The United Republic of

TANZANIA

Ministry of Health & Social Welfare

BUKOMBE

District Health Profile

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I. FOREWORD

The District Health Profile (DHP) offers insight into district health conditions by assessing priority health indicators that reflect the district health status of the population, status of health systems, and status of health service delivery. In Bukombe District Council DHP also tracks the progress in the district and highlights some of the challenges and successes has encountered.

The District Health Profile in Bukombe offers information through a reliable and transparent platform. It allows district health officials to monitor priority disease trends and adequately target relevant interventions. It helps the ministry of health determine what policies are needed to support work in the district, and in turn how to allocate resources to district efforts. It educates and empowers district health workers and in turn the community they serve.

II. ACKNOWLEDGEMENTS

The development of the Bukombe DHP is a collaborative effort, and the following people are being acknowledged for their direct contribution for the development of DHP. The Bukombe District Council would like to thank the following members of the task force, which prepared and edited the DHP.

I would like to thank the District Executive Director, Ms Lilian C. Matinga (District Executive Director), Dr. Archard Rwezahura (District Medical Officer), Mr. Jacob Kilatu (Planning Officer), Mr, Zachariah Isaack (Hospital Health Secretary), Ms Upendo Mhoja (Ag. District Nursing Officer), Mr. Nelson Mwanga (Health Secretary Mbogwe), Felister John Kibinza (District Reproductive and Child Health), Nasibu Bianchi (District Health Management Information System)

Bukombe District Council would like to express its appreciation for Ministry of Health and Social Welfare for their contribution and development of District Health Profile Template and DHP workshop.

Special acknowledgement go to Dr. Geoffrey Somi from Ministry of Health and Social Welfare, Caroline Paschal Shayo - Research Scientist – Ifakara Health Institute.

We are even more grateful to all Council Health Management Team (CHMT), and all Heath Workers of Bukombe District Council who generously contributed part of their time to enable us gather critical data and information for the development of this DHP.

Lastly but not least, the Bukombe District Council would like to extend her appreciation to many others not named, who provided valuable contribution in the process of prepared DHP.
To all of you we say, thank you so much. May GOD bless you all.

III. EXECUTIVE SUMMARY

Bukombe District Council Health comprises of all established priority health services provided into the district.

The DHP incorporates into packages of essential health intervention through consideration of beneficiary inputs. The DHP shows the actual performance, challenges and way forward. Also it considers donors as source of fund contributing towards district health activities. This links the health needs with available resources in a logical and realistic manner.

Bukombe District Council has 6 Division, 29 Wards, 134 Villages and 92 hamlets. It has 29 Health Facilities, 159 Primary School and 29 Secondary which save the population of 591,124 people. The District climate is tropic type with a mean annual temperature of 22^0c and average annual rainfall between 900-1200mm. The means of transportation and communication is by tarmac road of 115km run from Shinyanga District to Burundi/Rwanda, as well as rough road within the district which stimulate socio-economical activities. The means of communication is though mobile phones services which include Vodacom, Airtel, Zantel and Tigo.

District has shortage of water supply; people get water mainly from traditional wells and rain water harvesting tanks which is neither clean nor safe. However at present 40% of district population get clean and safe water from shallow well owned and maintained by water user groups (WUG'S)
The data used in the DHP are collected from different data source which include MTUHA registers, tall sheets and summary form, comprehensive HIV/AIDS District reports, Immunization and vaccine development reports. Malaria reports and other laboratory registers and reports.
The indicators used in this DHP, include Mandatory health indicators and Optional health indictors. All of this is used to measure the performance and the use of health service to different groups within the community. The district has good performance in ANC Attendance and vaccination coverage (<80%). However the use of family planning, IPT2 coverage an EmoC services is very low (10%).

The district faced some health problems such as malaria, childhood illness, Neonatal problems, HIV/TB problems, infant and maternal mortalities and shortage of skilled staff have relatively remained to be the challenge in implementation of the planned activities.

However the district has some strategies to overcome these challenges, such as allocation of more funds in reproductive and child health interventions including family planning, increased involvement and strengthened sensitization and mobilization of the community to participate and contribute to the implementation of MMAM development activities, to increase the allocation on Malaria control activities by ensuring adequate supplies of Drugs, Medical equipments, Hospital and diagnostic supplies. Apart from Malaria, treatment of Pneumonia, Intestinal Worms and Diarrhea is also addressed as among of top ten diseases in the district. Recruitment of more skilled health has been regarded.

IV. ACRONYMS AND KEY TERMS

Table 0-1. ACRONYMS

ACRONYM	LONG NAME
DHP	**District Health Profile**
MOHSW	**Ministry of Health and Social Welfare**
MTUHA	**Mfumo wa Takwimu wa Uendeshaji wa Huduma za Afya**
FBO	Faith Based Organazation
OPD	Out Patient Department
RCH	Reproductive and Child Health
PMTCT	Prevention of Mother to Child Transmission
IMCI	Integrated Management of Childhood Illness
mRDT	malaria Rapid Diagnostic Test
EmoC	Emergency Obstetric Care
ARI	Acute Resipiratory Infection
ANC	Antenatal Clinic
WDC	Ward Development Committee
OJT	On Job Training
CHMT	Council Health Management Team

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	Are Health services which must be done in a community such as vaccination, Care of patients, Reproductive and child health services, environmenta satinitation services etc.
OPTION HEALTH INDICATOR	Are those indicators which are uniquc in the District e.g Male Circumsion, Familiy Planning during mobile services,
MANDATORY HEALTH INDICATORS	Is a list of the standard health indicators that the district will assess from over time:

1 INTRODUCTION

1.1 MISSION AND VISION

1.1.1 MISSION

The mission of Bukombe District Council is to facilitate an effective provision and acquisition of sustainable quality socio-economic services to her people in collaboration with all stakeholders through optimal utilization of available opportunities and resources by adhering to principles of equity and good governance by 2015.

1.1.2 VISION

Bukombe District Council aspires to be a competent leading partners in the facilitation of participatory and sustainable well being of her people.

1.2 STRUCTURE OF DISTRICT

Bukombe Districts Council established by the Local government Authority of Tanzania in July 1995. The District lies in the western apex of Geita region in Tanzania. Between longitudes 31-32° east and latitudes 3-3.30° south.

The district covers an area of 10,482 km^2 of land.(4,047 mi^2); of this, 6,133 km^2 (2,368 mi^2) is estimated to be public land while 4,349 km^2 (1,679 mi^2) is forest reserves. The District stretches for about 124km between Kanegere minor settlements in the direction of South - East to North-West respectively.

According to the 2002 National Census, the District was having 395,298 people. Currently the district is estimated to have 591,124 people. The factors for population growth are births (55%), and migration (45%). The population density is 125 per km^2.

Bukombe District has 29 Wards,134 Villages and 92 Hamlets

Table 1-1 Ward. Village and Hamlets

S/N	Ward's Name	Number of Village	Number of Hamlet
1	USHIROMBO		15
2	IGULWA		17
3	NG'ANZO		32
4	BUTINZYA		28
5	**RUNZEWE MASHARIKI**	**6**	
6	**RUNZEWE MAGHARIBI**	**5**	
7	**UYOVU**	**5**	
8	**BUSONZO**	**5**	
9	**NAMONGE**	**8**	
10	**BUKOMBE**	**6**	
11	**LYAMBAMGONGO**	**5**	
12	**IYOGELO**	**4**	
13	**BUGELENGA**	**6**	
14	**MBOGWE**	**5**	
15	**USHIRIKA**	**8**	
16	**NYASATO**	**6**	
17	**NANDA**	**6**	
18	**NGEMO**	**7**	
19	**MASUMBWE**	**5**	
20	**NYAKAFURU**	**4**	
21	**LUGUNGA**	**6**	
22	**IPONYA**	**6**	
23	**BUKANDWE**	**4**	
24	**NHOMOLWA**	**3**	
25	**LULEMBELA**	**6**	
26	**IKUNGUIGAZI**	**6**	
27	**ILOLANGULU**	**4**	
28	**ISEBYA**	**4**	
29	**IKOBE**	**4**	
	TOTAL	**134**	**92**

1.3 FACILITY DISTRIBUTION

Health Services

Health services delivery in the district is still low compared with the population saved. There is one hospital, 4 health centres and 14 dispensaries which are public owned. Also nine dispensaries and one health centre are privately owned and one FBO dispensary, making a total of 29 Health Facilities in the District.

Table 1-2. Facility Distribution

TYPE OF FACILITY	NUMBER OF FACILITIES	OWNERSHIP
HOSPITAL	1	Government
DISPENSARY	23	14 Gornnment, 8 Private, 1 FBO
HEALTH CENTER	5	4 Government, 1 Private
CLINICS	0	

[PIE CHART SHOWING FACILITY DISTRIBUTION]

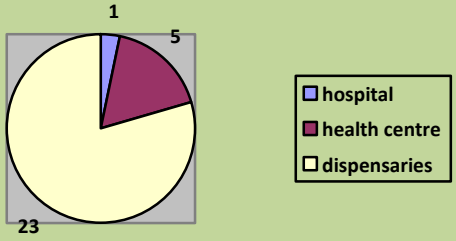
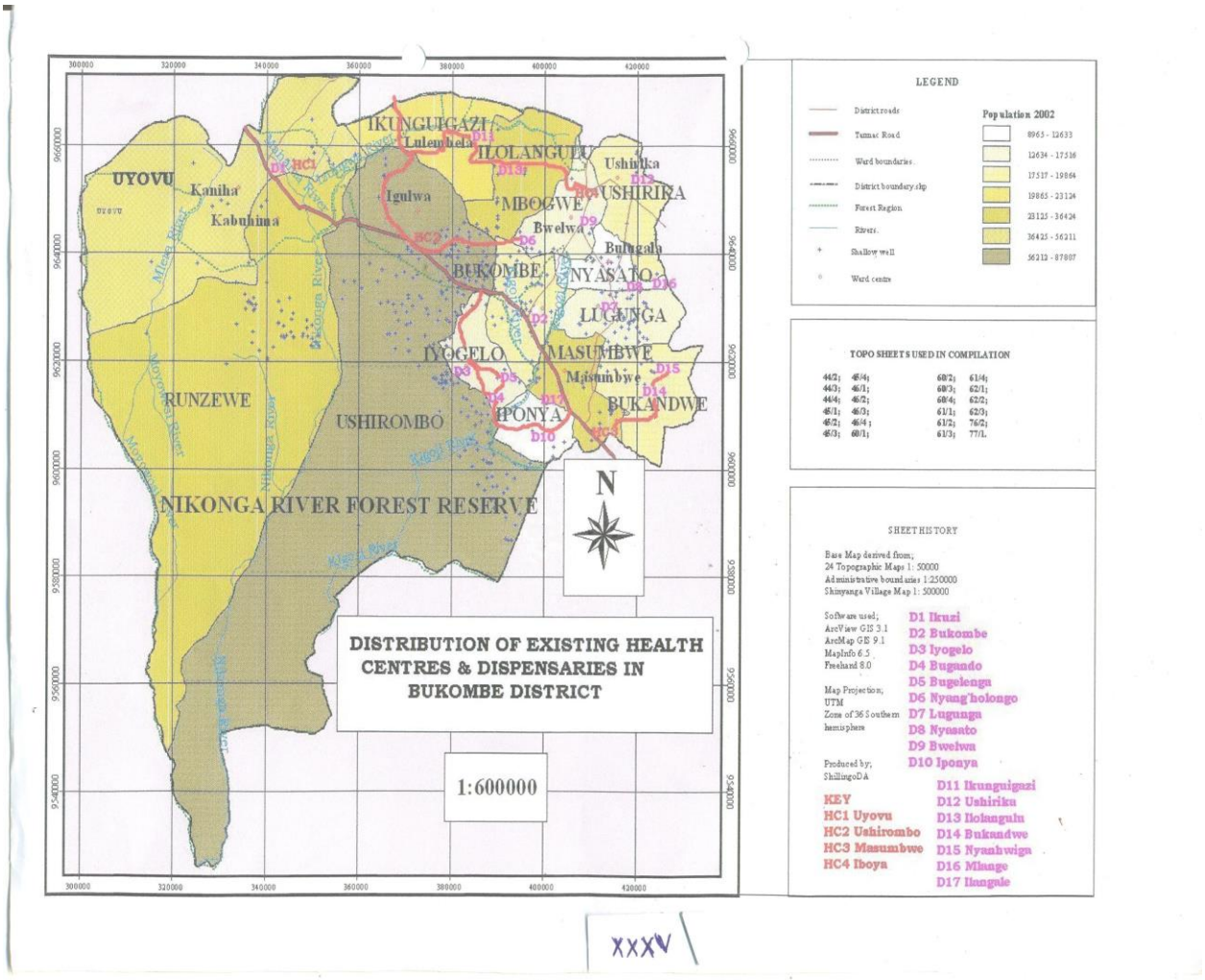


FIGURE 1-1 Bukombe District Map



1.4 POPULATION DISCRIPTION BY WARDS

The District has 591,124 people, in which 292,188 are female and 297,006 are men. Children under one year of age are 31,766, 1- 4 years are 104,881, 5-14 years are 172,930, 15 – 49 years are 248,075, where by 50 years and above are 33,472.

