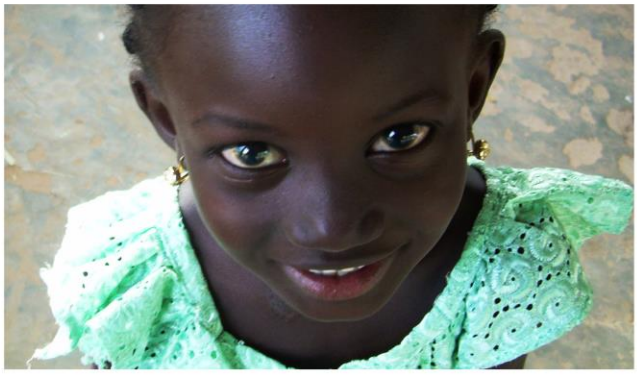
The United Republic of

TANZANIA

Ministry of Health & Social Welfare



BAGAMOYO

District Health Profile

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I. FOREWORD

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

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

The District Health Profile (DHP) Reports 2012 presents the assessment of the health system performance in Bagamoyo District for the year 2012. Bagamoyo District considers Monitoring and evaluation as an important means for measuring effectiveness of the various inputs, processes, outcomes and their impact on the system. Through this report, progress towards the National Health Policy Objectives and international commitments can be measured with a high degree of certainty.

II. ACKNOWLEDGEMENTS

The development of the DHP is a collaborative effort organizations are being acknowledged for their direct contribution towards the completion of this document.

It would be invidious to single out individuals. We would to take this opportunity to convey our sincere thanks to every department in our Council that has contributed towards the development of the document. We thank them for the time and efforts to make this document complete. Many thanks go to the members of the Council Health Management Team for the time in writing and refining the document. Many other thanks go to co-opted members of the CHMT for the valuable contribution towards the document. Representatives from private health service providers, faith based service providers, NGOs, community development department, district Hospital and other stakeholders

Many thanks go to the Ministry of Health and Social Welfare for their constant direction and support during orientation and throughout the development of the document

Lastly but not the least our appreciations go to the Department of Computer Science of the University of Dar es Salaam for their technical assistance in generating data through the DHIS software.

III. EXECUTIVE SUMMARY

The objective of this document is to provide snapshot of the monitoring and evaluation activities which are leading every day goals of making the vision and mission of the Bagamoyo District Council on delivering health care to its people for the year 2012.

The tool were designed by Ministry of Health and Social were fare (MOH&SW) IN Collaboration with other partner aimed at district council being able to have the quick information that can be used for development purposes and for giving feedback to lower facilities and community at large.

The document includes,Health status of the district population. District Health Services Delivery, District Health System and Progress in Health Sectors. The detailed information in the document tells how various indicators were performed in health care provision to the community. The document also provides the opportunity to the district to incorporate specific indicators that have been performed in the district.

Mainly the increase of diseases burden have been addressed. Challenges of the need of increase of Health facilities including Dispensary to each villages and Health centre to each ward need to be tackled in collaboration with different stakeholders. Human resources per facilities and staffs motives including houses, water and electricity will be addressed in feature. Health financing need to be increased through district innovations largely by involving native communities.

The success and challenges in the DHP will be discussed in various intra and outer meetings and it is our believe that the discussions will come with tangible solutions of minimizing addressed challenges. We expect to use the DHP to provide feedback to the lower facilities were the data and information have been generated.

Lastly , believe that, Every one reading this document will come forward for inputs of strategies we might use in making health service delivery and care a success. Be assured that the Council is dedicated to perform in providing services to the all Wananchi in Bagamoyo.

We thank you and Well come to Bagamoyo.

IV. ACRONYMS AND KEY TERMS

Table 0-1. ACRONYMS

ACRONYM	LONG NAME
DHP	District Health Profile
MOHSW	Ministry of Health and Social Welfare
MTHUA	Mfumo wa Takwimu wa Uendeshaji wa Hudumaza Afya
P4P	Payment for Performance
AMO	Assistant Medical Officer
CCHP	Comprehensive council Health Plan
CHF	Community Health Fund
CHMT	Council Health Management Team
PMTCT	Prevention Mother to Child Transmission
MMAM	Mpango wa Maendeleo wa Afya ya Msingi
LGCDG	Local Government Capital Development Grant
HMT	Hospital Management Team

AIDS	Acquired Immunity Defficincy Syndrome
AMO	Assistant Medical Officer
ANC	Antenatal Clinic
BCG	Bacillus Calmet Guelen
CO	Clinical Office
CYP	Couple Year Protection
DAWASCO	Dar es Salaam Water andSewarage Company
DHIS2	District Health Information System version 2
DC	District Council
DHP	District Health Profile
DNO	District Nurse Officer
DNUtriO	District Nutrition Officer
EHO	Environmental Health Officer
EHP	Essential Health Package
EmoC	Emmergency Obstetric Care
FBO	Faith Based Organisation
HC	Health Centre
HIV	Human Immunodeficiency Virus
HO	Health Officer
IPD	In Patient Department
IPT 2	Intermitent Presamptive Treatment dose 2
ITN	Insecticide Treated Nets
KDC	Kibaha District Council
KMC	Kangaroo Mother Care
LGA	Local Government Authority
MMAM	Mpango wa Maendeleo wa Afya ya Msingi

MOHSW	**Ministry of Health and Social Welfare**
MO	**Medical Officer**
MRDT	**Malaria Rapid Diagnosis Test**
NACTE	**National Authority…….Training …..**
NIMR	**National Institute for Medical Research**
NO	**Nursing Officer**
OPD	**Out patient Department**
OPV	**Oral Polio Vaccine**
P4P	**Pay for performance**
PMTCT	**Prevention of Mother to Child Transimission**
RCH	**Reproductive a nd Child Health**
TB	**Tuberculosis**
UDSM	**Univesity of Dar es salaam**

Table 0-2. KEY TERMS

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

1 INTRODUCTION

1.1 MISSION AND VISION

Bagamoyo District council is committed of making the whole population has access to quality health care services.

The Mission is to ensure that trained health providers are employed, more new health facilities are opened in rural areas and sufficient medicines and medical supplies are in place.

1.2 STRUCTURE OF DISTRICT

Bagamoyo District Council was established in August 1962 and is one of the 7 Local Government Authorities (LGAs) of Pwani Region. It is situated in the Eastern part of Pwani. It has an area of 9,842 sq km. whereas 8,987 sq km (91.3%) is a dry land area and 855 sq km is watered land. The district lies between 30^0-39^0Latitude South and 6^0 - 7^0 Longitude East.

Bagamoyo District Council is divided into 6 divisions. It has 22 Wards and 97 Villages. It has a population of 289,852 people (Male 144,556 and Female 145,296) according to National bureau of statistics projections 2002. The headquarters of the District is in Bagamoyo town.

Table 1-1. Wards And Villages

S/N	WARD NAMES	NUMBER OF VILLAGES	S/N	WARD NAMES	NUMBER OF VILLAGES
1	Dunda		**12**	Ubenazomozi	5
2	Magomeni		**13**	Mbwewe	4
3	Kiwangwa	5	**14**	Kibindu	3
4	Msata	5	**15**	Bwilingu	7
5	Miono	5	**16**	Fukayosi	4
6	Mkange	5	**78**	Kerege	4
7	Kiromo	4	**18**	Kimange	6
8	Zinga	4	**19**	Mandera	6
9	Yombo	4	**20**	Msoga	4
10	Vigwaza	7	**21**	Pera	4
11	Talawanda	5	**22**	Lugoba	6

Source: District Database

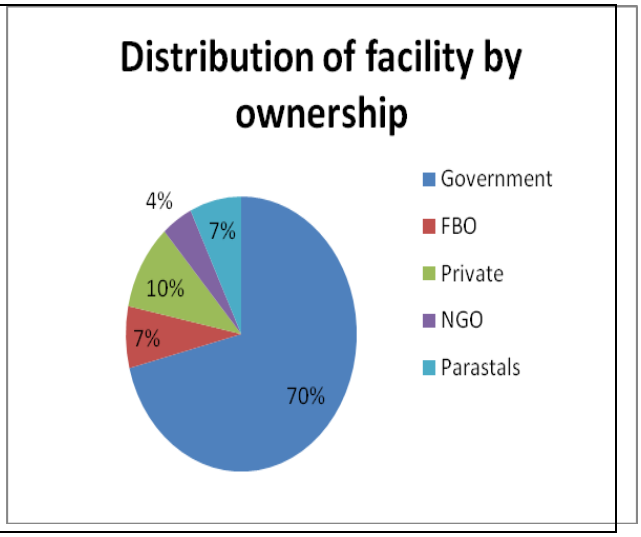
Dunda na Magomeni wards falls in Bagamoyo Townships and hamlets lower administrative level. A hamlet is a sub village so to say and is known in Swahili as Kitongoji. It has a total of 38 hamlets.

1.3 FACILITY DISTRIBUTION

Bagamoyo District Council has one District Hospital, four Government Health Centers and one Missionary Health Centre. The District also has 59 Dispensaries and 4 clinics. The following table below shows the distribution of these facilities:-

Table 1-2. Facility Distribution.

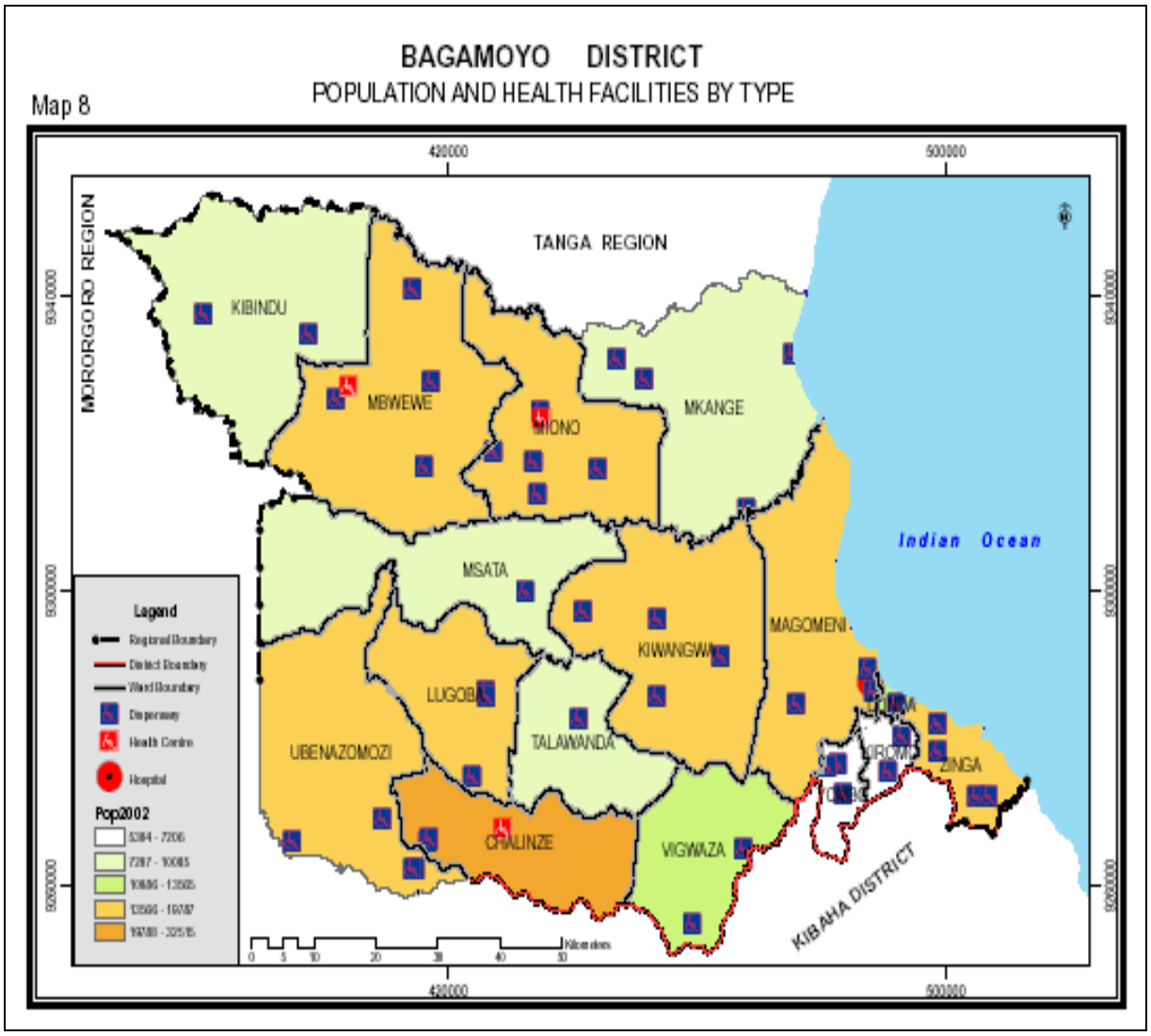
Type of facility	Number	Ownershership
Hospital	1	Government
Health Center	4	Government
	1	FBO
Dispensry	44	Government
	6	Private
	4	FBO
	5	Parastals
Clinics	1	Private
	1	NGO



Source: District Database

The large part of the district is served by government run health facilities. Most of private health facilities are found in Bagamoyo town. There are very few private health facilities in the rural areas.

FIGURE 1-1.Bagamoyo District Map



1.4 POPULATION

Bagamoyo District Council has a population of 289,852 people (Male 144,556 and Female 145,296) according to National bureau of statistics projections 2002. The population distribution is summarized in the table below

Table 1-3. Gender And Age Based Statistics

AGE RANGE	FEMALE	MALE
<1 YEAR	4,861	4,966
1-4	17,918	17,867
5-14	34,404	34,742
15-49	71,549	
>50	15,380	16,226
TOTAL	144,112	73,821

***Source**: NBS District Projection basing on 2002 census*

1.5 GEOGRAPHY

Nature, Climate and Season

The district has 2 ecological zones namely: the coastal strip which is mainly savannah, bushy and the upper country which is covered with dense forest.

The Coastal strip receives relatively more precipitation than the upcountry part. Rainfall ranges between 800 – 1200mm per annum and temperature ranges between 13^0 C to 30^0C. The short rain seasons is between July to October and the long rain seasons is February, March to June.

Agro – Economic Zones: The district has 1,607,620 Hectors of arable land, of which only 250,000 hector are used for agricultural activities, which is 16% of potential agricultural arable land.

There are two main/major agro-economic zones:
The Coastal strip (lowland); It is characterized by sandy loamy soil where maize rice, bananas and cane crops are grown.
The upcountry land; is characterized by red soils where maize, cotton and sorghum crops are grown. The population of cattle is 60,000, goats 10,028, and 2,486 sheep according to the 1984 census.

1.6 TRANSPORTATION AND COMMUNICATION

Transport and communication:

Roads, Road Conditions

Roads are the most important means of transportation within and outside the Locality. The District has a good road network of about 1,012.3 km that gives easy access within and outside Bagamoyo. The main tarmac highway covers neighboring Districts and Regions of Kibaha, Kinondoni, Tanga, Morogoro with a total of 204.2 Km. However, there are other Gravel and Earth road networks totaling to 808.1 km .The Msata Bagamoyo road which is under construction will improve referral system from Mbwewe and Miono division to Bagamoyo Hospital. Generally the road net work is good in Bagamoyo facilities except Matipwili, Kidogozero and milo Dispensary. We expect road improvement will facilitate referral system from dispensaries to tertiary level and hence will reduce disease complications and deaths especially Maternal ,infants and under five.

Electricity.

The source of power within the district is TANESCO and solar energy which are used by individual households or institution. Out of 65 facilities only 22 HF are connected with TANESCO electricity .More than 14 facilities are connected with solar power and the remainder have no electricity. The central government is installing electricity posts to Msata –Makurunge Road which covers 6 dispensaries of which will make access of power to health facilities. Some dispensaries are in progress to be connected to electricity .Community are being involved in installing electricity using village funds of which showed success, This includes Kiromo,Zinga ,Kerege and Mapinga where the village government has installed electricity using their own fund.

1.7 EDUCATION

General Overview

The main categories of education in the District are Pre-Primary, Primary, Secondary, Vocational Training and Complimentary Basic Education in Tanzania (BET) classes.
In addition, the District has also 1 Nursing School under the Ministry of Health and Social Welfare (MOHSW) that provides Certificate Award for Enrolled Nurses. It is expected the increase of education premises will improve community knowledge towards health services. The availability of nursing school within the district will provide opportunity for staffs to be employed in more remote facilities within the district. However, that has posed the need of expansion of health services including more health facilities and services such as awareness and improving HIV/ AIDS testing kits.

Primary Education
Currently, Bagamoyo District has 131 registered Primary Schools of which 128 are owned by the Government and 3 by Private Sector.

Secondary Education
There are 31 Secondary Schools of which, 19 are owned by the Government and 12 by individuals or religious organizations.

There are also other institutions; Agency for the Development of Education Management (ADEM), Bagamoyo College of Art, Mbegani Fisheries, School of Library Archives and Documentation Studies (SLADS), Bagamoyo Tourism Management College and Chalinze Teaching College (CTC).

Vocational Training

There are 5 Vocational Training Centers, 3 Special Education Centers and 99 Adult Education Centers. Also, there are 4 Teachers' Resource Centers (TRCs) in Magomeni, Chalinze, Miono and Msata Wards.

1.8 Water Supply

The main source of water for Bagamoyo District residents belong to Dar Es Salaam Water and Sewerage Company (DAWASCO).The district get a water supply from Lower Ruvu ,Upper Ruvu and Wami sources. Currently 89 out of 97 villages are in program to be supplied with piped water from those sources. The remaining 8 are receiving water from piped and water bore hole. This will improve the community health and reduce health related diseases .We expect by 2013 the 90% of villages will be connected with clean and safe water. The CHMT will sensitize community through villages fund and involving stakeholders in the village to connect water to health facilities within their villages ,However ,CCHP 2012/13 has addressed paying water bills and water connection to some facilities.

