BIRTH AND DEATH IN TANZANIA

November, 2025

The United Republic of Tanzania

Birth and Death in Tanzania

National Bureau of Statistics

Ministry of Finance and Planning

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and

Office of the Chief Government Statistician

Presidents' Office - Finance and Planning

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Notes:

Maps and land area used in this publication are derived from the 2022 Population and Housing Census (PHC) cartographic work; therefore, they are for statistical use only.

Map 1.1: UNITED REPUBLIC OF TANZANIA, ADMINISTRATIVE BOUNDARIES

Preface

The 2022 Population and Housing Census (PHC) for the United Republic of Tanzania was conducted with a reference date of midnight between August 22 and 23, 2022. This marked both the sixth census since the Union of Tanganyika and Zanzibar in 1964, and the first digital census in Tanzania's history. The previous censuses took place in 1967, 1978, 1988, 2002, and 2012. The Sixth Phase Government of Tanzania, led by Her Excellency Dr. Samia Suluhu Hassan, along with the Eighth Phase Government of Zanzibar, under Dr. Hussein Ali Mwinyi, fulfilled their obligation to conduct the 2022 PHC in accordance with the United Nations Principles and Recommendations for Population and Housing Census. Their commitment and support throughout the census implementation deserve our gratitude.

The Government of the United Republic of Tanzania, through the Ministry of Finance in collaboration with the National Bureau of Statistics (NBS) and the Office of the Chief Government Statistician in Zanzibar (OCGS), successfully conducted the 2022 Population and Housing Census (PHC) in accordance with the Statistics Act Cap 351 and international standards set by the United Nations. This marked Tanzania’s first fully digital census, utilizing advanced ICT tools for mapping, enumeration, data transmission, and processing.

The results of the 2022 PHC informs integrated planning, resource allocation, and monitoring of key development frameworks, including the Tanzania and Zanzibar Development Visions 2050, the Third National Five-Year Development Plans, regional strategies such as the EAC and SADC Visions 2050, and global agendas like the African Development Agenda 2063 and the UN Sustainable Development Goals (Agenda 2030). Census data will also support calculation of vital indicators such as literacy, maternal and infant mortality, and unemployment rates.

The "Birth and Death in Tanzania" monograph is the twentieth in a series of significant publications related to the 2022 PHC. Major reports produced so far include the Administrative Units Population Distribution Reports, Age and Sex Reports, the Tanzania Basic Demographic and Socio-economic Profile, Ripoti ya Idadi ya Watu katika Majimbo ya Uchaguzi (Constituency Population Distribution Reports) in two volumes for the United Republic of Tanzania and Tanzania Zanzibar and other Thematic Reports.

This monograph on Birth and Death in Tanzania draws on the 2022 PHC to provide an in-depth analysis of fertility and mortality patterns and trends. It examines differentials by sex, age, place of residence (Mainland and Zanzibar; rural and urban), education, occupation, wealth, and maternal reproductive history. The analysis translates raw numbers into

actionable insights on who is most affected, where, and why, allowing resources and interventions to be more precisely targeted.

We extend sincere appreciation to all government leaders, including Ministers, Members of Parliament, Members of the House of Representatives, Councillors/Sheha, and the Regional and District Census Committees. Special thanks go to Census Coordinators, Supervisors, Enumerators, local leaders, and all respondents for their active participation.

We are deeply grateful to our development partners United Nations Population Fund (UNFPA), the World Bank (WB), the United Nations Children's Fund (UNICEF), UN-Women, the International Organization for Migration (IOM), the International Labour Organization (ILO), the United States Agency for International Development (USAID), the Foreign, Commonwealth and Development Office (FCDO), the United States Census Bureau (USCB), the Republic of South Korea, the People's Republic of China, and others for their generous support in equipment, training, expertise and funding. Special recognition is given to Honourable Anne Semamba Makinda and Honourable Ambassador Mohamed Haji Hamza for their exemplary leadership as Census Commissars.

Finally, We would like to extend our heartfelt gratitude to all the experts who contributed their time and effort to this report, including Dr. Rutasha Dadi, Technical Advisor; Prof Herbert Hambati, Lead Author; Dr. Ruth Davison Minja, Director of Population Census and Demographic Statistics; Fahima Mohamed Issa, Director of the Social Statistics Department, OCGS; Seif Ahmad Kuchengo, Manager of Population Census and Vital Statistics; Abdul-majid Jecha Ramadhan, Zanzibar Census Coordinator; Steven Lwendo, IT Expert for data processing; and the dedicated National Census Technical Team along with all the statisticians, demographers, IT specialists, and GIS officers. Their commitment played a crucial role in the success of producing this Thematic report.

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Executive Summary

This report analyses births and deaths in Tanzania using the 2022 PHC, translating census data into actionable insights for planning, service delivery, and accountability. It summarises levels and differentials by sex, age, residence (Mainland/Zanzibar; urban/rural), education, occupation, wealth, and maternal reproductive history.

Key Findings

Births

1. Tanzania recorded 1.48 million births in the 12 months prior to the census, with 69.5 percent occurring in rural areas and 30.5 percent in urban areas.

2. Total fertility has declined from 6.9 children per woman in 1978 to 4.6 in 2022, but remains higher in rural areas (5.8) than in urban areas (3.8). Fertility peaks at age 25–34 and declines thereafter.

3. Women with primary education contributed 57.1 percent of the total births, while those with higher education contributed less than 4 percent. Married women account for 76 percent of the total births in Mainland Tanzania and 91.9 percent in Zanzibar. Births are concentrated among poorer households, with agriculture, forestry, and fishing as the leading occupations linked to higher birth rates.

Deaths

1. The census recorded 460,694 deaths, of which 66.5 percent occurred in rural areas.

2. Mortality is concentrated at the extremes of age: 0–14 years (30.9%) and 60+ (35.7%).

3. Regional disparities exist, with Dar es Salaam reporting the highest share of the total deaths (8.9%) and Njombe the lowest (1.2%).

4. Maternal mortality remains high, especially in rural areas (63.8% of all maternal deaths) on the mainland, while Zanzibar recorded a higher share in urban areas (56.8%). Risk is notably high in adolescents (10-19 years), with most deaths in rural areas.

5. Disease was the leading cause of death (83.7 %), affecting females (86.2%) than males (81.7%).

6. Mortality was strongly linked to poverty, with the poorest households accounting for 22.3 percent of deaths compared to 16.1 percent in the wealthiest.

These findings highlight Tanzania's dual challenge: fertility is declining but remains elders. Patterns differ by setting: rural areas face preventable maternal, neonatal, and infectious causes; urban areas carry a rising burden at older ages and from injuries. The evidence points to place-sensitive, equity-first delivery, linking education, SRH, and primary health care with social protection and transport/referral systems. High in rural and poor populations, while mortality continues to affect children, mothers, and the

Priority recommendations

1. Keep girls in school and expand women's opportunities. Remove cost barriers; provide safe boarding/transport; scale cash-plus in rural districts; promote skills and livelihoods, key levers for lower fertility.

2. Guarantee high-quality SRH and maternal–newborn care. Ensure method choice and reliable FP supplies; adolescent-friendly services; universalise ANC, skilled birth attendance, EmONC readiness, and strong referral, especially in rural areas with high maternal mortality.

3. Strengthen rural primary health care (PHC). Staff, equip, and finance dispensaries/health centres; ensure access to essential medicines; expand the number of community health workers; and integrate outreach to hard-to-reach communities where most deaths occur.

4. Child survival package (0–4). Maximise immunisation, IMCI, malaria prevention/treatment, nutrition, and WASH; rapidly detect and treat pneumonia/diarrhoea; focus on high-burden rural councils.

5. Injury and NCD risk reduction in urban areas. Implement road safety and emergency care improvements; scale up screening/management of hypertension/diabetes for ageing urban populations.

6. Pro-poor financing and social protection. Fee waivers/vouchers and insurance subsidies for the poorest quintiles; link health services to cash transfers and nutrition platforms to tackle the mortality–poverty gradient.

7. Measure, publish, and use results. Track district-level fertility (including high-parity births) and cause-specific mortality; improve CRVS and cause-of-death certification; publish routine dashboards to drive local action.

Table 1: Summary of Key Birth and Death Indicators,2022 PHC

Region	Birth			Death		
	Total	Male	Female	Male	Female	Total
Tanzania	**1,479,155**	**882,089**	**597,066**	**254,672**	**206,022**	**460,694**
Rural	1,027,392	616,112	411,280	170,187	136,238	306,425
Urban	451,763	265,977	185,786	84,485	69,784	154,269
Mainland Tanzania	**1,424,543**	**850,996**	**573,547**	**247,356**	**199,803**	**447,159**
Dodoma	75,136	44,889	30,247	12,309	10,130	22,439
Arusha	55,156	33,543	21,613	6,919	5,252	12,171
Kilimanjaro	39,135	23,133	16,002	11,596	8,783	20,379
Tanga	69,432	38,930	30,502	15,557	13,045	28,602
Morogoro	66,357	40,258	26,099	14,098	12,238	26,336
Pwani	39,160	23,986	15,174	9,684	8,268	17,952
Dar Es Salaam	101,810	58,700	43,110	21,794	18,164	39,958
Lindi	22,052	13,197	8,855	6,757	5,696	12,453
Mtwara	34,239	19,220	15,019	10,119	8,478	18,597
Ruvuma	39,440	23,574	15,866	7,587	6,129	13,716
Iringa	23,542	14,119	9,423	4,628	3,626	8,254
Mbeya	51,222	29,582	21,640	9,634	8,151	17,785
Singida	53,094	31,390	21,704	6,933	5,865	12,798
Tabora	82,707	52,162	30,545	12,798	11,099	23,897
Rukwa	42,602	25,311	17,291	5,552	4,257	9,809
Kigoma	60,665	37,639	23,026	9,782	7,432	17,214
Shinyanga	52,273	32,868	19,405	7,570	6,251	13,821
Kagera	81,791	48,619	33,172	13,446	10,395	23,841
Mwanza	93,852	57,073	36,779	14,168	11,341	25,509
Mara	66,002	39,241	26,761	10,938	8,337	19,275
Manyara	46,866	28,374	18,492	5,934	4,093	10,027
Njombe	16,393	9,340	7,053	2,908	2,266	5,174
Katavi	30,444	17,853	12,591	3,816	2,837	6,653
Simiyu	62,520	37,588	24,932	7,373	5,881	13,254
Geita	83,975	49,659	34,316	10,211	7,785	17,996
Songwe	34,678	20,748	13,930	5,245	4,004	9,249
Tanzania Zanzibar	**54,612**	**31,093**	**23,519**	**7,316**	**6,219**	**13,535**
Kaskazini Unguja	7,762	4,254	3,508	913	758	1,671
Kusini Unguja	5,188	3,155	2,033	699	574	1,273
Mjini Magharibi	24,259	13,582	10,677	3,538	3,160	6,698
Kaskazini Pemba	9,047	5,322	3,725	1,196	943	2,139
Kusini Pemba	8,356	4,780	3,576	970	784	1,754

Source: Tanzania, 2022 PHC

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List of Abbreviations

CEB	-	Children Ever Born
HSSP	-	Health Sector Strategic Plan
NBS	-	National Bureau of Statistics
OCGS	-	Office of the Chief Government Statistician
PHC	-	Population and Housing Census
UN	-	United Nations
UNDP	-	United Nations Development Programme
UNFPA	-	United Nations Population Fund
URT	-	United Republic of Tanzania
WHO	-	World Health Organisation

Basic Concepts and Definitions

Birth is defined as the emergence of a baby or other young from the body of its mother; the start of life as a physically separate being. Determinants of birth included: socio-economic, maternal health, and reproductive history factors.

Birth Differential refers to the study of birth differences between specific population groups. In this monograph, birth differentials are discussed in relation to: place of residence, marital status, maternal education level, age, and occupation.

Census Night is a reference night of the census. The reference night for the Tanzania 2022 Population and Housing Census was the night of 22nd /23rd August 2022.

Childlessness is the condition of being without children.

Children Ever Born (CBE) The number of children ever born to a woman is a measure of her lifetime fertility experiences up to the moment at which the data were collected.

Death is defined as the end of the life of a person or organism. Some literature also defined it as a fact of dying. Determinants of death included socioeconomic, biological, behavioural, and environmental factors.

Death Differential refers to the analysis of disparities in mortality among specific population groups. This report examines how factors such as place of residence, marital status, maternal education level, age, and occupation influence death, shedding light on the socio-economic and demographic factors that contribute to variations in life expectancy and health outcomes within different communities.

Divorced Persons are those persons who were once married but whose marriages were permanently terminated and have not remarried. Note that in polygamous marriages, the divorce of one or more wives does not categorise the husband as divorced if he still lives with the other wife (wives).

Fertility refers to the number of births a woman can have, whereas fecundity is the biological ability of women to reproduce.

Household refers to a person or group of persons who reside in the same homestead or compound but not necessarily in the same dwelling unit, have the same cooking arrangements, and are answerable to the same household head, except for a collective household.

Infertility: The biological inability of a man, a woman, or a couple to conceive.

Live Birth is defined as the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which after separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered live-born.

Married: Persons who are formally married, irrespective of the type of marriage, which may be customary, civil or religious marriage.

Maternal Mortality: deaths occurring to women of reproductive age due to pregnancy and childbirth-related causes. Such deaths occur during pregnancy or delivery or within 42 days of delivery due to childbirth-related complications.

Parity is the number of children born alive to a woman.

Separated: Persons who were once married but now are living apart because the marriage has challenges.

Urban Area: For the 2022 PHC, the urban population consists of people living in areas legally recognised (gazetted) as urban, as well as all areas recognised by Local Government Authorities as urban.

The Wealth Index is a composite measure used to assess the relative economic status of individuals, households, or populations based on various factors, including asset ownership, housing characteristics, access to utilities, education level, and employment status. It is commonly used in demographic studies, especially in developing countries, to understand socio-economic disparities and inform policy decisions related to health, education, and economic development. By classifying individuals or households into different wealth categories, such as the poorest, middle, or wealthiest groups, the Wealth Index provides insights into socio-economic conditions without directly relying on income data, which can be difficult to report accurately.

