The United Republic of

TANZANIA

Ministry of Health & Social Welfare

KISARAWE

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. The DHP also tracks the progress in the district and highlights some of the challenges and successes the district has encountered.

The DHP 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

We would like to take this valuable moment to convey our sincere thanks to 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 the DHP and Kisarawe 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,

Appreciation goes to CHMT and co-opted members, Representative from RHMT, Representative from Faith based organization health service providers, Private sector health service providers, private sector health service providers, community development department, planning Department and Hospital Management Team.

I further extent my appreciation to Health facility committees and supporting staff for their contribution during this session.

We are also deeply indebted to recognize our development partners (Plan International, ICAP, PATH, ENGENDER HEALTH, PSI, CHAI and MEDA) for their assistance and advice during planning session.

We acknowledge all individuals who in one 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.

III. EXECUTIVE SUMMARY

This District Health profile covers the introductory information of kisarawe district council i.e. mission and vision structure of district ,,geographical location of the area and climate, size, population, ward and village distribution. health facility distribution ,transportation and communication, education status. 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
B. Health Service Delivery
C. Health Systems
D. Progress in the Health Sector

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

District Council was established in 1906 and is one of the 7 Local Government Authorities (LGAs) of Pwani Region, situated at the Eastern part of Pwani and is divided into 4 divisions, 15 wards and 79 Villages with a population of 118,411 people (Male 59,789 and Female 58,622) according to 2002 population projection results. The headquarters of the District Council.

The model of health services delivery in Kisarawe District Council is based on preventive, p and curative care. The line of operation starts from the Dispensary, Health center to the District Hospital.

District has 24 health facilities that provide services of which 1 a hospitals, 3 health centers and 20 dispensaries. The Health and Social Welfare sector at Council level is one of the councils' departments. The Council Health Management Team provides technical health and social care development advice within the Council. The mission is to facilitate health facilities so as to enable them provide Quality Health Service to the Public.

A review of the performance of the CHMT regarding its capacity building, monitoring of the health facilities in general during the current year 2011/2012 up to December 2012, indicated that progress has been made in carrying out planned activities. Among the factors that contributed to this increase was that, the CHMT managed to conduct supportive supervision to 20 health facilities (83%) as per scheduled and provision of on

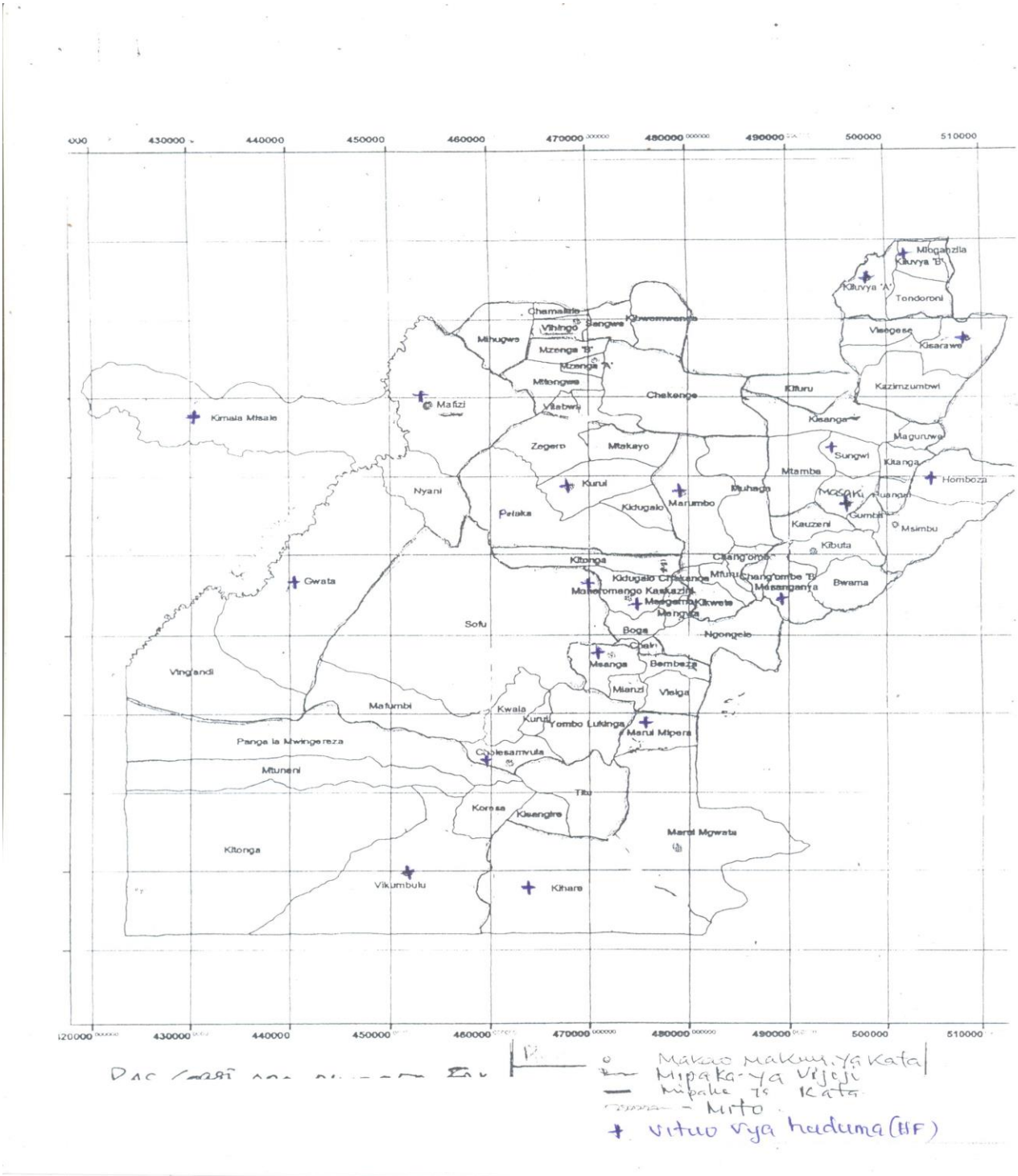
job training. However, more efforts are needed to improve technical and managerial capabilities and build confidence in HMTs; reporting of implemented activities, care of most vulnerable groups, and data collection, analysis and utilization.

Although the CHMT received funds as approved, implementation of 2011/2012 activities are still lagging behind due to lengthy tendering processes and untimely release of funds. The last year review indicates that out 168 planned activities 32(19%) were implemented as of December 2012 and 136(81%) not implemented. The remaining 136 activities will be implemented in the 3rd and 4th quarter.

The council need a total of 420 skilled health care workers, but only 316 are available with a deficit of 104 staff. This shortage is more critical in remote areas of the council with a percentage 25%.

The MOHSW with financial support from the Government of the Kingdom of Norway is piloting a Pay-for-Performance (P4P) scheme in the Pwani Region. The implementation of the pilot project is supported by the Clinton Health Access Initiative (CHAI) and the Ifakara Health Institute(IHI). The P4P scheme is designed to accelerate the reduction of maternal, neonatal and child morbidity and mortality through improving reproductive and child health services in accordance with the Millennium Development Goals (MDGs) 4 and 5.
Some of the indicators attained in 2012 despite the challenges in order to improve the health and social services were Vitamin A supplementation to under one year 91%, Immunization to under-one children, BCG is 112%, Immunization to under-one children OPV 0 is 98%, Immunization to under-one children, DPT - HB 3 is 98%; Vaccination against measles 101 %, Health Facilities deliveries 56 %, and 22 health facilities provide PMTCT services.

Malaria and HIV/AIDs are among the most communicable diseases occurring in our council. The council's HIV programmatic prevalence rate is 7.9 % the proportion of Morbidity due to Malaria in under five year old children is 57% and for the above five years of age is 21%.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Kwala
Kurui
Tombo Lukinga
Marui Mipera
Panga la Mwingereza
Mtuneni
Tiba
Koresa
Kisangire
Marui Mgwata
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Vikumbuku
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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 Hudumaza Afya**
AFP	Acute Flaccid Paralysis
AHEAD	Adventure in Health Education and Agriculture
AIDS	Acquired Immune Deficiency Syndrome
AMO	Assistant Medical Officer
ANC	Ante Natal Clinic
ARC	Aids Related Complex Syndrome
ARI	Acute Respiratory Infection
CIMCI	Community Integrated Management of Child illness
CBD	Community Based Distributor
CCHP	Comprehensive Council Health Plan
CHF	Community Health Fund
CHMT	Council Health Management Team
CO	Clinical Officer
DMO	District Medical Officer
HIV	Human Immune Virus
HMIS	Health Management Information System
NHIF	National Health Insurance Fund
IPD	In Patient Department

OPD	Out Patients Department
ITN	Impregnated Treated Nets
CHAI	Clinton Health Access Initiative
Plan International	Plan International
OC	Other Charges
HMT	Hospital Management Team
MDGs)	Millennium Development Goals
IHI	Ifakari health institute

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Table 0-2. KEY TERMS

[KEY TERMS USED IN DHP ACCOMPANIED BY THEIR DEFINITIONS]

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

To provide high quality social economic services to the community through efficient and effective use of resources' and good governance for improving living standards

VISION

Awell educated community with better livelihood by the years 2020

1.2 STRUCTURE OF DISTRICT

Kisarawe District Council was established in 1906 and is one of the 7 Local Government Authorities (LGAs) of Pwani Region.

GEOGRAPRAPHICAL LOCATION AND CLIMATE

The district is located between Latitudes 6.50S and 35S South of Equator and between Longitudes 38.15E and 39.30E 3 East of Greenwich. The district shares borders with

Mkuranga districts in East, Morogoro district in West, Ilala Municipal Council in Northeast, Kibaha district in North and Rufiji distinct in south. In terms of distance, the district is near to Dar es Salaam city.

Kisarawe District is sub-humid. It receives bimodal type of rainfall with short rains falling between October and December and long rain between mid March and June and is typically characterized by hot and humid weather. The hottest months are January to mid-March. Temperature varies from 28c to 30 c with mean temperature of 29c. The district is covered with dense forest.

SIZE

The total surface area of the district is 3535 Skm which is equivalent to 10.5% of the total area of Pwani region.

POPULATION

The district population is estimated to be 118,411 people of whom under five are 16,951, male 59,789, female 58,622 and women of bearing age between 15-49 years are 30976

WARDS AND VILLAGE DISTRIBUTION

The District is divided into 4 wards, namely Mzenga, Maneromango, Chole and Sungwi, which are further divided 15 wards and 79 villages.

Table 1-1. Wards And Villages

WARD NAMES	MUMBER OF VILLAGES
KISARAWE	4
KILUVYA	3
MSIMBU	6
MASAKI	4
KIBUTA	8
MANEROMANGO	8
MARUMBO	6
MSANGA	4
CHOLE	6
MARUI	5
VIKUMBULU	5
MZENGA	4
VIHINGO	7
KURUI	4
MAFIZI	5
TOTAL	79

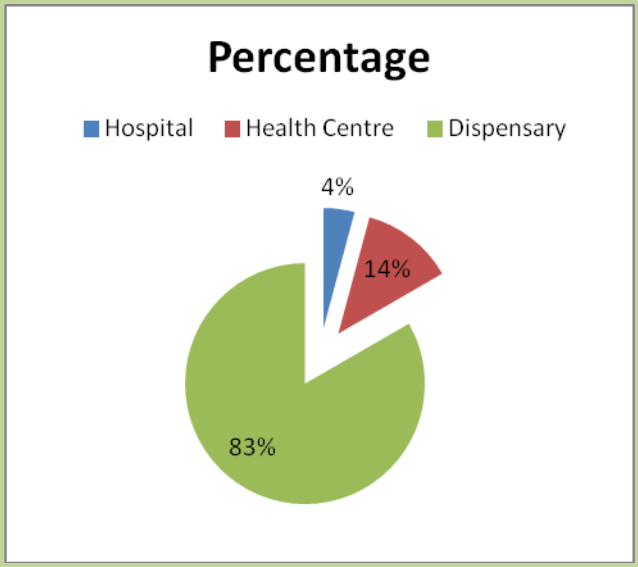
1.3 FACILITY DISTRIBUTION

The model of health services delivery in Kisarawe District Council is based on preventive, and curative care. The line of operation starts from the Dispensary, Health center to the District Hospital. Kisarawe District has 24 health facilities that provide services of which 1 Hospital, 3 health centers and 20 dispensaries. The Health and Social Welfare sector at

Council level is one of the councils' departments. The Council Health Management Team provides technical health and social care development advice within the Council.

Table 1-2. Facility Distribution

TYPE OF FACILITY	NUMBER OF FACILITIES	OWNERSHIP
HOSPITAL	1	Government
DISPENSARY	18	Government
	1	Parastotal
	1	Faith based
HEALTH CENTER	3	Government
CLINICS	0	



1.4 POPULATION

The district population is estimated to be 118,411 people of whom under five are 16,951, male 59,789, female 58,622 and women of bearing age between 15-49 years are 30976

Table 1-3. Gender And Age Based Statistics

AGE RANGE	FEMALE	MALE
<1 YEAR	1887	1878
1-4	6570	6616
5-14	13029	13518
15-49	30976	32718
>50	6160	5059
TOTAL	**58622**	**59789**

source of this data is NBS

1.5 GEOGRAPHY

Rainfall, Temperature and Water Bodies

Kisarawe District is sub-humid. It receives bimodal type of rainfall with short rains falling between October and December and long rain between mid March and June. It is characterized by hot and humid weather temperature varies from 28c to 30 c with mean temperature of 29c with the hottest months starting from January to mid-March.
Population accessible to clean water sources is 1.5%, irrigation scheme coverage is 1.4 %. Some communities lack access to water. Villagers use water from ponds and water from shallow well, dug wells for cooking, washing and recreation. Electricity is available in all urban health facilities except 20 rural dispensaries, Out of those 4 have solar power system and 1 dispensary has a generator.

1.6 TRANSPORTATION AND COMMUNICATION

The road network within the district is 676 km. Most commonly used means of communication is mobile phone of which almost 95% of health care workers have them. The Council has one fax which is shared among all council's departments. The CHMT has an email and the council's website is under construction. The CHMT has 1 vehicle which is used for supportive supervision and distribution. There are 4 ambulances of which one is for the district hospital and the 2 others are for two health centres and 1 for one dispensary.

1.7 EDUCATION

Kisarawe District Council has 83 primary schools, 81 being under LGA and 2 primary schools are owned by private sector. 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. There is one training institution with full NACTE accreditation.The literacy rate is 73% and primary school enrollment is 108%.