Table 1-3. Gender And Age Based Statistics

AGE RANGE	FEMALE	MALE
<1 YEAR	15,709	16,057
1-4	52,240	52,641
5-14	86,583	86,347
15-49	124,155	123,920
>50	15,431	18,041
TOTAL	294,118	297,006

1.5 GEOGRAPHY

The District has a tropical type of climate with a mean annual temperature of 22^0C and an average annual rainfall between 900 – 1200mm. The district has a bimodal rainfall character, rainfall is fairly evenly distributed with short rains from September to December followed by a dry spell from January – February before a long and heavy rains set in between the months of March until May.

The District consist of plains, hills, rivers and forests. Its parts of the plains that extend from the southern shores of Lake Victoria is used for habitation while the remaining is forest reserve managed by the community, District Council and Central Government .

1.6 TRANSPORTATION AND COMMUNICATION

The tarmac road of 115 km runs from Isaka to Burundi/Rwanda crosses the district from the South – East to North – West direction. The road has tremendously stimulated socio–economic opportunities and population influx to seek opportunities in areas of agriculture, mining, transport, trade, communication, marketing and construction industries.

Generally the district has inadequate road network during rain season, the available roads are impassable prohibiting the mobility of people and goods hence leading to increased prices of consumable goods.

Public transportation is available through the year within and out of the District.

The means of telecommunication services in Bukombe district includes land telephones, mobile phones, fax mails and internet services. Tanzania Telecommunication Company Limited (TTCL) extended wireless telephone to the district since 2002. The Mobile Service providers which are currently operating in the district include Vodacom, Airtel, Zantel and Tigo though in some areas the network is not accessible.

1.7 EDUCATION

Primary education is delivered at least in every village in the district. The district has 156 primary schools. (154 are public and 2 are private) and 26 secondary schools (24 public and 2 are private) . There is acute shortage of desirable accommodation for staff and their families, shortage of classrooms and learning and teaching materials. In line with the National Education policy, the community has been sensitized to take change in matters pertaining to primary and secondary schools development.

Literacy rate by gender in Bukombe districtis high, the percentage of female literacy rate in Bukombe district by the year 2002 was 38% per population and housing census; male literacy rate for the same year was 52%.

1 . 8 PEOPLE AND MIGRATION

The population increase by 7.4%, is mainly due to migration rather than natural growth. Major influx is by people from Eastern part of the region and few from nearby regions of Mwanza, Kagera and Kigoma infuluenced by minor gold mines found in the distrct. A seasonal activity also influences people's migration and labour demand. During the rainy season, October – March, most labour is concentrated in agricultural activities. During the

dry season, June–September when farmers sell their crops, rural – urban migration and vice versa is common for both men and women indicating increased affluence among the district community rush areas.

1.9 WATER AND POWER SUPPLY.

Water services in the district are generally not satisfactory. People get water mainly from traditional wells and rain water harvesting tanks .Water from the traditional wells is neither clean nor safe. However, at present 40% (235,038 people) of the district population get clean and safe water from shallow wells and rain water harvesting tanks owned and maintained by water user groups (WUG's). Likely the practice of user level operation and maintenance (ULOM) and legal framework over the improved shallows wells ensure sustainability of the existing shallow wells. Water harvesting tanks (RWHTs) have been constructed both at Institutional and Community level involving construction of small RWH tanks (Thai Jars) by trained local artesian who are found at village level. At a small, scale piped water scheme is currently operational Ushirombo urban, Bwelwa and Lunzewe. The scheme is run by Urban Water Supply Authority under the District Council.

The electricity power to any modern development is certainly of prime importance. To date the district is not connected to National Grid electricity power. The District Council and the District Hospital are served with fuel Generators, whereas some few people depend on the private owned generators. The district is working hard in collaboration with other development partners to ensure availability of reliable electricity in the district for rural electrification in the fiscal year 2013/2014.

CHAPTER 2:
DATA COLLECTION METHODS AND SOURCES OF DATA

2.1 DATA SOURCES AND THEIR DATA COLLECTION AND ANALYSIS METHODS

- MTUHA registers, tally sheets and summary forms
  - Used to collect information from the patients/ community at health facility level
  - Tally sheets make a summary of data
  - Summary forms used to report the health facility performance at district level

- DHIS 2
- Comprehensive HIV/AIDS District report
- Immunization and vaccines development report (IVD)
- Malaria report

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 Bukombe district population.
- The status of the Bukombe health system.
- The status of health service delivery in Bukombe district.
- Progress that has been made in the Bukombe district health sector.

The health status of the Bukombe district population in Maternal , Newborn and Child Health was:-

- Nutritional Status (Low body Weight) was 0.5%
- Neonatal Mortality rate was 0.5/1000
- Infant Mortality rate was 2/1000
- Underfive Mortality rate was 0.1%

Diseases

- Incidence of Malaria 124/1000
- HIV/AIDS prevalence 6.3%
- Top 10 causes of Admission Malaria is leading cause of admission 46 %
- Top 10 cause of death Malaria is leading cause of death 48%

The status of the Bukombe health system.

Health Financing

- Total GOT and donor allocation to health per capita is 10,285/=
- MO and AMO per 10,000 population is 0.3/10,000
- Nurse-midwives per 10,000 population is 1/10,000
- Pharmacists and Pharm Tech per 10,000 population is 0.2/10,000
- Health Officers per 10,000 population is 0.2/10,000
- Laboratory staff per 10,000 Population is 0.6/10,000

Infrastructure
1 – Hospital
5- Health Centre
23- Dispensary
84- Dispensary Under construction
Total 29 of Health Facilities are in operation and 84 are under construction.

The status of health service delivery in Bukombe district.

General

- OPD Attendance is 28%

Vaccination

- Proportion of children under 1 vaccinated against measles 83 out of 90
- Proportion of under 1 3rd Polio (OPV3) 81 out of 90
- Proportion of under 1 BCG dose 109 out of 90

Reproductive Health

- Percentage of health centers and dispensaries that can provide EmOC as defined in Essential Health Packege 10%
- Proportion of pregnant women starting ANC before 12 or 16 weeks gestation 29 out of 60

Infectious Diseases and Non-Communicable Diseases

- Proportion of mothers who received two doses of preventative intermittent treatment for malaria during last pregnancy is 10%
- Proportion of laboratory confirmed malaria cases among all OPD visits is 39%
- TB notification rate per 100,000 population is 320/100,000

2.3 HEALTH INDICATORS IMPORTANT TO BUKOMBE DISTRICT

Bukombe District Council has high HIV prevalence rate of 6.3%. Therefore the District has the programme of Male circumcision and Male involvement in RCH to reduce HIV transmission .

BUKOMBE DISTRICT SPECIFIC INDICATORS
1. **Male circumcision**
2. **Male Involvement in RCH**
3. **Percentage FSB among reported births**
4. **Contraceptive prevalence rate**
5. **Percentage of HIV positive women receiving ARVs to prevent MTCT**
6. **Percent of TB treatment success/completion**

2.4 KEY MESSAGES ABOUT HEALTH INDICATORS.

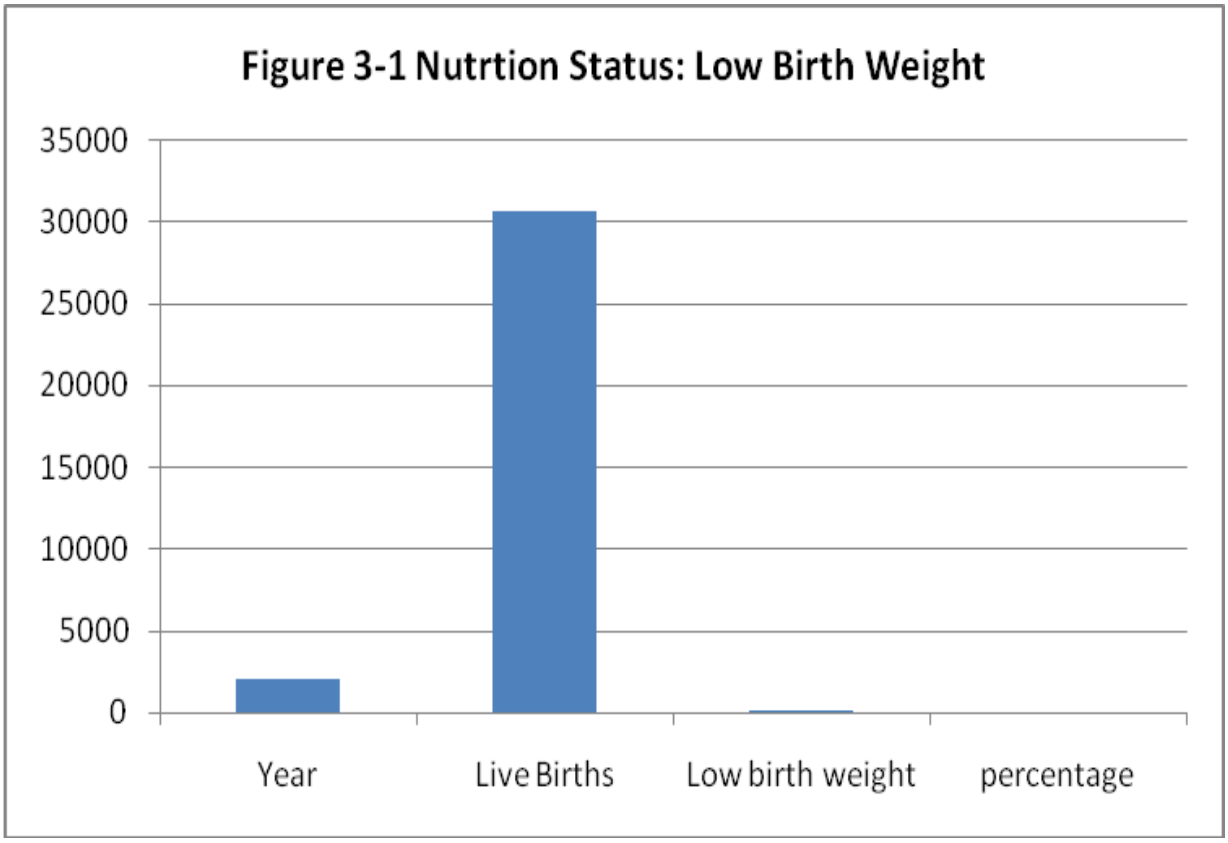
Male circumcision service is low compared to targeted group of 49,088 people per year. The number of clients registered for male circumcision was 10,483 and whose circumcised was 10,237(21%). This means that there is still high number of uncircumcised clients.

Contraceptive prevalence rate – There is slow increase of CPR of 0.3% compared to year 2011, but this indicates there is still a big gap that needs to be filled to reach the national target of 60% by 2015. This indicator has high contribution in prevention of Maternal and new born morbidity and mortality.

Increased the ratio of FSB from 4.4/1000 (2011) to 4.9/1000(2012). This increase contributed by many factors such as:- late referral from lower health facilities, Inadequate health facilities in the district, Inadequate transport (Only two Ambulances available in the district) and late referral from family as well as irregular availability of obstetric emergence drugs.

