have directly effects on infant growth and development.

Importance of pregnant women to visit to RCH clinics is of essential to be emphasized so that they can stand comfortable with their pregnant situation as better outcome and reduce neonatal, infant and under five mortality deaths.

Although the district have the strategies to reduce malaria by providing IT Net to pregnant and under five through provision of Hati punguzo programme and mass distribution campaign , other measures to eliminate malaria such as eradication of breeding site by using proper and safe sanitation should be applied.

HIV/AID's need more close follow up to reduce its infection as the prevalence stand at 5.7

Therefore the district should put more effort on providing education to their entire community on how they can be free from diseases and other related problems.

RECOMMENDATIONS

- More income generating activities should be initiated in the communities for the purpose of increasing household income hence reduces food insecurity within the household levels.
- Nutritional education should be promoted in advance and strengthen at RCH clinics in order for the clients to access it as time they visit clinic concerning dietary pattern.

- Men should be educated and involved in antennal clinics for the purpose of educating in family planning methods and other related maternal health.
- Obtain support of health policy from political leaders and all stake holders for promotion and awareness in the community.
- The Collected data should be used as a base for Planning interventions for the control and elimination of diseases and health conditions at all levels

WAY FORWARD

- Using DHP document for planning purposes
- Improving conditions found to be the cause of diseases and any bad health conditions
- Using DHP as base for measuring progress of health interventions

STATUS OF HEALTH SERVICE DELIVERY IN THE DISTRICT

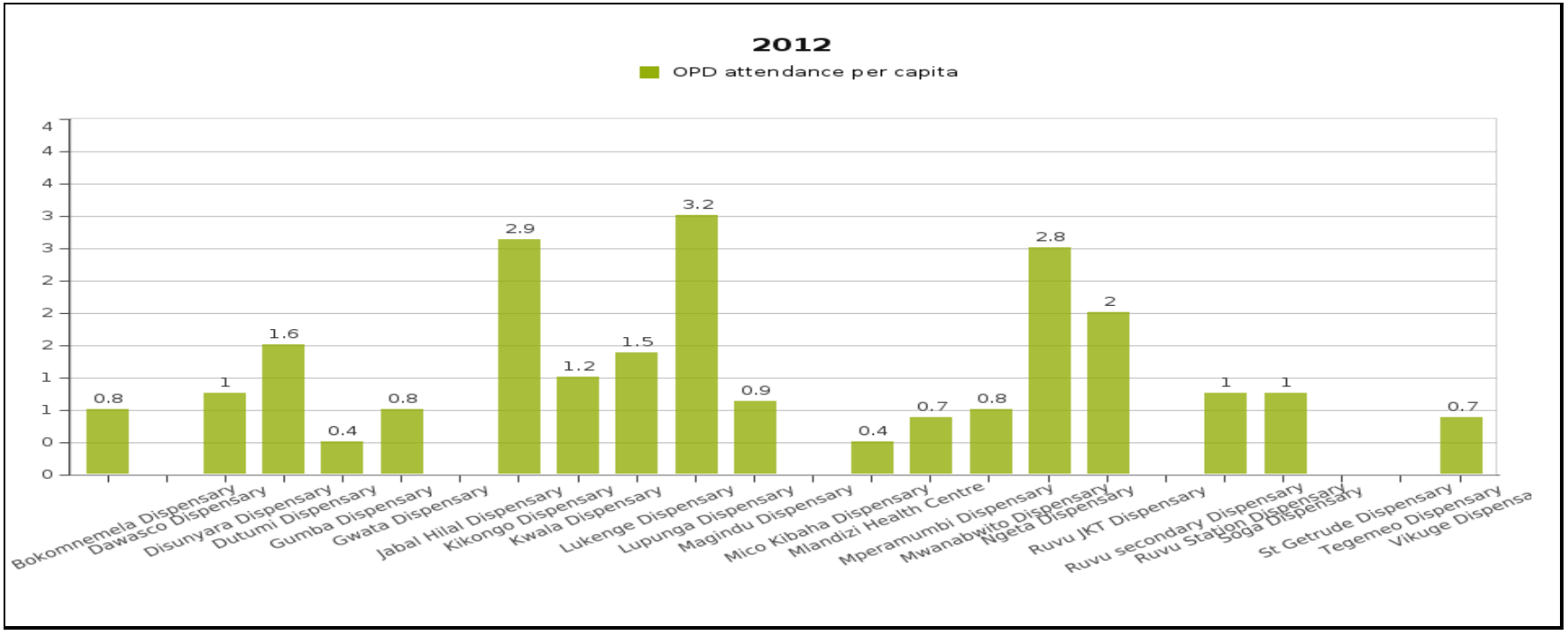
4.1 GENERAL HEALTH SERVICE

4.1.1 OPD ATTENDANCE

With the exception of Gwata, Kwala, Mperamumbi and Mwanabwito dispensaries the OPD attendance rate per capita is below 2.

The table below summarizes the attendance rate per capita in each health facility found in Kibaha DC.

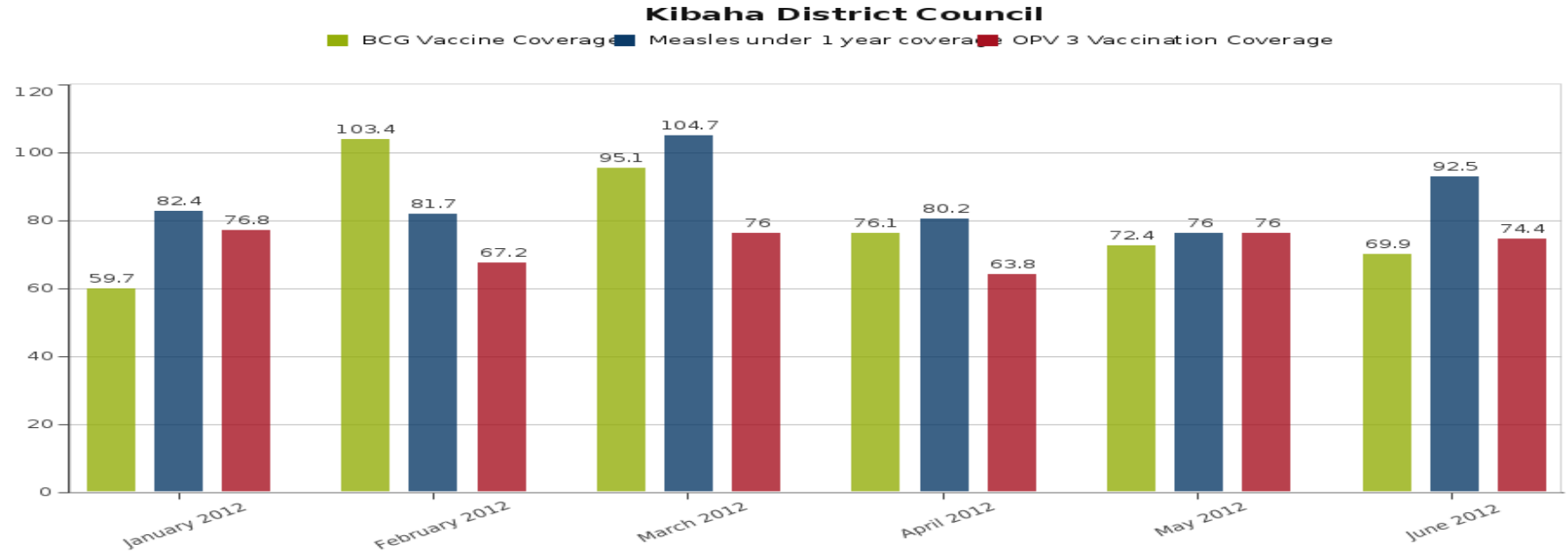
Figure 4-1. OPD Attendance



4.2 VACCINATION SERVICES

In the first six months of the year 2012 the proportion of children vaccinated against Measles, OPV 3 and those with BCG were low compared with the previous year coverage. The reason behind this variation is associated with multiple causes. Some of these being the variation of target population in the area caused by immigration of many people (pastoralists) who came in the area with their cattle looking for pastures.

