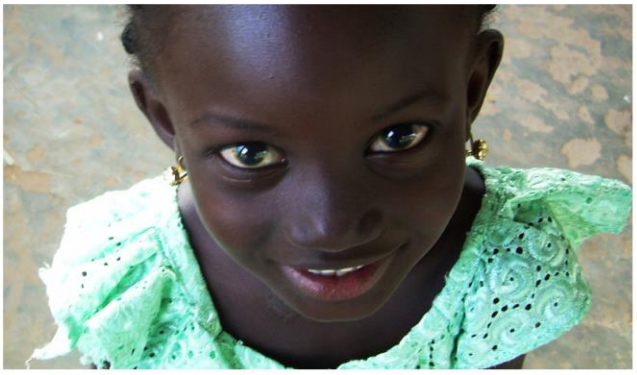
The United Republic of

TANZANIA

Ministry of Health & Social Welfare



2012 BARIADI

District Health Profile

BARIADI DISTRICT COUNCIL

TABLE OF CONTENTS

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

The development of the DHP is a collaborative effort, and the following people and/or organizations are being acknowledged for their direct contribution: The DMO and the entire CHMT, facility in-charges, MTUHA focal person, district planning office and everyone who contributed to the success of this DHP.

III. EXECUTIVE SUMMARY

INTRODUCTION

Bariadi district has a population of 811,382 (Census projection, 2002) and covers an area of 9445.7km^2. Administratively, the district has 8 divisions, 47 wards, 205 villages and 1292 hamlets.

Under the health sector, the district has 1 government hospital, 6 government and 1 private health centers, and 44 government and 6 privately owned dispensaries.

DATA COLLECTION METHODS AND SOURCES OF DATA

Development of Bariadi district health profile used different sources of data. Records review method was used to collect information while analysis of the data collected was done through Ms Excel and DHIS-2.

HEALTH STATUS OF THE DISTRICT

For 2 years, the district faced a period of drought that deteriorated nutrition status of the district where mothers and children under five were mostly affected. There was also an increase in number of moderately malnourished people by 27% from 2011 to 2012.

Records shows maternal, infants and under five mortalities to be under control, but they do not reflect the true picture because the district is still faced with the problem of low facility delivery coverage that is being accelerated by various factors like inadequate quality of care, facility understaffing and cultural taboos.

Malaria still stands as a leading disease among top 10 diseases in the district with a slight reduction in its morbidity and mortality.

HIV prevalence has decreased over the years though generally still high at 5.1%. The prevalence is highly contributed by low male circumcision coverage (14%) and other cultural taboos like inheritance of widows and polygamism.

General water and sanitation coverage in the district stands at 48% with low latrine coverage of 35%, a situation that has caused recurrent eruption of cholera and dysentery epidemic in 2010 and 2011.

Fertility rate in the district is still high at 6.1 children per woman

STATUS OF HEALTH SERVICE DELIVERY

There has been a markedly decrease in OPD attendance rate and attendance per health worker.

The general immunization coverage stood at 85% by the year 2012 with BCG coverage exceeding the target.

A very small proportion of pregnant women completes all the 4 ANC visits and gets IPT 2 and PIT 2 because most mothers come to health facilities at later stages of their pregnancies.

Contraceptive prevalence rate is still low at 12%, one of the reasons why the district has a high fertility rate and probably a big number of untraced maternal mortalities

STATUS OF DISTRICT HEALT SYSTEM

Generally, health financing system in the district is facing some challenges that hinder proper implementation of planned activities.

Human resource for health has always been inadequate in the district, and this is a cross-cutting issue all over the country.

There has been a problem of stock-out with tracer medicine and medicine in general both at the district level and zonal stores, Mwanza. This problem sometimes demoralizes staff working spirit and community morale to seek medical care.

CONCLUSION AND RECOMMENDATION

Generally, health sector in the district is facing a number of challenges that needs to be addressed. This has been reflected by most of percentages being below the national targets. Some of these challenges can be settled at a district level through multi-sectral approach, but some interventions require an upper hand.

The district under health sector together with other health stakeholders continues to work hand in hand to improve awareness and participation of the community in health related issues so as to make a dream of having a healthy community comes to reality.

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
DMO	District Medical Oficer
CHMT	Council Health Management Team
HIV	Human Immunodeficiency Virus
RCH	Riprodutive and Child Health
CCHP	Comprehensive Council Health Plan
IPD	In-Patient Department
OPD	Out Patient Department
PHC	Primary Health Care
HSSP III	Health Sector Strategic Plan III
TDHS	Tanzania Demographic Health Survey
RHMT	Regional 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	The specialized care of patients whose conditions are life-threatening and who require comprehensive care and constant monitoring

1 INTRODUCTION

1.1 MISSION AND VISION

Vision: A well educated community with better livelihood by the year 2014

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

1.2 STRUCTURE OF DISTRICT

Bariadi district was established in 1973. It was formally part of Shinyanga but is now found in Simiyu after division of regions. It is located in northern part of Tanzania. The district covers a total area of 9,445.7 km2 and has a total population of 811,382 people (Census projections, 2002).

Administratively, Bariadi District is divided into 8 divisions namely: Ntuzu, Dutwa, Kanadi, Mhango, Nkololo, Bumera, Kinang'weli and Itilima. The 8 divisions are sub-divided into 47 wards and the wards are further sub-divided into 205 villages and 1,292 hamlets.

Table 1-1. Wards And Villages

WARD NAMES	MUMBER OF VILLAGES
Ntuzu	21
Dutwa	37
Kanadi	27
Mhango	26
Nkololo	19
Bumera	26
Kinang'weli	28
Itilima	21
TOTAL	**205**

1.3 FACILITY DISTRIBUTION

The health services available are insufficient as compared to the total population. There is 1 district government hospital, 7 health centers and 55 dispensaries of which 44 are owned by government, 6 dispensaries and 1 health center are privately owned.

Table 1-2. Facility Distribution

TYPE OF FACILITY	NUMBER OF FACILITIES	OWNERSHIP
HOSPITAL	1	Government
	0	Parastatal
	0	Private
	0	FBO
DISPENSARY	44	Government
	0	Parastatal
	6	Private
	5	FBO
HEALTH CENTER	6	Government
	0	Parastatal
	0	Private
	1	FBO
CLINICS	0	Government
	0	Parastatal
	0	Private
	0	FBO

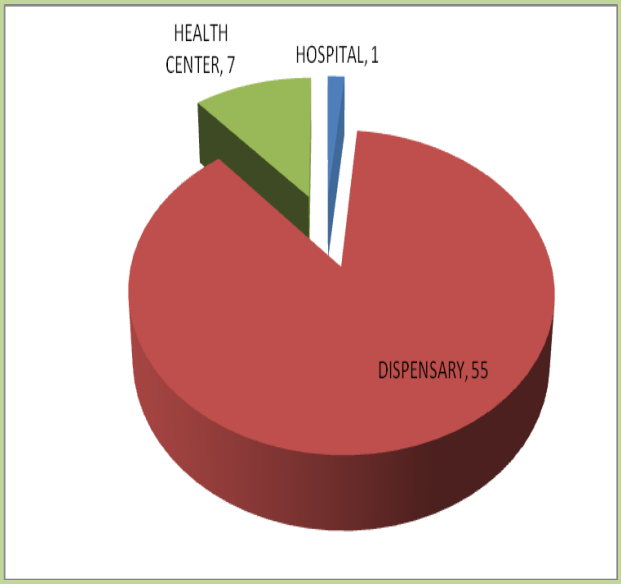
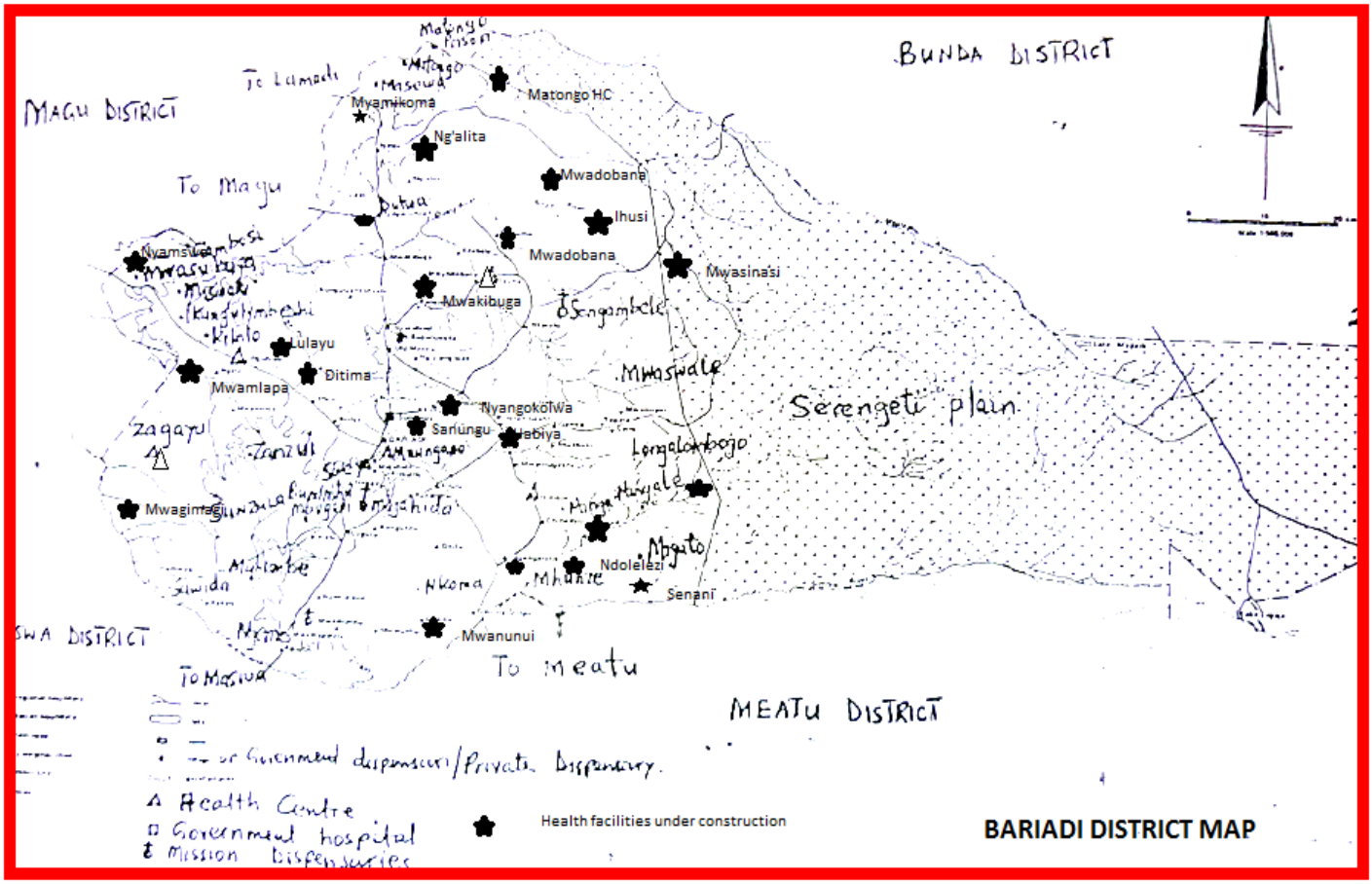


FIGURE 1-1. Bariadi District Map



1.4 POPULATION

Bariadi district population based on gender was projected to have 427,090 female and 384,292 male from the 2002 national census. By age the district was projected to have 489,734 people aged 0-17, 304,490 aged 18-64 and 17,158 people aged 65years and above.

Almost 60.36% of the total population is aged below 18 years, meaning a large number of people in Bariadi district is youth.

Table 1-3 (a) 2011 Gender based statistics (Census projections, 2002)

Census population projections		
Female	**Male**	**Total**
427,090	384,292	811,382

Table 1-3 (b) 2011 Age based statistics (Census projections, 2002)

Age	0-5	6-11	12-17	18-22	23-46	47-60	61-64	65^{+}	Total
Total	217,395	154,991	117,348	72,020	182,963	41,734	7,773	17,158	**811,382**
%	26.79	19.10	14.46	8.88	22.55	5.14	0.96	2.12	**100**

NB: Tables 1-3 a & b shows population projections from 2002 census because, by the time 2012 census was being conducted; the district had already been divided into 3 independent councils.