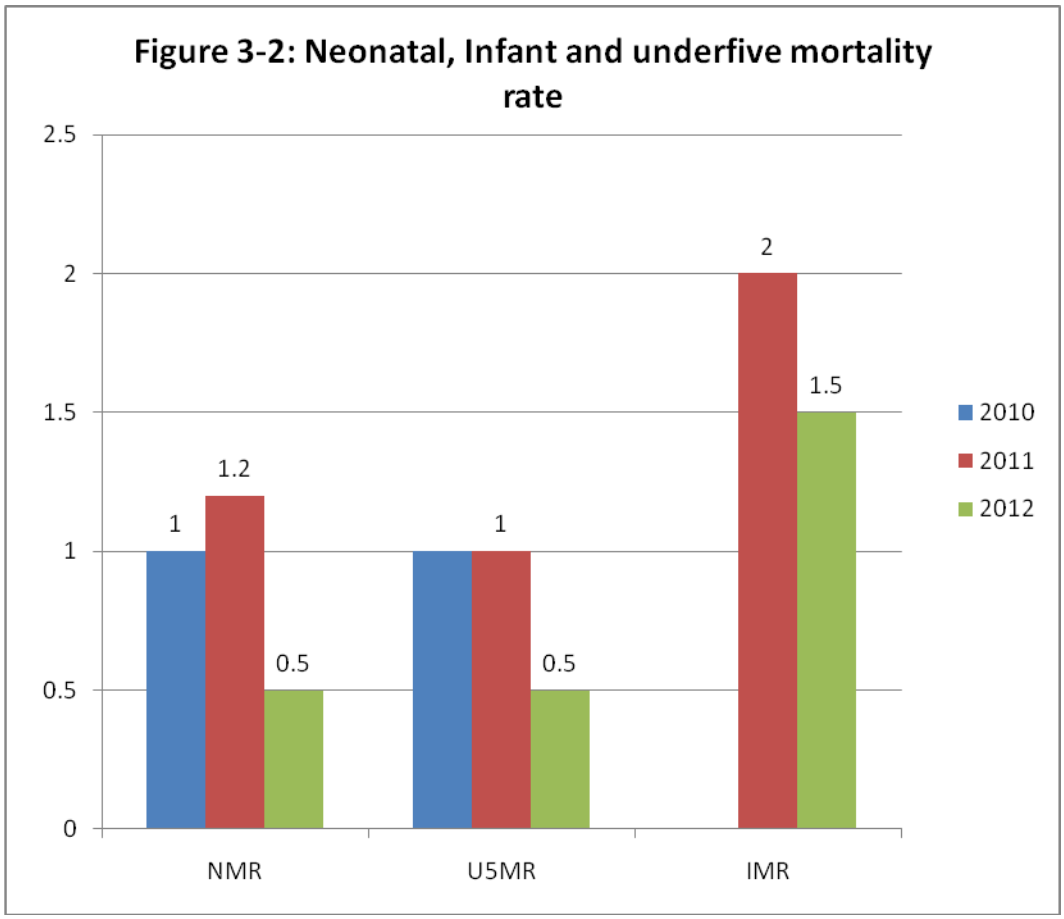
3 HEALTH STATUS OF THE DISTRICT POPULATION

3.1 MATERNAL,NEWBORN AND CHILD HEALTH



Among the number of children born alive which is 30,622 only 166 children born with low weight (0.5%) and the rest born with normal birth weight (>2.5 kgs). (2012)

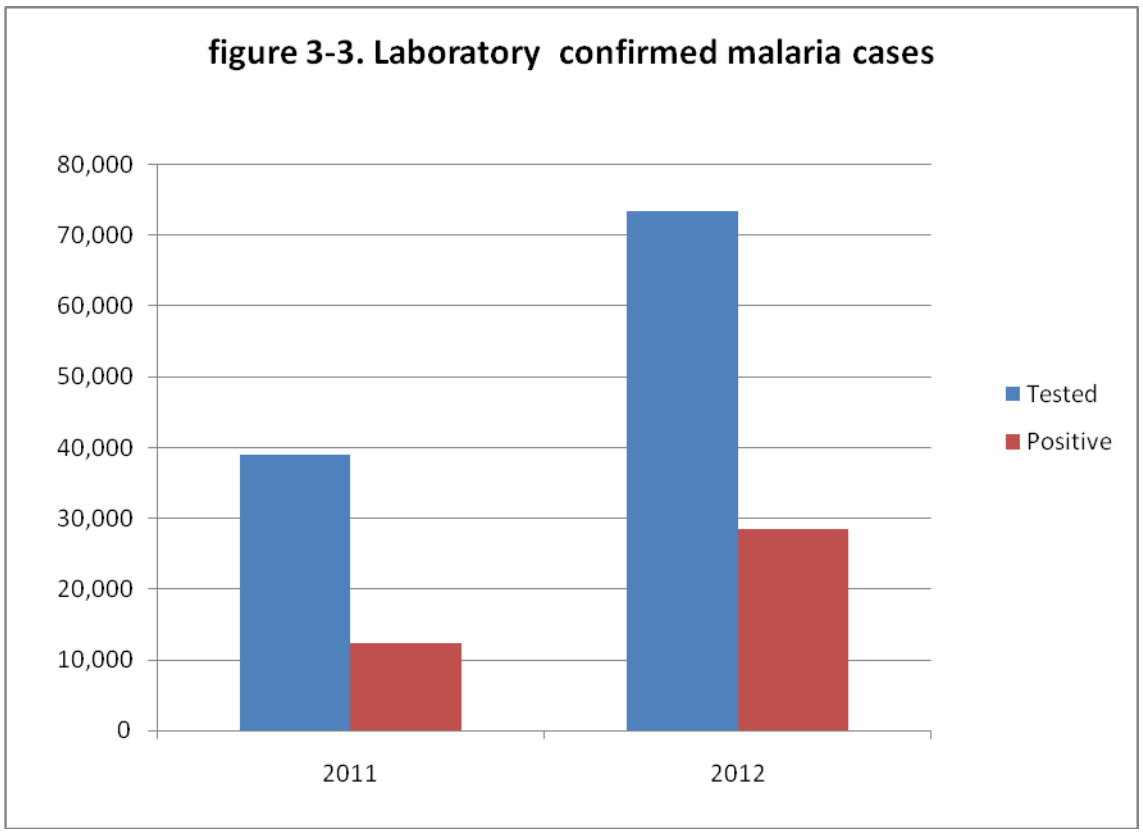
3.2 NEONATAL,INFANT AND UNDERFIVE MORTALITY RATE



The results show a significant decline of child mortality specifically neonatal and under five mortality rates, however high infant deaths remain a significant challenge in Bukombe. The decline of these indicators is attributed by various social and economic factors including the expansion of resource allocation and interventions to tackle various cases affecting under five such as immunization program, IMCI, PMTCT, EmoC etc.

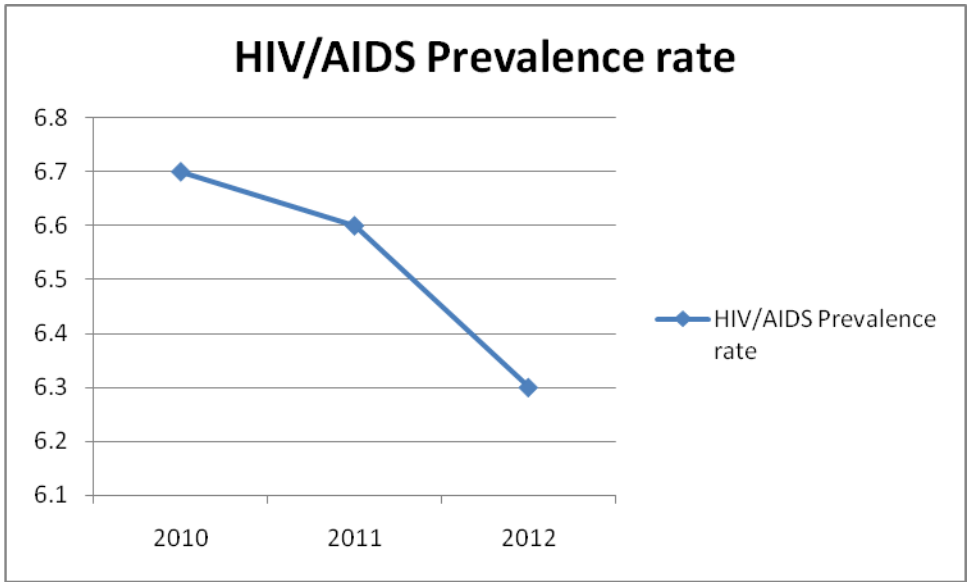
3.3 MORBIDITY.

MALARIA INCIDENCE



This shows that the number of malaria cases tested increased due to presence of mRDT tests from 38,922 (2011) to 73,556 (2012) which is available in all levels of health facilities. This enable health service providers to manage malaria cases accordingly and to prevent malarial mortality.

HIV/AIDS PREVALENCE



This indicator shows that the extent of HIV prevalence rate decline from 6.7% (2010) to 6.3% (2012). To decline of this indicator is attributed to various social economic Factors such as presence of HIV test kits, knowledge of community about HIV Prevention and Male circumcision activities.

TOP 10 CAUSES OF ADMISSION

Table 3-1 Top 10 Causes of Admission

		Under 5 years			5years and above		
No	**Diagnosis**	**M**	**F**	TOTAL	**M**	**F**	TOTAL
1	Severe, complicated Malaria	1214	1251	2465	809	903	1712
2	Anaemias	307	218	525	78	63	141
3	Pneumonia	239	167	406	24	28	52
4	Diarrhoea Diseases	128	110	238	8	11	19
5	ARI	86	137	223	0	0	0
6	Urinary Tract Infections	18	43	61	47	40	87
7	Burns	16	23	39	1	2	3
8	Sickle Cell Anaemia	7	9	16	0	0	0
9	Meningties	3	6	9	1	0	1
10	Malnutrition	7	3	10	0	0	0
	TOTAL	2025	1967	3992	968	1047	2015

This table shows that malaria is the leading cause of morbidity among other diseases for both under five and above five years. This may contribute to poverty and underdevelopment

3.3 MORTARITY Table 3-2. Top 10 Causes of Death

		Under 5 years			**5years and above**		
		DEATHS		**TOTAL**	**DEATHS**		**TOTAL**
No	**Diagnosis**	**M**	**F**		**M**	**F**	
1	Severe, complicated Malaria	47	35	82	13	16	29
2	Anaemias	12	9	21	0		0
3	Pneumonia	16	12	28	0	2	2
4	Diarrhoea Diseases	2	2	4	0	0	0
5	ARI	1	1	0	0	0	0
6	Urinary Tract Infections	0	0	0	0	0	0
7	Burns	0	0	0	0	0	0
8	Sickle Cell Anaemia	0	2	2	0	0	0
9	Meningitis	0	1	1	0	0	0
10	Malnutrition	0	0	0	0	0	0
	TOTAL	**78**	**62**	**138**	**13**	**18**	**31**

This table shows that malaria is the leading cause of mortality among other diseases for both under five and above five years.

3.4 OPTIONAL HEALTH STATUS OF THE DISTRICT POPULATION INDICATORS

1. Male circumcision is 21%
2. Male Involvement in RCH is 8.5%
3. Percentage FSB among reported births is 5/1000
4. Contraceptive prevalence rate is 10%
5. Percentage of HIV positive women receiving ARVs to prevent MTCT is 87%
6. Percent of TB treatment success/completion is 82%

SUCCESSES

- **Increase number of male involvement in RCH from 15.3%(2010) to 36% (2012)**
- **Increased number of male circumcision from 0% (2011) to 29%(2012)**
- **Increase contraceptive prevalence rate from 9.7%(2011) to 10%(2012)**

CHALLENGES

- Male circumcision service is low compared to targeted group of 49,088 people per year. The number of clients registered for male circumcision was 10,483 and whose circumcised was 10,237(21%). This means that there is still high number of uncircumcised clients.

- Contraceptive prevalence rate – There is slow increase of CPR of 0.3% compared to year 2011, but this indicates there is still a big gap that needs to be filled to reach the national target of 60% by 2015. This indicator has high contribution in prevention of Maternal and new born morbidity and mortality.

