THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH TANZANIA

TANZANIA MAINLAND HEALTH FACILITY'S ANNUAL MORTALITY STATISTICS REPORT 2024

SEPTEMBER, 2025

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ABBREVIATIONS

ANACoD3	Analysis of Causes of (National) Death for Action, Version 3
BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CoD	Cause of Death
CSMF	Cause Specific Mortality Fractions
COVID-19	Coronavirus Disease 2019
D4H	Data for Health
DHIS2	District Health Information Software 2
EMR	Electronic Medical Records
GF	Global Fund
HIV	Human Immunodeficiency Virus
ICD-10	International Classification of Diseases, 10th Revision
ICT	Information and Communication Technology
IHI	Ifakara Health Institute
IMCI	Integrated Management of Childhood Illness
IVD	Immunization and Vaccine Development
IPT	Intermittent Preventive Treatment
ITN	Insecticide-Treated Net
MCCD	Medical Certification of Cause of Death
MDSR	Maternal Death Surveillance and Response
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MRC	Mass Replacement Campaign
NBS	National Bureau of Statistics
NCD	Noncommunicable Disease
PHC	Primary Health Care
Po-RALG	Presidents' Office-Regional Administration and Local Government
RITA	Registration Insolvency and Trusteeship Agency
SBCC	Social and Behavior Change Communication
SNP	School Net Program
TB	Tuberculosis
WHO	World Health Organization

FOREWORD

The 2024 Annual Mortality Statistics Report summarizes progress made in the Health Sector of Tanzania on mortality indicators. In addition, by tracking patterns related to mortality and cause of death in the country for the year 2024, this report provides a valuable opportunity to assess the effects of the 5th Health Sector Strategic Plan on population health. The report contains the analysis of data generated through medical certification of cause of death. Classifications of causes of death through medical certification are captured in the health information management system DHIS2 used in most health facilities in the country. The analysis in this report also drew data from electronic medical records that are used in numerous tertiary hospitals in the country that do not use DHIS2. Importantly, this report provides insights into the 20 leading causes of death for all ages by sex and their contribution to total deaths. In addition, it highlights areas for interventions to improve public health and the quality of data for evidence-based planning and decision making.

This report provides highlights on the three categories of causes of death communicable disease, non-communicable disease and injury in terms of the conditions that comprise them, respectively, and how the conditions in each category, collectively, contribute to the national disease burden. The report also provides death statistics for major disease-specific causes of mortality, namely HIV, TB and Malaria. Based on all analyses, the report provides a summary of recommendations for policy improvement and action. The recommendations will inform guidance given to policy makers on the evidence-based public health interventions that can best address major causes of death in the country.

In addition, this report contains analysis of the quality of cause of death statistics as expressed by estimates of the level of completeness that was achieved by our data sources and the frequency with which they reported ill-defined causes of death in 2024. Based on this, the report points out areas for improvement that should be prioritized in the future.

The report calls on key health sector stakeholders to support the government in improving the quality of cause of death statistics, particularly by adopting measures that will help to increase the frequency with which mortality events receive a Medical Certification of Causes of Death (MCCD), which has improved to 15% in 2024 from 18% in 2023. The pace of improvement needs to accelerate from year to year.

Dr. Seif A. Shekalaghe
PERMANENT SECRETARY

ACKNOWLEDGMENTS

The 2024 Annual Mortality Statistics report was developed through consultative and participatory efforts of various stakeholders. The Ministry of Health (MoH) would like to thank the Monitoring and Evaluation (M&E) Unit for its coordination role in the preparation of this report. Sincere gratitude goes to the MoH Management for their proper, technical and practical guidance in developing this report.

I would also like to thank the MoH's departments and the President's Office-Regional Administration and Local Government (PO-RALG) officials for their commitment and valuable contributions. Special thanks are extended to Development Partners, Implementing Partners, Faith-Based Organizations (FBOs), the Private Sector, and different institutions for their dedication and support in improving cause of death data.

The Ministry recognizes the contribution of all individuals who participated directly or indirectly in the preparation of this report. The preparation process was very inclusive and involved many key players who contributed a lot in different ways (extraction of data from DHIS2 and other hospital databases, ICD coding, analysis and report writing).

The preparation of the 2024 Annual Mortality Statistics Report (AMSR) was made possible through financial support from the Global Fund (GF). Moreover, the Ministry recognizes technical and financial support from Vital Strategies through the Bloomberg Philanthropies Data for Health (D4H) Initiative, the Ifakara Health Institute (IHI), and the World Health Organization (WHO). Generally, the support from these partners in strengthening routine mortality data quality improvement is highly acknowledged.

Dr. Grace E. Magembe

CHIEF MEDICAL OFFICER

EXECUTIVE SUMMARY

Accurate and consistently accessible data on causes of death is crucial for guiding national health policies and tracking advancement toward the 2030 Sustainable Development Goals. Since 2014, Tanzania's health sector has made notable improvements in the quality of cause-of-death reporting. However, the overall coverage of this data remains limited. In fact, only 15% of the estimated 330,888 deaths in 2024 were assigned a medically certified cause of death.

- 85% of deaths that received a cause of death classification in health facilities were medically certified with a correct underlying cause of death. Efforts are still needed to ensure all health facility deaths are assigned correct causes of death.
- Perinatal conditions were the leading cause of death (8.7%), followed by birth asphyxia and trauma (7.3%), with lower respiratory infections, hypertensive disease, and HIV also ranking in the top five, while non-communicable diseases and road traffic injuries remained significant but less prevalent contributors.
- HIV-related deaths were extensively concentrated in urban and high-prevalence regions, with Dar es Salaam accounting for the highest share (21.8%) and women more affected than men.
- Tuberculosis-related deaths were highest in regions like Dar es Salaam, Kilimanjaro, and Dodoma, highlighting the need for region-specific interventions focused on improved case detection, expanded diagnostics, treatment adherence, and strengthened community and government collaboration.
- Communicable diseases accounted for the largest share of the mortality burden in Mainland Tanzania (48.4%), followed by noncommunicable diseases (43.4%), injuries (4.3%), and undetermined causes (4.6%).
- Maternal deaths showed significant regional variation, with the highest numbers in Dar es Salaam, Mwanza, Tabora and Kigoma. Maternal hemorrhage, other maternal conditions and hypertensive disorders remained the leading causes across all regions.
- Cancer-related deaths were driven by a wide range of malignancies, with unspecified cancers accounting for the largest share (18.7%), and cervical, esophageal, breast, liver, and respiratory cancers among the leading site-specific causes, underscoring the urgent need for improved prevention, early detection, and treatment.
- Injury deaths were highest in urban and semi-urban regions such as Dar es Salaam, Dodoma, and Mwanza, highlighting the impact of urbanization and the need for targeted interventions like improved road safety, trauma care, and occupational health measures.

CHAPTER 1: INTRODUCTION

1.1 Background

The Ministry of Health (MOH has taken several steps to improve the quality and availability of mortality statistics which it obtains from routine sources of health data, notably with the introduction and rollout of the District Health Information Software version 2 (DHIS2) starting in 2010. DHIS2 is an electronic system being implemented to record individual-level death data and to produce and classify causes of death according to WHO standards. It uses the International Classification of Diseases Version 10 (ICD-10) short list and enables for Medical Certification of Causes of Death (MCCD) for all episodes of mortality captured by the system. In addition, other Electronic Medical Records Systems (EMRs) are being used for data collection in zonal, specialized, and national referral hospitals.

Mortality statistics provide valuable information for assessing and measuring population health status. Death is not only significant insofar as it pertains to individuals' lives. When patterns of death are analyzed at the population level, they have the potential to generate knowledge that can be used to improve the public's health. Within the health sector, mortality statistics are critical for formulating health plans and policies that improve life expectancy and quality of life in the population.

The 2024 Annual Mortality Statistical Report (AMSR 2024) describes the sources of mortality data, and the methodologies used for data collection and analysis. It also provides information on the quality of mortality data and summarizes patterns related to the incidence and causes of mortality in the population of Mainland Tanzania. In doing so, it highlights areas where the health sector has made progress and others where further improvement is needed. The report presents the 20 leading causes of death for all ages, broken down by sex, as well as their contributions to the total mortality for the year. In addition, it categorizes causes of death into three broad disease groups by region. Finally, it offers recommendations for strengthening Tanzania Mainland's Civil Registration and Vital Statistics (CRVS) System in the future.

1.1.1 Special Population Groups in Tanzania Mainland 2024

For this annual mortality report, the demographic characteristics of the deceased are categorized by sex (male and female) and by key age groups: children under five years, adolescents aged 10–19 years, women of reproductive age (15–49 years), and older adults aged 60 years and above. These categories were used as denominators in specific analysis and reflect important epidemiological patterns and variations in risk factors across different segments of the population. Understanding mortality within these groups provides critical insights into the health challenges they face. Moreover, this disaggregated analysis supports evidence-based planning, facilitates the design of targeted interventions, and strengthens decision-making aimed at improving public health outcomes across Tanzania.

Table 1.1: Population Groups in 2024 by Region (Estimated)

Region	Under-5		Adolescents (10-19)		Women of Reproductive Age (15-49)	Elderly (60+)		Total Population		
	Male	Female	Male	Female		Male	Female	Male	Female	Total
Tanzania	4,906,170	4,877,129	7,435,110	7,421,794	15,517,175	1,600,068	1,910,170	31,043,962	32,588,278	63,632,240
Arusha	191,173	189,289	263,564	275,613	658,994	59,159	66,068	1,196,242	1,301,885	2,498,127
DSM	335,780	329,732	507,669	590,137	1,819,525	110,354	113,740	2,783,794	2,973,694	5,757,488
Dodoma	244,261	241,639	394,829	383,033	768,620	97,460	118,061	1,610,829	1,667,669	3,278,498
Geita	285,953	286,510	404,549	393,803	704,485	56,054	61,705	1,556,918	1,600,336	3,157,254
Iringa	84,673	83,921	143,994	141,378	319,761	34,994	51,451	612,545	657,936	1,270,481
Kagera	260,160	260,188	4m02,600	393,940	734,737	74,009	91,561	1,558,536	1,626,586	3,185,122
Katavi	115,541	115,968	147,600	147,664	270,068	21,192	21,380	605,457	615,638	1,221,095
Kigoma	236,424	234,545	335,365	335,688	589,623	59,638	72,586	1,261,329	1,354,376	2,615,705
Kilimanjaro	121,725	117,243	209,711	207,201	479,367	90,262	114,535	969,483	1,019,321	1,988,804
Lindi	80,288	80,476	139,056	132,210	323,755	46,252	59,074	621,428	653,133	1,274,561
Manyara	168,112	165,121	241,790	229,954	437,903	53,090	54,375	1,014,564	990,512	2,005,076
Mara	207,681	207,768	342,582	329,085	565,245	58,698	78,207	1,213,850	1,306,717	2,520,567
Mbeya	183,330	184,637	272,994	285,246	648,508	60,975	78,628	1,198,572	1,292,745	2,491,317
Morogoro	242,874	240,817	382,298	371,852	844,466	99,217	108,656	1,683,635	1,718,581	3,402,216
Mtwara	106,623	107,175	187,942	183,916	450,167	65,346	91,805	831,387	919,944	1,751,331
Mwanza	317,457	313,291	490,943	493,295	945,767	80,752	98,357	1,918,564	2,010,574	3,929,138
Njombe	60,526	61,156	106,055	105,661	246,262	26,880	41,526	449,313	500,471	949,784
Pwani	143,968	141,732	229,982	228,494	562,868	62,016	68,949	1,061,482	1,087,913	2,149,395
Rukwa	146,059	149,751	203,092	208,444	370,369	30,660	34,623	789,799	842,324	1,632,123
Ruvuma	139,249	140,228	227,568	221,657	490,824	58,571	68,791	966,083	1,012,031	1,978,114
Shinyanga	200,705	198,956	295,450	293,719	554,243	47,362	54,427	1,172,442	1,202,887	2,375,329
Simiyu	213,438	211,048	290,204	295,584	482,917	45,128	57,081	1,099,192	1,167,489	2,266,681
Singida	178,706	177,204	267,732	251,162	451,670	60,356	71,950	1,061,233	1,073,946	2,135,179
Songwe	116,652	118,564	165,257	168,058	350,400	30,775	38,789	685,432	741,876	1,427,308
Tabora	325,219	323,800	450,564	440,336	795,635	75,610	83,151	1,762,627	1,825,109	3,587,736

Region	Under-5		Adolescents (10-19)		Women of Reproductive Age (15-49)	Elderly (60+)		Total Population		
	Male	Female	Male	Female		Male	Female	Male	Female	Total
Tanga	199,593	196,370	331,720	314,664	650,996	95,258	110,694	1,359,226	1,424,585	2,783,811

Source: NBS. Population Projections (PHC 2022), Mainland Tanzania

1.2 Cause of Death Data

Data on causes of death yield valuable insights into the health status within a given population. Such data is compiled through the national CRVS systems under the MoH, and when analyzed, can illuminate current health problems, suggest persistent patterns of risk, and show trends of specific causes of death over time. These analyses can be disaggregated by sex and age to provide more focused information about the subpopulations during a given period.

Causes of death provide a basis for formulating health plans and policies to prevent or reduce avoidable mortality and improve quality of life. Many causes of death are preventable or treatable and therefore warrant the attention of public health officials. Furthermore, information on causes of death helps illuminate the impact of policies and programs aimed at increasing the healthy life expectancy of the population and can be used for planning programmatic improvements. For example, mortality data can help focus activities and resource allocation among sectors such as transportation, food and agriculture, and the environment as well as health.

The MoH in collaboration with Vital Strategies through the Bloomberg Philanthropies Data for Health Initiative, the Global Fund and other partners, are supporting the Government of Tanzania in strengthening the CRVS system, particularly by improving the completeness and reporting quality of cause of death statistics from the community and health facilities. Through this the MoH collects, processes and analyzes mortality data that it obtains from health facilities as well as from community sources. At health facilities, particularly tertiary hospitals, death events are captured using Electronic Medical Records (EMR) systems that are installed at the health facility, or through paper-based death registry forms that are later entered into DHIS2—the platform used throughout most of the Tanzanian health system for managing health information.

1.3 Scope/Objective of the Report

This report aims to highlight the burden of mortality and the causes of death recorded in the year 2024, while also showing the completeness and quality of mortality data. The analysis is based on information gathered from health facilities across Mainland Tanzania that provide medically certified causes of death. The report utilizes the WHO's ICD-10 classification system to determine causes of death. The findings portray mortality among both males and females of all age groups within health facilities, offering valuable insights to inform policies and programs aimed at enhancing the overall quality of life for the country's population.

CHAPTER 2: METHODOLOGY

2.1 Data Sources

In Tanzania, cause of death (CoD) statistics are drawn from two major sources: (1) Medical information from medical certificates of cause of death, which is used as a basis for ascertaining the underlying cause of death, and WHO ICD-standard coding of causes of death, and (2) Verbal Autopsy to obtain probable CoD for community deaths (verbal autopsy data is not included in this report). This report is focused on analyzing mortality and CoD that occur in health facilities for the year 2024. All deaths that occur in health facilities are assigned an underlying CoD, which are defined as, "the disease or injury that initiated the train of morbid events leading directly to death, or the circumstances of the accident or violence which produced the fatal injury." For deaths occurring in a community, a probable CoD is assigned using Verbal Autopsy. In this report, we present an analysis of deaths reported by health facilities.

About 27.1% of all mortality data is compiled from 14 tertiary hospitals that use EMR systems. These include national, zonal and specialized referral hospitals. Information on the remaining 72.9% of all facility deaths were obtained from DHIS2, which include Regional Referral Hospitals (RRH) and Primary Health Care Facilities (PHC). Maternal deaths were obtained from the MDSR system, in which all deaths associated with maternal causes were assigned a cause of death by clinicians and reviewed by the MDSR committee at the facility, council, and regional levels. Table 2.1 describes the extracted mortality data by source for the year 2024.

Table 2.1: Total Number of Deaths by Data Source (EMR and DHIS2)

Region	DHIS 2	EMR	Total
Tanzania	36,053(72.9%)	13,418(27.1%)	49,471
Arusha	1,926(3.9%)		1,926
Dar es Salaam	5,027(10.2%)	6,529(13.2%)	11,556
Dodoma	2,222(4.5%)	897(1.8%)	3,119
Geita	722(1.5%)	131(0.3%)	853
Iringa	1,824(3.7%)		1,824
Kagera	1,814(3.7%)		1,814
Katavi	926(1.9%)		926
Kigoma	1,088(2.2%)		1,088
Kilimanjaro	841(1.7%)	1,759(3.6%)	2,600
Lindi	723(1.5%)		723
Manyara	952(1.9%)		952
Mara	822(1.7%)		822
Mbeya	1,097(2.2%)	1,670(3.4%)	2,767

Region	DHIS 2	EMR	Total
Morogoro	2,672(5.4%)		2,672
Mtwara	958(1.9%)	164(0.3%)	1,122
Mwanza	2,021(4.1%)	2,268(4.6%)	4,289
Njombe	724(1.5%)		724
Pwani	1,474(3.0%)		1,474
Rukwa	561(1.1%)		561
Ruvuma	730(1.5%)		730
Shinyanga	575(1.2%)		575
Simiyu	736(1.5%)		736
Singida	1,640(3.3%)		1,640
Songwe	648(1.3%)		648
Tabora	1,685(3.4%)		1,685
Tanga	1,645(3.3%)		1,645

2.2 Data Collection

Data on MCCD is collected by physicians using the WHO 2016 MCCD paper-based form to complete information regarding the causes of death in all four lines (Annex 1). Then they transfer this information to the EMR/DHIS2 system by manually selecting the appropriate ICD-10 code for the respective cause from the drop-down list. The EMR/DHIS2 systems are programmed to capture the immediate, intermediate, and underlying CoD only. Since 2014, clinicians have received training on completing the MCCD form based on the WHO ICD-10. The health information staff were also trained to enter codes for these events and their causes into the EMR/DHIS2 system. Maternal deaths are obtained from the MDSR system, in which all deaths associated with maternal causes are assigned causes of death by clinicians and reviewed by the MDSR committee at the facility, council, and regional levels.

2.3 Data Analysis

Combined data sets of age, sex, and underlying COD ICD-10 codes extracted from EMR, DHIS2 and MDSR were entered in the WHO ANACoD3 analytical tool for analysis. This computer application assessed the quality of MCCD and ICD-10 coding for the underlying CoD for 48,269 deaths that occurred at health facilities in Tanzania Mainland in the year 2024. The tool also assessed the completeness and quality of the collected data. This included checking for missing data, ill-defined causes of death, and inconsistencies in age and sex distribution. We analyzed mortality patterns by broad categories, age, sex and by region. Further analysis was done to identify the leading causes of death, especially those

addressed by vertical programs such as HIV, TB and malaria. Data was presented in tabular and diagrammatic formats.

2.4. Data Quality Management

Data quality management provides a context-specific process for improving the quality of data used for analysis and decision-making. It is an essential process in making sense of data. In this report, data quality has been measured according to completeness and correctness. The computation of completeness is based on the number of reported deaths in a particular period divided by the expected number of deaths for that period, based on projections derived from analysis of data from the 2022 Tanzania Population and Housing Census. Given that this report is based only on health facility data, the completeness of MCCD for all facility deaths is also calculated in this report. At the same time, the correctness of CoD assignment refers to the degree to which underlying causes of death reported are acceptable and well-defined as specified by WHO. In this analysis, the accuracy of CoD data from health facilities was measured against WHO standards of medical certification of cause of death by using ANACoD3 software. This process was also used to identify the instances during which classifications could be used to identify a defined CoD and when they could not.

The high quality and completeness of the CoD data are crucial for evidence-based planning and decision-making. This quality enables the accurate measurement of mortality patterns in the population over time. This is especially important with regards to long-standing and emerging causes of death such as infant and maternal conditions, infectious diseases, accidents and suicide. In this chapter, a few quality measures are highlighted as key to providing users with an overall overview of the report's quality.

2.4.1 Quality of Causes of Death Data

The quality of CoD data is determined by the completeness of the medical certificate of cause of death and its accuracy. A death certificate should provide a clear description of the chain of events from the immediate to the underlying CoD and should also report any other conditions that contributed to death and provide specific information. In Tanzania, the Medical Certificate of Cause of Death is the primary source of mortality statistics for health facility deaths and provides the basis for describing mortality and for analyzing the conditions leading to death and changes in population health. Mortality statistics can be used in epidemiological studies that focus on the leading causes of death by age, sex, or other demographic variables. In official statistics, great importance has always been attached to the quality of data. Several systems for measurement and reporting of data quality have been introduced internationally.

2.4.2 Completeness of MCCD Data

It is very important that all the people responsible for the documentation and registration of deaths provide accurate, comprehensive, reliable, complete and timely information, and that they record all deaths. This statistical data is used by the health sector to develop public health policies and goals for decision-making. In addition, mortality data is critical for measuring and comparing health status at local, national and international levels, because they are regularly and extensively collected in every developed country and most developing ones.