Widowed: Persons whose marriages were terminated by death and have not remarried since. However, in polygamous marriages, the death of one or more wives does not make the husband a widower if he still has another wife (wives).

CHAPTER ONE

INTRODUCTION

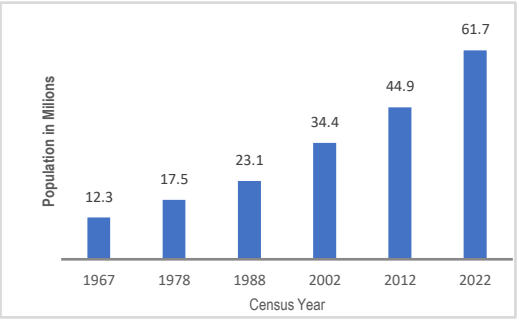
1.1 Background on the 2022 Population and Housing Census

National Bureau of Statistics (NBS), in collaboration with Office of the Chief Government Statistician (OCGS), Zanzibar, conducted PHC in the United Republic of Tanzania for 2022 in accordance with the Statistics Act CAP 351, requiring a census to be conducted every ten years. This is the sixth census, conducted after the Union of Tanganyika and Zanzibar in 1964, in accordance with international standards, particularly the United Nations Principles and Recommendations for population counts. Other censuses conducted include those of 1967, 1978, 1988, 2002, and 2012.

The Census, referenced as the night of 22nd/23rd August 2022, was undertaken on a de facto basis. Unlike the previous censuses, the 2022 PHC enumerated people based on place of residence on the census night. All persons found in the country were enumerated, regardless of nationality or citizenship. However, the enumeration planned for seven days took nine days. PHC 2022 utilised mobile technology for data and information collection, marking the first digital census in Tanzania.

The censuses show that Tanzania's population increased from 12.3 million in 1967 to 61.7 million people in 2022 (Figure 1.1). Furthermore, the average annual population growth rate in Tanzania increased from 2.7% in the 2002-2012 intercensal period to 3.2% in the 2012-2022 intercensal period.

Figure 1.1: Tanzania's Population since 1967 - 2022



1.2 Purpose of Birth and Death Monograph

This monograph uses the 2022 PHC to provide a clear, policy-ready picture of how births and deaths shape Tanzania's population. It quantifies levels and trends, and explains who is most affected, where, and why, by sex and age, as well as by residence (Mainland/Zanzibar, urban/rural), and by socio-economic characteristics (education, occupation, and wealth). Births and deaths, two of the three components of population

change (along with migration), are examined in depth to inform the planning and delivery of services.

The report adds value beyond earlier fertility and mortality monographs by explicitly integrating household wealth and women's socio-economic status at birth, and by presenting equity-focused differentials over time and space. It also summarises the population health context relevant to interpreting mortality patterns.

Practical uses. Findings are designed to:

1. inform health service planning, including SRH, maternal–newborn care, child survival, healthy ageing, and referral systems.

2. support epidemiological analysis and programme monitoring/audit against national targets.

3. guide resource allocation and review of development programmes; and

4. underpin evidence-based policy recommendations for the Government and partners working on human reproduction, primary health care, and social protection.

1.3 Census Questions on Birth and Death

The 2022 PHC used more questions on birth and death than the 2012 Census. In measuring birth and death, questions on marital status were the same. Regarding birth, questions on children ever born were the same, while the current birth had one question in 2022, compared with the two questions in 2012. The questions in 2012 were: how many male/female children were born alive to (Name) in the last 12 months, and how many male/female children were born alive in the previous 12 months, still alive. While in 2022, the question asked was how many male/female children were born alive in the 12 months preceding the Census. The 2022 PHC used six marital status categories: Never married, married, living together, divorced, separated, and widowed. The questions asked in the 2022 PHC was: "What is the current marital status of [NAME]?" (See Appendix 3 for more details).

The 2022 PHC Questionnaire had a total of eight questions directly related to mortality. Five of them enquired about the total number of deaths that occurred in a household by sex, age, and cause of death of the deceased. The questions on causes of death focused on whether it was road traffic accidents, other injuries, suicide, domestic violence, sickness/diseases, or maternal or other causes. The other three questions on maternal

deaths focused on whether it was during pregnancy, delivery, or six weeks after delivery (puerperium period). There were questions for the selected population related to orphanhood that sought information on whether one or both parents were alive or not. There were also questions on birth, which sought information on the number of children ever born alive and surviving to women aged 12-49. Such information is useful in the indirect estimation of death, which relies partially on model life tables in deriving childhood death and life expectancy. More details on questionnaires are provided in Appendix 3.

The questions on maternal deaths in the 2022 PHC facilitated a detailed analysis of maternal mortality in the country. Respondents in all households were asked whether any deaths occurred in the household in the last 12 months prior to the census reference date, and if so, the sex and age of the deceased at the time of death, and the cause of death, which allows the comparison with the 2022 Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS).

1.4 Quality of Birth and Death Data

Census data in Tanzania, like that in other countries, has coverage and content errors, which vary both in nature and magnitude from one region to another over time and space. Coverage errors result from the omission of certain pockets of population, while content errors pertain to misreporting or misclassification. Common census problems in developing countries were found. They had to be managed accordingly in this analysis, with more efforts on ensuring the generation of complete and accurate data on Birth and Death reports. The problems may include over/under-reporting of live births by younger women, under/over-reporting of live births by older women, and misreporting of the other types of events.

Birth estimates in this monograph are based on current and lifetime birth data. Errors that affect current birth data include the omission of births, incorrect recent birth dates, reference period errors, and the use of short periods, which create uncertainties in reported birth levels. Errors affecting lifetime birth data include possible misstatement of women's age, especially in early lifetime births, under-reporting of births to women above the age of 35, and unmarried adolescents who dislike being reported as mothers. Other errors in reported births are the omission of births to older women, mainly due to memory lapse, especially for those births that ended with an early child death. Older women also tend to forget to list in the household roster children born to another husband or man, or those who left the household soon after birth or were not present at home for various reasons. Errors in such data may also occur due to the inclusion of stillbirths and late foetal deaths. Other factors

may inflate the number of births, for example, the inclusion of step or adopted children or grandchildren, dead children, and parity of a sizeable proportion of women who did not disclose parities (Kumar and Yadav, 2024; UN, 1983).

The age and sex structure of a population is also important in explaining the levels, patterns, and trends of birth and death. Hence, the quality of age data is primarily assessed by examining the extent of age misreporting and age heaping among women of reproductive age. Furthermore, examining average parities, parity distributions, and the proportion of childless women would provide further insights into the quality of birth data reporting for various cohorts. Therefore, validation of such data is embedded in cultural norms and practices that determine respondents' perceptions and engagement with marital status and conditions. Given the possibilities of these distortions, caution needs to be taken in interpreting reported data. In this situation, indirect techniques shouldn't be avoided.

1.5 Methodology

1.5.1 Data Collection Method and Information Collected

Tanzania has collected socio-demographic data to evaluate birth and death patterns and trends, as well as other general characteristics of its population, for over five decades since 1967. These are the Population and Housing Censuses for the years 1967, 1978, 1988, 2002, 2012, and 2022. The 2022 PHC provided an opportunity to analyse relevant data on birth and death, where most determinants of birth and death may be obtained. Birth data in censuses includes information on recent births (live births occurred in households in the 12 months preceding the census), and about lifetime births (live children ever born in the woman's reproductive life). Questions about live births in the past 12 months enable the measurement of the current birth rate. Information on all live births (i.e., ever-born children) is used to determine the past childbearing ages of women (i.e., lifetime fertility). Death data in censuses provides information on recent deaths (deaths that occurred in households in the 12 months preceding the census). Questions about deaths in the last 12 months enable the measurement of the current death rate.

1.5.2 Limitations of Birth and Death Data

There are weaknesses in the birth and death data source, and this includes the lack of data on birth intervals, nutrition, sanitation, behavioural (smoking, excessive alcoholism, drug use), disease typology, ethnicity, and access to health services and facilities, which are not collected in relation to either deaths or births. In addition, defining the socio-economic status from birth and death registration records is very difficult and possibly even more tenuous

for single mothers. Death records are not reliable as a picture of the burden of morbidity of chronic illness; more people are living longer with illness than in the past; however, the PHC of 2022 did not capture the diseases that cause death in the households (Appendix 3).

Age at First Marriage (AFM) and Age at First Birth (AFB) data were not collected in the 2022 PHC. The lack of AFM and AFB data may have significant consequences in various demographic, public health, and socioeconomic contexts. AFM often correlates with an interruption in girls' education. Without data, programmes aiming to improve educational level attainment and delay marriage might become less effective. On the other hand, it is difficult to analyse birth timing, which is critical for understanding population growth and reproductive behaviour without AFB data. Therefore, we recommend that AFM and AFB be taken into account in future Censuses to deepen the understanding of the determinants of gender inequalities in our communities.

Data on deaths from censuses was scrutinised all along. This is due to possible errors in reporting or measurement biases that may affect the quality of data. Respondents in households may be reluctant to report a recent death of a household member, or if it occurred to an infant, especially in the first few days of birth, or if the death occurred elsewhere. There are also problems in identifying causes of death or misreporting the age of the deceased, or the way questions were asked, or the probing on deaths, coupled with characteristics of the respondents, may cause errors in the reported deaths.

1.6 Organisation of the Report

The report is organised for ease of use. Chapter Two presents the birth analysis, highlighting the residence, age, education, marital status, occupation, and wealth gradients, as well as the role of parity and maternal history. Chapter Three examines deaths, illustrating how mortality rates vary by place, age, and sex, and summarises maternal and cause-of-death profiles alongside the wealth gradient. Chapter Four draws the evidence together into a clear set of conclusions and policy recommendations. The aim throughout is straightforward: to move from counts to consequences, pinpointing who is most affected, where and why, so that resources can be targeted where they will have the greatest impact.

CHAPTER TWO

BIRTH ANALYSIS

Key Points

- About 69.5 percent of births in Tanzania occurred in rural areas, while only 30.5 percent were in urban areas, reflecting socio-economic and cultural differences
- Women aged 25–34, contributed nearly half of all births. Fertility rates declined significantly after age 35, with minimal births recorded in women aged 45–49
- Women typically begin childbearing early, with 1–3 children common at ages 20–29, 3–5 children at ages 30–39, and increasingly report 6 or more children at ages 40–54, reflecting a steady progression toward higher parity as age advances despite fewer women in older groups.
- Women with primary education accounted for the largest share of births (57.1%), while those with higher education contributed 3.8 percent.
- Around 76 percent of births occurred within marriage, with cohabiting women contributing about 9 percent. In Zanzibar, the proportion of births within marriage was higher (91.9%), compared to Tanzania Mainland (75.4%)

2.1 Introduction

Tanzania has experienced a gradual decline in birth rates up to 2022. The crude birth rate declined from above 40 births per 1,000 population in earlier decades (1970s-2000s) to approximately 35.6 in 2022, marking a steady downward trend. The total fertility rate also declined, reaching around 4.6 children per woman in 2022, compared to 6.2 in the 1980s and 1990s. This reflects changes in socioeconomic conditions, increased education, and wider access to family planning services.

Despite the lower fertility rate, the total number of births remains high because of the demographic transition. Urban areas show lower fertility compared to rural areas, which slows the overall national decline. The data indicate that while fertility and birth rates are steadily reducing, population growth will likely continue for some time due to the youthful population structure.

Birth, being an emergence of a baby from the mother, is a key driver of population dynamics in any society. Birth analysis is closely tied to a society's economic conditions, underscoring a broader connection between population dynamics and socio-economic development. Examining birth in the context of socio-economic factors is therefore vital for developing policies that promote balanced human population growth and sustainable development.

The analysis discussed in this chapter relies on two main data points: (1) reported live births within the past 12 months, categorised by the mother's age at the time of the census, and (2) the total number of children ever born, also categorised by the mother's age. This information has enabled the analysis of socioeconomic differentials in birth by Place of Residence (Tanzania, Mainland Tanzania, and Tanzania Zanzibar), Age Group, Sex, Region, and Rural and urban areas. Reproductive history differentials of birth were also analysed through parity.

2.2 Birth Differentials in Tanzania

Birth differentials in developing countries can be influenced by a variety of factors, including place of residence, education, age at first union, family planning, socioeconomic conditions, and cultural practices. Other factors include child mortality, family size, polygamy, and the practice of levirate marriage (URT, 2025a; Ezeh and Zulu, 2004). Birth differentials in this chapter are discussed in relation to rural/urban residence, household wealth index, marital status, maternal education, maternal age, maternal occupation, and the reproductive history of a mother, specifically parity. As noted by Ezeh and Zulu (2004), socioeconomic factors often influence health-related outcomes; for example, lower maternal education can lead to higher birth risks, while wealth improves access to healthcare, resulting in a reduction in mortality rates. Health systems accessibility and cultural practices also play significant roles, highlighting the need for integrated interventions addressing both social disparities and health care quality to reduce death risks.

2.3 Distribution of Birth by Place of Residence

Tanzanian women are estimated to have given 1,479,155 births in the 12 months prior to the 2022 PHC (Table 2.1). The results show a significant variation in rural-urban birth rates in Tanzania, with a large proportion of births occurring in rural areas. These differences are likely influenced by the distribution of populations across rural and urban areas, as observed in the 2022 Tanzania Population and Housing Census. Among males, 69.8 percent were born in rural areas, and for females, 68.9 percent were born in rural areas, collectively making up 69.5 percent of the total births. Urban areas have a smaller share of births, with

30.2 percent of males and 31.1 percent of females, making 30.5 percent of the total births that occurred in urban areas. This distribution highlights the predominance of rural births in Tanzania, especially when compared to urbanization trends.

The majority of Tanzanians were born in Mainland Tanzania, accounting for 96.3 percent of the total births, with 96.5 percent of the births being males and 96.1 percent being females, reflecting a consistent trend across both sexes. Within Mainland Tanzania, Regions like Dar es Salaam (7.1%), Mwanza (6.6%), and Tabora (5.8%) have reported the highest number of births compared to Regions like Njombe and Katavi, which reported less than 2%.

