The United Republic of

# TANZANIA

Ministry of Health & Social Welfare



## KINONDONI 2012

## District Health Profile

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# KINONDONI DISTRICT HEALTH PROFILE

## I. FOREWORD

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

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

## II. ACKNOWLEDGEMENTS

The development of the DHP is a collaborative effort, and the following people and/or organizations are being acknowledged for their direct contribution: Ministry of Health and Social Welfare (MoH&SW) and their stakeholders, and Kinondoni District Council Health Management Team (CHMT).

# III. EXECUTIVE SUMMARY

Kinondoni District Council is one of the three Municipalities in Dar es Salaam Region with an area of 531 $km^2$. It is located in northern part of the Region. According to the 2012 Tanzanian National Census showed that the population of Kinondoni was 1,775,049 (860,802 male, 914,247 female), average household size is 4.0 and sex ratio of 94. The estimated population density is 1,179 people per square km. currently, there are 227 health facilities, 43 government (19%) and 184 (81%) private owned. On the other hand the council has a total of 1271 Human Resources for Health versus the actual requirement of 2238.

The District Health Plan intends to offers insight into district health conditions by assessing priority health indicators that reflect the district health status of the population, status of health systems, and status of health service delivery. The overall objective is to make sure health care services are improved by ensuring efficient utilization of the available resources.

Despite the achievements some activities were partially or not implemented in last year's CCHP (2011/2012) like to provide package for payment for performance, to strengthen management of health provision by equipping RCH and Labour ward with required supplies and equipment, patient food, rehabilitation activities, procurement of emergency preparedness supplies. These activities have been incorporated in 2012/2013 CCHP.

Through important health indicators for year 2011/2012, the following challenges have been pinpointed:

- Inadequate funds to handle two Hospitals ( Mwananyamala Regional referral Hospital and Sinza District /Municipal Hospital),considering that we have one hospital cost centre funds allocation
- Under reporting of HMIS and IDWE weekly/quarterly and annual reporting of health facilities.
- Shortage of staff due to labour market situation which hinder the district to fill some vacant posts.
- Scarce resources (funds) affect District Human Resources Development Plan.
- Financial instability of the Government affects Human Resources Planning
- Inadequate vehicles which affect timely implementation of some planned activities
- Frequent shortage of medicines, medical supplies and equipments as well as low quality in some of the items from MSD.

Towards addressing previous year 2011/2012 challenges, interventions were identified to mitigate challenges that included to ensure retention mechanism for health workers, increase availability of pharmaceuticals, supplies and equipments, increase immunization coverage of under-fives through outreach services, focusing on burden of diseases to reduce maternal and neonatal mortality rate by equipping health facilities with required supplies and equipments, conducting BEmOC training to labour ward staffs and allocating adequate number of staffs in labour and neonatal ward.

# IV. ACRONYMS AND KEY TERMS

**Table 0-1. ACRONYMS**

| ACRONYM | LONG NAME |
|---|---|
| DHP | District Health Profile |
| MOHSW | Ministry of Health and Social Welfare |
| MTUHA | Mfumo wa Takwimu wa Uendeshaji wa Huduma za Afya |
| HMIS | Health Management Information System |
| KMC | Kinondoni Municipal Council |
| CHMT | Council Health Management Team |
| NBS | National Bureau of Statistics |
| mRDT | Malaria Rapid Diognostic Test |
| AMO | Assistant Medical Officer |
| CO | Clinical Officer |
| MO | Medical Officer |
| HRH | Human Resource for Health |

**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** | Relationships with physicians and other healthcare professionals lead to positive clinical outcomes and quality patient care. |
| **ESSENTIAL HEALTH PACKAGE** | A means to concentrate scarce resources on interventions which provide the best value for money. |
| **CASCADE SYSTEM** | Management tool enhancing involvement of lower level of the health systems in supportive supervision, mentoring , coaching, monitoring of health activities as well as maintaining maximum communication between health facilities staff and CHMT. |

# KINONDONI DISTRICT HEALTH PROFILE

## 1 INTRODUCTION

### 1.1 MISSION AND VISION

**VISION:** A community which is motivated, dynamic, with socio economic development.

**MISSION:** Provision of quality services to the community through effective and efficient use of resources, capacity building, good governance and rule of law hence improve the living standard of people

### 1.2 STRUCTURE OF DISTRICT

Kinondoni District was first established as a Town authority in 1982. It is among the three (3) Municipality located on the northernmost of three districts in Dar es Salaam, Tanzania. Others are Temeke (to the far Southeast) and Ilala (downtown Dar es Salaam). To the east is the Indian Ocean, to the north and west the Pwani Region of Tanzania. According to the 2012 Tanzanian National Census showed that the population of Kinondoni was 1,775,049 (860,802 male, 914,247 female), average household size is 4.0 and sex ratio of 94. Area of Kinondoni is 531 km². The Government Notice No. 4 of the year 2000 issued by the President's Office, Regional Administration and Local Government established the Kinondoni Municipal Council (KMC) as an autonomous body. The move was part of the ongoing Local Government Reforms in the Country. There are 4 divisions namely Magomeni, Kibamba, Kawe and Ubungo with 34 wards, and 171 streets. The original inhabitants of Kinondoni were the Zaramo and Ndengereko, but due to urbanization the district has become multi-ethnic.

# KINONDONI DISTRICT HEALTH PROFILE

**Table 1-1. Wards And Villages**

| SN | WARD NAMES | NUMBER OF STREETS |
|---|---|---|
| 1 | Magomeni | 5 |
| 2 | Makurumla | 6 |
| 3 | Ndugumbi | 4 |
| 4 | Mzimuni | 4 |
| 5 | Manzese | 8 |
| 6 | Sinza | 5 |
| 7 | Kimara | 6 |
| 8 | Saranga | 7 |
| 9 | Ubungo | 5 |
| 10 | Makuburi | 5 |
| 11 | Mabibo | 6 |
| 12 | Kigogo | 3 |
| 13 | Mburahati | 3 |
| 14 | Tandale | 6 |
| 15 | Makumbusho | 5 |
| 16 | Kinondoni | 4 |
| 17 | Hananasif | 4 |
| 18 | Mwananyamala | 7 |
| 19 | Kijitonyama | 7 |
| 20 | Msasani | 5 |
| 21 | Mikocheni | 6 |
| 22 | Kawe | 4 |
| 23 | Makongo | 4 |
| 24 | Kunduchi | 6 |
| 25 | Wazo | 6 |
| 26 | Bunju | 5 |
| 27 | Mabwepande | 3 |
| 28 | Mbweni | 3 |
| 29 | Mbezi | 6 |
| 30 | Msigani | 4 |
| 31 | Kibamba | 5 |
| 32 | Kwembe | 5 |
| 33 | Goba | 4 |
| 34 | Mbezi juu | 5 |
| | **Total** | **171** |

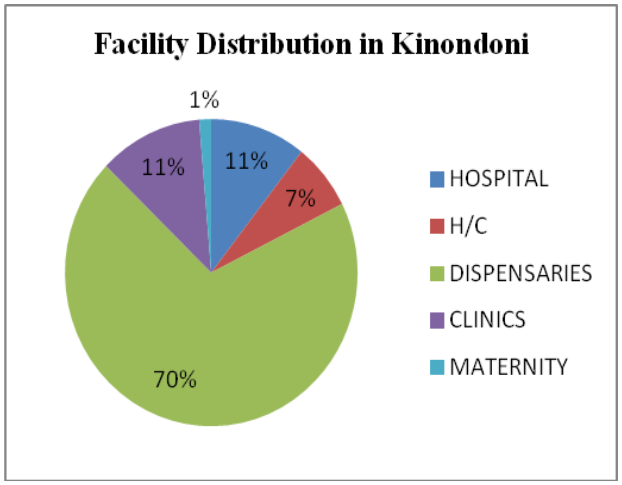
# KINONDONI DISTRICT HEALTH PROFILE

## 1.3 FACILITY DISTRIBUTION

Kinondoni district has a total of 227 health facilities private (81%) and public (19%) owned, and distribution are as follows; 24 hospitals, 16 health centres, 158 dispensaries, 26 clinics and 3 maternity homes. CHMT has a roll of providing supportive supervision to all facilities, reproductive and child health supplies including vaccines and family planning and issuing HMIS books. Most private facilities are located within the urban setting while majority of public facilities are located within the peri urban settings. There are 17 sites for outreach services where RCH services are offered. Among all facilities available in the council 106 (47%) facilities are offering RCH services, 102 (45%) facilities offering PMTCT services, 6 (11%) facilities with BEmOC services, 12 facilities offering youth friendly services, 78 facilities offering family planning services and 54 facilities are offering delivery services.

**Table 1-2. Facility Distribution**

| TYPE OF FACILITY | NUMBER OF FACILITIES | OWNERSHIP |
|---|---|---|
| HOSPITAL | 2 | GOVERNMENT |
| | 2 | PARASTATAL |
| | 20 | PRIVATE |
| HEALTH CENTRE | 1 | GOVERNMENT |
| | 1 | PARASTATAL |
| | 14 | PRIVATE |
| DISPENSARIES | 40 | GOVERNMENT |
| | 3 | PARASTATAL |
| | 115 | PRIVATE |
| CLINICS | 2 | GOVERNMENT |
| | 2 | PARASTATAL |
| | 22 | PRIVATE |
| MATERNITY HOME | 0 | GOVERNMENT |
| | 0 | PARASTATAL |
| | 3 | PRIVATE |



# KINONDONI DISTRICT HEALTH PROFILE

**FIGURE 1-1.Kinondoni District Map (**Source. DHIS2**)**


NB**:** Data on Population for each facility were not available.

## 1.4 POPULATION

**Table 1-3. Gender and Age Based Statistics (source: Census 2002)**

| AGE RANGE | Population |
|---|---|
| **Under one Year** | 40,698 |
| **Under 5** | 159,274 |
| **Under 15** | 533,149 |
| **10-24 years** | 349,927 |
| **Women 15 -49** | 404,275 |
| **Total** | 1,423,042 |

## 1.5 GEOGRAPHY

### Climate

Kinondoni Municipality experiences a modified type of equatorial climate. It is generally hot and humid throughout the year with an average temperature of $29^0$C .The hottest season is from October to March while it is relatively cool between May and August with temperature around $25^0$C. There are two rain seasons: - short rain from October to December and long rain season between March and May. The average annual rainfall is 1300mm. Humidity is around 96% in the mornings and 67% in the afternoons. The climate is also influenced by the Southwest monsoon winds from April to October and Northeast monsoon winds between November and March.

## 1.6 Transport and communication:

### Roads and their cconditions

The Kinondoni Municipality has a total length of 786.74 kilometers of roads, out of which 197.55 kms are served by TANROADS (a road agency under the Ministry of Works) and the rest of kilometers (589.19) are served by Municipality. The Municipality's road network is divided into three categories namely: -

1. Paved: 111.59 Kms

2. Gravel: 318.25 Kms
3. Earth:356.90 Kms

The Council undertakes routine and recurrent maintenance, periodic maintenance, spot improvement, rehabilitation and reconstruction. The maintenance management system used by the Council gives priority to roads in good condition. These roads get full maintenance throughout the year to ensure sustainability and durability. Roads in fair conditions are planned for rehabilitation and periodic maintenance at the same time given routine maintenance to slow down its deterioration, while those in poor condition are given spot improvement to make them passable while waiting for reconstruction.

**Phone/Fax and E-mail**

Kinondoni Municipal council has a well defined communication networks. The company which provide landline communication network in the district is the Tanzania Telecommunication Network Ltd (TTCL). Mobile telephone services are provided by Vodacom, Airtel, Zantel Tigo and TTCL. Other services such as Fax, Television, Internet services and Radio Broadcasts are also available. The existence of reliable and modern type of communication has facilitated all 226 health facilities served by the Municipal Medical Officer of Health to easily communicate and therefore strengthening consultations and systems of referral of patients to different health facility levels.

## 1.7 Education (literacy rate)

The Kinondoni Municipality has a total of 3905 adults illiterates where by 1,832 are males and are 2073 are females. Adult education learners who are in classes are 339 (126 Females and 213 Males**)** in stage I – IV and stage V-VII. The Municipal has 5 classes of new curriculum that includes agriculture and a total of 2 Classes are for technical education. There are 4,716 employed teachers in the Municipal, 781 are Males and 3,934 females. The Ministry of Education and Culture has arranged the programme for over aged children, which are known as 'Complementary Basic Education in Tanzania' (COBET). Accordingly, the Municipal Council is using COBET programme to can provide primary education to children who missed at the age of 8-13. In 2011 there are total 678 pupils of COBET enrolled, 403 boys and 275 are girls. The

# KINONDONI DISTRICT HEALTH PROFILE

Kinondoni Municipality besides giving formal education, also offers special education for disabled (mentally retarded, deaf and Autism).