Table 2.2 below shows that a total of 48,269 deaths were medically certified and captured through the DHIS2 system, and through EMR systems in the year 2024 in Mainland Tanzania. Compared to the estimated total number of deaths in Tanzania in 2024, 14.6% received an MCCD. Of note, it's estimated that 30% of the deaths that occurred in Mainland Tanzania in 2024 happened in health facilities, while 70% occurred in the community. This suggests that approximately half of the deaths in health facilities are getting MCCD.

The completeness and quality of CoD data from health facilities can be improved by providing refresher training to physicians, strengthening electronic data collection systems and increasing the number of supportive supervisions (e.g., by following up to ensure that every facility-reported death gets an MCCD).

Table 2.2: Completeness of MCCD Data in Mainland Tanzania

Region	Total Population	CDR	Estimated Deaths	Total # of Deaths	Total # with MCCD	Proportion of deaths with MCCD (%)
Tanzania	63,632,240	5.2	330,888	49,471	48,269	14.6
Arusha	2,498,127	5.2	12,990	1,926	1,926	14.8
Dar	5,757,488	5.2	29,939	11,556	11,556	38.6
Dodoma	3,278,498	5.2	17,048	3,119	3,119	18.3
Geita	3,157,254	5.2	16,418	853	853	5.2
Iringa	1,270,481	5.2	6,607	1,824	1,824	27.6
Kagera	3,185,122	5.2	16,563	1,814	1,814	11.0
Katavi	1,221,095	5.2	6,350	926	926	14.6
Kigoma	2,615,705	5.2	13,602	1,088	1,088	8.0
Kilimanjaro	1,988,804	5.2	10,342	2,600	2,600	25.1
Lindi	1,274,561	5.2	6,628	723	723	10.9
Manyara	2,005,076	5.2	10,426	952	952	9.1
Mara	2,520,567	5.2	13,107	822	822	6.3
Mbeya	2,491,317	5.2	12,955	2,767	1,565	12.1
Morogoro	3,402,216	5.2	17,692	2,672	2,672	15.1
Mtwara	1,751,331	5.2	9,107	1,122	1,122	12.3
Mwanza	3,929,138	5.2	20,432	4,289	4,289	21.0

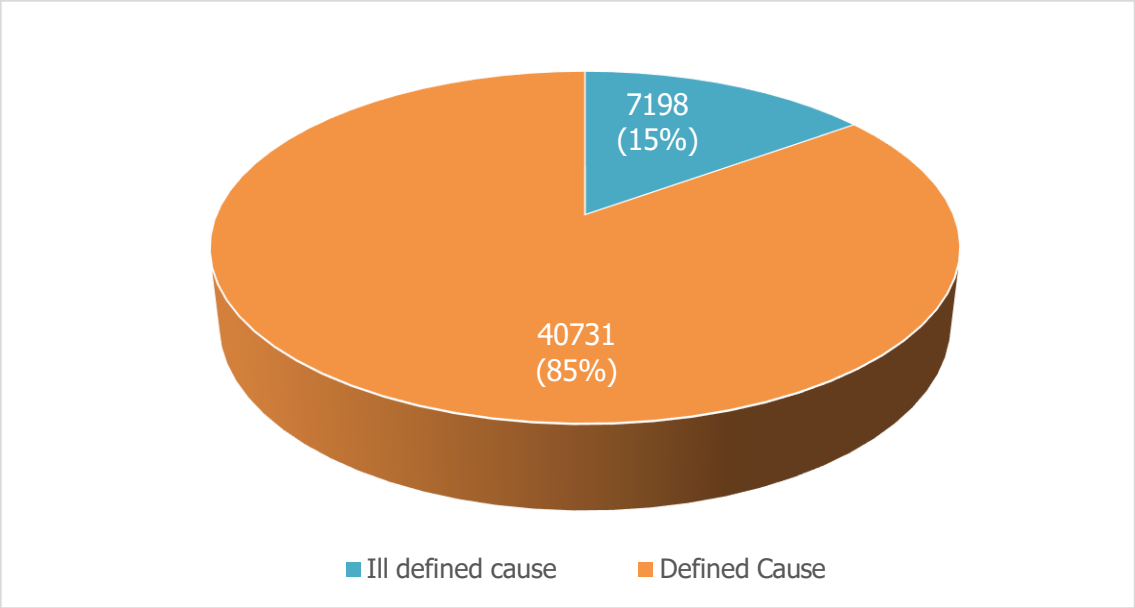
Region	Total Population	CDR	Estimated Deaths	Total # of Deaths	Total # with MCCD	Proportion of deaths with MCCD (%)
Njombe	949,784	5.2	4,939	724	724	14.7
Pwani	2,149,395	5.2	11,177	1,474	1,474	13.2
Rukwa	1,632,123	5.2	8,487	561	561	6.6
Ruvuma	1,978,114	5.2	10,286	730	730	7.1
Shinyanga	2,375,329	5.2	12,352	575	575	4.7
Simiyu	2,266,681	5.2	11,787	736	736	6.2
Singida	2,135,179	5.2	11,103	1,640	1,640	14.8
Songwe	1,427,308	5.2	7,422	648	648	8.7
Tabora	3,587,736	5.2	18,656	1,685	1,685	9.0
Tanga	2,783,811	5.2	14,476	1,645	1,645	11.4

Source: Population and Housing Census Report 2012

2.4.3 Ill-Defined Causes

Ill-defined causes of death are vague diagnoses often described as "symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified" that the ICD-10 advises should not be used as the underlying cause of death. WHO recommends that health systems take measures to avoid classifying deaths as ill-defined and unknown during the certification process, since doing so does not give any information concerning the possible conditions that led to the death.

Defined causes accounted for 85% and ill-defined causes accounted for 15%, as illustrated in Table 2.3. When a death occurs and is medically certified, recordkeepers should make every effort to correctly ascertain the underlying CoD to draw conclusions about the leading causes and the need for priority public health interventions. Classification of deaths to ill-defined conditions significantly undermines public health value mortality data. Furthermore, where a high proportion of all deaths is classified as being due to ill-defined causes, the cause of death distribution will be biased and unreliable. Despite these problems, ill-defined cause of death classification can still help describe the overall mortality due to broad disease (e.g., cardiovascular or respiratory disease) or injury groups.



2.1: Figure Percentage of Ill-Defined Versus Defined Causes of Death in 2024

Table 2.3 shows the breakdown of ill-defined causes for 2024. Among the top 20 ill-defined causes, Chronic renal failure was the leading culprit at 16.5%, followed by essential hypertension at 14.7%. Other ill-defined and unspecified causes of mortality, with 11.6%, came in third.

Table 2.3: Breakdown of Ill-Defined Causes

Rank	Ill-defined ICD code	Description	Number	% of ill-defined
1	N18	Chronic renal failure	1188	16.5
2	I10	Essential (primary) hypertension	1061	14.7
3	R99	Other ill-defined and unspecified causes of mortality	837	11.6
4	A40	Streptococcal septicaemia	614	8.5
5	R96	Other sudden death, cause unknown	595	8.3
6	J96	Respiratory failure, not elsewhere classified	586	8.1
7	A41	Other septicaemia	543	7.5
8	N17	Acute renal failure	476	6.6
9	I50	Heart failure	186	2.6
10	R58	Haemorrhage, not elsewhere classified	147	2
11	R65	Systemic Inflammatory Response Syndrome	113	1.6
12	D65	Disseminated intravascular coagulation [defibrination syndrome]	111	1.5
13	R98	Unattended death	111	1.5
14	R09	Other symptoms and signs involving the circulatory and respiratory systems	101	1.4
15	I98	Other disorders of circulatory system in diseases classified elsewhere	87	1.2

Rank	Ill-defined ICD code	Description	Number	% of ill-defined
16	J81	Pulmonary oedema	72	1
17	K72	Hepatic failure, not elsewhere classified	46	0.6
18	C76	Malignant neoplasm of other and ill-defined sites	44	0.6
19	G97	Postprocedural disorders of nervous system, not elsewhere classified	30	0.4
20	J99	Respiratory disorders in diseases classified elsewhere	30	0.4

2.4.3.1 Percentage Distribution of defined Causes by region

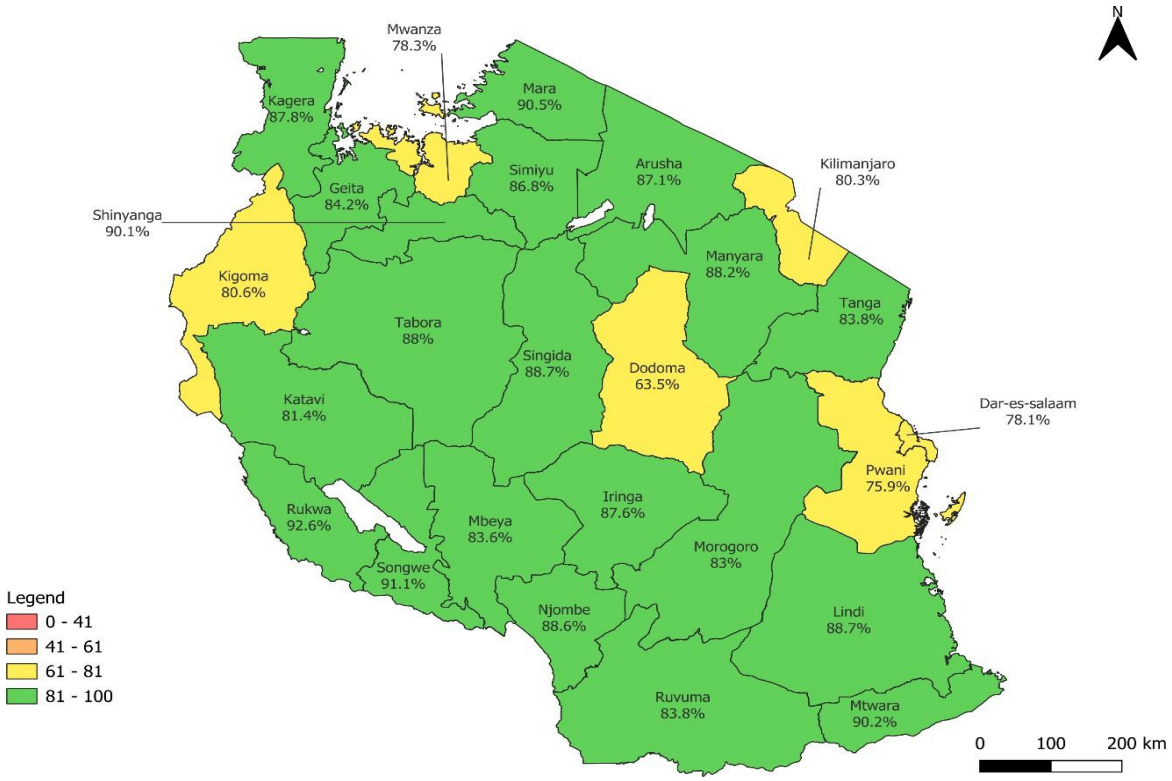


Figure 2.2: Map showing the distribution of defined causes of deaths by region

2.5 Areas for Improvement

The analysis shows that not all health facilities are reported in DHIS2 and that only an estimated 50% of deaths in reporting facilities (DHIS2 and other EMR systems) are getting an MCCD (Table 2.2). At the hospital level, it may be due to the existence of electronic data collection systems that do not have the ICD dictionary installed, as well as the existence of an electronic ICD version that is not compatible with existing systems. This

highlights the need for MoH to ensure that all health facilities install the electronic data collection system with the appropriate version of the ICD dictionary.

The proportion of health facility deaths that receive an MCCD, but not one that is usable (e.g. ill-defined or unknown) was 15%. It is therefore important to keep on strengthening training for clinicians both in-service clinicians and those in medical schools. In addition, the MoH must make sure that each health facility's electronic system is integrated with DHIS2.

Furthermore, supportive supervision to in-service clinicians as well as medical universities and colleges that relates to assignment of causes of death and CoD data entry needs to be strengthened to ensure sustainable quality assurance and performance improvement mechanisms, particularly in teaching and referral hospitals. There is a need to improve the central coordination of mortality data-related interventions/activities as well as make sure that the health facility management committees are functional and put mortality data quality improvement on their agenda during their weekly management meetings. Findings reported here can be used to strengthen training efforts to improve practices that comprise the medical certification of causes of death to minimize the number of deaths coded as due to ill-defined. In addition, health facilities staff should consider ways to measure the quality of data on CoD data and use such measures to regulate and monitor health facility performance. For this to succeed, mortality coding practices should be assessed routinely.

The MoH aims to introduce or change existing legislation on CoD investigations to ensure that all deaths whose cause is classified as unknown are investigated with a forensic autopsy. It is important for clinicians to properly report the underlying cause or condition that precipitates the sequence of events leading to death, as doing so will allow death certificates to be correctly coded by the trained coders as they apply the rules of the International Statistical Classification of Diseases.

Among the approaches that will improve the quality of mortality and CoD data is to conduct more frequent data analysis and to use information at national and subnational levels to inform policy and support the decision-making process for public health programs.

CHAPTER 3: LEADING CAUSES OF DEATH IN HEALTH FACILITIES

3.1 Introduction

In 2024, a total of 48,269 deaths were recorded, with males accounting for 53.1% and females 46.9%. Most deaths occurred in the 15–59 age group, while neonatal and under-five mortality remain significant, highlighting ongoing child health challenges. Dar es Salaam recorded the highest percentage of deaths at 23.9%, followed by Mwanza 8.9% and Dodoma 6.5%. In contrast, regions like Shinyanga 1.2% reported the lowest percentage of deaths. Overall, male deaths slightly exceed female deaths, and urban areas exhibit higher absolute numbers, which is not surprising, as it reflects the population distribution.

Table 3.1: Distribution of Number of Deaths by Age, Sex and Region

Region	Overall	Male	Female	Neonates		Infants (<1 Year)	< 5	5+	5-14	15-59	60+
				0-7 Days	8-28 Days						
Tanzania	48,269	25,628	22,641	9320	1203	12,976	15,602	32,667	1,672	18,190	12,805
Arusha	1,926 (4.0%)	1,026	900	309	33	424	487	1,439	95	704	640
Dar es Salaam	11,556 (23.9%)	6,012	5,544	2420	375	3,242	3,603	7,953	222	4,883	2,848
Dodoma	3,119 (6.5%)	1,789	1,330	260	51	384	464	2,655	93	1,436	1,126
Geita	853 (1.8%)	438	415	27	4	85	224	629	65	383	181
Iringa	1,824 (3.8%)	965	859	430	34	501	568	1,256	67	642	547
Kagera	1,814 (3.3%)	1,016	798	369	27	511	679	1,135	83	648	404
Katavi	926 (1.9%)	500	426	219	56	337	442	484	54	310	120
Kigoma	1,088 (2.3%)	604	484	155	17	267	377	711	82	388	241
Kilimanjaro	2,600 (5.4%)	1,531	1,069	252	91	418	495	2,105	70	1,008	1,027
Lindi	723 (1.5%)	413	310	258	24	303	335	388	16	216	156
Manyara	952 (2.0%)	515	437	186	27	245	283	669	25	325	319
Mara	822 (1.7%)	394	428	128	16	194	291	531	52	270	209
Mbeya	1,565 (3.2%)	774	791	612	63	718	768	797	27	436	334
Morogoro	2,672 (5.5%)	1,408	1,264	563	55	751	927	1,745	109	957	679

Region	Overall	Male	Female	Neonates		Infants (<1 Year)	< 5	5+	5-14	15-59	60+
				0-7 Days	8-28 Days						
Mtwara	1,122 (2.3%)	559	563	436	15	484	543	579	18	319	242
Mwanza	4,289 (8.9%)	2,275	2,014	544	114	1,289	1,570	2,719	181	1,551	987
Njombe	724 (1.5%)	367	357	81	10	118	155	569	26	286	257
Pwani	1,474 (3.15)	799	675	390	32	454	520	954	33	583	338
Rukwa	561 (1.2%)	277	284	260	14	302	350	211	9	140	62
Ruvuma	730 (1.5%)	376	354	106	19	147	199	531	24	310	197
Shinyanga	575 (1.2%)	255	320	136	1	161	227	348	35	207	106
Simiyu	736 (1.5%)	388	348	184	18	238	308	428	48	196	184
Singida	1,640 (3.4%)	888	752	300	39	411	510	1,130	65	569	496
Songwe	648 (1.3%)	345	303	129	17	189	235	413	23	224	166
Tabora	1,685 (3.5%)	854	831	357	36	507	652	1,033	89	566	378
Tanga	1,645 (3.4%)	860	785	209	15	296	390	1,255	61	633	561

3.2 Leading Causes of Death

In 2024, conditions arising during the perinatal period emerged as the leading contributors, accounting for 8.7% (CSMF), followed by "birth asphyxia and birth trauma" at 7.3%. Lower respiratory infections (7%), hypertensive disease (4.8%), and HIV (4.4 %) were also among the top five causes. Non-communicable diseases, including cerebrovascular disease (4.3%), nephritis and nephrosis (3.9%) and diabetes mellitus (2.7%), remained among the top 20, although at lower proportions compared to the leading perinatal and infectious causes. Road traffic accidents (2.4%) continued to be a notable contributor, highlighting the increasing impact of injuries on overall mortality.

3.2.1 Leading Causes of Death for All Age Groups and Sex

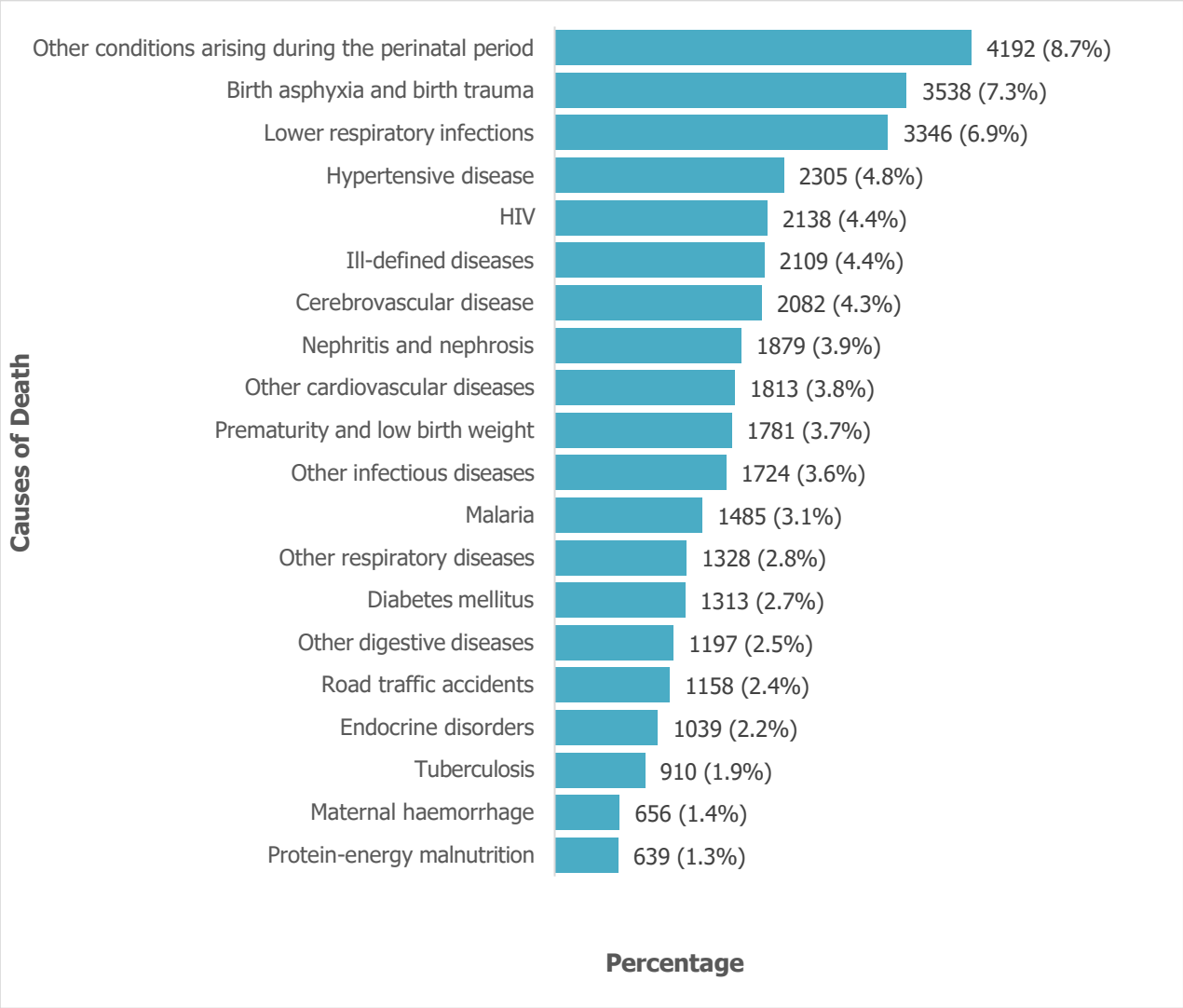


Figure 3.1: Top 20 Causes of Overall Mortality Burden

3.2.2 Top 20 Causes of Death for All Male Age Groups

Figure 3.2 depicts the leading causes of death among males and females for year 2024. For males, communicable diseases such as lower respiratory infections and HIV showed fluctuating patterns. Lower respiratory infections, which peaked in 2021 at 16.0% (largely linked to the Coronavirus Disease 2019 (COVID-19) pandemic), declined steadily to 7.8% in 2024. HIV also remained a significant cause of mortality, accounting for 3.8% of male deaths in 2024. Malaria and other infectious diseases maintained relatively stable contributions to overall mortality, though their rankings shifted slightly over the years.