In Zanzibar, the reported births account for 3.7 percent of the total births, with 3.5 percent males and 3.9 percent females. Mjini Magharibi stands out with the highest birth proportion of 44.4 percent, followed by Kaskazini Pemba (16.6%) and Kusini Pemba (15.3%). The remaining Regions, such as Kusini Unguja and Kaskazini Unguja, show slightly smaller proportions, with Kaskazini Unguja 14.2 percent and Kusini Unguja contributing 9.5 percent of the total births. This highlights a higher concentration of births in urban Tanzania, Zanzibar, and specific regions within Mainland Tanzania.

The urban-rural differential in birth rates is well-documented in fertility studies, with urban areas generally demonstrating lower fertility rates than rural areas (URT, 2025a). The difference may be caused by various socio-economic, cultural, and healthcare access factors (Chelogoi et al., 2020). This is simply because children in rural settings are seen as a source of family labour and old-age social security. This is contrary to urbanisation, which may lead to changes in family dynamics, priorities, and access to resources, contributing to smaller family sizes (Geovani et al., 2021).

Generally, urban birth rates, especially in developing countries, are lower than rural birth rates, as shown in Table 2.1. Studies show that, on average, urban births in sub-Saharan Africa are almost 30 percent lower than rural births (Shapiro, 2015). Results from the 2022 Tanzania PHC show a similar pattern, with the total birth rate in rural areas being higher (5.3 children per woman) compared with that of urban areas (3.8 children per woman), implying that, on average, women living in rural areas have about two children more than those living in urban areas (URT, 2025a). Variations observed in births between rural and urban areas are probably due to, among other factors, differences in socio-economic development between rural and urban areas in the country.

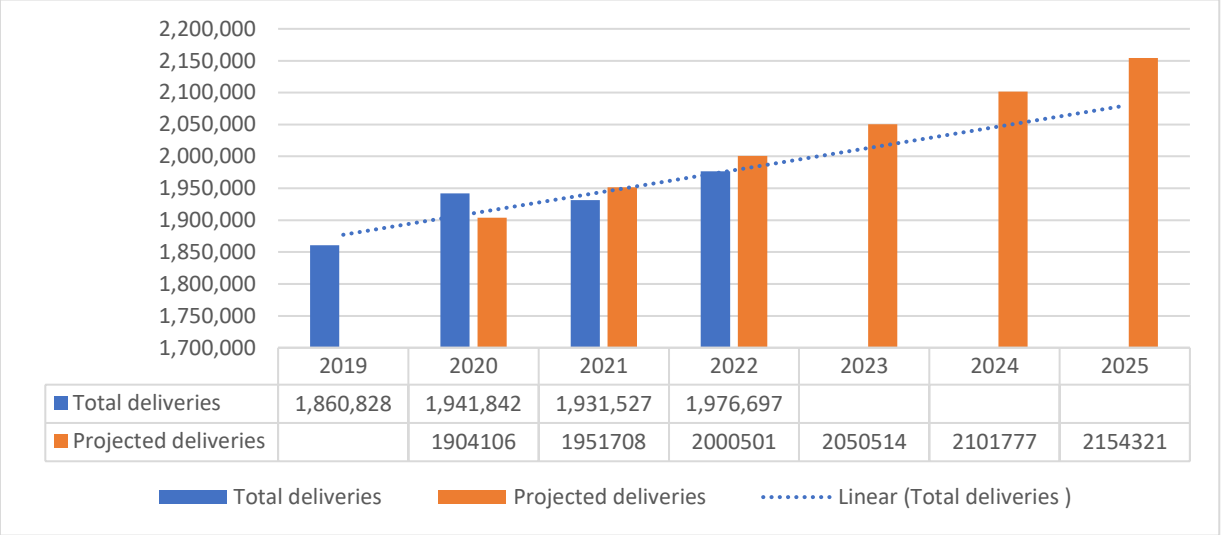
Table 2.1: Percentage Distribution of Birth by Place of Residence and Region; Tanzania Mainland, 2022 PHC

Place of Residence	Birth			Birth Percentage		
	Both Sexes	Male	Female	Male	Female	Both Sexes
Tanzania	**1,479,155**	**882,089**	**597,066**	**59.6**	**40.4**	**100**
Rural	1,027,392	616,112	411,280	69.8	68.9	69.5
Urban	451,763	265,977	185,786	30.2	31.1	30.5
Mainland Tanzania	**1,424,543**	**850,996**	**573,547**	**96.5**	**96.1**	**96.3**
Dodoma	75,136	44,889	30,247	5.3	5.3	5.3
Arusha	55,156	33,543	21,613	3.9	3.8	3.9
Kilimanjaro	39,135	23,133	16,002	2.7	2.8	2.7
Tanga	69,432	38,930	30,502	4.6	5.3	4.9
Morogoro	66,357	40,258	26,099	4.7	4.6	4.7
Pwani	39,160	23,986	15,174	2.8	2.6	2.7
Dar Es Salaam	101,810	58,700	43,110	6.9	7.5	7.1
Lindi	22,052	13,197	8,855	1.6	1.5	1.5
Mtwara	34,239	19,220	15,019	2.3	2.6	2.4
Ruvuma	39,440	23,574	15,866	2.8	2.8	2.8
Iringa	23,542	14,119	9,423	1.7	1.6	1.7
Mbeya	51,222	29,582	21,640	3.5	3.8	3.6
Singida	53,094	31,390	21,704	3.7	3.8	3.7
Tabora	82,707	52,162	30,545	6.1	5.3	5.8
Rukwa	42,602	25,311	17,291	3	3	3
Kigoma	60,665	37,639	23,026	4.4	4	4.3
Shinyanga	52,273	32,868	19,405	3.9	3.4	3.7
Kagera	81,791	48,619	33,172	5.7	5.8	5.7
Mwanza	93,852	57,073	36,779	6.7	6.4	6.6
Mara	66,002	39,241	26,761	4.6	4.7	4.6
Manyara	46,866	28,374	18,492	3.3	3.2	3.3
Njombe	16,393	9,340	7,053	1.1	1.2	1.2
Katavi	30,444	17,853	12,591	2.1	2.2	2.1
Simiyu	62,520	37,588	24,932	4.4	4.3	4.4
Geita	83,975	49,659	34,316	5.8	6	5.9
Songwe	34,678	20,748	13,930	2.4	2.4	2.4
Tanzania Zanzibar	**54,612**	**31,093**	**23,519**	**3.5**	**3.9**	**3.7**
Kaskazini Unguja	7,762	4,254	3,508	13.7	14.9	14.2
Kusini Unguja	5,188	3,155	2,033	10.1	8.6	9.5
Mjini Magharibi	24,259	13,582	10,677	43.7	45.4	44.4
Kaskazini Pemba	9,047	5,322	3,725	17.1	15.8	16.6
Kusini Pemba	8,356	4,780	3,576	15.4	15.2	15.3

Source: Tanzania, 2022 PHC

Figure 2.1 shows that the Health Sector Strategic Plan (HSSP V) projected total births in Tanzania to reach approximately 2,154,321 by 2025, with actual deliveries rising from 1.86 million in 2019 to nearly 1.98 million in 2022, and projections indicating a steady increase to 2.15 million by 2025. The linear trend reflects sustained population growth and high fertility levels. Furthermore, in 2022, the routine health data from the DHIS reported that 82 percent of all births in Mainland Tanzania occurred in health facilities, indicating more than two million deliveries higher than those captured in the Census. This discrepancy suggests potential underreporting in the Census, likely due to recall errors, gaps in household reporting, or new-borns not being recorded if absent from the household at the time of enumeration.

Figure 2.1: Current and projected number of deliveries HSSP V lifespan (estimated population of 65M by 2025)



	2019	2020	2021	2022	2023	2024	2025
Total deliveries	1,860,828	1,941,842	1,931,527	1,976,697			
Projected deliveries		1904106	1951708	2000501	2050514	2101777	2154321

Source: Tanzania, 2022 HSSP

2.4 Distribution of Birth by Age Group of Mothers

The data on births by age group reveal that in the year preceding the census, a total of 2,687,934 women of reproductive age gave birth. Out of the total aforementioned births, 1,944,870 (72%) are males, while 743,064 (28%) are females, as presented in Table 2.2. This aligns with HSSP V projections and DHIS data presented in Figure 2.1. Generally, the results revealed that the total number of births changes as women age, with a noticeable shift in birth patterns and trends across different age groups. In the 10-14 age group, no births are recorded, which is expected since this group is generally not engaged in childbearing, and most of them are still in primary school. In the 15-19 age group, the total number of births accounts for 3.8 percent of total births, reflecting limited childbearing in early adolescence, as many of these individuals are in secondary school.

In the 20-24 age group, the total number of births rises to 17.0 percent of the total births. This group shows a significant increase in childbearing, with women in this age group contributing to nearly a fifth of total births, and the trend continues towards higher birth rates in the next age groups. The 25-29 age group accounts for 22.8 percent of total births, making it one of the most fertile periods in a woman's reproductive life. In the 30-34 age group, the total number of births increases to 23.7 percent of the total births, reflecting the continuing trend of higher fertility in women's reproductive cycle. This group shows a higher percentage of women with an increasing number of births in their 30s.

The 35-39 age group accounts for 20.2 percent of total births. The total number of births in this group starts to decrease slightly, reflecting the natural decline in fertility of women as

their age increases, although the percentage remains notable. In the 40-44 age group, the total number of births is 9.2 percent, indicating a further decline in the number of births as women reach their 40s. Fertility rates continue to decrease, but this age group still contributes to a notable portion of total births, especially in women who have children later in life. The 45-49 age group contributes 3.2 percent of total births, indicating a substantial decline as fertility rates continue to drop further. Births in this age group are less frequent but still present, reflecting the fact that some women continue to have children into their late 40s. In the 50-54 age group, no births are recorded, reflecting the end of the childbearing for most women.

Overall, births are concentrated in ages 25–34 and diminish steadily beyond 35, a pattern consistent with wider East African and Sub-Saharan African profiles. These age-specific patterns underscore the importance of prioritising maternal health and family planning services for women in their reproductive prime, while sustaining adolescent SRH efforts to keep early pregnancies low and tailoring services for older mothers (Bongaarts & Casterline, 2013; Shumet & Geda, 2024).

Table 2.2: Percentage Distribution of Distribution of Birth by Age Group of Mothers and Place of Residence; Tanzania Mainland, 2022 PHC

Women Age	Birth			Birth Percent		
	Male	Female	Both Sexes	Male	Female	Both Sexes (%)
Total	**1,944,870**	**743,064**	**2,687,934**	**72**	**28**	**100**
10-14	0	0	0	0	0.0	0.0
15 - 19	95,971	7,294	1,03,265	4.9	1.0	3.8
20 - 24	369,870	87,012	456,882	19	11.7	17.0
25 - 29	449,586	164,130	613,716	23.1	22.1	22.8
30 - 34	442,934	194,379	637,313	22.8	26.2	23.7
35 - 39	365,961	177,562	543,523	18.8	23.9	20.2
40 - 44	164,509	83,947	248,456	8.5	11.3	9.2
45 - 49	56,039	28,740	84,779	2.9	3.9	3.2
50 - 54	0	0	0	0.0	0.0	0.0

Source: Tanzania, 2022 PHC

2.5 Social Economic Differentials of Birth

Birth is normally influenced by the wealth status of the household, which in turn may have effects on educational level, marital status, and occupation. The socio-economic differential of birth in this monograph was analysed through maternal education level, marital and occupational status.

2.5.1 Birth by Education Level

The 2022 PHC findings revealed that Tanzania has a significant variation in rural-urban birth numbers by educational attainment. Table 2.3 shows that a large number of births (1,026,622), which is approximately 70 percent of the total births, were reported in rural areas, and 451,057 (30.5%) in urban areas. Furthermore, 57.1 percent of the woman population who gave birth have attained primary education, with rural areas showing a higher proportion of births (60.1%) compared to urban areas (50.3%). Secondary education remains limited at 20 percent, with urban areas showing a higher proportion of births (32.6%) compared to rural areas (14.5%).

Women with higher education attainment are still modest, contributing only 3.8 percent of the total births, with urban areas showing a higher proportion of births (8.6%) compared to rural areas (1.6%). A significant proportion of women population (18.1%) has never attended school, with rural areas showing a higher proportion of births (23.1%) compared to urban areas (6.7%). Overall, the disparity between rural and urban educational attainment underscores the need for targeted interventions to enhance access to and quality of education, particularly in rural areas.

Mainland Tanzania mirrors the national trend of having a higher birth rate in the rural population (70.1%), with educational attainment significantly influenced by residence. Women with Primary education are more prevalent, contributing to 58.5 percent of the total births. However, rural areas (61.1%) have a higher birth proportion than urban areas (52.2%). This is followed by women with Secondary education, who contribute 18.5 percent of the total births. Notably, rural areas have a significantly lower percentage (13.3%) compared to urban areas (30.7%). A significant portion of births (18.4%) occurred among women who had never attended school, particularly in rural areas (23.4%). Women with Higher education are contributing only 3.6 percent of the total births, with urban areas showing a higher proportion of births (8.4%) compared to rural areas (1.5%). This highlights a clear need for improved educational infrastructure and policies to support secondary and tertiary education.

In Tanzania Zanzibar, the trend of births is higher in rural areas (54.3%) compared to urban areas (45.7%). The women with Secondary education contribute to 60.6 percent of the total births. However, urban areas have a higher birth proportion (64.8%) than rural areas (57.0%). Women with Primary education account for 21.1 percent of the total births. Urban areas have a lower percentage (17.7%) compared to rural areas (23.9%). The women who have never attended school contributed 8.7 percent of the total births, with rural areas

having a higher birth proportion (12.7%) compared to urban areas (4.0%). Women with higher education are contributing 3.6 percent of the total births, with urban areas showing a higher proportion of births (8.4%) compared to rural areas (1.5%).

