The United Republic of

TANZANIA

Ministry of Health & Social Welfare

CHAMWINO

District Health Profile

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FOREWORD

This is the first district health profile (DHP) for Chamwino district council. Chamwino is one of the new Districts of Dodoma region which was formed in 2007 from Dodoma Rural District. The DHP is important to any district as it offers information on the health status of the district, for example; 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. For Chamwino District council this DHP is vital for example in disease surveillance since it can help to detect diseases which need to be under surveillance. Status of tracer medicines at health facilities can also be followed; top ten diseases and top ten causes of deaths in the district can be found in DHP. Through the DHP district officials can put in place various interventions necessary to address various challenges encountered by the district in order to improve the health status of the population.

ACKNOWLEDGEMENTS

May I take this opportunity to express my sincere thanks to all whom, in one way or another have participated in preparation of this DHP. I would like to acknowledge the following for their contributions;

Dr. James Charles – DMO

Cuthbert J. Kongola – DHO

Tadey Assenga – DHS

Selemani Sungi – DPHARM

Mwanahamisi Msuya – DHIS-FP

Vendelino Raymond – DMIFP

Kalinga Mwandishi – Environ. Planner

Sifael Mkamba – Ag DRCHCO

III. EXECUTIVE SUMMARY

Introduction

Chamwino district is one of the seven districts in Dodoma region. The district is located between latitude 4º and 8º south and between longitude 35 and 37 East. It borders Chemba and Kondoa district to the north, Dodoma municipal and Bahi district to the west, Iringa Rural district to the south/ south –west and Kongwa and Mpwapwa districts to the East.

The district has an area of 8,742 square Km with 773 hamlets (Vitongoji), 77 Villages and 32 wards which together aggregate into five (5) divisions namely Chilonwa, Itiso, Makang'wa, Mvumi and Mpwayungu.

The district has a population of 314,768 with growth rate of about 2.4%. Women of bearing age are 76,174 and children under one are 11,749 while children under five are 54,658.Per capital income is Tanzanian shillings 180,000/= per annum. The literacy rate is 60%, population accessing clean water is 62%.The district has 61 functioning health facilities among them 1 is District Designated Hospital,5 public Rural Health centers, 53 Government Dispensaries and 2 faith based dispensaries.

Sources of data for the DHP in chamwino district are the community,(source of data could be- Annual HIMS report, Annual DNO report, Annual DHO report Annual District report(DMO) report ,Annual DWE report for the year 2012 etc-Please rectify) health facilities, department of education, department of water and sanitation and department of engineering. Data are collected and analyzed for various activities of the district council for example; in planning, in establishing various challenges faced by the communities, data can also be used as performance indicators for various interventions and programs.

Methods which are used to collect and analyze data are:-

i. MTUHA
ii. Vertical program such as HIV, FP, EPI, TUNAJALI, WFP, HPSS, ONE UN/JP2

Various performance indicators have been considered in this document to give an insight of the health status of the district. Some of those indicators include; maternal, newborn and child health, infectious diseases, progress in district health financing, progress in district health financing, Progress in district health facility coverage.

In the area of Maternal, Newborn and Child Health, the district is doing reasonably well. However more work needs to be done in order to ensure a much better health status of the district. Nutritional status for under 1 year old has increased from 94% in 2011 to 96% in 2012.

Under 5 Mortality Rate at 12/1000 was higher than both neonatal and infant mortality rate which were at 1/1000 and 3/1000 respectively.

Malaria is still a number one cause of both admissions and deaths; malaria incidences have increased from 50,214 in 2011 to 54,598 in 2012. One of the successes in the area of Malaria incidence is the Introduction and use of MRDT. In 2012 all health facilities in the district were using MRDTs in Malaria diagnosis. 3463 cases of Malaria were confirmed using MRDT.

HIV/AIDS prevalence for Chamwino was 3.6% in 2012 compared to 2.6% for the previous year.

The district is doing very good in the area of vaccination services, In 2012 proportions of children under 1 year of age vaccinated against measles, OPV3 and BCG were 98% meaning that most children were properly vaccinated.

For the year 2012, a total of 213,974 OPD attendances were recorded in all health facilities. This is an increase of 19,185 attendances from 2011 due to the fact that 2 more health facilities started operating in 2012.

Best practices for chamwino district in 2012 include; the initiation of construction of placenta pit at each health facility in the district. A strategy of retaining health care workers through provision of beddings to the newly employed staffs is another best practice. The district also initiated the practice of cascade supervision in order to improve general supervision of the health facilities and relieving CHMTs off some of the work load.

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 Officer
MRDT	Malaria Rapid Diagnostic Test
DHO	District Health Officer
DRCHCO	District Reproductive and Child health Coordinator
DPHARM	District Pharmacist
DHISFP	District Health Information System Focal Person
DMIFP	District Malaria and IMCI Focal Person
Env. Planer	Environmental Planer
MUAC	Middle Upper Arm Circumference
TBSD	Tanzania Bearue Of Statistics and Demography
MMAM	Mpango wa Maendeleo na Afya ya Msingi
DHIS	District Health Information System
WFP	World Food Programme
CSB	Corn Soya Blend

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.
Middle Upper Arm Circumference	A measure of middle upper arm circumference with respect to height in order to determine nutritional status of individuals
Road to Health Card	A card for documenting the weight with respect to the age of a child under five years of age in order to determine growth status

1 INTRODUCTION

The purpose of this document is to simplify packages and communicate complex information on vital statistics and the local burden of disease in a practical, accessible format for District Health Planning. It is intended for use by CHMTs and other high members of the government. Information in this document is provided in tabular format with some explanatory captions and related text to provide picture of the current demography and disease burden. The data source is the district health and education departments; however, specific data in this report has been taken from 2002 census report.

1.1 MISSION AND VISION

The mission of Chamwino District Council is to facilitate and coordinate the provision of quality economic and social services to the communities through various stakeholders' participation.

The vision is to be a model council in the country with sustainable development by the year 2015.

1.2 STRUCTURE OF DISTRICT

Chamwino District is among seven districts in Dodoma region. The district was formed in 2007 from Dodoma Rural district which was divided to form the two districts of Chamwino and Bahi. Chamwino District is located on the central Plateau of Tanzania in the eastern direction to Dar es Salaam. It extends between latitude 4^0 and 8^0 south and between longitude 35^0 and 37^0 east. It borders Kondoa and Chemba Districts to the north, Bahi district to the west, Iringa district (Iringa region) to the south-west and Kongwa and Mpwapwa districts to the East.

The population of Chamwino District according to 2002 Population and Housing Census was 258,931, with a population growth rate of 1.6% per annum. Population projection for the year 2012 is 319,044.
The district has a total area of 8,742 sq.km^2 with 773 hamlets (vitongoji), 77 villages and 32 wards which together aggregate into five (5) divisions namely Chilonwa, Itiso, Makang'wa, Mvumi and Mpwayungu.

Table 1-1. Wards And Villages

WARD NAMES	MUMBER OF VILLAGES
Haneti	4
Itiso	3
Segala	3
Dabalo	4
Membe	2
Msanga	2
Chilonwa	2
Buigiri	3
Majeleko	2
Manchali	4
Ikowa	2
Msamalo	3
Igandu	3
Muungano	3
Mvimi Makulu	1
Handali	2
Mvumi Mission	2
Makangw'a	3
Idifu	2
Iringa Mvumi	4
Manzase	3
Fufu	2
Mlowa Bwawani	2

Mpwayungu	2
Nkambaku	2
Chinugulu	1
Manda	2
Nhinhi	2
Loje	2
Zajilwa	2
Chiboli	1
Huzi	2
TOTAL	77

1.3 FACILITY DISTRIBUTION

Chamwino District Council had 63 working health facilities in 2012 out of 77 which are required to meet the national target of having a health facility in every village by 2017. The distribution of those health facilities has been described on the table below:

Table 1-2. Facility Distribution

HEALTH FACILITIES DISTRIBUTION.

TYPE OF FACILITY	NUMBER OF FACILITIES	OWNERSHIP
HOSPITAL	1	FBO
DISPENSARY	55	GOV (55)
DISPENSARY	2	FBO
HEALTH CENTER	5	GOV

FIGURE 1-1. Chamwino District Map

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Comment [RS1]: Better district map is needed. TDHIS2 should be able to generate a similar map.

1.4 POPULATION

The population of Chamwino District according to 2002 Population and Housing Census was 258,931, with a population growth rate of 1.6% per annum. Population projection for the year 2012 was 319,044 (TBSD 2013).

Source;TBSD 2011.
Note. Data from TBSD in the year 2012 indicate that Chamwino had a projected population of 314,768 but for the year 2013 the projected population is 319,044

Population Density:

It is striking to note that the District with its relative poor resource base have a higher population density compared to many districts in the region/country. The population size of **319,044** translates itself into an average of population density of 34 persons per sq. Km which is higher than the national average of 26 persons per sq.km recorded in 1988.