2 DATA COLLECTION METHODS AND SOURCES OF DATA

2.1. DATA SOURCES AND THEIR DATA COLLECTION AND ANALYSIS METHODS

District health information system(DHIS) unit is recognized as the collection , compiling and analyzing centre for the health data generated from all health facilities in the District. The unit uses specified tools to collect, compile and analyze data. Analyzed data used by CHMT and health facility to identify the health problems and set strategies to address. However feedback material which was introduced early Dec. 2012 as been new reporting tool it was seen of been a useful tool as it explored health problems, helped to spot problems/challenges. Dissemination of feedback material which went in line with existing management capacities

Data collection is mainly of Health related issues. These are collected from all health facilities found in the council (Public and Private). Some are from communities surrounding the Health facilities e.g. death reports. The data are of health issues (diseases and services) i.e. Curative and Preventive from each facility and community. The data are collected through HMIS tools and 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 Kisarawe district council population.*
- *The status of the Kisarawe District council health system.*
- *The status of health service delivery in Kisarawe district council.*
- *Progress that has been made in the Kisarawe 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

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

population

- Health Offices per 10,000 population (modified to include Environmental Health Officer (EHO)
- Laboratory staff per 10,000 population

Infrastructure

Health Indicator Still Being Determined

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

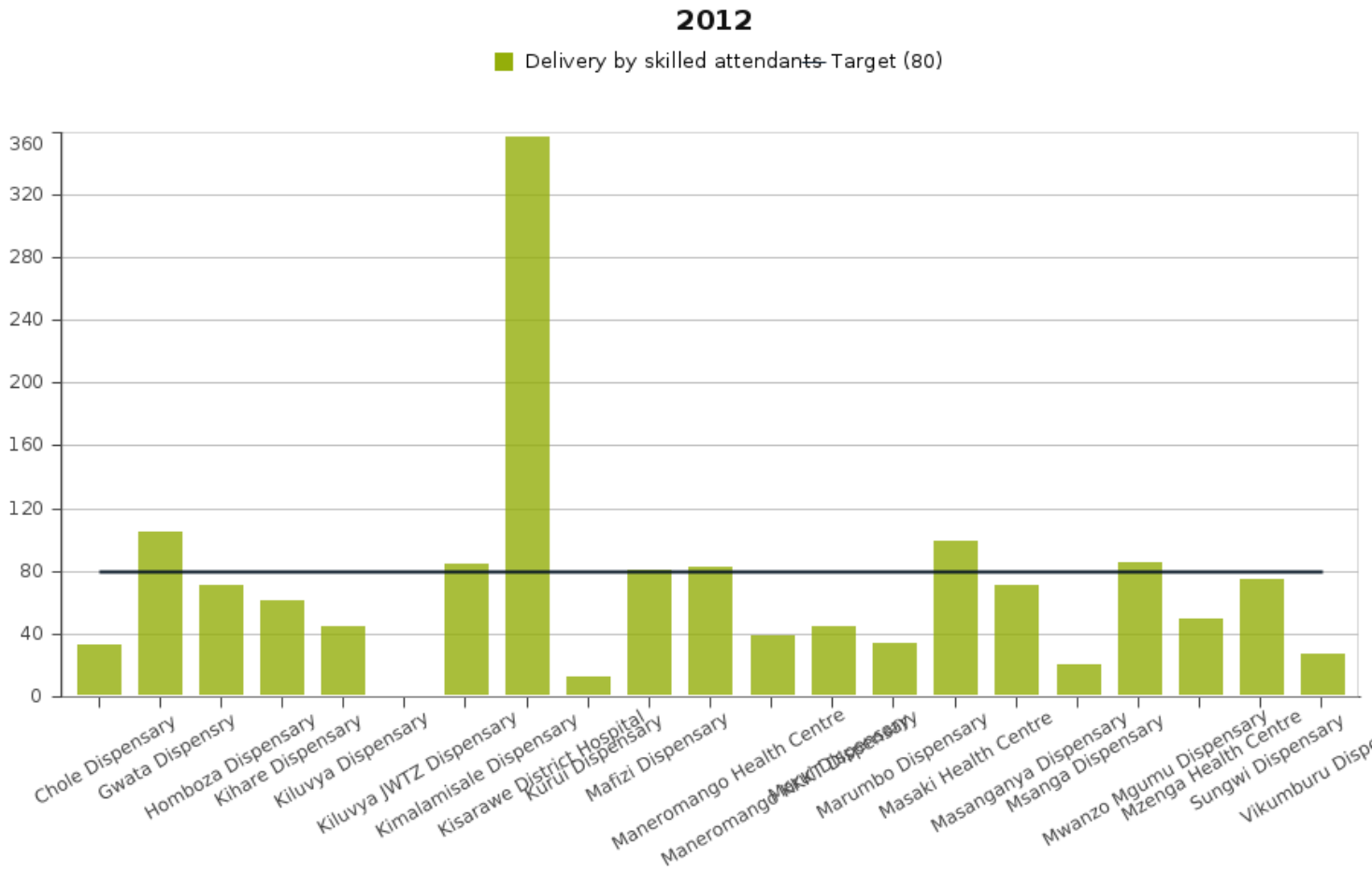
- Social welfare and protection for vulnerable populations
- Vaccination coverage
- Environmental Health Service Safe Water Initiatives

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 KISARAWE DISTRICT

KISARAWE DISTRICT SPECIFIC INDICATORS
1. Percentage of health facilities with functioning Health Governing Committee
2. Percentage of health facilities with CHF scheme
3. Percentage of deliveries assisted with skilled personnel
4. Percentage of deliveries with complete and appropriately filled pantograph



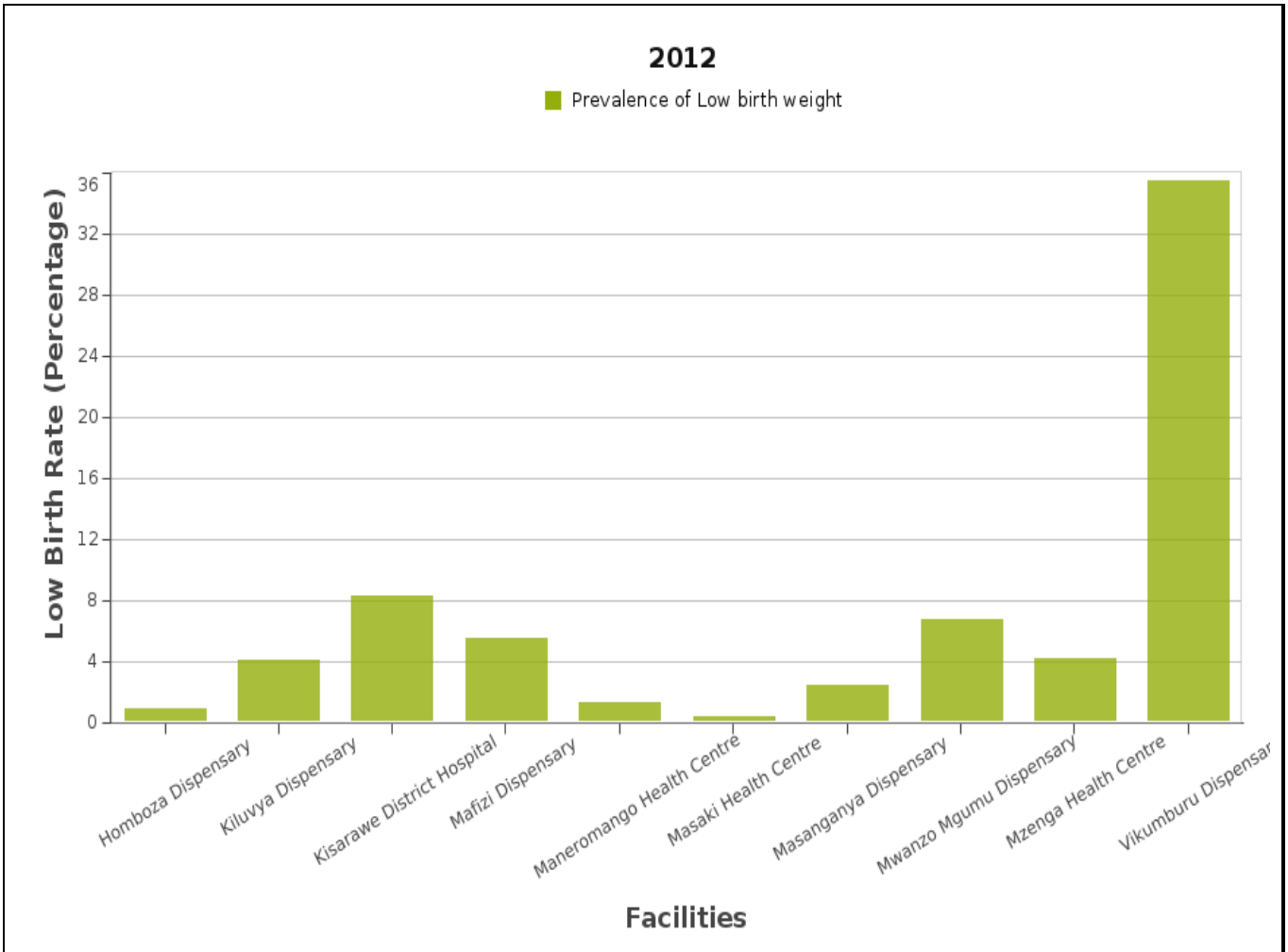
The focus to improve health service delivery by skilled attendant the district reduction of maternal, neonatal and child morbidity and mortality through improving reproductive and child health services in accordance with the Millennium Development Goals (MDGs) 4 and 5.

3 HEALTH STATUS OF THE DISTRICT POPULATION

3.1 MATERNAL, NEWBORN AND CHILD HEALTH

Nutritional Status: Low Birth Weight

Figure 3-1. Nutritional Status: Low Birth Weight



source of this data is HMIS annual report

From the graph above the health facility Vikumbulu dispensary ,Kisarawe hospital prevalence of low birth weight is high, in order to improve nutrition status the health facility, the District provide Vitamin A supplementation for pregnant mother during attend ANC Clinic

Figure 3-2. Neonatal Mortality Rates

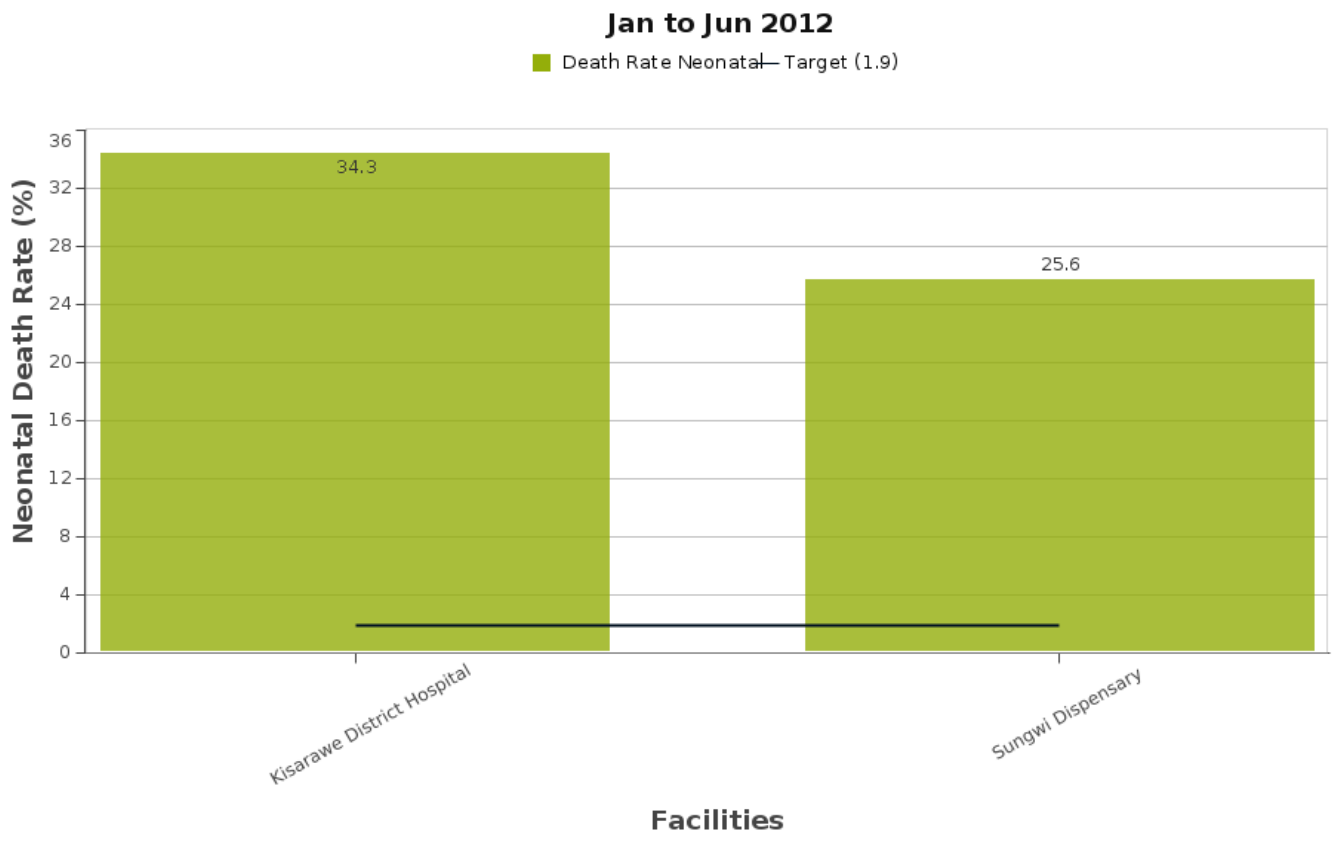
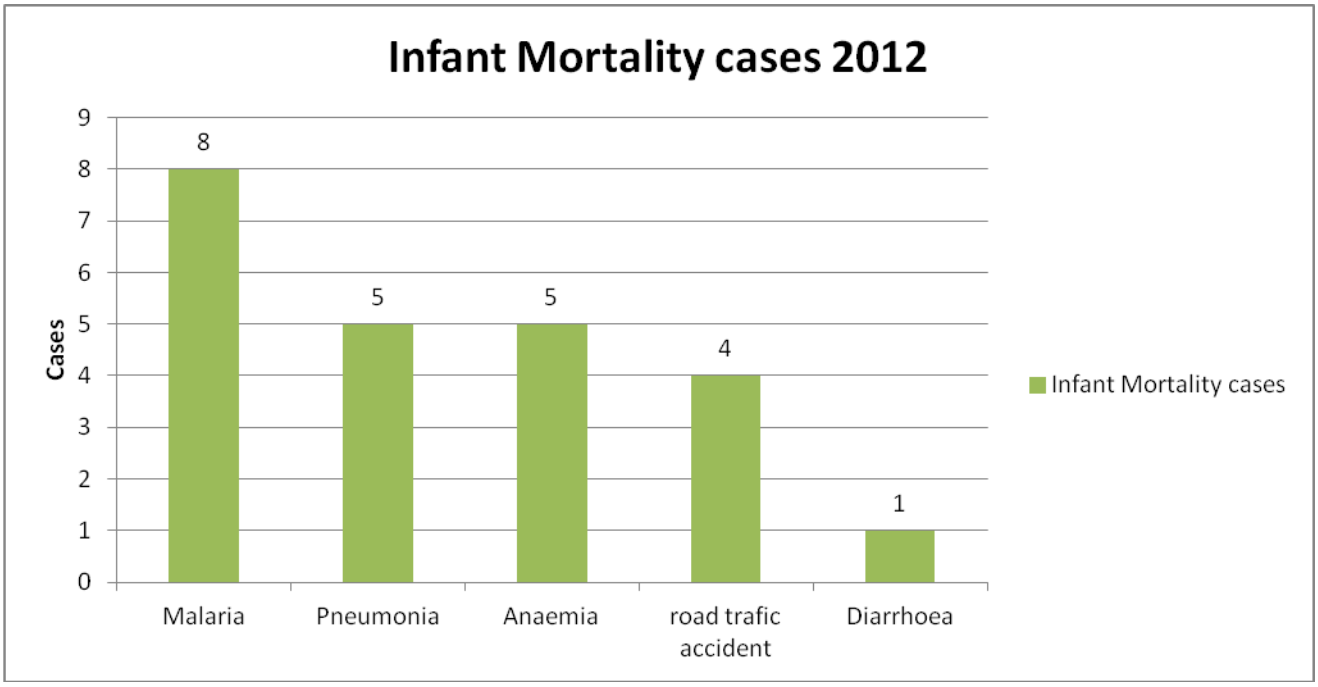


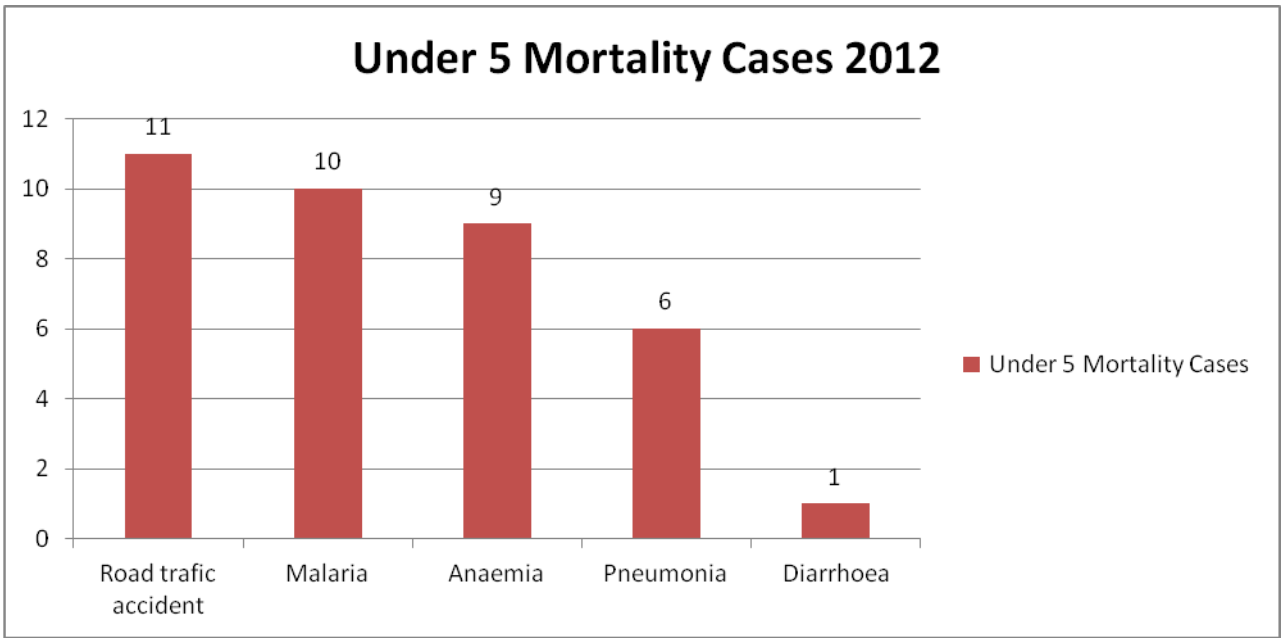
Figure 3-3. Infant Mortality Rate



source of this data is HMIS annual report

The graph above shows that Malaria is the leading cause of death . The disease is found in the area almost throughout the year and becomes more prevalent during rainy seasons. Other diseases commonly affecting both under five and above five years are pneumonia, Anaemia,