Education level is an important factor in determining birth levels in any society. Education facilitates the acquisition of information on family planning and is associated with the use of more effective contraceptive methods. It also increases husband-wife communication and imparts a sense of control over one's destiny, which may encourage attempts to control childbearing. Furthermore, education increases couples' income potential, making a wide range of contraceptive methods affordable and delaying entry into marital unions and, in so doing, reducing fertility. Regions with lower educational attainment tend to have higher TFRs, because limitations in education can lead to early marriages and less use of family planning(Bongaarts, 2020; Götmark & Andersson, 2020).

Table 2.3: Percentage Distribution of Women's Social Economic Differentials of Birth by Education and Place of Residence; Tanzania Mainland, 2022 PHC

Social Economic Variables	Tanzania			Mainland Tanzania			Tanzania Zanzibar		
	Total	Rura	Urban	Total	Rural	Urban	Total	Rural	Urban
Total	1,477,679	69.5	30.5	1,423,099	70.1	29.9	54,580	54.3	45.7
Education Attainment									
Pre-Primary	1,853	0.1	0.2	1,810	0.2	0.1	43	0.1	0.1
Primary	844,289	57.1	60.1	832,782	61.1	52.2	11,507	23.9	17.7
Post-Primary training	1,134	0.1	0.1	1,114	0.1	0.1	20	0.0	0.0
Pre-Form One	492	0.0	0.0	194	0.0	0.0	298	0.7	0.3
Secondary	296,479	20	14.5	263,394	13.3	30.7	33,085	57.0	64.8
Post-Secondary training	10,484	0.7	0.4	10,279	0.4	1.4	205	0.3	0.5
University & Other	55,675	3.8	1.6	51,027	1.5	8.4	4,648	5.2	12.5
Special Education	8	0.0	0.0	7	0.0	0.0	1	0.0	0.0
None/Never Attended	267,265	18.1	23.1	262,492	23.4	6.9	4,773	12.7	4.0

Source: Tanzania, 2022 PHC

2.5.2 Births by Marital Status

The relationship between marital status and total births is a key area in population change studies, since marital status significantly impacts birth patterns and trends. The results in Table 2.4 show that in Tanzania, a large proportion of total births (76%) occurs within marriage, with rural areas contributing 77.7 percent, slightly outpacing urban areas (72.2%). Never-married individuals contributed 9.7 percent of the total births, with urban areas (13.2%) compared to rural areas (8.2%). Living together accounts for 9.1 percent of the total births, with urban areas (9.9%) compared to rural areas (8.8%). Divorced individuals account for 2.7 percent of the total births, with rural areas (2.8%) slightly lower than urban areas (2.5%). Separated individuals contribute 1.6 percent of the total births, with no significant difference between rural and urban areas. Widowed individuals account for 0.8 percent of births, with rural areas (0.9%) having a marginally higher birth rate than urban

areas (0.7%). This implies that Married women have higher birth rates than unmarried women (single, separated, divorced, or widowed). This is because marriage typically provides a stable social and economic environment conducive to childbearing.

In Mainland Tanzania, 75.4 percent of the total births occur within marriage, with rural areas (77.2%) having higher birth rates than urban areas (71.2%). Never-married individuals accounted for 10 percent of the total births, with urban areas (13.7%) exhibiting a significantly higher birth rate than rural areas (8.4%). Living together contributed 9.4 percent of the total births, with urban areas (10.4%) having a higher rate than rural areas (9.0%). Divorced women contributed 2.7 percent of the total births, with rural areas (2.8%) slightly higher than urban areas (2.4%). Separated women account for 1.6 percent of the total births, with rural areas (1.7%) showing a marginally higher birth rate than urban areas (1.6%). Widowed women contributed 0.8 percent, with rural areas (0.9%) having a slightly higher birth rate than urban areas (0.7%). The findings suggest that a significant proportion of births occur among married women compared to unmarried women.

In Zanzibar, 91.9 percent of total births occur within marriage, with no significant difference between rural (91.9%) and urban (90.8%) areas, respectively. Never-married individuals contributed 2.5 percent of total births, with urban areas (3.2%) having slightly higher births than rural areas (2.5%). Living together accounts for just 0.8 percent of the total births, with urban areas (0.9%) having a marginally higher birth rate than rural areas (0.8%). Divorced women contributed 4.1 percent of the total births, with urban areas (4.4%) having slightly higher births than rural areas (4.1%). Separated women contributed only 0.3 percent of total births, with no significant difference between rural and urban areas. Widowed women contributed 0.4 percent of births, with no major variation between rural and urban areas. This implies that Tanzania Zanzibar has a large proportion of total births occurring in marriage (91.9%) compared to Mainland Tanzania (75.4%).

The results, as mentioned earlier, showed that married women generally have higher birth rates than unmarried women (single, separated, divorced, or widowed). This finding contradicts the observations by Osterman et al. (2022), who noted a decreasing trend in births among both married and unmarried women, regardless of whether marriage provides a stable social and economic environment conducive to childbearing. Furthermore, cohabitation in many regions is becoming increasingly common and is often associated with births, similar to marriage, especially in contexts where cohabiting relationships are socially accepted and legally recognised. Cohabitating women may exhibit birth rates closer to those of married women, though this can vary by region and cultural context (Lesthaeghe,

2010). In Tanzania, unlike many other countries in Sub–Saharan Africa, marriage is a strong determinant of birth, as women are expected to bear children once they are married.

Table 2.4: Percentage Distribution of Births by Marital Status and Place of Residence; Tanzania Mainland, 2022 PHC

Marital Status	Total			Mainland Tanzania			Tanzania Zanzibar		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
Total	**1,478,701**	**69.5**	**30.5**	**1,424,089**	**70.0**	**30.0**	**54,612**	**54.3**	**45.7**
Never Married	143,976	8.2	13.2	142,622	8.4	13.7	1,354	2.5	3.2
Married	1,123,957	77.7	72.2	1,073,764	77.2	71.2	50,193	91.9	90.8
Living Together	134,821	8.8	9.9	134,381	9	10.4	440	0.8	0.9
Divorced	40,296	2.8	2.5	38,060	2.8	2.4	2,236	4.1	4.4
Separated	23,410	1.6	1.5	23,244	1.7	1.6	166	0.3	0.3
Widowed	12,241	0.9	0.7	12,018	0.9	0.7	223	0.4	0.4

Source: Tanzania, 2022 PHC

2.5.3 Birth by Occupation of Women

Birth rates often vary by occupation, as different types of work are associated with varying socio-economic conditions, time demands, cultural norms, and job security levels. Occupations requiring higher education or extensive time commitments, such as professional and managerial roles, tend to be associated with lower birth rates in developing countries. Women in these occupations often have fewer children due to career priorities.

It can be observed from Table 2.5 that in Tanzania, Agriculture, Forestry, and Fishing is the largest sector contributing to total births, particularly in rural areas for both Mainland Tanzania and Tanzania Zanzibar, where a significant portion of the population is involved in agricultural activities. In rural areas, the share of births linked to agriculture is very high, 81.7 percent in Mainland Tanzania and 39.4 percent in Zanzibar. Women in these sectors often have higher birth rates due to the rural lifestyle, where agriculture remains the primary means of livelihood. This sector's dominance reflects the reliance of rural families on farming and fishing for survival, which traditionally encourages larger family sizes.

The Wholesale and Retail Trade sectors also play a major role in contributing to births, particularly in urban areas. In Tanzania, both on the mainland and in Zanzibar, urban women engaged in trade activities experienced a notable increase in births, with urban areas having a higher concentration of women working in this sector. In Zanzibar, Wholesale and Retail Trade contributes 8.7 percent of the total births, while in Mainland Tanzania, the contribution is 6.6 percent. This sector often sees women running small businesses, markets, and informal shops, which could correlate with higher birth rates due to improved access to economic independence and stability within urban environments.

In both Mainland Tanzania and Zanzibar, the Accommodation and Food Services sector has a significant impact on the total birth rate, particularly in urban areas. This sector encompasses activities such as running restaurants, hotels, and catering services, which attract a significant number of women. In Zanzibar, the Accommodation and Food Services sector accounts for 9.4 percent of the total births, with a notable contribution from urban areas. In Mainland Tanzania, the contribution is 5.0 percent, with urban areas again showing higher births (10.2%) than rural areas (3.1%). This trend may reflect the urbanisation of women working in service industries, where employment opportunities, improved living conditions, and urban family dynamics contribute to higher birth rates among these women.

The three sectors, including Agriculture, Wholesale and Retail Trade, and Accommodation and Food Services, play pivotal roles in shaping birth patterns and trends across Tanzania. Rural areas contribute more to agriculture, while urban areas have a more diversified contribution from trade and service industries, which in turn influences the total birth rate.

According to Owoo & Lambon-Quayefio (2022), occupations with better job security, maternity benefits, and flexible work options can positively influence births by reducing the opportunity cost of childbearing. On the other hand, women in informal or low-income occupations may have higher fertility rates than those in formal, stable employment due to socio-economic constraints and limited access to family planning resources.

Table 2.5: Percentage Distribution of Birth by Occupation of Women and Place of Residence; Tanzania Mainland, 2022 PHC

Births By Occupation Status	Tanzania			Mainland Tanzania			Tanzania Zanzibar		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
Total	**1,129,704**	**72.5**	**27.5**	**1,094,916**	**72.8**	**27.2**	**34,788**	**61.1**	**38.9**
Agriculture, forestry, and fishing	779,474	81.7	35.6	769,470	**72.8**	**27.2**	10,004	39.4	12.0
Mining and quarrying	16,425	1.3	1.9	15,743	82.8	36.6	682	2.5	1.1
Manufacturing	16,339	0.8	3.1	14,647	1.2	2.0	1,692	4.8	5.0
Electricity, gas, steam and air conditioning supply	532	0.0	0.1	512	0.7	3.1	20	0.0	0.1
Water supply, sewage waste management, and remediation activities	752	0.0	0.1	703	0.0	0.1	49	0.1	0.2
Construction	2,223	0.1	0.4	2,132	0.0	0.1	91	0.3	0.3
Wholesale and retail trader repair of motor vehicles and motorcycles	74,803	3.6	14.6	71,767	0.1	0.4	3,036	7.1	11.3
Transportation and storage	2,915	0.1	0.7	2,788	3.5	14.7	127	0.2	0.6
Accommodation and food service activities	58,060	3.2	10.3	54,788	0.1	0.7	3,272	8.3	11.2
Information and communication	1,607	0.0	0.4	1,357	3.1	10.2	250	0.4	1.2
Financial and insurance activities	4,166	0.1	1.1	3,892	0.0	0.4	274	0.4	1.4
Real estate activities	1,953	0.1	0.3	1,871	0.1	1.1	82	0.2	0.3

Births By Occupation Status	Tanzania			Mainland Tanzania			Tanzania Zanzibar		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
Professional scientific and technical activities	9,111	0.4	1.8	8,068	0.1	0.3	1,043	2.4	4.0
Administrative and support services activities	39,566	2.0	7.5	35,909	0.4	1.7	3,657	9.1	12.7
Public administration and defence compulsory social security	4,056	0.1	0.9	3,371	1.8	7.3	685	1.1	3.3
Education	14,930	0.7	3.0	12,547	0.1	0.8	2,383	5.3	9.3
Human health and social work activities	8,903	0.4	1.8	8,110	0.5	2.8	793	1.4	3.6
Arts, entertainment, and recreation	4,570	0.2	0.9	3,917	0.4	1.7	653	1.7	2.2
Other service activities	46,366	2.1	9.4	43,172	0.2	0.9	3,194	7.3	12.1
Activities of households as employers; undifferentiated goods and services -producing activities of households for own use	41,923	2.9	5.8	39,235	2.0	9.3	2,688	7.7	7.8
Activities of extraterritorial organizations and bodies.	1,030	0.1	0.2	917	2.8	5.7	113	0.3	0.4

Source: Tanzania, 2022 PHC

2.5.4 Differentials of Birth by Wealth Index

The wealth index is derived from quantiles. The lower quantiles represent the poorest population, followed by the second quantile, which indicates the relatively poorer population. The middle quantile represents the average wealth of the population, while the fourth and fifth quantiles represent the wealthier portions of the population, respectively.

Table 2.6 illustrates the distribution of births across different wealth quintiles, showing both the total number of births and the percentage of births within each quintile. The total number of births is 1,479,155, with the lowest wealth quintile having the highest share at 25.9 percent (383,617 births). The second wealth quintile accounts for 334,755 births (22.6%), while the middle quintile represents 284,096 births (19.2%). The fourth quintile has 236,196 births (16.0%), and the highest wealth quintile has a slightly higher share of 240,491 births (16.3%). This data provides insight into how birth distribution varies across different wealth levels, with a noticeable concentration of births in the lower to middle wealth quintiles.

In developing countries, fertility rates often vary significantly across different wealth groups, with wealthier households typically having fewer children. This pattern is particularly evident in Sub-Saharan Africa, where disparities in fertility rates between the rich and poor are pronounced.

A study analysing data from 64 low- and middle-income countries found that wealthier households generally have lower birth rates. However, this relationship is not uniform; in some contexts, wealthier individuals may have more children, especially in rural areas where children are seen as economic assets. The study emphasizes the importance of

considering both wealth and education when examining birth patterns and trends (Low, 2017).

In Ethiopia, for example, a study utilising data from the 2016 Demographic and Health Survey revealed that women in the poorest wealth quintile had a higher fertility preference, desiring an average of 5.3 children, compared to 3.9 children among women in the richest quintile. This disparity was attributed to factors such as education, media exposure, and differences between urban and rural residences. The study highlighted that media exposure and education were significant contributors to reducing the wealth-related disparity in birth preferences (Alemu et al., 2024).