2 A COLLECTION METHODS AND SOURCES OF DATA

2.1 DATA SOURCES AND THEIR DATA COLLECTION AND ANALYSIS METHODS

Data are collection from 65 Health Facilities have been improving since introduction of P4P in the data collection in terms of completeness and timeliness has increased from 36% in 2011 to 95% in the end of 2012.The CHMT since 2011 is collecting data from every facility from 4th of every months instead of Facility in charges to bring data to DMO office due to difficulties they face to submit timely and correctly .The practice showed the rise data timeliness from 36% in 2011 to 95% by the end of 2012 also it has improved data quality . The data collection tools were received from ministry of Health and Social Welfare (MOH & SW) and distributed to all Health Facilities. Data quality is still a challenge in some facilities ,this issues have been tackled by CHMT team do conduct data and information on every 13th of every months and giving feedback to lower facilities also mentoring is conducted to poor performing facilities. The Data collected through the HMIS are entered into the DHIS 2 Software which is online. The DHIS 2 software is used as a data warehouse and as analysis tool. The data collected is used to prepare various reports such as CCHP, DHP and is also used in preparation of various interventions and plans.

2.2 MANDATORY HEATH INDICATORS

MANDATORY DHP HEALTH INDICATORS

HEALTH STATUS OF THE DISTRICT POPULATION

Maternal, Newborn and Child Health

- Nutritional Status
- Neonatal, infant, and under 5 mortality rates

Diseases

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

DISTRICT HEALTH 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

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

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

PROGRESS IN THE HEALTH SECTOR

Progress in district health financing

- Overall Health Financing
- Expansions in Health spending

Progress in district health services

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

Progress in district neonatal health

- Low birth weight

Progress in district health facility coverage

- Expansions in facility coverage across districts

Progress in district health facility performance

- Expansions in critical health services
- Improvements in referral hospital performance
- Progress in ANC Attendance
- Progress in health facility reporting rates

- Timeliness and completeness of data

Progress in district health services

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

Progress against milestones from previous year

- Progress against milestones set by the technical review of the joint annual
- health service sector review from previous year

2.3 HEALTH INDICATORS IMPORTANT TO BAGAMOYO DISTRICT

Bagamoyo District Council has health indicator that are uniquely important. These include the following:-

Bagamoyo District council has been under a pilot project study since last year. The project is known as Pay for Performance (P4P). The project is carried out in Pwani region. The project has helped us to have a drastic increase in the post natal attendances in the health facilities.

Another important indicator that is unique to Bagamoyo is the tracking of health personnel who have attended certain in service training through train SMART database . It is again a pilot project that is conducted in Bagamoyo Council since 2011.It records the in-service trainings conducted in the district in details.

Table 2-2. Specific DHP Indicators for Bagamoyo District

***BAGAMAOYO* DISTRICT SPECIFIC INDICATORS**
1. Progress on P4P scheme
2. In service trainings conducted to health personnel

2.4 KEY MESSAGES ABOUT HEALTH INDICATORS

For the past 12 months the district attained immunization coverage of 119% compared to 96% of 2012, this was above the National immunization Coverage which is 90%. However, there are several health facilities that did not reach the target including Talawanda ,Pongwekiona,and Ubena Estate dispensary. And this means that we need to conduct extra outreach services to help the facilities. There are also other localities Including Kitame ,Mkoko and Gongo of which are hard to reach dispensaries ,To tackle that the CCHP outreach programs and we expect to open the dispensaries the dispensaries in that had to reach areas.

Under five mortality rate have decreased from 0.6 /1000 in 2010 to 0.4/1000 in 2011 however malaria continued to be a leading cause of mortality among under five.

Maternal deaths continue to be a challenge due to slight decreased from 15 deaths in 2011 to 11 deaths in 2012 and more than half were from Miono Division ,this was due to the delay of attending to the health facilities from the traditional birth attendants. Community sensitization were addressed in CCHP 2012/13 in order to rise community awareness on early facility attendance.

The overall indicator has increased since the introduction of P4P in Bagamoyo district. The Health workers attitude toward delivering health facilities has also changed hence contributing in indicators rise.

Postnatal attendance has increased dramatically from 8 % in 2011 to 44% in 2012 . The reason behind such an increase is the introduction of P4P project in the district and introduction of data collection tools which were limited in programs.

Facility delivery have been improving district wise and per facilities. The Facility delivery increased from 72% in 2011 to 91.2% in 2012 compared to 44 % of the National target. Likewise ,the facility which had 0 rate deliveries including Msinune ,Masuguru,Pongwekiona and Kwamduma has increased facility delivery to more than 60% .

The Antenatal attendance increased from 87% in 2011 to 123.5% in 2012 .Also the women attending average of 4 visit is increasing to 34% in the end of 2012.Women receiving second dose of IPT has increased from 53%in 2011 to 84.5% in 2012 ,This was contributed to management ensuring proper ordering of sp from medical store department timely and facility themselves buying SP through P4P Facility fund.

There has been poor reporting on neo natal deaths in the district of which through HIMS only 143 deaths in all district were reported against 96 deaths in only Mbwewe ward through SAVVY pilot. Most of health facilities did not report on neonatal deaths. It is not that there are no neonatal deaths in the community but this is due to poor reporting mechanisms in the community and especially in the rural areas.

2.5 .IN SERVICES TRAINING CONDUCTED TO HEALTH PERSONAL

The district is using the database known as TrainSMART Database developed by ITECH Tanzania in collaboration with Ministry of Health and Social work. It helps to trace human resource in-service training conducted in various site in Tanzania that involved the district staffs. The system managed to solve long time challenges including repletion of training and trainees in various causes, improper allocation of resources and proper planning of human resources in-service training.

Table 2-3: Summary of in-service trainings Involved District staffs in 2012.

Participants	Unique Participants	Category	Qualification (primary)	Gender
1	1		Dentist	male
53	41		Other	female
42	28		Nurse	female
1	1		Dentist	female
43	30		Clinical	female
1	1		Laboratory	male
17	16		Other	male
3	3		Nurse	male
1	1		Social Work	male
60	41		Clinical	male
2	2	N/A - Not an HIV/AIDS Training	Nurse	male
1	1	N/A - Not an HIV/AIDS Training	Social Work	male
29	29	N/A - Not an HIV/AIDS Training	Clinical	male
2	1	N/A - Not an HIV/AIDS Training	Dentist	male
33	32	N/A - Not an HIV/AIDS Training	Other	female
30	28	N/A - Not an HIV/AIDS Training	Nurse	female
1	1	N/A - Not an HIV/AIDS Training	Pharmacy	male
20	20	N/A - Not an HIV/AIDS Training	Clinical	female
7	6	N/A - Not an HIV/AIDS Training	Other	male

9	9	unknown	Clinical	male
9	9	unknown	Other	female
4	4	unknown	Nurse	female
6	6	unknown	Clinical	female

Source: Train SMART database 2012.ssss

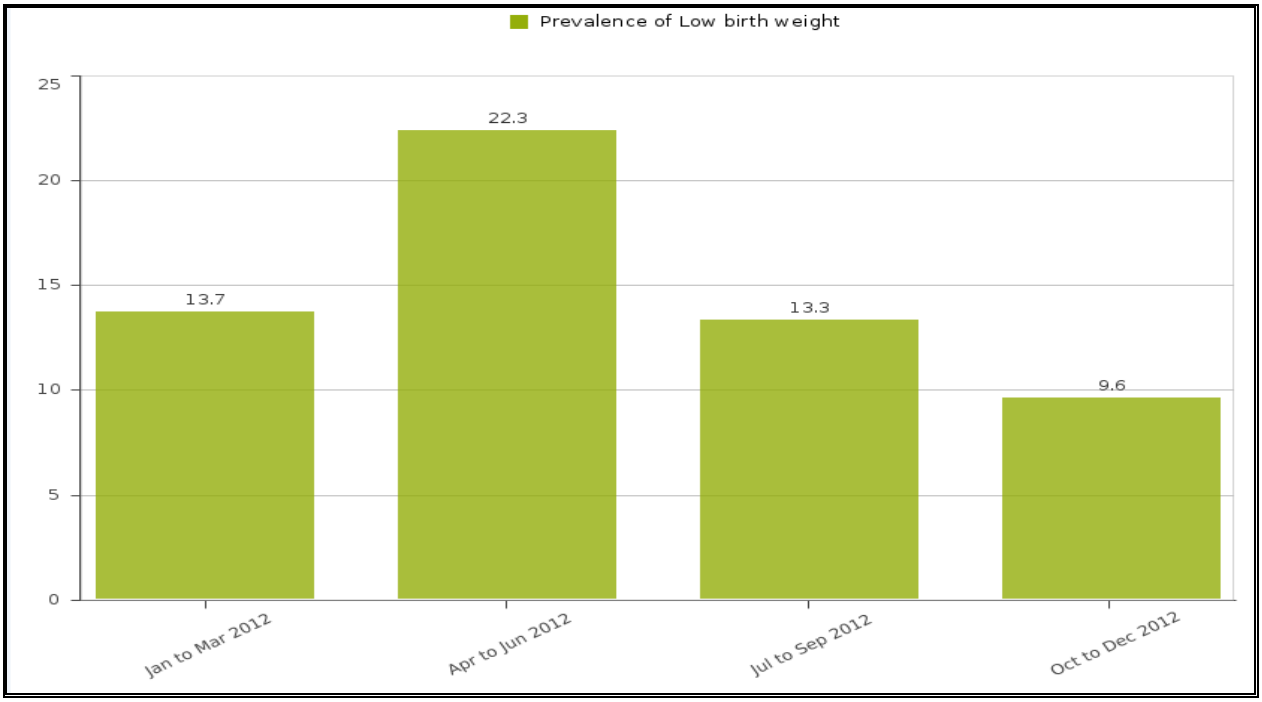
3 HEALTH STATUS OF THE DISTRICT POPULATION

3.1 MATERNAL, NEWBORN AND CHILD HEALTH

Nutritional Status

The nutritional reflects the level and pace of household, community, and national development. Malnutrition is a direct result of insufficient food intake or repeated infectious diseases or a combination of both. It can result in increased risk of illness and death and can also result in a lower level of cognitive development. From the figure 3-1 it shows the prevalence of low birth weight was high (22.3) in the second quarter but has decreased to 9.6 in the fourth quarter during the year 2012 .The rise and fall of the nutrition status thought to be because food scarcity in the district during the first quarter and third to forth quarter where by the central government intervened to distribute only maize for most staving families. It believed most families were starving and hence children received inadequate nutrition.

Figure 3-1. Nutritional Status: Low Birth Weight



Neonatal, Infant and Under Five Mortality Rate

Neonatal mortality measures the probability of dying in the first month of life, while Infant mortality is the probability of dying before the first birthday and Under-five mortality provide probability of dying before the fifth birthday. These indicators reflect a country's level of socio-economic development and quality of life. Analyzing these three indicators it can potentially predict the overall performance of the health sector. The rise or decline of these indicators is attributed to various social economic factors. Under five mortality rate has dropped from 0.6/1000 in 2010 to 0.4/1000 in 2011. This implies that maternal, infant and under 5 mortality are still primary health problems in the district and require a special interventional measures.

Neonatal deaths have decreased by 28.9 in 2011 compared to 2010 with Case Fatality Rate of 59.67.

Figure 3-2. Bagamoyo District Council, Neonatal Mortality Rates

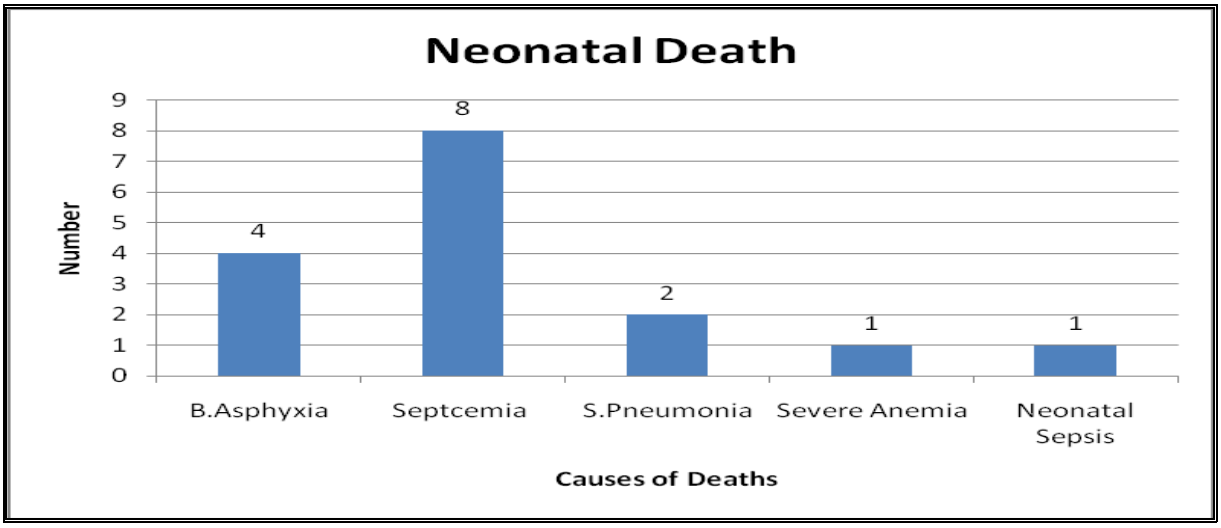


Figure 3-3.Bagamoyo District Council, Infant Mortality Rate 2012

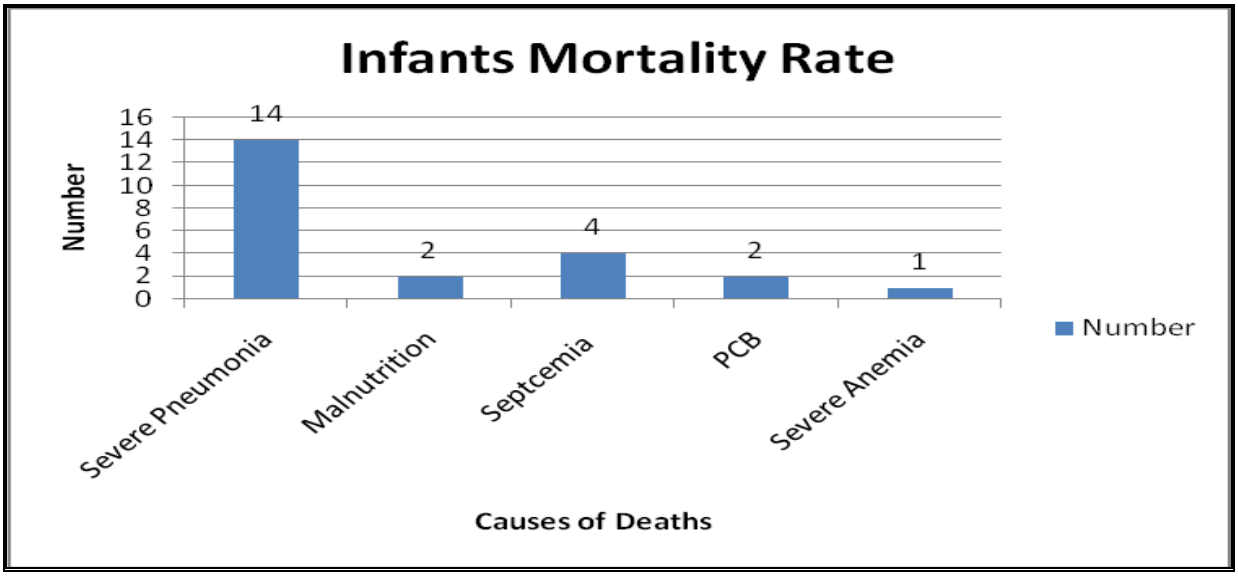
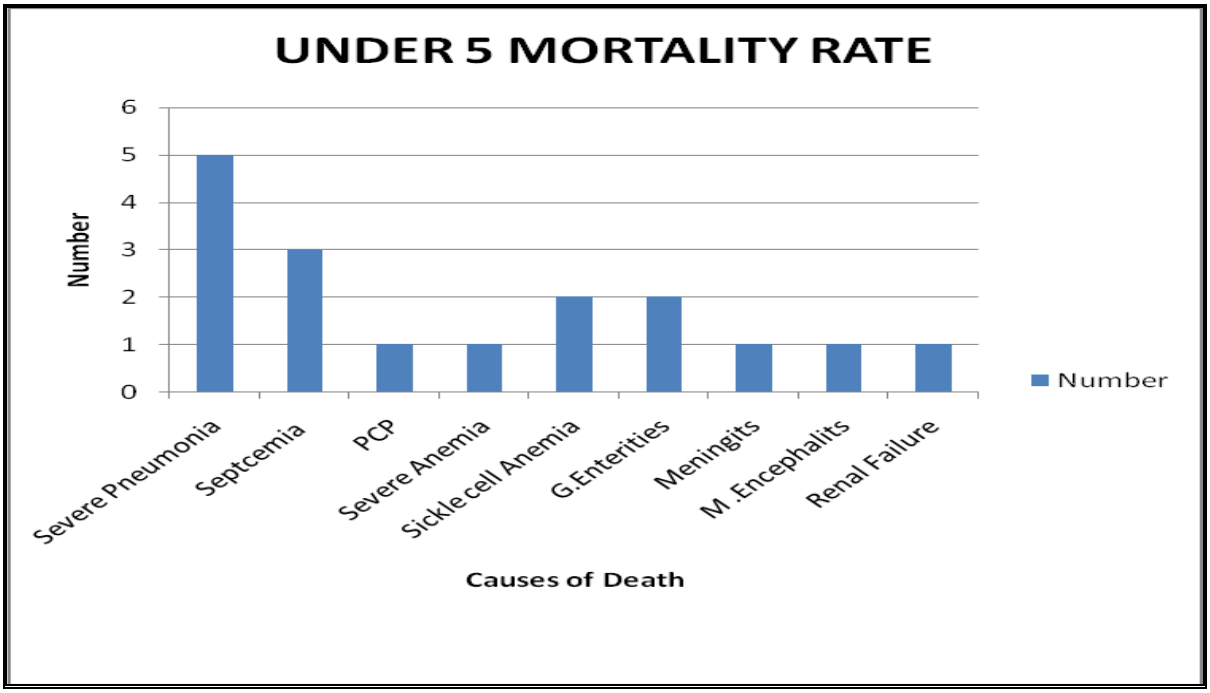


