

Policy Brief

Closing Gaps in Adolescent Reproductive and Maternal Health in Tanzania

United Republic of Tanzania



Ministry of Health



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Introduction: Tanzania's Adolescents

Approximately 10.2% of Tanzania's population comprises adolescents aged 15-19 years. Of the maternal deaths in Tanzania, 2 out of 30 occur among girls in this age group. Over time, several strategic plans have been introduced to promote adolescent health, including the National Accelerated Action and Investment Agenda for Adolescent Health and Wellbeing (NAIA-AHW) 2021/22–2024/25, the National Adolescent Health and Development Strategy (ADHD) 2018–2022, One Plan III (2021), the Health Policy (2007), the Fifth Revision of the Health Sector Strategic Plan (HSSPV-2021), ICPD25 Commitments, FP2030 Commitments, and the National Adolescent Health and Development Strategy (2018–2022).

These initiatives aim to create an enabling environment for adolescents in the country.

- The most recent policies prioritize improving adolescent reproductive and maternal health by emphasizing high attendance at antenatal care (ANC1: first visit in the first trimester, and at least four visits) and postnatal care within two days of delivery. They also focus on increasing the utilization of health facilities and skilled birth attendance during childbirth. Despite these efforts, adolescent girls face unique health challenges that threaten their long-term well-being, education, and economic prospects, including high fertility and teenage pregnancy.

- Stalled progress in contraceptive use.
- Persistent inequities by education, residence, and wealth.

Without urgent intervention, Tanzania risks undoing progress made in adolescent reproductive and maternal health.

There are 6,083,495
Adolescents (15-19 years)
in Tanzania Mainland

10.2%
of the total
Population

The Current State of Adolescent Girls in Tanzania

The **adolescent girls** of Tanzania are spread across urban and rural areas, with substantial disparities in health, education, and access to services.

According to the NBS report on adolescents and youth in Tanzania, published in November 2025, the education status of adolescents and youth reveals significant disparities across age groups and regions. In primary education (10-13 years), the national enrollment rate is 82.9%, with urban areas at 89.6% and rural areas at 79.7%. Females slightly outperform males in this category. For lower secondary education (14-17 years), the enrollment rate drops to 43.7%, with urban areas at 57.8% and rural areas at 36.6%, and females continue to outperform males. At the upper secondary level (18-19 years), the rate declines further to 7.8%, with rural areas at 4.6% and urban areas at 13.0%.²

Key Findings (TDHS 2004/05–2022)

Adolescent Fertility and Teenage Pregnancy

Adolescent reproductive health encompassing Adolescent Fertility Rate (AFR), teenage pregnancy, and family planning metrics (modern contraceptive use, met and unmet need for family planning, and demand satisfied by modern methods).

The AFR is more than four times higher among adolescent girls with no education compared to those with secondary or higher education. AFR is nearly four times higher among adolescents in the poorest wealth quintile compared to those in the richest quintile. Additionally, AFR in rural areas is more than twice as high as that in urban areas.

Teenage pregnancy refers to the percentage of women aged 15–19 who have ever been pregnant, including those who have experienced live births, miscarriages, or abortions. It is consistently higher in rural areas and among adolescents with no education or from lower wealth groups. In rural areas, the prevalence was 1.5 times higher than in urban areas, with a rate of 28.7% in 2004-05, dropping to 24.1% in 2022. In urban areas, the prevalence decreased from 19.6% in 2004-05 to 15.3% in 2022.

Adolescents with no education consistently had the highest prevalence, peaking at 49.1% in 2022, compared to 31.3% for those with primary education and 8.8% for those with secondary education. Additionally, adolescents in the lowest wealth group experienced the highest prevalence, with 33.9% in 2022, while those in the highest wealth group had a significantly lower rate of 11%.