The following interventionists (measures) are expected to improve the situation of primary school education in the Municipal.

1. To improve the environment through conducting proper survey for school age children.
2. To ensure that every classroom has enough desks for all pupils (1:3)
3. To enhance teacher's performance and effectiveness through regular seminars, workshops and refresher courses.

**Number of Schools in Municipality**

| Ownership | Pre-Primary schools | Primary schools | Teachers' College | Universities |
|---|---|---|---|---|
| Government | 126 | 138 | 0 | 3 |
| Non-Government | 105 | 90 | 4 | 5 |
| TOTAL | **231** | **227** | **4** | **8** |

## 1.8 Socio-economical with Gender Perspective:

### Ethnic groups

The original inhabitants of Kinondoni were the Zaramo and Ndengereko, but due to urbanization the district has become multi-ethnic.

### Main economical activities and employment situation

It is estimated that 741,155 residents of Kinondoni Municipality are employed in private, public sectors and self employed. 452,557 (61%) are employed in the private sector, 264,857 are self employed while the rest 23,741 are employed in the public sector. The majority of the residents are street vendors, service and shop sales workers, craftsmen fisheries, livestock keepers and farmers. Only 3% of the working force is engaged in subsistence agriculture in the peri-urban areas. There are no big farms but small plots ranging from 2.5 to 6 acres. Others make small gardens around their houses in which various vegetables and root crops like cassava and sweet potatoes are grown for family food and the surplus for income generating.

About 39,720(Ha) of land in the Municipality are potential for agricultural practices especially crop cultivation (Though the figure might differ due to rapid expansion of urban related

activities). Land estimated under use for both cash crops and food crops is 13,600 (Ha); approximately 7.5% of land is potential for agriculture. Farmers engage in small and large farming, and they mostly till their land using hand equipments. Few of them use tractors and traditional upgraded technology. Agriculture provides the Municipality with 17,332.14 tons of food crops, which is only 7.37% of the total food requirement. Other economic activities include Livestock, Bee keeping, fishing, lumber, recreational, tourisms and Mining.

### 1.9 Water supply

The main source of water for Kinondoni residents is Dar Es Salaam Water and Sewerage Authority (DAWASA), which contributes 95% of water consumed daily and the rest 5% is contributed by shallow and deep wells own both privately and by public. 60% of total population of Kinondoni has direct access to clean and safe water while 40% have no direct access. Other sources include drilled deep and shallow wells.

### 1.10 Electricity

Municipal Electrical Supply System covers almost the whole of Kinondoni Municipal council with the exceptional of few areas within the peri urban such as Mabwepande, Mbweni Mpiji, and Msumi. It originates from the National Gridline of Electricity. Currently, the use of Solar Energy has also been promoted in some of remote dispensaries. Because of frequent electrical fluctuations, a generator was installed at Mwananyamala and Sinza Hospital and Magomeni Health centre.

# 2 METHODS AND SOURCES OF DATA

## 2.1: DATA COLLECTION AND ANALYSIS

Data used for this profile had been collected routinely at the facilities and from the community through Home Based Care providers (HBCs) and Community Based Health Care providers (CBHCs). Fifteen (15) New HMIS tools are used to for data collection and data are entered in the computer at the district and analyzed using DHIS2 software. Other sources are Demographic Health Survey, National Bureau of Statistics (NBS), Census 2002 and 2012, and operational research conducted in the council.

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

# KINONDONI DISTRICT HEALTH PROFILE

**Table 2-1. MANDATORY DHP HEALTH INDICATORS**

**HEALTH STATUS OF THE DISTRICT POPULATION**

**Maternal, Newborn and Child Health**

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

**Diseases**

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

**DISTRICT HEALTH 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***

**DISTRICT HEALTH SERVICE DELIVERY**

**General**

- OPD Attendance

**Vaccination**

- Proportion of children under 1 vaccinated against measles
- Proportion of under 1 3rd Polio (OPV3)
- Proportion of under 1 BCG dose

**Reproduction Health**

- Percentage of health centers and dispensaries that can provide EmOC as defined in EHP
- Proportion of pregnant women starting ANC before 12 or 16 weeks gestation

**Infectious Diseases and Non-Communicable Diseases**

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

# KINONDONI DISTRICT HEALTH PROFILE

## 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

# KINONDONI DISTRICT HEALTH PROFILE

## 2.3. HEALTH INDICATORS IMPORTANT TO KINONDONI DISTRICT

| ***OPTIONAL DISTRICT HEALTH STATUS OF THE POPULATIONS INDICATORS*** |
|---|
| 1. Life expectancy |
| 2. Maternal Mortality (MMR) |
| 3. Population having acceptable latrine |
| 4. Total fertility rate (TFR) |
| 5. Population Growth rate |
| 6. Crude death rate |
| ***OPTIONAL DISTRICT HEALTH SYSTEM INDICATORS*** |
| 1. Per capital Income |
| 2. Population per physician |
| 3. Population per health Facility |
| 4. Population per nursing staff |
| 5. Population per bed |
| ***OPTIONAL DISTRICT HEALTH SERVICE DELIVERY INDICATORS*** |
| 1. Proportion % access to clean water |
| 2. Population % access to health |
| 3. Population % access to health facility within a radius of 5 Km |
| ***OTHERS*** |
| 1. Population Literacy rate |

## 2.4 KEY MESSAGES ABOUT HEALTH INDICATORS

Maternal, newborn and child health performed well for the year 2012. District data on severe malnutrition in under five showed a decline of 10% between year 2011 (0.96%) and 2012 (0.86%).

ANC HIV prevalence in some areas was more than 35%. This was mostly in high populated areas like Tandale (Omeki Family Dispensary), Mabibo (MNA Dispensary) and Mwenge (Mwenge Dispensary). However, there is a proportion of facilities with ANC clients with very low or no HIV infection.

Regardless of the effort of introducing the mRDT for proper and immediate diagnosis, the use of BS to diagnose malaria is still high at health facilities, both at OPD and IPD.

Pneumonia has become the leading cause of morbidity in both age groups followed by eye infection. Malaria (severe and uncomplicated) are still among the top 3 causes of admission in children.

Non communicable diseases including hypertension and fracture are among the top 10 causes of admission in adults.

No enough data were available to demonstrate the real situation of mortality in the district. Data were available for Lugalo and Kinondoni hospitals only.

# 3 HEALTH STATUS OF THE DISTRICT POPULATION

## 3.1 MATERNAL, NEWBORN AND CHILD HEALTH

The presented Figures show the performance of facilities based on data for year 2012 (last quarter). Data for the previous financial year (2011) on low birth weight were not available hence no comparison between the two periods was done. On the other hand, overall district data on severe malnutrition in under five showed a decline of 10% between year 2011 (0.96%) and 2012 (0.86%). Facility based performance are shown in Figures 3-1 A and B.

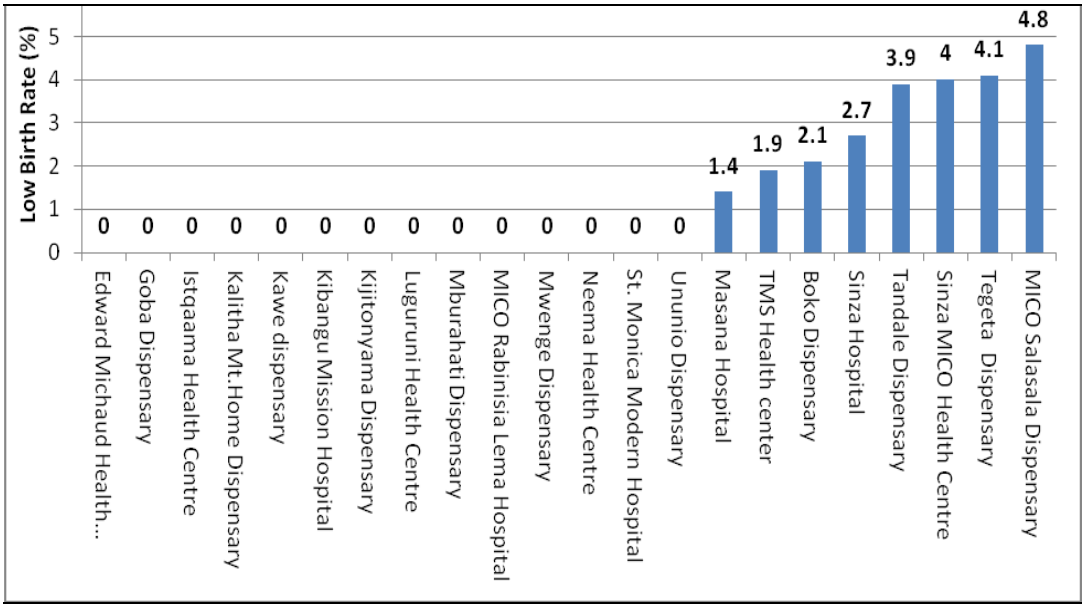



**Figure 3-1A. Nutritional status – Low Birth Weight, Oct-Dec 2012 (<5%)**

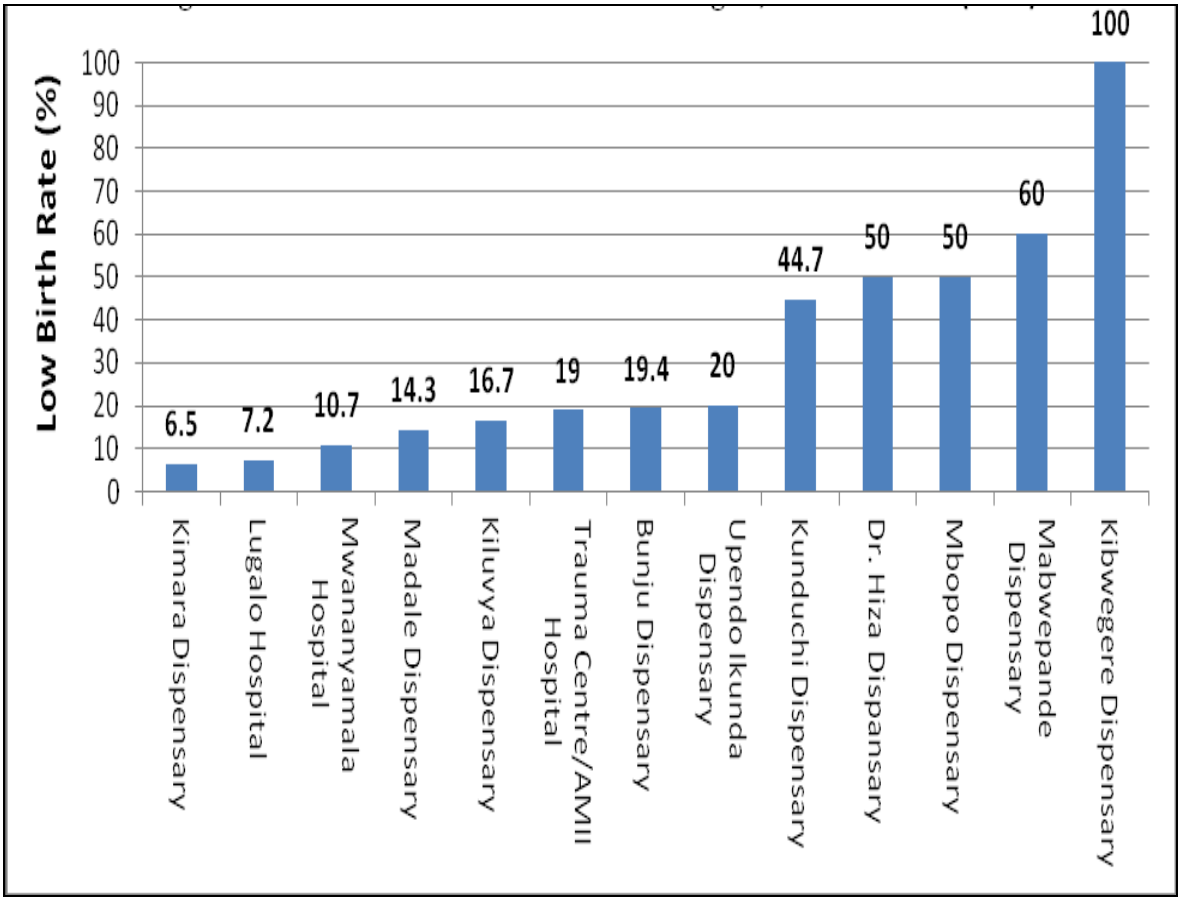



**Figure 3-1B. Nutritional status – Low Birth Weight, Oct-Dec 2012 (≥5%)**

Kibwegere dispensary had 100% of children with low birth weight. This might be due to the misinterpretation or related to data quality (correctness in filling the reports). CHMT has to make follow up to rectify the shortfall. Of all the facilities offering delivery service at the district, 26% had no low birth weight, 19% had low birth weight ranging from (1.4% - 7.2%), 11% had low birth weight ranging from (10.7% - 20%), 7% had low birth weight ranging from ( 44.7% - 60%) while 2% had 100% low birth weight and 35% did not report at all (October – December 2012). Peri- urban settings could also be another factor for low birth weight children.

