The United Republic of

TANZANIA

Ministry of Health & Social Welfare

NGARA

District Health Profile

HMIS REPORT

INTRODUCTION

Ngara District council is among of eight councils in Kagera Region. It has a total population of 379,057 according to national census of 2012. Ngara District is divided into four divisions namely Nyamiaga, Kanazi, Rulenge and Mursagamba. There are 22 wards, 75 villages, and 63,177 Households. It consist of 61 health facilities; 3 hospitals, 5 health centers and 53 dispensaries.

HEALTH STATUS OF THE DISTRICT	*Target*	*Baseline*	*Achievement*	*Achievement*

POPULATION	*by 2020*	*2015*	*2016*	*2017*
Nutrition Status				
Incidence of low birth-weight among newborns	2	8.6	5.5	4.3
Children under 5 who are underweight	11	141	123.2	103
Children under 5 who are stunted	27	0.81	0	0.05
Percentage of pregnant women with anemia	35	0.64	0.41	0.13
Maternal, Newborn and Child Health				
Neonatal Mortality rate (institutional)	16	4.2	0.5	3.45
Infant mortality rate (institutional)	35	6.9	6.9	4.97
Under five mortality rate (institutional)	55	6/1000	5/1000	3/1000
Maternal case fatality rate in health facilities	292	56/100000	66/100000	77/100000
Morbidity				
Confirmed malaria cases	**95**	91.9	98.9	**100**
Incidence of Leprosy for under 15 years	**<2**	0	0	**0**
HIV/AIDS prevalence 15-24 years	**3.2**	1.6	1.7	**0.39**
New outpatient (OPD) cases per capita in a given year	0.8	0.84	0.91	0.95
Number of Inpatient (IPD) admissions/100 population/year	2.5	9.1	5.7	4.1
Environmental Health				
Population using improved water source	**70**			
Population using improved sanitation facility	**30**	46.1	58.0	**69**
Social Welfare				
Adults in need of welfare & protection who received service	**50**	62	70	**70**
Children in need of welfare & protection who received service	**50**	6.4	7.3	**7.1**
District Specific Indicators*				
Indicator 1*				
Indicator 2*				

Part 2: District service delivery

DISTRICT HEALTH SERVICE DELIVERY	***Target by 2020***	***Baseline 2015***	***Achievement 2016***	***Achievement 2017***
Child Health (Immunization Coverage)				
Measles under one year	90	97.2	71.7	105
Penta3 under one year	90	84.9	88.3	88.5
Vitamin A supplementation coverage	56	109.3	133.3	123.7
Reproductive Health				
Contraceptive prevalence rate (Modern Methods)	35	10.5	10.4	32.3
ANC first visit before 12 weeks gestational age	40	6.2	11.5	32.3
Antenatal coverage : 4thvisits and above	60	25.3	35.1	46.3
Proportion of women uses IPT2 for malaria during pregnancy	80	61.4	69.5	69.5
Institutional (health facility) delivery coverage	90	60	63	72.4
Percentage of deliveries assisted by skilled health personnel	80	54.2	63	72.4
Postnatal care coverage within 7 days after delivery	70	85.8	84.2	110.2
Adolescents (under 20 years) birth rate				
Dispensaries and health centers providing BEmONC services	70	6	6	12
Health centers and hospitals providing CEmONC services	50	0.4	0.4	0.4
INFECTIOUS & NON COMMUNICABLE DISEASES				
HIV prevalence in 15-24 year age group	3.3	1.5	1.3	0.6
Vulnerable groups sleeping under LLINs previous night	80	0.13		60
Disability grade 2 among newly diagnosed Leprosy patients		0	0	0
Case detection rate for all forms of tuberculosis	72	90	91	96
Treatment success rate for all forms of tuberculosis	>90	90	91	92
HIV pregnant women on ARV for PMTCT	90	77.7	88.7	108
Adults & Children current on ARVs	80	385	723	16352
Raised blood pressure among adults (25-64 years)	25	2049	2519	3044
Raised glucose / diabetes among adults (25-64 years)	10	1317	1504	1470
Cervical cancer screening with VIA (30-50 years)	11	0	0	1.4
Incidence of Cholera		4.2	1.4	0
District Specific Indicators*				
Indicator 1*				
Indicator 2*				

Part 3: District Health systems

STATUS OF DISTRICT HEALTH SYSTEMS	***Target by 2020***	***Baseline 2015***	***Achievement 2016***	***Achievement 2017***
Financing				
Total GOT and donor allocation to health in the district				
Proportion of population enrolled in any health insurance				
Human Resources for Health				
Number of MO per 10,000 population	0.0005	0.05	0.05	0.2
Number of AMO per 10,000 population	0.0004	0.13	0.13	0.2
Number of CO per 10,000 population	0.132	0.36	0.36	0.5
Number of ACO per 10,000 population	0.012	0.5	0.5	0.05
Medical Officer (MO), Assistant Medical Officer (AMO), Clinical Officer (CO), and Assistant Health Officer(AHO) per 10,000 population	0.0381	4	4.1	4.5
Nurses and midwives per 10,000 population	0.03	3.3	3.4	3.5
Medicines and medical products				
Health facilities with all 10 Tracers	80	88.2	86.2	95.6
Order fill rate from supply agency	90			
M&E for Health				
Proportion of expected reports submitted in a given year	95	100	100	100
Proportion of reports entered in the system on time at district	95	100	100	100
Primary health facilities with 3-start rating or higher	50		3.4	27.5
District Specific Indicators*				
Indicator 1*				
Indicator 2*				

HEALTH STATUS OF THE DISTRICT POPULATION

- **Maternal, newborn and child health**

Nutrition status under 5 Children who are stunted decreased due to improved focused antenatal care .

The main causes of neonatal death are pneumonia, prematurity, hypothermia and birth asphyxia. Neonatal mortality rate was increased from 0.5 2016 to 3.45 in 2017 due to shortage of skilled personnel

The main causes of under five death were; severe malaria, diarrhea, acute and anemia. The under five death was reduced from 5/1000 to 3/1000 due to improved health services

Maternal mortality rate was increased by 77/100,000 from previous year. This was due to inadequate knowledge to health workers on SBMR leading to high number of community death. Through the review of maternal and perinatal death by using maternal and perinatal death surveillance and response guideline introduced by Ministry of Health Community Development Gender, Elderly and Children. The guideline was used to all levels (CHMT, hospital, health centre and dispensaries). The dysfunction identified during review meeting addressed accordingly, includes strengthened community linkage, using of partograph, family planning, focused antenatal, post natal care and referral system. The interventions are incorporated in CCHP 2018/2019.

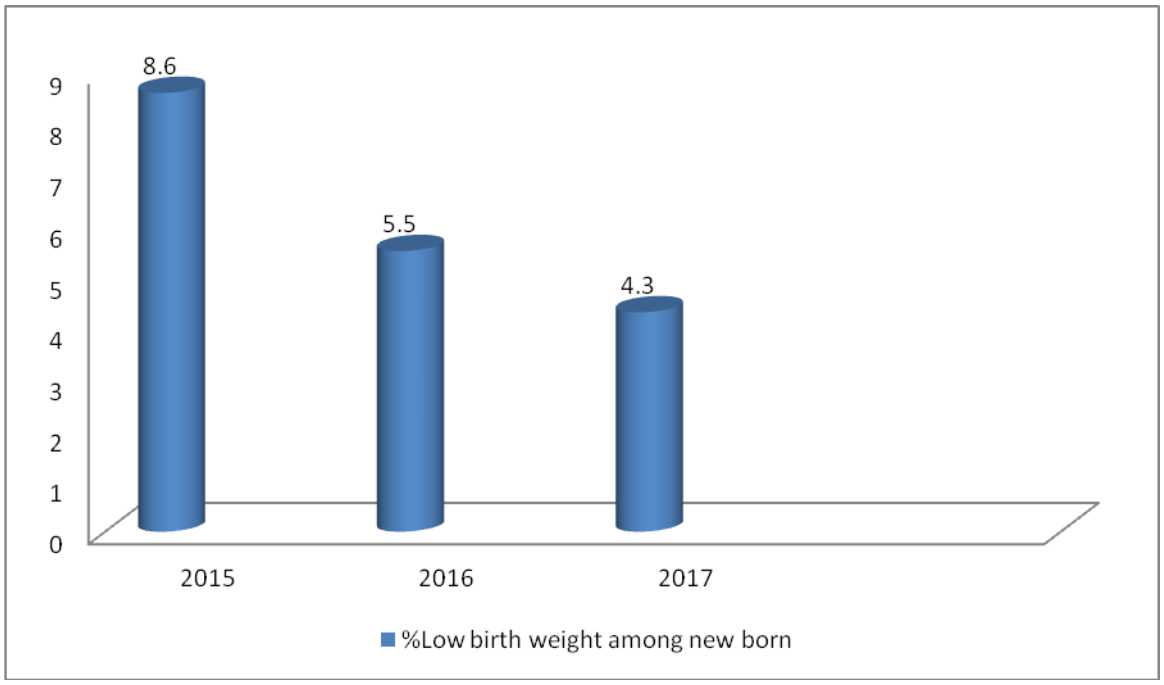
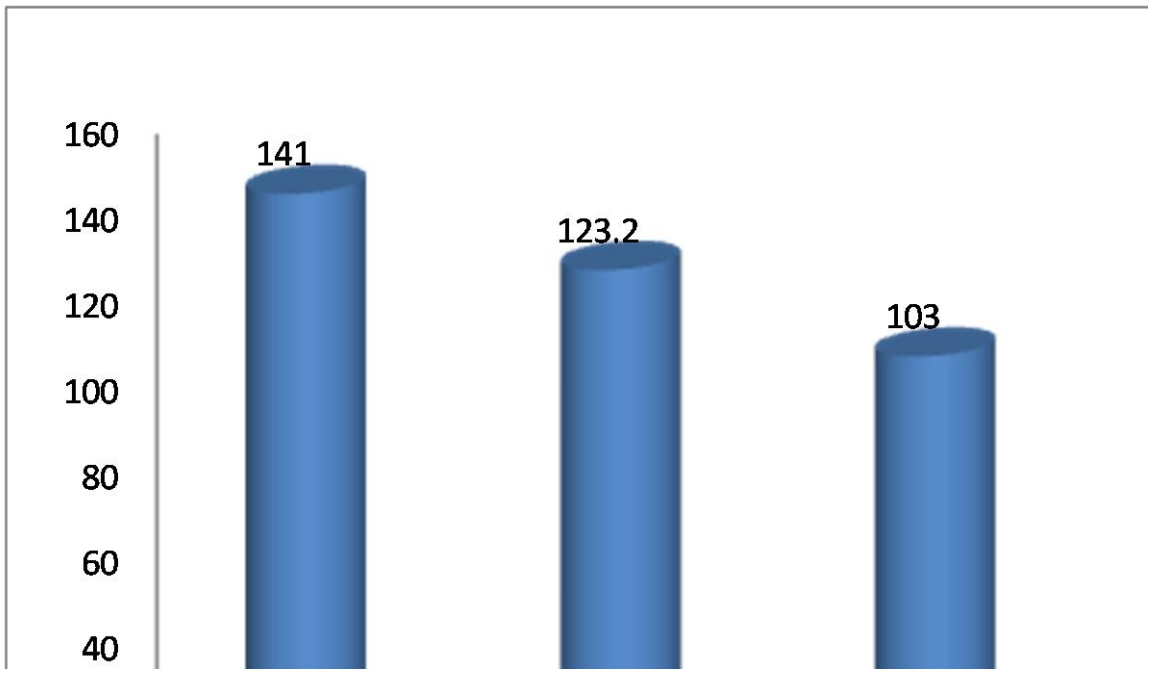
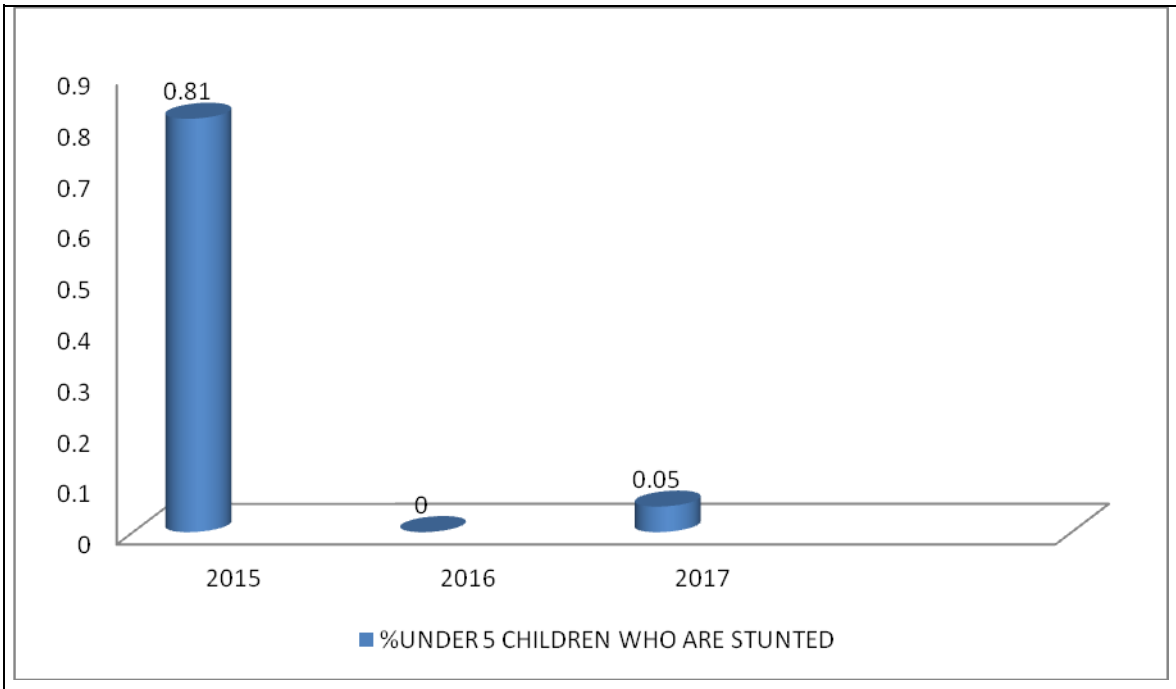