1.5 GEOGRAPHY

The district climate is generally tropical type. The annual rainfall ranges from 700mm-950mm per year. There are two districted periods of rain seasons. The short rain period is normally between October-December with a dry spell in January and February. Long rain falls in between March to mid May. The period from June-September is hot and dry. The average temperature during the day is 290C and 190C at night.

Water bodies, forest and hilly areas cover (1.21%) 114 sq. kms of the total land.

1.6 TRANSPORTATION AND COMMUNICATION

Bariadi district has a road network of 1,278 kms categorized into three main groups namely regional, district and feeder roads. The distribution of these kilometers is 237kms, 176kms and 829kms for regional, district and feeder roads respectively.

The district has STD telephone system, mobile phones, 1 post office and there are 18 Radio calls of which 2 are located at Council hospital, 4 health centers and 3 at the dispensaries while 3 are for other government institutions and 6 are owned by NGOs including World Vision Tanzania. There are also 4 fax machines at the post office, in DED's office, DMO's office and TASAF office. There is also an internet at DMO's office

1.7 EDUCATION

Statistics shows that pre-primary education student's enrollment raised from 1,895 students in 2005 to 19,942 students in 2011. There are 189 government and 2 privately owned primary schools. A total of 15,227 students sat for 2011 standard VII national examination, of which 5,354 (35.1 passing rate) student passed and were all selected to join form I.

For secondary education, there are 65 government school (64 level and 1'level) and 4 private secondary schools (2 O'level and 2 A 'level).

There is one government vocation training center at Somanda 'A' primary school with 26 students and 1 private teacher's college namely Bariadi teachers college with 97 students

1.8 OTHER INTRODUCTORY INFORMATION

1.8.1.1 WATER SUPPLY

The major water sources in Bariadi District are traditional wells, shallow wells, Dams, Deep wells and seasonal rivers. Main sources of drinking water are not protected, only 50% of the population has access to safe water.

Water sources are shown in the table below.

DIVISION	SHALLOW WELLS	PIPED SCHEME	DAMS
DUTWA	316	1	2
KANADI	229	-	3
TOTAL	**545**	**1**	**5**

Source: District Water Office.

2 DATA COLLECTION METHODS AND SOURCES OF DATA

2.1 DATA SOURCES AND THEIR DATA COLLECTION AND ANALYSIS METHODS

- 2012 Annual PHC report
- OPD and IPD reports
- RCH reports
- MTUHA
- CCHP
- TDHS 2010
- Bariadi District profile report 2011
- 2002 National census report
- HSSP III
- RS/RHMT Annual Plan

These data sources have been chosen for production of DHP because they give relevant and direct information that is needed for development of DHP. DHIS-2, Ms Excel software and records review methods were used to collect and analyze data from most of the sources.

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

Table 2-1: DHP MANDATORY HEALTH INDICATORS

HEALTH STATUS OF THE DISTRICT POPULATION

Maternal, Newborn and Child Health

- Nutritional Status: Low Birth Weight
- Neonatal, infant, and under 5 mortality rates

Diseases

- Incidence of Malaria/Laboratory Confirmed Malaria
- HIV/AIDs prevalence
- Top 10 causes of admission
- Top 10 causes of death

DISTRICT HEALTH SYSTEMS

Health Financing

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

Infrastructure

Health Indicator Still Being Determined

DISTRICT HEALTH SERVICE DELIVERY

General

- OPD Attendance

Vaccination

- Proportion of children under 1 vaccinated against measles
- Proportion of under 1 3rd Polio (OPV3)
- Proportion of under 1 BCG dose

Reproduction Health

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

Infectious Diseases and Non-Communicable Diseases

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

BARIADI DISTRICT HEALTH PROFILE

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 BARIADI DISTRICT

Given the rate at which maternal, infant and under fives mortality stands, it would be of a great importance to consider other optional indicators like life expectance at birth, total fertility rates per woman, contraceptive prevalence rate, women attending ANC at least 4 times and percentage of adolescent pregnancy.

Considering their relation to maternal and child health, they may help in decreasing mortalities.

From OPD and IPD, cases of water related diseases seem to appear in top 10 leading causes of morbidity. A closer look at access to safe water supply and latrine coverage may help reducing the number of cases.

OPTIONAL DISTRICT HEALTH STATUS OF THE POPULATIONS INDICATORS
1. Total fertility rates
2. Latrine coverage
3. Percentage of population with access to safe water supply
OPTIONAL DISTRICT HEALTH SYSTEMS INDICATORS
1. Proportion of national budget spent on health in the district
2. Proportion of population enrolled in CHF/TIKA
OPTIONAL DISTRICT HEALTH SERVICE DELIVERY INDICATORS
1. Proportion of pregnant women attending ANC at least 4 times during pregnancy
2. Proportion of births attended by trained personnel in health facility
3. Contraceptive prevalence rate

3 HEALTH STATUS OF THE DISTRICT POPULATION

3.1 MATERNAL, NEWBORN AND CHILD HEALTH

There has been a period of drought in the region for the last past 2 years that led to poor nutrition status of the general community but the situation was worse in mothers and children under five years of age.

The district Maternal mortality rate, Infant mortality rate and underfive mortality rates seems unchanged over the years, almost low to zero rate. This is due to the fact that, most of these mortalities occurs in the community and remain unrecorded and untraced. This condition has mainly been contributed by low the health facility coverage that is at 55% and shortage of qualified staffs which is now at 30% of the actual need according to defined staffing norms, which all together causes;

High fertility rate of 6.7 children per woman

Poor health facility delivery of 33%

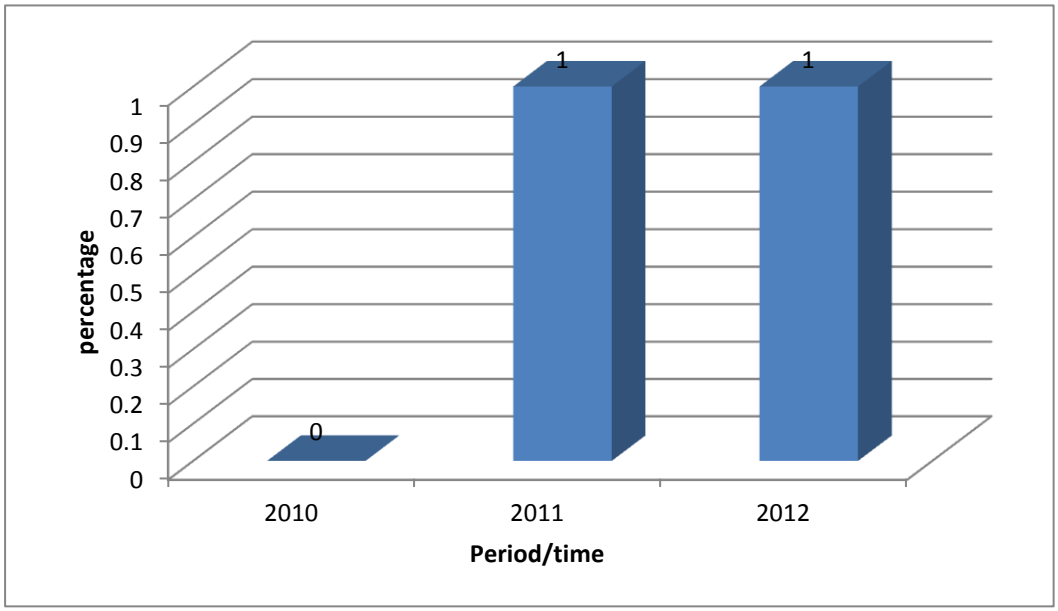
Poor Antenatal and Postnatal Care attendance

Low family planning coverage of 12%

Although, there are other cultural practices that compliments the poor performance of maternal and child health that may be compounded by the low literacy rate of 30.7%

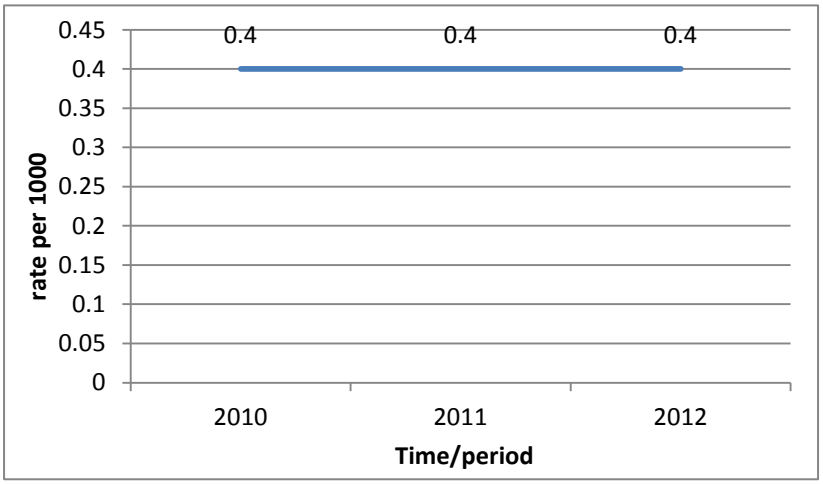
This being the case then, the achievement of MDG 4 & 5 may not be a reality.

Figure 3-1. Nutritonal Status: Low Birth Weight



The trend shows an increase of 1% low birth weight from 2010 to 2011. This has mainly been contributed by poor ANC attendance by pregnant women making it hard to detect risk factors. There are a number of reasons also leading to poor ANC attendance like poor staffing, quality of care and facility accessibility.

Figure 3-2. Neonatal Mortality Rates

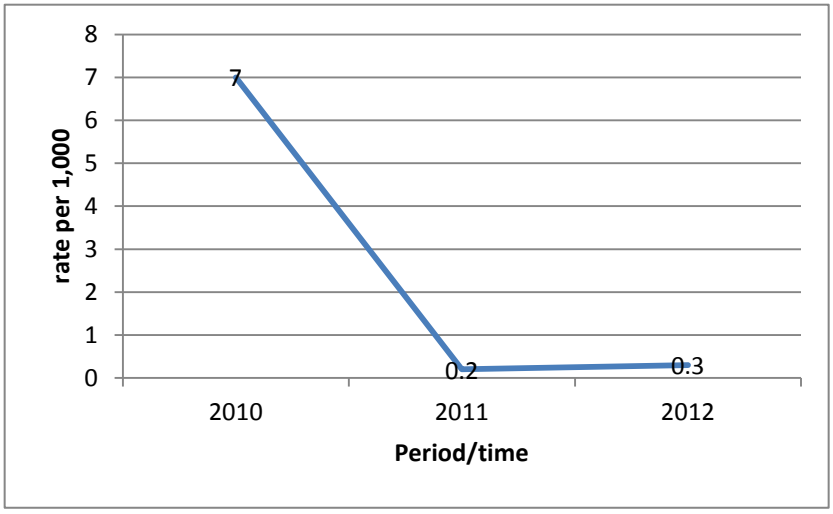


The trend of mortality seems constant (at 0.4/1000) over the years, although it does not give a true reflection of the general population because most of deliveries and these mortalities occur in the community and remain untraced.

Figure 3-3. Infant Mortality Rate

Infant mortality in Bariadi district has been 0/1,000 over the three years. But still this is not the true reflection of the mortalities occurring in the district as some deaths are not recorded because most mothers do not seek for medical care.

Figure 3-3. Under 5 Mortality Rate



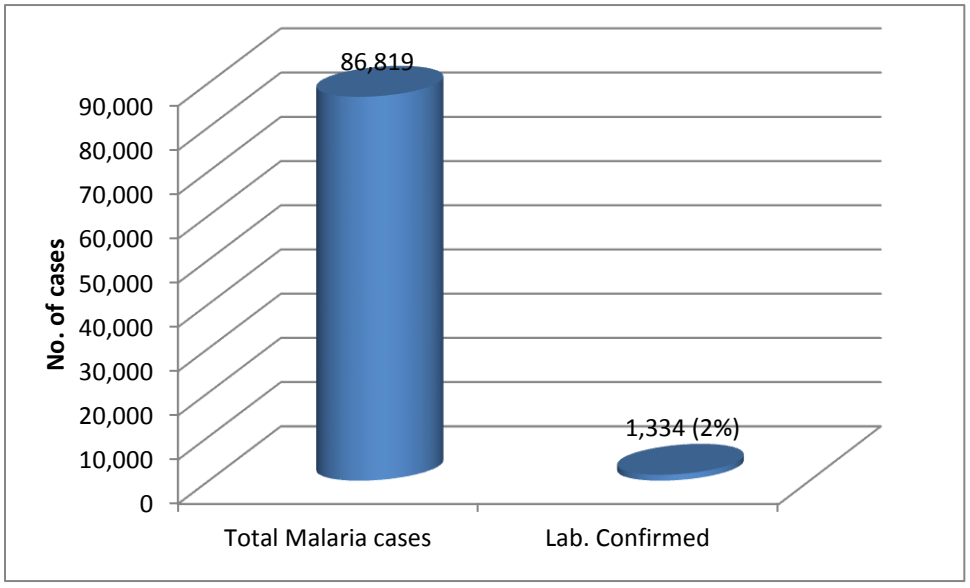
There seem to be a drastic drop in underfive mortality from 2010 to 2011. This was as a result of combined efforts from public and private health stakeholders to fight against under five mortality. The slight increase in 2012 is because most mothers come late to seek for medical care and most facilities are facilities are facing the problem of qualified staffing and inadequate resuscitation equipments.