Figure 4-2. Under 1 Year Vaccinated (OPV3, BCG, and Measles)

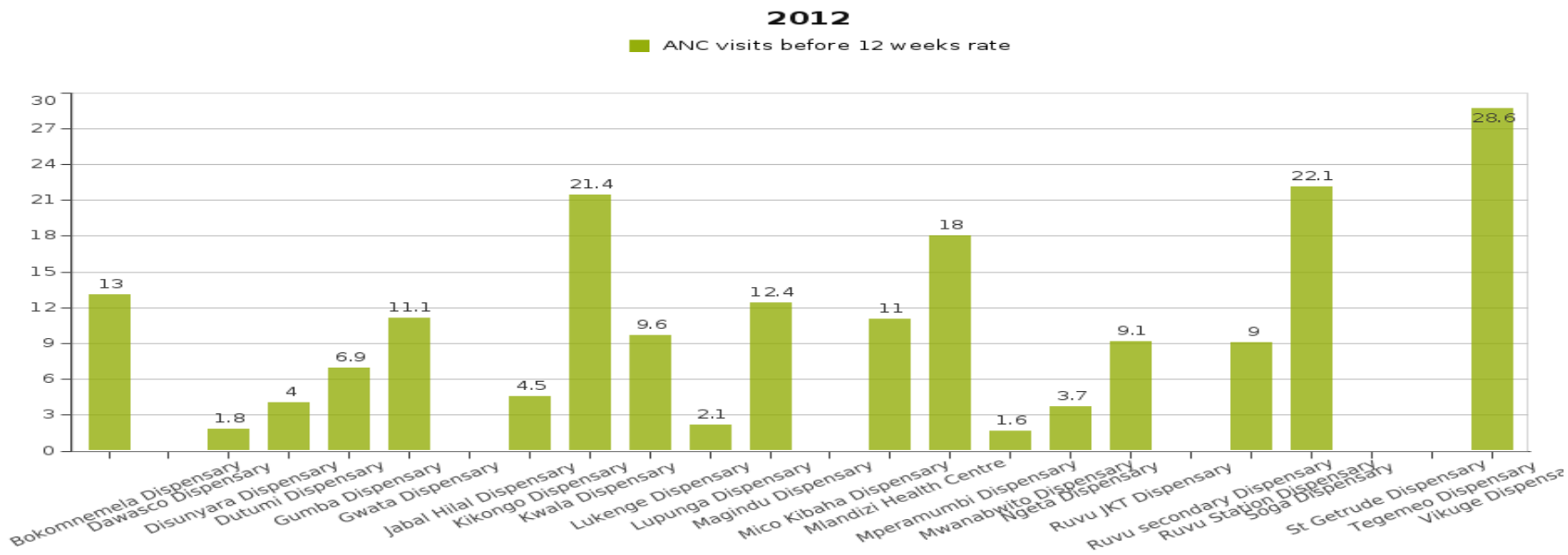


4.3 REPRODUCTIVE HEALTH SERVICES

4.3.1 PROPORTION OF PREGNANT WOMEN STARTING ANC BEFORE 12 or 16 WEEKS GESTATION

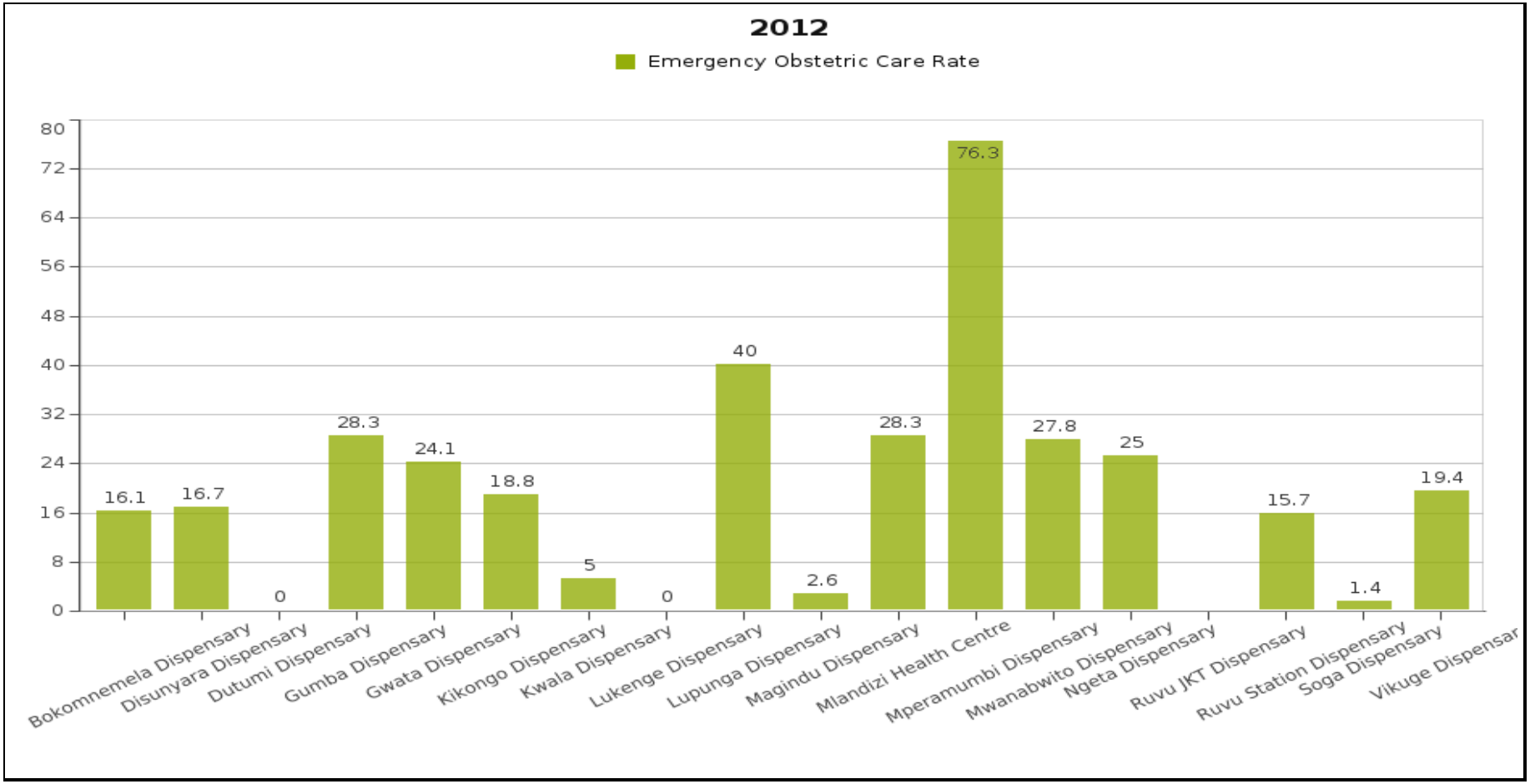
Despite of the fact that coverage of health facilities with RCH services in Kibaha DC is high, the proportion of ANC attendants starting ANC before 12 weeks is low. In most facilities they proportion is below 20%.

Figure 4-3. Proportion of Pregnant Women Starting ANC before 12 or 16 Weeks Gestation



All health facilities in Kibaha DC provides EmOC services. The percentage defers from one facility to another as shown in the figure below.

Figure 4-4. Percentage of health centers and dispensaries that can provide EmOC as defined in EHP



4.4 INFECTION DISEASE AND NON-COMMUNICABLE DISEASE HEALTH SERVICES

4.4.1 PROPORTION OF MOTHERS WHO RECEIVED TWO DOSES OF PREVENTATIVE INTERMITTENT TREATMENT FOR MALARIA DURING LAST PREGNANCY.

The proportional of mother received two doses of preventive intermittent treatment for malaria during last pregnancy at the year 2012 in all facilities ranged above 50%. This means that majority of the target population in the district received two doses of IPT. Data on the chart below shows that the lowest facility to provide two dose of IPT was 51.2% and highest was 101.8%.

Figure 4-5. Proportion of Mothers who received two doses of Preventative Intermittent Treatment for Malaria During Last Pregnancy