Community Involvement

Community involvement is observed in three main areas: Planning, Implementation, monitoring and evaluation.
O and OD tool is used to identify planning priorities from the community.
The community is represented through facility Governing committees and District Health board in Community Mobilization, Community participation in implementation of health activities e.g. Construction of dispensaries through MMAM program, monitoring and evaluation through committee meetings.

Table 1-3. Gender And Age Based Statistics

AGE RANGE	FEMALE	MALE
<1 YEAR	5808	5941
1-4	21371	22239
5-14	40334	42201
15-49	76174	64562
>50	26101	10037
TOTAL	169788	144980

1.5 GEOGRAPHY

The predominating pen plain of the district is dissected from north to South/west by a number of mountain chains. Between and around these mountains and hill ranges are lower-lying relatively flat areas of about 1200m elevation. A number of depressions are associated with these lower areas. They are generally Water-lodged during rainy season and have a tendency of salinity because of their limited outflow and are locally known as Mbuga. There is one river system in the district, the Kizigo River, which originates in the mountain to the north and flows south west direction. The rest of the district has patterns of impeded drainage.
Chamwino District has a dry Savannah type of Climate which is characterized by a long dry season between late April to early December, and a short single wet season between late December and early April.

In the long dry season, persistent desiccating winds and low humidity contribute to high evapo-transpiration and soil erosion.
The average rain fall is 500 - 800 mm per annum, of which about 85% fall in four months duration which is between December and March. The amount of rainfall in the District is not only low, but is rather unpredictable in its frequency and amount particularly in January in which most crops are generally sown. The district is generally hit by drought which culminates to problems of hunger and malnutrition. By-laws have been introduced, which requires farmers to cultivate among other crops, drought resistant crops, namely millet (tegemeo, okoa), sorghum, cassava and Sweet Potatoes.

1.6 TRANSPORTATION AND COMMUNICATION

Road Networks:
The district has a total of 808.7 Km of road network, which comprise of 149.5 Km of District roads, 210 Km of trunk roads and 659.2 Km of feeder roads.
These road networks are serviced and maintained through the Road Fund, Village Travel and Transport Program and Local Government Transport Programme.
About 40% of road networks are impassable during the rainy season.

Railway Services:
The district is well served by inter-regional transport links with the Central line of the Tanzania Railways Line (TRL). The railway line passes through two villages in the District, these are Igandu and Mnase.

Communication Facilities:
The existing communications in the district consists of a number of networks which include mobile phones (Vodacom, Airtel, Tigo and Zantel), and TTCL with a coverage of 90%.Fourteen health facilities are served with radio call services.

1.7 EDUCATION

Chamwino District Council has 110 primary schools and 26 secondary schools. Of these, 2 secondary schools are privately owned and the rest are public schools. Literacy rate currently stands at 60%.

1.8 GEOGRAPHICAL CONDITION.

Other factors that may influence health conditions or access to health services in the district include: dry conditions of the district due to the central region it belongs to. The dry conditions are conducive for the thriving of unique house flies which are vectors of trachoma bacteria. This coupled with shortage of clean water due to draught results into Trachoma being an endemic disease for Chamwino district.

The geography of Chamwino district may also be a factor which influences access to health service. The location of the designated district hospital (DDH) is not favorable for access by most of the population in the district. For example one has to travel from their village past Dodoma Municipal Council where the regional hospital is located in order to reach the DDH.

2 DATA COLLECTION METHODS AND SOURCES OF DATA

2.1 DATA SOURCES AND THEIR DATA COLLECTION AND ANALYSIS METHODS

Sources of data for the DHP are the community, health facilities, department of education, department of water and sanitation and department of engineering. Data is collected and analyzed for various activities of the district council, for example; in planning, in establishing various challenges faced by the communities.

Methods which are used to collect and analyze data are:-
MTUHA
Vertical program such as HIV, FP, EPI, TUNAJALI, WFP, HPSS, ONE UN/JP2.

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

Table 2-1. MANDATORY DHP HEALTH INDICATORS

HEALTH STATUS OF CHAMWINO DISTRICT POPULATION
Maternal, Newborn and Child Health ❖ Nutritional Status, Neonatal,Infant, and Under 5 mortality rate: ❖ Incidence of Malaria ❖ HIV/AIDs prevalence Top 10 causes of admission; Malaria ❖ Top 10 causes of death

CHAMWINO 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*

CHAMWINO DISTRICT HEALTH SERVICE DELIVERY
General ❖ OPD Attendance **Vaccination** ❖ Proportion of children under 1 vaccinated against measles ❖ Proportion of under 1 3rd Polio (OPV3) ❖ Proportion of under 1 BCG dose **Reproduction Health** ❖ Percentage of health centers and dispensaries that can provide EmOC as defined in EHP ❖ Proportion of pregnant women starting ANC before 12 or 16 weeks gestation **Infectious Diseases and Non-Communicable Diseases** ❖ Proportion of mothers who received two doses of preventative intermittent treatment for malaria during last pregnancy ❖ Proportion of vulnerable groups sleeping under ITN the previous night ❖ Proportion of laboratory confirmed malaria cases among all OPD visits ❖ TB notification rate per 100,000 population

PROGRESS MADE IN CHAMWINO DISTRICT 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

HEALTH STATUS OF THE DISTRICT POPULATION

2.3 MATERNAL, NEWBORN AND CHILD HEALTH

Nutritional status for under one year old has improved from 94% in 2011 to 96% in 2012. The success has been due to the continuous health education provided by the heath care workers to the clients attending clinics. 11 facilities out of 61 facilities are under the WFP supplementary feeding program where pregnant and breast feeding women are provided with CSB flower. This has been one of the reasons why nutritional status in the district is reasonably well.

Being a national priority the district is employing the use of growth monitoring cards and MUAC to follow the nutritional status of children under 5 years of age. The target of nutritional status in low birth weight has been set at 90% for Chamwino district.

Road to health cards(growth monitoring cards) are being used at all heath facilities since all health care workers and community health workers have the knowledge on how to use the cards. Measurements of MUAC are used at only 11 health facilities whose health care workers have been trained on how to conduct the exercise. At these facilities children found to be malnourished are provided with supplementary feeding in form of Corn Soya Blend (CSB) flour.

In 2012 358 (4%) children with low birth weight were delivered in Chamwino district. This is an increase from the year 2011 whereby 174 (1.8%) children with low birth weight were delivered.