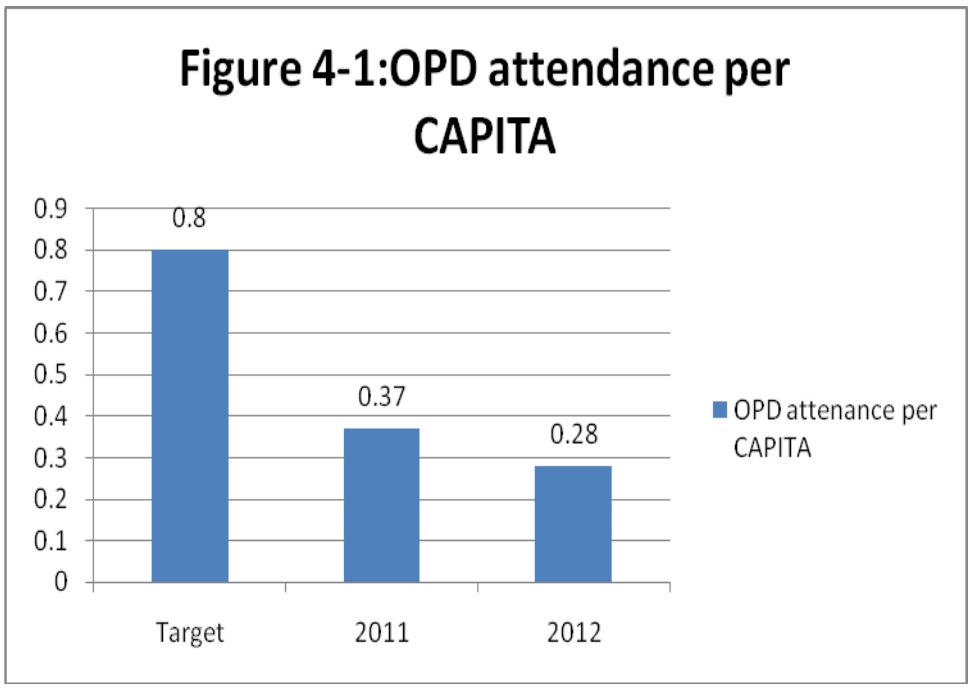
- Increased the ratio of FSB from 4.4/1000 (2011) to 4.9/1000(2012). This increase contributed by many factors such as:- late referral from lower health facilities, Inadequate health facilities in the district, Inadequate transport (Only two Ambulances available in the district) and late referral from family as well as irregular availability of obstetric emergence drugs.

3.5 DISTRICT HEALTH STATUS CONCLUSIONS, RECOMMENDATIONS AND WAY FORWARD.

- Community sensitization on Male Circumcision and male partner involvement in RCH is carried out to different Wards in the district to sensitize males to participate in RCH Clinic and MC in order to minimize the transmission of HIV.
- The District integrated the family planning services into immunization outreach and mobiles in order to increase family planning up take as a part of maternal , perinatal, mortality reduction.
- To provide health education about the important of ANC early booking and health facility deliveries to the community during ANC services provision, immunization outreaches and WDC meetings.
- To strengthen comprehensive supportive supervision to all levels of health facilities and to carry out OJT and mentorship to existing staff.
- To construct more health facilities.

4 STATUS OF HEALTH SERVICE DELIVERY IN THE DISTRICT

4.1 GENERAL HEALTH SERVICE



This indicator shows that the extent of facility utilization by population is decline, contributed by the presence of few health facilities comparison to the high population which is mostly in villages where there are few health facilities.

4.2 VACCINATION SERVICES

- Children under one year of age in 2012 were estimated to be 31,766.
- Under one year children received measles vaccines were 26,284 (83%), OPV 3 were 25,809 (81.2%) and BCG vaccines were 34,705 (109.3%)

Challenges

- Most of antigen is below National target that is 90% (OPV3 and measles)

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

Year	Target	OPV3		BCG		Measles	
		Number Vaccinated	%	Number Vaccinated	%	Number vaccinated	%
2011	30,777	25,674	84	31,716	103	24,988	82
2012	31,766	25,809	81.2	34,705	109.3	26,284	83

This showing a high number of unvaccinated children 5,957(18.8%) not vaccinated with polio vaccines and 5,482 (17%) not vaccinated with measles Vaccine. This may result in outbreak of vaccines preventable diseases.

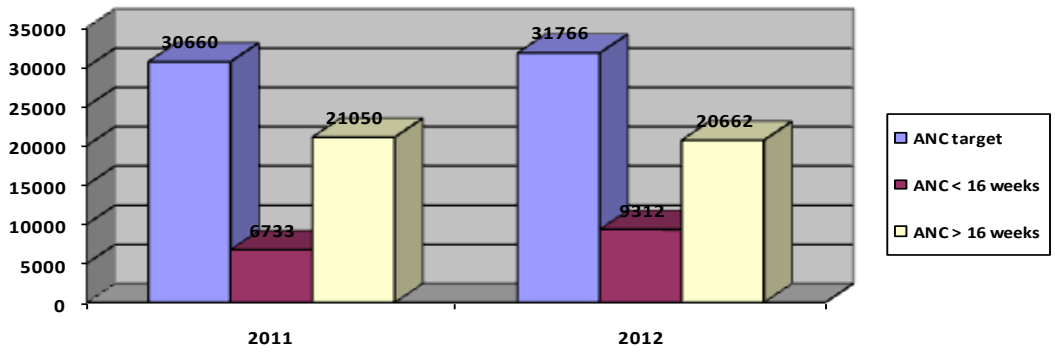
4.3 REPRODUCTIVE HEALTH SERVICES

- Targeted pregnant mothers were 31,766 for the year 2012
- Total number of women attended ANC at least once were 29,974 (94.3%)
- Total number of pregnant mothers attended ANC before 16 weeks of gestation were 9,312 (29.3%)
- Total numbers of health facilities provide EmOC services were 2 out of 19 health facilities providing RCH services.

Challenges

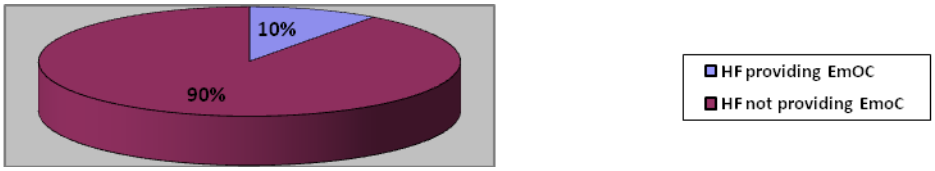
- Late ANC booking
- Low coverage of EmOC services

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



This shows that low number of pregnant mothers attended at ANC clinic before 16 weeks (24% 2011 and 29.3% in 2012), resulting in late detection of danger signs, delay in receiving proper care and treatment, leading to increased number of maternal newborn morbidity and mortality

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



This shows that the percentage of health facilities providing Emoc services is very low (10%) compired with population served (591,124). More training to health service providers is needed to expand services as well as regular availability of emergency obstetric drugs.

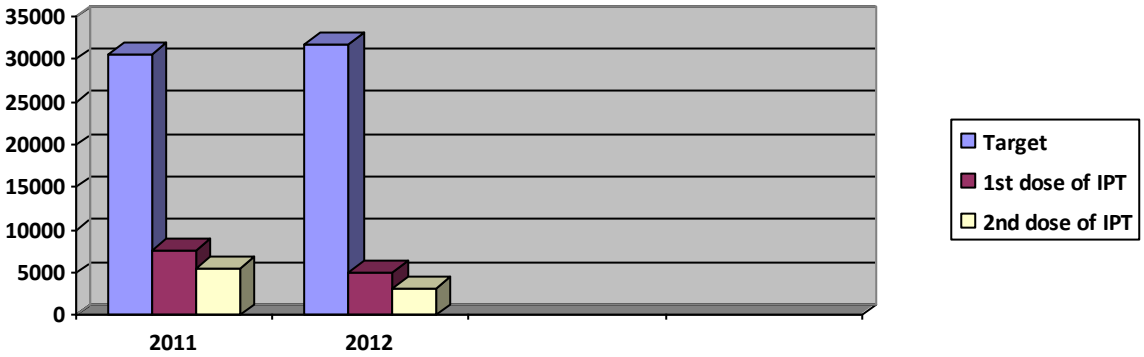
4.4 INFECTION DISEASE AND NON-COMMUNICABLE DISEASE HEALTH SERVICES

- Number of pregnant mothers targeted to attend ANC clinic in 2012 were 31,766.
- Total number attended were 29,974 (94.3%) in which 5056 (16%) received 1st dose of SP.
- Total number of pregnant mothers received 2nd dose of SP were 3233 (10.1%)
- Proportion of laboratory confirmed malaria cases among all OPD visit 17%
- Total number of patients notified to have TB were 1,891, hence notification rate per 100,000 population were 320/100,000

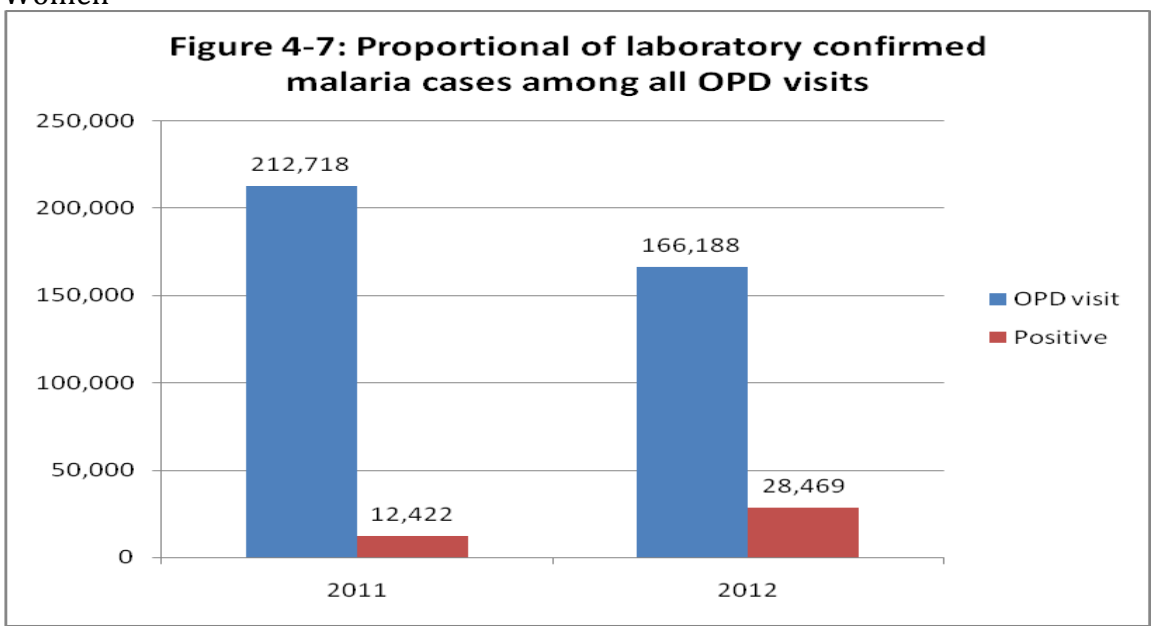
Challenges

- Irregular availability of SP drugs at health facilities
- Late ANC visit by pregnant women resulting into few pregnant mothers received 2 doses for SP.

Figure 4.5 Proportion of mothers who received two doses of Preventive Intermittent Treatment for Malaria During Last Pregnancy

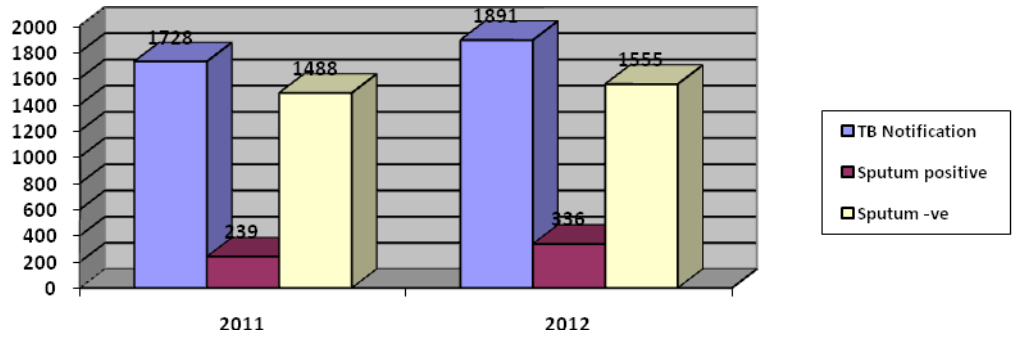


This table shows that there is decrease in SP coverage to pregnant women from 18% (2011) to 16% (2012). This is due to in adequate supplies of SP drugs from MSD. If this persist may results into abortion, MSB, Malaria and Anemia in Pregnancy
Women



This table shows that the proportional of laboratory confirmed malaria cases among all OPD visits increased from 12,422 (2011) to 28,469 (2012) due to presence of mRDT test kits in dispensaries and microscopy in Hospital and Health Center