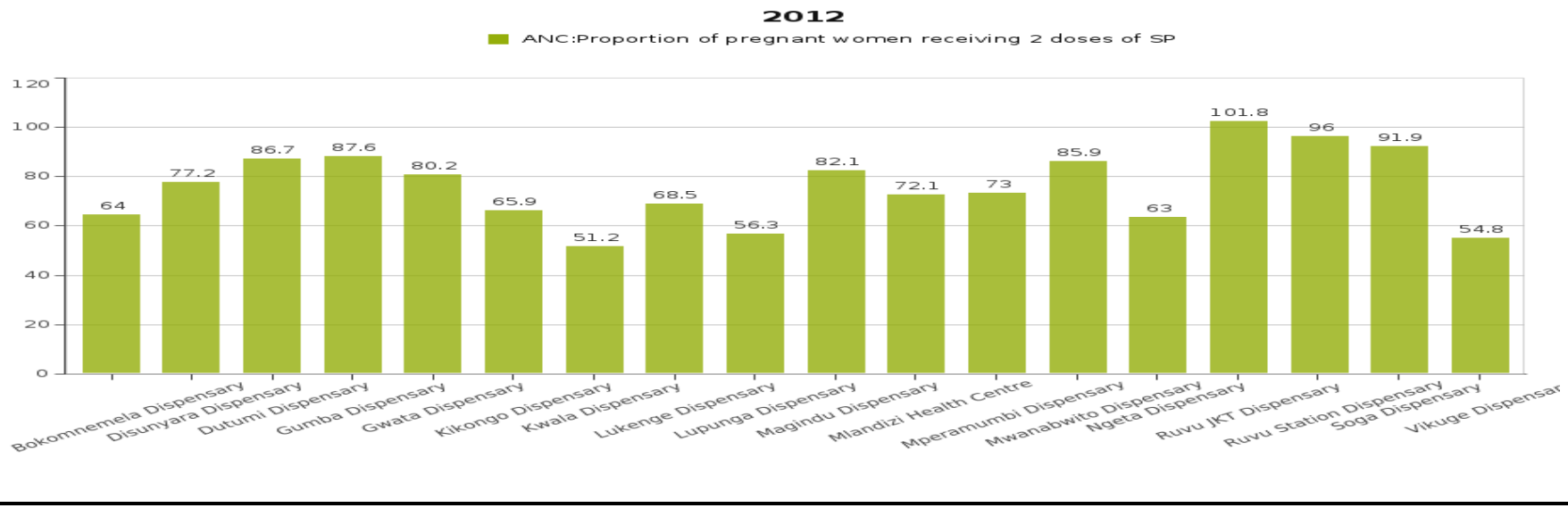
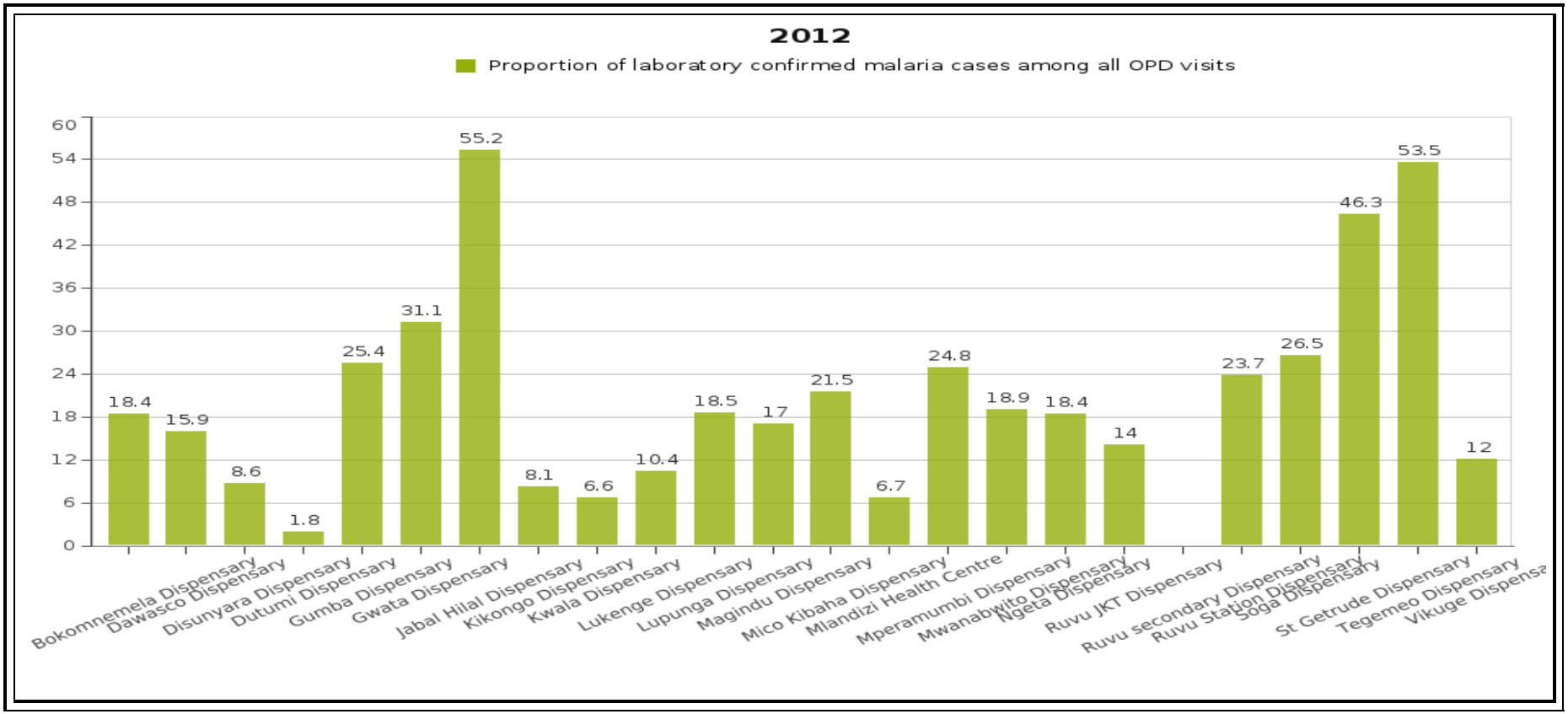


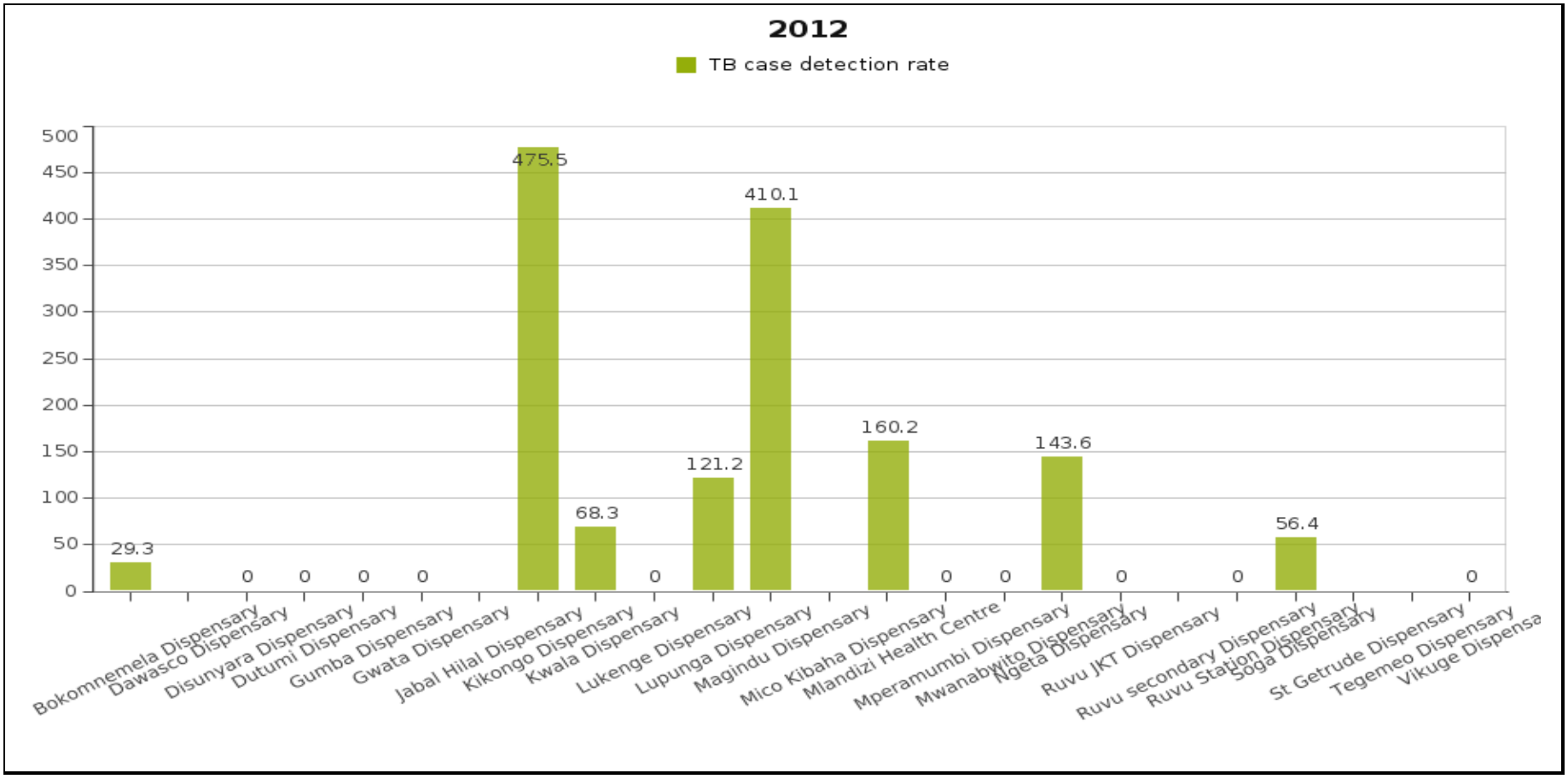
Figure 4-7. Proportion of laboratory confirmed malaria cases among all OPD visits



4.5 TB notification

Only eight health fcilities notify the incidence of TB in the district; Testing of TB is done only in facilities with Laboratory equipment and staff. The figure below stipulate those facilities based on their population as well as the incidence

Figure 4-8. TB notification rate per 100,000 population



4.6 DISTRICT HEALTH SERVICE DELIVERY CONCLUSIONS AND RECOMMENDATIONS

Despite the District managing to deliver health services within the sphere standard, malaria is still the leading cause for mortality and morbidity for both under five and adult. More intervention especially on preventive measure is needed to eliminate the problems for the better health and production activities hence increases income among the community in the district. However the district should make the effort to ensure that trained personnel in laboratory are available in each health facilities for correct diagnosis of malaria and other related diseases that need laboratory specimen.