Table 2.6: Percentage Distribution of Differentials of Birth by Wealth Index and Place of Residence; Tanzania Mainland, 2022 PHC

Wealth Quintile	Birth			
	Both Sexes	Both Sexes	Male	Female
Total	**1,479,155**	**100.0**	**59.6**	**40.4**
Lowest	383,617	25.9	60.0	40.0
Second	334,755	22.6	60.9	39.1
Middle	284,096	19.2	60.7	39.3
Fourth	236,196	16.0	59.0	41.0
Highest	240,491	16.3	56.6	43.4

Source: Tanzania, 2022 PHC

2.5.5 Maternal Reproductive History and Birth

Maternal reproductive history is important in determining the birth rate in a society. It included the differential in parity and the ability to bear children. Parity distribution is crucial in assessing birth patterns and trends, as well as reproductive behaviours within different demographic groups, as it provides insights into family size preferences, birth rates, and potential implications for population growth.

In Table 2.7, the 2022 PHC results reveal that among women aged 10-14, 100 percent have zero parity, indicating that this age group has not yet begun childbearing. Furthermore, in the 15-19 age group, there is a significant number of parities, with 66 percent of women having 1 to 3 children. However, the number of women with one child (27.5%) and two children (6.5%) starts to appear, though the overall birth rate in this group remains relatively low. This implies that most women in this age group are in school and unmarried.

Among women aged 20-24, there is a notable increase in births, with 22.9 percent having one child, 37.1 percent having two children, and 26.1 percent having three or more children. As women progress into the 25-29 age group, birth rates continue to rise, with a large

proportion of women having two children (18.1%) or three children (26.4%), and a significant number having four children (25.5%).

Overall, the proportion of births per woman continues to increase in the 30-34 age group, with women having a higher number of children; specifically, 21.2 percent have five children, and 20.2 percent have four children. The pattern of increasing birth rates continues through the 35-39 and 40-44 age groups, with many women having six or more children, peaking at 18.0 percent of women in the 40-44 age group having eight or more children. These age groups correspond to the peak of a woman's reproductive cycle throughout her lifetime.

In the 45-49 age group, women have reached or are close to their childbearing limit, with many having six to eight children. Birth rates slightly decline in the 50-54 age group, where 13.6 percent of women had 10 or more children. Overall, the data illustrate a progressive increase in births as women age, with younger age groups predominantly having fewer children. In comparison, older age groups have a higher proportion of women with multiple children.

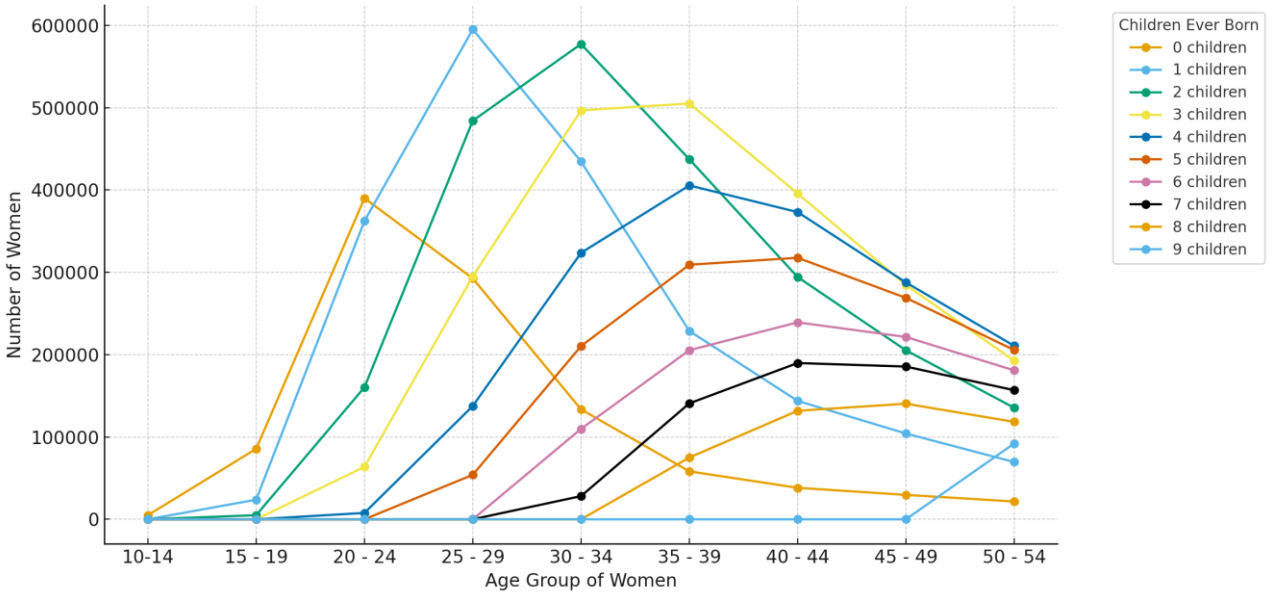
Table 2.7: Percentage Distribution of Women's Parity Distribution by Age Group; Tanzania Mainland, 2022 PHC

Women Age	Number of women	Number of Children Ever Born										
	Total	0	1	2	3	4	5	6	7	8	9	10+
Total	**28,034,164**	**0**	**4.4**	**8.5**	**11.4**	**13.5**	**14**	**14**	**12.7**	**11**	**8.7**	**1.8**
10-14	12,358	0	100	0	0	0	0	0	0	0	0	0
15 -19	426,385	0	66	27.5	6.5	0	0	0	0	0	0	0
20 -24	2,399,105	0	22.9	37.1	26.1	12.1	1.8	0	0	0	0	0
25 -29	3,680,284	0	5.3	18.1	26.4	25.5	17.4	7.3	0	0	0	0
30 -34	4,424,577	0	1.7	7.2	14.9	20.2	21.2	18.8	12.9	3.1	0	0
35 -39	4,842,719	0	0.7	2.8	7.5	13.1	16.6	18.4	17.4	14.7	8.8	0
40 -44	4,548,561	0	0.6	2.1	5	9.7	13.8	16.9	18	18	15.9	0
45 -49	4,074,557	0	0.7	2.1	4.4	8.3	12.4	16.3	18.3	19.4	18	0
50 -54	3,625,618	0	0.7	1.9	3.9	6.9	10.4	14	16	16.9	15.5	13.6

Source: Tanzania, 2022 PHC

The trend in Figure 2.2 shows that the proportion of women with parity increases steadily for those aged 20–29, with 1–3 children. By the ages of 30–39, the distribution shifts toward larger families, with many women reporting having 3–5 children. In older age groups (40–54), high-parity births (6 or more children) become more frequent, though the total number of women declines slightly with age. The overall trend highlights early childbearing and a progression toward larger family sizes as women age.

Figure 2.2: Trend of Children Ever Born by Age of Women



Source: Tanzania, 2022 PHC

CHAPTER THREE

DEATH ANALYSIS

Key Points

- An estimated 460,694 deaths occurred in Tanzania in the 12 months preceding the 2022 PHC, with 66.5 percent in rural areas and 33.5 percent in urban areas.
- Dar es Salaam recorded the highest share of deaths (8.9%), while Njombe reported the lowest (1.2%).
- Deaths were highest among children aged 0–14 (30.9%) and the elderly aged 60+ (35.7%), showing vulnerability at both ends of the age spectrum.
- Most maternal deaths occurred in rural areas (63.8%). In Zanzibar, however, urban areas reported a higher share (56.8%).

3.1 Introduction

This chapter examines death rates within Tanzania's general population, reflecting the socio-economic development and quality of life in society. Using data from the 2022 PHC, which gathered information on deaths in households during the year preceding the census and child survivorship status, the analysis explores socio-economic differentials in death rates. These differentials are assessed by place of residence (Tanzania, Mainland Tanzania, and Tanzania Zanzibar), age group, sex, rural versus urban areas, and disease prevalence. Understanding death patterns and trends is crucial for identifying vulnerable populations at risk. This analysis aims to provide insights into variations in death rates based on residence and socio-economic factors, informing health interventions and national strategies to improve societal welfare and health.

3.2 Distribution of Death by Place of Residence and Region

The deaths in Tanzania are estimated to be 460,694 in the 12 months prior to the 2022 PHC (Table 3.1). Mainland Tanzania experienced the highest deaths for both males (97.1%) and females (97.0%), while Tanzania Zanzibar reported fewer deaths for males (2.9%) and females (3.0%). Based on the analysis, a notable difference is observed in the number of deaths reported between rural and urban areas. More deaths were reported in

both sexes in rural and urban areas; 66.5 percent of deaths were in rural areas, while 33.5 percent were in urban areas. In rural areas, there are slightly more deaths of males (66.8%) compared to females (66.1%). In urban areas, slightly more deaths were reported for females (33.8%) than males (33.2%), closely consistent with a larger rural population distribution in Tanzania.

Furthermore, the Dar es Salaam Region reported the highest number of deaths for both males (8.8%) and females (9.1%), followed by the Tanga Region, with males (6.3%) and females (6.5%), and the Morogoro Region, with males (5.7%) and females (6.1%). Despite the fact that the Tanga Region is not among the top five in total population according to the 2022 PHC, it ranked second in total deaths. Furthermore, Njombe Region reported the fewest deaths, males (1.2%) and females (1.1%), followed by Katavi and Iringa Regions, which reported fewer deaths for both males and females.

Table 3.1: Percentage Distribution of Deaths by Sex and Place of Residence; Tanzania Mainland, 2022 PHC

Place of Residence	Number of Death			Death (%)		
	Male	Female	Both Sexes	Male	Female	Both Sexes
Tanzania	**254,672**	**206,022**	**460,694**	**55.3**	**44.7**	**100**
Rural	170,187	136,238	306,425	66.8	66.1	66.5
Urban	84,485	69,784	154,269	33.2	33.9	33.5
Mainland Tanzania	**247,356**	**199,803**	**447,159**	**97.1**	**97.0**	**97.1**
Dodoma	12,309	10,130	22,439	5	5.1	5.0
Arusha	6,919	5,252	12,171	2.8	2.6	2.7
Kilimanjaro	11,596	8,783	20,379	4.7	4.4	4.6
Tanga	15,557	13,045	28,602	6.3	6.5	6.4
Morogoro	14,098	12,238	26,336	5.7	6.1	5.9
Pwani	9,684	8,268	17,952	3.9	4.1	4.0
Dar Es Salaam	21,794	18,164	39,958	8.8	9.1	8.9
Lindi	6,757	5,696	12,453	2.7	2.9	2.8
Mtwara	10,119	8,478	18,597	4.1	4.2	4.2
Ruvuma	7,587	6,129	13,716	3.1	3.1	3.1
Iringa	4,628	3,626	8,254	1.9	1.8	1.8
Mbeya	9,634	8,151	17,785	3.9	4.1	4.0
Singida	6,933	5,865	12,798	2.8	2.9	2.9
Tabora	12,798	11,099	23,897	5.2	5.6	5.3
Rukwa	5,552	4,257	9,809	2.2	2.1	2.2
Kigoma	9,782	7,432	17,214	4.0	3.7	3.8
Shinyanga	7,570	6,251	13,821	3.1	3.1	3.1
Kagera	13,446	10,395	23,841	5.4	5.2	5.3
Mwanza	14,168	11,341	25,509	5.7	5.7	5.7
Mara	10,938	8,337	19,275	4.4	4.2	4.3
Manyara	5,934	4,093	10,027	2.4	2.0	2.2
Njombe	2,908	2,266	5,174	1.2	1.1	1.2
Katavi	3,816	2,837	6,653	1.5	1.4	1.5

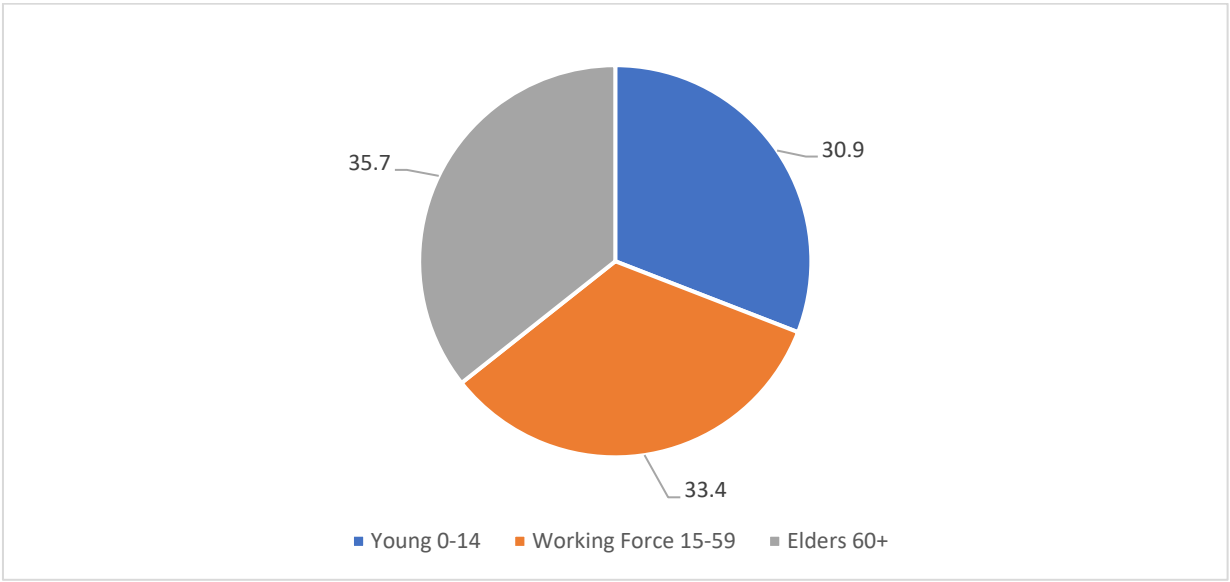
Place of Residence	Number of Death			Death (%)		
	Male	Female	Both Sexes	Male	Female	Both Sexes
Simiyu	7,373	5,881	13,254	3.0	2.9	3.0
Geita	10,211	7,785	17,996	4.1	3.9	4.0
Songwe	5,245	4,004	9,249	2.1	2.0	2.1
Tanzania Zanzibar	**7,316**	**6,219**	**13,535**	**2.9**	**3.0**	**2.9**
Kaskazini Unguja	913	758	1,671	12.5	12.2	12.3
Kusini Unguja	699	574	1,273	9.6	9.2	9.4
Mjini Magharibi	3,538	3,160	6,698	48.4	50.8	49.5
Kaskazini Pemba	1,196	943	2,139	16.3	15.2	15.8
Kusini Pemba	970	784	1,754	13.3	12.6	13.0

Source: Tanzania, 2022 PHC

3.3 Distribution of Death by Age Group

Generally, as indicated in Figure 3.1, the death differential analysis by age group and sex has shown that there is a higher number of deaths at older ages from 60+ (35.7%), followed by Middle Ages from 15-59 (33.4%), and younger ages from 0-14 (30.9%). The distribution of deaths by age groups and sex has shown a significant difference. There is a higher number of deaths at younger and older ages compared to the Middle Ages (15 -59).