**Figure 3-2. Neonatal Mortality Rates**

Neonatal mortality rate for year 2011 was 4.9/1000 live births.

**No data for 2012**

**Figure 3-3. Infant Mortality Rate**

Infant mortality rate for 2012 was 0.2/1000 live births (source DHIS2)

***(No HF data available for the previous year for plotting chart)***

**Figure 3-3. Under 5 Mortality Rate**

**No data available and there were issues related to manual calculation of this indicator**

**(Guide needed)**

## 3.2 MORBIDITY

Few health facilities had ANC HIV prevalence of more than 35% this is mostly in high populated areas like Tandale (Omeki Family Dispensary), Mabibo (MNA Dispensary) and Mwenge (Mwenge Dispensary). However, there is a proportion of facilities with ANC clients with very low or no HIV infection. The major challenge is poor submission of reports to the district. There are 101 Health Facilities providing ANC services however only 69% of facilities submitted their reports.

Data on morbidity were compiled from HMIS report since very few data has been entered in DHIS in 2012, thus the data are presented for only under 5 and above 5 years age categories.

Malaria incidence was higher in under five (BS positive and reactive mRDT) at OPD and lower in IPD. Despite of the introduction of mRDT, the use of BS to diagnose malaria is still high at health facilities both at OPD and IPD. , It is proposed to supply private facilities mRDT to reduce false BS.

- **MALARIA INCIDENCE**

**Figure 3-3. Laboratory Confirmed Malaria Cases (October - December 2012)**

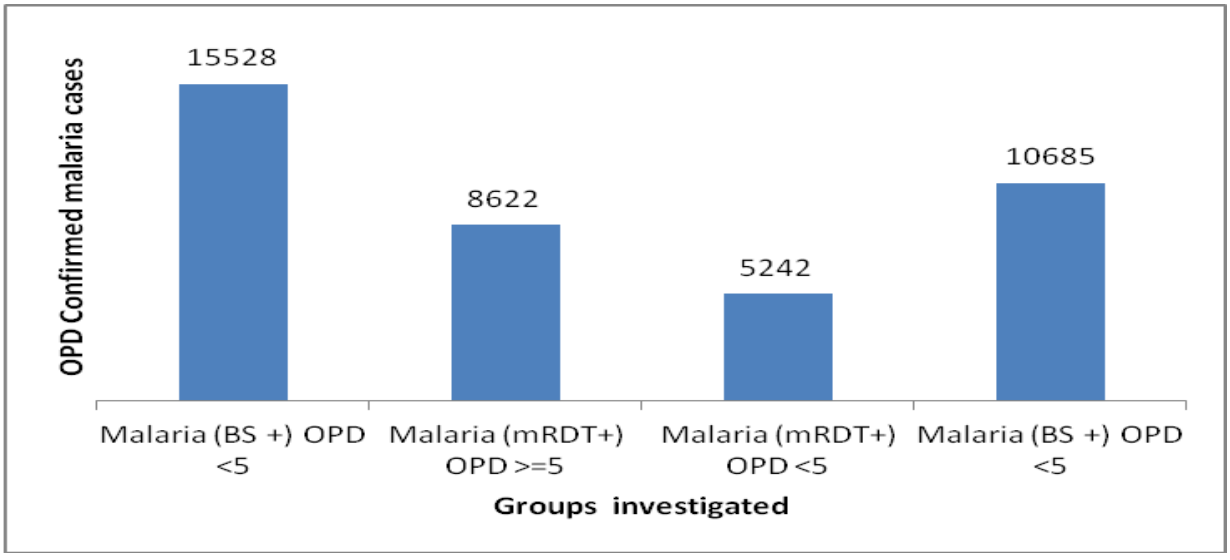
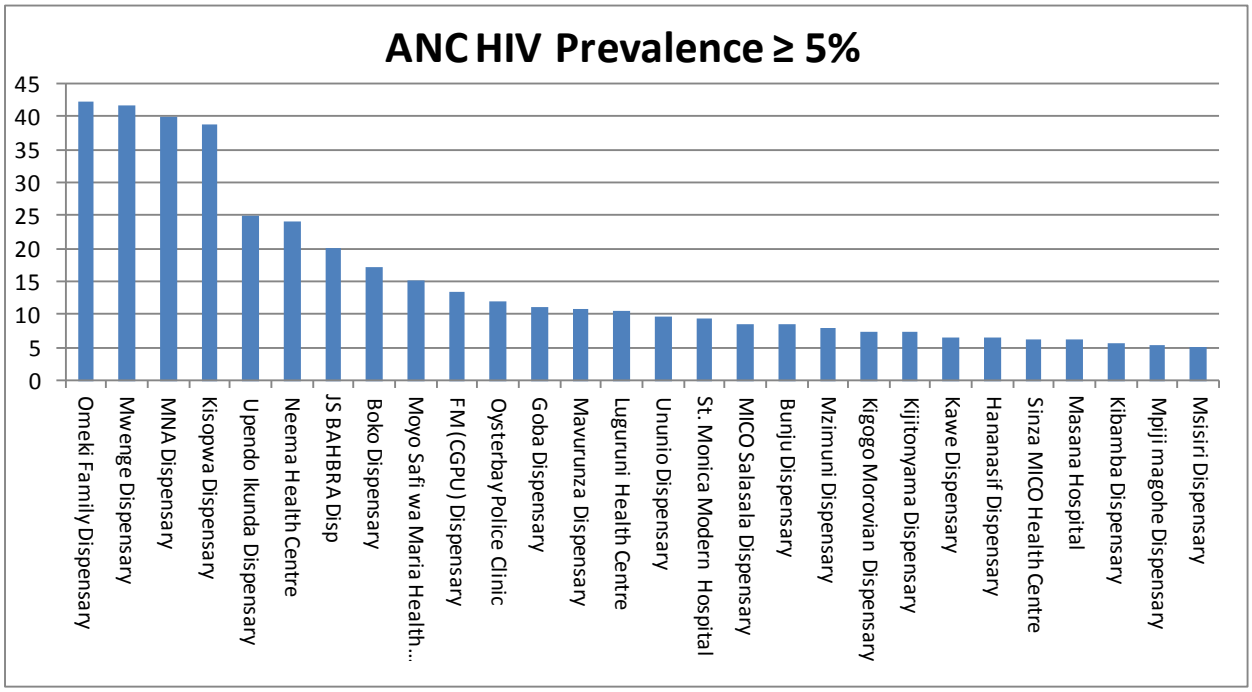
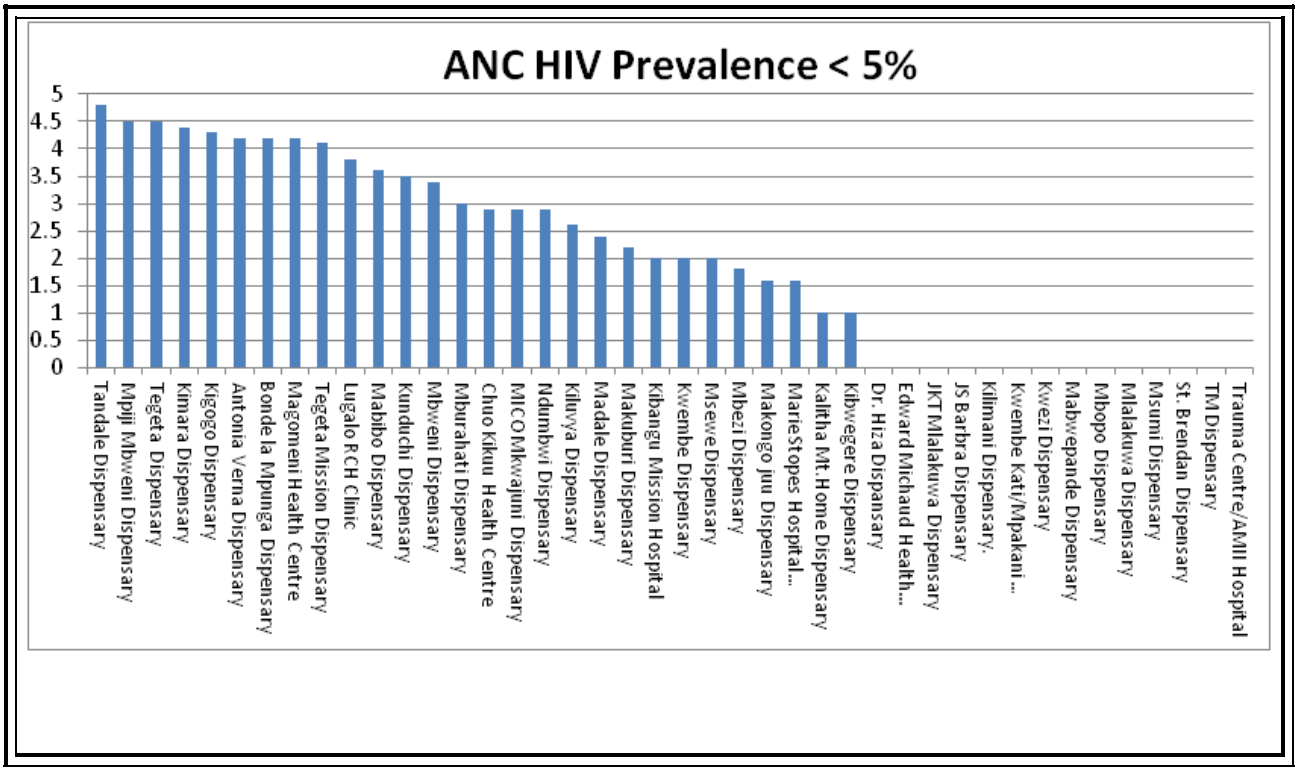


**Figure 3-4. HIV/AIDS Prevalence – October –December 2012**






## Table 3-1. Top 10 Causes of Admission/Inpatient Diagnosis (October – December 2012)

| | **Age below 5** | | | **Age above 5** | |
|---|---|---|---|---|---|
| **SN** | **Diagnosis** | **Cases** | | **Diagnosis** | **Cases** |
| **1** | Pneumonia | 2,633 | | Pneumonia | 1,041 |
| **2** | Eye Infection | 428 | | Eye Infection | 872 |
| **3** | Severe (complicated) malaria | 189 | | Pregnancy Complication | 457 |
| **4** | Uncomplicated malaria | 95 | | Severe (complicated) malaria | 397 |
| **5** | ARI | 51 | | Uncomplicated malaria | 265 |
| **6** | Anemia | 42 | | Hypertension | 220 |
| **7** | Other Diarrheal Disease | 38 | | Clinical AIDS | 179 |
| **8** | Other anemia | 38 | | Gyno Disease excl. PID | 150 |
| **9** | Other eye deficiency | 26 | | Fracture | 116 |
| | | | | | |

Pneumonia is the leading cause of morbidity in both age groups followed by eye infection. Malaria (severe and uncomplicated) are still among the top 3 causes of admission in children. Non communicable diseases including hypertension and fracture are among the top 10 causes of admission in adults which could be associated with life style and traffic accidents (cars and motorcycles), respectively.

Cascade system can be used improve quality of data (completeness, timeliness, and accuracy) at the district hence reducing the burden of work to the CHMTs considering the large number of facilities available in the district.

## 3.3 MORTALITY

Most of the Health Facilities do not submit reports on deaths. The data presented here do not represent the real picture of the district. The bigger problem is with higher level Health facilities and those with large number of patients. These data are from Lugalo and Kinondoni Hospitals only.

