

THE UNTOLD STORY OF MATERNAL MORTALITY IN TANZANIA.

**The paradigm shift requiring policy and programmatic shift
Dar es Salaam. September, 2026**

1.0 Background and Context

Tanzania has made good progress in reducing maternal mortality, from 556 to 104 deaths per 100,000 live births, this corroborates with the findings from the Population and Housing Census which showed a decline from 432 to 147 per 100,000. Tanzania's TDHS-MIS estimate of 104 deaths per 100,000 live births. While the average shows steady decline, the question remains who is still dying, what are they and what can be done to reach the most vulnerable groups? This policy brief therefore examines the questions of who continues to die, where do they live, what are their sociodemographic profiles and what barriers are contributing to their risk? It also provides recommendations for strengthening equity-focused interventions.

2.0 The untold story

2.1 Geographical Inequities in Maternal Mortality

Geography is one of the most important dimensions of maternal health services inequality in Tanzania, because it determines service availability, skilled health workers available, quality of care, the reliability of referral systems etc. In 2022 Tanzania recorded a maternal mortality of 174 per 100,000 in urban areas compared to 135 per 100,000 live births in rural areas, this findings challenges the assumption that living in urban areas where hospitals are more concentrated automatically translates into better maternal survival. Urban women were over four times as likely than rural women to receive antenatal care from a doctor or assistant medical officer (18% vs 4%) , rising to 52% in Dar es Salaam).

Urban women were more likely than rural women to receive timely postnatal care- 59.8% compared with 47.0%, with the coverage varying dramatically across regions, from only 20.9% in Katavi to 86.4% in Iringa. Dar es Salaam illustrates why urban residence should not automatically be equated with equitable access; despite its concentration of health facilities and skilled providers, only 65.9% of mothers received a postnatal check within two days, while 18.4% received none

2.2 Wealth Inequities in Maternal Mortality

Household wealth represents another major dimension of protection, the findings indicate that 22.3% of recorded maternal deaths occurred among women from the poorest households, compared with 16.1% among the wealthiest (PHS 2022). Assistance by a doctor during delivery increased from 4.0% in the poorest wealth group to 27.0% in the wealthiest, while caesarean section increased from 4.1% to 23.7%. The policy challenge is therefore to ensure that ability to pay does not determine whether a woman receives timely emergency obstetric care when her life is at risk.

2.3 Educational Inequities in Maternal Mortality

Education represents a third major dimension of maternal health service access; in that it can influence a woman's knowledge, confidence, decision-making and ability to navigate the health system. Assistance by a doctor during delivery increased from 3.3% among women with no education to 19.5% among women with secondary education or higher. Caesarean section showed a similar pattern, increasing from 4.3% among women with no education to 19.8% among women with secondary education or higher.

3.0 Policy Recommendations

- 1. Health programs focus to shift from service coverage to effective, equity-adjusted coverage:** track not just whether women access care but whether they receive the right care, from the right provider, at the right time and quality, disaggregated by geography, wealth and education.
- 2. Develop targeted maternal services with the aim to best reach the most vulnerable population:** target resources to populations with the highest maternal death risk and weakest access to CEmONC, skilled providers, transport and referral, with financial, transport and information support to offset wealth- and education-related gaps.
- 3. Adopt differentiated urban, peri-urban and rural health strategies:** do not assume urban residence confers a maternal-health advantage; address urban overcrowding and quality gaps while continuing rural investment in access and referral, guided by mortality risk rather than urban–rural classification alone.

References

¹National Bureau of Statistics, United Republic of Tanzania, 2022 Population and Housing Census: Age and Sex Distribution and Administrative Units Report, Dodoma, 2023.

²Ministry of Health and National Bureau of Statistics, TDHS-MIS 2022, op. cit.

³Ministry of Health and National Bureau of Statistics, United Republic of Tanzania, TDHS-MIS 2022, op. cit.

³Ministry of Health and National Bureau of Statistics, United Republic of Tanzania, TDHS-MIS 2022, op. cit.



FUTHER INFORMATION



ed@hdt.or.tz



AFYA HOUSE | AFYA ROAD | KISOTA |
KIGAMBONI MUNICIPAL COUNCIL
P.O.Box.

65147 Dar Es Salaam, Tanzania.