

What does Dar make of health?

Health service and practice in Dar es Salaam



Introduction

The 2010 Tanzania Demographic and Health Survey (DHS) shows significant improvements in several key health outcomes; for example, a decrease in child mortality and an increase in the use of bed nets to prevent malaria. But other indicators lag behind. For example, less than 4 in 10 children under 5 years receive the proper first line anti-malaria treatment (*dawa ya mseto*; DHS, 2010), and the 2010 Service Delivery Indicators (SDI) Survey showed that about one-quarter of all basic drugs were out of stock in Tanzanian public sector health facilities.

What has been happening to basic health services in Dar es Salaam, Tanzania's largest city, and what do Dar residents think about the health services that they use?

To answer these and other questions, Uwazi at Twaweza conducted a public service delivery survey in August and September 2010. A total of 550 randomly selected households were visited by the survey team in Ilala, Temeke, and Kinondoni districts. The survey asked about citizens' living conditions and their experiences with public services. To understand experiences with health services, respondents were asked about illnesses in their families, recent experiences with health services, and about their attitudes and practices relating to preventive health practices. This brief presents key findings from the survey.



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Seven facts about health in Dar es Salaam

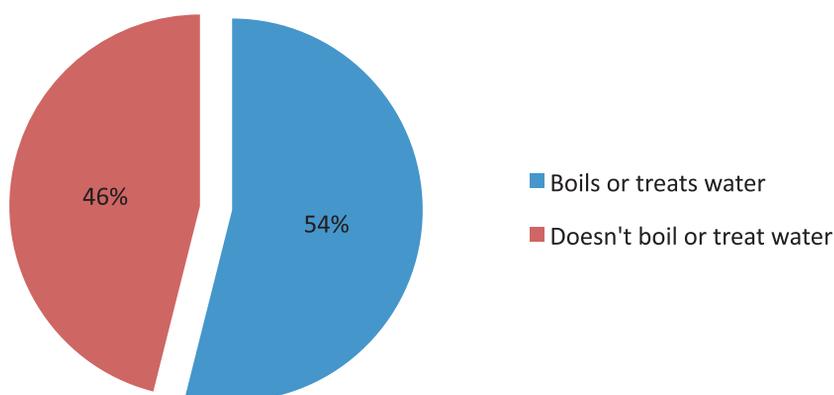
Fact 1: Ownership of mosquito nets is nearly universal

Malaria is a major health problem, and a key preventive step that households can take is to sleep under a bed net. This is especially important for children under 5 years and pregnant women. Distribution of nets and promotion of bed net use has been a major priority for the Ministry of Health and Social Welfare in Tanzania. The survey found that bed net ownership at household level in Dar es Salaam is almost universal; 95 percent of the households reported ownership of at least one mosquito net.

Fact 2: Only half of Dar es Salaam residents boil or treat their drinking water

Some of the water borne diseases such as cholera and typhoid fever that afflict Tanzanians can be avoided with simple preventive actions. Few Dar es Salaam residents have access to clean drinking water on a regular basis. For example, only 9.7 percent of all households have home delivery of water by truck or primarily use bottled water for drinking. But even when water is clean at source it can be contaminated when stored at home. This makes treating water with chlorine or boiling it before drinking an important preventive measure for much of the population. Yet only half (54 percent) of all interviewed residents reported treating their water. Moreover, this varies dramatically by wealth quintile: 75 percent of residents in the top wealth quintile treat or boil water, as compared to 23 percent of those in the lowest quintile.

Figure 1: Percentage of households that treat or boil drinking water

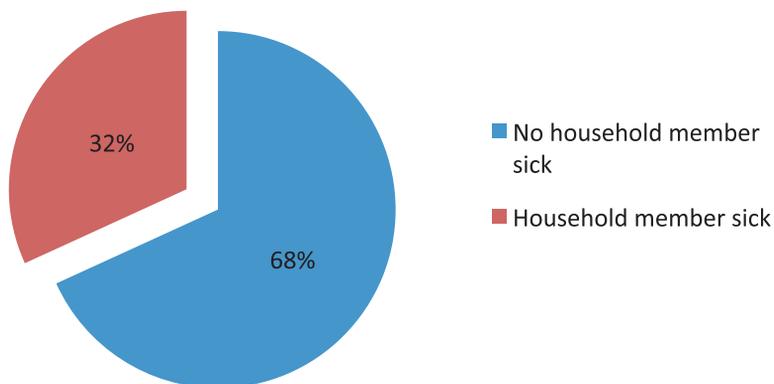


Source of Data: Uwazi, Public Service Delivery Survey, Dar es Salaam, 2010

Fact 3: One in 3 households had a sick household member in the week before the survey

Sickness is not uncommon in Dar es Salaam households. Thirty-two percent of households that were interviewed had at least one member that fell sick in the week prior to the survey. About one-third of the time this was a very young child. In almost 9 out of 10 cases (86 percent), these sick family members were taken to a health facility to receive treatment.