3.2 MORBIDITY

Malaria is still a leading disease among top ten diseases in the district. However, there is a slightly reduction of morbidity and mortality cause by Malaria as compared to previous years due to various interventions that aimed at reducing Malaria cases in infants, under fives and pregnant mothers like giving education to the community, usage of arthemisinins combined therapy (ACT) which have proved to cause some inactiveness of reproductive stages of the parasites causing Malaria and also the widely spread sensitization to the community on the proper use of Insecticides treated mosquito nets.

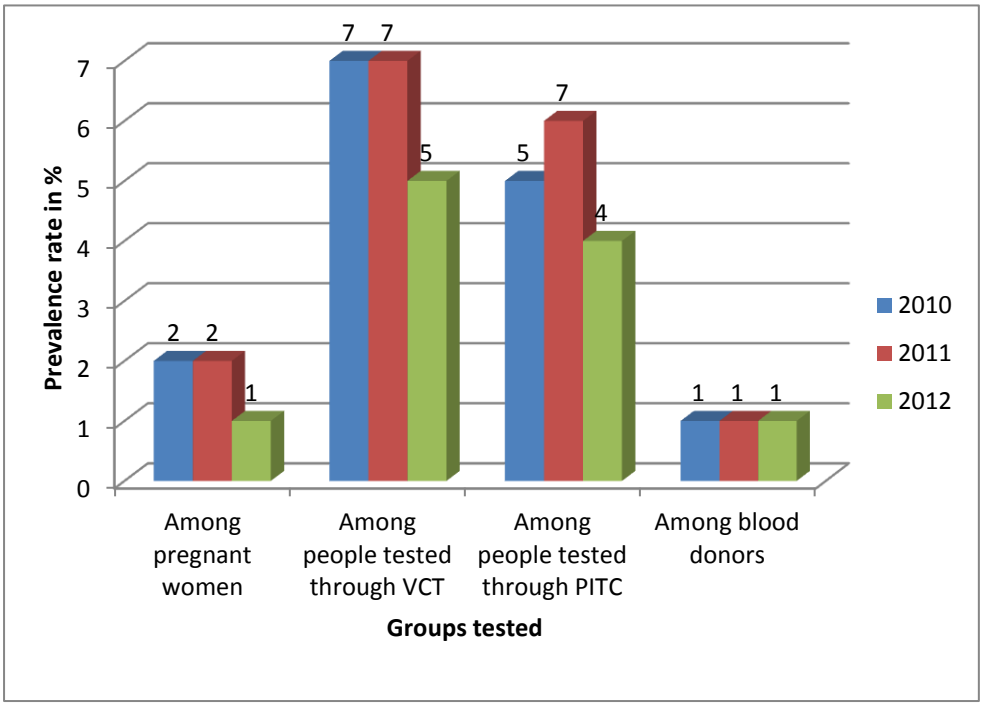
HIV prevalence has been decreasing over the years but generally still high. The situation has steered by a number of factors like low coverage of male circumcision (14% by 2012), strong traditional practices like inheritance of widows and male dominance which may be caused by the illiteracy rate (30.7%) and the scarcity of facilities.

Figure 3-3. Laboratory Confirmed Malaria Cases



Out of all 86,819 reported malaria cases, only 1,334 (2%) case were confirmed in the laboratory. This could be because not all health facilities have access to laboratories and sometimes those with laboratories run out-of-stock with supplies (testing reagents).

Figure 3-4. HIV/AIDS Prevalence



There seem to be a high prevalence of HIV in people tested through VCT and PITC because of the massive number that turns up for testing. But generally the prevalence stands at 5.1% as of 2012 (HTC data).

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

	Diagnosis	Under 1Month		1Month - < 1Year		1Year – < 5Years		5Years - > 5Years		Total
		FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	
1	Acute Respiratory Infection (ARI)	0	0	0	44	49	116	118	218	**246**
2	Urinary Tract Infections (UTI)	0	10	20	12	24	91	108	170	**301**
3	Malaria, mRDT positive	0	1	3	34	29	109	95	135	**178**
4	Upper Respiratory Infections (Pharyngitis, Tonsillitis, Rhinitis)	0	0	0	29	28	73	66	116	**166**
5	Pneumonia, Non Severe	0	4	6	48	40	89	62	74	**107**
6	Malaria, Clinical (No test)	0	0	1	20	20	71	59	84	**149**
7	Malaria, Blood Slide positive	0	1	2	36	44	84	119	58	**55**
8	Diarrhea, Acute (<14 days)	0	6	13	47	60	52	51	61	**83**
9	Ill Defined Symptoms (No Diagnosis)	0	1	1	9	6	7	43	52	**119**
10	Intestinal Worms	0	0	0	1	0	15	18	67	**101**

Because of the age grouping selection, male children seem to be more prone to falling sick than female. There could be a biological explanation behind the trend.

3.3 MORTALITY

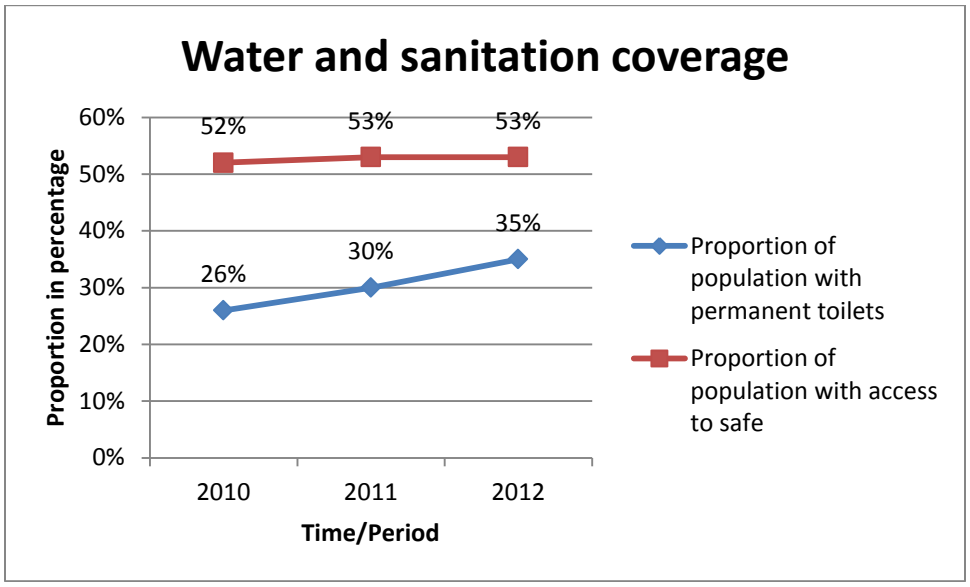
Severe Malaria, pneumonia and diarrhoeal diseases of all causes are the leading causes for patients' admissions in all age groups in the district. However, comparatively the number of patients admitted per age group and fatalities, clinical Aids is still high in the hierarchy.

Table 3-2: Top 10 Causes of Death

	Causes of Death	Under 1 Month		1Month - < 1Year		1Year –< 5Years		5Years - > 5Years		Total
		FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	
1	Malaria Severe / Complicated	0	0	24	21	46	33	15	10	**149**
2	Anaemia, Severe	2	0	1	2	3	15	56	3	**82**
3	Anaemia, Mild / Moderate	0	0	0	0	5	14	4	2	**25**
4	Diarrhea Acute	3	2	0	2	3	4	7	3	**24**
5	Pneumonia Severe	0	1	0	3	8	4	4	2	**22**
6	Diarrhea Chronic	0	0	0	1	2	8	3	2	**16**
7	Typhoid	0	0	0	0	1	2	8	3	**14**
8	Moderate Malnutrition	0	0	0	0	5	3	1	2	**11**
9	Sickle cell Disease	0	0	0	0	3	6	1	0	**10**
10	Gastrointestinal diseases, Other Non-infectious	0	0	4	4	0	0	0	0	**8**
TOTAL		**5**	**3**	**29**	**33**	**76**	**89**	**99**	**27**	**361**

3.4 OPTIONAL HEALTH STATUS OF THE DISTRICT POPULATION INDICATORS

3.4.1: Water Hygiene and Sanitation



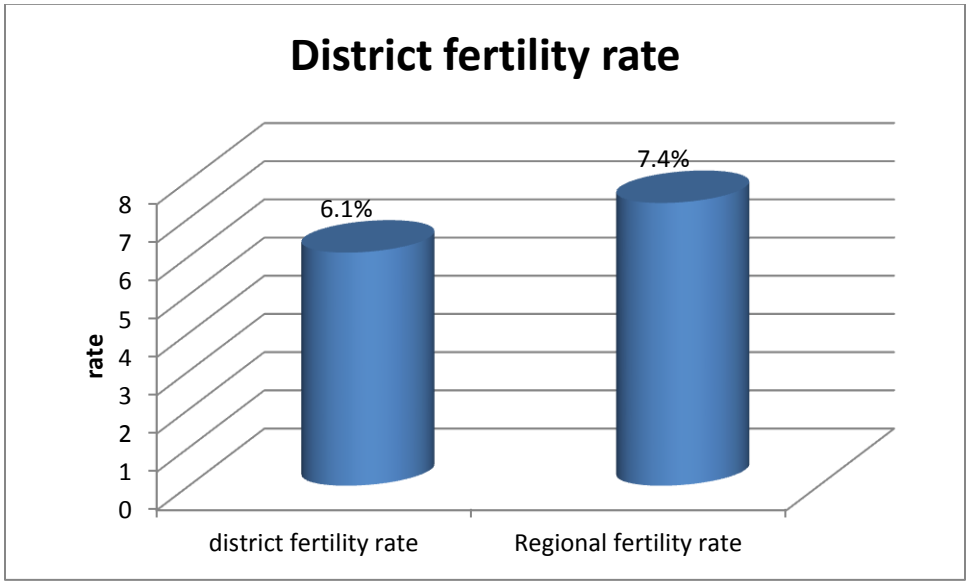
In general, water hygiene and sanitation coverage in the district is low at 48%. Management of solid waste coverage is at 53% while coverage of permanent toilets is at 35%-lower by 5% from the national percentage.

These low coverage all together have paused a great concern in the district as they are reflected by frequents eruption of cholera epidemics in 2010 and 2011 with case fatality rate of less than 3% and an epidemic of dysentery in 2011. There has also been an increase in water, hygiene and sanitation related diseases by 30% by the year 2012

This problem could be partly contributed by socio-cultural taboos and possibly lack of commitment by the environmental health staffs in addressing the situation

3.4.2 Fertility rate

The district experiences a high fertility rate of 6.7 children per woman (slight lower than the regional rate that is at 7.4) and hence growth rate which are attributed by the socio-cultural beliefs that hinders usage of family planning methods in the community leading to booming population which in-turn disrupts the development programs in the district. But there has been a slow increase in trend of family planning usage. This gives a bit of hope to the district, that if more efforts are put in sensitizing communities on the importance of family planning and improve on service delivery, the situation may come back to a controllable state.



3.5 DISTRICT HEALTH STATUS CONCLUSIONS, RECOMMENDATIONS AND WAY FORWARD

1. Generally, nutrition status in the district for the last 3 years has not been good, the situation has been worse to pregnant mothers and children under five. The lack of rainfall had doubled the problem.

   To help solving the problem, multi-sectorial approach should be considered (Health, Education and Agriculture) in setting achievable goals and policies that may help in handling and controlling the problem and hence improving nutrition status of the community thus reducing mortalities too.

2. On Malaria and HIV, efforts are being done in collaboration with the private sector to see the prevalence going down by improving quality of care and service delivery and educating communities, although it is a not an easy task.

