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1999

National Bureau of Statistics

MEASURE *DHS+*
Macro International Inc.

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This report presents results from the 1999 Tanzania Reproductive and Child Health Survey (TRCHS) which was undertaken by the National Bureau of Statistics in collaboration with the Reproductive and Child Health Section of the Ministry of Health. Financial assistance for the survey was provided by the U.S. Agency for International Development (USAID/Tanzania), UNICEF/Tanzania, and the United Nations Population Fund (UNFPA/Tanzania). The TRCHS is part of the worldwide MEASURE Demographic and Health Surveys (*DHS+*) project which is designed to collect, analyse and disseminate data on fertility, family planning, maternal and child health, and HIV/AIDS.

Additional information about the TRCHS may be obtained free of charge from the National Bureau of Statistics, P.O. Box 796, Dar es Salaam (telephone: 135-602; fax: 135-601). Information about the MEASURE *DHS+* project may be obtained from Macro International Inc., 11785 Beltsville Drive, Suite 300, Calverton, MD 20705 (telephone: 301-572-0200; fax: 301-572-0999).

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FOREWORD

The National Bureau of Statistics takes pleasure in presenting this report on the 1999 Reproductive and Child Health Survey (TRCHS). The 1999 TRCHS is the latest in a series of periodic surveys to measure levels, patterns, and trends in demographic and health indicators, the first having been the 1991-92 Tanzania Demographic and Health Survey (TDHS).

This report contains findings from the 1999 TRCHS regarding data from the households visited. The tables and text cover the most important indicators and should be of use to policy makers and program administrators who need up-to-date data for evaluating their activities and planning future directions. Findings from the survey covering health facilities will be produced in a separate report.

The successful completion of the 1999 TRCHS was made possible by the joint effort of a number of organisations and individuals, whose participation we would like to acknowledge with gratitude. First, is the U.S. Agency for International Development (USAID)/Tanzania which has long supported the collection and utilisation of data to evaluate the family planning and health programmes in Tanzania and which initiated planning for this survey and provided the bulk of the funding to implement it. UNICEF/Tanzania and UNFPA/Tanzania also contributed substantially to both the survey design and the funding for the survey. Many other organisations contributed to the questionnaire content and/or the field staff training, including the Reproductive and Child Health Unit at the Ministry of Health, the Tanzania Food and Nutrition Centre, and the National AIDS Control Programme and Mount Meru Hospital. We would also like to thank the Demographic and Health Surveys program of Macro International Inc. in Calverton, Maryland, U.S.A. for providing technical assistance in all phases of the project. The survey would not have gotten off the ground without the exemplary and tireless efforts of the staff at the National Bureau of Statistics. Their many long days of overtime work have served to make this survey effort a success. Similarly, the nurses who acted as interviewers for the survey deserve our heartfelt thanks. Finally, we are ever more grateful to the survey respondents who contributed generously part of their time to enable us to gather crucial data for our country's future planning.

Cletus P.B. Mkai
Director General
National Bureau of Statistics

Dar es Salaam, Tanzania

SUMMARY OF FINDINGS

The 1999 Tanzania Reproductive and Child Health Survey (TRCHS) is a nationally-representative sample survey covering 4,029 women age 15-49 and 3,542 men age 15-59. The TRCHS was designed to provide information on levels and trends of fertility, family planning knowledge and use, infant and child mortality, and indicators of maternal and child health and nutrition. Fieldwork for the TRCHS took place from early September to late-November 1999.

Survey data generally confirm patterns observed in the 1996 Tanzania Demographic and Health Survey (TDHS), showing increasing contraceptive use and more widespread knowledge about HIV/AIDS; however, results show that many challenges still exist.

FERTILITY

Fertility Decline. The TRCHS data indicate that there has been a small decline in fertility since the 1996 survey. The total fertility rate has dropped from 5.8 births per woman in the period 1994-96 to 5.6 births for the period 1997-99. The rate of decline may be slowing somewhat, however, and the level of fertility is still high.

