
Trends in Demographic Family Planning, and Health Indicators in Tanzania



Bureau of Statistics
Planning Commission



Demographic and Health Surveys
Macro International Inc.

**TRENDS IN DEMOGRAPHIC,
FAMILY PLANNING, AND HEALTH INDICATORS
IN TANZANIA**

Bureau of Statistics
Dar es Salaam, Tanzania

Demographic and Health Surveys
Macro International Inc.
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This report was prepared as part of the worldwide Demographic and Health Surveys (DHS) programme, which is designed to collect data on fertility, family planning, and maternal and child health. Additional information about the 1996 Tanzania Demographic and Health Survey (TDHS) may be obtained from the Bureau of Statistics, P.O. Box 796, Dar es Salaam, Tanzania (Telephone 051-111993). Additional information about the DHS programme may be obtained by writing to: DHS, Macro International Inc., 11785 Beltsville Drive, Suite 300, Calverton, MD 20705, USA (Telephone: 301-572-0200; Fax: 301-572-0999; Internet: <http://www.macroid.com/dhs/>; E-mail: reports@macroint.com).

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1 Introduction

This report describes trends in key population, family planning, and health indicators in Tanzania over the past three decades. The primary objective is to assist policy makers and programme administrators in assessing the current situation and in formulating future population, family planning, and maternal and child health programmes. In particular, the report addresses the prevailing demographic situation and describes trends in fertility, family planning, maternal and child health, infant and child mortality, and knowledge of AIDS and sexually transmitted diseases (STDs).

The report highlights findings from the 1996 Tanzania Demographic and Health Survey (TDHS), which was a nationally representative survey of 8,120 women age 15-49 and 2,256 men age 15-59. The 1996 TDHS was the third national sample survey of its kind to be undertaken. The first was the 1991-92 TDHS, followed by the Tanzania Knowledge, Attitudes and Practices Survey (TKAPS) in 1994. The Bureau of Statistics implemented all three surveys with technical assistance from Macro International Inc. through the Demographic and Health Surveys (DHS) programme, funded by the U.S. Agency for International Development (USAID).

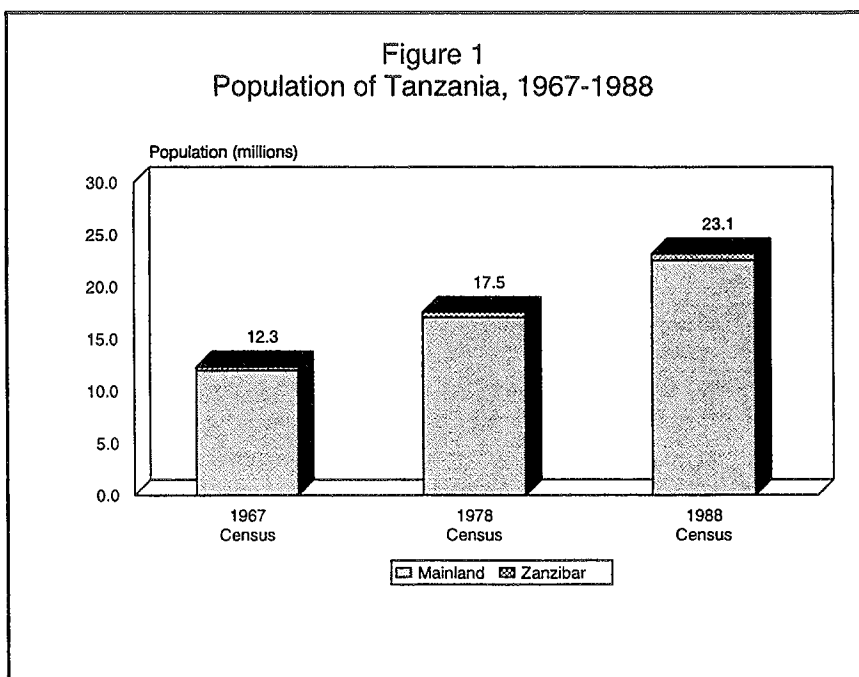
Data sources used in this report include the 1967, 1977, and 1988 population censuses of Tanzania, as well as the 1991-92 TDHS and the 1994 TKAPS; however, only those indicators that have a substantial impact on family planning and health programmes are discussed. The analysis is limited by the availability and comparability of data: the various sources present differences in survey methodology, geographic coverage, and methods of estimation. However, for the purpose of analyzing trends, estimates based on the population censuses are presented alongside those based on the surveys. In some cases, comparable data are only available from the 1991-92 TDHS, limiting analysis to the five-year period between 1991 and 1996.

2 Demographic, Social, and Economic Indicators

2.1 Population Distribution

The population of Tanzania almost doubled between 1967 and 1988, from 12.3 to 23.1 million (Figure 1). It is estimated that the population is currently increasing by more than 600,000 persons per year. By the year 2000, the population is expected to be about 33 million (on the assumption of a slight decline in fertility which will be offset by continued decline in mortality).

The population of Tanzania is not evenly distributed: in 1988, 54 percent of the population occupied 25 percent of the total land area. Regions such as Mwanza, Shinyanga, Mbeya, Dar es Salaam, Arusha, Kagera, Tanga, Kilimanjaro, Iringa, Morogoro, Tabora, and Dodoma have over a million people each. Census information indicates that the population is more widely distributed today than it was in 1978 (Bureau of Statistics, 1994).



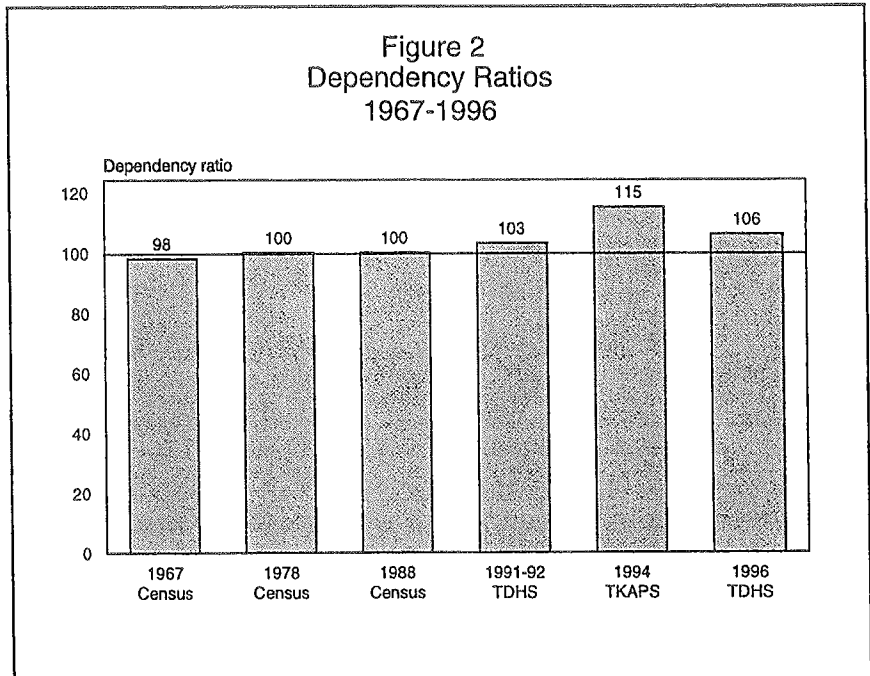
At the same time, population density has increased from 14 persons per square kilometre in 1967 to 26 persons per square kilometre in 1988. Although the population is still predominantly rural, the proportion living in urban areas has increased steadily, from 6 percent in 1967 to 18 percent in 1988.