Figure 3.1 Percentage Distribution of Death by Age Group; Tanzania Mainland, 2022 PHC



Source: Tanzania, 2022 PHC

The age of 0-14 reported the highest number of deaths for both females, 254,674 (26.7%), and males, 206,023 (25.9%), respectively. Likewise, the higher number of deaths was reported in the age 85+ for both males, 25,187 (9.9%), and females, 29,589 (14.4%), as indicated in Table 3.2. This implies there are more deaths in early and older ages. This

situation is raising an alarm about the need for government intervention at an early age (0-4) and among the 60+ age group, respectively.

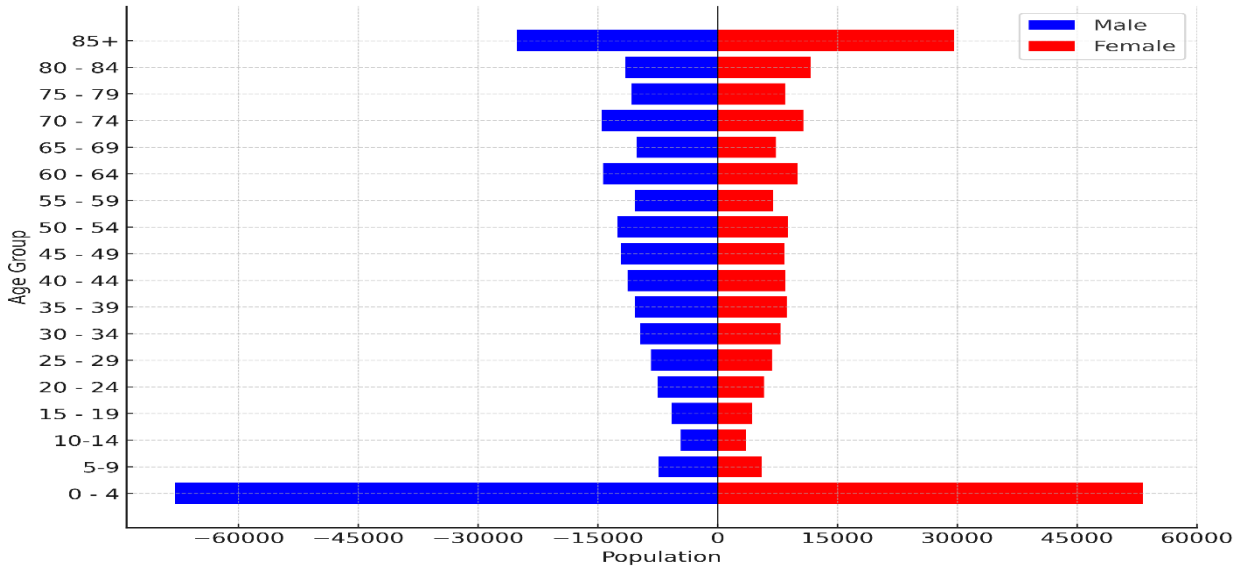
Table 3.2 Percentage Distribution of Death by Sex and Age Group; Tanzania Mainland, 2022 PHC

Age group	Sex			Sex (%)	
	Both Sexes	Male	Female	Male	Female
Total	**460,697**	**254,674**	**206,023**	**55.3**	**44.7**
0 - 4	121,236	67,978	53,258	26.7	25.9
5-9	12,911	7,391	5,520	2.9	2.7
10-14	8,189	4,648	3,541	1.8	1.7
15 - 19	10,033	5,753	4,280	2.3	2.1
20 - 24	13,310	7,512	5,798	2.9	2.8
25 - 29	15,162	8,359	6,803	3.3	3.3
30 - 34	17,550	9,687	7,863	3.8	3.8
35 - 39	19,036	10,398	8,638	4.1	4.2
40 - 44	19,773	11,295	8,478	4.4	4.1
45 - 49	20,528	12,131	8,397	4.8	4.1
50 - 54	21,410	12,594	8,816	4.9	4.3
55 - 59	17,281	10,359	6,922	4.1	3.4
60 - 64	24,384	14,364	10,020	5.6	4.9
65 - 69	17,450	10,136	7,314	4.0	3.6
70 - 74	25,258	14,531	10,727	5.7	5.2
75 - 79	19,221	10,794	8,427	4.2	4.1
80 - 84	23,189	11,557	11,632	4.5	5.6
85+	54,776	25,187	29,589	9.9	14.4

Source: Tanzania, 2022 PHC

The results in Table 3.2 are reflected in Figure 3.2, which shows a broad base with the largest share of the population in the 0–4 age group, gradually narrowing toward older ages. This pattern indicates a young population with high birth rates and a large proportion of children and youth. The pyramid also shows fewer people in the older age groups, reflecting lower life expectancy. The elderly population (85+) shows higher female deaths, while early loss deaths under 5 are more male-dominated, typical of demographic mortality patterns and determinant of population distribution. Overall, the pyramid reflects a rapidly growing population, characterised by high fertility and declining but still significant mortality.

Figure 3.2: Death Population Pyramid by Age and Sex



Source: Tanzania, 2022 PHC

3.4 Maternal Differentials of Death

In Tanzania, the determinants of death are influenced by a range of factors, reflecting the country's diversity and socio-economic disparities. These factors include variations in place of residence, where rural and urban areas experience different health outcomes due to differences in access to healthcare and living conditions. Gender and age also play significant roles, with death differing between males and females and varying across age groups, particularly affecting children and the elderly. Additionally, wealth status is a key determinant, as wealthier individuals often have better access to healthcare services, leading to lower mortality rates compared to those in lower wealth quintiles, who face greater challenges in accessing adequate healthcare. These socio-economic and demographic differentials contribute to significant disparities in death rates across the country.

3.4.1 Maternal Differentials of Death by Residence and Age Group

Maternal mortality in Tanzania is significantly higher in rural areas, where it accounts for 3,579 deaths (63.8%) per year, compared to 2,027 deaths (36.2%) in urban areas. A similar trend is observed in Mainland Tanzania, where rural areas report 64.5 percent of maternal deaths, which is consistent with population distribution in Tanzania, while urban areas account for 35.5 percent. However, in Zanzibar, the situation is reversed, with urban areas experiencing 56.8 percent of maternal deaths, compared to 43.2 percent in rural areas.

In both rural and urban settings, the highest percentage of maternal deaths occurs in the 10-14 age group, with 82.5 percent of these deaths occurring in rural areas and 17.5 percent

in urban areas. This is followed by the 15-19 age group, where rural areas contribute 73.6 percent of deaths, and the urban areas account for 26.4 percent. The pattern of maternal death indicates that adolescents aged 10–14 are at the highest risk, with most deaths occurring in rural areas. The age group is also highly vulnerable, with rural areas again experiencing the majority of deaths. Furthermore, early childbearing disproportionately affects girls, reflecting underlying gender inequalities such as limited access to education, lack of empowerment, and societal norms that promote early marriage and pregnancy. Mainland Tanzania follows this same pattern, but in Zanzibar, no maternal deaths were reported in the 10-14 age group. Furthermore, maternal deaths for women aged 20-49 range from 61.4 percent to 67.3 percent in rural areas, and from 32.7 percent to 40.8 percent in urban areas, respectively. These statistics highlight the continued high rate of maternal deaths in Tanzania, emphasizing the urgent need for increased government intervention in maternal health.

Table 3.3: Percentage Distribution of Maternal Differentials of Death by Residence and Age Group; Tanzania Mainland, 2022 PHC

Age groups	Total			Mainland Tanzania			Tanzania Zanzibar		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
Total	**5,606**	**63.8**	**36.2**	**5,444**	**64.5**	**35.5**	**162**	**43.2**	**56.8**
10- 14	40	82.5	17.5	40	82.5	17.5	0	-	-
15 - 19	500	73.6	26.4	493	74.2	25.8	7	28.6	71.4
20 - 24	1,063	67.3	32.7	1,038	67.7	32.3	25	48.0	52.0
25 - 29	1,184	62.0	38.0	1,141	63.0	37.0	43	34.9	65.1
30 - 34	1,145	62.1	37.9	1,107	62.5	37.5	38	50.0	50.0
35 - 39	1,027	59.2	40.8	999	60.0	40.0	28	32.1	67.9
40 - 44	476	64.1	35.9	461	64.2	35.8	15	60.0	40.0
45 - 49	171	61.4	38.6	165	61.2	38.8	6	66.7	33.3

Source: Tanzania, 2022 PHC

3.4.2 Disease Differentials of Death by Place of Residence and Age Group

Overall, Table 3.4 shows that the largest proportion of deaths by disease in both the urban and rural populations is reported in the younger age group (0-4), which makes up 24.3 percent. The highest proportions are observed in the 80-84 and 85+ age groups, with 6.2% and 15.4% of the population, respectively. The percentages for the age group 5 to 59 are notably increasing from 1.6 percent to 4.6 percent. Moreover, for the 60-64 and 70-74 age groups, the percentage increases drastically, from 5.3 percent to 5.7 percent, respectively. This implies that after the age of 60, most of the population dies due to various diseases.

In Mainland Tanzania, rural areas show a higher concentration of deaths caused by diseases in younger populations (with 26.7% in the 0-4 age group) compared to urban areas (19.7%). As age increases, the urban areas show a higher percentage of deaths caused by

diseases in the older age groups, particularly noticeable in the 85+ category, where urban areas account for 14.2 percent compared to 16.1 percent in rural areas. Similarly, in Tanzania Zanzibar, rural areas also have a larger proportion of deaths caused by diseases for younger populations (27.6%) in the 0-4 age group. In comparison, urban areas have a slightly higher proportion in the older age groups, with the 85+ age group at 9.6 percent.

This distribution of deaths caused by diseases emphasizes the demographic differences between rural and urban areas in both Mainland Tanzania and Zanzibar, with rural areas tending to have more deaths in the younger population. In contrast, urban areas show a higher percentage of older individuals. These demographic trends could inform policy decisions, especially those related to healthcare, education, and social services.

As highlighted in URT 2025b, diseases are the primary causes of death in Tanzania, accounting for 83.7 percent of all deaths. The impact of diseases on mortality is particularly pronounced among females, who contribute 86.2 percent of the total disease-related deaths, compared to 81.7 percent among males. This gender disparity is consistent across Mainland Tanzania, where the percentage of disease-related deaths among females is similarly higher. However, in Zanzibar, the proportion of deaths attributed to diseases is comparatively lower, at 78.1 percent, indicating regional variations in the prevalence of disease-related mortality. These findings highlight the substantial impact of diseases on public health in Tanzania, with notable gender and regional disparities in their effects.

Based on the Annual Vital Statistics Report (2020-2023), lower respiratory infections emerged as the leading cause of death in 2021 and 2022, accounting for 15.9 percent and 9.4 percent of all deaths, respectively. Additionally, road accidents have remained among the top ten causes of death, accounting for 1.7 percent of deaths in 2021 and 3.0 percent in 2022 (RITA, 2024). The two causes of death are more likely to occur in urban than rural areas.

Table 3.4: Percentage Distribution of Disease Differentials of Death by Place of Residence and Age Group; Tanzania Mainland, 2022 PHC

Age Group	Total			Mainland Tanzania			Tanzania Zanzibar		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
0 - 4	24.3	26.7	19.7	24.2	26.53	19.5	27.6	32.8	23.2
5- 9	2.5	3	1.7	2.6	2.99	1.7	1.7	1.9	1.5
10-14	1.6	1.9	1.1	1.6	1.86	1.2	1.3	1.7	0.9
15 -19	1.8	1.9	1.5	1.8	1.88	1.5	1.6	1.8	1.4
20 -24	2.2	2.2	2.2	2.2	2.25	2.2	1.8	1.8	1.7
25 -29	2.7	2.6	3	2.7	2.57	3.1	2	2.1	2
30 -34	3.3	3.1	3.8	3.4	3.12	3.8	2.7	3.1	2.5
35 - 39	3.8	3.5	4.6	3.9	3.48	4.6	2.7	2.6	2.8
40 - 44	4.1	3.6	5.1	4.1	3.61	5.1	3.9	3.7	4
45 - 49	4.2	3.6	5.4	4.2	3.63	5.4	4.7	3.7	5.5
50 - 54	4.6	4.1	5.7	4.6	4.05	5.6	5.7	4.5	6.7
55 - 59	3.6	3.2	4.5	3.6	3.17	4.5	4.3	3.5	5
60 - 64	5.3	4.8	6.2	5.3	4.81	6.1	7	5.9	7.8
65 - 69	3.9	3.6	4.4	3.9	3.6	4.4	4.5	4	4.9
70 - 74	5.7	5.5	6.3	5.7	5.41	6.2	8.7	8.6	8.8
75 - 79	4.5	4.5	4.7	4.5	4.47	4.7	4.5	4.3	4.6
80 - 84	6.2	6.3	6.1	6.2	6.32	6	6.3	5.5	7.1
85+	15.4	16.1	14.2	15.6	16.24	14.4	9.1	8.4	9.6

Source: Tanzania, 2022 PHC

3.4.3 Death differentials by Wealth Index

The wealth index is a composite measure derived from the distribution of households across different wealth quantiles. These quantiles are categorized based on various socio-economic indicators, such as asset ownership, access to services, and housing conditions. The lower quantiles represent the poorest segment of the population, where individuals or households face significant economic hardship and limited access to basic services. The second quantile represents the "poor" population, where individuals may still struggle with access to resources but may have slightly better living conditions than the poorest. The middle quantile represents the "average" wealth population, which typically has moderate access to resources and services, corresponding to the middle-income group. In contrast, the fourth and fifth quantiles represent the wealthier segments of society, with the fourth quantile including the "richer" population, who have better access to resources and services, while the fifth quantile represents the "richest" population, often characterized by high asset ownership and the ability to access the best services and opportunities. This distribution enables a nuanced understanding of economic disparities within a population, offering insights into how wealth affects health, education, and access to essential services.

