THE UNITED REPUBLIC OF TANZANIA

NATIONAL AUDIT OFFICE

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PERFORMANCE AUDIT REPORT ON THE PROVISION OF MATERNAL HEALTHCARE SERVICES

CONTROLLER AND AUDITOR GENERAL

MARCH 2026

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About the National Audit Office

Mandate

The statutory mandate and responsibilities of the Controller and Auditor-General are provided for under Article 143 of the Constitution of the United Republic of Tanzania of 1977 and in Section 10(1) of the Public Audit Act, CAP. 418.

Core Values

Independence and Objectivity: We are an impartial public institution, independently offering high-quality audit services to our clients in an unbiased manner.

Integrity: We observe and maintain high ethical standards and rules of law in the delivery of audit services.

Results-Oriented: We focus on achievements of reliable, timely, accurate, useful, and clear performance targets.

Professional competence: We deliver high quality audit services based on appropriate professional knowledge, skills, and best practices.

Creativity and Innovation: We encourage, create and innovate value-adding ideas for the improvement of audit services.

Team Work Spirit: We value and work together with internal and external stakeholders.

PREFACE

Section 28 of the Public Audit Act, CAP. 418 gives the mandate to the Controller and Auditor General to carry out Performance Audit (Value-for-Money Audit) to establish the economy, efficiency and effectiveness of any expenditure or use of resources in the Ministries, Departments and Agencies (MDAs), Local Government Authorities (LGAs) and Public Authorities and Other Bodies which involves enquiring, examining, investigating, and reporting, as deemed necessary under the circumstances.

I have the honour to submit to Her Excellency, the President of the United Republic of Tanzania, Hon. Dr. Samia Suluhu Hassan, and through her to the National Assembly of the United Republic of Tanzania, the Performance Audit Report on the Provision of Maternal Healthcare Services in the Country.

The report contains findings, conclusions, and recommendations directed to the Ministry of Health and the Prime Minister's Office - Regional Administration and Local Government. The Ministry of Health and the Prime Minister's Office - Regional Administration and Local Government were given the opportunity to review the report and provide comments. I sincerely acknowledge that the inputs provided were constructive and valuable.

My Office will conduct a follow-up at an appropriate time to assess the actions taken in implementing the recommendations outlined in this report.

I would like to thank my staff for their commitment to preparing this report. I also acknowledge the audited entities for their cooperation with my Office, which facilitated the timely completion of the audit.

Charles E. Kichere
Controller and Auditor General
The United Republic of Tanzania
March 2026

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LIST OF ABBREVIATIONS AND ACRONYMS

BEmONC	-	Basic Emergency Obstetric and Newborn Care
CEmONC	-	Comprehensive Emergency Obstetric and Newborn Care
CHW	-	Community Health Worker
DHIS2	-	District Health Information System 2
EmONC	-	Emergency Obstetric and Newborn Care
FYDP III	-	Third Five-Year Development Plan
HSSP V	-	The Fifth Health Sector Strategic Plan
HSSP V	-	The Fifth Health Sector Strategic Plan
LGAs	-	Local Government Authorities
M&E	-	Monitoring and Evaluation
MMR	-	Maternal Mortality Rate
MoF	-	Ministry of Finance
MoH	-	Ministry of Health
MPDSR	-	Maternal and Perinatal Death Surveillance and Response
NEMLIT	-	National Essential Medicines List for Tanzania Mainland
PMO-RALG	-	Prime Minister's Office - Regional Administration and Local Government
PPH	-	Postpartum Haemorrhage
RCH	-	Reproductive and Child Health
RMNCAH	-	Reproductive, Maternal, Newborn, Child, and Adolescent Health
RPOC	-	Retained Products of Conception
SARA	-	Service Availability and Readiness Assessment
SDGS	-	Sustainable Development Goals
STG	-	Standard Treatment Guideline
WISN-POA	-	Workload Indicator of Staffing Needs – Prioritisation and Optimisation Analysis

DEFINITION OF TERMS

Basic Emergency Obstetric and Newborn Care	-	A set of essential services that health facilities provide to manage common, life-threatening complications during childbirth and immediately after birth is normally provided by dispensaries.
Comprehensive Emergency Obstetric and Newborn Care	-	Advanced life-saving services are provided at higher-level health facilities to manage severe complications during pregnancy, childbirth, and the newborn period, provided by Health centers and Hospitals.
Maternal Health	-	Any deaths that occur during pregnancy or childbirth or within 42 days after the birth or termination of a pregnancy, excluding deaths due to accidents or violence.
Maternal Mortality Ratio	-	The number of maternal deaths per 100,000 live births.
Postpartum Haemorrhage	-	Blood loss of 500 ml or more after vaginal delivery, or 1,000 ml or more after caesarean section, usually occurs within the first 24 hours after birth.
Signal Function	-	A specific set of key medical interventions used as indicators to assess a facility's "readiness" to handle obstetric emergencies.
Three Delays	-	A model identifying three barriers to care: (1) Deciding to seek care, (2) Reaching a facility, and (3) Receiving quality care at the facility.

EXECUTIVE SUMMARY

Background Information

Good health is recognised as a major resource essential for poverty eradication and economic development in the country. A healthy population contributes to national development and overall well-being. Tanzania's health sector aligns with global goals, including the Sustainable Development Goals (SDGs), particularly Goal 3, which focuses on ensuring healthy lives and promoting well-being for all ages. Despite government efforts to improve maternal healthcare, significant challenges persist in Emergency Obstetric and Newborn Care (EmONC) facilities. These include inadequate quality of care due to an insufficient number and skills of healthcare workers, inadequate infrastructure to support EmONC services, a gap in the community linkages for maternal health, and a lack of follow-up actions after regular maternal and perinatal death reviews at regional, district, and facility levels.

The main objective of the audit was to evaluate whether the Ministry of Health and the Prime Minister's Office – Regional Administration and Local Government have adequately provided maternal healthcare services in Tanzania to reduce the maternal mortality ratio to 70 per 100,000 live births by 2030, as targeted under SDG 3. The audit covered five financial years from 2020/21 to 2024/25.

Main Audit Findings

Despite substantial Government initiatives, the Audit noted a gradual decline in maternal mortality in Tanzania from 1,744 deaths in 2018 to 1,498 in 2023, representing a 14.1% reduction; however, the pace of decline remained insufficient to achieve SDG 3.1, which aims to reduce the maternal mortality ratio to 70 per 100,000 live births by 2030. Moreover, the number of deaths was noted to stay the same since 2023, with 346 cases reported in the first quarter of 2025, mainly affecting women aged 20–34 years and largely caused by preventable conditions such as postpartum haemorrhage and eclampsia. Also, the Audit noted inadequate implementation of the initiatives to reduce the maternal mortality rate by the MoH and PMO-RALG, as evidenced by underutilization of Antenatal Care (ANC) and Postnatal Care (PNC) Services and a shortage of skilled birth

attendants across the sampled region. The following shortcomings demonstrated the limited provision of maternal healthcare services in the country.

(a) Limited Availability of Emergency Obstetric Care (EmONC) Services

The audit identified inadequacies in Emergency Obstetric and Newborn Care (EmONC) services, particularly at primary and first-referral health facilities, weakening the system's ability to manage obstetric emergencies. Dispensaries providing Basic EmONC (BEmONC) suffered from equipment shortages and limited staff skills, preventing key life-saving procedures like assisted vaginal delivery and removal of retained products. While 92% of district hospitals qualified as Comprehensive EmONC (CEmONC) facilities, only 53% of health centres did so. Overall CEmONC readiness was 71%, but major gaps in anaesthesia equipment (21% availability) and in the availability of sufficient blood supply (56%) continued to hinder safe, effective emergency interventions.

The audit found that, staffing and financing constraints affected EmONC service delivery. Staff-to-mother ratios in 30 sampled facilities exceeded national standards, reaching 1:10 in labour wards and 1:20 in antenatal/postnatal wards, particularly in district hospitals, health centres, and dispensaries. These shortages originated from inadequate human resource planning, incomplete use of the Workload Indicator of Staffing Needs - Prioritisation and Optimisation Analysis (WISN-POA), and unequal urban–rural staff distribution. Additionally, declining domestic funding and increasing dependence on donors limited investment in essential EmONC equipment and supplies. Consequently, lower-level facilities struggled to manage obstetric complications, resulting in increased referrals and delays in care. During the review period, 85% of maternal deaths at Regional Referral Hospitals and 70% at District Hospitals involved referred cases, underscoring major systemic gaps in the maternal and newborn care continuum.

(b) Inadequate Maternal Mortality Data Collection, Monitoring, and Reporting

The audit noted that maternal mortality data collection, monitoring, reporting, and utilisation under the Maternal and Perinatal Death Surveillance and Response (MPDSR) system were inadequate, and therefore, the ineffective use of maternal mortality data to prevent avoidable deaths was not met. Although maternal deaths were almost fully notified, only 65% were reviewed; 49% of notified cases were not reviewed; 45% of reviewed cases lacked action plans; and 62% of action plans lacked evidence of follow-up. Documentation was inadequate at Regional Referral Hospitals, where 48% (165 of 344) of notified deaths were documented for the period 2021/22 to 2024/25, and data inconsistencies between facility registers and DHIS2 further undermined reliability. Consequently, MPDSR processes failed to generate timely, complete, and actionable information as required by the MPDSR Guidelines, 2019.

These were caused by non-functional Maternal and Perinatal Death Surveillance and Response (MPDSR) committees, delayed and irregular review meetings, staff shortages and high workloads, inadequate training on MPDSR procedures and data management, insufficient supervision, fragmented information systems, reliance on paper-based records, and the absence of a structured national follow-up and action-tracking mechanism. As a result, findings were not translated into evidence-based interventions, leading to repeated and avoidable maternal deaths, as evidenced by 198 avoidable deaths recorded at visited facilities between Financial Years 2021/22 and 2024/25, mainly due to haemorrhage and hypertensive disorders. This situation undermines accountability, wastes resources invested in surveillance and reviews, limits decision-making, and delays progress toward achieving SDG 3.1 and national targets for reducing maternal mortality.

(c) Improper Functioning of the Referral System

The audit noted that the referral system is not functioning effectively, with partial operationalisation across health facilities, insufficient oversight, and inadequate documentation, contrary to One Plan III, the National Referral Guidelines, and WHO standards for a functional and equitable referral system. Ineffective communication and coordination between referring and

receiving facilities, limited training in BEmONC/CEmONC, and inconsistent feedback mechanisms have led to delays in decision-making, patient transfers, and emergency care. Although 96.7% of initiated referrals were completed between 2021/22 and 2024/25, 3.3% remained untracked, highlighting gaps in monitoring, coordination, and data management that compromise timely access to life-saving interventions.

Additionally, emergency transport systems for high-risk pregnancies were inadequate and unevenly distributed: 607 (49%) of the required 1,245 ambulances were available, most were unequipped, and they were concentrated in urban areas. Of the required 21 Marine ambulances, three were grounded, leaving the facilities without ambulances. Non-functional or poorly equipped ambulances, lack of driver training in Cardiopulmonary Resuscitation/Automated External Defibrillator (CPR/AED), and inadequate on-board resuscitation and obstetric supplies exacerbate referral delays. Consequently, women experienced prolonged transfers, delayed emergency interventions, and increased risks of maternal and neonatal complications, contributing significantly to preventable deaths and undermining progress toward SDG 3.1 and national maternal health targets.

(d) Inadequate Awareness Campaigns and Education Programs for Pregnant Women of Reproductive Age on Maternal Health

The audit found that maternal health awareness campaigns and education programs for women of reproductive age were inadequately implemented and unevenly distributed, with a bias toward urban areas and limited reach in rural communities. Awareness activities lacked annual planning, clear implementation frameworks, and measurable performance indicators, resulting in inconsistent coverage and weak accountability. Despite rural areas comprising about 60% of the population, maternal health education reached fewer rural women than urban women (for instance, 9 million rural vs 10 million urban women in 2024/25), with disparities widening during periods of low or no budget allocation.

The audit further established that inconsistent and donor-dependent financing, delayed deployment of 9,383 trained Community Health Workers, overlapping institutional mandates within the Ministry of Health, and the absence of outcome-based KPIs undermined community education, birth

preparedness, and male involvement in maternal health. Consequently, behavioural change outcomes could not be demonstrated, rural women remained at higher risk of delayed care-seeking and preventable complications, and the effectiveness, efficiency, and sustainability of maternal health interventions were compromised, limiting progress toward national maternal mortality reduction targets under SDG 3.1.

Audit Conclusion

The audit concluded that the Ministry of Health (MoH) and PMO-RALG have not sufficiently ensured the provision of maternal healthcare services, resulting in high maternal mortality and suboptimal progress toward SDG 3.1 targets. The audit noted limited availability and functionality of EmONC services, critical shortages of skilled staff, inadequate maternal mortality data collection and utilisation under the MPDSR system, and a suboptimal referral system. Additionally, maternal health awareness and education programs were unevenly implemented, particularly in rural areas, compounded by inadequate deployment of Community Health Workers and overreliance on donor funding. These systemic gaps have led to preventable maternal deaths and facility-based deliveries, persistent home births in underserved regions, delayed care-seeking, and inefficiencies in the continuum of maternal care, undermining national efforts to achieve zero preventable maternal deaths.

Audit Recommendations

The Ministry of Health is urged to:

(a) Establish a National MPDSR Digital Platform by establishing and managing a Centralised Platform for MPDSR Case Reporting, data storage, outcome tracking, and feedback. Establish a National MPDSR recommendations register to document, track, and monitor the implementation status of proposed interventions across the Health Sector; and
(b) Implement Region-Specific Digital Applications (e.g., Expanding Afya Tek Pilots) and enhanced BEmONC/CEmONC Training for Health Providers to address gaps in the referral system and align with National Guidelines.

PMO-RALG is urged to:

(a) Enforce MPDSR Compliance by ensuring regular committee meetings, timely reporting to regional and national levels, and systematic analysis of maternal mortality data to guide targeted facility-level interventions; and
(b) The Government should procure additional ground ambulances to expand coverage and ensure timely emergency transport, and introduce marine ambulances to improve access for communities residing in water-bound areas.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Audit

Good health is recognised as a major resource essential for poverty eradication and economic development in the country. A healthy population contributes to national development and overall well-being. Tanzania's health sector aligns with global goals, including the Sustainable Development Goals (SDGs), particularly Goal 3, which focuses on ensuring healthy lives and promoting well-being for all ages. Tanzania increased its budget allocation to the health sector from TZS 1,109.42 billion in the Financial Year 2022/23 to TZS 1,207.12 billion in 2023/24, reflecting the sector's growing significance in enhancing national performance and improving citizens' well-being[1].

The country's health sector has significantly reduced its maternal mortality ratio (MMR) by 80% from 556 deaths per 100,000 live births in 2015 to 104 per 100,000 in 2022. The achievement is attributed to increased political commitment, expansion of Emergency Obstetric and Newborn Care (EmONC) facilities, a strengthened health workforce, and improved referral and surveillance systems. Maternal mortality can be approached using a delay model that includes delays in deciding to seek life-saving care, delays in reaching a health care facility, and delays in receiving the needed services upon reaching the facility. This model takes into account human, health system, and socioeconomic factors such as poverty, poor emergency obstetric services, and fatalistic beliefs[3].

Despite the measures taken to improve the maternal healthcare by the government there are still challenges such as inadequate provision of quality care in the EmONC facilities caused by insufficient number and skills of health care workers, inadequate infrastructure to support EmONC services, Gap in the community linkage on Maternal Health, Lack of follow-up actions after conducting regular maternal and perinatal death reviews at regional, district and facility level.

1 Estimates of Public Expenditure supply votes (Regional) volume III
2 Annual Health Sector Performance Profile 2023
3 2022 TDHS - MIS

The Government continues to face a number of challenges that hinder maternal healthcare despite measures taken to improve the maternal mortality rate. Maternal deaths in Tanzania are predominantly caused by direct obstetric complications such as eclampsia, obstetric haemorrhage, and maternal sepsis, with indirect causes including anaemia and cardiovascular disorders also contributing significantly.

1.2 Motivation of the Audit

Deficiency in the Health Facilities: The Ministry of Health's 2024/25 Budget Speech highlights persistent gaps in the quality of services provided by public health facilities, underscoring the need to strengthen management structures at regional, council, and facility levels while enhancing accountability and service effectiveness. The government aims to address these deficiencies by improving infrastructure across all facility tiers, including dispensaries, health centres, hospitals, and training colleges, through ensuring reliable electricity, water supply, and consistent availability of medicines, equipment, and medical supplies to support effective health service delivery.

Aspiration to Achieve Agenda 2063: Agenda 2063's Aspiration 1 envisions a prosperous Africa with modern, well-equipped health, education, and sanitation systems, ensuring universal access to quality and affordable healthcare for all, including vulnerable groups. Achieving its health goals—such as eliminating maternal mortality and guaranteeing sexual and reproductive health rights requires strengthening integrated and comprehensive health services, making them accessible, affordable, and of acceptable quality to support a growing and diverse population.

***Target of Tanzania Development Vision 2025*:** Tanzania Development Vision 2025 prioritises improving citizens' quality of life through universal access to quality primary and reproductive healthcare and a significant reduction of maternal mortality. By setting measurable health targets and guiding strategic interventions, the Vision underscores the central role of health in national development. It aims to strengthen systems and services that support sustainable improvements in population well-being.

Target of Tanzania Development Vision 2050: Goal 2, Target 3 of the Vision 2050 emphasises the elimination of maternal, newborn and child mortality. The Vision aspires to achieve optimal health outcomes for all

Tanzanians, with a particular focus on women, children, persons with disabilities, and older persons.

The necessity of Meeting the Fifth Health Sector Strategic Plan (HSSP V) Outcomes (2021-2026) emphasises improving maternal health by ensuring strict adherence to quality standards in antenatal and delivery care and by strengthening the referral system for timely and appropriate patient transfers. While government efforts aim to ensure that regional and national hospitals focus on specialised services, persistent challenges in referral capacity highlight the need for continued system improvements to optimise healthcare efficiency and outcomes.

The Realisation of the Third Five-Year Development Plan (FYDP III) Targets (2021/22-2025/26) seeks to strengthen Tanzania's healthcare system by improving infrastructure, expanding the health workforce, enhancing referral efficiency, and promoting private-sector participation in health service delivery. With a key goal of reducing maternal mortality from 220 to 180 per 100,000 live births by 2025/26, the plan aligns health improvements with the national agenda of competitiveness, industrialisation, universal health coverage, and the long-term aspirations outlined in Development Vision 2025.

1.3 Audit Design

The audit design includes the audit objective, scope, criteria used during the audit, sampling methods, and data collection and analysis methods.

1.3.1 Audit objective

The main objective of the audit was to assess whether the Ministry of Health and the Prime Ministers' Office, Regional Administration and Local Government have sufficiently provided quality maternal healthcare services in Tanzania, thereby reducing the maternal mortality rate to 70 per 100,000 live births by 2030 in line with SDG 3.1.

Specific Audit Objectives

Specifically, the audit aimed at assessing whether the Ministry of Health and PMO-RALG have;

(a) Ensured availability of Comprehensive Emergency Obstetric (CEmONC) services that are well equipped with trained personnel, necessary equipment and medical supplies to effectively manage obstetric complications and ultimately reduce maternal mortality;
(b) Ensured proper functioning of the Referral System to reduce barriers to accessing essential health facilities and ensure timely interventions for maternal health complications
(c) Established and implemented a robust system for data collection, monitoring, and reporting maternal health data to support evidence-based planning for timely interventions and the promotion of transparency and accountability in reducing maternal mortality; and
(d) Ensured maternal awareness campaigns and education programs for pregnant women and women of reproductive age have been implemented to improve maternal health outcomes.

1.3.2 Audit Questions

The Audit team used five main audit questions to address critical audit issues. The details of the main and sub-questions are elaborated in **Appendix 2**. The five main audit questions include:

a) To what extent have the MoH and PMO-RALG ensured the reduction of maternal mortality in the country?
b) Have the MoH and PMO-RALG ensured the availability of comprehensive Emergency Obstetric Care in the country?
c) Do MoH and PMO-RALG ensure a proper functioning of the referral system?
d) Has the MoH and PMO-RALG established and implemented a robust system for data collection, monitoring, and reporting maternal mortality data?
e) Have the MoH and PMO-RALG ensured the implementation of awareness campaigns and education programs for pregnant women and women of reproductive age?

1.3.3 Scope of the Audit

The main audited entities were the Ministry of Health and the Prime Minister's Office - Regional Administration and Local Government. The

Ministry of Health, through the Directorate of Reproductive, Maternal, Child and Adolescent Health, and PMO-RALG, through the Directorate of Health Services Nutrition and Social Welfare, are both responsible for ensuring the smooth implementation and coordination of measures intended to reduce Maternal Mortality from the National to the community level.

The Audit covered four specific aspects of the Provision of maternal healthcare services, namely: availability of Emergency Obstetric and Newborn Care (EmONC) services; establishment and implementation of a system for data collection, Monitoring, and reporting of maternal data; functioning of the referral system; and maternal awareness campaigns and education programs.

Regarding the availability of Comprehensive Emergency Obstetric and Newborn Care (CEmONC) services, the Audit assessed the extent to which health facilities were equipped with the necessary equipment and infrastructure to provide EmONC services, had skilled birth attendants, and had sufficient budgets to ensure the availability of EmONC services. It assessed the identification and addressing of systematic risks that hinder the availability of EmONC services by the MoH and PMO-RALG.

Regarding the proper functioning of the referral system, the assessment evaluated the effectiveness of communication and coordination between initiating and receiving facilities, the adequacy of monitoring the referral system's performance, and the adequacy of emergency transport systems for high-risk pregnancies.

Pertaining to the establishment and implementation of a system for data collection, monitoring, and reporting of maternal data, the Audit assessed the extent to which MoH and PMO-RALG implemented Maternal and Perinatal Death Surveillance and Response (MPDSR) and ensured the use of collected data for targeted interventions to address maternal mortality.

In the implementation of awareness campaigns and education programs for pregnant women and women of reproductive age, the Audit assessed the promotion of these programs for community awareness and participation, and the usability of indicators/metrics to measure their effectiveness.

The audit covered health facilities at all levels, including Dispensaries, Health Centres, District Hospitals, Regional Referral Hospitals and Zonal

Referral Hospital. These facilities play a vital role in the continuity of care for the provision of maternal healthcare services.

The audit covered five financial years, from 2020/21 to 2024/25. This period was chosen to establish a trend in the performance of the government entities responsible for the provision of maternal healthcare services in the country.

1.3.4 The Audit Assessment Criteria

To assess the provision of maternal healthcare services, assessment criteria were drawn from legislation, standards, good practices, and strategic plans from the MoH and PMO-RALG. The following are the assessment criteria for each of the specific audit objectives:

(a) Availability of Emergency Obstetric Care Services in the Country

Target 3.8 of the SDGs stresses that, by 2030, countries should achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. Furthermore, the National Five-Year Development Plan (FYDP III 2021-2025) identifies the availability of medicines, medical supplies, reagents, vaccines, and pharmaceutical equipment as a key intervention provision of maternal healthcare services. Also, Para 3.3.6 of the One Plan III National Plan for Reproductive, Maternal, Newborn, Child and Adolescent Health & Nutrition (2021/2022 – 2025/2026) is committed to maintaining a high availability of essential injectable medication, including uterotonics, magnesium sulphate, and injectable antibiotics within Emergency Obstetric and Neonatal Care (EmONC).