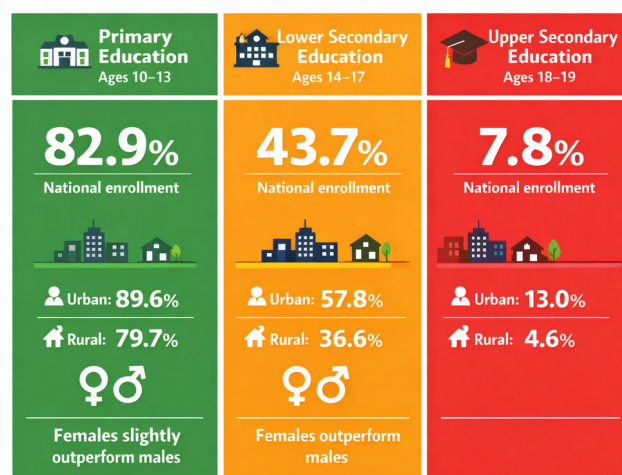
From 2022 DHS rural areas, adolescents with no education and low household quintile exceeded the 2025 targets of 20% hence much effort is required to reduce the teenage pregnancy.

1. MoH et al. Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS). 2022.

2. MoH et al. Tanzania Adolescents and youth in Tanzania (november 2025).

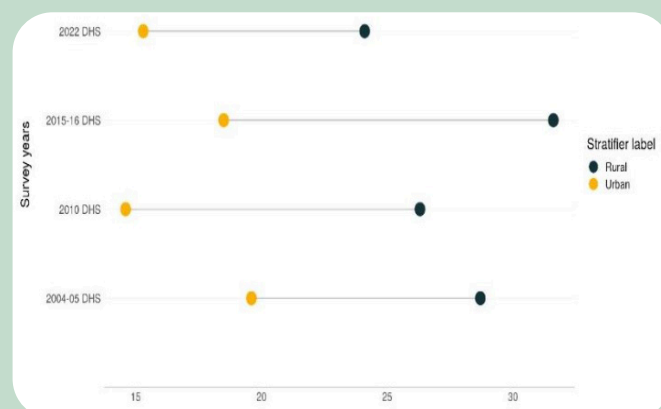
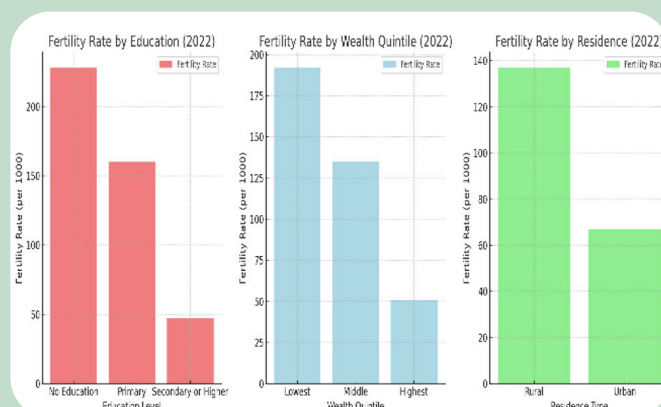
School Enrollment in Tanzania

By education level, sex & residence



Source: National Bureau of Statistics

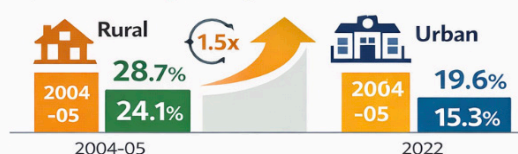
Teenager Pregnancy by Residence



Teenage Pregnancy Prevalence by Residence

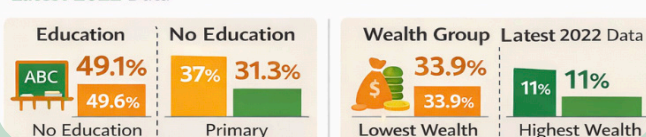
2004-05 vs 2022

Rural prevalence was **1.5x higher** than in urban areas in 2022.



Teenage Pregnancy Prevalence by Education & Wealth Group

Latest 2022 Data



Contraceptive Use and Family Planning Bridging the Gap

Despite high demand for family planning in Tanzania, modern contraceptive use remains low. While 48.2% of the demand was satisfied in 2010, this fell to 37.6% by 2022. Similarly, adolescent contraceptive use dropped from 9.4% to 6.6%. This gap suggests barriers to access and usage, highlighting the need for improved policies and better service delivery to meet the growing demand.

Furthermore, Inequalities in access to family planning persist across education levels in Tanzania. While adolescents with higher education report higher demand with family planning services and greater contraceptive use, both have declined over time.

