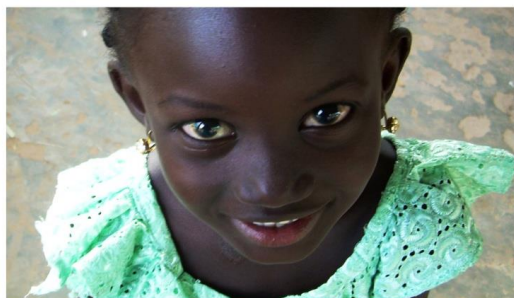


The United Republic of
TANZANIA
Ministry of Health &
Social Welfare



LINDI MUNICIPAL
District Health Profile



TABLE OF CONTENTS

I.	FOREWORD	1
II.	ACKNOWLEDGEMENTS	2
III.	EXECUTIVE SUMMARY	3
IV.	ACRONYMS AND KEY TERMS	4
1	INTRODUCTION	7
1.1	MISSION AND VISION	7
1.2	STRUCTURE OF DISTRICT	7
1.3	FACILITY DISTRIBUTION	8
1.4	POPULATION	9
1.5	GEOGRAPHY	Error! Bookmark not defined.
1.6	TRANSPORTATION AND COMMUNICATION	2
1.7	EDUCATION	2
1.8	[OTHER INTRODUCTORY INFORMATION 1]	Error! Bookmark not defined.
2	DATA COLLECTION METHODS AND SOURCES OF DATA	2
2.1	DATA SOURCES AND THEIR DATA COLLECTION AND ANALYSIS METHODS	4
2.2	MANDATORY HEALTH INDICATORS	4
2.3	HEALTH INDICATORS IMPORTANT TO [DISTRICT NAME] DISTRICT	7
2.4	KEY MESSAGES ABOUT HEALTH INDICATORS	Error! Bookmark not defined.
3	HEALTH STATUS OF THE DISTRICT POPULATION	8
3.1	MATERNAL, NEWBORN AND CHILD HEALTH	8
3.2	MORBIDITY	10
3.3	MORTALITY	12
3.4	OPTIONAL HEALTH STATUS OF THE DISTRICT POPULATION INDICATORS	12
3.5	DISTRICT HEALTH STATUS CONCLUSIONS, RECOMMENDATIONS AND WAY FORWARD	13
4	STATUS OF HEALTH SERVICE DELIVERY IN THE DISTRICT	14
4.1	GENERAL HEALTH SERVICE	14
4.2	VACCINATION SERVICES	Error! Bookmark not defined.
4.3	REPRODUCTIVE HEALTH SERVICES	15
4.4	INFECTION DISEASE AND NON-COMMUNICABLE DISEASE HEALTH SERVICES	18
4.5	OPTIONAL DISTRICT HEALTH SERVICE DELIVERY INDICATORS	21
4.6	DISTRICT HEALTH SERVICE DELIVERY CONCLUSIONS, RECOMMENDATIONS AND WAY FORWARD	2
5	STATUS OF DISTRICT HEALTH SYSTEMS	3
5.1	HEALTH FINANCING	3

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

5.2 HUMAN RESOURCES FOR HEALTH	1
5.3 MEDICINES/DRUGS.....	2
5.4 INFRASTRUCTURE	4
5.5 OPTIONAL DISTRICT HEALTH SYSTEM INDICATORS	5
5.6 DISTRICT HEALTH SYSTEM CONCLUSIONS AND WAY FORWARD.....	6
6 AREAS OF PROGRESS IN THE DISTRICT HEALTH SECTOR.....	7
6.1 PROGRESS IN DISTRICT HEALTH FINANCING	7
6.2 PROGRESS IN DISTRICT HUMAN RESOURCES.....	8
6.3 PROGRESS IN DISTRICT NEONATAL HEALTH	8
6.4 PROGRESS IN DISTRICT HEALTH FACILITY COVERAGE	9
6.5 PROGRESS IN DISTRICT HEALTH FACILITY PERFORMANCE	9
6.6 PROGRESS IN DISTRICT HEALTH SERVICES	12
6.7 PROGRESS AGAINST MILESTONES	13
6.8 BEST PRACTICES/CASE STUDIES.....	13

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

I. FOREWORD

The District Health Profile is one of the most important tools to the district and externals as it gives room to know where the district is, where it intends to be and efforts toward the needs and problems facing it. It is like the mirror that enables the District to know what is prevailing in the area, causes and what measures can be taken to address the problems.

The DHP helps the district to effectively utilize resources available based on the magnitude and priorities of the district.

The DHP is an essential tool for monitoring and evaluating the implementation of programs and knowing the impact of health interventions. It is a good way for Monitoring and Evaluation to draw the success and failure of certain objected goals and to measure efforts in the entire community. It also enables donors, researchers and other stakeholders to priorities areas to support or draw some research findings.

It's our Expectation that the Ministry of health will use this DHP to get a proper view to the council on health conditions, to help better prioritize and support related work being done in Lindi, led by the district, other development partners and donors.

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

II. ACKNOWLEDGEMENTS

This important document is a result of full participatory approach with collaborative effort and commitment among CHMT members and other stakeholders in Lindi Municipal Council. On behalf of the Council Management team I would like to share my appreciation and acknowledgement of the valuable support and brilliant contributions from all participants in the process of producing the DHP.

I am greatly indebted to all health facility Governance committees in charge of submission of data that reflect the health needs in their catchments areas. Also, a deep thanks should go to the Council Director as well as Council Health Service Board for their valuable contribution in preparation of this document.

It is not possible to mention all who in one way or another participated in the preparation of this document by their names. I would like to take this opportunity to thank all and acknowledge their efforts that led to the completion of this document.

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

III. EXECUTIVE SUMMARY

This District Health profile covers the introductory information of Lindi Municipal Council. It describes the geographical location of the area, size, population, health status and education status. It also explains the common health problems dominating the community and the efforts done by the District to alleviate that needs or problems, it covers the data collection and analysis methods and achievements observed in various aspects in meeting the health indicators covered in this DHP.

The Health Indicators included in this DHP includes, Health Status of the Population, Health Service Delivery, Health Systems and progress in Health Sector. However the document explains the outcomes in relation to control and management of diseases in different spheres that is, morbidity and mortality, reproductive health services, immunization services, causes of admission and causes of deaths. Human resources for Health, Health financing and Availability of medicine, progress in health sector and best practices for improving quality of health services.

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

IV. ACRONYMS AND KEY TERMS

Table 0-1. ACRONYMS

ACRONYM	LONG NAME
AIDS	Acquired Immune Defficiency Syndrome
AMO	Assistant Medical Officer
ANC	Antenatal Clinic
ALU	Artimether Lumefantrine
BCG	Bacillus Calmet Guelen
CO	Clinical Office
LUWASA	Lindi urban Water and Sewarage Authority
DC	District Council
DHP	District Health Profile
EHO	Environmental Health Officer
EHP	Essential Health Package
EmoC	Emmergency Obstetric Care
BmoC	Basic Obstetric Care
FBO	Faith Based Organisation
HC	Health Centre
HIV	Human Immunodeficiency Virus
HO	Health Officer
IPD	In Patient Department
IPT 2	Intermitent Presumptive Treatment dose 2
ITN	Insecticide Treated Nets
MMAM	Mpango wa Maendeleo wa Afya ya Msingi
MOHSW	Ministry of Health and Social Welfare
MO	Medical Officer

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

MRDT	Malaria Rapid Diagnosis Test
NO	Nursing Officer
OPD	Out patient Department
OPV	Oral Polio Vaccine
RCH	Reproductive and Child Health
TB	Tuberculosis
TIKA	Tiba kwa kadi

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

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 Indicators that are not necessarily important to all but can be optionally included

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

1 INTRODUCTION

1.1 MISSION AND VISION

1.1.1 Vision

The vision of Lindi Municipal Council is to be among the best councils with ability to provide better and sustainable quality health services to the community.

1.1.2 MISSION

The mission of Lindi Municipal Council is to ensure that all residents deliver health services for the achievement of improved health status of the community.

1.2 STRUCTURE OF DISTRICT

Lindi Municipality is one of the oldest towns in Tanzania. It was established in 11th Century by the Arab traders. Lindi Municipal Council is located on the Southern part of Tanzania Mainland. It lies between Latitudes 9° 31' and 10° 45' South of the Equator and between Longitude 38° 4' and 40° 0' East of Greenwich. The Municipal Council is bordered by Lindi District Council in all of its boundaries except the Eastern part where it is bordered by the Indian Ocean

Lindi Municipal Council covers an area of about 945 square kilometers which is equivalent to 14.1% of the total area of Lindi Region. Out of the said area, 833 km² is covered by land and 112 km² covered with water

According to NBS population census of 2002 Regional and District projection of 2006 volume XII. Lindi Municipal Council is estimated to have a total population of 111,235 people with growth rate of 1.4%.

Table 1-1. Wards And Villages

	NAME OF WARD	No. OF STREETS	NO. SUBURBS
1	RASBURA	6	0
2	MAKONDE	2	0
3	MITANDI	6	0
4	MIKUMBI	3	0
5	RAHALEO	4	0
6	NDORO	4	0

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

7	NACHINGWEA	4	0
8	WAILES	5	0
9	MATOPENI	6	0
10	MWENGE	5	0
11	MTANDA	4	0
12	JAMHURI	7	0
13	MSINJAHILI	7	2
14	MBANJA	0	3
15	NG'APA	0	3
16	CHIKONJI	0	4
17	TANDANGONGORO	0	4
18	MINGOYO	0	4
		63	20

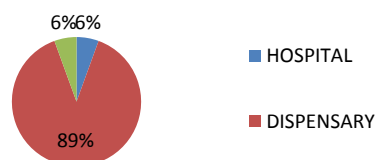
1.3 FACILITY DISTRIBUTION

The council has 18 health facilities. 16 Dispensaries, 1 Health Center and 1 Hospital (Regional Referral Hospital). The majority of the population **84,094** (75.6%) are served within 5 km.