**Table 3-2. Top 10 Causes of Death (October – December 2012)**

| | **Age below 5** | **No. Deaths** | **Age above 5** | **No. Deaths** |
|---|---|---|---|---|
| 1 | Fever Chronic (> 1 month) | 4 | Pneumonia | 12 |
| 2 | Pneumopathies | 4 | HIV Opportunistic Infections Other | 9 |
| 3 | Trauma | 4 | Fever Chronic (> 1 month) | 6 |
| 4 | Asthma | 1 | Asthma | 4 |
| 5 | Delivery Indirect Causes | 1 | Cancer Uterine | 3 |
| 6 | Diarrhea with dehydration | 1 | Cardiomyopathy | 3 |
| 7 | Malaria severe confirmed | 1 | Meningitis | 3 |
| 8 | Respiratory Infection Acute ARI) | 1 | Diabetes | 2 |
| 9 | | | Encephalitis | 2 |
| 10 | | | TB | 2 |

Adult mortality is seems to be due to HIV/AIDS related infection.

## 3.4 OPTIONAL HEALTH STATUS OF THE DISTRICT POPULATION INDICATORS

Table 3-3 shows performance of optional population indicators for Kinondoni district. Maternal mortality rate has reduced since one previous year (81/100,000 in 2011). That could be due to slight improvement in BEmOC, decongestion of Mwananyamala Hospital hence shift of clients to Sinza Hospital, promoting facility deliveries of which new 14 Labor wards has been equipped to conduct deliveries at the dispensary level under BEmOC program and health workers undergone short orientations in BEmOC. The crude death rate in Kinondoni is 143/1000 population. No much difference is observed on life expectancy of male and female individuals in the district.

**Table 3-3. Optional health status of the district population indicators 2012**

| No | Type of Indicator | 2012 |
|---|---|---|
| 1. | Life expectancy | 49yrs Male, 50yrs Female |
| 2. | Maternal Mortality (MMR) | 70/100,000 |
| 3. | Population having acceptable latrine | 75 % |
| 4. | Total fertility rate (TFR) | 5.4 % |
| 5. | Population Growth rate | 4.1% |
| 6. | Crude death rate | 143/1000 |

## 3.5 DISTRICT HEALTH STATUS CONCLUSIONS, RECOMMENDATIONS AND WAY FORWARD

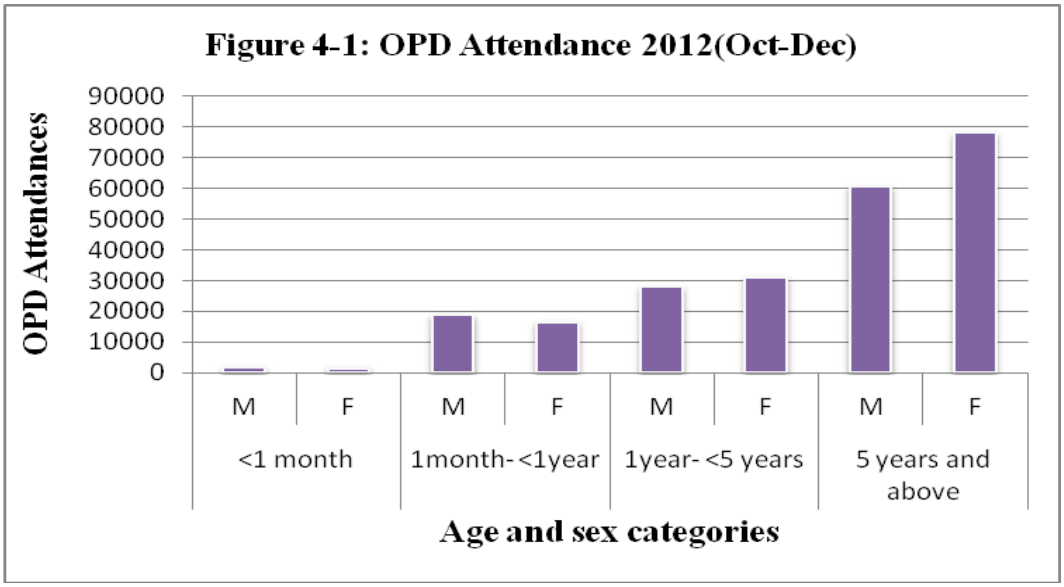
The quality of reporting of HMIS data is still very poor in the district. To improve quality of data (timeliness, completeness and reporting rates) the district is plan to implement cascade system where 15 nodes will be given mandatory to supervise satellite facilities. This is done to reduce the burden of work to the CHMTs considering the large number of facilities available in the district. However for the available data, showed maternal, newborn and child health is progressing well. There was improvement of nutritional status despite the fact that ANC-HIV prevalence was higher. To reduce ANC HIV more interventions are needed including individual behavioral change. To improve maternal health more facilities should provide BEmOC service.

# 4 STATUS OF HEALTH SERVICE DELIVERY IN THE DISTRICT

## 4.1 GENERAL HEALTH SERVICE

Data for 2012 were only available for the last quarter with low reporting rate. No much difference on attendance between male and female was observed in all age categories.

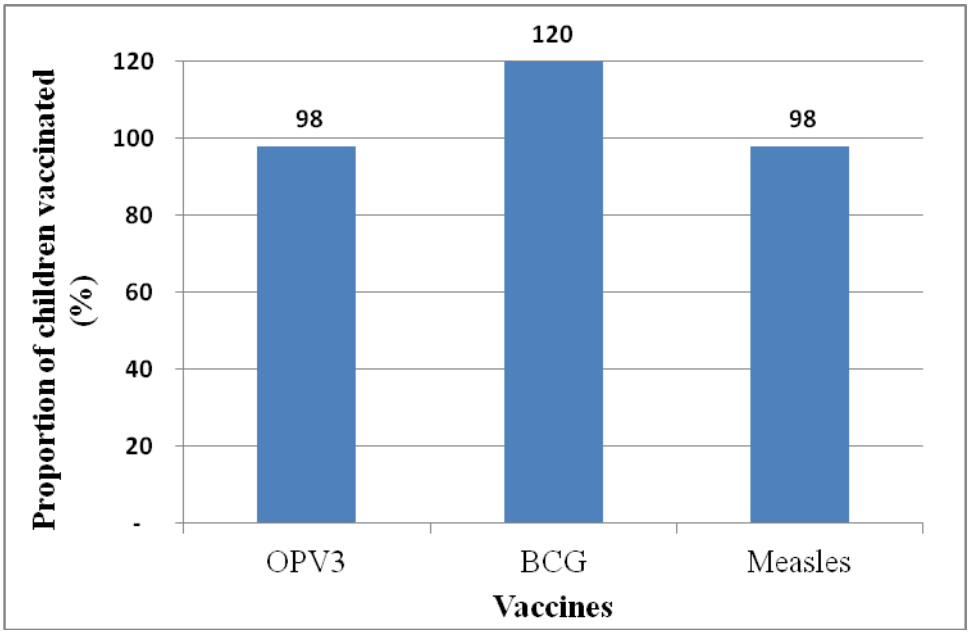
**Figure 4-1. OPD Attendance**



## 4.2 VACCINATION SERVICES

The performance of vaccination for year 2012 for measles, OPV3 and BCG in the district was good. This is facilitated by community awareness, functional cold chain system and supportive supervision.

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



## 4.3 REPRODUCTIVE HEALTH SERVICES

Data for 2012 are shown for women who started ANC clinic before 20 weeks. The proportion of the women was high (over 70%). This could be due the community sensitization through HBC and CBHC. The district also receives support on implementation of reproductive health services from partners including JHPEIGO, CCBRT and Path Finder.

Currently, the district has only 6 facilities (3%) which provide BEmOC, 8 facilities (4%) which provide CEmOC and 54 facilities (24%) facilities providing EmOC services as defined in Essential Health Package. This is an area where CCBRT is supporting the council while JPHIEGO is supporting all facilities (54) conducting delivery with Help Baby Breath (HBB) program to reduce neonatal death.

**Figure 4-3. Proportion of Pregnant Women Starting ANC before 16 or 20 Weeks Gestation**

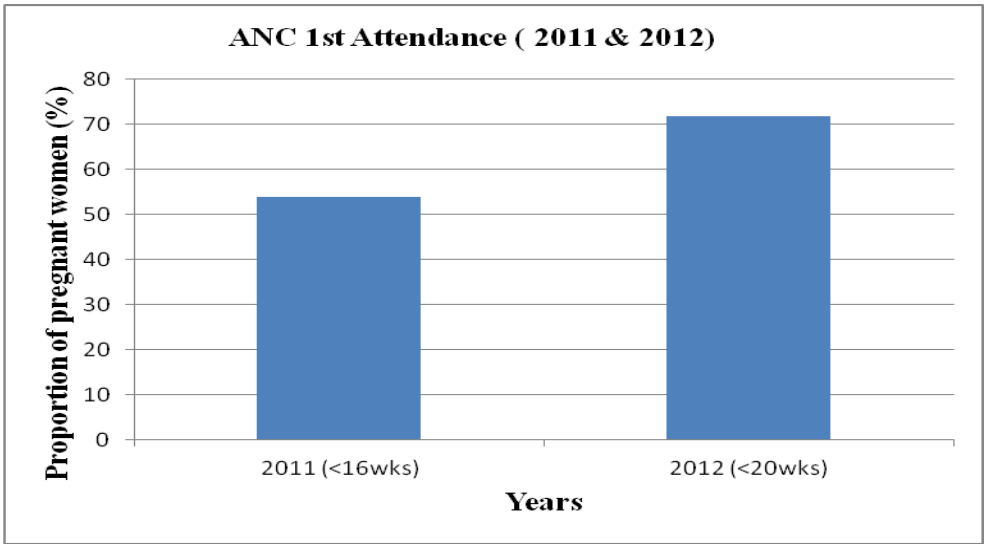
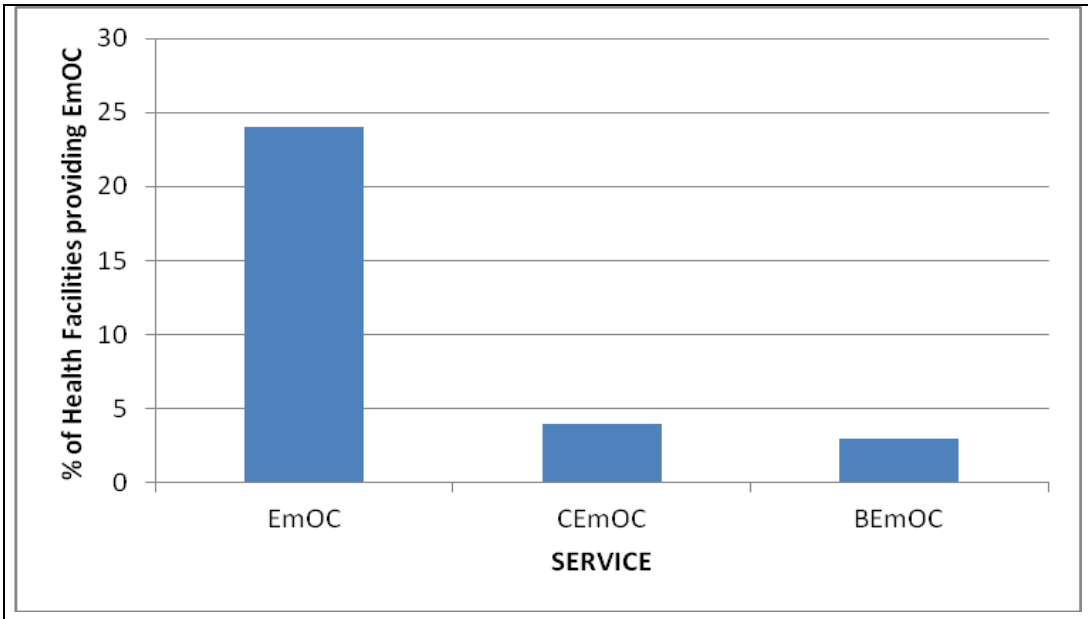


**Figure 4-4. Percentage of health centers and dispensaries that can provide EmOC as defined in EHP**




## 4.4 INFECTION DISEASE AND NON-COMMUNICABLE DISEASE HEALTH SERVICES

The proportion of mothers who received 2 doses of preventative intermittent treatment for malaria during last pregnancy is still low in many HFs which provide ANC services. Higher proportion observed in some HFs might be due to the wrong denominator. Few number of visits made by pregnant women to the clinic could also be a factor. Wrong perception on the Focused Antenatal Care (FANC) might also contribute to low revisit of ANC attendance. Some women might perceive that they need to return to the clinic only if there are pregnancy complications. Stock out of SP also contributes to the low coverage of IPT.

