

THE UNTOLD STORY OF MATERNAL MORTALITY IN TANZANIA.

The paradigm shift requires policy and programmatic shift.

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1.0 Background and Context

The 2022 TDHS-MIS estimated under-five mortality at 43 deaths per 1,000 live births, down from 67 in 2015–16 (35.8%), while infant mortality declined from 43 to 33 per 1,000 (23.3%). In contrast, neonatal mortality has changed much more slowly: the 2022 TDHS-MIS estimated neonatal mortality decreased from 25 per 1,000 live birth to 24 deaths per 1,000 in 2015–16 (4.0%). This means that the period immediately after birth is increasingly becoming one of the most important remaining gaps in Tanzania's child-survival agenda.

This policy brief examines which neonates are dying more than others based on their socio-economic characteristics. Finally it presents overarching recommendations to unlock the current inequity challenges.

2. What the Data Show: Four Equity Dimensions

2.1 Geographical Inequities in Neonatal Mortality

The 2022 TDHS-MIS estimated neonatal mortality at 27 deaths per 1,000 live births in urban areas, compared with 21 deaths per 1,000 in rural areas about 29% higher in urban areas. The 2022 RAMOS study estimated neonatal mortality Salaam city at 26 deaths per 1,000 live births, but with large differences between councils: neonatal mortality was 53 per 1,000 in Ilala compared

with only 7 per 1,000 in Ubungo more than seven times higher. Even within urban neonatal mortality calling for intra-urban strategic investment. The policy question is not simply whether urban areas have enough health facilities, but whether those facilities are ready and able to provide the right care at the right time to the mothers and newborns who need it most.

2.2 Wealth Inequities in Neonatal Mortality

Household wealth presents one of the most unexpected findings in the neonatal mortality analysis. The 2022 TDHS-MIS showed neonatal mortality increasing from 13 deaths per 1,000 live births among newborns in the poorest wealth quintile to 31 per 1,000 among those in the richest quintile. Timely newborn postnatal care increased from 40.2% among newborns in the poorest households to 66.7% among those in the richest a 26.5-percentage-point gap and the difference was even more striking in the first hour, where only 3.2% of newborns in the poorest households received a postnatal check compared with 16.1% among the richest. Wealth is thus clearly associated with how quickly newborns come under professional observation, but it does not seem to be protective.

2.3 Educational Inequities in Neonatal Mortality

Maternal education is usually expected to protect child survival because education can improve health knowledge, decision-making, care-seeking and the ability to navigate health services. The Tanzanian neonatal mortality data, however, do not show this conventional gradient, the finding indicates that neonatal mortality increases with increase in education; mothers with no education recorded 17 deaths per 1,000 and those with secondary education and above 31 per 1,000 live births. Service data show that education is associated with timely newborn care: timely postnatal care increased from 41.5% among newborns of mothers with no education to 64.7% among those whose mothers had secondary or higher education.

3. Policy Recommendations

Tanzania has made important progress in expanding maternal and newborn health services. The next policy frontier is to convert this service coverage into equitable newborn survival. The following are policy recommendations:

1. Shift from service coverage to effective, equity-adjusted newborn coverage: monitoring should go beyond whether a newborn or mother reaches a facility, and measure whether the newborn receives the right assessment, from a competent provider, at the right time, with the required equipment, medicines, referral and follow-up, disaggregated by geography, wealth, maternal education, age and place of delivery.

2. Make the first 48 hours a national newborn survival priority: every facility birth should include documented newborn assessment before discharge, including breathing, temperature, feeding and danger-sign assessment, with a clear treatment and referral pathway for newborns requiring additional care, supported by community health workers for early identification and follow-up.

3. Close socioeconomic inequities in timely newborn care: priorities poorer households with targeted transport, referral, information and post-discharge support; the large gap in timely

postnatal care between the poorest and richest households should be treated as an equity and survival indicator.

5. Adopt differentiated urban, peri-urban and rural newborn strategies: rural areas require continued investment in transport, staffing, referral and geographical access; urban and peri-urban areas require additional attention to overcrowding, high-volume maternity facilities, informal settlements, intra-urban inequality, referral coordination and quality of care.

References

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