The wealth distribution across quintiles shows notable differences in the proportion of deaths for males and females in each category. The lowest wealth quintile (the poorest) represents 22.3 percent of the total population, with 12.4 percent being male and 9.9 percent being female, indicating a higher death concentration among males in this category (Table 3.5). The second quintile (poor population), accounting for 23.4 percent of the total death population, has 13 percent of deaths of males and 10.4 percent of females, maintaining the trend of more male deaths in lower wealth groups. The middle quintile (21.9 percent of the population) follows a similar death pattern, with 12.1 percent males and 9.8 percent females. In the fourth wealth quintile, 16.3 percent of the population is represented, with 9 percent males and 7.3 percent females, respectively, showing a further decrease in male dominance. Finally, in the highest wealth quintile, which represents 16.1 percent of the total death population, males make up 8.8 percent, and females make up 7.4 percent, indicating a slight gender balance in deaths among wealthier segments. Overall, males' deaths are more concentrated in the lower wealth quintiles. In contrast, the highest quintile has a nearly balanced gender distribution of deaths, suggesting that while males dominate the poorer wealth categories, the wealthiest quintile exhibits a more even split.

Evidently, the analysis of wealth distribution and deaths reveals a clear socioeconomic gradient in mortality by gender. Male deaths are disproportionately concentrated in the lower wealth quintiles, indicating that poorer males face higher mortality risks. In contrast, the highest wealth quintile exhibits a nearly balanced distribution of deaths between males and females, suggesting that wealth mitigates gender disparities in mortality. Overall, these findings highlight the intersection of poverty and gender in influencing mortality patterns and trends, emphasizing the need for targeted interventions to reduce health inequities among lower-income and vulnerable male populations.

According to reports from the World Health Organisation (WHO, 2014) and the United Nations Development Programme (UNDP), socio-economic inequality and health system challenges are key drivers behind the disparities in mortality rates (WHO/UNDP, 2020). These organisations highlight the profound impact of the unequal distribution of resources, which limits access to essential healthcare services, particularly for disadvantaged populations.

Further studies from the Tanzania Ministry of Health and the Zanzibar Health Research Foundation (ZHRF, 2020) highlight the vulnerabilities faced by women, particularly those in low-income and manual labour occupations. Women under these categories are exposed to poor working conditions, limited access to healthcare, and the constraints of gendered

social roles, which may have triggered death rates compared to men, as opposed to results shown by the wealth index (Table 3.3).

Additionally, the intersection of economic disadvantage and inadequate healthcare infrastructure exacerbates the health challenges faced by both men and women, particularly in poorer regions. Local socio-economic and cultural factors further exacerbate these issues, resulting in varying health outcomes that are influenced by geography and access to resources. Therefore, the interplay of socio-economic status, gender, and healthcare access plays a crucial role in shaping mortality patterns and trends, highlighting the need for targeted interventions to address these systemic inequities.

Table 3.5: Percentage Distribution of Differentials of Death by Wealth Index; Tanzania Mainland, 2022 PHC

Wealth Quintile	Birth			
	Both Sexes	Both Sexes	Male)	Female
Total	**460,694**	**100**	**55.0**	**45.0**
Lowest	102,891	22.3	12.4	9.9
Second	107,477	23.4	13.0	10.4
Middle	101,032	21.9	12.1	9.8
Fourth	74,994	16.3	9.0	7.3
Highest	74,300	16.1	8.8	7.4

Source: Tanzania, 2022 PHC

CHAPTER FOUR

CONCLUSION, POLICY IMPLICATION AND RECOMMENDATIONS

This chapter is divided into two main sections, focusing on birth and death analyses based on data from the 2022 PHC. Section 4.1 and 4.2 provide conclusions, policy implications and policy recommendations concerning birth and death related issues, as discussed in Chapter Two and Three respectively. These sections aim to synthesise key findings from the previous chapters and propose targeted strategies to address the socio-economic and health disparities revealed by the data.

4.1 Births: Conclusion, Policy Implications and Recommendations

4.1.1 Conclusion

This analysis of birth trends in Tanzania highlights the profound impact of socio-economic factors on fertility patterns and trends. The data reveal significant birth differentials across regions, socio-economic status, and educational attainment, with rural areas consistently showing higher birth rates compared to urban regions. Notably, maternal education plays a pivotal role, with higher levels of education correlating with lower fertility rates, particularly in urban settings. The findings also emphasise that the wealth index, marital status, and occupation have a strong influence on birth outcomes, with poorer women and those in rural areas tending to have larger families.

The data further underscores that fertility rates peak in the 25-34 age group, with a gradual decline thereafter, reflecting the broader trend of declining fertility with age. The relationship between wealth and birth rates reveals that wealthier households typically have fewer children, although this pattern is not universally applicable. In developing countries like Tanzania, where economic constraints and cultural practices continue to shape reproductive behaviour, targeted interventions in maternal health, education, and family planning are essential to addressing these disparities.

Therefore, the analysis illustrates the complex interaction between socio-economic factors and fertility, suggesting that comprehensive policies addressing education, healthcare access, and economic development are key to managing population growth and promoting sustainable development in Tanzania and similar contexts across East Africa and Sub-Saharan Africa.

4.1.2 Policy Implications

Fertility patterns showed that rural communities require stronger investment in health outreach, reliable family planning supplies, and reproductive health education due to higher births compared to urban settings. Fertility peaks among women aged 25 to 34, so services that offer guidance on spacing and planning should concentrate on this group while still supporting older women who continue to contribute many births. Education remains a major influence on fertility, which makes expansion of girls' schooling and adult learning programmes especially important in rural areas where many women have limited schooling. Since most births occur within marriage, health initiatives should work closely with married couples to encourage spacing, while urban programmes should recognise the growing role of non-marital births by strengthening access to reproductive services for all women. Women working in agriculture often have higher fertility, so mobile health clinics and flexible outreach can help bring services closer to their daily routines. Higher fertility among poorer households highlights the need for free or subsidised reproductive health services, wider access to contraceptives, and improved financial support mechanisms. Because many older women continue to have large families, policies should promote birth spacing, routine reproductive health checks, and information on the health risks associated with late-age pregnancies.

4.1.3 Policy Recommendations

To achieve a more balanced population growth and improved maternal and child health outcomes, the following policy recommendations should be considered:

1. **Promote Education for Women**: Policies aimed at increasing access to secondary and tertiary education for girls, particularly in rural areas, are crucial.

2. **Enhance quality SRH and Family Planning Services**: Expand and improve access to family planning services, especially in rural areas. These services should be tailored to address the specific needs of different socio-economic groups, including women in agricultural sectors, where birth rates are higher.

3. **Support Women in Agriculture**: Since agriculture remains the dominant sector in rural areas, policies should prioritise empowering women in this sector through access to improved healthcare, agricultural technology, and financial support. This could help reduce the economic need for larger families and improve overall well-being.

4. **Address Social Norms and Demand**: Run locally led behaviour-change campaigns on ideal family size, birth spacing, and male engagement, leveraging faith and community leaders.

5. **Improve Maternal Health Services**: Universalise ANC contacts, skilled birth attendance, and respectful care; reinforce emergency referral (ambulances, maternity waiting homes) in remote areas.

6. **Strengthen Socio-Economic Support for Women in Low-Income Occupations**: Policies should be developed to support women working in low-income and informal sectors, ensuring that they have access to maternity leave, healthcare, and child-rearing support to reduce the birth gap between different occupational groups.

7. **Targeted Interventions for Low-Wealth Groups**: Develop programs focused on reducing fertility rates among women in the lowest wealth quintiles by increasing access to education, family planning, and healthcare services.

8. **Promote Gender Equality**: Strengthen initiatives that promote gender equality, including improving the status of women in both rural and urban areas, which can lead to more equitable access to resources and lower fertility rates.

9. **Data and accountability.** Track fertility and high-parity births by district, education, and wealth; monitor stock-outs and method mix; publish quarterly dashboards to drive local action.

4.2 Death: Conclusion, Policy Implications and Recommendations

4.2.1 Conclusion

Mortality in Tanzania reflects the structural inequities in living conditions and access to services. Rural residence, poverty, and early/late life stages align with higher mortality risks. Elevated maternal mortality in rural adolescents and young women points to service gaps and harmful norms. The contrasting rural–urban age patterns imply different priorities: preventable infectious and perinatal causes in rural/poorer settings; chronic disease and geriatric care needs increasing salience in urban/older populations. Reducing mortality requires primary-health-care (PHC)–centred, district-led strategies with strong referral, prevention, and social protection linkages.

4.2.2 Policy Implication

Higher death rates in rural areas show the need for stronger primary healthcare services, reliable emergency care, and more consistent outreach programmes to reduce preventable deaths, especially for men who form the largest share of rural deaths. Regions such as Dar es Salaam and Tanga require additional support to manage their higher mortality burden, while low-mortality regions can be used as examples for strengthening local health systems. The concentration of deaths among older adults and children indicates the importance of improving geriatric care, routine screening for chronic conditions, child nutrition services, and disease prevention initiatives aimed at reducing avoidable deaths. Maternal deaths being more frequent in rural areas, especially among very young mothers, calls for expanded access to skilled birth attendants, stronger adolescent reproductive health programmes, and stricter measures to prevent early pregnancies. The higher number of disease-related deaths among young children in rural settings highlights the need for improved immunisation, better sanitation, clean water supply, and faster referral pathways during illness, while urban areas require stronger long-term care for older individuals. The strong link between low socio-economic status and higher mortality rates suggests the need for pro-poor health financing, widened insurance coverage, and targeted community health investments to reduce preventable deaths among poorer families.

4.2.3 Policy Recommendations

To address the aforementioned challenges that trigger death in the population, Tanzania can significantly reduce the death disparities across different regions, age groups, and socio-economic backgrounds, and ultimately improve the overall health outcomes and quality of life for its citizens. The following policy recommendations should be considered:

1. **Improve Healthcare Access in Rural Areas**: Targeted investments in healthcare infrastructure and services in rural regions are essential. This includes establishing mobile clinics, expanding access to essential medications, and training healthcare personnel to address the specific needs of rural populations, especially the elderly and children.

2. **Gender-Specific Health Programs**: Given the higher death rates among women in low-income occupations, policies should be developed to improve working conditions for women in rural and informal sectors. Initiatives that focus on providing better maternal care, especially in rural areas, are critical to reducing maternal mortality.

3. **Targeted Interventions for Vulnerable Age Groups**: Government programs should focus on the high deaths observed in both the younger (0-14) and older (60+) populations. Early childhood health initiatives, including vaccinations and nutrition programs, as well as geriatric healthcare services, are crucial for reducing mortality in these groups.

4. **Socioeconomic Equity in Health Services: To address disparities driven by wealth, the government should implement policies that provide equitable access to healthcare, particularly for lower-income** quintiles. This may include subsidized healthcare for the poorest, alongside public-private partnerships to improve the quality of healthcare services available to disadvantaged communities.

5. **Promote Health Education and Awareness**: Implement community-based education programs on disease prevention, sanitation, and maternal health, with a focus on rural populations, to reduce mortality from preventable diseases.

6. **Strengthen Maternal Health Services**: With maternal deaths being disproportionately higher in rural areas, there is an urgent need for improved maternal health programs. Expanding access to quality antenatal care, skilled birth attendants, and postnatal services, especially in rural Tanzania, will help lower maternal mortality rates.

7. **Cross-Sectoral Collaboration**: Enhance coordination among the health, education, and social welfare sectors to address the broader socioeconomic factors that impact health outcomes. A holistic approach will better target the root causes of health disparities.

8. **Target Disease Prevention Programs**: Prioritize disease prevention and health interventions for children (0-4 years old) and elderly populations (60 years and older), particularly in rural areas. Improve access to immunization, sanitation, and healthcare services for these vulnerable groups.