8.6
5.5
4.3
9
8
7
6
5
4
3
2
1
0
2015
2016
2017
%Low birth weight among new born

Figure 3.1.2: UNDER 5 CHILDREN WHO ARE UNDER WEIGHT



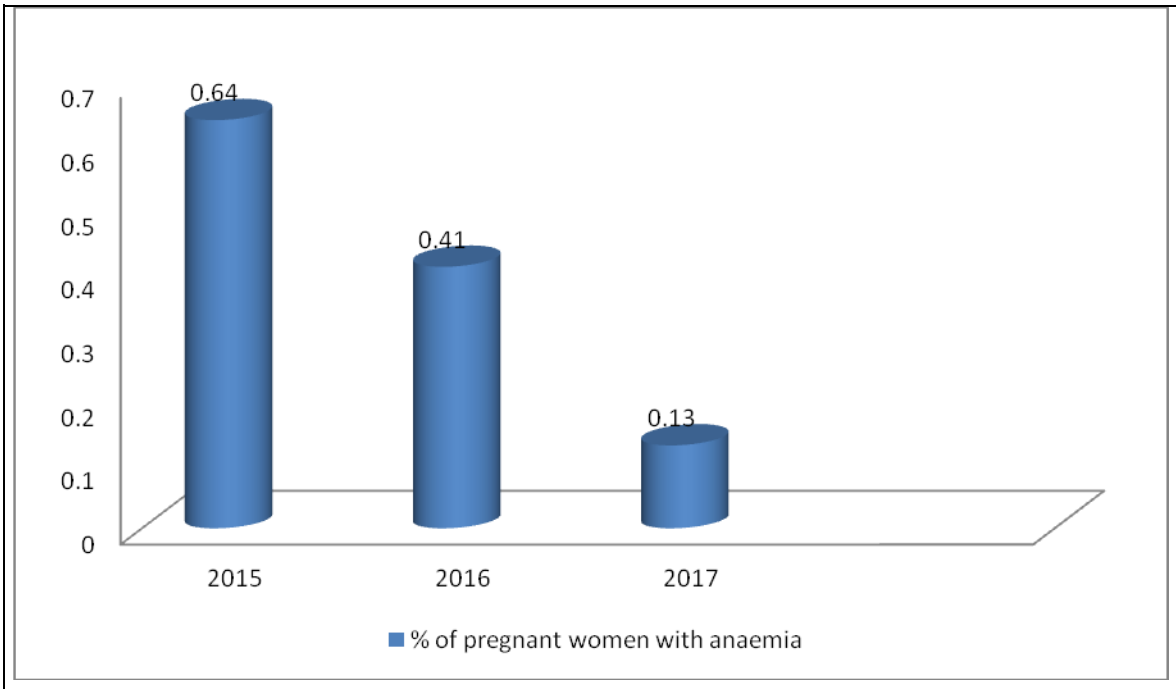
Charts showing the decrease of children under 5 yrs who are under weight due to community sensitization have done

Figure 3.1.3: Nutritional Status: Children under 5 - Stunted (past 3-5 years)



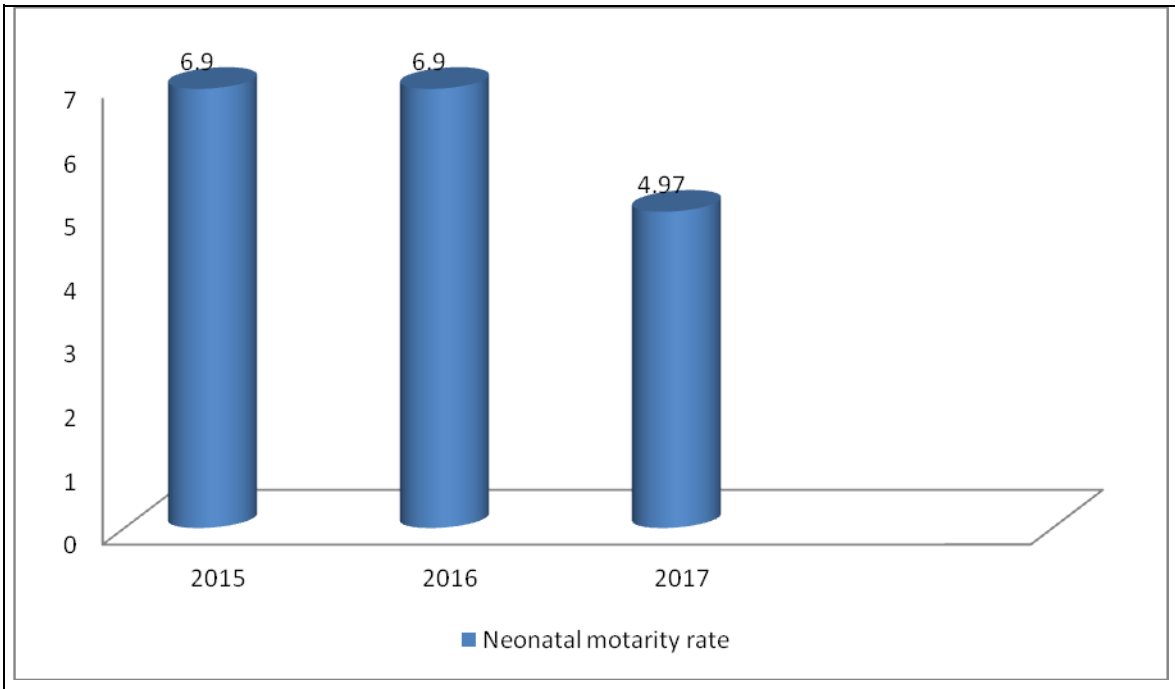
Charts shows the increased children who are under five stunted due to proper documentation

Figure 3.1.4: Nutritional Status: Pregnant women with anemia (past 3-5 years)



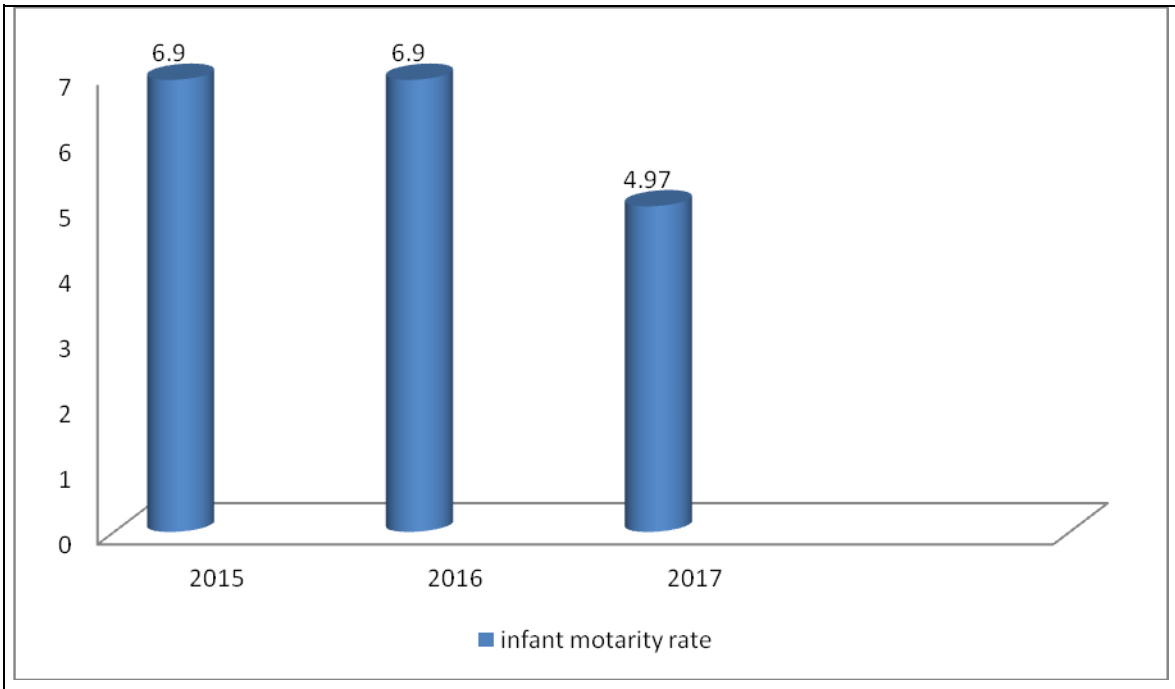
Charts showing the decrease of anaemia in pregnancy due the increase of ANC attendees and availability of Iron folic acid

Figure 3.1.5: Neonatal Mortality Rates (Institutional) – Past 3-5 years



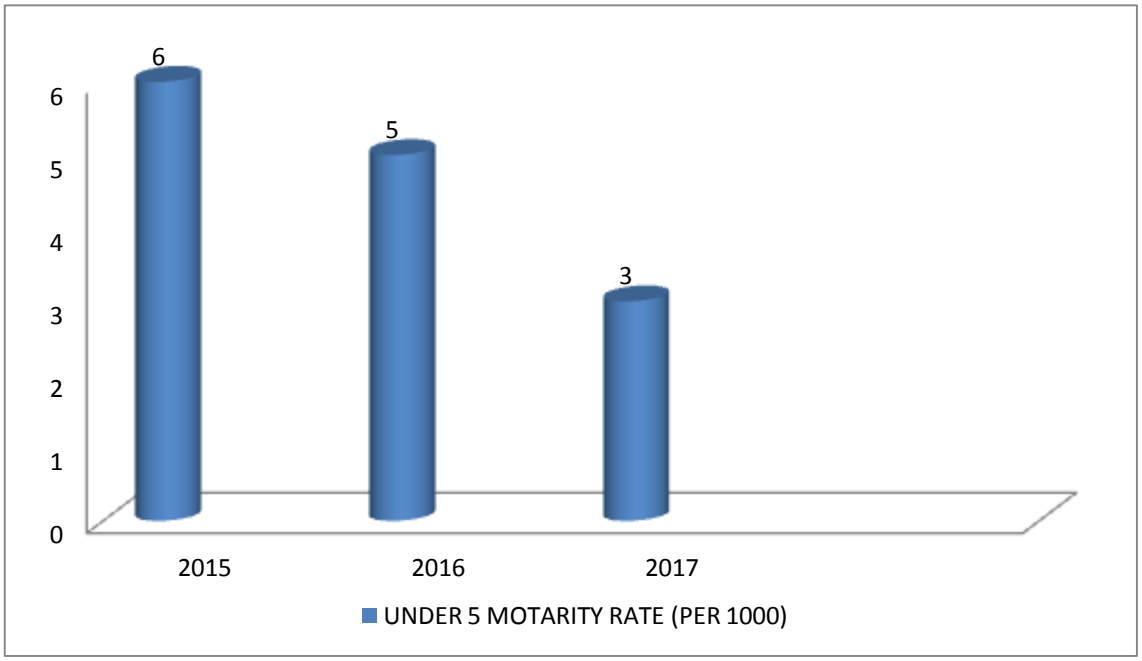
Charts showing the decrease of neonatal death due to MPDSR Training and mentorship done to Health workers

Figure 3.1.6: Infant Mortality Rate (Institutional) – Past 3-5 years



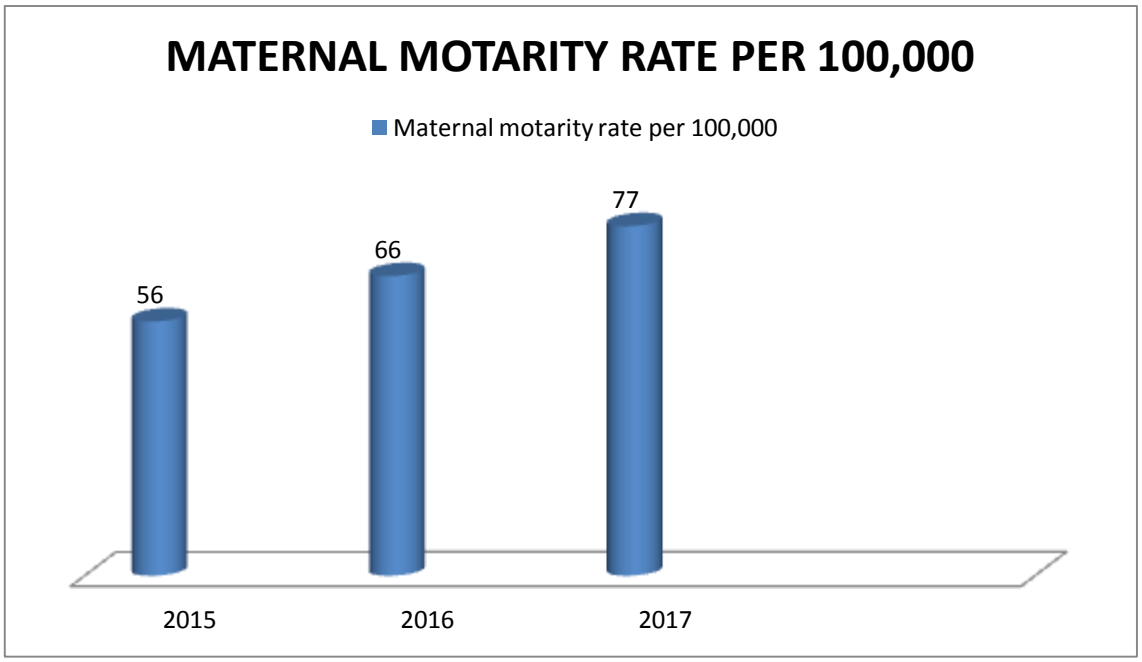
Charts shows the decrease of infant mortality rate due to Availability of immunization, Early detection also availability of Tracer medicine to all health facilities.

Figure 3.1.7: Under 5 Mortality Rate (Institutional) – Past 3-5 years



Charts shows the decrease of under five motarity rate due to improved referral system. Also availability of Tracer medicine to all health facilities and early detection.

Figure 3.1.8: Maternal Mortality Ratio (Institutional) – Past 3-5 years



Charts shows the increase of maternal motarity rate due to shortage of staff who are trained on SBMR

3.2 MORBIDITY

Confirmed malaria cases was increased from clinical malaria due to strengthened mentorship and supportive supervision on malaria case management to clinicians and nurses working in RCH departments, HIV prevalence still decreasing due to adequate knowledge to the community because sensitization have done.

Severe malaria was leading cause of morbidity in the district to under five year's children and above 5 years clients among OPD attendance followed by by acute respiratory diseases followed by diarrhea, pneumonia, Intestinal worms,skin diseases' eye condition,oral conditions,injuries and anaemia.