2.2 Population Structure

The population structure in Tanzania has changed little in the past three decades. As observed in the censuses (1967, 1978, 1988) and the 1991-92 TDHS, the distribution of population in the 1996 TDHS conforms to the pattern typical of a high fertility population, that is, a larger proportion of the population is in the younger age groups than in the older age groups.

In 1996, children under age 15 represented 47 percent of the population, indicating a high level of fertility. This proportion has remained roughly the same since 1978.

The dependency ratio in Tanzania—the number of persons age 0-14 and 65 years and older (dependents) per 100 persons in the productive age group (age 15-64)—was 106 in 1996, an increase from 1978 and 1988 when it was 100. The continuing high dependency ratio indicates that the economic burden on persons in the productive age groups has not lessened in the past 29 years (Figure 2).



Households have become somewhat smaller over time; the mean household size decreased from 5.3 in the 1991-92 TDHS to 4.9 in the 1996 TDHS.

Seventy-eight percent of households are headed by men; this figure is higher than that in the 1988 Census (70 percent), but lower than reported in the 1991-92 TDHS (81 percent).

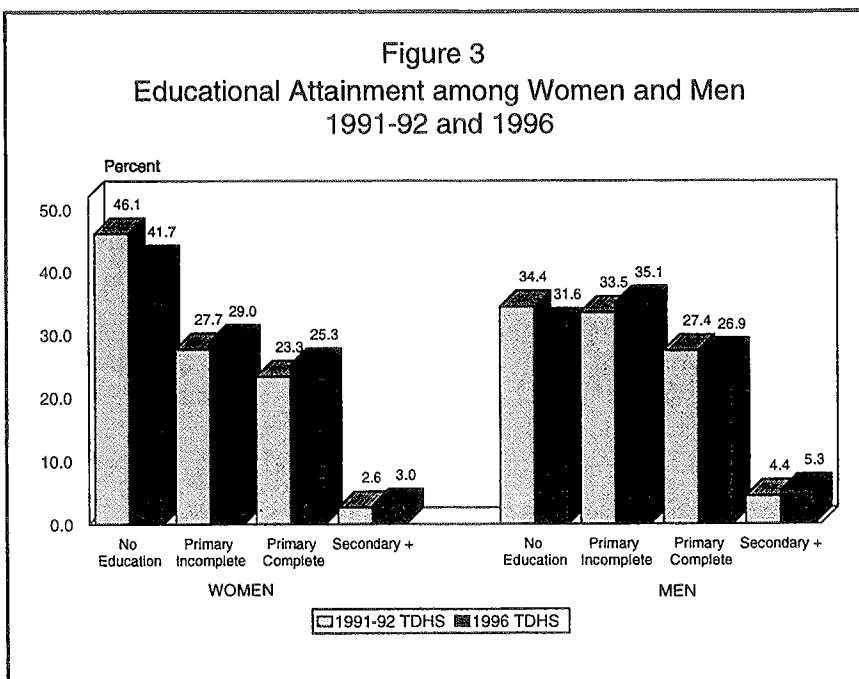
About 1 in 5 households has foster children, that is, children under age 15 whose biological parents are not present in the household. Figures from the 1991-92 TDHS indicate there has been a slight decline in the proportion of households with foster children (from 23 percent in 1991-92 to 21 percent in 1996). However, many families continue to have the additional economic burden of foster children.

2.3 Educational Attainment

In the three and half decades since independence, the education sector has expanded to reach most parts of the country, and some growth has been recorded in both enrolment and the number of new institutions. For example, in 1970, a nationwide literacy programme was launched, and in 1975 a national policy of Universal Primary Education was adopted.

In general, men have received more education than women. In 1996, 42 percent of females and 32 percent of males age six and over had never been to school. In 1991-92, the corresponding proportions were 46 and 34 percent, respectively, indicating a slight improvement between the two surveys (Figure 3).

School enrolment is higher for children age 11-15 (71 percent) than for those age 6-10 (27 percent), suggesting that many children start primary education after age 6 or 7. Urban enrolment has risen from 52 percent of children age 6-15 in 1991-92 to 57 percent in 1996.



2.4 Household Characteristics

Electricity has become more available to Tanzanian households. In 1991-92, 7 percent of households had electricity; by 1996, 9 percent had electricity.

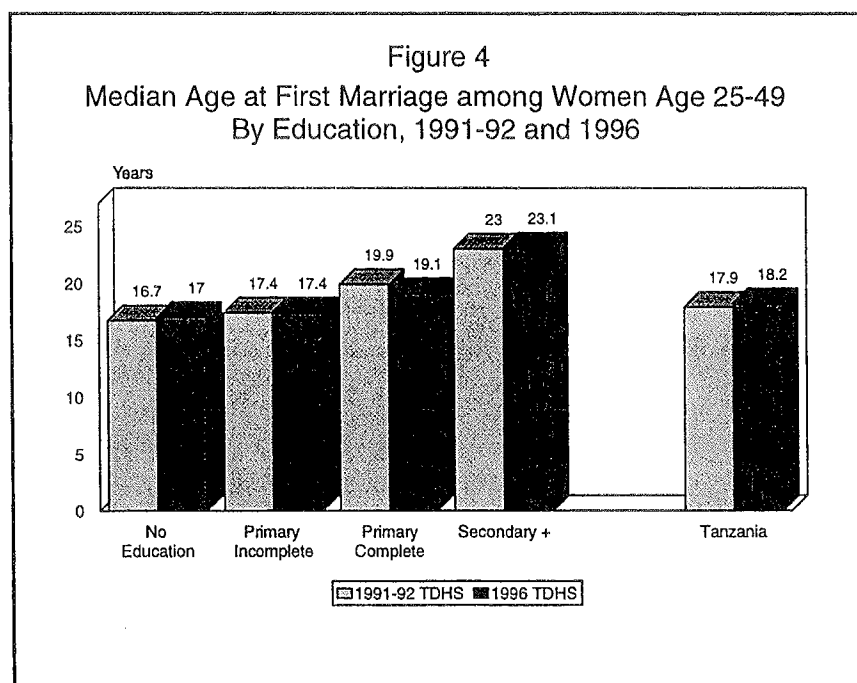
Access to safe drinking water is important to public health. In 1996, about 37 percent of all Tanzanian households had access to piped water—up from 34 percent in 1991-92.

Radios, televisions, and bicycles have become increasingly common in Tanzanian households. Forty-one percent of households own a radio, and 2 percent own a television. Both radio and television ownership is higher in urban than in rural areas. Bicycles are the most common means of transport: 25 percent of urban households and 34 percent of rural households own a bicycle. Ownership of radios, televisions, and bicycles has increased since 1991-92. For example, the proportion of households with a radio has increased from 33 to 41 percent and the proportion with a bicycle has increased from 22 to 32 percent. The proportion of households with a television in urban areas has increased from 1 percent in 1991-92 to about 6 percent in 1996. The increase reflects the introduction of three television stations in the country during the period between the two surveys.

3 Marriage and Fertility

3.1 Age at First Marriage

Marriage is almost universal in Tanzania; by the end of their reproductive years, all but 1 percent of women have been married. The median age at first marriage has risen steadily from less than 18 years among women age 45-49 to 19 years among women age 20-24 (representing recent marital patterns). The proportion of women married by age 15 declined from 22 percent among those age 45-49 to 4 percent among women age 15-19. Overall, two-thirds of Tanzanian women currently age 25-49 were married by age 20. Between 1991-92 and 1996, the median age at first marriage increased from 17.9 to 18.2 years among women age 25-49 (Figure 4).