In 2022, demand with family planning was lowest among those with no education (30.1%) and highest among those with secondary education (41.4%). Similarly, contraceptive use increased slightly among those with no education but dropped significantly among those with secondary education (4.5%).

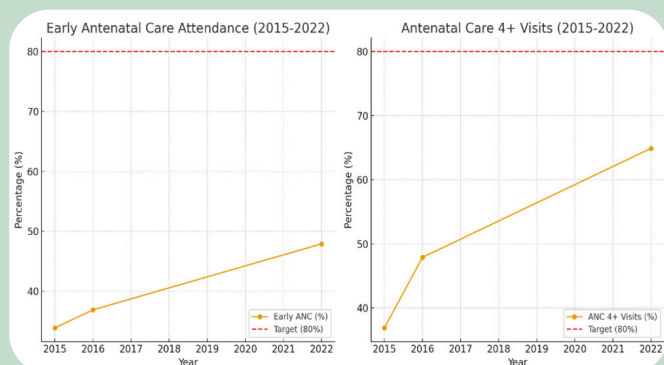
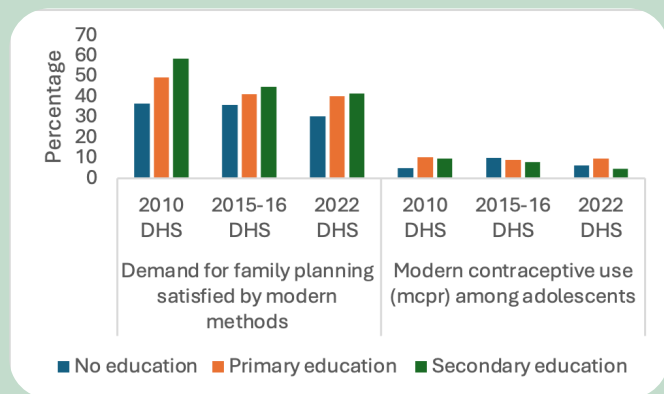
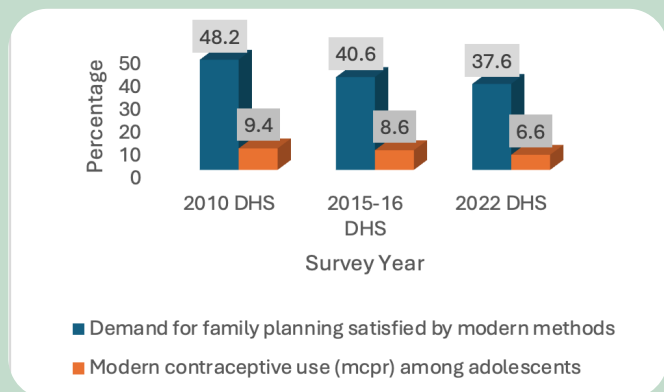
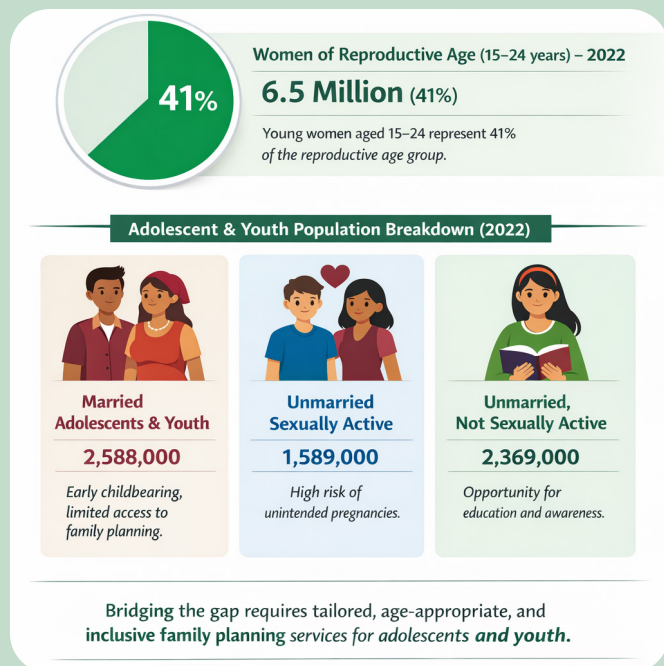
These trends highlight the need for targeted interventions to improve access to family planning, particularly for less-educated adolescents, while addressing barriers even among the more educated groups.