Table 1-2. Facility Distribution

TYPE OF FACILITY	NUMBER OF FACILITIES	OWNERSHIP
HOSPITAL	1	Government
DISPENSARY	11	Government
	3	Parastatal
	2	Private
HEALTH CENTER	1	Government
CLINICS	0	

Distribution of Health facility by type



LINDI MUNICIPAL COUNCIL HEALTH PROFILE

FIGURE 1-1.[DISTRICT NAME] District Map

[A DISTRICT MAP SHOWING THE FOLLOWING INFORMATION:

1.4 POPULATION

According to October 2002 population and housing census, the Council recorded a total population of 41,549 out of which 21,249 were Males and 20,300 Females. The District annual population growth rate is 0.14% and population density is 110 people per square kilometer. Projections for December, 2012 show that the Council has 111,235 People (**54,505** males and **56,730** females). This includes population from the five added wards from Lindi District Council.

Table 1-3. Gender And Age Based Statistics

AGE RANGE	FEMALE	MALE
<1 YEAR	928	893
1-4	5,557	5,339
5-14	11,446	11,913
15-49	16,037	16,691
>50	20,537	21,894
TOTAL	54,505	56,730

1.5 GEOGRAPHY

The Council is dominated by Coastal zone where its temperature ranges from 24°C and 27°C. The hottest month being July to October. There are two rainfall seasons. The shortest rainfall season is from November to January and the wetter months are between March and May. The average annual rainfall is between 800mm and 1200mm. The dry season starts in the mid May to October and the average temperature range between 24°C – 32°C.

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

1.6 TRANSPORTATION AND COMMUNICATION

The District is covered by 518.80 roads network. Tarmac roads covers 76.20 kms, gravel roads covers 79.60 kms, earth roads covers 360.40 kms including roads which need to be opened.

The main public transport within and out of the District is road and sea. Air transport is not mostly used although there is Air port to provide air travel services.

Telephone service in the Council is provided by TTCL, VODACOM, ZANTEL, TIGO, and AIRTEL. Almost all areas are accessible to telephone.

Transportation and communication contribute to economic growth and development of the community, facilitate transportation of basic commodities needed to support life, accessibility to health services i.e. distribution of drugs, medical supplies as well as referral services from lower level facilities to high levels.

WATER BODIES

The main water body is sea found in the eastern part of the district. Within the district there are few seasonal rivers that can supply water for animal and domestic use . The only rivers available in all season are river Lukuledi and Muloweke at Mimgoyo ward. This has lead to inadequate water supply were only 26% of the total population is accessible to tap water supplied by LUWASA and the rest depend on domestic shallow wells which are not safe hence poor hygiene and sanitation.

1.7 EDUCATION

The Council has 31 Primary schools and 9 Secondary schools. Enrolment in primary schools stands at 90% where as drop out and truancy rate stands at 3%. On the other hand, while pass rate at standard seven is estimated at 56.6%. Literacy rate is 54.8%.

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

2. DATA COLLECTION METHODS AND SOURCES OF DATA

2.1. DATA SOURCES AND THEIR DATA COLLECTION AND ANALYSIS METHODS

Data collection is one of the main activities during provision of health services. The collected data are very useful in formulation of different interventions, preparations of the council strategic plan, and with CCHP in solving health needs and problem. These data are collected from different levels, the community and health facilities found in the council (Public and Private).

Different methods are used to collect data i.e HMIS forms and books available in all health facilities, RITA tool for registration of birth and births in the community and other forms used by community health workers. All collected data are analyzed by DHIS 2 software at district level. However data from vertical programs, surveys and census are also used in preparation of different intervention and reports.

2.2. MANDATORY HEALTH INDICATORS

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

- *The health status of the **LINDI MUNICIPAL** -district council population.*
- *The status of the **LINDI MUNICIPAL** health system.*
- *The status of health service delivery in **LINDI MUNICIPAL** district council.*
- *Progress that has been made in the **LINDI MUNICIPAL** district council health sector.*

Table 2-1. MANDATORY DHP HEALTH INDICATORS

HEALTH STATUS OF THE DISTRICT POPULATION	DISTRICT HEALTH SERVICE DELIVERY
Maternal, Newborn and Child Health <ul style="list-style-type: none"> ❖ Nutritional Status ❖ Neonatal infant, and under 5 mortality rates Diseases <ul style="list-style-type: none"> ❖ Incidence of Malaria ❖ HIV/AIDs prevalence ❖ Top 10 causes of admission ❖ Top 10 causes of death 	General <ul style="list-style-type: none"> ❖ OPD Attendance Vaccination <ul style="list-style-type: none"> ❖ Proportion of children under 1 vaccinated against measles ❖ Proportion of under 1 3rd Polio (OPV3) ❖ Proportion of under 1 BCG dose Reproduction Health <ul style="list-style-type: none"> ❖ Percentage of health centers and dispensaries that can provide EmOC as

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

DISTRICT HEALTH SYSTEMS	
<p>Health Financing</p> <ul style="list-style-type: none"> ❖ 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 <p>Infrastructure</p> <p><i>Health Indicator Still Being Determined</i></p>	<p>defined in EHP</p> <ul style="list-style-type: none"> ❖ Proportion of pregnant women starting ANC before 12 or 16 weeks gestation <p>Infectious Diseases and Non-Communicable Diseases</p> <ul style="list-style-type: none"> ❖ 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
<p>Progress in district health financing</p> <ul style="list-style-type: none"> ❖ Overall Health Financing ❖ Expansions in Health spending <p>Progress in district health services</p> <ul style="list-style-type: none"> ❖ Increases in skilled health workers ❖ Progress in human resource availability by cadre over a period of time <p>Progress in district neonatal health</p> <ul style="list-style-type: none"> ❖ Low birth weight <p>Progress in district health facility coverage</p> <ul style="list-style-type: none"> ❖ Expansions in facility coverage across districts <p>Progress in district health facility performance</p> <ul style="list-style-type: none"> ❖ Expansions in critical health services ❖ Improvements in referral hospital performance ❖ Progress in ANC Attendance

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

- ❖ 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

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

2.2. HEALTH INDICATORS IMPORTANT TO LINDI MUNICIPAL COUNCIL

Health indicator is important to measure achievement, to reflect the changes connected to an intervention, target, or to help assess the performance of planned activities.

The council has indicators that help in measuring the success in improving quality of health service. These indicators are maternal Health i.e. reduction of maternal and child deaths, accessibility to health services.

Through strengthening of Health delivery services by ensuring that community is accessible to quality health services. Sensitization of community to join health schemes (TIKA), MMAM and P4P programs has been implemented as a strategy towards achieving the goals for the reduction of those health problems facing the community and increasing staff commitment to deliver promptly health care services.

DISTRICT SPECIFIC INDICATORS
1. Expansions in facility coverage across districts
2. Progress in implementation of P4P program
3. Percentage of Health facilities with TIKA scheme

2.3. KEY MESSAGES ABOUT HEALTH INDICATORS

Community in different areas has been sensitized to participate in process of construction and rehabilitation of health facility infrastructure. Two facilities are under construction through community initiatives and different partners i.e. MKUUMI. Improvement of RCH services is one of the strategies where the service providers are awarded. This is through P4P program.

2 HEALTH STATUS OF THE DISTRICT POPULATION

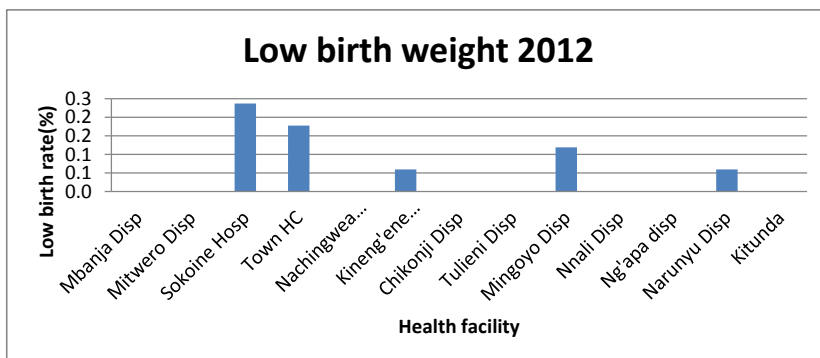
2.1 MATERNAL, NEWBORN AND CHILD HEALTH

NUTRITIONAL STATUS: LOW BIRTH WEIGHT

Good nutrition is a prerequisite for the national development and for the well being of individuals. In fact poor nutrition affects the whole population but the effects have more impact to women and children. This is because of nutrients is more required to pregnant women and children as physiologically they in need of more nutrients.

At child hood nutrition is needed for growth, health and development. The anthropometric on weight data from all health facilities shows that a total of 1689 delivery children 11(0.7%) had low weight. Sokoine Hospital had 4(0.24%) children followed by Town Health center where 3 (0.18%) children found.

Figure 3-1. Nutritional Status: Low Birth Weight



NEONATAL, INFANT, AND UNDER 5 MORTALITY RATES

Data collected from health facilities show that in the year 2012 a total of 33 neonatal deaths, 47 infants, 45 under five death, and 4 maternal deaths were occurred. Maternal deaths were caused by PPH 1 case, anemia 2 cases and puerperal psychosis 1 case.