Figure 2: Presence of a sick household member, one week prior to the survey



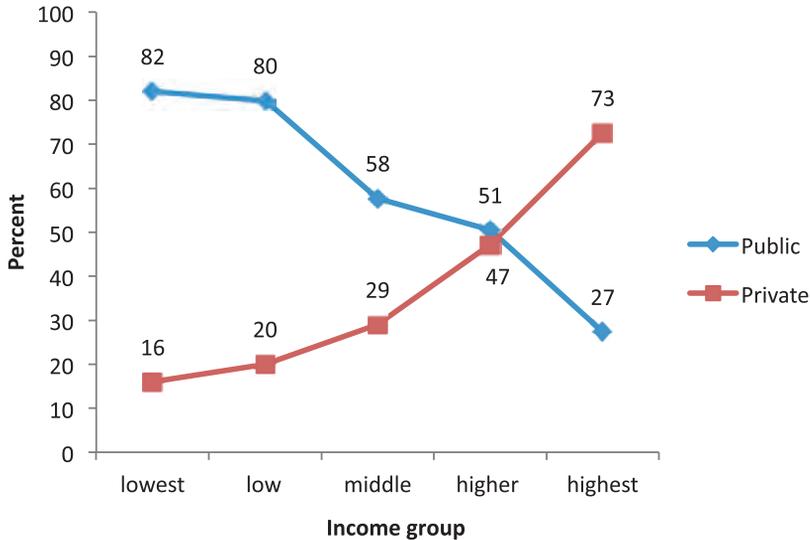
Source of Data: Uwazi, Public Service Delivery Survey, Dar es Salaam, 2010

Fact 4: Poorer households are more likely to visit government health facilities

In Dar es Salaam there is a wide range of places offering health advice or treatment: drug shops or *duka la dawa*, private clinics and hospitals, government dispensaries, health centers, and hospitals. The majority (60 percent) of respondents in our survey reported using government facilities when their family member was sick. Thirty-seven percent sought care at private facilities, while 3 percent reported that they sought care at religious or NGO facilities.

Wealth is a major determinant of where patients go to seek medical care. Figure 3 shows that 82 percent of the poorest households use government services, as compared to just 27 percent of the richest households. The higher the household income, the less likely it is that household members will seek services from government facilities. Just 16 percent of the poorest quintile use private services, as compared to 73 percent of the richest residents of Dar es Salaam. As a consequence it is the poor that suffer most when public health care facilities do not provide good quality services.

Figure 3: Choice between public and private health facilities by wealth quintile

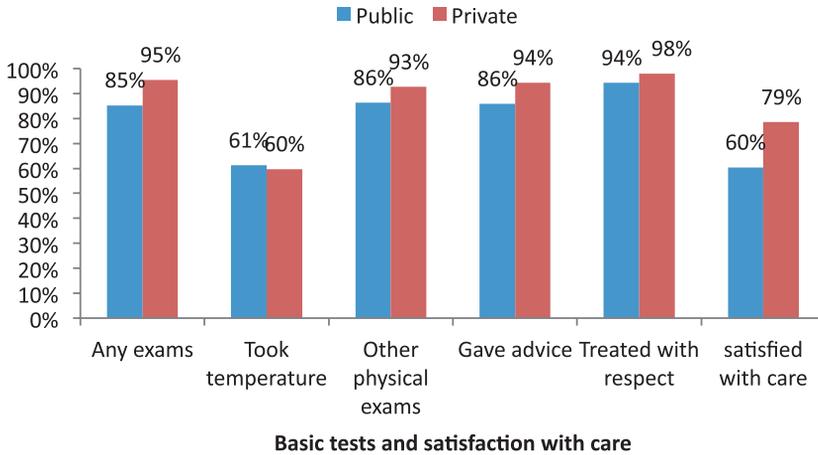


Source of Data: Uwazi, Public Service Delivery Survey, Dar es Salaam, 2010

Fact 5: Private facilities do slightly better on several measures of quality of care, and significantly better on patient satisfaction

Quality of medical care is difficult to evaluate through after-the-fact surveys of patients or the family members who accompanied these patients when they visited health facilities. However, some idea of quality can be gauged by whether patients received basic physical exams during their consultation, whether they were given advice about how to treat their illness, and whether in their opinion they were treated with respect at the health facility. As Figure 4 shows, there is a relatively small difference on each scale of service provided between private and public hospitals with respect to the most basic components of a health facility visit. On the other hand, 8 in 10 patients are satisfied with the service they received from private health facilities, compared to 6 in 10 in patients that report satisfaction with public health facilities.