Figure 3-4.Bagamoyo District Council, Under 5 Mortality Rate 2012



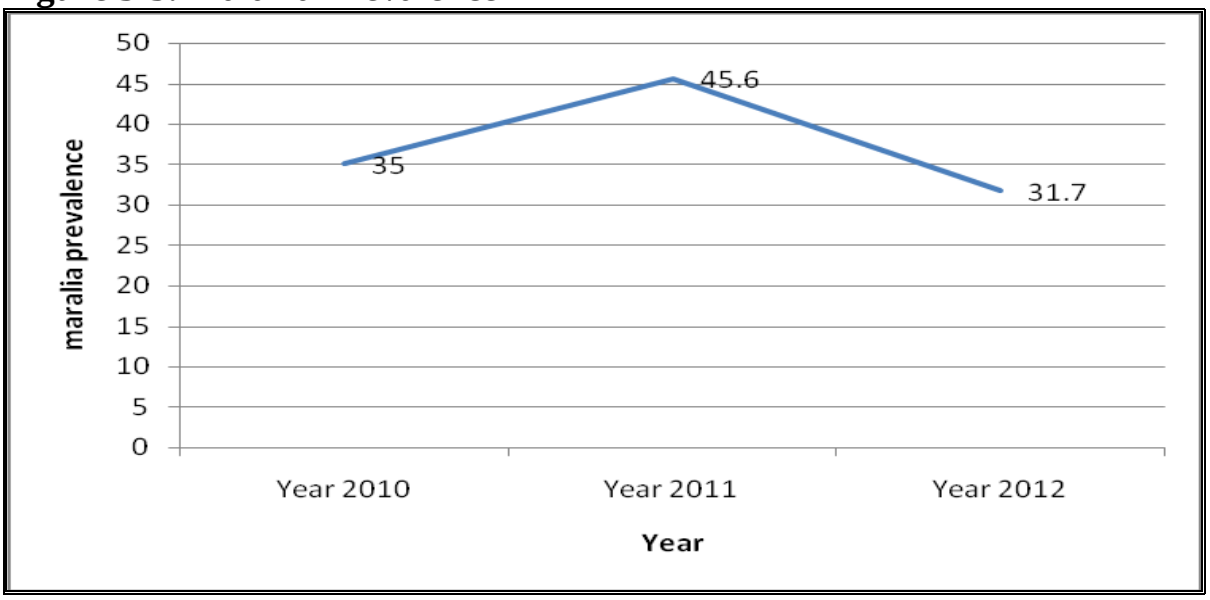
3.2 MORBIDITY

3.2.1. Maralia.

Malaria is a leading disease among all OPD diagnoses for both under 5 and above 5 years.

When compared to previous years, proportion of morbidity due to malaria cases had increased from 35%% (2010) to 45.56 % (2011) but the prevalence decreased in 2012 to 31.7% among Outpatients. This might be because of mass distribution of mosquito nets in early 2012 and availability of Malaria Rapid Testing Kits (MRDT) which has reduced numbers of unconfirmed malaria. The district will strengthen availability of MRDT and sensitize community on proper use of mosquito nets as shown in figure 3-3.

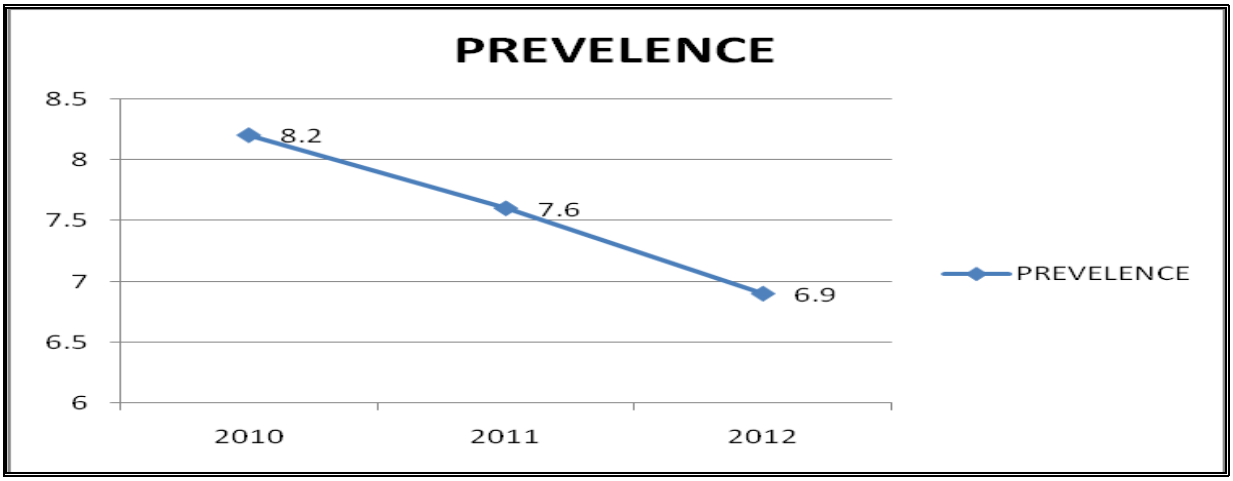
Figure 3-5. Malaria Prevalence



3.3.2 .HIV Prevalence

The HIV prevalence in the district shows decrease in three consecutive years .The decrease might be because of different intervention taking place including Strengthening of PMTCT services by expanding centers and enrolment, Also increasing of testing centers from 46 in 2012 to 57 in 2012 and improving Provider Initiatives cancelling and testing (PITC) .Also Care and treatment Centers Increased from 5 in 2010 to 8 in 2012

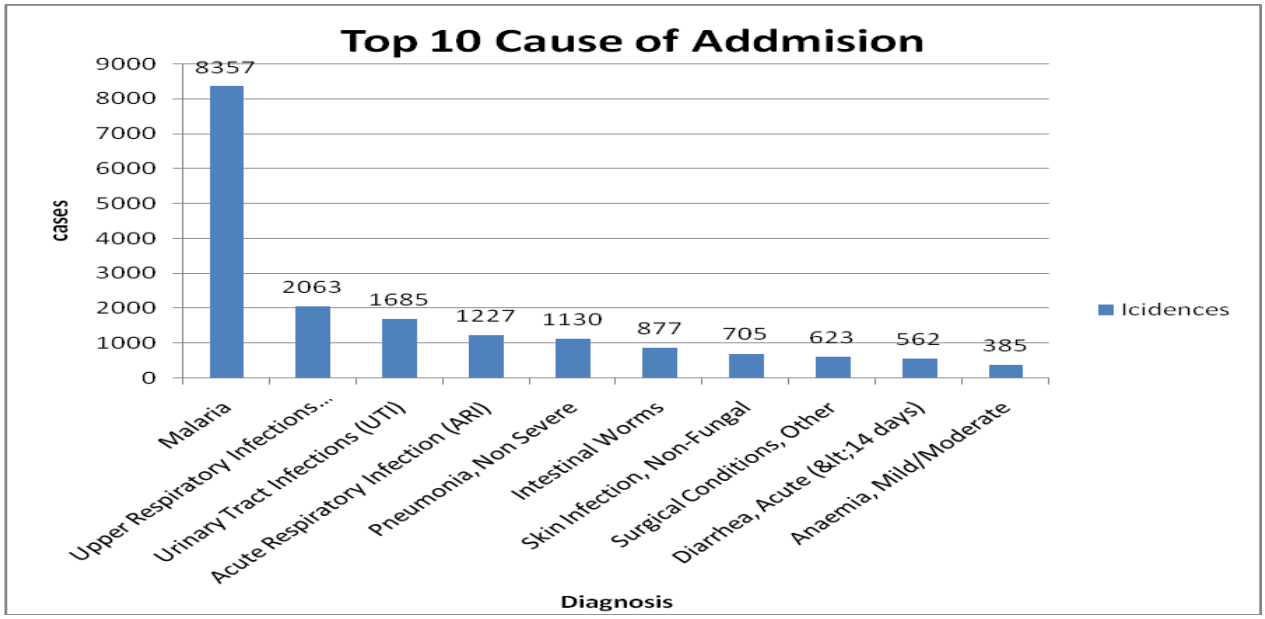
Figure 3-6. HIV/AIDS Prevalence



Source: DHIS**, 2012.**

Malaria has remained the top cause of admission followed by Upper Respiratory Infections. However, the admission due to malaria has been decreasing comparing to 2012.

Figure 3-7.Top 10 Causes of Admission

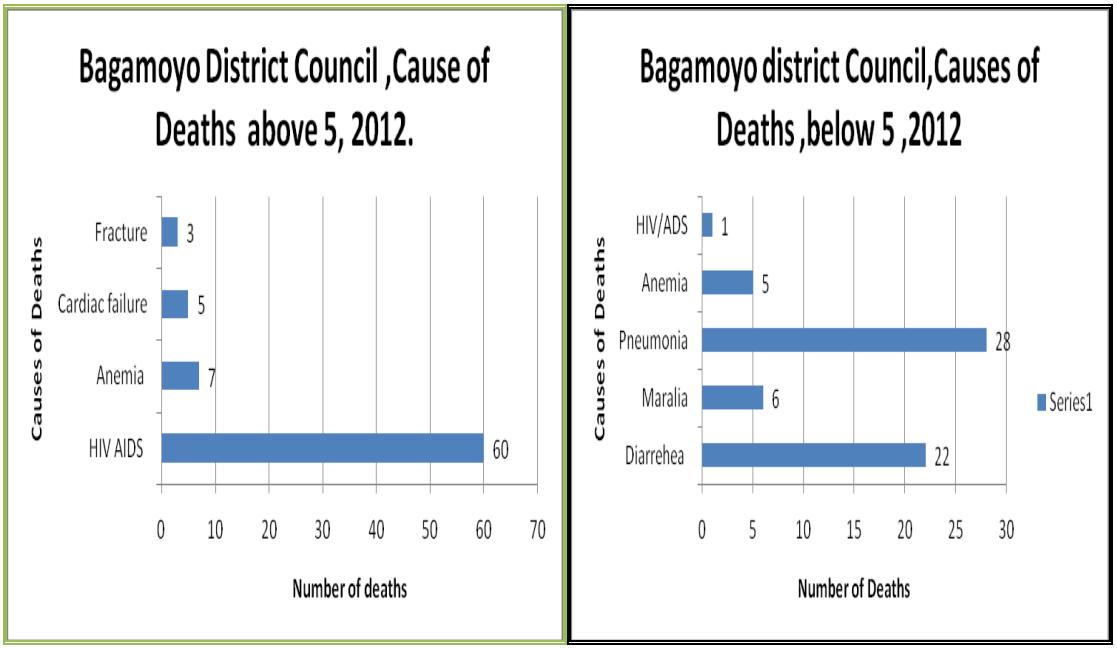


Source: DHIS, 2012

3.3 MORTALITY.

Deaths due to HIV /AIDS has led the cause of death among above 5 years followed by Anemia which contributed to maternal deaths due to delay of pregnant women to reach to HF, cardiac failure also contributed to several deaths among adults. NCD, s has shown shocking increase in recent years and it has a high fatality rate among admission. The increase of NCD,s is coming high year after year. Has set a strategies to create awareness on how to control NCD,s since they are causing sufferance to individuals ,families and it is costly to manage. Likewise, Pneumonia and diarrhea has a leading effect of deaths among under fives as shown in figure 3.6 and 3.7 respectively.

Figure: 3.8. Causes of Deaths above 5 **Figure: 3.9. Causes of Deaths, under 5**



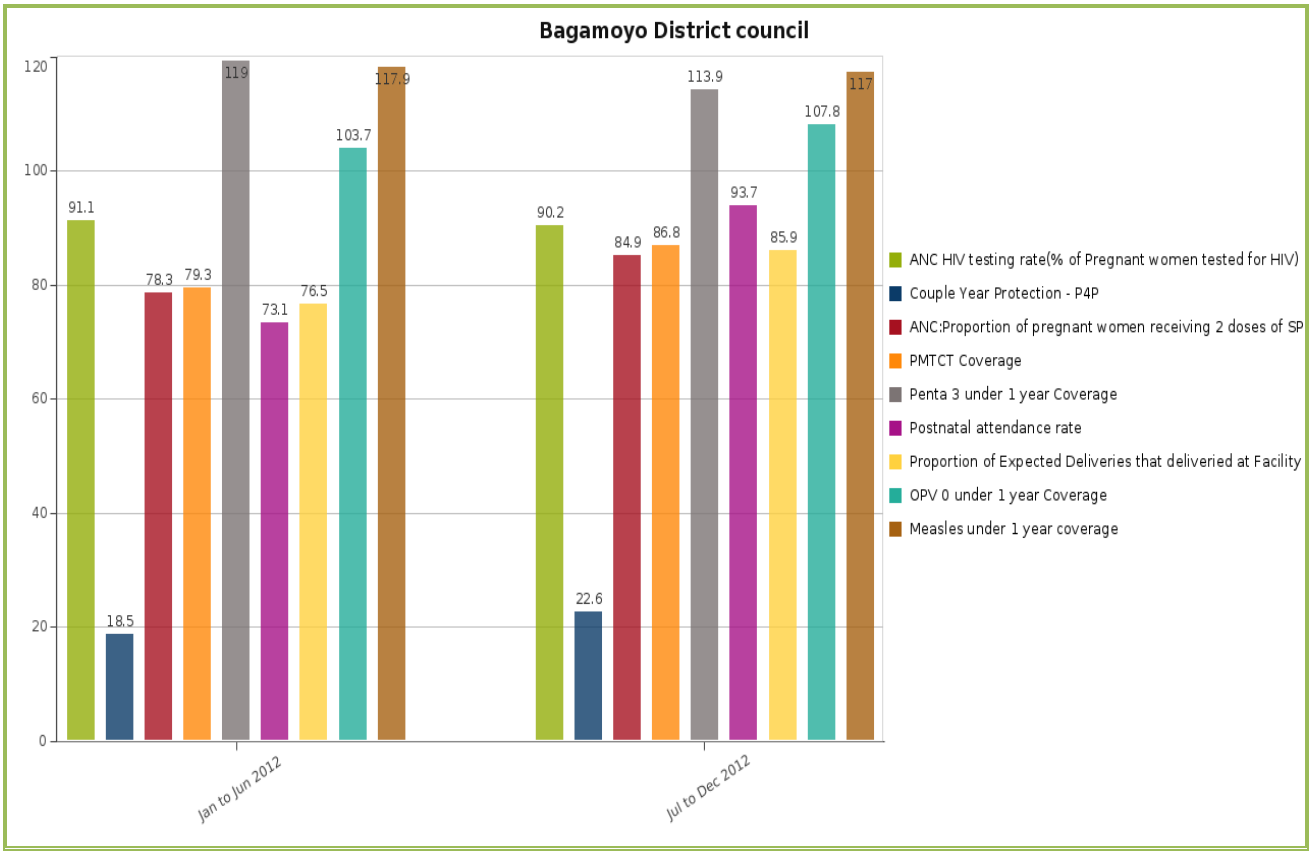
Source: DHIS, 2012

3.3. OPTIONAL HEALTH STATUS OF THE DISTRICT POPULATION INDICATORS

Progress in implementing P4P Scheme

All indicators have shown improvement as indicated in figure 3.10.

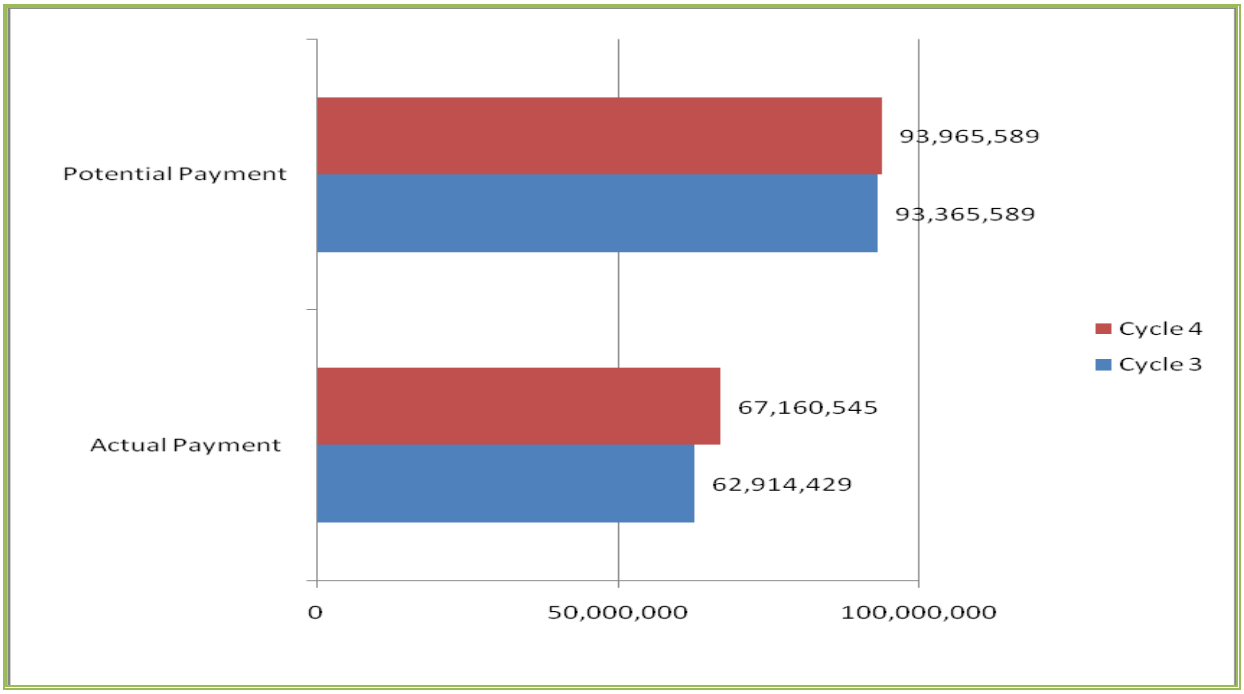
Figure 3.10. P4P Indicators



SOURCE: DHIS, 2012

The Actual payments have increased from 70 % in cycle 3 to 71 % in cycle 4.The slight increase were because of poor performance in Auditing and pantograph form filling. The district formulated strategies to ensure high performance in next cycle and hence high achievement in payment.