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

Figure 3-2. Neonatal Mortality Rates

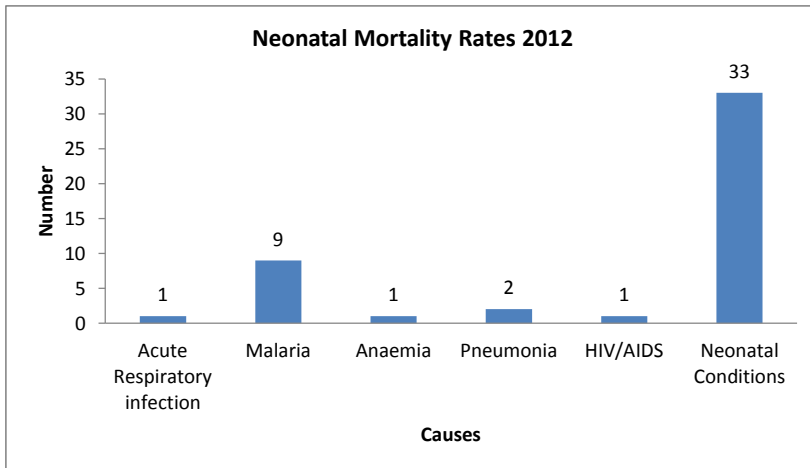


Figure 3-3. Infant Mortality Rate

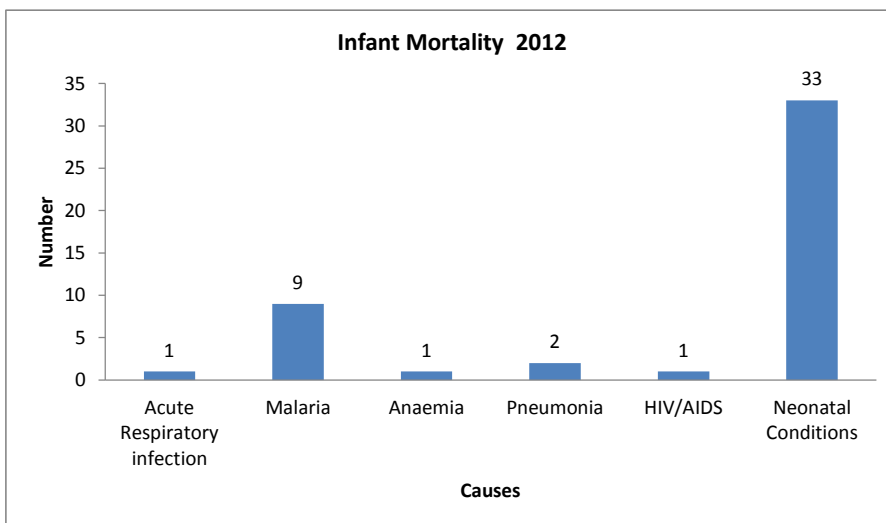
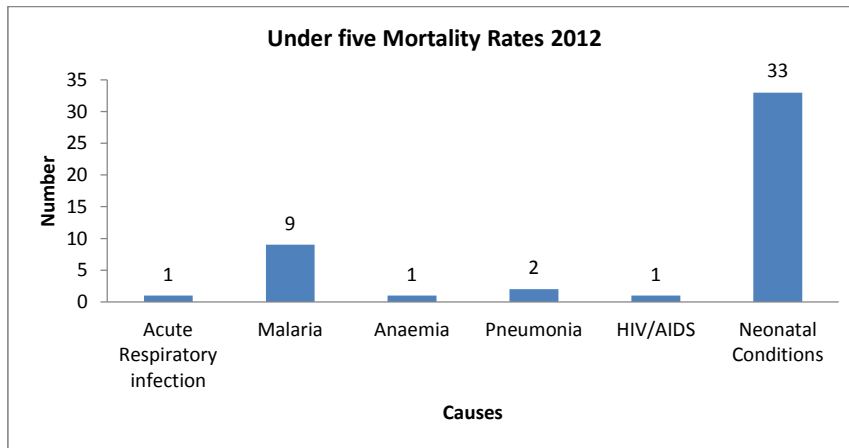


Figure 3-4. Under 5 Mortality Rate

LINDI MUNICIPAL COUNCIL HEALTH PROFILE



2.2 MORBIDITY

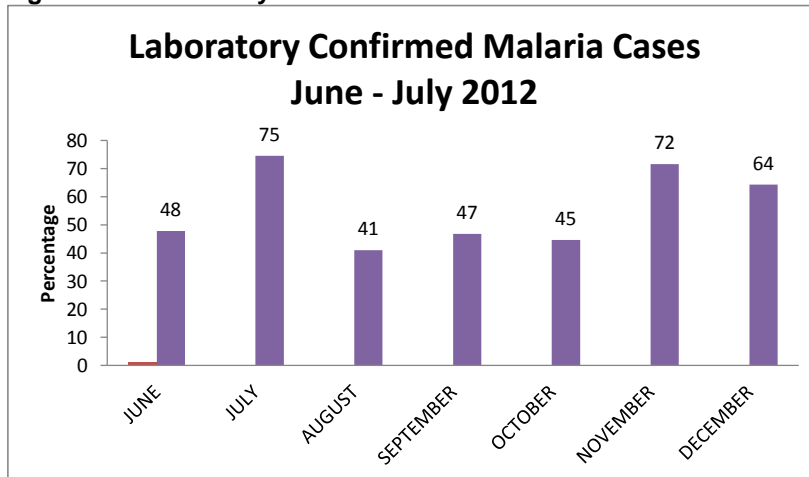
Data collected from all Health facilities shows among the cases reported malaria was the leading cause of morbidity.

The detection of Malaria cases was facilitated by the introduction of Malaria Rapid Diagnostic test (MRDT). The technique has facilitated clinician to test and treat confirmed malaria case compare to the previous time where diagnosis was basing on clinical sign.

Here below is Laboratory confirmed cases of Malaria for the year 2012 from both public and private Facilities in the distinct.

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

Figure 3-5. Laboratory Confirmed Malaria Cases

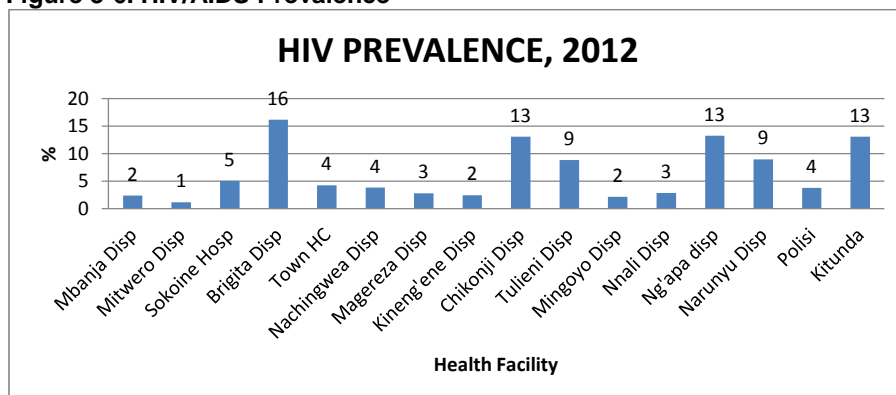


- HIV/AIDS PREVALENCE**

Data from Health facility shows that a total of 12567 clients tested for HIV where 667 were positive.

This is equivalent to 5.3% of the total population tested.

Figure 3-6. HIV/AIDS Prevalence



LINDI MUNICIPAL COUNCIL HEALTH PROFILE

Top 10 Causes of Admission/Inpatient Diagnosis

Data from health facilities shows that during the year 2012 the top ten cause of admission was Malaria. Below, table 3-1 shows a list of top ten cases of admission.

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

Na.	Diagnosis	Under 1 Month	1 Month - < 1 Year	1 Year —< 5 Years	5 Years - > 5 Years
1	Malaria uncomplicated	0	247	401	865
2	Malaria severe	0	103	196	254
3	Other diagnoses	54	43	65	358
4	HIV/ AIDS	0	0	28	156
5	Pneumonia	11	68	87	135
6	Anemia	0	0	15	104
7	Diarrhea diseases	0	32	99	97
8	ARI	2	17	65	75
9	Fractures	0	0	7	27
10	Injuries	0	0	53	21

2.3 MORTALITY

Data from health facilities shows that during the year 2012 the top ten cause of death was malaria in both under five and above five followed by HIV/AIDS. Below, table 3-2 shows a list of top ten cases of deaths in the district.

Table 3-2. Top 10 Causes of Death

Na.	Diagnosis	Under 1 Month	1 Month - < 1 Year	1 Year —< 5 Years	5 Years - > 5 Years
1	Malaria severe	0	6	19	18
2	Malaria uncomplicated	0	2	7	15
3	HIV/AIDS	0	0	3	8
4	Fractures	0	0	4	8
5	TB	0	2	6	7
6	Injuries	0	0	1	7
7	Diarrhea diseases	0	2	3	4
8	Pneumonia	1	3	4	2
9	Anemia	0	0	1	2
10	ARI	0	0	1	1

2.4 OPTIONAL HEALTH STATUS OF THE DISTRICT POPULATION INDICATORS

On improving the quality of health services in the district, the council has set indicators that enable to measure achievement toward improvement or failure and take proper measures to

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

improve or maintain the quality. Among the indicators selected are proportion of births attended in health facility, Contraceptive prevalence rate, Proportion of children under 5 receiving vitamin A twice per year and postnatal attendance.

Data from Reproductive and Child Health (RCH) shows that 98.2% of deliveries were attended in health facilities and 1% delivered before arrival to health facility and 0.8 delivered to traditional birth attendant. Concern with uses of family planning methods, data from facility indicated that 77 percent of women used contraceptives this includes pills, implants, injection and condoms.

Vitamin A supplementation has been conducted twice a year in June and December aiming to reduce infant and under five deaths. The proportion of children under 5 receiving vitamin A is 98% for children 6-11 months and 93% for fewer than five.

During ANC attendance women has been advising to deliver at Health facility and also attend postnatal clinic. Health facility data shows that it is only 43% delivered women attend postnatal clinic within seven days.

2.5 DISTRICT HEALTH STATUS CONCLUSIONS, RECOMMENDATIONS AND WAY FORWARD

Apart from implementation of different intervention such as providing mosquito net to every household, Hati punguzo to pregnant women and under 5 children etc, the District team has come to realize that Malaria is still a problem that needs more effort to reduce morbidity and mortality caused by the disease. Like Malaria HIV/AIDS prevalence is still high 5,3% regardless the effort on reduce the problem.