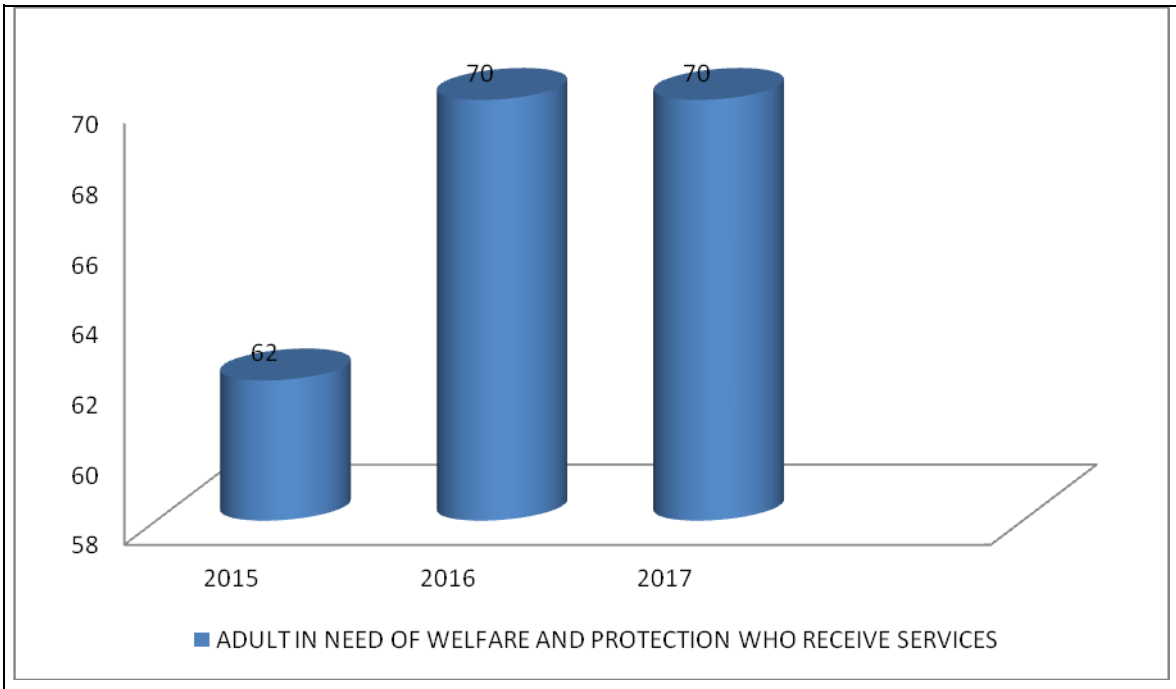
Severe malaria was a leading cause of hospital admission followed by UTI,pneumonia, Diarrhoea, ARI, Other injuries,Fracture, anaemia, PUD and abortion complication.

The leading cause of death is pneumonia followed by severe malaria, Anaemia, Fracture, other injuries, Normal deliveries.
Also the availability of medicine, medical equipments and diagnostic supplies was improved

The health seeking behavior was the main challenges for the patient delayed decision making at the family level for seeking hospital treatment hence leading to chronic illness.

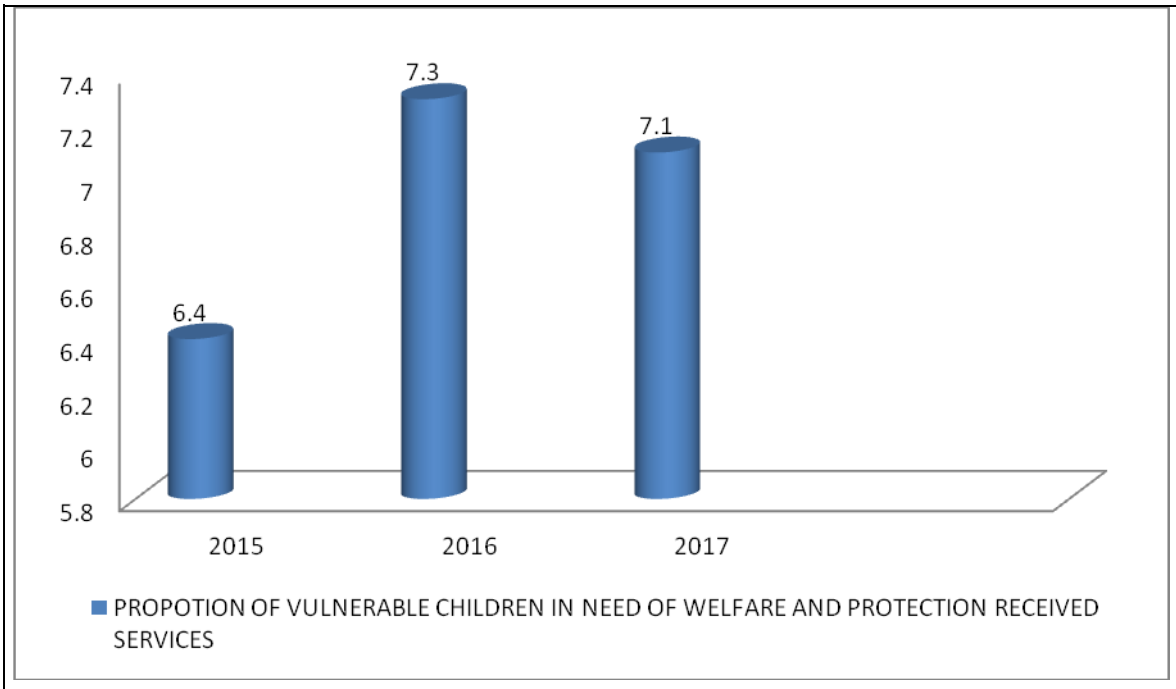
Main challenge during implementation of CCHP in previous year were shortage of health personnel, delay in fund release from the central government
The reduction of top ten diagnoses for OPD and IPD was addressed through CCHP for a year 2017/2018.

Figure 3.4.1: Proportion of adults (elderly, disabled & poor) in need of welfare & protection who received the services (Past 3-5 years)
[CHART



Charts shows the increase of adult in need of social and welfare and protection who received services

Figure 3.3.2: Proportion of vulnerable children in need of welfare & protection who received the services (Past 3-5 years)



Charts shows the decrease of vulnerable children in need of welfare and protection received services due to shortage of income.

1. STATUS OF HEALTH SERVICE DELIVERY IN THE DISTRICT

3.6 STATUS OF HEALTH SERVICE DELIVERY IN THE DISTRICT

A: VACCINATION SERVICES

Proportion of children under 1 vaccinated against measles, opv3, penta 3 & vitamin A

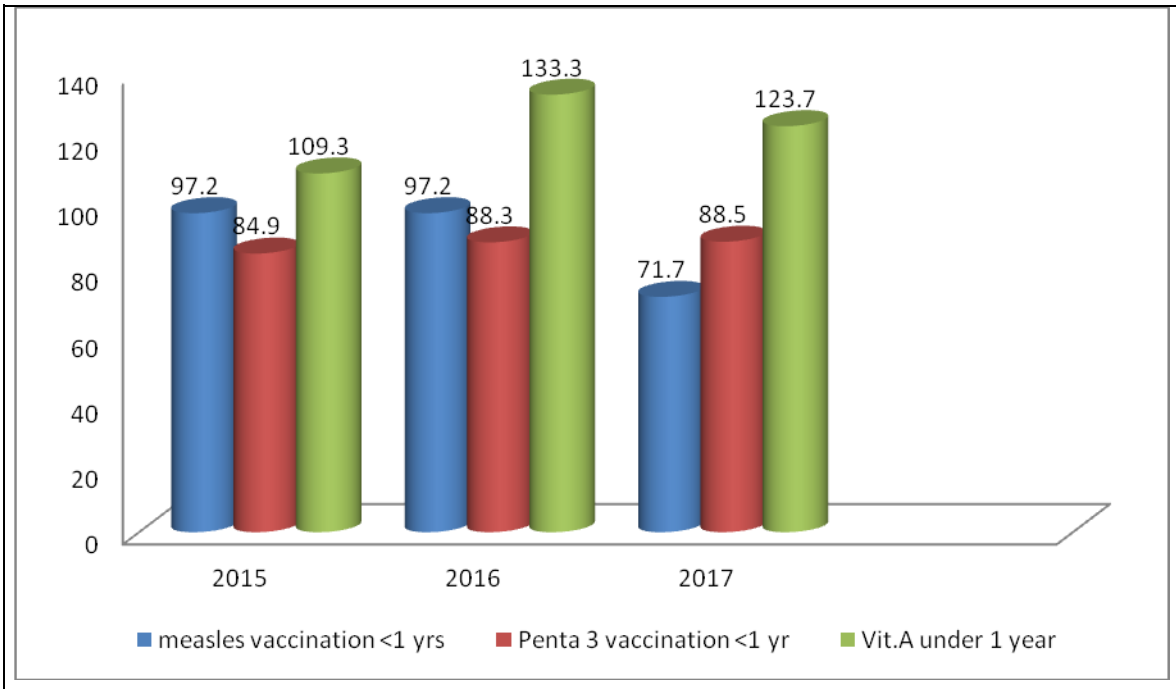
The district has 54 health facilities providing immunization to under five children and women in bearing age. From the past financial year (2016/2017) Ngara district council achieved to procure and refill gas cylinder, distribute vaccine and conducting immunization outreach services in hard to reach communities.

Also community sensitization was done on important of vaccination through local radio available in the District. Vitamin A capsules issued biannual through vertical programs from nutrition department based on target population of under five children

The vaccination coverage increased from 84.9% in 2015 for PENTA3 to 88.5% for measles rubella (MR 1), decreased from 97.2 in 2015 to 71.7% in 2017 100% and 109% in 2015 to 123.7% in 2017 for vitamin A supplement. In spite there is a good coverage of immunization there are some of the health facility with low coverage of immunization, those facilities include Kasange,Mukikomero,shanga,kumtana,mukarehe,mukatabo,Ntobeye,Lukole,magamba,Rwimbo go, kumugamba, katerere,Nyamiaga, Muruvyagira. The District decided to include the above mentioned poor performing facilities in REC exercise so as to ensure that all under five children are vaccinated.

4.1 VACCINATION SERVICES

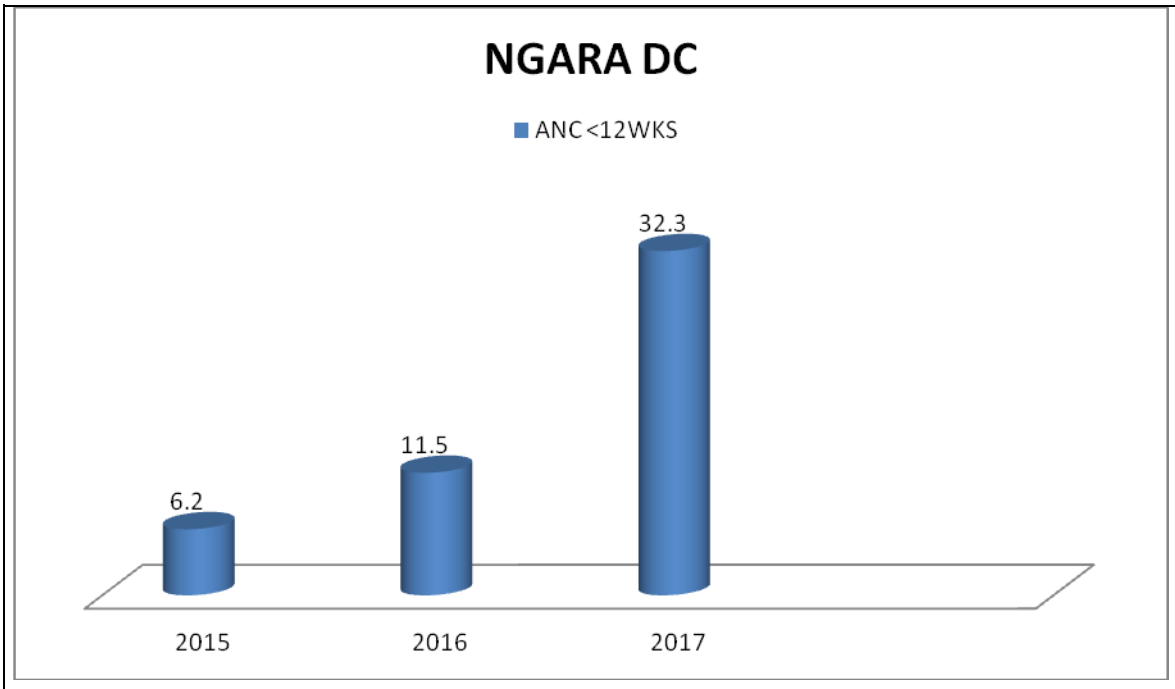
Figure 4.1.1: Under 1 Year Vaccinated (Measles, OPV3 and Vit A)



Charts shows the decrease of measles vaccination <1yrs due to some of H/facilities were closed after their staff found unfit for EDUCATION STATUS.