Figure 3.11. P4P Achievement against Potential Payment Cycle 3 and 4.



Source: DHIS 2012

3.3 DISTRICT HEALTH STATUS CONCLUSIONS, RECOMMENDATIONS AND WAY FORWARD

Low income of the household contributes to poor health status of the community. The Nutrition status of children depends on the economic status of their families. More campaign needs to be put in place to reduce malaria which is a first cause of admission and death in Bagamoyo District. Also more efforts need to be put in place to reduce the prevalence of HIV.Therefore the district should put more effort on providing education to their entire community on how they can be free from diseases and other related problems. Maternal ,infant and neonatal deaths will be addressed in CCHP 2013/14.We need to involve stakeholders including community leaders in addressing the issues and hence making reduction of the disease burden.

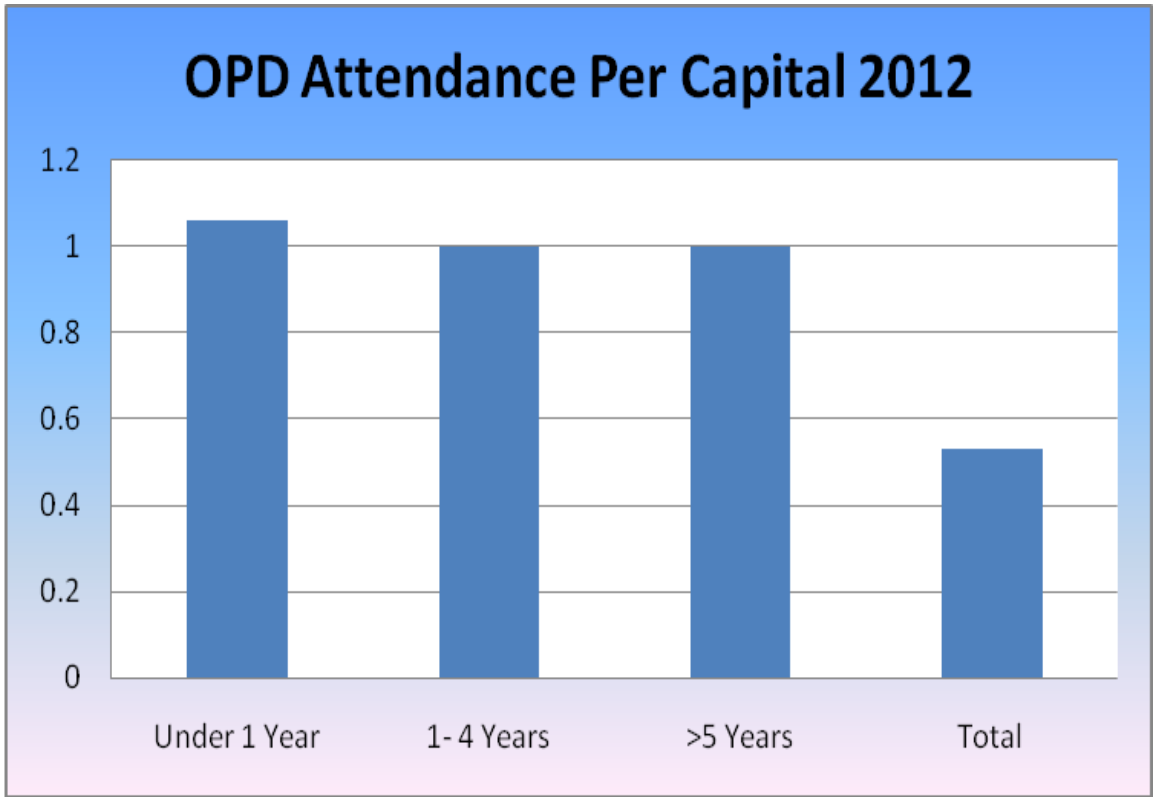
RECOMMENDATIONS/ WAY FORWARD

- Increase outreach services to areas/ health facilities where there has been poor performance
- Improve supportive supervision to the health facilities for quality services provision.
- Get other stakeholders from the communities involved in reporting of important indicators such as neonatal deaths
- Conduct quarterly meetings for updating the District Health Profiles and sharing on important indicators of the same

4 STATUS OF HEALTH SERVICE DELIVERY IN THE DISTRICT

4.1 GENERAL HEALTH SERVICE

Figure 4-1. OPD Attendance

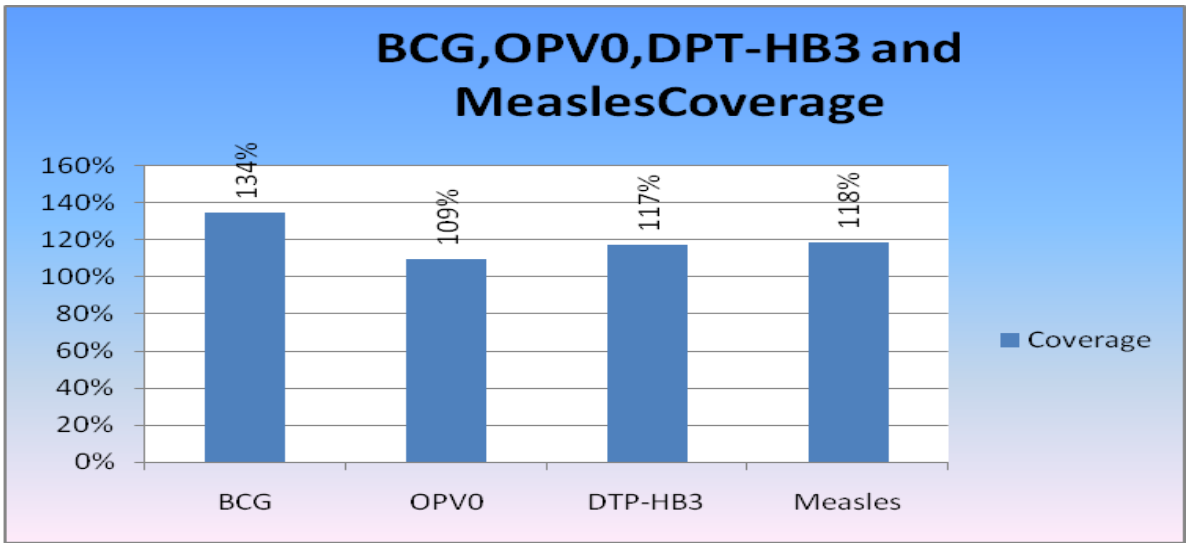


4.2 VACCINATION SERVICES

The vaccination coverage for under 1 year children is above the HSSPII 2015 target of 85% as show in Figure 4-2. For future years, the current rate should be maintained or improved further as there is room for additional improvement. The un-constant trend is because of changes of actual number of attendances every month. The sharp Increase in April and October was because of Vaccination Company conducted twice in the district which involves outreaches.

Figure 4-2.**Measles Vaccination Trends 2012**.

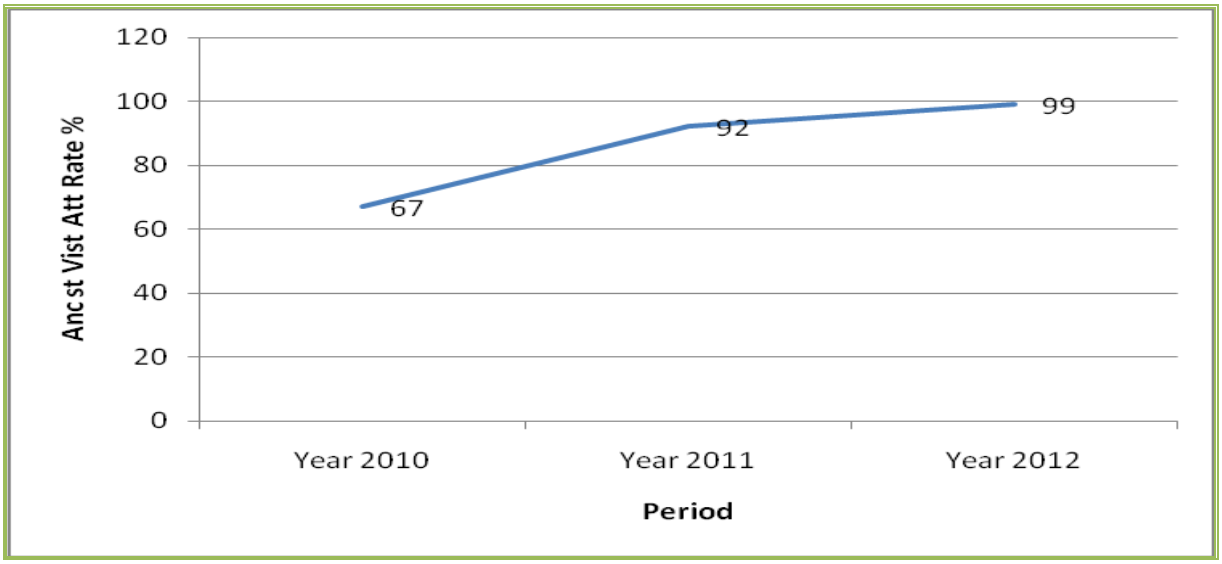
Figure 4-3. Under 1 Year Vaccinated (OPV0, BCG, and Measles)



4.3 REPRODUCTIVE HEALTH SERVICES

Figure 4-3: shows the proportion of women starting ANC before 12 or 16 weeks of gestation is increasing for three consecutive years .This is due to increase of community sensitization on early arrival to ANC clinic. Only Bagamoyo District Council provides EMOC service in the district. The district is improving Chalinze and Miono Health centers so that they will be providing EMOC services.

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


120
100
80
60
40
20
0
Anc st Vist Att Rate %
67
92
99
Year 2010
Year 2011
Year 2012
Period

4.4 INFECTION DISEASE AND NON-COMMUNICABLE DISEASE HEALTH SERVICES

Provision of first and second dose of SP increased from January to December as shown in figure 4-5 .This was due to different intervention mainly P4P opportunity in facilities providing Reproductive and Child health Services.

Distribution of ITN increased from 2010 to 2012 as shown on figure 4-6 because universal distribution done by the Ministry of Health to every households. The decrease in 2012 was because no more net distributed except people who are coming asking for nets.

As the mortality due to malaria decreased from previous year ,also malaria confirmation rate were increasing from January to December 2012.This were because of increasing of availability of malaria testing kits at lower level of service deliveries. Compared to previous year, TB notification rate decreased from 178 to 164 as indicated in figure 4-8 .

Road traffic accidents and NCD, s occurrence among out patients is among diagnosis as indicated in figure 4-9 and it demands urgent measures to take. It involves fatalities, severity and chronic situations including disabling normal body functions .Also it involves loss of economic family resources and stability. Diabetic cleaning at the district hospital will be strengthened and we are planning in feature to improve causality services at district hospital.

Figure 4-4. Proportion of Mothers who received first and second dose of Preventative Intermittent Treatment for Malaria during Pregnancy

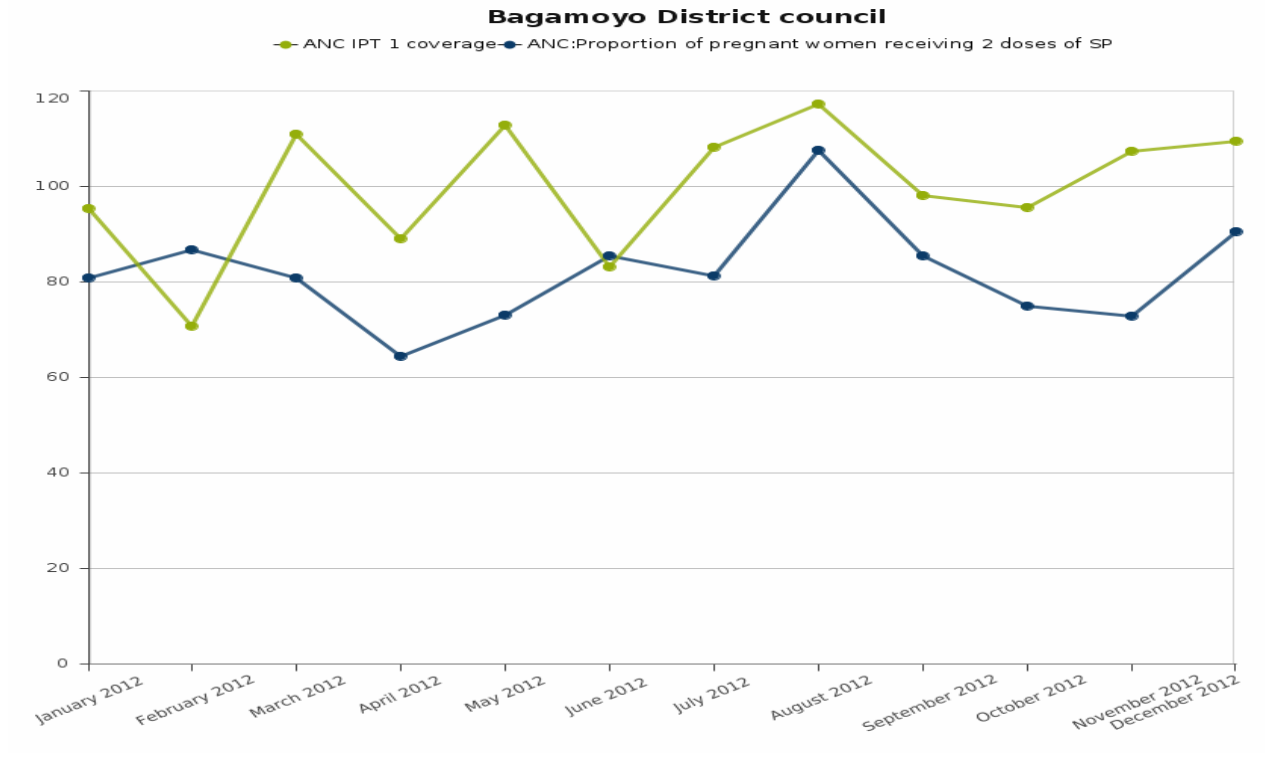


Figure 4-5. Proportion of Vulnerable Groups Sleeping under ITN the Previous Night

(Represented by Number of Net Distributed).

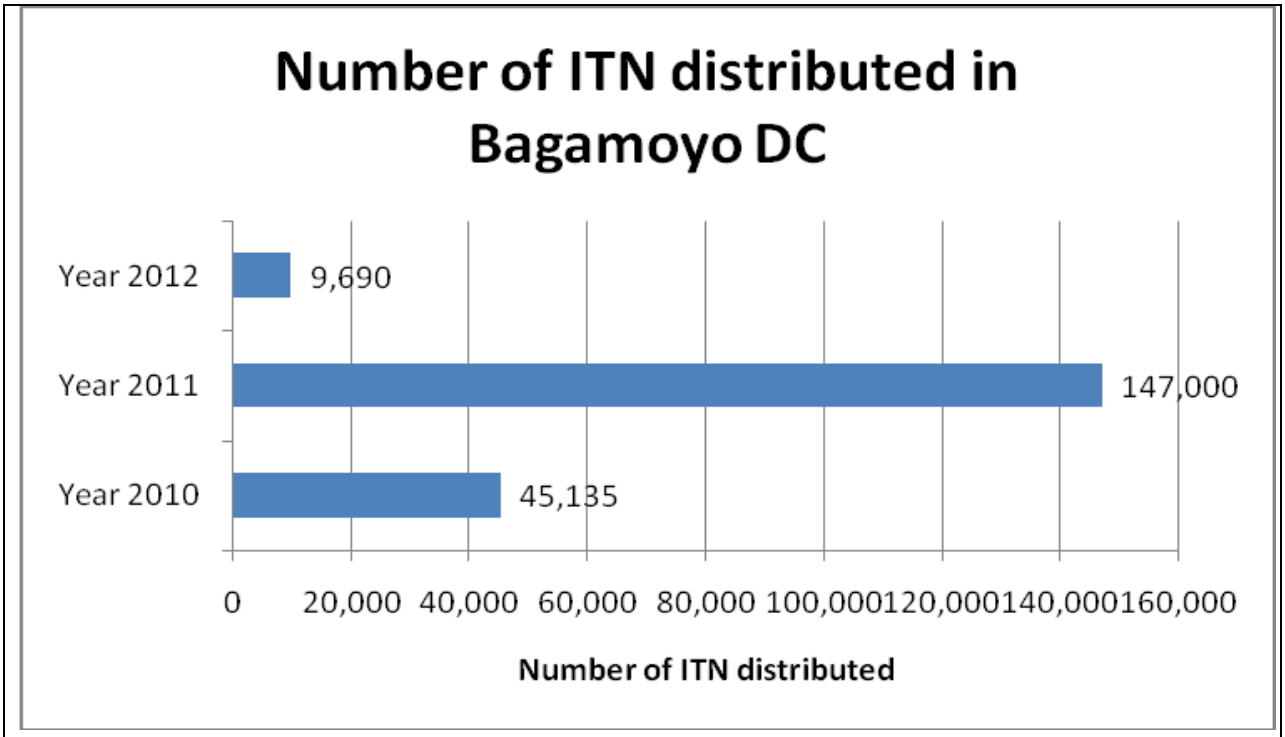


Figure 4-6. Proportion of laboratory confirmed malaria cases among all OPD visits

