# Fast facts

<table>
<thead>
<tr>
<th>Children age less than 5 years</th>
<th>Women age 15-49 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stunting&lt;sup&gt;1&lt;/sup&gt;</td>
<td>42%</td>
</tr>
<tr>
<td>Wasting&lt;sup&gt;1&lt;/sup&gt;</td>
<td>5%</td>
</tr>
<tr>
<td>Anaemia&lt;sup&gt;2&lt;/sup&gt;</td>
<td>69%</td>
</tr>
<tr>
<td>Iron deficiency&lt;sup&gt;2&lt;/sup&gt;</td>
<td>35%</td>
</tr>
<tr>
<td>Vitamin A deficiency&lt;sup&gt;2&lt;/sup&gt;</td>
<td>33%</td>
</tr>
<tr>
<td>Undernutrition</td>
<td>11%</td>
</tr>
<tr>
<td>Iodine deficiency</td>
<td>36%</td>
</tr>
<tr>
<td>Anaemia</td>
<td>40%</td>
</tr>
<tr>
<td>Iron deficiency</td>
<td>30%</td>
</tr>
<tr>
<td>Vitamin A deficiency</td>
<td>37%</td>
</tr>
</tbody>
</table>

Source: TDHS 2010; TDHS Micronutrients 2010.

<sup>1</sup> Children 0-59 months.

<sup>2</sup> Children 6-59 months.
Poor Nutrition Undermines Development

Tanzania has made striking progress in many health indicators over the past decade, but not nutritional status. Stunting currently affects 42 percent of under five children, and is only a two percentage points lower than it was five years ago. Child underweight (16 percent) also remains at unacceptable levels, and the country is not on track to achieve the MDG 1 target to reduce underweight by one-half by the year 2015. There are pockets of very high acute malnutrition, including Zanzibar where 12 per cent of children are affected. About one third of children age 6-59 years are iron deficient and vitamin A deficient, 69 percent are anaemic, and over 18 million Tanzanians do not consume adequately iodized salt.

Inequities in child nutrition continue to persist. Children in the lowest household wealth quintile record the greatest stunting levels (48 percent) compared with children from the highest wealth quintile (26 percent).

The nutrition situation of adolescent girls and women in Tanzania is also alarming. About one third of women age 15-49 years are deficient in iron, vitamin A and iodine, two fifths of women are anaemic and one in ten women are undernourished. Malnourished adolescent girls and women are more likely to give birth to low birth weight infants, who are malnourished in childhood and later life, thus transferring undernutrition from one generation to the next.

The high levels of stunting in the country, affecting over 3 million children, constitute a silent emergency. Stunting does not generally receive the same attention as acute malnutrition or underweight because the effects are hidden and the threats to health and survival are not immediate. However, the consequences of stunting are serious and long-lasting. In fact, height at the age of two years is the strongest predictor of future human capital.

The World Health Organization regards stunting as ‘very high’ if it is greater than 40 percent in a population. This threshold is exceeded in fourteen regions of the country. The five regions with the highest stunting include Iringa, Mbeya and Rukwa which are all areas with high food crop production. The common assumption that increasing agriculture food production will automatically lead to improvements in nutrition is therefore not valid.

There are many causes of stunting and other forms of undernutrition, not just a lack of food. Children become malnourished if they suffer diseases that cause undernutrition or if they are unable to eat sufficient nutritious food. These two causes – diseases and inadequate dietary intake and – often occur together and are caused by multiple underlying factors including inadequate physical or economic access to food, poor health services, an unhealthy environment and inadequate caring practices for children and women. More basic causes include poverty, illiteracy, low status of women, social norms and behaviours.

Trends in childhood mortality
(Deaths per 1,000 live births: TRCHS, TDHS)

147
99
112
68
81
51
26

1999
2004–2005
2010

Under-5 mortality (before 5th birthday)
Infant mortality (before 1st birthday)
Neonatal mortality (0–28 days)

Trends in nutritional status of children under-5

TDHS 2004–2005
TDHS 2010

Stunting
Wasting
Underweight

44%
4%
17%

42%
5%
16%

Trends in exclusive breastfeeding by age
(TDHS, 2010)

80%
51%
23%

0–1 month
2–3 months
4–5 months

Age of infant
Two of the most important caring practices for good nutrition in early life are breastfeeding and complementary feeding. Breast milk provides all of the nutrients, vitamins and minerals an infant needs for growth for the first six months, and no other liquids or food are needed. At 2-3 months, only 51 per cent of infants are exclusively breastfed, and this falls to 23 per cent by the age of 4-5 months. The duration of exclusively breastfeeding is on average only 2.5 months in mainland Tanzania and 2 weeks in Zanzibar. Complementary foods given to children are often carbohydrate-based and lack sufficient protein, minerals and vitamins. Many mothers lack the knowledge and support from other family members to exclusively breastfeed and feed their young children in the best way possible.