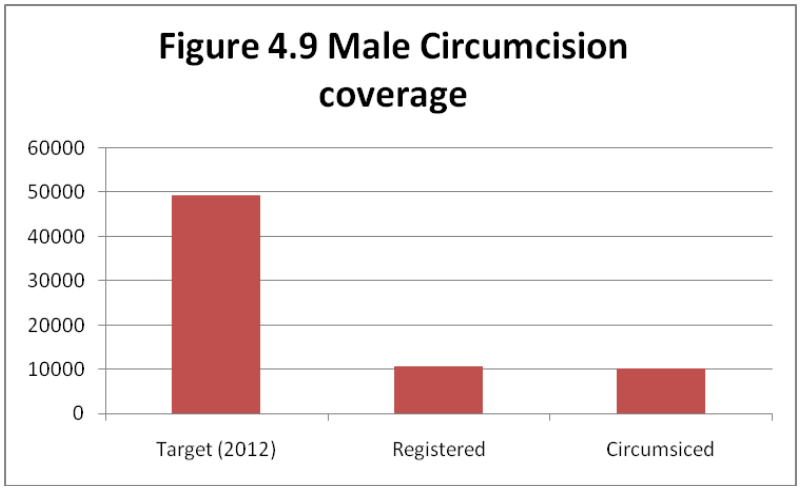
Figure 4-8. TB notification rate per 100,000 population



This shows that there is an improvement in TB notification from 304:100,000 (2011) to 320:100,000 (2012) resulting in early detection and treatment of TB cases. Also decreased incidence of TB infection in the community

4.5 OPTIONAL DISTRICT HEALTH SERVICE DELIVERY INDICATORS

1. Male circumcision is 21%
2. Male Involvement in RCH is 8.5%
3. Percentage FSB among reported births is 5/1000
4. Contraceptive prevalence rate is 10%
5. Percentage of HIV positive women receiving ARVs to prevent MTCT is 87%
6. Percent of TB treatment success/completion is 82%



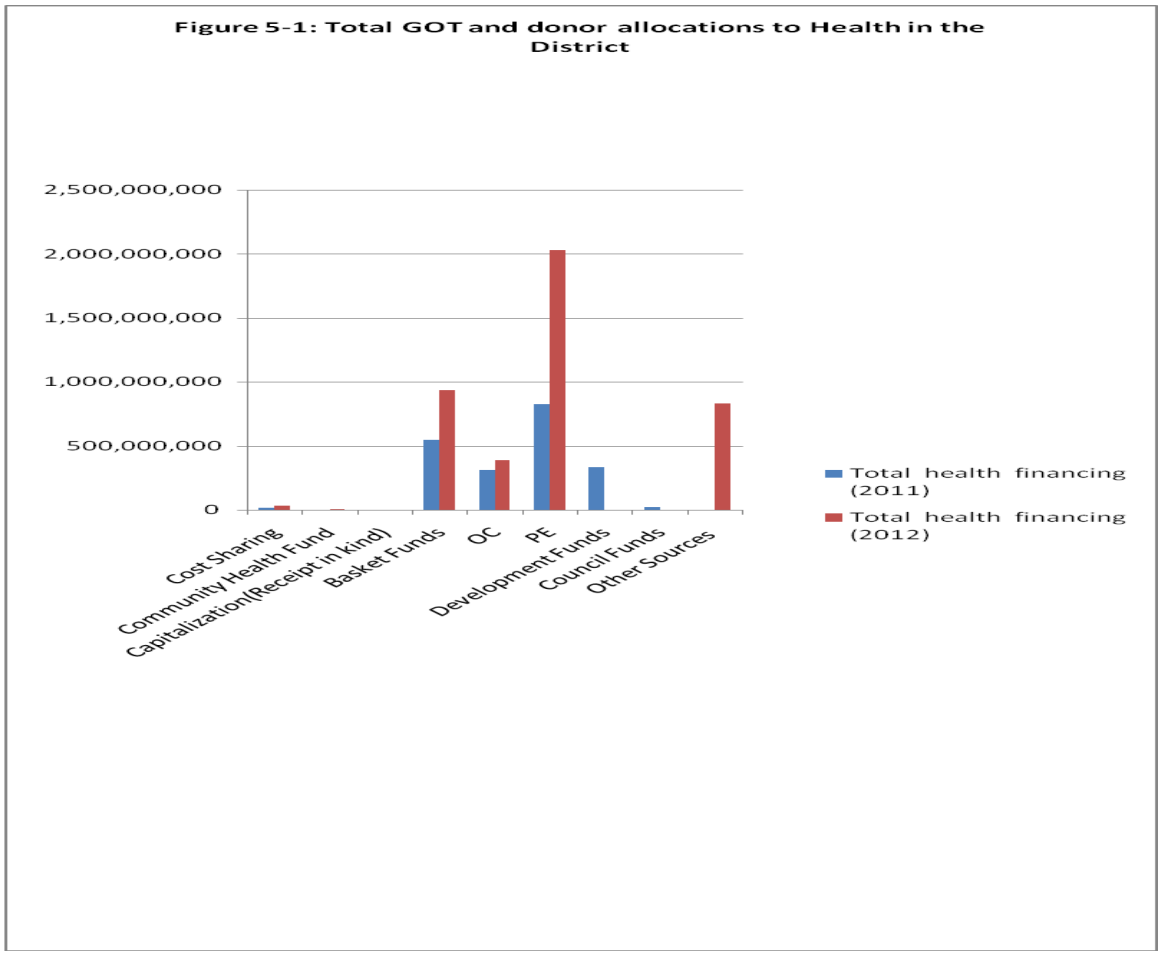
Male circumcision service is low compared to targeted group of 49,088 people per year. The number of clients registered for male circumcision was 10,483 and whose circumcised was 10,237(21%). This means that there is still high number of uncircumcised clients.

4.6 DISTRICT HEALTH SERVICE DELIVERY CONCLUSIONS, RECOMMENDATIONS AND WAY FORWARD

- Community sensitization on Male Circumcision and male partner involvement in RCH is carried out to different Wards in the district to sensitize males to participate in RCH Clinic and MC in order to minimize the transmission of HIV.
- The District integrated the family planning services into immunization outreach and mobiles in order to increase family planning up take as a part of maternal , perinatal, mortality reduction.
- To provide health education about the important of ANC early booking and health facility deliveries to the community during ANC services provision, immunization outreaches and WDC meetings.
- To strengthen comprehensive supportive supervision to all levels of health facilities and to carry out OJT and mentorship to existing staff.
- To construct more health facilities.

5 STATUS OF DISTRICT HEALTH SYSTEMS

5.1 HEALTH FINANCING

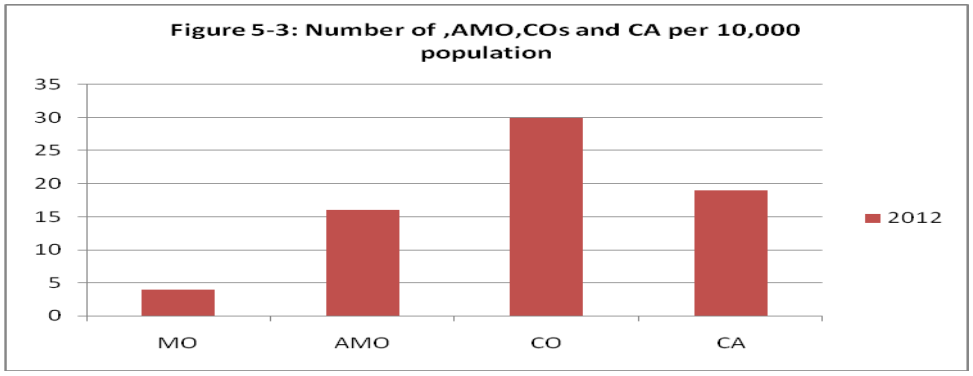


The above figure shows that in both 2011 and 2012 had no fund allocate for Capitalization. In 2011 there were no allocation for Community Health Fund and Capitalization and in 2012 no allocated fund from Development fund and Council fund. However there was increase of PE Fund in 2012 by 145.32% from 2011

5.2 HUMAN RESOURCES FOR HEALTH

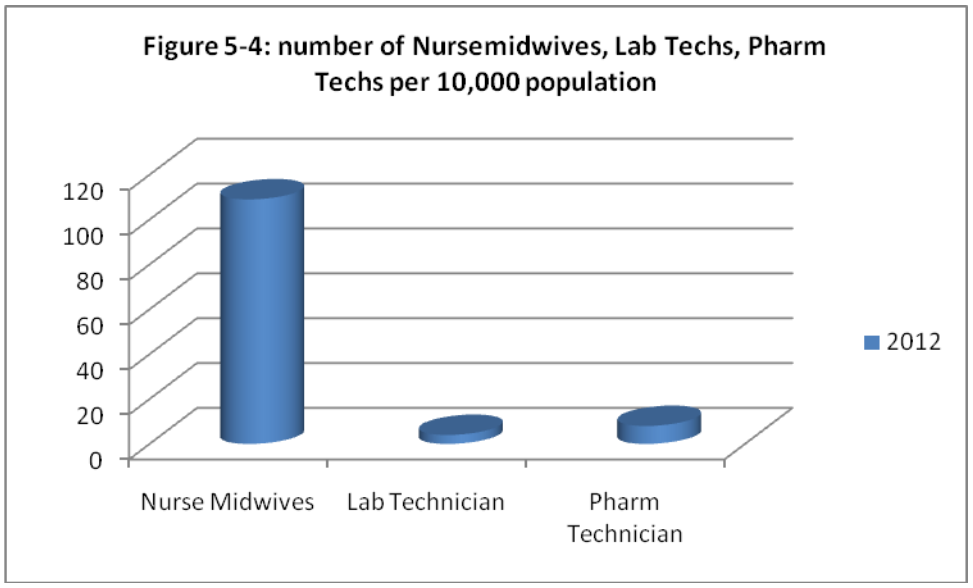
- NUMBER OF TRAINING INSTITUTIONS WITH FULL NACTE ACCREDITATION IN THE DISTRICT- **No Training Institute in Bukombe**

- NUMBER OF MEDICAL OFFICERS (MO), ASSISTANT MEDICAL OFFICER (AMO), CLINICAL OFFICER AND CLINICAL ASSISTANT PER 10,000 POPULATION



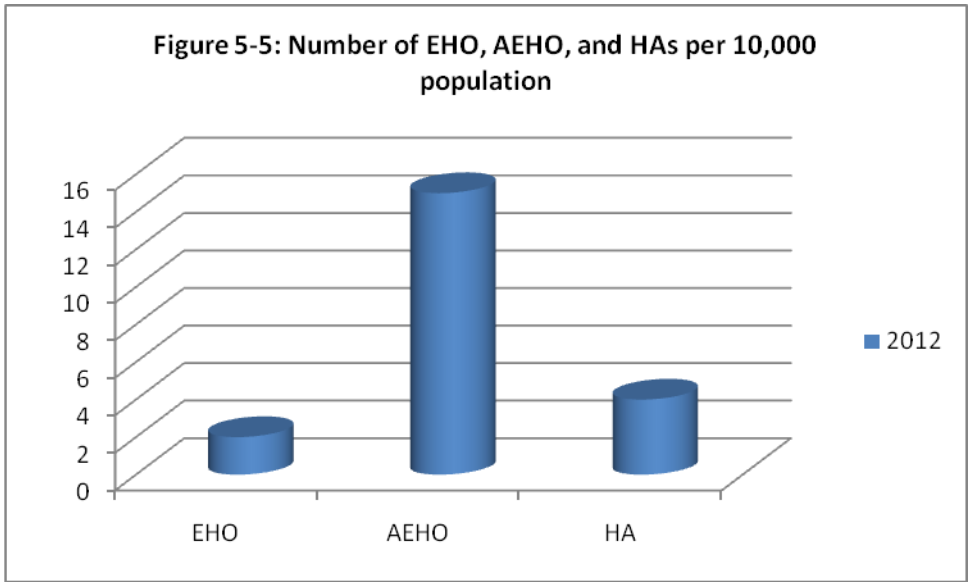
The table above shows that the number of MO available is 4,AMO 16,CO's 30 and CA's 19 which makes a proportional 1.1/10,000 on provision of Health services in total population.

- **NUMBER OF NURSE MID WIVES, LAB TECHS AND PHARM TECHS PER 10,000 POPULATION.**



The table above shows that the number of available is Nurse Midwives 109 which makes a proportional of 2/10,000 on Health services provision,
The table also shows that the number of Lab Tech 4 and Pharm Tech 8 which makes a proportional 0.2/10,000 on provision of Health services in total population.