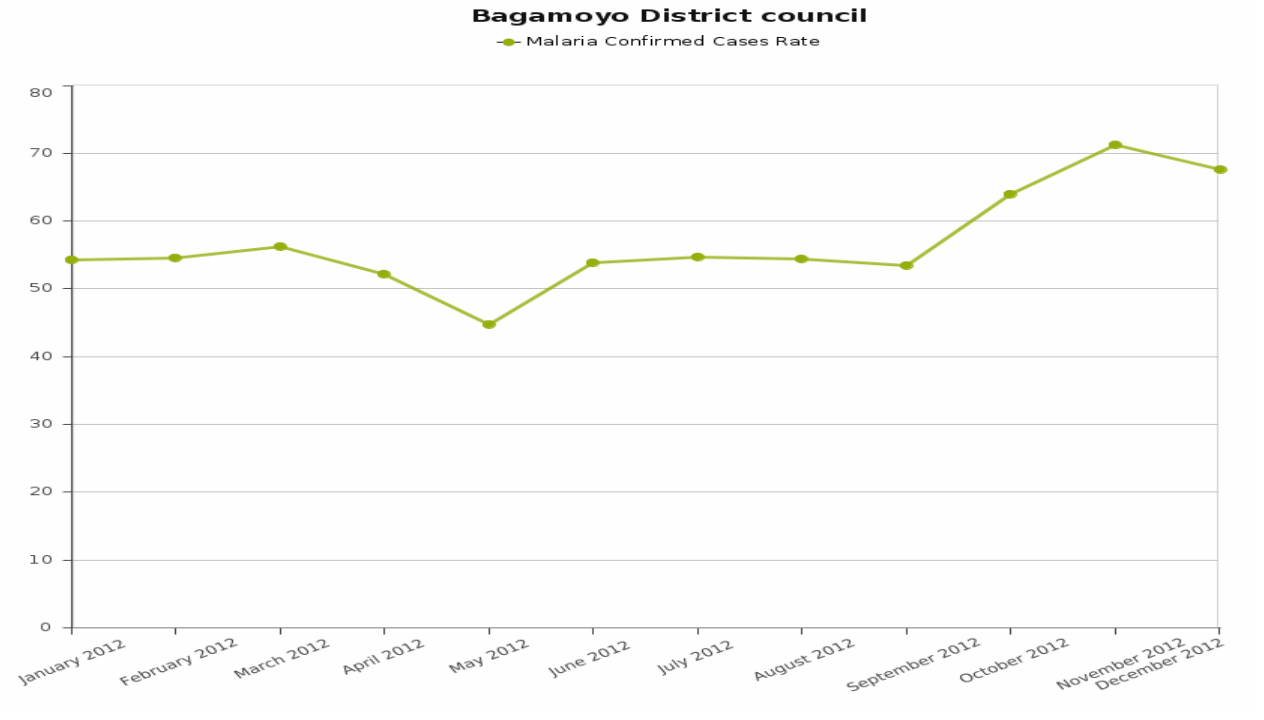


Figure 4-7. TB notification rate per 100,000 population

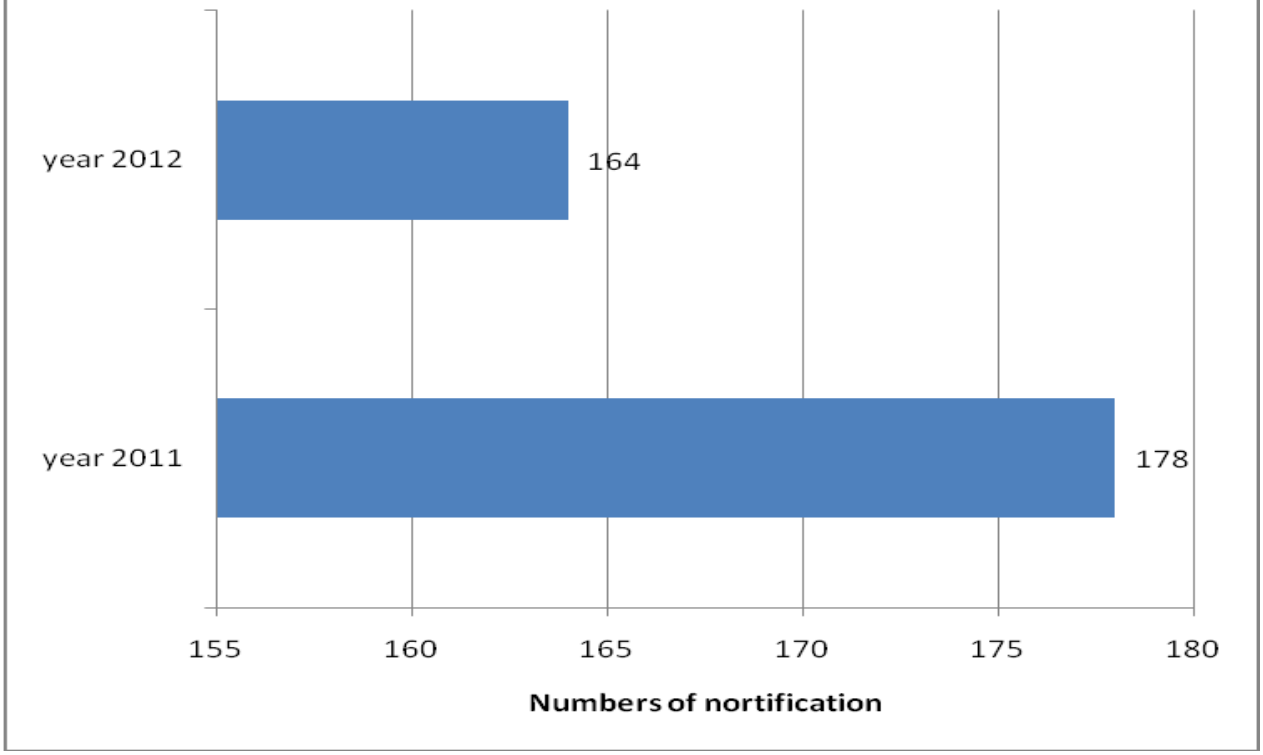
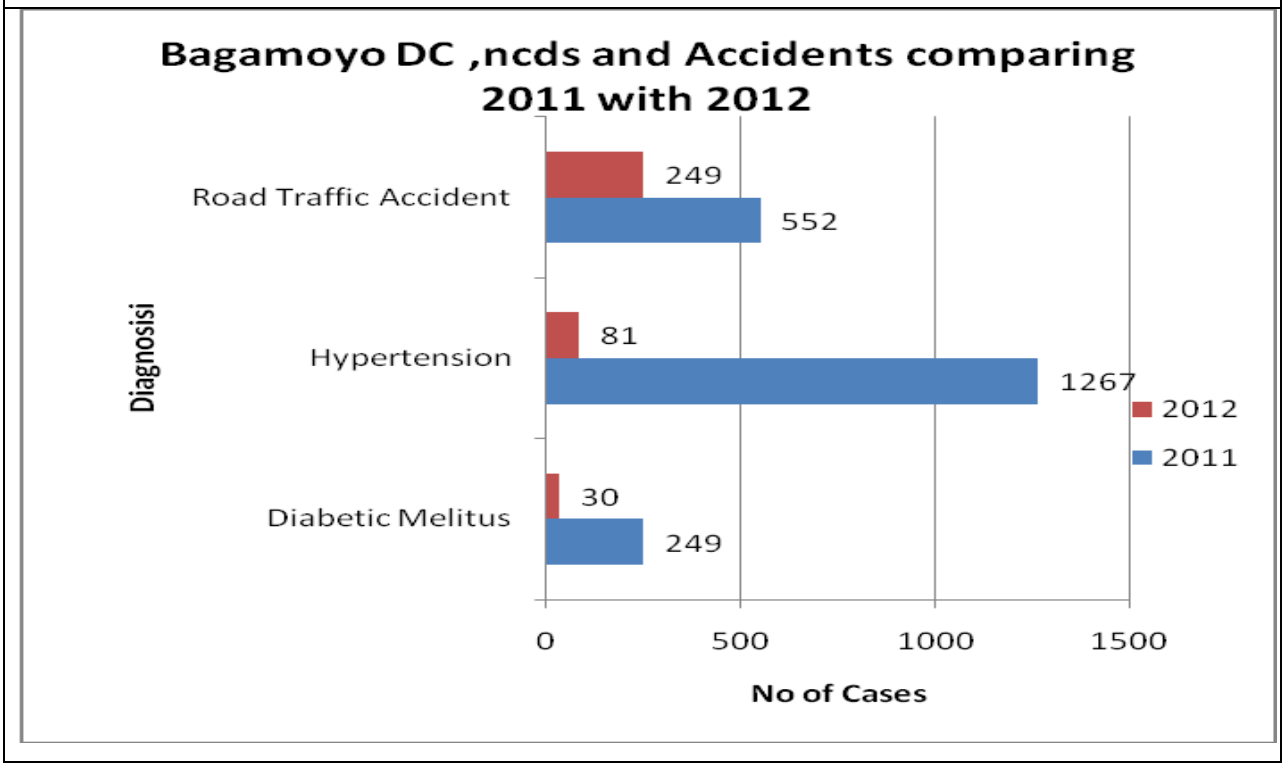


Figure 4-8. Comparison Of NCD,s with Road Accident in 2011 and 2012



4.5 OPTIONAL DISTRICT HEALTH SERVICE DELIVERY INDICATORS

Availability of Health Centers per Ward and Dispensary per Village

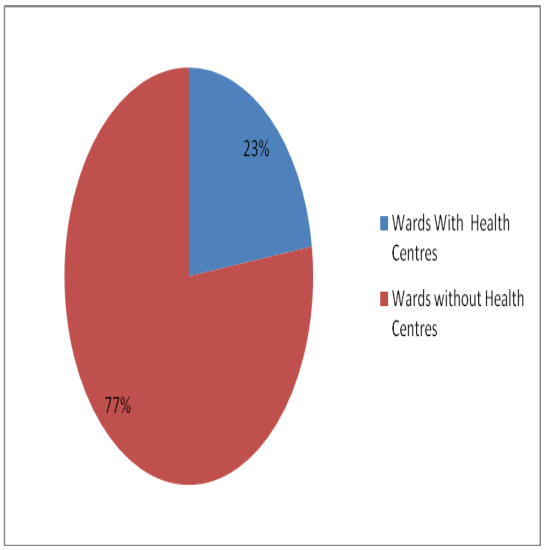


Figure 4-9

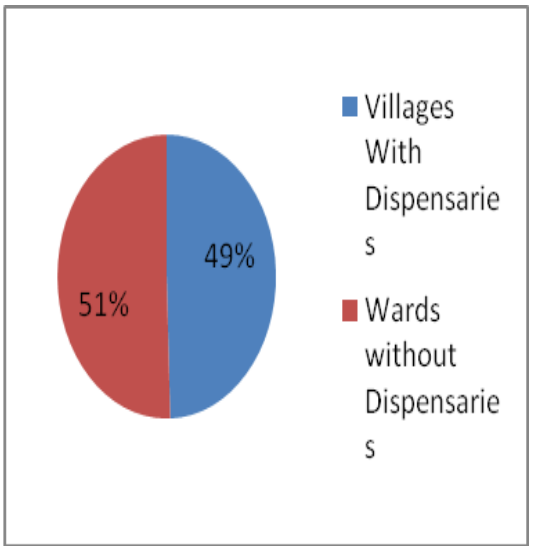


Figure 4-10

4.6 DISTRICT HEALTH SERVICE DELIVERY CONCLUSIONS, RECOMMENDATIONS AND WAY FORWARD

Despite all the improvements reached in the provision of health services in the district, more interventions are needed especially on preventive measures. While malaria is still the number one diseases, HIV/ AIDS related complications need to be seriously addressed. More health personnel needed to be placed in rural areas where the majority of the populations live. The need to get more stakeholders involved in imminent.

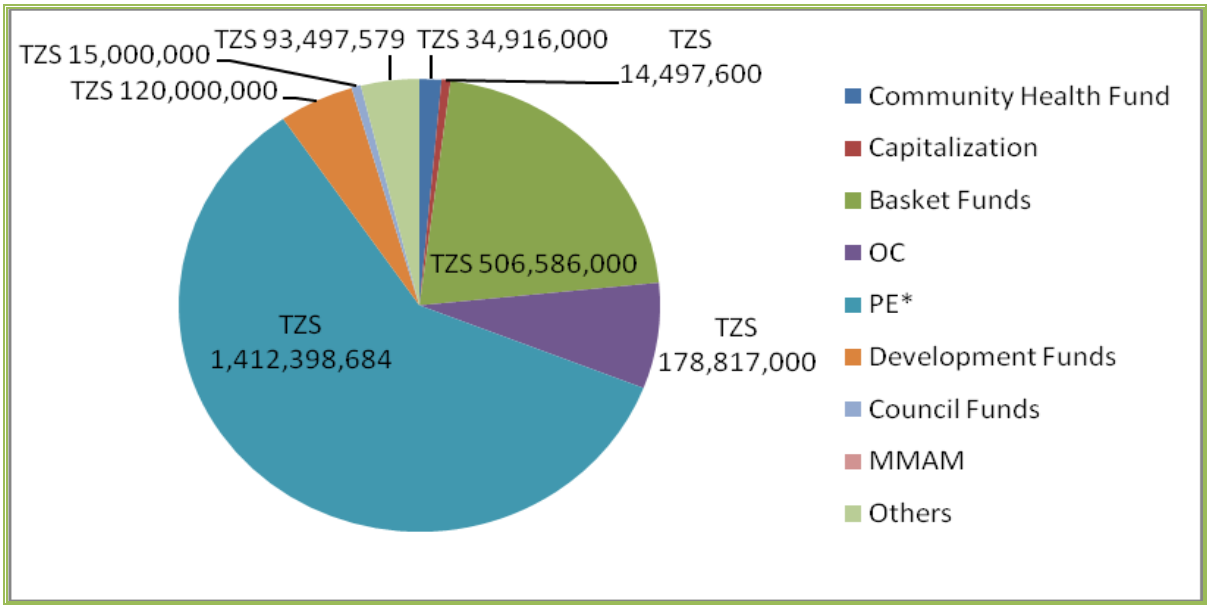
RECOMMENDATIONS/WAY FORWARD

- Supportive supervision need to be improved and adhered to
- The question of medical equipments and supplies need to address too.
- The district supplies office should work hand in hand with the district medical office to make sure the availability of medical supplies is the first priority.

5 STATUS OF DISTRICT HEALTH SYSTEMS

5.1 HEALTH FINANCING

Figure 5-1. Total GOT and Donor Allocations to Health in Bagamoyo 2012



5.2 HUMAN RESOURCES FOR HEALTH

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

SN	*Name of Institution*
1	Agency for the Development of Education Management (ADEM)
2	Bagamoyo Nursing School.
3	Bagamoyo College of Art
4	Mbegani Fisheries
5	School of Library Archives and Documentation Studies (SLADS)
6	Bagamoyo Tourism Management College
7	Mapinga Montesory Teaching College
8	Kaole Agriculture and Livestock College