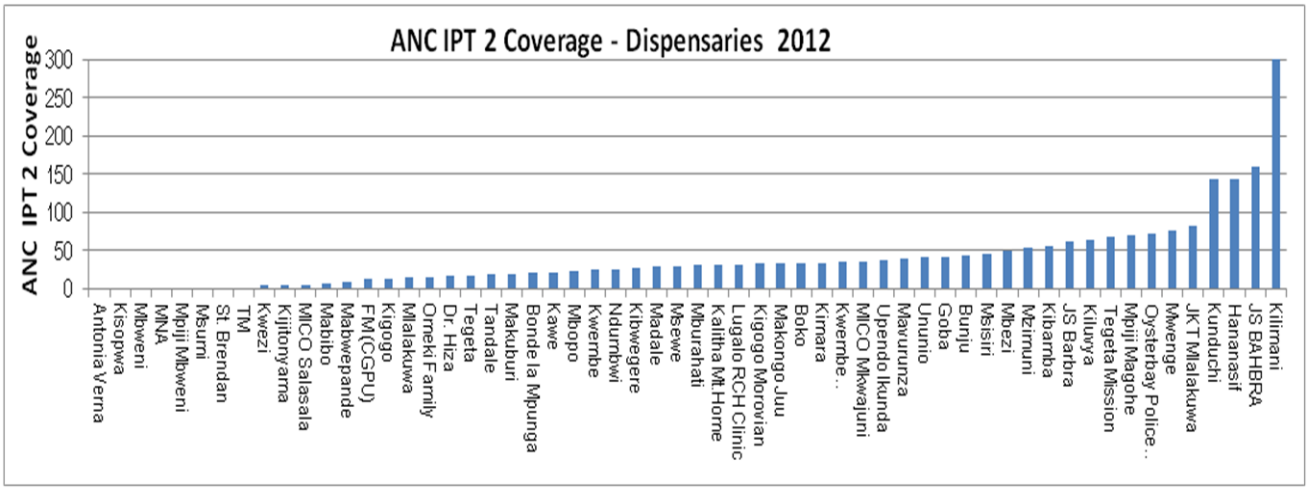
Data from population surveys (TDHS and THMIS) were used to asses' utilization of ITN in vulnerable population. The performance of this indicator was good, however no data could be found for Kinondoni district. Results are presented using zonal and regional figures.

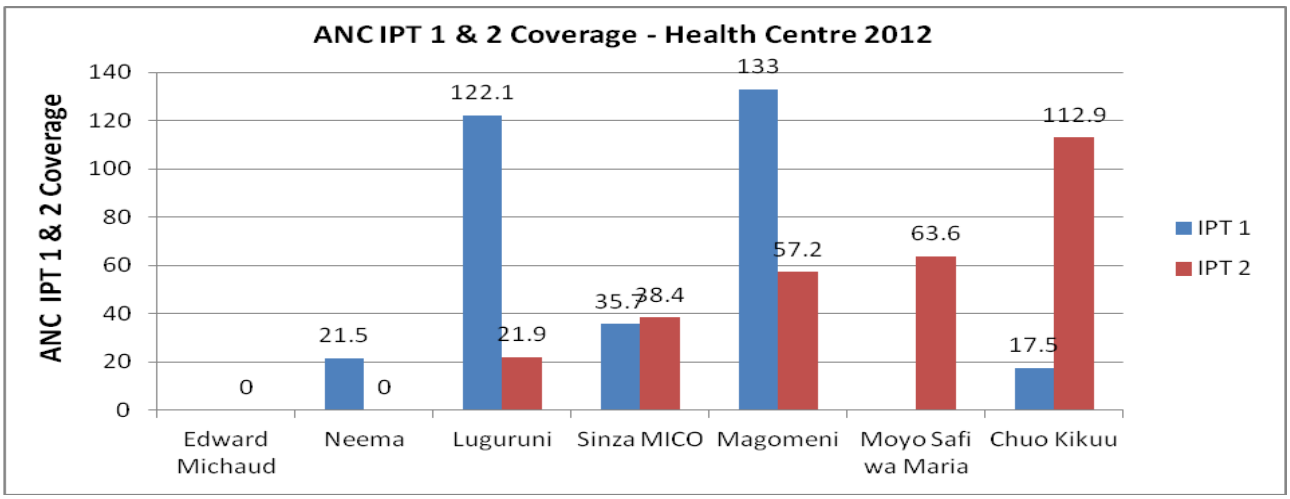
# KINONDONI DISTRICT HEALTH PROFILE

Introduction of mRDT for malaria diagnosis has resulted to dramatic decrease of confirmed malaria cases in the district.

TB notification rate per 100,000 populations in 2012 was 300/100,000. The rate has been stable since 2010.

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



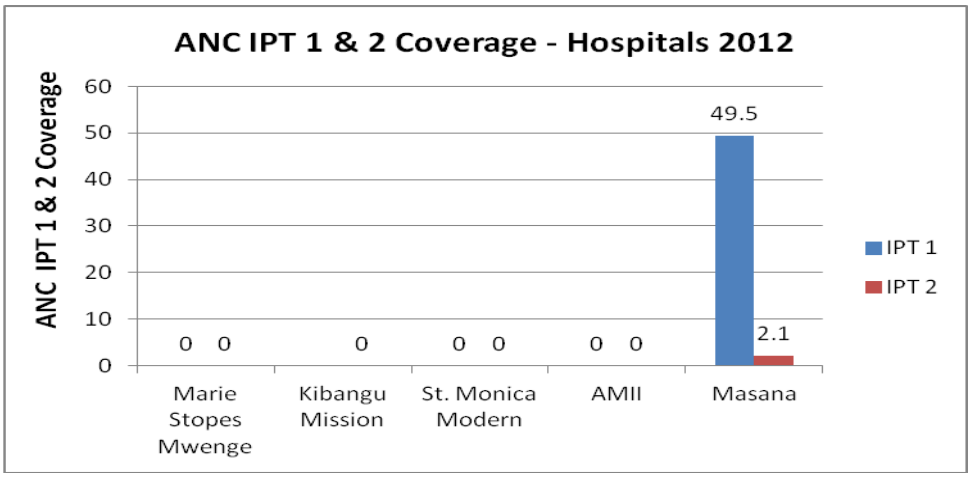
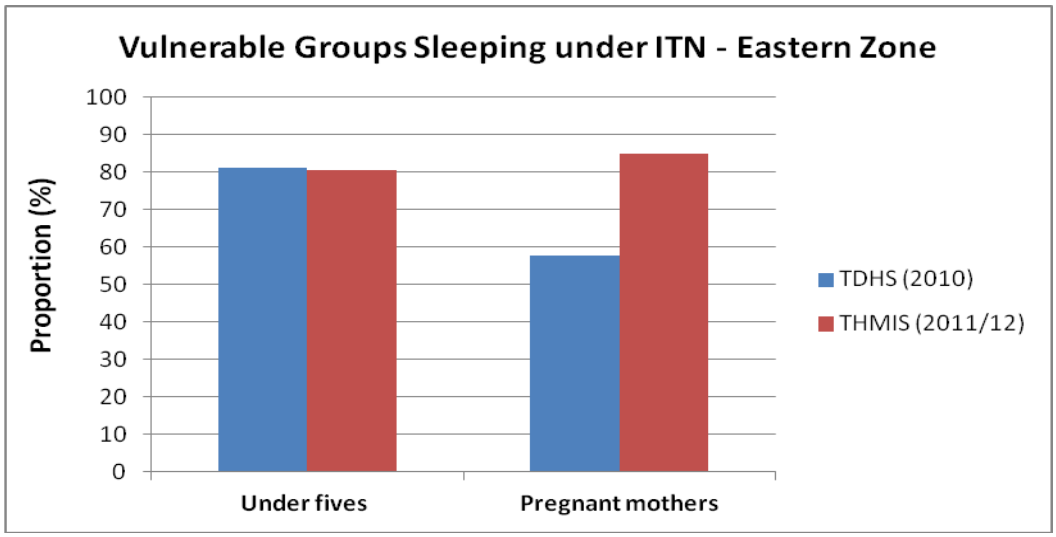