Although there some improvement on the provision of IPT 2 doses in the health facilities but additional education to the entire community on importance of early visits to health facilities for maternal health services such as antenatal, delivery and postnatal services. This will help to increase and maintain the coverage vaccination and other RCH services.

WAY FORWARD:

1. Strengthen the supplies of drugs and medical equipment to ensure adequate and safe health services.
2. CHMT to conduct supportive supervision in order to reinforce partners supported interventions to ensure sustainability of these existing projects in the district.

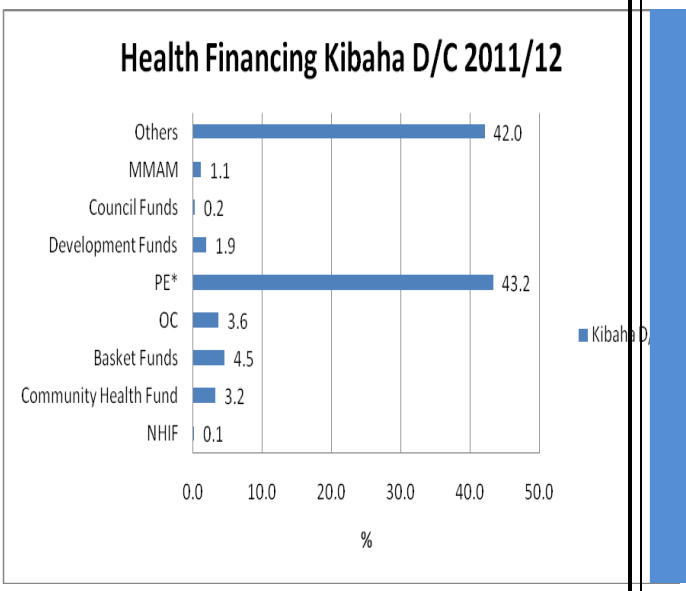
STATUS OF DISTRICT HEALTH SYSTEMS

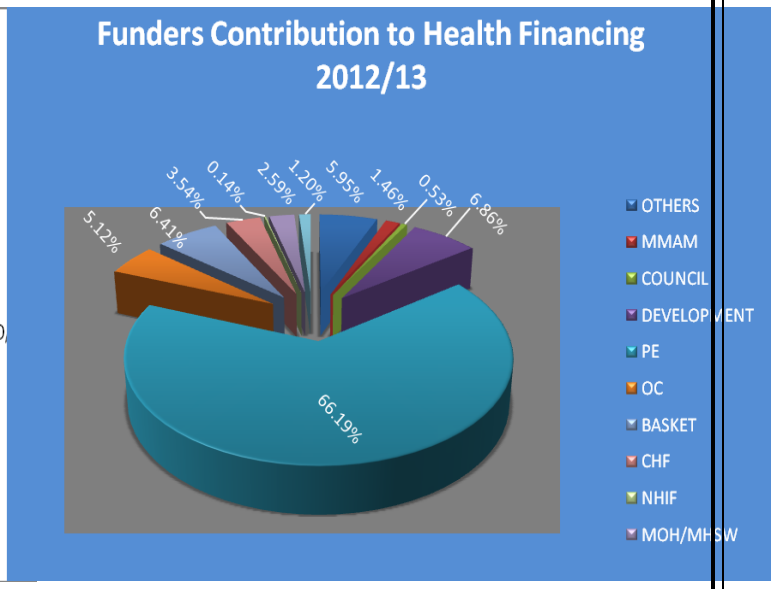
5.1. HEALTH FINANCING

Health activities in the districts are funded by nine main sources of funds, these includes, Local Government block grants, Own sources (council funds), Health Sector Basket Fund, community funds (Cost Sharing/CHF), NHIF, Health sector development Grants, Capital development Grants and MMAM and other donors. Every donor provides fund for activities of interest but no activity is funded by more than one donor at a time. A good number of the targeted activities were covered during the year of implementation. A big challenge is that some of donors do not meet the criteria either by submit funds on the late period of implementation or withdraw their sponsor.

In the year 2012/13 there was an increase in health financing comparing with the previous year. PE increased from 43.5% of total health budget to 66.19% this was also seen on Basket fund and OC. Also dependence on other sources decreased from 42.0% to 6.4%

Figure 5-1. Total GOT and Donor Allocations to Health in the District





5.2. HUMAN RESOURCES FOR HEALTH

- **Number of training institutions with full NACTE accreditation**
  - The council has no institution with full NACTE accreditation.
- **Medical Officer (MO), Assistant Medical Officer (AMO), Clinical Officer (CO), and Assistant Health Officer(AHO) per 10,000 population**

The council has a population of approximately **73,952** people the council has **1** Medical Officer, **1** Dental Officer, **9** AMO, **44** Cos, **11** Assistant Environment officers. The council has **21,** Registered Nurses **35,** Enrolled Nurses, **2** Laboratory Technologists, **14** Laboratory Technicians, **1** Pharmacists, **1** Pharmaceutical Technicians, **34** Medical attendants. The distributions is shown in the figures below from figure 5 – 3 to figure 5 – 5.