9	Chalinze Teaching College (CTC)

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

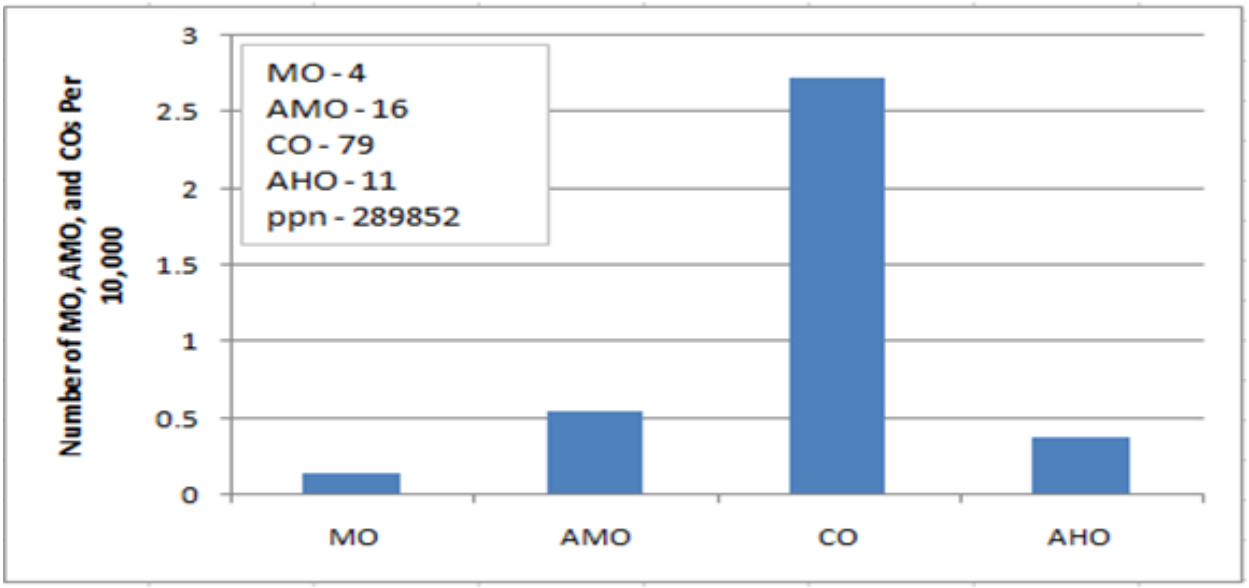


Figure 5-4. Number of Nurse mid-wives, Lab Techs, Pharm Techs Per 10, 000

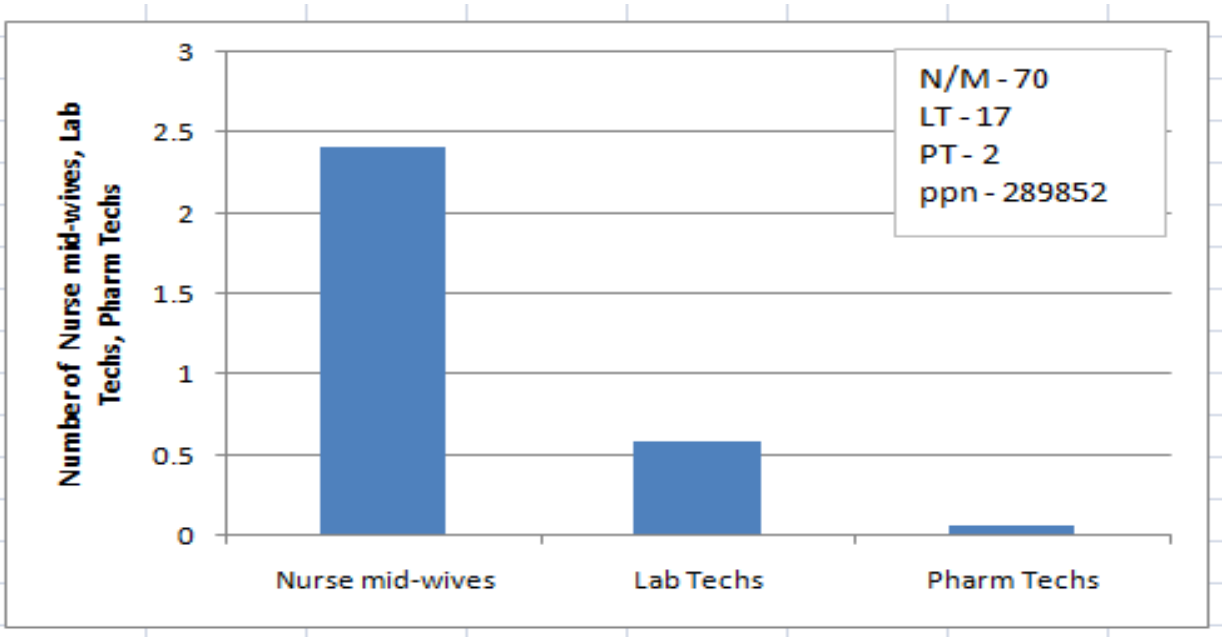
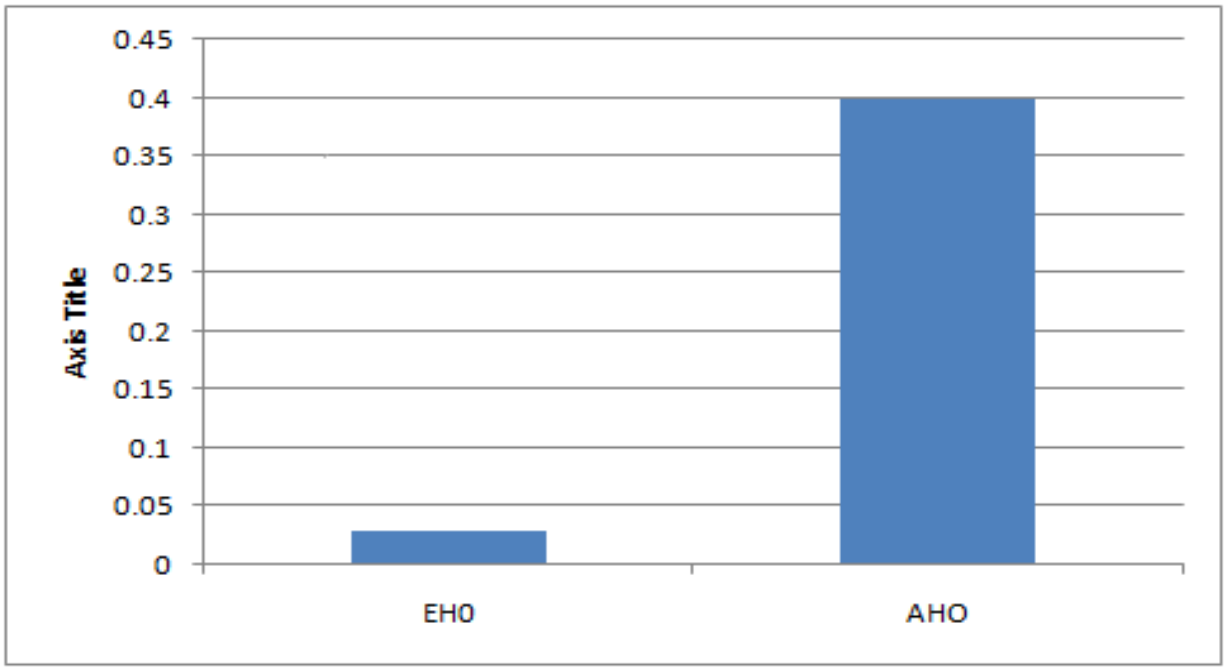


Figure 5-5. Number of HO, AHO, and EHOs Per 10, 000



5.3 MEDICINES/DRUGS

Drug and medical supplies in the district is still a challenge .Persistent missing items from MSD including delay of ordered medicine to health facilities. Also the fund through busket fund and other sources including community fund is not enough to cut the need of the community. The community will be sensitized to join the community health fund so that we can increase much fund for medicine and equipments.

All facilities including district Hospital were required to make sure they make proper management of cost sharing money collected and medicine so that they can fill the gap of absences medicines.

Figure 5-6. Health Facilities with Stockout of Tracer Drugs 6

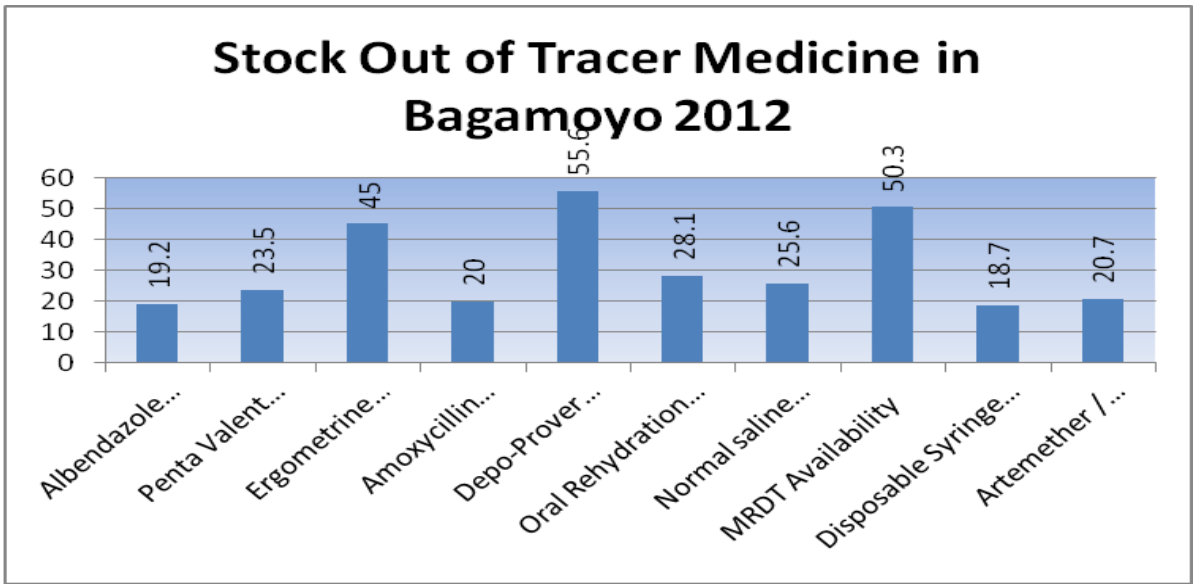
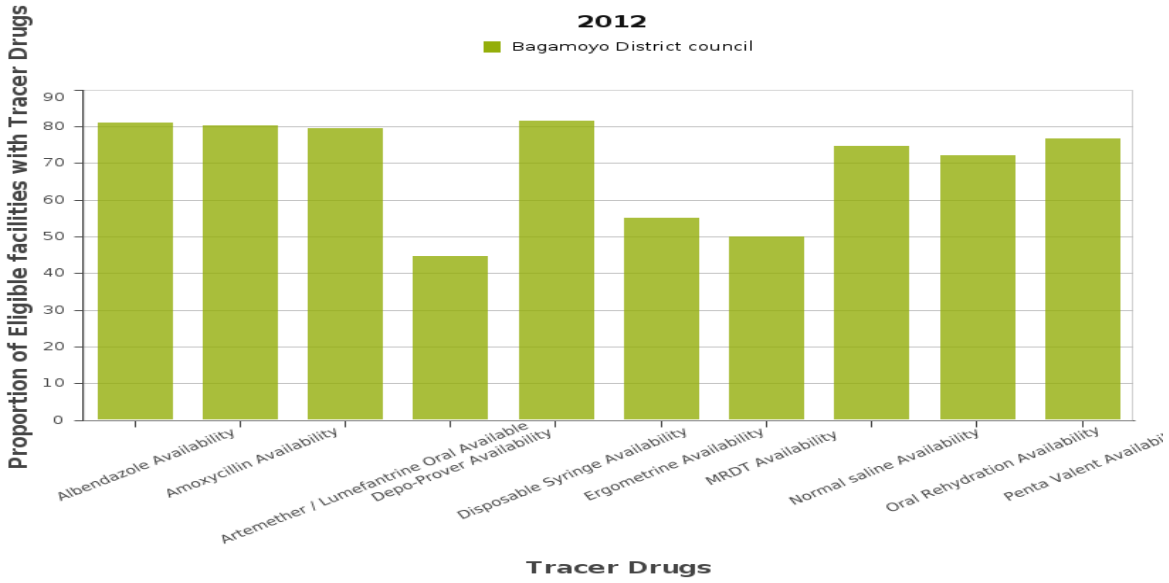


Figure 5-7. Availability of Tracer Drug

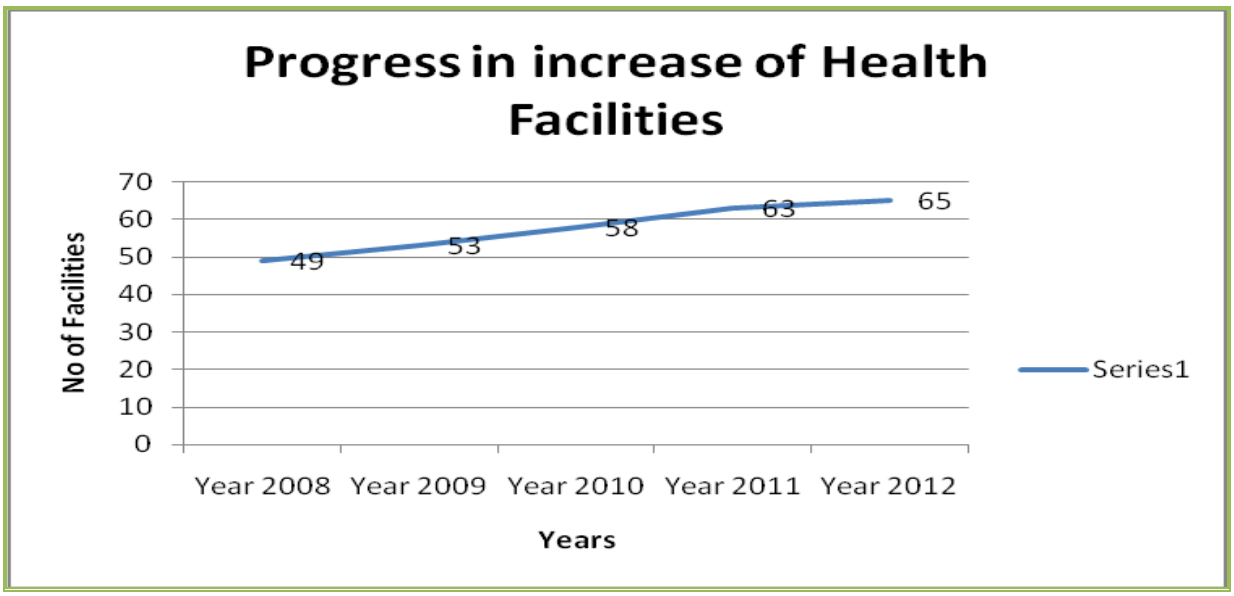


5.4 INFRASTRUCTURE.

5.4.1. INCREASE OF HEALTH FACILITIES.

There is the increase of health facilities for five years consecutively. He efforts are put so that the facilities dispensaries per each village and Health in each ward are met. Currently 7 dispensaries are under construction and are expected to operate in 2013. We expect to upgrade Yombo and Kiwangwa Dispensaries to become Health Centers.

Figure 5-8. Progress in health facilities



5.4.2: STAFF HOUSING.

The district is still facing housing problems in its facilities .most Facilities have a single house of which only one staffs especially facility in charge do own the houses leaving nurses leaving away f4om dispensary area. This brings disturbances to patients at night especially emergence procedure such as deliveries.

Most houses also do not have water and electricity /solar power the situation which complicates district efforts to retain workers especially in remote areas. The health facilities owned by district Council have poor condition than that owned by parastatal, Private or FBO, as highlighted in yellow in table 5.1.

District through MMAM and other district funds will continue to plan for provision of such services. The district also is involving partners such as Benjamini Mkapa Foundation ,stakeholders such as Tanzania National Park ,Shubash and villages in collaboration of different investors to solve that challenges, For example ,staff house is under construction at Chalinze Health Centre and Masuguru funded by Tanzania National Park.

Table 5.1:Table Showing Conditions of staff houses in the District.

Facilty	Having Electricity or Solar Power	Having Water	Have 2 or more Staff Houses	Comments
Bagamoyo.	√	√		
Chalinze.	√	√		
Miono.	√	√	√	
Kwaruhombo.	√	√	√	
Lugoba.	√	√		Houses are dilapidated unfit for human habitation
St. Elizabeth.	√	√		
Zinga.	√	√		Village council installed electricity and water in dispensary and staff qouter.
Kerege.	√	√		Village council installed electricity and water in dispensary and staff qouter
Mapinga.	√	√		Village council installed electricity and water in dispensary and staff quarter
Mlingotini.	√	√		

Mbegani.	√	√	√	
Kiromo.	√	√	√	Village council installed electricity and water in dispensary and staff quater
Mataya.	√			
Chambezi.	√	√	√	
Yombo.	√	√		
Kongo.			√	The HF has no water in spite of Lower Ruvu water source is located in this village.
Vigwaza.	√			
Kidogozero.	√	√		
Matuli.	√	√	√	
Kiwangwa.				It need urgent measures due high number of deliveries conducted and big number of staffs
Masuguru.				
Fukayosi.	√			
Msata.	√	√		
Talawanda.				
Ubena Estate.	√	√	√	
Ubena Prison.	√	√	√	
Mbwewe.				It need urgent measures due high number of deliveries conducted and big number of staffs
Pongwekiona.			√	
Kibindu.			√	
Kwamduma.				
Mkange.				
Mandamazingara.				
Saadani.	√			
Matipwili.	√			

Hondogo.		√	√	
Mandera.	√			
Rupungwi.				
Kigongoni.	√	√	√	
Lugoba Mission.	√	√	√	
Makurunge.	√			
Recco.	√	√		
Chalinze RC.	√	√		
Mkenge.	√		√	
Kifuleta.				
Kwang'andu.				
Kaole.				
Tayma.	√	√		
Mihuga.				
Tukamisasa.				
Narco.	√	√	√	
Kweikonje.				
Msoga.	√	√	√	
Lower Ruvu.	√	√	√	
Lugoba Secondary.	√	√	√	
Bwawani.	√	√	√	
Kwamsanja.				
Kimange.				
Micco.	√	√		
Visezi.	√			
Msinune.	√			
Epyphan.	√	√		
CM Wambura.	√	√		
Baobab.	√	√	√	
Milo.	√			
Ubena Zomozi.				
FACCGBF-MARTENITY HOME	√	√		

5.5 OPTIONAL DISTRICT HEALTH SYSTEM INDICATORS

In 2012 in Collaboration with Ifakara Health Institute accused the qualitative situation in provision of Health Services using Access –TIQH tools**.**

- The Tool for Improving Quality of Health Care (TIQH) uses a performance based approach to improve the quality of services in health facilities
- The services available at health facilities are compared with the expectations on these services, as defined by the national standards of care and community preferences.
- Performance gaps are identified when the observed services fail to meet these expectations.

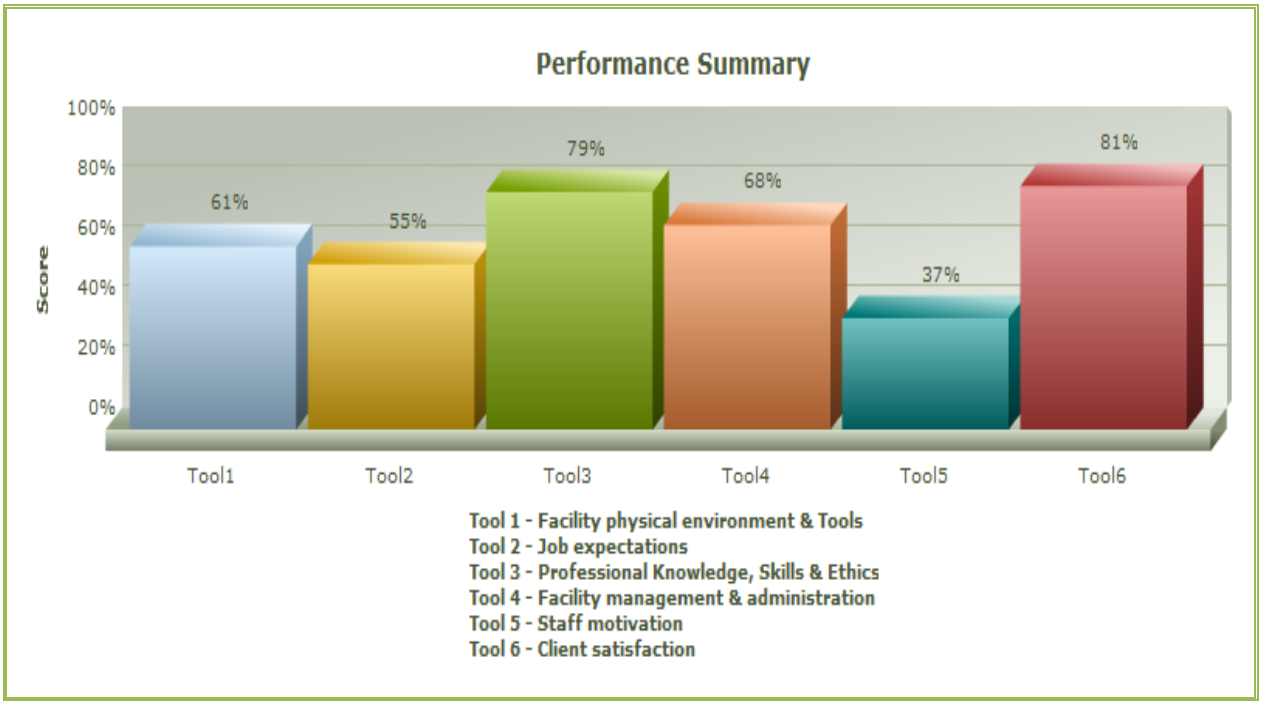
Table:5.2 Indicators measured

Assessment area/Indicators	Guiding question: To which extent...	Indicators, pts
1. Infrastructure, tools and equipment	Do health facilities have **sufficient resources** and provide a supportive environment to enable providers to meet their job expectations?	9 (41), 117 pts
2. Job expectations	Do providers know **what is expected** from them?	4 (17), 34 pts
3. Knowledge, skills and ethics	Do health providers have **sufficient knowledge and skills** to meet their job expectations?	6 (79), 308 pts
4. Management and administration	Do health facilities have a **sound management system** that provides supportive supervision and feedback to providers and the community?	12 (33), 109 pts
5. Staff motivation	Are providers **motivated** to meet their job expectations?	6 (23), 63 pts

6. Client satisfaction	Are **community expectations** of health service performance met?	6 (6), 24 pts
TOTAL		**43 (199), 655 pts**

District performance summary in all 6 Quality indicators indicated that staffs were least motivated by 37%, this were because most workers were not confirmed since were employed other for 20 years.