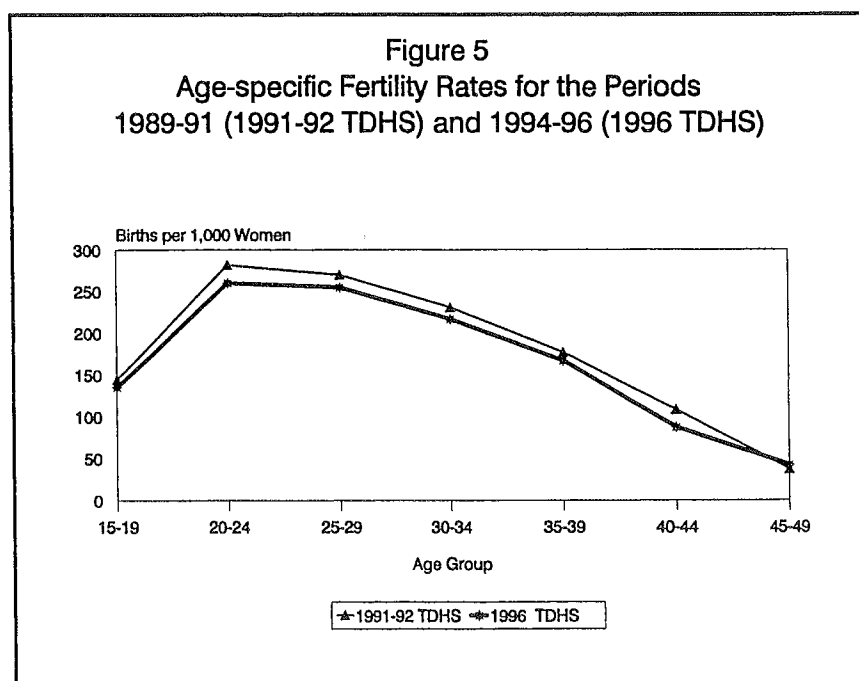
Men enter their first union at a much later age than women; the median age at first marriage among men 30-59 is 25 years, compared with 18 years for women 25-49. Only 14 percent of men are married by age 20, compared with 67 percent of women 25-49. By age 25, which is the median age at first marriage for men, 89 percent of women have married.

Urban women marry later than their rural counterparts. The median age at first marriage among women 25-49 on the mainland is 2.4 years higher than among women on Zanzibar. The median age at first marriage for men 30-59 is about one year higher on the mainland than on Zanzibar. There are significant differentials in age at first marriage by education.

3.2 Total Fertility Rate

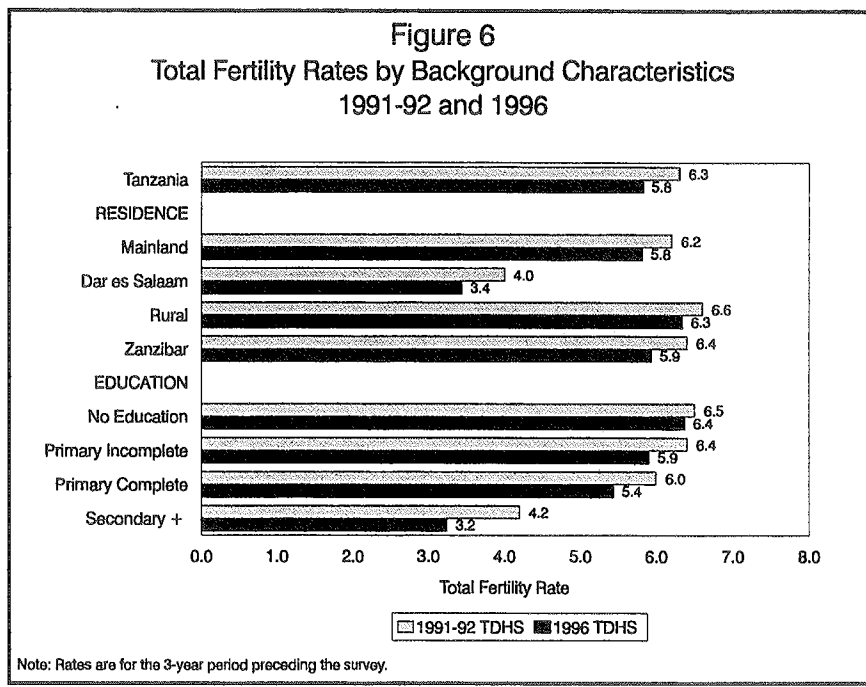
The 1996 TDHS indicates that fertility in Tanzania is declining. The total fertility rate (TFR) calculated from the 1991-92 TDHS (for the period 1989-91) was 6.3 children per woman, compared with 5.8 derived from the 1996 TDHS (for the period 1994-96). Examination of changes in age-specific fertility rates in Figure 5 shows a roughly equal decline at all ages.

The TFR in Tanzania is one of the highest in the region. The following are TFRs in selected sub-Saharan countries: Botswana (4.9), Burkina Faso (6.9), Kenya (5.4), Mali (6.7), Niger (7.4), Uganda (6.9), Zambia (6.1), and Zimbabwe (4.3).



Fertility levels are higher in rural areas (6.3) than in urban areas (4.1). Women with secondary education have the lowest fertility rate (3.2) of any subgroup. Additionally, the gap in fertility between women with no education and those with some secondary education has widened substantially. In 1991-92, women who had never gone to school had an average of 2.3 more children than women who had attended secondary school. In 1996, the difference was 3.2 children (Figure 6).

Overall, 26 percent of teenagers (age 15-19) have already begun childbearing, with 21 percent having had a child and 5 percent pregnant with their first child. These figures represent a decline in teen childbearing: the 1991-92 TDHS reported that 23 percent of women age 15-19 were already mothers, and 6 percent were pregnant with their first child.

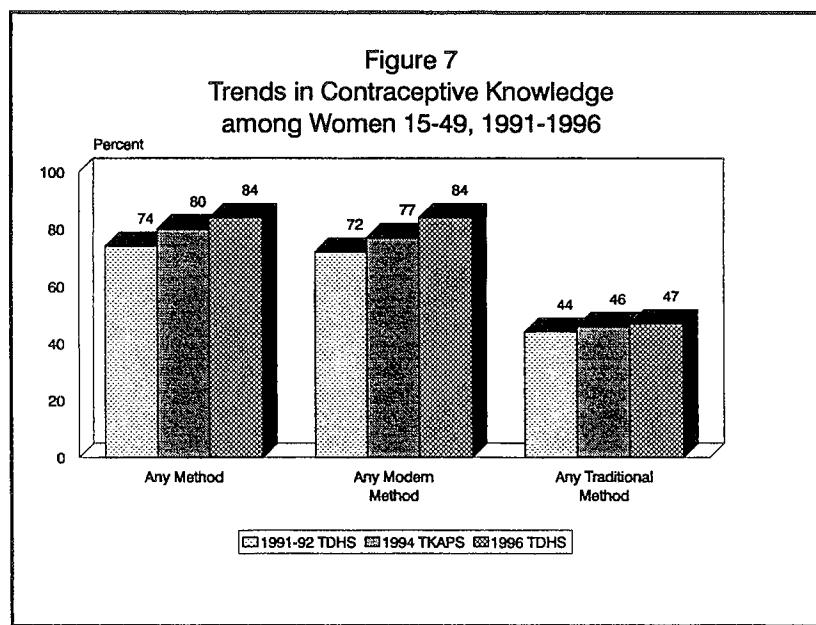


4 Family Planning

4.1 Knowledge of Contraception

More than 80 percent of women and men know of at least one modern method of family planning. Among women, the pill is the best-known method (78 percent), while among men, the condom is the best-known method (86 percent).