Figure 3-1. Nutritonal Status: Low Birth Weight

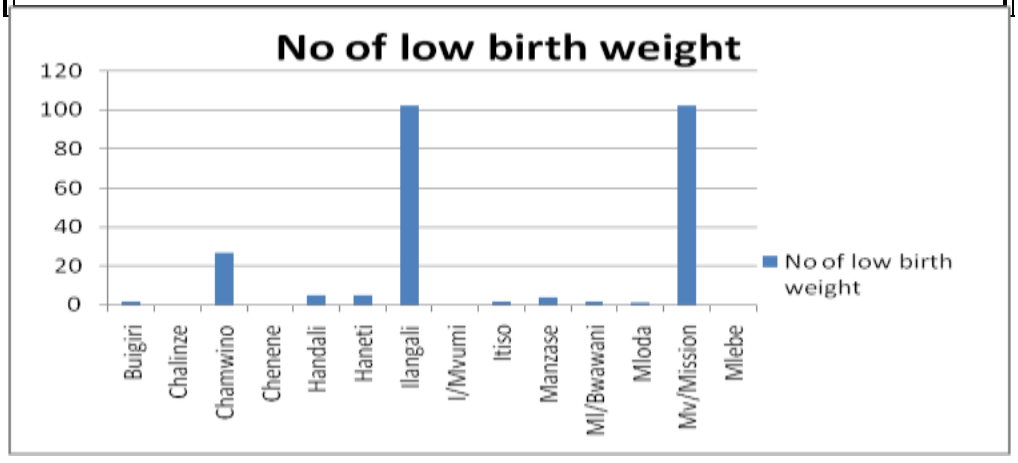


Figure 3-2. Neonatal Mortality Rates

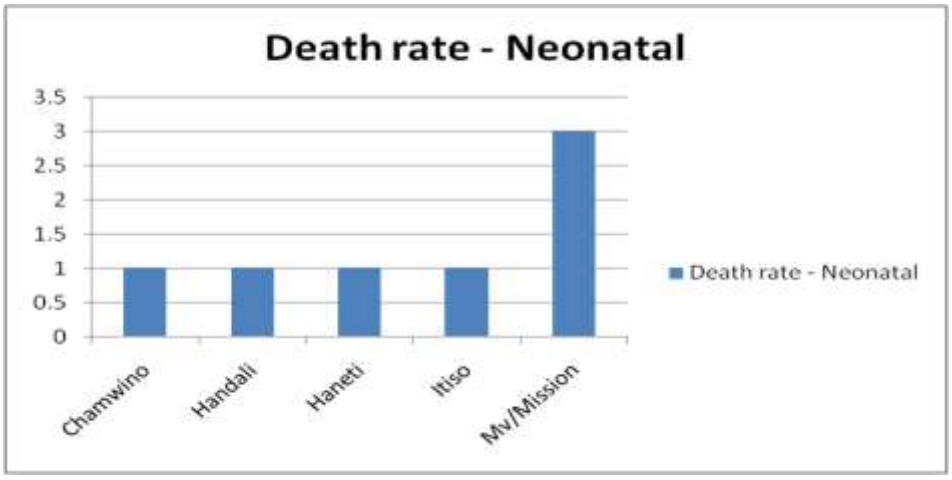


Figure 3-3. Infant Mortality Rate

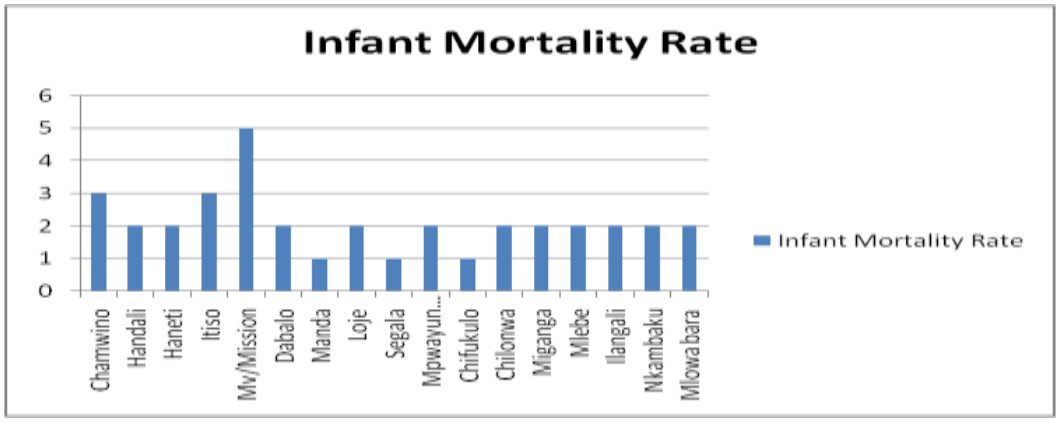
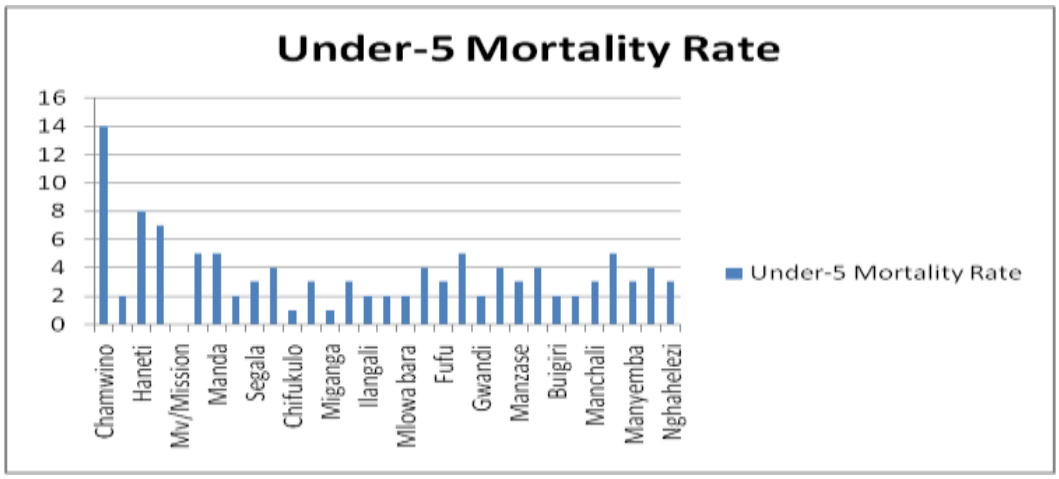


Figure 3-3. Under 5 Mortality Rate



2.4 MORBIDITY

Malaria is still a number one cause of both admissions and deaths; malaria incidences have increased from 50,214 in 2011 to 54,598 in 2012. One of the successes in the area of Malaria incidence is the Introduction and use of MRDT. In 2012 all health facilities in the district were using MRDTs in Malaria diagnosis. 3463 cases of Malaria were confirmed using MRDT.

Challenges in the area of Malaria incidence include; clinicians not trusting the results given by MRDTs resulting in people being prescribed with anti-malarials despite the negative result shown by MRDTs.

Poor quality data collection by the health care workers, inadequate use/misuse of ITNs, Misdiagnosis of Malaria cases (most cases are clinical cases which have not been diagnosed in the lab), inadequate staff/lab personnel, self diagnosis of malaria by members of the community putting pressure on health care workers to provide malaria treatment. All these are among the challenges faced in the area of Malaria incidence.

HIV/AIDS prevalence for Chamwino was 3.6% in 2012 compared to 2.6% for the previous year. The increase of 1% is considered as an indication of more people being diagnosed with HIV/AIDS. One of the successes in the area of HIV/AIDS is an increase of facilities providing PITC services from 8 facilities in 2011 to 26 in 2012. Therefore more people were tested on HIV/AIDS in 2012.

The top ten causes of admission for 2012 are the same as those for 2011, these were; Malaria, Pneumonia, Diarrhea, Anemia, Clinical AIDS, Injuries and Trauma, Burns, Chronic Bronchitis, Tuberculosis, Severe Malnutrition.

Challenges; severe malnutrition is among the top ten admitted cases due to the dry nature of the district which leads to food shortages, injuries and trauma for 2012 is a top ten case because of the increase in the use of motor bikes (boda boda) as a means of transport.

For the year 2012 all deaths in the district were due to the following seven diseases; Severe Malaria, Clinical AIDS, Dysentery, Diarrhea Diseases, Pneumonia, Anaemia, Poisoning, Burns. Successes in this area include the decrease in the number of deaths from 111 in 2011 to 97 in 2012. The decrease is attributed to the wide spread practices of health promotion carried out by HPSS in collaboration with the district council.

In 2012 compared to 2011 the use of ITNs is still low despite the fact that a number of ITNs were distributed to households by the district in 2010 and 2011. In spite of some improvements being registered however low understanding by the community on proper hygiene and sanitation is still a challenge. Poor hygiene

and sanitation is a result of diseases such as diarrhea which rank among the top ten causes of deaths.

