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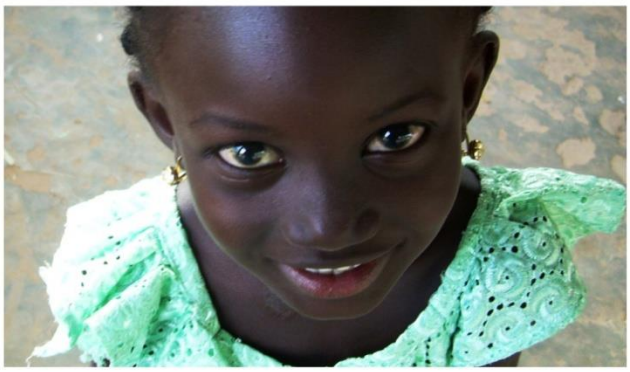
The United Republic of
TANZANIA
Ministry of Health & Social Welfare



RUFIJI DISTRICT COUNCIL

District Health Profile Report

Year: 2012/2013

RUFIJI DISTRICT HEALTH PROFILE

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4.1.1. FOREWORD

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 and Social welfare determines 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) is a scope that enables the District to know what is prevailing in the entire area, its causes and what measures can be taken to solve the problems. The profile also allows the District to budget and allocate the resources basing on the magnitude of the problem or disease.

This tool is essential for monitoring and evaluating the implementation of activities and knowing the impact of health interventions. Through observing the trend of diseases covered in this document, it will be easy to note the success and failure of the efforts ever tried to alleviate or control the problems prevailing in the entire community.

4.1.2. ACKNOWLEDGEMENTS

I would like to extend my heartfelt gratitude to all CHMT members for their effort to come up with this essential document.

My words of thanks are also directed towards Rufiji Demographic Surveillance System (RDSS) for collecting, processing and finally availing to with relevant demographic data thus enrich our DHP document.

Nevertheless I would not forget to mention our Facilitators from MOHSW, Regional Secretariat / RHMT, HMT, UDSM, IHI and CHAI for their contributions made through provision of essential guidelines and other important materials.

Finally I would like to extend my gratitude to all stakeholders International, National and Local as well as individuals who contributed in one way or another in the production of this important document

Thanks to you all.

4.1.3. EXECUTIVE SUMMARY

Rufiji District Council is one of the seven councils of Pwani Region. According to 2002 census the district council has a population of 247,414 and a growth rate is 1.9 per annum. The population density is 17.7 people per square km.

The District Medical Officer (DMO) through the Council Health Management team (CHMT) plays the main role of managing, coordinating and supervising all health services provided at both public and private health facilities. In addition, through the DMO Office Coordinators have the role of supervising 64 health facilities existing in the Council.

The overall performance in implementation of last year's plan was 66.23%. The last year's performance standard increased by 10%, when compared to the previous year. Out of 154 funded activities, 102 (66.23%) of them were completely implemented and 3 partially implemented. There was success in the collaboration between the Private facilities owners, especially during supervision and inspection.

Reasons for not implementing and partial implementation of activities were due to unreleased funds from donors, long tendering procedures and bureaucracies; interference of vertical mass campaigns and other related programs and delay of fund or inadequate fund disbursement versus fund allocation.The remaining activities are expected to be implemented by the end of 4th quarter for the funded activities.

The main challenges which usually hinder implementation of the DHP activities also include late disbursement of funds, shortage of qualified and skilled staff and infrastructure problems in terms of transport during supportive supervision and distribution of drugs and other medical supplies.

RUFIJI DISTRICT HEALTH PROFILE

This DHP document expresses the activities which conducted by the Health Department for the year 2012/2013. The activities have been prioritized based on the major health problems and health needs aiming at improving health services in the council. Some of the major health problems include Malaria, ARI, HIV/ AIDS and Diarrhea.

Other problems are shortage of drugs and medical supplies, poor environmental sanitation, frequent breakdown of vehicles and motorcycles during supportive supervision due to poor infrastructure. Therefore it has been planned to address the above problems.

Also in this DHP different interventions have been put into consideration to tackle factors which contributed the decrease of performance in last year and also enable smooth implementation of activities. In a Nutshell the plan gives emphasis on Multilateral Collaboration approach in which various partners will participate in supporting the implementation of health services in the Council both in kind and cash.

In order to address the above problems the following are our strategies/interventions

1. Strengthen control measures against STI, TB/HIV & HIV/AIDS
2. Strengthening of integrated management of child hood illness
3. Strengthening Malaria control through insecticide treated material and adult case management
4. Strengthen control measures and management of maternal conditions
5. Strengthening TB, DOT and prevention of disability POD for leprosy Clients
6. Strengthening control measures and management of diarrhea diseases
7. Strengthening measures against lymphatic filariasis and trachoma
8. Strengthening sanitation activities in the community.
9. Improve and strengthen the existing health delivery system.

4.1.4. ACRONYMS AND KEY TERMS

Table 0-1. ACRONYMS

ACRONYM	LONG NAME
DHP	District Health Profile
MOHSW	Ministry of Health and Social Welfare
MTUHA	MfumowaTakwimuwaUendeshajiwaHudumazaAfya
HF	Health Facility
HW	Health Worker
D.C	District Council
TB	Tuberculosis
POD	Prevention of Disability
DOT	Direct Observation Treatment
HIV	Human Imunodeficience Virus
STI	Sexual Transimited Diseases
AIDS	Aquired Imunodeficience Virus
DHP	District Health Profile
CHMT	Council
RDSS	Rufiji Demografic Suveilance System
MOHSW	Ministry of Health and Social Welfare
UDSM	University of Dar es salaam
IHI	Ifakara Health Institute
DMO	District Medical Officer

NGO	Non GOvenmental Organization
TTCL	Tanzania Telecomunication Council Limited
DED	District Executive Director
LGA	Local Government Authority
CCHP	Comprehensive Council Health Plan
OPD	Outpatient Department
EHO	Environmental Health Officer
DHIS	District Health Information System
HMIS	Health Management Informantion System
HFGCs	Health Facility Government Comitees
MRDT	Malaria Rapid Diagnostic Test
CHF	Community Health Fund
LGDG NHIF	Local Government Divelopment Grunt
ADB	African Development Bank
CHAI	Clinton Health Access Initiative
FDC	Focal Development College

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 are of paramount importance at all levels

RUFIJI DISTRICT HEALTH PROFILE

4.1.5. INTRODUCTION

1.1 MISSION AND VISION

MISSION:

To ensure conducive environment for easy access to social and economic services to Communities and other Stakeholders by improving human resources, working tools and encouraging participation of all Stakeholders in different sectors.

VISION:

To provide top quality services to the Community and other stakeholders.

1.2 STRUCTURE OF DISTRICT

GEOGRAPHICAL LOCATION

Rufiji District is among six administrative districts comprising Coast Region. It is situated in the Southern part of the Region and bordered by Kilwa district on the southern side, Mafia district on the eastern side, Mkuranga district on the northern side and Liwale district on the south-western side.

SIZE

The district covers an area of 13,339 sq kilometers, of which 1,524 sq km is covered by forest reserves and 6,258 sq km is covered by the Selous game reserve.

POPULATION

For the year 2012 the projected population is **247,414** calculated at 1.9 annual growth rates. Population density is 16 people per square kilometer. In that population Males are **119,690** and females are **127,724**.

WARDS AND VILLAGES

The district is divided into 6 divisions, 27 wards and 96 Villages with a the headquarters of the District is at Utete town.

Table 1-1. Wards And Villages

S/N	WARD NAMES	MUMBER OF VILLAGES
1	**Ikwiriri**	3
2	**Mgomba**	3
3	**Umwe**	3
4	**Utete**	2
5	**Mkongo**	4
6	**Ngorongo**	7
7	**Mwaseni**	3
8	**Kibiti**	7
9	**Bungu**	4
10	**Mahege**	8
11	**Mchukwi**	2
12	**Chumbi**	4
13	**Mbwara**	3
14	**Mtunda**	4
15	**Salale**	2
16	**Mbuchi**	5
17	**Mbwera**	3
18	**Kiongoroni**	5
19	**Maparoni**	4
20	**Kipugira**	2
21	**Dimani**	3
22	**Mtawanya**	2

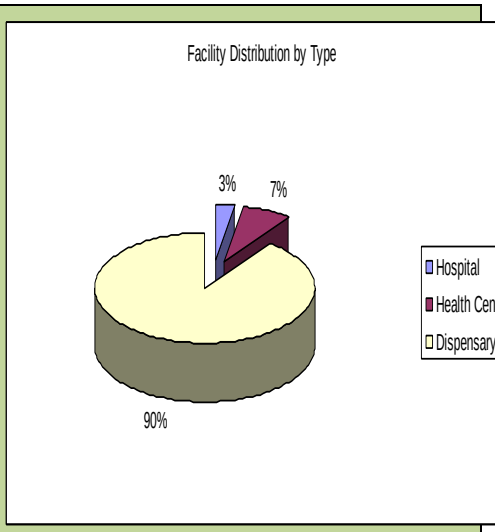
23	**Mjawa**	4
24	**Mlanzi**	2
25	**Mwambao**	3
26	**Chemchem**	2
27	**Ngarambe**	2

1.3 FACILITY DISTRIBUTION

Rufiji D.C has a total of 70 health facilities that provide services of which 2 are hospitals (one is District Hospital and another is Regious Hospital), 5 health centres (owned by District Council) and 63 dispensaries (of which 4 are religious, 4 are from Private sector, 1 is under NGO, 2 are Parastatal and 52 are owned by District Council).

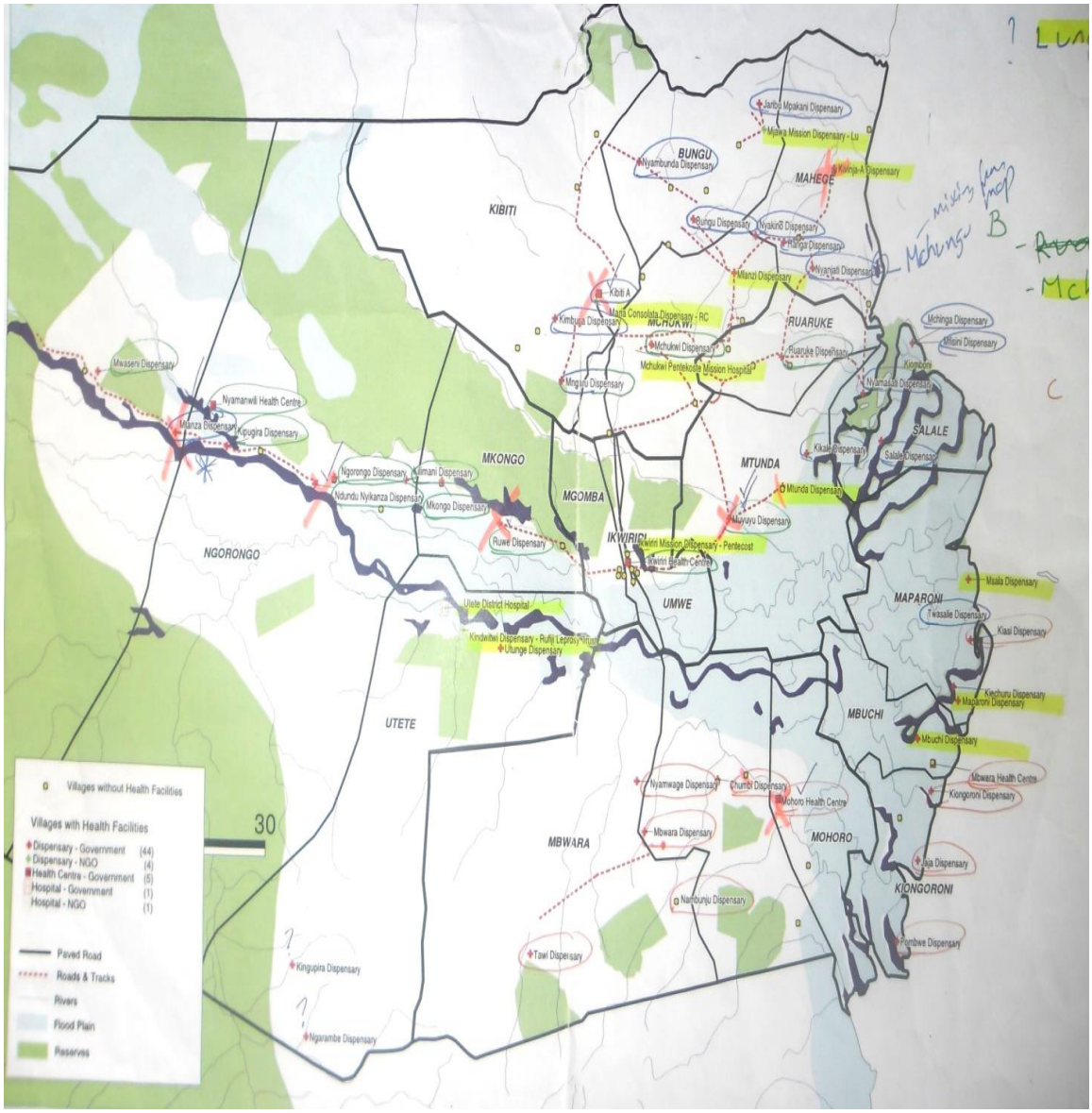
Table 1-2. Facility Distribution

TYPE OF FACILITY	NUMBER OF FACILITIES	OWNERSHIP
HOSPITAL	2	1 LGA 1 FAITH BASED
DISPENSARY	57	47 LGA 4 PRIVATE 3FAITH BASED 2 PARASTATAL 1 NGO
HEALTH CENTER	5	5 LGA
CLINICS	0	-



Comment:-84% of Health Facilities are owned by LGAs while the rest are private owned.