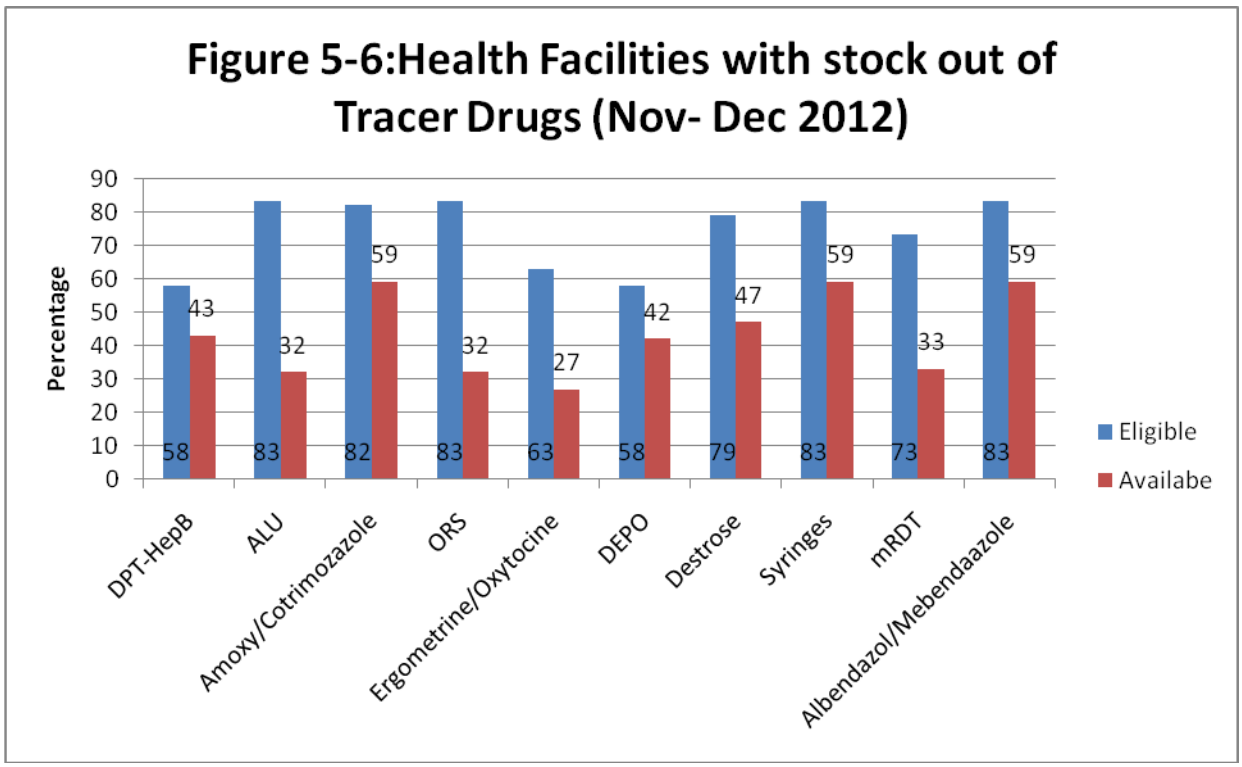
- NUMBER OF HEALTH OFFICERS, ASSISTANT HEALTH OFFICER AND ENVIRONMENTAL HEALTH OFFICERS PER 10,000 POPULATION



The table above shows that the number of EHO available is 2,AEHO 15, and HA's 4 which makes a proportional 0.3/10,000 on provision of Health services in total population.

5.3 Medicines/ Drugs

Figure: 5-6 Health Facilities with stock out of Tracer Drugs, 1 Vaccine and Medical supplies



According to the figure above, shows that there is unadquate of important drugs and medical supplies to the different runing health facilities.

5.4INFRASTRUCTURE

Infrastructure and equipment shortcomings:

Based on table 26 a list with medical equipment needed could be developed.

Based on table 17 twenty health facilities need rehabilitation. However, Bukombe District has only 19 government health facilities in comparison to 123 villages. Moreover, all private health facilities are located in town centers. Thus, 102 villages remain without any health facility. Therefore, construction of new dispensaries and health centre is urgently needed.

Problems concerning the efficiency of the referral system including transport and communication: The tarmac road runs from Isaka to Burundi crosses the district from Southeast to Northwest direction; a stretch of 115Km is in Bukombe District. The road tremendously stimulated socio-economic opportunities and population influx for agriculture, mining, transport, trade communication, marketing, construction and industry especially along the tarmac road.

However, on average the district has a poor road network. Most of the existing roads are in bad condition and some of them are impassable during the rainy season limiting mobility of people, hindering mobile health services of vaccinations and referral of patients.

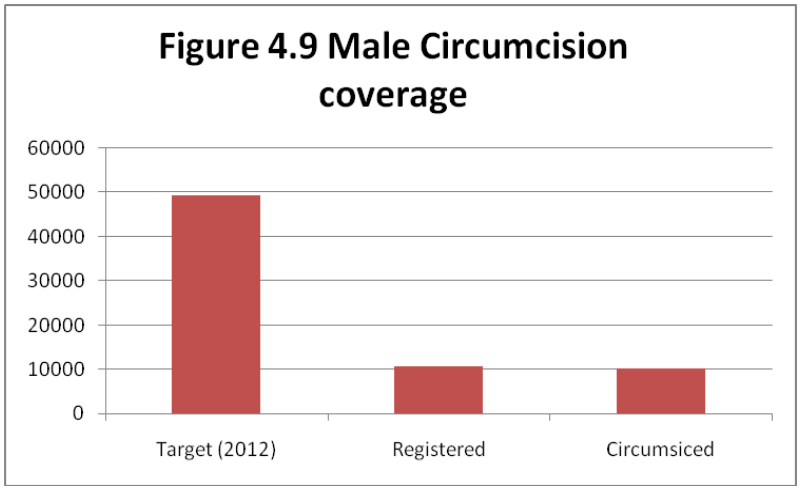
5.4.1 Management and Supervision

There are inadequate trained personnel in the area of specialization of laboratory, radiology, clinicians, nursing and MTUHA management. The above mentioned areas hamper the proper delivery of health services to the community.

The implementation of facilitative supportive supervision was not conducted as planned due to seasonally or roads, where some of the roads are not passable during rainy season.

5.5OPTIONAL DISTRICT HEALTH SYSTEM INDICATORS

1. Male circumcision
2. Male Involvement in RCH
3. Percentage FSB among reported births
4. Contraceptive prevalence rate
5. Percentage of HIV positive women receiving ARVs to prevent MTCT
6. Percent of TB treatment success/completion



Male circumcision service is low compared to targeted group of 49,088 people per year. The number of clients registered for male circumcision was 10,483 and whose circumcised was 10,237(21%). This means that there is still high number of uncircumcised clients.

5.6 District health system conclusion and way forward

Conclusion

Issues and challenges

- Irregular availability of essential drugs, supplies and reagents for pregnant mothers to the heath facility(SP, RCH Cards, RPR test kits, and HIV test kits).
- Other indicators has no data collection tool eg. Vulnerable groups, women sleeping under mosquito nets last night.
- Late compilation and submission of data from Health Facilities to district level.
- Too many data collection and data submission tools from different programs.
- Limited data analysis and data use at health facilities levels .
- No feedback of data from high level to lower level.
- Newborns survival still a major challenge.
- Family planning uptake still a big challenge in the district .
- In adequate of health facilities in the district.
- Low number health facilities delivery

6 : AREAS OF PROGRESS IN THE DISTRICT HEALTH SECTOR

6.1 PROGRESS IN DISTRICT HEALTH FINANCING

Table 6-1 Overall Health Financing

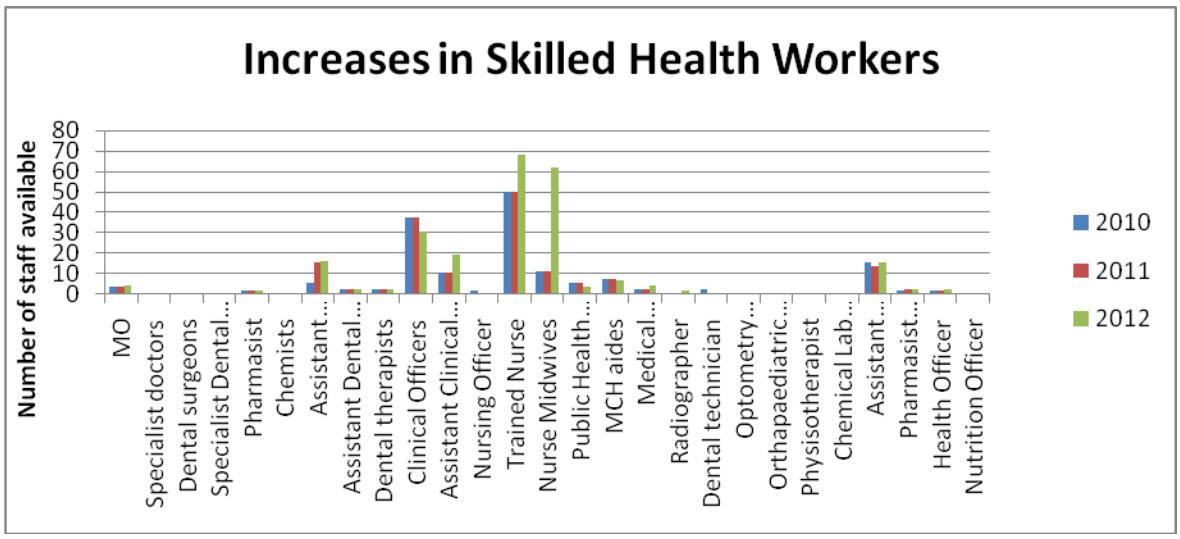
Source of Fund	2009/2010	2010/2011	2011/2012
Cost Sharing	15,785,400	15,000,000	34,574,200
Community Health Fund	29,276,000	-	5,688,300
Capitalization (Receipt in kind)	548,838,270	-	-
Basket Fund	1,157,579,550	548,789,000	935,424,600
OC	319,400,970	313,245,067	386,088,100
PE	1,316,241,922	827,603,417	2.030,307,998.45
Development Fund	640,623,536	334,210,000	-
Council Fund		20,000,000	-
Other Sources			**830,586,191**

The table above shows the flow of Income for the past Three years (2010 – 2012) whereby 2009/2010 no fund allocated on Development Fund Council Fund and Other sources, where by 2010/2011 no fund allocated on Community Health Fund, Capitalization and other sources. 2011/2012 there is no fund allocated on Capitalization, Development Fund and Council Fund. However there was increase of PE Fund in 2011/2012 by 145.32% from 2010/2011.

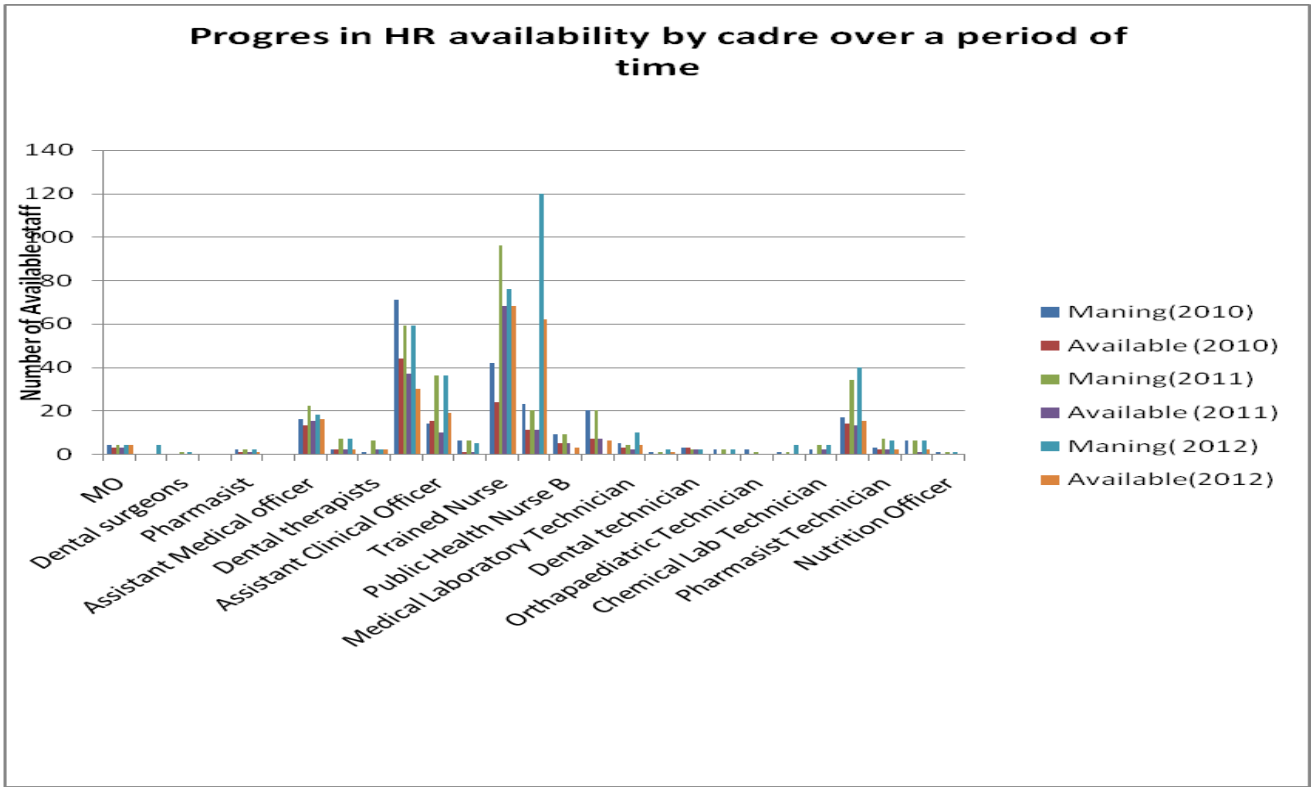
Table 6-2: Expansion in Health spending.