(b) Functioning of the Referral System to ensure Women Receive the Best Possible Care at All Levels

SDG Target 3.8 emphasises the achievement of universal health coverage, including access to quality essential health care services, for which a functional referral system is a critical prerequisite to ensure timely access to higher levels of care when required. In this regard, Annex 3 of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), under the health sector investment area of service equity, accessibility, and quality, calls for policies that prioritise the establishment and strengthening

of functional referral systems. Paragraph 1.6 of the National Health Policy (1997) consistently requires referral hospitals to be equipped with emergency medicine and intensive care units to provide specialised care for patients in critical condition.

(c) Data Collection, Monitoring and Reporting of Maternal Mortality Data

Annex 5 of the Global Strategy for Women's, Children and Adolescents' Health (2016–2030) underscores the importance of a robust health information system for tracking progress on maternal health indicators. Similarly, Para 3.3.1 of the Maternal and Perinatal Death Surveillance and Response (MPDSR) Guideline (2019) provides guidance on the collection of reliable data on maternal and perinatal deaths through systematic identification, notification, review, and analysis.

Furthermore, the Basic Standards for Health Facilities in Hospitals at Levels III and IV (November 2017) require the Ministry of Health and health facilities to maintain comprehensive data management systems that ensure all collected data are appropriate, timely, accurate, complete, and readily retrievable.

(d) Awareness Campaigns and Education Program for Pregnant Women of Reproductive Age on Maternal Health

Para 5.1.2 of the Health Sector Strategic Plan Five (July 2021 – June 2026) emphasises that the health sector will strengthen community health education to improve health literacy and empower individuals to make informed decisions about their health and wellbeing. In line with this, Para 4.2.8(1) of the National Operational Guideline for Community-Based Health Services (2021) assigns health facilities the responsibility of creating awareness at the village level on available health services and citizens' health entitlements. Furthermore, SDGs Goal 3, Target 3.7 underscores the commitment to achieving, by 2030, universal access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes.

1.4 Sampling, Methods for Data Collection and Analysis

The audit Team used various methods for sampling, data collection, and analysis to gather sufficient and reliable audit evidence and address the audit questions. These methods are presented below.

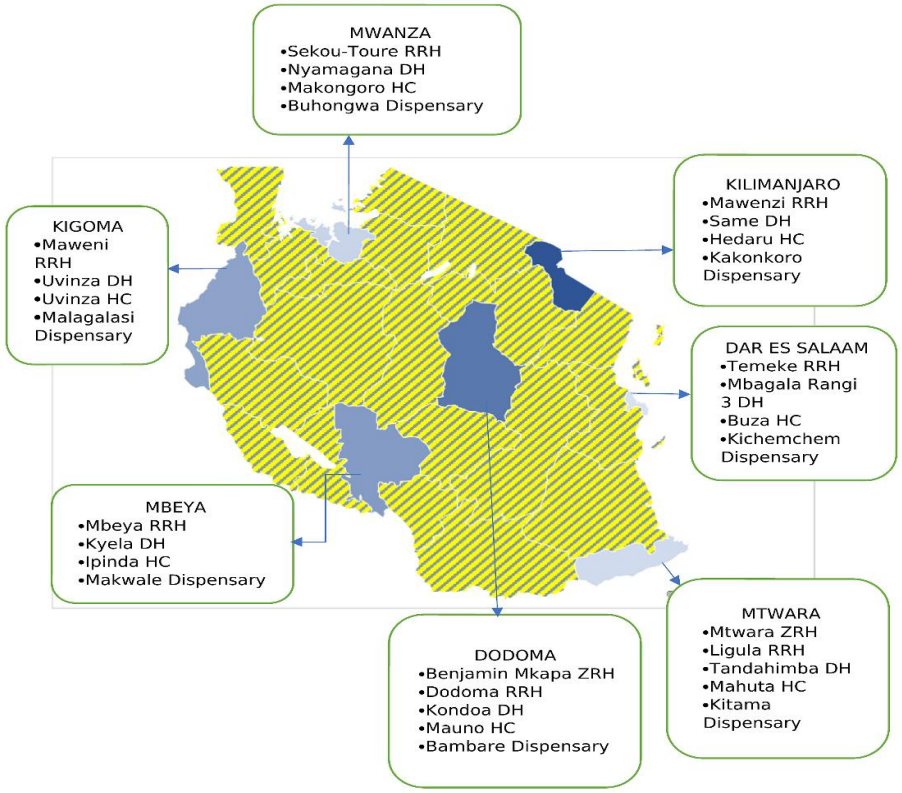
1.4.1 Selection of Health Facilities

A purposive sampling approach was used to select regions from all seven geographical zones in the country, based on two criteria. The first criterion was the total number of maternal deaths from 2020/21 to 2024/25, and the second was the total number of first visits, which measures the workload of each region. In each zone, regions were ranked based on the total number of maternal deaths and the total number of first visits. The average ranking across the two rankings was used to select the highest-ranked regions in each zone, as detailed in **Appendix 3**. The selected regions were Dar es Salaam, Mtwara, Mwanza, Kigoma, Mbeya, Dodoma, and Kilimanjaro.

Additionally, out of the six Zonal Referral Hospitals, two were selected based on the availability of Maternal, Newborn, and Child Health (MNCH) programmes supported by multiple Implementing Partners (IPs). Dodoma Region, with 17 IPs, and Mtwara Region, with 20 IPs, were therefore selected, as they provided an opportunity to evaluate the impact of multiple interventions on service quality at their respective Zonal Referral Hospitals (ZRH). Furthermore, in each sampled region, the respective Regional Referral Hospital was purposefully selected: Temeke RRH for Dar es Salaam, Maweni RRH for Kigoma, Dodoma RRH for Dodoma Region, Sekou Toure RRH for Mwanza, Ligula RRH for Mtwara Region, Mbeya RRH for Mbeya Region, and Mawenzi RRH for Kilimanjaro Region, as shown in **Appendix 4.** Also, District Hospitals were sampled based on the total number of First Visits for 2024, as detailed in **Appendix 5.** Health facilities were purposively sampled to ensure representation of different levels of care and urban–rural settings. Rural settings were given particular consideration because almost 80% of the marginalised population lives in rural areas, where the quality of maternal health facilities is compromised. In each selected district, one health centre and one dispensary were included in the sample based on their referral pathways. This sampling allowed comparisons between health centres and dispensaries and facilitated the assessment of service delivery performance across urban and rural contexts, as shown in **Appendix 6.**

Therefore, the healthcare facilities visited are shown in **Figure 1.1.**

Figure 1.1: Visited Health Facilities



Source: Auditors' Analysis of Sampled Health Facilities, 2025

1.4.2 Methods for Data Collection

Both qualitative and quantitative data were collected to obtain sufficient and appropriate evidence for assessing the provision of maternal healthcare services to children. The Audit Team employed documentary review and interviews as described below.

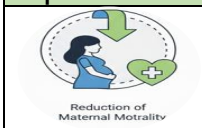
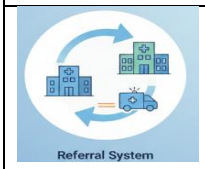
(a) Documents Review: The Audit Team reviewed documents from MoH, PMO-RALG, and selected Zonal and Regional Referral Hospitals, District Hospitals, Health centres, and Dispensaries to obtain information regarding the provision of quality Maternal Healthcare Services in the country. The reviewed documents from the Audited entities were within the period under audit, that is, from 2020/21 to 2024/25. The documents reviewed included MPDSR Reports and Bulletin Reports, as detailed in **Appendix 7.**

(b) Interviews: Officials from MoH, PMO-RALG, and the selected healthcare facilities were interviewed regarding the provision of quality Maternal Healthcare Services in the country. Interviews were conducted with health practitioners in administrative roles, health practitioners at health facilities, and beneficiaries of the services (pregnant women) to gather information and seek clarification on data obtained from reviewed documents. Details of the officials interviewed from the MoH, PMO-RALG, and Health Facilities are provided in **Appendix 8.**

1.4.3 Methods for Data Analysis

The collected information was analysed using both qualitative and quantitative methods. This was done to obtain facts and sufficient information regarding the overall performance of the Ministry of Health and the Prime Minister's Office - Regional Administration and Local Government in facilitating the provision of quality maternal healthcare services in Tanzania, aimed to reduce the maternal mortality rate to 70 per 100,000 live births in line with SDGs Goal 3, Target 3.1. The methods used for data analysis are presented in **Table 1.1.**

Table 1.1: Methods for Data Analysis

Aspect	Quantitative Analysis	Qualitative Analysis
	Maternal death trends over time. Distribution of maternal death by age category.	Thematic analysis of interviews.
	Gap analysis, comparing the availability of services, medicines and equipment. Analysis of required vs available staff.	Comparative analysis of the availability of CEmONC services.
	Gap analysis of available emergency Transport. Timeliness and coverage analysis.	Comparative analysis of the completeness of referral forms. Compliance analysis of referral timelines.
	Recurrence analysis of causes of death. Compliance Analysis of MPDSR Timeliness Analysis.	Thematic analysis of interviews. Comparative analysis of MPDSR Committee sittings
	Plan vs implementation analysis of awareness campaigns. Budget vs activity execution analysis of awareness programs.	Thematic Analysis of interviews with pregnant mothers and ministry officials.

Source: Auditors' Analysis on the Methods Used for Data Analysis, 2025

1.5 Validation of the Data and Findings

MoH and PMO-RALG were given the opportunity to go through the draft performance audit report and comment on the figures and information presented. They both confirmed the accuracy of the information and figures presented in the report and prepared their action plans as detailed in **Appendix 1**.

The information in the report was also cross-checked and discussed by experts in the field of Maternal healthcare services to confirm its validity.

1.6 Standards used for the Audit

The audit was carried out in accordance with the International Standards of Supreme Audit Institutions (ISSAIs) for performance audits, issued by the

International Organisation of Supreme Audit Institutions (INTOSAI). These standards require the audit to be planned and performed to obtain sufficient and appropriate evidence to provide a reasonable basis for the findings and conclusions.

1.7 Structure of the Audit Report

The audit report consists of five chapters, organised as shown in **Figure 1.2**.

Figure 1.2: Structure of the Audit Report

CHAPTER TWO

SYSTEM FOR THE PROVISION OF QUALITY MATERNAL HEALTHCARE SERVICES

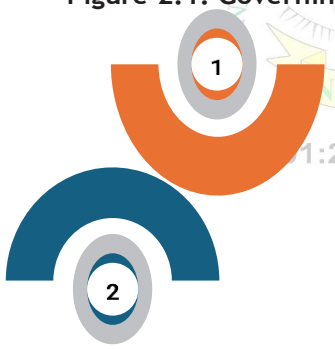
2.1 Introduction

This chapter outlines the National system for delivering maternal healthcare services. It highlights the policies, legislation, strategies, and guidelines that govern maternal health, as well as the roles and responsibilities of key stakeholders in the provision of maternal health care services. Additionally, it describes the processes and activities designed to ensure the effective and efficient delivery of maternal healthcare across the country.

2.2 Policy and Legal Framework Governing the Provision of Maternal Healthcare Services

Key policy and legislation that safeguard and promote the provision of maternal healthcare services in the country are as detailed in **Figure 2.1**.

Figure 2.1: Governing Policies and Legislation



Health Policy, 2007: This policy aims to give direction on how to expand and strengthen the scope and quality of maternal health services. Reduce the burden of disease, maternal and increase life expectancy through the provision of adequate and equitable maternal and child health services

Public Health Act, 2009: The Act elaborates on how, upon the occurrence of any maternal death reporting within its area of jurisdiction, the incident should be reported to the Chief Medical Officer.

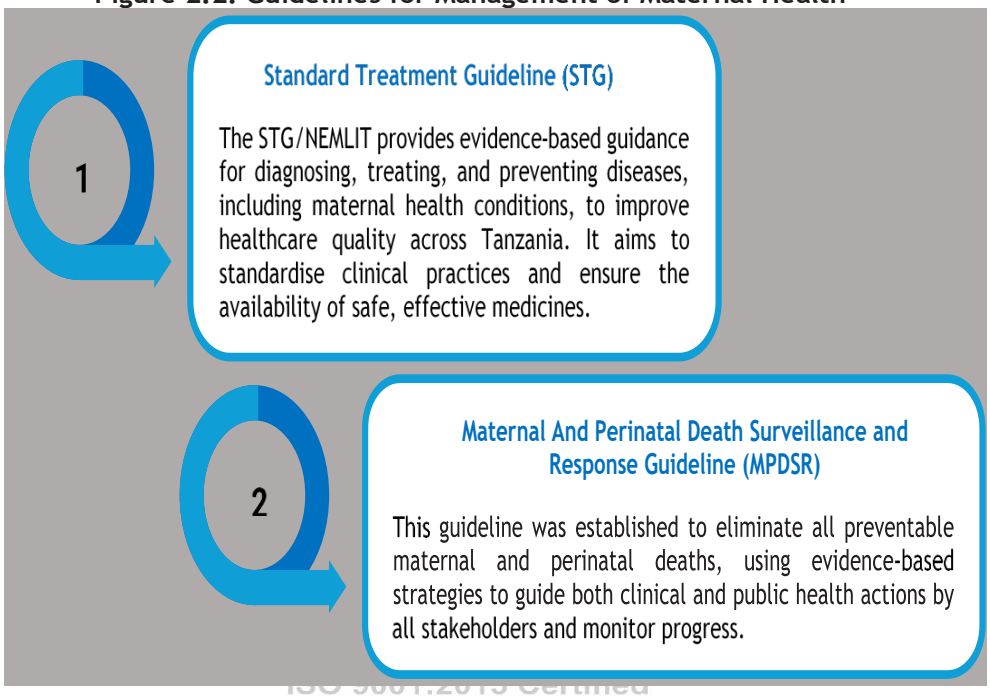
***Source*:** Auditors' Analysis of Policies and Legislation, 2025

2.3 Guidelines for the Provision of Maternal Healthcare Services

Figure 2.2 provides the guidelines on the provision of maternal healthcare in Tanzania, prepared by the Ministry of Health. The first guideline provides for diagnosis, treatment and prevention of maternal health conditions,

while the second guideline provides for measures to combat maternal and perinatal death. The details are provided below.

Figure 2.2: Guidelines for Management of Maternal Health

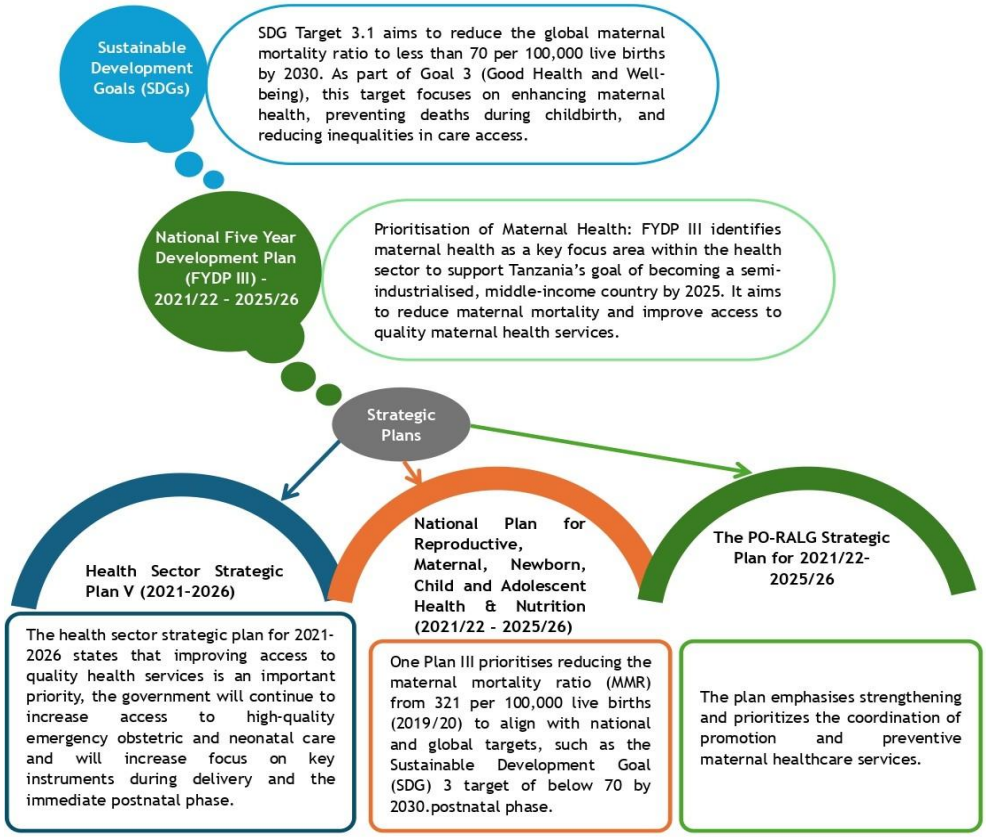


***Source*:** Auditors' Analysis of MoH Guidelines on Management of Maternal Health, 2025

2.4 Plans and Strategies for Provision of Maternal Healthcare Services

The provision of maternal healthcare services is guided by the national health sector strategic plans, which are linked to the national five-year development plan and the targets outlined in SDG 3.1. **Figure 2.3** provides an analysis of the linkages between different national health sector strategic plans, national five-year development plans, and Agenda 2030, particularly Sustainable Development Goal 3.

Figure 2.3: Linkages between Health Sector Strategic Plans, FYDPs and SDG 3.1 on Provision of Maternal Healthcare Services

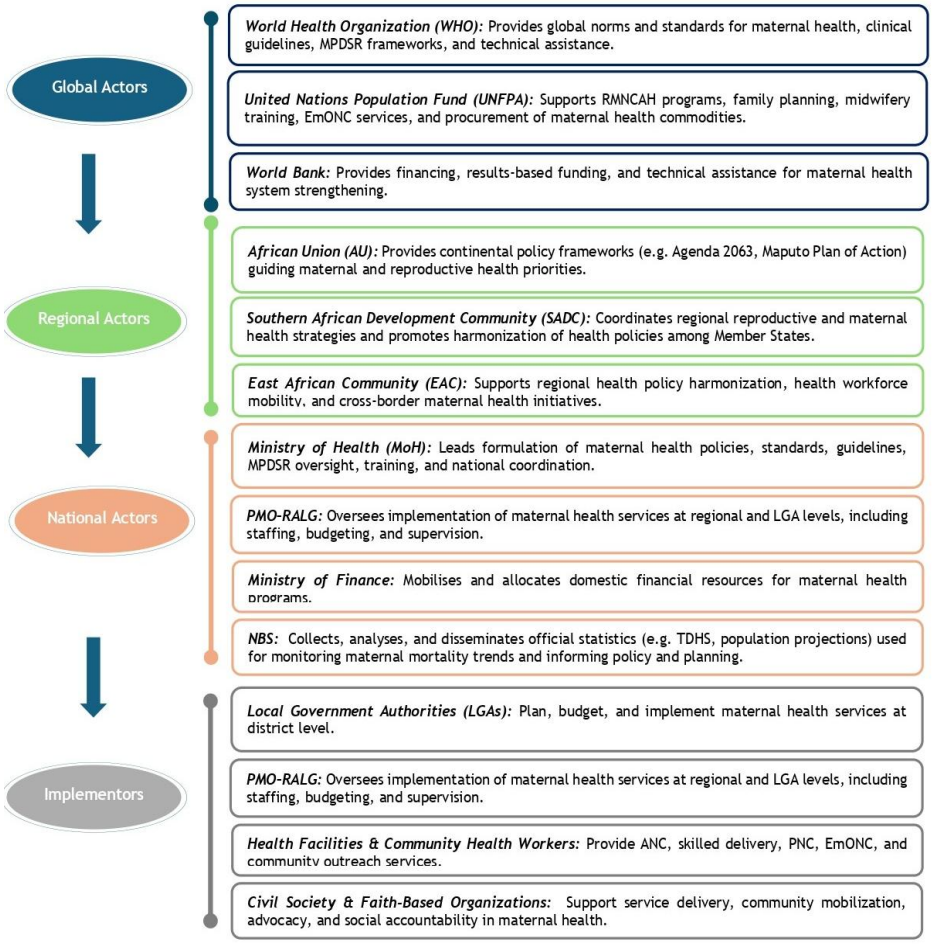


Source: Auditors' Analysis of the Review of the SDGs, FYDPs and Strategic Plans, 2025

2.5 The Roles and Responsibilities of Key Stakeholders in the Provision of Quality Maternal Healthcare Services

Figure 2.4 provides the list of stakeholders involved in the provision of Maternal Healthcare Services and their relationship.

Figure 2.4: Roles and Responsibilities of Key Actors

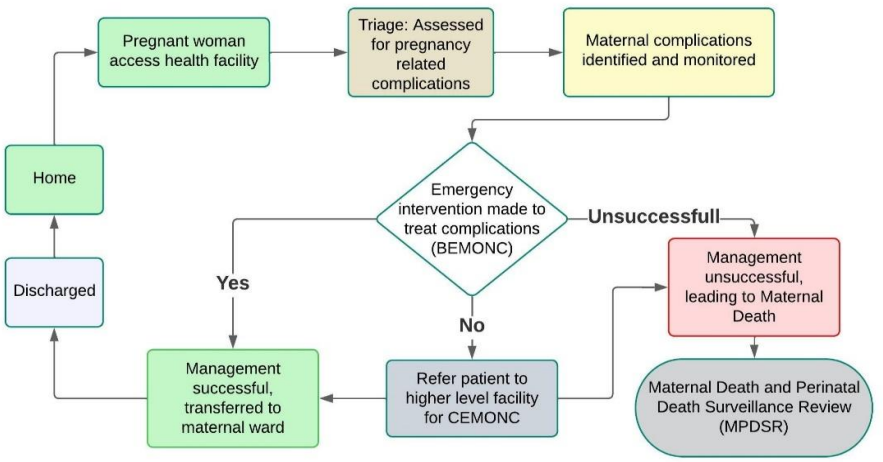


***Source*:** Auditors' Stakeholders Analysis on the Provision of Quality Maternal Healthcare Services, 2025

2.6 Process for Provision of Quality Maternal Healthcare Services

Figure 2.5 describes the process for the Provision of Quality Maternal Healthcare Services.

Figure 2.5: Process for Provision of Quality Maternal Healthcare Services



Source: Auditors' Analysis of Process for Provision of Maternal Healthcare Services, 2025

2.7 Resources for Provision of Maternal Healthcare Services

The Ministry of Health and PMO-RALG are jointly responsible for providing maternal healthcare services. Below are the financial and human resources required to provide maternal healthcare services. The MoH is the sector ministry responsible for issuing guidelines, acts, strategic plans and policies for the provision of maternal healthcare services, whereas PMO-RALG is the chief implementer in the primary healthcare setting.

2.7.1 Financial Resources for the Provision of Maternal Healthcare Services

Table 2.1 indicates the financial resources allocated to the provision of maternal healthcare services in the country to reduce maternal mortality to less than 70 per 100,000 live births, in line with SDG 3.1.

Table 2.1: Budget for Provision of Maternal Healthcare Services from the Ministry of Health

Financial Year	Approved (TZS million)	Actual Expenditure (TZS million)	Gap (%)
2022/23	117,935,158,737.00	42,050,305,925.05	64.3
2023/24	125,396,961,644.95	41,026,658,851.27	67.3
2024/25	144,183,978,131.65	34,793,285,485.81	75.9

***Source*:** Auditors' Analysis of RMNCAH Budget, 2025

From the financial years 2022/23 to 2024/25, the approved budget for the provision of maternal healthcare services increased steadily from TZS 117.94 billion to TZS 144.18 billion, an increase of 22.3%. However, the actual expenditure fell from TZS 42.05 billion in 2022/23 to TZS 34.79 billion in 2024/25, widening the funding gap from 64.34% to 75.88%.

Table 2.2 indicates the financial resources allocated to PMO-RALG for the provision of maternal healthcare services in the country to reduce maternal mortality to less than 70 per 100,000 live births, in line with SDG 3.1.