4.2 REPRODUCTIVE HEALTH SERVICES

Figure 4.2.1: Proportion of Pregnant Women Starting ANC before 12 weeks Gestation (past 3-5 years)



Charts shows the increase of ANC < 12 WKS attendees due to community sensitization

Figure 4.2.2: Proportion of Pregnant Women attending ANC at least 4 times during pregnancy Gestation (past 3-5 years)

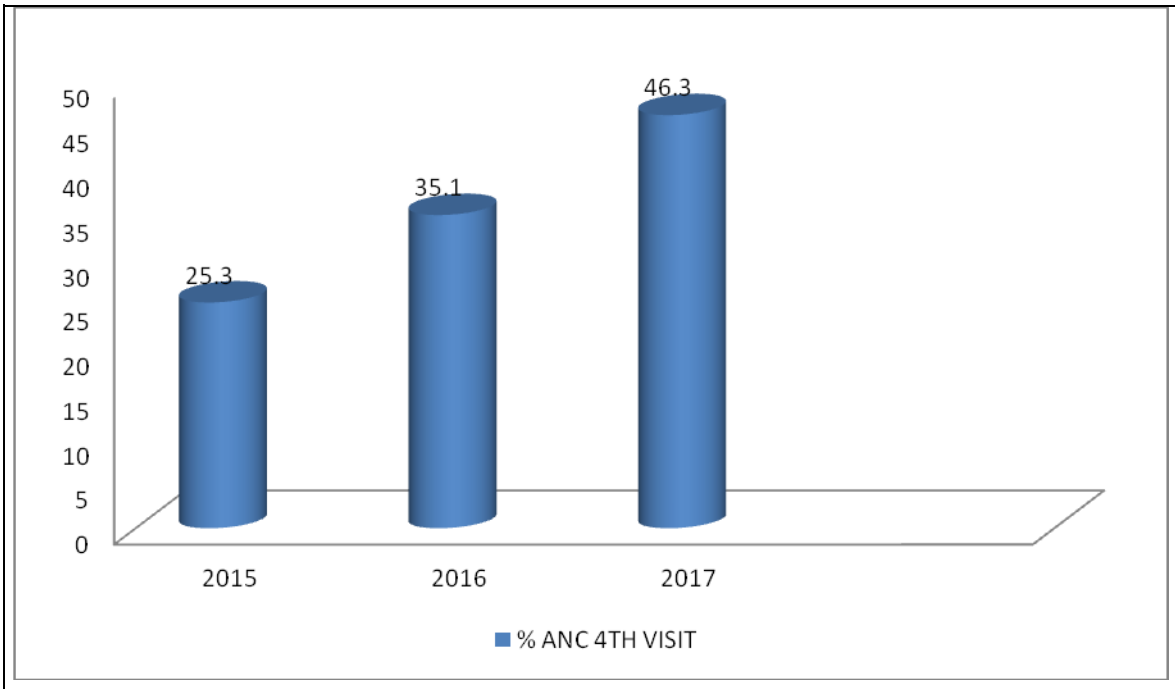
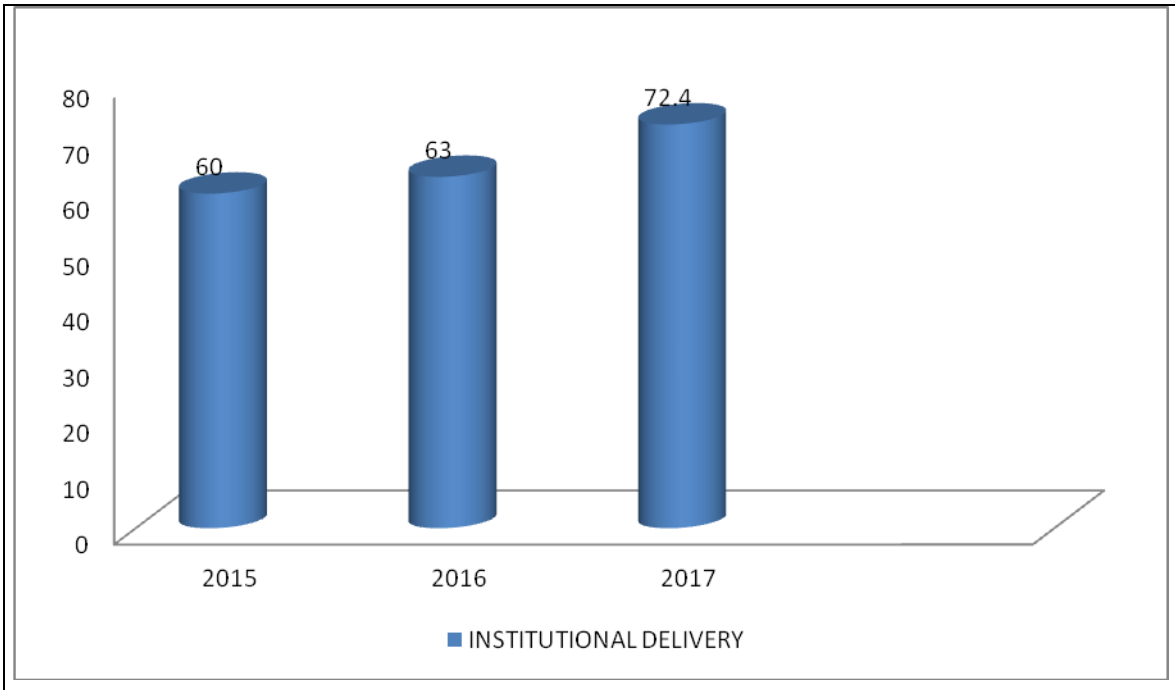


Figure 4.2.3: Proportion of Births attended in Health Facility (past 3-5 years)



Charts shows the increase of institutional delivery due to community sensitization also almost each village have health facility

Figure 4.2.4: Proportion of Births attended by Skilled Personnel (past 3-5 years)

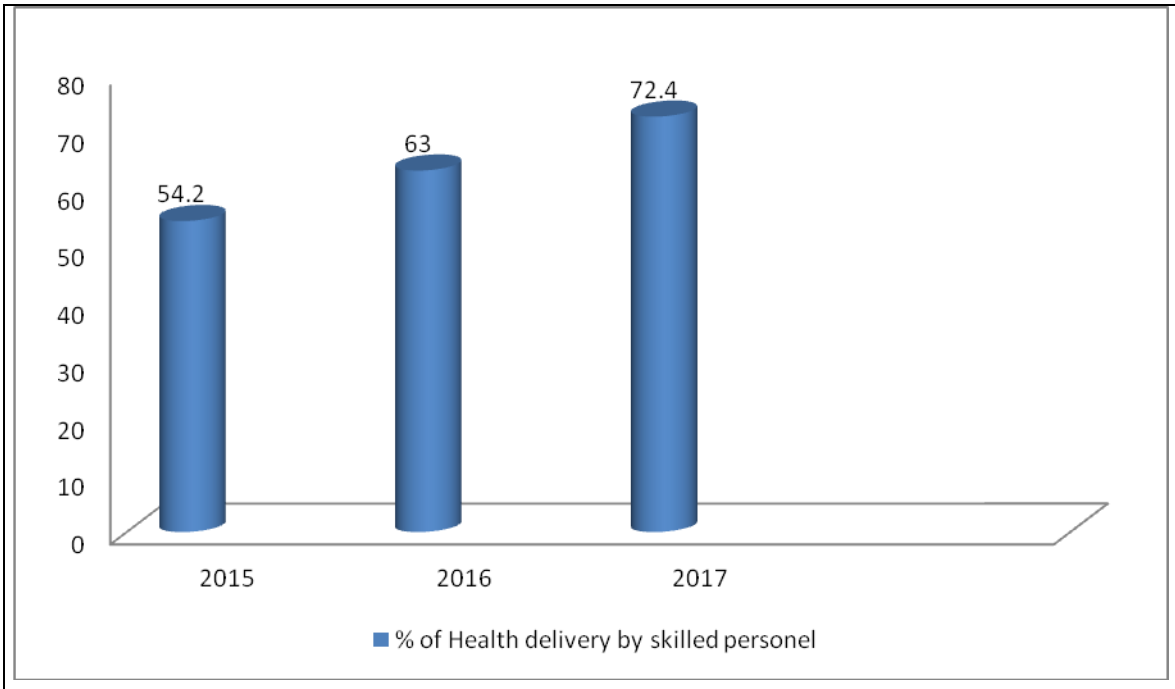
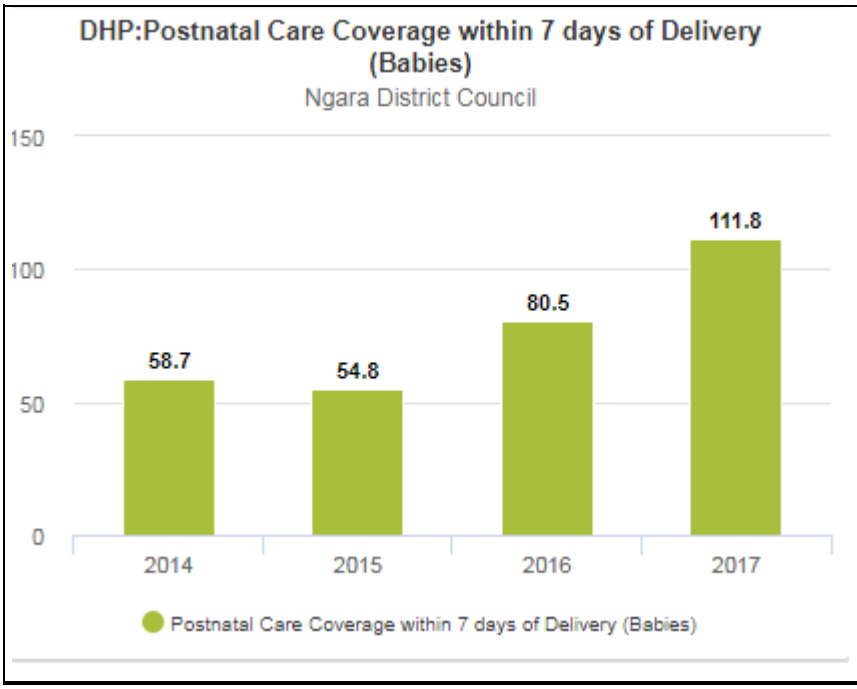
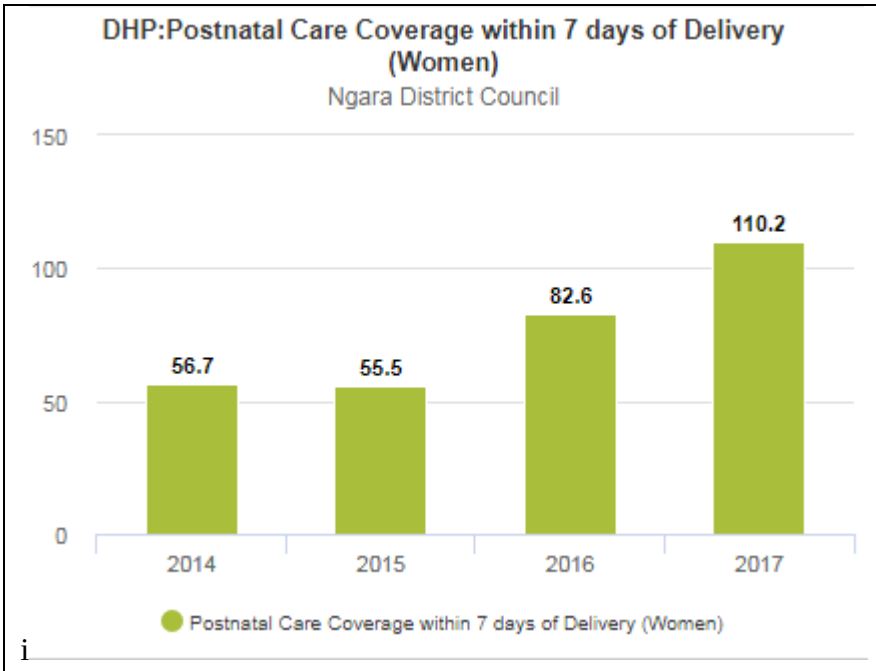
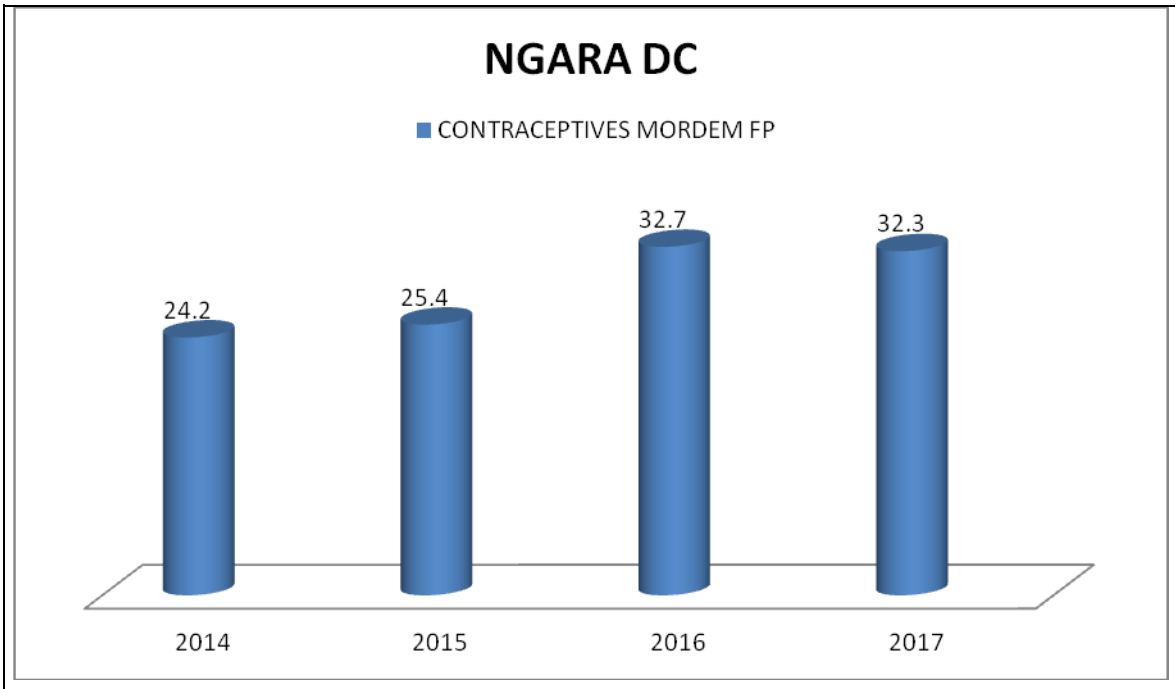


Figure 4.2.5: Postnatal care within 7 days after delivery (past 3-5 years)


DHP:Postnatal Care Coverage within 7 days of Delivery (Babies)
Ngara District Council
150
100
50
0
58.7
54.8
80.5
111.8
2014
2015
2016
2017
Postnatal Care Coverage within 7 days of Delivery (Babies)


DHP:Postnatal Care Coverage within 7 days of Delivery (Women)
Ngara District Council
150
100
50
0
56.7
55.5
82.6
110.2
2014
2015
2016
2017
Postnatal Care Coverage within 7 days of Delivery (Women)

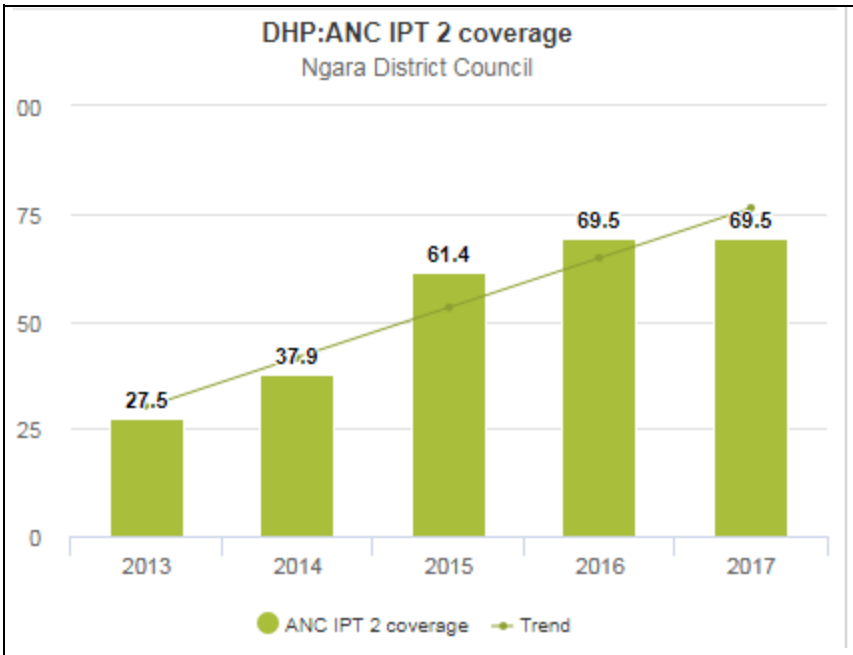
i



Charts shows the increase of modem family planning due the national family planning launching done by implementing partners

4.3 INFECTION DISEASE AND NON-COMMUNICABLE DISEASE HEALTH SERVICES

Figure 4.3.1: Proportion of Mothers who received two doses of Preventative Intermittent Treatment for Malaria During Last Pregnancy (past 3-5 years)



Charts shows that

No increase of IPT2 coverage in 2016 and 2017 due to O/S of SP .