There has been some increase over time in the proportion of women and men who have heard of family planning methods (Figure 7). The proportion of all women who have heard of at least one method has increased from 74 percent in 1991-92 to 80 percent in 1994 and to 84 percent in 1996. The proportion who have heard of a modern method increased from 72 percent in 1991-92 to 77 percent in 1994 and to 84 percent in 1996. Knowledge of specific methods has increased even more dramatically. For example, in 1991-92 only 40 percent of women had heard of injectables; by 1996, this figure had increased to 71 percent. Similarly, the proportion of women who had heard of condoms rose from 51 percent of married women in 1991-92 to 72 percent in 1996.



4.2 Ever Use of Contraception

Among women who have ever used contraception, modern methods are more popular than traditional/folk methods (23 percent and 15 percent, respectively). The modern methods used most frequently by women are the pill (15 percent), condoms (7 percent), and injectables (6 percent); the traditional methods used most frequently are withdrawal (9 percent) and the calendar/mucus method of periodic abstinence (8 percent). Ever use of contraception among men is about the same for modern (26 percent) and traditional methods (24 percent). The most frequently used methods among men are condoms (18 percent), calendar/mucus method (17 percent), and withdrawal (14 percent).

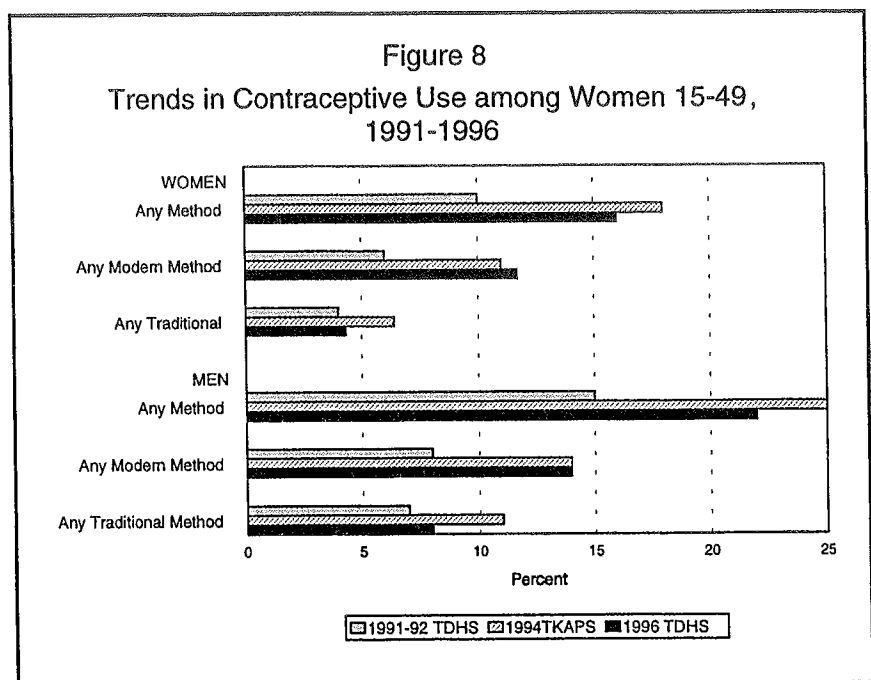
As with contraceptive knowledge, ever use of modern contraceptive methods has increased moderately since 1991-92. In 1991-92, 14 percent of women had used a modern method at some time, compared with 21 percent in 1994 and 23 percent in 1996. Increases in ever use were greatest for injectables. Among men, ever use of modern methods increased from 24 to 26 percent between 1994 and 1996.

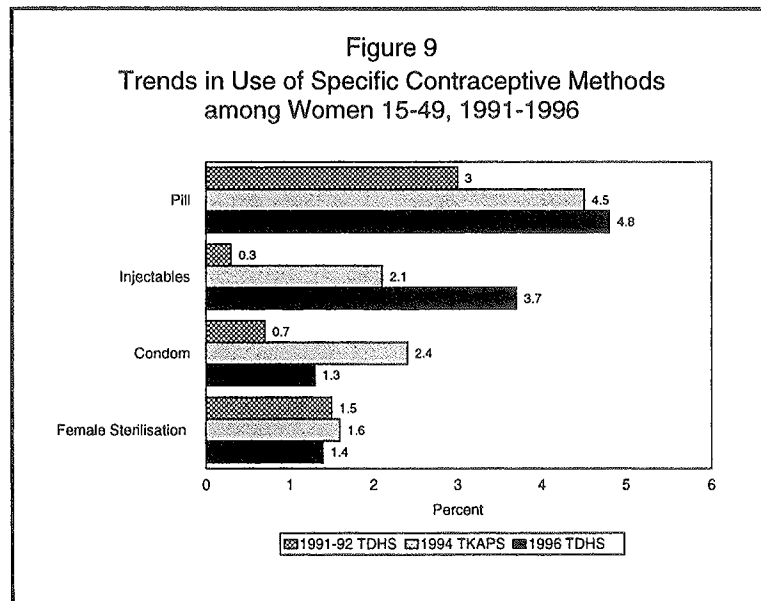
4.3 Current Use of Family Planning

Sixteen percent of all women in Tanzania are currently using a contraceptive method, and 12 percent are using modern methods. The most widely used methods are the pill (5 percent) and injectables (4 percent). Current use among men is slightly higher than among women: 22 percent of men in Tanzania are currently using contraception (14 percent modern methods and 8 percent traditional methods). The condom is the method most frequently used by men (7 percent), followed by the calendar/mucus method (6 percent).

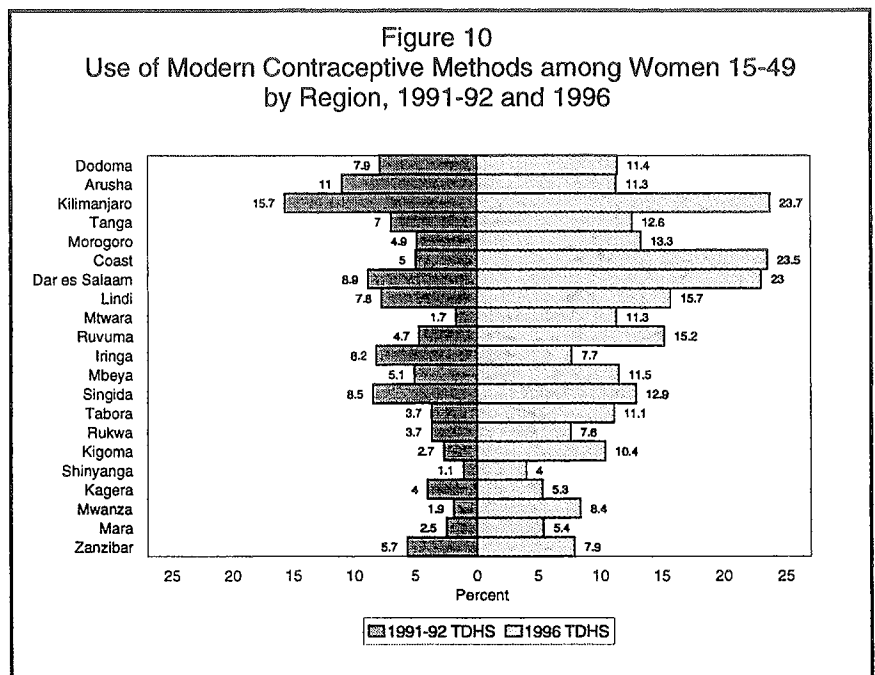
Contraceptive use among women has increased since the 1991-92 TDHS, from 10 to 16 percent for use of any method and from 6 to 12 percent for use of a modern method (Figure 8).