Table 2. 2: Budget for Provision of Maternal Healthcare Services from PMO-RALG

Financial Year	Approved budget (TZS Millions)	Actual Expenditure (TZS million)	Gap (%)
2021/22	32,263,490,846.46	24,263,490,846.46	24.8
2022/23	29,384,965,069.14	22,587,377,004.76	23.1
2023/24	59,727,192,242.57	44,912,806,173.03	24.8
2024/25	28,113,714,876.69	27,398,755,698.43	2.5

***Source*:** Auditors' Analysis of RMNCAH Budget, 2025

Table 2.2 shows that, over three consecutive Financial Years (2021/22-2023/24), underspending amounted to approximately 24% of the Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) budget implementation. This suggests systemic challenges in the execution of expenditures. However, in Financial Year 2024/25, there is a marked turnaround, with near-full budget utilisation (only 2.5% gap). This suggests improved planning and better financial management. The trend is encouraging, but sustained performance at the 2024/25 level will be critical to ensure RMNCAH services receive the full intended funding in future years.

2.7.2 Human Resources for the Provision of Maternal Healthcare Services

To ensure the provision of maternal health care in the country, reproductive, maternal, newborn, child, and adolescent health must

improve human resources for effective management. **Table 2.3** indicates the required and available staff numbers for the period from 2021/22 to 2024/25, as detailed below.

Table 2.3: Staff Availability for Provision of Maternal Healthcare Services

Facility Level	Required Number of Staff	Available Number of Staff	Gap (%)
Dispensaries	113,633	48,242	58
Health Centers	76,228	43,021	44
District Hospitals	145,640	47,006	68
Regional Referral Hospitals	16,324	13,825	15
National/Specialised/Zonal Hospitals	27,941	20,028	28
Grand Total	**379,766**	**172,122**	**54.7**

***Source*:** Auditors' Analysis on Manning Level from PMO-RALG & MoH, 2025

CHAPTER THREE

AUDIT FINDINGS

3.1 Introduction

This chapter presents audit findings on the provision of maternal healthcare facilities in Tanzania, managed by the Ministry of Health and the PMO-RALG, for the period under review. The findings cover the availability of emergency obstetric care services, a robust system for the collection, monitoring, and reporting of Maternal Mortality data, the functioning of the Referral System to ensure women receive the best possible care at all levels, and awareness campaigns and education programs for Pregnant Women of Reproductive Age on Maternal Health.

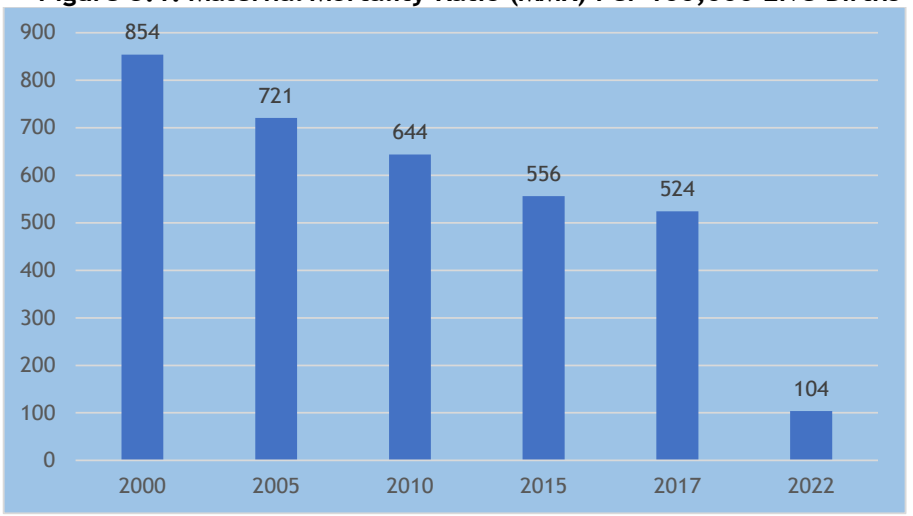
3.2 The Maternal Healthcare Services were not Adequately Provided by the MoH and PMO-RALG

The Health Sector Strategic Plan July 2021 – June 2026 (HSSP V) prioritises access to quality maternal healthcare services. However, the audit noted that maternal healthcare services were not sufficiently provided, as evidenced by the continued prevalence of maternal deaths, despite Tanzania's commitment to eliminate all preventable maternal deaths as articulated in the National Plan for Reproductive, Maternal, Newborn, Child and Adolescent Health & Nutrition (2021/22-2025/26).

3.2.1 Gradual Reduction of Maternal Deaths

The audit noted that the trend in maternal deaths showed a gradual decline over the years, as shown in **Figure 3.1.** This was contrary to Para 3.3.4 of the Maternal and Perinatal Death Surveillance and Response Guidelines, which aims to enhance accountability and reduce maternal and perinatal mortality at all levels (from individual families to the national level).

Figure 3.1: Maternal Mortality Ratio (MMR) Per 100,000 Live Births

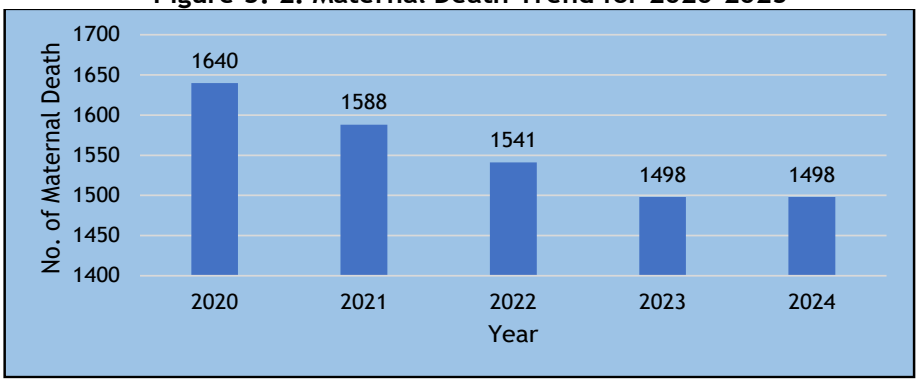


***Source*: Auditors' Analysis of MMR from Demographic Health Survey, 2025**

Figure 3.1 shows a consistent decline in the Maternal Mortality Ratio from 854 deaths per 100,000 live births in 2000 to 524 in 2017, indicating gradual improvements in maternal health services and access to care. Despite this progress, the pace of reduction during this period was modest and remained insufficient to rapidly lower maternal deaths to internationally acceptable levels, suggesting the persistence of health system constraints such as limited availability of CEmONC services, referral delays, and shortages of skilled health personnel.

A pronounced reduction to 104 deaths per 100,000 live births in 2022 represented a sharp departure from the historical trend. While this figure suggested substantial progress and potential alignment with SDG 3.1. However, the reduction of the absolute number of maternal deaths during the audit scope from 2020 to 2024 has been gradual, as evidenced in **Figure 3.2.**

Figure 3. 2: Maternal Death Trend for 2020-2025



Source: Auditors' Analysis on Maternal and Perinatal Death Surveillance Review Bulletin, 2025

Figure 3.2 shows that in 2020, a total of 1,640 maternal deaths were reported, decreasing to 1,588 in 2021 and 1,541 in 2022. However, in 2023 and 2024, the number remained constant at 1498.

In addition, the review of the Maternal and Perinatal Death Surveillance and Response (MPDSR) report revealed that the number of maternal deaths in Tanzania has gradually declined from 1,744 deaths in 2018 to 1,498 deaths in 2023, representing a 14.1% decrease over six years. This trend reflects an average annual reduction of approximately 2.8%, though it still falls short of global (SDG 3.1) maternal mortality reduction targets of less than 70 per 100,000 live births by 2030.

The review of the MPDSR Report, 2025, further revealed that maternal deaths were most prevalent among women aged 35 and above, as indicated in **Table 3.1.**

Table 3.1: Distribution of Maternal Death by Age Category from 2024 to March 2025

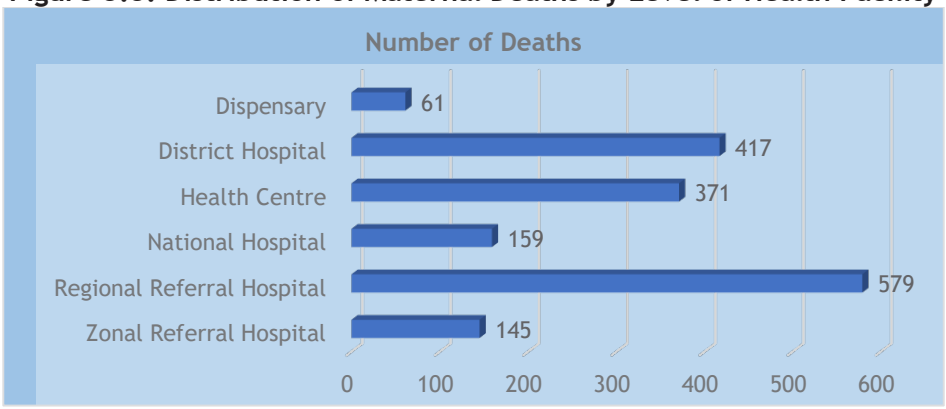
Age Category (Years)	Number of Deaths	Age Death (%)
14-19	150	8
20-24	383	21
25-29	393	22
30-34	392	21
35+	521	28
Total	1839	100

Source: Auditors' Analysis on MPDSR Report, 2025

Table 3.1 indicates that maternal deaths between 2024 and March 2025 were predominantly concentrated among women aged 35 years and above, who accounted for 28% of all cases, reflecting increased risks associated with advanced maternal age, while adolescents aged 14–19 years contributed the smallest share at 8%. Overall, the distribution shows that maternal mortality largely affects women in their active reproductive years.

Further review of the Maternal and Perinatal Death Surveillance and Response (MPDSR) Reports for the periods January–December 2024 and January–March 2025 revealed that the majority of maternal deaths occurred in health facilities, particularly at higher levels of care, as indicated in **Figure 3.3.**

Figure 3.3: Distribution of Maternal Deaths by Level of Health Facility



***Source*:** Auditors' Analysis of Information from Maternal and Perinatal Death Surveillance and Response (MPDSR) Report, 2025

Figure 3.3 shows that Regional Referral Hospitals recorded the highest proportion of maternal deaths at 31.7% (579 deaths), followed by District Hospitals with 22.8% (417 deaths) and Health Centres with 20.3% (371 deaths). These three facility levels accounted for more than three-quarters of all reported maternal deaths. Overall, the distribution highlights weaknesses across the continuum of maternal healthcare, from community and primary facilities to referral hospitals.

The audit further noted through the review of Maternal and Perinatal Death Surveillance and Response (MPDSR) Report, 2025 that more than one third (30.6%) of maternal deaths reported were caused by excessive bleeding occurring after childbirth (postpartum haemorrhage (PPH)), followed by convulsions (Eclampsia (17.7%)), blood clot blocks (pulmonary embolism)

(5.5%) and ruptured uterus (5.1%). The least leading cause of maternal deaths was the ingestion of traditional or herbal medicines (herbal intoxication (0.3%)) and ectopic pregnancies (0.8%).

Generally, the audit noted that insufficient provision of maternal healthcare services resulted from inadequate implementation of initiatives to reduce maternal mortality, limited coverage of ANC and PNC, and a shortage of skilled delivery, as elaborated below.

3.2.2 Inadequate Implementation of Initiatives to Reduce Maternal Mortality Rate by the MoH and PMO-RALG

In aligning with Sustainable Development Goal (SDG) 3.1, which aims to reduce the global maternal mortality ratio (MMR) to less than 70 deaths per 100,000 live births by 2030, the Ministry of Health (MoH) and Prime Minister's Office - Regional Administration and Local Government (PMO-RALG) did not adequately implement the suggested actions as indicated in **Table 3.2.**

Table 3.2: Implementation of Initiatives to Reduce Maternal Mortality Rate

Initiative	Target by 2025 (%)	Implementation Status by 2025 (%)
Institutional Deliveries	80	Achieved (85[4])
Modern Contraceptive Use	60	Not Achieved (42[5])
CEmONC in Hospitals	100	Not Achieved (92)
Reduce Adolescent Pregnancy	15	Not Achieved (22[6])

Source: Auditors' Analysis of Initiatives to Reduce Maternal Mortality Rate, 2025

Table 3.2 indicates that institutional deliveries exceeded the national target, reaching approximately 85% against a target of 80%; however, other key interventions lagged behind planned targets. Modern contraceptive use reached only 42%, falling short of the 60% target, limiting progress in preventing unintended and high-risk pregnancies. Similarly, the availability of CEmONC services in hospitals was recorded at 92%, below the target of 100%. In addition, adolescent pregnancy declined only to 22%, remaining

4 https://apps.who.int/gb/statements/WHA76/PDF/United-Republic-of-Tanzania-12.pdf?utm.Accessed on 10 January , 2026
5 https://www.nairobisummiticpd.org/tanzania?utm.Accessed on Janury,2026
6 https://pmc.ncbi.nlm.nih.gov/articles/PMC10388620/?utm.Accessed on 10 January,2026

considerably above the 15% target, thereby continuing to expose adolescents to elevated risks of maternal morbidity and mortality.

Inadequate implementation of Initiatives to reduce the Maternal Mortality Rate by the MoH and PMO-RALG resulted from reliance on donor funding for key maternal health interventions, leading to implementation delays, fragmented activities, and sustainability risks when donor funding was reduced or reprogrammed. As a result, despite the existence of well-designed initiatives, implementation gaps have constrained progress in reducing maternal mortality, thereby threatening the achievement of SDG 3.1 by 2030 and national targets.

Furthermore, the audit noted that the MoH AND PMO-RALG did not ensure effective implementation of the initiatives to reduce Maternal Mortality, as evidenced by the utilisation of maternal health facilities, the Performance of ANC and PNC, and the availability of skilled birth attendants, as detailed below.

(a) Underutilization of ANC Services

The Audit noted that the MoH and PMO-RALG did not ensure full utilisation of ANC services where for the period covering Calendar Year 2020 to 2024 the ANC coverage in Tanzania showed moderate improvement but remained below national targets contrary to Health Sector Strategic Plan V (HSSP V, 2021-2026) and the One Plan III for Reproductive, Maternal, Newborn, Child, and Adolescent Health (2021-2025), which emphasized that at least 90% of pregnant women should receive a minimum of four ANC visits during pregnancy. **Table 3.3** shows the status of ANC Visits and the percentage of completion, which is below 90% as recommended by WHO.

Table 3.3: Status of ANC Visits and Percentage of Completion

Calendar Year	No. Attended ANC First Visit	No. Completed the Recommended ANC	Completion of ANC Visits (%)
2020	2,400,304	1,941,842	81
2021	2,401,187	1,931,526	80
2022	2,442,589	1,976,696	81
2023	2,597,668	2,151,672	83
2024	2,716,057	2,259,642	83

***Source*:** Auditors' Analysis of ANC Attendances from DHIS2, 2025

Table 3.3 shows that, from 2020 to 2024, ANC coverage followed a generally positive but suboptimal trend. The number of women attending their first ANC visit increased from 2,400,304 in 2020 to 2,716,057 in 2024, representing an overall growth of approximately 13.15%. Similarly, the number of women completing the recommended ANC visits increased from 1,941,842 to 2,259,642, a 16.37% increase over the period. The completion percentage of ANC Visits fluctuated slightly, dropping to 80% in 2021 before recovering to 81% in 2022 and stabilising at 83% in 2023, with an average of 81.6% across the years, which is below the 90% national target.

Additionally, the World Health Organisation (WHO) and Every Newborn Action Plan emphasise early initiation (first trimester) and at least four visits (ideally eight) to ensure comprehensive screening, counselling, and interventions such as blood pressure monitoring, testing for syphilis and HIV, iron supplementation, and intermittent preventive treatment for malaria (IPTp). Underutilization of ANC Services was caused by:

(i) Low Levels of Education among Women

Low levels of education among women reduced awareness and understanding of the importance of ANC services. Women with limited education did not understand the purpose of early ANC attendance, the recommended number of visits, or the benefits of screening for pregnancy-related conditions such as anaemia, hypertension, infections, and foetal growth complications. As a result, some pregnant women attended ANC once for registration purposes and failed to return for follow-up visits.

Limited literacy also affected women's ability to understand health messages delivered during ANC sessions, including nutrition guidance, danger signs in pregnancy, birth preparedness, and the importance of skilled delivery. This weakened compliance with medical advice, reduced uptake of preventive interventions, and contributed to poor maternal and neonatal health outcomes.

(ii) Limited Awareness among Women

The Audit noted that limited awareness of the ANC Services led to the existence of cultural norms that discouraged early and regular ANC attendance due to beliefs that pregnancy was a natural process that did not require medical attention unless complications arose. Some communities

also considered pregnancy a private matter that should not be disclosed early, leading women to delay the first ANC visit until the pregnancy becomes visible. In addition, traditional beliefs promoted the use of local herbs, traditional birth attendants, or spiritual interventions as alternatives to facility-based ANC services, thereby increasing the number of Home Deliveries as detailed in **Table 3.4**.

Table 3.4: Status of Home Deliveries in the Sampled Regions

Region	2021	2022	2023	2024	Total	Ranking
Dar Es Salaam	505	213	429	116	1263	5
Dodoma	727	387	404	412	1930	4
Kigoma	239	152	162	170	723	6
Kilimanjaro	105	120	62	46	333	7
Mbeya	783	800	624	350	2557	3
Mwanza	1535	1350	1159	1169	5213	1
Mtwara	819	750	884	429	2882	2

Source: Auditors' Analysis of Delivery Information from MoH, 2025

Table 3.4 shows the status of home deliveries, with the highest in Mwanza at 5213 and the lowest in Kilimanjaro at 333. This was attributable to lower levels of education and awareness of maternal health issues in the respective regions.

(iii) Distance and Transport Barriers

Access to antenatal care (ANC) services in Tanzania remained constrained by long distances to health facilities and inadequate transport, particularly in rural and hard-to-reach areas. For pregnant women who resided far from dispensaries, health centres, or hospitals that provide ANC services, and in some cases, the nearest facility was located several kilometres away. This situation discouraged early initiation of ANC and reduced the likelihood of completing the recommended number of ANC visits.

In remote communities, poor road infrastructure and seasonal weather conditions further limit physical access to health facilities. For example, in rural districts such as Uvinza, Tandahimba, Same and Kyela, poor infrastructure affects access because during the rainy season, roads may become impassable and transport services may be unavailable or unreliable, forcing pregnant women to delay or miss ANC appointments. These challenges are more pronounced in areas with limited public transport,

where women may be required to walk long distances or rely on motorcycles and other unsafe modes of transport.

Consequently, inadequate ANC coverage has a significant impact on maternal and child health outcomes. Women who didn't attend all four ANC visits faced a risk of untreated complications such as hypertension, anaemia, and malaria in pregnancy, which contributed to a persistent maternal mortality ratio (MMR) of 104 per 100,000 live births in 2022, which was down from 556 in 2015-16 but above the 2030 target of less than 70 per 100,000 live births.

(b) Underutilization of Post-Natal Care Services (PNC) (3-7 days)

The audit noted that the MoH and PMO-RALG did not ensure full utilisation of the PNC Services, to mothers after delivery, contrary to intervention 3.2.6 of the National Plan for Reproductive, Maternal, Newborn, Child and Adolescent Health & Nutrition (2021/2022 - 2025/2026) that aimed to improve coverage and utilisation of postnatal care services and integration of other RMNCAH services.

Postnatal care is critical, as nearly one-third of newborn complications and deaths occur within the first 24 hours after birth, and approximately 75 per cent occur within the first week of life. **Table 3.5** shows the trend of postnatal care attendances.

Table 3.5: Postnatal Care Services Trend

Indicator	2020	2021	2022	2023	2024	Total Growth
Percentage of Mothers who received Post Natal Care 48 hours after delivery	86	87.5	89.7	91.5	93.8	7.8
Percentage of mothers who received postnatal care within 3-7 days	59	58	59.7	60.6	62.4	3.4

Source: Auditors' Analysis of PNC Services, 2025

Table 3.5 shows improvement in postnatal care (PNC) service coverage over the period 2020–2024, with gains observed in early postnatal visits. The proportion of mothers who received postnatal care within 48 hours of delivery increased steadily from 86.0 per cent in 2020 to 93.8 per cent in 2024, representing a total increase of 7.8 percentage points. In contrast,

coverage of postnatal care within 3–7 days after delivery recorded a comparatively moderate increase, rising from 59.0 per cent in 2020 to 62.4 per cent in 2024, a 3.4 percentage-point increase. This indicates challenges in ensuring continuity of care after discharge from health facilities.

This was attributed to:

(i) **Limited Follow-Up Mechanisms After Discharge:** Follow-up mechanisms after discharge remains a challenge to achieving comprehensive postnatal care coverage, particularly for services required within 3–7 days after delivery contrary to activity 3.2.6 of One Plan III that required orientation of HCP to Identify, manage and track women and newborn with danger signs in postpartum/ natal period Although all mothers receive an initial postnatal check before discharge, arrangements to ensure continuity of care once they return to their communities are often absent. Discharge processes in 10 out of 30 sampled facilities do not consistently include scheduled postnatal appointments, documented referral notes, or active tracking of mothers expected to return for follow-up care.

In addition, systems for tracking mothers due for postnatal follow-up, including community registers and active follow-up mechanisms, were absent in those 10 sampled facilities.

(ii) **Inadequate Community Health Workers (CHWs) Coverage:** The audit noted an inadequate distribution of CHWs; 9383 CHWs have not been deployed in wards and villages, pending approval from PMO-RALG due to funding constraints at the time of the audit. In the absence of adequately deployed CHWs, reliance on facility-based services alone proved insufficient to reach mothers after discharge, particularly within the recommended 3–7 days postnatal period. This situation limited the effective integration of RMNCAH services at the community level, contrary to the objectives of the One Plan III.

Overall, the disparity between early postnatal care (within 48 hours) and late-stage (3–7 days) shows a gap in post-discharge continuity of care, undermining the interventions to combat maternal deaths. As a result of inadequate follow-up and limited community outreach, a significant proportion of mothers and newborns did not receive essential postnatal care within the critical first week after delivery. This increased the risk of undetected and unmanaged postnatal complications, including postpartum

infections, haemorrhage, neonatal sepsis, and feeding-related problems, many of which contribute substantially to preventable maternal and neonatal deaths.

(c) Shortage of Skilled Birth Attendants Across the Sampled Region

The audit noted a critical shortage of skilled Birth Attendants across 30 sampled health facilities, contrary to Para 5.4.1 of the Health Sector Strategic Plan V, which aims to ensure adequate staffing with the necessary skills and expertise to provide quality services and operate health facilities at all levels.

Additionally, Para 5.5.1 of the National Health Policy (2003) ensures the Ministry of Health in collaboration with the Prime Minister's Office - Regional Administration and Local Government, to set up a clear programme for recruitment, deployment and retention of trained health personnel in appropriate numbers and skills mix to ensure that deployed staffs are retained in those service areas to ensure sustainable provision of quality health services. Further explanation of the staff shortage is provided below.

The Audit noted gaps in the sampled Regions regarding the required Skilled Birth Attendants, as shown in **Table 3.6.**

Table 3.6: Status of Skilled Birth Attendants (SBA) in the Country

Category	Available (%)	Gap (%)
Midwives	36	64
Obstetricians & Gynaecologists	24	76
Anaesthetist	61	39

Source: Auditors' Analysis of HRH Country Profile (2024), 2025

Table 3.6 shows a systematic Shortage of Skilled Birth Attendants (SBAs) across the Country. The situation contributes to an increase in Maternal Deaths. However, the government has consistently issued recruitment permits over the past three years, yet they remain insufficient.