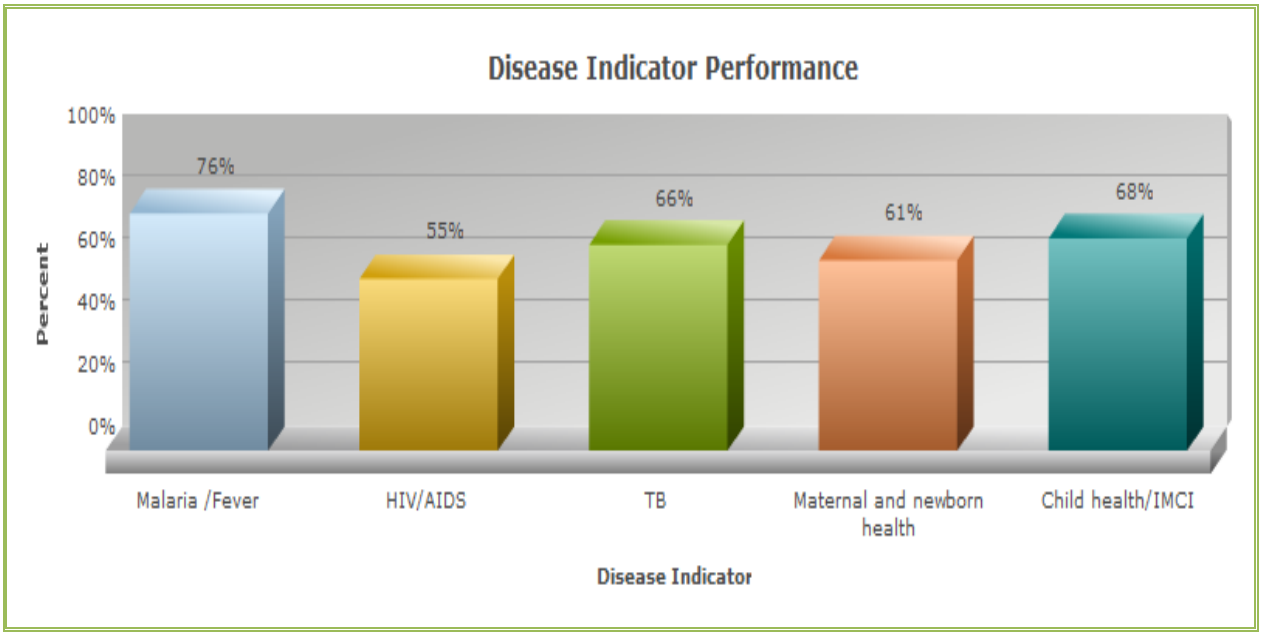
Figure: 5-9



Performance of district in Disease indicator

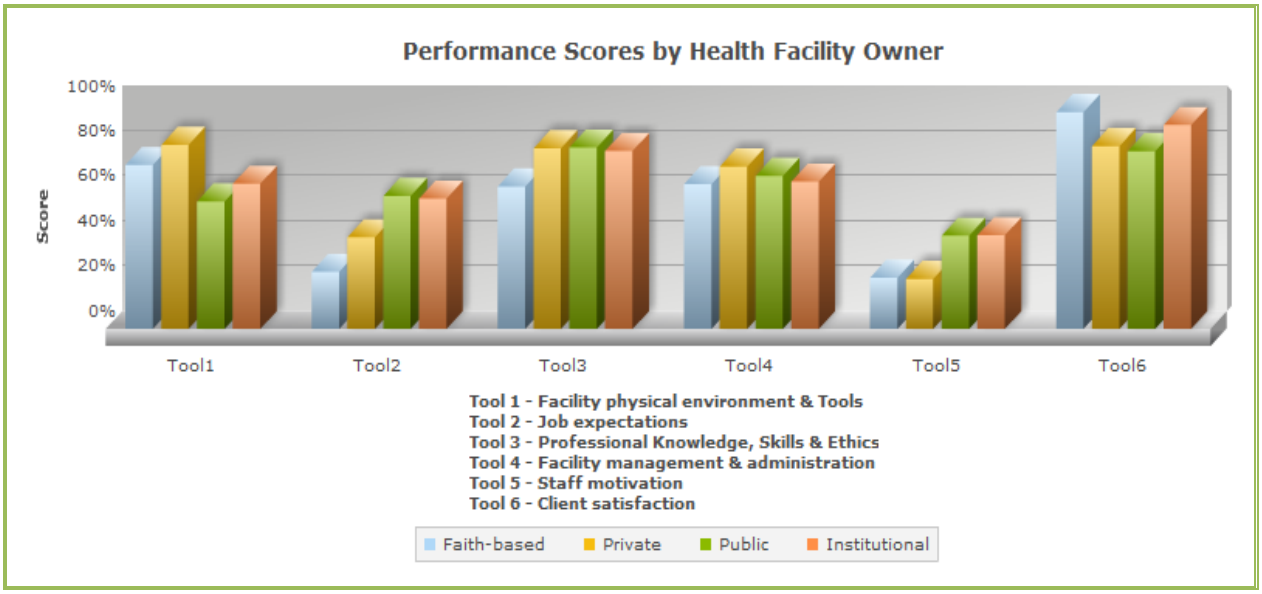
The tool indicates the management of diseases is low in HIV/AIDS followed by maternal and newborn health. The district will strengthen mentoring to health care providers on proper provision of services**.**

Figure: 5-10. Disease Indicator Performance



Performance scores among facilities by ownership indicated that facilities owned by private, institutional and FBO, s are performing better in all six indicators than those run by the district council. District team and IHI will conduct 14 days to facilities which are poorly performing in order to increase the council facility delivery.

Figure :5-11. Performance Score by Health Facility Owner



5.6. DISTRICT HEALTH SYSTEM CONCLUSIONS AND WAY FORWARD

Low income of the household contributes to poor health status of the community. The Nutrition status of children depends on the economic status of their families. More campaign needs to be put in place to reduce malaria which is a first cause of admission and death in Bagamoyo District. Also more efforts need to be put in place to reduce the prevalence of HIV.Therefore the district should put more effort on providing education to their entire community on how they can be free from diseases and other related problems. The question of neonatal deaths should be taken seriously.

Medicine and medical supplies is still a challenge in our district .Funds allocated through MSD ,and Busket fund is still not enough to satisfy the need .Efforts have been stressed to make sure that community join in Community Health Fund (CHF) so that to increase the source of fund as the alternative means for drug procurement.

The district has not provided the Health facility to every village as per MMAM guideline which require dispensary in each village and Health centre in each ward. Out of 97 have access to dispensaries .Some localities are far are hard to reach and still have no access to health facilities ,This includes Kitame ,Mkoko Pongwemsungura. Through MMAM program and Private –Public partenership 9 dispensaries are under construction including Kitame ,Pongwemsungura ,Masimbani ,Mkoko ,Pande ,Pera Saleni and Madaula.The mentioned facilities is expected to be opened late 2013 .

The district is overcoming housing problems to make sure that workers retention is addressed .The district has decided not to open the dispensary until the community is providing the house to working staffs.

RECOMMENDATIONS/ WAY FORWARD

- Increase outreach services to areas/ health facilities where there have been poor performances
- Improve supportive supervision to the health facilities for quality services provision.

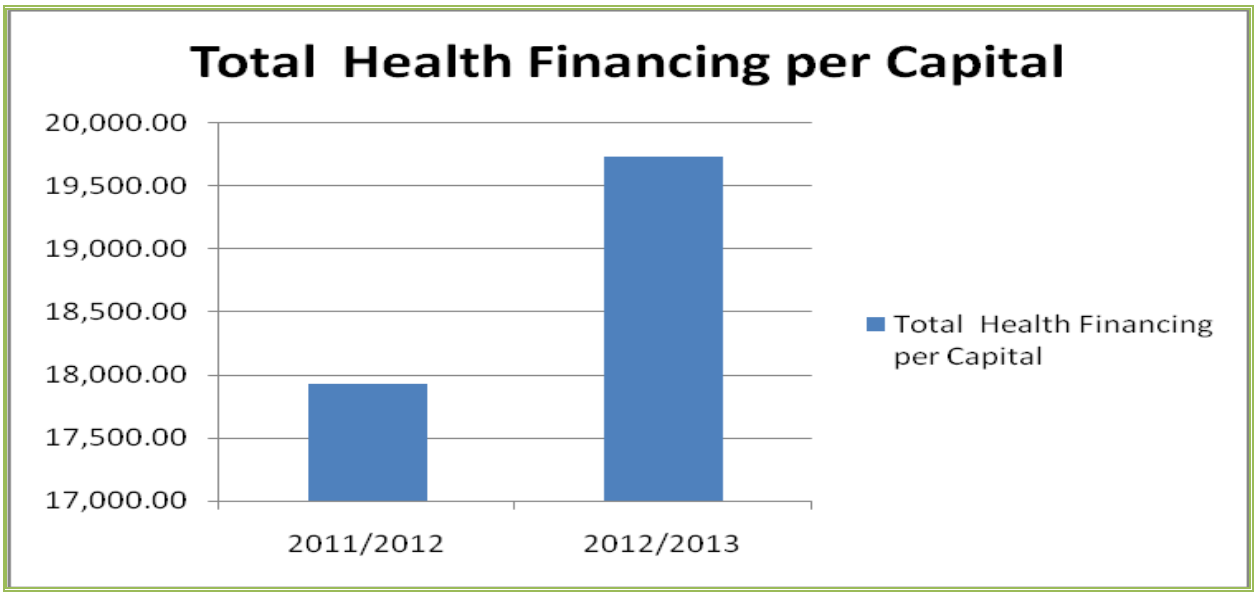
- Get involved other stakeholders from the communities to report on important indicators such as neonatal deaths
- Conduct quarterly meetings for updating the District Health Profiles and sharing on important indicators of the same.

6 AREAS OF PROGRESS IN THE DISTRICT HEALTH SECTOR

6.1 PROGRESS IN DISTRICT HEALTH FINANCING

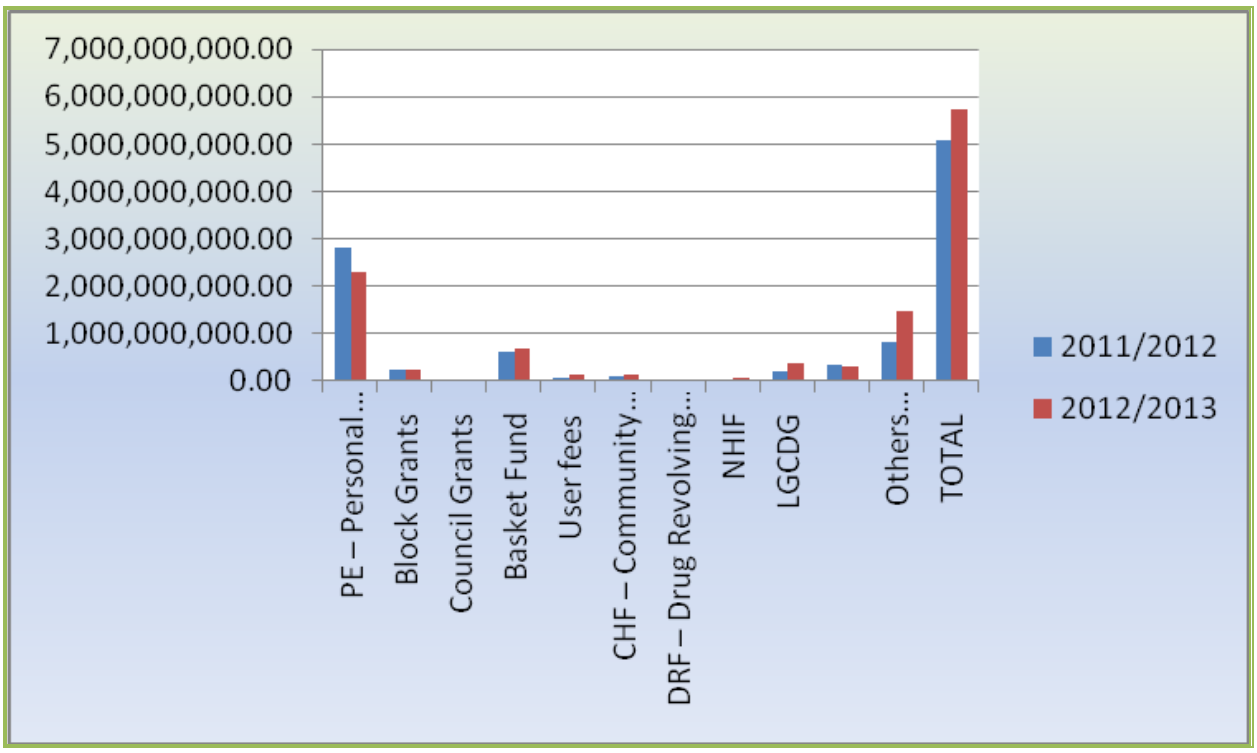
OVERALL HEALTH FINANCING

In 2012/2013 the health financing per capital was higher than that of 2011/2012 as shown in the graph below.



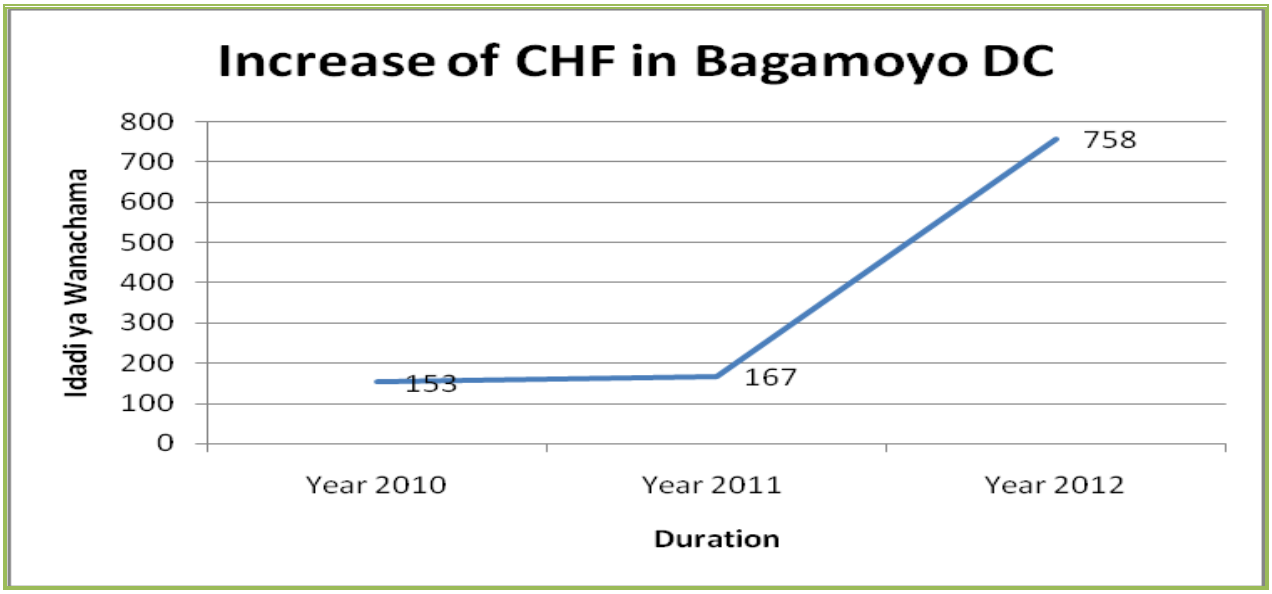
EXPANSIONS IN HEALTH SPENDING

The graph below shows the health spending of various sources of funds for the Bagamoyo District Council.