**WHY NUTRITION MATTERS**

In Tanzania, an estimated 130 children die every day because they are malnourished. These children rarely starve to death, and their plight seldom makes headline news. They die because their immune systems are weakened through lack of essential nutrients, and so they easily succumb to common childhood diseases that they would otherwise be able to fight.

Beyond these daily tragedies, there are millions of children who fail to reach their potential because they have been deprived of essential nutrients for healthy growth and brain development. Children from communities that are iodine deficient can lose an average of 13.5 IQ points, and iron deficiency makes them tired and slow. Undernourished children often miss and do less well at school, and are less productive in later life because short and weak adults cannot work as hard, making it very difficult for poor households to escape from poverty.

The threats of undernutrition to the economic growth of Tanzania are considerable. Recent analysis determined that vitamin and mineral deficiencies alone cost Tanzania TZS 650 billion (about USD 390 million) in lost revenue each year, equivalent to 2.65 percent of GDP. Most of these losses are within the agriculture sector (almost TZS 400 billion), where physical stature and strength are critical to productivity.

**WHAT IS UNICEF DOING**

UNICEF is a leading advocate for nutrition in Tanzania. UNICEF works with government and partners to ensure nutrition is positioned within the country’s national and sectoral plans and strategies, and in supporting districts to translate the National Nutrition Strategy to effective action for children on the ground. Under the United Nations Development Assistance Plan (2011-2015) UNICEF has a lead role in strengthening the capacity of all sectors, in particular the health sector as well as civil society, to improve the nutritional status of children and women.

**Positioning nutrition on the development agenda**

UNICEF is playing a key role in raising the profile of nutrition within the political leadership, and ensuring national plans and strategies include nutrition priorities. With technical support from UNICEF, nutrition is firmly anchored in current poverty reduction strategies for mainland Tanzania and Zanzibar and the National Nutrition Strategy (2011-2016) is now in place.

UNICEF works by establishing and maintaining collaborative partnerships among government agencies, development partners, civil society and the private sector that are vital to positioning nutrition high on the political and development agenda. UNICEF is supporting the Prime Minister’s Office in leading the newly formed High Level Steering Committee for Nutrition. This Steering Committee brings together senior government officials from over ten central ministries with development partners to agree on action to combat the country’s most pressing nutrition challenges. UNICEF also initiated the formation of a multi-sectoral Technical Working Group on Nutrition and is leading the Development Partners Group on Nutrition.

UNICEF has catalysed the formation of a civil-society led Partnership for Nutrition to harness the collective support of organizations operating at both the district and national level in advocating for increased commitments and actions for nutrition. UNICEF also encourages stronger alliances between private sector enterprises, including salt producers for salt iodization.
Scaling up essential nutrition interventions and services

In partnership with the government, UN agencies and other actors, UNICEF aims to scale-up proven, high impact, cost-effective nutrition interventions to reduce undernutrition. These interventions include vitamin and mineral supplementation, the promotion of breastfeeding and complementary feeding, and the treatment of severe acute malnutrition, amongst others.

UNICEF’s top priority is to ensure that local government authorities genuinely own and effectively lead their work to improve nutrition status. This is critical if actions are to be sustained. UNICEF advocates with district health departments to ensure they prioritize nutrition, and works with them to build their skills in planning, budgeting and coordinating the delivery of nutrition services for children and women.

The government has recently introduced a new cadre of nutrition officers at district and regional level. UNICEF is working with the government to develop an in-service training program for these officers so that they have the knowledge, skills and competencies to function as effective managers.

UNICEF assists the district health departments in building the skills of health services providers in delivering services to children and women. In addition, UNICEF works through district health and community development departments, health providers and communities in the field, to help families learn essential skills and basic knowledge in the nutritional care of young children. This includes best practices in breastfeeding and complementary feeding, the promotion of iodized salt consumption, and health-seeking behavior.