**Figure 4-6. Proportion of Vulnerable Groups Sleeping under ITN the Previous Night**



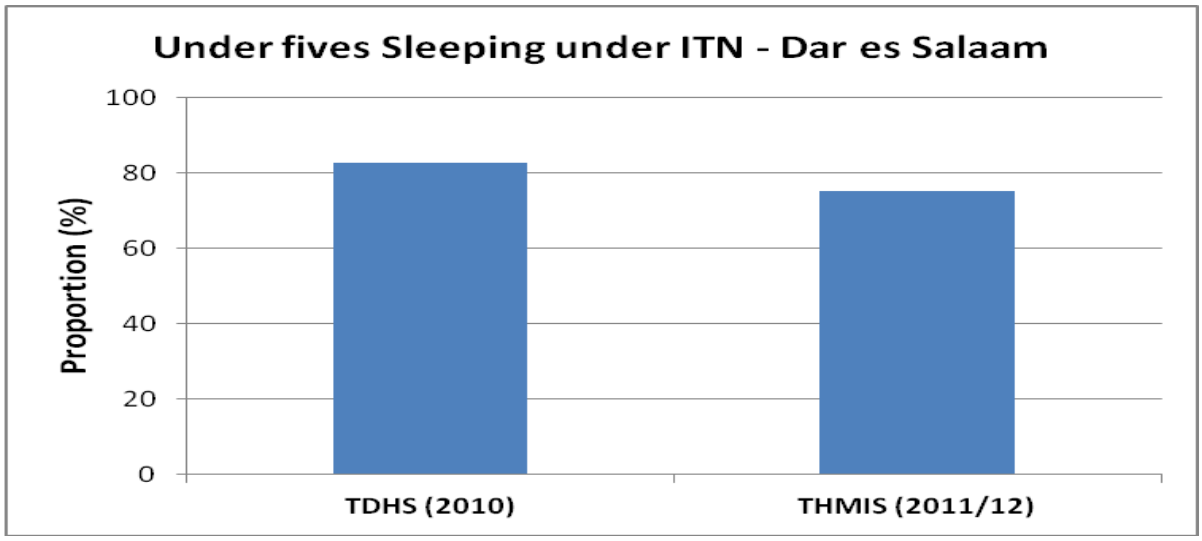



**Figure 4-7. Proportion of laboratory confirmed malaria cases among all OPD visits**

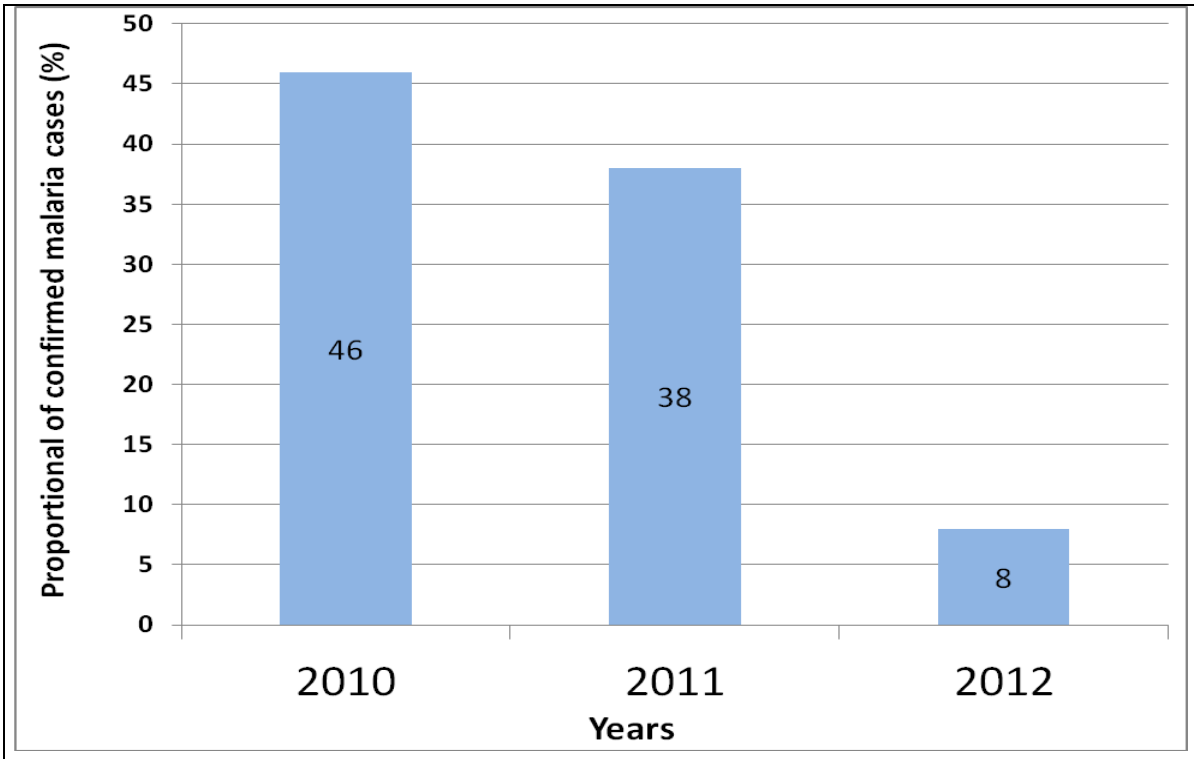
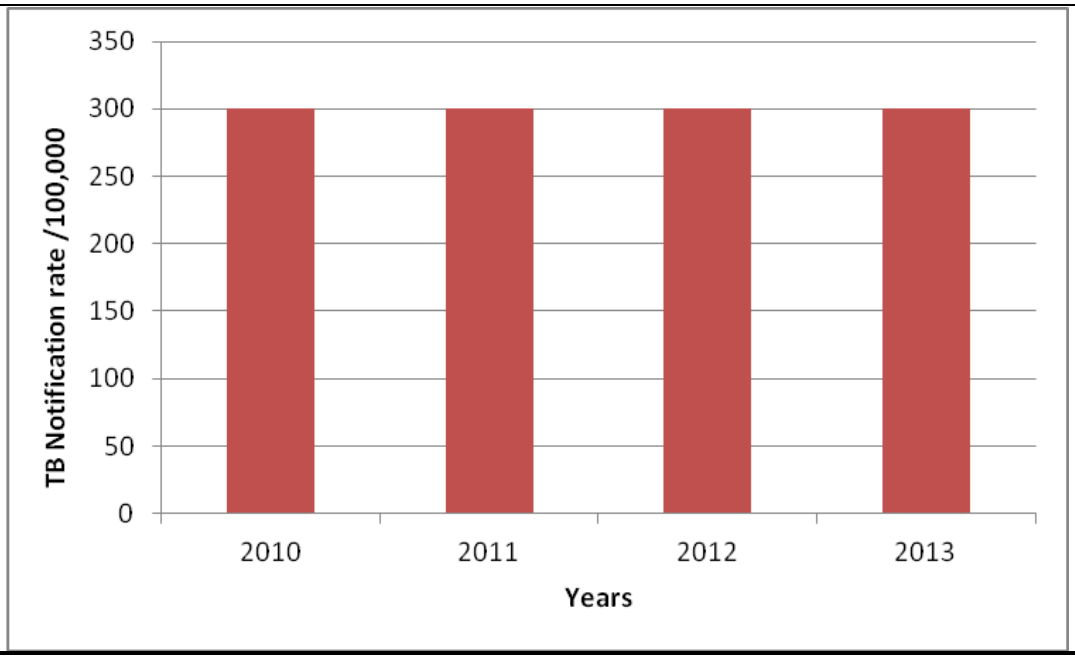



**Figure 4-8. TB notification rate per 100,000 population**



## 4.5 OPTIONAL DISTRICT HEALTH SERVICE DELIVERY INDICATORS

Poor infrastructure affects one third of the population in accessing to clean water. Implementation of the Primary Health Care Development Programme (locally known as the MMAM) is ongoing and would increase access to population to nearest health facility.

**Table 4-1: Performance of Other Health related Indicators at District level**

| No | Type of Indicator | 2012 |
|---|---|---|
| 1. | Proportion % access to clean water | 65 % |
| 2. | Population % access to health | 85 % |
| 3. | Population % access to health facility within a radius of 5 Km | 75 % |
| 4. | Population Literacy rate | 75 % |
| 5. | Population per nursing staff | 1:6593 |

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

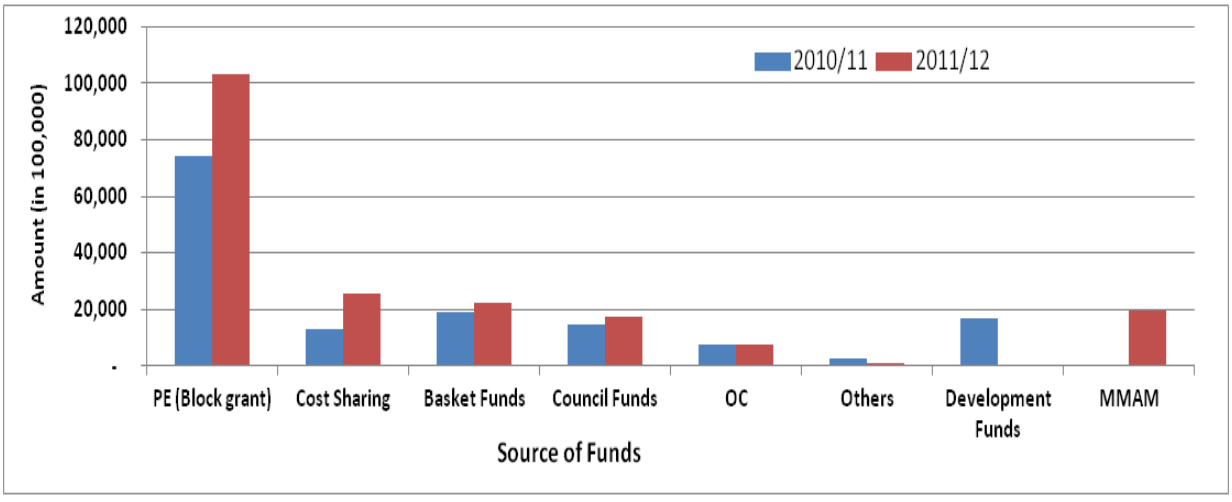
Health department has a role for curative, preventive and rehabilitative services. For the year 2012, IPT for ANC was not good this could probably be due to frequent stock out of SP and mis understanding of FANC. OPD attendance for adults was higher compared to under five, this signify that under five obtain their service at RCH clinic as per guideline. Vaccination for under one year was good and need to be sustained. Early booking for ANC was also good (70%) however the CHMT need to strengthen more on ANC services to capture the missed 30%.

# 5 STATUS OF DISTRICT HEALTH SYSTEMS

## 5.1 HEALTH FINANCING

Health department received funds from different sources (Figure5-1) that was used to support implementation of planned activities. In the year 2011/2012 there was an increase on PE budget as compared to year 2010/11. This could be due to increase on recruitment of different cadres of health workers and increase of salary for promoted staff. There was an increase in cost sharing allocation budget for 2011/2012 due to increase in number of public facilities and availability of medicines and supplies in the facilities. The basket fund allocation for 2011/2012 had increased compared to 2010/2011 based on 3 criteria's per capital income, population and number of supervision routes. MMAM fund which is disbursed from the central government was used for construction, rehabilitation and renovation of health center and dispensaries buildings and infrastructure as well as procurement of medical equipments for these facilities. MMAM funds for the past 3 years have been constant.

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



## 5.2 HUMAN RESOURCES FOR HEALTH

The district has a total of 6 Training Institutions, 1 – government namely Lugalo, 5 Non government namely KAM, Paradigm, Kairuki, IMTU and Masana which have full NACTE Accreditation. The district recruits more health workers however, due to the increase in population the doctor-patient ratio has not increased. Shifting of staff cadre from AMO's and CO's to MO's due to upgrading also affects the HRH.