3.3 Limited Availability of Emergency Obstetric and Newborn Care (EmONC) Services

The audit noted limited availability of Emergency Obstetric and Newborn Care (EmONC) in primary health care settings which was contrary to Para 5.1.5 of the Health Sector Strategic Plan, 2021-2026, in which the Ministry of Health's commitment in improving access to quality health services, in collaboration with stakeholders, the government is required to ensure

increased access to high-quality emergency obstetric and neonatal care, with specific emphasis on the consistent availability and proper use of key life-saving instruments and practices during delivery and the immediate post-natal period.

The limited availability of Emergency Obstetric Care was attributed to the following:

3.3.1 Inadequate Provision of EmONC Services

The audit noted inadequate provision of Emergency Obstetric and Newborn Care (EmONC) services, including both Basic EmONC (BEmONC) and Comprehensive EmONC (CEmONC), which are critical medical interventions for managing major obstetric complications that account for most maternal deaths. The Analysis of the availability of EmONC services was based on whether these functions were performed in the past three months; a broader list of functions and supplies is detailed below.

(a) Inadequate Availability of BEmONC Services

The audit noted low availability of BEmONC services, particularly at the primary healthcare level, where it was most needed. For the majority of expectant mothers, the dispensaries were the first point of contact since they are easily accessible to most people. The availability of these BEmONC services was low, as evidenced by the five sampled dispensaries across various regions, as detailed in **Table 3.7.**

Table 3.7: Availability of BEmONC in Dispensaries

Basic Services (Signal Functions)	Dispensaries that Had Signal Function for the Last 3 months (Out of 5 visited)	Availability of Service	Reason for Non-Performance
Administer parenteral antibiotics	5/5	Available	Not applicable
Administer uterotonic drugs (parenteral oxytocin)	4/5	Available	No patients requiring the service
Administer parenteral anticonvulsants (magnesium sulfate)	3/5	Available	No patients requiring the service
Manually remove the placenta	3/5	Not available (skills gap)	Lack of staff skills for manual removal of the placenta
Remove retained products (MVA / D&C)	2/5	Not available (skills gap)	Staff lack the skills to remove retained products
Perform assisted vaginal delivery (vacuum/forceps)	2/5	Not available (equipment gap)	Absence of a vacuum extractor and forceps
Perform basic neonatal resuscitation (bag and mask)	4/5	Available	No neonates requiring resuscitation

Source: Auditors' Analysis BEmONC Availability in Dispensaries, 2025

Table 3.7 shows inconsistent performance in the provision of Basic Emergency Obstetric and Newborn Care (BEmONC) signal functions across the five dispensaries visited. All dispensaries were able to administer parenteral antibiotics, indicating the capacity to manage maternal infections. Similarly, uterotonic drugs and anticonvulsants were largely available (4/5 and 3/5 dispensaries, respectively), with non-performance mainly attributed to the absence of patients requiring these interventions rather than systemic constraints. Basic neonatal resuscitation was also available in most facilities (4/5), suggesting reasonable preparedness to manage immediate newborn complications.

However, gaps were observed in signal functions that require higher clinical skills and specialised equipment. Manual removal of the placenta and removal of retained products were not available at the majority of dispensaries, primarily due to staff skill gaps, highlighting inadequate training and competency in managing obstetric complications. Even more

pronounced was the inability to perform assisted vaginal deliveries, where only 2 out of 5 dispensaries had provided the service, largely due to the absence of essential equipment such as vacuum extractors and forceps.

This was attributed to the scarcity of trained staff and specialised equipment, such as vacuum extractors. The problem was compounded by a resource allocation model that appeared to favour higher-level hospitals over primary healthcare facilities such as dispensaries and health centres, which are the first point of contact for most of the population, and by the pyramidal nature of our health system.

The consequence of this situation was a fragile healthcare safety net for pregnant women and newborns. The inability to manage basic obstetric emergencies at the dispensary level increased the risk of preventable maternal deaths. It created significant geographic disparities in care and places an unsustainable burden on an already fragile referral system, where delays in receiving advanced care can be fatal.

(b) Inadequate Availability of Fully Functional CEmONC Services

The state of CEmONC, which includes BEmONC services, blood transfusion, and caesarean section, faced a gap between secondary, higher-level facilities and primary healthcare lower-level facilities, as well as a critical lack of preparedness, even where services existed, as shown in **Table 3.8**.

Table 3.8: Comprehensive Emergency Obstetric and Newborn Care Service Availability

Facility Level	Total Number of Facilities	Facilities with CEmONC	CEmONC Availability (%)
District Hospital	219	201	92
Health Centre	924	491	53

Source: Auditors' Analysis of Availability of CEmONC Services in Primary Healthcare Facilities, 2025

Table 3.8 presents the distribution of Comprehensive Emergency Obstetric and Newborn Care (CEmONC) services and reveals a marked disparity by facility level. District hospitals demonstrate high availability, with 201 out of 219 facilities (92%) providing CEmONC services, indicating that most hospitals at this level are relatively well positioned to manage obstetric and neonatal complications. This suggests stronger infrastructure, staffing, and equipment readiness at district hospitals.

In contrast, health centres show limited availability, with 491 out of 924 facilities (53%) offering CEmONC services. This means nearly half of all health centres lack full CEmONC capacity, despite being critical first-referral facilities, particularly in rural and peri-urban areas. The gap at the health centre level implies persistent constraints in skilled personnel, theatre capacity, blood transfusion services, and essential equipment. As a result, many women with obstetric emergencies are likely to experience delays due to referrals to district hospitals, increasing the risk of adverse maternal and neonatal outcomes. Overall, while CEmONC coverage at district hospitals is encouraging, the inadequate availability at health centres undermines equitable and timely access to life-saving obstetric care.

While the overall readiness score for CEmONC improved to 71%. The most dangerous bottleneck was the low availability of anaesthesia equipment, present in only 21% of facilities. Similarly, the sufficiency of the blood supply was a major concern, with only 56% as shown in **Table 3.9.**

Table 3.9: Comprehensive Obstetric Care Readiness

Category	Item	Percentage Availability (%)
Staff and Guidelines	Staff trained in surgery	95
	Staff trained in anaesthesia	92
	At least one trained staff CEmONC	61
	Guidelines available CEmONC	56
Equipment	Resuscitation table	90
	Spinal needle	79
	Oxygen	75
	Incubator	48
	Anaesthesia equipment	21
Diagnostics	Blood typing	96
	Cross-match testing	58
Medicines and Commodities	Ketamine (injectable)	100
	Epinephrine (injectable)	89
	Atropine (injectable)	85
	Lidocaine 5%	75
	Halothane (inhalation)	72
	Suxamethonium bromide	63
	Blood supply safety	60
	Blood supply sufficiency	56
	Thiopental (powder)	56
Readiness Score	Mean availability of tracer items	71

***Source*:** Auditors' Analysis of the SARA Survey, 2025

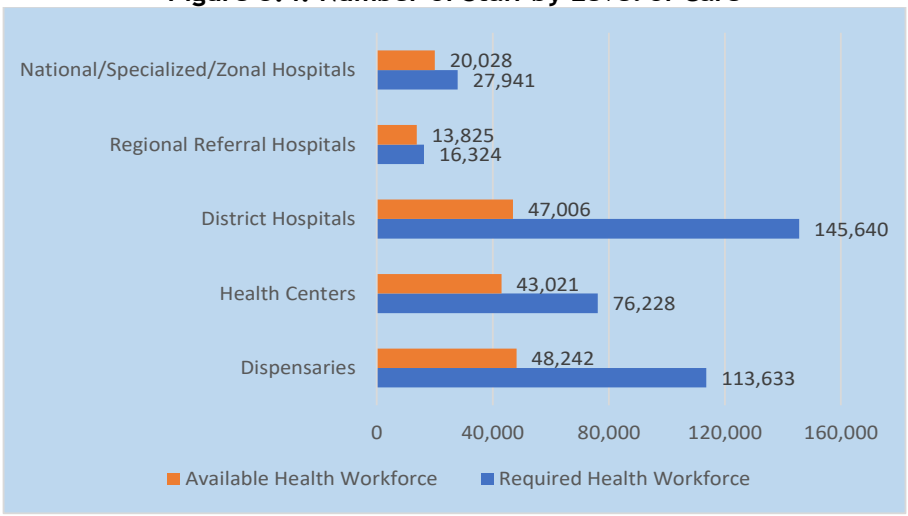
Table 3.9 shows the CEmONC readiness of healthcare facilities. Surgical services required expensive infrastructure, highly specialised staff, and logistical support for functions such as blood banking, all of which were challenging to maintain. The discrepancy between the high percentage of staff trained in surgery (95%) and the low availability of anaesthesia equipment (21%) suggested that many facilities possessed the human skills but lacked the fundamental tools to perform life-saving procedures safely.

The direct consequence was an increased risk of death for women who experience complications during childbirth. A woman arriving at a facility needing emergency surgery may be denied care or receive it late, as the hospital may lack a sufficient blood supply and the equipment to administer anaesthesia. Consequently, the capacity of trained surgeons was not optimally utilised, and treatable complications progressed to fatal outcomes.

3.3.2 Mismatch Between Skilled Staffing Levels and Maternal Service Demand at Health Facilities

The audit noted a shortage of health staff in health facilities across all levels of care, though the country, contrary to Para 5.4.1 of the Health Sector Strategic Plan V, aimed to expand the use of the Workload Indicator of Staffing Needs Prioritisation and Optimisation Analysis (WISN-POA) to allocate health workers where they are most needed, as shown in **Figure 3.4.**

Figure 3.4: Number of Staff by Level of Care



Source: Auditors' Analysis of Human Resource for Health, 2025

Figure 3.4 shows the distribution of staff across different levels of care, from dispensaries to national hospitals. As evidenced, the distribution was insufficient; for example, in National and Regional Referral Hospitals, the gaps were 28% and 15%, respectively. In District Hospitals, Health centres, and Dispensaries, the staff gaps were 67%, 43%, and 58%, respectively.

Tables 3.10-3.13 provide details on staff-to-mother ratios across the sampled healthcare facilities at various levels. National standards require a 1:1 staff-to-mother ratio in labour wards and a 1:8 staff-to-mother ratio in antenatal, postnatal, and antenatal clinic wards to ensure continuous monitoring and timely management of complications. To assess the performance implications of staffing levels, the audit analysed staff-to-patient ratios across sampled facilities. **Table 3.10** shows the staff-to-mother ratio at Regional Referral Hospitals (RRHs).

Table 3.10: Staff to Mother Ratios at Regional Referral Hospitals

Section	Standard	Ligula	Seko-Toure	Maweni	Mawenzi	Temeke
Labor ward	1:1	1:1	1:2	1:4	1:2	1:2
Antenatal ward	1:8	1:8	1:8	1:17	1:16	1:3
Postnatal ward	1:8	1:10	1:8	1:17	1:16	1:2
Antenatal clinic	1:8	1:10	1:10	1:12	1:12	1:2

Source: Auditors' Analysis of Staff Workloads at the Sampled Facilities, 2025

Table 3.10 shows that while some regional referral hospitals, such as Ligula, met the labour ward standard, others did not. Maweni Hospital's labour ward ratio of 1:4 implies that one skilled provider simultaneously manages four women in labour, reducing the effectiveness of intrapartum monitoring. In antenatal and postnatal wards, ratios reaching 1:17 indicated staff overload, which limited counselling, follow-up, and early detection of post-delivery complications. These deviations demonstrated reduced effectiveness, despite better staffing than at lower-level facilities.

Staffing pressures were more pronounced at district hospitals, which play a critical role in delivering CEmONC services and managing referrals from health centres and dispensaries, as evidenced in **Table 3.11**.

Table 3.11: Staff-to-Mother Ratios at District Hospitals

Section	Mbagala Rangitatu	Nyamagana	Tandahimba	Kondoa	Kyela	Uvinza	Same
Labor ward	1:2	1:7	1:3	1:3	1:3	1:10	1:5
Antenatal ward	1:24	1:15	1:10	1:5	1:12	1:10	1:11
Postnatal ward	1:21	1:17	1:10	1:5	1:12	1:17	1:15
Antenatal clinic	1:18	1:13	1:13	1:5	1:20	1:17	1:14

***Source*:** Auditors' Analysis of Staff Workloads at the Sampled Facilities, 2025

Table 3.11 indicates inefficiencies at district hospitals. Labour ward ratios of up to 1:10 in Uvinza compromise safe delivery practices and explain the observed reliance on referrals. Antenatal and postnatal ward ratios exceeding 1:20 show that available staff cannot adequately manage patient volumes, resulting in reduced service output per facility. This mismatch between staffing and workload undermines efficiency, as infrastructure

investments at district hospitals are underutilised due to constraints on Human Resources for Health (HRH).

Health centres are expected to provide CEmONC; adequate staffing at this level is therefore critical for system-wide performance. **Table 3.12** shows the staff-to-mothers ratio at the sampled health centres.

Table 3.12: Staff-to-Mother Ratios at Health Centres

Section	Makongoro	Mahuta	Mauno	Ipinda	Hedaru	Uvinza	Buza
Labor ward	1:7	1:5	1:5	1:4	1:3	1:4	1:7
Antenatal ward	n/a	1:13	1:15	1:12	1:12	1:10	1:15
Postnatal ward	1:5	1:20	1:15	1:12	1:12	1:12	1:20
Antenatal clinic	1:3	1:16	1:18	1:20	1:20	1:13	1:15

***Source*:** Auditors' Analysis of Staff Workloads, 2025

Table 3.12 highlights staffing deficits at health centres. The Buza labour ward ratio of 1:7 indicates that continuous intrapartum care is effectively impossible. Health centres with such ratios cannot sustain functional CEmONC services, leading to frequent referrals for conditions that should be managed at this level. This reflects low effectiveness and poor value for money from health centre upgrades intended to reduce pressure on hospitals.

Dispensaries serve as the first point of contact for most pregnant women, particularly in rural areas. Staffing adequacy at this level is essential for preventive care, early risk detection, and the provision of BEmONC services, as evidenced in **Table 3.13**.

Table 3.13: Staff-to-Mother Ratios at Dispensaries

Section	Buhongwa	Kitama	Bambare	Kichemchem	Makwale	Malagarasi	Kakonkoro
Labor ward	1:5	1:7	1:4	1:5	1:6	1:3	1:5
Antenatal clinic	1:10	1:13	1:14	1:13	1:17	1:15	1:18

***Source*:** Auditors' Analysis of Staff Workloads, 2025

Table 3.13 confirms that dispensaries are operating far below staffing standards. Labour ward ratios of 1:4 to 1:7 and antenatal clinic ratios reaching 1:18 significantly limit preventive care, health education, and early identification of high-risk pregnancies. These inefficiencies at the

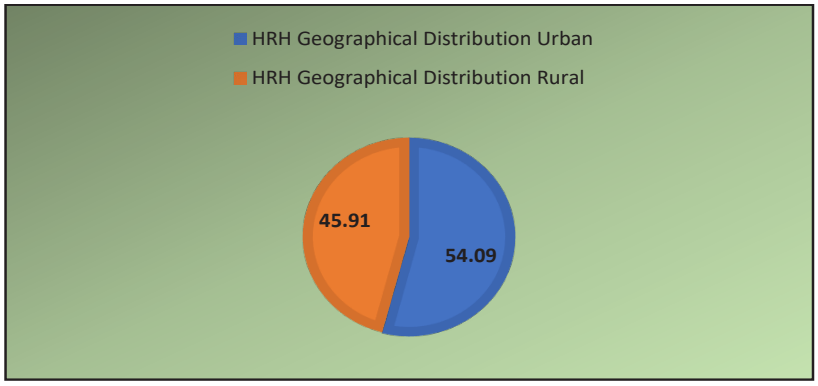
primary level result in late presentation of complications, increased referrals, and avoidable maternal emergencies, undermining overall system effectiveness.

Further explanation of the staff shortage is provided in detail below.

a) Staff Allocation Disparities between Urban and Rural Distribution

Additionally, the Interview and review of the Annual Health Performance Profile, 2023, revealed that Human Resource Personnel for Health were not allocated based on the Populations of the areas, resulting in disparities between staff deployed in Health Facilities located in Rural Versus those located in Urban areas across the country. **Figure 3.5** shows Rural and Urban Disparities in staffing of Human Resources for Health (HRH).

Figure 3.5: Distribution of Human Resources for Health in the Country



***Source*: Annual Health Performance Profile, 2023**

Figure 3.5 above shows disparities in Human Resources for Health (HRH) between Urban and Rural settings. Urban has 54.09% of Human Resources for Health (HRH), and Rural has 45.91% of Human Resources for Health (HRH). This is attributed to factors such as working conditions and remuneration.

b) Imbalance Mix of Skilled Staff in Sampled Regions

Additionally, the audit found an imbalanced mix of skilled staff in the visited Regions, with over-reliance on general nurses and underrepresentation of specialists. **Table 3.14** shows the status of Midwives, Obstetricians, and Anesthesiologists in the sampled Regions.

Table 3.14: Status of Midwives, Obstetricians and Anaesthetists in Sampled Regions

Region	Midwives		Obstetricians	Anesthetists	Total Health Personnel	Rank	Pregnant Women Delivered at Health
Dar Es Salaam	6820	1725	87	4	8636	1	576,784
Dodoma	3893	521	39	6	4459	2	391,684
Kigoma	635	74	2	1	712	6	434,379
Kilimanjaro	1249	251	19	10	1529	5	248,502
Mbeya	2443	898	18	5	3364	3	301,281
Mwanza	705	138	12	9	864	5	619,727
Mtwara	1664	172	3	0	1839	4	156,382

Source: Auditors' Analysis of HRH Country Profile (2024) and Delivery Information from MoH, 2025

Table 3.14 showed imbalances and regional disparities in the distribution of skilled maternal health personnel compared to the number of facility-based deliveries. Dar es Salaam, Dodoma, Mbeya, and Mtwara showed relatively better alignment between staffing levels and delivery volumes, with roughly 110–150 skilled personnel per 10,000 deliveries.

In contrast, Mwanza (only 14 personnel per 10,000 deliveries) and Kigoma (16 per 10,000) faced the most severe understaffing relative to workload. This extreme pressure on staff led to overwork, reduced quality of care, longer waiting times, and increased risks during obstetric emergencies. Kilimanjaro (62 per 10,000) experienced moderate overload, better than in Mwanza and Kigoma, but still considerably worse than in the better-staffed regions. Overall, while Dar es Salaam had the highest number of personnel and deliveries, the real strain falls on high-volume regions with poor staffing ratios.

Furthermore, duty rosters showed average weekly hours exceeding the 40-hour policy limit, with an overall average of 52 hours, leading to burnout and quality compromises. Rural regions reported the highest workloads due to shortages, which correlated with increased delays in care and a rise in EmONC complications.

The staff shortage was caused by weak human resource (HR) planning within the Ministry of Health and by the partial use of the Workload Indicator of Staffing Needs – Prioritisation and Optimisation Analysis (WISN-POA), which

could assist in allocating health workers where they are most needed. This led to persistent shortages and imbalances in the skills mix.

Additionally, limited incentives for rural postings, such as inadequate housing allowances and career progression opportunities, discouraged skilled attendants from serving in underserved regions like Kigoma and Mtwara, exacerbating urban-rural disparities.

Furthermore, high staff turnover driven by burnout and better opportunities elsewhere was compounded by inadequate training budgets, allocating less than 30% of required funds for in-service EmONC programs, as per reviewed HR policy documents. These factors collectively hindered effective deployment and competency maintenance during the audit period.

Consequently, the shortages and disparities in skilled birth attendants have resulted in compromised EmONC service delivery, increasing maternal and neonatal mortality risks in rural regions, where delays in interventions could lead to preventable complications such as postpartum haemorrhage. Overworked staff have contributed to reduced care quality, straining facility resources, as evidenced by higher referral rates from understaffed areas.

Additionally, long-term consequences include widened health inequities across the country, with urban areas like Dar es Salaam benefiting disproportionately, while rural populations in sampled regions face heightened vulnerability. Ultimately leading to increased healthcare costs from emergency escalations and failure to meet Sustainable Development Goal 3.1 for maternal health.

Analysis of the staff-to-mother ratio provided quantitative evidence that deviations from staffing standards are directly associated with reduced service efficiency, compromised quality of care, and weakened effectiveness of EmONC services. Facilities with staffing ratios closer to national standards demonstrated better service continuity and capacity, while those with deviations experienced increased referrals and greater risks to maternal and newborn health. This failure to align HRH deployment with workload, contrary to WISN-POA requirements, has constrained progress towards achieving Sustainable Development Goal 3.1.

3.3.3 Inadequate Budget Allocation for Maternal Health Care Services

The audit noted funding gaps and increased donor dependency financing for maternal healthcare services, contrary to Para 5.4.8 of the Health Sector Strategic Plan (HSSP V, 2021-2026), which states that health care financing is a crucial element in the process of service delivery and requires the inclusion of all relevant sources of funding. Attention was paid to increasing domestic health financing and expanding strategic purchasing in the sector. **Table 3.15** provides details of the budget allocated to Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) activities.

Table 3.15: Budget for RMNCAH Activities

Financial Year	Total Approved (TZS billion)	Foreign Approved (%)	Domestic Approved (%)	Total Allocation (TZS billion)	Allocation Rate Approved (%)	Utilisation Rate Allocation (%)
2022/23	138.8	15.0	85.0	51.0	36.7	94.7
2023/24	182.0	31.1	68.9	79.0	43.4	**96.7**
2024/25	212.5	32.1	67.9	101.3	47.7	93.1
Total/Average	**533.3**	**27.3**	**72.7**	**231.3**	**43.4**	**94.7**

Source: Auditors' Analysis of RMNCAH Budget, 2025

As shown in **Table 3.15**, the audit noted a shift in funding sources over time, with the proportion of domestic funding decreasing from 85% in 2022/23 to 68% in 2024/25. Conversely, foreign funding had increased from 15% to 32% over the same period.

Additionally, regarding Allocated vs Approved discrepancies, in 2024/25, domestic funds received only 41% of their approved amount, indicating under-allocation. Foreign funds, however, received 59% of their approved budget, which exceeds their approval percentage.

Furthermore, the analysis of expenditure trends demonstrated that the RMNCAH department possessed a high capacity to utilise funds once they were made available. Across the three-year period, the average utilisation rate stood at 94.7%, peaking at 96.7% in 2023/24. Despite this high efficiency in spending, the actual impact on service delivery was constrained by the fact that total allocations never exceeded 50% of the approved budget. Consequently, the primary barrier to improving RMNCAH outcomes was not the inability of departments to spend money, but rather the significant gap between budget approval and the actual release of funds.

The multi-year quantification report for RMNCAH commodities projects a supply value of USD 71.7 million for 2025, 2026, and 2027, with USD 59.8 million still uncommitted. The inadequate budget allocation was further increased by a decline in donor support and by the government's insufficient budget allocation for reproductive health commodities, resulting in a funding gap of USD 19.7 million in 2025 and increasing the risk of commodity stockouts nationwide.

Furthermore, the audit noted the following:

a) Unequal Health Financing through CCHP

The audit noted unequal Comprehensive Council Health Planning (CCHP) budget allocations across the visited regions for the Financial Year 2024/25, along with population figures and the computed budget per capita. **Table 3.16** provides a basis for assessing the equity and adequacy of health sector financing across regions by showing how allocated resources correspond to population size and by enabling direct comparison of per capita investment in health service delivery.