RECOMMENDATION

- ❖ On reducing morbidity and mortality caused by malaria more intervention for eradication of breeding site by using proper methods is needed
- ❖ Male involvement in issues concern with maternal should be more advocated so as to reduce infant, under five and maternal deaths.

4 STATUS OF HEALTH SERVICE DELIVERY IN THE DISTRICT

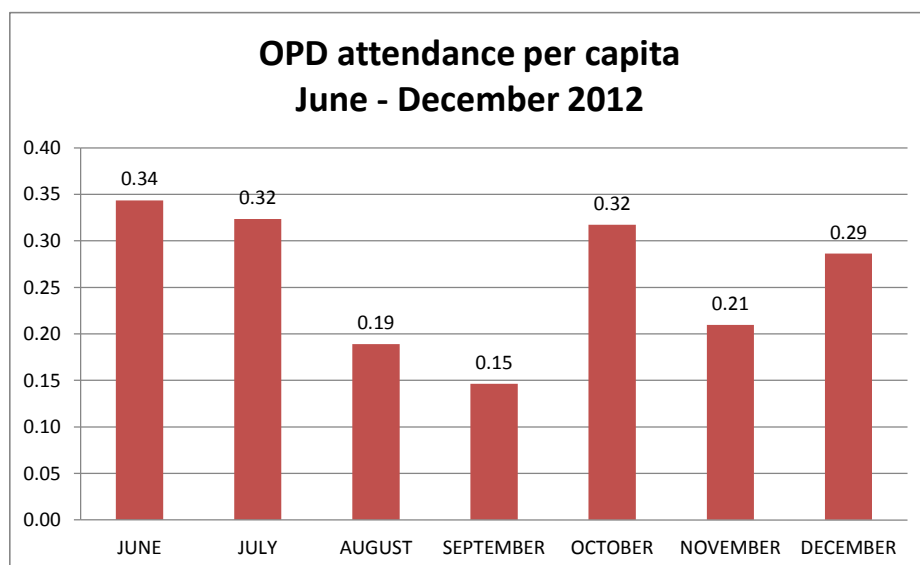
4.1. GENERAL HEALTH SERVICE

OPD ATTENDANCE

One of the key indicators to assess performance on the provision of health services in the district. Number of people attending and receiving services at health facilities during periods of illness. A good indicator of this is the outpatient attendance per capita. This indicator shows the extent of facility utilization by the population. If Out Patient Department (OPD) attendance is found to be high in the public health facilities, it implies that the population is highly satisfied by provision of services in these facilities.

Data collected at OPD in both public and private Health facilities it shows that OPD attendance per capita range from 0.15 to 0.34. Below, Figure 4.1 summarizes the attendance rate per capita for the past 6 months (June- December, 2012).

Figure 4-1. OPD Attendance



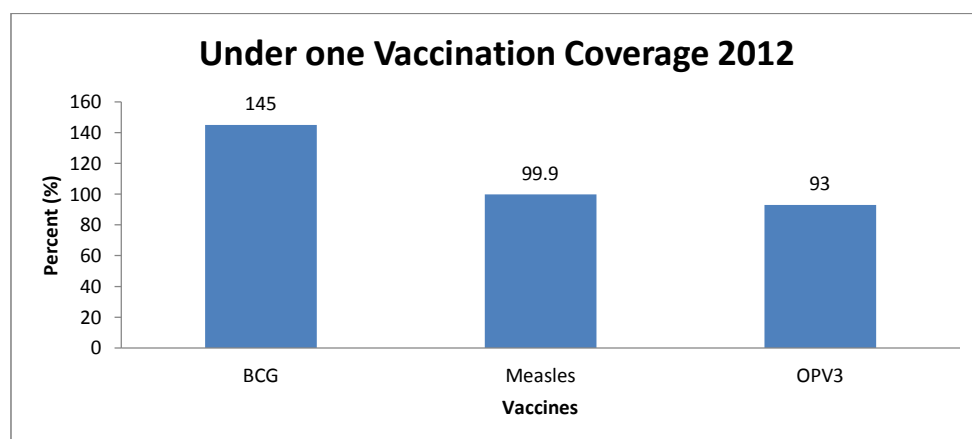
LINDI MUNICIPAL COUNCIL HEALTH PROFILE

4.2. VACCINATION SERVICES

The Tanzania 2007 -15 strategy is to raise level of national immunization coverage among children to 90% in all vaccines. To achieve this target the district facilitate implementation of immunization activities in all health facility and outreach services to hard to reach areas by supplying vaccine and vaccination facilities such as LPG and electricity for refrigerators and pay service providers who conduct routine and outreach services.

Data collected from health facility shows that children vaccinated against BCG were 2638 (145%), Measles 1689(99.8%) and OPV3 1571 (93%).

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



4.3. REPRODUCTIVE HEALTH SERVICES

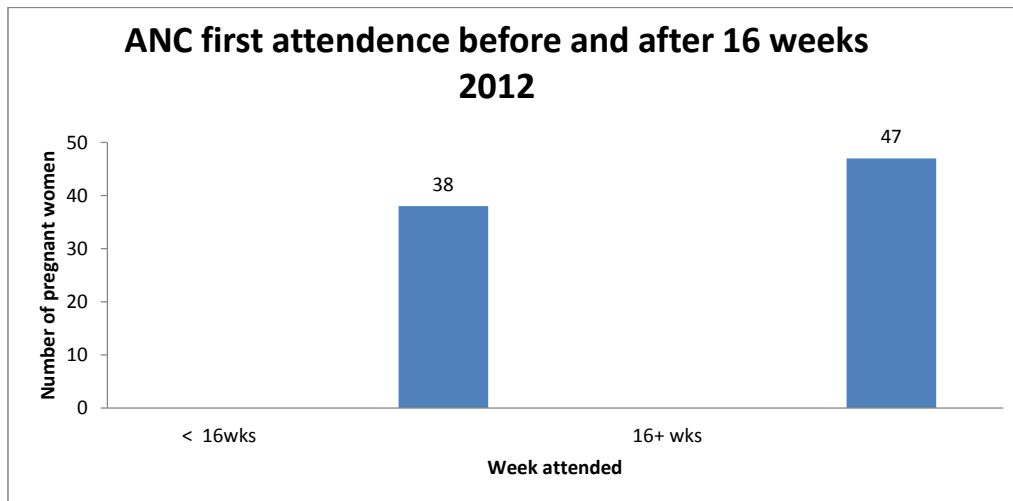
PROPORTION OF PREGNANT WOMEN STARTING ANC BEFORE 12 or 16 WEEKS GESTATION

Early and regular checkups of pregnant women by well trained medical provider are very important in assessing the physical status of women during pregnancy. It is very important as it allows intervention to occur in a timely manner if problem are detected. From this point of it is very important to make sure that pregnant women start early ANC services.

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

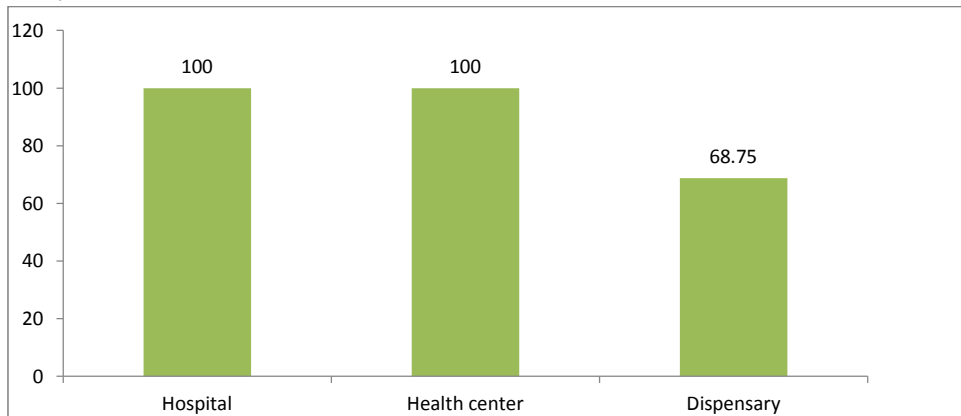
Data from RCH clinics in the district shows that the proportional of pregnant women to start ANC services before 12 or 16 weeks of gestation was 688(38%) compare to 857(47%). Below figure 4.3 shows the proportional of pregnant women starting ANC before 16 of gestation.

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



The figure above shows that 38% of pregnant women attend RCH for ANC services before 16 weeks of gestation compare to 47% who attend after 16 and above weeks of their gestation.

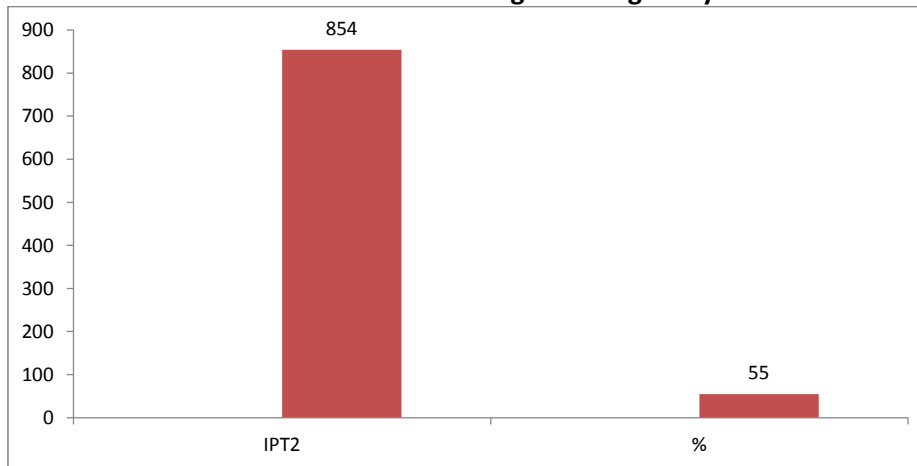
Figure 4-4. Percentage of health centers and dispensaries that can provide EmOC as defined in EHP.