Figure 3-3. Laboratory Confirmed Malaria Cases

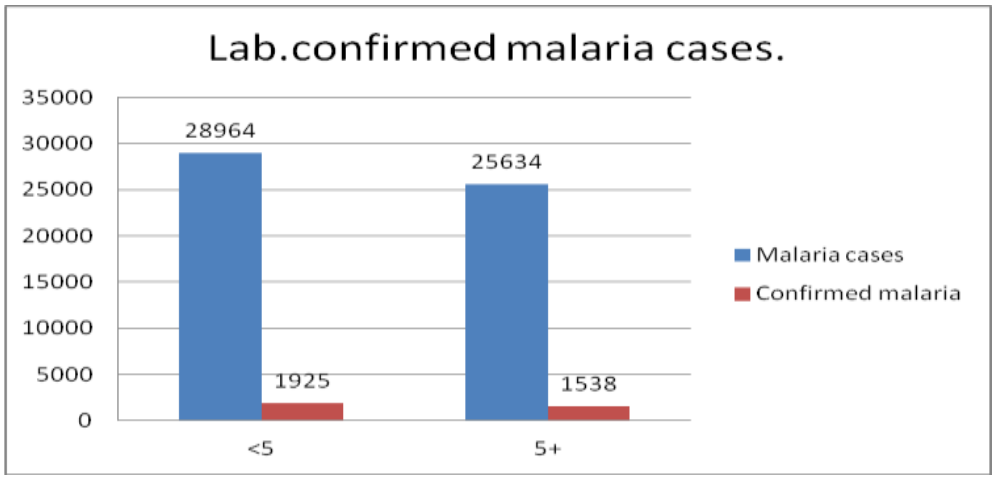


Figure 3-4. HIV/AIDS Prevalence

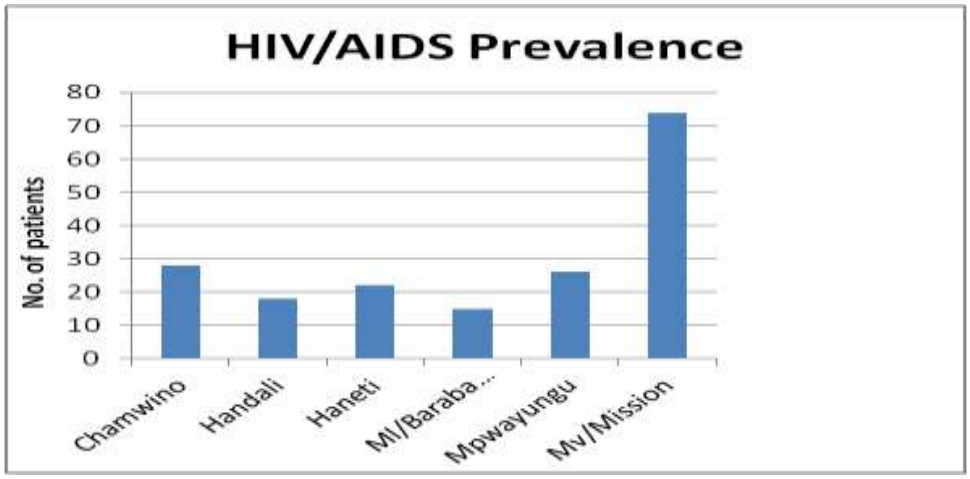


Table 3-1. Top 10 Causes of Admission/Inpatient Diagnosis

	IPD	1 Year –< 5 Years		5 Years - > 5 Years	
		FEMALE	MALE	FEMALE	MALE
1	Malaria	629	606	361	376
2	Pneumonia	76	73	3	3
3	Diarrhea	58	56	31	33
4	Anemia	50	48	14	14
5	Clinical AIDS	2	2	34	35
6	Injuries & trauma	4	3	21	22
7	Burns	10	9	5	6
8	ARI, chronic bronchitis	37	35	60	65
9	Tuberculosis	0	0	0	0
10	Severe malnutrition	0	0	0	0

2.5 MORTALITY

Malaria is still the leading cause of both morbidity and mortality in the district (refer the table below).

Table 3-2. Top 10 Causes of Death

	Causes of Death	1 Year –< 5 Years		5 Years - > 5 Years	
		FEMALE	MALE	FEMALE	MALE
1	Malaria	14	13	14	16
2	Pneumonia	7	6	1	2
3	Diarrhea	2	2	3	3
4	Anemia	7	6	2	2
5	Clinical AIDS	1	1	16	18
6	Injuries & trauma	0	0	0	0
7	Burns	1	0	0	0
8	ARI, chronic bronchitis	0	0	0	0
9	Tuberculosis	0	0	0	0
10	Severe malnutrition	0	0	0	0

2.6 OPTIONAL HEALTH STATUS OF THE DISTRICT POPULATION INDICATORS

3.5. DISTRICT HEALTH STATUS CONCLUSIONS, RECOMMENDATIONS AND WAY FORWARD

In the area of Maternal, Newborn and Child Health, the district is doing reasonably well. However more work needs to be done in order to ensure a much better health status of the district. Nutritional status for under 1 year olds has increased from 94% in 2011 to 96% in 2012.

Under 5 Mortality Rate at 12/1000 was higher than both neonatal and infant mortality rate which were at 1/1000 and 3/1000 respectively. In order for the mortality rate to be reduced among under 5 children, more work must be done in both ANC and post natal care. For example; to increase the number of health facilities providing Emoc services from 2 in 2012 to 3 in 2013, continuous health education on early booking to clinics by pregnant women, encouraging/sensitizing more male involvement in reproductive health, continuous supervision of the health facilities and ensuring availability of essential medicines and medical supplies for maternal and infant health.

HIV/AIDS prevalence was 3.6% in 2012 compared to 2.6% for the previous year. The increase number of people being diagnosed with HIV/AIDS was caused by increase number of facilities providing PITC services from 8 facilities in 2011 to 26 in 2012. Therefore more people were tested on HIV/AIDS in 2012.

Maternal, Newborn and Child Health

- Nutritional Status = 60% for under 5 years old.
- Neonatal mortality rate = 1/1000
- Infant mortality rate = 3/1000
- Under 5 mortality rate = 1/1000

Diseases

- Incidence of Malaria = 54598
- HIV/AIDs prevalence = 3.6%
- Top 10 causes of admission; Malaria, Pneumonia, Diarrhea, Anemia, Clinical AIDS, Injuries and Trauma, Burns, Chronic Bronchitis, Tuberculosis, Severe Malnutrition

  Top 10 causes of death; Severe Malaria, Clinical AIDS, Dysentery, Diarrhoea Diseases, Pneumonia, Anaemia, Poisoning, Burns

3 STATUS OF HEALTH SERVICE DELIVERY IN THE DISTRICT

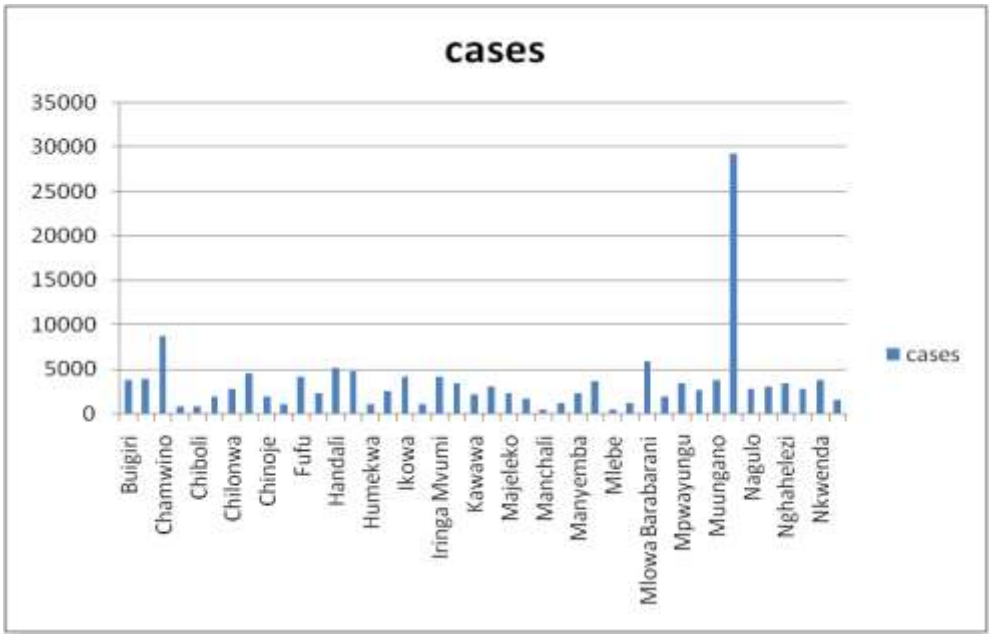
3.1 GENERAL HEALTH SERVICE

For the year 2012, a total of 213,974 OPD attendances were recorded in all health facilities. This is an increase of 39185 attendances from 2011. One of the successes in this area is that more people could assess a health facility due to the fact that 2 more health facilities started operating in 2012. Another success in this area is that 36 health care workers of various cadres were employed and posted to various health facilities.

All health care workers in the district received comprehensive training on the improved DHIS (MTUHA). This has also improved data collection at all facilities.

Despite the successes observed, challenges faced in OPD attendances are inevitable which include; shortage of health care workers which lead to long delays for clients to receive health care services. The number and size of data collection tools for the improved DHIS has tremendously increased leading to difficulties in data collection and report writing.

Figure 4-1. OPD attendance as per 2012.



3.2 VACCINATION SERVICES

The district is doing very good in the area of vaccination services. This is due to the fact that proper follow up on defaulting children is conducted by the health care workers in collaboration with community health workers. Thanks to the Ministry of Health all vaccines are available at all times at the District level and these are timely made available to all health facilities.

In 2012 proportions of children under 1 year of age vaccinated against measles, OPV3 and BCG were 100% meaning that all children were properly vaccinated. Successes in vaccination services include; high understanding of the community on vaccination. High understanding by the community is attributed to proper health education provided by the health care workers at health facilities and in communities. The district is also conducting immunization outreach services whereas 7 outreach routes are carried out monthly. Mobile clinics are also available; 48 mobile clinic services are carried out every month at hard to reach areas. The availability of 5 motor bikes also makes easy the provision of mobile clinics services.

Despite the success in vaccination services challenges in this area include; the population of services areas provided by the bureau of statistics is lower than the actual number of people receiving services, this leads to proportions of children vaccinated being unrealistic (more than 100%). Nomadic style of life makes vaccination services to be very hard due to the movement of people from one area to another. Poor road infrastructures also contribute to hardship in the provision of vaccination services.