Injectables have had the largest increase, from less than 1 percent to 4 percent (Figure 9). Among men, use of modern methods increased from 8 to 14 percent. The 1996 TDHS data indicate a slight decline in contraceptive use among women since 1994—from 18 to 16 percent. This is due to a decline in the use of traditional methods; use of modern methods increased slightly between 1994 and 1996. Thus, it appears that use of modern methods of contraception increased rapidly between 1991-92 and 1994 and then levelled off.





There are differences in current use between the mainland and Zanzibar by region, educational level, and number of living children. Use of modern family planning methods is lower in Zanzibar (8 percent) than on the mainland (12 percent). On the mainland, urban women are much more likely to be using modern contraceptive methods (24 percent) than rural women (8 percent). Levels of current use of modern family planning methods are highest in Kilimanjaro, Coast, and Dar es Salaam regions (23-24 percent) and lowest in the Shinyanga, Kagera, and Mara Regions (4-5 percent). Coast Region experienced the largest increase in use of modern methods, from 5 percent in 1991-92 to 24 percent in 1996. However, with the exception of Iringa, all regions showed substantial increases in the use of modern methods (Figure 10).



4.4 Source of Supply for Family Planning Services

Overall, contraceptive users in Tanzania are more likely to obtain their methods from the public sector than from a private provider. About three-fourths of women currently using modern contraceptives obtained their method from the public sector, including government and district hospitals (24 percent), government health centres (22 percent), and government dispensaries or parastatal facilities (28 percent). Private medical sources account for 18 percent of current users. Community-based distribution (CBD) workers supply nearly 2 percent of modern methods.

The source of family planning methods varies according to the type of method used. The public sector is the principal source for the pill, IUD, injectables, and female sterilisation, while the private sector is the principal source for condoms; more than half of condom users obtained their method from pharmacies and shops. There is little change in the sources of family planning methods since the 1991-92 TDHS.

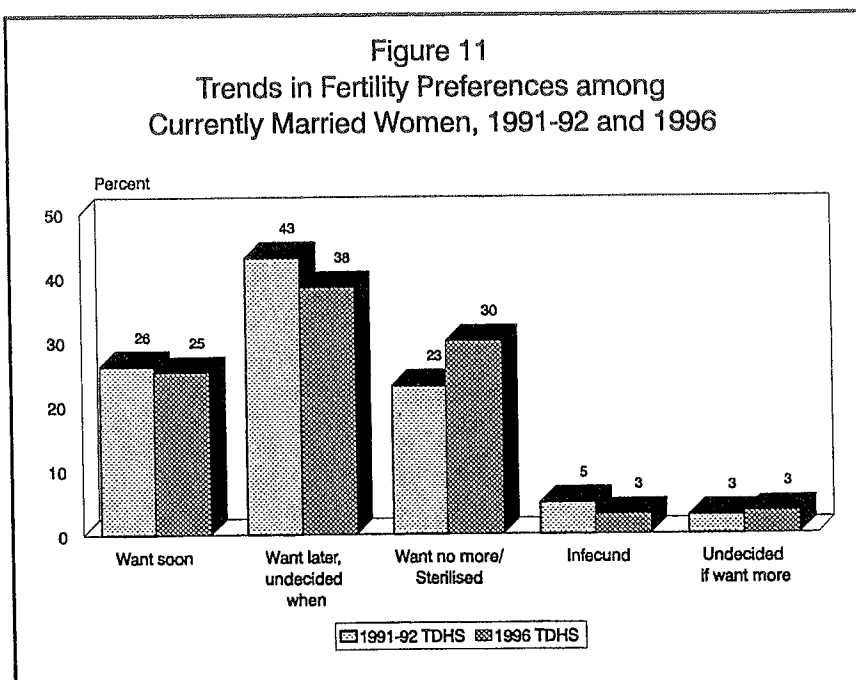
5 Fertility Preferences

5.1 Desire for Children

Although most women and men say they want to have more children, 33 percent of women and 39 percent of men say they want to wait two or more years before having their next child. These women and men can be considered potential users of contraception for the purpose of *spacing* births. Twenty-six percent of women and 13 percent of men say they want no more children; they can be considered potential users of contraception for the purpose of *limiting* their family size.

Twenty-two percent of women and 24 percent of men say they want to have another child soon, while 15 percent of women and 21 percent of men are unsure about whether or not they want another child or are undecided on the timing of the next birth. A small proportion—3 percent of women and 1 percent of men—believe they cannot have any more children.

Results indicate that there has been a downward trend in the desire for more children. The proportion of married women who want no more children or are sterilised increased from 23 to 30 percent (Figure 11). Among married women with six or more children, the proportion who want to have another child declined from 28 percent in 1991-92 to 20 percent in 1996.



It is estimated that if all unwanted births were eliminated, the total fertility rate in Tanzania would be 5.1 children per woman. This *wanted* fertility rate has declined from 5.6 in 1991-92 to 5.1 in 1996, suggesting a move toward smaller family norms.

5.2 Ideal Number of Children

Another measure of fertility preferences is ideal family size—the number of children a woman would like to have if she could start her life over again. More than half of all women report five or more children as ideal and another 23 percent want four children. Overall, women report a mean ideal family size of 5.5 children, compared with 5.9 for men.

Despite the high fertility preferences reported in Tanzania, data indicate that there has been a gradual decline in mean ideal family size among women, from 6.1 children in 1991-92 to 5.5 in 1996 (Figure 12).

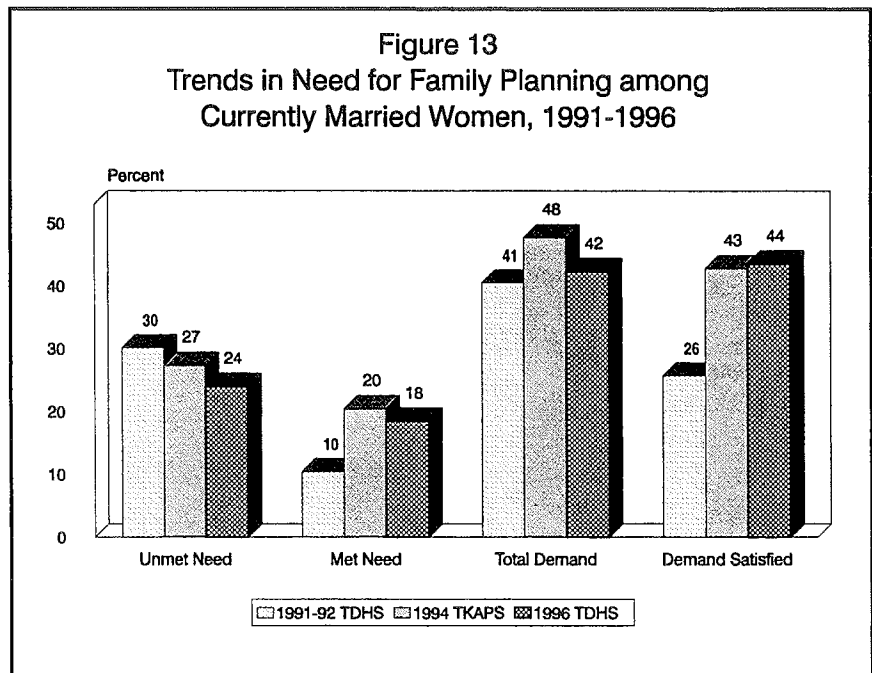
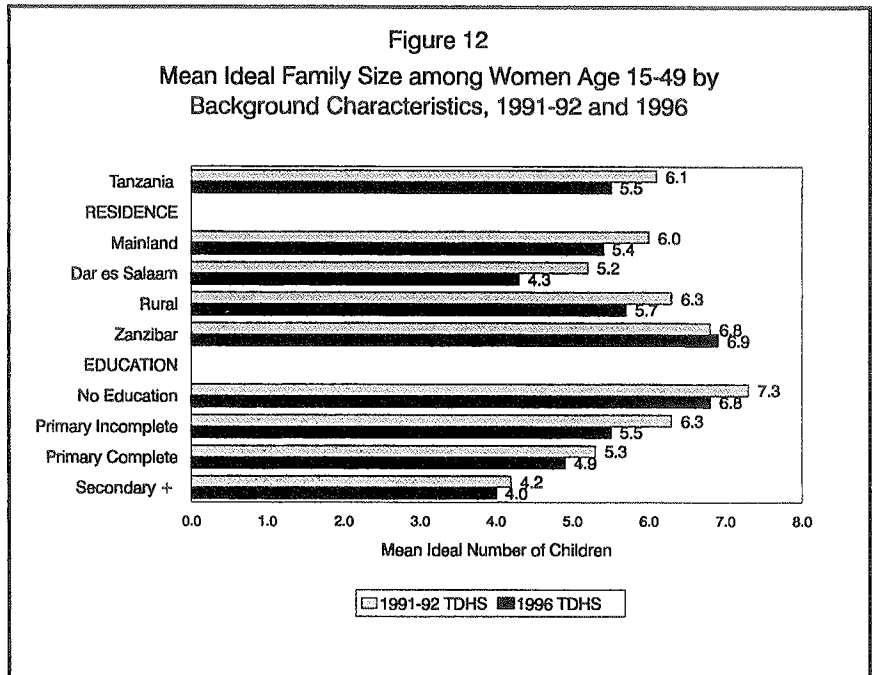
Ideal family size increases substantially with age, from 4.5 for women age 15-19 to 6.9 for women 45-49; the pattern is similar for men. In 1991-92 the ideal family size was 5.5 for women age 15-19 and 7.5 for women age 45-49. Highly educated women exhibit a low mean ideal family size (4.0 children), while those with no education have a high mean ideal family size (6.8 children). Similar differentials were observed in 1991-92.