FIGURE 1-1.RUFIJIDistrict Map showing Health facilities



1.4 POPULATION

For the year 2012 the projected population is **247,414** (**Males** are **119,690** and females are **127,724)**.

Table 1-3. Gender and Age Based Statistics

AGE RANGE	FEMALE	MALE
<1 YEAR	4763	4732
1-4	18118	18001
5-14	33334	33447
15-49	56313	51180
>50	15151	12140
TOTAL	**127,724**	**119,690**

1.5 GEOGRAPHY

Terrain, Rainfall, Relief, Temperature and Water bodies

The rainfall pattern in Rufiji district is bimodal. The short period rains are from November to January while the long period rains are from mid-March to May. Dry periods are experienced from January to mid-March and June to October; the heaviest rains are experienced in March and April. The average minimum and maximum temperatures are 18 and 35 Celsius centigrade respectively.

The Rufiji delta and coastal zone extends north to South along about 75 kilometers of the coast and stretches inland around 25 km in a roughly deltaic shaped caused by the interaction of the river floods and the tides. Tides of up to 4m extend upstream through distributaries of the delta as far as 40 km from the coast and cause the flood to be forced back so that silt is deposited to form the mud banks and islands of the delta.

1.6 TRANSPORTATION AND COMMUNICATION

The district is intercepted by the trunk road that connects it with the rest of Pwani Region and Dar es Salaam to the north and Lindi and Mtwara to the south across Mkapa Bridge over Rufiji River.

The district headquarters- Utete is about 240 km south of Dar es Salaam across the Mkapa Bridge. The rest of 35 km, the district headquarter is accessible throughout the year by grated road. Other parts of the district are accessible by rough roads while for the delta zone the only means of transport is by canoes and boats.

We have telephone links by TTCL as well as Vodacom, Airtel, Zantel and TIGO. Fax services are available at DED's office. DEDs' and DMO Offices are connected by Internet services.

1.7 EDUCATION

Rufiji district Council has 115 Primary Schools owned by LGA. At least each village has one primary school. There are 16 public Secondary schools. The enrollment in Primary schools is 90%. Also the district has Focal Development College providing the vocational training.

1.8 OTHER INTRODUCTORY INFORMATION

Other factors that influence health conditions or access to health services in Rufiji district comprises three Agro-ecological zones as follows:-

i. The Flood Plains Zone

This zone is situated along the Rufiji river basin .It begins at an attitude of 200ft above sea level where the river leaves the steep side of Stigler's gorge and spreads out along the flat valley floor and extends up to 130 kilometers downstream to the Delta.

ii. The Delta and Coastal Zone

The Rufiji delta and coastal zone extends north to South along about 75 kilometers of the coast and stretches inland around 25 km in a roughly deltaic shaped caused by the interaction of the river floods and the tides.

iii. The Plateau (Hill area zone)

The plateau zone is between the Rufiji floodplain and Kisarawe district in the north.

4.1.6. DATA COLLECTION METHODS AND SOURCES OF DATA

2.1. DATA SOURCES AND THEIR DATA COLLECTION AND ANALYSIS METHODS

Data collection is mainly of Health related issues. These are collected from all health facilities found in the council (Public and Private). Some are from communities surrounding the Health facilities e.g. death reports. The data are of health issues (diseases and services) i.e. Curative and Preventive from each facility and community. The data are collected through HMIS tools and analyzed by the aid of DHIS 2 software at district level. Also there some data which are collected through vertical programs, surveys and census. These data are used in preparation of various reports and interventions plans such as CCHP and Council strategic plan. Also these data have been used in preparation of this DHP.

2.2 MANDATORY HEALTH INDICATORS

The following is a list of the standard health indicators that the district will assess from over time:

- The health status of the **Rufiji District** population.
- The status of the**Rufiji District Council** health system.
- The status of health service delivery in **Rufiji** district.
- Progress that has been made in the **Rufiji**district health sector.

Table 2-1. MANDATORY DHP HEALTH INDICATORS

HEALTH STATUS OF THE DISTRICT POPULATION	DISTRICT HEALTH SERVICE DELIVERY
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	**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

RUFIJI DISTRICT HEALTH PROFILE

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

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 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 RUFIJI DISTRICT

RUFIJI DISTRICT SPECIFIC INDICATORS
a. Percentage of health facilities with functioning HFGCs.
b. Percentage of facilities Referring patients using canoes and Boats for the hard to reach area -DELTA
c. Provision of P4P to health facilities that provide RCH services

2.4 KEY MESSAGES ABOUT HEALTH INDICATORS

- In order to reduce maternal deaths in Rufiji district all health facilities should provide delivery services. Out of 64 health facilities, 56 health facilities are providing RCH services.
- All health facilities in the district should be governed by HFGCs. This aspect will provide chance for the Community to be involved in improving health services. To date we have 60 Health facilities with HFGCs and only 4 facilities owned by Private sector do not have HFGCs.
- There are 10 health facilities providing Emoc services located in Delta area.

3. HEALTH STATUS OF THE DISTRICT POPULATION

3.1 MATERNAL, NEWBORN AND CHILD HEALTH

Nutritional Status: Low Birth Weight

Rufiji District Council is one of the districts that experience incidences of malnutrition.

In the year 2012 the children with malnutrition were 13,301 (15%) among them 1% had severe malnutrition. The opportunity that the district has in regard to nutrition is that the majority of Rufiji Inhabitants are famers, fishermen and few are livestock keepers. All the available data on nutrition were obtained through under five clinic visits.

Figure 3-1. Nutritonal Status: Low Birth Weight

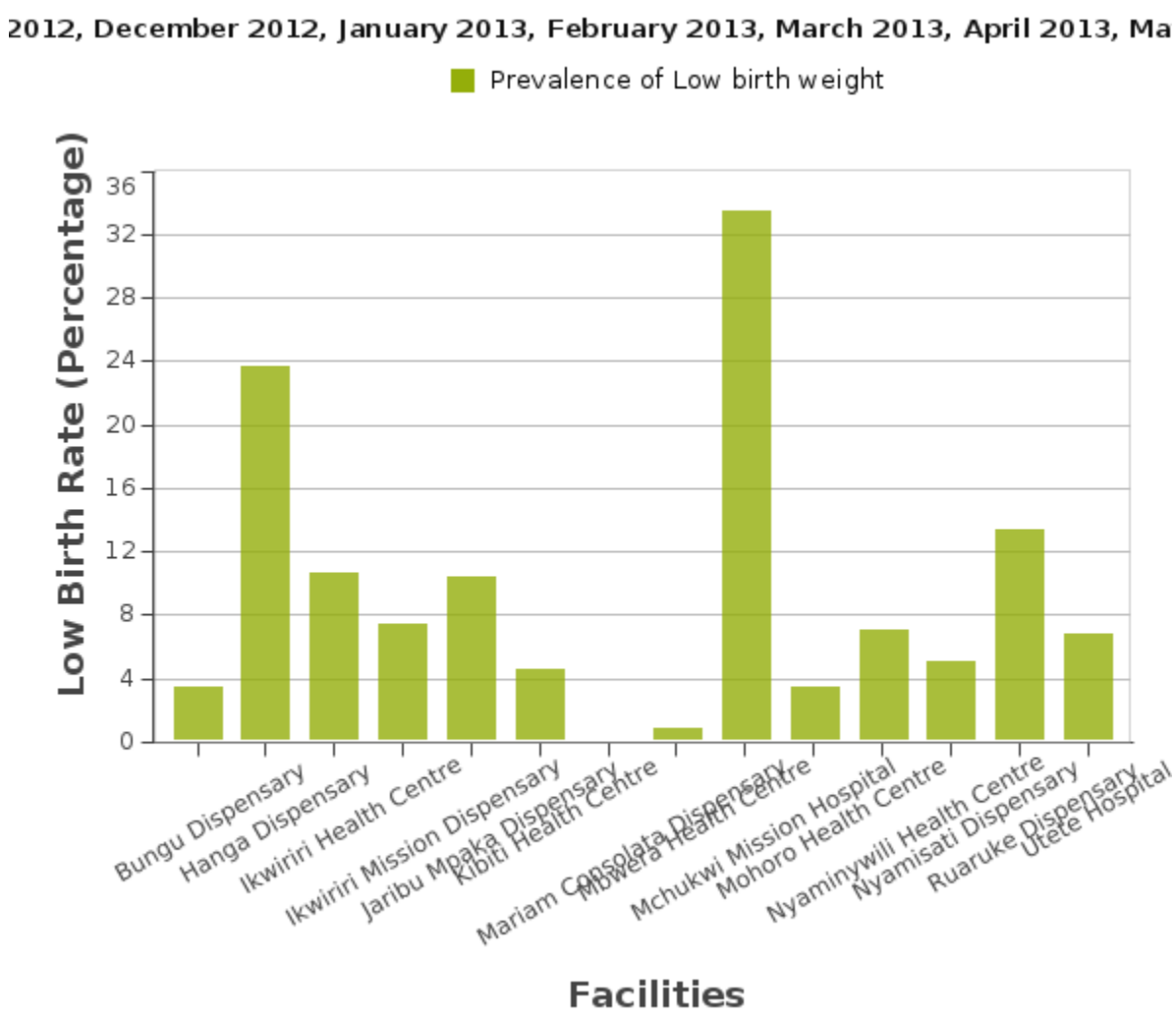


Figure 3-2. Below is the graph showing Neonatal motality rate for 2010,2011 AND 2012 from Facilities providing delivery services