Figure 4-2. Under 1 Year Vaccinated (OPV3, BCG, and Measles . year 2012

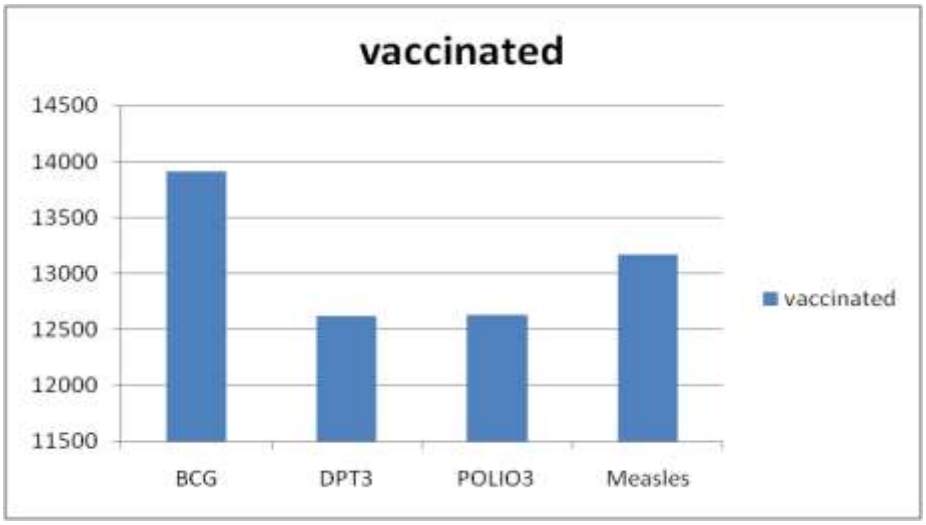
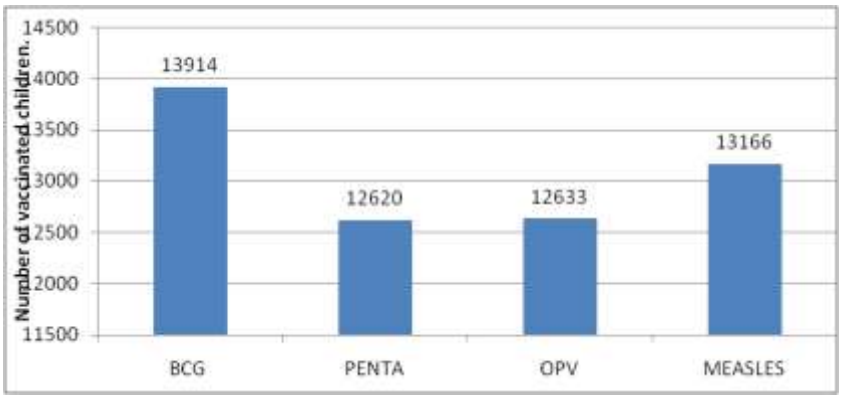


Fig.4.0 Chart to show immunization coverage in the district.



3.3 REPRODUCTIVE HEALTH SERVICES

In the area of reproductive health services, in 2012, 59% of pregnant women started ANC clinic before 12 or 16 weeks of gestation. This is still a low coverage considering that all (100%) pregnant women are required to attend ANC clinic before the fore-mentioned time.

Successes in this area include; all health facilities in the district provide ANC services, 48 mobile clinic services and 7 outreach routes conducted every month also provide ANC services at areas with no health facilities and hard to reach areas.

Challenges; inadequate knowledge by the community on the importance of early booking,

In 2012 the district opened a theatre in one of the health centres (Chamwino), this is one of the success in the category of EmOC since the facility started operating in April. 87 people received EmOC services in 2012.

Challenges include; shortage of medicines and medical supplies for EmOC services such as Spinal Needles, Atropine Injection and Lignocaine spinal injection.

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

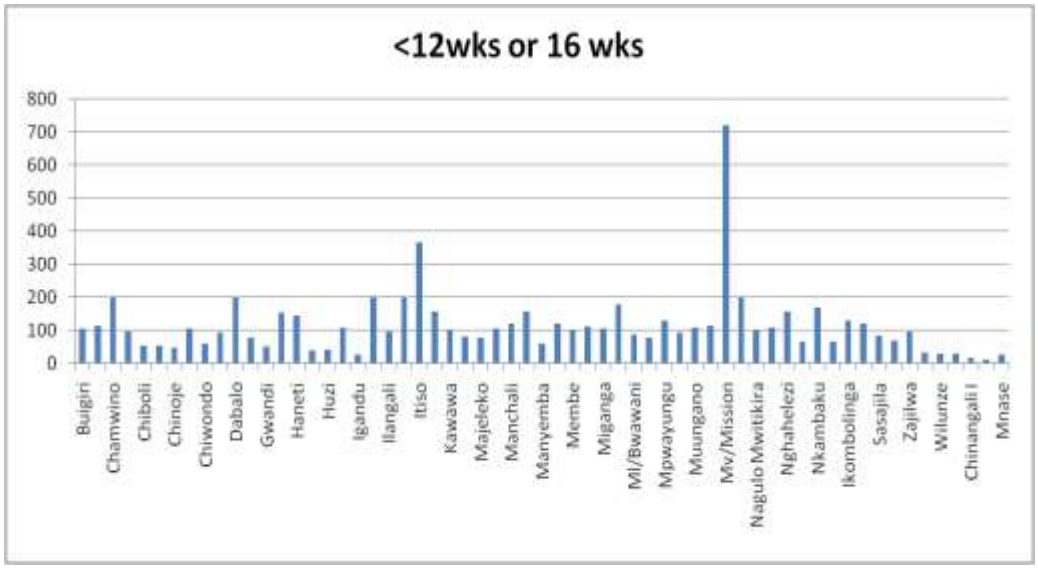
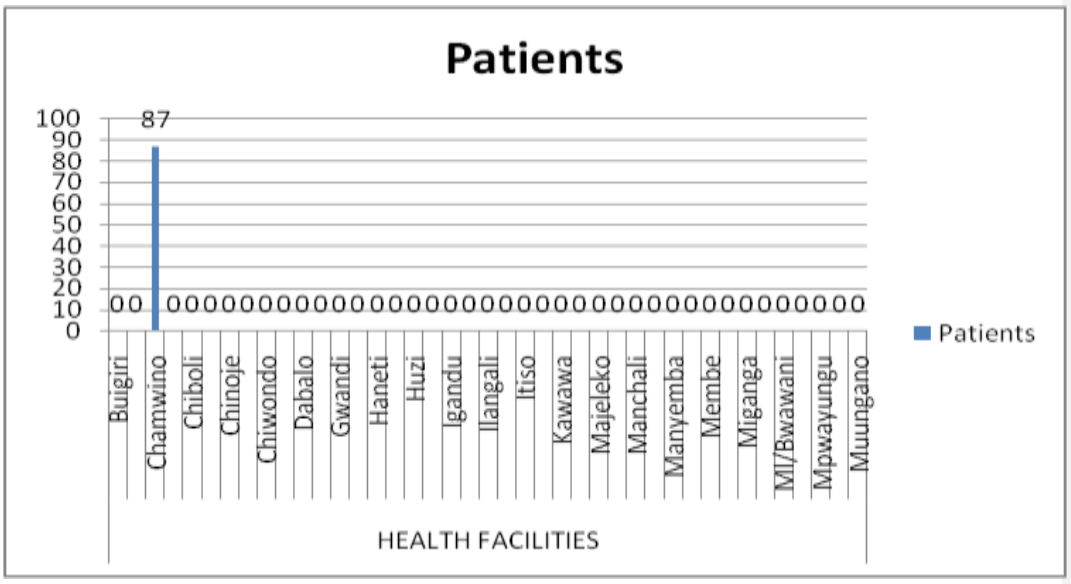


Figure 4-4. Percentage of health centers and dispensaries that can provide EmOC as defined in EHP



3.4 INFECTION DISEASE AND NON-COMMUNICABLE DISEASE HEALTH SERVICES

Proportion of mothers who received two doses of preventive intermittent treatment for malaria was 73% in the year 2012. This is still low since all pregnant women should receive two doses of SP during pregnancy. Successes in this category include; all health facilities provide two SP to women during pregnancy.

Challenges faced include; inadequate availability of SP at health facilities in 2012; availability of SP at health facilities was approximately 81%.