The figure above shows that and only one facility (Regional Referral Hospital provide EmOC, the lest 11(68%) provide BmOC service.

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

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



The figure above shows that 854(55%) of pregnant mothers received two doses of Preventative Intermittent Treatment for Malaria during their last pregnancy.

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

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

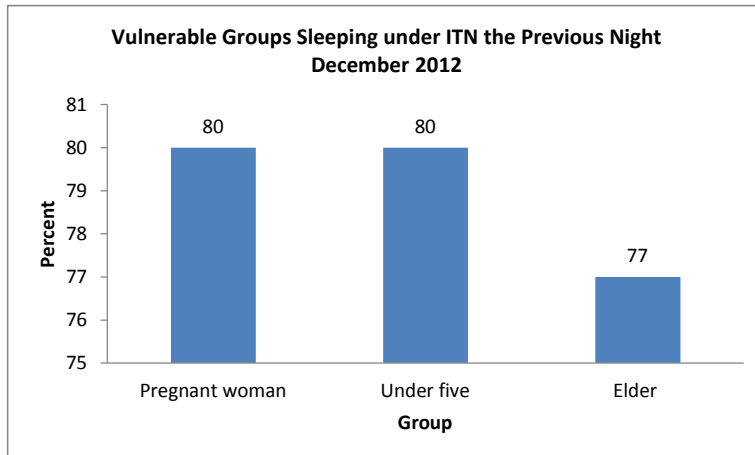
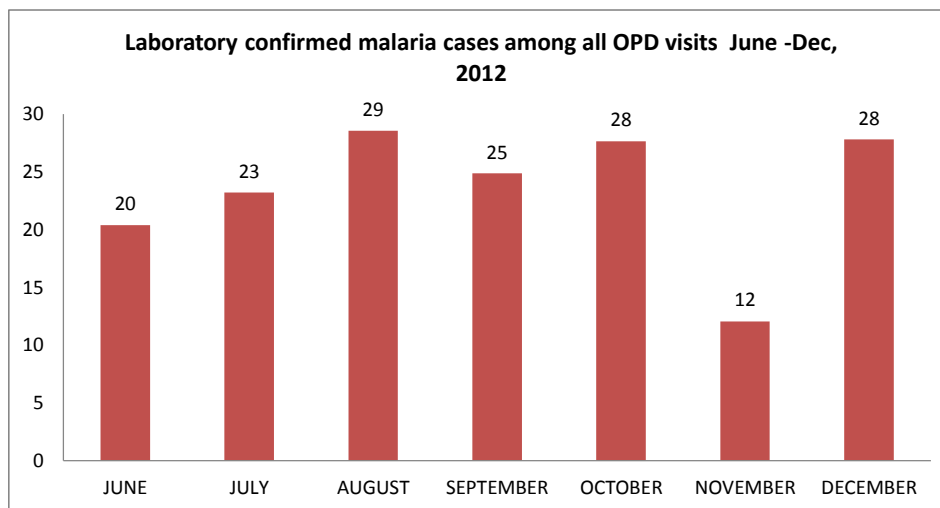


Figure 4-7. Proportion of laboratory confirmed malaria cases among all OPD visits.



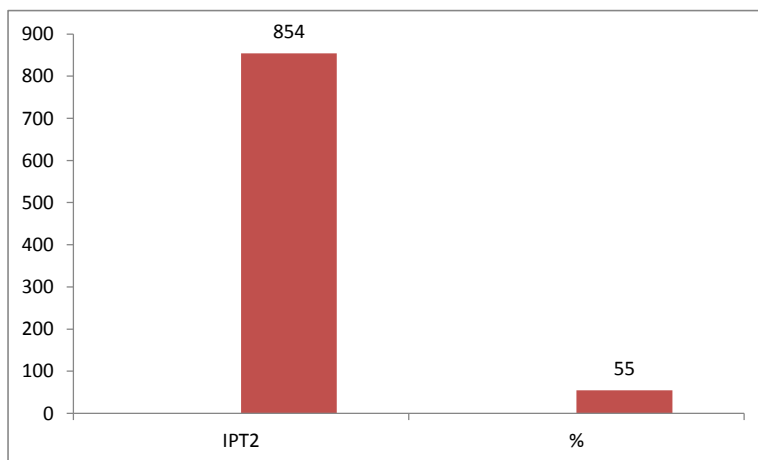
LINDI MUNICIPAL COUNCIL HEALTH PROFILE

4.4. INFECTION DISEASE AND NON-COMMUNICABLE DISEASE HEALTH SERVICES

PROPORTION OF MOTHERS WHO RECEIVED TWO DOSES OF PREVENTATIVE INTERMITTENT TREATMENT FOR MALARIA DURING LAST PREGNANCY.

It is very important to prevent mother and children from malaria parasite that is why all pregnant mothers are advised to take SP as preventive measure to both fetus and mother. Data from RCH shows that the proportion of mother received two doses of preventive intermittent treatment for malaria during last pregnancy in 2012 was 854(55%).

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



The figure above shows that 854(55%) of pregnant mothers received two doses of Preventative Intermittent Treatment for Malaria during their last pregnancy.

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

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

Vulnerable Groups Sleeping under ITN the Previous Night - December 2012

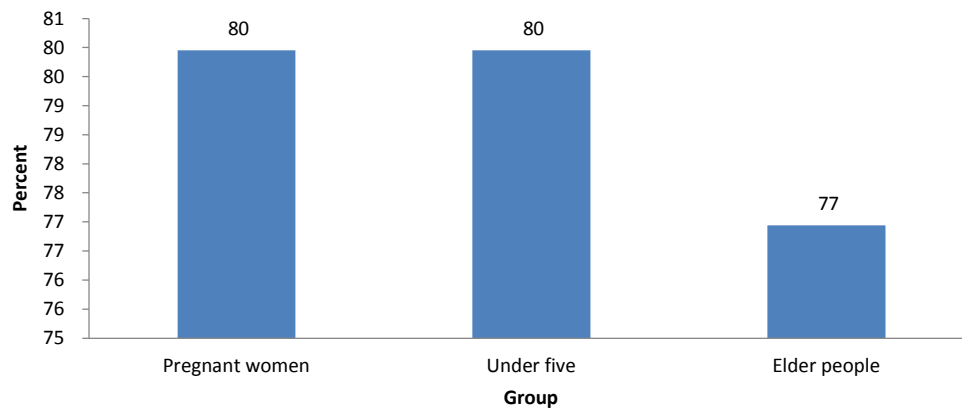
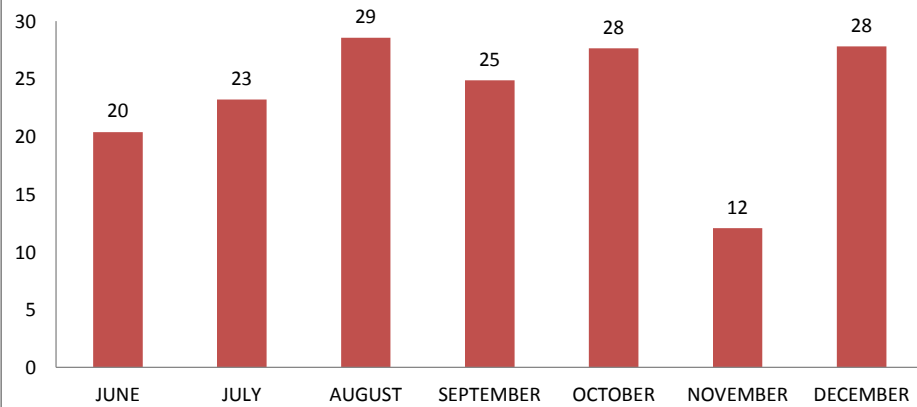


Figure 4-7. Proportion of laboratory confirmed malaria cases among all OPD visits

Laboratory confirmed malaria cases among all OPD visits June -Dec, 2012

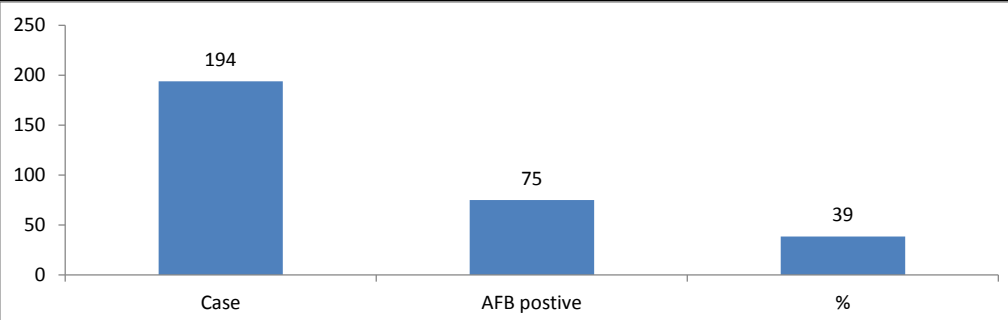


TB notification rate per 100,000 population

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TB diagnosis is conducted by one Health facility on in the district testing of TB is done only in facilities with Laboratory equipment and staff. Most of diagnosed cases are those come to facility after being treated from other signs of diseases without improvement. Below, figure 4.8 shows the TB notification rate per 100,000 populations in year 2012.

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



The above figure shows that out of 194 cases diagnosed 75 (39%) where AFB positive

4.5. OPTIONAL DISTRICT HEALTH SERVICE DELIVERY INDICATORS

In the year 2012, data from RCH shows that the proportional of pregnant mothers received Hati punguzo was 1,223(67%), the proportional of children under 1 vaccinated against DPT-Hb3 was 1,587(94%), proportion of children under 5 received vitamin A twice per year was 10,227(93%) and the proportional of women received at least 2 doses of TT vaccine was, 470(95%).

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

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

Apart from effort taken by the district in improving the quality of health services still malaria has remain to be the number one cause for mortality and morbidity for both under five and adult.