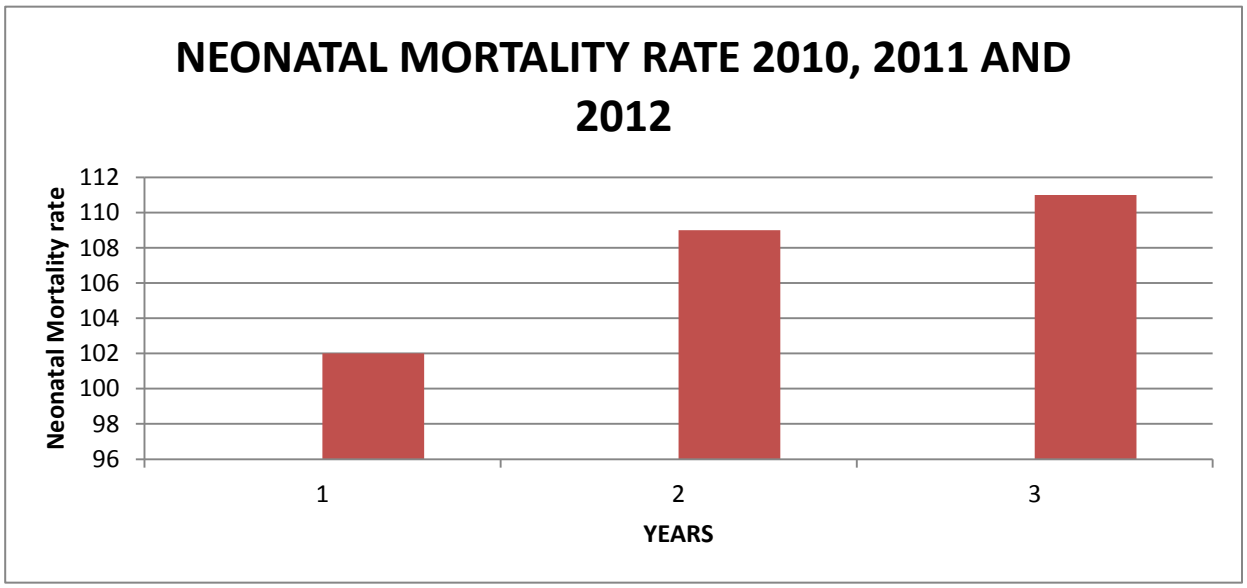


Figure 3-3. Infant Mortality Rate

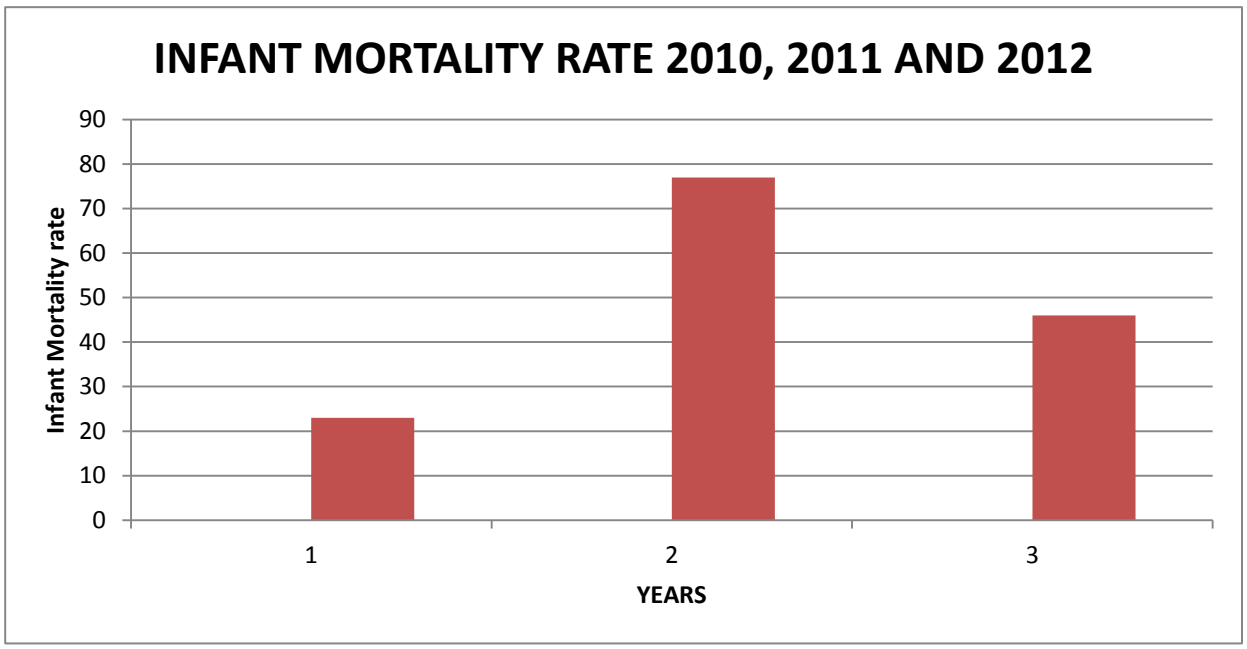
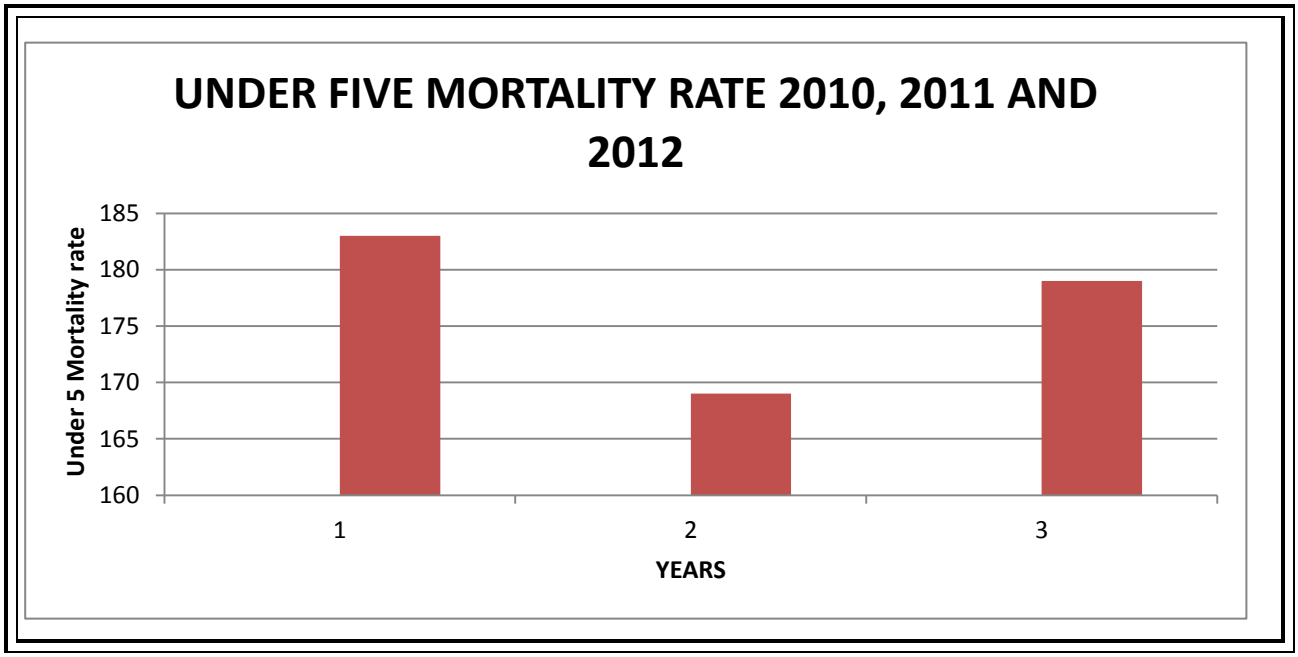


Figure 3-3. Under 5 Mortality Rate



3.2. MORBIDITY

In the table below 17 facilities represents 64 facilities available in Rufiji D.C in malaria confirmed cases. The detection of malaria cases was facilitated by the introduction of rapid malaria testing algorithm by aid of MRDT as well as microscopes in some facilities. Laboratory confirmed cases of Malaria for the year 2012 is as shown in the figure below:

Figure 3-3. Laboratory Confirmed Malaria Cases

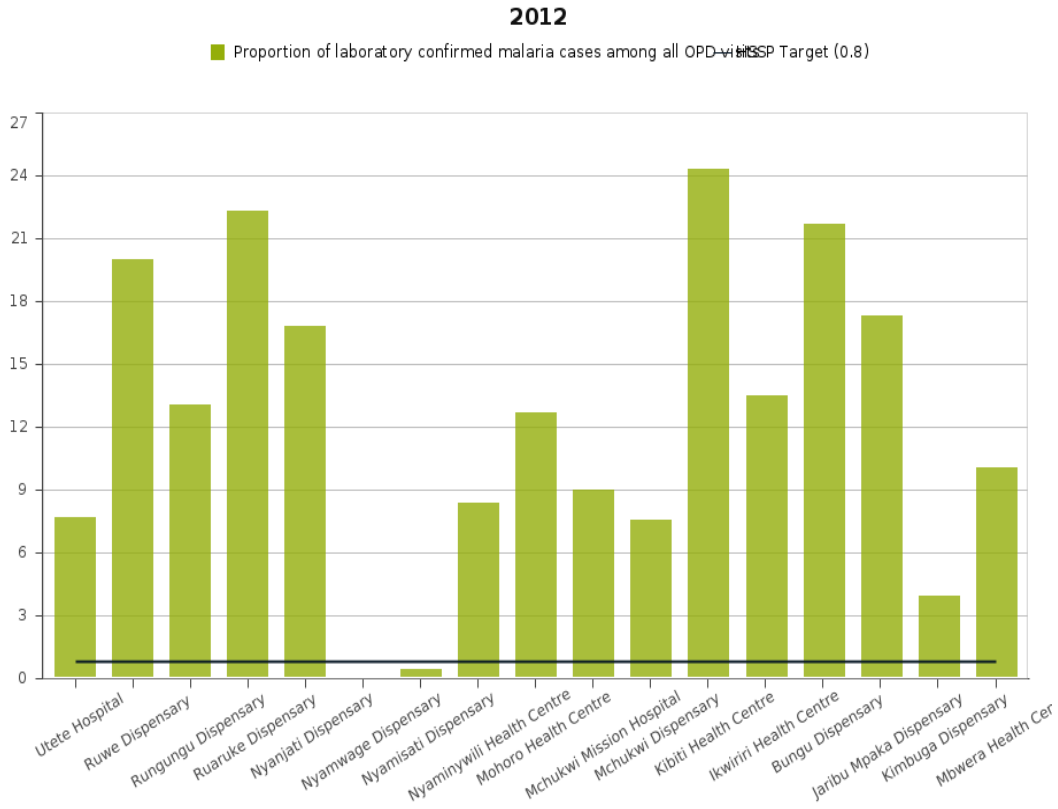


Figure 3-4. ANC HIV/AIDS Prevalence

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RUFIJI DISTRICT HEALTH PROFILE

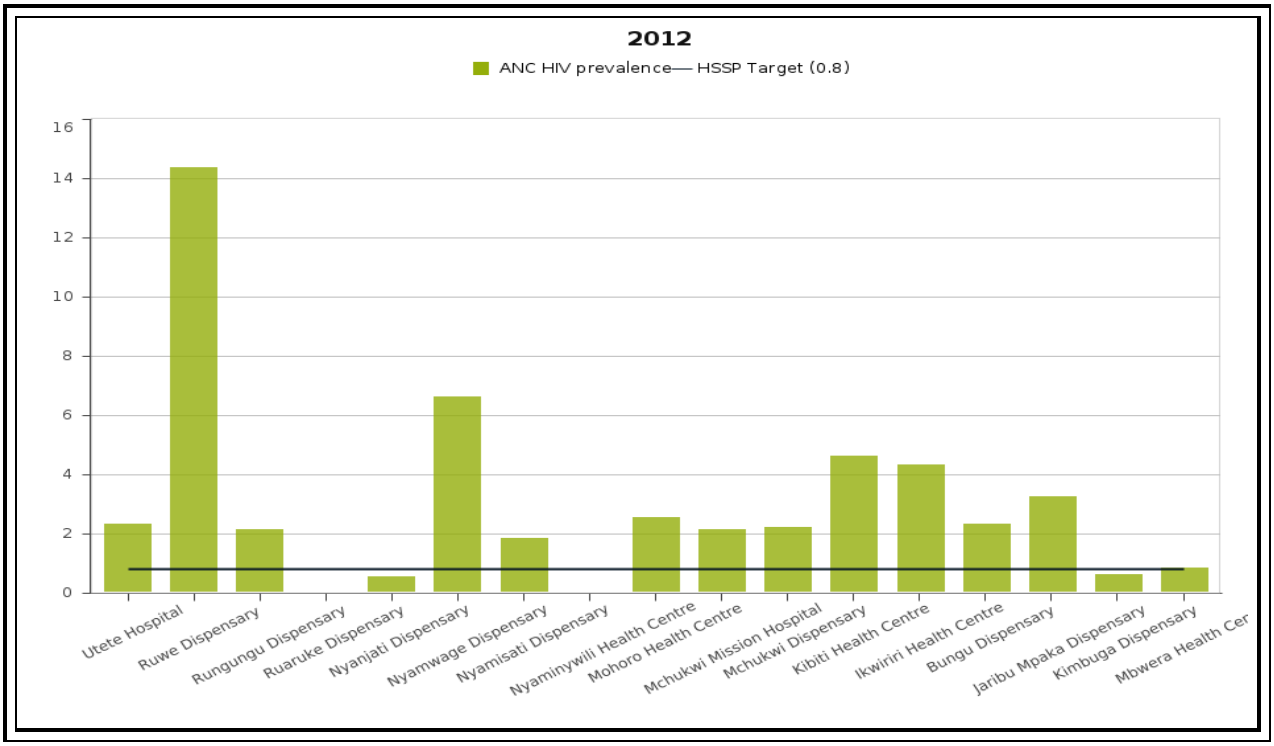


Table 3-1. Top 10 Causes of Admission/Inpatient Diagnosis

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

Table 3-2. Top 10 Causes Of Death

S/N	Causes of Death	Under 1 Month	1 Month - < 1 Year	1 Year –< 5 Years	5 Years - > 5 Years	TOTAL
1	Acute Diarhea (< 14 days)	1	68			69
2	Other Diagnosis	1	1	6	14	22
3	Severe / Complicated Malaria	1	3	13	2	19
4	Severe Pneumonia		2	17		19
5	Other gynaecological diseases				12	12
6	Uncomplicat- ed Malaria	2	2	3	1	8
7	Severe Anaemia			4	3	7
8	Mild / Moderate Anaemia			5	1	6
9	Pneumonia	1		2	3	6
10	Urinary Tract Infections (UTI)				6	6

3.3. OPTIONAL HEALTH STATUS OF THE DISTRICT POPULATION INDICATORS

Rufiji is among the districts in Pwani region which owns 14 health facilities located in hard to reach areas all over the year, but the district struggles to make sure that all health services are provided accordingly.