3. The general water hygiene and sanitation coverage in the district is low. This problem could be partly be contributed by socio-cultural taboos and possibly lack of commitment by the environmental health staffs in addressing the situation.

   Efforts should be done by the district to see the percentage improve by bringing all stakeholders on board.

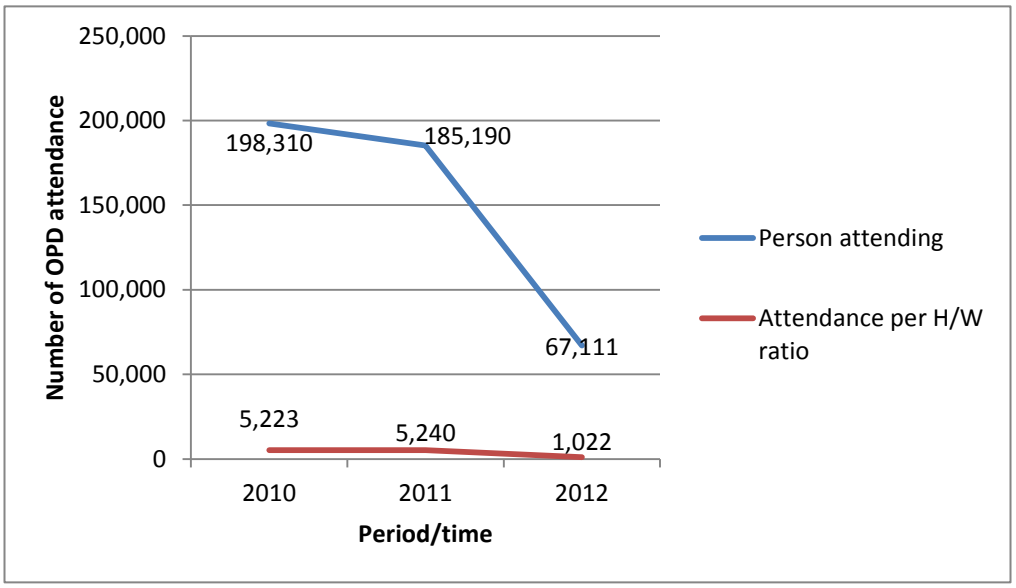
4. Some information that was first expected to be included in this chapter as optional health indicators could not be traced as they are not being reported.

   CHMT should discuss about their inclusion in reports or make a format that this information will be reported from, as they are not in the current reporting formats. This is because they are also important in reflecting and assessing the health status of the community and may also help in planning for intervention.

4 STATUS OF HEALTH SERVICE DELIVERY IN THE DISTRICT

4.1 GENERAL HEALTH SERVICE

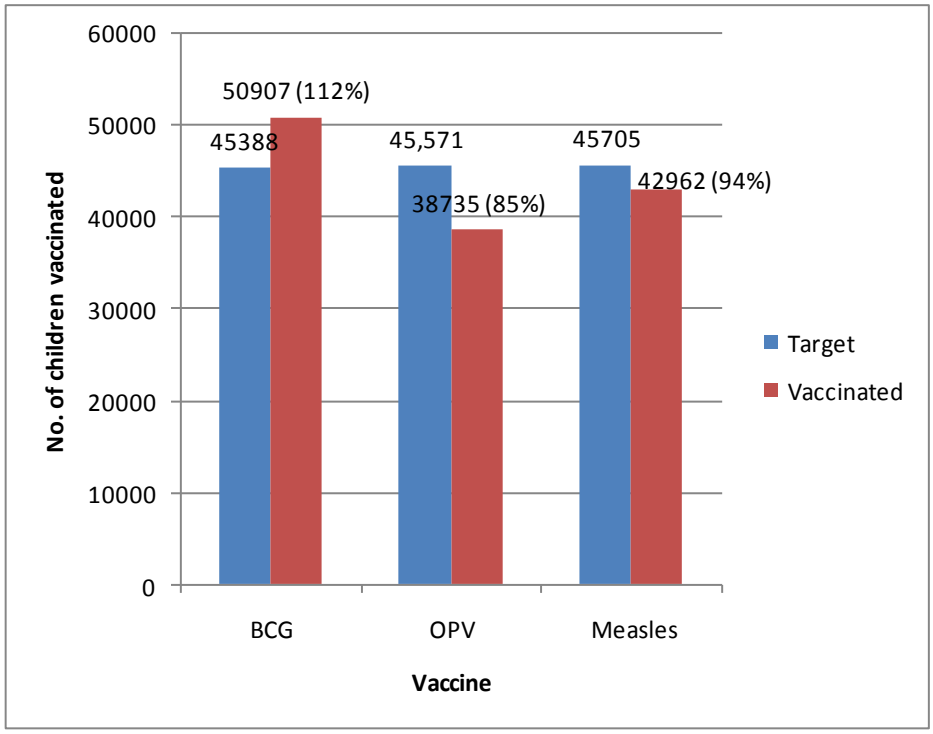
Figure 4-1. OPD Attendance



There have been a markedly decrease in OPD attendance rate and the OPD attendance per health worker over the three years. This trend is contributed by the opening of new facilities in the community, reducing the number to the facilities that were formally overloaded.

4.2 VACCINATION SERVICES

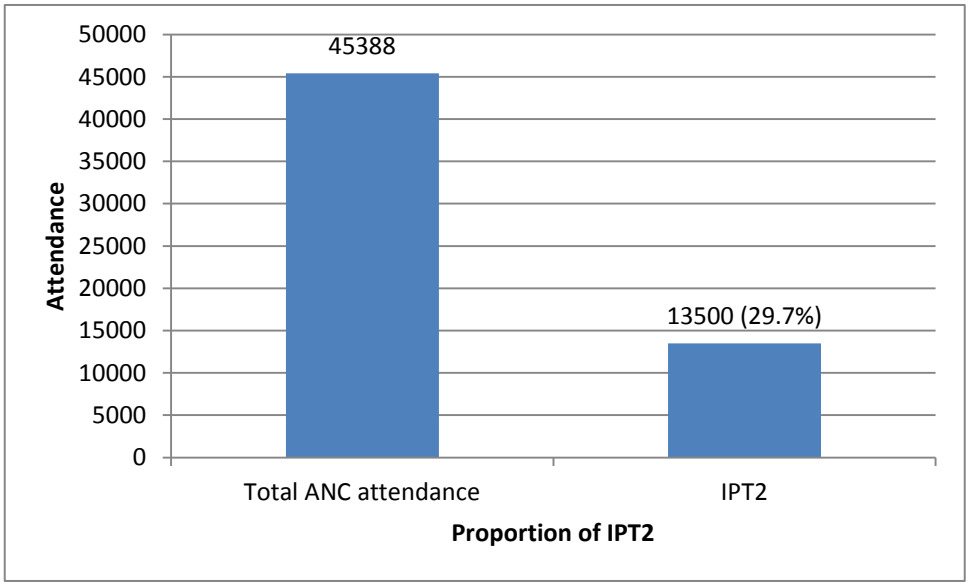
Figure 4-2. Under 1 Year Vaccinated (OPV3, BCG, and Measles)



BCG coverage exceeded the target because some children came from nearby villages (outside the catchment area) and some had not been vaccinated at birth.

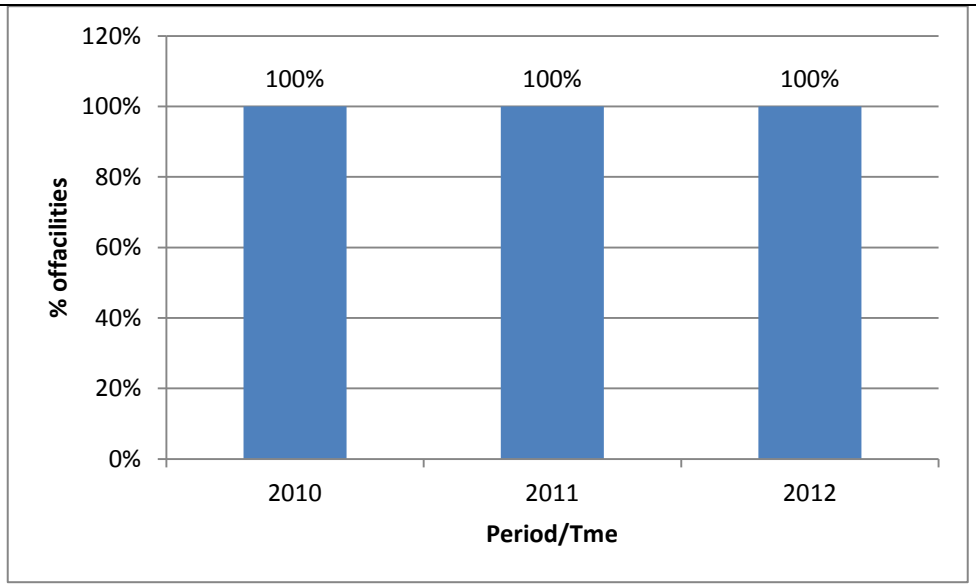
4.3 REPRODUCTIVE HEALTH SERVICES

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



A small proportion of mothers (29%) get IPT 2 because some do not complete the ANC visits schedule and some come at a later stage of pregnancy.

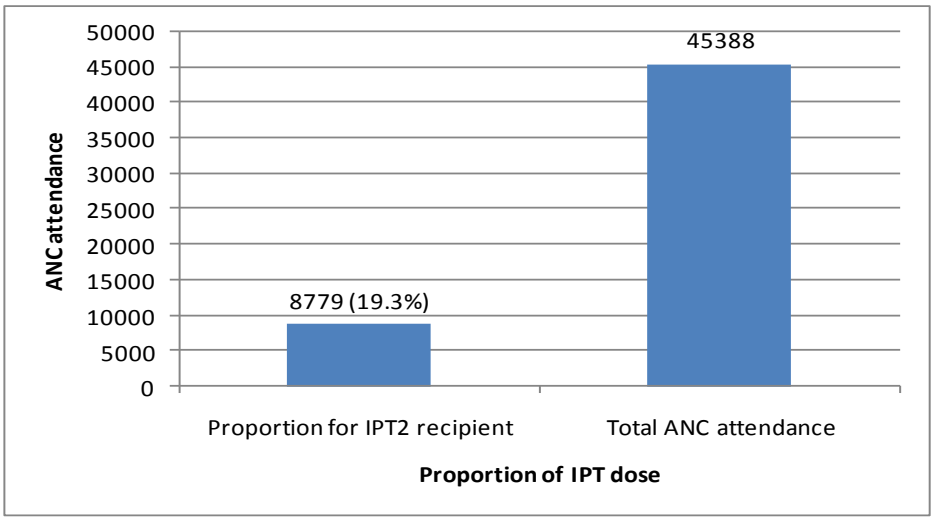
Figure 4-4. Percentage of health centers and dispensaries that can provide EmOC as defined in EHP



All facilities provide provides the basic EMoC but the comprehensive EMoC is only being provided at the council hospital. There is an ongoing infrastructure improvement, training and positioning of health workers in other identified health facilities so that they can also provide comprehensive EMoC. So far 2 health centers have been identified in the disrict.