In the year 2024, hypertensive disease (4.1%), cerebrovascular disease (3.9%), nephritis and nephrosis (4.2%), diabetes mellitus (2.4%), and other cardiovascular diseases (3.5%) were all among the leading causes of death, reflecting the growing burden of chronic and lifestyle-related illnesses. Road traffic accidents accounted for 3.6% of all male causes in 2024. A striking new trend is the prominence of perinatal conditions: other conditions arising during the perinatal period (8.8%) and birth asphyxia and birth trauma (7.9%) were the top two causes of death in 2024, while prematurity and low birth weight contributed an additional 3.7%.

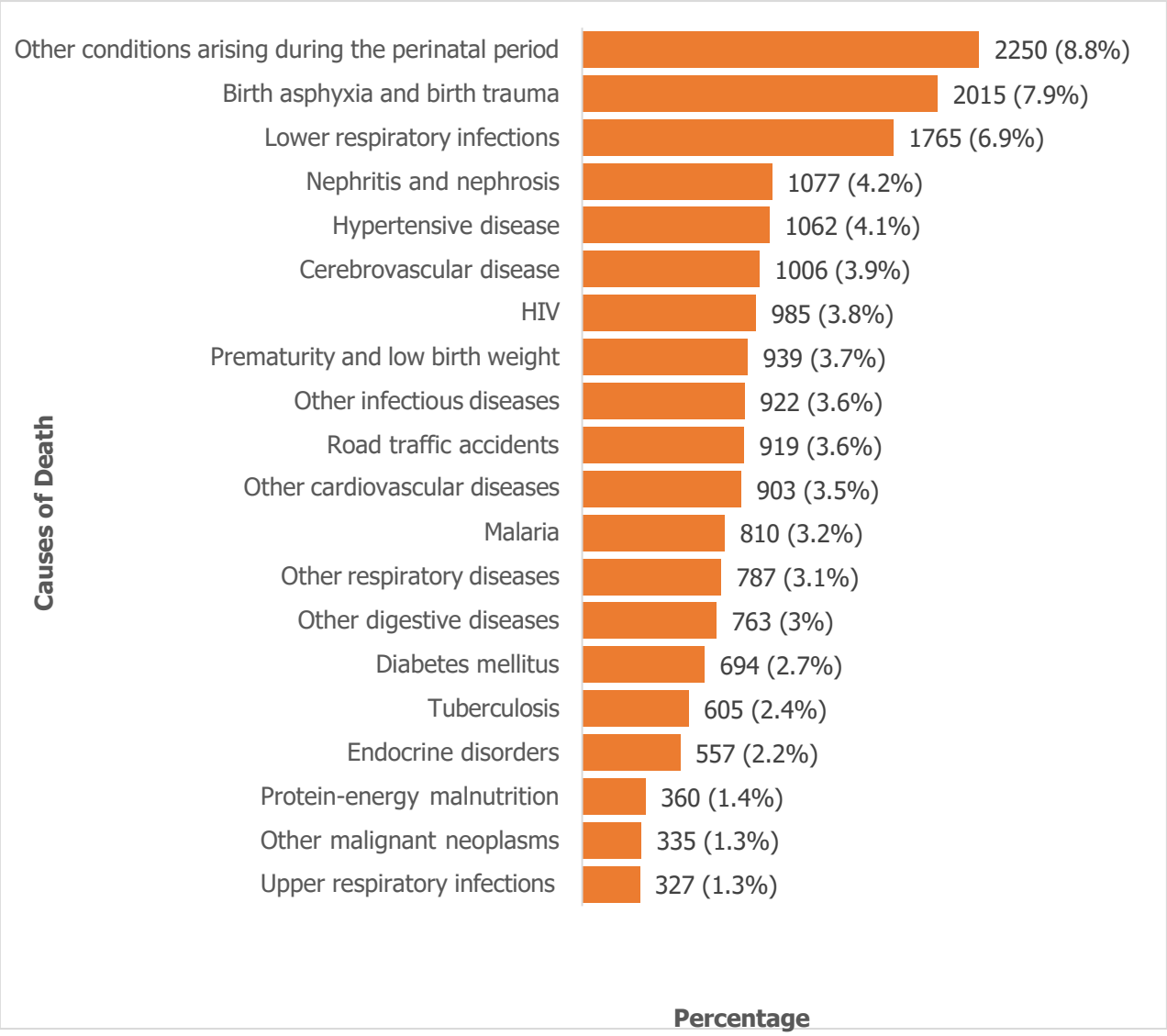


Figure 3.2: Leading Causes of Death in Males

3.2.3 Top 20 Causes of Death for All Female Age groups

Among females, the leading causes of death in 2024 mirrored some male patterns but also showed distinct differences. Perinatal conditions dominated, with other conditions arising

during the perinatal period (8.6 %) and lower respiratory infections (7%) as the leading causes. Birth asphyxia and birth trauma (6.7%) and HIV (5.1 %) were also significant. Hypertensive disease (5.5 %), cerebrovascular disease (4.8%), other cardiovascular diseases (4%) and diabetes mellitus (2.7%) reflecting a higher burden of noncommunicable diseases compared to males.

Overall, while infectious diseases such as malaria and tuberculosis remain part of the mortality profile, the 2024 data show an increasing dominance of perinatal conditions and noncommunicable diseases in shaping the mortality burden for both males and females. Comparatively, females bore a higher relative burden of noncommunicable diseases, while males experienced a higher share of deaths from injuries.

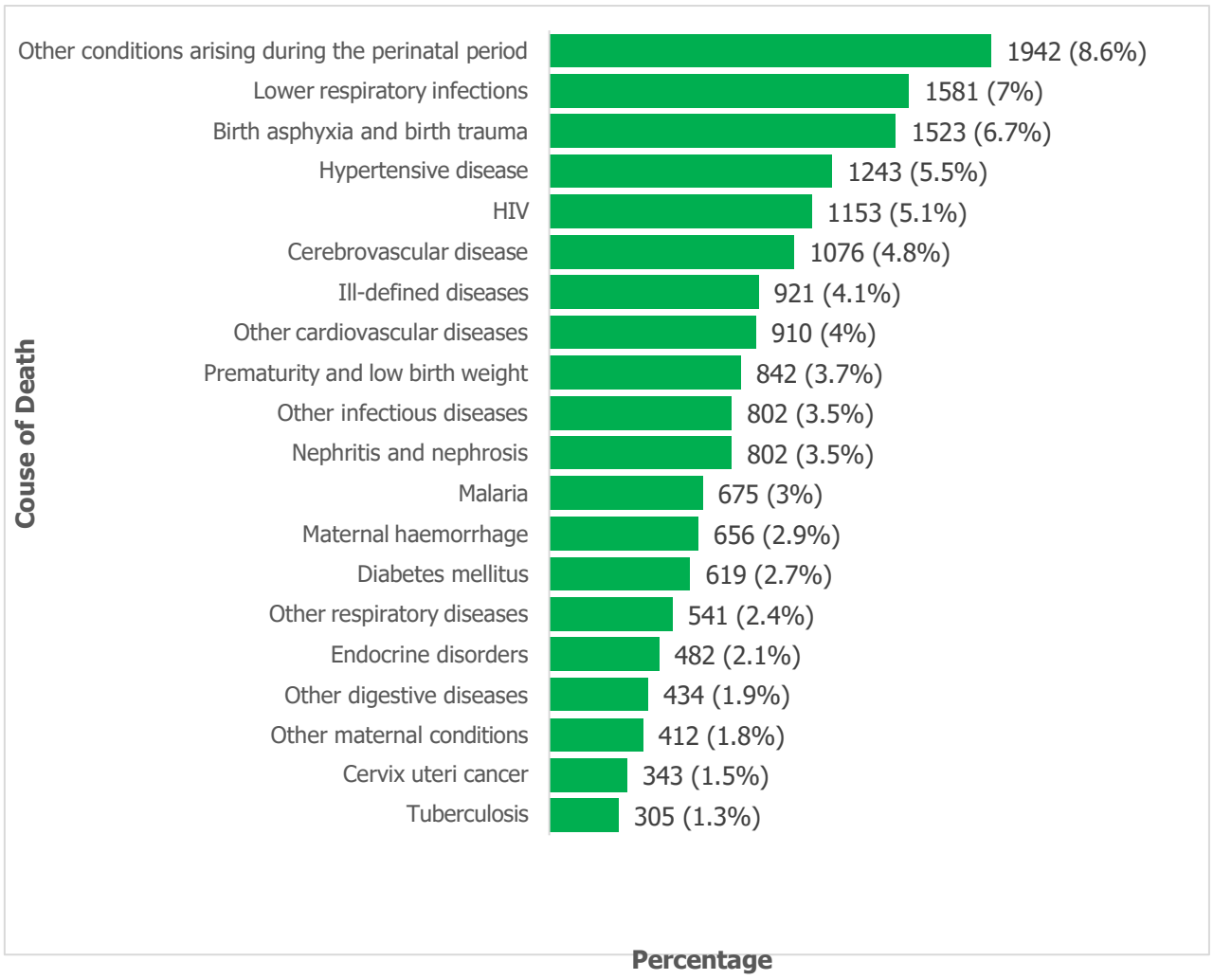


Figure 3.3: Leading Causes of Death in Females

3.2.4 Top 20 Causes of Death for Children Under 5

Figure 3.4 highlights that mortality among children under five is overwhelmingly dominated by perinatal and neonatal conditions. Other perinatal conditions (26.9%), birth asphyxia

and trauma (22.7%), and prematurity/low birth weight (11.4%) together accounted for over 60% of all deaths, underscoring the importance of maternal and newborn care.

Respiratory infections were also major contributors, with lower respiratory infections (9.1%) ranking fourth, while upper respiratory and other respiratory diseases added about 1.8% combined. Preventable infectious and nutritional causes remained significant: malaria (4.0%), protein-energy malnutrition (3.3%), Diarrhoeal diseases (1.8%), and other infectious diseases (2.5%).

Chronic and congenital conditions, though less common, were still relevant, including congenital heart anomalies (1.9%) and other congenital anomalies (1.8%). Nephritis/nephrosis (0.7%) and endocrine disorders (1.1%) reflected additional vulnerabilities. Injuries contributed minimally, with unintentional injuries (0.4%) and road traffic accidents (0.2%) appearing in the top 20.

Overall, under-five mortality is heavily concentrated in preventable and treatable perinatal, infectious, and nutritional causes, with congenital conditions also contributing, pointing to priorities in maternal health, neonatal care, infection control, and nutrition interventions.

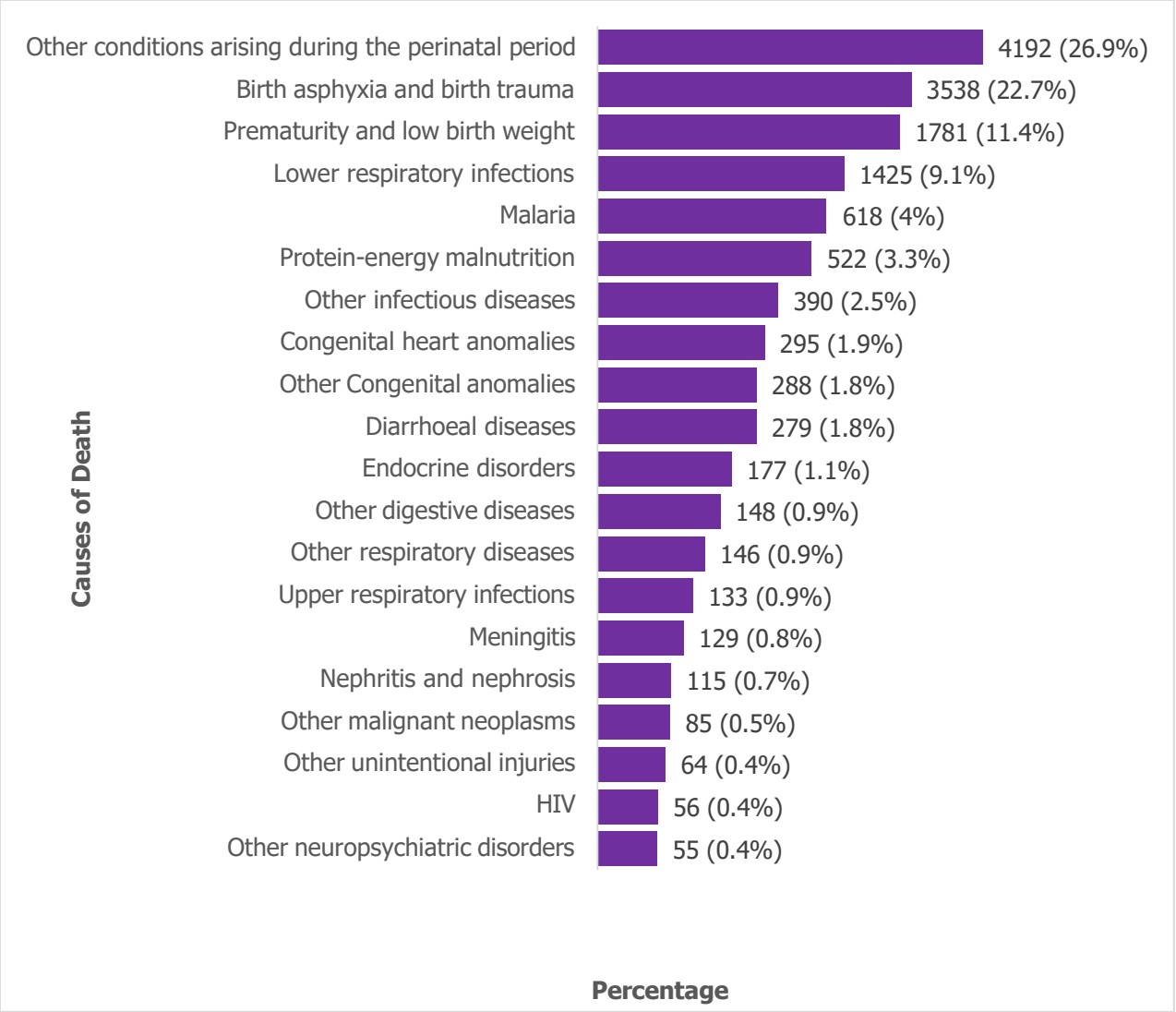


Figure 3.4: Top 20 Leading Causes of Death for Children Under 5

3.2.5 Top 20 Causes of Death for Children Aged 5 to 14

Figure 3.5 shows that deaths among children aged 5–14 are dominated by malaria, respiratory infections, and endocrine disorders, with additional contributions from malnutrition, injuries, and congenital conditions. Malaria was the leading cause (20.0%), followed by lower respiratory infections (9.6%) and endocrine disorders (9.4%). Other infectious diseases (5.4%) and meningitis (2.5%) also played important roles. Nutrition-related and chronic conditions such as protein-energy malnutrition (3.3%), nephritis and nephrosis (3.2%), and diarrhoeal diseases (2.8%) added further burden.

Injuries contributed notably, with road traffic accidents (2.8%), drownings (1.3%), and other unintentional injuries (1.4%) in the top 20 causes. Neoplasms such as leukaemia (1.6%) and other malignant cancers (1.7%) appeared alongside congenital heart

anomalies (2.1%). Ill-defined diseases, though outside the top 20, accounted for 4.7%, highlighting diagnostic and certification gaps.

Overall, compared with under-five mortality dominated by perinatal causes, the 5–14 profile shifts toward malaria, respiratory infections, chronic endocrine and nutritional conditions, and injuries. This underscores the need for malaria control, acute respiratory care, injury prevention, and stronger diagnostic practices for school-age children.

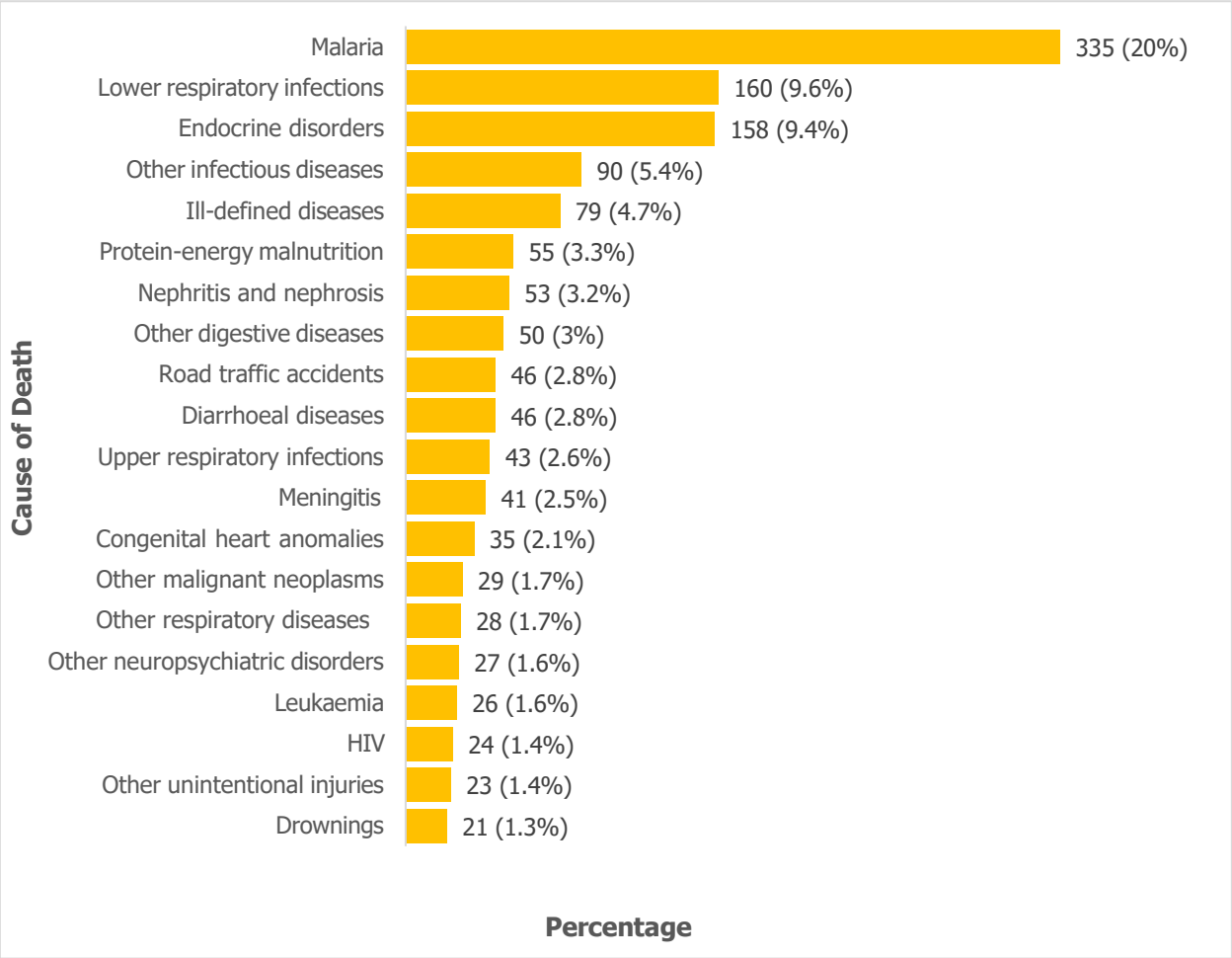


Figure 3.5: Top 20 Causes of Death for Children aged 5 to 14

3.2.6 Top 20 Causes of Death for Ages 5 years and above

Figure 3.6 shows that mortality among individuals aged 5 years and above is dominated by noncommunicable diseases (NCDs), with infectious diseases and injuries still contributing significantly. Hypertensive disease was the leading cause (7%), followed by HIV (6.4%), cerebrovascular disease (6.3%), and lower respiratory infections (5.9%). Other major NCDs included nephritis and nephrosis (5.4%), cardiovascular diseases (5.4%), and diabetes (3.9%). Infectious diseases such as other infectious conditions (4.1%), tuberculosis and malaria (each 2.7%) also remained important. Road traffic

Accidents were the leading cause of injury (3.4 %), while maternal hemorrhage contributed 2%.