3.4. DISTRICT HEALTH STATUS CONCLUSIONS, RECOMMENDATIONS AND WAY FORWARD

The overview done through District health profile shows low birth weight is still high, this is because of low education/ knowledge on how to care/ diet of nutrition

status because Rufiji is among the districts which contribute the income of the country through cultivation/ agriculture. So the effort must be added on RCH to insist health education to pregnant mothers and increase male involvement whose take care of their wives.

Also malaria is still one of top ten diseases, so ITN must be provides to pregnant and under five by using Hatipunguzo as well as health education on how to eliminate malaria breeding sites.

Community sensitization must be insisted/improved on HIV/AIDs as well as adherence of PLHA on ARV for those who are eligible and attendance to CTC in order to reduce number of transmission HIV.

RECOMMENDATIONS

- Low male involvement on RCH services is one of the reasons that increase maternal deaths and low birth weight; therefore all facilities should at least reach 80%.
- Because of presence of malaria confirmed positive cases the district must ensure availability of skilled medical personnels in all facilities who will diagnose and treat all malaria cases correctly.
- Nowadays all plans in district relays on DHIS2, so Data entry and data verification must be done by all coordinators before and after data entry to help correct planning.

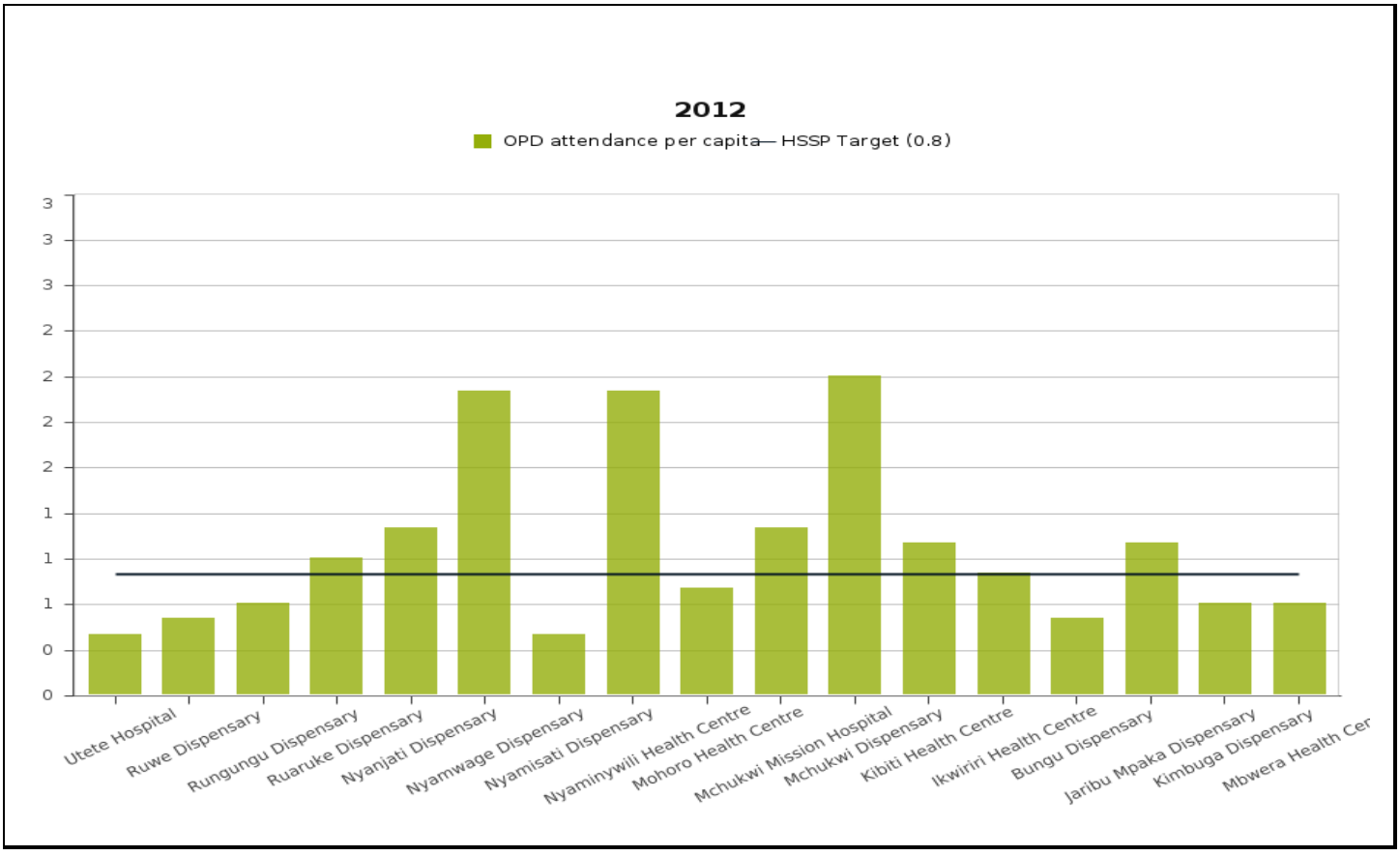
4.1.7. STATUS OF HEALTH SERVICE DELIVERY IN THE DISTRICT

4.2. GENERAL HEALTH SERVICE

4.2.1. OPD ATTENDANCE

With the exception of Utete, Nyamwage and Ruwe health facilities the OPD attendance rate per capita is below 1. The table below summarizes the attendance rate per capita in each health facility found in Rufiji DC.

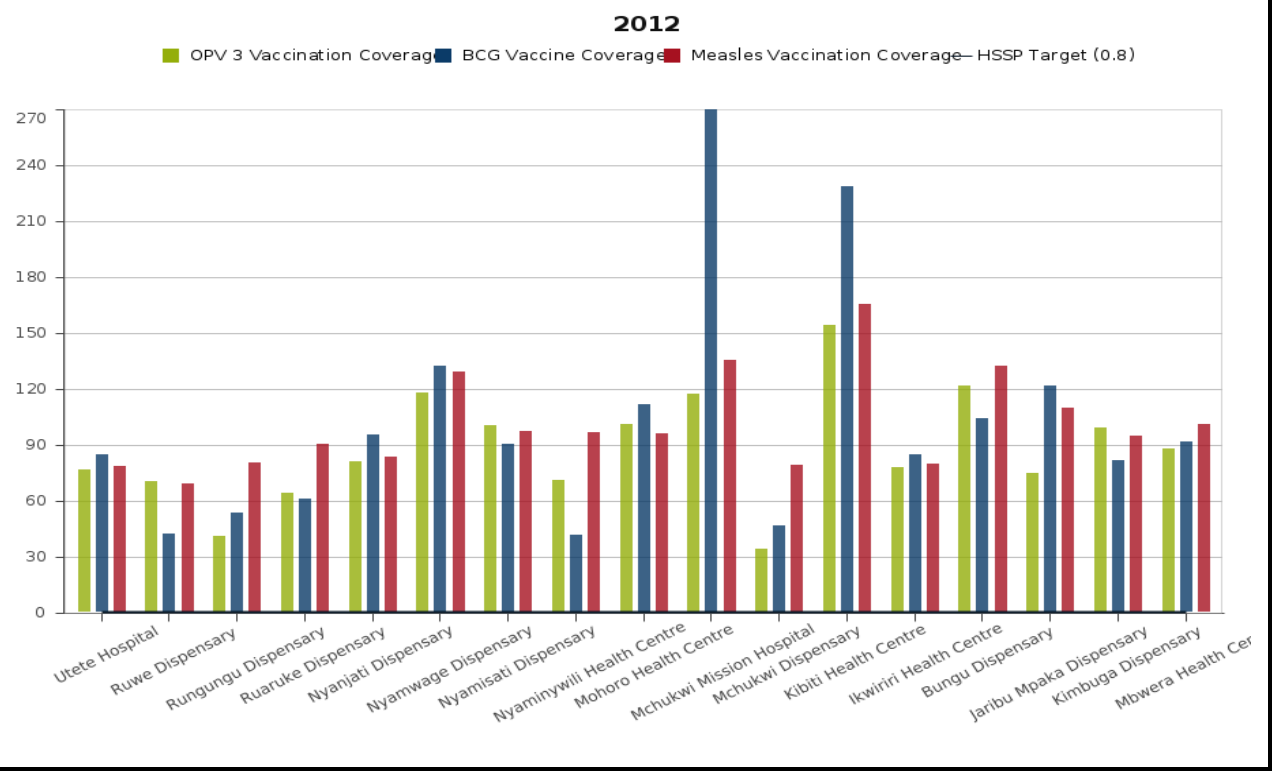
Figure 4-1. Some of all facilities selected to represent the OPD attendance but most of them is below



4.2.2. VACCINATION SERVICES

The table below showssome of health facilities having low vaccine coverage compared to the target population, this could be attributed by low completeness of data entry in DHIS2

Figure 4-2. Under 1 Year



4.3. REPRODUCTIVE HEALTH SERVICES

4.3.1. Out of 64 health facilities 56 provide EMoC and among of them three provide CEmoC but the district is planning to provide Emoc in all 64 facilities because of geographical location of the district, also table show some of H/F have low number of the ANC attendance bellow 12 weeks Gestation.

4.3.2.