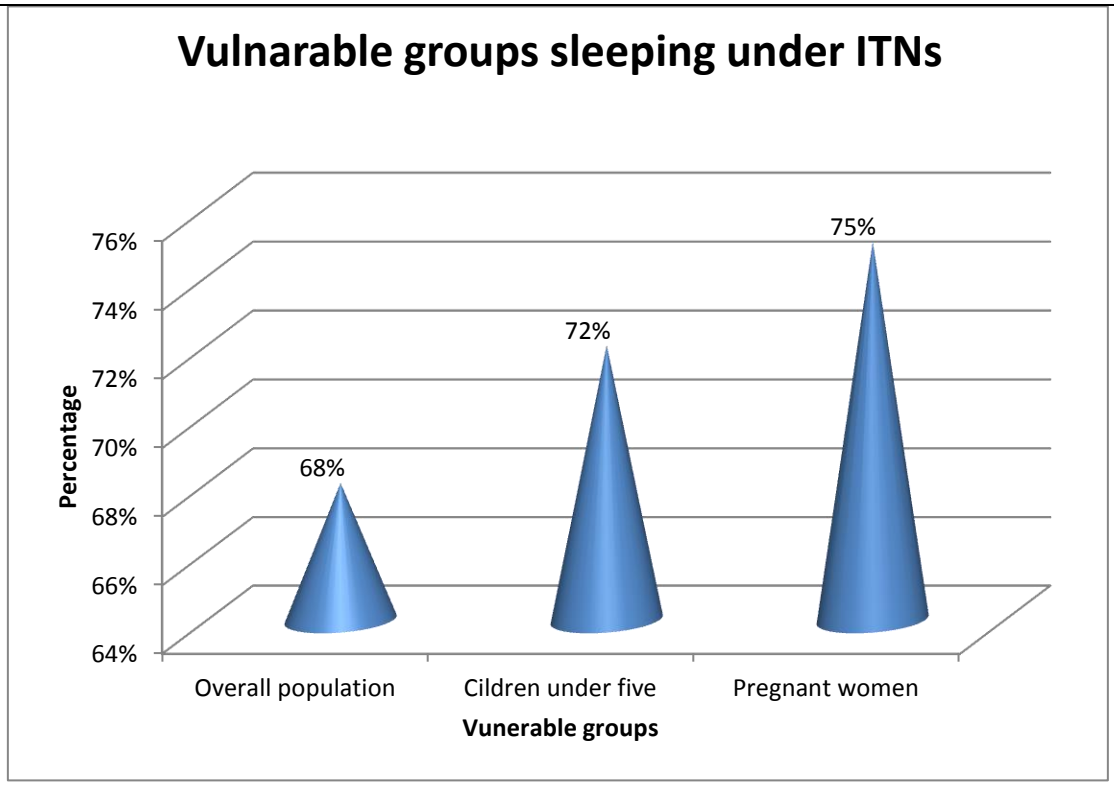
4.4 INFECTION DISEASE AND NON-COMMUNICABLE DISEASE HEALTH SERVICES

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



The proportion seems to be very low at 19.3% because of a number of factors like incomplete ANC attendance. Some mothers come only once and some come at later stages of their pregnancies. Sometimes drugs becomes out of stock both at the district and zonal stores.

Figure 4-6. Proportion of Vulnerable Groups Sleeping under ITN the Previous Night

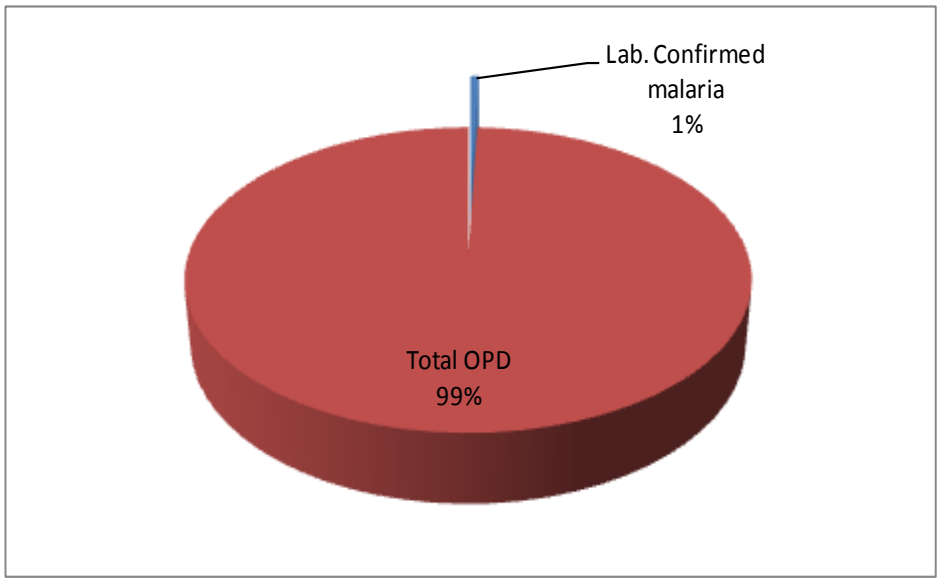


From the 2011-2012 HIV/AIDS and Malaria indicator survey, it showed that

Overall, 68% of the household population slept under an ITN the night before the survey. Among children under age 5, 72% slept under an ITN the night before the survey. Among pregnant women, 75% slept under an ITN the night before the survey.

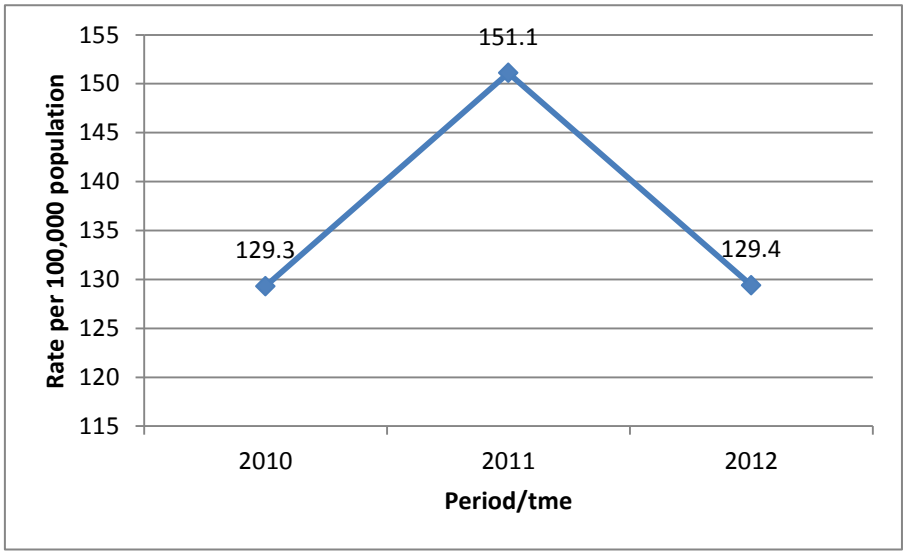
This source of data was used because there is no such information collected at district level in daily data collection methods.

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



Out of all OPD visits, Malaria cases took up only 1% of all reported cases because not all reported Malaria cases are confirmed in the laboratory.

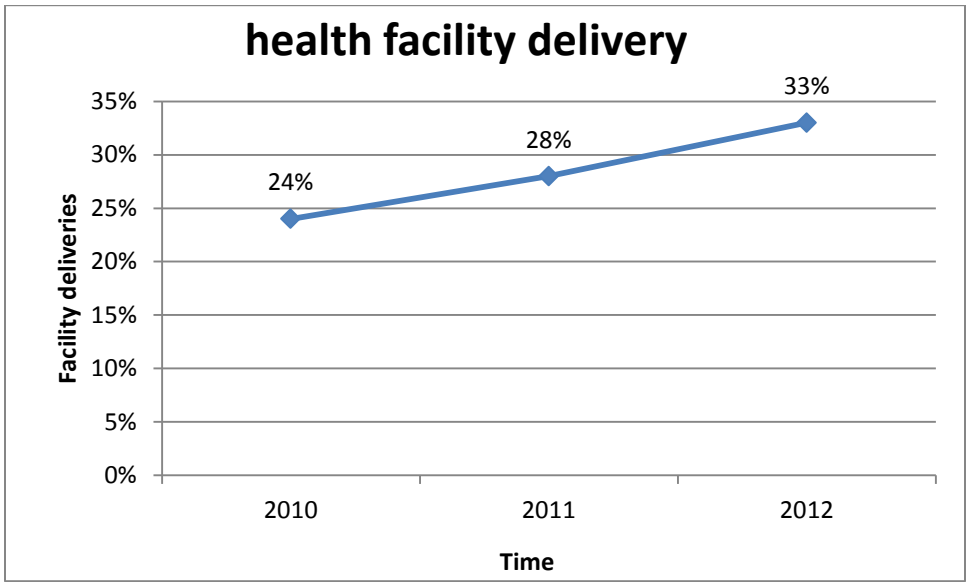
Figure 4-8. TB notification rate per 100,000 population



The trend dropped in 2012 because of some facilities stopped delivering services due to stock out problem.

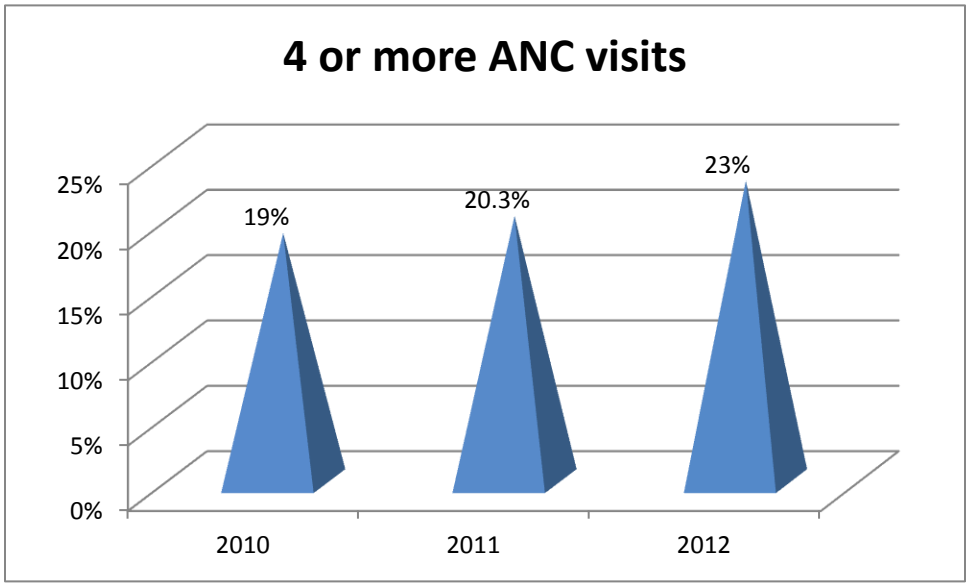
4.5 OPTIONAL DISTRICT HEALTH SERVICE DELIVERY INDICATORS

Birth attended by trained personnel in Health Facilities



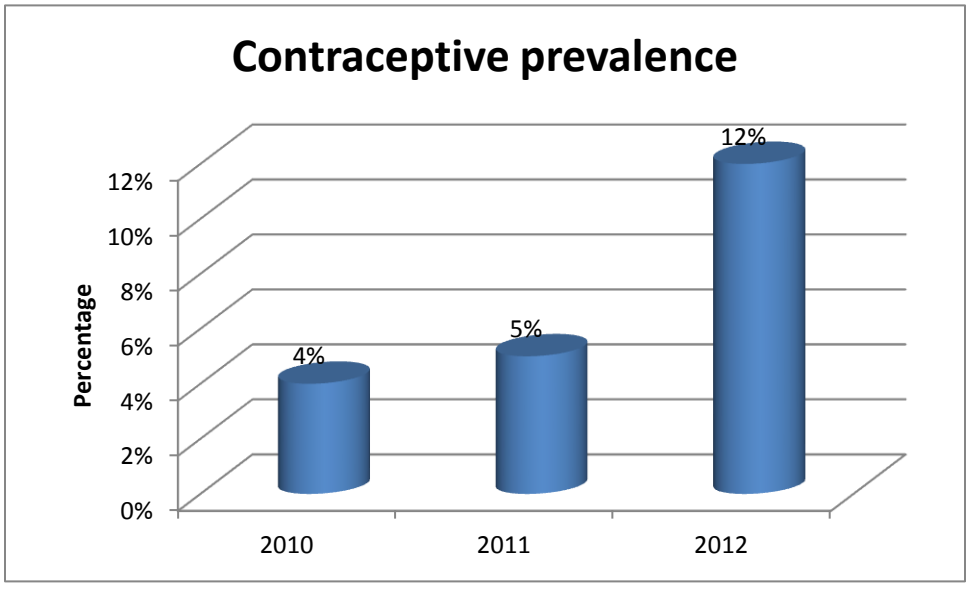
The trend shows a slow improvement in the proportion of pregnant mothers delivering in health facilities, where percentage have remained lower than the national target which stands at 85% (HSSP III). Factors like low community awareness on the importance of delivering in health facilities, strong cultural factors and shortage of skilled human resource for health can be linked to the trend.

Pregnant women attending ANC at least four times during pregnancy



There has been a slight improvement in percentage of mothers attending ANC four or more times over the years, though the percentages are still below the national target that stands at 80%.

Contraceptive prevalence rate



There has been an overall low coverage in the past 3 years, although there is a remarkably increase in the trend. Reasons for the trend's behaviour includes low community awareness, inadequate health facilities, and equipments, few skilled service providers, family planning commodity shortages and cultural factors.