Table 3.16: CCHP Budget allocation for Financial Year 2024/25

Region	Budget Allocated (TZS)	Population	Budget per Capita (TZS/capita)
Dar es Salaam	87,809,212,362.49	5,383,728	16,310
Dodoma	28,336,829,899.97	3,085,625	9,183
Kigoma	21,875,722,125.06	2,470,967	8,853
Kilimanjaro	21,178,062,437.31	1,861,934	11,374
Mbeya	23,460,472,712.61	2,343,754	10,010
Mtwara	22,046,018,559.57	1,634,947	13,484
Mwanza	27,356,498,176.52	3,699,872	7,394

Sources: Auditors' Analysis of CCHP Budget, 2025

Table 3.16 shows disparities in Comprehensive Council Health Planning (CCHP) budget allocations across regions when adjusted for population size. Dar es Salaam received the highest allocation (TZS 87.8 billion), reflecting its large population. It also recorded the highest budget per capita (TZS 16,310), demonstrating a stronger level of financing for health service delivery per resident.

Mwanza, despite being among the most populous regions with approximately 3.7 million people, recorded the lowest budget per capita (TZS 7,394). This confirms that the region is under-resourced per capita, placing pressure on service delivery and limiting councils' capacity to adequately meet health care needs.

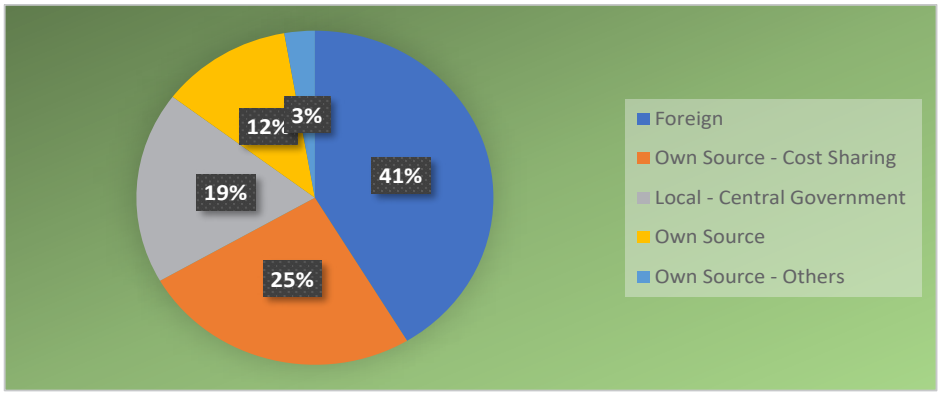
Dodoma and Kigoma also show relatively low per capita allocations of TZS 9,183 and TZS 8,853, respectively. This indicates constrained health service provision in these regions, notwithstanding Dodoma's national administrative role and Kigoma's additional service demands associated with hard-to-reach populations.

Overall, the analysis confirms that CCHP budget allocation for FY 2024/25 is not strictly population-based. Contrary to the Health Financing Strategy (2016-2026), which reinforces population-based principles as the foundation for equitable allocation to councils. This also aligns with the Plan's focus on leaving no one behind, reducing urban-rural inequalities, and ensuring resources reach the population with greater needs. The wide variation in per capita funding demonstrates the application of differentiated allocation considerations, resulting in uneven levels of health financing across regions and clear inequities in per capita resource availability.

b) Over-reliance on Donor/Foreign Health Financing for CCHPs

The audit noted reliance on external donors for health financing in the CCHP for the Financial Year 2024/25. **Figure 3.6** shows the contribution of external funding, central and local government transfers, and own sources under the Comprehensive Council Health Planning (CCHP) framework.

Figure 3.6: Health Budget Allocation Domestic vs Foreign for the FY 2024/25



***Source*: Auditors' Analysis of CCHP Budget, 2025**

Figure 3.6 shows that foreign sources constitute the largest share of the health budget, accounting for TZS 269.6 billion, or 41.37 per cent of the total allocation. This shows a substantial reliance on external financing to support health sector activities, underscoring the continued dependence of the health system on development partners for service delivery, programmes, and investments.

Domestic sources account for 58.63 per cent of the total health budget. Within this category, own-source revenue from cost-sharing accounts for TZS 165.2 billion (25.35 per cent), the largest domestic financing component. This reflects the significant role of user fees and insurance-related contributions in financing health services at the council level. Local and central government contribute TZS 121.2 billion, equivalent to 18.60 per cent of the total budget. This level of contribution indicates a substantial, though not dominant, commitment by the Government to health sector financing through intergovernmental transfers.

Other own-source revenues, including general own-source funds (11.93 per cent) and other minor own-source contributions (2.75 per cent), amount to TZS 95.7 billion. While these sources play a supportive role, their combined contribution remains relatively limited compared to foreign funding and cost-sharing revenues.

The analysis demonstrates that although domestic financing accounts for the majority of the health budget, external funding remains the single largest source. This financing structure highlights structural vulnerability to

fluctuations in donor support and underscores the need to strengthen sustainable domestic resource mobilisation to ensure predictable, resilient health sector financing under the CCHP framework. Consequently, the increasing reliance on foreign funds suggested growing external support or dependency. Domestic funds, while still constituting the majority of approved budgets, were underspent relative to allocations due to funding constraints and implementation challenges.

3.3.4 Inadequate Mitigation of Systemic Risks that Limited the Availability of EmONC

The audit noted that the MoH and PMO-RALG had not adequately addressed systemic risks, including the shortage of skilled birth attendants and a deficit of functional Emergency Obstetric and Newborn Care (EmONC) equipment. These gaps were found to be contrary to Strategic Objective 3 of the One Plan III, which mandated the strengthening of intrapartum care by expanding the availability of both Basic (BEmONC) and Comprehensive (CEmONC) services, including safe surgery, anaesthesia, and a reliable supply of blood products.

The failure to mitigate these risks, compounded by a heavy dependency on donor funding for core maternal health interventions, contributed to a stagnation in the reduction of maternal mortality. The audit noted that the lack of functional EmONC services at the primary level directly hindered the timely management of obstetric emergencies. Analysis of facility records indicated that lower-level facilities were unable to provide basic life-saving interventions and relied on higher-level care, thereby increasing the risk of Phase 3 Delay (delays in receiving adequate care at the facility).

Consequently, the audit found that Regional Referral Hospitals were significantly overwhelmed by a high volume of cases that could have been effectively managed at the primary health care level. Data reviewed during the audit showed that at the sampled seven referral facilities, maternal deaths that occurred were mostly referrals from lower-level facilities, as evidenced in **Table 3.17,** and a substantial percentage of admissions involved normal deliveries and minor complications that bypassed lower-level facilities.

Table 3.17: Maternal Deaths by Percentage Referral

Facility Level	Maternal Death	Referral Cases (%)
Regional Referral Hospitals	259	85
District Hospitals	84	70
Health Centers	15	33

Source: Auditors' Analysis of Maternal Deaths, 2025

Table 3.17 shows that Regional Referral Hospitals recorded the highest number of maternal deaths (259), with 85 per cent being referral cases, indicating that these facilities predominantly manage severe and complicated obstetric cases referred late from lower levels, often with limited pre-referral stabilisation. Although District Hospitals reported fewer maternal deaths (84 cases), a high proportion (70 per cent) were also referrals, reflecting persistent weaknesses in timely referral, emergency management, and capacity at primary-level facilities.

This congestion not only strained referral centres' resources but also caused further delays in the management of high-risk cases requiring specialised surgery or anaesthesia. Ultimately, these systemic challenges undermined the implementation of the One Plan III strategic objectives and hindered the country's progress toward achieving the SDG 3.1 target for maternal mortality.

3.4 Inadequate Maternal Mortality Data Collection, Monitoring, and Reporting

The review of the Maternal and Perinatal Death Surveillance and Response (MPDSR) Report for Six Years (2018–2023), issued in March 2025, revealed inadequate maternal mortality data collection, monitoring, and reporting. This was contrary to Para 3.3.3 of the Maternal and Perinatal Death Surveillance and Response Guidelines, 2019, which insists on the provision of information, recommendations, and actions to be taken to eliminate preventable maternal deaths at health facilities.

Inadequate maternal mortality data collection, monitoring, and reporting were reflected in weak implementation of the Maternal and Perinatal Death Surveillance and Response (MPDSR) system, limited use of MPDSR data for evidence-based interventions, and inadequate documentation and record-keeping. The details of each aspect are provided below.

3.4.1 Inadequate Implementation of Maternal and Perinatal Death Surveillance and Response (MPDSR)

The Audit noted that MoH and PMO-RALG did not adequately implement the Maternal and Perinatal Death Surveillance and Response (MPDSR) at the health facilities, contrary to the Maternal and Perinatal Death Surveillance and Response Guidelines, 2019, which requires the provision of information, recommendations and actions to be taken to eliminate preventable maternal deaths at health facilities.

The challenges in implementing MPDSR were evidenced by an insufficient number of maternal deaths reviewed within the required timelines, the presence of facilities without functional MPDSR committees, limited MPDSR review meetings, and inadequate monitoring and evaluation. The details are indicated in **Table 3.18.**

Table 3.18: Implementation Status of Maternal and Perinatal Death Surveillance and Response (MPDSR)

Aspect	Planned Action	Implementation Status
Maternal and Perinatal Death Review	The review should be conducted within 7 days of the facility deaths.	Reviews not conducted in the 5/23 facilities.
Existence of Functional MPDSR Committees	Each facility should set up a facility MPDSR committee	5/23 facilities had committees which were inactive
MPDSR Review Meetings	Regular MPDSR review meetings with documented minutes and action plans	Meetings were irregular and lacked documented minutes, and 5/23 facilities had no MPDSR Review Meetings
Monitoring and Evaluation	Biannually at the National Level	Not consistently conducted, and feedback was absent

***Source*:** Auditors' Analysis of the Maternal and Perinatal Death Surveillance and Response (MPDSR) Report for Six Years (2018-2023), 2025

Table 3.18 shows that MPDSR was not effectively implemented at the health facility and national levels. Death reviews were not conducted at the 5/23 facilities; MPDSR committees were largely dysfunctional; review meetings were irregular and poorly documented; and national monitoring and feedback were inconsistent.

Additionally, it was noted that the primary causes of maternal deaths in the country have remained consistent over the years, predominantly direct

obstetric complications such as postpartum haemorrhage (PPH), eclampsia, and infections/sepsis. This pattern persists despite the MPDSR system's aim to identify and address preventable factors through surveillance and response. **Table 3.19** shows the Recurrent Causes of Maternal Deaths in Tanzania mainland despite MPDSR implementation.

Table 3.19: Status of Recurrent Causes of Maternal Deaths

Year	Number of Maternal Deaths	Causes of Death by ranking		
		Top Cause 1	Top Cause 2	Top Cause 3
2020	1640	Obstetric Haemorrhage (45%)	Pre-Eclampsia /Eclampsia (17%)	Puerperal Sepsis (10%)
2021	1588	Obstetric Haemorrhage (44%)	Pre-Eclampsia /Eclampsia (17%)	Abortion complications (10%)
2022	1541	Obstetric Haemorrhage (46%)	Pre-Eclampsia /Eclampsia (16%)	Puerperal Sepsis (9%)
2023	1498	Obstetric Haemorrhage (44.4%)	1 Pre-Eclampsia /Eclampsia (6.6%)	Puerperal Sepsis (9.5%)
2024	1498	Obstetric Haemorrhage (44%)	Pre-Eclampsia /Eclampsia (17%)	Puerperal Sepsis (10%)

Source: Auditors' Analysis on MPDSR Report, October 2023 -Cross-Referenced with Africa CDC

Table 3.19 shows that, despite a downward trend in annual maternal deaths in Tanzania, declining from 1,640 in 2020 to 1,498 in 2024, a reduction of approximately 9% over five years Obstetric hemorrhage remains dominant at 44-46% across years, with no notable proportional reduction, Pre-eclampsia/eclampsia that holds at 16-17% and secondary causes like puerperal sepsis or abortion complications fluctuate around 9-10%. The recurrence of these top causes persists, suggesting that MPDSR implementation needs to be strengthened in areas such as emergency obstetric care to achieve more transformative prevention.

Furthermore, inadequate implementation of maternal and perinatal death surveillance (MPDSR) resulted from the following factors:

a) Inadequate Review of Maternal and Perinatal Deaths at the Healthcare Facilities

The audit noted significant inadequacies in MPDSR reviews across the health facilities visited. In the seven sampled regions, the notification rate of maternal death was not fully implemented, 80% of maternal deaths were

not reviewed. MPDSR committees lacked documented minutes for required monthly and quarterly meetings throughout the audit period (2021/22–2024/25). Health facilities experienced delays in conducting reviews, often exceeding the 7-day guideline, and in some cases, remained unreviewed due to irregular schedules.

Additionally, the Maternal and Perinatal Death Surveillance and Response (MPDSR) process in the healthcare facilities was responsible for reviewing maternal deaths to identify causes, contributing factors, and actionable improvements in the occurrence of Maternal deaths. However, the audit noted that the number of maternal cases reviewed at the visited healthcare facilities was lower than the total number of notified maternal cases. This can be depicted in **Table 3.20**.

Table 3.20: Maternal Death Notified and Reviewed Cases

Health Facilities	No. of Notified Cases	No. of Reviewed Cases	No. of Reviewing Gap	Reviewing Gap (%)
Regional Referral Hospital	259	37	222	86
District Hospital	84	23	61	73
Health centre	15	11	4	27
Total	**358**	**71**	**287**	**80**

Source: Auditors' Analysis on the MPDSR Report, 2025

Table 3.20 presents 358 notified maternal cases at the healthcare facilities, while only 71 cases were reviewed by the MPDSR Committee. This reveals a discrepancy of 80% of maternal cases that were not reviewed by the MPDSR Committee at a specific healthcare facility.

Inadequate review of Maternal deaths was attributed to poor documentation of the reported incidences, which limits thorough discussions in the healthcare facilities, staffing gap of skilled healthcare providers at the healthcare facilities, system challenges in storing the notified cases at healthcare facilities, inadequate training to the healthcare providers on the MPDSR procedures and data management.

Additionally, high workloads for healthcare providers, shifting focus from care to administrative duties, negative attitudes among healthcare providers, ineffective communication among healthcare facilities, the absence of obstetricians at primary healthcare facilities, and fear of blame despite the "no blame" policy.

Inadequate review of Maternal deaths resulted in an increase and repetition of maternal deaths, and a delay in identifying the causes of occurrence of maternal death.

b) Inadequate Recommendation Provided Against the Reviewed Cases

The Audit noted that the visited healthcare facilities provided fewer recommendations than the reviewed Maternal cases in the MPDSR conducted, contrary to Para 4.2.3 of the Maternal and Perinatal Death Surveillance and Response Guidelines, 2019, which required that information from the MPDSR reviews be analysed, and recommendations for action be made. This is further illustrated in **Table 3.21**.

Table 3.21: Status of Action Plans Developed

Health Facilities	No. of Reviewed Cases	No. of Action Plans Developed	No. of Action Plan Gap	Action Plan Gap (%)
Regional Referral Hospital	37	21	16	43
District Hospital	23	16	7	30
Health Center	11	7	4	36
Total	**71**	**44**	**27**	**38**

Source: Auditors' Analysis on the MPDSR Report, 2025

Table 3.21 indicates the gap of 38% of the reviewed maternal cases that were not provided with the recommended action plan in the review of the maternal deaths at healthcare facilities.

A lesser number of action plans developed was attributed to inadequate review of the MPDSR, unrecorded information on maternal and perinatal cases, training gaps among staff in recording and handling documents, data management and MPDSR requirement, weak supervision at district and regional levels, inactive participation of the MPDSR committee, weak enforcement of the MPDSR requirement and inconsistent MPDSR meetings.

Not developing the action plan in the reviewed case results in repetitive occurrences of maternal deaths of similar causes, like delay in referrals, improper use of equipment, and inadequate staffing levels.

c) Inconsistencies of Maternal and Perinatal Data Collected in the Healthcare Facilities

The audit noted inconsistencies in maternal mortality data across the sampled health facilities between facility registers and data from the District Health Information System 2 (DHIS2). In the sampled regions, there was underreporting of maternal mortality and inaccurate data entry. Facility registers often capture more detailed individual cases through continuous surveillance, such as MPDSR, while DHIS2 aggregates monthly reports.

Inconsistencies in the data were attributed to resource shortages in data collection, weak integration with the national HMIS, weak inter-departmental coordination across the healthcare facilities, manual data entry at the healthcare facilities, limited Information and Communication Technology (ICT) infrastructure in the healthcare facilities, and errors in compiling fragmented data from the healthcare facilities.
Furthermore, data inconsistency undermines efforts to track progress toward national health goals, such as reducing the maternal mortality ratio (MMR), and additionally, misguided resource allocation.

3.4.2 Limited Use of Collected Data for Targeted Maternal Mortality Interventions/Recommendations

The Audit noted that MoH and PMO-RALG did not use the collected Maternal Mortality data to issue evidence-based interventions aimed at reducing maternal and perinatal deaths, contrary to objective 3.3.3 of the Maternal and Perinatal Death Surveillance and Response Guidelines, 2019, which requires using maternal and perinatal mortality data to inform and implement evidence-based strategies reducing maternal and perinatal deaths.

The main purpose of the MPDSR meeting was to identify solutions to gaps in the management of the case(s) under consideration. The effective use of maternal and perinatal death reviews generates high-quality information on the identification of maternal and perinatal causes of death and important common contributors to those deaths. The information helped inform the prioritisation of quality improvement interventions in healthcare facilities and promoted understanding of common contributors and promising changes to systems or service delivery to overcome identified gaps.

The inability to translate MPDSR findings into documented, tracked, and implemented evidence-based interventions results in preventable maternal deaths recurring due to unaddressed challenges, as seen in **Table 3.22**.

Table 3.22: Number of Deaths at Visited Facilities 2021/22-2024/25

Level	Facility	Maternal Deaths	Remarks
Zonal	Mtwara Zonal	6	Preventable
RRH	Ligula	58	Preventable
	Sekou Toure	54	Preventable
	Mawenzi	6	Preventable
District Hospitals	Mbagala Rangitatu	32	Preventable
	Nyamagana	11	Preventable
	Tandahimba	22	Preventable
Health Center	Mahuta	6	Preventable
	Ipinda	3	Preventable
Total		198	

Source: Auditors' Analysis of Maternal Deaths, 2025

Table 3.22 shows that the number of maternal deaths from visited healthcare facilities covering the financial years 2021/22-2024/25 was 198. All the deaths were avoidable and were caused by excessive blood loss and higher blood pressure in pregnancy. This inaction wastes the resources invested in data collection and review meetings and undermines the fundamental purpose of the surveillance system, leading to stagnant mortality rates.

Additionally, limited use of collected data for targeted Maternal Mortality Interventions is attributed to the factors below;

a) Inadequate Follow-Up and Monitoring of the Agreed Recommendation from the MPDSR Review

The Audit noted that MoH had inadequate follow-up on the agreed recommendation from the MPDSR review conducted at the healthcare facility, contrary to Para 4.2.4 of the Maternal and Perinatal Death Surveillance and Response Guidelines, 2019, which requires monitoring of the implementation of recommendations from maternal and perinatal death reviews.

Moreover, the audit noted unsatisfactory follow-up after MPDSR reviews, during which individuals are typically assigned to specific recommendations, which are monitored through meeting minutes or verbal updates within the

healthcare facilities visited. **Table 3.23** shows the status of evidence of follow-ups.

Table 3.23: Status of Follow-up Cases

Health Facilities	Action Plans Developed	Evidence of Follow-up	Follow-up Gap	Follow-up Gap (%)
Regional Referral Hospital	21	11	10	48
District Hospital	16	9	7	44
Health Center	7	5	2	29
Total	**44**	**25**	**19**	43

***Source*:** Auditors' Analysis on the MPDSR Report, 2025

Table 3.23 shows that 44 action plans were developed for the reviewed maternal and perinatal cases, but only 57% had documented follow-up, indicating that 43% lacked evidence of follow-up.

Inadequate follow-up and monitoring is caused by absence of fully centralised digital system for maternal and perinatal case files, rely on paper-based storage facility at primary health care centres and regional referral hospitals, incomplete MPDSR committee composition, shortage of staff at the healthcare facilities, outdated guidelines in use (e.g., 2018 versions), fragmented reporting systems like MPDSR, DHIS2, and RITA overlap, causing redundancy and inconsistencies), and limited internet/computers for digitalisation.

Consequently, inadequate follow-up and monitoring of agreed recommendations by the MPDSR Committee leads to an increase in maternal deaths of similar causes, which would otherwise be mitigated by interventions recommended during facility MPDSR sittings, delaying the government's initiatives to achieve zero maternal deaths and efforts to achieve SDG 3.1.

b) Absence of a Clear Follow-up Mechanism

Interviews with MoH Officials noted that, MoH had no clear follow-up mechanism for the recommendations provided by the MPDSR committee; there was no designated register to document the implementation of the MPDSR system, including the solutions recommended by the MPDSR steering committees. Maternal and Perinatal Cases were normally discussed daily on a rotating regional basis via an online meeting held on every working day at 1400hrs. However, there was no national recommendation register or

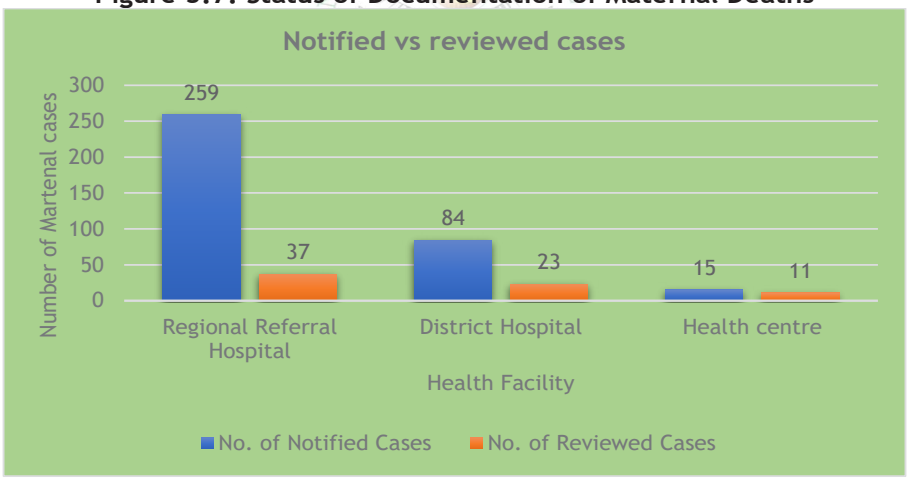
structured action-tracking systems to monitor the implementation of recommendations issued at the national and all levels of healthcare facilities, and no defined steps or timelines for improving the recommendations.

The absence of a structured follow-up mechanism led to unaddressed recommendations and action plans set by the MPDSR committee, data inconsistencies, and delays in improving maternal and perinatal care in the healthcare facilities.

3.4.3 Inadequate MPDSR Documentation and Record-keeping

The review of the MPDSR Report revealed that the MPDSR documentation and record-keeping at sampled health facilities were inadequate. This was contrary to the Maternal and Perinatal Death Surveillance and Response (MPDSR) Guidelines, 2019, which require that all maternal and perinatal deaths be fully documented, reviewed, and reported using standard MPDSR tools. The status of maternal death documentation is presented in **Figure 3.7.**

Figure 3.7: Status of Documentation of Maternal Deaths



Source: Auditors' Analysis on the MPDSR Report, 2025

Figure 3.7 indicates that at Regional Referral Hospitals, 37 of 259 notified deaths were documented, reflecting inadequate record-keeping despite high caseloads. The District Hospitals performed relatively better, with 23 out of 84 notified deaths documented. The Health Centres showed 11 out of 15 notified deaths were recorded. Overall, these findings demonstrate

inadequate MPDSR documentation, particularly at higher-level and primary care facilities.

The inadequacies were primarily due to:

(a) **Limited Capacity and Training of Health Workers:** The MPDSR report revealed that many staff, particularly at Health Centres, lacked knowledge and skills to complete MPDSR forms correctly. Health workers were often unaware of how to document case summaries, contributing factors, recommendations, or reporting timelines.