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

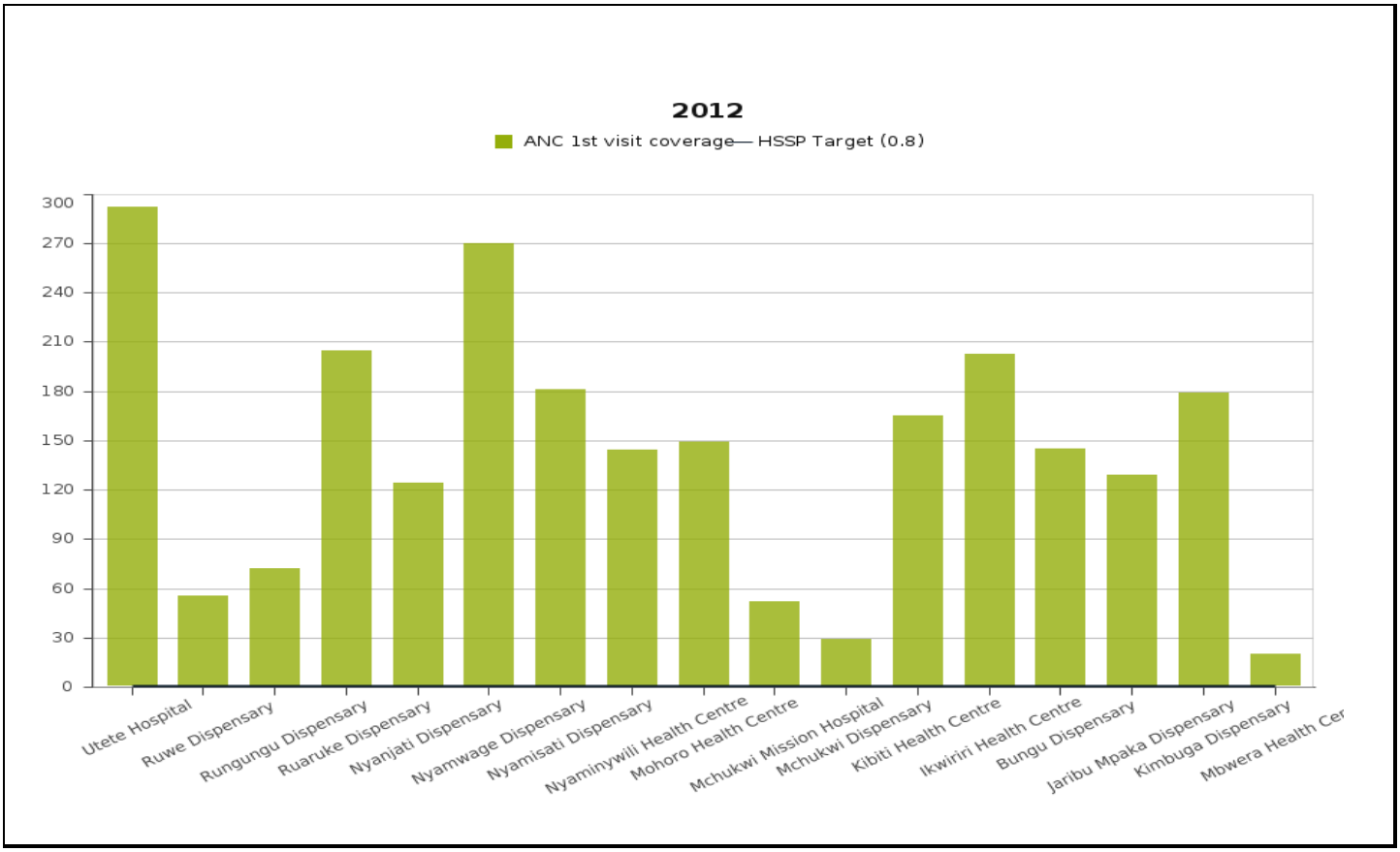
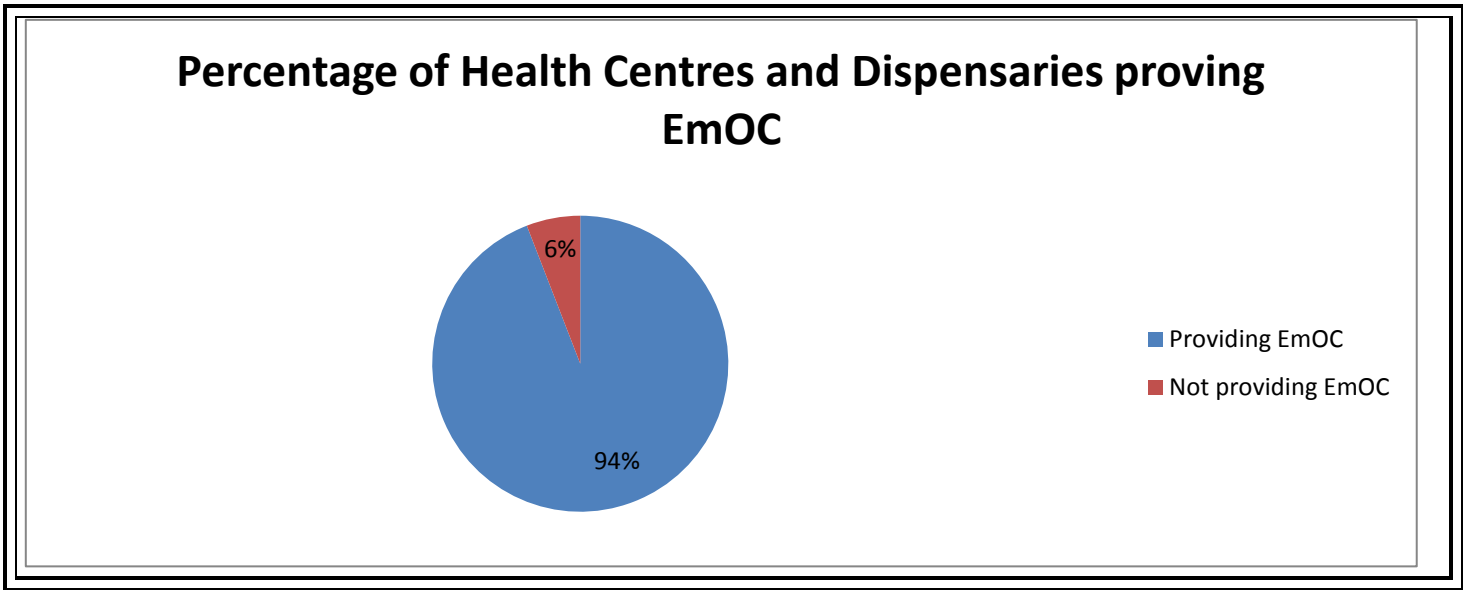


Figure 4-4. Percentage of health centers and dispensaries which provide EmOC as defined in EHP



4.4. INFECTIOUS DISEASE AND NON-COMMUNICABLE DISEASE HEALTH SERVICES

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

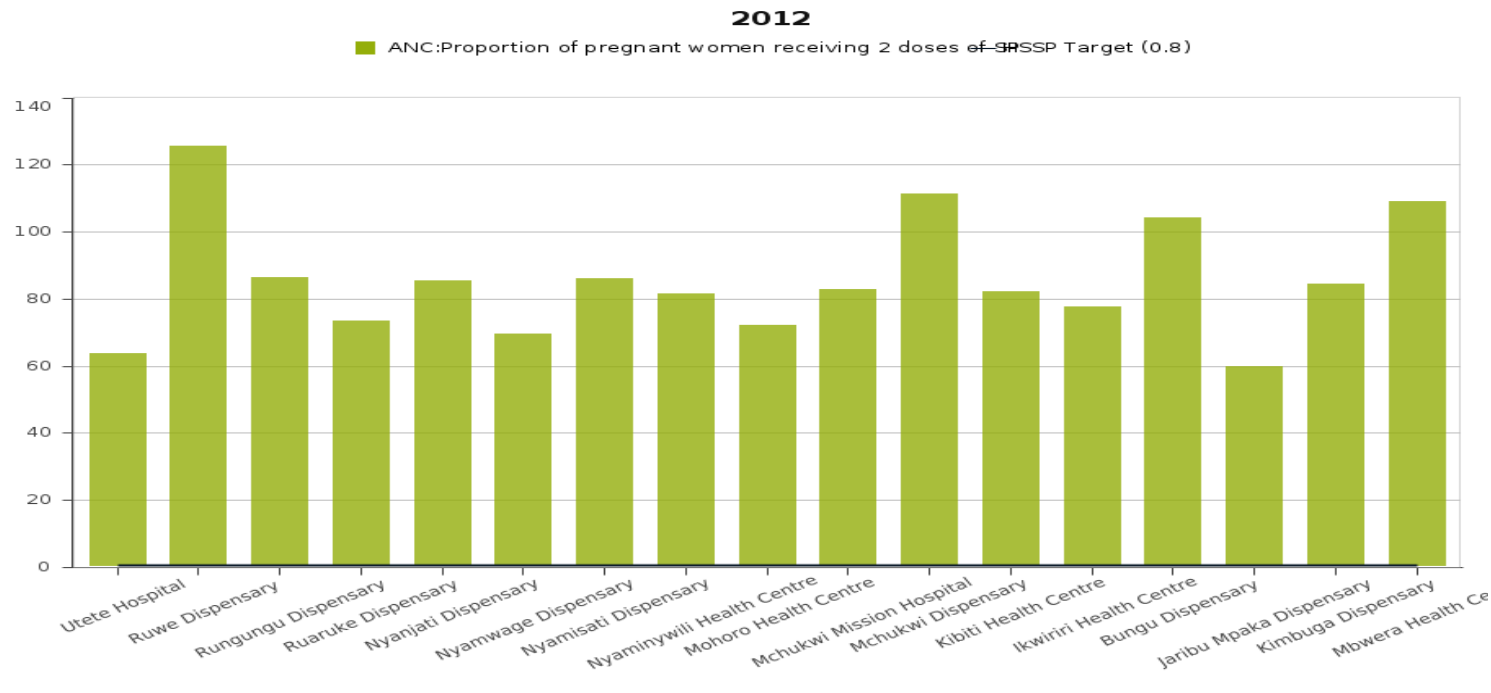


Figure 4-6. On the table below shows that other facilities are performing very low which reflect on lack of

knowledge of the entire community on important of buying and use ITN

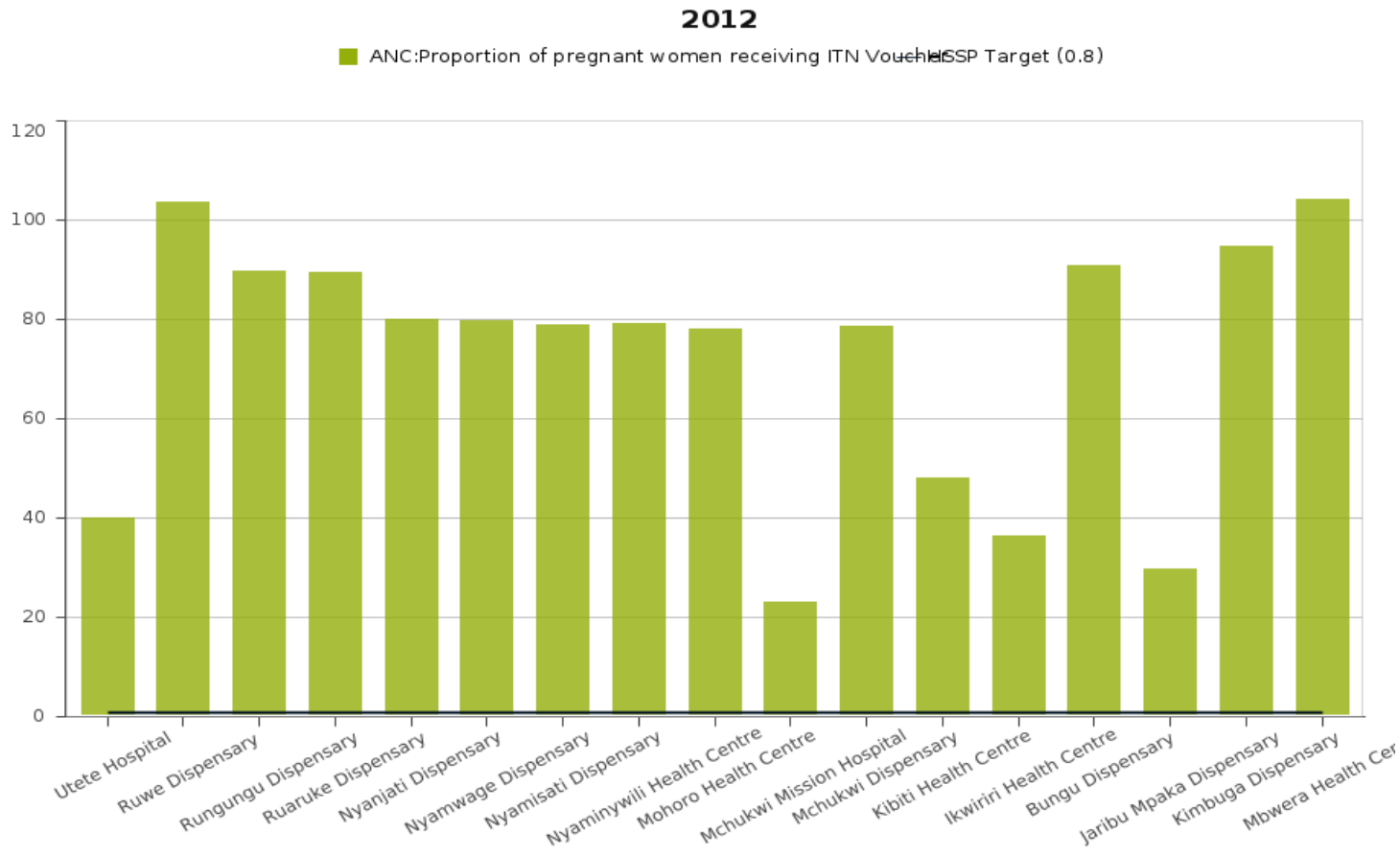


Figure 4-7. Proportion of laboratory confirmed malaria cases among all OPD visits