Figure 5-3. Number of MO, AMO, and COs Per 10, 000

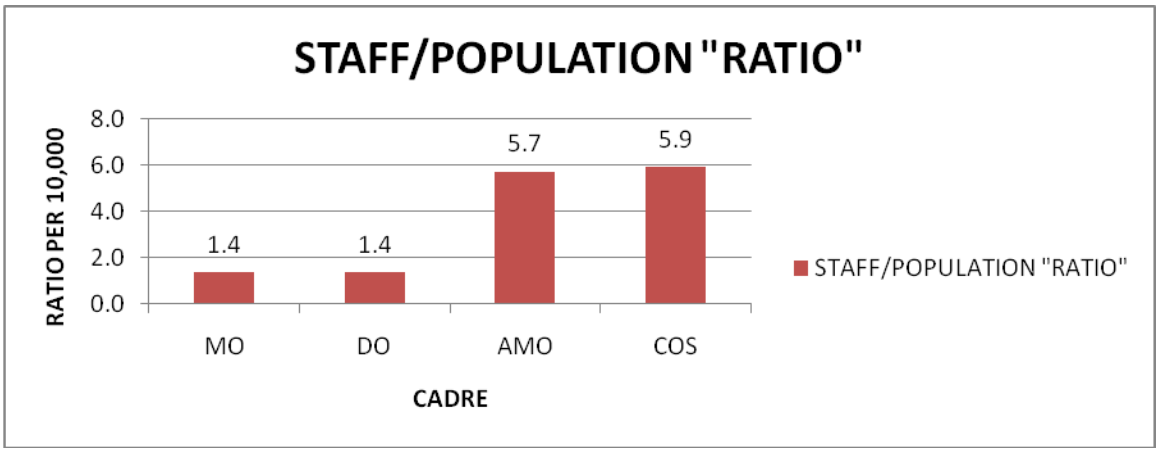


Figure 5- 4. Number Nurses, Lab Tech, and Pharm techs Per 10, 000

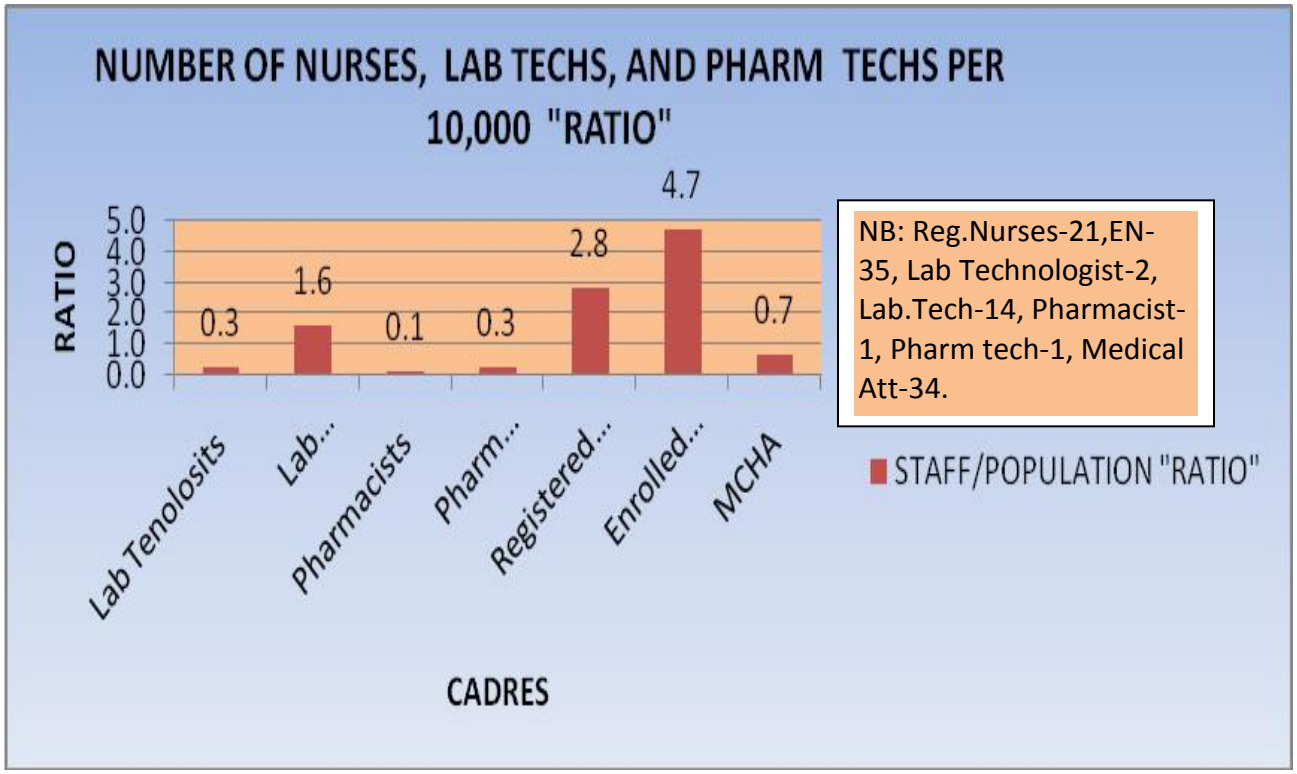
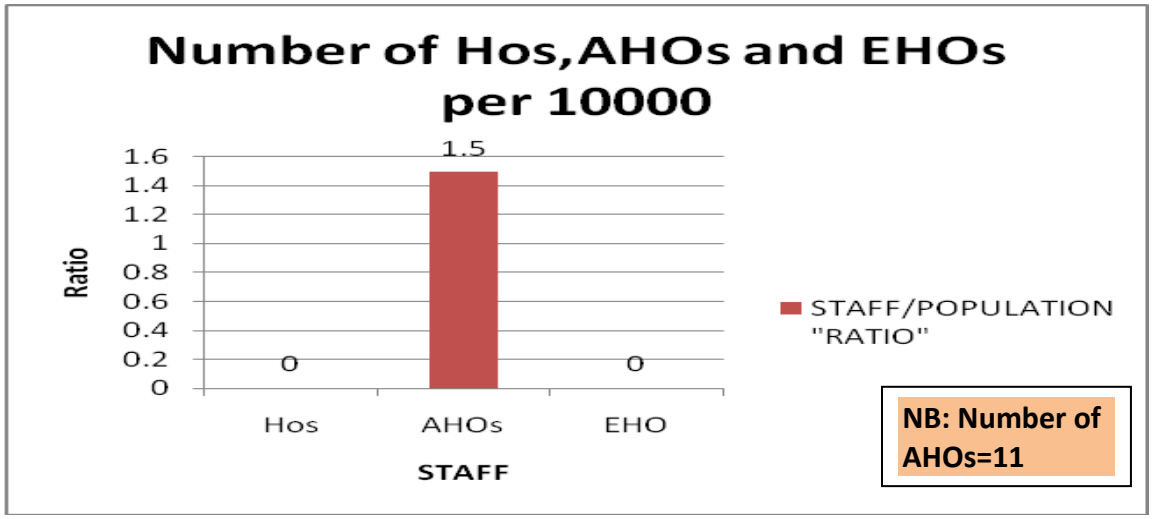


Figure 5-5. Number of HO, AHO, and EHOs Per 10, 000



5.3. MEDICINES/DRUGS

In the year 2012 the stock out of tracer drug, vaccines and medical supplies was experienced by facilities in different levels. The availability situation and stock out are as shown in the figures below:

Figure 5-6. Distrct level Stockout of 5 Tracer Drugs, 1 Vaccine and Medical Supplies

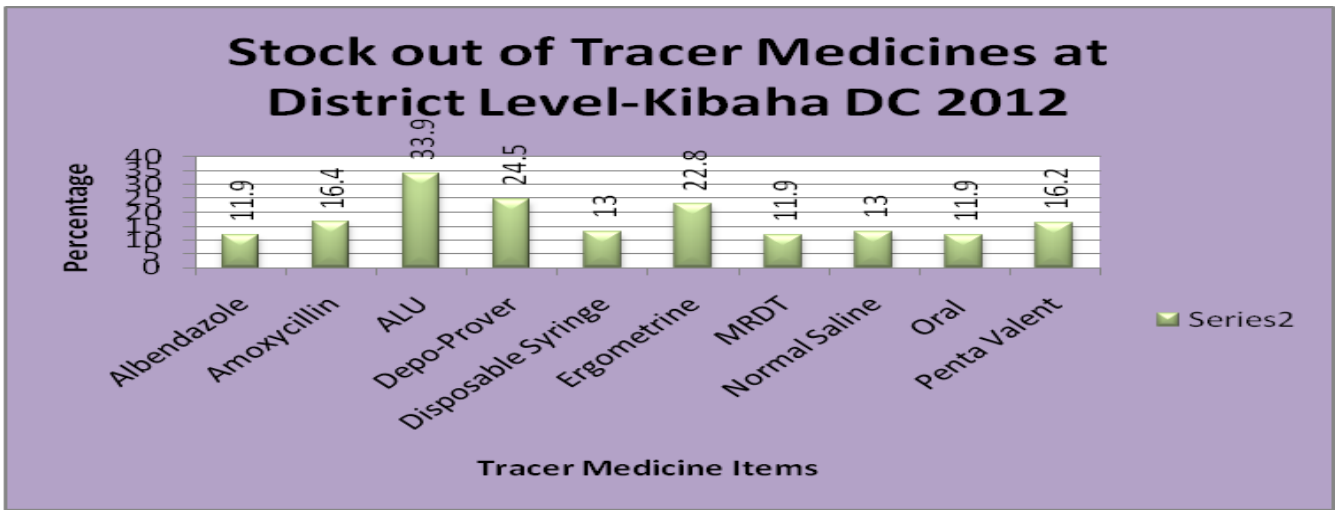
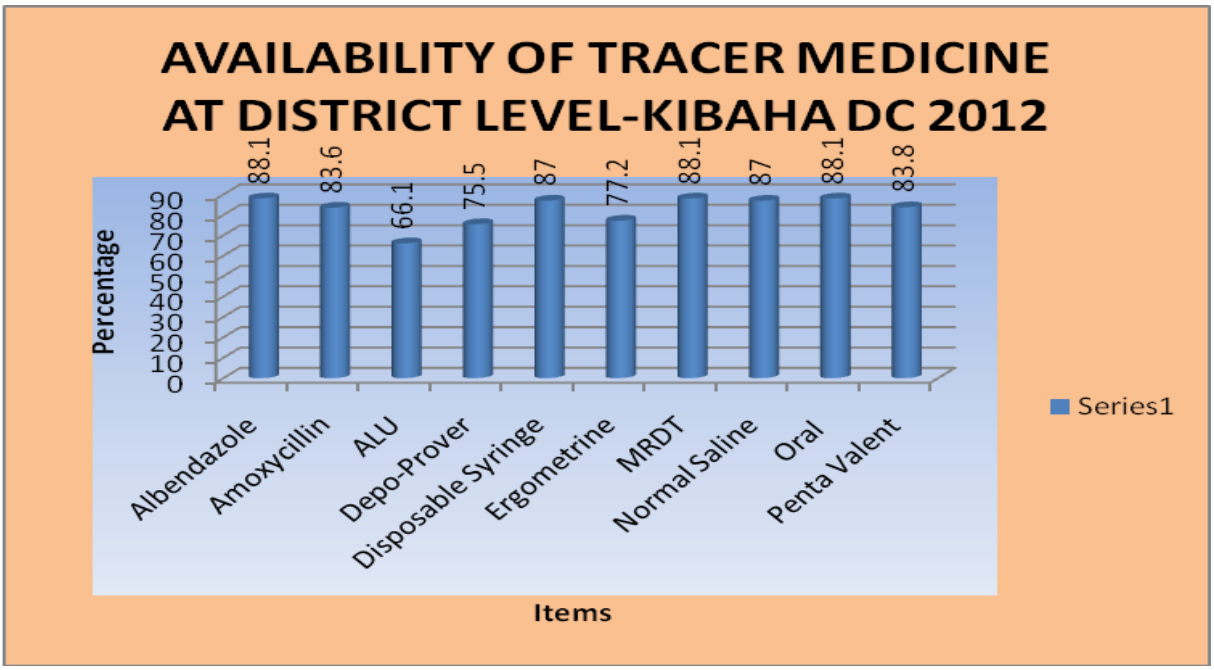