5.3 Unmet Need for Family Planning Services

Unmet need for family planning is defined as the percentage of currently married women who do not use family planning despite the fact that they do not want any more children or want to delay their next birth. According to this definition, in 1996, 24 percent of married women in Tanzania had an unmet need for family planning—15 percent for spacing and 9 percent for limiting births. Unmet need for all women is 19 percent.

Combined with the 18 percent of married women 15-49 who are currently using contraception (met need for family planning), the total demand for family planning is 42 percent. Thus, if married women who say they want to space or limit births were to use contraceptive methods, the contraceptive prevalence rate in Tanzania would more than double—from 18 to 42 percent.

Figure 13 shows that unmet need for family planning among currently married women has declined from 30 percent in 1991-92 to 24 percent in 1996 and the total demand satisfied has increased from 26 percent to 44 percent during the same period.



6 Maternal and Child Health

6.1 Antenatal Care

Antenatal care is almost universal in Tanzania. In most cases, it is provided by a trained nurse or midwife (43 percent), or a health aide (40 percent). More women are receiving antenatal care from a health aide than previously. In 1991-92, mothers received antenatal care from a trained nurse or midwife for 56 percent of births, while health aides provided care to 30 percent of mothers.

For 70 percent of the births in the five years before the 1996 survey, mothers made four or more antenatal care visits and for 23 percent of births they made between two and three visits. For 2 percent of births women did not make any antenatal visits. (The recommended number of antenatal care visits is 12.) There has been very little change in this pattern since 1991-92.

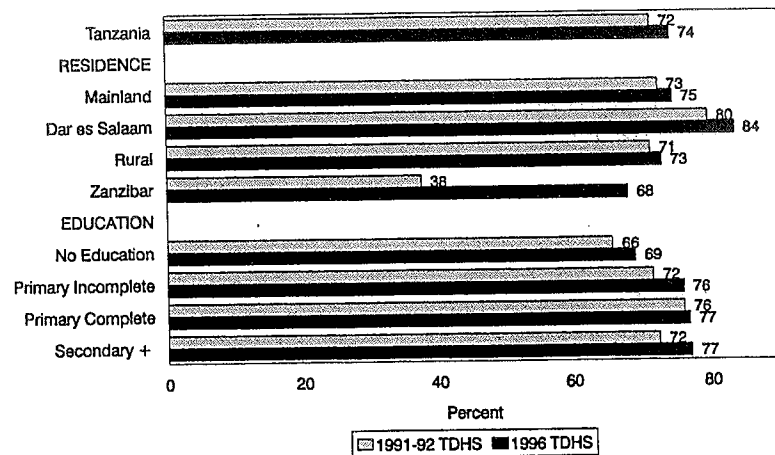
As in 1991-92, the median duration of pregnancy at the time of the first antenatal care visit was 5.6 months. If mothers are to receive the benefits of antenatal care, they need to start seeking care earlier.

6.2 Tetanus Toxoid Coverage

Tetanus toxoid injections are given during pregnancy for the prevention of neonatal tetanus—one of the principal causes of death among infants in developing countries. Generally, two doses of tetanus toxoid are given during pregnancy, with five doses considered lifetime protection.

In Tanzania, almost all women (91 percent) received a tetanus toxoid vaccination during pregnancy, with women receiving two or more doses for almost three-quarters of births and one dose for 17 percent of births. The proportion of mothers who received two or more doses of tetanus toxoid has increased slightly since 1991-92 TDHS (from 72 percent to 74 percent) (Figure 14).

Figure 14
Tetanus Toxoid Coverage by Background Characteristics
1991-92 and 1996



Note: Percentage of births in the 5 years preceding the survey for which the mother received two or more tetanus toxoid injections.

6.3 Place of Delivery

Half of births in Tanzania take place at home and half in a health facility. While all births in a health facility are attended by medically trained personnel, home deliveries are often attended by relatives who may not have received training.

The proportion of births delivered in a health facility decreases with mothers' age and birth order. Urban births are much more likely to take place in health facilities than rural births. Births on the mainland are more likely to take place in a health facility than those on Zanzibar (47 and 31 percent, respectively). The corresponding figure for the 1991-92 TDHS are 53 and 33 percent, respectively.

Comparison of the 1991-92 TDHS and the 1996 TDHS shows that the proportion of births delivered in health facilities has declined from 53 to 47 percent.

6.4 Breastfeeding

The 1996 TDHS results indicate that breastfeeding is almost universally practised in Tanzania, with 97 percent of babies being breastfed for at least some time. The median duration of breastfeeding is 22 months and has remained unchanged since 1991-92.

Although bottle feeding is not commonly practised in Tanzania, its use has increased since 1991-92. Among children still breastfeeding, the level of bottle feeding was 7 percent for those age 2-3 months in 1991-92 and increased to 14 percent for this age group in 1996.