(b) **Weak Supervision and Oversight:** The audit noted that oversight by the Ministry of Health (MoH) and PMO-RALG was inconsistent, allowing poor documentation practices to persist. The supervisory visits frequently focused on service delivery rather than MPDSR record-keeping. Furthermore, feedback on missing or incomplete reports from councils and regions was limited, reducing accountability at the facility level.

(c) **Lack of Standardised Filing and Data Management Systems:** The audit found that MPDSR records were often stored in ad hoc files, scattered registers, or poorly organised filing systems. There was also limited integration with routine Health Information Systems (HIS), such as DHIS2, hindering real-time tracking of maternal deaths. The absence of centralised digital or structured filing systems made analysis, follow-up, and monitoring difficult.

Inadequate MPDSR documentation results in incomplete and unreliable data, reducing the ability to analyse trends and identify systemic weaknesses. For example, at Regional Referral Hospitals, only 48% (165 of 344) of notified maternal deaths were documented, leaving over half of the cases unanalyzed. This gap undermines preventive actions, as missing information on causes and contributing factors limits the effectiveness of interventions. Delayed reporting also affects oversight and policy decisions.

3.5 Improper Functioning of the Referral System

The audit noted that the referral system in Tanzania was not functioning properly. It was characterised by partial operationalisation of the referral system across health facilities. The system also had

poor/incomplete/missing referral documentation, and weak oversight and supervision at the council and regional levels. This was contrary to One Plan III (2021/22–2025/26) and ANC Guidelines (2018), which require a clear, structured referral pathway from dispensaries/health centres, i.e., Basic Emergency Obstetric and Newborn Care (BEmONC), to district/regional hospitals, i.e., Comprehensive Emergency Obstetric and Newborn Care (CEmONC). Additionally, it was contrary to Annex 3 of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), under the health sector investment area of service equity, accessibility and quality, which calls for a policy focused on a functional referral system.

The improper functioning of the referral system was caused by limited dissemination of referral guidelines to frontline staff and facilities, inadequate training for healthcare workers on referral procedures and criteria that leave gaps in knowledge and skills, as well as weak accountability mechanisms and insufficient supervision from higher administrative levels like RHMTs and CHMTs that did not enforce adherence or address deviations effectively.

Consequently, improper referrals for maternal emergencies increase the risk of maternal complications, leading to increased maternal morbidity and mortality rates that undermine national goals under HSSP V and One Plan III, as well as progress towards SDG 3.1.

Additionally, other anomalies noted in the referral system were;

3.5.1 Ineffective Communication and Coordination Between Facilities for Timely Maternal Emergency Referrals

The Audit noted unsatisfactory communication and coordination between facilities before patient transfer, contrary to WHO guidelines pp. 41, 50-56, which mandate standardised protocols for maternal referral, including pre-transfer coordination via reliable channels, and 24-hour feedback to minimise delays and ensure preparedness across facilities. This was also contrary to Para 3.4 of the National Guidelines for Patients/Clients Referral at all Health Facility level, 2020, which states that, for a fully functional referral system, effective communication and coordination between various health service facilities should be established to maximise the utilisation of existing resources and ensure an effective feedback mechanism between the initiating and receiving facilities.

Table 3.24 shows the status of 4 sampled cases in the visited health facilities regarding effective communication and coordination between Health Facilities.

Table 3.24: Status of Visited Health Facilities in Adhering to Effective Communication and Coordination Between Health Facilities

Levels	Docs Complete (%)	Pre-Transfer coordination			Feedback <24 hours (%)	All Criteria Met
		Decision less than 30 mins (%)	Stabilization (%)	pre-transfer call (%)		
Regional/Zonal	85	75	90	80	70	60
District	70	60	75	65	50	45
Health Centre	60	55	65	50	40	35
Dispensary	50	45	55	40	30	25
Total	66	59	71	59	48	41

Source: Auditors' Analysis of Collected Data from Health facilities, 2025

Table 3.24 shows that, out of 100 sampled cases across all visited healthcare facility levels, only 66% of referral documents were complete, 59% had timely decisions and pre-transfer calls, 48% received feedback within 24 hours, and 41% of cases met all key criteria. Moreover, the healthcare facility levels were not performing well because Regional/Zonal Hospitals performed at 60%, followed by District (45%), Health Centres (35%), and Dispensaries (25%). Feedback mechanisms were not satisfactory across all facilities, ranging from 30% to 70%, while document completeness and Pre-Transfer coordination were not well implemented at Health Centres and Dispensaries.

Ineffective communication and coordination between health facilities for timely maternal emergency referrals were caused by the following:

(a) Limited Training in BEmONC/CEmONC: The audit found that a significant proportion of health workers involved in maternal emergency referrals lacked up-to-date training in Basic and Comprehensive Emergency Obstetric and Newborn Care (BEmONC/CEmONC).

As a result, some staff were unable to promptly recognise obstetric emergencies requiring urgent referral, to apply standard referral

protocols, or to communicate critical clinical information effectively to receiving facilities.

(b) **Lack of Standardised, Enforced Communication Systems across Health Facilities:** The audit noted the absence of a uniformly applied, enforced communication system to support maternal emergency referrals. The visited facilities relied on ad hoc methods such as personal mobile phones, patient relatives, or handwritten notes, rather than standardised, institutionally supported communication channels.

(c) **Unsatisfactory Network Connectivity in Remote Areas, and the Absence of Consistent Feedback**: The audit noted that poor mobile and internet network coverage in remote and hard-to-reach areas constrained timely communication between referring and receiving facilities. Additionally, there was no consistent feedback mechanism to inform referring facilities about patient outcomes or referral appropriateness.

Consequently, ineffective communication and coordination between initiating and receiving facilities pose risks during patient transfers due to unprepared receiving facilities, resulting in delays in emergency care and higher rates of maternal outcomes, such as preventable deaths or complications, also contributing to inequities in maternal healthcare access across the country.

3.5.2 Inadequate Monitoring of the Functionality and Performance of the Maternal Referral System

The Audit noted inadequate monitoring of the maternal referral system's functionality and performance, including inconsistent tracking of referral initiations, completions, and feedback loops across the facilities, contrary to Para 4.1 of the National Guidelines for Patients/Clients Referral at all Health Facility level,2020, which mandate regular follow-up and evaluation of the referral systems to ensure their sustainability and effectiveness. This was also contrary to the Tanzania Quality Improvement Framework in Health Care (2011-2016), which requires the Ministry of Health to prioritise and strengthen supportive supervision and monitoring, and to ensure surveillance of the performance of referral health facilities.

Inadequate monitoring of the maternal referral system was reflected in the limited number of referrals completed, as shown in **Table 3.25**, which shows the status of referral initiation, referral completion, and missing referrals.

Table 3.25: Status of Referral Initiation, Referral Completions & Missing Referrals

Financial Year	Indicators		
	Number of Referral Initiations	Number of Referral Completions	Missing Referrals from the Initiated
2020/21	-	-	-
2021/22	3,372	3083	289
2022/23	40,543	37933	2,610
2023/24	68,628	66963	1,665
2024/25	39,259	38748	511
Total	151,802	146,727	5,075

***Source*:** Referral Performance Report from MOH, 2025

Table 3.25 shows that in Financial Year 2020/21, no referrals were recorded, and from Financial Year 2021/22-2024/25, a total of 151,802 referrals were initiated, of which 146,727 (96.7%) were completed, leaving 5,075 (3.3%) referrals missing. Overall, the trend indicates a strengthening of the referral system over the years, with missing referrals highlighting the need for continued monitoring and follow-up to enhance communication and referral tracking across health facilities.

The inadequate monitoring of the functionality and performance of the maternal referral system was caused by the following factors, supported by audit evidence:

(a) **Absence of Standardised, Regular Monitoring and Evaluation (M&E) Processes:** The Audit noted the absence of a standard M&E framework specifically for maternal referrals. Referral indicators were not consistently included in routine performance review meetings. At the visited facilities, no documented quarterly or annual reviews were found assessing referral timeliness, completion, or feedback, indicating irregular and non-standardised monitoring practices.

(b) **Weak Information Flow and Coordination across Different Levels of Health Facilities**: The review of referral registers and patient files

from the visited healthcare facilities revealed incomplete documentation of referral outcomes, with many referrals lacking confirmation of receipt or feedback from receiving facilities. This is further evidenced by the existence of 5,075 missing referrals over the period 2021/22–2024/25, demonstrating gaps in coordination and follow-up between referring and receiving facilities, as shown in **Table 3.25.**

(c) **Limited Digital Integration and Underutilization of DHIS2 for Real-Time Tracking:** The assessment of DHIS2 data showed that referral-related data were either partially captured or aggregated without details on referral completion.15/30 sampled facilities relied on paper-based referral forms, which were not routinely entered into DHIS2.

Consequently, inadequate monitoring of the functionality and performance of the maternal referral system creates discrepancies between initiated, completed, and referral Feedback. Such discrepancies contribute to unmet EmONC needs and ultimately perpetuate delays in critical referrals.

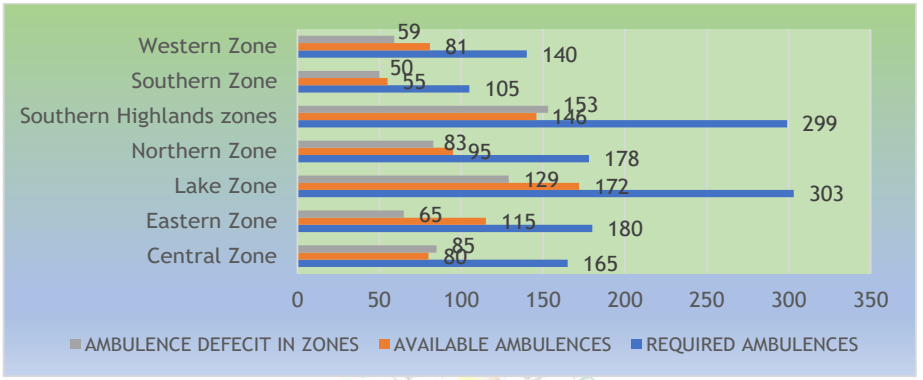
3.5.3 Lack of Adequate and Functional Emergency Transport Systems for High-Risk Pregnancies

The Audit noted inadequate and non-functional emergency transport systems for higher-risk pregnancies, contrary to Section 3.3.6 of the National Plan for Reproductive, Maternal, Newborn, Child and Adolescent Health & Nutrition (2021/2022 - 2025/2026), which stresses the improvement of the referral system, especially accessibility of emergency transport from one facility to a higher level.

The Audit further noted that, the Emergency Transport Systems for High-Risk Pregnancies was not adequate and functional in the sense that the estimated number of ambulances required in the country was 1245 to cater to the needs for all health facilities in the country but during the time of Audit there were 607 Ambulances equivalent to 49% of which the majority are non-equipped and situated at regional and council hospitals (Urban areas) meanwhile most of referrals are being made from community, dispensaries and health centres. **Figure 3.8** shows the availability of ground Ambulances in the Health zones.

Consequently, lower-level facilities frequently relied on alternative, inappropriate modes of transport, resulting in delays in referral completion and increased risks to mothers and newborns. The status of Ground Ambulance availability in the Health Zones is shown in **Figure 3.8.**

Figure 3.8: Status of Availability of Ground Ambulances in the Health Zones



Source: Auditors' Analysis of Ambulances' Status from PMO-RALG's Reports, 2025

Figure 3.8 shows that all health zones faced shortages of ground ambulances, with available numbers falling short of requirements. The largest deficits were in the Lake Zone and Southern Highlands Zone, while the Central, Eastern, Northern, Western, and Southern Zones also experienced substantial gaps. Overall, ambulance availability was uneven and insufficient, particularly in zones with large rural populations where most maternal referrals originate, leading to delays in emergency transport and increased risks for high-risk pregnancies.

Additionally, the noted inadequacy of ground ambulances in the visited regions is shown in **Table 3.26.**

Table 3.26: Status of Ambulances in Sampled Regions

Region	Required	Available	Deficit	Total Maternal Death
Dar Es Salaam	51	29	22	1,143
Dodoma	74	42	32	463
Kigoma	54	37	17	570
Kilimanjaro	57	33	24	300
Mbeya	59	27	32	451
Mtwara	15	10	5	477
Mwanza	66	31	35	1,043
Total	376	209	167	4447

***Source*:** Auditors' Analysis of Ground Ambulances from PMO-RALG Report, 2025

Table 3.26 shows that all sampled regions experienced ambulance shortages, with deficits ranging from 5 to 35 vehicles, covering 31% to 54% of the required fleet. Regions like Mwanza, Mbeya, and Dodoma had the largest gaps, which coincide with high maternal deaths, suggesting that limited emergency transport contributes to maternal mortality. However, some areas, such as Mtwara, experience high deaths despite smaller deficits, indicating that other factors like facility readiness, staffing, and geographic access also play a role.

The audit further noted that, despite the presence of a few ground ambulances **(Figure 3.8),** there are virtually no marine ambulances in Mara, Mbeya and Kagera, except for the Pwani and Lindi Regions, where there was one grounded ambulance in each region. **Table 3.27** shows the status of availability of marine ambulances.

Table 3.27: Status of Availability of Marine Ambulances

Region	Councils	Name of Health Facility	Required Number of Ambulances	Grounded Number of Ambulances
Mara	Musoma DC	Makojo H/C	3	0
	Bunda DC	Nafuba Dispensary	2	0
	Rorya Dc	Ruhu Dispensary	2	0
	Musoma MC	Bweri Health H/C	1	0
Mbeya	Kyela DC	Ikombe Dispensary	2	0
Lindi	Kilwa DC	Songosongo H/C	3	1
Kagera	Muleba DC	Mazinga H/C	2	0
	Bukoba MC	Bandari ya Bukoba	1	0
Pwani	Kibiti DC	Mbwera DH	3	1
	Mafia DC	Mafia	2	1

***Source*:** Auditors' Analysis of Boat Ambulances from PMO-RALG Report, 2025

Table 3.27 shows a shortage of marine ambulances across the surveyed regions, with only 4 of the 21 required ambulances operational (approximately 19% availability). Mara, Mbeya, and Kagera had no functioning marine ambulances, despite having areas crossed by lakes, rivers, and other water bodies, leaving lakeside and riverside communities without emergency transport. This shortage limits timely maternal referrals in water-access areas, increasing the risk of maternal deaths and highlighting the need for a comprehensive emergency transport system that integrates both ground and marine ambulances.

The inadequacy of the Emergency Transport System was caused by a shortage of ambulances and outdated equipment. Health facilities lack sufficient ambulances, and those available are often not equipped for medical emergencies, hindering the ability to handle urgent transports. However, the Ministry of Health, in collaboration with PMO-RALG, launched the m-mama system to coordinate emergency transport for maternal and neonatal patients as an alternative to Community transport when Government ambulances are unavailable.

Consequently, inadequate Emergency Transport Systems for High-Risk Pregnancies (Ground Ambulances and boat ambulance shortage in the water-bound areas) contribute to delays in reaching facilities during labour complications like haemorrhage or eclampsia, resulting in a 1 - 3 hour wait and other Delays, ultimately contributing to elevated Maternal death rates.

3.5.4 Referral Delays and Bottlenecks

The audit noted delays across all three phases of the maternal healthcare referral system. Transport-related delays were the most prevalent, often due to unavailable or unreliable ambulances, while receiving facilities experienced congestion, leading to prolonged wait times. Also, documentation of time intervals was inadequate, with incomplete records of referral timestamps, ambulance logs, and incident reports. This was despite the fact that referral processes in maternal healthcare should ensure timely transitions, minimising delays in decision-making, transportation, and reception at higher-level facilities, with clear timestamp documentation for all stages[7]. Standards require that referrals

[7] https://www.sciencedirect.com/science/article/abs/pii/0277953694902267?via%3Dihub.Accessed on 08 January 2026

occur within specified time frames, such as less than one hour for decision and departure, and immediate treatment upon arrival, supported by adequate infrastructure and coordination to prevent bottlenecks.

Table 3.28 shows referral delays across the maternal healthcare referral system.

Table 3.28: Referral Delays Across the Maternal Healthcare Referral System

Category of Delay	Standard Time	Actual Time
Delayed Referral from Home	≤ 1 hour from recognition of complication	Several hours to >24 hours[8]
Delay in arrival at the referred facility	≤ 1 hour from referral	1.5 to 2 hours[9]
Delay in receiving healthcare	≤ 30 min from arrival to first emergency intervention	Often >30 min; up to several hours[10]

***Source*:** Auditors' Analysis of Referral Delays, 2025

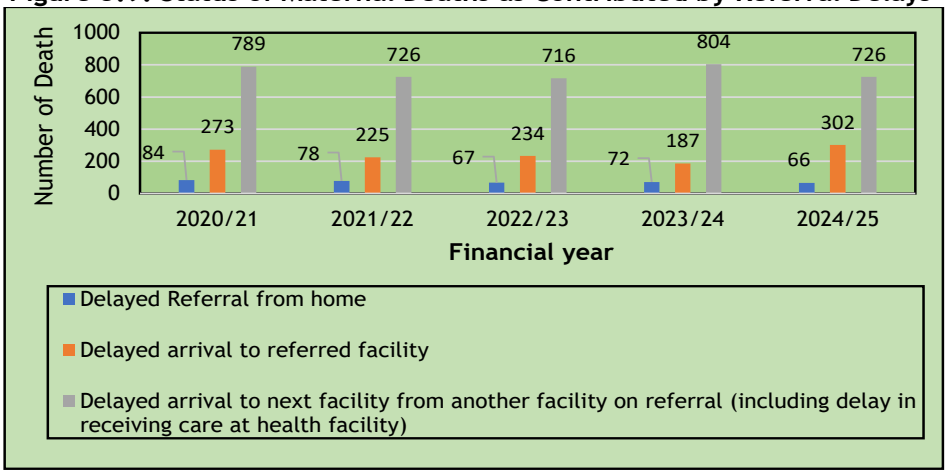
Table 3.28 indicates that the actual referral times consistently exceed recommended standards across all delay categories. Women often take several hours to more than 24 hours to seek care after complications arise, travel to referral facilities takes 1.5–2 hours instead of the recommended one hour, and emergency care was frequently initiated later than 30 minutes after arrival, sometimes taking several hours.

The referral delays were caused by inadequate availability of ambulances and weak road infrastructure, which contributed to transport delays, staffing shortages at receiving facilities, weak referral coordination between lower and higher-level facilities, lack of standardised protocol for prioritising cases or ensuring seamless handovers, insufficient training and resources for documentation, leading to gaps in tracking time intervals.

Consequently, delays have contributed to the slow pace in the reduction of maternal and neonatal mortality rates, as high-risk pregnancies were not addressed promptly, resulting in preventable complications during transit or upon arrival. Overall, the inefficiencies undermined National efforts and SDG 3.1 to reduce maternal deaths. **Figure 3.9** shows the status of maternal deaths as contributed by referral delays.

[8] https://link.springer.com/article/10.1186/s12913-019-4019.Accessed on 08 January 2026
[9] https://pubmed.ncbi.nlm.nih.gov/31478017/.Accessed on 08 January, 2026
[10] https://pmc.ncbi.nlm.nih.gov/articles/PMC7290896/?utm. Acessed on 08 Janury 2026

Figure 3.9: Status of Maternal Deaths as Contributed by Referral Delays



***Source*:** Auditors' Analysis of Three Delays from MoH Data, 2025

Figure 3.9 shows that maternal deaths due to referral delays remained high throughout 2020/21–2024/25. The largest contributor was consistently delayed transfer and care between health facilities. Delayed arrival at the referred facility was the second-leading cause and showed a sharp increase in 2024/25. In contrast, delayed referral from home contributed the fewest deaths and showed a gradual decline, reflecting some improvement in early care-seeking.

The noted challenges on referral delays resulted from the following:

Non-functional Emergency Transport Systems for High-Risk Pregnancies

The audit team noted that, despite insufficient ambulances, some were grounded and unequipped, contrary to Para 3.3 of the National Guidelines, 2020, for Referral of Patients and Clients, which requires a fully functional referral system, appropriate, well-equipped modern ambulances, a planned preventive maintenance system, and driver training on safe operations. **Table 3.29** shows the status of ambulance usability.

Table 3.29: Status of Ambulance Usability and Maintenance

Healthcare Facility	Number of Ambulances	Ambulance not in Use	Ambulance not in Use (%)	Remarks
Referral Hospital	117	44	38	Maintenance at TEMESA[11]
District Hospital	217	77	35	Written off
Health Centre	377	91	24	Maintenance at TEMESA
Dispensary	50	9	18	Written off
Total	**761**	**221**	**29**	

***Source*:** Data on Ambulance Status as Submitted by MoH & PMO-RALG, 2025

Table 3.29 shows that out of 761 ambulances, 221 (29%) were not in use, indicating a major gap in emergency referral capacity. The highest proportions of non-functional ambulances were at referral hospitals (38%) and district hospitals (35%), mainly due to maintenance delays and the use of written-off vehicles. Health centres also recorded a large number of ambulances out of service, while dispensaries, despite lower percentages, had limited capacity overall.

Furthermore, the Audit noted that non-functional Emergency Transport was caused by;

Lack of Scheduled or Corrective Maintenance: The Audit noted that some vehicles were permanently written off due to irreparable damage from accidents. For example, in Mtwara and Kigoma, multiple ambulances had been grounded for over six months awaiting spare parts, while in Dar es Salaam, others were scrapped after major crashes. This underscores the urgency of a robust maintenance program, prompt procurement of spare parts, and contingency measures to maintain ambulance availability and reduce disruptions to the referral system.

Inadequate Training of Ambulance Drivers: The Audit noted that Ambulance drivers in visited healthcare facilities lacked training/certifications in Cardio-Pulmonary Resuscitation (CPR) and Automated and External Defibrillation (AED) Usage, contrary to Para 6.2.1.3.1 of Emergency Medical Services -Ground Ambulance Requirements, which emphasise that the Ambulance driver should have minimum

[11] Tanzania Electrical, Mechanical and Electronics Services Agency

qualifications as listed in the Minimum Qualifications Column as shown in **Table 3.30.**

Table 3.30: Qualifications for Ambulance Drivers from Visited Health Facilities

Minimum Required Qualifications	Health Centre	District Hospital	Regional Referral Hospital
Licence to Drive the Emergency Ambulance	Yes	Yes	Yes
Certificate in Defence Driving	Yes	Yes	Yes
Certification for Cardio-Pulmonary Resuscitation (CPR)	No	No	No
Automated External Defibrillation (AED) Usage	No	No	No
Understand the Use of Stretchers and be able to assist with the Care and Evacuation.	Yes	Yes	Yes
Trained in Advanced First Aid	Yes	Yes	Yes

***Source*:** Auditors' Analysis of Drivers' Qualification, 2025

Table 3.30 indicates that ambulance drivers possess the required qualifications, except for CPR/AED certification. The CPR and AED skills are vital for immediate intervention in cardiac arrests or respiratory failures during the route to hospitals.

The lack of CPR and AED certification for Ambulance Drivers was caused by the absence of a formalised National pre-hospital EMS system. Ambulance drivers are not trained in emergency medical care, as their role was perceived as merely driving rather than as initial responders to assist Nurses accompanying the pregnant woman in case of Emergencies. Also, there was no Mandatory National Curriculum for Ambulance drivers in CPR and AED.

Consequently, the lack of training in CPR and AED delays critical care, highlighting a potential systemic oversight in driver preparation for medical emergencies, ultimately impacting efforts to reduce preventable deaths, as drivers cannot initiate life-saving interventions.