Source of Fund	2009/2010	2010/2011	2011/2012
Cost Sharing	15,785,400	15,000,000	322,999,500
Community Health Fund	29,276,000	-	1,088.724
Capitalization (Receipt in kind)	548,838,270	-	91,005,538
Basket Fund	1,157,579,550	548,789,000	785,751,324
OC	319,400,970	313,245,067	316,001,429
PE	1,316,241,922	827,603,417	2,017,021,398
Development Fund	504,950,000	334,210,000	-
Council Fund		20,000,000	-
Other Sources			577,005,908.41

6.3 PROGRESS IN DISTRICT HUMAN RESOURCES

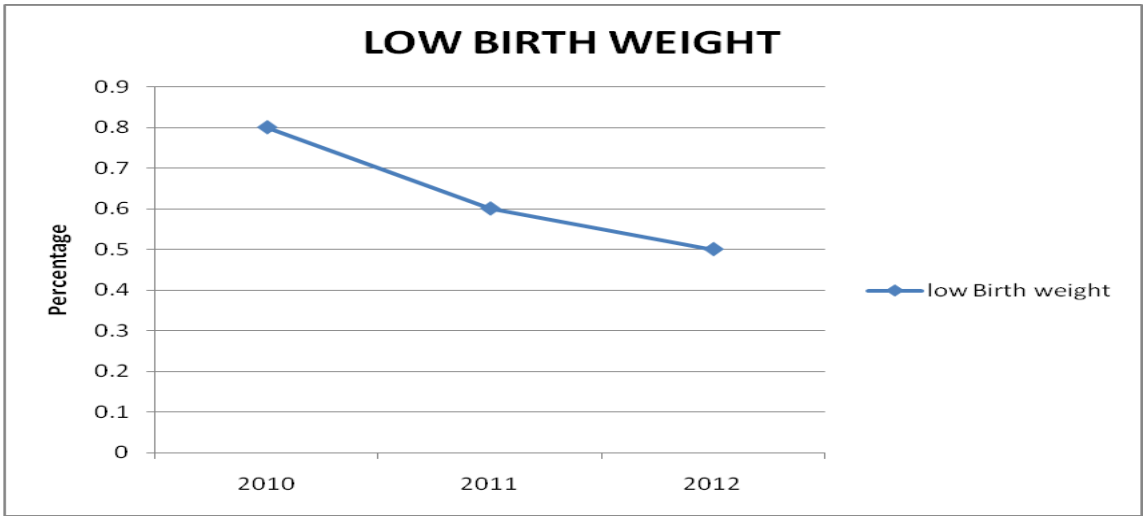


Shortage of Skilled Health Workers is a challenge for existing health facilities in Bukombe District. i.e. Medical Officers, Dental Surgeon, Optometry Technicians, Orthapaediatric



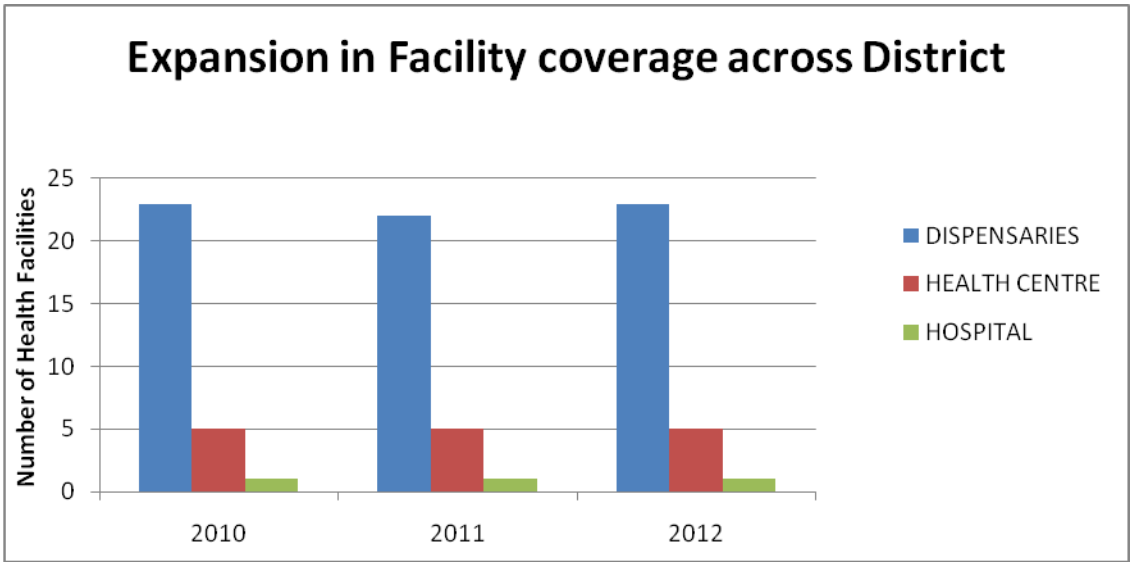
According to the above figure shows that from 2010 to 2012 there had been shortage of some health cadres i.e dental surgeon, radiographer, orthapaediatric technician, nutrition officer etc. However despite the fact that the number of cadre requested there were no staff posted to cover the above stipulated carders.

6.3 PROGRESS IN DISTRICT NEONATAL HEALTH



This chart shows that there is decline in low birth weight from 0.8% (2010) to 0.5% (2012). This can be contributed by improved diet to pregnant women in the community.

6.4 PROGRESS IN DISTRICT HEALTH FACILITY COVERAGE



The District has total number of 123 villages as compared to 29 available operating health facilities. This contradicts the National Policy which requires one Health Centre for each ward and one dispensary for each village. In 2011 the number of health facilities was reduced because some private dispensaries were closed because of failure to meet the required health services provision standard.

6.5 PROGRESS IN DISTRICT HEALTH FACILITY PERFORMANCE

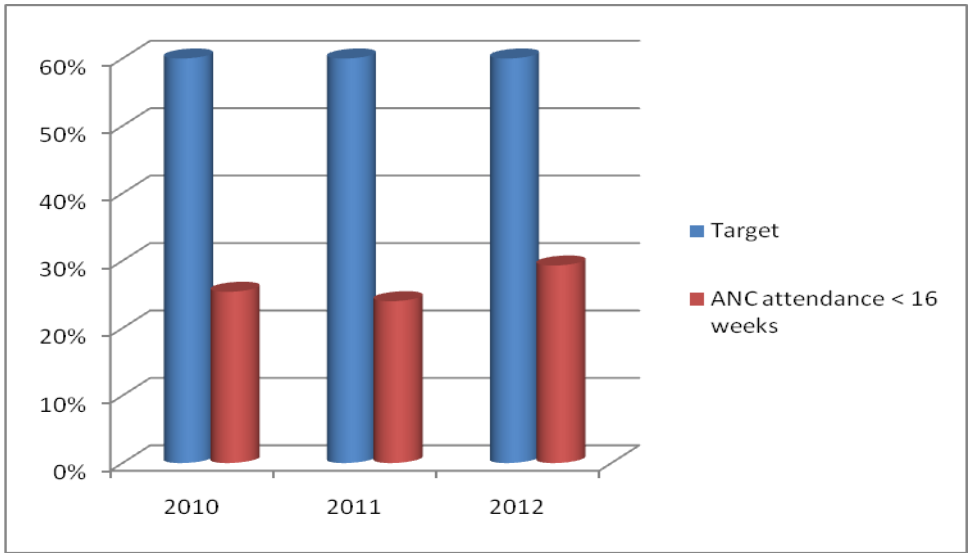
- **EXPANSION IN CRITICAL HEALTH SERVICES**

Bukombe District Council is expected to open seven health facilities by the year 2013/2014 namely Ilangale Disp, Msasani Disp, Nyakafuru Disp, Mlange Disp, Bulugala H/C, Butinzya H/C, and Bulega H/C. As well as Lugunga Dispensary proposed to be Health Centre.

- **IMPROVEMENT IN REFERRAL HOSPITAL PERFORMANCE**

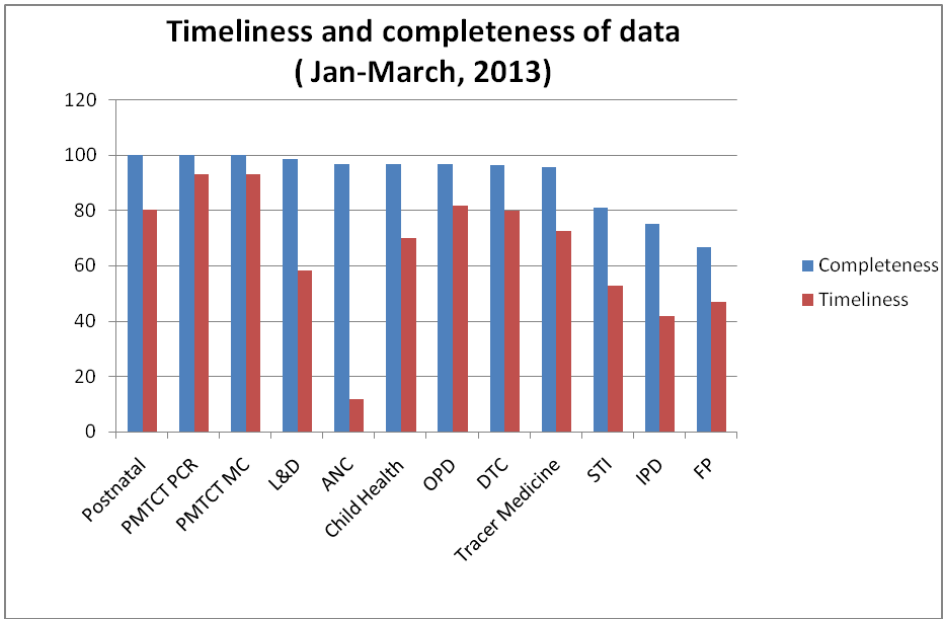
Bukombe District council there are two Motor vehicle ambulance ,and two Bajaj for referral services, however there are improvement of referral system from Dispensary to Health Center then to District Hospital.

- **PROGRESS IN ANC ATTENDANCE**



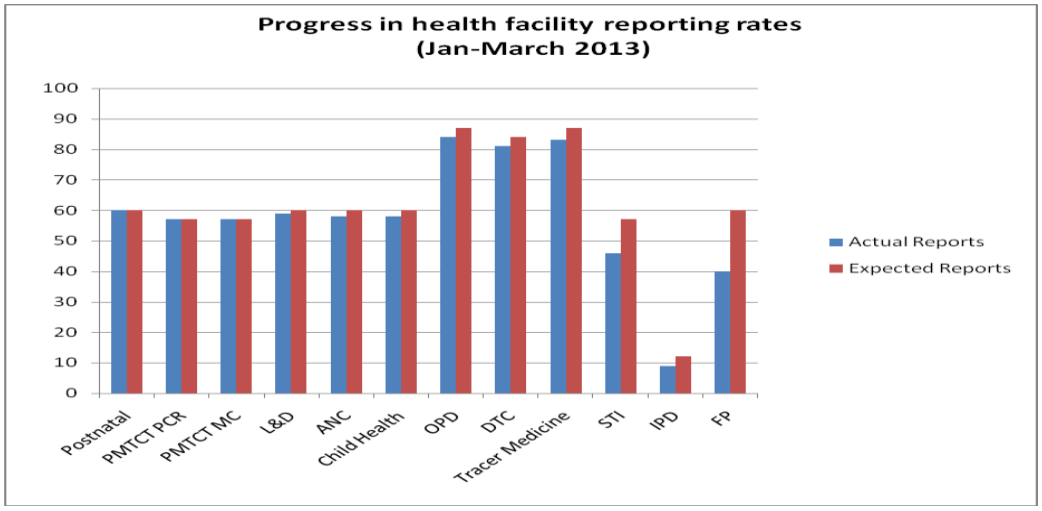
This table shows that there is an improvement of pregnant mother attended at ANC Clinic before 16 weeks from 25.4% (2010) to 29.3%(2012) this results in early detection and proper provision of care and treatment of Malaria and other conditions this leading to decrease number of Maternal newborn morbidity and mortality.