Overall, the profile reflects a dual burden: rising chronic NCDs alongside unfinished infectious disease challenges, with injuries adding further impact. Compared with under-fives, whose mortality is dominated by perinatal causes, older populations face a growing weight of NCDs that require integrated long-term care strategies.

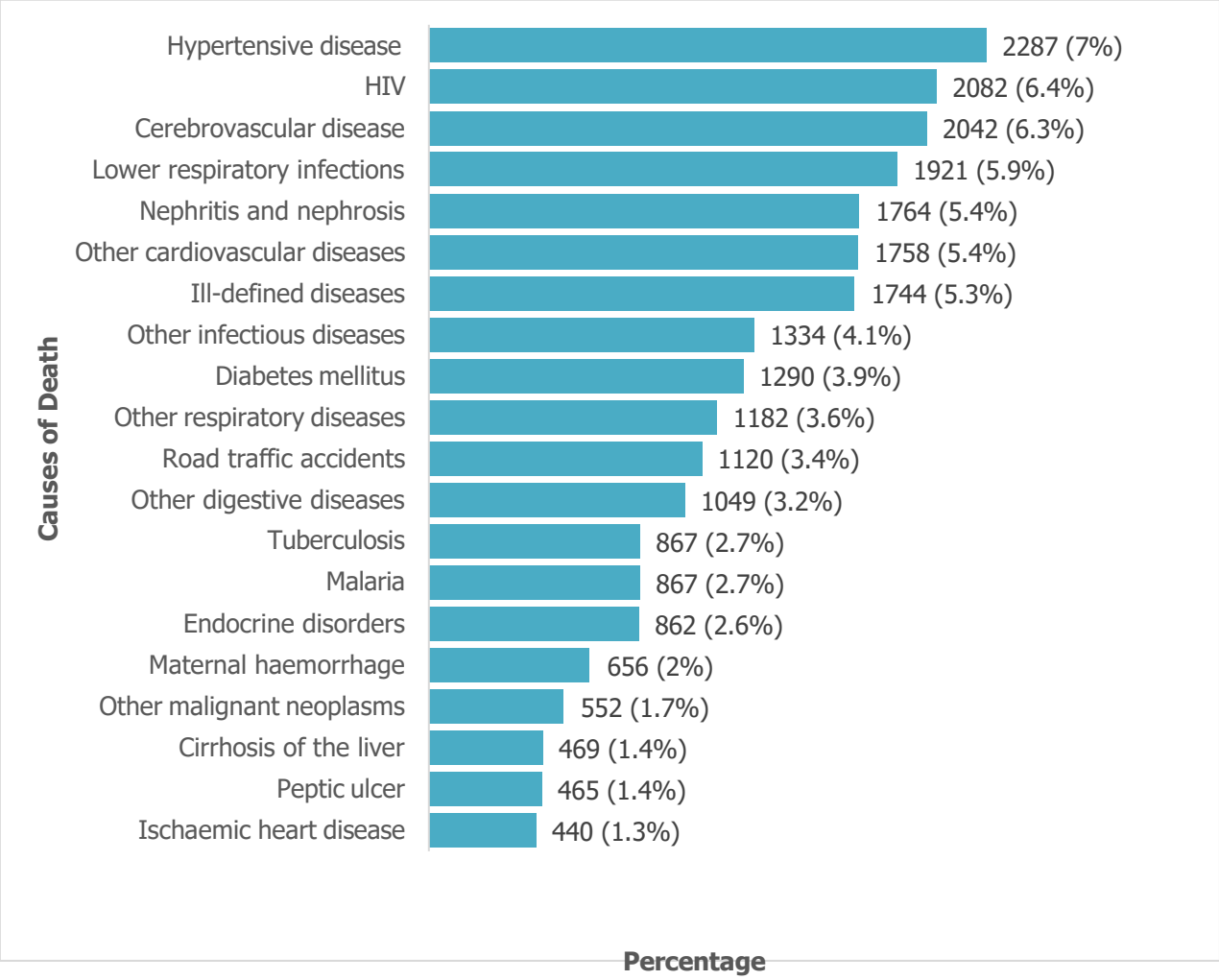


Figure 3.6: Top 20 Causes of Death for Ages 5 years and above

3.2.7 Top 20 Causes of Death for Adults Aged 15 to 59

Figure 3.7 shows that mortality among adults aged 15-59 is shaped by a mix of infectious diseases, non-communicable diseases (NCDs), injuries, and maternal causes. HIV was the leading cause of death, accounting for 9.4%, followed by road traffic accidents (5.2%), nephritis and nephrosis (4.9%), other infectious diseases (4.5%), lower respiratory infections (4.3%), and cerebrovascular disease (4.3%). Other NCDs such as hypertensive disease, cardiovascular disease, respiratory disease, and diabetes contributed 3-4% each,

while tuberculosis (3.2%) and malaria (2.1 %) remained significant communicable causes. Maternal complications including hemorrhage and hypertensive disorders of pregnancy together made up a notable share of female mortality.

Overall, the 15-59 profile reflects a triple burden: persistent infectious diseases, rising NCDs, and a high toll from injuries and maternal causes. This distribution reflects both unfinished agendas in infectious disease control and the growing importance of NCD and injury prevention in safeguarding the health of working-age populations.

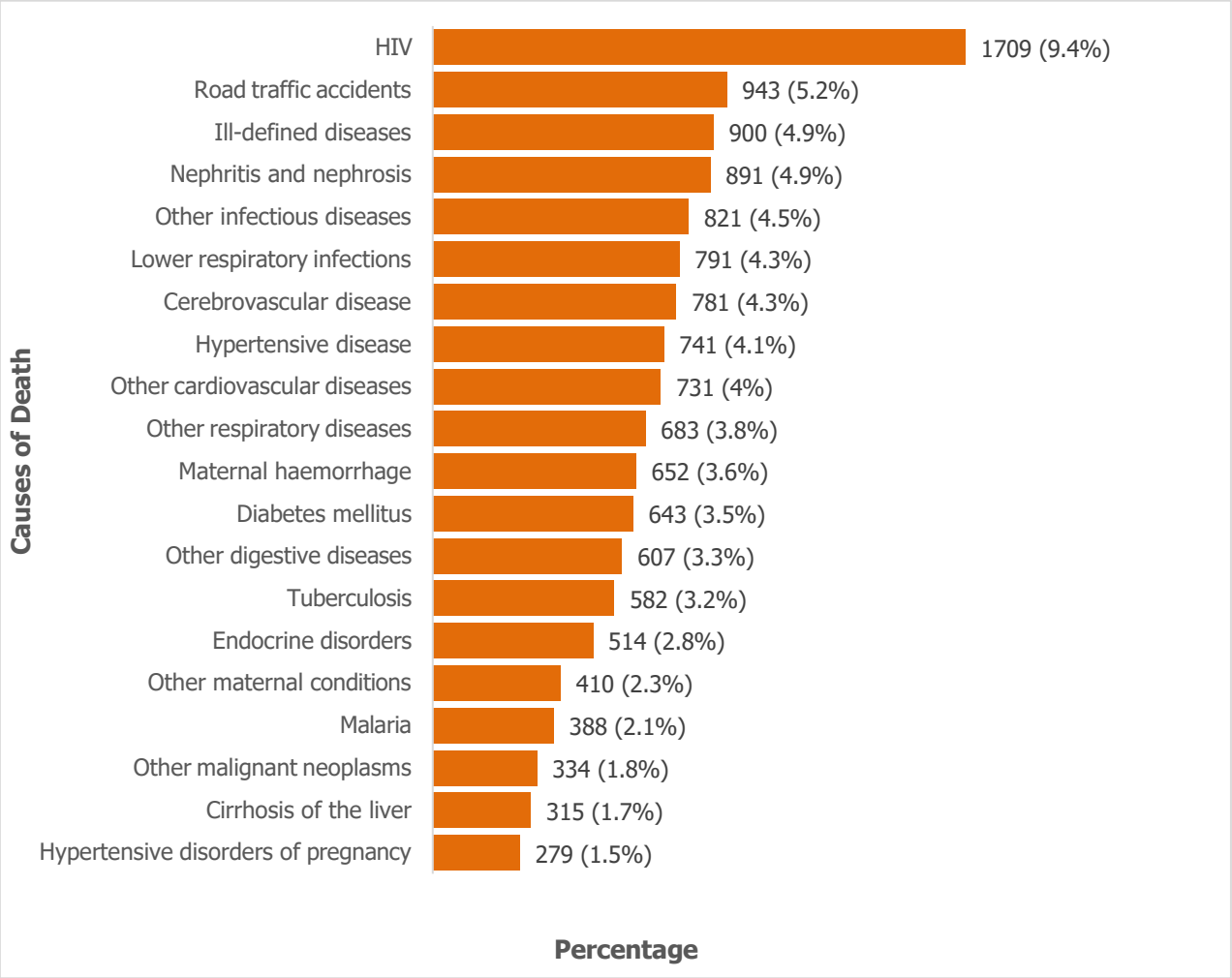


Figure 3.7: Top 20 Causes of Death for Ages 15 to 59

3.2.8 Top 20 Causes of Death for Adults Aged 60 and up

Figure 3.8 shows that deaths among adults aged 60 and above are mainly driven by noncommunicable diseases (NCDs). In overall, the mortality pattern for older adults highlights the dominance of chronic cardiovascular, renal, and metabolic conditions, alongside lingering infectious and respiratory diseases, with cancers and injuries playing a smaller but significant role.

Hypertensive disease was the leading cause, accounting for 11.9% of deaths, followed by cerebrovascular disease (9.7%) and other cardiovascular diseases (7.9%). Lower respiratory infections (7.6%), nephritis and nephrosis (6.4%), and diabetes mellitus (4.9%) were also major contributors. Other notable causes included other respiratory diseases (3.7%), other infectious diseases (3.3%), HIV (2.7%), and tuberculosis (2.1%). Cancers, such as those of the oesophagus, prostate, trachea/bronchus/lung, cervix uteri, and liver, each contributed between 0.7% and 1.4%. Injuries accounted for a small fraction, with road traffic accidents at 1.0% and falls at 0.2%. Ill-defined diseases made up 6.0%, reflecting gaps in cause-of-death certification.

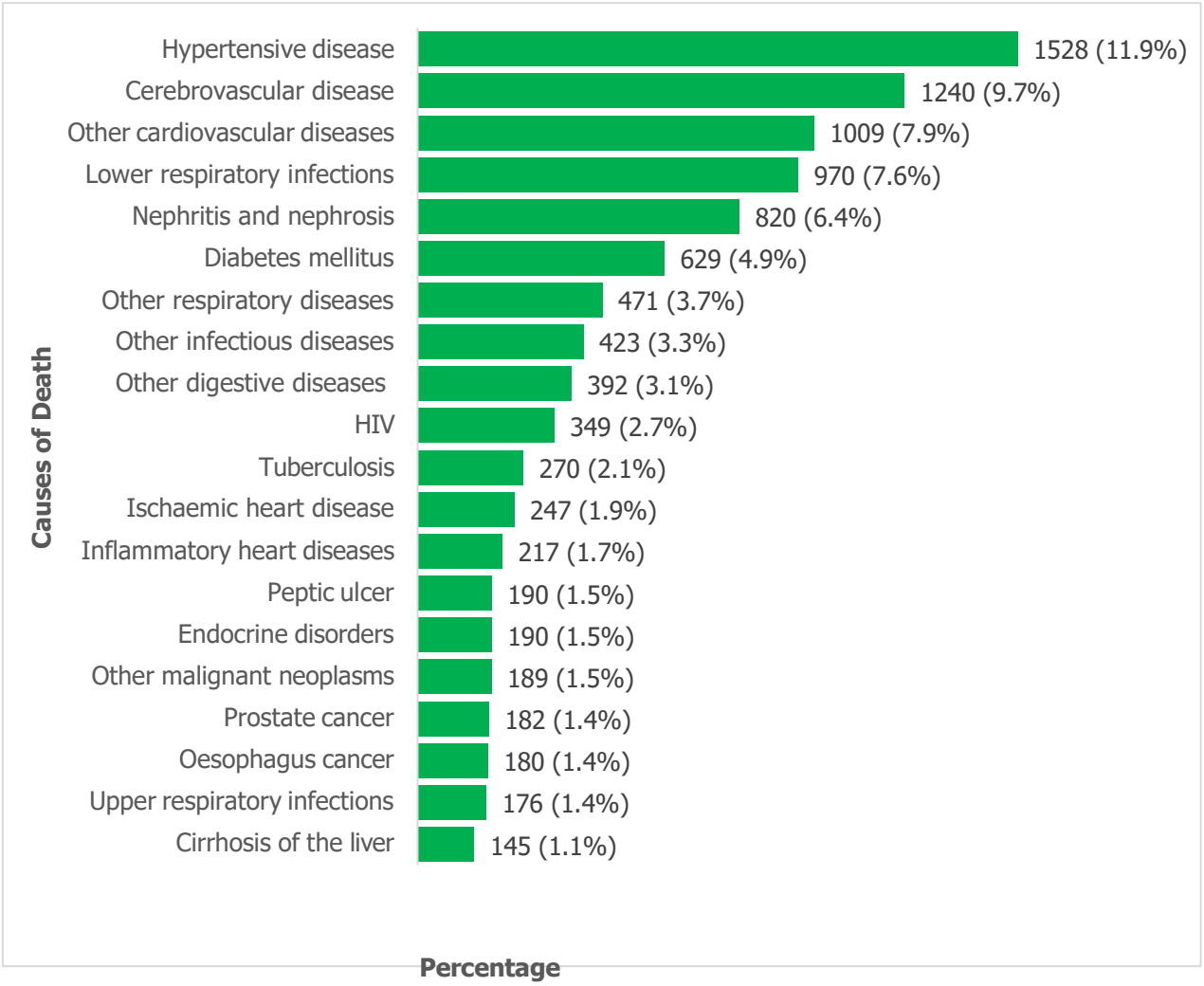


Figure 3.8: Top 20 Leading Causes of Death for Ages 60 and above

CHAPTER 4: BROAD CATEGORIES OF CAUSES OF DEATH FROM HEALTH FACILITIES

4.1 Introduction

This section provides an analysis of the broad categories of death for year 2024. Per this categorization of mortality events, deaths are organized into groups defined by those that are due to communicable diseases, noncommunicable diseases, injuries and undetermined. By analyzing the levels and patterns within these categories, the section aims to highlight significant public health challenges and inform targeted interventions to reduce the burden mortality across different age and sex groups.

4. Broad Categories of Causes of Mortality Burden

Figure 4.1 presents the total burden of disease in Mainland Tanzania in 2024, categorized into four groups. Group I includes communicable, maternal and nutritional conditions; Group II covers noncommunicable diseases, and Group III comprises external causes and injuries (i.e road traffic crashes, falls, self-inflicted, etc.). Group IV represents undetermined causes by available methods, accounting for about 4.6% of the total. Communicable diseases contributed the largest share at 48.4%, followed by noncommunicable diseases at 43.4%, while injuries accounted for 4.3% of the total mortality burden in 2024.

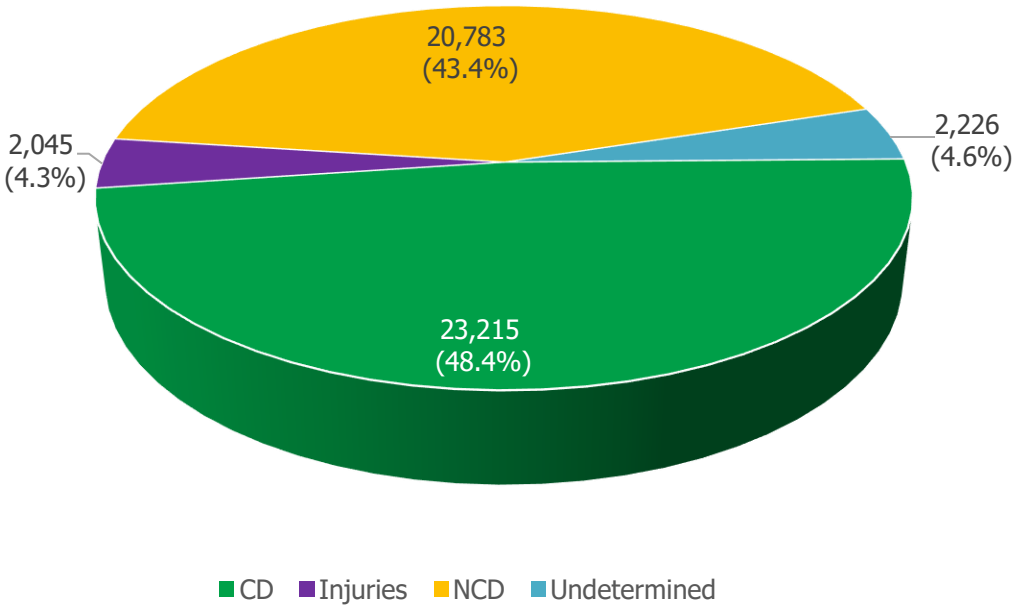


Figure 4.1 Broad Categories of Causes of Death

4.2.1 Percentage distribution of Broad Categories of Causes of death by age

Figure 4.2 illustrates the percentage distribution of causes of death across age groups in Mainland Tanzania. Communicable diseases (CD) dominate in the youngest age groups, peaking sharply among children under one year (<1) at nearly 24%, before declining steeply and remaining below 5% across older ages. In contrast, noncommunicable diseases (NCDs) show a gradual increase with age, becoming the leading causes of death from early adulthood onward and peaking at about 4% in the 60–64 age group. Injuries contribute minimally across all age groups, with proportions consistently below 1%, though they are slightly more pronounced in young adults (15–34 years). Overall, the figure highlights the shift from a high burden of communicable diseases in early childhood to a predominance of noncommunicable diseases in older age groups.

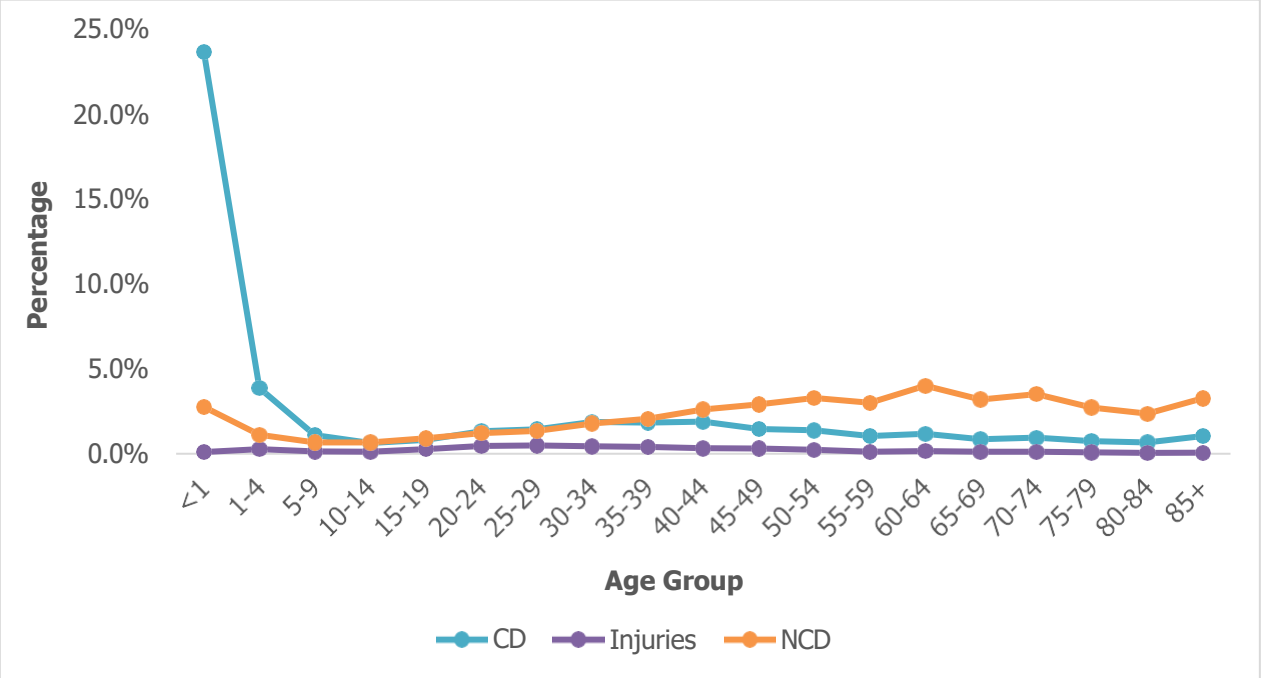


Figure 4.2: Percentage distribution of broad group categories across ages

4.2.2 Broad categories of causes of Death by region

The distribution of broad categories of causes of death by region in Mainland Tanzania shows epidemiological disparities linked to demographic, social, and health system factors (Table 4.1). In Dar es Salaam, Dodoma, Kilimanjaro, Mwanza, and Tanga, non-communicable diseases (NCDs) contribute more deaths than communicable diseases and injuries, reflecting advanced epidemiological transition. This is likely driven by urbanization, lifestyle changes, and longer life expectancy, which heightened exposure to NCD risk factors such as unhealthy diets, physical inactivity, tobacco, and alcohol use. In contrast, many other regions remain dominated by communicable diseases and injuries, highlighting persistent challenges with infectious disease control, limited healthcare access, and

vulnerability to external causes. These differences call for region-specific interventions, with urban areas prioritizing NCD prevention and management, while rural regions focus on communicable disease and injury control.