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

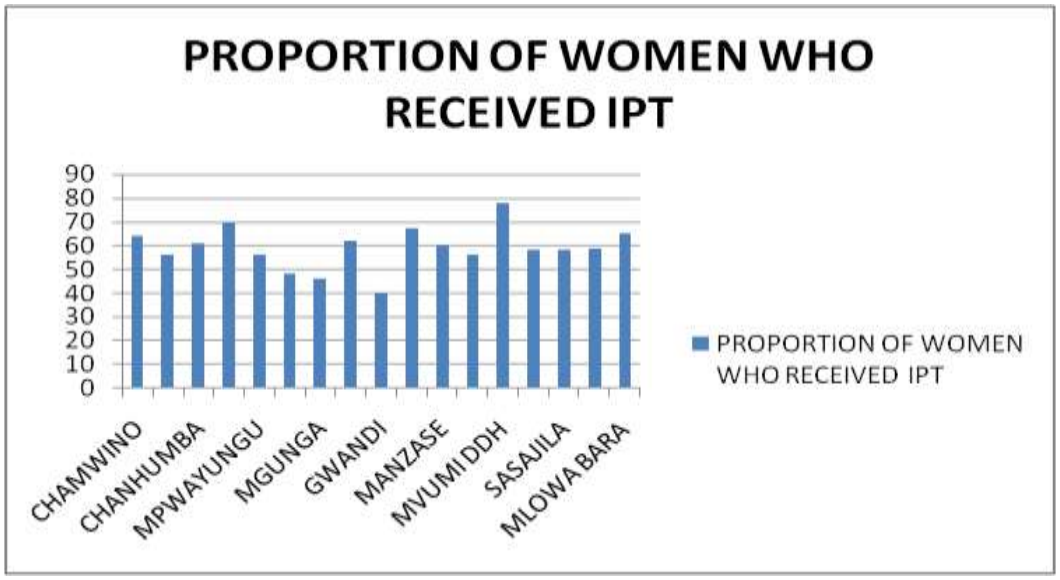


Figure 4-7. Proportion of laboratory confirmed malaria cases among all OPD visits

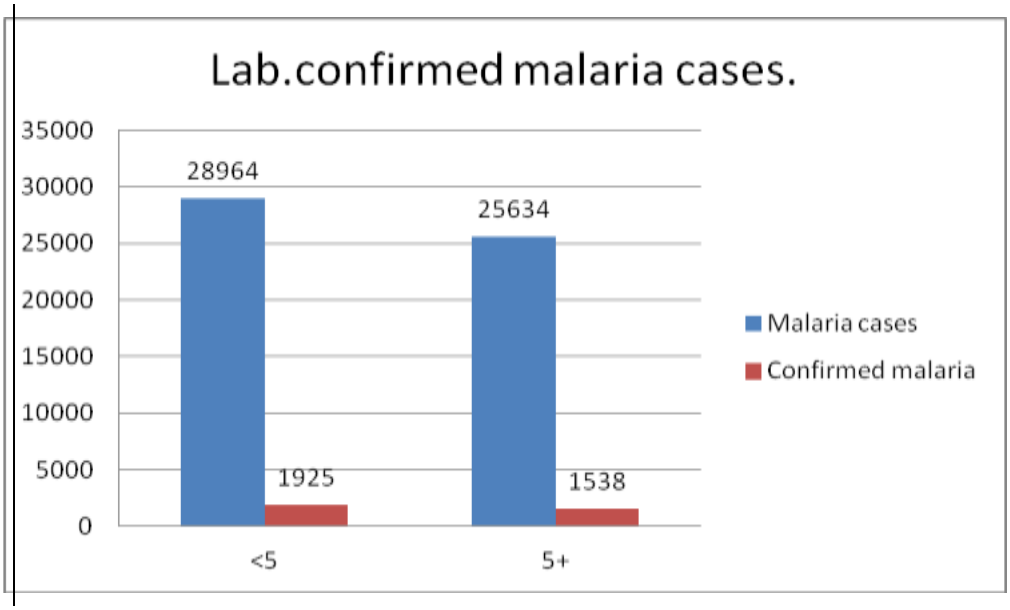
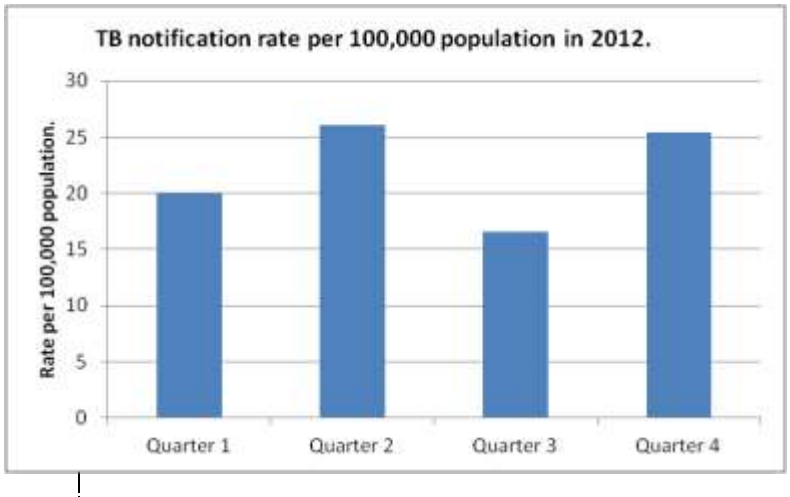


Figure 4-8. TB notification rate per 100,000 population



3.5 DISTRICT HEALTH SERVICE DELIVERY CONCLUSIONS, RECOMMENDATIONS AND WAY FORWARD

The vision of Chamwino District Council is to be a model council by the year 2015; for this vision to be realized the population's health status of the district needs to be improved by increasing access to quality preventive, curative, rehabilitative and promotive health services which will be affordable, sustainable and equitable to all.

The goals of the district council therefore lie at creating a healthy, prosperous population through improving RCH services, controlling communicable diseases and non communicable diseases, improving environmental health and sanitation, improving social welfare services, strengthening management of HRH, strengthening organisational structure and capacity to deal with emergencies and local diseases of priority.

To achieve this, the following recommendation has to been proposed; this is:

Timely disbursement of funds by the Government for health services; this will ensure that all planned activities are implemented fully and on time,

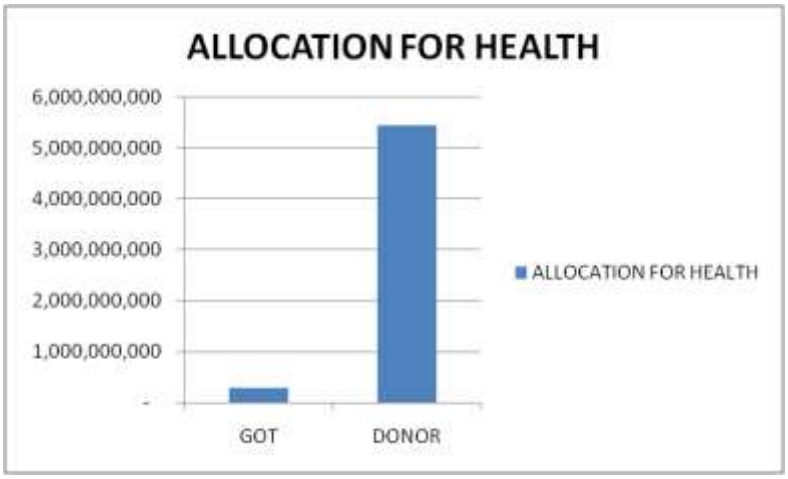
4 STATUS OF DISTRICT HEALTH SYSTEMS

4.1 HEALTH FINANCING

In the financial year 2012/13 the council planned to collect from different sources a total of Tanzanian Shillings 4,539,168,470/=, however up to March 2013 the district collected Tanzanian Shillings 2,024,975,164/= (44.6%) and utilized Tanzanian Shillings 1,835,975,164/= (90.6%). Per capital income is Tanzanian Shillings. 150,000/= per annum.

Chamwino district in CCHP had a total budget of 5,436,743,890/= year 2011/2012. The success of CCHP implementation for the FY 2011/2012 was about 60% (fully implemented activities) while 6% of the planned activities were partially implemented. This was attributed by late disbursement of funds and partly funds not received.

Figure 5-1. Total GOT and Donor allocations to Health in the District 2011/2012 FY.



4.2 HUMAN RESOURCES FOR HEALTH

Chamwino District has 3 Health training institutions with full NACTE accreditation which are; Clinical Officer Training Centre, Nursing Training School and Laboratory Training School. The institutions which are owned by a faith based organization are used by the district in trying to overcome the problem of shortage of staff. This is done through offering students placements for field work and encouraging and sensitizing graduates from the institutions to join the district council during graduation ceremonies.

Chamwino district has 315 health staffs of different cadres out of 615 who are needed. The distribution of some staffs in various cadres are as follows; MO and AMO per 10,000 population = 15/314,768, Nurse-midwives per 10,000 population = 111/314,768, Pharmacists and pharm tech per 10,000 population = 3/314,768, Health Officers per

10,000 population (modified to include Environmental Health Officer (EHO) = 0.29 (9/314,768), Laboratory staff per 10,000 population = 0.54 (17/314,768)

Successes for 2012 include; the provision of various trainings, short courses, and workshops to health care workers of different cadres. This builds the capacity of health care workers and makes them more competent in their responsibilities. Routine supportive supervisions have contributed to build the capacity of health workers. Timely provision of statutory benefits to the health staffs has also been a motivating factor to the staffs.