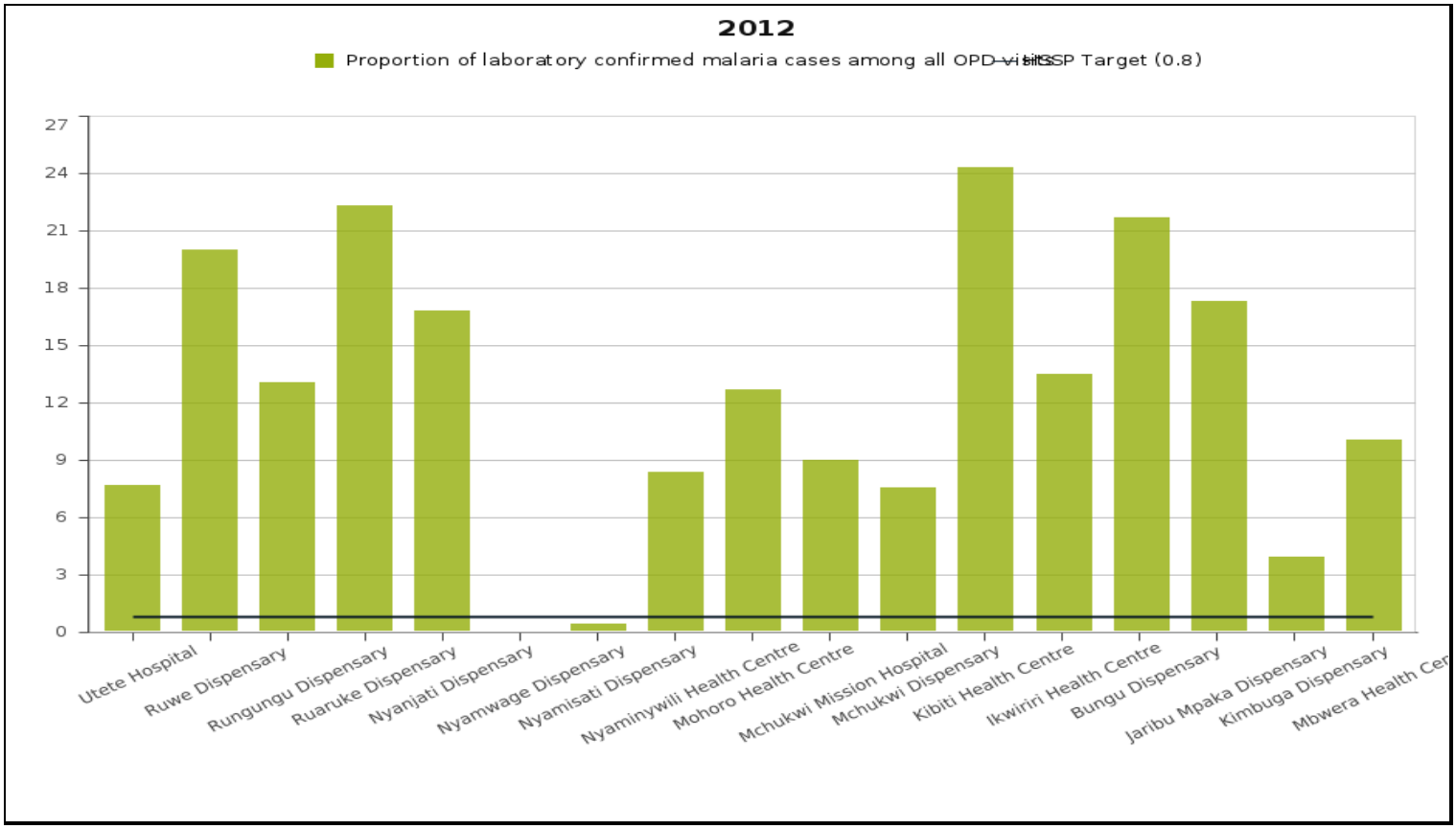
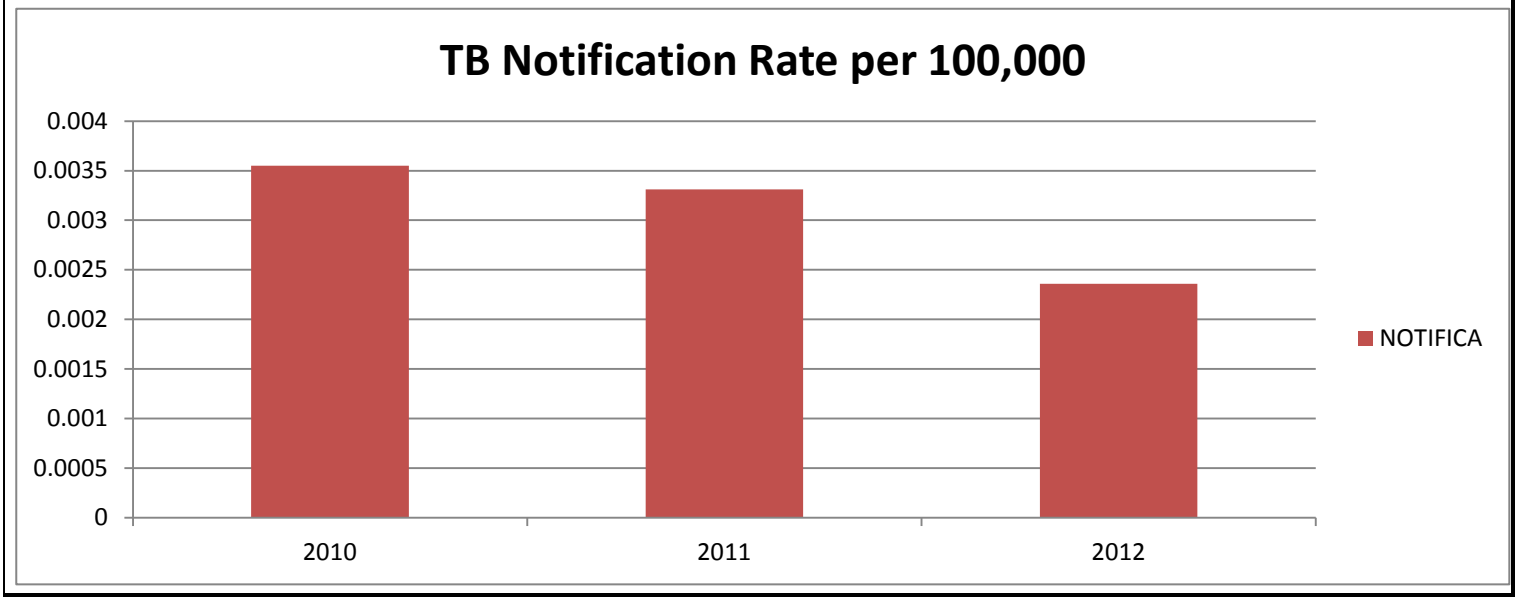


Figure 4-8. The below shows decline of case detection rate for three years



4.5. DISTRICT HEALTH SERVICE DELIVERY CONCLUSIONS, RECOMMENDATIONS AND WAY FORWARD

According to an overview of the above situations the district must take efforts to reduceall problems detected such aslow Malaria and TB detection rates and to improve collection and entry of correct data in DHIS2.

WAY FORWARD

TB notification by 2013 must involve pediatric TB

To orient CHMT and train Health Care providers on pediatric TB

To train mobile sputum fixers on 3 wards

To intensify laboratory services

5. STATUS OF DISTRICT HEALTH SYSTEMS

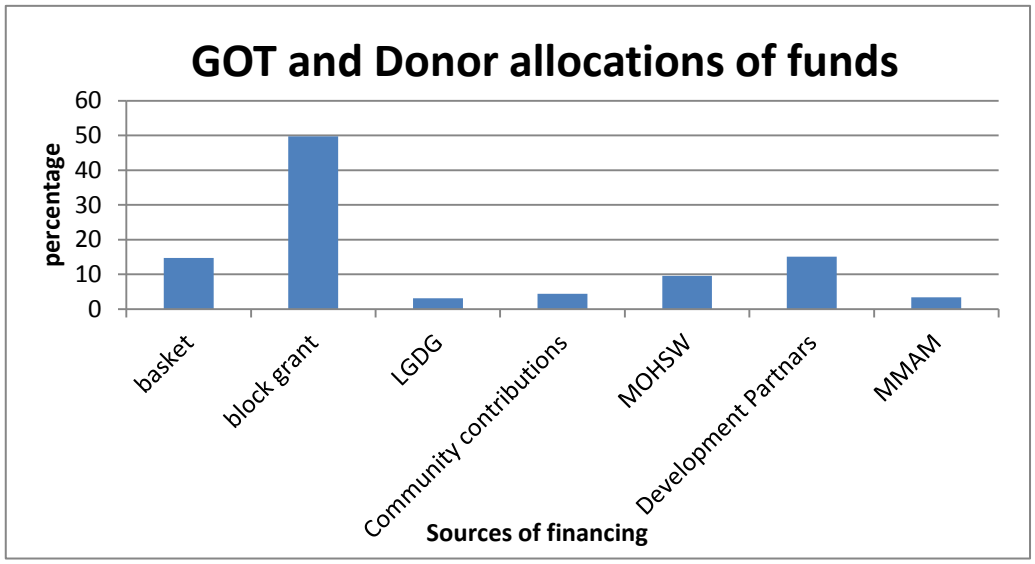
5.1. HEALTH FINANCING

For the financial year 2011/2012 the Rufiji Comprehensive Council Health Plan approved budget was from 7 main sources of funds, these include

i. Block Grants
ii. Basket Fund
iii. LGDG
iv. Community contributions (CHF, User fee, DRF & NHIF)
v. MOHSW
vi. Development Partners (PATHFINDER, PATH, ADB, CHAI, TANAM, PAMOJA TUWALEE, CONNECT & KLCCDA)
vii. HSDG/ MMAM.

Every donor provided fund for activities of interest but no activity was funded by more than one donor at a time. During 2011/ 2012 period the Council planned to implement 150 activities, however only 116 were implemented (77.33%). The main challenge was delaying of disbursement of funds from different sources, which led to accumulation of activities to be implemented thus affecting implementation schedule.The figure below show TOTAL GOT AND DONOR (BUDGET AND OFF-BUDGET) allocated per capital in the district

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



5.1.1.

5.2. HUMAN RESOURCES FOR HEALTH

The projected population for Rufiji D. C in the year 2012 was 247,414.

The Council has 4 Medical Officers, 10 Assistant Medical Officers, 51 Clinical Officers, 39 Nurse Midwives, 3 Pharmacist Staff, 6 Environmental Health Officers and 10 Laboratory Staff.