Maternal Health – Improving Access to Care

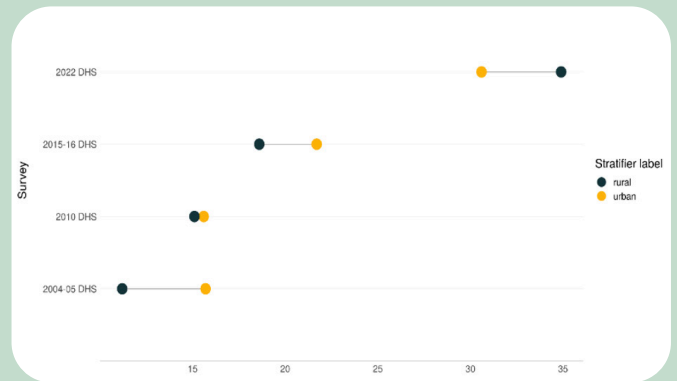
Adolescent Maternal Health indicators include early antenatal care (ANC), ANC 4+, institutional delivery, skilled birth attendance, and Caesarean section rates.

- Early ANC among adolescents remains very low. The 2025 target is for 80% pregnant adolescents to attend ANC in the first trimester, but according to the 2022 DHS, only 33.9% do so. Across all socio-economic groups by education, residence, or wealth none have reached the target.
- Adolescents attending 4 visits show some progress by increasing from 47.9 percent by 2015/16 to 64.9 percent in 2022 but still lag behind by 15.1% to reach target of 80% by 2025. In the socio-

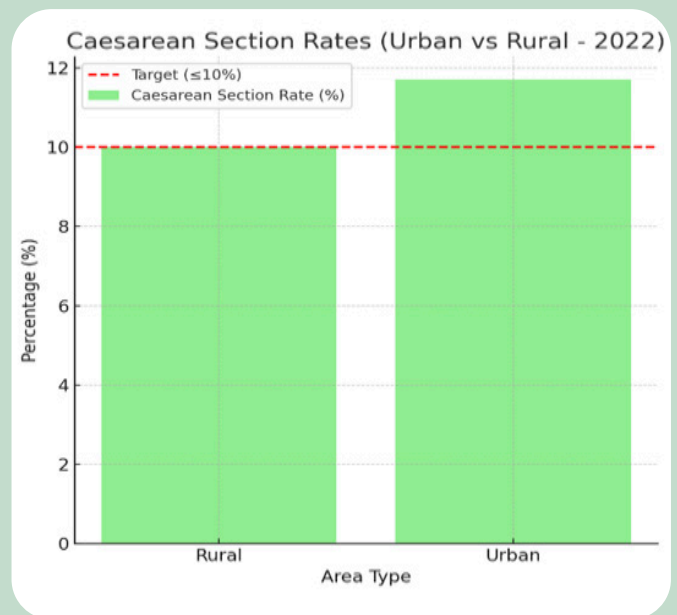


economic group only adolescents with highest wealth quintile managed to reach the targets by achieving the coverage of 79.5 in the recent survey while others including residence and education level all are still lagging behind the target and require much attention to improve the coverage of the ANC 4.