Figure 4.3.4: TB (all forms) notification rate per 100,000 population

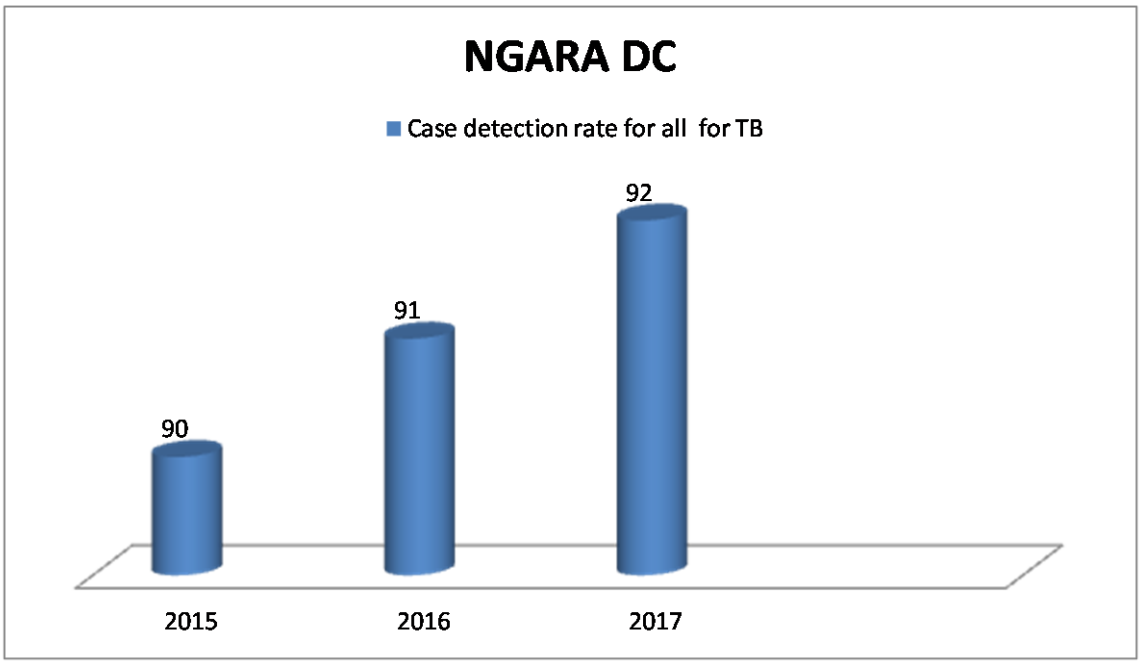


Figure 4.3.5: Treatment success rate for all forms of TB (past 3-5 years)

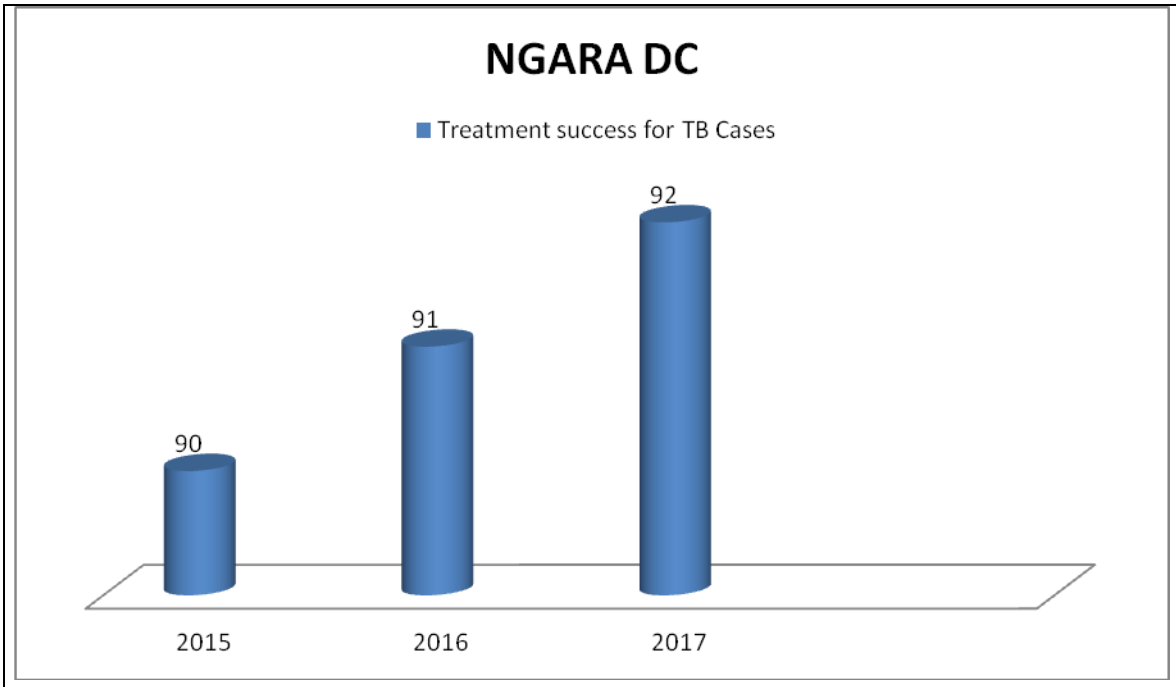
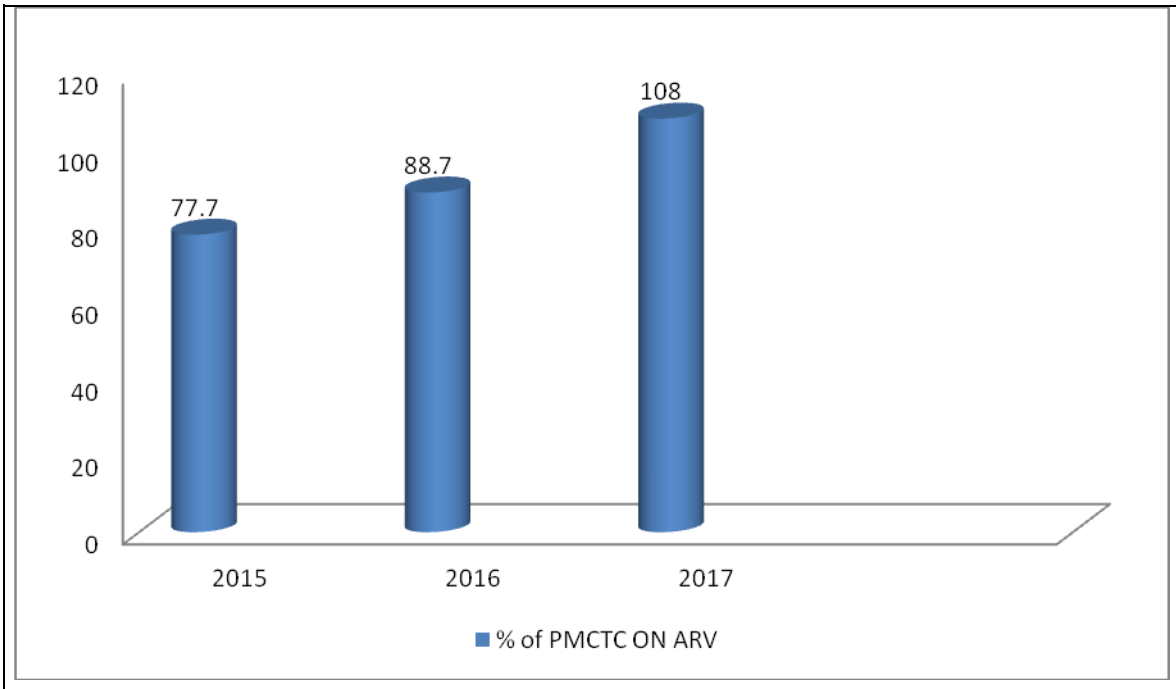
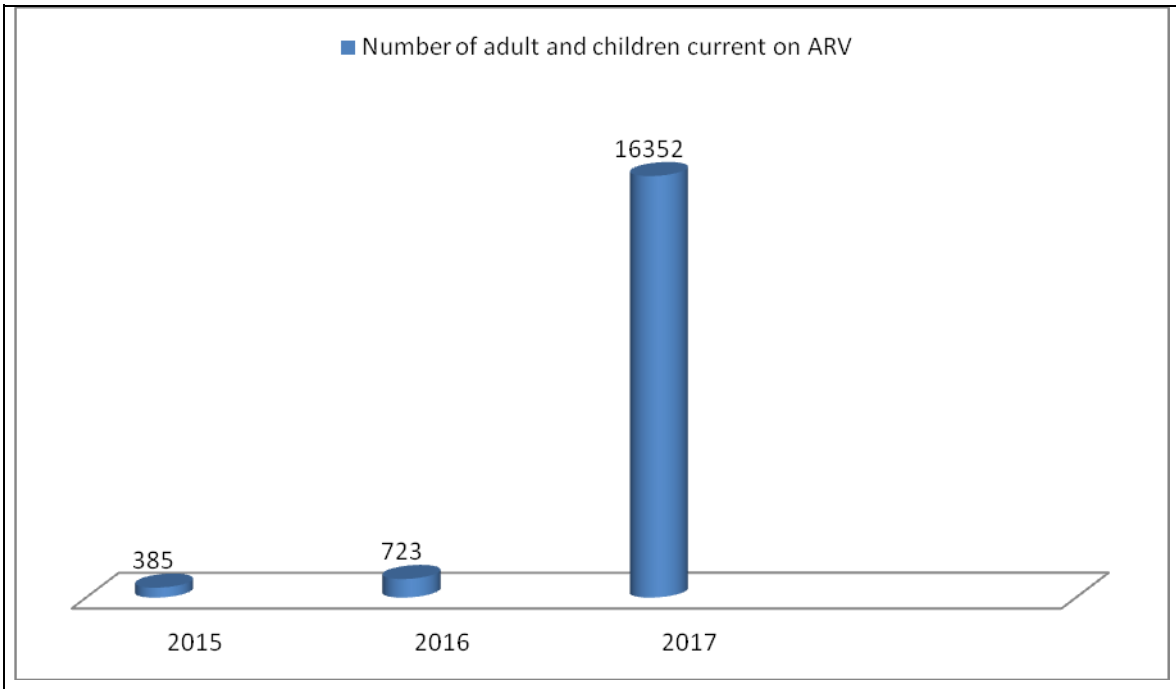


Figure 4.3.6: Percent of HIV pregnant women on ARV for PMTCT (past 3-5 years)



Charts shows the increase of PMCTC on ARV due to initiation of test and treat strategy.

Figure 4.3.7: Number (& percent) of adult and children current on ARV (past 3-5 years) patients (past 3-5 years)



Charts shows the increase number of adult and children current on ARV due to initiation of test and treat strategy.

Figure 4.3.8: Percent of adults 25-64 years with raised FBG or current on medication for raised Blood Glucose (past 3-5 years)

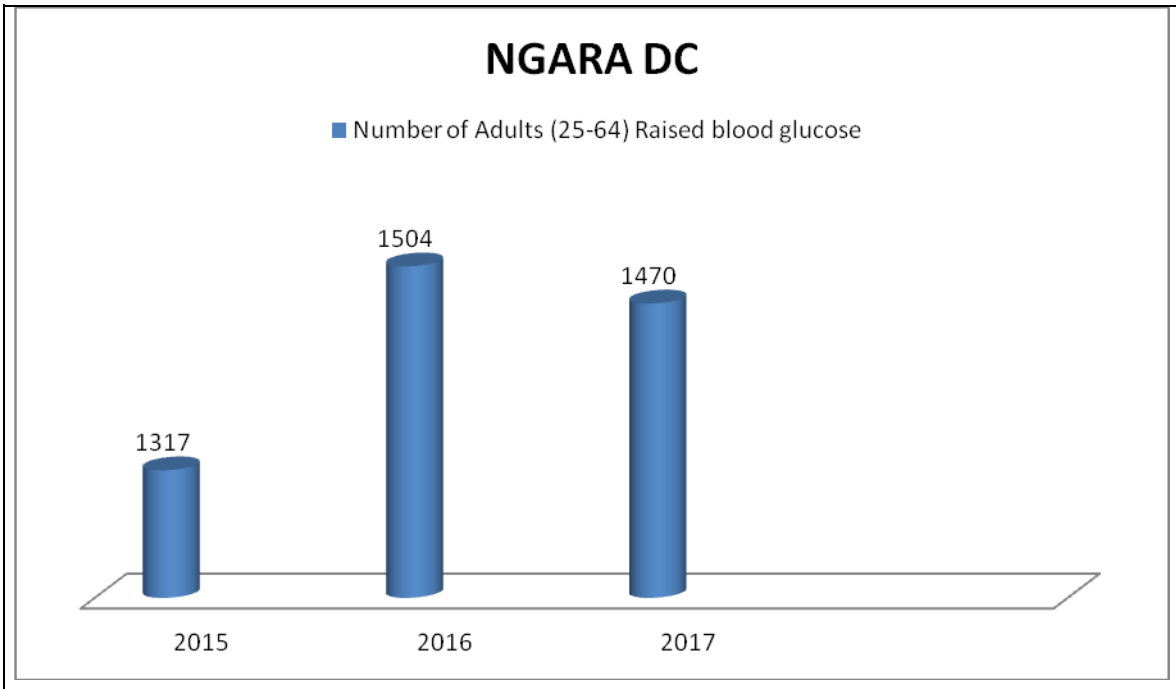


Figure 4.3.9: Proportion of women age 30-50 screened for cervical cancer with VIA (past 3-5 years)

Figure 4.3.10: Proportion of adult 25-64 years with BP>140/90 or currently on BP medication (past 3-5 years)