Table 4.1: Broad categories of causes of Death by region

Region	CD	Injuries	NCD	Undetermined	Overall
Tanzania	23,215	2,045	20,783	2,226	48,269
Arusha	883	107	882	54	1,926
Dar Es Salaam	4,846	445	5,977	288	11,556
Dodoma	810	233	1,444	632	3,119
Geita	497	54	278	24	853
Iringa	935	108	733	48	1,824
Kagera	1,016	104	651	43	1,814
Katavi	639	47	227	13	926
Kigoma	572	56	370	90	1,088
Kilimanjaro	835	115	1,636	14	2,600
Lindi	450	35	228	10	723
Manyara	550	30	343	29	952
Mara	535	16	259	12	822
Mbeya	912	70	494	89	1,565
Morogoro	1,533	116	816	207	2,672
Mtwara	683	42	371	26	1,122
Mwanza	1,819	135	2,041	294	4,289
Njombe	356	13	350	5	724
Pwani	816	69	394	195	1,474
Rukwa	422	11	124	4	561
Ruvuma	353	41	303	33	730
Shinyanga	386	20	150	19	575
Simiyu	466	8	259	3	736
Singida	791	47	779	23	1,640
Songwe	365	42	231	10	648
Tabora	1,022	42	594	27	1,685
Tanga	723	39	849	34	1,645

4.3. Communicable Diseases

4.3.1 Percentage distribution of communicable diseases deaths across ages by sex

Figure 4.3 presents the percentage distribution of CD mortality by age and sex in Mainland Tanzania. Mortality from communicable diseases is highest among infants under one year of age, accounting for about 27% among males and 23% among females. The burden then drops sharply after the first year of life, falling below 5% in the 1–4 age group and remaining under 2% across all older age groups. From young adulthood onwards, both sexes exhibit relatively low but persistent levels of communicable disease mortality, with females showing slightly higher percentages than males in the 20–39 age range. In older age groups (50+ years), the differences between males and females narrow, and both remain below 2%. Overall, the figure highlights the overwhelming concentration of communicable disease mortality in infancy, with minimal sex differentials in older ages.

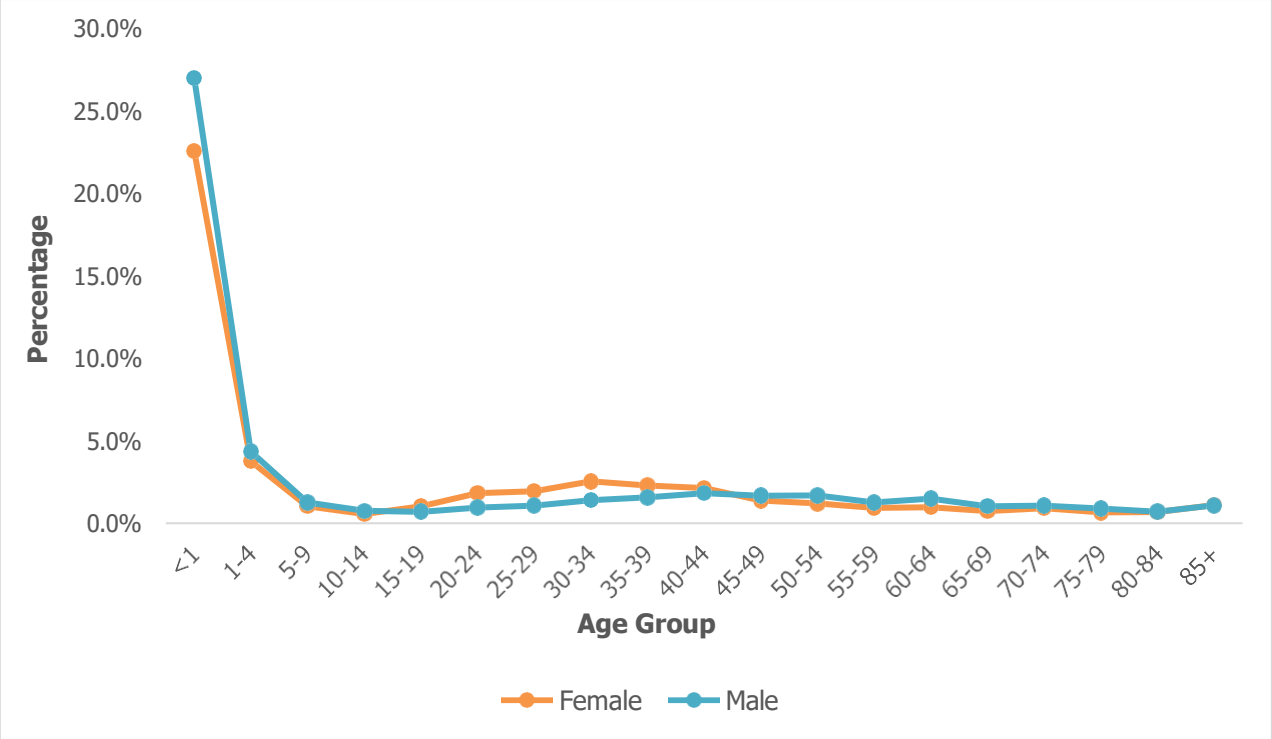


Figure 4.3: Percentage distribution of deaths due to communicable diseases by sex across ages

4.3.2 Distribution of Deaths due to Communicable Diseases by Age and Sex

The distribution of deaths due to communicable diseases in Tanzania (Table 4.2) shows clear regional disparities. Dar es Salaam had the highest share, 20.9%, with most among children under five. Mwanza followed with 7.8%, also dominated by under-five deaths.

Morogoro contributed 6.6%, nearly split between under-fives and older ages. Kagera 4.4% and Tabora 4.3%. In contrast, Ruvuma registered the lowest burden, 1.5%, including just 154 deaths. These variations highlight the disproportionate vulnerability of young children in high-burden regions and the need for targeted public health interventions.

Table 4.2: Distribution of Deaths Due to Communicable Diseases by Age and Sex

Region	Overall	Male	Female	< 5	5+	5-14	15-59	60+
Tanzania	23,215	11,834	11,381	13,187	10,028	828	6,601	2,599
Arusha	883 (3.8%)	454	429	409	474	58	268	148
Dar Es Salaam	4,846 (20.9)	2,432	2,414	2,949	1,897	61	1,366	470
Dodoma	810 (3.5%)	400	410	325	485	22	331	132
Geita	497 (2.1%)	230	267	192	305	48	203	54
Iringa	935 (4.0%)	499	436	524	411	42	260	109
Kagera	1,016 (4.4%)	565	451	596	420	49	252	119
Katavi	639 (2.28%)	333	306	414	225	38	155	32
Kigoma	572 (2.5%)	295	277	302	270	41	181	48
Kilimanjaro	835 (3.6%)	491	344	353	482	21	271	190
Lindi	450 (1.9%)	259	191	315	135	10	93	32
Manyara	550 (2.4%)	286	264	258	292	13	165	114
Mara	535 (2.3%)	245	290	278	257	36	159	62
Mbeya	912 (3.9%)	447	465	678	234	8	163	63
Morogoro	1,533 (6.6%)	813	720	839	694	78	431	185
Mtwara	683 (2.9%)	313	370	502	181	6	138	37
Mwanza	1,819 (7.8%)	911	908	1,099	720	66	477	177
Njombe	356 (1.5%)	189	167	142	214	18	136	60
Pwani	816 (3.5%)	428	388	480	336	21	241	74
Rukwa	422 (1.8%)	204	218	339	83	8	68	7
Ruvuma	353 (1.5%)	170	183	154	199	12	151	36
Shinyanga	386 (1.7%)	160	226	202	184	22	122	40
Simiyu	466 (2.0%)	251	215	293	173	34	99	40
Singida	791 (3.4%)	408	383	430	361	29	240	92
Songwe	365 (1.6%)	200	165	211	154	12	106	36
Tabora	1,022 (4.4%)	503	519	565	457	42	290	125
Tanga	723 (3.1%)	348	375	338	385	33	235	117

4.3.3 Top 20 Communicable-Disease-Related Causes of Death

Figure 4.4 presents the top 20 communicable disease–related causes of death in Mainland Tanzania. The leading contributors are perinatal causes 18.1%, birth asphyxia and birth trauma 15.2%, and lower respiratory infections 14.4%, together accounting for nearly half of all communicable-related deaths. HIV follows at 9.2%, while prematurity and low birth weight 7.7%, other infectious diseases 7.4%, and malaria 6.4% also contribute

significantly. The least common causes include Hepatitis B 0.8%, iron deficiency anaemia 0.6%, maternal sepsis 0.4%, tetanus 0.2%, and abortion 0.2%.

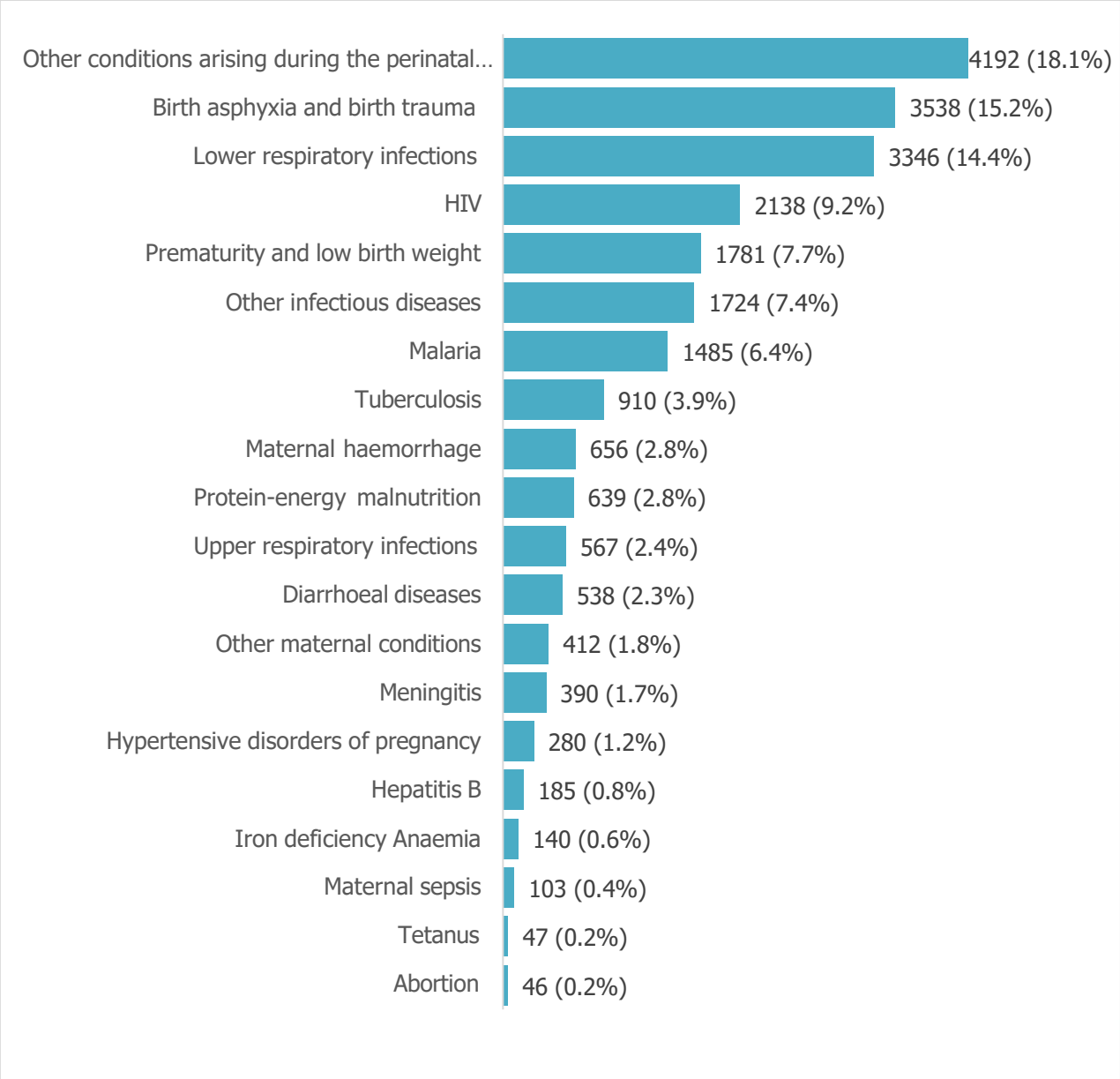


Figure 4.4: Top 20 communicable causes of deaths

4.4 Non-communicable Causes of Death

4.4.1 Percentage distribution of non-communicable causes of death across ages by sex

The percentage distribution of deaths due to NCDs in Mainland Tanzania shows distinct age and sex patterns as illustrated in Figure 4.5. Mortality is highest among infants under one year, particularly for males 3.6% compared to females 2.8%. The percentages decline

sharply in childhood (1–14 years) and remain low through adolescence and early adulthood. From ages 30 onward, mortality gradually increases, with a steeper rise after 45 years. Male deaths consistently exceed female deaths in most adult age groups, peaking at 60–64 years (5.0% for males vs. 4.3% for females). Among the oldest adults 85+, females show a higher proportion at 4.1% than males 3.4%. These trends highlight a double burden of NCD mortality in infancy and advanced ages, with males more affected in midlife.

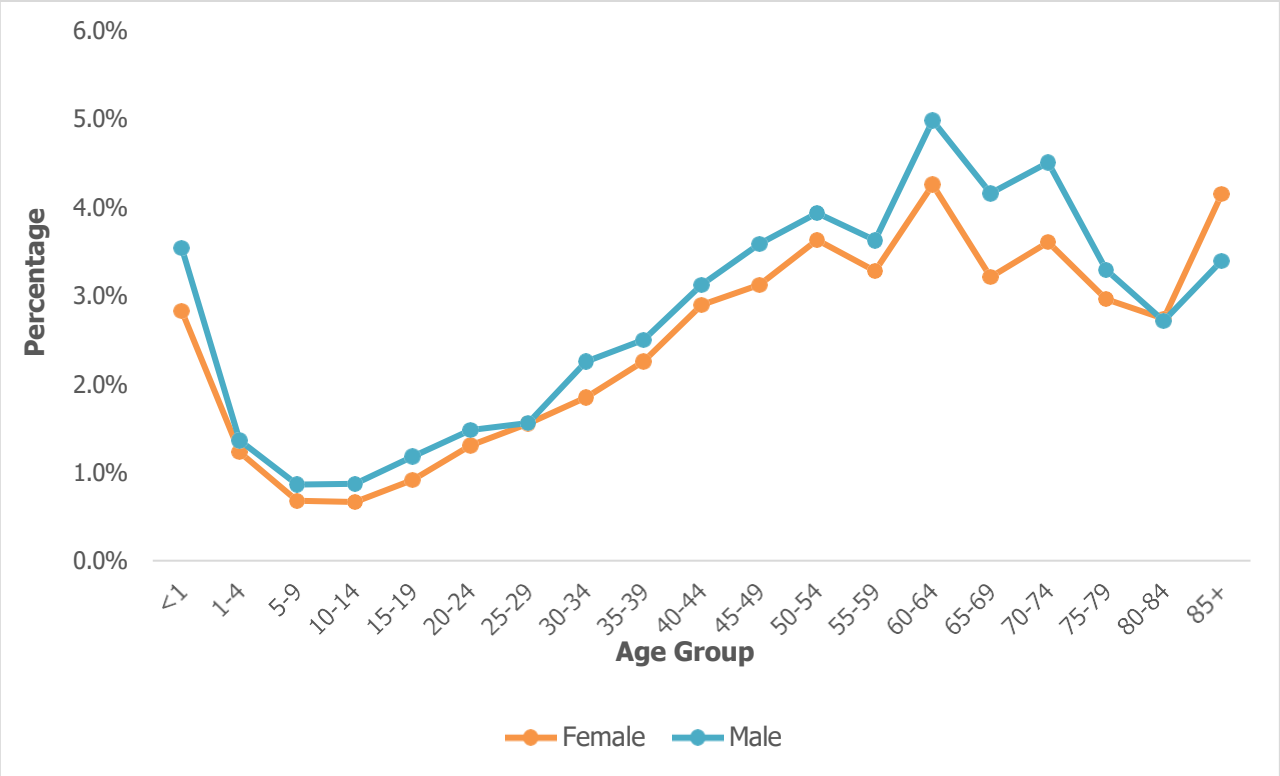


Figure 4.5: Percentage distribution of deaths due to non-communicable diseases by sex across ages

4.4.2. Distribution of Deaths Due to Non-Communicable Diseases by Age, Sex and region.

The distribution of deaths due to NCDs by age, sex, and region, as shown in Table 4.3, highlights significant geographic disparities. Dar es Salaam, Mwanza, Kilimanjaro, Dodoma, and Tanga emerge as the top five regions with the highest proportions of NCD-related deaths. This concentration of mortality reflects the combined effects of urbanization, lifestyle transitions, and greater life expectancy in these areas. To avert the growing mortality burden, targeted interventions are essential. These include strengthening early detection and screening programs for common NCDs, promoting healthy lifestyle practices

through community-based education and improving access to quality treatment and palliative care. Additionally, region-specific strategies such as enhancing urban health infrastructure, integrating NCD services into primary healthcare, and addressing modifiable risk factors like diet, physical inactivity, tobacco, and alcohol use are critical in reducing premature NCD mortality.

Table 4.3: Distribution of Deaths Due to Noncommunicable causes of death by Age, Sex and region.

Region	Overall	Male	Female	<5	5+	5-14	15-59	60+
Tanzania	20,783	10,994	9,789	1,862	18,921	639	9,148	9,134
Arusha	882 (4.2%)	465	417	70	812	19	333	460
Dar Es Salaam	5977 (28.8%)	3,098	2,879	561	5,416	145	3,051	2,220
Dodoma	1444 (6.9%)	808	636	63	1,381	34	641	706
Geita	278 (1.3%)	155	123	27	251	14	123	114
Iringa	733 (3.5%)	350	383	37	696	17	284	395
Kagera	651 (3.1%)	350	301	64	587	27	294	266
Katavi	227 (1.1%)	121	106	18	209	12	114	83
Kigoma	370 (1.8%)	218	152	35	335	20	147	168
Kilimanjaro	1636 (7.9%)	935	701	131	1,505	45	663	797
Lindi	228 (1.1%)	125	103	17	211	4	89	118
Manyara	343 (1.7%)	183	160	23	320	8	129	183
Mara	259 (1.2%)	128	131	10	249	11	99	139
Mbeya	494 (2.4%)	235	259	69	425	13	188	224
Morogoro	816 (3.9%)	409	407	40	776	20	328	428
Mtwara	371 (1.8%)	196	175	32	339	11	141	187
Mwanza	2041 (9.8%)	1,123	918	376	1,665	87	896	682
Njombe	350 (1.7%)	166	184	12	338	8	137	193
Pwani	394 (1.9%)	200	194	24	370	5	179	186
Rukwa	124 (0.6%)	63	61	8	116	1	62	53
Ruvuma	303 (1.5%)	154	149	21	282	10	126	146
Shinyanga	150 (0.7%)	70	80	12	138	10	65	63
Simiyu	259 (1.2%)	128	131	14	245	12	91	142
Singida	779 (3.7%)	437	342	69	710	33	290	387
Songwe	231 (1.1%)	110	121	20	211	8	86	117
Tabora	594 (2.9%)	310	284	77	517	39	232	246
Tanga	849 (4.1%)	457	392	32	817	26	360	431

4.4.3 Top 20 Noncommunicable causes of death

The leading noncommunicable causes of death in Mainland Tanzania reveal a heavy burden from cardiovascular and related conditions (Figure 4.6). Hypertensive disease ranks first, accounting for 11.1%, followed by cerebrovascular disease at 10%. Nephritis and nephrosis contribute 9%, while other cardiovascular diseases account for 8.7%. Other respiratory diseases round out the top five with 6.4%. Together, these conditions dominate NCD mortality, reflecting the growing challenge of chronic illnesses linked to hypertension,

kidney disease, and cardiovascular complications. Additional notable causes include diabetes mellitus at 6.3%, digestive diseases at 5.8%, and endocrine disorders at 5%. Though cancers such as cervical, breast, liver, and oesophagus appear lower in ranking, their cumulative burden underscores the rising threat of NCDs nationwide.