(i) Presence of Non-Equipped Ambulances

The Audit noted that, most of the ambulances were modified vans or basic vehicles with limited medical fittings, leading to gaps in handling high-risk pregnancies, contrary to Para 5.1.11 of the WHO Blue Book, 2021, which

requires ambulances to provide parenteral antibiotics, uterotonics, eclampsia treatment, and basic maternal and neonatal resuscitation to handle high-risk transports. Additionally, Para 5.1.2 of the same details general life support equipment applicable to obstetric cases.

Table 3.31 compares the WHO minimums (from the 2021 Blue Book) with the available ambulances from the field assessment.

Table 3.31: Comparison of WHO Requirements of Ambulances and Status of Ambulances

Category	WHO Requirements	Actual status of the Ambulance	Purpose	Gap
Resuscitation and Airway Management	Naso-or oro-pharyngeal airways; Bag valve Mask (BVM) Ventilation device, Basic neonatal resuscitation kit (including warmed resuscitation table).	Oxygen supply was almost 95% but non-functional, with limited neonatal kits, and no warmed tables.	To support breathing difficulties, cyanosis or resuscitation such as eclampsia or haemorrhage.	There was a major gap in functionality, and neonatal-specific tools often rely on basic manual methods, which increase risks during eclampsia or asphyxia.
Vascular Access and Fluids	Intravenous (IV) access kit (cannulas, fluids, administration sets)-Haemostatic measures (e.g., pressure dressings, tourniquets)	Basic Dressing was available but inconsistent; the cannula was insufficient and mostly not always sterile.	For fluid resuscitation in shock or haemorrhage, it is essential for high-risk cases like antepartum/postpartum bleeding.	No advanced haemostatics
Obstetric-Specific Medications and Treatments	Parenteral antibiotics, Uterotonics, eclampsia treatment, Neonatal resuscitation drugs	Resuscitation drugs, uterotonic agents, and antibiotics are in stock. Magnesium sulphate was	To manage obstetric emergencies like sepsis, postpartum haemorrhage, pre-eclampsia/ecla	No dedicated drug kits, relying on pre-loaded facility supplies

Category	WHO Requirements	Actual status of the Ambulance	Purpose	Gap
		rare in transit.	mpsia during transit.	
Monitoring and Diagnostics	Portable ultrasound, Basic vital signs monitors (BP cuff, pulse oximeter).	Basic BP cuff in some, no ultrasound, rare pulse oximeters	To prevent Complications like infections or hypothermia in vulnerable pregnant patients.	Vital signs were rarely monitored in transports.

Source: Auditors' Analysis of WHO Requirements vs. Ambulances in the Field, 2025

Consequently, the gaps in ambulances contribute to the accumulation of delays in reaching Referred Health facilities, resulting in higher rates of complications, stillbirths and maternal and neonatal deaths.

3.6 Inadequate Awareness Campaigns and Education Programs for Pregnant Women of Reproductive Age on Maternal Health

The Audit noted inadequate awareness campaigns and education programs for pregnant women of reproductive age on maternal health, contrary to Para 4.2.8 (1) of the National Operational Guideline for Community-based Health Services, 2021, which requires awareness creation in the village about services available in the health facility and their health entitlements, as amongst the responsibilities of the Health Facility. This was caused by the following:

3.6.1 Insufficient Implementation of Maternal Health Education Programs and Awareness Campaigns at The National and Community Level

The Audit noted that the Ministry of Health (MoH) 's implementation of maternal health programs was insufficient, as the existing awareness programs were unevenly implemented across regions. The Maternal Health Education Programs and Awareness Campaigns were conducted without an annual plan for health education activities. The Education provided was largely demand-driven, which led to insufficient reach.

Additionally, it was noted that the Ministry of Health had limited documentation of participants' audience segmentation by Age category and

of evaluation plans for education activities, as well as a standardised mechanism to capture Participants' feedback, coverage, and behavioural outcomes impacted by the Health Education program.

The Audit noted that insufficient implementation of maternal health education was due to the absence of national strategies and guidelines for maternal health education, leading to low prioritisation of health education at the national and community levels, with greater focus on curative services.

Further, the Audit noted insufficient implementation of the Maternal Health Education Programs and Awareness Campaigns due to the absence of clear implementation frameworks that would translate policies into operational, community-level actions.

Consequently, this led to a disparity in the Education and awareness campaign on maternal health, with the program's coverage mostly in urban areas rather than in rural areas. The Audit noted limited access to mass media in the rural setup. The Health Promotion Unit at the MoH used Television, Mabango, to educate society, whereas in Rural areas, most citizens did not have televisions. **Table 3.32** elaborates further on the disparities in health promotion between rural and urban areas.

Table 3.32: Disparities of Maternal Health Education to Women of Reproductive Age in Rural and Urban

Item	Area	Year 2020 /21	Year 2021 /22	Year 2022 /23	Year 2023 /24	Year 2024 /25
Estimated Reach/Coverage of Maternal Health Education (Number of women)	Rural	-	13,000,000	12,000,000	8,000,000	9,000,000
	Urban	-	17,000,000	15,000,000	10,000,000	10,000,000

***Source*:** Auditors' Analysis of Health Promotion Sector Performance Reports,2025

Table 3.32 reveals rural-urban disparities in women's exposure to maternal health education. In Year 2021/22, urban programs reached 17,000,000 women versus 13,000,000 in rural areas; this dropped to 15,000,000 urban

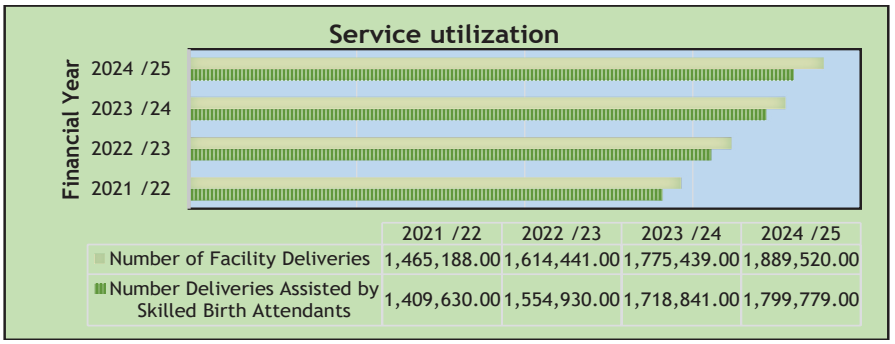
vs 12,000,000 rural in 2022/23, then to 10,000,000 urban vs 8,000,000 rural in 2023/24, and remained at 10,000,000 urban vs 9,000,000 rural in 2024/25. These disparities contribute to higher maternal mortality risks in rural areas, where limited education increases complications from haemorrhage, infections, and hypertensive disorders due to delayed responses and lower utilisation of skilled services. Persistent rural gaps without considering that rural women form the majority of the female population (approximately 65% rural vs. 35% urban based on the 2022 data), further prolong preventable deaths among the larger rural female population.

Interviews with Health Promotion officers indicated that this imbalance was caused by resource-allocation inefficiencies that have led to prioritising accessible urban centres over logistically challenging rural areas.

The situation disseminated health disparities, with rural women facing higher risks of unplanned pregnancies, inadequate spacing between births, and limited access to skilled care, ultimately inflating exemption costs for the government. The failure to sustain sufficient awareness campaigns had effects, including slow improvements in family planning adoption, which intensifies maternal health risks such as complications from closely spaced pregnancies and higher mortality rates—particularly noticeable in the nil-funding years of 2022/23 and 2023/24.

However, insufficient awareness campaigns had little impact on the utilisation of delivery services in health facilities, as shown in **Figure 3.10**.

Figure 3.10: Status of Utilisation of Delivery Services in the Health Facilities



	2021 /22	2022 /23	2023 /24	2024 /25
Number of Facility Deliveries	1,465,188.00	1,614,441.00	1,775,439.00	1,889,520.00
Number Deliveries Assisted by Skilled Birth Attendants	1,409,630.00	1,554,930.00	1,718,841.00	1,799,779.00

Source: Auditors' Analysis of Service Delivery in Health Facilities, 2025

Figure 3.10 highlights a steady upward trend in maternal health service utilisation from Financial Year 2021/22 to 2024/25, indicating improved access to facility-based deliveries and skilled birth attendant support, key factors in addressing maternal mortality risks.

Additionally, Skilled Birth Attendant-Assisted Deliveries increased from 1,409,630 to 1,799,779 (+27.68% overall), with Year-over-Year growth of 10.31% (2022/23), 10.54% (2023/24), and 4.71% (2024/25). This indicates a growing reliance on professional assistance, though there is a slowdown in Year 2024/25, suggesting saturation.

Furthermore, facility deliveries rose from 1,465,188 to 1,889,520 (+28.96% overall), with YoY gains of 10.19% (2022/23), 9.97% (2023/24), and 6.43% (2024/25). Facilities consistently outpace skilled-assisted cases by 3-4%, suggesting some deliveries occur without optimal skilled oversight.

This was attributed to overlapping responsibilities following the Education and Awareness program on maternal health, conducted by both the Health Promotion unit under the Department of Preventive Services and the Department of Reproductive, Maternal and Child Health (DRMCH). This, in turn, places no accountability for the ineffectiveness of the programs.

It was further noted that the Ministry of Health did not monitor and evaluate the impact of Health Promotion through key performance indicators, such as reach per capita and mortality trends.

3.6.2 Insufficient Promotion and Support of Community Education Program to Enhance Public Awareness, Birth Preparedness and Male Involvement in Maternal Health

The Audit team noted insufficient promotion and support of community education program to enhance public awareness, birth preparedness and male involvement in maternal health contrary to Para 5.1.2 of Health Sector Strategic Plan Five (July 2021 – June 2026) which states that the health sector will enhance the provision of community health education to motivate people to improve their health Literacy, empowering them to take decisions about health and wellbeing.

The Audit noted that the maternal health policies prioritise facility-based clinical services over community education and preventive interventions,

which do not enhance public awareness and birth preparedness, as coverage was limited to expectant mothers and the community was not motivated to visit health facilities for preparation. The Audit noted the absence of interventions to increase community coverage of Birth Preparedness.

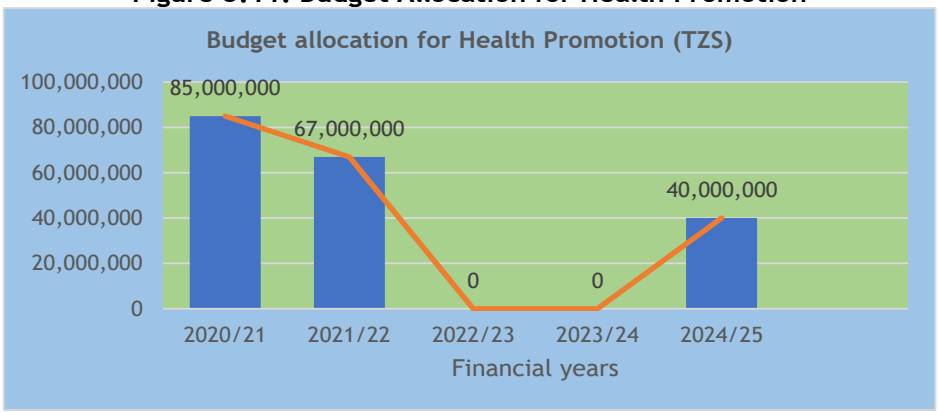
Also, the Audit noted that the male involvement strategies were poorly articulated as optional, despite the MoH insisting on at least a first visit with the expected fathers; implementation remained low, and there was no enforcement mechanism to ensure that male involvement in maternal health is enhanced.

Insufficient promotion and support of the community Maternal Health Education Program was caused by:

a) Inconsistent Budget for Health Promotion Activities

An interview with an Official from the Health Promotion Unit and a review of documents indicated that the budget allocation for health promotion in maternal healthcare services from 2020/21 to 2024/25 was inconsistent, as detailed in **Figure 3.11**, which shows the status of the allocated budget for the Health Promotion Unit.

Figure 3.11: Budget Allocation for Health Promotion



Source: Auditors' Analysis of Health Promotion Budget, 2025

Figure 3.11 shows that the average is 38.4M TZS per year, the median (middle value) is 40M TZS, and the mode (most frequently occurring value) is 0 TZS. The Health Promotion Unit largely depends on donor funds for health promotion, resulting in underfunded advocacy activities. Low

funding undermined the sustainability of the maternal health awareness campaign.

b) Delays in Deployment of Trained Community Health Workers (CHWs) under the Integrated Community Health Workers Program

The Audit noted that, there was an Integrated and Coordinated Community Health Workers Program, launched in the financial year 2023/24 and running through 2027/28, which aimed to deploy 137,294 CHWs across 4,263 Streets and 64,384 Hamlets to enhance community-level health education.

The program started in 2022, by selecting 12,832 citizens from 12 regions and 25 councils for a six-month training (three months in-class, three months field-based). The batch enrolled was as detailed in **Table 3.33.**

Table 3.33: Information on the Enrolled and Employed

Aspect	Enrolled	Completed	Employed
First Batch	4309	3706	0
Second Batch	5677	5677	0
Total	9986	9383	0

Source: Auditors' Analysis on the Enrolled Batches, 2025

Table 3.33 shows that of the 12,832 citizens selected for enrolment in the program, 9,986 were successfully enrolled, leaving 2,846 citizens not enrolled. The reason for non-enrolment was financial barriers that prevented them from enrolling in nearby colleges. Furthermore, the Audit noted that the 9383 completers have not been deployed, as contracts and payment arrangements coordinated by PMO-RALG have not yet been issued.

The situation was caused by reliance on donor funding, which disrupted program planning and timelines, leading to unpredictable funding. Additionally, inadequate coordination between the Ministry of Health (MoH) and the Prime Minister's Office - Regional Administration and Local Government (PMO-RALG) led to delayed contract preparation, which was to be initiated in advance of training completion rather than post-graduation.

Consequently, the Program's objectives were not met on schedule, delaying community health education and outreach on critical issues such as maternal care and disease prevention. Also, Trained CHWs faced job insecurity and lack of remuneration, resulting in low morale and heightened dropout risks, potentially undermining the program's overall scalability and

effectiveness.

3.6.3 Lack of Defined Indicators/Metrics to Measure Effectiveness and Impact of Maternal Health Programs and Community Awareness Interventions

The Audit Team noted that there were no KPIs to measure the effectiveness and impact of maternal health programs, and that, for community interventions. The effectiveness and impact of maternal health programs and community awareness interventions were undermined by the absence of clearly defined, standardised, and outcome-oriented indicators.

Additionally, although maternal health data were available in the HMIS/DHIS2, there were no indicators to capture the effectiveness or impact of the programs, and there was no integrated framework linking MPDSR recommendations to measurable results. The Audit noted that the data collected were routine service statistics that mainly focused on inputs and outputs rather than on behavioural change, community awareness, birth preparedness, and male involvement. The health management information system was primarily designed to capture facility-based service delivery data and does not adequately accommodate community-level indicators related to health promotion and behavioural outcomes. This limited the availability of reliable and disaggregated data necessary for monitoring program effectiveness and equity.

The Audit noted that at the policy and program design level, maternal health strategies lacked a comprehensive results framework that clearly links activities, outputs, outcomes, and intended impacts. As a result, implementers were not guided on what to measure, how to measure it, or at what frequency, leading to inconsistent tracking of program performance across regions and Local Government Authorities.

The lack of KPIs to measure the impact of maternal health education Programs was also attributed to HMIS/DHIS2 configuration gaps, as it lacked standardised, MoH-approved indicators to measure the effectiveness of maternal health programs and community awareness efforts.

At the implementation level, community education and awareness activities were rarely accompanied by measurable performance indicators such as changes in knowledge, attitudes, practices, or decision-making behaviour

within households. Indicators for male participation in antenatal care, birth preparedness planning, early recognition of danger signs, and timely care-seeking were not defined, making it difficult to assess whether community interventions were achieving their intended objectives.

The Audit noted that the lack of defined indicators was attributed to the following;

(a) Limited Capacity in Monitoring and Evaluation

The Audit noted that there was limited capacity in monitoring and evaluation due to inadequate training of health workers and community implementers in results-based monitoring. Consequently, the data collected were underutilised for planning, learning, and improvement, weakening accountability for results and evidence-based decision-making.

(b) Weak Results-Based Planning Frameworks

The Audit noted that Maternal health programs were designed without comprehensive results frameworks that clearly define outputs, outcomes, and impacts, resulting in unclear measurement priorities for community awareness and behavioural change interventions.

(c) Over-Emphasis on Service Delivery Indicators

The audit noted that the existing monitoring systems prioritise facility-based indicators such as antenatal visits and skilled deliveries, while community education, awareness, male involvement, and birth preparedness indicators were not adequately incorporated.

Consequently, this causes an inability to demonstrate progress towards maternal health goals despite the huge efforts made to improve maternal healthcare. Additionally, this led to less periodisation of community awareness strategies because their effectiveness was not measured.

CHAPTER FOUR

AUDIT CONCLUSIONS

4.1 Introduction

This chapter draws the conclusion of the audit. The basis for the conclusion is the General and Specific Audit Objectives presented in Chapter One of this report. The conclusions drawn are general and specific, as elaborated below.

4.2 General Audit Conclusion

The Government, through the Ministry of Health and the Prime Minister's Office - Regional Administration and Local Government, has made remarkable progress in maternal health towards attainment of Sustainable Development Goal 3.1, which aims to reduce the maternal mortality ratio to 70 per 100,000 live births by 2030. The Government's initiatives have expanded access to skilled birth attendance, antenatal care, facility-based deliveries, and emergency services, resulting in significant declines in preventable maternal deaths and positioning the country as a regional model for improvement.

Despite these initiatives, challenges persist that hinder the full realisation of Sustainable Development Goal 3.1, which aims to reduce the MMR to below 70 per 100,000 live births by 2030. The audit identified key gaps in the availability and functionality of Emergency Obstetric and Neonatal Care (EmONC) services, the effective implementation of Maternal and Perinatal Death Surveillance and Response (MPDSR), including data collection, reporting, and utilisation for quality improvements, the proper functioning of referral systems, and sufficient awareness campaigns and education programs for women of reproductive age. These gaps are discussed in the specific audit conclusions below.

4.3 Specific Audit Conclusions

4.3.1 Limited Availability of Emergency Obstetric Care (EmONC) Services

The audit concludes that the MoH and PMO-RALG did not ensure adequate and equitable availability of Emergency Obstetric and Newborn Care (EmONC) services. EmONC services were partially delivered and ineffective,

particularly at primary healthcare facilities and referral levels. Only 53% of health centres met CEmONC criteria, compared to 92% of hospitals, while at the dispensary level, several BEmONC signal functions were not performed for three consecutive months due to a lack of equipment and skills. Although the overall CEmONC readiness score stood at 71%, there were critical gaps in anaesthesia equipment (21%) and in the availability of sufficient blood (56%). Staffing levels further constrained service delivery, as staff-to-mother ratios exceeded national standards in most facilities, reaching up to 1:10 in labour wards and 1:20 in antenatal and postnatal wards, particularly in district hospitals, health centres, and dispensaries.

This was attributed to inadequate human resource planning and deployment, including partial application of Workload Indicator of Staffing Needs – Prioritisation and Optimisation Analysis (WISN-POA), inequitable urban–rural staff distribution, inadequate investment in EmONC equipment at lower-level facilities, and insufficient and uneven financing, marked by declining domestic funding and increasing reliance on donor support. The consequences included an overstretched referral system and delayed care, with 85% of maternal deaths at Regional Referral Hospitals and 70% at District Hospitals being referral cases, indicating late presentation from lower-level facilities. These delays increased the risk of preventable maternal and neonatal deaths, widened regional inequities in access to life-saving care, reduced efficiency and value for money of health investments, and ultimately constrained progress toward achieving SDG target 3.1 on maternal mortality reduction.

4.3.2 Inadequate Maternal Mortality Data Collection, Monitoring, and Reporting

The audit concludes that the Ministry of Health did not adequately manage MPDSR implementation across healthcare facilities. Committee meetings were often delayed or not held, and there was limited documentation of proceedings. Healthcare facilities failed to meet the guideline requirement to review deaths within 7 days. Also, there is an absence of a centralised digital system for storing and tracking case files, further undermining timely learning and action, limited use of the findings from the MPDSR Review, inconsistency of maternal and perinatal data across the healthcare facilities and a technical facility gap across the Healthcare facilities hinder the SDG 3.1 target.

Additionally, Maternal and perinatal mortality data collected through MPDSR were neither systematically translated into evidence-based interventions nor adequately documented or recorded across health facilities. There was no standardised register or follow-up mechanism to track and monitor the implementation of the MPDSR committee's recommendations, which is essential to the effectiveness of the surveillance system. The inadequacies are due to limited capacity and training of health workers, weak supervision and oversight, and an ICT infrastructure gap in the health facilities.

4.3.3 Improper Functioning of the Referral System

The Audit concludes that the Ministry of Health has not adequately managed the referral system for maternal healthcare services due to poor communication and coordination between health facilities, inadequate monitoring and supervision, and delays in referral response times. A major contributing factor is the insufficient number of emergency transport vehicles, most of which lack essential equipment such as oxygen, defibrillators, or basic life-support tools for obstetric emergencies. Additionally, the distribution of ambulances remains uneven, often failing to account for population density, geographic barriers, and the unique needs of coastal and island communities, where marine ambulances receive minimal attention.

These shortcomings are due to inadequate planning and budgeting for referral infrastructure and equipment, the lack of a comprehensive national and regional referral mechanism with clear guidelines, protocols, and communication channels, and inequitable resource allocation that favoured urban or administrative priorities over rural, remote, or coastal areas. Weak monitoring and evaluation systems, poor inter-facility coordination, and insufficient supportive supervision further exacerbate the issues, preventing the timely identification and resolution of performance gaps.

As a result, these shortcomings contributed to preventable maternal deaths from complications like postpartum haemorrhage or obstructed labor, which escalated without prompt intervention. The ineffective referral system also promoted higher rates of home deliveries or delayed facility-based care, increased risks for mothers and newborns, and overburdened higher-level hospitals with advanced cases, all of which hinder Tanzania's progress

toward Sustainable Development Goal (SDG) 3.1 of reducing the maternal mortality ratio to below 70 deaths per 100,000 live births by 2030.

4.3.4 Inadequate Awareness Campaigns and Education Programs for Pregnant Women and Women of Reproductive Age on Maternal Health

The Ministry of Health (MoH) and PMO-RALG have not adequately ensured the provision of awareness campaigns and education programs on maternal health for pregnant women and women of reproductive age. This is evidenced by the absence of annual plans, lack of demand-driven delivery approaches, limited evaluation mechanisms, and urban-biased coverage, which have resulted in insufficient outreach and low awareness levels among target groups.

The inadequate provision of awareness campaigns was caused by a coordination gap between the MoH and PMO-RALG, leading to fragmented efforts, funding uncertainties that hinder consistent implementation, and duplication of health promotion tasks between the Health Promotion and DRMCH units. These factors have also contributed to delays in deploying 3,706 trained Community Health Workers (CHWs) under the 2023/24 Integrated Program, further limiting community-level education and engagement.

Consequently, many women of reproductive age remained less informed about maternal health risks, danger signs, birth preparedness, and the importance of timely antenatal and facility-based care. This also contributed to low utilisation of services, delays in seeking care, and ultimately contributes to preventable maternal and neonatal morbidity and mortality in Tanzania.

CHAPTER FIVE

AUDIT RECOMMENDATIONS

5.1 Introduction

This chapter provides recommendations to the Ministry of Health and PMO-RALG on how to improve the provision of quality maternal healthcare services in the country.

Auditors acknowledge the government's efforts to provide high-quality maternal healthcare services across the country. However, more interventions are required to improve the observed gaps. The National Audit Office expects that, based on the 3Es principles, namely Economy, Efficiency, and Effectiveness, these recommendations need to be fully implemented to improve the provision of quality maternal healthcare services in the country.