Figure 5-7. Availability of Tracer Medicine



KIBAHA DC DISTRICT HEALTH PROFILE

STOCKOUT OF TRACER MEDCINE AT THE FACILITY LEVEL - KIBAHA DISTRICT COUNCIL											
		TRACER MEDICINE ITEMS									
NO	FACILITY NAME	ALBENDAZOLE	AMOXYCILLIN	ALU	DEPO PROVERA	DISPOSAL SYRINGE	EGOMETRINE	MRDT	NORMAL SALINE	ORAL	PENTA VALENT
1	BOKOMNEMELA	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.5
2	DISUNYARA	37.5	25	25	25	25	25	75	37.5	25	25
3	DUTUMI	50	25	12.5	12.5	12.5	12.5	25	25	12.5	12.5
4	GUMBA	25	25	0	12.5	0	12.5	0	0	0	0
5	GWATA	62.5	25	25	37.5	37.5	37.5	75	37.5	25	25
6	KIKONGO	0	0	37.5	12.5	0	0	0	0	0	0
7	KWALA	0	12.5	62.5	12.5	0	0	0	0	0	0
8	LUKENGE	12.5	12.5	12.5	50	12.5	12.5	12.5	12.5	12.5	12.5
9	LUPUNGA	12.5	25	50	12.5	0	2.5	12.5	12.5	12.5	25
10	MAGINDU	14.3	28.6	42.9	14.3	0	0	0	0	0	0
11	MLANDIZI	25	25	25	25	25	25	25	25	25	25
12	MPERAMUMBI	25	37.5	37.5	12.5	12.5	50	12.5	12.5	25	37.5
13	MWANABWITO	25	25	50	12.5	12.5	25	12.5	12.5	25	25
14	NGETA	12.5	12.5	50	25	12.5	12.5	25	25	25	12.5
15	RUVU JKT	12.5	12.5	12.5	87.5	12.5	0	12.5	12.5	12.5	12.5
16	RUVU STATION	0	0	50	0	0	0	0	0	0	0
17	SOGA	12.5	12.5	25	12.5	25	12.5	12.5	12.5	12.5	12.5
18	VIKUGE	12.5	37.5	75	50	62.5	50	12.5	12.5	12.5	25
19	ST GETRUDE	0	14.5	0	N/A	0	N/A	0	0	0	N/A
20	TEGEMEO	0	0	0	N/A	16.7	N/A	16.7	33.3	0	N/A
21	MICO	14.3	14.3	14.3	N/A	28.6	N/A	14.5	28.6	14.5	N/A
22	JABAL HIRA	0	0	0	N/A	0	N/A	0	14.5	14.3	N/A
23	DAWASCO	0	0	0	N/A	0	N/A	0	14.3	0	N/A

KIBAHA DC DISTRICT HEALTH PROFILE

AVALIBILITY OF TRACER MEDCINE AT THE FACILITY LEVEL - KIBAHA DISTRICT COUNCIL											
		TRACER MEDICINE ITEMS									
NO	FACILITY NAME	ALBENDAZOLE	AMOXYCILLIN	ALU	DEPO PROVERA	DISPOSAL SYRINGE	EGOMETRINE	MRDT	NORMAL SALINE	ORAL	PENTA VALENT
1	BOKOMNEMELA	87.5	87.5	87.5	87.5	87.5	87.5	87.5	87.5	87.5	87.5
2	DISUNYARA	62.5	75	75	75	75	75	25	62.5	75	75
3	DUTUMI	50	75	87.5	87.5	87.5	87.5	75	75	87.5	87.5
4	GUMBA	75	75	100	87.5	100	87.5	100	100	100	100
5	GWATA	37.5	75	75	62.5	62.5	62.5	25	62.5	75	75
6	KIKONGO	100	100	62.5	87.5	100	100	100	100	100	100
7	KWALA	100	87.5	37.5	87.5	100	100	100	100	100	100
8	LUKENGE	87.5	87.5	87.5	50	87.5	87.5	87.5	87.5	87.5	87.5
9	LUPUNGA	87.5	75	50	87.5	100	87.5	87.5	87.5	87.5	75
10	MAGINDU	85.7	71.4	57.1	85.7	100	100	114.3	100	100	100
11	MLANDIZI	75	75	75	75	75	75	75	75	75	75
12	MPERAMUMBI	75	62.5	37.5	87.5	87.5	50	87.5	87.5	75	62.5
13	MWANABWITO	75	75	50	87.5	87.5	75	87.5	87.5	75	75
14	NGETA	87.5	87.5	50	75	87.5	87.5	75	75	75	87.5
15	RUVU JKT	87.5	87.5	87.5	12.5	87.5	100	87.5	87.5	87.5	87.5
16	RUVU STATION	100	100	50	100	100	100	100	100	100	100
17	SOGA	87.5	87.5	75	87.5	75	87.5	87.5	87.5	87.5	87.5
18	VIKUGE	87.5	62.5	25	50	37.5	50	87.5	87.5	87.5	75
19	ST GETRUDE	100	85.5	100	N/A	100	N/A	100	100	100	N/A
20	TEGEMEO	100	100	100	N/A	83.3	N/A	83.3	66.7	100	N/A
21	MICO	85.7	85.7	85.7	N/A	71.4	N/A	85.5	71.4	85.7	N/A
22	JABAL HIRA	100	100	100	N/A	100	N/A	100	85.7	85.7	N/A
23	DAWASCO	100	100	100	N/A	100	N/A	100	85.7	100	N/A

5.4. INFRASTRUCTURE

In Kibaha district council all health facilities structures especially of those owned by government are in a good condition. This is contributed to by the existence of MMAM program which is being implemented by the council towards achieving the goals for the reduction of those health problems facing the community to deliver promptly health care services. The challenges that the district face is lack of staff houses for CHMT members and health facilities staffs that make it difficult for staff to report to their duties at and perform services at sites at the right time.

5.5. DISTRICT HEALTH SYSTEM CONCLUSIONS AND RECCOMENDATION

Kibaha district council is among the council that is donor dependent in the issue of implementing health activities. About 90% of the health budget depends on donors and other implementing partners. For the district to reduce dependence mobilization and sensitization on cost sharing especially CHF to the entire community is of provident important. This will help the council to manage to purchase and distribute drugs and medical equipment's and other supplies with the absence from outside support.

The Situation of the health staffs in district is somehow good, but more budgets to increase staffs according to the health policy and standard is required. Provision of staffs house and other motivation to the staffs will retain and attract other health staffs to work in the district for era.

WAY FORWARD

1. Strengthen Integrated Logistic System with quarterly visits to MSD to ensure adequate supplies and equipment.
2. To construct 2 more health facilities and to recruit more health staffs of different cadre to ensure that the peripheral villages of Kitomondo and Msua has accessible to health facilities.
3. CHMT to conduct supportive supervision with RHMT and other partners for the purpose of ensuring the sustainability of these existing projects in the district.

6. AREAS OF PROGRESS IN THE DISTRICT HEALTH SECTOR

6.1. PROGRESS IN DISTRICT HEALTH FINANCING

The health activities in the districts are funded by nine main sources of funds, theses includes, Local Government block grants, Own sources (council funds), Health Sector Basket Fund, community funds (Cost Sharing/CHF), NHIF, Health sector development Grants, Capital development Grants and MMAM and other donors. Some of the sources increased its contributions in the past one year these include Cost sharing/CHF, NHIF and own sources. A good number of the targeted activities were covered during the year of implementation. Also dependence on other sources decreased from 42.% to 6.4% in the past two to three years

6.2. PROGRESS IN DISTRICT HUMAN RESOURCES

- ***INCREASES IN SKILLED HEALTH WORKERS***

In the past three years Kibaha district council has achieved to recruit, 1 Dental Officer, 3 dental technician, 6 clinical officers, 8 Registered nurses. Also the council Permitted its staffs to upgraded for higher learning institutions these included 1 dental technician, 1 Environmental Health officer, 3 clinical officer to AMO, 10 Midwife nurses to nurse officer, 2 Laboratory assistant to laboratory technician, and 4 clinical officer to medical Doctor but they are still on studied.