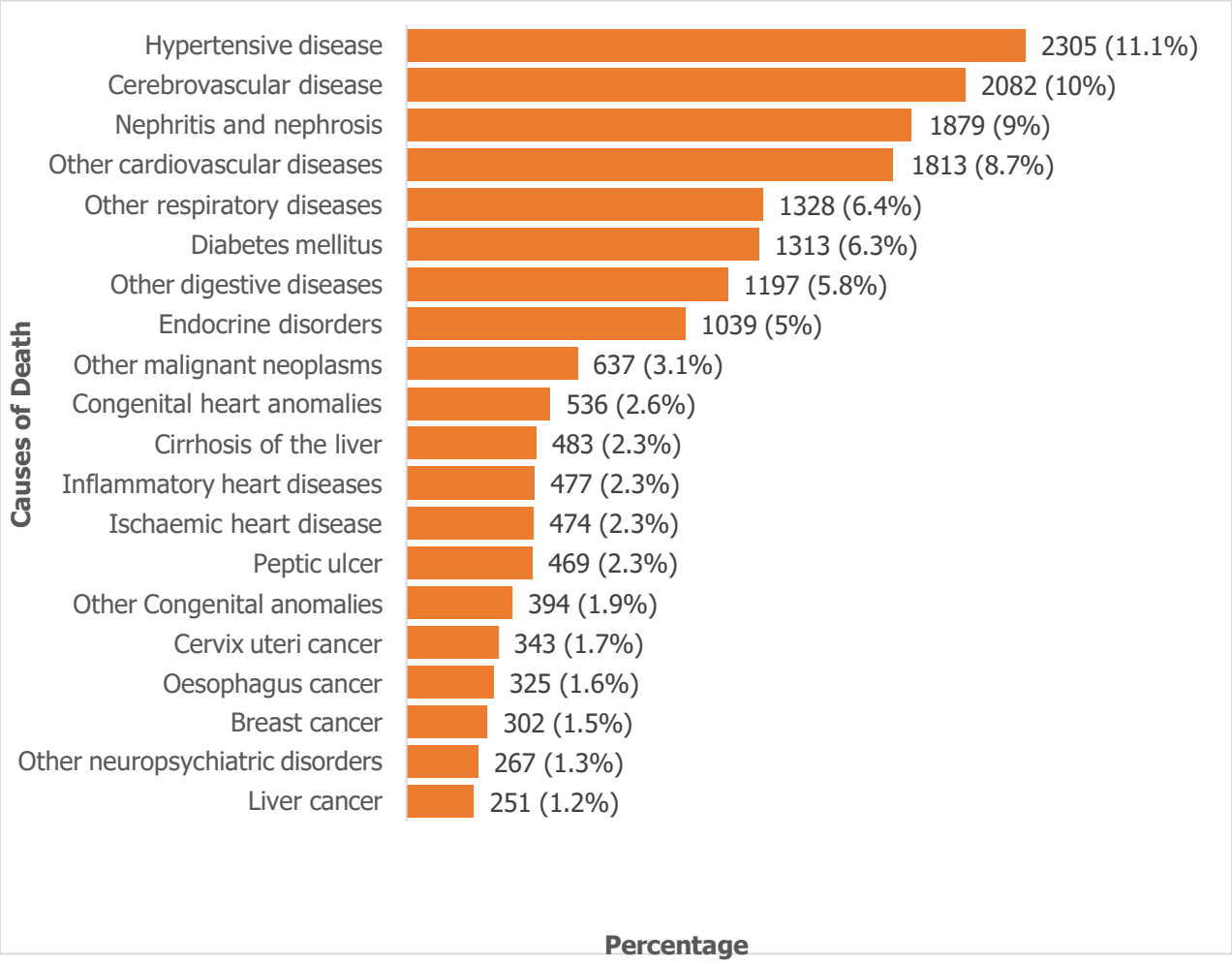


Figure 4.6: Top 20 Leading Causes of death due to Noncommunicable diseases

4.5 Injuries

The percentage distribution of deaths due to injuries in mainland Tanzania shows a clear variation by both age and sex (Figure 4,7). Overall, males consistently record a higher proportion of injury-related deaths compared to females across almost all age groups. The burden is particularly pronounced among young adult men, peaking in the age groups 20–34 years, where more than 8–10% of deaths are injury-related. In contrast, females maintain relatively low and stable proportions, generally below 3%, across all ages. Among children under five, both sexes experience elevated injury-related mortality, though boys remain slightly higher. These findings suggest that young men in Mainland Tanzania are disproportionately affected by injuries—likely linked to risk-taking behaviors, road traffic accidents, and occupational hazards—while females experience a

relatively lower and more stable injury burden. This pattern underscores the need for targeted injury prevention interventions, particularly for young men.

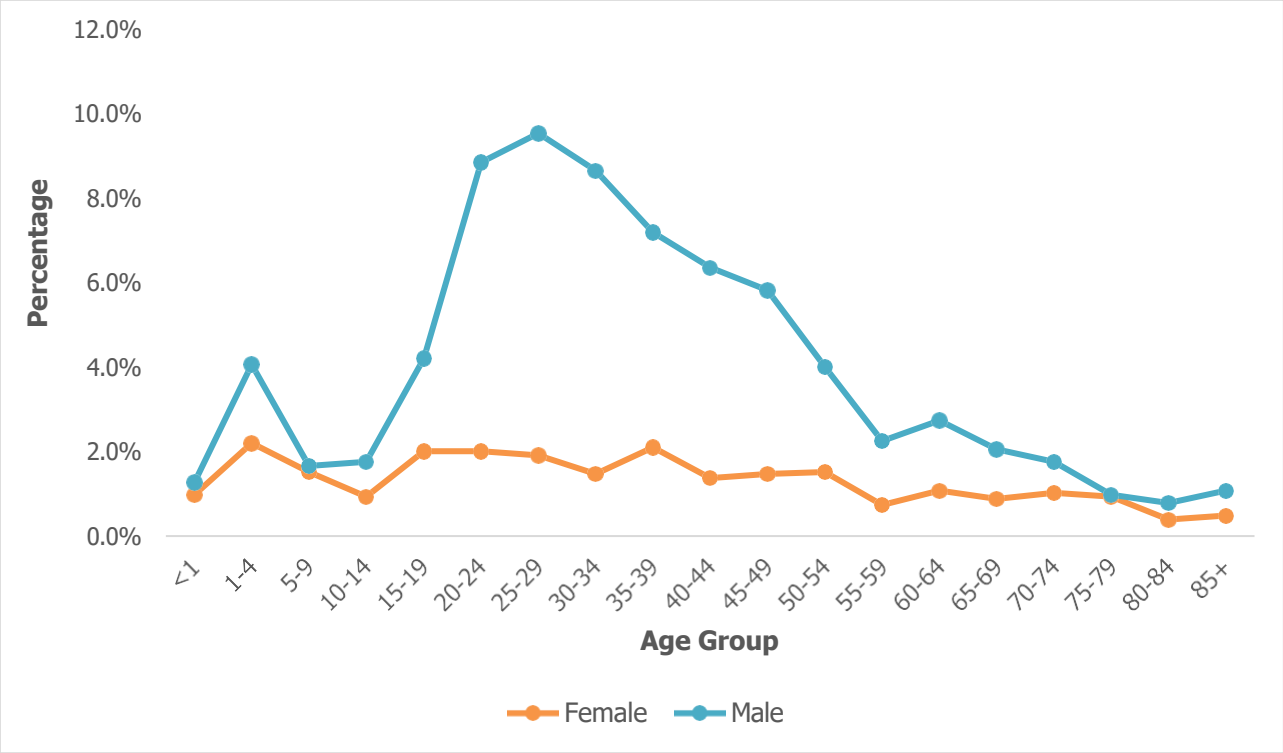


Figure 4.7: Percentage distribution of deaths due to injuries by sex across ages

4.5.1 Distribution of Deaths due to Injuries by Age, Sex and Region

The distribution of deaths due to injuries across regions in Mainland Tanzania highlights important geographic variations that are critical for guiding targeted interventions. As shown in Table 4.4, Dar es Salaam, Dodoma, Mwanza, Morogoro, and Kilimanjaro account for the highest proportions of injury-related deaths in 2024. These regions represent both urban and semi-urban settings, suggesting that factors such as rapid urbanization, increased road traffic, industrial activities, and population density may be contributing to the elevated injury burden.

The observed regional disparities emphasize the need for context-specific prevention strategies, including strengthening road safety measures, improving trauma care services, and enhancing occupational health and safety regulations.

Table 4.4: Distribution of Deaths Due to Injuries by Age, Sex and Region

Region	Overall	Male	Female	<5	5+	5-14	15-59	60+
Tanzania	2045	1534	511	174	1871	120	1461	290
Arusha	107 (5.2%)	80	27	4	103	15	80	8
Dar Es Salaam	445 (21.8%)	331	114	24	421	10	328	83
Dodoma	233 (11.4%)	194	39	15	218	19	179	20
Geita	54 (2.6%)	40	14	2	52	2	45	5
Iringa	108 (5.3%)	85	23	5	103	5	80	18
Kagera	104 (5.1%)	80	24	8	96	5	77	14
Katavi	47 (2.3%)	37	10	8	39	4	33	2
Kigoma	56 (2.7%)	36	20	13	43	8	29	6
Kilimanjaro	115 (5.6%)	98	17	10	105	4	71	30
Lindi	35 (1.7%)	23	12	2	33	0	27	6
Manyara	30 (1.5%)	26	4	1	29	4	22	3
Mara	16 (0.8%)	12	4	3	13	4	8	1
Mbeya	70 (3.4%)	47	23	9	61	3	45	13
Morogoro	116 (5.7%)	73	43	3	113	2	109	2
Mtwara	42 (2.1%)	38	4	4	38	0	30	8
Mwanza	135 (6.6%)	81	54	26	109	14	75	20
Njombe	13 (0.6%)	10	3	1	12	0	10	2
Pwani	69 (3.4%)	58	11	4	65	2	56	7
Rukwa	11 (0.5%)	8	3	2	9	0	8	1
Ruvuma	41 (2%)	34	7	8	33	1	25	7
Shinyanga	20 (1%)	14	6	4	16	2	12	2
Simiyu	8 (0.4%)	7	1	1	7	2	5	0
Singida	47 (2.3%)	33	14	6	41	2	27	12
Songwe	42 (2.1%)	29	13	3	39	2	27	10
Tabora	42 (2.1%)	27	15	4	38	8	28	2
Tanga	39 (1.9%)	33	6	4	35	2	25	8

4.5.2 Top 10 Causes of Death due to Injuries

Figure 4.8 indicates the top 10 causes of death due to injuries. The findings from the figure below indicate road traffic accidents were the leading causes of death in 2024. Other unintentional injuries, self-inflicted injuries, poisonings and homicides also appeared among the top five causes of injury death for the same period.

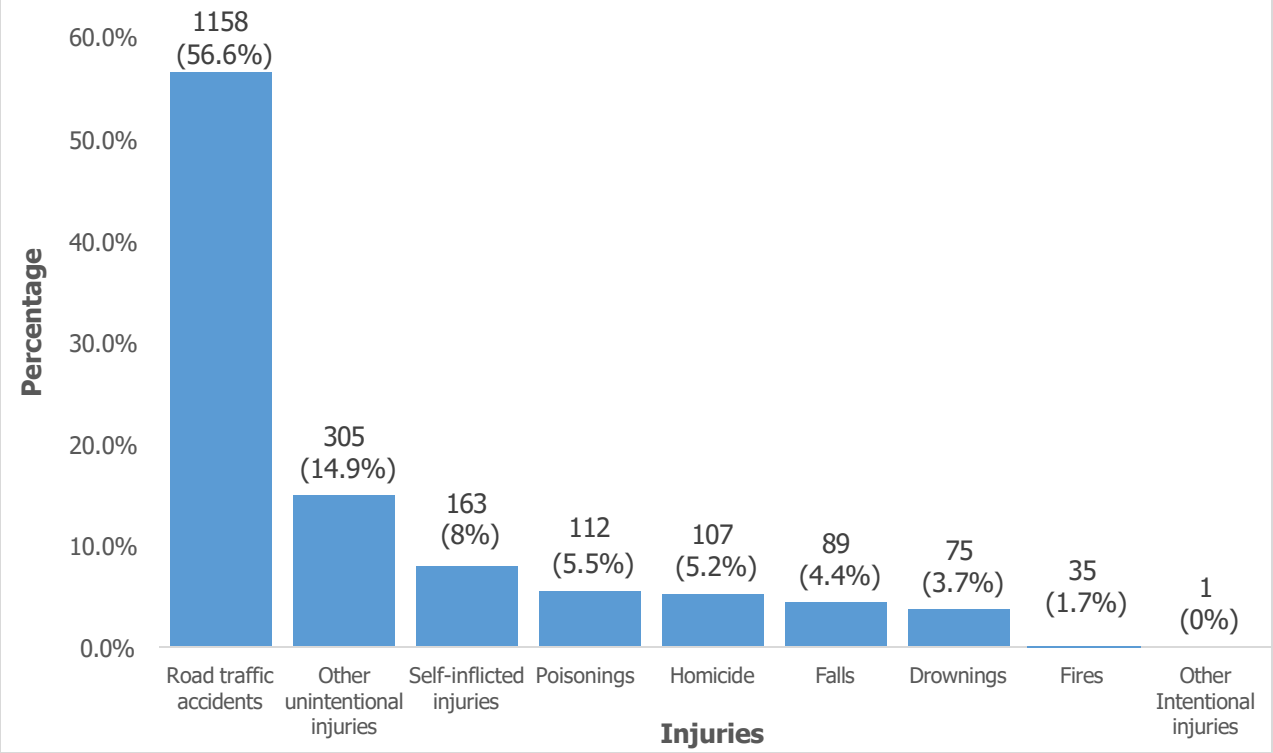


Figure 4.8: Top 10 Fatal Injuries

4.6 Diseases of National Priority

In Tanzania, malaria, HIV and TB are designated as communicable diseases of national priority due to their significant health and socioeconomic impact. These diseases impose a heavy burden on health care systems, hinder economic development and threaten the well-being of the population. Addressing them is essential for achieving public health goals, reducing morbidity and mortality, and promoting sustainable development in the country.

4.6.1 Human Immunodeficiency Virus Disease

Figure 4.9 shows the distribution of deaths due to HIV-related diseases that occurred in Mainland Tanzania in 2024 by age and sex. An especially high proportion of deaths due to HIV is observed among adults between 15 and 49 years of age, as well as among those aged 60 and above. A smaller proportion of deaths were observed among children. Additionally, data shows that females are dying more from HIV-related causes than males. Overall, the higher burden of HIV mortality highlights the importance of strengthening national HIV control interventions such as voluntary counseling and testing, and the prevention of mother to child transmission. Making provider-initiated counseling and testing available and establishing more care and treatment centers would alleviate the burden of HIV mortality in the country.

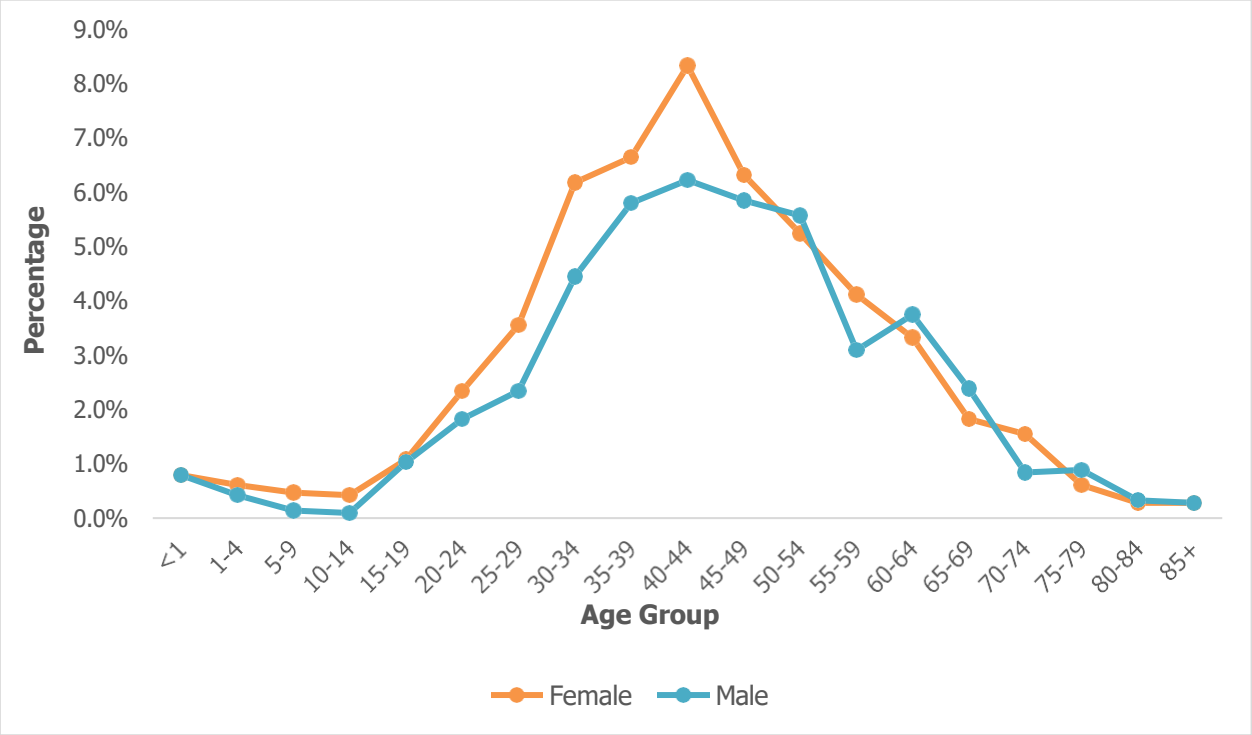


Figure 4.9: Percentage distribution of deaths due to HIV by sex across ages

4.6.1.2 Distribution of Deaths Due to HIV by Age, Sex and Region

The distribution of deaths due to HIV in Mainland Tanzania (Table 4.5) shows that Dar es Salaam carries the highest burden, accounting for 21.8%, with women more affected than men. Dodoma follows with 6.5%, while Morogoro ranks third at 6%. Pwani contributes 5.7%, and Mwanza 5.2%, completing the top five regions. Other regions with notable shares include Arusha at 5.1%, Iringa at 5.1%, and Kilimanjaro at 5%. In contrast, regions such as Kigoma at 0.6%, Rukwa at 0.7%, and Njombe at 1.4% report the lowest numbers. Overall, the data highlights a disproportionate concentration of HIV-related deaths in urbanized and high-prevalent regions.

Table 4.5: Distribution of Deaths Due to HIV by Age, Sex and Region

Region	Overall	Male	Female	<5	5+	5-14	15-59	60+
Tanzania	2138	985	1153	56	2082	24	1709	349
Arusha	109 (5.1%)	48	61	0	109	0	93	16
Dar Es Salaam	466 (21.8%)	182	284	14	452	2	377	73
Dodoma	139 (6.5%)	65	74	4	135	3	107	25
Geita	48 (2.2%)	25	23	2	46	2	40	4
Iringa	108 (5.1%)	56	52	5	103	1	87	15
Kagera	70 (3.3%)	45	25	0	70	2	60	8
Katavi	48 (2.2%)	21	27	3	45	0	40	5
Kigoma	13 (0.6%)	5	8	0	13	1	10	2
Kilimanjaro	106 (5%)	55	51	1	105	1	82	22

Region	Overall	Male	Female	<5	5+	5-14	15-59	60+
Lindi	33 (1.5%)	17	16	1	32	1	24	7
Manyara	43 (2%)	19	24	1	42	1	32	9
Mara	46 (2.2%)	15	31	0	46	1	35	10
Mbeya	54 (2.5%)	28	26	1	53	1	43	9
Morogoro	129 (6%)	57	72	5	124	2	97	25
Mtwara	39 (1.8%)	10	29	3	36	0	31	5
Mwanza	111 (5.2%)	59	52	12	99	2	76	21
Njombe	29 (1.4%)	17	12	0	29	0	28	1
Pwani	121 (5.7%)	62	59	0	121	1	100	20
Rukwa	15 (0.7%)	8	7	1	14	0	13	1
Ruvuma	76 (3.6%)	29	47	1	75	1	67	7
Shinyanga	21 (1%)	11	10	0	21	0	13	8
Simiyu	24 (1.1%)	15	9	0	24	0	16	8
Singida	81 (3.8%)	45	36	1	80	1	70	9
Songwe	22 (1%)	14	8	0	22	0	17	5
Tabora	69 (3.2%)	33	36	1	68	0	54	14
Tanga	118 (5.5%)	44	74	0	118	1	97	20

4.6.2 Malaria

Figure 4.10 shows the distribution of death due to malaria that occurred in Mainland Tanzania by age and sex. A high proportion of malaria deaths were observed in children, adolescents and young adults. Children aged 0-4 years mostly died of malaria, with a slight difference in percentages based on sex. The findings indicate that the government should continue implementing national malaria control programs (such as school net programs, and the mass distribution of bed nets for children under 5 and pregnant mothers) aimed at alleviating the burden of malaria in these age categories.