The recommendations are specifically addressed to the Ministry of Health and PMO-RALG, as set out below.

5.2 Recommendations to the Ministry of Health and PMO-RALG

5.2.1 Recommendations to the Ministry of Health

The Ministry of Health is urged to:

a) Increase and ring-fence domestic allocations for maternal healthcare services to reduce dependency on external donor funds;

b) Establish a national MPDSR digital platform: Establish and manage a centralised platform for MPDSR case reporting, data storage, outcome tracking, and feedback. Establish a national MPDSR recommendations register to document, track, and monitor the implementation status of proposed interventions across the health sector;

c) Implement region-specific digital applications (e.g., expanding Afya Tek pilots) and enhanced BEmONC/CEmONC training for health providers to address gaps in the referral system and align with national guidelines;

d) Establish a robust M&E framework, including KPIs and inter-facility coordination to enhance accountability and compliance; and

e) In collaboration with PMO-RALG, develop and enforce an integrated annual maternal health education plan that features a standardised evaluation mechanism with KPIs (e.g., per capita reach and behavioural outcomes such as family planning uptake), and prioritise rural outreach through community channels, such as CHWs and local media.

5.2.2 Recommendations to the PMO-RALG

PMO-RALG is urged to:

a) Enforce compliance with MPDSR guidelines, ensuring the timely and regular convening of MPDSR committees at facility and council/district levels. Strengthen accountability by requiring the timely submission of MPDSR reports to the regional and national levels (MoH). Systematically analyse maternal data at the district level to prioritise and implement targeted, facility-specific interventions;

b) Institute periodic evaluation of outcomes; institute a system for periodic local evaluation of MPDSR outcomes to assess the practical impact of implemented interventions on maternal and perinatal mortality reduction within each local Government Authority (LGA);

c) Prioritise the procurement of additional ground ambulances. As well as procure marine ambulances to serve citizens residing in water-bound areas; and

d) In collaboration with the MoH, expedite the deployment of all trained CHWs from the 2023/24 integrated program.

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20) Global Strategy for Women's, Children and Adolescents' Health (2016-2030).

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APPENDICES

Appendix 1: Response from the Audited Entities

This section provides details on the recommendations issued to the two audited entities, their responses to comments, the actions to be taken, and the implementation timelines for each recommendation.

Appendix 1(a): Responses from the Ministry of Health (MoH)

S/N	Recommendations	Comments	Planned Action(s)	Implementation on Timeline
1.	Increase and ring-fence domestic allocations for maternal healthcare services to reduce dependency on external donor funds.	Current health spending remains below the Abuja Declaration target of 15%. Dependence on fragmented donor funding persists despite rising domestic commitments.	• Engage the Ministry of Finance to establish specific budget lines for maternal health. • Implement the Direct Health Facility Financing (DHFF) to ensure funds reach service points.	Financial Year 2025/26 – 2025/26
2.	Establish a national MPDSR digital platform: Establish and manage a centralised platform for MPDSR case reporting, data storage, outcome tracking, and feedback. Establish a national MPDSR recommendations register to document, track, and monitor the implementation status of	The MoH has transitioned from aggregate data to capturing individual-level data within DHIS2 to enhance granularity. Virtual Zoom-based review systems already exist, but require integration into a centralised database.	• Fully integrate electronic MPDSR Notifications and Review into the national health data warehouse (DHIS2). • -Scale up electronic data at the regional level capture to work concurrently with manual summaries.	By December 2026

S/N	Recommendations	Comments	Planned Action(s)	Implementation on Timeline
	proposed interventions across the health sector.			
3.	Implement region-specific digital applications (e.g., expanding Afya Tek pilots) and enhanced BEmONC/CEmONC training for health providers to address gaps in the referral system and align with national guidelines.	Readiness to provide CEmONC services currently sits at approximately 69%, with significant gaps in guidelines and staff training at the facility level.	• Scale up the "Hub and Spoke Model package across high-volume regions. • Expand Afya Tek pilots to additional regions to digitise the referral continuum.	2026 – 2027
4.	Establish a robust M&E framework, including KPIs and inter-facility coordination to enhance accountability and compliance.	The current Monitoring and Evaluation Strategic Framework (MESF 2025-2026) focuses on data quality and evidence-based decision-making but requires better facility-level accountability.	Revise HSSP V indicators to include specific process and outcome KPIs for maternal health.	Quarterly reviews through December 2026
5.	In collaboration with PMO-RALG, develop and enforce an integrated annual maternal health education plan that features a standardised evaluation mechanism with KPIs (e.g.,	Collaboration between MoH and PMO-RALG is mandated under the Decentralisation-by-Devolution approach, but community-level reach for family planning and postnatal care is still below targets in rural areas.	• Develop an integrated annual health education plan targeting the "last mile" in hard-to-reach areas. • Deploy Community Health Workers (CHWs) to	By December 2026

S/N	Recommendations	Comments	Planned Action(s)	Implementation on Timeline
	per capita reach and behavioural outcomes such as family planning uptake), and prioritise rural outreach through community channels, such as CHWs and local media.		provide standardised education and track behavioural outcomes. • Continue Health Education through the Health Promotion Section of the MoH.	

Appendix 1(b): Responses from Prime Minister's Office - Regional Administration and Local Government (PMO-RALG)

S/n	Recommendations	Comments	Planned Action(s)	Implementation timeline
1.	Enforce compliance with MPDSR guidelines, ensuring the timely and regular convening of MPDSR committees at facility and council/district levels. Strengthen accountability by requiring the timely submission of MPDSR reports to the regional and national levels (MoH). Systematically analyse maternal data at the district level to prioritise and implement targeted, facility-specific interventions.	Recommendation acknowledged. The guideline was distributed rather than disseminated; as a result, some newly employed health workers have limited knowledge of the guidelines. Health facilities are supposed to appoint an MPDSR focal person by letter. The letter should narrate all responsibilities pertaining to Surveillance and Response. However, some of these health facilities did not appoint an MPDSR focal person, resulting in irregular meetings and poor documentation. Although RHMT and CHMT have shared their timetable for MPDSR quarterly meetings with PMO RALG,	To disseminate the MPDSR guideline in all 26 regions. The RHMT will cascade dissemination to the respective councils. PMO RALG should write a letter to RHMT, who will, in turn, inform CHMT to direct the Health facilities in charge to appoint an MPDSR focal person. PMO RALG should disburse budgeted and requested funds in a timely manner. Continue with the current practice.	2026/27 to 2027/28, through the use of existing RHMT MPDSR scheduled meetings. In collaboration with implementing partners, 26 RHMT will be disseminated from July 2026 to June 2027 and from July 2027 to June 2028. By the End of February 2026, a letter to RHMT will be written from the PO RALG central level. PMO RALG will ensure that funds are disbursed on time. By June 2028.

S/n	Recommendations	Comments	Planned Action(s)	Implementation timeline
		some of them do not follow it for several reasons, including financial constraints stemming from their reliance on implementing partners. MoH and PMO RALG convene daily meetings to discuss selected MDs from selected regions. The practice has proved very useful and therefore provides an opportunity for the high-level to identify real-time gaps and respond accordingly. It also provides a learning platform and a space for experience sharing across regions with different interventions.		
2.	Institute periodic evaluation of outcomes: institute a system for periodic local evaluation of MPDSR outcomes to assess the practical impact of implemented interventions on maternal and	Acknowledge that there is a need for periodic evaluation of outcomes to assess the practical impact of implemented interventions	PMO RALG, in collaboration with MoH, will conduct quarterly MPDSR data (desk review). Maternal and Perinatal Deaths will be compared against interventions implemented in LGAs.	By Fourth quarter (April - June, 2025/26)

S/n	Recommendations	Comments	Planned Action(s)	Implementation timeline
	perinatal mortality reduction within each local Government Authority (LGA).	on maternal and perinatal mortality reduction within each LGA.		
3.	Prioritise the procurement of additional ground ambulances. As well as procure marine ambulances to serve citizens residing in water-bound areas.	Acknowledge that ground and marine ambulances are vital to the referral chain. Moreover, the Government, through the Ministry of Health, in collaboration with the Prime Minister's Office - Regional Administration and Local Government, has already procured 603 ground ambulances. Also, 10 more ambulances were donated by India, bringing the total number of functional ambulances to 1153. These ambulances have been duly distributed to regions, Councils and health facilities across the country in line with identified gaps. With regards to	To solicit Funds from different sources and to instruct LGAs to budget for the procurement of ambulances and boat ambulances annually from their own collections.	From July 2027/28 FY.

S/n	Recommendations	Comments	Planned Action(s)	Implementation timeline
		Marine ambulances, the Ministry further wishes to clarify that the figure of 50 Marine ambulances in the audit query was misquoted. Based on the national needs assessment and geographical considerations, the Government had planned for six (6) marine ambulances and is in the process of procuring three (3), which are planned to be strategically deployed in the Great Lakes zones to serve populations residing in water-bound and hard-to-reach areas. The Government remains committed to the progressive expansion of ambulance services in accordance with available resources, demonstrated needs, and phased implementation plans.		

S/n	Recommendations	Comments	Planned Action(s)	Implementation timeline
4.	In collaboration with the MoH, expedite the deployment of all trained CHWs from the 2023/24 integrated program.	Acknowledge the fact that all 3,706 trained CHWs from the 2023/24 integrated program should be deployed as planned.	All 3,706 trained CHWs have already been deployed on a basis in 25 LGAs across 12 Regions.	The first batch was deployed in July 2025; it was batch 2999. 2nd batch - 707 was deployed in October, 2025,

Appendix 2: Detailed Main Audit Questions with Sub-audit Questions

This section presents the audit questions developed from the main and specific objectives. These questions guided the collection and analysis of data, enabling the audit team to assess the adequacy, effectiveness, and efficiency of maternal healthcare services.

Question 1	**To what extent have the MoH and PMO-RALG ensured the reduction of maternal mortality in the country?**
Sub-questions 1.1	What is the status of the maternal mortality rate in the Country?
Sub-questions 1.2	What initiatives have been taken by the MoH and PMO-RALG to ensure the reduction of maternal mortality?
Question 2	**Have the MoH and PMO-RALG ensured the availability of comprehensive Emergency Obstetric Care in the country?**
Sub-questions 2.1	Have the MoH and PMO-RALG mobilised the necessary Equipment and Infrastructure to provide EmONC services?
Sub-questions 2.2	Have the MoH and PMO-RALG ensured the availability of required skilled birth attendants at different levels to ensure the provision of EmONC services?
Sub-questions 2.3	Have the MoH and PMO-RALG budgeted for ensuring the availability of EmONC services
Sub-questions 2.4	Have the MoH and PMO-RALG identified and addressed systemic risks that hinder the availability of EmONC services?
Question 3	**Has the MoH and PMO-RALG Established and implemented a robust system for data collection, monitoring, and reporting maternal mortality data?**
Sub-question 3.1	Have the MoH and PMO-RALG adequately implemented Maternal and Perinatal Death Surveillance and Review (MPDSR)?
Sub-question 3.2	Have the MoH and PMO-RALG ensured the use of collected data for targeted interventions to address maternal mortality?
Question 4	**Do MoH and PO-RALRG ensure the proper functioning of the referral system?**
Sub-question 4.1	Do the initiating and receiving facilities ensure effective communication and coordination?
Sub question 4.2	Do the MoH and PMO-RALG ensure adequate monitoring of the performance referral system?
Sub question 4.3	Do MoH and PMO-RALG ensure adequate emergency transport systems for high-risk pregnancies?

Question 5	Have the MoH and PMO-RALG ensured the Implementation of awareness campaigns and education programs for pregnant women and women of reproductive age?
Sub-question 5.1	Have the MoH and PMO-RALG ensured the implementation of the planned education programs and awareness campaign?
Sub-question 5.2	Do the MoH and PMO-RALG promote education programs for community awareness and participation?
Sub-question 5.3	Do the MoH and PMO-RALG use indicators/metrics to measure the effectiveness of these programs?

Appendix 3: Sampling

This section presents the sampling of regions based on ranks in total maternal deaths and the total number of first ANC Visits.

Geographical Zones	Region	Total Maternal Death (2020 - 2024)	Ranks	Total Number of 1st ANC Visits (2020 - 2024)	Ranks	Average Position	Sampled Region
Eastern	Dar es Salaam	887	1	924,287	1	1.0	Dar Es Salaam
	Pwani	200	18	351,097	18	18.0	
	Morogoro	501	3	585,999	7	5.0	
Western	Kigoma	447	4	622,340	6	5.0	Kigoma
	Tabora	330	8	919,754	2	5.0	
	Katavi	211	17	317,593	20	18.5	
Central	Dodoma	353	6	562,917	10	8.0	Dodoma
	Singida	266	11	420,258	15	13.0	
	Manyara	200	19	408,385	16	17.5	
Lake	Mara	241	13	584,865	8	10.5	Mwanza
	Mwanza	802	2	864,610	3	2.5	
	Geita	285	9	705,113	4	6.5	
	Kagera	237	14	675,560	5	9.5	
	Shinyanga	252	12	525,862	11	11.5	
	Simiyu	156	23	583,497	9	16.0	
Southern	Lindi	196	21	190,223	25	23.0	Mtwara
	Mtwara	359	5	224,943	23	14.0	

Geographical Zones	Region	Total Maternal Death (2020 - 2024)	Ranks	Total Number of 1st ANC Visits (2020 - 2024)	Ranks	Average Position	Sampled Region
Southern Highlands	Iringa	191	22	195,906	24	23.0	Mbeya
	Rukwa	274	10	372,249	17	13.5	
	Njombe	111	26	134,261	26	26.0	
	Mbeya	336	7	464,141	13	10.0	
	Songwe	153	24	464,141	22	23.0	
	Ruvuma	126	25	342,391	19	22.0	
Northern	Arusha	227	15	308,000	21	18.0	Kilimanjaro
	Kilimanjaro	225	16	486,515	12	14.0	
	Tanga	197	20	457,621	14	17.0	

Source: Auditors' Analysis of Maternal Deaths and the Total number of first visits Reports, 2025

Appendix 4: Sampling of the Zonal and Regional Referral Hospitals

This section presents the sampling of the Zonal and Regional Referral Hospitals based on the availability of Maternal, Newborn, and Child Health (MNCH) programmes supported by multiple Implementing Partners (IPs).

Zone	Sampled Region	Selected ZRH	Selected RRH
Eastern	Dar es Salaam	-	Temeke
Western	Kigoma	-	Mawenzi
Central	Dodoma	Benjamini Mkapa	Dodoma
Lake	Mwanza	-	Sekou Toure
Southern	Mtwara	Mtwara	Ligula RRH
Southern Highlands	Mbeya	-	Mbeya RRH
Northern	Kilimanjaro	-	Mawenzi RRH

Source: Auditors' Analysis of Zonal and Regional Referral Hospitals, 2025

Appendix 5: Visited District Hospitals

This section presents the sampled District Hospitals which were visited by the auditors across selected districts.

Region	District Hospital	Number of First Visits	Set up	Selected District
Dar Es Salaam	Temeke MC	53,951	Urban	V
	Ilala CC	49,922	Urban	
	Kinondoni MC	49,922	Urban	
	Ubungo MC	36,863	Urban	
	Kigamboni MC	10,745	Urban	
Kigoma	Uvinza DC	28,812	Rural	V
	Kigoma MC	11,734	Urban	
	Kibondo DC	11,220	Rural	
	Kasulu TC	10,694	Urban	
	Kasulu DC	23,018	Rural	
	Kakonko DC	8,218	Rural	
	Buhigwe DC	10,071	Rural	
Dodoma	Bahi DC	14,063	Rural	
	Chamwino DC	21,740	Rural	
	Chemba DC	12,929	Rural	
	Dodoma MC	29,443	Urban	
	Kondoa TC	12,291	Urban	V
	Kongwa DC	18,972	Rural	
	Mpwapwa DC	16,200	Rural	
Mwanza	Buchosa DC	18,133	Rural	
	Ilemela MC	24,110	Urban	
	Kwimba DC	23,544	Rural	
	Magu DC	22,938	Rural	
	Misungwi DC	25,088	Rural	
	Nyamagana MC	28,244	Urban	V
	Sengerema DC	20,898	Rural	
	Ukerewe DC	19,712	Rural	
Mtwara	Masasi TC	11,672	Urban	
	Mtwara MC	7,530	Urban	
	Tandahimba DC	9,214	Rural	V
	Newala TC	6,213	Urban	
Mbeya	Busekelo DC	8250	Rural	
	Chunya DC	9,363	Rural	
	Kyela DC	18,252	Rural	V
	Mbarali DC	10,847	Rural	
	Rungwe	13,783	Urban	
Kilimanjaro	Hai DC	38,417	Rural	
	Moshi MC	53,267	Urban	
	Moshi DC	79,572	Rural	
	Mwanga DC	20,522	Rural	
	Rombo DC	44,571	Rural	
	Same DC	48,402	Rural	V
	Siha DC	23,249	Rural	

Source: Auditors' Analysis of Health Facilities Data Base, 2025

Appendix 6: Sampled Health Centres and Dispensaries

This section presents the health facilities sampled across selected districts. Facilities were sampled to include different levels of health centres and dispensaries across both urban and rural settings to provide a representative overview of service delivery.

District	Health Centre	Dispensary	Urban/Rural
Temeke	Buza	Kichemchem	Urban
Uvinza	Uvinza	Malagalasi	Rural
Kondoa	Mauno	Bambare	Rural
Nyamagana	Makongoro	Buhongwa	Urban
Tandahimba	Mahuta	Kitama	Rural
Kyela	Ipinda	Makwale	Rural
Same	Hedaru	Kakonkoro	Rural

Source: Auditors' Analysis of Sampled Health Facilities, 2025

Appendix 7: List of Documents Reviewed

This section presents the list of documents reviewed in the selected entities and healthcare facilities. The reviewed documents enabled the Audit team to obtain sufficient information and evidence to develop audit findings.

Entity	Name of the Document	Reason
MoH	• IKAMA (Staffing Level) • Staffing Levels for the Ministry of Health and Social Welfare Departments, Health Service Facilities, Health Training Institutions and Agencies 2014-2019	To assess the staffing level responsible for the provision of maternal health.
	• Strategic Plans for Rehabilitation Services • Annual Plans (2021/22 -2024/25)	To assess the strategies set for the provision of maternal healthcare.
	• National Health Management Information System (HMIS/DHIS2) summary reports • Bullet in Report • Maternal and Perinatal Death Surveillance Review Bulletins (2025)	To assess the performance trend in the reduction of the maternal mortality rate.
	• Maternal and Perinatal Death Surveillance and Response (MPDSR) Guidelines (2019 & 2018)	To assess the strategies set in the provision of maternal healthcare and the reduction of the Maternal mortality rate.
	• National Guidelines for Referral of Patients and Clients (2020) • Antenatal Care (ANC) Guidelines (2018): Structured requirements for the health pyramid and referral levels. • TEMESA Maintenance Records: Status of grounded and out-of-service ambulances	To assess the strategies in the referral process for providing maternal healthcare services.

Entity	Name of the Document	Reason
	• WHO "Blue Book" (2021): International benchmarks for ambulance equipment and maternal care	
	• National Operational Guideline for Community-Based Health Services (2021) • Health Promotion Sector Performance Reports: Disparity data between rural and urban education reach	To assess the community engagement and awareness in the provision of maternal healthcare.
	• Service Availability and Readiness Assessment (SARA) Reports (2023 & 2024	To assess the availability of CEmONC and BEmONC services
	• Multi-year Quantification Report for RMNCAH Commodities (2025-2027):	To assess financial projections and the facilities needed for the provision of maternal healthcare facilities
	• RMNCAH Budget and Expenditure Reports (FY 2022/23 – 2024/25):	To assess the funds allocated for the provision of maternal healthcare.
PMO-RALG	• IKAMA (Staffing Level)	To assess the staffing level responsible for the provision of maternal health.
	• Statistics from DHIS2 • HMIS Data	To assess the performance trend in the reduction of the maternal mortality rate.
	• Annual Plans (2021/22 -2024/25)	To assess the strategies set for the provision of maternal healthcare.
	• Tanzania Quality Improvement Framework in Health Care (2011-2016): Regarding supportive supervision and monitoring.	To assess the extent of the implementation of Monitoring and evaluation.
	• Emergency Medical Services - Ground Ambulance Requirements.	To assess the strategies in the referral process for providing maternal healthcare services.
	• M-Mama reports on service provision.	To assess the performance in the provision of healthcare facilities.
Zonal & Regional	• Maternal death reports (2021/22 – 2024/25)	To assess the trend of the maternal mortality rate.

Entity	Name of the Document	Reason
Referral Hospitals	• EmONC Readiness reports	To assess the provision of EmONC Services
	Manning level (IKAMA	To assess the staffing level responsible for the provision of maternal health.
	• Delivery records	To assess the performance of the provision of maternal healthcare in the hospitals.
	• Medical Equipment inventory	To assess the availability of equipment in the provision of maternal healthcare.
District Hospitals, Health Centres, and Dispensaries	• Maternal death reports • Delivery records	To assess the trend of the maternal mortality rate
	• EmONC & BEmONC Readiness reports	To assess the availability of CEmONC and BEmONC services
	• Manning level (IKAMA)	To assess the staffing level responsible for the provision of maternal health services.
	• Medical Equipment inventory	To assess the availability of equipment in the provision of maternal healthcare

Source: Auditors' Analysis of Reviewed Documents, 2025

Appendix 8: List of Officials Interviewed

This section presents the list of officials interviewed in the selected entities and healthcare facilities.

Entity	Official interviewed	Reason(s) for the interview
MoH	• Director RMNCAH	To assess the provision of maternal healthcare
	• Director of Health Promotion	To assess the awareness programs set in the provision of maternal healthcare
	• Coordinator of Self Motherhood Initiative	To assess the provision of maternal healthcare
	• Director of M&E	To assess the implementation and follow-up of the initiatives set in the provision of healthcare facilities
PMO-RALG	• Director of Health, Social Welfare and Nutrition Services	To assess the strategies in the provision of maternal healthcare
	• Assistant Director of Health	To assess the provision of maternal healthcare
	• RMNCAH Coordinator	To assess the efficiency and effectiveness of coordination among different actors in the provision of maternal healthcare
	• M-mama Coordinator	To assess the performance in the provision of maternal healthcare
Zonal Hospitals and Regional Referral Hospitals	• Medical Officer in charge	To assess the process of provision of maternal healthcare
	• Nursing officers & Midwives	To assess the process of provision of maternal healthcare
	• Pregnant women	To assess the extent of service provided in maternal healthcare
Health Facilities (District Hospital, Health Centres, and Dispensaries)	• Medical Officer-in-Charge	To assess the process of provision of maternal healthcare
	• Nursing officers & Midwives.	To assess the process of provision of maternal healthcare
	• Pregnant women	To assess the extent of service provided in maternal healthcare.

Source: Auditors' Analysis of PMO-RALG and MoH Organisation Structure, 2025

Entity	Name of the Document	Reason
Referral Hospitals	• EmONC Readiness reports	To assess the provision of EmONC Services
	Manning level (IKAMA	To assess the staffing level responsible for the provision of maternal health.
	• Delivery records	To assess the performance of the provision of maternal healthcare in the hospitals.
	• Medical Equipment inventory	To assess the availability of equipment in the provision of maternal healthcare.
District Hospitals, Health Centres, and Dispensaries	• Maternal death reports • Delivery records	To assess the trend of the maternal mortality rate
	• EmONC & BEmONC Readiness reports	To assess the availability of CEmONC and BEmONC services
	• Manning level (IKAMA)	To assess the staffing level responsible for the provision of maternal health services.
	• Medical Equipment inventory	To assess the availability of equipment in the provision of maternal healthcare

Source: Auditors' Analysis of Reviewed Documents, 2025

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