4.6 DISTRICT HEALTH SERVICE DELIVERY CONCLUSIONS, RECOMMENDATIONS AND WAY FORWARD

1. There has been a markedly decrease in OPD attendance rate and attendance per health worker. Reaseach has not been conducted to acertain the true reasons for the decrease in the trend. It could either be because of the opening of new facilities closer to communities reducing an overload to the formally existing facilities, or it could be that controll measures put in place are working effectively to the extent people are less falling sick or people are losing trust in health facility services so they do not come for care.

   The district will work hard mostly with private partners to find out the true picture.

2. General trend in immunization coverage is promising though there are some challenges that the district is facing like stock-out of supplies, improper utilizalization of routine outreach services due to shortage of staff and inadequate supply of liquidfied gas.

   Efforts are being done to see the districts percentages improve especially by improving on the frequencies of outreach services.

3. Proportion of mothers attending ANC and receiving IPT2 and PIT 2doses is still a challenge because most mothers do not complete their ANC attendance schedules and some of them come only once at later stages of their prgnancies; and even when they are due for delivery not all of them deliver in health facilities.

   The district has taken note of the problem and is trying to improve it's service delivery and improve community awareness too through RCH clinics.

4. Contraceptive prevalence rate has been low for years because of mainly two factors; the cultural beliefs where people in the district believe in having a big number of children as an asset and also there has been a challenge of inadequate trained service providers together with supplies stock-out.

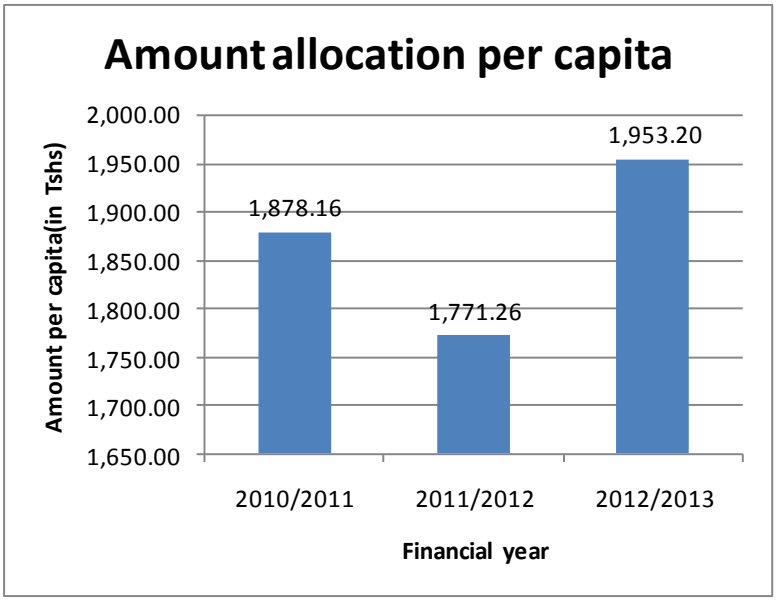
   The district is trying to train more staff to improve on the service delivery and improve on acceptance rate.

5 STATUS OF DISTRICT HEALTH SYSTEMS

5.1 HEALTH FINANCING

In the financial year 2012/2013 the district planned to spend 13,455,515,961.30/= (16,583.45/= per capita) to facilitate the implementation of planned activities from various sources of funds, but only 6,477,110,096.79/= (48%) was actually received.

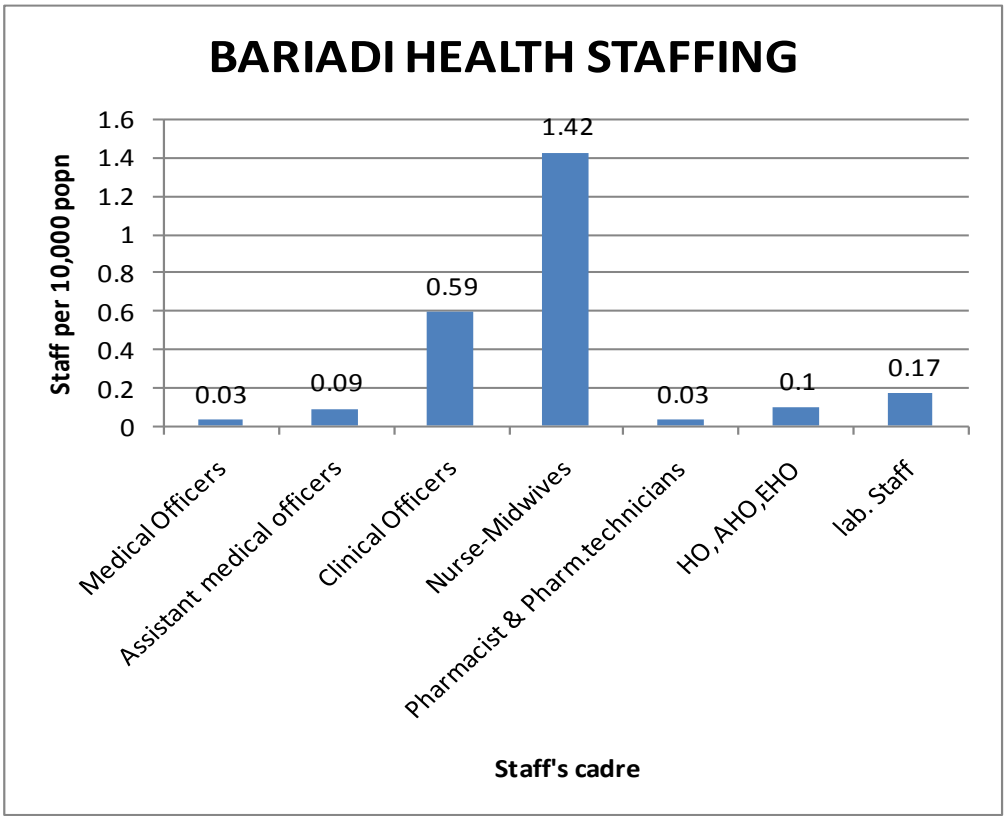
Figure 5-1. Total GOT and Donor Allocations to Health in the District



The amount displayed in the above graphs shows funds allocation from basket fund only because it covers 24.5% of the total funds being allocated for health in the district.

5.2 HUMAN RESOURCES FOR HEALTH

Bariadi district has no any health training institutions (with full NACTE accreditation).
The district has a total of 0.04/10,000 MOs, 0.96/10,000 AMOs, 0.59/10,000 COs, 1.42/10,000 Nurse-Midwives, 0.04/10,000 pharmacists and pharm. technicians, 0.1/10,000 HOs, AHOs & EHOs and 0.17/10,000 laboratory staffs.

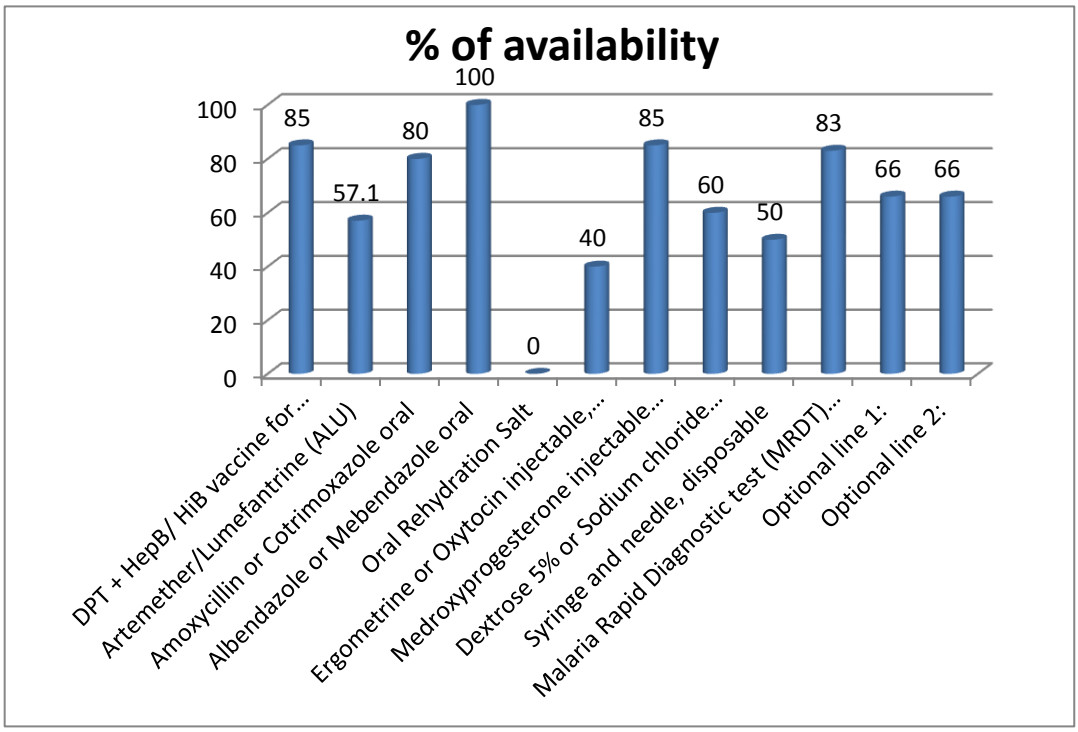


5.3 MEDICINES/DRUGS

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

No	Description	Eligible to this HF	Available	If no		
				A: < 1 Week	B: 1-4 Weeks	C: > 4 Weeks
1	DPT + HepB/ HiB vaccine for immunization	7	6			
2	Artemether/Lumefantrine (ALU)	7	4			1
3	Amoxycillin or Cotrimoxazole oral	5	4			1
4	Albendazole or Mebendazole oral	7	7			
5	Oral Rehydration Salt	4	0		1	5
6	Ergometrine or Oxytocin injectable, or Misoprostol oral	5	2		1	4
7	Medroxyprogesterone injectable contraceptive	7	6			
8	Dextrose 5% or Sodium chloride Dextrose IV solution	5	3			3
9	Syringe and needle, disposable	6	3		2	2
10	Malaria Rapid Diagnostic test (MRDT) or Supplies for Maria	6	5			1
11	Optional line 1:	3	2			1
12	Optional line 2:	3	2			

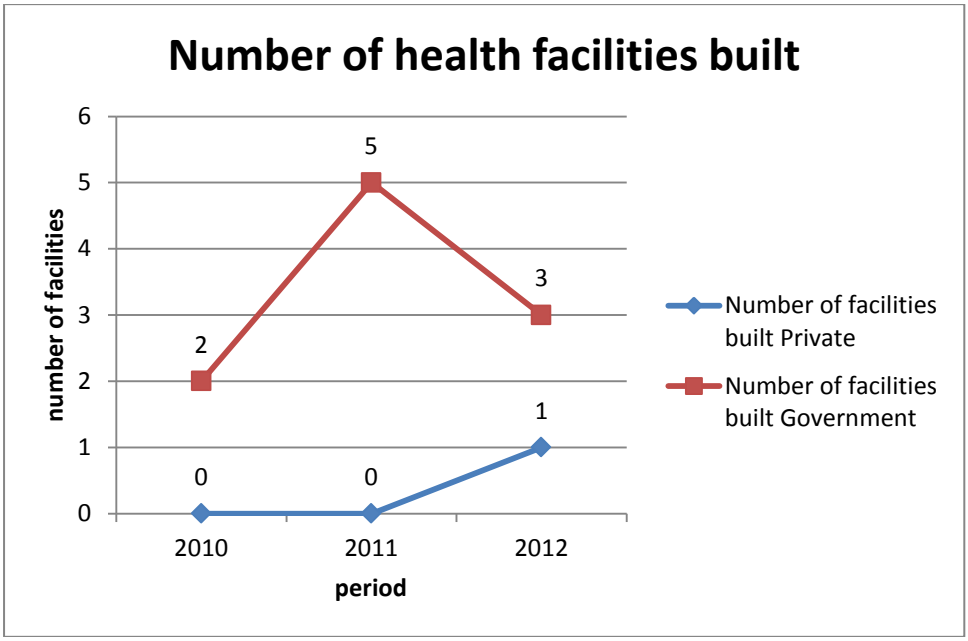
Figure 5-7: Availability of Tracer Drugs



5.4 INFRASTRUCTURE

Number of health facilities built against the target

For the period of 3 years the district in collaboration with private partners has managed to put up a number of health facilities as shown in the table below.



As it appears in the figure above, in 2011 there seem to have 5 facilities being completed. 3 out of those facilities were in their final stages in 2010.

5.5 DISTRICT HEALTH SYSTEM CONCLUSIONS AND WAY FORWARD

1. Health financing in the district has generally been facing a number of challenges like late disembursemet of fund. Some partners promise to help by implementing some activities but they do not do so up to the end of financial year.