Challenges in this area include; inadequate working tools and housings for health staffs. The system of motivating staff by paying for performance Bonus will improve the staff performance and health services delivery however availability of enough fund to sustain the P4P system are also inadequate. Retention of health care workers is also a challenge due to poor or inadequate infrastructure such as lack of electricity, water supply, communication networks and roads. This leads to a continuous shortage of staff at more remote health facilities.

Figure 5-2. Training instituations with full NACTE accreditation in the District

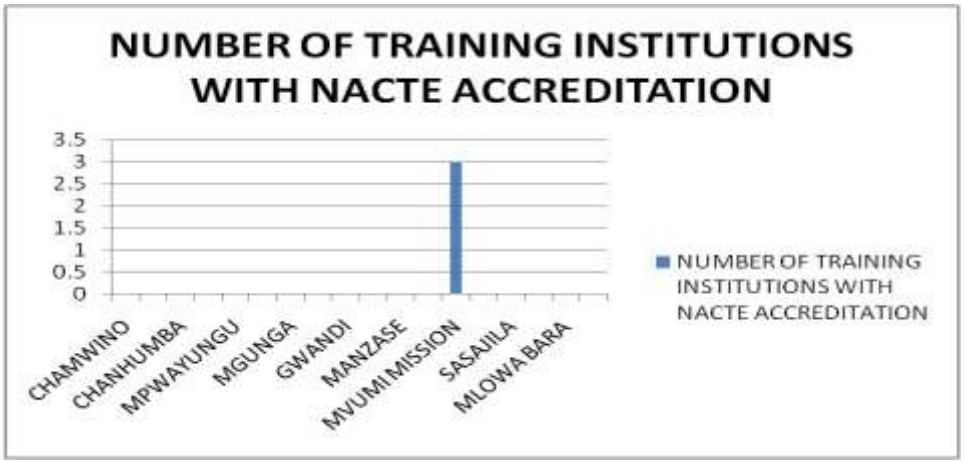


Figure 5-3. Number of MO, AMO, and COs Per 10, 000 population year 2011/2012.

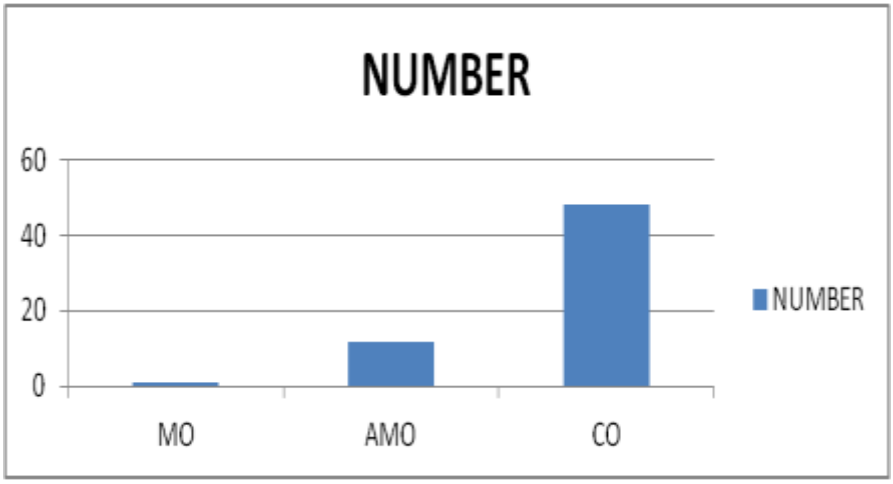


Figure 5-4. Number of Nurse mid-wives, Lab Techs, Pharm Techs Per 10, 000

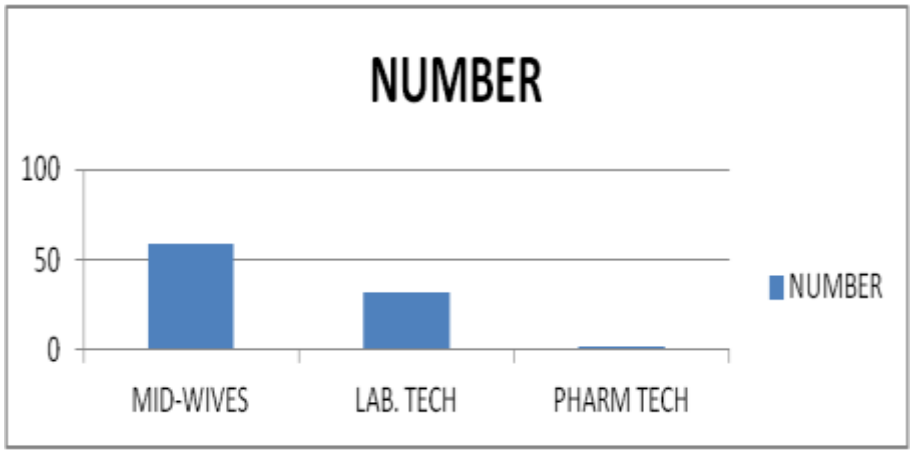
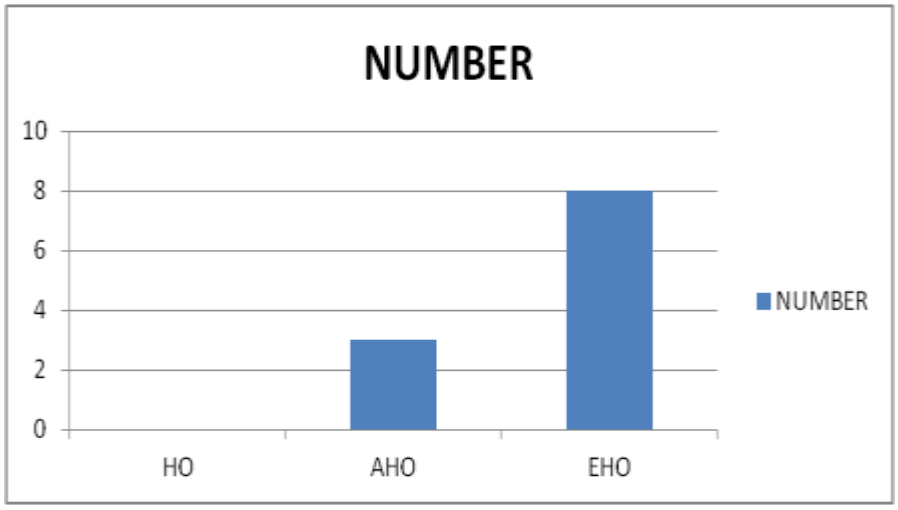


Figure 5-5. Number of HO, AHO, and EHOs Per 10, 000 population.



4.3 MEDICINES/DRUGS

The performance of health facilities in the section of medicines for the year 2012 was relatively encouraging. Percentage availability of health facilities with tracer medicines vary from 50% of facilities for Ergometrine/Oxytocin and Normal Saline to 100% for BCG vaccines.

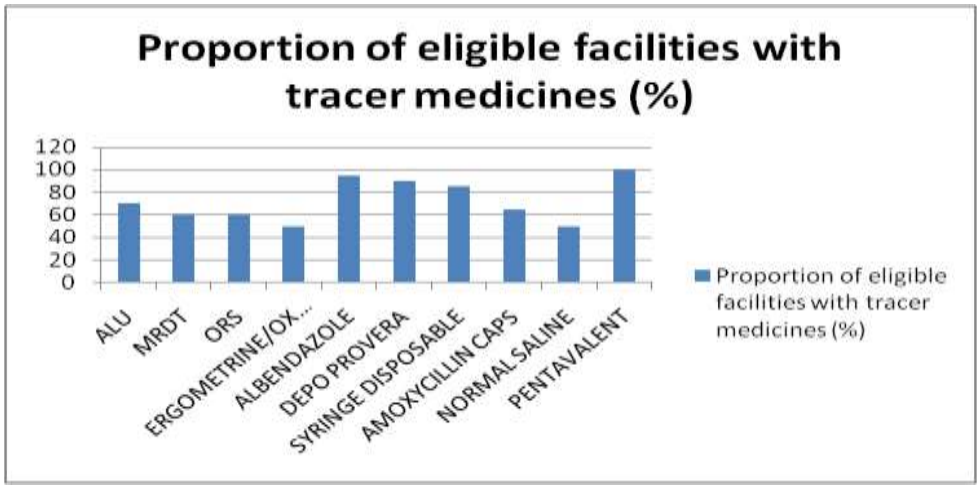
Successes in this area include; health facilities were able to procure supplementary medicines from private pharmacies using their cost sharing funds. This was the case when supplies from MSD were not enough or were delayed. For 2012, 58 (95%) facilities procured medicines from local suppliers at least once.