- **PROGRESS IN HEALTH FACILITY REPORTING RATES**



According to the above figure shows that the completeness of report is higher than timeliness because other health facilities they bring report at late time. However there is improvement of reporting time.

- **TIMELINESS AND COMPLETENESS OF DATA**



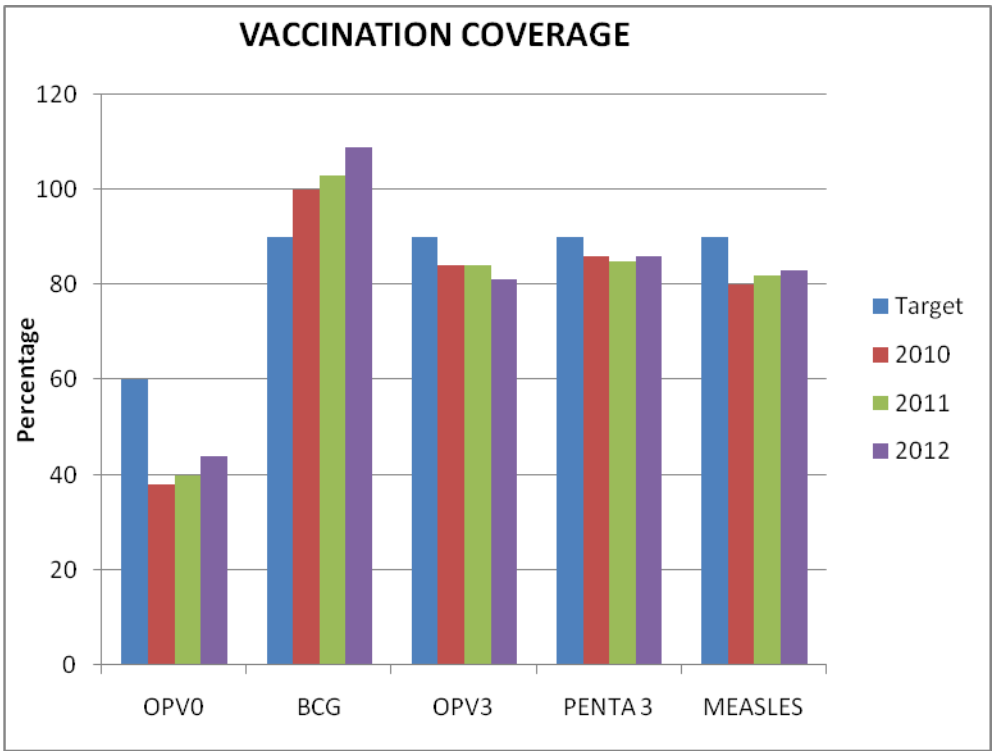
According to the above figure shows that the expected reports is higher than actual reporting because other health facilities they bring report at late time.eg. L$D, ANC, Child Health, OPD, DTC, Tracer medicine, STI, IPD and Family Planning. However there are improvements of reporting time at Postnatal, PMTCT PCR, PMTCT MC.

6.6 PROGRESS IN DISTRICT HEALTH SERVICES

- SOCIAL WELFARE AND PROTECTION SERVICES FOR VULNERABLE POPULATIONS

OVC				MVCS		
YEAR	**M**	**F**	**T**	**M**	**F**	**T**
2011	1213	1257	2470	1267	1422	2689
2012	1820	1441	3261	1952	1838	3790

- VACCINATION COVERAGE



This shows that some antigen have low coverage for year 2010 and 2011 but 2012 coverage is raised for OPV0, BCG, PENTA 3 and Measles, this may be contributed by long distance from the served population and health facilities. The council is planning to increase the health facilities through MMAM program to achieve the coverage of 90%

- **ENVIRONMENTA HEALTH SERVICES SAFE WATER INITIATIVES**

Year	Total House Holds	Households Inspected	With appropriate Latrine	%	Safe source of Water	%
2010	90,888	53,977	32,133	59.5	37,976	70.3
2011	94.630	69,080	44,554	64.4	54,146	78.3
2012	98,521	74,341	59,112	79.5	59,785	80

This table shows that there is an improvement of appropriate Latrine and safe source of water from 70.3% (2010) to 80% (2012) according to Households inspected.

6.7 PROGRESS AGAINST MILESTONES

[SUMMARY OF PROGRESS OVER THE PAST 1-3 YEARS IN THE FOLLOWING AREAS:

- **PROGRESS AGAINST MILESTONES SET BY THE TECHNICAL REVIEW OF THE JOINT ANNUAL HEALTH SECTOR REVIEW FROM PREVIOUS YEAR.**

Health SWApMilestones 2012/13

Area/Resp.	Milestone	Process Action Plan	Output/Indicator/Assumptions	Implementation Status
1) District Health Services **TWG 1**	All council's health plans 2013/2014 and reports 2012/2013 are prepared using existing tools (revised CCHP guidelines, Plan Rep, EPCOR) and are of improved quality.	1) Conduct training Intensify supportive supervision and coaching/ mentoring to all CHMTs on the use of existing tools.	1) Number of CHMT trained on the use of existing tools 2) Number of CHMTs provided with targeted coaching and mentoring by on the application on the existing tools 3) Number of supportive supervision visits to CHMTs by RHMTs on the application of the existing tools	1) ..... CHMT trained on CCHP/PlanRep in October to November 2012. 2)..... CHMTs provided coaching/mentoring for CCHP 2013/14 preparation after receiving the training on how to support CCHP in October and November 2012.. 3)..... RHMT routes conducted to provide Supportive supervision to CHMTS by their existing tools. .
2) Human Resources **TWG 2**	An increased number of health and Social welfare workers with the right skills and more equitably distributed by June 2013.	1. Increase number of posted health and social welfare workers, tracking of their reporting rates and retention 6 months after being posted	1. District report on number of posted health and social welfare workers (per cadre and levels) by June 2013; HRHIS disaggregated HWs reports by cadre, Skilled & unskilled, and ownership by June 2013.	The report generated by HRHIS shows: The total posted is 31 The reported cadre is as follows: (skilled) CO – 2 CA- 4 Assistant Nursing Officer 4 Nurse – 12 Tech Pharm – 1 Asst Tech Pharm – 2 Tech Radiology – 1 Lab Asst - 1 Unskilled (Workers). Medical Attendant - 2

3) Service delivery MNCH **TWG 5**	1. Availability of basic EmONC services strengthened to 50% of dispensaries by June 2013	1. Identify EmONC and child care equipment gaps at the dispensary level 2.Procure and Distribute essential Reproductive, Maternal and Child Care equipment /Supplies to dispensaries (including basic EmONC) .	1. % of dispensaries equipped with EmONC and child care equipment 2. National guidelines and job aids for integrated maternal, newborn and child health services including STI/HIV services developed	The RCHS continued to follow-up with MSD on distribution of EmONC equipment procured by WB, SDC and Aus AID in 2011. RCH staff made physical follow of remaining equipment and other equipment supported by other partners to ensure that distribution is completed. A report was submitted to the Deputy Minister who visited MSD to follow up on the same. Distribution is expected to be complete in May 2013. Once distribution is complete the TWG led by RCHS will follow up to ensure equipment was received and put to use. Plans to orient health workers on use and routine maintenance of equipment have been developed in collaboration with PMU and Maintenance Unit in Directorate of Hospital services. Development of EmONC equipment database: With support from USAID, JSI developed database (DB) for entering EmONC equipment. The purpose of the Data Base is to ensure better coordination of support for MNCH equipment and ensure informed distribution when equipment is donated. The data base has been developed and available data is being entered.. Equipment to be entered in the DB facilities at all levels, Consultant, Regional and district hospitals and for Health Centres and dispensaries Strengthening Availability of Equipment at Dispensary Level: The MNCH technical working group assigned a task force to look at contents and prices of available delivery kits from MSD, UNICEF,

				WHO and UNFPA, in order to decide type and content of kits to be procured for dispensary level. • RCH Services Integration: The TWG developed terms of reference and with USAID and GIZ support carried out consultancies to assess and give recommendations for better integration within RCH services provision and RCH/FP and HIV Services integration. Two reports are: (i) Reproductive and Child Health services Integration report and (ii) Family Planning /HIV integration report and guidelines. The MNCH-TWG will review these reports and discuss and agree the next steps to take the integration agenda forward. Other Key Activities • Mid Term Review of One Plan (National Strategic Plan to accelerate reduction on maternal, Newborn and Child Deaths (2008-2015). The review will be carried out to assess MNCH progress and performance of the plan in order to inform the implementation for the remaining period upto 2015. In addition the review will inform and be linked to the MTR of the HSSP III (2009-2015).A task team has been formed and TOR will be developed this month. Initial contry wide data on Ambulances, Upgraded health centres, maternity homes and neonatal units has been collected with guidance from the TWG. The MTR process will be supported by WHO HQ and Country Office • Mapping of MNCH Partners: In view of the increasing number of MNCH partners the TWG agreed on the need for a detailed mapping of RMNCH

				implementing partners. A task team was assigned to develop mapping tools that are in the final stages. Mapping will identify area of support coverage and financing source and amount. This will enable to improve coordination, transparency, create synergies and avoid duplication of efforts. • Commodity support by DFID: Distribution of the donated commodities (magnesium sulphate, oxytocin and iron folate) will be done through a "push" – by MSD • The Tanzania Service Provision Assessment (SPA) survey (which focuses on MNCH service delivery) will be carried out this year By NBS and Macro-DHS. The tools were shared with the MNCH TWG and the group held a working session with NBS colleagues to provide input to the tools. Among the things that will be covered are assessment for Basic and Comprehensive EMONC. The survey is expected to cover all hospitals, 75% of health centres and few dispensaries. NBS colleagues have been asked to share the additional finances that would be required if all health centres were to be covered. Introduction of New vaccines Pneumococcal and Rotavirus was launched by honorable Mama Salma Kikwete at Buguruni HC, Dar es Salaam in December 2012. Scaled up in regions and districts countrywide was carried out in January 2013. The post introduction supervision is underway from end of February through March 2013. Evaluation of Delivery Pack: In collaboration with MDH the evaluation of distribution of the

				delivery pack is ongoing. The lessons learnt will be used to inform the scale up the programme. RMNCH Essential Health Package: The TWG met with consultant relevant document will be circulated to members and a working session will be held on 27th March to give inputs.

6.8 BEST PRACTICES/CASE STUDIES

- Improvement of Appropriate Latrine and Safe source water from 70.3%(2010) to 80% (2012)
- Iimprovements of pregnant mother attended at ANC Clinic before 16 weeks from 25.4% (2010) to 29.3%(2012).
- Decline in low birth weight from 0.8% (2010) to 0.5% (2012).

- Increase number of male involvement in RCH from 15.3%(2010) to 36% (2012)
- Increased number of male circumcision from 0% (2011) to 29%(2012)
- Increase contraceptive prevalence rate from 9.7%(2011) to 10%(2012
- Increased the number of malaria cases tested due to presence of mRDT tests from 38,922 (2011) to 73,556 (2012
- HIV prevalence rate decline from 6.7% (2010) to 6.3% (2012).
- Increased Health Facility from 28(2010) to 29 (2012)
- Improvement of District Health Information Software from 2010 – 2012.
- Women receiving ARVs for MTCT has remained high

Conclusion

Issues and challenges

- Irregular availability of essential drugs, supplies and reagents for pregnant mothers to the heath facility(SP, RCH Cards, RPR test kits, and HIV test kits).
- Other indicators has no data collection tool eg. Vulnerable groups, women sleeping under mosquito nets last night.
- Late compilation and submission of data from Health Facilities to district level.
- Too many data collection and data submission tools from different programs.
- Limited data analysis and data use at health facilities levels .
- No feedback of data from high level to lower level.
- Newborns survival still a major challenge.
- Family planning uptake still a big challenge in the district .
- In adequate of health facilities in the district.
- Low number health facilities delivery