In collaborating with different partners, the district has been conducting different interventions to reduce malaria prevalence among the affected groups. Among them are distribution of ITNs, provision of ant malaria drugs to pregnant mothers and conduct health education to the community on the important of environmental sanitation to reduce mosquito breeding sites, early attendance to health facility for diagnosis and proper treatment hence reduce deaths due to malaria

WAY FORWARD:

- Establish proper means of order and supply of drugs and medical equipment to all health facilities in order to ensure that all people are accessible to affordable and quality health services.
- Conduct supportive supervision to all health facilities so as to ensure health staff provides quality health services that conform to standards.
- Involve the community to participate in all stages of improving the quality of health services such as construction Health facility and staff houses.

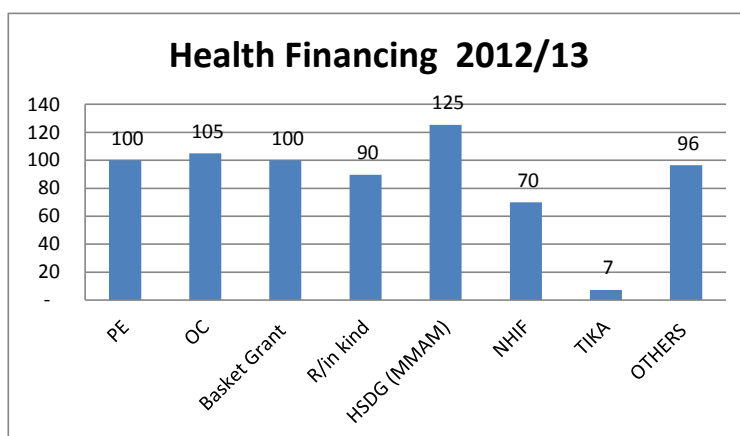
5. STATUS OF DISTRICT HEALTH SYSTEMS

5.1. HEALTH FINANCING

The health activities in the districts are funded from nine main sources of funds, these includes, Local Government block grants, Own sources (council funds), Health Sector Basket Fund, community funds (Cost Sharing/CHF), NHIF, Health sector development Grants, Capital development Grants and MMAM and other donors. Every donors fund activities of interest but no activities funded by more than one donor at time. A good number of the targeted activities were covered during the year of implementation. Figure 5-1 below shows health financing in 20011 and 2012

Challenges in health financing are many among them are late imbursement of fund that has been leading to late implementation of planned activities or carry forward the activities. Some donors do not release fund as planned (Withdraw), some funders do not participate in planning process hence no planned activities in CCHP but during implementation come with fund for implementation.

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



LINDI MUNICIPAL COUNCIL HEALTH PROFILE

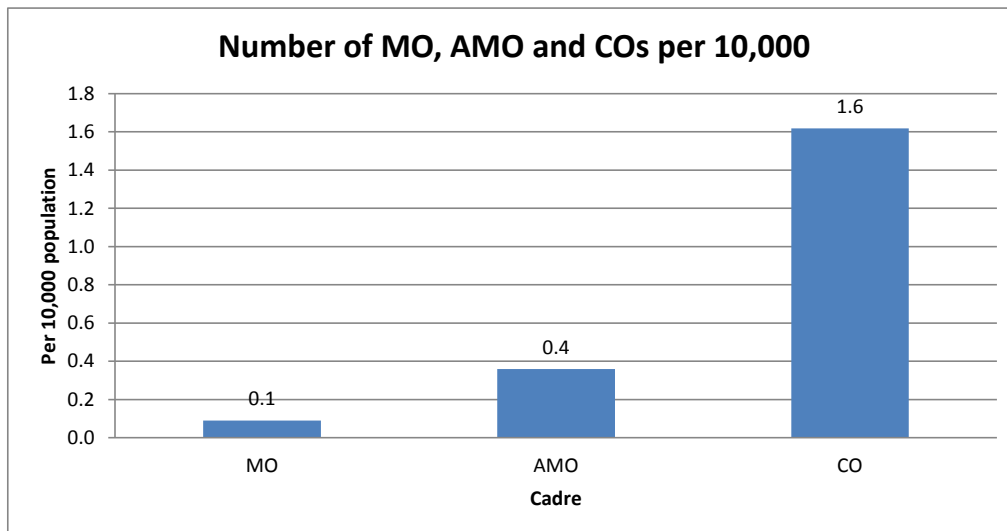
5.2 HUMAN RESOURCES FOR HEALTH

The council has **3** Medical Officer, **1** Specialist , **4** AMO, **24** Cos, **5** Assistant Environment officers. The council has **7** Registered Nurses, **21** Enrolled Nurses, **1** Laboratory Technicians, **16** Medical attendants. The distributions is shown in the figures below from figure 5 – 3 to figure 5 – 5.

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

At the moment there is no full NACTE accredited institute in the district

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



LINDI MUNICIPAL COUNCIL HEALTH PROFILE

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

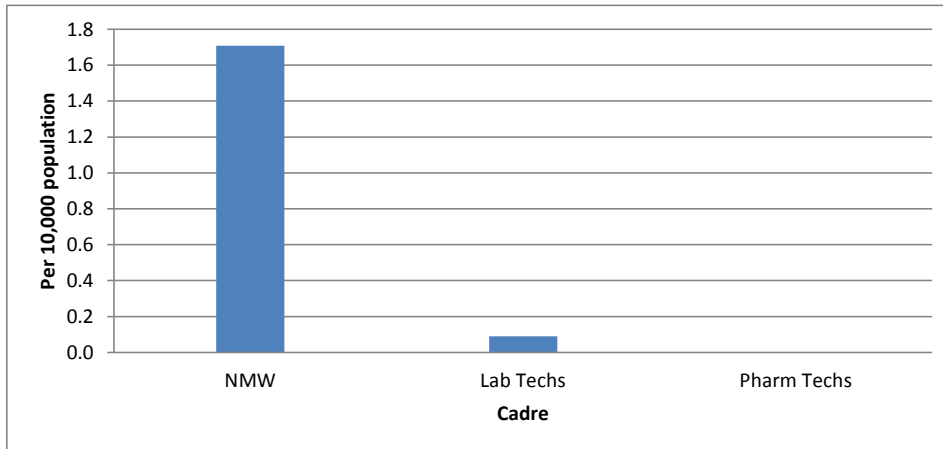
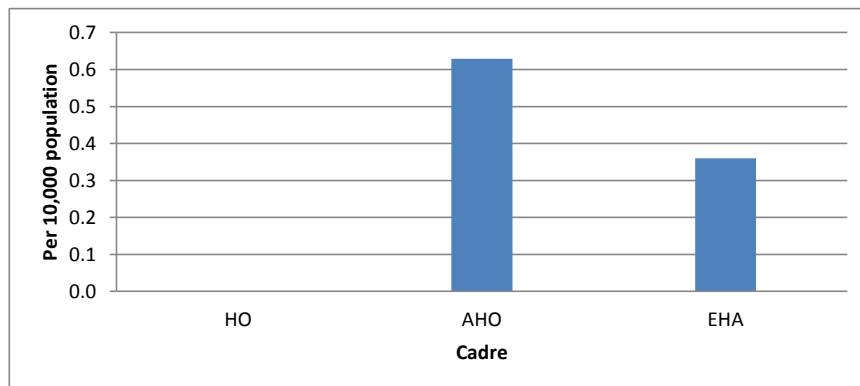


Figure 5-5. Number of HO, AHO, and EHOs Per 10, 000

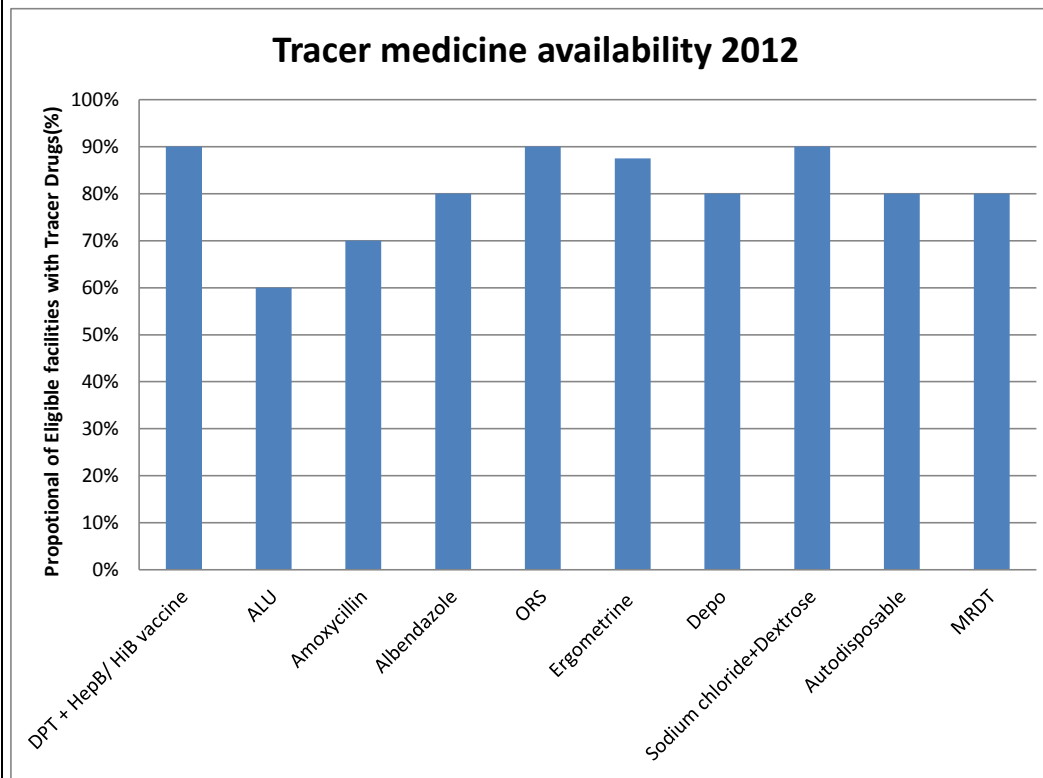


5.2. MEDICINES/DRUGS

Availability of medicines and medical supplies is the major indicator of quality in health care services in the district. The district has set mechanism that enable the district the availability, shortages and/or stock-out medicines and medical supplies. Figure 5-6 show the stock out of 5 tracer drugs, vaccine and medical supplies in the District.