Figure 3-3. Under 5 Mortality Cases



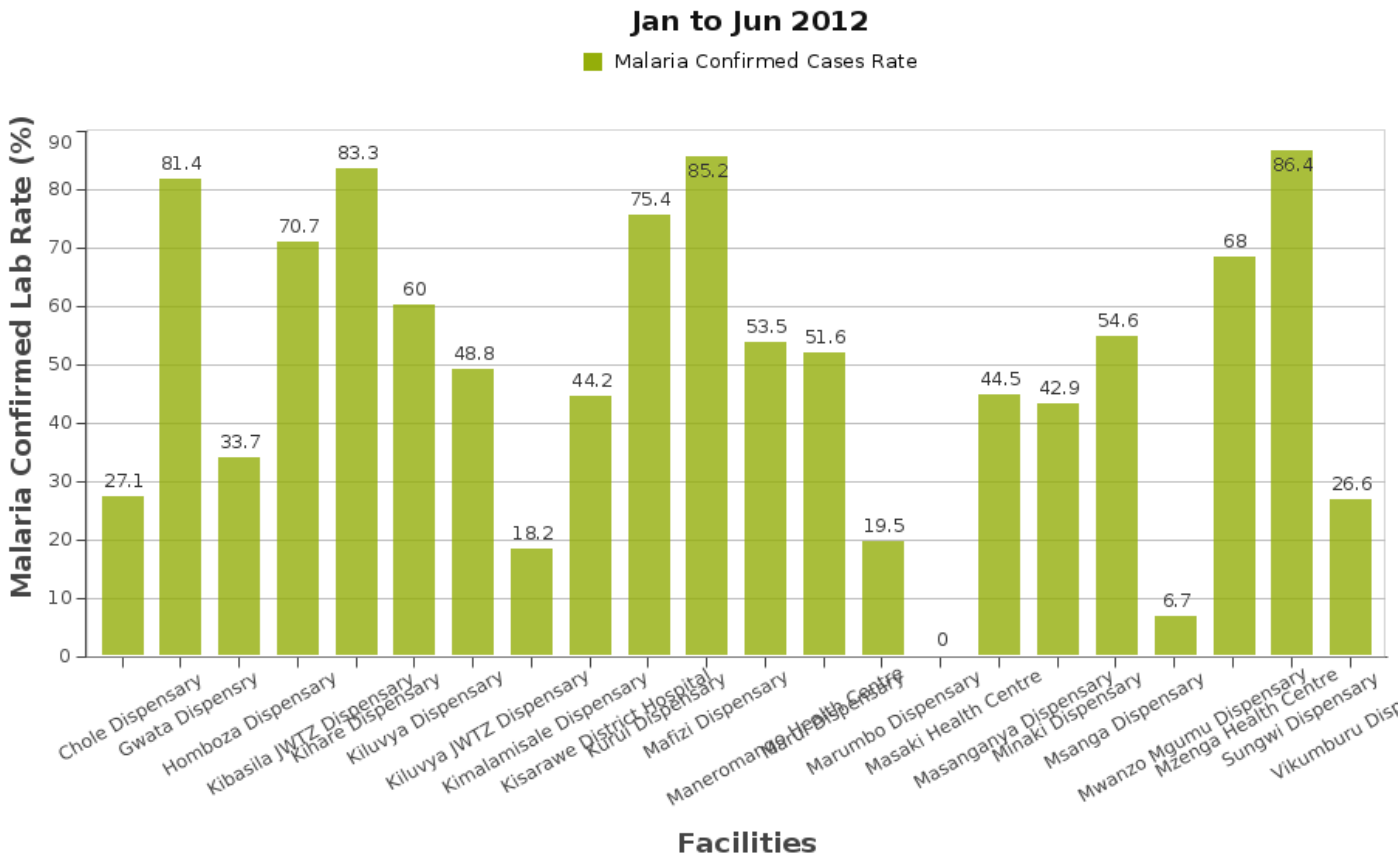
source of this data is HMIS annual report (death verification report

The graph above shows that under five motility cases, road traffic accident, malaria and anemia is the leading cause of death.

3.2 MORBIDITY

In the year 2012 Malaria was one among 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) Malaria is the leading cause of OPD attendances. The disease is found in the area almost throughout the year and becomes more prevalent during rainy seasons. Other diseases commonly affecting both under five and above five years.

Figure 3-3. Laboratory Confirmed Malaria Cases

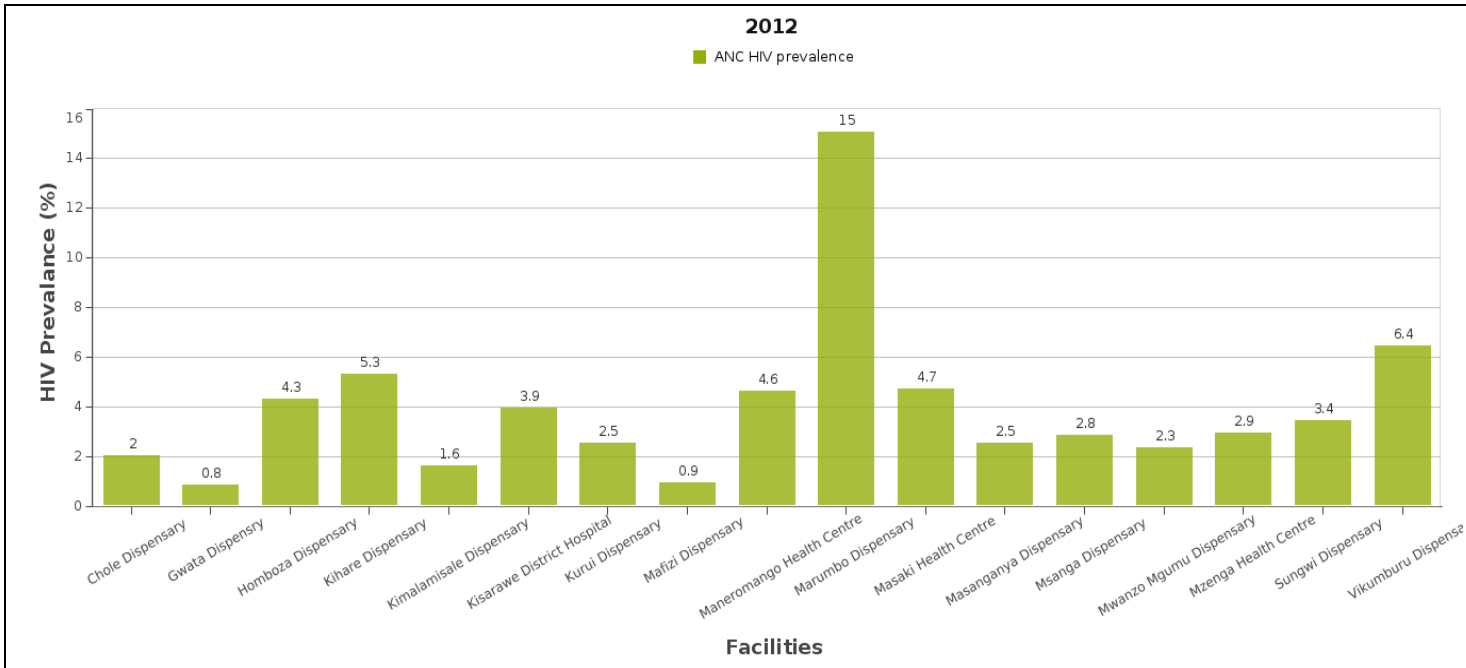


Malaria confirmed cases by use MRDT tests were taken as an indirect measure of malaria confirmed cases using laboratory . MRDT test result of 2012 were selected in the compellation and analyzing process which involved 21 health facility sites (gwata dispensary kIhare dispensary Mafizi dispensary ,and Sungwi dispensary Malaria confirmed cases is very high facility performed more than 80%

Factors contribute increase malaria cases

Following increased case of confirmed malaria cases to health facility settings the factor mentioned was poor knowledge about malaria diseases, inadequate proper use of ITN , poor environment sanitation, poor family economy to purchase insecticides and ITN.

Figure 3-4. HIV/AIDS Prevalence



source of this data is HMIS annual report

The graph show that Marumbo dispensary ANC HIV prevalence rate is 15% and vikumbulu dispensary is 6.4% the following increased of ANC HIV prevalence rate **factors contribute high ANC HIV prevalence rate for health facility**, Inadequate VCT skills for newly employed staffs, Tradition and custom the community they loves (ngoma) increasing infection rate.

HIV/AIDs is one among the most communicable diseases occurring in our council. The council's HIV prevalence rate is 7.9% .However the ANC HIV prevalence has decreased from 6% 2011 to 5% in 2012 ,this decreased is most likely caused by increase of community awareness on HIV/AIDs due to provision of regular sensitization on HIV/AIDS in the District .

Table 3-1. 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 other diagnosis and malaria ranked first and second in the list. Other diseases in the list are as shown in the table below

3.3 TOP 10 COUSES OF ADMISSION

	IPD	Under 1 Month		1 Month - < 1 Year		5 Years - > 5 Years		
		FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	TOTAL
1	Other Diagnosis in IPD	85		245		487	4927	5744
2	HIV infection Symptomatic in IPD	8		25		33	977	1043
3	Malaria Severe / Complicated (Blood	24		832		2045	2341	5242
4	Other Gynaecological Diseases in IPD						1091	1091
5	Hypertension in IPD			2		1	972	975
6	Anaemia Severe in IPD	3		166		703	1060	1932
7	Other Cardiovascular Disorders in IPD			2		3	163	168
8	Road Traffic Accidents in IPD	10				44	1538	1592
9	Tuberculosis in IPD	1		6		9	382	398
10	Cardiac Failure in IPD			1		2	254	257

Malaria and HIV/AIDs are among the most communicable diseases occurring in our District. The council's HIV prevalence rate is 7.9% the proportion of Morbidity due to Malaria in under five year old children is 57% and for the above five years of age is 21%. . Among other activities planned for the financial year 2011/ 2012 is geared at giving support to health facility during the preparation of facility plans, collaborate with different stakeholders in the Councils in the fight against HIV, Malaria and other diseases

Table 3-2. Top 10 Causes Of Death

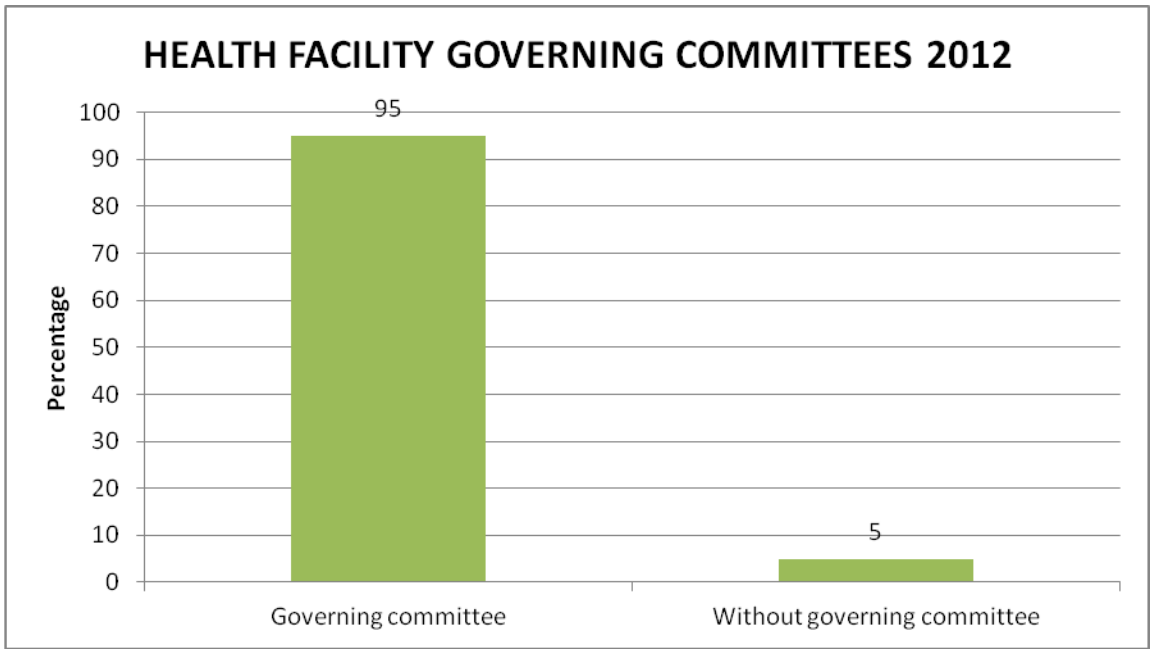
	Causes of Death	Under 1 Month		1 Month - < 1 Year		1 Year –< 5 Years		5 Years - > 5 Years	
		FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE
1	Malaria Severe / Complicated (Blood	0	0	4	4	1	1	3	7
2	HIV infection Symptomatic in IPD	0	0	0	0	0	0	15	4
3	Road Traffic Accidents in IPD	2	0	1	3	2	3	3	11
4	Tuberculosis in IPD					0	0	9	15
5	Anaemia Severe in IPD	0	0	2	3	2	1	5	7
6	hypertention	0	0	0	0	0	0	4	5
7	pneumonia	0	0	1	4	1	0	0	0
8	CCF	0	0	0	0	0	0	3	1
9	URTI	0	0	0	0	0	0	0	2
10	Diarrhoea	0	0	0	1	0	0	1	0

source of this data is HMIS annual report

The table above shows that Malaria severe and complicated is the leading cause of death, and HIV infection symptomatic in IPD attendances. Malaria and HIV/AIDs are diseases occurring in our District. Couses high motality in our district council's HIV prevalence rate is 7.9

3.4 OPTIONAL HEALTH STATUS OF THE DISTRICT POPULATION INDICATORS

HEALTH FACILITYWITH GOVERNING COMMITTEES



The districtl has a functioning community health services board (CHSB)and health facilities commitees have functioning health governing committees, 23 health facilities out of 24 have health governing commitees in Kisarawe .

3.5 DISTRICT HEALTH STATUS CONCLUSIONS, RECOMMENDATIONS AND WAY FORWARD

This profile comes up with the fact that although the district have the strategies to reduce malaria by providing

ITN to pregnant mother and under five children through provision of Hati punguzo programmed and mass distribution campaign**,** 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 and Community IMCI should be emphasized so as to reduce morbidity in under five children.

Other measures to eliminate malaria such as proper environment sanitation should be applied. To reduce neonatal death, emphasize should put on educating pregnant women on the importance of early ANC visit, Women should attend ANC below 12 weeks of gestation age ,District most pregnant women attend ANC after 12weeks.

HIV/AID's need more close follow up to reduce its infection as the prevalence stand at 7.9

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

- 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.