   These challenges have caused sometimes CHMTs to use their out-of-pocket money to facilitate completion of some activities and sometimes divert expenditures.

   The district is still looking for best ways to handle this problem

2. Health sector in the district is still understaffed, with capacity building of staff being often fragmented, linked to vertical program not targeting the right cadres.

   But despite all the challenges with human resource, the district extends its gratitude to the MoHSW for allocating staffs of different cadres to the district, though the number has not yet met the demand.

3. There has been a problem of stock-out with tracer medicine for a period of time, a problem that always compromises the quality of service delivery and staff productivity. Although this has been a crosscutting issue across the country.

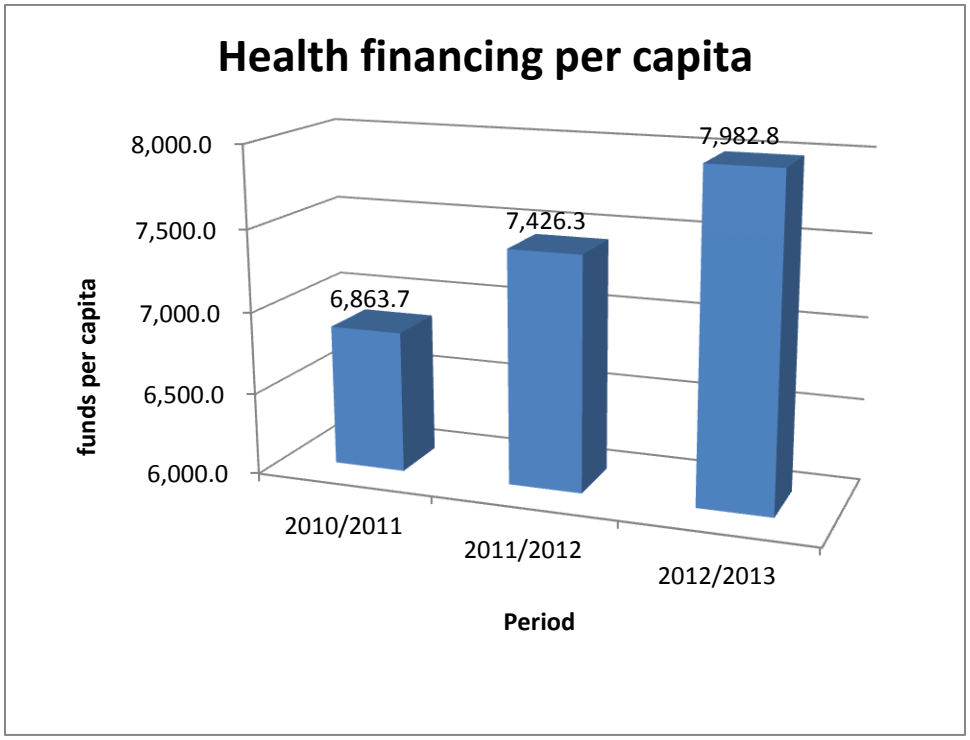
4. In collaboration with private partners and the government, the district has managed to construct a number of health facilities and staff houses.

   It would be a pleasure to the district to see these efforts pulls up so as to enable taking services closer to the community.

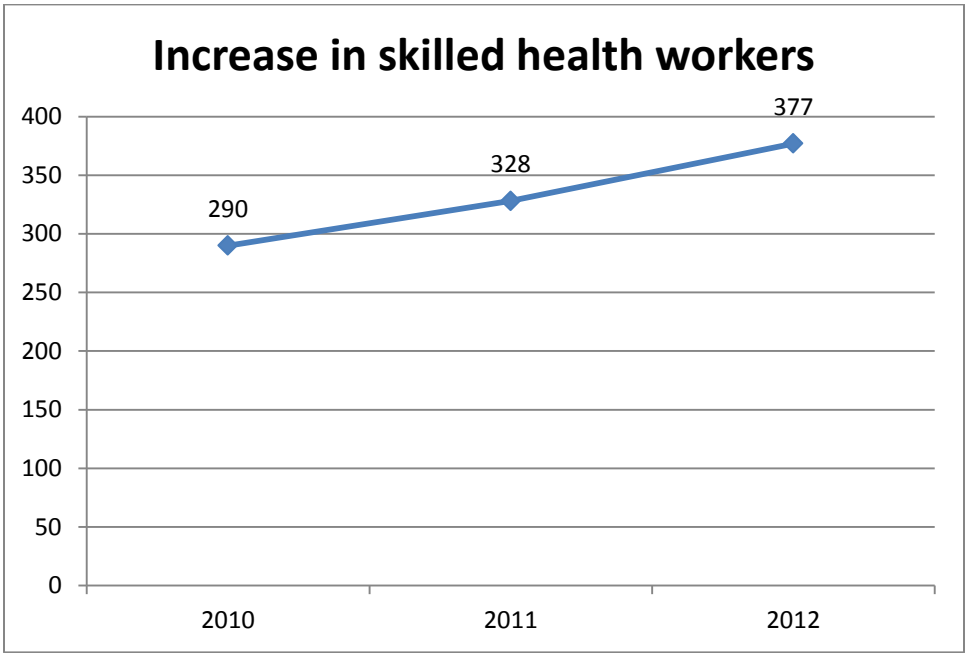
6 AREAS OF PROGRESS IN THE DISTRICT HEALTH SECTOR

6.1 PROGRESS IN DISTRICT HEALTH FINANCING

There has been an improvement on the overall health financing in the district for the health sector for the past three years from budgeted to actual amount received as shown in the table below.



6.2 PROGRESS IN DISTRICT HUMAN RESOURCES

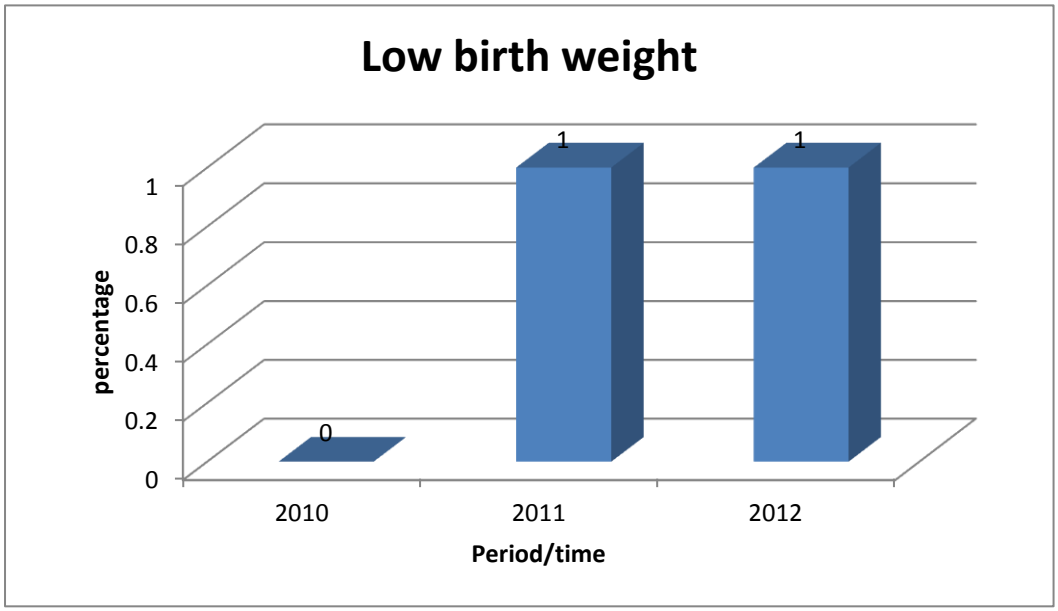


Over the three years, the district has had an improved number of health staffing as shown in the figure above. Although, the number is still not enough to serve the growing population.

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

S/N	Type of Personnel	Staff available					
		FEMALES			MALES		
		2012	2011	2010	2012	2011	2010
1	MO	1	0	0	1	1	1
2	ASST MEDICAL OFFICER	2	2	1	6	4	3
3	CLINICAL OFFICER	2	1	1	29	25	19
4	CLINICAL ASST.	7	5	3	18	13	9
5	NURSES	82	75	60	25	20	14
6	LABORATORY TECH	1	0	0	2	2	2
7	PHARMACIST	0	0	0	1	1	1
8	PHARMACEUTICAL TECH	0	0	0	0	0	0
9	DENTAL SURGEON	0	0	0	1	1	0
10	ASST. DENTAL SURGEON	1	0	0	0	0	0
11	DENTAL THERAPIST	1	1	1	0	0	0
12	PHARMACEUTICAL ASST	1	1	1	0	0	0
13	RADIOGRAPHER	0	0	0	2	2	1
14	OPMESTRICT (FUNDI SANIFU MACHO).	1	1	1	1	1	1
15	PHYSIOTHERAPIST	0	0	0	1	0	0
16	HEALTH SECRETARY	1	1	1	1	0	0
17	HEALTH OFFICER	1	0	0	0	0	0
18	ASST. HEALTH OFFICER	2	2	1	0	0	0
19	LAB. ASST.	9	7	5	9	6	4
20	ASSISTANT ACCOUNTANT	0	0	0	0	0	0
21	PERSONAL SECRETARY	1	1	1	0	0	0
22	SUPPLIES ASSISTANT	0	0	0	1	1	1
23	GENERAL TECHNICIAN	0	0	0	0	0	0
24	MEDICAL RECORDER	0	0	0	0	0	0
25	MEDICAL ATTENDANTS	85	73	69	16	13	9
26	DRIVERS	5	5	4	0	0	0
27	DHOBI	1	1	1	3	3	3
28	COOKS	4	3	3	0	0	0
JUMLA		**208**	**179**	**153**	**117**	**93**	**68**

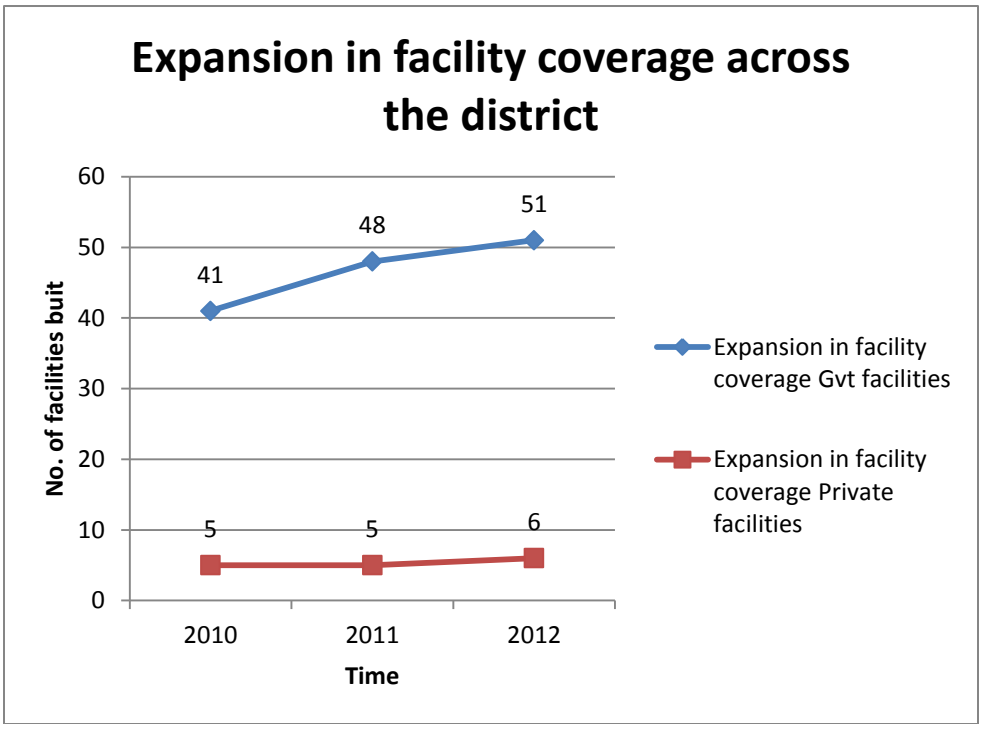
6.3 PROGRESS IN DISTRICT NEONATAL HEALTH



The trend shows an increase of 1% low birth weight from 2010 to 2011. This has mainly been contributed by poor ANC attendance by pregnant women making it hard to detect risk factors. The trend can also be linked with the period of drought that had hit the region for almost three consecutive years.