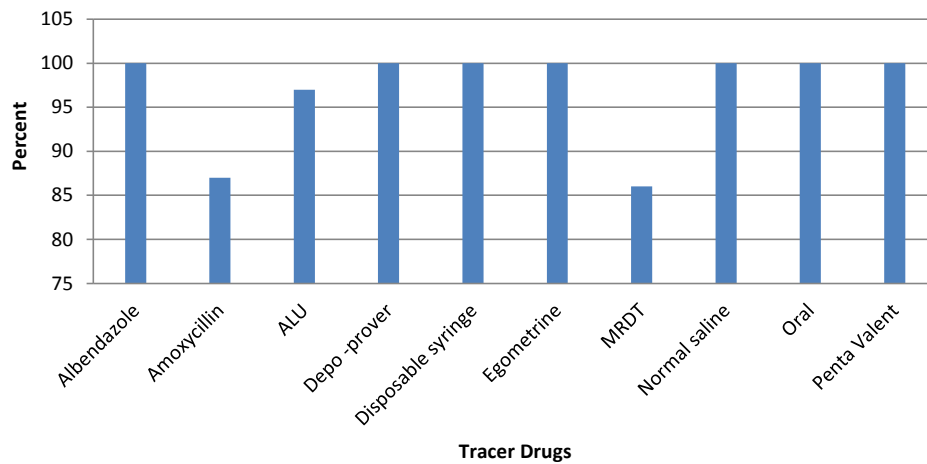
LINDI MUNICIPAL COUNCIL HEALTH PROFILE

Figure 5-6. District level Stockout of 5 Tracer Drugs, 1 Vaccine and Medical Supplies



LINDI MUNICIPAL COUNCIL HEALTH PROFILE

Figure 5-7. Availability of Tracer Medicine



5.3. INFRASTRUCTURE

Improving infrastructure is one of the strategy toward provision of quality health services, in year 2012 data shows that 10(56%) of health facilities structures are in fair condition, 6(33%) are in good state of repair and 2(11%) need major repair.

On improving the quality of health services the council construct two dispensaries at Narunyu and nandambi Village 3 staff houses at Mnali and Kineng'ene village using Community contribution, Council own source and MMAM.

The main challenges on improving the mentioned infrastructure is lack of community involvement (contribution in form of manpower of fund) during the implementation apart from involving them in all stages of project initiation.

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

5.4. OPTIONAL DISTRICT HEALTH SYSTEM INDICATORS

Fund from GOT and donors are not enough to meet the needs of the District in the process of improving the quality of health services. For that case the council has established other sources of fund so as to complement the shortage. Among the established sources is contribution from revenue collection, health insurance offering from the National Health Insurance Fund (NHIF), the Community Health Fund known as TIKa and user fees in the form of cost sharing.

The establishment of Community Health Finance which aimed to involve community to participate in financing provision of health services through cost sharing is not doing well up to date, In year 2012 data shows that the proportion of population enrolled in TIKa is 2% the least population are member of NHIF and some pay at the time when they seek medical services (user fees). The district has no District hospital that can be used as referral Hospital to provide service to member of TIKa this challenge has caused reluctant of community to join the scheme. There is no specific account to deposit collected fund, instead of this every health facility deposit in Health facilities account.

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

5.5. DISTRICT HEALTH SYSTEM, RECOMMENDATIONS, -CONCLUSIONS AND WAY FORWARD

Comment [RS1]: This is incomplete.

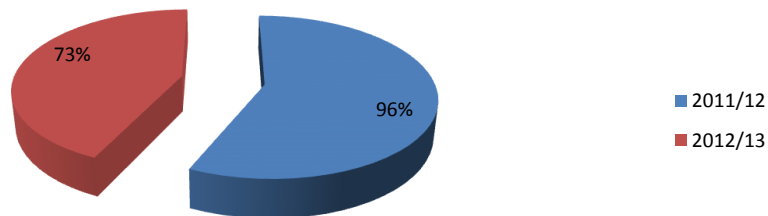
LINDI MUNICIPAL COUNCIL HEALTH PROFILE

6. AREAS OF PROGRESS IN THE DISTRICT HEALTH SECTOR

6.1. PROGRESS IN DISTRICT HEALTH FINANCING

OVERALL HEALTH FINANCING

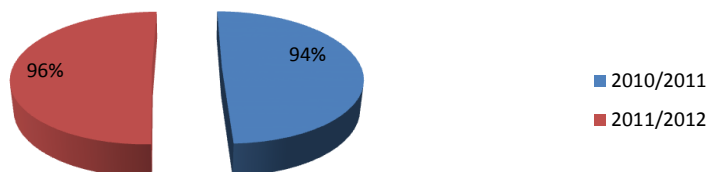
**Allocation of Fund for two financial years
2011/12 and 2012/13**



EXPANSIONS IN HEALTH SPENDING

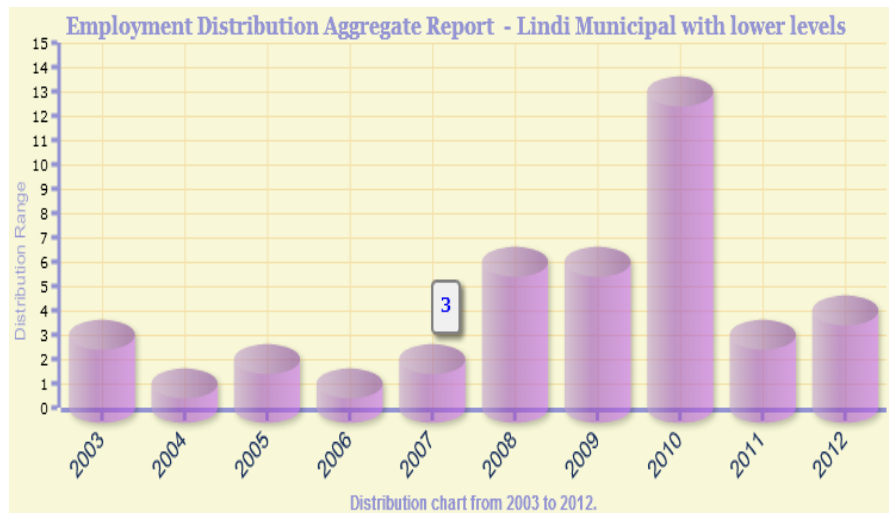
Allocation and expenditure of funds plays an important role in improving the quality of health services in the district. Data from department of planning shows that health budget in 2010/11 was 1.19% and 2011/12 was 1.3% of the council budget and the expenditure of the allocated fund was 94% in 2010/12 and 94% in 2011/12. Below the figure illustrate expenditure of fund allocate in two last two years.

**Health expending
year 2010/2011 and 2011/2012**



LINDI MUNICIPAL COUNCIL HEALTH PROFILE

6.2. PROGRESS IN DISTRICT HUMAN RESOURCES

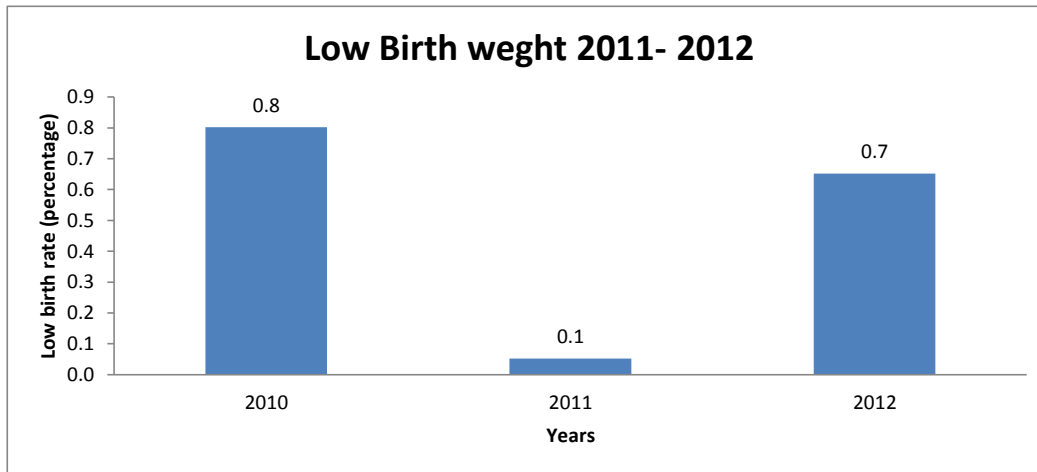


Number of skilled health staff has been increasing gradually where in 2010 the council received 13 health staff of different cadre, in 2011 received 3 and in 2012 received 4 staff.

6.3. PROGRESS IN DISTRICT NEONATAL HEALTH LOW BIRTH WEIGHT

Birth weight is a powerful predictor of infant growth and survival. Infants born with low birth weights begin life immediately disadvantaged and face extremely poor survival rates. A birth weight of less than 2.5 kg is considered low. It is very important to weigh babies and take proper intervention to rescue life. For the past three years the district has experienced dramatic changes of children with low birth weight in 2010 the rate was 0.8, 2011 was 0.1 and 2012 was 0.7%. No baby let is a program under taking in the district, this program aim to make sure no baby die before and even after birth.