Figure 4: Details about health consultation by facility type

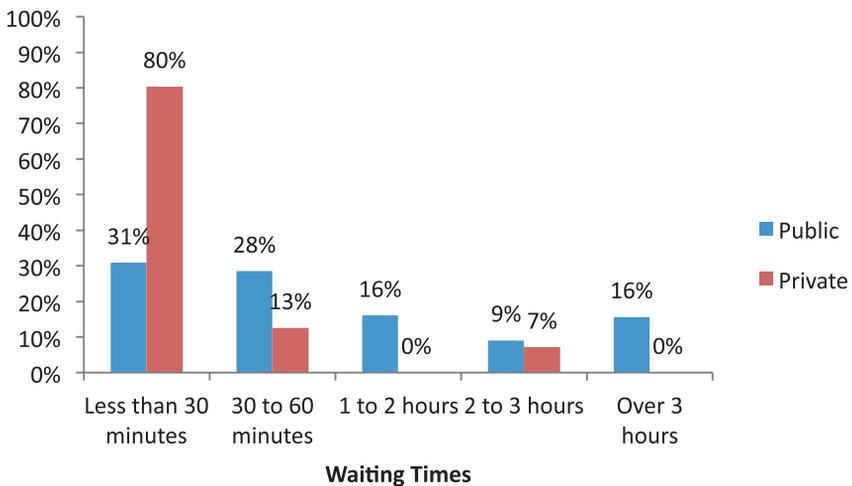


Source of Data: Uwazi, Public Service Delivery Survey, Dar es Salaam, 2010

Fact 6: One-quarter of public health facility visits had over two hours waiting time

Why do Dar es Salaam residents report preferring private facilities? One reason might be waiting times: service is faster in private sector facilities compared to public facilities. Eighty percent of patients were attended to within 30 minutes at private facilities, as compared to just 31 percent in public facilities. One-quarter reported having to wait for two or more hours in public facilities, and 16 percent waited for more than three hours.

Figure 5: Waiting time at health facility, by facility type

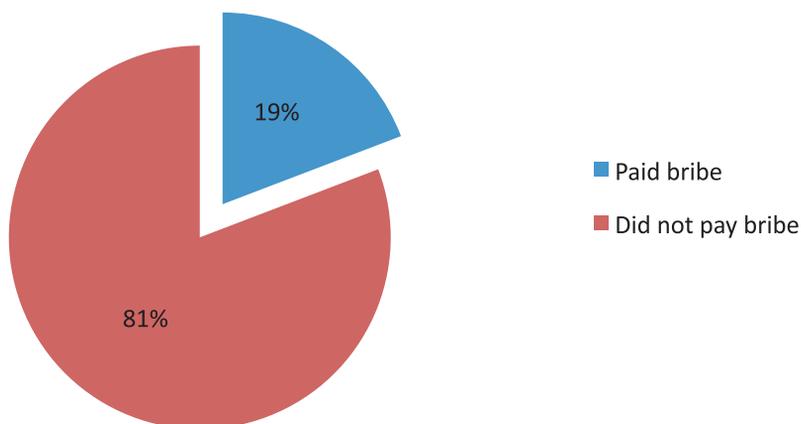


Source of Data: Uwazi, Public Service Delivery Survey, Dar es Salaam, 2010

Fact 7: One in five residents found it necessary to pay a bribe at a public health facility

Another reason why Dar es Salaam residents prefer private facilities (if they can afford them) may be due to the prevalence of bribes at public health facilities. Almost one in five Dar residents reported that they had paid a bribe to get service at a public health facility in the past 12 months. The fact that bribes have to be paid may mean that the poorest residents are less able to acquire the services they need.

Figure 6: Respondents who paid a bribe at a public health facility in the past year



Source of Data: Uwazi, Public Service Delivery Survey, Dar es Salaam, 2010

Conclusion

This brief has presented some findings related to preventive health practices and use of health services in Dar es Salaam. Our findings suggest that in part, government policies (i.e. free distribution of bed nets) have enabled families to take preventive health measures. On the other hand, a substantial proportion of residents still do not take key preventive measures, such as treating or boiling drinking water. Many residents also feel that health services still leave much to be desired: it appears that bribery is not uncommon in public health facilities and a significant proportion of residents are unsatisfied by the services that they receive from these facilities.

Recent achievements in health in Tanzania may have therefore been reached through the easier ('low-hanging fruit') interventions, such as distributing free mosquito nets. Making further gains is likely to be much harder as it will entail addressing aspects of quality of care, including better diagnosis, responsiveness to patients, and improvements in drug supply. Such steps should also include measures to reduce financial barriers to access and better accountability (e.g. dealing with bribery and diversion) in dispensaries, health centers, and hospitals. Greater transparency of the conditions of services, resources and entitlements may be a good place to start.