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

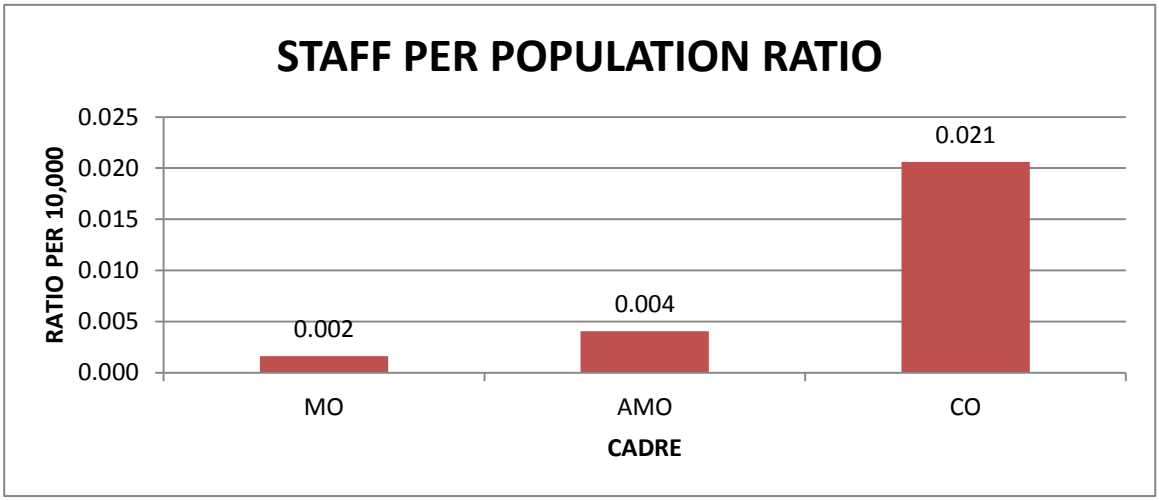


Figure 5-4. Number of Nurse mid-wives, Lab Techs, Pharm Techs Per 10, 000

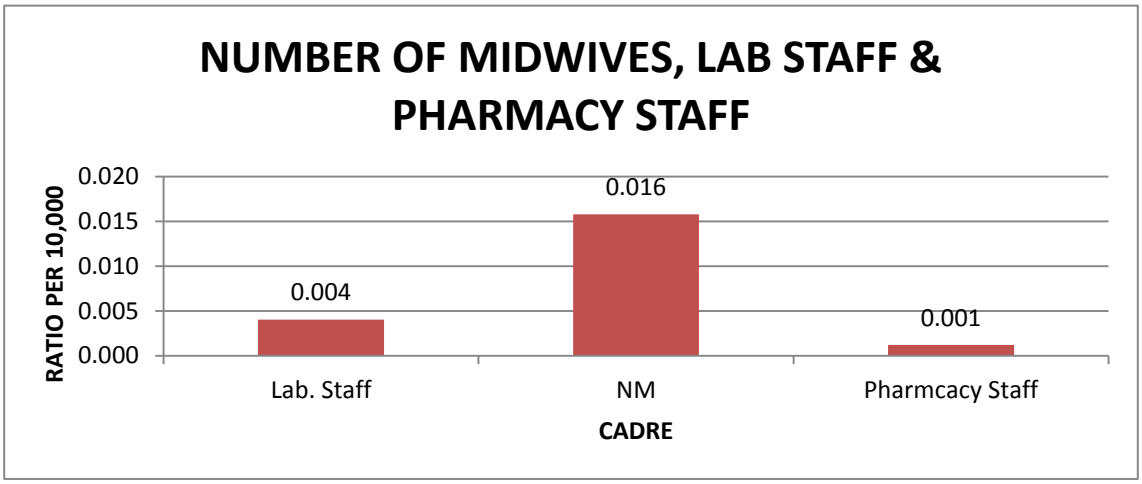
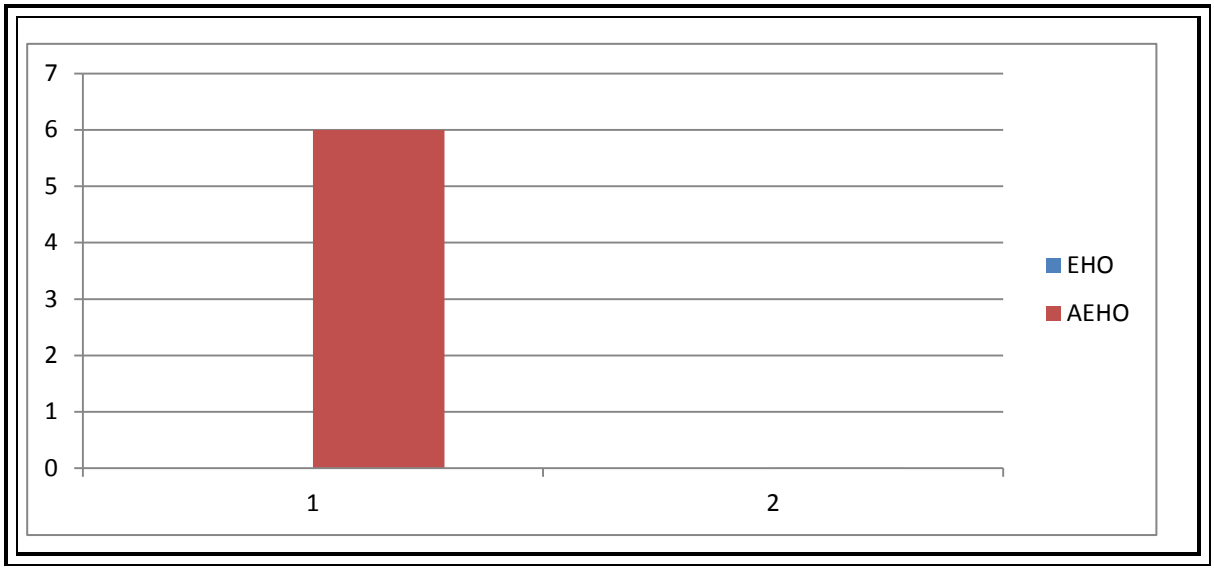


Figure 5-5. Number of EHOs, and AEHOs Per 10, 000



5.2.1.

5.3. MEDICINES/DRUGS

In the year 2012 the stock out of tracer medicines, vaccines and medical supplies was experienced by facilities in different levels. The availability situation and stock out are as shown in the figures below

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

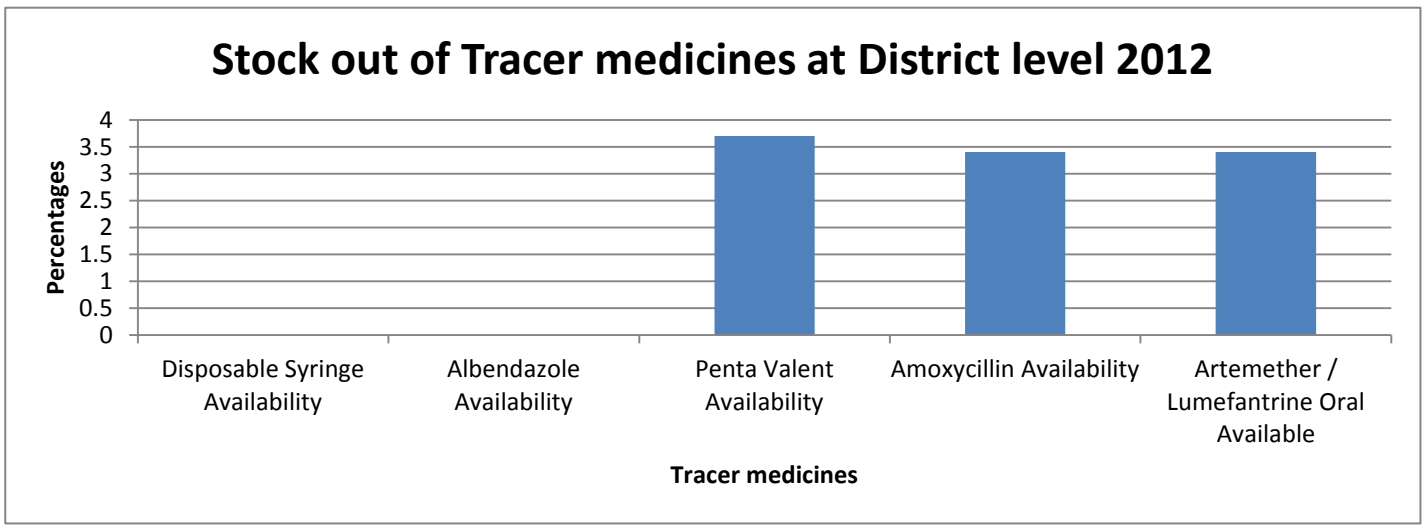
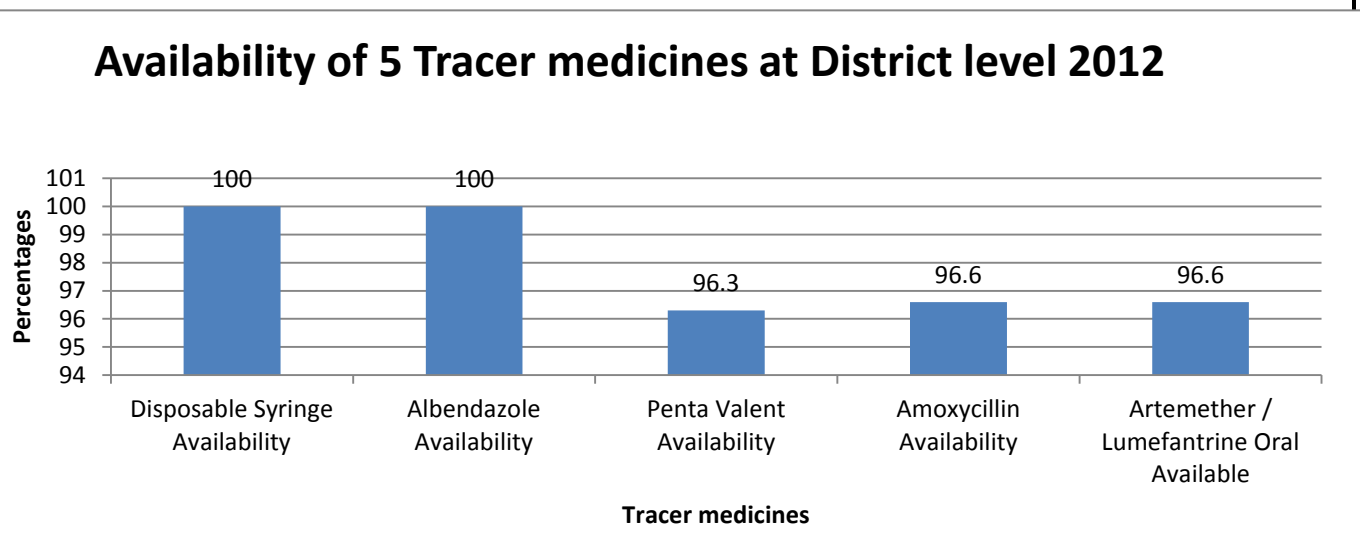
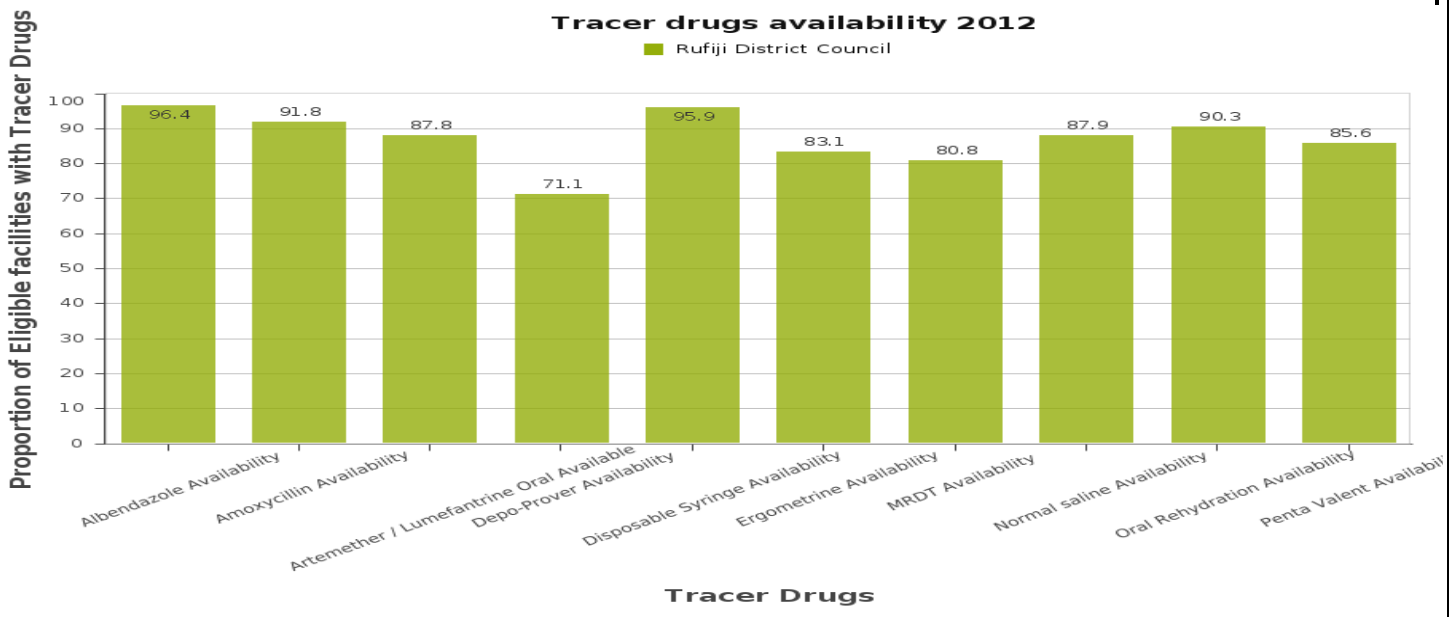


Figure 5-7. Availability of Tracer Drugs





5.4. INFRASTRUCTURE

In Rufiji district council 38 HFs (54.3%) need minor rehabilitation while 14 HFs (20%) need major rehabilitation. Under MMAM program the District Council has managed to construct 11 new HFs (4 H.Cs and 7 Dispensaries) which is being implemented by the council towards achieving the goals for the reduction of those health problems facing the community to deliver promptly health care services. The challenges that the district face is lack of staff houses for CHMT members and at the health facility level the deficiency of staff houses is 50%.