Large Fertility Differentials. Significant differences in fertility levels are evident from survey data. For example, the total fertility rate among rural women is twice that of urban women (6.5 versus 3.2). Fertility levels are closely related to women's education. Women with no formal education give birth to an average of 6.5 children in their lifetime, compared with 4.9 for women who have completed primary school.

Unplanned Fertility. One reason for the relatively high fertility levels is that unplanned pregnancies are still common. Overall, more than one in five births in the three years prior to the survey were reported to be unplanned; 11 percent were mistimed (wanted later) and 11 percent were unwanted. Unwanted births are disproportionately high among older women who already have several children, the very women who are at higher risk of fertility-related illness and higher child mortality. If unwanted births could be eliminated altogether, the total fertility rate in Tanzania would be 4.8 births per woman instead of the actual level of 5.6.

Ideal Family Size. Although a reduction in the number of unplanned births would reduce fertility substantially, Tanzanian women and men still want to have large families. Even those who have two children or fewer say they would ideally like to have almost five children on average.

FAMILY PLANNING

Increasing Use of Contraception. A major cause of the declining fertility in Tanzania has been the slow but steady increase in contraceptive use over the last decade. The contraceptive prevalence rate has doubled since 1991-92, from 10 to 22 percent of all women. Use of modern methods has grown from 6 to 16 percent of all women. Overall, there has been a steady growth in the contraceptive prevalence rate with an average increase of one and a half percentage points a year.

Method Mix. In terms of "method mix," the dominant change over the last 8 years has been the large increase in the number of women using injectable contraception. The proportion of women relying on injectables increased from less than half a percent in 1991-92 to over 5 percent in 1999 and the injectable now accounts for one-quarter of all contraceptive use.

Use of condoms, periodic abstinence and withdrawal have also increased somewhat over the past few years. A levelling off in pill use may indicate that some women are switch-

ing from the pill to injectables. The low level of use of permanent methods such as sterilisation and implants is of concern, given the high level of unplanned births among high-parity, older women.

Differentials in Family Planning Use. Differentials in current use of family planning are large. Urban women are almost twice as likely as rural women to be using a contraceptive method (33 versus 18 percent). Women in the Mainland are more likely to use than those on Zanzibar. However, the largest differences are found by education—contraceptive use among women with some secondary education is three times higher than among those with no education.

Knowledge of Contraception. The proportion of women and men who know of at least one contraceptive method has been over 75 percent for some time and the TRCHS results indicate that the proportion has increased to over 90 percent. Moreover, the mean number of methods that women and men say they have heard of has grown from 4 in 1996 to 6 in 1999. Knowing about more methods provides a basis for wider choice.

Unmet Need for Family Planning. Unmet need for family planning has declined slightly since 1996. Data from the 1996 TDHS show that 19 percent of all women were in need of services, compared with 17 percent in the 1999 TRCHS. Two-thirds of the unmet need is comprised of women who want to space their next birth, while just one third is for women who do not want any more children (limiters). If all women who say they want to space or limit their children were to use methods, the contraceptive prevalence rate could be increased from 22 percent to 40 percent of all women. Currently, 56 percent of this "total demand" for family planning is being met.

Family Planning Messages. Survey data show that family planning messages are continuing to get through to couples. As in 1996, just over 40 percent of women have heard a family planning message on the radio in the six months prior to the survey, while 5 percent have seen a message on the television and one-fifth have seen a poster. Taking all sources into account, two-thirds of women and 70 percent of men say they have seen or heard a family planning message in the last six months. The proportion of women and men who say they have seen or heard specific programs such as *Zinduka!* and *Twende na Wakati* has also increased since 1996.