- ❖ Pregnant women should educated on the importance of early ANC visits so as to reduce pregnancy related complications that could be detected during early ANC visits.
- ❖ 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

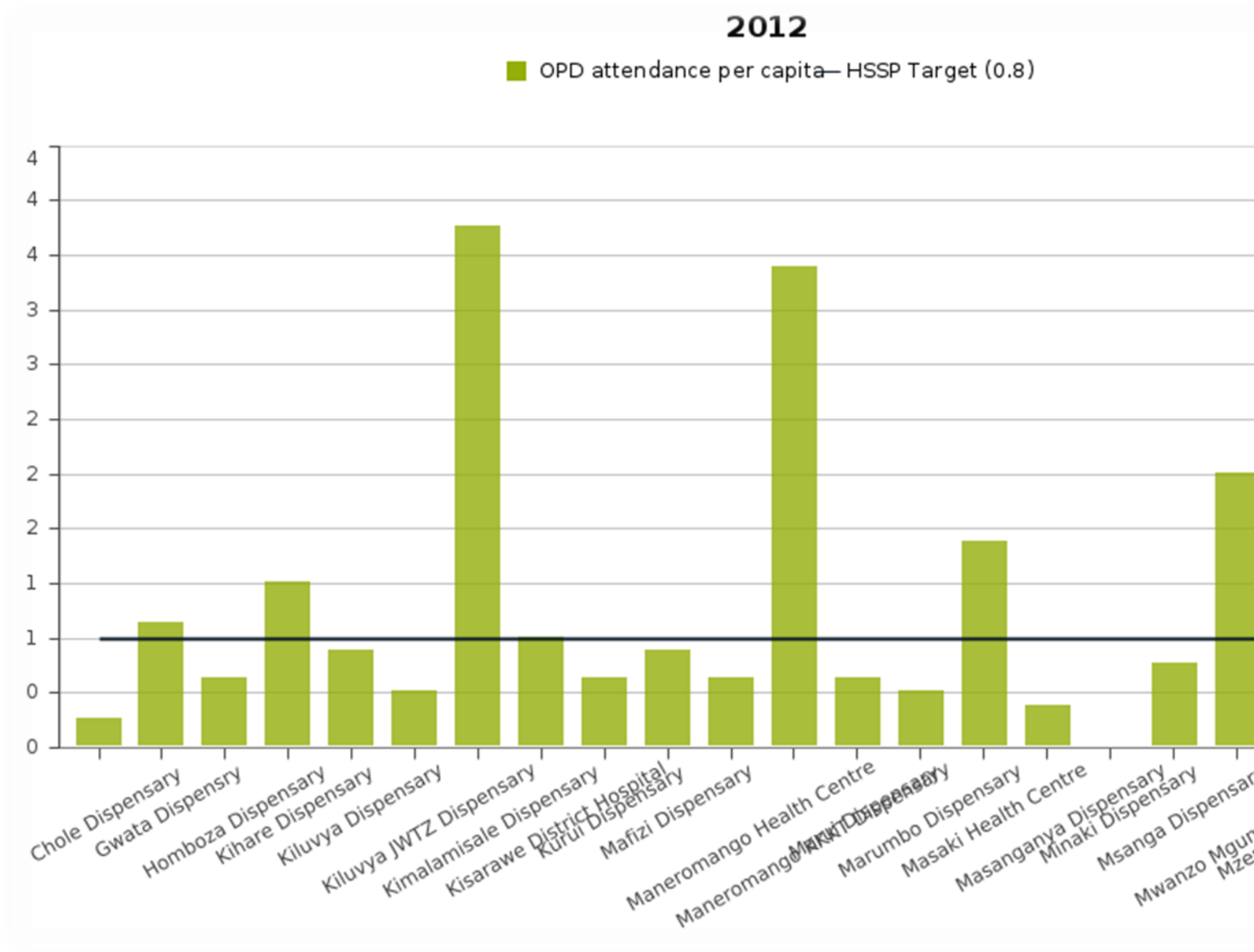
WAY FOWARD

- Using DHP document for planning purposes
- To improve data quality in every health facility.
- Using DHP as base for measuring progress of health interventions
- To establish more CTC in our district

4 STATUS OF HEALTH SERVICE DELIVERY IN THE DISTRICT

4.1 GENERAL HEALTH SERVICE

Figure 4-1. OPD Attendance



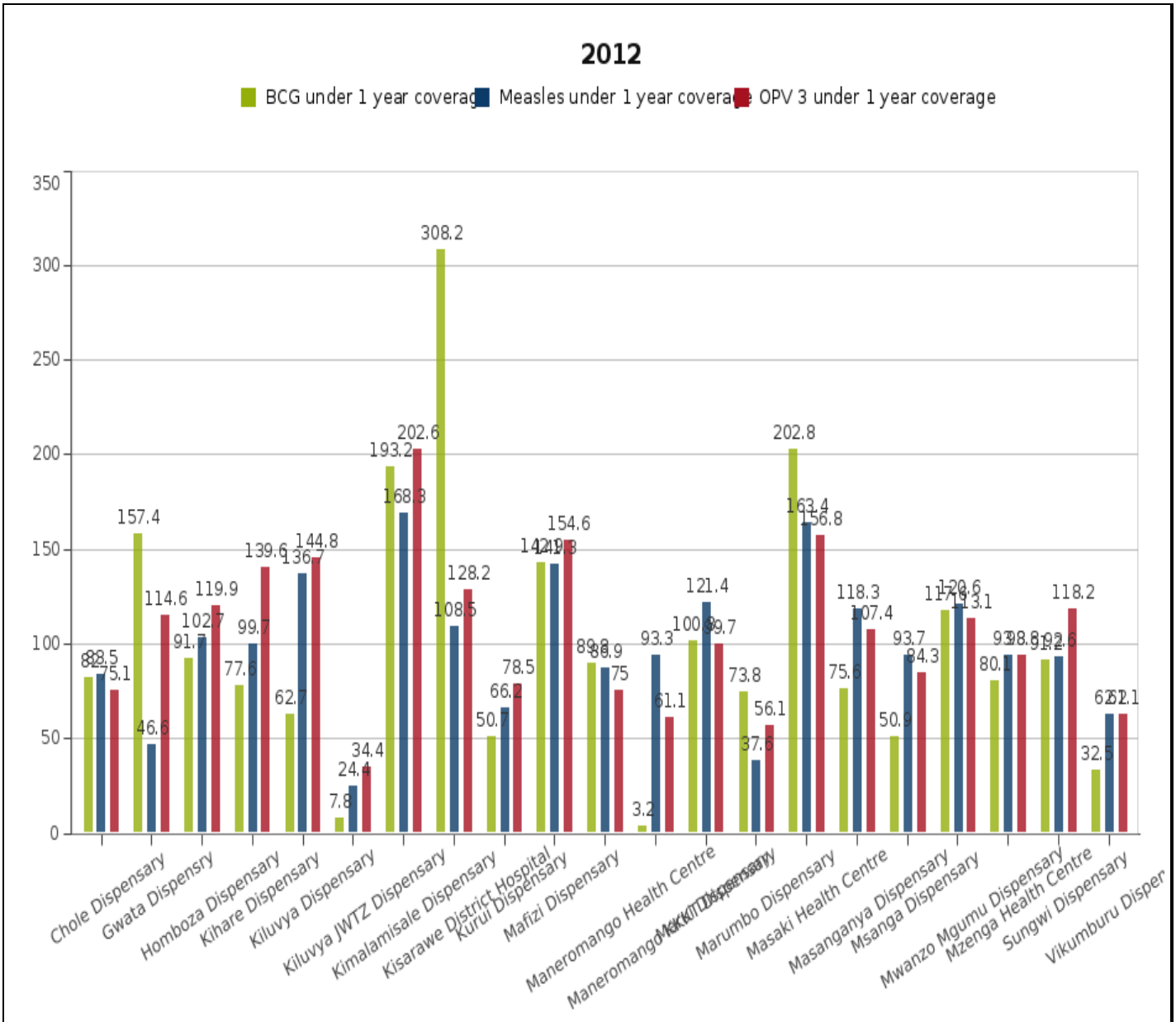
OPD ATTENDANCE

With the exception of Kimalamisale, Maneromango KKKT dispensaries and Masaki health centre the OPD attendance rate per capita is below 2. This may caused by poor record , most clinicians don't record patient in MTUHA register The table below summarizes the attendance rate per capita in each health facility found in Kisarawe DC.

4.2 VACCINATION SERVICES

Vaccination coverage in Kisarawe District is high, this may be contributed by mobile clinics and outreach services.

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



Some of the indicators attained in 2012 despite the challenges in order to improve the health services, and social services to vaccinate under one year children BCG 112%, immunization to under 0ne children, DPT - HB 3 is 98%; Vaccination against measles 101 %, Health Facilities deliveries .

4.3 REPRODUCTIVE HEALTH SERVICES

PROPORTION OF PREGNANT WOMEN STARTING ANC BEFORE 12 WEEKS GESTATION

Despite of the fact that coverage of health facilities with RCH services in Kisarawe DC is high, the proportion of ANC attendants starting ANC before 12 weeks ,16 health facility out of 21 health facility is very low, kisarawe hospital, most facilities the proportion is below 10%. This may be caused by culture and beliefs,

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

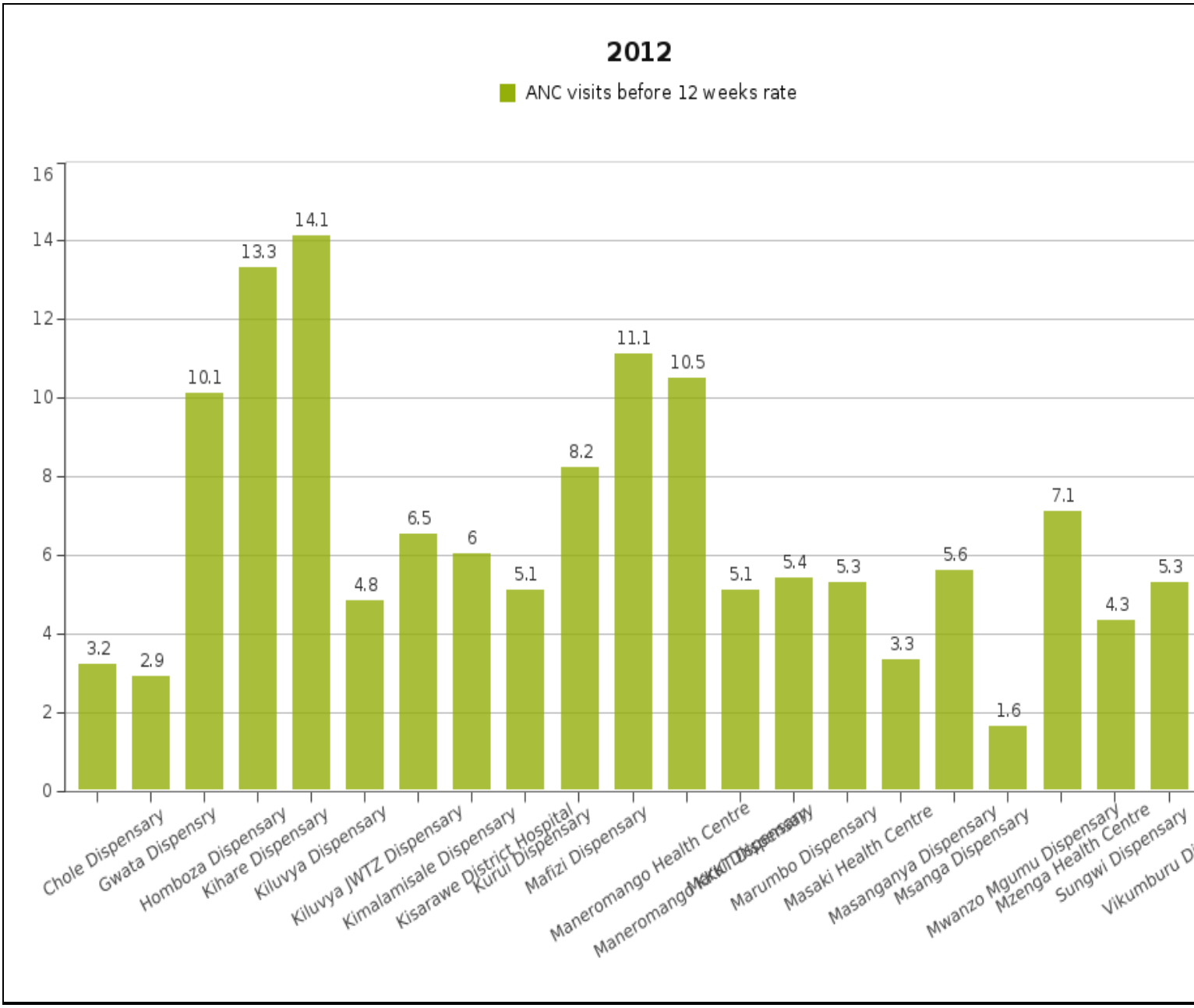
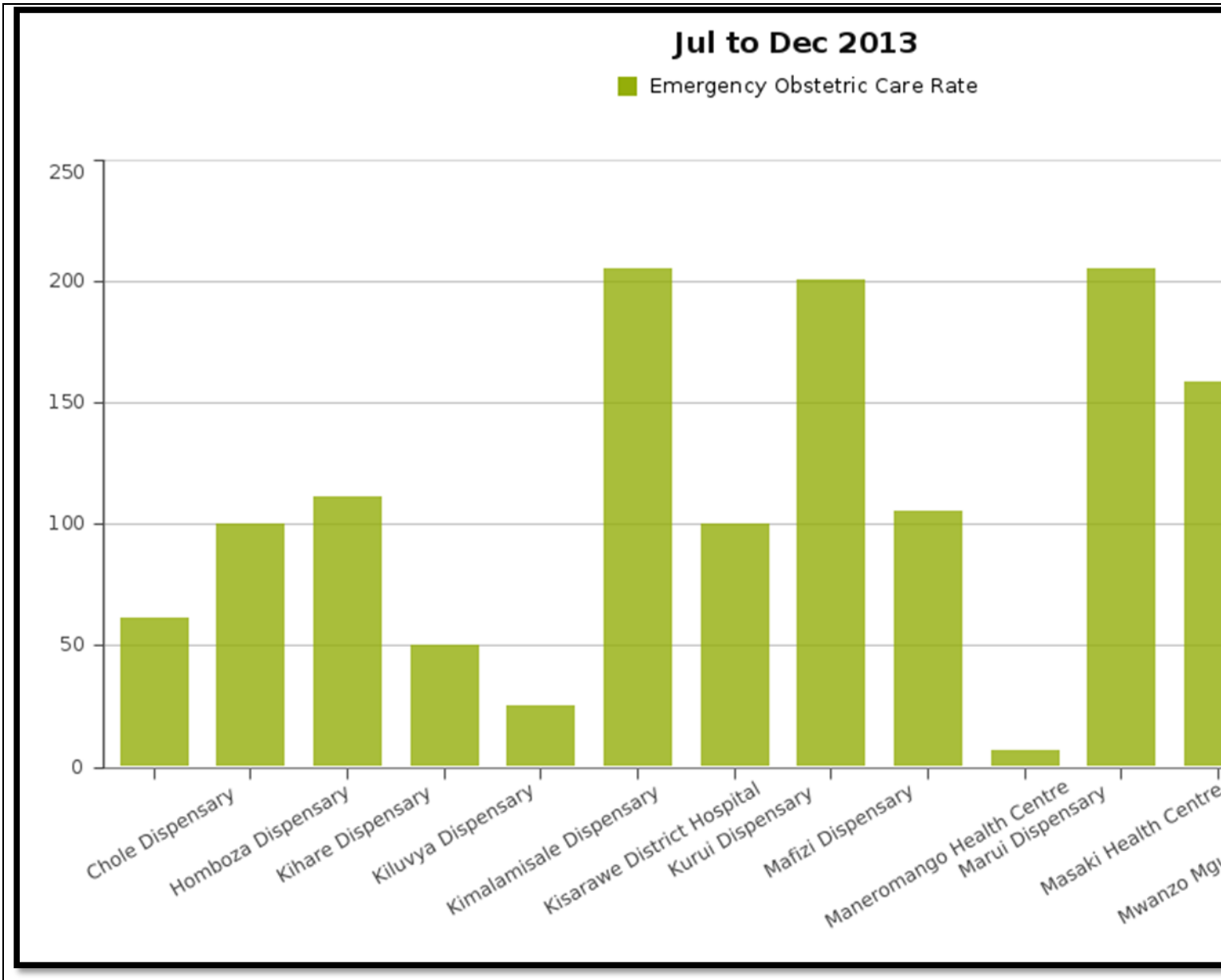


Figure 4-4. Percentage of health centers and dispensaries which provide EmOC as defined in EHP



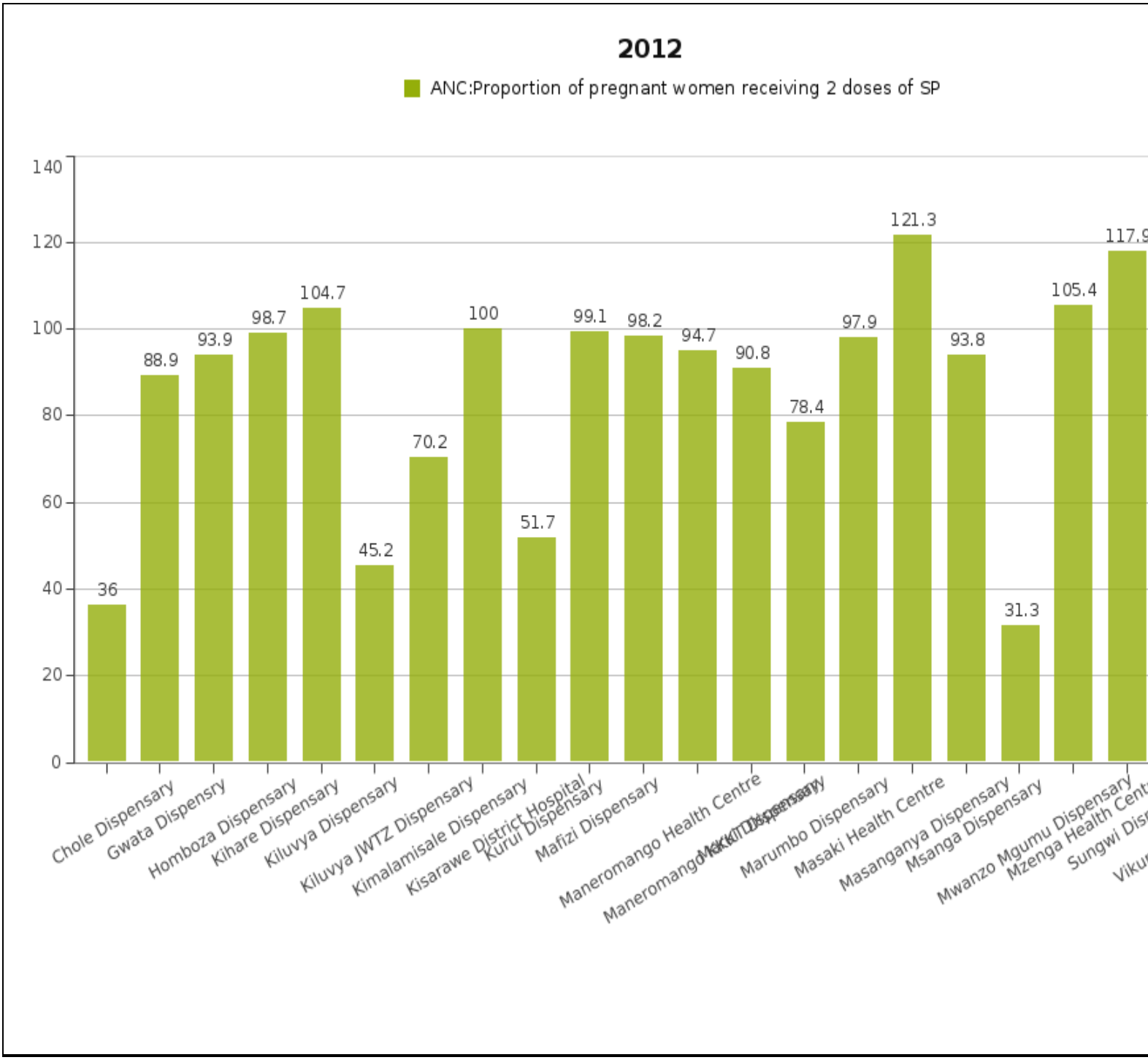
19 health facilities out of 24 health centres and dispensaries in Kisarawe DC provides EmOC services

4.4 INFECTION DISEASE AND NON-COMMUNICABLE DISEASE HEALTH SERVICES

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 was high. This means that majority of the target population in the district received two doses of IPT. Data on the chart below shows that the highest facility to provide two dose of IPT was 121.3%.