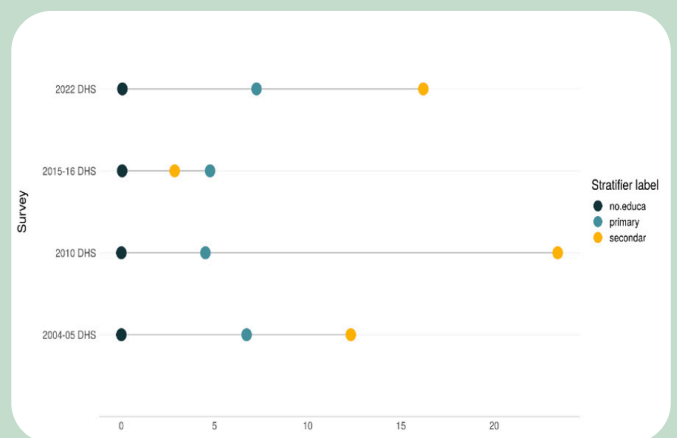
- In 2004, urban areas had higher early ANC visit rates (15.7%) compared to rural areas (11.2%), but by 2010, the gap narrowed significantly. In 2022, rural areas surpassed urban areas with 34.9% of adolescents attending early ANC visits, compared to 30.9% in urban areas, reflecting efforts to improve access in rural regions. However, both areas are still far from the target of 80%.
- The Institutional delivery coverage has improved from 56.2% in 2004 to 82.6% in 2022 but still lag behind the targets of 90% in 2025 by 7.4%. Major attention is required in rural areas (79.7%) where the urban reach the targets by 92.6%. Adolescents with higher or secondary education reach the targets (96.6%) hence much attention required with adolescents with no or primary education. Adolescents with richest wealth reach the target in 2015 and 2022 with a percentage of 94.5 and 97.4 respectively, which is above the 90% target. Hence major efforts are required with the adolescents with low household wealth quintile.
- Tanzania has set a target of 80% by 2025 to ensure adolescents are attended by skilled birth attendance. In general, all adolescents have reached the targets to be attended by skilled birth in all socio demographic groups and even the country trends.



Early Antenatal care attendance among adolescents by residence



- The data on Caesarean sections from the DHS indicates that the C-section rate in Tanzania is generally high, with urban areas surpassing the target of a 10% rate, reaching 11.7% in 2022. Similarly, adolescents with secondary education also exceed the target, with a C-section rate of 16.2% in 2022. Additionally, higher wealth quintiles show higher C-section rates, also surpassing the 10% threshold. This suggests that the unmet need for Caesarean sections is likely minimal, as the target rate is used as an indicator of whether the need is being met. Importantly, the urban-rural difference in C-section rates is remarkably small, indicating that both urban and rural areas require attention in addressing this issue.



Cesarean section among adolescents by education

Policy Implications

- Persistently high teenage pregnancy and stagnating contraceptive use hinder progress toward the demographic dividend and SDG targets.
- Inequities expose systemic barriers: rural, poor, and uneducated adolescents remain most at risk.
- Weak integration of adolescent health into routine care perpetuates unmet needs.

Without accelerated, equity-focused action, national and global adolescent health commitments will not be achieved.

Policy Recommendations

1. Scale up adolescent-friendly reproductive health services
 - Establish and strengthen youth-friendly corners in health facilities.
 - Train providers on confidentiality and respectful care.
2. Expand contraceptive access and education
 - Reach the 20% adolescent mCPR target by 2025 through improved supply chains, school-based programs, and peer-led outreach.
 - Address myths and misconceptions via community engagement.
3. Strengthen maternal health services for adolescents
 - Promote early ANC attendance with digital reminders and community health worker follow-up.
 - Expand skilled birth attendance in rural and underserved areas.
4. Address equity gaps
 - Prioritize poor, rural, and uneducated adolescents with tailored interventions.
 - Integrate adolescent reproductive health into Comprehensive Council Health Plans (CCHPs).
5. Leverage cross-sectoral approaches
 - Keep girls in school through conditional cash transfers and community sensitization.
 - Link SRHR, education, and nutrition programs to reduce multidimensional vulnerabilities.

Conclusion

Analysis of both reproductive and maternal health indicators across socio-demographic groups reveals persistent inequalities. Adolescents from rural areas, those with low household wealth, and those with lower levels of education continue to have poor coverage across most indicators. In contrast, adolescents with secondary or higher education, from urban areas, or from higher wealth quintiles generally experience better access to reproductive and maternal health services.

These findings highlight the need for targeted interventions to reduce teenage pregnancy, which remains a high-risk issue for this age group. Additionally, the high use of Caesarean sections among urban adolescents, those with higher wealth, and those with secondary or higher education warrants attention, as it exceeds recommended targets for this population.

In conclusion, addressing these disparities through equitable access to health services, comprehensive sexuality education, and focused policy measures is essential to improve adolescent reproductive and maternal health outcomes and reduce risks among the most vulnerable groups.