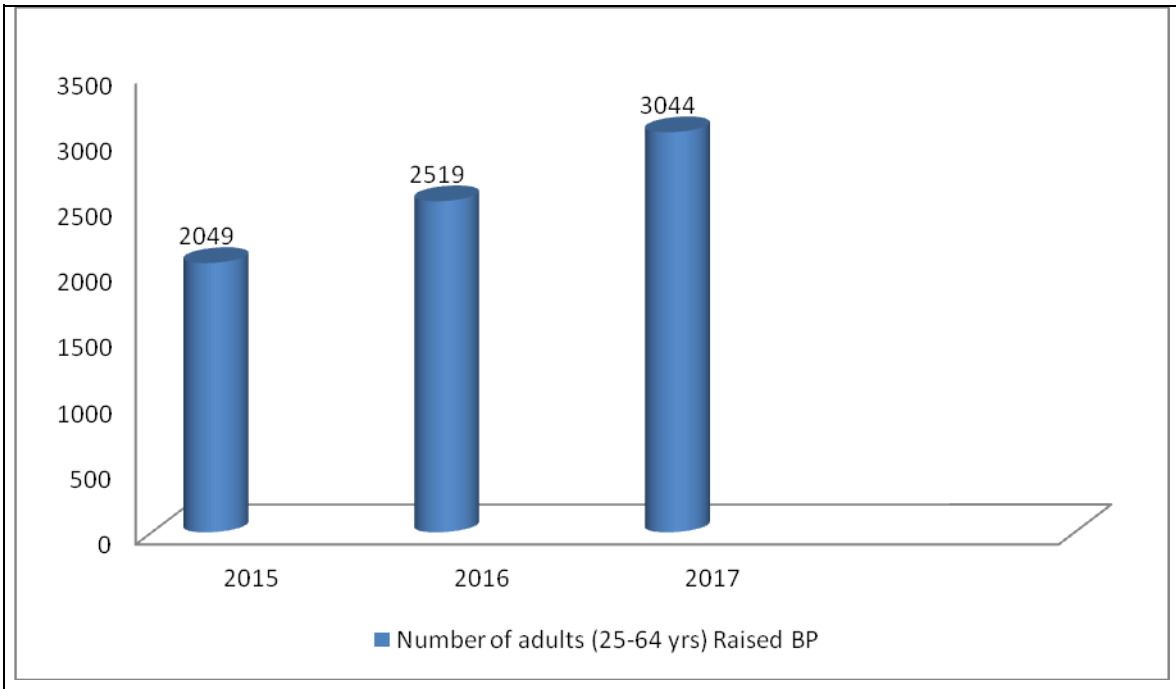


Figure 4.3.11: Incidence of Cholera cases (past 3-5 years)

5.1 HEALTH FINANCING

Figure 5.1.1: Total GOT and Donor Allocations to Health in the District (past 3-5 years)

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5.2 HUMAN RESOURCES FOR HEALTH

Figure 5.2.1: Number of clinicians (MO, AMO, CO and ACOs) per 10, 000 (past 3-5 years)

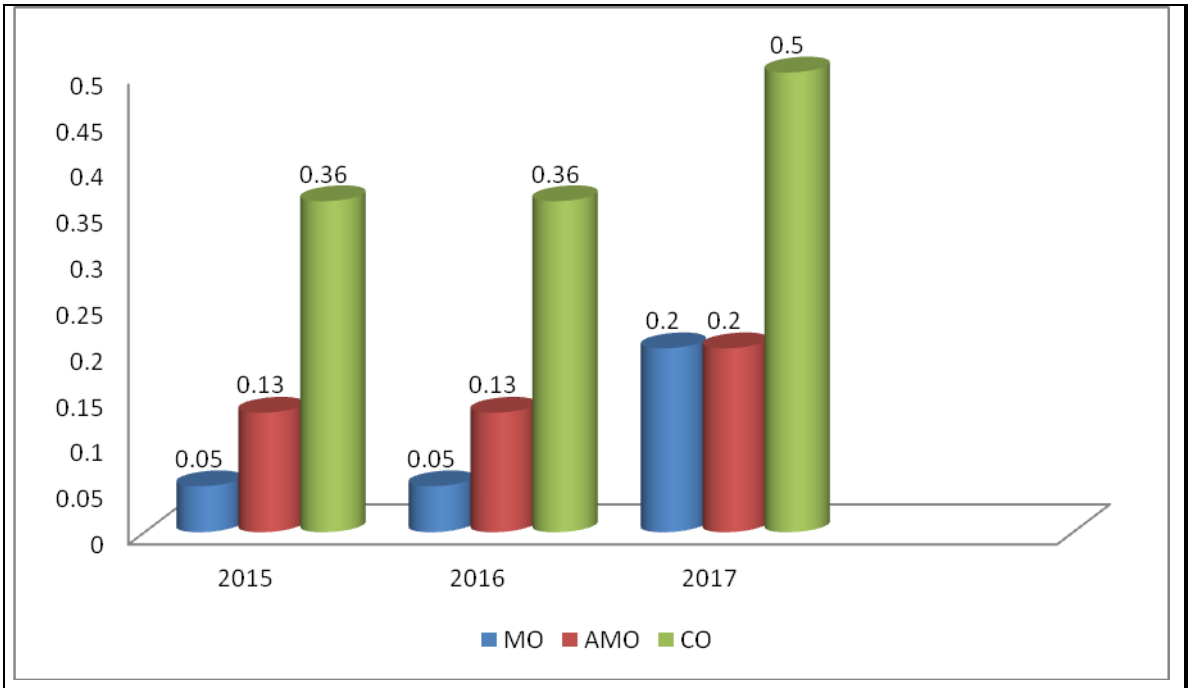


Figure 5.2.2: Number of MO per 10, 000 (past 3-5 years)

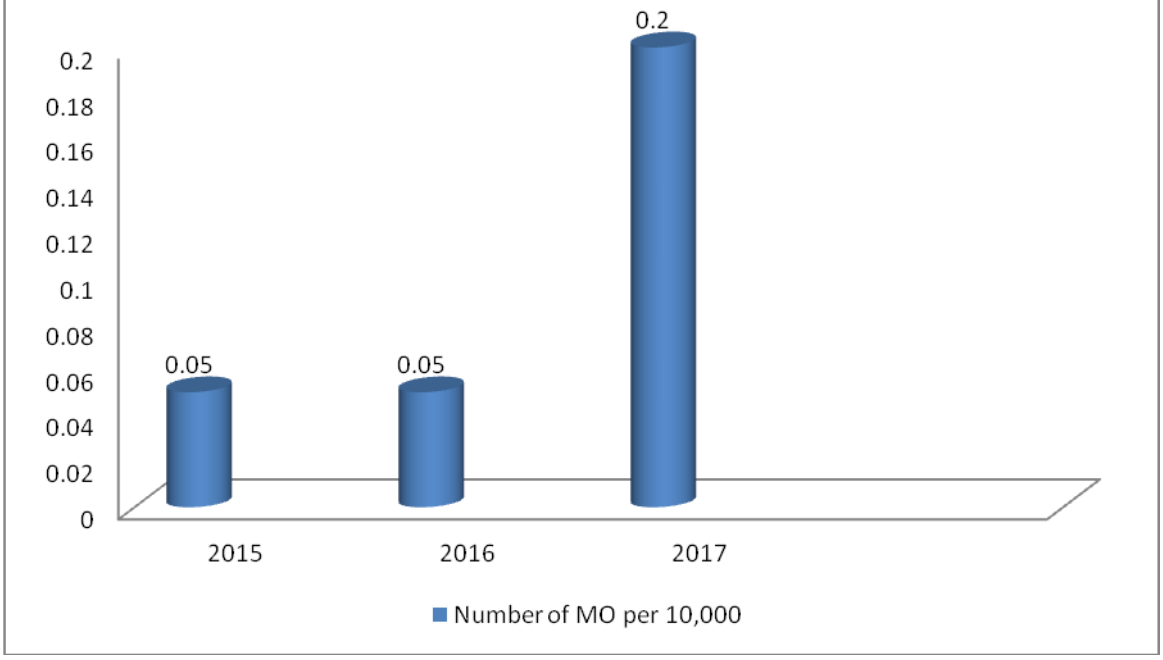


Figure 5.2.3: Number of AMO per 10, 000 (past 3-5 years)

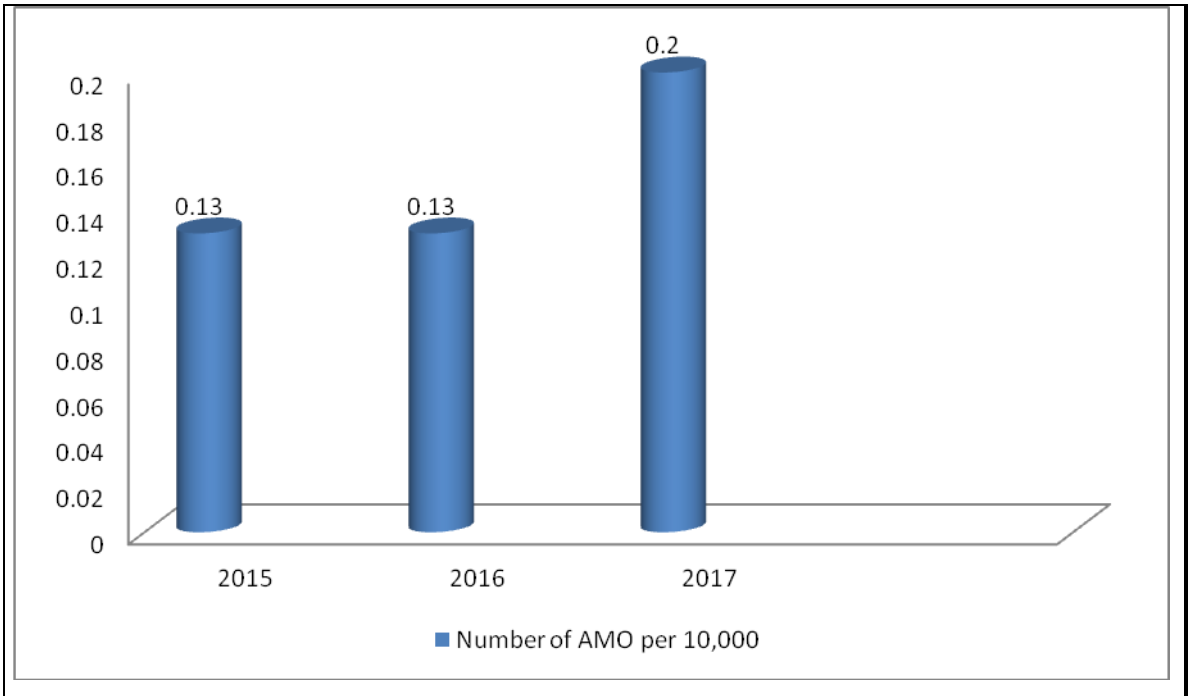


Figure 5.2.4: Number of CO per 10, 000 (past 3-5 years)

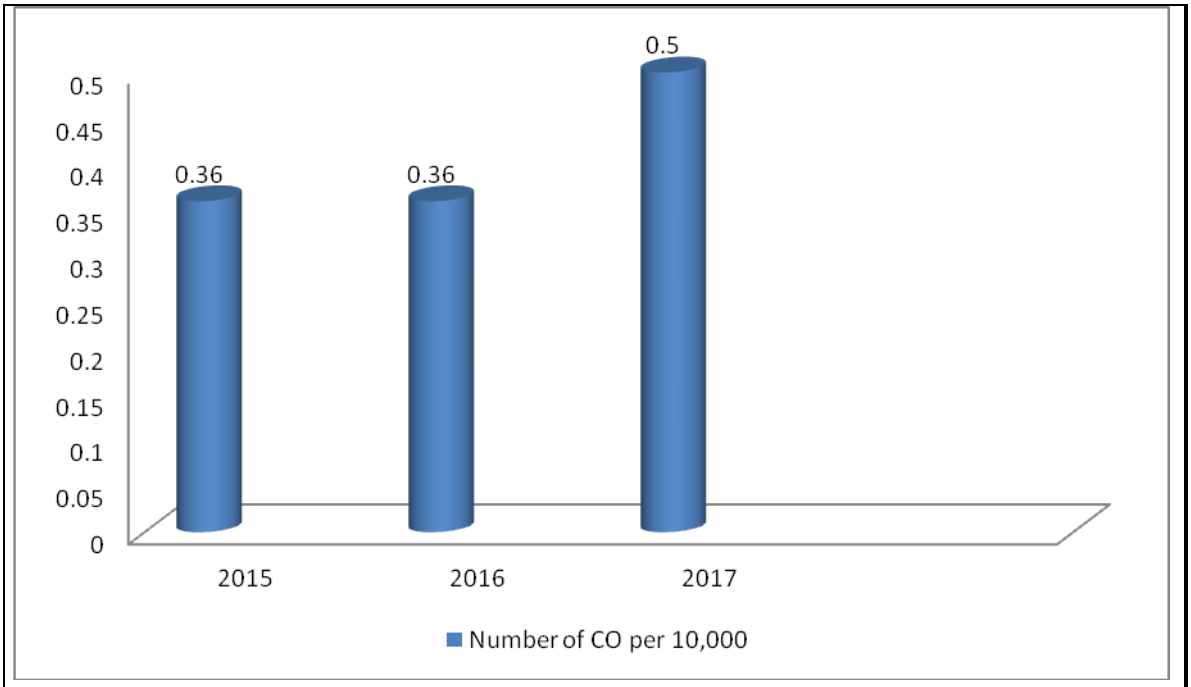


Figure 5.2.5: Number of ACOs per 10, 000 (past 3-5 years)