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



proportional of mother received two doses of preventive intermittent treatment for malaria durin pregnancy at the year 2012 , Chole dispensary, kiluvya JWTZ dispensary,kimalamisale dispensary,

dispensary,marumbo dispensary, mzenga health center facilities they have been below 80%

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

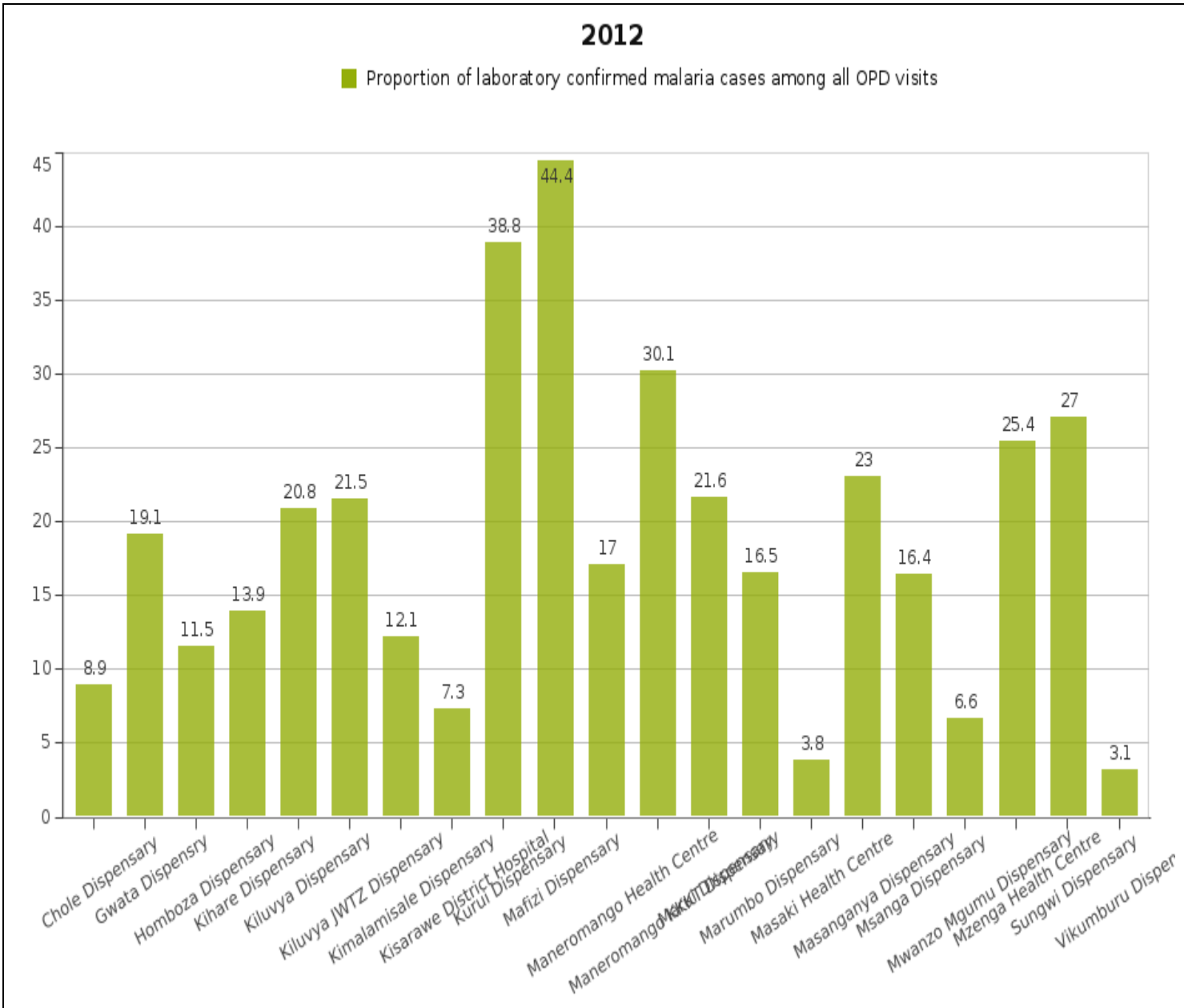
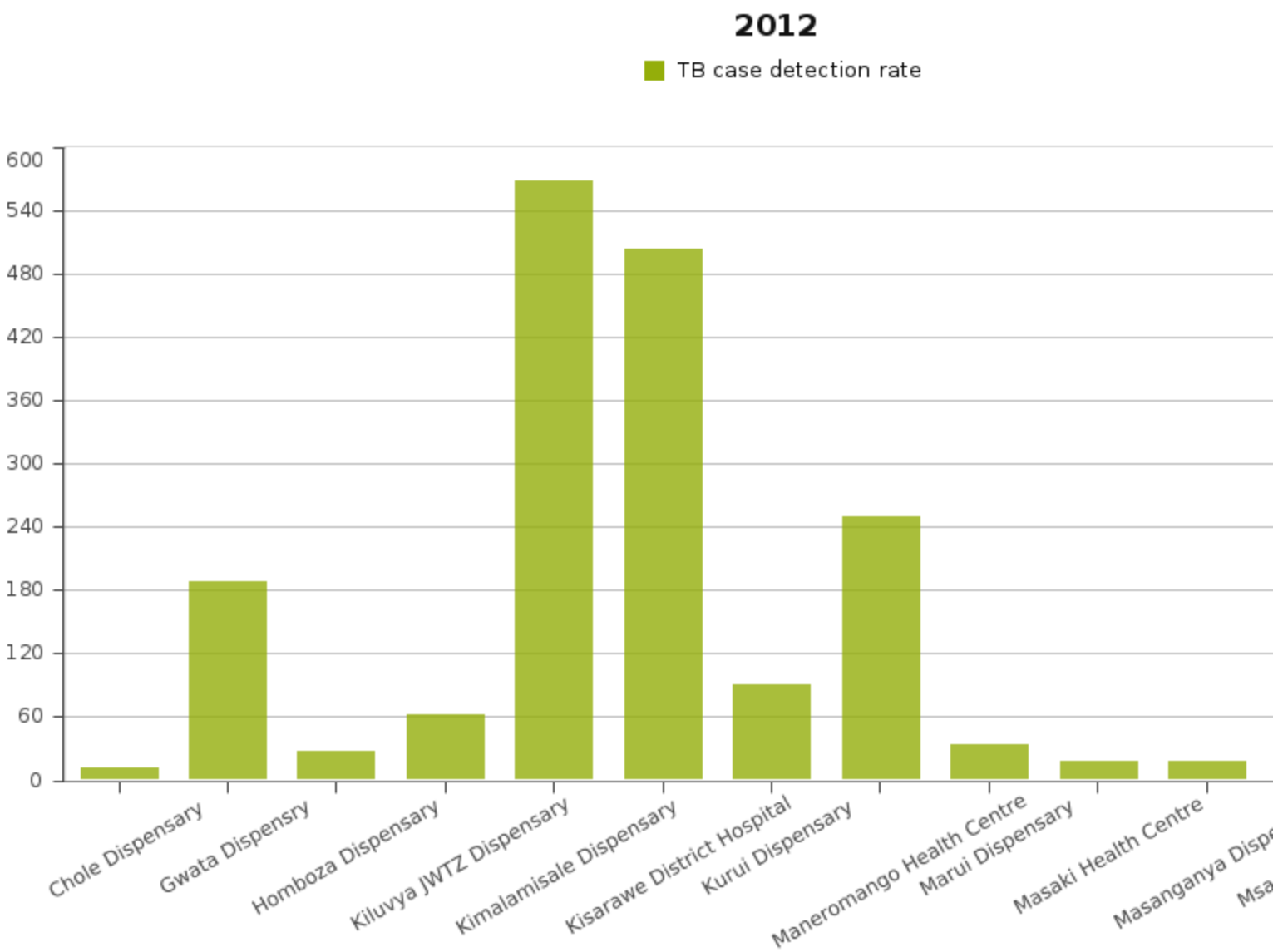


Figure 4-8. TB notification rate per 100,000 population



4.5 OPTIONAL DISTRICT HEALTH SERVICE DELIVERY INDICATORS

SUCCESSES

23 health facilities out of 24 have health governing commitees in Kisarawe DC

The proportional of mother received two doses of preventive intermittent treatment for malaria during last pregnancy at the year 2012 in all facilities was high.

Vaccination coverage in Kisarawe District is high, this may be contributed by mobile clinics and outreach services.

Increase number of ARV uptake

Increase number of enrollment

Increase number of patient diagnosed for TB in adult and pediatric.

CHALLENGES

Low coverage of pregnant mothers attended ANC before 12 weeks

Increase prevalence of HIV

Low response of community to join community health fund (CHF)membership

There was inadequate Basic OPD equipment like BP machines, Stethoscopes, thermometers, forceps especially in the new constructed dispensaries. Adequate funds have been allocated to procure these basic equipments including laboratory and delivery equipment.

4.6 DISTRICT HEALTH SERVICE DELIVERY CONCLUSIONS, RECOMMENDATIONS AND WAY FORWARD

Despite the District managed 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 sensitization to the entire community on importance of early visits to health facilities for maternal health services such as antenatal care , delivery and postnatal services should be conducted, however more community education is needed so as to increase community awareness on HIV/AIDS prevention. Mobile clinics and outreach should be maintained so that vaccination coverage remains high.

WAY FORWARD:

1. Strengthen drugs and medical equipment supply to ensure adequate and quality, health services.
2. CHMT to conduct supportive supervision, mentoring and couching in order to improve the quality of health services provided in health facilities.
3. sensitization to the entire community on importance of early visits to health facilities for maternal health services such as antenatal care , delivery and postnatal services should be conducted,

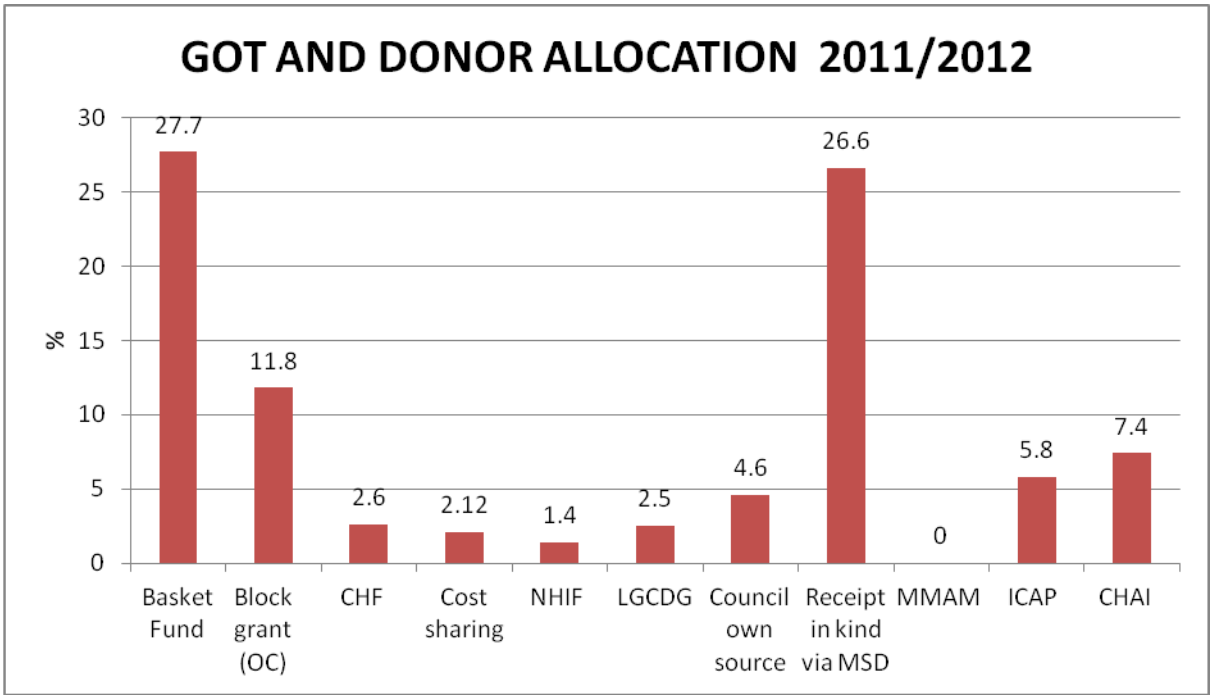
Provide Community awareness on HIV/AIDS prevention through meetings and health promotion

5 STATUS OF DISTRICT HEALTH SYSTEMS

5.1 HEALTH FINANCING

TOTAL GOT AND DONOR (BUDGET AND OFF-BUDGET) ALLOCATION TO HEALTH PER CAPITA IN THE DISTRICT

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



Source fund CHF,COST SHARING, NHIF,LGCDG,COUNCIL ON SOURCE is below 5%

Although the District received funds as approved, implementation of and 2011/2012 activities are still lagging behind due to lengthy tendering processes and untimely release of funds. The last year review indicates that out 168 planned activities 32(19%) were implemented as of December 2012 and 136(81%) not implemented. The remaining 136 activities will be implemented in the 3rd and 4th quarter.

5.2 HUMAN RESOURCES FOR HEALTH HUMAN RESOURCES FOR HEALTH

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- **Medical Officer (MO), Assistant Medical Officer (AMO), Clinical Officer (CO), and Assistant Health Officer(AHO) per 10,000 population**

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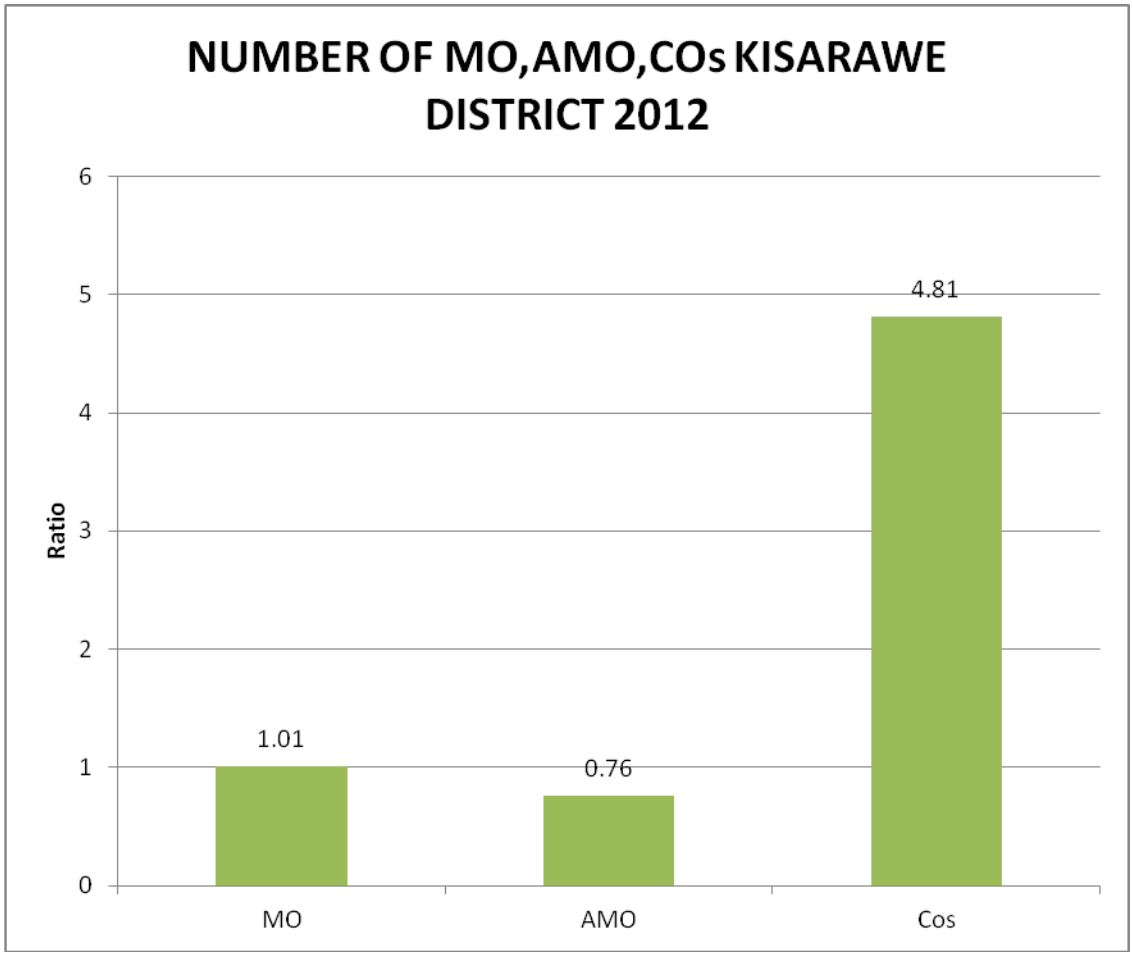
Figure 5-3. Number of MO, AMO, and COs Per 10, 000



12 Medical Officer , 1 Dental Officer , 9 AMO, 57 Cos, 9 Assistant Environment officers .1 Environment health officers The council has Nurses-Midwives 85, 5 Laboratory staff ,3 Pharmacists, 3 Pharmaceutical Technicians.