Challenges for 2012 include; critical delays of medicines delivery from MSD. All health facilities received 3 deliveries of medicines and medical supplies instead of 4 in 2012. On average lead time for facility delivery of medicines and medical supplies was 77 days. Apart from delays, medicines delivered were also not enough whereby on average order fulfilling rate by MSD was 58%.

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

Description	
DPT + HepB/HiB/vaccine for immunization	1
Artemether/Lumefantrine (Alu)oral	1
Amoxycillin or Co trimoxazole oral	0
Albendazole or Mebendazole oral	1
Oral Rehydration Salts	1
Ergometrine or Oxytocin injectable, or Misoprostol oral	0
Dextrose 5% or Sodium Chloride + Dextrose IV solution	1
Syringe and needle, dispose	0
Malaria rapid diagnostic test (MRDT) or supplies for malaria microscopy.	0
KEYS	
Available	If "No"
1=Yes	A: < 1 week
0=No	B: 1-3 weeks
	C: 1 month

Figure 5-7. Availability of Tracer Drugs



4.4 INFRASTRUCTURE

Chamwino District Council has 56 dispensaries, 5 Rural Health Centers, and 1 DDH Hospital. Among these dispensaries 2 are faith based organization.
44 (70 %) of Health facilities are in good state of repair, 13 (21 %) need minor maintenance and 5 (9%) need major maintenance.

Water Supply:
Chamwino district has 205 water supply schemes capable of providing clean and safe water to 58% of the population. These water schemes include 88 shallow wells, 85 boreholes, 3 springs, 5 dams, and 28 rainwater harvesting structures. However, due to a number of factors, about 148 of the existing schemes are in good state of repair which serves 58% of the population.

Electricity:
About 5% of the population is served by hydro-electricity from Mtera dam. The villages served include: Chamwino, Buigiri, Wilunze, Chinangali 2, Chinangali 1, Manchali, Chilonwa, Makang'wa, Mlowa Barabarani, Mvumi Mission and Mvumi Makulu. However, 85% of the population depends on firewood and charcoal as the source of energy for cooking. Four health facilities (Mvumi DDH, Chamwino RHC, Mvumi makulu and Buigiri dispensaries) are connected to the grid electricity and 29 health facilities have solar power in the main dispensary buildings.

Communication Facilities:

The existing communications in the district consists of a number of networks which include mobile phones (Vodacom, Airtel, Tigo and Zantel), and TTCL with a coverage of 90%. 4 health facilities are not covered by any GSM network. Fourteen health facilities are served with radio call services.

4.5 DISTRICT HEALTH SYSTEM CONCLUSIONS AND WAY FORWARD

District health system in the past year was growing positively. The service delivery improved with employment of staffs of different cadres as well as increase of health facilities. The gap from villages without health facilities to those with health facilities is being reduced as there are other villages under constructing their dispensaries e.g.; the construction of 4 dispensaries in the past year 2012 and the ongoing construction of other 4 dispensaries. The health system has somewhat improved regardless of some shortcomings e.g. shortage of staff especially skilled personnel.

The district has planned to do and or improve the following areas of services. These are as follows:

1. Construction of health facilities in the 11 villages without dispensaries by 2017,
2. Improving data collection, storage and uses by the year 2014, and
3. Improve system of fund disbursement.
4. Increase of skilled health personnel.

5 AREAS OF PROGRESS IN THE DISTRICT HEALTH SECTOR

5.1 PROGRESS IN DISTRICT HEALTH FINANCING

	Source of Funds					
No	Districts	Basket Funds	OC	Development Funds	Councils Funds	Other Sources Global Fund
5	CHAMWINO	575,479,800	107,200,000	215,115,300	0	4,300,000
	Total	575,479,800	107,200,000	215,115,300	0	4,300,000

Expenditure.

No	District	Basket Funds	OC	Development Funds	Council Funds	Others
5	CHAMWINO	524,125,000	107,200,000	191,000,000	0	4,300,000
	Total	524,125,000	107,125,000	191,000,000	0	4,300,000

5.2 PROGRESS IN DISTRICT HUMAN RESOURCES

	MO	AMO	CO	HO	EN	PHARM/ PHARM-Tech	RN	Dental	LAB
Availability of HR by Cadre	1	7	69	14	120	3	35	3	27
New Employments	0	0	4	1	13	2	0	0	15
Total	1	7	73	15	133	5	35	3	42

5.3 PROGRESS IN DISTRICT NEONATAL HEALTH

Chamwino District has been proved health services to all of its people even at areas which have no dispensary by conducting mobile heath services, this services go hand in hand with health education on how to care pregnancy mothers, feeding , important of early booking and others, in order to prevent problems which may face mother during birth or low birth weight.

The progress in the district neonatal health over the 1-3 years it shows that there were an increase in numbers of low birth weight for 3 years consecutively, from 2010 – 2013 that is 169, 174 and 358 respectively, increases of these numbers are due to; increase number of health facilities that causes the number of reports, improvement of data collection, and in the community level some traditional and culture that not consider pregnant women as a special group that need to get enough food and reduction of heavy works is an another factor which contribute the problem.

5.4 PROGRESS IN DISTRICT HEALTH FACILITY COVERAGE

Chamwino district has 77 villages; among of these 61 have health facilities, 3 villages have started constructing the health facilities which are in different stages, only 13 villages (16%) are without a health facility. The district in collaboration with MMAM is implementing a strategy which aims at ensuring that each village has a health facility by the year 2017.

5.5 PROGRESS IN DISTRICT HEALTH FACILITY PERFORMANCE

- In order to improve emergence health service provision in the district, one theatre has been constructed at one of the health centres. The theatre at Chamwino Health Centre is already in use and 87 patients benefited from the theatre. The district is planning to construct 3 maternal wards in 3 dispensaries in order to improve RCH services.
- In improvements in referral Hospital performance, district has got one Hospital owned by DCT that is used as a Designated District Hospital for referring critical patients, there are 5 rural health centers which are receiving patients from dispensaries and also district has 6 Ambulances which are using to transport the referred patients.
- Reporting rate has improved from 96 to 98 and still some efforts are being done to make sure that reporting rate reach 100%.
- Timeliness and completeness of data is 98% though there are some health facilities which are always delay to prepare the report as early as possible that make the district not to reach 100 % but follow up is going on to make sure that they prepare all reports in time and complete.

5.6 PROGRESS IN DISTRICT HEALTH SERVICES

- social welfare and protection services for vulnerable populations ,District has the mechanisms of provision of elder health services in a whole 54 dispensaries, CHF services in a whole 54 HFs that up to date there are 13125 members ,and 2754 members of NHIF.

- *vaccination coverage*

	BCG		DPT3	%	POLIO3	%	MEASLES	%
Total	Vaccinated	%	Vaccinated		Vaccinated		Vaccinated	
11749	13914	118	12620	107	12633	108	13166	112
11749	13914	118	12620	107	12633	108	13166	112

TT^2 Vaccinations			
	Projected Clients	TT_2 Vaccination Coverage	Percent%
	11,749	9,878	84
Total	12,315	9,878	84

Vitamin A*						
	Children Age 6 - 11 Months	Received Vitamin A	%	Children 1 - 5 Years	Received Vitamin A	(%)
	5872	5845	100	44017	44236	100
Total	5872	5845	100	44017	44236	100

- *Environmental health service safe water initiatives*

Environmental Health							
	Total House holds	Households Inspected	With Appropriate Latrines	%	Safe source of water	(%)	
	52,461	1,745	16787	32	32525	62	
Total	52,461	1,745	16787	32	32525	62	

5.7 PROGRESS AGAINST MILESTONES

- Progress against milestones set by the technical review of the joint annual health sector review from previous year.
  - ✓ Increase number of CHF member from 13125 up to 18886 for the year 2013.
  - ✓ Increase number of Health facilities with Solar power from 45(71%) to 57 (90%) for the year 2013.
  - ✓ Construction of placenta pit in each HFs .
  - ✓ Introduction of cascade supervision in the district.

5.8 BEST PRACTICES

To showcase some of the successes of the district a few best practices have been selected; the initiation of the construction of placenta pits at each facility in 2012 is one example; 58 (95%) health facilities had placenta pit constructed. In order to attract and retain new staff the district introduced an incentive of providing beddings to the new staff; in 2012 twenty-three newly employed staff benefited from this strategy.

The introduction and implementation of cascade supervision is another best practice Chamwino. The district has 6 health facilities (1 hospital and 5 health centres) which act as cascade nodes supervising surrounding dispensaries.