MATERNAL AND CHILD HEALTH

Maternal Health Care. TRCHS data point to several areas regarding maternal health care in which improvements could be made. Although the proportion of Tanzanian mothers who receive antenatal care from a doctor, nurse, midwife or medical aide has remained steady at just over 90 percent since 1991-92, there has been a shift in providers from nurses and midwives to the less well-trained health aides. The proportion of pregnant women receiving at least one tetanus toxoid injection has declined from 92 percent in 1996 to 83 in 1999. The data also show a disturbingly steady decline in the proportion of births that occur in a health facility—from 53 percent in 1991-92 to 47 percent in 1996 to 44 percent in 1999. Because of this decline, the proportion of births assisted by trained medical personnel (doctors, nurses, midwives) has declined from 44 percent in 1991-92 to 36 percent in 1999. Less than one in five of those who deliver at home go to a health facility for a postnatal check-up within a month after delivery.

Possible Leveling Off of Childhood Mortality Decline. Survey results imply that the decline in childhood mortality documented in the 1996 TDHS may be stagnating or even increasing slightly. The TRCHS rates show that almost 1 in 7 children born in Tanzania dies before reaching the fifth birthday, an indication that there is still much improvement to be made. The under-five mortality rate measured in the survey is 147 deaths per 1,000 births; the infant mortality rate is 99 per 1,000.

Childhood Vaccination Coverage. The 1999 TRCHS results show that 68 percent of children age 12-23 months are fully vaccinated, close to the 71 percent in 1996.

Childhood Health. The TRCHS provides data on some of the more common childhood illness and their treatment. Just over 1 in 3 children under age five had a fever and 14 percent had respiratory illness in the two weeks before the survey. Of these, two-thirds were taken to a health facility for treatment. Twelve percent of children under five were reported to have had diarrhoea in the two weeks preceeding the survey. The fact that two-thirds of children with diarrhoea received some type of oral rehydration therapy (fluid made from an ORS packet or increased fluids) is encouraging.

Breastfeeding Practices. The TRCHS results document a relatively long duration of breastfeeding, with a median duration of 21 months. Although breastfeeding has beneficial effects on both the child and the mother, TRCHS data indicate that supplementation of breastfeeding with other liquids and foods occurs too early in Tanzania. For example, among newborns less than four months of age, 60 percent are already receiving complementary foods or liquids.

Nutritional Status of Children. Results show no appreciable change in the nutritional status of children in Tanzania. Over 40 percent of children under five show evidence of chronic malnutrition or stunting, while 5 percent are acutely malnourished (wasted).

Vitamin A Supplementation. Over the past decade, several studies have proved the importance of adequate vitamin A in mitigating the severity of maternal and childhood illnesses and thereby reducing mortality. Supplementing young children and postpartum women with a capsule containing a high dose of vitamin A is an easy way to ensure adequate intake. However, survey data show that only 14 percent of children aged 6-59 months received a high-dose vitamin A supplement in the six months prior to the survey. Vitamin A supplementation for postpartum women has about the same coverage; 12 percent of women received a supplement within 2 months after delivering.