LINDI MUNICIPAL COUNCIL HEALTH PROFILE



6.4. PROGRESS IN DISTRICT HEALTH FACILITY COVERAGE

Lindi Municipal Council has 18 Health facilities. 16 Dispensaries, 1 Health Center and 1 Hospital (Regional Referral Hospital) allocated in 63 streets and 20 suburbs that formulate 18 wards. Before extend boundaries to formulate Municipality, there were no suburb with ought Health facility. In 2011 the Council extended its boundaries where 20 villages included in Municipality boundaries. Among these villages/suburbs only 5 (25%) has health facility. In 2012 the district in collaboration with other stockholders has started to construct three dispensaries.

6.5. PROGRESS IN DISTRICT HEALTH FACILITY PERFORMANCE EXPANSIONS IN CRITICAL HEALTH SERVICES

Accessibility of the community to health services has been increased from 60% year 2010 to 70% year 2012. This has been contributed by implementation of PPP policy that emphasize on involving private sector in provision of health services. The district work together with 2 private dispensaries available. We proved services such as medical waste management facilities, vaccination faculties. Introduce HIV/AIDS services.

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

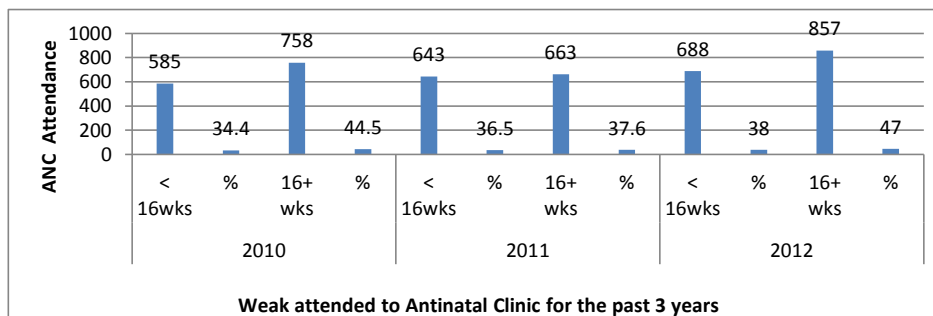
IMPROVEMENTS IN REFERRAL HOSPITAL PERFORMANCE

System of referral from lower level to referral hospital has been strengthened by ensuring that all the time there is a standby ambulance for transferring patient to Regional referral Hospital

PROGRESS IN ANC ATTENDANCE

Antenatal care can be most effective in avoiding adverse pregnancy outcome when it is sought early in the pregnancy and continues through to delivery.

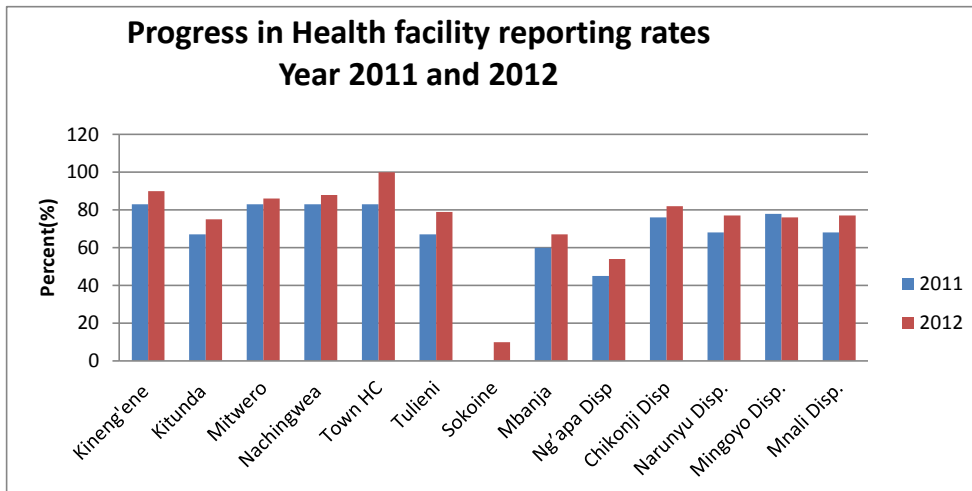
In Lindi Municipal Council data from Health facilities for the period of three years past shows that there is an increase of pregnant women who starts ANC services before 16 weeks of gestation from 34.4% (2010) to 38%(2012). These successes have been contributed by quality and accessible ANC services that are provided by skilled staff available in all health facilities.



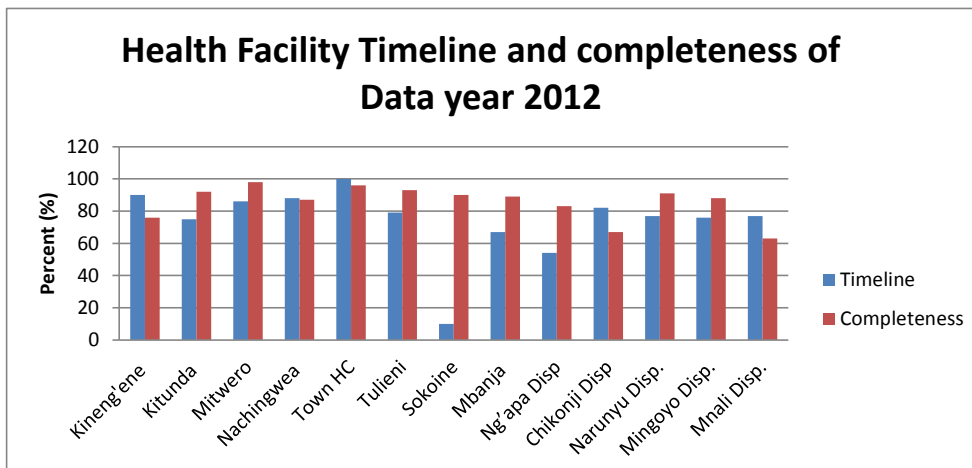
The graph above shows that for the past three years there is an increase of pregnant women who start ANC services before 16 weeks of gestation from 34.4% (2010) to 38%(2012).

LINDI MUNICIPAL COUNCIL HEALTH PROFILE

PROGRESS IN HEALTH FACILITY REPORTING RATES



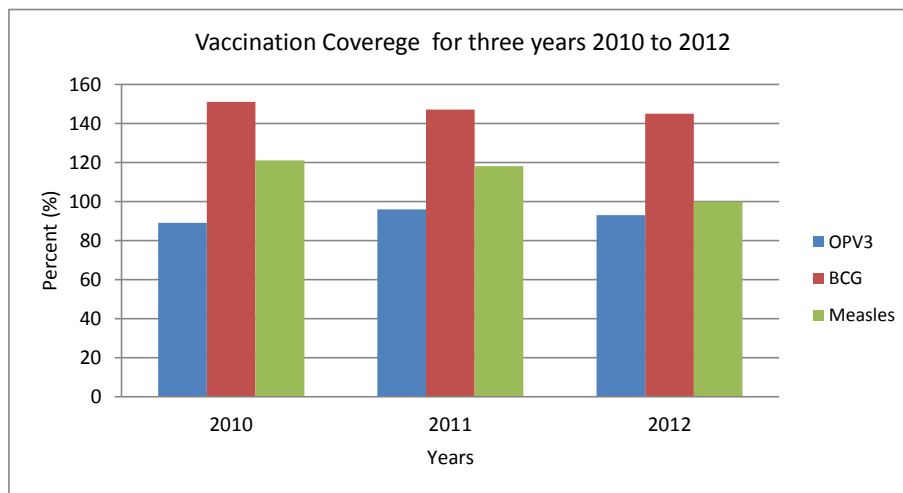
TIMELINESS AND COMPLETENESS OF DATA



LINDI MUNICIPAL COUNCIL HEALTH PROFILE

6.6. PROGRESS IN DISTRICT HEALTH SERVICES

VACCINATION COVERAGE

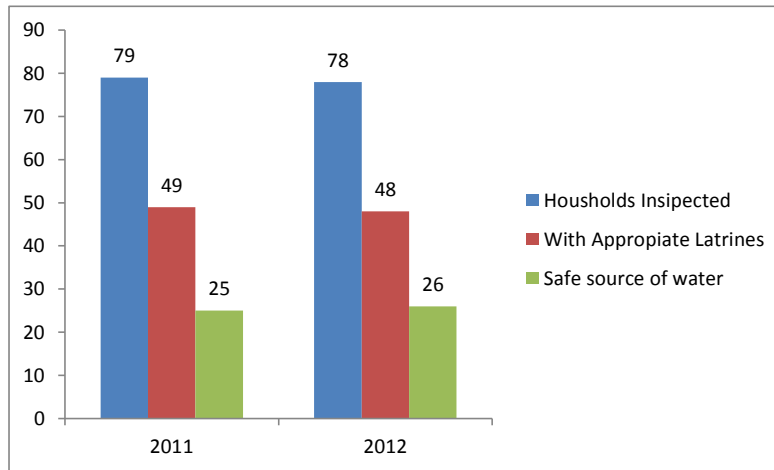


ENVIRONMENTAL HEALTH SERVICE SAFE WATER INITIATIVES

The amount of water supply required per day is 8.2 Million liters; most of the residents depends on shallow wells where its water is not safe. The Council has only 3 sources of tap water. These sources produce only 700,000 liters per day which is only 8.5% of the actual required amount. Only 26% of the population has access to tap water and the rest 74% depend on shallow wells owned by households. The main and reliable water sources in the district are surface water from river Mambulu, underground water from Mmango/Liwayawaya and Kitunda springs and underground water from shallow wells, mostly constructed within the Municipal area.

Improvement of hygiene and sanitation is one of the most important issues to be considered, the chart below shows that there is decline of toilet coverage and water supply. This is a result of expanding administration area.

LINDI MUNICIPAL COUNCIL HEALTH PROFILE



6.7. PROGRESS AGAINST MILESTONES

6.8. BEST PRACTICES/CASE STUDIES

To reduce neonatal deaths in the district, the council has introduced a system that will enable health workers monitor the progress of new born by recording weight at delivery, apgar score, birthing, condition of the skin and other important indicator that can help to take immediate action to rescue baby's life. All these are recorded in checklist. Actions to take are based on what have seen. The system has been introduced in all health facilities

14