5.5. DISTRICT HEALTH SYSTEM CONCLUSIONS

Rufiji district council is among the Councils that are donor dependent in implementing health activities. About 90% of the health budget depends on donors and other implementing partners. For the district to reduce dependence mobilization and sensitization on cost sharing especially CHF to the entire community is of paramount importance. This will help the council to manage to purchase and distribute drugs, medical equipments and other supplies in absence of outside support.

WAY FORWARD

- Purchasing Medicines, medical supplies and reagents in private markets when are out of stock in MSD.
- Rufiji District Council continues to allocate hardship allowances to hard to reach and hard to stay areas so as to motivate HWs, especially Skilled Health Staff.
- The district continue to think about strategies on how to retain HWs by adding equipment and supplies to the HFs, Constructing more Staff houses, providing fringe benefits such as on call and extra duty allowances and supporting HWs during upgrading studies.
- Strengthen Integrated Logistic System with quarterly visits to MSD to ensure adequate supplies and equipment.

- To construct 2 more health facilities and to recruit more health staffs of different cadre to ensure that the peripheral villages of Kitomondo and Msua has accessible to health facilities.
- CHMT to conduct supportive supervision with RHMT and other partners for the purpose of ensuring the sustainability of these existing projects in the district.

6. AREAS OF PROGRESS IN THE DISTRICT HEALTH SECTOR

6.1. PROGRESS IN DISTRICT HEALTH FINANCING

6.1.1. There are nine sources of funds support including Local Government block grants, Own sources (council funds), community funds (Cost Sharing/CHF), NHIF, Health sector development Grants, Health Sector Basket Fund, Capital development Grants and MMAM and other donors. Some of the activities targeted covered during the year of implementation.

6.2. PROGRESS IN DISTRICT HUMAN RESOURCES

In the past three years Rufiji district council recruited 2 Medical Officers, 2 Nursing Officers, 4 Clinical officers, 6 Assistant Nursing Officers and 2 Assistant Environment Health Officers. Also the following Cadres upgraded for higher learning institutions these included 10 Clinical Officers to Medical Doctor course, 1 Pharmaceutical Technologist to Pharmaceutical Science course, 3 clinical officer to AMO course, but they are still on studies.

CADRE	2010	2011	2012
MO	1	1	4
AMO	4	5	10
NO	0	0	3
ANO	24	26	33
CO	76	72	54

NM	27	30	30
Pharmacist	1	1	1
Lab. Tech	2	1	3
TOTAL	**135**	**136**	**138**

6.3. PROGRESS IN DISTRICT NEONATAL HEALTH

6.3.1. LOW BIRTH WEIGHT

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 together with three ambulances to facilitate referral to near health centre and hospital these assisted in reduction of the number of targeted indicators. The malnutrition rate in the district is low compare to that of region and national wide.

Presence of unit (KMC) to care low birth weight babies at the district reduces the mortality rate for the parameter. Education for pregnant women during ANC visits on the importance of good health and nutrition also helps to reduce number of low birth weight.

6.4. PROGRESS IN DISTRICT HEALTH FACILITY COVERAGE

From 2010 to 2012 coverage of health facilities has increased from 59 facilities (2010) to 64 facilities (2012. So it shows that increase number of health facilities was minimal, but the policy indicating that every village to have dispensary and Health center in wards.Also every district to have not more than 5 kilometers to reach by the client.

6.4.1. PROGRESS IN DISTRICT HEALTH FACILITY PERFORMANCE

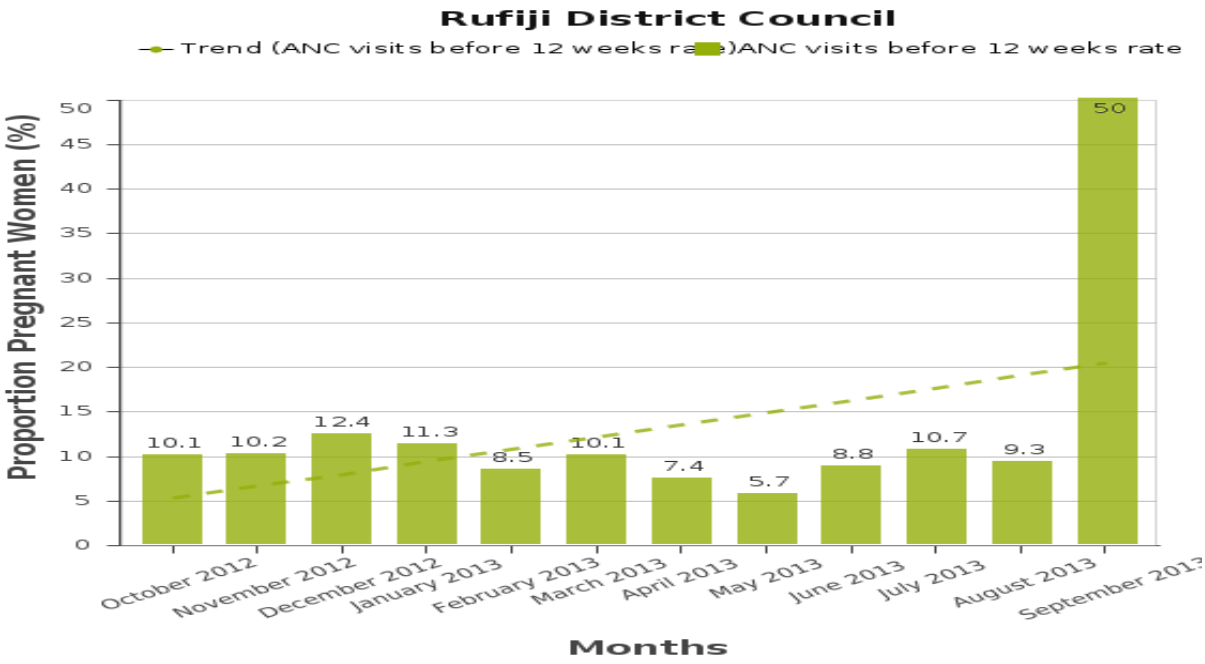
- In Rufiji district the critical health services are Improvement of referral system done by introduction of the use of mobile phones in all health facilities whereby Clinicians and Nurses are normally discussing on difficult cases prior to their referral. This situation has reduced to a large extent the number of referred cases to higher level. Also the district has increased number of Ambulance cars from 1 to 3, and we are about to receive another 2 ambulance boats for North and South delta.

- In the past 3 years there is improvement of health facility reporting rate, from less than 70%(two years ago) to 98%.

6.4.2. EXPANSIONS IN CRITICAL HEALTH SERVICES

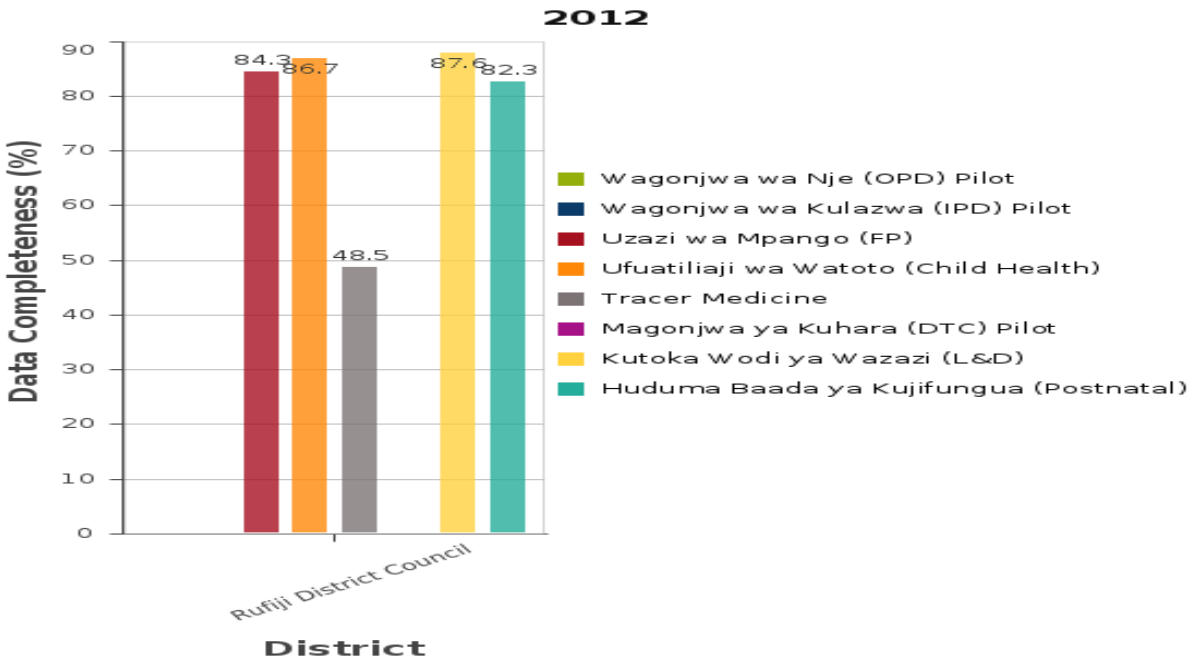
6.4.3. IMPROVEMENTS IN REFERRAL HOSPITAL PERFORMANCE

6.4.4. PROGRESS IN ANC ATTENDANCE



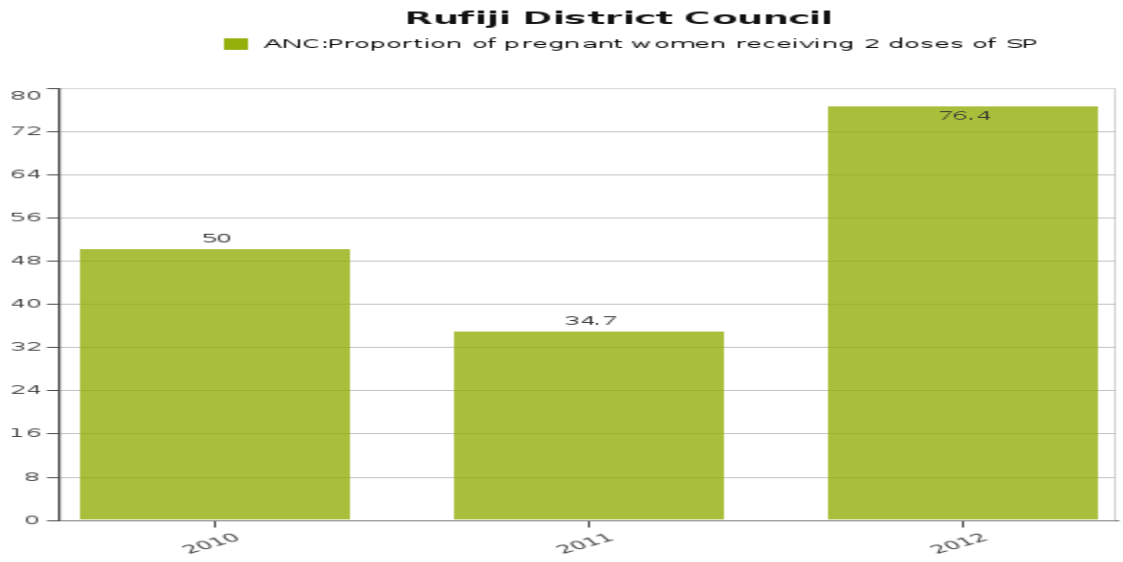
6.4.5. PROGRESS IN HEALTH FACILITY REPORTING RATES

6.4.6. TIMELINESS AND COMPLETENESS OF DAT



6.5. PROGRESS AGAINST MILESTONES

The proportional of pregnant women receiving IPT 2 showing the progress which show that 2010 50% was on the middle which is half way but 2011 reduced to 34.7% and the percentage increased to 76.4% but the problem was very low on DHS because data entry was very low.



6.6. BEST PRACTICES/CASE STUDIES

- Some of the clients with leprosy at Kindwitwi Dispensary developed septic wounds. To address this problem the health facility used pawpaw which helped to clear pus within short time and continued dressing using other antiseptics.
- Also to manage sustainability of health services in the hard to reach areas which is Delta area, Different measures were used to inssure availability of health services in 14 health facilities, some measures are like using canoes help to reach those facilities.