Figure 5-4. Number of Nurse mid-wives, Lab Techs, Pharm Techs Per 10, 000 2012

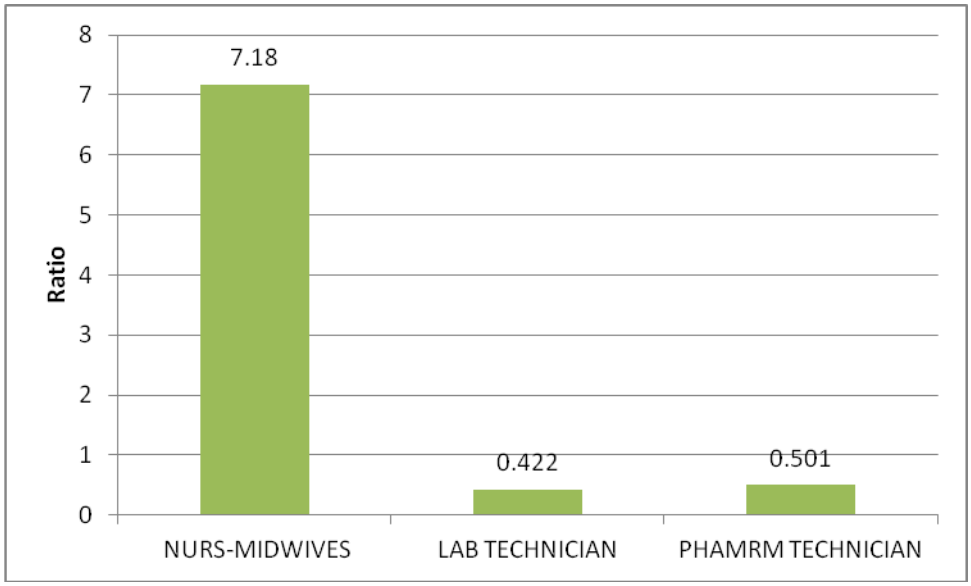
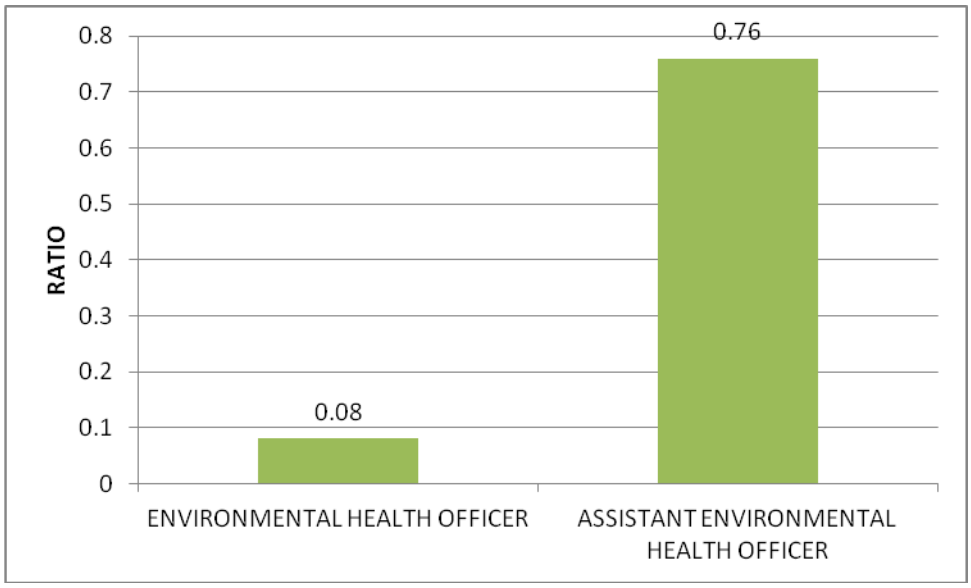


Figure 5-5. Number of HO, AHO, and EHOs Per 10, 000 2012

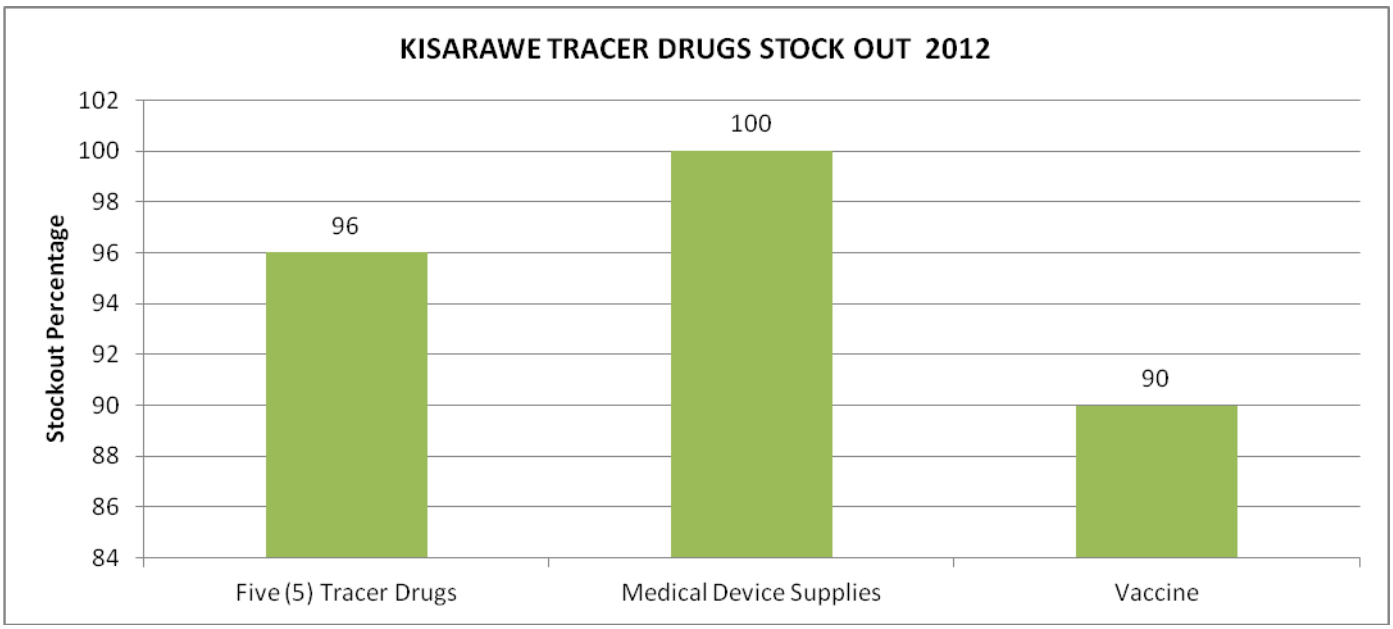


council need a total of 420 skilled health care workers, but only 316 are available with a deficit of 104 staff. This shortage is more critical in remote areas of the council with a percentage 25%

The quality of health services provided depends mainly on the availability of health professionals with required skills in the health facilities. There is still need for more Environmental Health Officers, Nurses, Lab technician, pharmacist staff.

5.3 MEDICINES/DRUGS

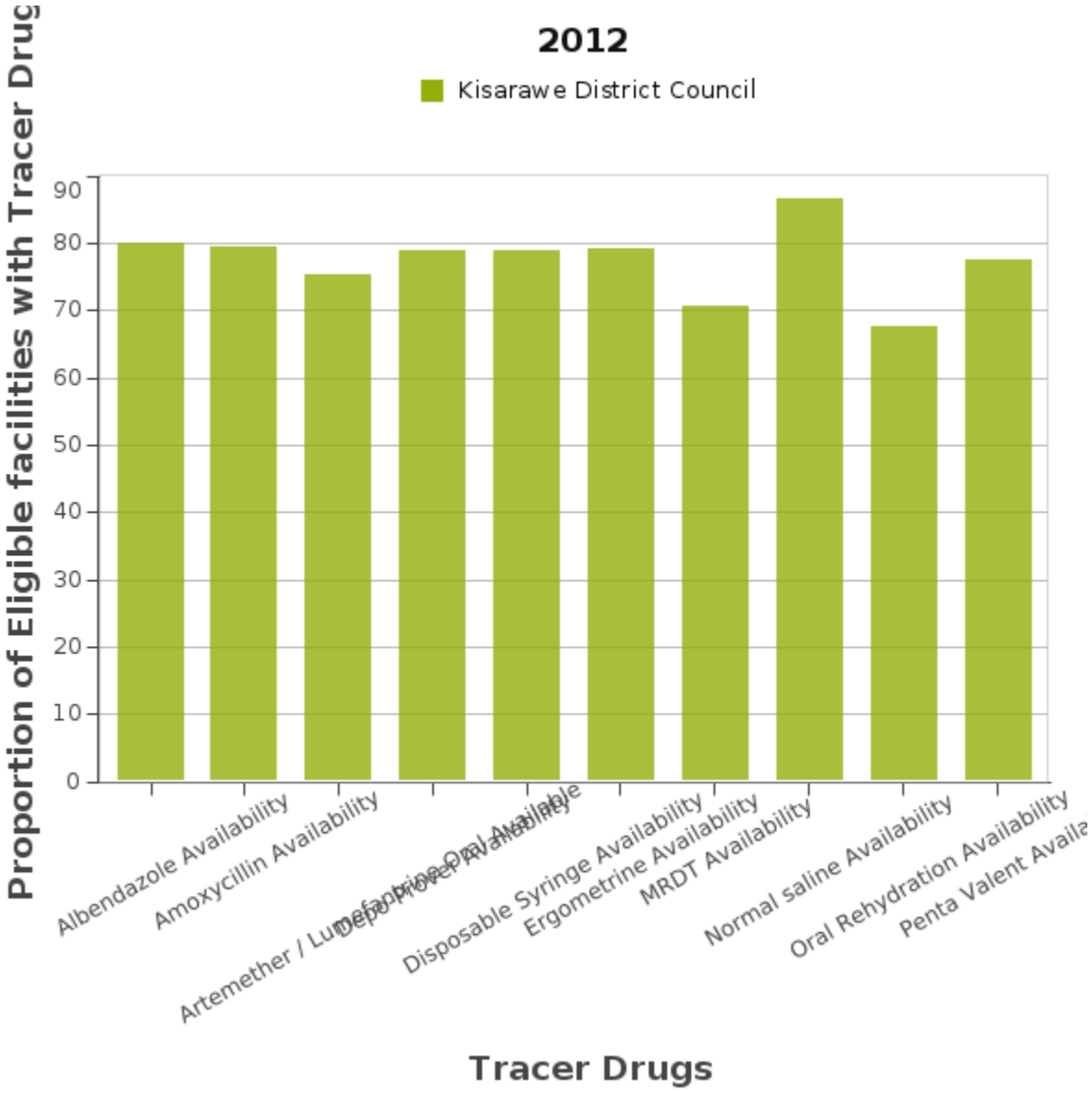
Figure 5-6. Health Facilities with Stockout of 5 Tracer Drugs, 1 Vaccine and Medical Supplies



KISARAWE DISTRICT HEATH FACILITY WITH STOCK OUT OF 5 TRACER DRUGS ,1 VACCINE,AND MEDICAL SUPPLI

Organisation unit	Albenda zole	Amoxy cillin	AL U	Depo-Prover	Ergomet rine	Stock out	MR DT	Disposable Syringe	Stock out	Penta Valent	S o
Chole Dispensary	75	75	62 .5	50	62.5	0	37. 5	42.9	0	75	
Gwata Dispensry	75	75	75	75	75	0	57. 1	50	0	62.5	
Homboza Dispensary	50	87.5	37 .5	75	87.5	0	62. 5	87.5	0	75	
Kibasila JWTZ Dispensary	83.3	83.3	83 .3		133.3	0	83. 3	83.3	0		
Kidugalo Dispensary	100	100	10 0	0	0	100	0	100	0		
Kihare Dispensary	87.5	87.5	75	87.5	87.5	0	75	87.5	0	87.5	
Kiluvya Dispensary	75	75	75	75	75	0	75	85.7	0	75	
Kiluvya JWTZ Dispensary	50	37.5	37 .5	75	28.6	0	100	85.7	0	75	
Kimalamisale Dispensary	87.5	87.5	62 .5	100	87.5	0	75	100	0	100	
Kisarawe District Hospital	71.4	85.7	71 .4	85.7	85.7	0	85. 7	57.1	0	57.1	
Kurui Dispensary	87.5	87.5	87 .5	87.5	87.5	0	42. 9	75	0	87.5	
Mafizi Dispensary	71.4	71.4	71 .4	71.4	71.4	0	57. 1	71.4	0	71.4	
Maneromango Health Centre	75	75	75	75	75	0	85. 7	62.5	0	62.5	
Marui Dispensary	100	66.7	10 0	100	100	0	80	80	0	83.3	
Marumbo Dispensary	85.7	85.7	85 .7	85.7	71.4	0	66. 7	85.7	0	71.4	
Masaki Health Centre	87.5	87.5	75	75	87.5	0	75	75	0	75	
Masanganya Dispensary	83.3	100	83 .3	100	83.3	0	80	100	0	100	
Minaki Dispensary	100	100	83 .3			0	83. 3	100	0		
Msanga Dispensary	85.7	71.4	85 .7	100	100	0	85. 7	85.7	0	85.7	
Mwanzo Mgumu Dispensary	50	50	62 .5	75	75	0	37. 5	62.5	0	75	
Mzenga Health Centre	87.5	75	87 .5	87.5	62.5	0	87. 5	75	0	87.5	
Sungwi Dispensary	87.5	87.5	75	62.5	62.5	0	50	87.5	0	87.5	
Vikumburu Dispensary	85.7	71.4	85 .7	85.7	85.7	0	71. 4	85.7	0	71.4	

Figure 5-7. Availability of Tracer Drugs



The table abov show that

SUCCESSES

Mostly of essential Health commodities are available to our facility

CHALLENGE

Inadequate funds purchases of medicine and other medical device to fulfill demands of our health facility

Most of old and new health facility Buildings constructed or planned have no rooms for dispensing and storing health commodities resulting into poor damage pf medicine and the country losing needed resources

Essential health commodities including medicine rarely available at MSD resulting into pour health services to our health facility

Health commodities KITS for Hospital health center ,dispensary are not arrived in time from MSD.

WAY FOWARD

Request government to increase fund given to our facility

Old health facility needs renovation to include dispensing and store room MOHSW ,Council shout use and store if available standard plan four contraction health facility if not available then MOHSW should provide needed plan which will make sure all needed department are include department Dispensing

Special program needs to be taken by the government to make sure pharmacy staff are available as for nurses and doctor.

MSD with help the help of the government needs to solve all issues related to health commodities this include availability a delayment of medicines

5.4 INFRASTRUCTURE

In Kisarawe district council all health facilities structures especially those owned by government are in a good condition. This is contributed by the existence of MMAM program which is being implemented by the council towards achieving the goals for improving health status, however the council under MMAM programe has managed to construct 4 dispensaries (Bembeza, Zegelo, Sofu and Vihingo which are expected to be opened at the end of this year). Also the Council is constructing one staff house at mwanzomgumu dispensary and one dispensary at kazimzumbwi.