6.3. PROGRESS IN DISTRICT NEONATAL HEALTH

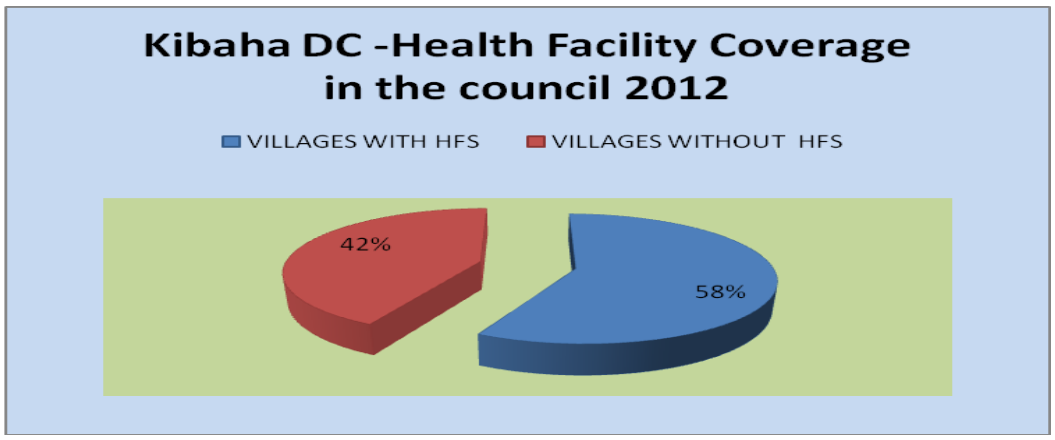
6.3.1 LOW BIRTH WEIGHT

Due to easy accessibility to health facilities in most of the communities in the council as well as increased trained health staffs in such health facilities together with three ambulances to facilitate referral to near health centre and hospital these assisted in reduction of the number of targeted indicators. The malnutrition rate in the district is low compare to that of region and national wide.

Presence of unit (KMC) to care low birth weight babies at the district reduces the mortality rate for the parameter. Education for pregnant women during ANC visits on the importance of good health and nutrition also helps to reduce number of low birth weight.

6.4. PROGRESS IN DISTRICT HEALTH FACILITY COVERAGE

The council has 33 registered villages. The number of villages with Health facilities is 19 and 14 village have no HFs. Following portioning of some villages and wards the number of villages raised from 25 to 33. The increase in number of villages lead to increased demand of Health facilities in the new villages. The current Health facilities coverage in the District is as shown in the figure below.



6.5. PROGRESS IN DISTRICT HEALTH FACILITY PERFORMANCE

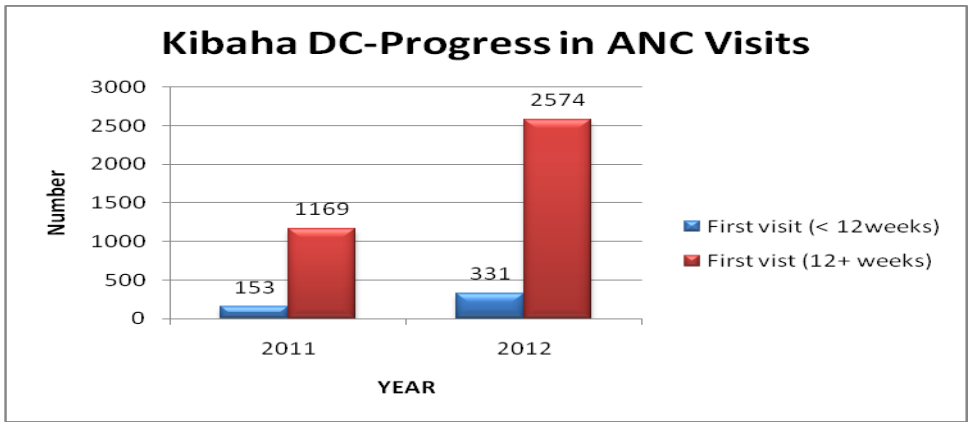
6.5.1 EXPANSIONS IN CRITICAL HEALTH SERVICES and IMPROVEMENTS IN REFERRAL HOSPITAL PERFORMANCE

The council is embarking its effort to upgrade the available health centre to be a district hospital. The districts use this health centre as the referral point from other health facilities. The distribution of three ambulances and one motorcycle facilitate the transportation of patients from peripheral areas to the health centre and then to regional referral Hospital (Tumbi Regional referral Hospital) but this apply for serious cases only. The construction and start of surgical services at Mlandizi health centre will decrease the referrals from the district to higher referral hospital.

Recruitment of professional health staffs as well as upgrading of staffs (e. g CO to AMO, Nurse Midwife to Nurse Officer) in the district helps its health facilities to perform procedure/treatment that require referral. Also Installation of modern laboratory equipment (e.g CD4 machine) at Mlandizi health centre reduces the transportation of sample to higher referral Hospital.

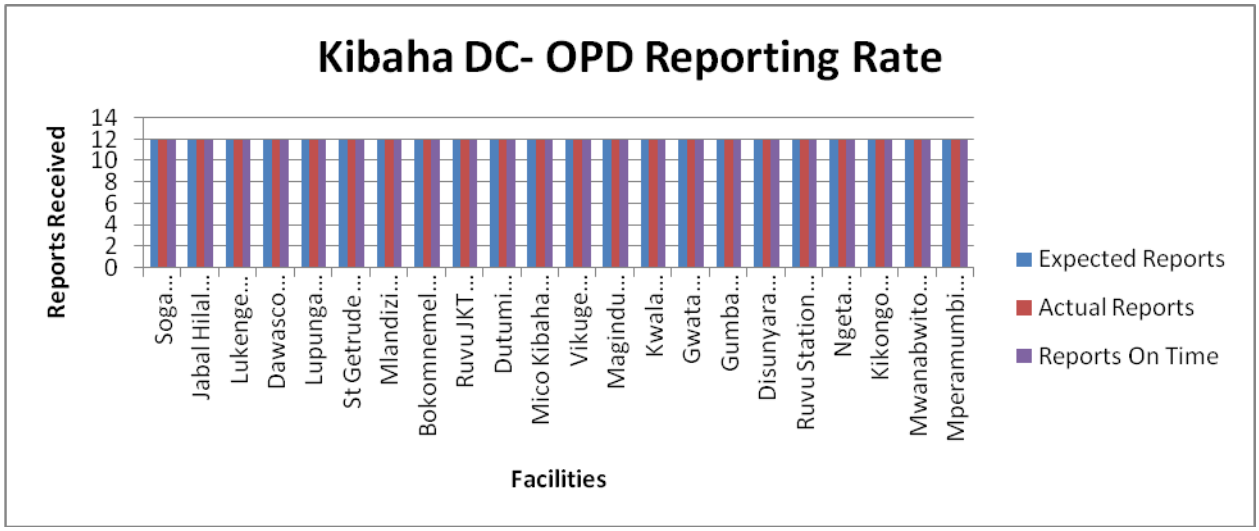
6.5.2 PROGRESS IN ANC ATTENDANCE

The ANC visit in the district in year 2012 had showed higher improvement compared to year 2011especially for pregnant women of 12 weeks and above. This improvement aided by education delivery to the entire community through using community owned resource person (CORPS) and other health stockholder.