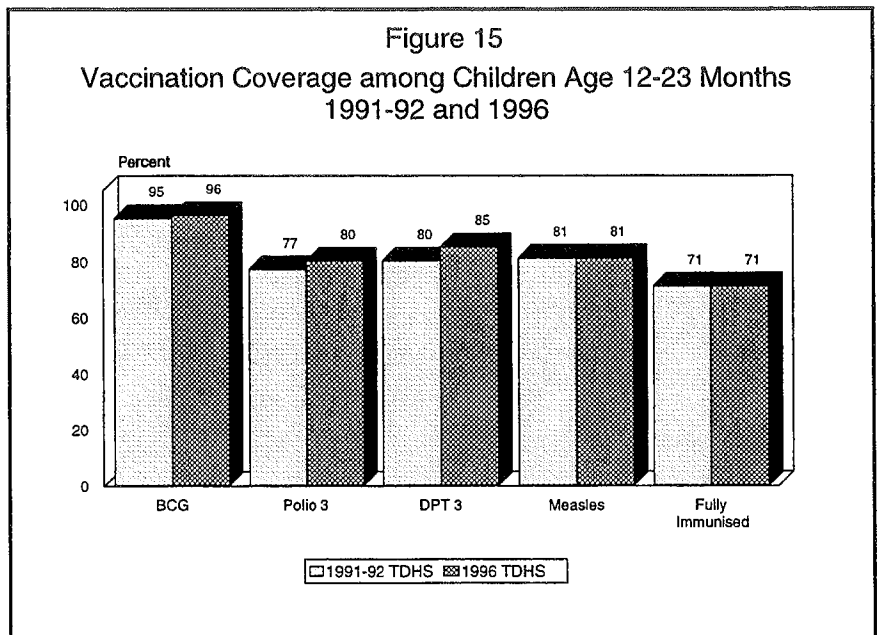
Data show that about 60 percent of the children were breastfed within an hour of birth and 88 percent in the first 24 hours after delivery. Though exclusive breastfeeding is recommended until 4-6 months of age, 77 percent of children age 4-5 months receive complementary foods. This is the same as in 1991-92.

6.5 Child Immunisation

In TDHS surveys, information on vaccination coverage was collected in two ways: from vaccination cards shown to the interviewer and from the mother's verbal report. The 1996 TDHS results indicate that 71 percent of children age 12-23 months have received all the recommended vaccinations,¹ while 3 percent received no vaccinations. The remaining 26 percent of children were partially vaccinated.

Vaccination coverage is higher in Zanzibar than on the mainland. Less than half of the children age 12-23 months were fully vaccinated in Shinyanga Region, compared with 94 percent in Kilimanjaro Region. Immunisation coverage increases as mother's level of education increases, from 58 percent for children whose mothers have no formal education to 77 percent for those whose mothers have completed primary education or higher.

Although the proportion of children fully immunised has remained at 71 percent since 1991-92 (Figure 15), the dropout rate between the first and third dose of DPT vaccine has declined from 15 to 10 percent.



¹ The recommended vaccinations are BCG, measles, and three doses of DPT and polio (excluding polio 0).

7 Nutritional Status of Mothers and Children

7.1 Mothers' Nutritional Status

The 1996 TDHS included anthropometric measurements for children under age 5 and their mothers. Indicators used to measure mothers' nutritional status are mean height, mean weight, and body mass index (BMI).²

The average height of mothers in Tanzania is 156 centimetres (cm), which is well above the cutoff point of 145 cm, below which a woman is considered too short. Stunted growth is usually a result of chronic malnutrition in childhood. The average height of Tanzanian mothers has not changed since 1991-92. Only about 3 percent of mothers are shorter than 145 cm.

The fact that mothers' mean BMI has also remained the same since 1991-92 is an indication that nutritional status has changed little over the period.

Overall, there is little variation in maternal height and body mass measures among Tanzanian women by background characteristics; however, there have been major improvements in Morogoro, Coast, and Mtwara regions since 1991-92.

7.2 Children's Nutritional Status

The measurements for children include height (or length, for children under two years of age) in centimetres and weight in kilograms.

Three indices were constructed to measure the children's nutritional status: *height-for-age* to measure the level of stunting, *weight-for-height* to measure wasting, and *weight-for-age* to measure underweight. Height-for-age is an indicator of linear growth retardation. In 1996, 43 percent of children under age five were classified as stunted (18 percent severely stunted). Results show that the proportion of children under age five exhibiting chronic malnutrition or stunting (low height-for-age) has been stable at 43 percent since 1991-92.

On the mainland, stunting is more prevalent among children in rural areas than among their urban counterparts: 46 percent of rural children are stunted, compared with 33 percent of urban children. The proportion of stunted children is highest in Iringa Region (71 percent) and lowest in Tabora Region (26 percent). The proportion of stunted children ranges from 49 percent among children whose mothers have no education to 24 percent among those whose mothers have some secondary education.

The weight-for-height index (wasting) is used to measure recent nutritional status. Severe wasting represents failure to receive adequate nutrition in the period immediately preceding the survey and may be the result of recent illness or of seasonal variations in the food supply. Overall, there has been little change in the prevalence of wasting in Tanzania since 1991-92—6 percent, compared with 7 percent in 1996.

² Body Mass Index (BMI) also known as the Quetelet Index, is defined as weight in kilograms divided by the square of the height in metres (kg/m^2). The main advantage of the BMI is that it does not require a reference table compiled from a well-nourished population. A person with a BMI of less than 18.5 is said to suffer from chronic energy deficiency.

8 Infant and Child Mortality

8.1 Trends in Infant and Child Mortality

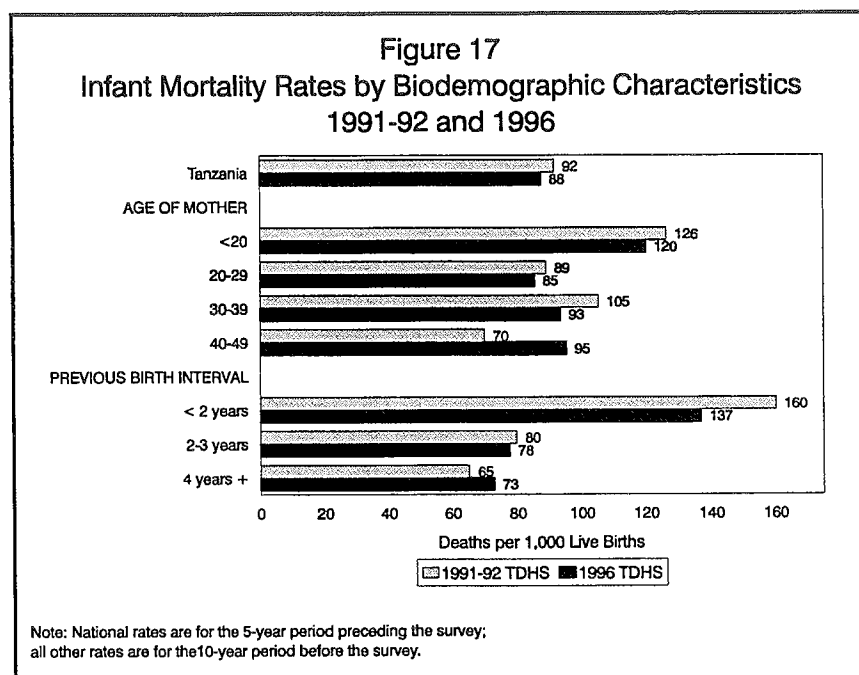
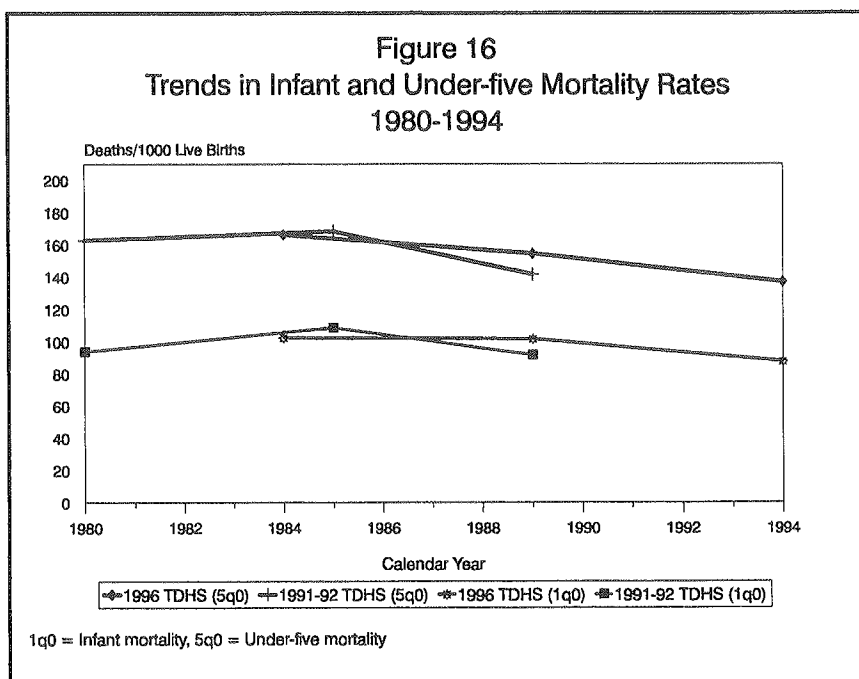
At current mortality levels, one in every seven children born in Tanzania will die before the fifth birthday, with two-thirds of the deaths occurring during the first year of life. Results from the 1996 TDHS suggest a marked decline in child mortality over the years preceding the survey.