5.5 NOT selected for now

5.6 DISTRICT HEALTH SYSTEM CONCLUSIONS AND RECCOMENDATION

Kisarawe district council is among the council that is donor dependent in the issue of implementing health activities. 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 medical supplies.

The Situation of the health staffs in district is good, but more budgets is needed so as to increase staffs according to the health policy and standard, however Provision of staffs house and other motivation to the staffs will retain and attract other health staffs to work in the district

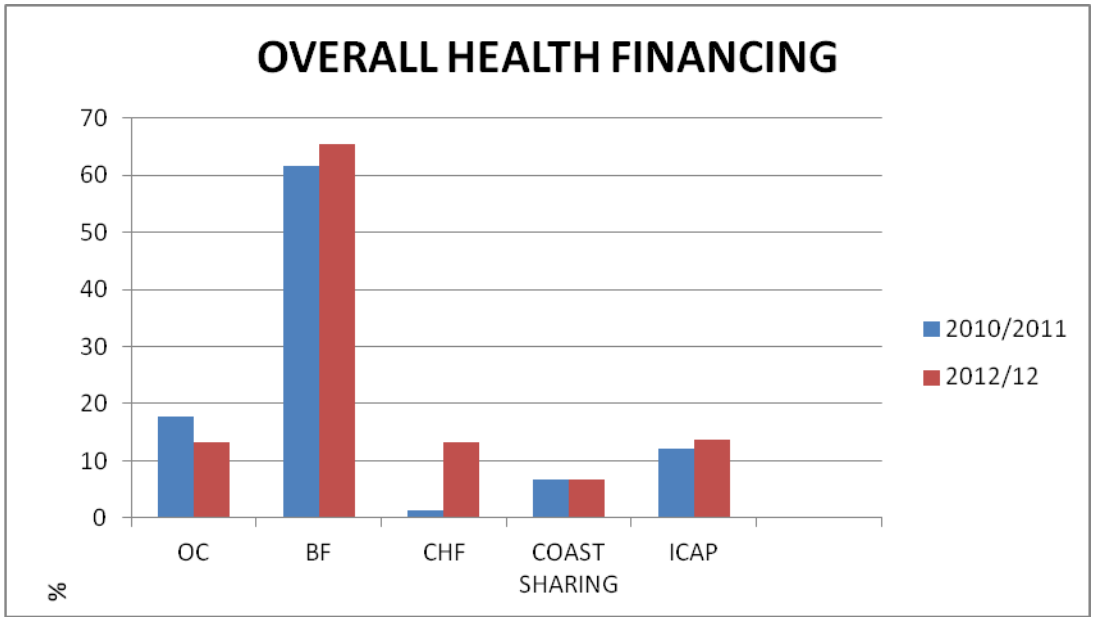
WAY FORWARD

1. To emphasize on CHF sensitization within the council so as to increase source of fund and hence improve the quality of health services.
2. To construct more health facilities and recruit more health staffs of different cadre to ensure that all people within the council have accessible health services.
3. CHMT to conduct supportive supervision, mentoring and couching for the purpose of ensuring sustainability in provision of quality health services.

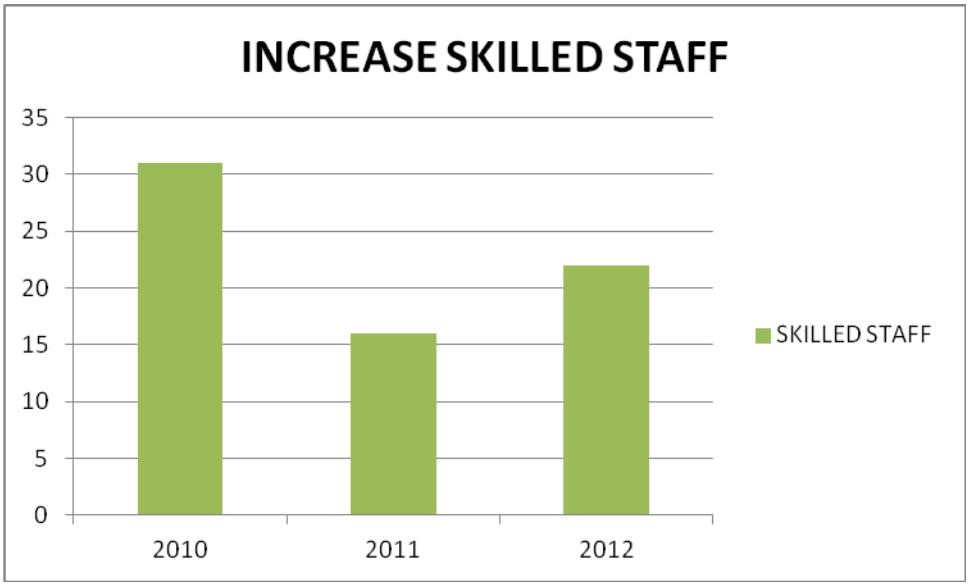
6 AREAS OF PROGRESS IN THE DISTRICT HEALTH SECTOR 7

6:1 PROGRESS IN DISTRICT HEALTH FINANCING

EXPANSIONS IN HEALTH SPENDING

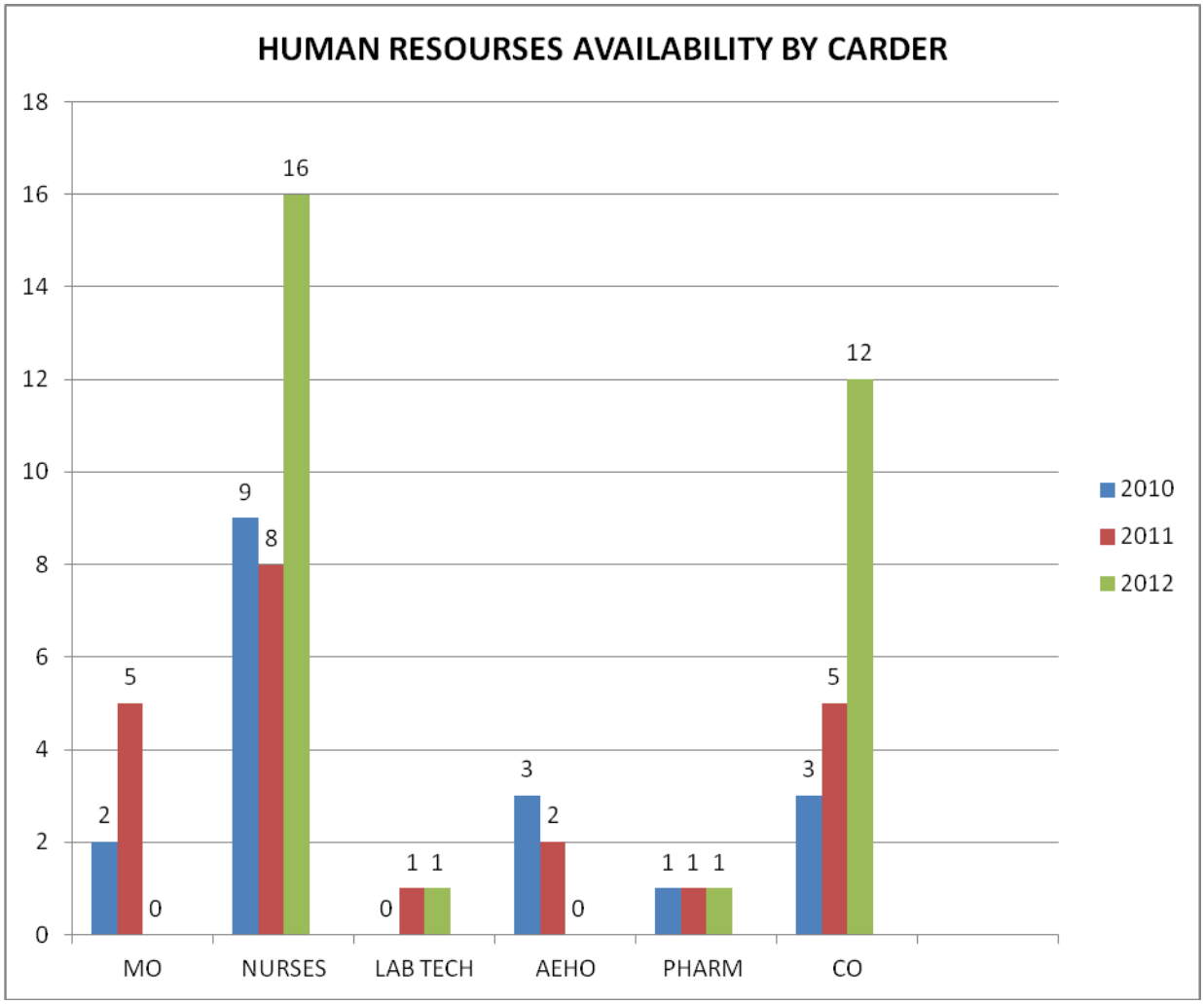


7.1 PROGRESS IN DISTRICT HUMAN RESOURCES



In the past three years Kisarawe district council has achieved to recruit, 69 skilled staff in 2010 years recruit 31 staff, 2011 years recruit 16 staff. And 2012 years recruit 22 staff,

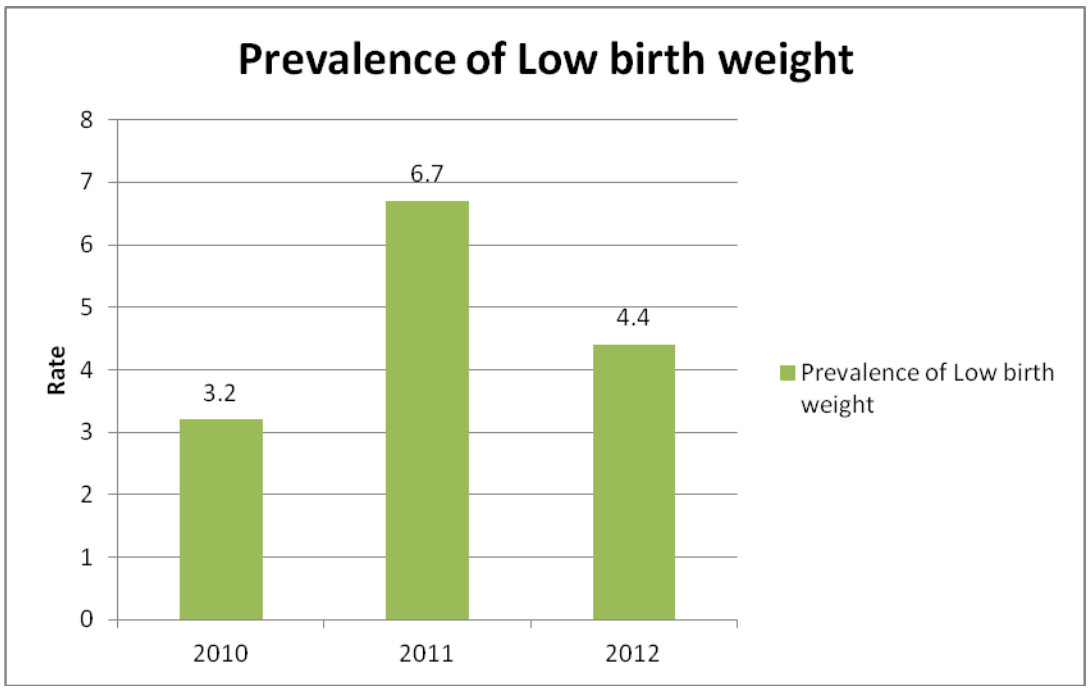
PROGRESS IN HUMAN RESOURCES AVAILABILITY BY CADRE OVER A PERIOD OF TIME



In the past three years district council has achieved to recruit, 7 medical doctors, 20 clinical officers, 33 Registered nurses, 2 pharmacists, 2 laboratory technicians, 5 assistant environment health assistat

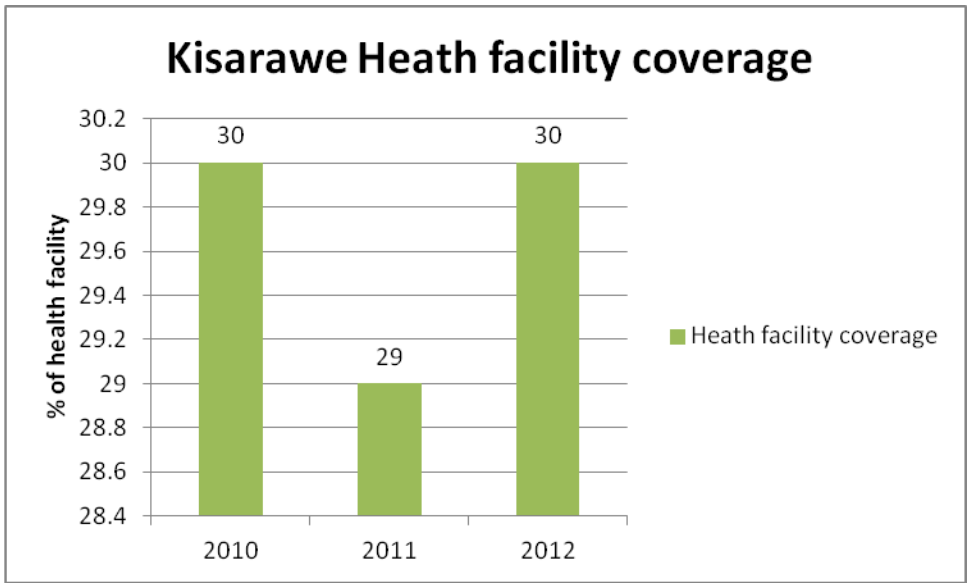
7.2 PROGRESS IN DISTRICT NEONATAL HEALTH

LOW BIRTH WEIGHT



7.3 PROGRESS IN DISTRICT HEALTH FACILITY COVERAGE

EXPANSIONS IN FACILITY COVERAGE ACROSS DISTIRCTS



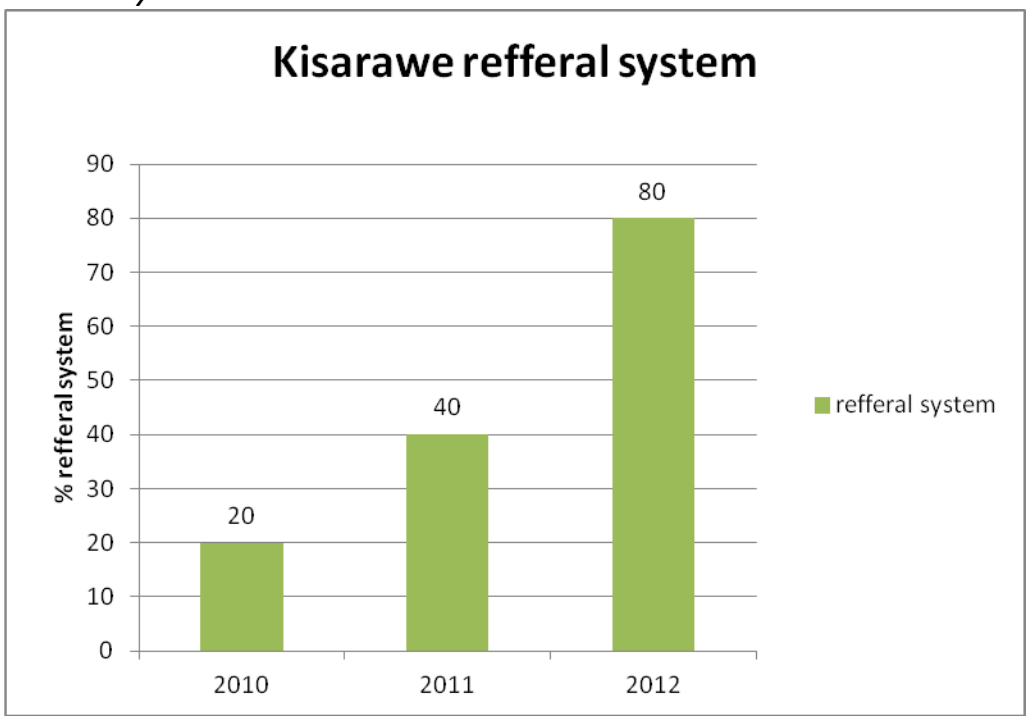
The model of health services delivery in Kisarawe District Council is based on preventive, and curative care. The line of operation starts from the Dispensary, Health center to the District Hospital.

2010 distict has 30% health facilities that provide services of which 1 a hospitals, 3 health centers and 20 dispensaries. 2011 distict has 29% health facilities that provide services of which 1 a hospitals, 3 health center and 19 dispensary, 2012 has 30%health facility that provide services of which 1 district hospital,3 health center,20 dispensary. The Health and Social Welfare sector at Council level is one of the councils' departments. The Council Health Management Team provides technical health and social care development advice within the Council. The mission is to facilitate health facilities so as to enable them provide Quality Health Service to the Public.