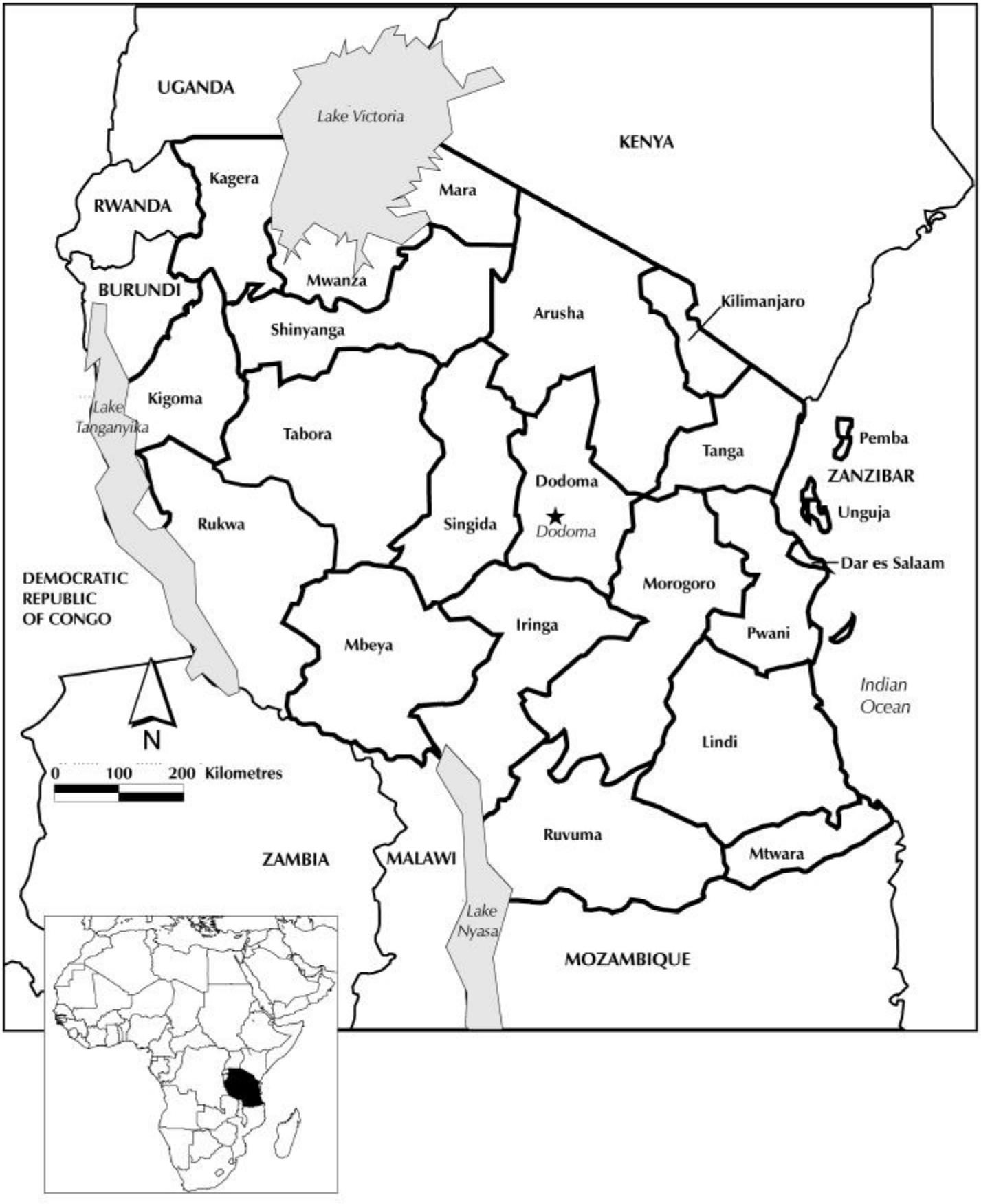
HIV/AIDS-Related Indicators

Awareness of AIDS. The TRCHS results confirm the fact that 97 percent of women and 99 percent of men have heard of HIV/AIDS. They also indicate an improvement in knowledge about how the disease is spread, which is reflected in an increase in the proportion of women and men who can list most of the major ways to avoid getting the illness. Around three-quarters or more of respondents know that HIV can be passed from a mother to her child and that a healthy-looking person can be infected.

Condom Use. One of the main objectives of the Tanzanian AIDS control programme is to encourage consistent use of condoms, especially with partners who may be exposed to HIV with other partners or through other risky behaviour. TRCHS data show that condom use with extramarital partners has increased since 1996 for women but not for men. Almost one in four women and 34 percent of men who had sex with someone other than a husband or wife in the previous 12 months said they used a condom the last time. Half of the respondents feel it is acceptable for a woman to ask a man to use a condom, while almost 60 percent say that if a man has a sexually transmitted disease, it is acceptable for his wife to ask him to use condoms or to refuse to have sex with him.

HIV Testing. TRCHS data show that 7 percent of women and 12 percent of men have been tested for HIV, which represents a slight increase from 1996 (4 and 11 percent, respectively). As before, about two-thirds of those not tested say they would like to be. Major reasons for not getting tested are not knowing where to go and not having the time to go.

TANZANIA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