UNICEF works with the MoHSW and with districts to ensure that vital nutrition supplies and equipment are available in health facilities, including vitamin A supplements, deworming tablets, highly nutritious therapeutic foods to treat severe acute malnutrition, and equipment to measure nutrition status.

Essential nutrition interventions and services

- Supplement children and women with vitamins and minerals to prevent deficiencies
- Support and promote breastfeeding and complementary feeding
- Treat severe acute malnutrition as a medical emergency
- Prevent and treat diseases that precipitate malnutrition
- Fortify foods with vitamins and minerals, and salt iodization
- Nutrition-sensitive agriculture and livestock policies and programmes
- Safety nets and social cash transfers to help the poorest families
- Early warning and response to nutrition crises

Mitigating the impact of emergencies on nutrition

UNICEF is responsible globally and in Tanzania for ensuring an effective humanitarian response in nutrition to emergencies. Building in-country capacity to respond is vital as Tanzania suffers multiple small-scale emergencies such as drought, flooding, and cholera. Almost all emergencies threaten nutritional status, often by creating unhealthy living environments and disease outbreaks, destroying agricultural production and livelihoods, and impairing the ability of caregivers to provide adequate care for children and women. UNICEF is one of the first aid organizations on the scene following the outbreak of an emergency.

UNICEF plays a lead role in maintaining emergency stocks of nutrition supplies and equipment, and in building the capacity of the government and its partners to better prepare and respond to emergencies. UNICEF’s contribution has been critical in developing a common Emergency Preparedness and Response Plan for Nutrition for the Government and all humanitarian actors in Tanzania.

Impact with equity

UNICEF’s contribution focuses on the agency’s comparative advantage in addressing capacity gaps in the nutrition sector. Poor nutrition, in particular stunting, is a key factor in determining the regions where UNICEF focuses its work. UNICEF seeks to better understand the factors that underlie the disparities in nutritional status, and to work with partners to design and introduce new approaches that ensure nutrition services reach the children and mothers who need them.

UNICEF is advocating for the inclusion of pregnant women and young children from chronically poor families among the beneficiaries of a national program to provide income support through regular cash transfers to help poor households protect consumption during periods of stress and invest in the nutrition, health and education of their offspring. UNICEF advocates for including nutrition interventions alongside the program’s cash component.
“When well-nurtured, children are more likely to grow normally, to have fewer illnesses, and to develop strong thinking, language, emotional and social skills.”

UNICEF, 2010

KEY RESULTS HEALTH AND NUTRITION BY 2015

Prioritize nutrition in policies, plans and budgets
• Support government to ensure nutrition is adequately reflected in national and sectoral plans and strategies.
• Support improved coordination structures for nutrition and a civil-society led partnership for nutrition.
• Support development of national technical guidelines on nutrition, and national communication strategies to promote health and nutrition behaviours.
• Advocate for the reduction of inequities in access to nutrition services.
• Leverage resources for scaling-up nutrition services for children and women.

Nutrition in emergencies
• Preposition emergency nutrition supplies and equipment in strategic locations for a population of 50,000 for rapid deployment in the event of an emergency.
• Build the capacity of the government and its partners to provide essential nutrition services to children and women affected by emergencies.

Enhancing equity
• Target nutrition interventions to regions and districts with high prevalence of child stunting, and integrate them with other key interventions in the areas of maternal and child health, water, sanitation and hygiene.
• Analyse budget allocations and expenditures on nutrition, to benchmark the amount of resources necessary for achieving the priorities set in the National Nutrition Strategy.
• Integrate nutrition concerns into the design and roll-out of a national social safety net program focused on extremely poor households.

FUNDING GAP (USD) 2011–2015

<table>
<thead>
<tr>
<th>Programme intervention</th>
<th>Funds required</th>
<th>Funding gap</th>
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<tbody>
<tr>
<td>Prioritization of nutrition in policies, plans and budgets</td>
<td>1,230,000</td>
<td>0</td>
</tr>
<tr>
<td>Essential nutrition services</td>
<td>8,200,000</td>
<td>7,070,000</td>
</tr>
<tr>
<td>Nutrition in emergencies</td>
<td>960,000</td>
<td>700,000</td>
</tr>
<tr>
<td><strong>Total nutrition</strong></td>
<td><strong>10,390,000</strong></td>
<td><strong>7,770,000</strong></td>
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