6.4 PROGRESS IN DISTRICT HEALTH FACILITY COVERAGE

EXPANSIONS IN FACILITY COVERAGE ACROSS DISTIRCTS



For the period of 3 years, the district has had an increase in the number of health facilities both public and privately owned as shown in the figure above

6.5 PROGRESS IN DISTRICT HEALTH FACILITY PERFORMANCE

EXPANSIONS IN CRITICAL HEALTH SERVICES

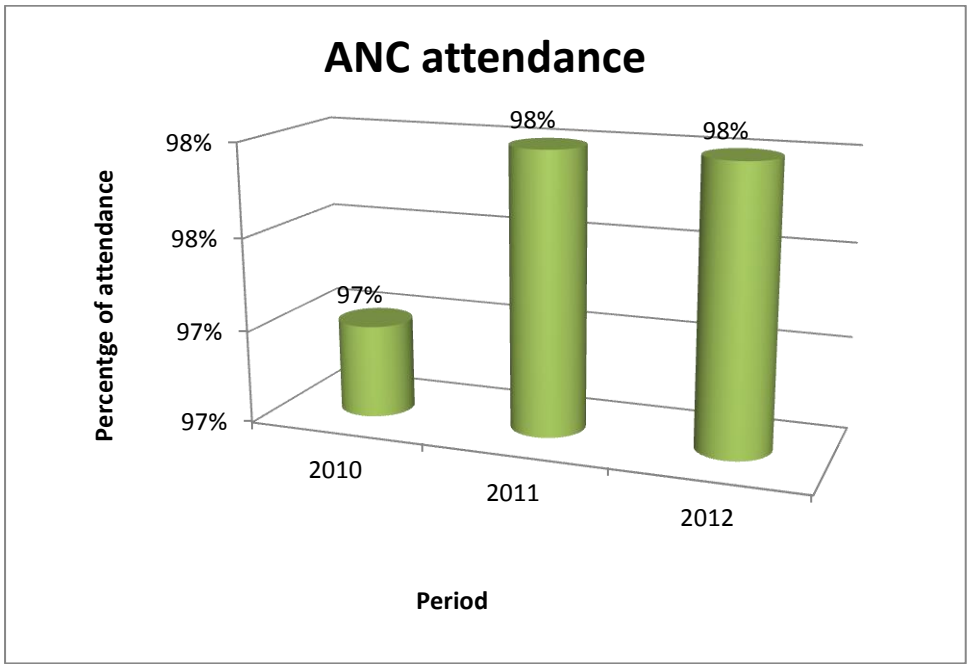
Critical health service in the district have not been so effective because the sector is not well equipped with trained and experienced staffs and equipment, so most cases are still being referred to Bugando-Mwanza.

IMPROVEMENTS IN REFERRAL HOSPITAL PERFORMANCE

The referral system is partially functioning. It now stands at 40% due to the number of issues like inadequate number of qualified human resources for health, inadequate health facilities, inadequate transport facilities, inadequate equipment and poor infrastructure.

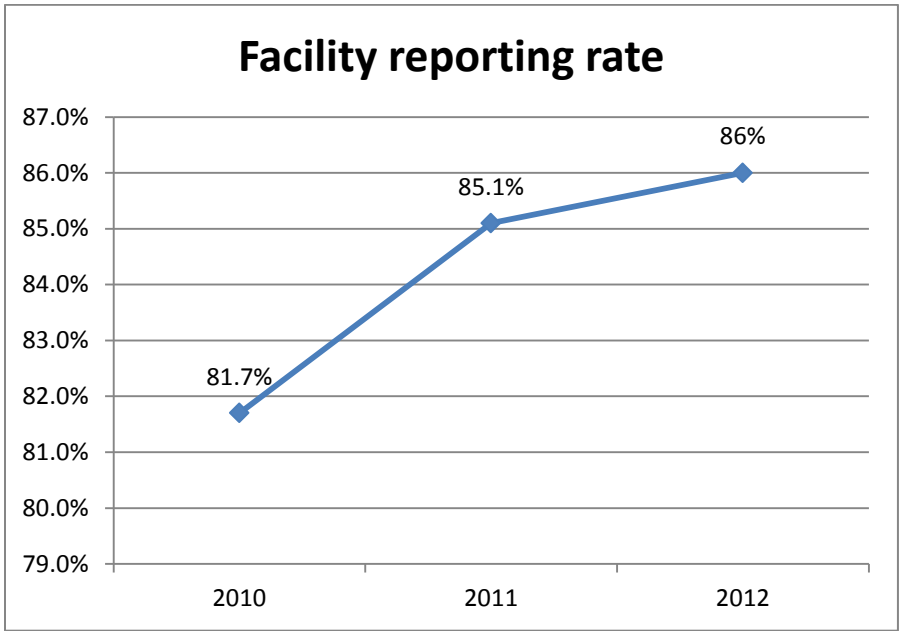
Needs of transport facilities have been identified and forwarded to partners for implementation

PROGRESS IN ANC ATTENDANCE



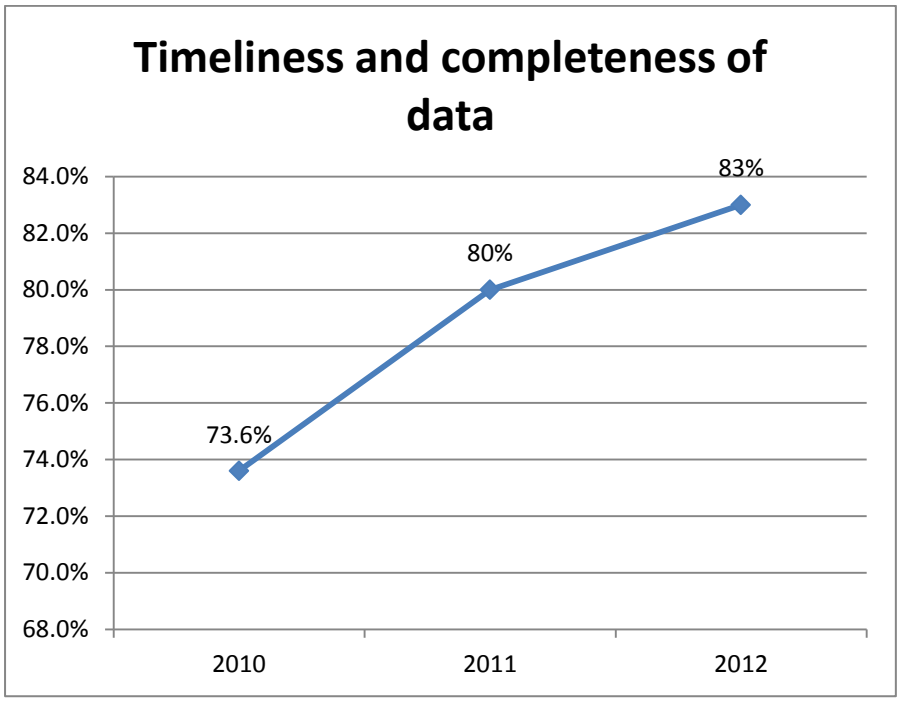
ANC attendance has been improving over the years, though not all mothers come early and completes their visits schedules as required.

PROGRESS IN HEALTH FACILITY REPORTING RATES



Health facilities in the district try their best in reporting, as shown in the figure above, the trend being improving over the 3 years.

TIMELINESS AND COMPLETENESS OF DATA



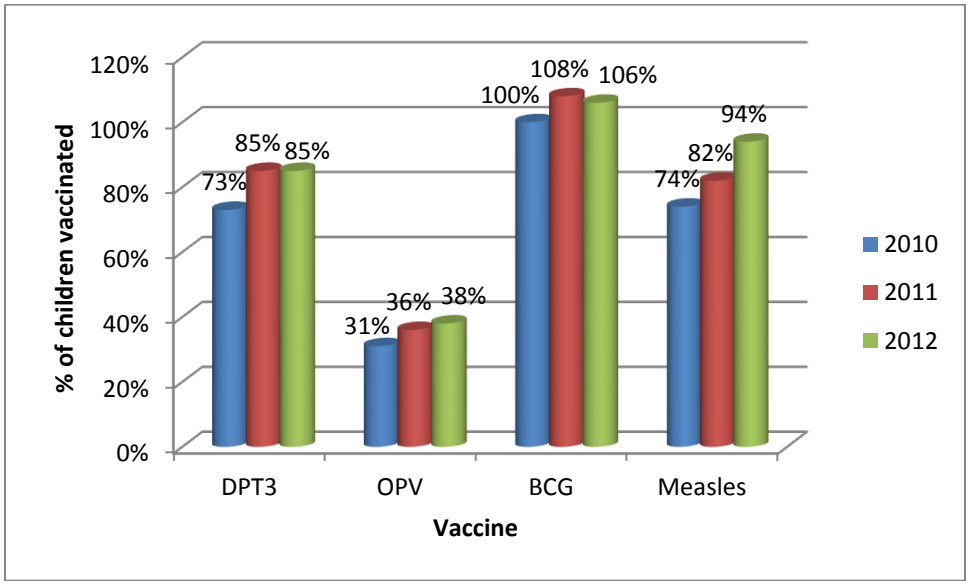
There has been an improvement over the 3 years on timeliness and completeness of data. A problem still lies in the way of filling report forms. Efforts are being done to make sure every person responsible for reporting are well trained.

6.6 PROGRESS IN DISTRICT HEALTH SERVICES

SOCIAL WELFARE AND PROTECTION SERVICES FOR VULNERABLE POPULATIONS

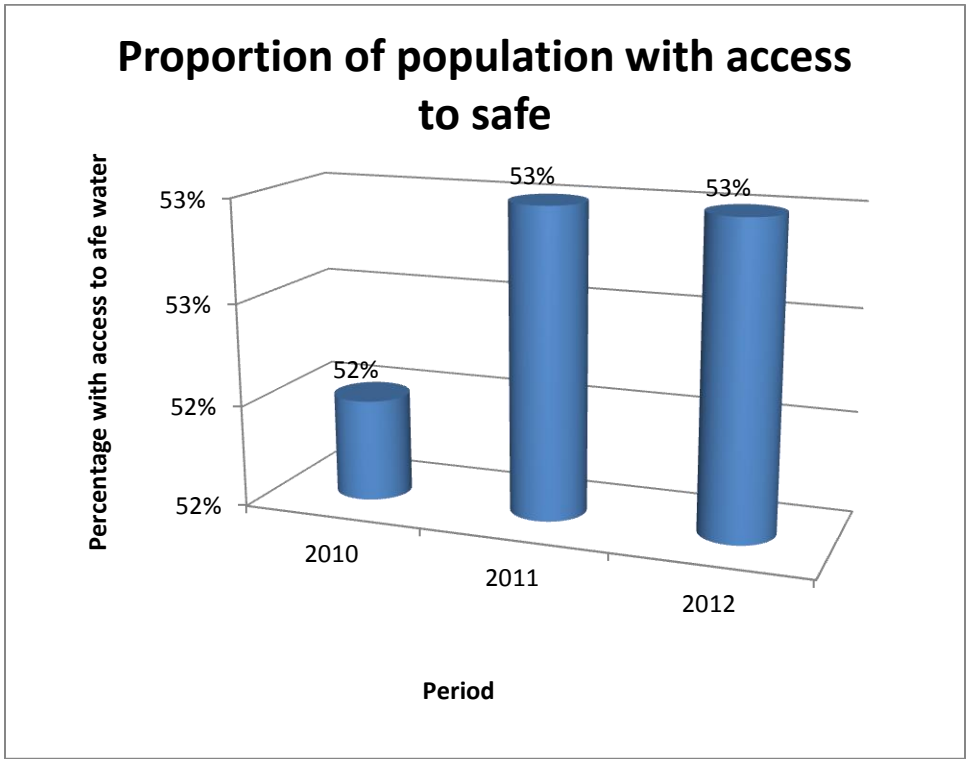
There has been only one care center for vulnerable groups like orphans and the system has not been fully functioning because of challenges of staffing, building and transport facilities.
Though the situation has not improved much to date, the district has always tried to seek ways to address the problem by requesting for staffs and sending proposals to potential partners for acquiring the needed facilities.

VACCINATION COVERAGE



Improvement is being observed on the trend of immunization coverage in the district over a period of time. But struggles are still low on OPV coverage because of long periods of stock-outs.

ENVIRONMENTAL HEALTH SERVICE SAFE WATER INITIATIVES



6.7 PROGRESS AGAINST MILESTONES