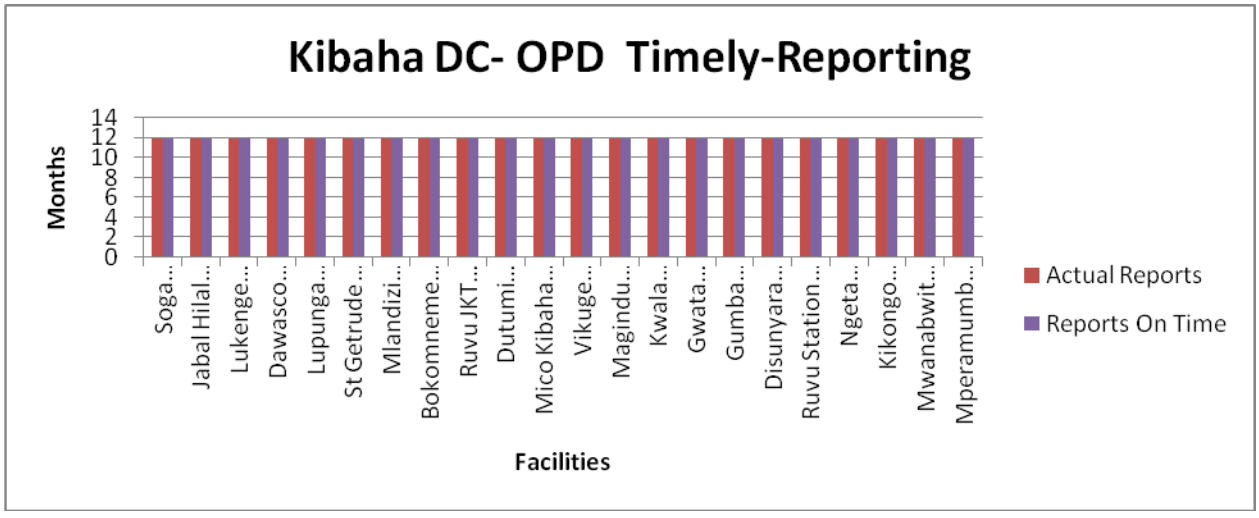
6.5.3 PROGRESS IN HEALTH FACILITY REPORTING RATES

Despite the geographical location of the district is not well defined in term of public transport but all facilities scored 100% of reporting rate. This achievement was made smooth by the provision of P4P which is in the stage of pilot at PWANI region districts including Kibaha district Council.



6.5.4 TIMELINESS AND COMPLETENESS OF DATA

Immediately after raw data have been collected from health facilities and submitted to the district level, process of data entry using new software tools (DHIS) is done with the aid of two data entry Managers. Process for data entry ends within first two weeks of the next month and always meets time needed for reporting.



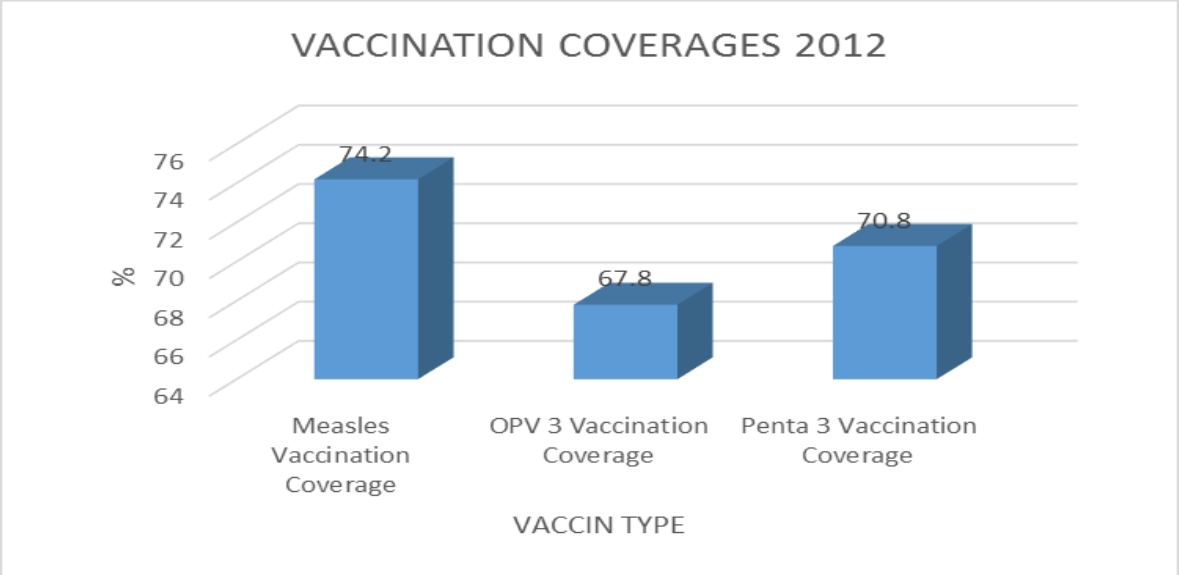
6.6 PROGRESS IN DISTRICT HEALTH SERVICES

6.6.1 SOCIAL WELFARE AND PROTECTION SERVICES FOR VULNERABLE POPULATIONS

6.6.1.1 VACCINATION COVERAGE

Although there are many obstacles that happen in connection with immunization process such as variation of target population, immigration of many people in the district but the district achieved to vaccinate their targeted population over 100%. The vaccination coverage included all vaccination such as BCG, Polio, Pentavalent, Measles and TT for pregnant women.

The figure below shows the achievement on the area of vaccination of underfive children in the general population i.e irrespective of the population from within and outside the council

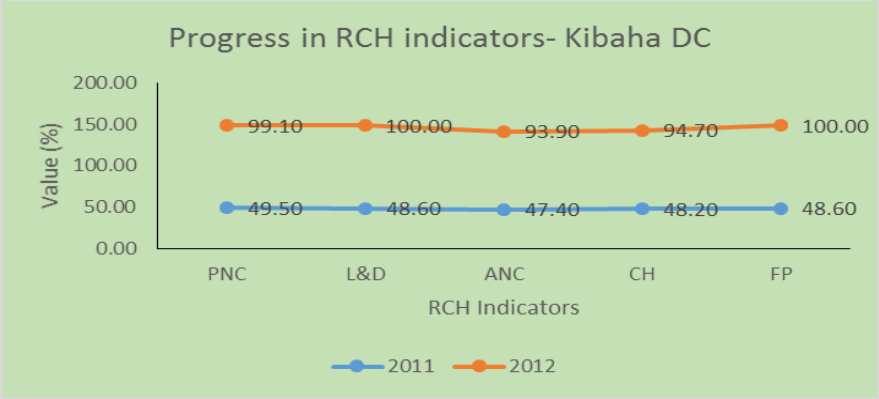


6.6.1.2 ENVIRONMENTAL HEALTH SERVICE SAFE WATER INITIATIVES

Kibaha district council through preventive health services section and water department have a program for protection of water source for the aim of providing potable and safe water to their residence. The protection includes all water sources found in the district like shallow and deep well, rivers, damps and tape water.

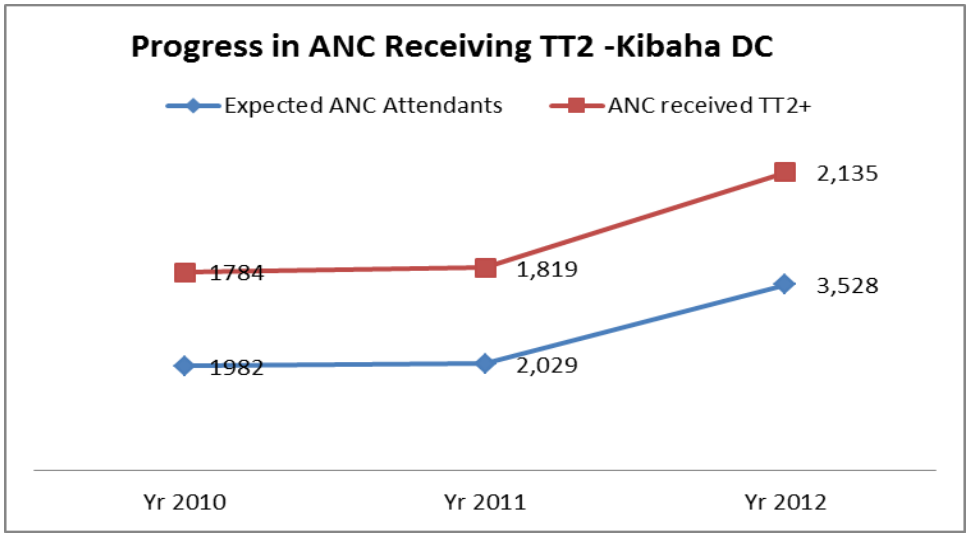
The Campaign for safe collection and disposal of refuse is an ongoing activity in the district to ensure water source are not contaminated and remain safe and clean. All this activities were done in the council to ensure the council meets its strategic plan of providing clean and safe water to 95% of total population by the year 2016.

6.6. PROGRESS AGAINST MILESTONES



- *For the period of one year we have observed a drastically increase in terms of RCH indicators as shown in the graph above.*

The progress in TT2+ coverage for the period of 3 years showed a positive trend as can be seen in the graph below.



Source: HMIS

6.7. BEST PRACTICES/CASE STUDIES

One of the best practices demonstrated in the district was involvement of males in RCH services including Family planning, Antenatal and Postnatal (Taking children to clinics). A good example of these practices is shown in the figure below during 2013 National Vaccination Campaign held at Mlandizi health centre one of the Kibaha district council health facilities**.** Following intensive campaign on male involvement in RCH services it is now common to see among the attendants at a clinic are males bringing their children for vaccination services and also some males escorting their wives for RCH services. This is a big change and an indication of shared responsibility in family health. (**See the snaps below**)


baby