INCREASE OF COMMUNITY HEALTH FUND

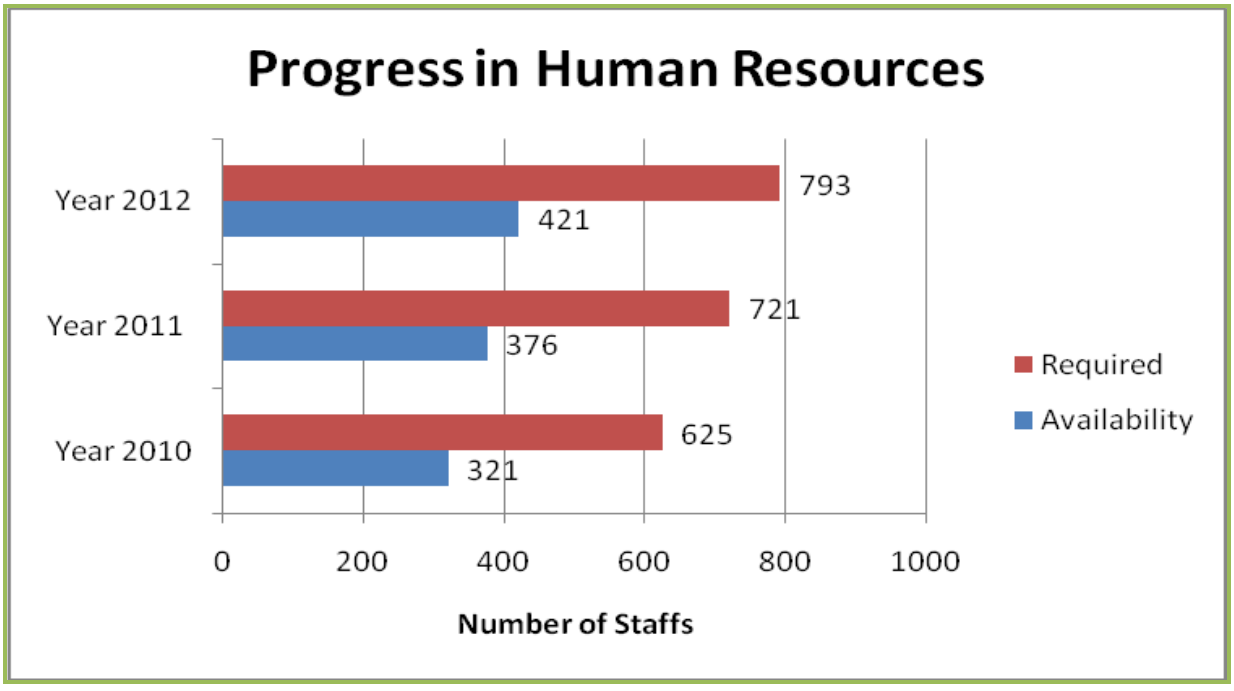
Efforts have been made to make sure that community health members are increasing in order to rise the CHF fund. In 2012 only 3%of the household joined the CHF in Bagamoyo District. This small number has retarded the efforts of increasing request of medicine and medical supplies in the district. After increasing the cost sharing from 1,000/= at Dispensary level to 3,000/= is expected to rise the member who are joining CHF in 2013.



6.2 PROGRESS IN DISTRICT HUMAN RESOURCES

The human resource challenges have been solved by the Central Government year after year. Due to the increase of health facilities in the district it creates more demands of health workers.

The graph below summarizes the Availability of Human Resources.



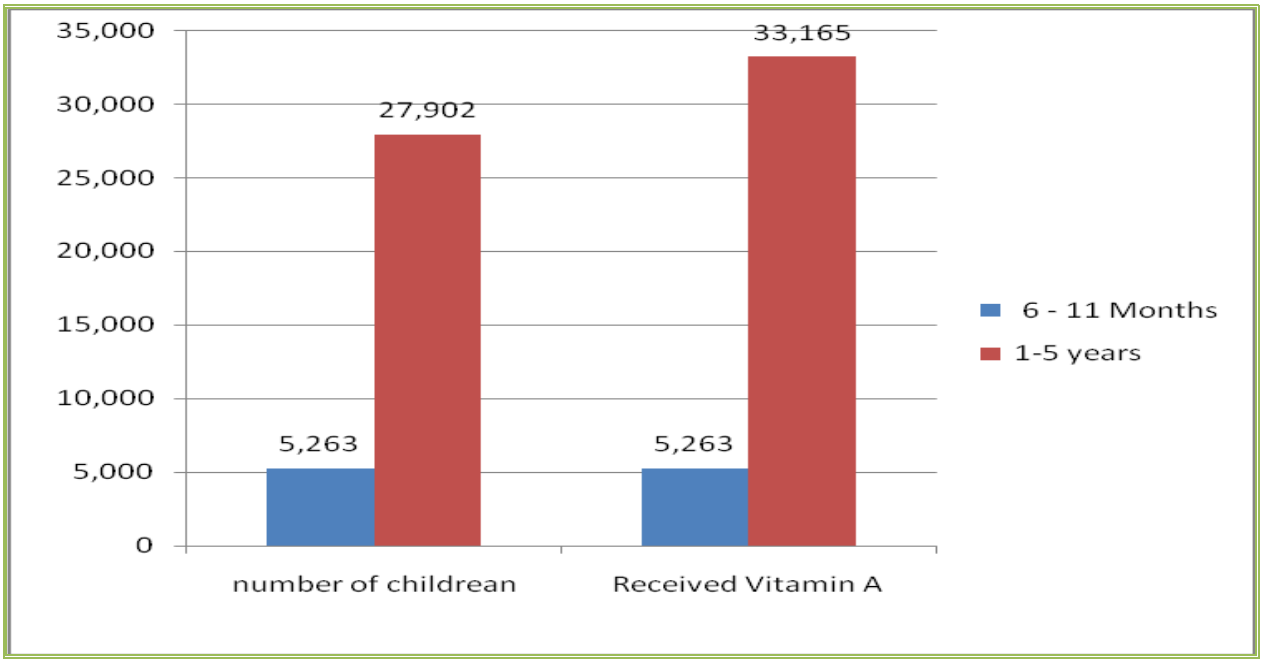
6.3 PROGRESS IN DISTRICT NEONATAL HEALTH MANULTRITION

Due to easy accessibility to health facilities in most of the communities in the council as well as increased trained health staffs in such health facilities the % of neonatal with severe malnutrition has continued to decrease. In 2012 the percentage of children with severe malnutrition was 2.97%

District	Total Weighted	Severe Mulnitrition (Average < 60%)	%)
Bagamoyo	12,745	379	2.97

VITAMIN A

Also 119% children aged 6-11 months received Vitamin A supplements and 119% of all children aged 1-5 years received vitamin A supplements as shown in the table below.



6.4 PROGRESS IN DISTRICT HEALTH FACILITY COVERAGE

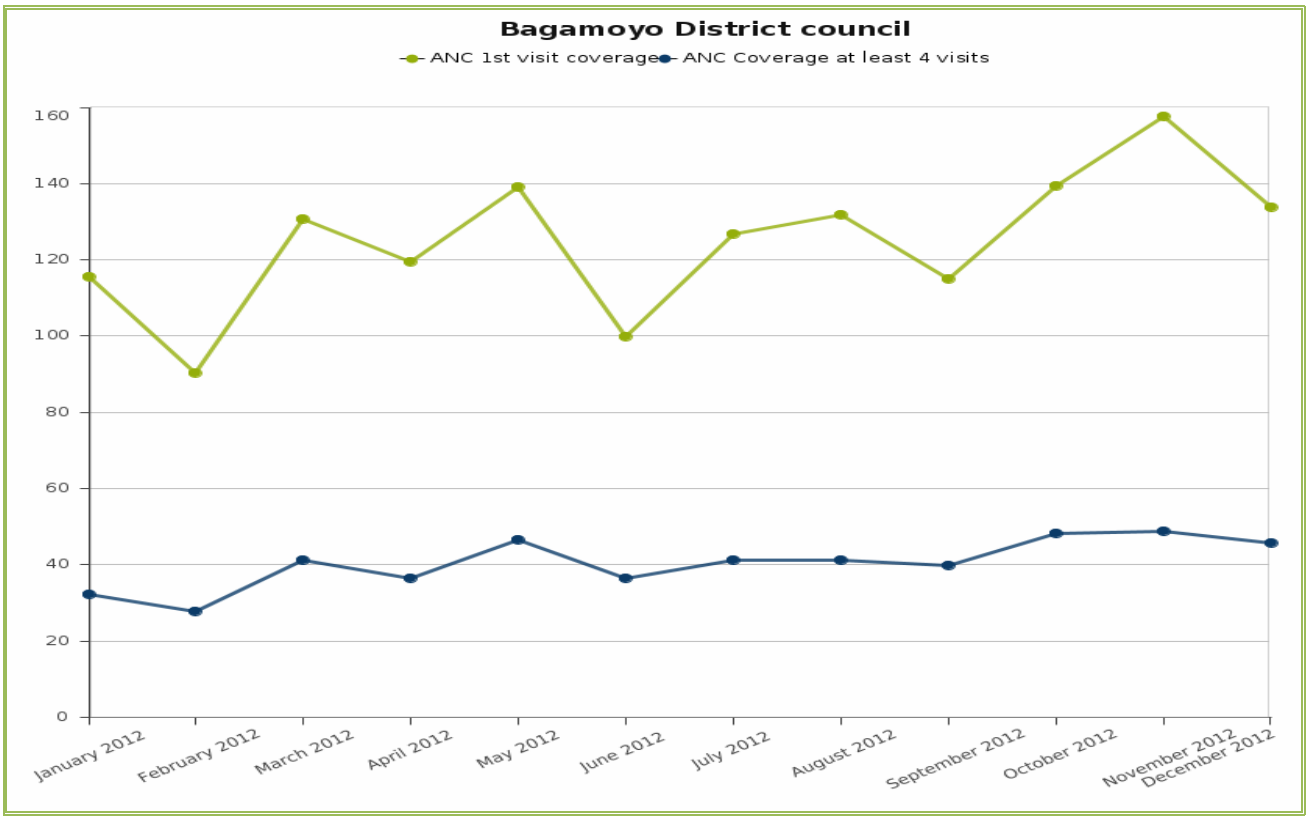
The council has 97 registered villages. In 2012, 67% of villages had health facilities. The table below summarizes the number of wards and villages with health facilities.

With/Without	Coverage of Health Centre per ward	Coverage of Dispensaries per Village
With	23%	49%
Without	77%	51%

6.5 PROGRESS IN DISTRICT HEALTH FACILITY PERFORMANCE

PROGRESS IN ANC ATTENDANCE

The ANC visit in the district in year 2012 had showed higher improvement compared to year 2011 especially for pregnant women of 12 weeks and above. This improvement aided by education delivery to the entire community through using community owned resource person (CORPS) and other health stockholder. The first ANC visit coverage in 2012 was 123.5%.



PROGRESS IN HEALTH FACILITY REPORTING RATES

In 2012 all facilities proving RCH services reported their data through the routine Health Management Information System. The data were collected from the facilities by the CHMT before the 14th of every month.

The following table shows the percentage of facilities reporting HMIS data in 2012

TIMELINESS AND COMPLETENESS OF DATA

The reporting rate of all HMIS data set was 87% in 2012.Despite the higher reporting rates of facility data into the DHIS2 software the district faced a number of challenges such as unreliable internet connectivity and occasionally failure of the DHIS2 server. The table below summarizes the reporting rates of various data sets in 2012.

COMPLETENESS BASED ON COMPOSORY DATA SETS

Bagamoyo District council -Completeness and Timeliness report, 2012

Name	Actual Reports	Expected Reports	Percent	Reports On Time	Percent On Time
Wagonjwa wa Kulazwa (IPD) Pilot	60	60	100	51	85
Wagonjwa wa Nje (OPD) Pilot	770	780	98.7	665	85.3
Magonjwa ya Kuhara (DTC) Pilot	765	780	98.1	662	84.9
Kliniki ya Wajawazito (ANC)	608	624	97.4	321	51.4
Kutoka Wodi ya Wazazi (L&D)	608	624	97.4	471	75.5
Huduma Baada ya Kujifungua (Postnatal)	606	624	97.1	438	70.2
Ufuatiliaji wa Watoto (Child Health)	604	624	96.8	402	64.4
Uzazi wa Mpango (FP)	595	624	95.4	380	60.9
Idadi ya Watu (Population)	51	69	73.9	51	73.9
Tracer Medicine	487	792	61.5	448	56.6

EXPANSION IN CRITICAL HEALTH SERVICES AND IMPROVEMENTS IN REFERRAL HOSPITAL PERFORMANCE

The district referral system is facing a serious problem. And this is lack of ambulances in good shape that need frequent maintenances and repairs. The hospital ambulance needs to be replaced with a new one .Other three ambulances of Miono ,Lugoba and Kwaruhombo are supper dilapidated and so they need replacement .Chalinze were donated ambulance from one partner while Lugoba is using the Lugoba secondary school ambulance which serves both secondary and villages within Lugoba catchment.

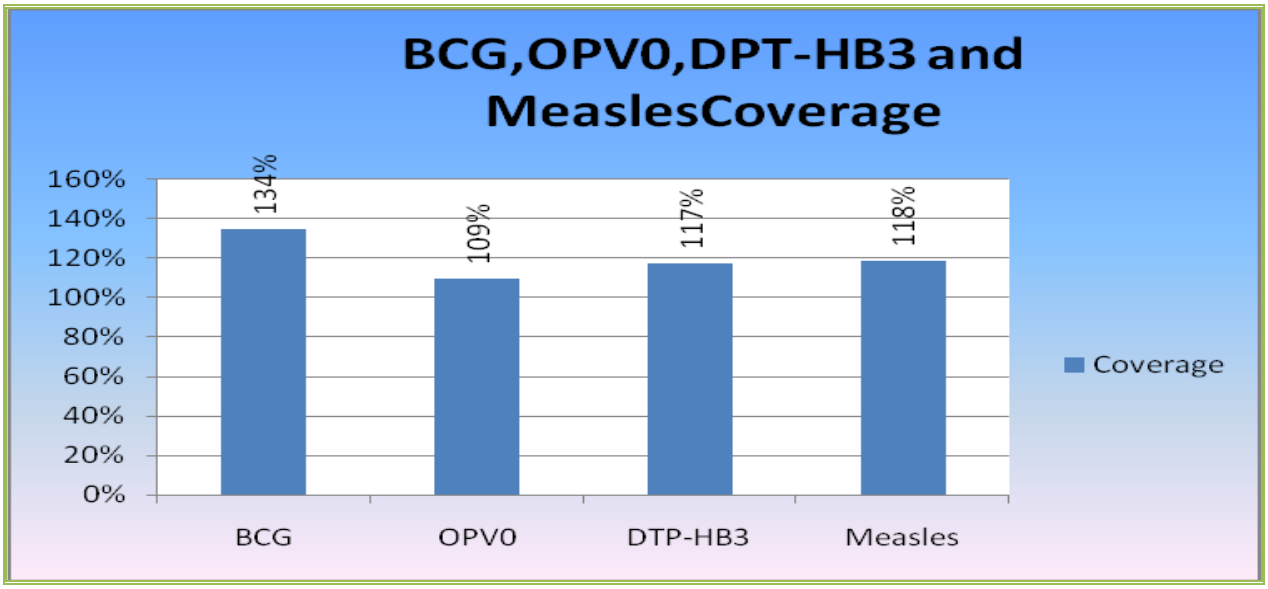
District Hospital is conducting an average of one route to Muhimbili national Hospital ,Most referral conducted are due to maternal conditions and injuries /trauma due to different accidents. This rise the need of improving infrastructure at Bagamoyo Hospital including sophisticated equipments and having a skilled staffs. In feature ,the district is dedicated to initiate causality system which will cutter several accidents as Msata –Bagamoyo road and other roads are under construction.

Fuels for referral transport is another challenge, Community are still resistant to contribute some cost of relative referral transportation of which rise a high demand of fuel for that purpose.

6.6 PROGRESS IN DISTRICT HEALTH SERVICES

VACCINATION COVERAGE

The vaccination coverage of all vaccines has shown improvements in 2012 compared to the previous years. Despite the high increase in coverage of causes variation of the target population. The challenge which has faced the department in the year was availability of gas to run the refrigerators in the facilities. The figure below shows the immunization coverage for BCG, OPV0, DPT-HB3 and Measles.



SOCIAL WELFARE AND PROTECTION FOR VULNERABLE POPULATIONS

Bagamoyo District Council through the Department of Water supply and preventive services has made progress in providing clean and safe water to the population. The district is also providing education to the community on the use safe and clean water and the use of latrines. The District conducted an inspection of 12,345 households out 60,363 households available in Bagamoyo. 50% of all inspected households were found to have appropriate latrines. 67% of households were using safe source of water.

The table below shows the percentage of households using clean and safe water and households with appropriate latrines.

Environmental Health							
Districts	**Total House holds**	**Households Inspected**	**%**	**With Appropriate Latrines**	**%**	**Safe source of water**	**(%)**
Bagamoyo	60,363	12,345	20	6,117	50	8,230	67

6.7 PROGRESS AGAINST MILESTONES

Area	Milestone	Process Action Plan	Output/Indicator/ Assumptions	Updates
1) District Health Services TWG 1	All council's health plans 2013/2014 and reports 2012/2013 are prepared using existing tools (revised CCHP guidelines, Plan Rep, Epicor) and are of improved quality.	Conduct training of all CHMTs and RHMTs on the use of existing tools Provide coaching/ mentoring by RHMT/ZHRC to all CHMTs on the application of the existing tools	Number of CHMT and RHMT trained on the use of existing tools Number of CHMTs provided with targeted coaching and mentoring by RHMTs/ZHRCs on the application on the existing tools	Two people from Bagamoyo CHMT have been trained on the use of existing tools to develop the district health profile report The Pwani RHMT provided mentoring to Bagamoyo CHMT on the development of the CCHP

6.8 BEST PRACTICES/CASE STUDIES

Bagamoyo District Council was awarded a certificate of Excellency for Baby Friendly Hospital Initiatives (BFHI) implementation in 2012. The award came from Tanzania Food and Nutrition Centre (TFNC).This were due to improvement of health services at RCH department due to change of staff attitude.

BFHI is a way of promoting, protecting and supporting and breastfeeding. The objective of this initiative is to improve quality of health and nutrition care services provided to mothers and their children to reduce morbidity and mortality.

The assessment was conducted in the district sometime in 2011. Bagamoyo hospital met the BFHI criteria and was awarded a certificate of Excellence.

Bagamoyo is one of the districts implementing P4P scheme. The overall goal of P4P is to accelerate the reduction of maternal, neonatal and child morbidity and mortality through improving reproductive and child health services. The MoHSW seeks to improve the

performance of health services in Tanzania through a P4P strategy in order to accelerate the attainment of MDGs 4 and 5. Through this scheme staff motivation and team work has increased.