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

**No plot provided**

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

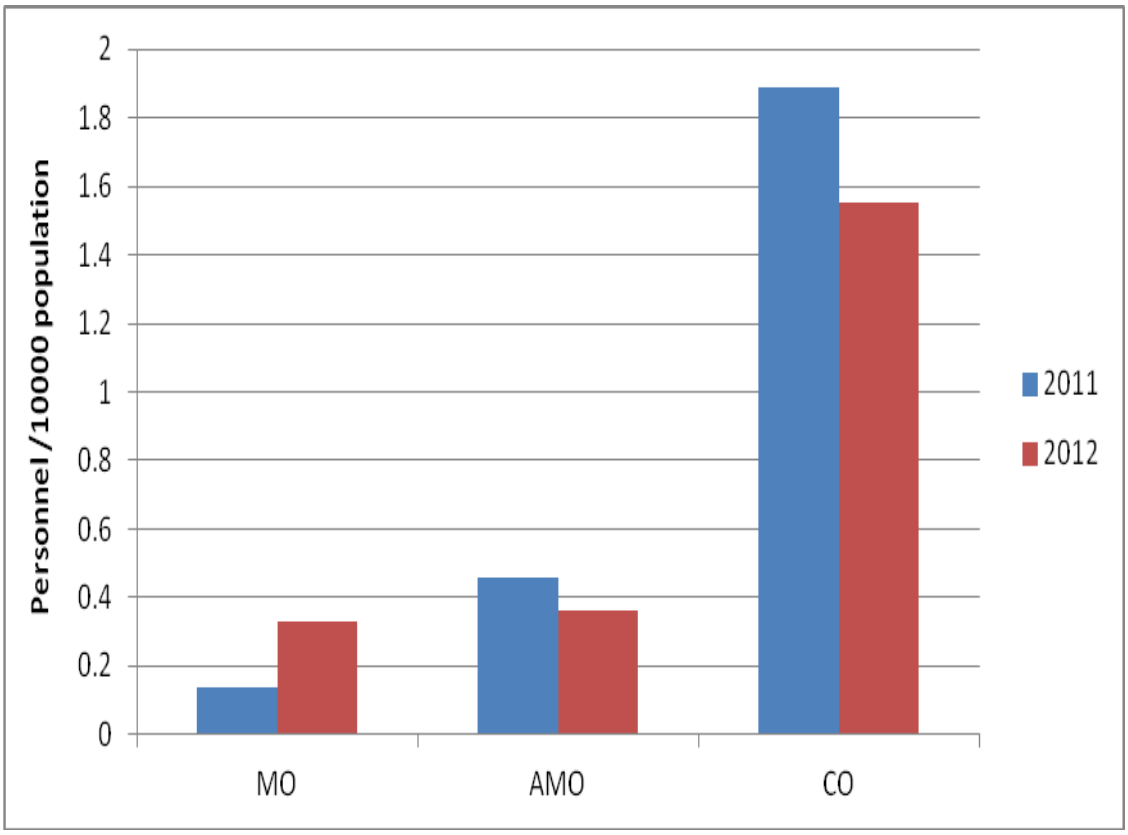


**Figure 5-4. Number of Nurse mid-wives, Lab Techs, Pharm Techs Per 10, 000**

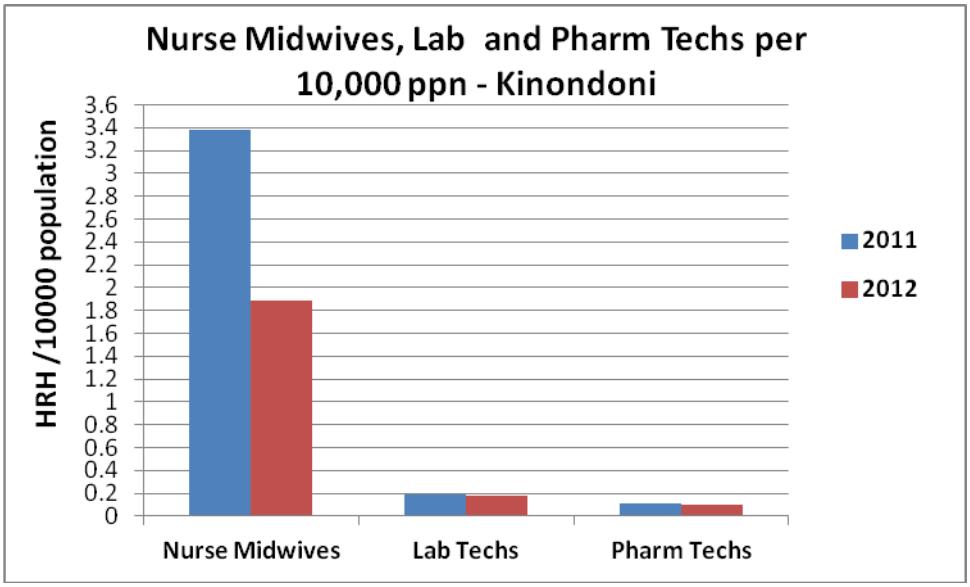
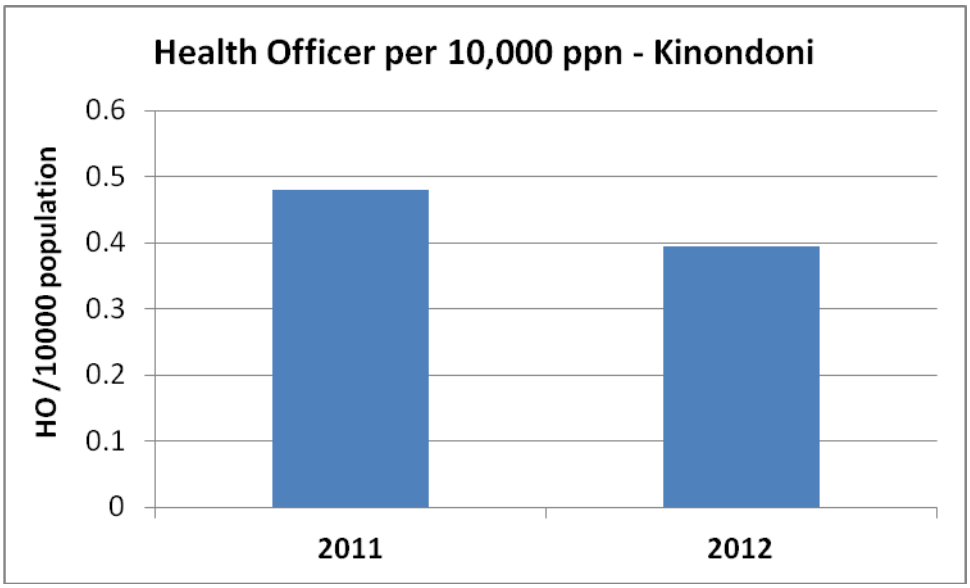



**Figure 5-5. Number of HO, AHO, and EHOs per 10, 000**



## 5.3 MEDICINES/DRUGS

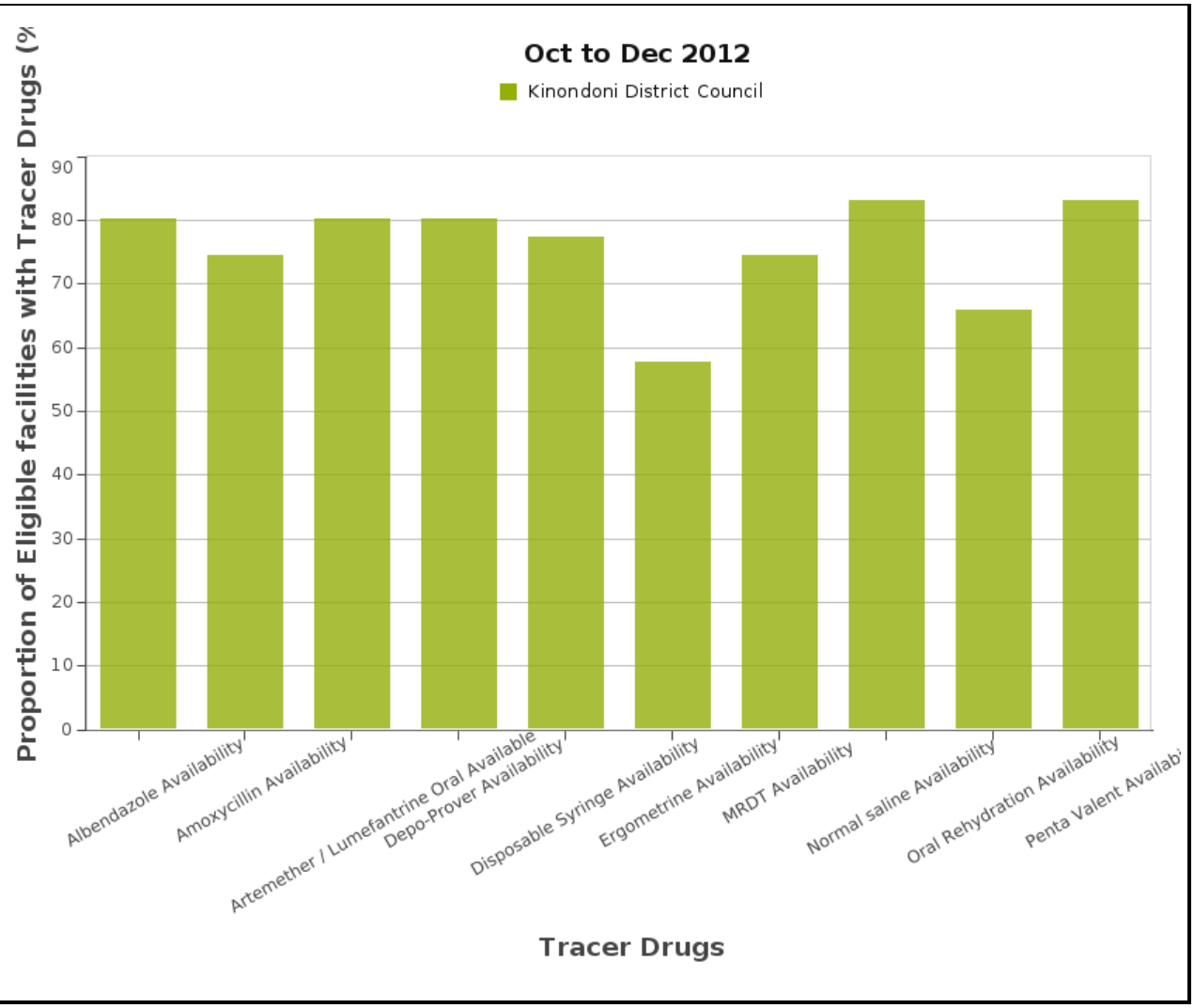
No stock out of Tracer Drugs, 1 Vaccine and Medical Supplies has reported for the year 2012.

Availability of medicine, medical supplies and equipment has been maintained at 85%.

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

**NO HEALTH FACILITY HAD STOCKOUT OF 5 TRACER DRUGS**

**Figure 5-7. Availability of Tracer Drugs**



## 5.4 INFRASTRUCTURE

During the financial year (2012/2013) construction of new Hospital at Mabwepande initiated (OPD building) while dispensaries at Salasala and Manzese are at final stage. Construction of neonatal and postnatal units at Mwananyamala, staff house at Mwenge dispensary , maternity buildings at 6 dispensaries (Hananasif, Msumi, Mavurunza, Kwembe kati, Mbweni Mpiji , Wazo), TB laboratory unit (Centre of Excellency) at Mwananyamala, new CTC at Mwenge dispensary, diagnostic building at Sinza Hospital all have been completed by 100%. Moreover major rehabilitation was conducted at Kibwegere, Mbweni, Kawe, Mbweni, Mpiji magohe, Makongo, Kawe, Ndumbwi Dispensaries and Osterbay RCH clinic. On the other hand the number of solid waste collected increased from 458 to 871 tons per day.

## 5.5 OPTIONAL DISTRICT HEALTH SYSTEM INDICATORS

Table 5.1 shows performance of optional health system indicators. The situation on human resource is still very poor (large number of population per specialist (internal medicine). Per capita income is low which might influence poor access to health service. There is still a challenge on population per bed which is highly visible in maternal service.

**Table 5.1 Performance of optional health system indicators**

| No | Type of Indicator | 2012 |
|---|---|---|
| 1. | Per capital Income | $150 |
| 2. | Population per physician | 1:73622 |
| 3. | Population per health Facility | 1:7661 |
| 4. | Population per bed | 1:5060 |

## 5.6 DISTRICT HEALTH SYSTEM CONCLUSIONS AND WAY FORWARD

Health department receive funds from different sources (Block grant, Basket Funds, Cost sharing, MMAM and from others sources such as council revenue collection) that are used to support implementation of planned activities to improve quality of service delivery at the council. The district has a total of 6 Training Institutions where recruitment of health cadres is developed. However, due to the increase in population the doctor-patient ratio has not increased. Human resource attrition affects the Human Resource for Health.

Drug logistic management indicates to be well functioning since no stock out of Tracer Drugs has happened for the year 2012. Availability of medicine, medical supplies and equipment has been maintained at 85%. To avoid missed items at MSD, the central government should consider of having an alternative source for medicines, medical supplies and equipment procurement to supplement MSD out of stock. Fund allocation for medicines, medical supplies and equipment should be split to more than one procurement source/agent rather than only MSD where you cannot retrieve the fund in case of missed items.

To improve the quality of service delivery infrastructure has been improved through construction of new buildings and renovating the existing one.

The situation on human resource, per capita income and infrastructure are still concerns to strengthen the quality of service provided.

# 6 AREAS OF PROGRESS IN THE DISTRICT HEALTH SECTOR

## 6.1 PROGRESS IN DISTRICT HEALTH FINANCING

There was a slight increase in Council funds which might be due to improvement in revenue collection. The allocation of Basket funds increased slightly from 2011 to 2012. Cost sharing collection at facilities level has increases by 40% in the year 2012/13 from the year 2011/12.

The district is planning to establish Tiba kwa Kadi (TIKA) scheme to improve quality of service in terms of availability of medicine and supplies and reduce out of pocket expenses.

Figure 6.1 shows health spending for 3 previous financial years. There were increase of expenditure for financial year 2011/12 followed by decrease in the year 2012/13. This could be due to non disbursement of funds e.g. Block Grant funds were not released from central government and other sources from Stakeholders. MMAM funds budgeted for this financial year will be disbursed in the next financial year which also does affect the financing spending for the particular year. Sharing of account with more than one department also contributed to increase in expenditure.

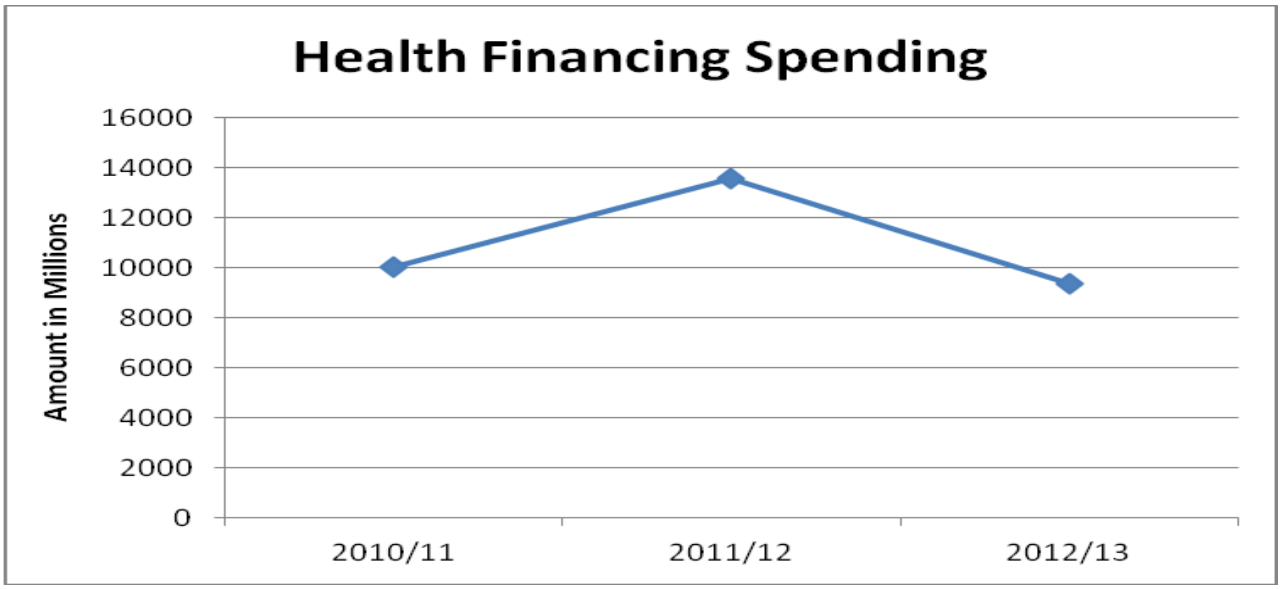



**Figure 6.1** Health spending for financial years 2010/11 2011/12 and 2013, Kinondoni District

However, the district still lack funds to handle two hospitals (Mwananyamala Regional referral Hospital and Sinza District /Municipal Hospital), considering that there is one hospital cost centre funds allocation.