All mortality rates with the exception of postneonatal mortality have declined in the 5 years between the 1991-92 TDHS and 1996 TDHS. For example, the infant mortality rate has declined from 92 to 88 deaths per 1,000 births and under-five mortality has declined from 141 to 137 (Figure 16).

8.2 Differentials in Infant and Child Mortality

In the 10 years preceding the survey, infant mortality was about 14 percent lower and under-five mortality was 19 percent lower in urban than in rural areas on the mainland. Infant mortality rates were the lowest (41 per 1,000 live births) in the northern highlands area. With the exception of this area, infant mortality is about 100 per 1,000 live births. However, childhood mortality has declined since the 1991-92 TDHS in all areas except the southern highland areas of the country. The largest decline in infant mortality has been observed in the central areas of the country.

As in 1991-92 TDHS, the 1996 TDHS data indicate that short birth intervals significantly reduce a child's chance of survival. Children born less than two years after a preceding sibling are almost twice as likely to die in infancy as those born four or more years after a preceding sibling (137 vs. 78 per 1,000 in 1996 and 160 vs. 80 in 1991-92) (Figure 17).



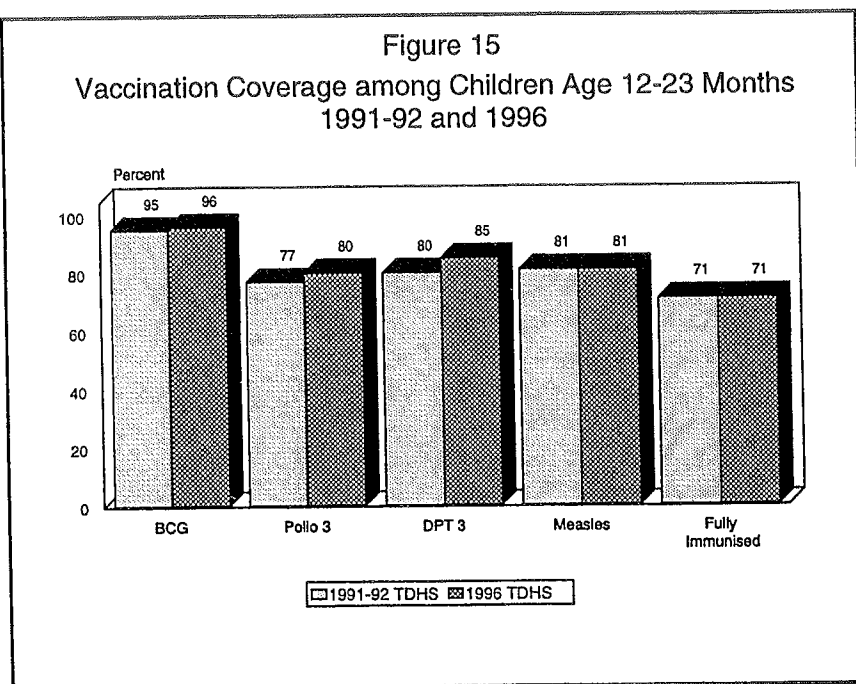
9 Sexually Transmitted Diseases

Like the 1994 TKAPS, the 1996 TDHS collected detailed information about women and men's knowledge of sexually transmitted diseases (STDs) including AIDS, perception of their risk of getting AIDS, sources of information about AIDS, and sexual practices relating to prevention of AIDS.

According to the 1996 TDHS, AIDS is by far the most widely known STD among respondents. Without probing, more than 80 percent of women and men reported they had heard of AIDS. The next most commonly reported STD was gonorrhoea, with 57 percent of women and 78 percent of men spontaneously reporting knowledge of the disease. This gender difference in knowledge also occurs regarding knowledge of syphilis, with men more likely (72 percent) than women (51 percent) to mention this disease. Fifteen percent of women and 7 percent of men could not cite a single STD.

Two percent of women and 8 percent of men reported having had an STD in the year prior to the 1996 survey. These levels are likely to be underestimates of the true prevalence for two reasons. First, STD cases may go unrecognized by respondents, and, perhaps more important, many respondents will not report a recent STD because of the perceived social stigma. Since the 1994 TKAPS, the prevalence of STDs has remained the same for women and has increased from 4 to 8 percent for men.

Similar to the findings in the 1994 TKAPS, the most commonly mentioned sources of information about AIDS are radio and friends or relatives, with 64 percent of women and 87 percent of men citing radio as a source, and 65 percent of women and 55 percent of men mentioning friends or relatives as a source of AIDS information (Figure 18). Men are more likely than women to cite newspapers and pamphlets as sources of AIDS information. On the other hand, women are more likely than men to receive information about AIDS from health workers. Religious institutions such as churches and mosques are also sources of information on AIDS, as are schools. About 7 to 9 percent of respondents have received information from religious institutions or from school.



Among respondents who have heard of AIDS, one-third either believe that there is no way to avoid AIDS or do not know if there is any way to avoid AIDS. Thirty-nine percent of women and 55 percent of men cite use of condoms as a way to avoid AIDS; this is an improvement since 1994, when only 36 percent of women and 49 percent of men cited condoms as an AIDS prevention measure. One-fourth say that having only one partner is a way to avoid contracting the disease, and 20 percent of women and 17 percent of men report that limiting the number of sexual partners can prevent AIDS. Fifteen percent of women and 22 percent of men say that abstaining from sex can protect against getting the AIDS virus. Seventy percent of women and 79 percent of men know that it is possible for a healthy-looking person to have AIDS. This indicator has not changed significantly since the 1994 TKAPS, when 69 percent of women and 78 percent of men reported knowing it is possible for a healthy-looking person to have the AIDS virus.

The proportion of women who believe they are at risk of being infected with the AIDS virus has increased from 20 percent in 1994 to 24 percent in 1996. More than half of women and 45 percent of men reported that sticking to one sexual partner or limiting the number of sexual partners is the reason for their low risk. Men (15 percent) are more likely than women (4 percent) to report that condom use is the reason for their low risk of getting AIDS. More respondents in the 1996 TDHS reported that their risk of getting AIDS was low or nil because of abstaining from sex than in the 1994 TKAPS.

Women and men are changing their behaviour in order to avoid getting AIDS. In 1994, 74 percent of women said they had changed their sexual behaviour in order to avoid AIDS; by 1996, this proportion had increased to 82 percent. Among men, the proportion increased from 88 to 91 percent.

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