7.4 PROGRESS IN DISTRICT HEALTH FACILITY PERFORMANCE

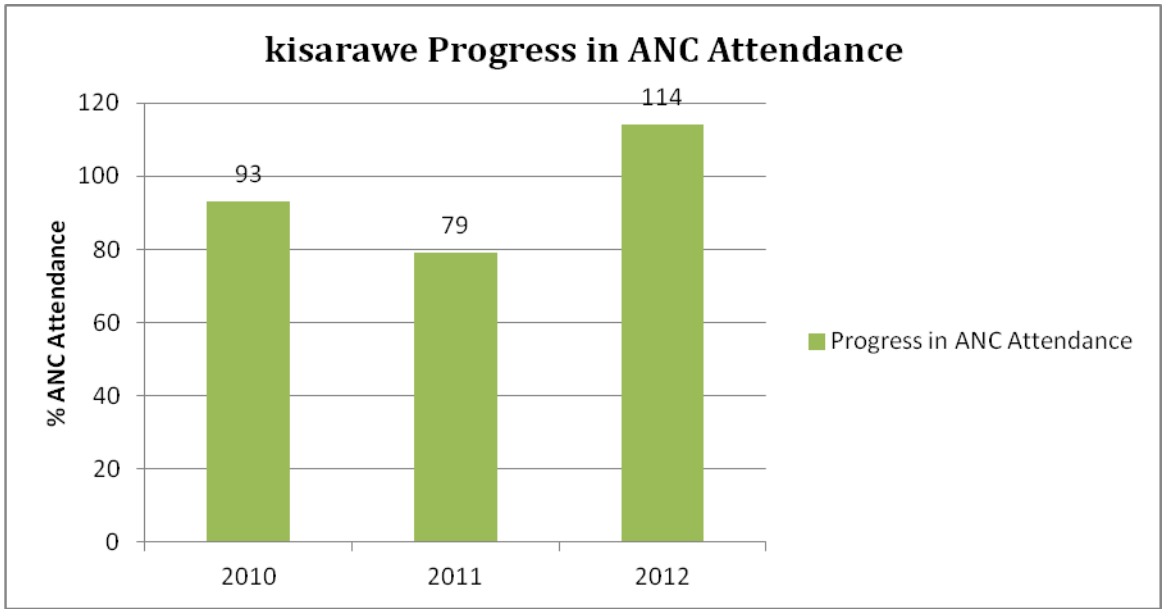
EXPANSIONS IN CRITICAL HEALTH SERVICES

1 Delivery service

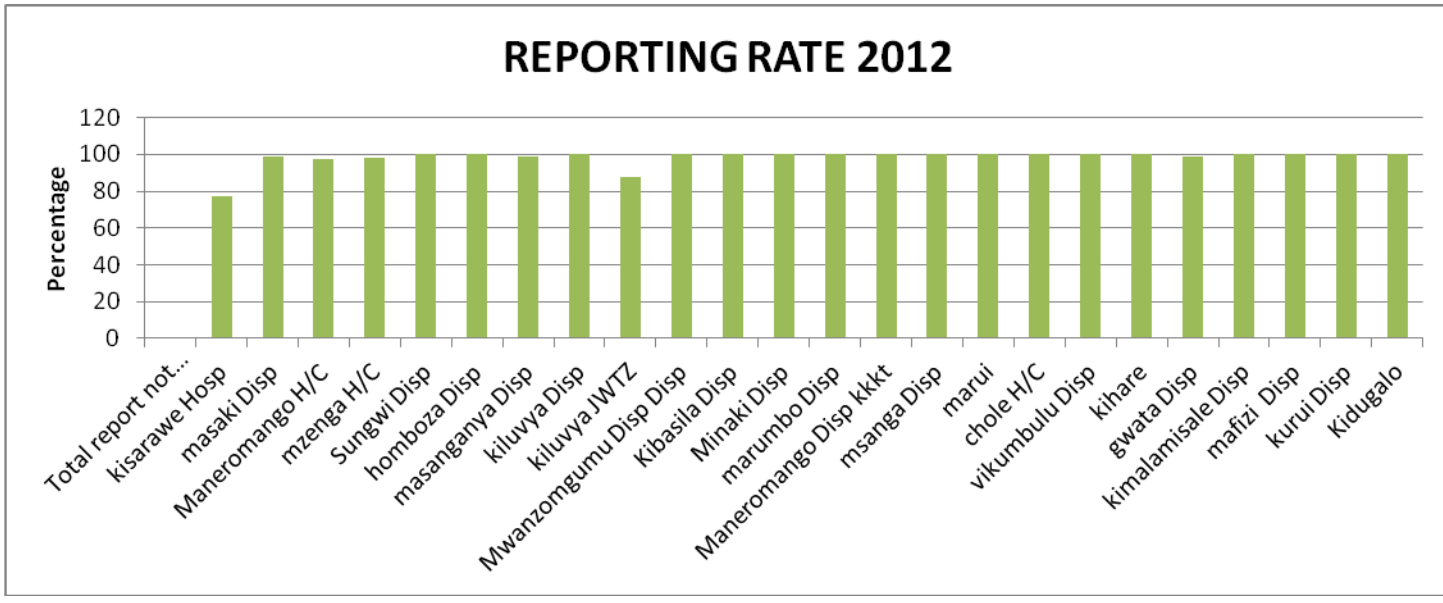


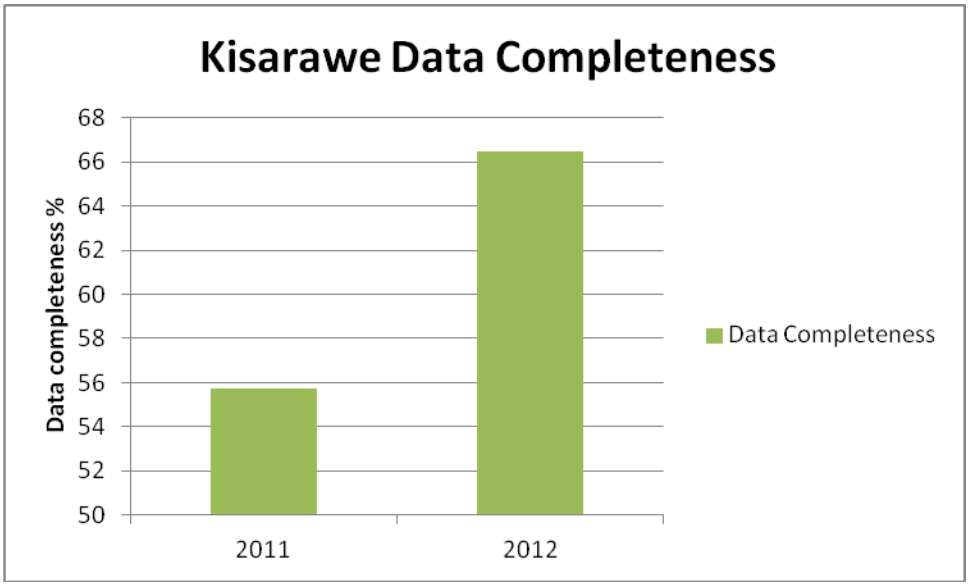
The existing referral system in Council is inadequate in terms of geographical location of the district hospital vs the Regional referral hospital, availability of ambulances and transport. Patients are referred to Muhimbili National Hospital I, There are 4 ambulances of which 1 is for the district hospital, 2 for the 2 health centres and 1 for one dispensary.

PROGRESS IN ANC ATTENDANC



PROGRESS IN HEALTH FACILITY REPORTING RATES





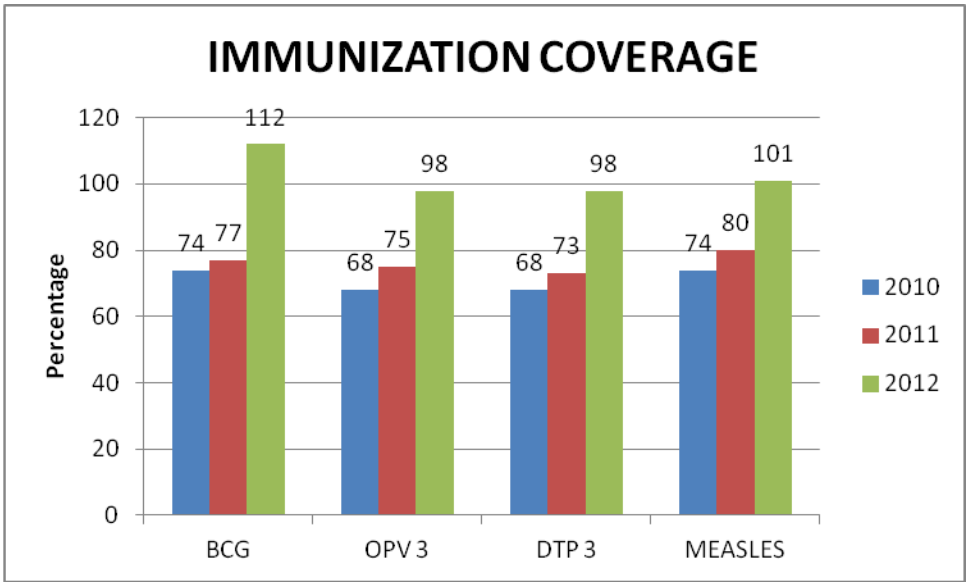
The District health management information system (HMIS unit) is recognized as the collection , data entry,compiling and analyzing centre for the health data generated from 24 health facilities in the District. The HMIS uses specified tools to collect, compile and analyze data. Analyzed data used by CHMT and co-opted member and health facility to identify the health problems and set strategies to address. However feedback material which was introduced early 2012 as been new reporting tool it was seen of been a useful tool as it explored health problems, helped to spot problems/challenges. dissemination of feedback material which went in line with existing management capacities (CHMT, Facility helped to draw implementation calendar.

Collect and submit report DHIMS unit (MTUHA summary forms) 1-7 every moth

7.5 PROGRESS IN DISTRICT HEALTH SERVICES

- ***SOCIAL WELFARE AND PROTECTION SERVICES FOR VULNERABLE POPULATIONS***

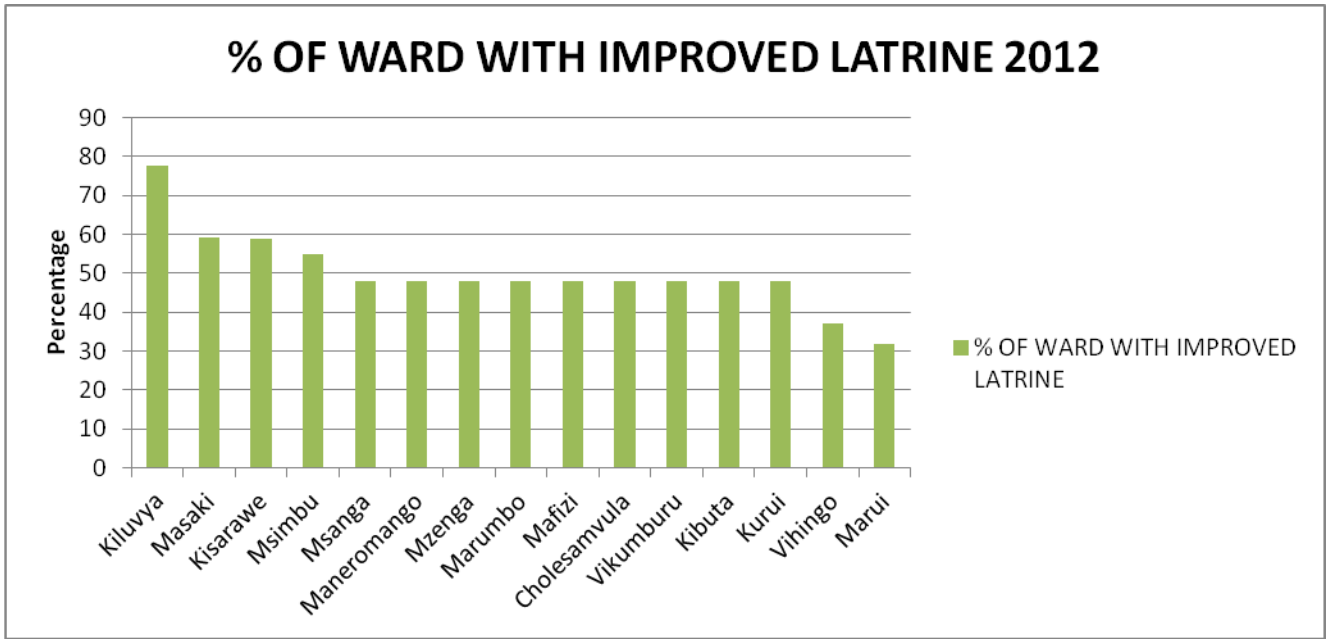
IMMUNIZATION COVERAGE



WAYFOWAD

To strethening immunization data analysis and use of data for action at all level
To strethening and maintaining mobile and out reach services
To improved cold chain management at all level DVS, by replacement new regenerator
To involve community leaders and village health workers on tracking unvaccinated children

ENVIRONMENTAL HEALTH AND SANITATION.



SUCCESS;

No diseases outbreak occurred in the year 2012, like cholera and others.
Proper involvement and participation of the community in sanitation activities.
Sensitization of the community on the importance of sunrise water treatment and hand washing procedures on the control of sanitation related diseases.
Community awareness on the construction and use of Ventilated Improved Pit latrine (VIP) and hand washing facilities.

CHALLENGES

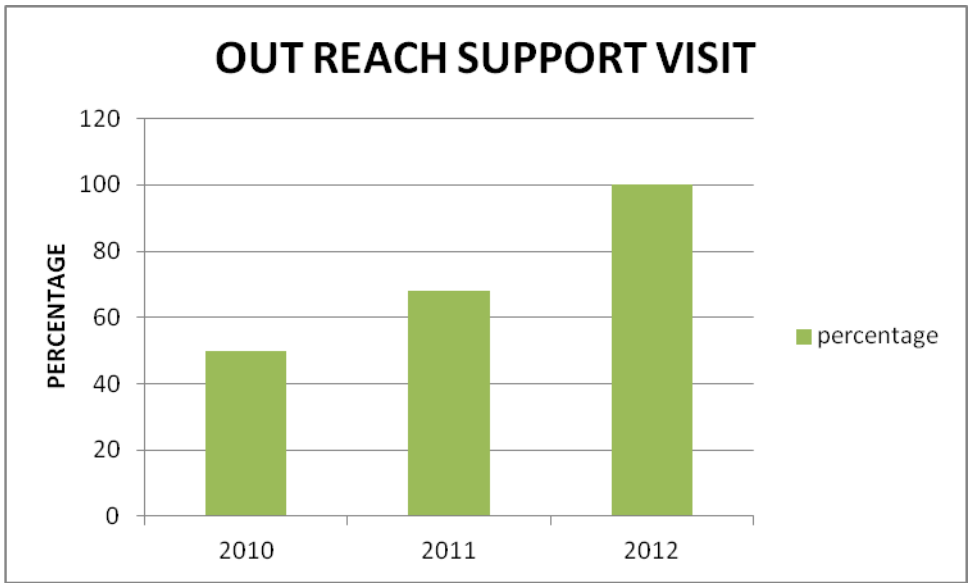
High costs for transportation of wastes from Kisarawe to Ilala (Dare es slaam) disposal point as the district has no area for final disposal of wastes (dump site).

No planned area for construction of public cemetery especially for unknown dead bodies of human being.
In adequate released budget for environmental sanitation activities
In adequate environmental health staffs as not every ward has such staff. .
Lack of truck/lorry for transportation of wastes from the collection point to the disposal point.
Lack of labourers for cleanliness of the public premises
Lack of environmental sanitation district by laws.
Lack of standard slaughter house.

WAY FOWARD

To enhance the inspection of food premises and provision of health education and promotion to the community.
To improve the environmental sanitation activities through Community Lead Total Sanitation-CLTS approach.
Prepare and implement the environmental sanitation by laws
Enhance and support the village health committee in each village
To improve and maintain the inspection of different premises such as house to house, food and public premises.
To prepare and advise on the proper plan and suitable area for dump site construction in the district.
Involvement of different development partners in different environmental sanitation activities implementation such as PLAN Tanzania..
Inclusion of the budget for the construction of slaughter house and area planned for public cementry in the district plans.

7.6 PROGRESS AGAINST MILESTONES



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Out reach support visit conducted and trip report submitted including obstacle to performance pass 3 years

7.7 BEST PRACTICES/CASE STUDIES

Improvement in under one year's immunization coverage from 68% in 2010 to 100% in 2012

Problems identified

- Inadequete mobile and outreach clinics
- Lack of mobile cars
- Inadequete funds
- Inadequete supportive supervision

Strategies

Identification of the above problems was done by CHMT and other stakeholders in the district

Request was done to PLAN Kisarawe (NGO) to assist us in the identified problems.

Willingly PLAN TANZANIA Kisarawe agreed to support us in the following items

- Capacity building to health workers and village health workers
- To purchase one mobile car
- Sensitization to community leaders
- Vaccine equipments such as vaccine carriers, weighing scales for newborns and under fives

Implementation started in January 2012 up to December 2012 it was 100%

We are very proud of what we received from our partner PLAN Kisarawe, we thank them and our promise is to sustain the programme using our resources.