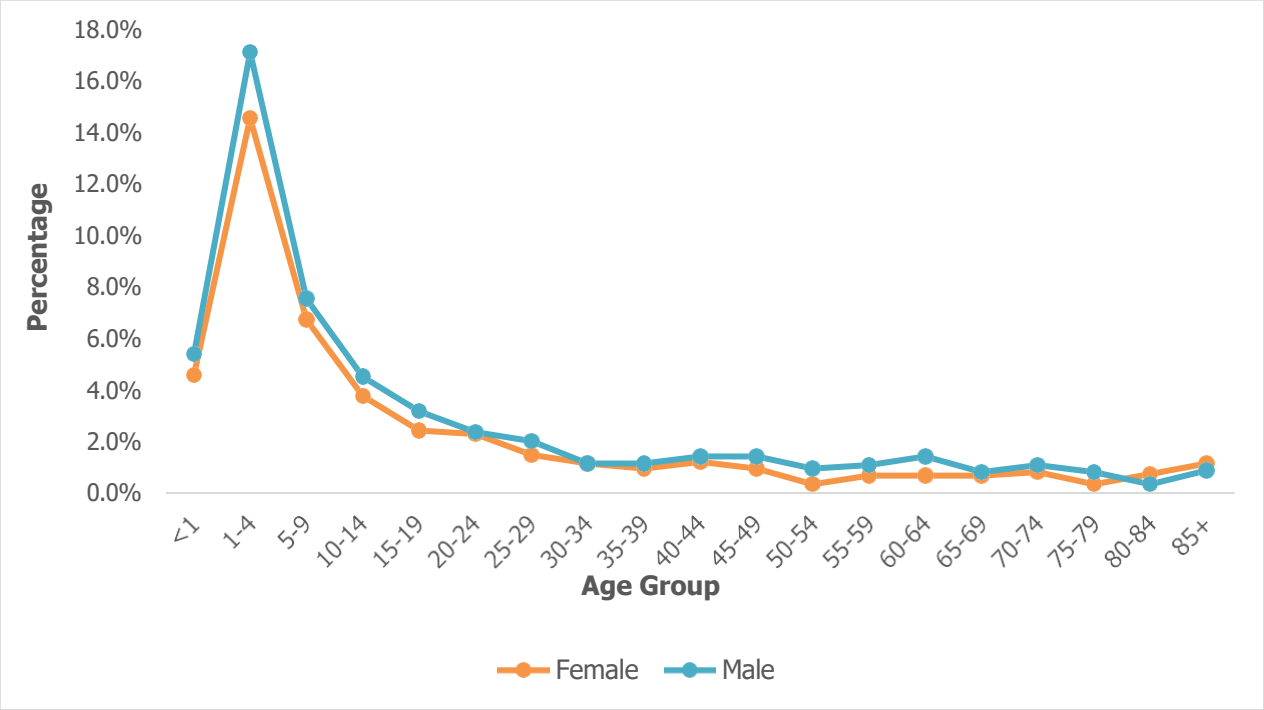


Figure 4.10: Percentage distribution of deaths due to Malaria by sex across ages

4.6.2.2 Distribution of Deaths Due to Malaria by Age, Sex and Region

Table 4.6 presents the distribution of deaths due to malaria by age, sex, and region. The five regions with the highest proportions of malaria-related deaths are Geita, Kagera, Tabora, Dar es Salaam, and Kigoma, while the regions with the lowest proportions include Manyara, Njombe, Kilimanjaro, Iringa, and Singida. To reduce the burden of malaria in high-risk areas, the Government of Tanzania could intensify region-specific interventions such as scaling up access to insecticide-treated bed nets (ITNs), strengthening indoor residual spraying, expanding access to timely diagnostic testing and effective treatment, and implementing targeted health education campaigns. Additionally, enhancing surveillance and addressing social determinants that contribute to malaria transmission in these regions would be crucial in accelerating progress towards malaria reduction.

Table 4.6: Distribution of Deaths Due to Malaria by Age, Sex and Region

Region	Overall	Male	Female	< 5	5+	5-14	15-59	60+
Tanzania	1485	810	675	618	867	335	388	144
Arusha	56 (3.8%)	27	29	9	47	37	8	2
Dar Es Salaam	103 (6.9%)	60	43	18	85	8	69	8
Dodoma	18 (1.2%)	9	9	0	18	1	11	6
Geita	139 (9.4%)	81	58	55	84	40	33	11
Iringa	12 (0.8%)	4	8	3	9	0	6	3
Kagera	112 (7.5%)	57	55	55	57	23	21	13
Katavi	71 (4.8%)	35	36	40	31	21	7	3
Kigoma	99 (6.7%)	63	36	47	52	20	20	12
Kilimanjaro	11 (0.7%)	8	3	1	10	4	6	0
Lindi	27 (1.8%)	11	16	14	13	6	4	3
Manyara	2 (0.1%)	1	1	0	2	0	1	1
Mara	95 (6.4%)	44	51	50	45	19	16	10
Mbeya	19 (1.3%)	9	10	8	11	2	8	1
Morogoro	101 (6.8%)	70	31	33	68	40	25	3
Mtwara	33 (2.2%)	12	21	22	11	5	4	2
Mwanza	157 (10.6%)	82	75	72	85	27	40	18
Njombe	8 (0.5%)	5	3	3	5	3	1	1
Pwani	26 (1.8%)	12	14	10	16	5	10	1
Rukwa	39 (2.6%)	20	19	24	15	7	7	1
Ruvuma	18 (1.2%)	11	7	9	9	4	4	1
Shinyanga	65 (4.4%)	36	29	29	36	14	12	10
Simiyu	37 (2.5%)	23	14	12	25	14	9	2
Singida	13 (0.9%)	7	6	5	8	3	5	0
Songwe	26 (1.8%)	20	6	5	21	4	13	4
Tabora	104 (7%)	52	52	52	52	15	23	14
Tanga	94 (6.3%)	51	43	42	52	13	25	14

4.6.3 Tuberculosis

Figure 4.11 shows the distribution of deaths due to TB by age and sex in Mainland Tanzania. The proportion of deaths due to TB was prominent among adults aged 15 and 49; elders aged 60 years and above, and a smaller proportion of deaths observed in children. Males are at higher risk of dying of TB as compared to their female counterparts. Overall, this highlights the importance of getting the government to strengthen national TB control programs such as free testing and treatment to alleviate the burden of TB mortality in the country.

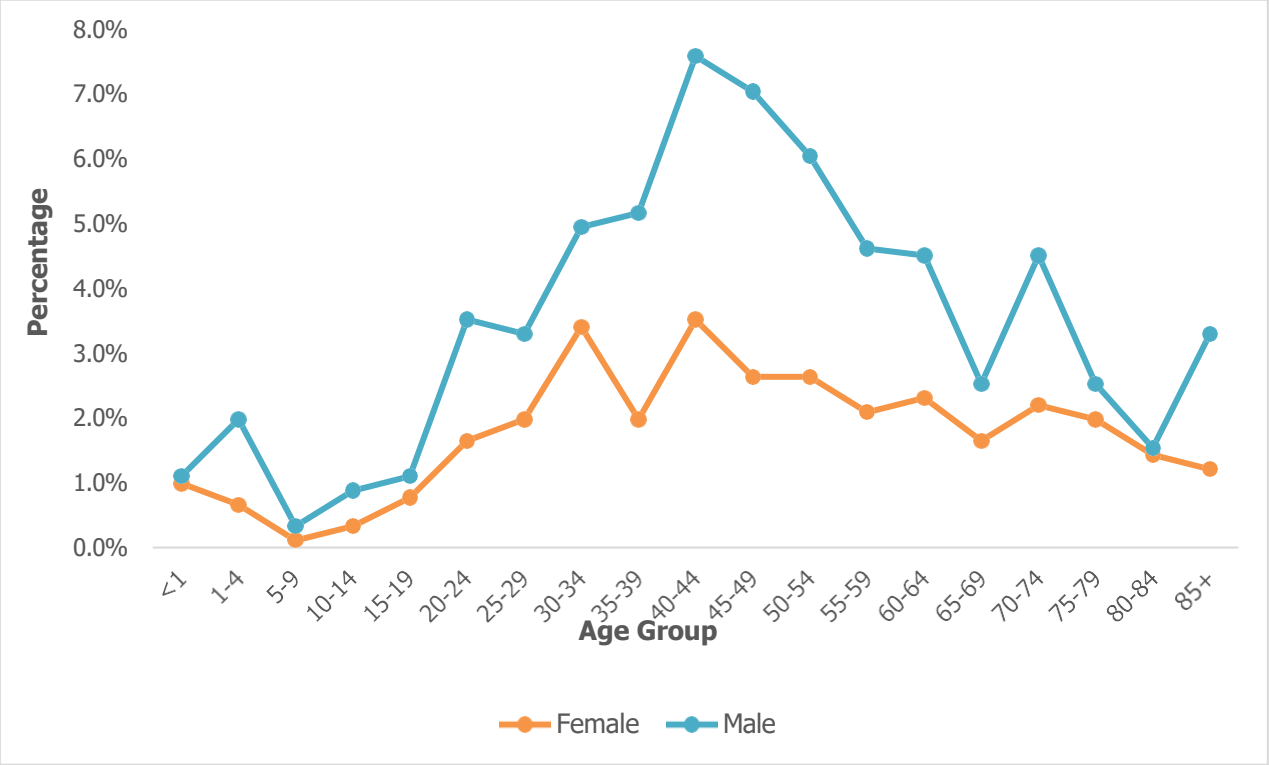


Figure 4.11: Percentage distribution of deaths due to Tuberculosis by sex across ages

Table 4.7 presents the distribution of deaths due to tuberculosis (TB) by age, sex, and region. The top five regions with the highest proportions of TB-related deaths are Dar es Salaam, Kilimanjaro, Dodoma, Arusha, and Manyara. To address this burden, region-specific interventions are essential. The efforts to avert TB in Mainland Tanzania could focus on strengthening TB case detection in densely populated urban settings, expanding diagnostic services, and improving treatment adherence through community health workers. Other efforts could include enhancing regional surveillance, screening, and cross-district coordination, integrating TB services into primary health care, improving access to diagnostic facilities in rural areas, and scaling up community awareness campaigns to reduce stigma and encourage early care-seeking. Strengthening collaboration with local governments and civil society organizations across these regions would further enhance the effectiveness of TB control efforts.

Table 4.7: Distribution of Deaths Due to TB by Age, Sex and Region

Region	Overall	Male	Female	<5	5+	5-14	15-59	60+
Tanzania	910	605	305	43	867	15	582	270
Arusha	60 (6.6%)	35	25	4	56	1	38	17
Dar Es Salaam	216 (23.7%)	127	89	10	206	2	176	28
Dodoma	63 (6.9%)	45	18	1	62	0	35	27
Geita	15 (1.6%)	10	5	0	15	0	10	5
Iringa	36 (4%)	26	10	0	36	2	22	12
Kagera	33 (3.6%)	20	13	4	29	0	21	8
Katavi	19 (2.1%)	16	3	3	16	0	12	4
Kigoma	20 (2.2%)	19	1	1	19	1	14	4
Kilimanjaro	84 (9.2%)	65	19	2	82	0	55	27
Lindi	12 (1.3%)	11	1	0	12	0	7	5
Manyara	48 (5.3%)	30	18	2	46	1	29	16
Mara	14 (1.5%)	8	6	1	13	1	6	6
Mbeya	22 (2.4%)	11	11	0	22	1	11	10
Morogoro	22 (2.4%)	15	7	0	22	0	15	7
Mtwara	9 (1%)	4	5	1	8	0	3	5
Mwanza	22 (2.4%)	18	4	2	20	1	12	7
Njombe	20 (2.2%)	13	7	1	19	0	10	9
Pwani	11 (1.2%)	9	2	0	11	0	10	1
Rukwa	2 (0.2%)	0	2	0	2	0	0	2
Ruvuma	12 (1.3%)	12	0	1	11	0	4	7
Shinyanga	7 (0.8%)	4	3	1	6	1	5	0
Simiyu	10 (1.1%)	7	3	0	10	0	7	3
Singida	48 (5.3%)	33	15	3	45	2	28	15
Songwe	20 (2.2%)	12	8	0	20	0	9	11
Tabora	52 (5.7%)	36	16	3	49	2	26	21
Tanga	33 (3.6%)	19	14	3	30	0	17	13

4.6.4 Maternal

Figure 4.12 illustrates the percentage distribution of proportion of maternal death among women of reproductive age. Overall, most maternal deaths occurred among women aged 20–40 years. As shown in Figure 4.13, the leading causes of maternal mortality in Tanzania in 2024 were maternal hemorrhage, other maternal conditions, hypertensive disorders of pregnancy, and maternal sepsis.

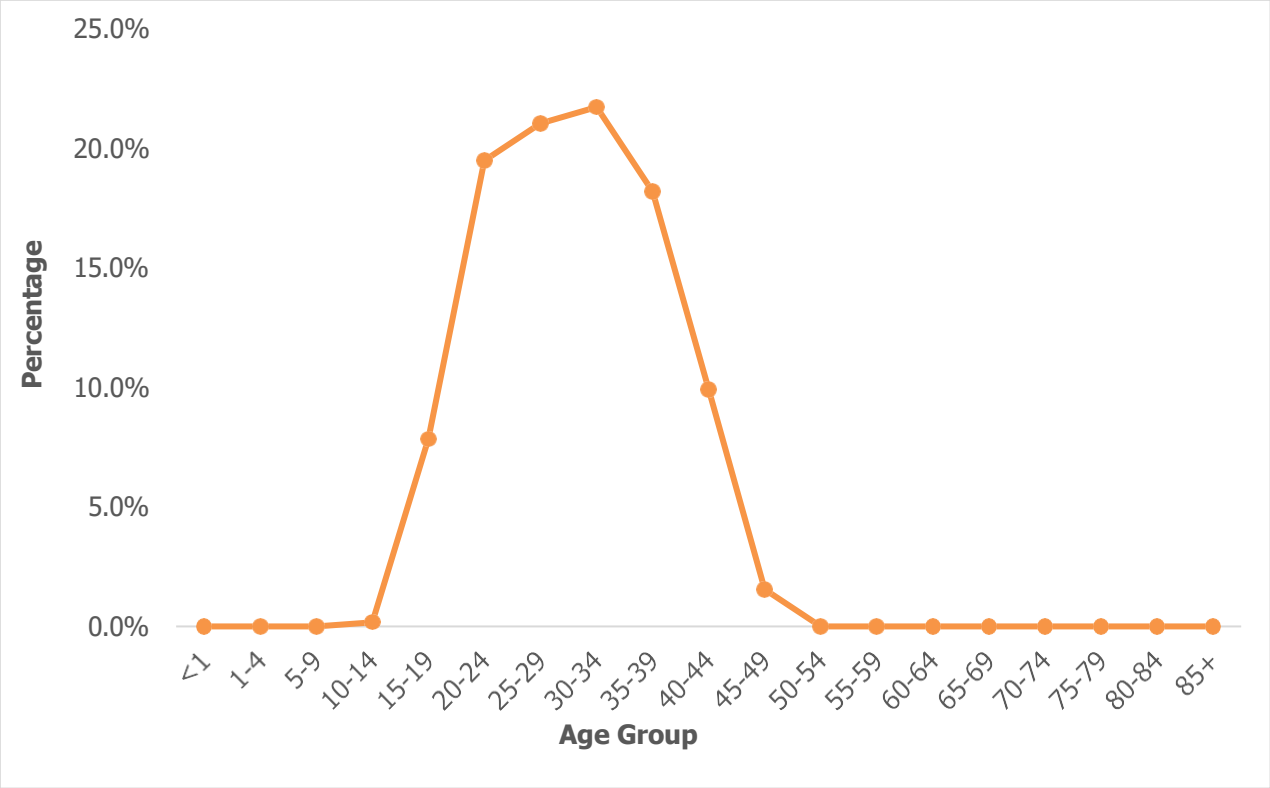


Figure 4.12: Percentage distribution of deaths due to maternal conditions by age

4.6.4.2 Percentage distribution of Maternal Causes in Tanzania

Figure 4.13 presents the distribution of specific causes of maternal deaths in 2024. Maternal hemorrhage accounts for the largest proportion at 43.8%, followed by other maternal conditions at 27.5% and hypertensive disorders of pregnancy 18.7%. Maternal sepsis contributes 6.9% while abortion related deaths represent 3.1%. Obstructed labor accounts for smallest share with only 0.1%. Patterns from these data indicate most maternal deaths in Tanzania remain linked to preventable obstetric complications, underscoring the urgent need to strengthen emergency obstetric care and early intervention across the health system.

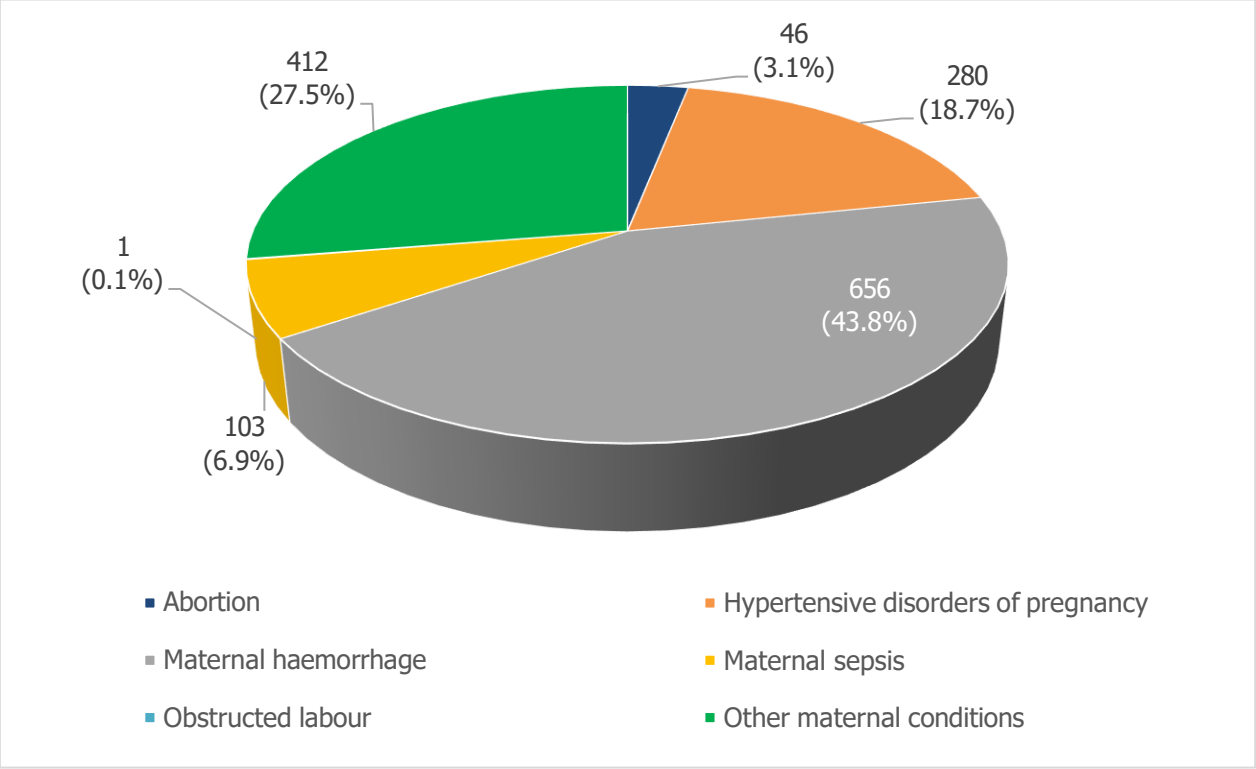


Figure 4.13: Percentage distribution of deaths due to maternal conditions

4.6.4.3 Specific Maternal Causes of Death by region

The distribution of maternal deaths in Mainland Tanzania highlights major regional variations and leading causes (Table 4.8). Dar es Salaam recorded the highest number of deaths at 173, mainly due to maternal hemorrhage 47, hypertensive disorders 28, and other maternal conditions 68. Mwanza followed closely with 165 deaths, with hemorrhage 66 and hypertensive disorders 39 as leading causes. Kigoma ranked third with 78 deaths, dominated by hemorrhage 35 and other maternal conditions 21. Dodoma with 75 deaths and Morogoro with 71 also featured prominently, with hemorrhage and hypertensive disorders as key contributors. In contrast, Ruvuma, with 24 deaths, and Njombe, with 22, reported the lowest numbers. Overall, hemorrhage, hypertensive disorders, and other maternal conditions remain the top drivers of maternal mortality across regions.