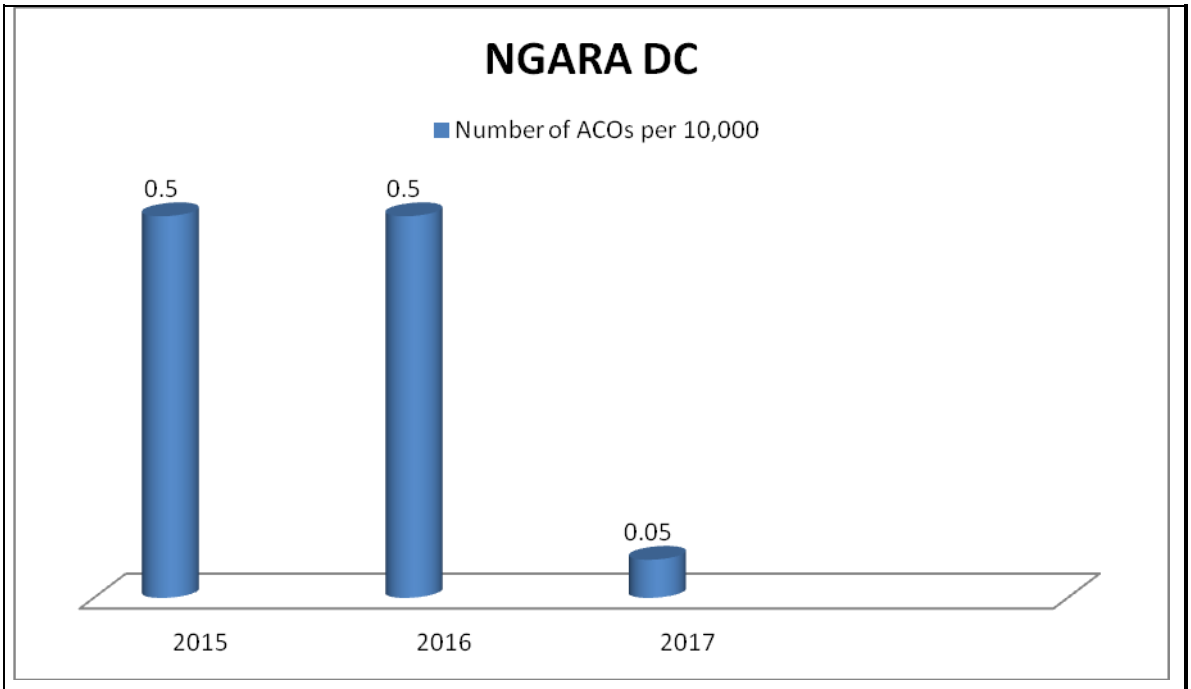
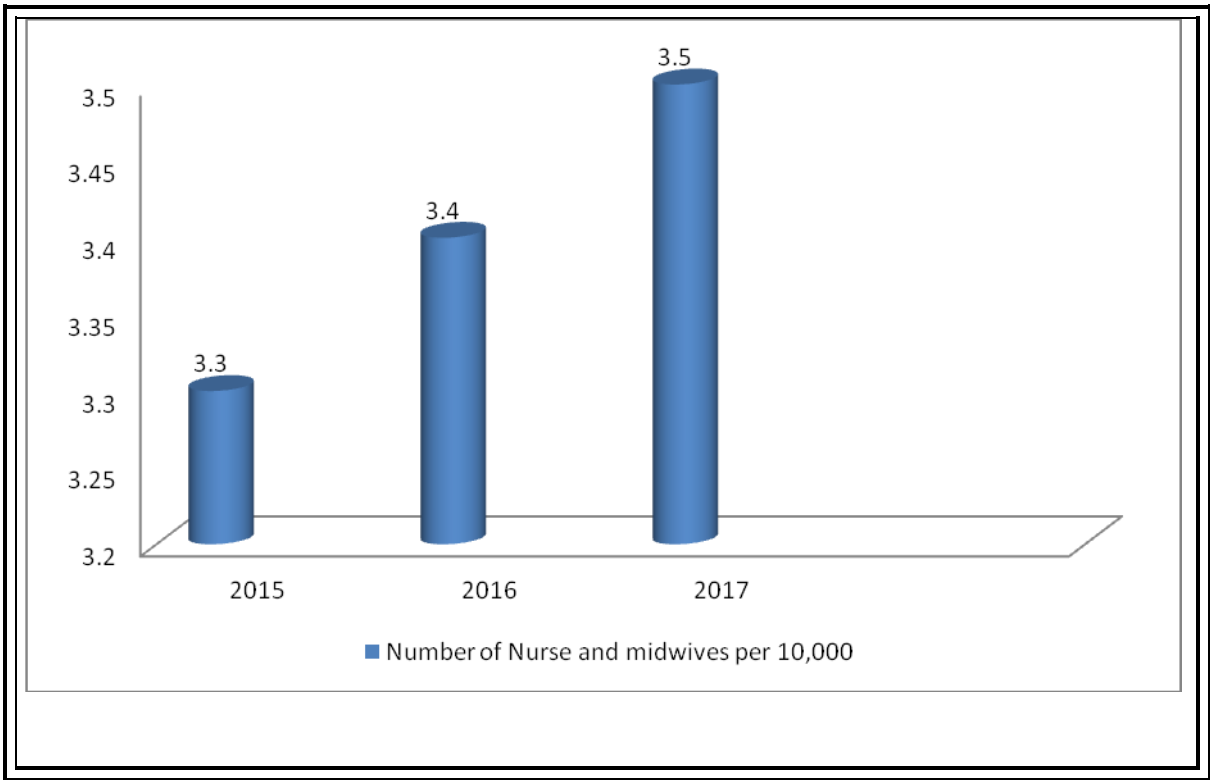


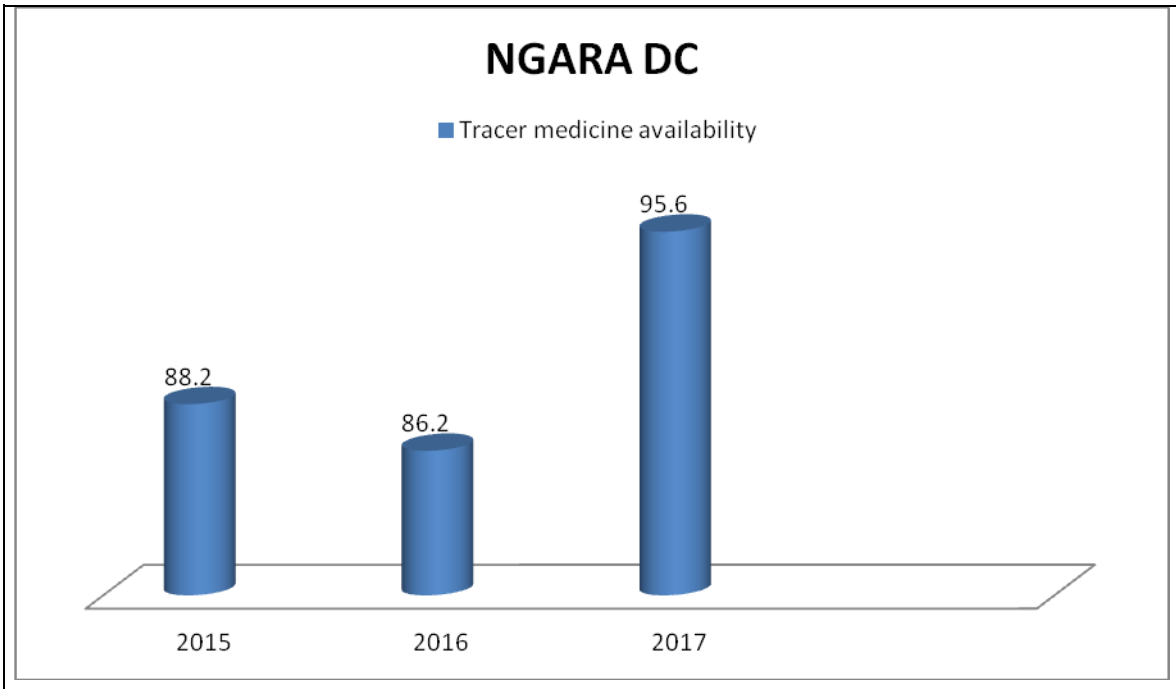
Figure 5-4. Number of Nurse & mid-wives per 10, 000 (past 3-5 years)

[CHART



5.3 MEDICINES AND MEDICAL PRODUCTS

Figure 5.3.1: Health Facilities with all 10 Tracers (Drugs, Vaccine and Medical Supplies)



Charts shows the increase of all health facilities with all 10 tracer medicine availability due to regular ordering from MSD.

5.4 MONITORING & EVALUATION

Figure 5.4.1 Proportion of expected reports (ANC, L&D, Child Health, OPD, IPD, FP) submitted in a given year (Past 3-5 years)

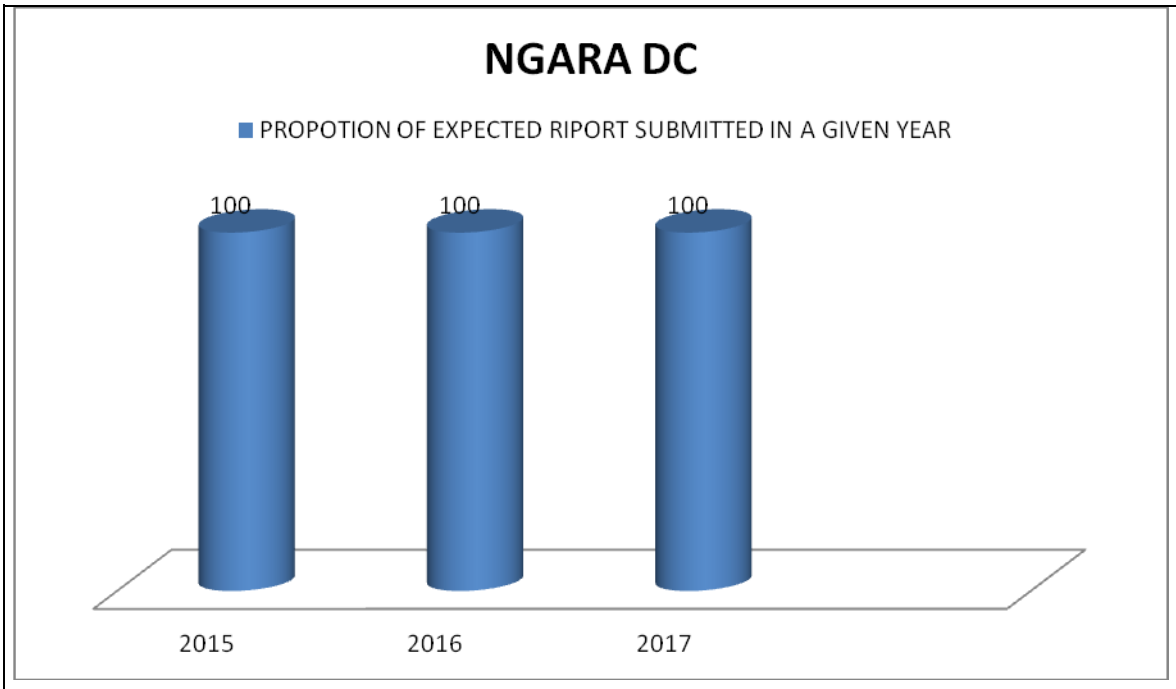


Figure 5.4.3: Proportion of reports entered in the system on time at the district (past 3-5 years)

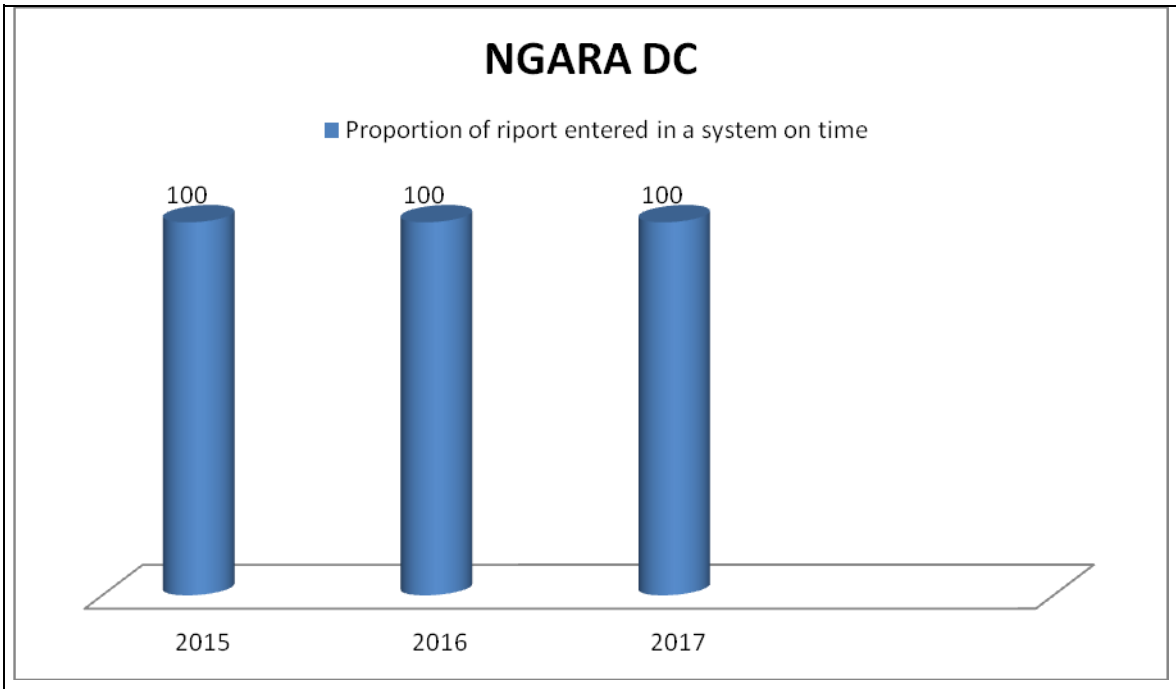
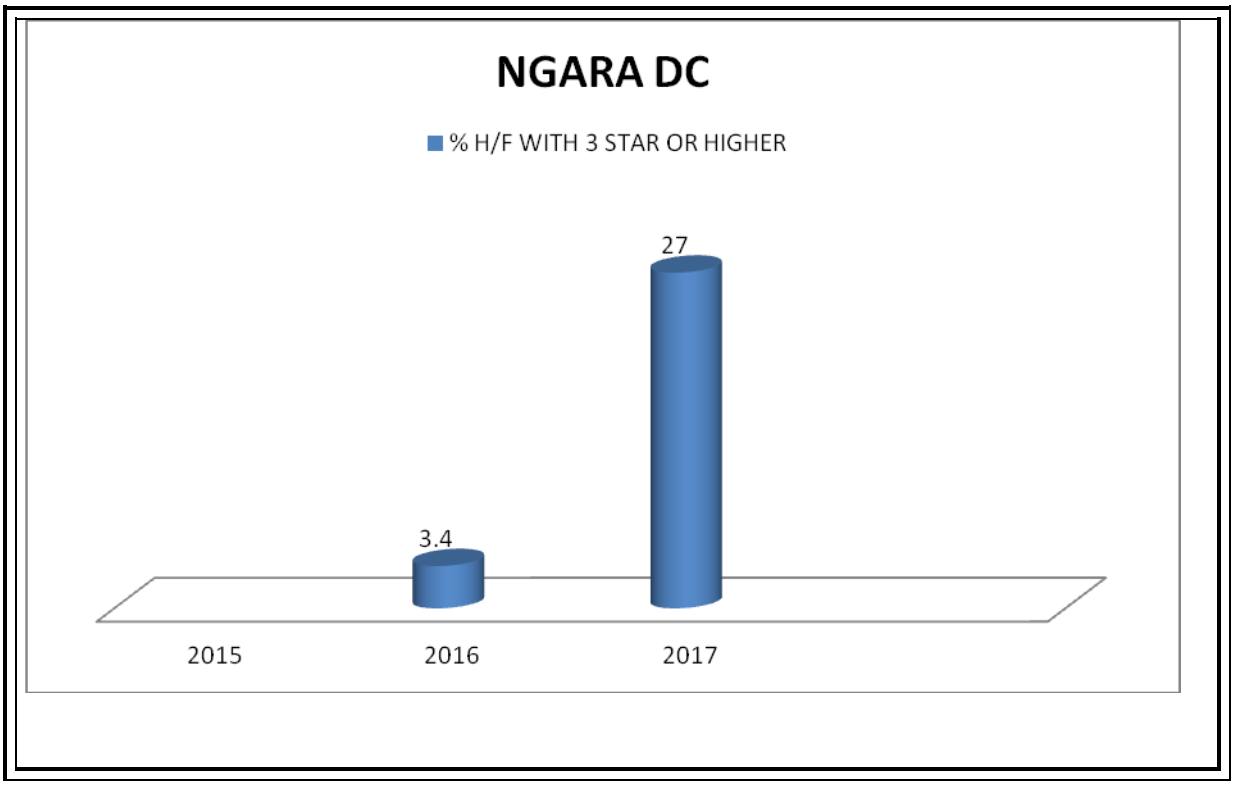