## 6.2 PROGRESS IN DISTRICT HUMAN RESOURCES

Progress over the past 2 years has been shown in the previous sections. A total number of 111 new staff were recruited and posted at public health facilities in 2012. In the year 2012/13 new 67 staff had been employed (recruited) including 43 casual laborers in all facilities employed under contract to reduce burden of unprofessional duties to the medical staff. During 2012/13, 70 staff were supported to attend continuous education while 60 staff undergone short orientations in BEmOC, TB HIV, Quality control and managerial issues.

## 6.3 PROGRESS IN DISTRICT NEONATAL HEALTH

Construction of neonatal and postnatal units at Mwananyamala was done to improve child and maternal health.

## 6.4 PROGRESS IN DISTRICT HEALTH FACILITY COVERAGE

To facilitate facility coverage across the district, there had been construction of neonatal and postnatal units at Mwananyamala, staff house at Mwenge dispensary, maternity buildings at 6 dispensaries of Hananasif, Msumi, Mavurunza, Kwembe kati, Mbweni Mpiji, Wazo, TB laboratory unit (Centre of Excellency) at Mwananyamala, new CTC at Mwenge dispensary, diagnostic building at Sinza Hospital all have been completed by 100% during 2011/12 and 2012/13 financial year. Moreover major rehabilitation was conducted at Kibwegere, Mbweni, Kawe, and Mbweni, Mpiji Magohe, Makongo, Kawe, Ndumbwi Dispensaries and Osterbay RCH clinic.

New construction of Mabwepande Hospital is ongoing while dispensaries at Manzese and Salasala are at final stages. Through "*Mfuko wa Jimbo wa Mbunge"* the district has managed to construct RCH clinic at Msakuzi Mbezi where it used to be an outreach clinic.

## 6.5 PROGRESS IN DISTRICT HEALTH FACILITY PERFORMANCE

EXPANSIONS IN CRITICAL HEALTH SERVICES

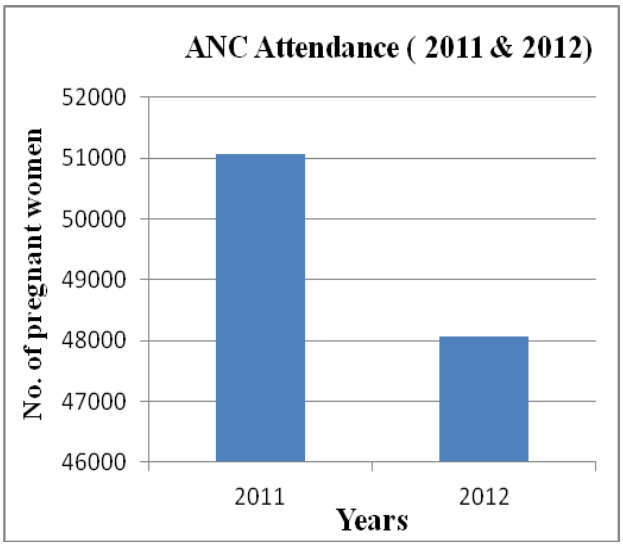
Services strengthened as part of expansion in critical service include the following:

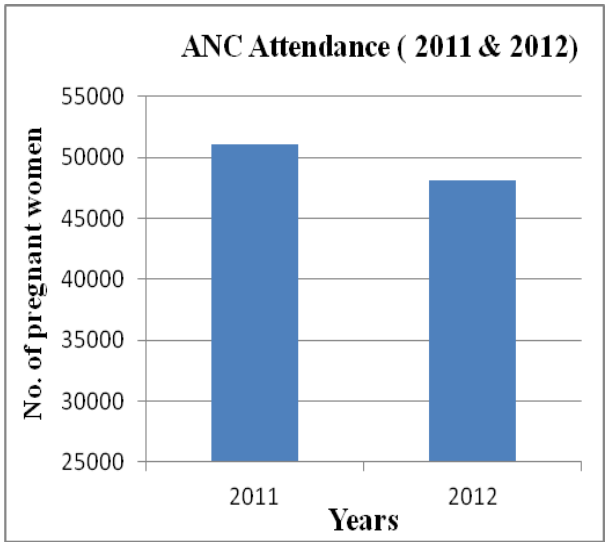
- Outreach services- for RCH and family planning
- Family planning (managed to provide IUCD/Norplant insertion and permanent methods Min lap and vasectomy)
- Expansion of Sinza hospital to accommodate NHIF member
- building ward for NHIF member at Mwananyamala hospital

IMPROVEMENTS IN REFERRAL HOSPITAL PERFORMANCE

To improve referral system funds for transportation were allocated in each health facility in the area where there in ambulance. The next plan is to purchase 2 additional ambulances which will be stationed along Bagamoyo and Morogoro Road.

PROGRESS IN ANC ATTENDANCE

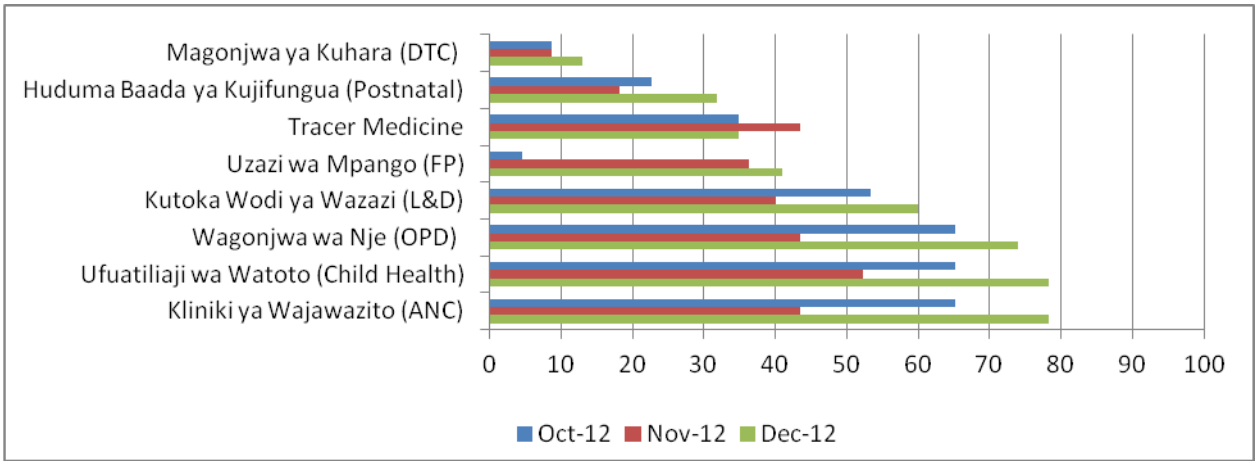



Early antenatal attendance in our facilities (early booking) has increased from 100-300 per month through the use of Community volunteers and CBHC during follow-up.

# KINONDONI DISTRICT HEALTH PROFILE

Progress In Health Facility Reporting Rates (Oct-Dec 2012)

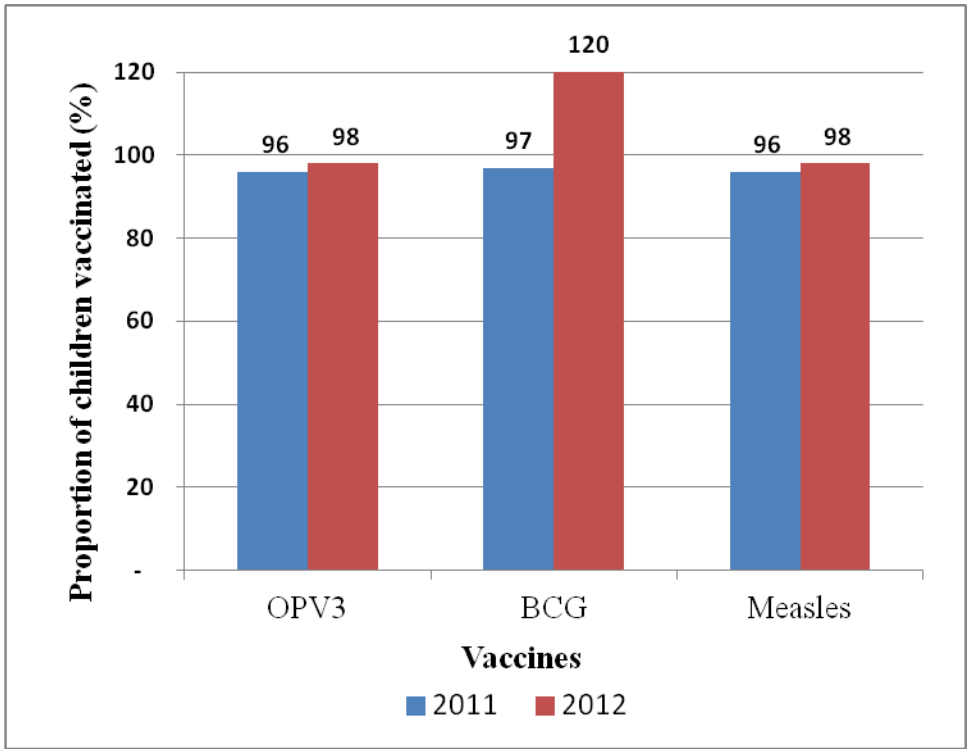



TIMELINESS AND COMPLETENESS OF DATA

- Still very low, more marked by private facilities , 83(37%) HFs has zero report .
- Under reporting of HMIS and IDWE weekly/quarterly and annual reporting of health facilities.

## 6.6 PROGRESS IN DISTRICT HEALTH SERVICES

VACCINATION COVERAGE




There has been an improvement in the vaccination coverage in 2012 as compared to 2011. The over 100% coverage for BCG could be due to large catchment area.

ENVIRONMENTAL HEALTH SERVICE SAFE WATER INITIATIVES

Treatment of water source ( shallow and deep wells) with Chlorine. The district has been budgeting for this every year.

## PROGRESS AGAINST MILESTONES

Assessment of CCHP at ministerial level and provision of feedback to districts on areas that need improvement / rectification before approval of the funding for CCHP. Generally Kinondoni Municipal received good report with minor correction whereby it was later approved for funding. The Comprehensive Council Health Plan for 2012/13 is an initiative intends to minimize health problems by providing resources thereby having involvement of all potential stakeholders and ultimately reduce health problems in the district. The overall objective is to make sure health care services are improved by ensuring efficient utilization of the available resources. The CCHP 2012/13 has been developed by the CHMT, based on the eleven priorities as described in the CCHP.

## 6.7 BEST PRACTICES/CASE STUDIES

**Silencing Cholera Outbreaks**

In early 2000's to 2008 Cholera outbreak was at its peak in Kinondoni district. Cholera camp at Mburahati dispensary was full of patients and staff had to work day and night. CHMT team had to make follow up to make sure things are going on well by putting guarantees, *mgambo* chasing food venders, medicine and supplies were available etc but all these efforts were not successful till the day we thought of treating water sources with chlorine. Health officers were assigned to identify all sources of water in the district and MMOH office bought enough stock of chlorine to treat all identified wells putting into consideration that DAWASCO has failed to supply tape water to the whole community of Dar es Salaam. Wells were treated as planned and we started to experience reduction of patients at the camp and eventually the camp closed to date. This has become a routine activity in the council and every year we budget for chlorine.

# KINONDONI DISTRICT HEALTH PROFILE

**Umbilical Sepsis in New Born**

The management initiated spot check at Municipal hospital where every day one officer from MMOH office has to visit the hospital after working hour. On each report brought by the officers, a notable number of neonatal having umbilical sepsis was found and all those babies were born at the same hospital. Care taker reported that the baby developed high fever within two to three days after being discharged hence had to be brought back to the hospital. That prompted the CHMT to make follow up of what was happening at the hospital particularly in the labor ward. It was found that the cord clamps used were not appropriate. Due to shortage of clamps, providers improvised clamps by using glove ends to tie new born umbilical cord which was thought to be the source of infection. The district management decided to purchase cord clamps and provide to the facilities with shortage an effort which halted the umbilical sepsis problem to date.

**Uplifting health facility delivery**

Best practice was noted from Tandale dispensary during data use training conducted in Dar es Salaam. It was a testimonial provided by a health provider from one facility in Tandale on how data helped to increase facility delivery after noting low delivery at the facility (10 -15 per month) , high ANC visit and high child follow up visits. The team analyzed their data and came out with suggestion for interventions (health education, exit interview and physical visit of clients to labor ward) and set indicators to tract changes. Today the facility conducts 90 – 100 deliveries per month.