Table 4.8: Specific Maternal Causes of Death by region

Region	Abortion	Hypertensive disorders of pregnancy	Maternal hemorrhage	Maternal sepsis	Obstructed labor	Other maternal conditions	Grand Total
Tanzania	**46**	**280**	**656**	**103**	**1**	**412**	**1,498**
Arusha	0	4	17	2	0	11	34
Dar Es Salaam	8	28	47	22	0	68	173
Dodoma	0	17	33	5	0	20	75

Geita	2	11	31	2	0	13	59
Iringa	1	10	16	2	0	10	39
Kagera	2	8	19	3	0	15	47
Katavi	1	8	23	8	0	7	47
Kigoma	1	15	35	6	0	21	78
Kilimanjaro	3	6	15	2	0	7	33
Lindi	0	1	14	3	0	9	27
Manyara	1	5	20	3	0	13	42
Mara	3	7	27	5	0	11	53
Mbeya	2	20	20	3	0	13	58
Morogoro	3	11	31	2	1	23	71
Mtwara	5	17	27	2	0	18	69
Mwanza	3	39	66	17	0	40	165
Njombe	0	3	8	1	0	10	22
Pwani	1	11	14	0	0	9	35
Rukwa	1	9	18	0	0	10	38
Ruvuma	0	2	16	0	0	6	24
Shinyanga	1	8	36	5	0	13	63
Simiyu	1	4	15	4	0	9	33
Singida	2	6	36	2	0	19	65
Songwe	1	4	21	2	0	3	31
Tabora	3	19	42	2	0	21	87
Tanga	1	7	9	0	0	13	30

4.6.5 Cancer

The percentage distribution of deaths due to cancer in Mainland Tanzania demonstrates notable age and sex differences (Figure 4.14). Overall, cancer-related mortality increases with age, with both sexes showing relatively low proportions in childhood and adolescence, followed by a gradual rise from young adulthood onwards. Among females, the burden increases sharply after age 35, peaking between 50–64 years where nearly 6% of deaths are attributable to cancer, before declining steadily in older ages. For males, cancer-related deaths rise more gradually, with a peak around 60–64 years (just above 5%), followed by a decline in the older age groups. While females bear a higher cancer mortality burden in the middle age groups (40–64 years), males show relatively higher proportions in older ages (70+ years). This pattern suggests sex-specific differences in cancer risk factors and disease profiles, with women likely affected more during their reproductive and peri-menopausal years, while men show an increasing burden at advanced ages. These findings underscore the importance of strengthening age- and sex-specific cancer prevention, early detection, and treatment services in Tanzania.

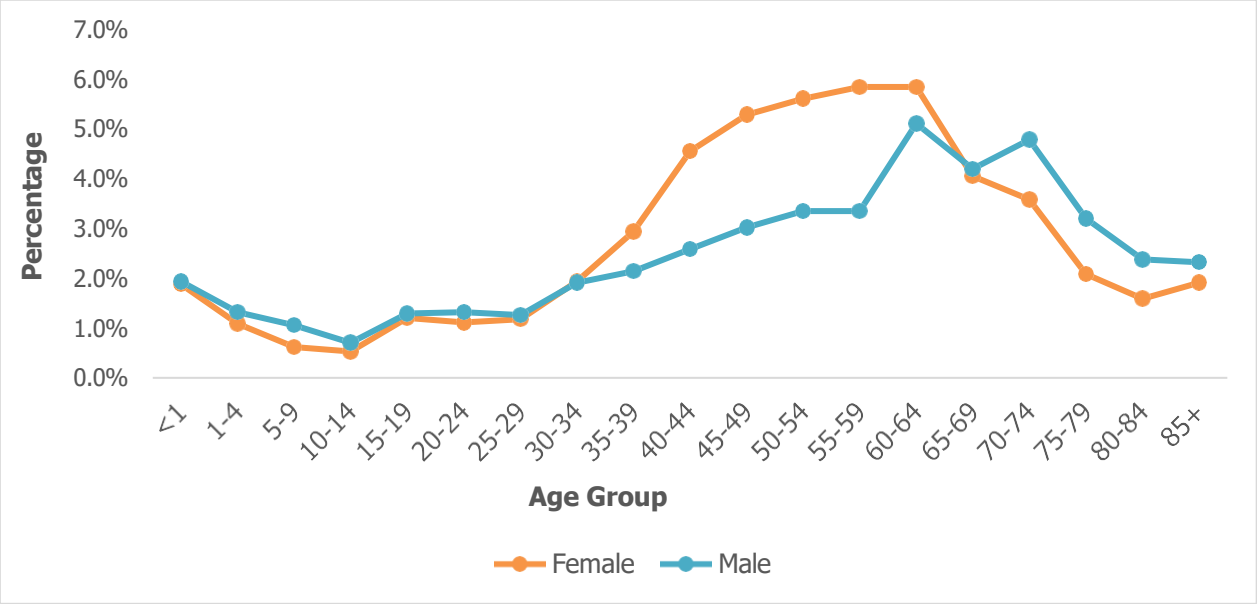


Figure 4.14: Percentage distribution deaths due to cancer by sex across ages

4.6.5.2 Top 20 Causes of Death due to Cancer

Table 4.9 illustrates the leading causes of cancer-related deaths in Mainland Tanzania, which show a diverse profile of malignant neoplasms, with both site-specific and unspecified cancers contributing substantially to the overall burden. Other malignant neoplasms account for the largest share at 18.7%, reflecting cases with ill-defined primary sites. Among site-specific cancers, cervical cancer leads to 10.1% of deaths, followed by oesophageal (9.5%) and breast cancer (8.9%). Liver (7.4%) and respiratory system cancers (7.2%) also contribute significantly. Prostate cancer (6.4%), leukaemia (6.3%), colorectal cancers (5.6%), and lymphomas (4.7%) further add to mortality. Stomach (4.0%) and bladder cancers (2.6%), along with less frequent cancers of the mouth, pancreas, ovary, uterus, and skin, highlight the need for prevention, early detection, and treatment to reduce premature deaths.

Table 4.9: Top 20 Causes of Death Due to Cancer

Disease	Number	Percent
Other malignant neoplasms	637	18.7%
Cervix uteri cancer	343	10.1%
Oesophagus cancer	325	9.5%
Breast cancer	302	8.9%
Liver cancer	251	7.4%
Trachea, bronchus and lung cancers	245	7.2%
Prostate cancer	217	6.4%
Leukaemia	213	6.3%
Colon and rectum cancers	191	5.6%
Lymphomas and multiple myeloma	159	4.7%
Stomach cancer	136	4.0%
Bladder cancer	89	2.6%
Mouth and oropharynx cancers	87	2.6%
Pancreas cancer	85	2.5%
Ovary cancer	61	1.8%
Corpus uteri cancer	35	1.0%
Melanoma and other skin cancers	32	0.9%
Grand Total	**3408**	**100.0%**

4.6.5.3 Distribution of causes of death due to cancer by region

The distribution of deaths due to cancer in Mainland Tanzania shows marked regional disparities, with the highest concentration observed in urban and densely populated areas. As illustrated in the map, Dar es Salaam alone accounts for nearly half of all reported cancer deaths (44.2%), reflecting both its large population size and the availability of diagnostic and reporting services. Other regions with a substantial burden include Mwanza (13.8%), Kilimanjaro (10.2%), and Dodoma (6%), while moderate proportions are reported in Arusha (3.8%), Iringa (2.5%), Tanga (2.2%), Singida (2%), Morogoro (2%), and Njombe (2%). In contrast, most peripheral and rural regions such as Rukwa, Lindi, and Shinyanga report less than 1% of cancer-related deaths. This distribution suggests that cancer mortality in Tanzania is strongly associated with urbanization, health service accessibility, and possibly higher exposure to risk factors in urban settings. The findings highlight the need to strengthen cancer prevention, early detection, and treatment services beyond major urban centers to ensure equitable access to care across the country.

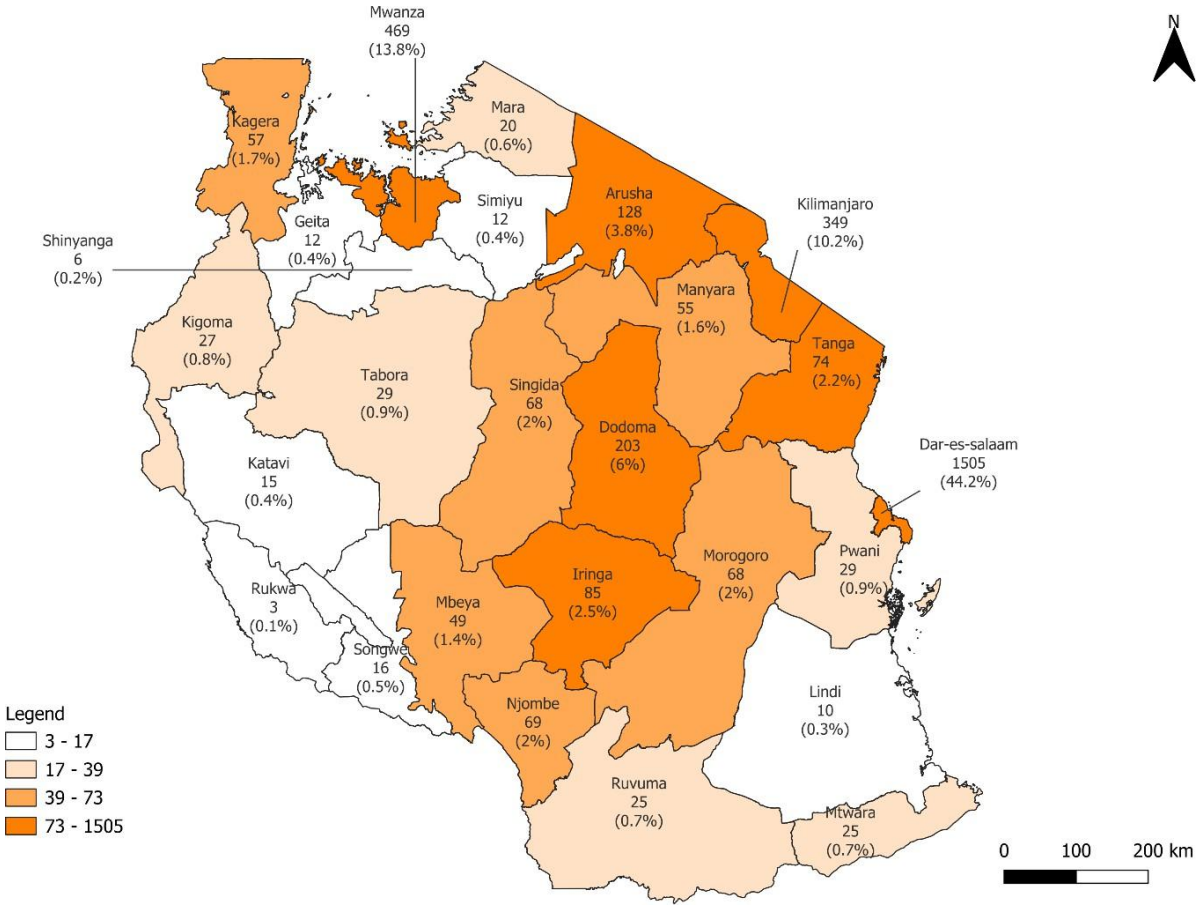


Figure 4.15: Distribution of causes of death due to cancer by region

CHAPTER 5: DISCUSSION AND RECOMMENDATIONS

A total of 48,269 deaths were medically certified and captured through the DHIS2 system and EMR systems in 2024, in Mainland Tanzania. The proportion of certified deaths with defined causes was at around 85% in the year 2024. Further completeness and quality of CoD information from health facilities can be improved by providing refresher training to physicians, strengthening electronic data collection systems, and providing supportive supervision. This report has highlighted the high burden of mortality associated with lower respiratory diseases in health facilities of Mainland Tanzania despite the various interventions undertaken by the health sector that include the use of Standard Treatment Guidelines and the National Essential Medicines List. Since lower respiratory diseases are avoidable, public health measures are needed to increase awareness, and education and strong health services delivery capacity are urgently needed.

The top 20 causes of death accounted for more than 60% of all facility deaths reported in 2024. Perinatal causes, Birth asphyxia and birth trauma and lower respiratory infection remain the leading causes of death in health facilities among children under 5. To address these challenges, the government must strengthen the availability and quality of health care services during the antenatal period, labor and delivery, and during children's first month of life. Additionally, in Tanzania, the management of childhood diseases is guided by the WHO program on Integrated Management of Childhood Illness (IMCI) aimed at preventing these childhood illnesses. It is therefore necessary to improve and scale up these intervention packages, which will continue to further reduce morbidity and mortality in children under 5.

Maternal mortality remains a critical public health challenge in Tanzania's Mainland. Overall, most maternal deaths occurred among women aged 20-40 years. Maternal hemorrhage, other maternal conditions, hypertensive disorders of pregnancy, and hypertensive disorder are common causes of maternal death in health facilities in Tanzania. To avoid this problem, the government should continue efforts that help ensure the availability, accessibility and quality of key maternal health interventions such as modern contraceptives, Antenatal Care services four or more times (ANC4+), skilled birth attendants (SBA) in health facilities, and Basic Emergency Obstetric Care (BEmOC) and Comprehensive Emergency Obstetric Care (CEmOC). The use of Maternal Death Surveillance and Response (MDSR) must be strengthened to ensure that local data is available in a timely fashion to steer efforts to prevent maternal mortality in the country. Additionally, further analysis of data is important to identify where maternal deaths occur. This will give insight into what interventions are needed.

The proportion of deaths due to HIV was pronounced among adults between ages 15 and 49, as well as among those aged 60 and above. A smaller proportion of deaths were observed among children. Additionally, more women than men died of HIV. This highlights the importance of strengthening national HIV control programs. The government should continue focusing on the implementation of the global 90-90-90 treatment target to eliminate HIV and AIDS by 2030.

Tanzania has experienced huge success in the fight against malaria. However, malaria continues to be a major public health concern in Tanzania Mainland as it mostly affects children under 5, the school-age population, and elders. These findings challenge Tanzania's goal of eliminating malaria by 2030. It is therefore suggested that the government should continue to use innovative, cost-effective and practical solutions to influence both access and use of programmatic efforts for malaria elimination such distribution of ITNs through a Mass Replacement Campaign (MRC), School Net program (SNP), and Reproductive Child Health Services (RCHs); indoor residual spraying, larvicide and the distribution of malaria diagnostic materials and provision of antimalarial drugs.

Noncommunicable diseases are an emerging global health concern, and similarly, they are also a concern in Tanzania. This report shows that death due to NCDs ranks second among the broad categories of causes of death, and the elderly (60 years plus) in both sexes are the ones most affected. It was also found that the most common NCDs are hypertensive diseases, cerebrovascular diseases, nephritis and nephrosis, diabetes and chronic respiratory diseases. This list is like what is reported by WHO. The increase in the prevalence of NCDs is attributed to demographic change with longer life spans and lifestyle factors that underlie NCD risk, such as dietary patterns, physical activity, and alcohol and tobacco consumption. Therefore, NCDs need to be addressed before they reach unaffordable epidemic proportions. Tanzania should continue to promote activities focusing on increasing awareness of NCDs and associated risk factors, ensuring the delivery of quality NCD services that includes incorporating NCD screening into routine PHC, targeting high-risk groups with tailored mass-media and Social Behavioral Change Communication (SBCC) intervention to encourage service utilization and healthy lifestyles.

Mortality due to injuries reported to be at 4.3% all-cause mortality in 2024 and thus poses a growing public health problem in Tanzania. Road traffic crashes, unintentional injuries, self-inflicted injuries, poisonings and homicide are observed to be the leading causes of death in this category. To avert the burden of injury mortality, the country has to strengthen efforts to raise community awareness on safe road use and improve post-injury and trauma care by training health care workers on the management of acute injuries, promotion of laws and legislation that ensure road safety (such as use of safety belts, child

restraints, speed limits, motorcycle helmets, drinking and driving laws, etc.), and building and maintaining safe roads.

The high proportion of undetermined and ill-defined causes of death call for refresher trainings on the assignment of causes of death, as well as close supportive supervisions to ensure regular data quality. This will enhance the improvement of quality of mortality data, leading to more accurate results that can be used to inform a wider range of health policy decisions and monitor the impacts of investments in injury prevention and management.

Annex 1: The Medical Certification of Cause of Death Form

FOMU YA KUTOLEA TAARIFA NA SABABU YA KIFO

Jina la kituo..............................Halmashauri..................................Mwezi......................Mwaka ....

Taarifa za msingi za marehemu				
Tarehe ya kifo	D D M M Y Y Y Y	Namba ya usajili wa kituo		
Jina la marehemu	Jina la kwanza	Jina la kati	Jina la Mwisho	
Jinsi	☐ Ke ☐ Me ☐ Haijulikani	Alipokuwa anaishi		
Tarehe ya kuzaliwa	D D M M Y Y Y Y	Umri/ makadirio ya umri	Mwaka Mwezi Siku saa	
Mahali kifo kilipotokea				

***Sehemu A: Taarifa za kitabibu:* Sehemu ya 1 na 2**				
1: Andika sababu ya kifo "immediate cause of death" kwenye safu "a" Andika sababu zingine za msingi zilizochangia kifo kwenye safu "b" na "c" (KAMA ZIPO) Andika "underlying cause of death" kwenye mstariwa mwishouliotumika		Sababu ya kifo	ICD 10 code	Ameugua muda gani? (masaa, dakika, siku n.k)
	a			
	b	Imesababishwa na:		
	c	Imesababishwa na:		
	d	Imesababishwa na:		
2: Andika sababu nyingine za msingi zilizochangia kifo kwenye safu	....			

***Sehemu B:* Taarifa nyingine za kitabibu**			
Je upasuaji ulifanyika ndani ya wiki 4 zilizopita?	☐ Ndio	☐ Hapana	☐ Haijulikani
Kama ndio, andika tarehe ya upasuaji	D D M M Y Y Y Y		
Andika sababu ya upasuaji			
Je uchunguzi ulifanyika?	☐ Ndio	☐ Hapana	☐ Haijulikani
Kama ndio, majibu yalitumika kuthibitisha kifo?	☐ Ndio	☐ Hapana	☐ Haijulikani

Namna Kifo kilivyotokea (Manner of death)		
☐ Ugonjwa ☐ Shambulio		☐ Haijatambulika
☐ Ajali	☐ Hatua za kisheria	☐ Uchunguzi unaendelea
☐ Kujinyonga mwenyewe kwa makusudi ☐ Vita		☐ Haijulikani
Kama kisababishi cha kifo sio ugonjwa (external cause) au sumu :	Andika tarehe ya tukio	D D M M Y Y Y Y
Eleza namna tukio lilivyotokea (kama ni sumu taja aina ya sumu, kama ajali taja aina ya ajali)		

Mahali tukio lilipotokea:		
☐ Nyumbani ☐ Makazi ya Taasisi	☐ Shuleni au sehemu nyingine ya jumuia	☐ Sehemu za michezo
☐ Mtaani ☐ Sehemu ya biashara au kazini	☐ Kiwandani au sehemu ya ujenzi	☐ Shambani
☐ Sehemu nyingine (taja):		☐ Haijulikani

Kifo cha mtoto tumboni au mtoto mchanga			
Mimba ya watoto pacha	☐ Ndio	☐ Hapana	☐ Haijulikani
Mtoto amezaliwa mfu? Macereted Still Birth	☐ Ndio	☐ Hapana	☐ Haijulikani
Mtoto amezaliwa mfu? Fresh Sitill Birth	☐ Ndio	☐ Hapana	☐ Haijulikani
Je kifo kimetokea ndani ya masaa 24 tangu kuzaliwa? (Andika masaa alioishi mtoto)			Uzito wa mtoto wakati wa kuzaliwa (kg/gm)
Umri wa mimba kwa wiki			Umri wamama
Kama kifo ni cha mtoto mchanga, ainisha hali ya mama iliopelekea kifo hicho.			

Kwa wanawake wenye umri wa uzazi	Je marehemu alikuwa mjamzito? ☐ Ndio	☐ Hapana	☐ Haijulikani
Kama ndio je tukio la kifo lilitokea wakati gani?			
☐ Akiwa mjamzito ☐ Wakati wa kujifungua	☐ Ndani ya siku 42 baada ya kujifungu		
Kati ya siku 43 mpaka mwaka mmoja	☐ Ndio	☐ Hapana	☐ Haijulikani
Je ujauzito ulichangia kifo?	☐ Ndio	☐ Hapana	☐ Haijulikani
Je kifo kimekaguliwa?	☐ Ndio	☐ Hapana	☐ Haijulikani

UTHIBITISHO	Kwa kadiri ninavyofahamu taarifa iliyotolewa hapo juu ni sahihi Jina.....................................Tarehe.................... Sahihi .... Cheo ....