Figure 5.4.4: Percentage of primary health facility with 3-star rating or higher (past 3-5 years)



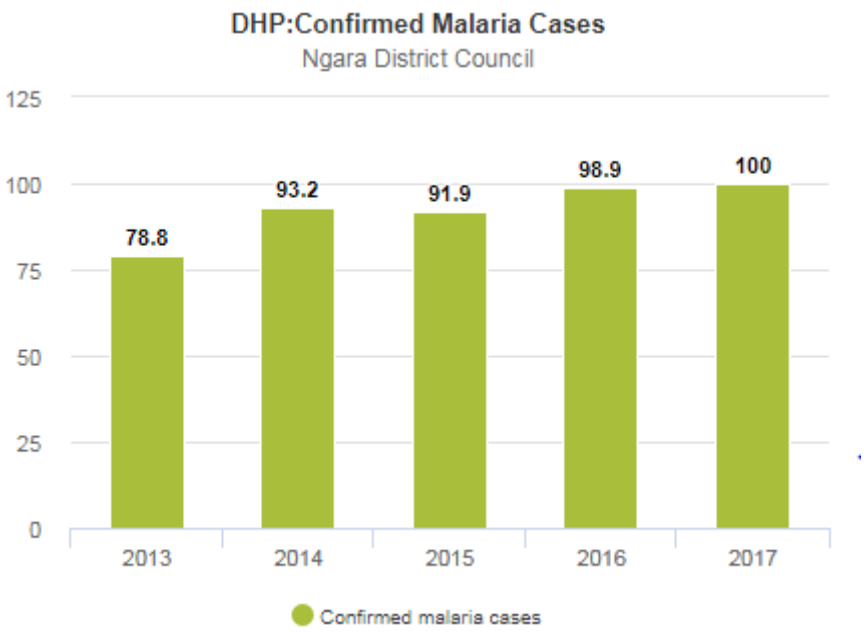
5.4 MONITORING & EVALUATION

During BRN assessment which was conducted in March 2016 there were only 1 health facility scored 3 Star and above. After implementing quality improvement plan (QIP) according to the gaps identified, the CHMTs planned to conduct assessment to monitor the progress of BRN star rating to all health facility in the district.

The CHMTs achieved to collect data timely from the health facility by 100%. This was facilitated by availability of HIMS reporting tools which was procured through Health Basket Fund. Quaterly data review meeting and supportive supervision were conducted. Every facility prepare chart for performance indicators and displayed on the notice board.

3.2 MORBIDITY

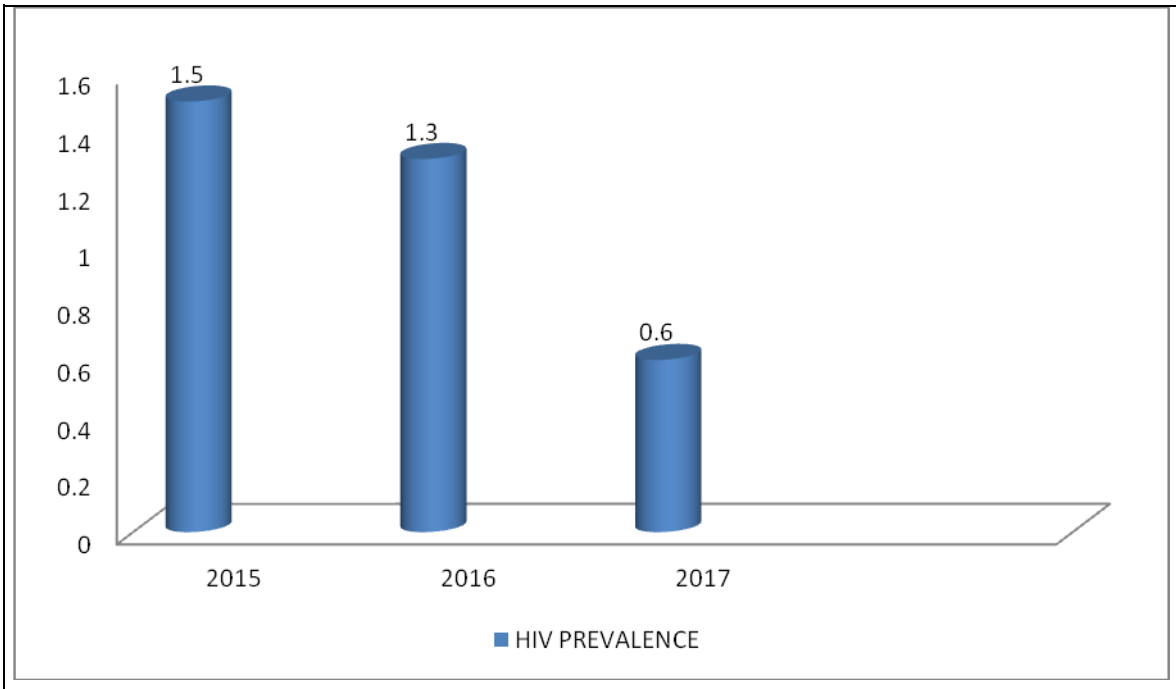
Figure 3.2.1: Confirmed Malaria Cases (Past 3-5 years)



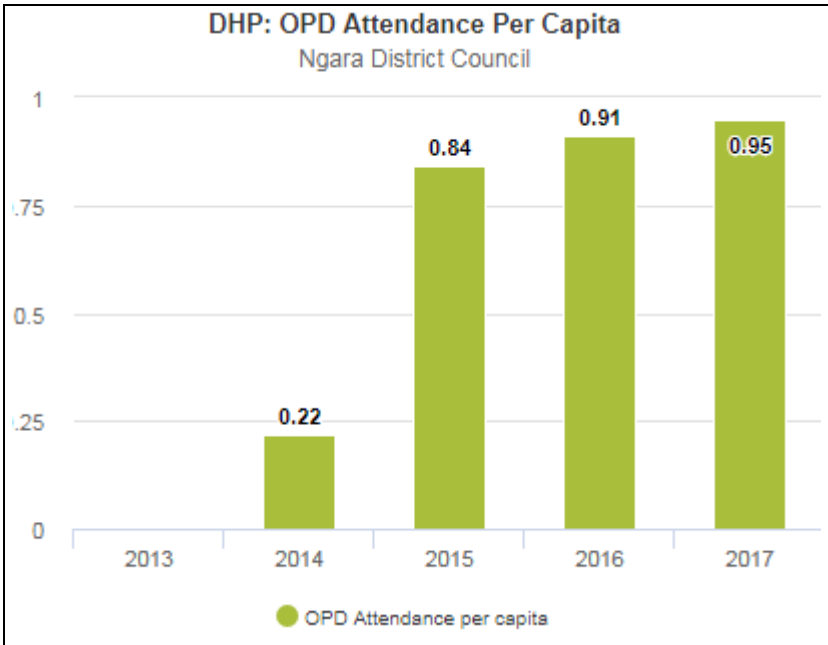
Charts shows the increase of confirmed malaria cases due to strengthening of mentorship and coaching of malaria case management and availability of MRDT

Figure 3.2.3: HIV/AIDS Prevalence 15-24 years (Past 3-5 years)

Figure 3.2.4:

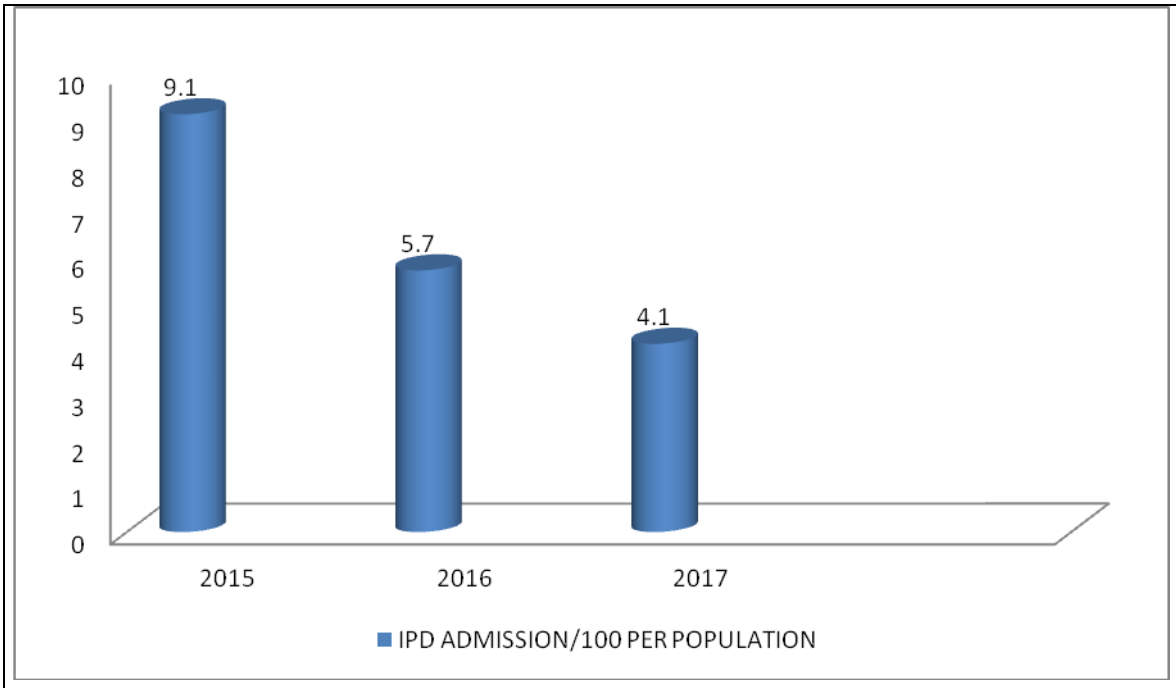


Charts shows the decrease of HIV due to male circumcision campain done



Charts shows the increase of OPD attendance due to proper documentation

Figure 3.2.5: IPD attendance per year (Past 3-5 years)



Charts shows the decrease of IPD admission due to improved health services

Table 4 Top cause of Death

	Causes of death	< 5 Years		Causes of death	5 Years and above	
		FEMALE	MALE		FEMALE	MALE
1	**PNEUMONIA**	28	33	PNEUMONIA	13	18
2	**ANAEMIA**	13	12	MALARIA SEVERE	12	13
3	**MALARIA SEVERE**	9	11	ANAEMIA	2	3
4	**FRACTURE**	2	8	FRACTURE	9	2
5	**DIARRHOEA**	1	5	DIARRHOEA	5	1
6	**OTHER INJURIES**	2	3	NORMAL DELIVERIS	9	
7	**TYPHOID**	5		BURNS		2
8				TYPHOID	2	
9				MENINGITIS	1	
10				POISONING	1	

Table 1: Top 10 OPD Diagnoses.

	Causes of death	< 5 Years		Causes of death	5 Years and above	
		FEMALE	**MALE**		**FEMALE**	**MALE**
1	**MALARIA**	31483	34996	MALARIA	43809	73781
2	**ARI**	21360	23200	UTI	21745	10655
3	**DIARRHOEA**	6724	6167	ARI	25067	16225
4	**PNEUMONIA**	4491	4382	PNEUMONIA	3309	6159
5	**INTESTINAL WORMS**	2608	2326	DIARRHOEA	4804	2966
6	**SKIN DISEASEA**	1447	1445	PEPTIC ULCER	3357	2166
7	**EYE CONDITION**	1925	1673	INTESTINAL WORMS	373	4257
8	**ANAEMIA**	342	306	SKIN DISEASES	1745	1741
9	**EAR INFECTION**	426	393	INJURIES	886	655
10	**PEM**	49	30	ORAL CONDITION	888	597

Table 2: Top 10 IPD DIAGONOSES

	Causes of admission	< 5 Years		Causes of admission	5 Years and above	
		FEMALE	**MALE**		**FEMALE**	**MALE**
1	**MALARIA SEVERE**	1000	1198	MALARIA SEVERE	1008	484
2	**PNEUMONIA**	794	892	PNEUMONIA	551	313
3	**DIARRHOEA**	263	346	DIARRHOEA	184	157
4	**ANAEMIA**	153	200	ARI	162	100
5	**BURNS**	11	25	OTHER INJURIES	88	232
6	**OTHER INJURIES**	11	22	FRACTURE	53	154
7	**FRACTURE**	10	21	ANAEMIA	131	122
8	**UTI**	180	152	PEPTIC ULCER	108	182
9	**GIT DISEASES**	58	59	UTI	755	265
10	**ARI**	124	131	ABORTION COMPLICATION		274

CHALLENGES

1.Increase of maternal mortality rate ,

2. Inconsistence of data from register, tally sheet, monthly summary and DHIS2

3. Shortage of skilled health personnel.

WAY FORWARD

1. , Ngara district council planned to adopt different health policies and regulations to have clear roles and responsibilities of community in maternal mortality reduction also to Conduct SBMR training and mentorship to Health workers. Apart from that Health behavior among community members should be a progress agenda by making sure that there is a fully involvement of the community in all matters concerning health

2.The challenges were inconsistence of data from register, tally sheet, monthly summary and DHIS2. The CHMTs planned to conduct Data Quality Assessment (DQA) on data quality and continue with data review meeting with facility inchargies in monthly basis.

3.continue requesting permit.