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Appendices

Appendix 1: Disease Differentials Number of Deaths by Place of Residence and Age Group, PHC, 2022

Age group	Total			Mainland Tanzania			Tanzania Zanzibar		
	Total	Rural	Urban	Total	Rural	Urban	Total	Rural	Urban
Total	**1,77,626**	**1,17,769**	**59,857**	**1,72,599**	**1,15,475**	**57,124**	**5,027**	**2,294**	**2,733**
0 - 4	43,163	31,394	11,769	41,776	30,641	11,135	1,387	753	634
5-9	4,496	3,498	998	4,410	3,454	956	86	44	42
10-14	2,879	2,191	688	2,816	2,153	663	63	38	25
15 - 19	3,120	2,207	913	3,042	2,166	876	78	41	37
20 - 24	3,963	2,637	1,326	3,874	2,595	1,279	89	42	47
25 - 29	4,822	3,019	1,803	4,720	2,971	1,749	102	48	54
30 - 34	5,931	3,677	2,254	5,793	3,607	2,186	138	70	68
35 - 39	6,799	4,075	2,724	6,662	4,015	2,647	137	60	77
40 - 44	7,284	4,258	3,026	7,089	4,172	2,917	195	86	109
45 - 49	7,527	4,276	3,251	7,291	4,191	3,100	236	85	151
50 - 54	8,164	4,781	3,383	7,878	4,677	3,201	286	104	182
55 - 59	6,431	3,743	2,688	6,213	3,662	2,551	218	81	137
60 - 64	9,415	5,694	3,721	9,065	5,558	3,507	350	136	214
65 - 69	6,908	4,252	2,656	6,683	4,160	2,523	225	92	133
70 - 74	10,195	6,439	3,756	9,758	6,242	3,516	437	197	240
75 - 79	8,045	5,259	2,786	7,820	5,161	2,659	225	98	127
80 - 84	11,063	7,422	3,641	10,744	7,296	3,448	319	126	193
85+	27,421	18,947	8,474	26,965	18,754	8,211	456	193	263

Appendix 2: List of Contributors

Contributors to the Birth and Death in Tanzania

Census Commissars	
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Appendix 3: Questionnaires

The United Republic of Tanzania

QUESTIONNAIRE FOR THE 2022 POPULATION AND HOUSING CENSUS

The Sixth Post Union Census

Strictly Confidential

This census is conducted in accordance with Section 6(2)(a) of the Statistics Act Cap. 351 || All responses collected in this census are protected under this Act

SECTION A: IDENTIFICATION

Region	District	Council	Constituency	Division/Wadi	Ward/Shehia	Village/Mtaa	Hamlet/Enumeration Area (EA)	Household Number	CONFIDENTIAL

A01 Please State the number all persons who Spent here at the Census Night

SECTION B: DEMOGRAPHICS INFORMATION

B01 No.	B02 HOUSEHOLD MEMBERS	B03 RELATIONSHIP TO THE HEAD							B04 SEX		B05 AGE	B06 MARITAL STATUS (APPLICABLE TO AGE 10+)							B07 MOBILE PHONE (AGE 15+)
	Please state the names of all persons who spent the census night, that is Monday night before Tueday 23rd August, 2022 in your household, starting with the name of the head of household. DO NOT FORGET TO INCLUDE ALL INFANTS, HOUSEHOLD MEMBERS WHO SLEPT IN A NEARBY FUNERAL AND THOSE WORKING NIGHT SHIFTS SUCH AS NURSES, DOCTORS, POLICE, GUARDS, ETC. WRITE DOWN FULL NAME OF EACH HOUSEHOLD MEMBER	What is the relationship of [NAME] to the head of the household?							Is [NAME] a male or a female?		How old is [NAME]? WRITE AGE IN COMPLETE YEARS. IF UNDER ONE YEAR WRITE "00" FOR 97 YEARS AND ABOVE WRITE '97'	What is current marital status of [NAME]? never married, married, living together, divorced, separated, widowed?							Please give the mobile number of [NAME]? WRITE THE MOBILE NUMBER OF ALL HOUSEHOLD MEMBERS AGED 15+.
		Head	Spouse	Son/Daughter	Biological Parent	Grand Child	Other Relative	Not Related	Male	Female		Never Married	Married	Living Together	Divorced	Separated	Widowed	Not Stated	
		1	2	3	4	5	6	7	1	2		1	2	3	4	5	6	9	
0 1																			
0 2																			
0 3																			
0 4																			
0 5																			
0 6																			
0 7																			
0 8																			

SECTION A: IDENTIFICATION

Region	District	Council	Constituency	Division/Wadi	Ward/Shehia	Village/Mtaa	Hamlet/Enumeration Area (EA)	Household Number	CONFIDENTIAL

SECTION C: INFORMATION ON DISABILITIES/DIFFICULTIES

B01	C01 ALBINISM	C02 SEEING	C03 HEARING	C04 WALKING	C05 REMEMBERING	C06 SELFCARE
No.	Is [NAME] an albino?	Does (NAME) have difficulty seeing, even if wearing glasses?	Does (NAME) have difficulty hearing, even if using a hearing aid?	Does [NAME] have difficulty walking or climbing steps?	Does (NAME) have difficulty remembering or concentrating?	Does (NAME) have difficulty with self-care, such as washing all over or dressing?
	Yes (1) / No (2)	No Difficulty (1) / Some Difficulty (2) / A Lot of Difficulty (3) / Unable to See (4) / Not Applicable (5)	No Difficulty (1) / Some Difficulty (2) / A Lot of Difficulty (3) / Unable to Hear (4) / Not Applicable (5)	No Difficulty (1) / Some Difficulty (2) / A Lot of Difficulty (3) / Unable to Walk (4) / Not Applicable (5)	No Difficulty (1) / Some Difficulty (2) / A Lot of Difficulty (3) / Unable to Remember (4) / Not Applicable (5)	No Difficulty (1) / Some Difficulty (2) / A Lot of Difficulty (3) / Unable to Care (4) / Not Applicable (5)
01						
02						
03						
04						
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SECTION A: IDENTIFICATION

Region	District	Council	Constituency	Division/Wadi	Ward/Shehia	Village/Mtaa	Hamlet/Enumeration Area (EA)	Household Number	
									CONFIDENTIAL

SECTION C: INFORMATION ON DISABILITIES/DIFFICULTIES

B01	C07 COMMUNICATION	C08 OTHER DISABILITIES	C09 CAUSE OF DISABILITY	C10 ASSISTIVE DEVICES AND MATERIALS
No.	USING THE COMMON LANGUAGE: Does [NAME] have difficulty communicating; for example understanding or being understood?	Does, [NAME] have other type of disabilities/difficulties among the following? READ ALL TYPES OF DISABILITIES/ DIFFICULTIES TO RESPONDENT Yes = 1 | No = 2 | Don't know = 9	ASK FOR EVERY TYPE OF DISABILTY FROM C02 TO C07 IF CODE 3 OR 4 OR CODE 1 IN QUESTION C08 What is the cause of disability for [NAME]? MULTIPLE RESPONSE IS ALLOWED	ASK IF QC01 = 1 OR ANY QUESTION FROM QC02 TO Q07 = 3 OR 4 OR QC08 IS CODE 1 FOR B,C,D Does [NAME] has disability assistive devices or materials? Yes = 1 | No = 2

		No Difficulty	Some Difficulty	A Lot of Difficulty	Unable to communicate	Not Applicable	Cleft Palate	Hydrocephalus	Spinal bifida	Spinal cord injuries	Epilepsy or seizures	Psoriasis	Storiasis	Autism	Mental Health	Mental Disorder	Person with short stature	Leprosy	Person with hunchback	Other disability	Inborn	Disease	Accident	Old age	Beaten	Contaminated water	Stress	Drug abuse	Pregnancy/birth complications	
		1	2	3	4	5	A	B	C	D	E	F	G	H	I	J	K	L	M	X	A	B	C	D	E	F	G	H	I	
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SECTION A: IDENTIFICATION

Region	District	Council	Constituency	Division/Wadi	Ward/Shehia	Village/Mtaa	Hamlet/Enumeration Area (EA)	Household Number	CONFIDENTIAL

SECTION D: MIGRATION INFORMATION

B01	D01 CITIZENSHIP	D02 DUAL CITIZENSHIP	D03 PLACE OF RESIDENCE	D04 WHERE RESPONDENT SPENDS MOST OF THE DAY TIME	D05 PLACE OF BIRTH
No.	What is (NAME) country of citizenship? IF TANZANIAN, WRITE CODE 001 IF NON-TANZANIAN WRITE APPROPRIATE CODE, FOR DUAL CITIZENSHIP WRITE "888" ►IF THE ANSWER IS CODE OF RESPECTIVE COUNTRY GO TO DO3	What is (NAME) countries of citizenship? WRITE CODES FOR THE COUNTRIES MULTIPLE RESPONSE IS ALLOWED FISRT COUNTRY SECOND COUNTRY	Which region/country does [NAME] usually live? WRITE CODE FOR THE COUNTRY, REGION AND DISTRICT IF LIVING IN TANZANIA, OR COUNTRY CODE IF LIVING OUTSIDE TANZANIATHEN GO TO THE NEXT QUESTION	Where do you spend most of your time during the day? WRITE COUNTRY, REGION AND DISTRICT CODES IF SPENDS MOST OF THE DAY TIME IN TANZANIA OR COUNTRY CODE IF OUTSIDE TANZANIA THEN GO TO THE NEXT QUESTION CODES FOR THE 8th BOX Rural =1 Regional /District Headquarters =2 Other Urban= 3	In which region/country was [NAME] born? WRITE CODE FOR COUNTRY, REGION AND DISTRICT IF BORN IN TANZANIA OR COUNTRY CODE IF BORN OUTSIDE TANZANIA. IF COUNTRY OF BIRTH IS UNKNOWN WRITE "9999999" ►IF THE RESPONDENT WAS BORN IN THE REGION WHERE THE INTERVIEW IS TAKING PLACE GO TO D10
01					
02					
03					
04					
05					
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08					

SECTION A: IDENTIFICATION

Region	District	Council	Constituency	Division/Wadi	Ward/Shehia	Village/Mtaa	Hamlet/Enumeration Area (EA)	Household Number	
									CONFIDENTIAL

SECTION D: MIGRATION INFORMATION

B01	D06 TIME OF ARRIVE	D07 LIVING PERIOD	D08 PREVIOUS RESIDENCE	D09 MAIN REASON FOR MIGRATION	D10 PLACE OF RESIDENCE IN YEAR 2012	D11 PLACE OF RESIDENCE IN YEAR 2021
No.	When did [NAME] arrive to live in this region/country? WRITE MONTH AND YEAR OF ARRIVAL OF A CURRENT PLACE MM YYYY	How long has [NAME] been living in this region/Country? WRITE COMPLETE YEARS. IF LESS THAN ONE YEAR WRITE "00"	Where was [NAME] living before coming here? IF IN TANZANIA WRITE CODE 01 FOR RURAL, 02 FOR URBAN AREA AND COUNTRY CODE FOR OUTSIDE TANZANIA AND IF COUNTRY IS UNKWOWN WRITE CODE 999	What was [NAME's] main reason for moving to this region/to Tanzania?	In which Region /Country was [NAME] living during 2012 census? WRITE CODE FOR THE COUNTRY, REGION AND DISTRICT IF LIVING IN TANZANIA, OR COUNTRY CODE IF LIVING OUTSIDE TANZANIA THEN GO TO THE NEXT QUESTION IF COUNTRY IS UNKOWN WRITE CODE 999 ►TO BE ASKED FOR PERSONS AGED 11 YEARS OR ABOVE	In which Region /Country was [NAME] living in 2021? WRITE CODE FOR THE COUNTRY, REGION AND DISTRICT IF LIVING IN TANZANIA, OR COUNTRY CODE IF LIVING OUTSIDE TANZANIA THEN GO TO THE NEXT QUESTION ► FOR CHILDREN AGED '00' DON'T ASK THIS QUESTION SKIP TO E01

	To take up a paid job	Job transfer	To look for work/green pasture/clients	Study/training	Marriage	Family moved/joining familily	Medical treatment/health care	Conflict/insecurity/natural disater	Looking for suitable land for agriculture	Looking for suitable site for fishery activities	Looking for suitable grazing land	Cost of living	Moving into a new homestead	Visit friend/family	Conflict of Marriage/Family	Death of parent (s)	To be cared
	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17
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SECTION A: IDENTIFICATION

Region	District	Council	Constituency	Division/Wadi	Ward/Shehia	Village/Mtaa	Hamlet/Enumeration Area (EA)	Household Number	CONFIDENTIAL

SECTION E: INFORMATION ON POSSESSION OF NATIONAL DOCUMENTS AND ORPHANHOOD

B01	E01 BIRTH CERTIFICATE, PASSPORT, AND HEALTH INSURANCE							E02 OTHER DOCUMENTS - FOR PERSON AGED 18+						E02F ENTREPRENEUR ID - FOR PERSON AGED 5+		E03 SURVIVAL OF PARENTS (APPLICABLE TO PERSONS BELOW AGE 18)	
No.	Does [NAME] have the following Identification? Yes = 1 | No = 2 | Don't know = 9 QUESTION E01F SHOULD BE ASKED FOR A PERSON AGED 60 YEARS OR ABOVE							Does [NAME] have the following National Documents? Yes = 1 | No = 2 | Don't know = 9 ► IF D01 NOT TANZANIAN DON'T ASK CODE C, E AND F E02A1: IF A or B IS CODE 1, ASK, Please, mention National ID number of [NAME] E02C1: IF CODE C IS 1, ASK, Please, mention Zanzibar ID number of [NAME]						► IF D01 NOT TANZANIAN DON'T ASK THIS QUESTION Does [NAME] have small entrepreneur ID? Yes = 1 | No = 2 | Don't know = 9 IF CODE 2 OR 9 SKIP TO E03 E02F1: IF CODE 1, ASK, Please, mention Entrepreneur ID number of [NAME] IF ID IS NOT FOUND OR DOES NOT REMEMBER THE ID NUMBER WRITE CODE "999999999"		Is [NAME]'s Father alive? Is [NAME]'s Mother alive? Yes = 1 | No = 2 | Don't Know = 9	
	Birth Certificate	Birth Notification	Travel Passport	National Health Insurance/ Community Health Insuarence	Other Health Insuarence	Card for elderly treatment		National ID (NIDA)	National ID Number (NIDA)	Zanzibar ID	Driving Licence	Voter's ID	FILL ID NUMBER		FILL ID NUMBER		
	A	B	C	D	E	F		A	B	C	D	E				Father	Mother
01																	
02																	
03																	
04																	
05																	
06																	
07																	
08																	

SECTION A: IDENTIFICATION

Region	District	Council	Constituency	Division/Wadi	Ward/Shehia	Village/Mtaa	Hamlet/Enumeration Area (EA)	Household Number	CONFIDENTIAL

SECTION F: EDUCATION INFORMATION - ALL PERSONS AGED 4 YEARS OR ABOVE

B01	F01 READING AND WRITING	F01A NUMERACY	F02 SCHOOL ATTENDANCE	F03 REASON FOR SCHOOL DROPOUT - 4 TO 24 YEARS	F04 LEVEL OF EDUCATION
No.	Can [NAME] read and write a short sentence in Kiswahili, English, Kiswahili and English or any other language? Kiswahili = 1 English = 2 Kiswahili and English = 3 Other Languages = 4 Illiterate = 5	Can [NAME] do a simple arithmetics addition, substraction, division or multiplication? Yes = 1 | No = 2	Is [NAME] currently attending, partially attended, completed or never attended school? Now attending =1 Partially attended =2 Completed =3 Never attended =4 ► IF CODE 1 OR 3 SKIP TO F04	What was the main reason for [NAME] school dropout/never attended? Financial Constraints (01) | School too far away (02) | Ill/Sick (03) | Disability (04) | Pregnancy (05) | Truancy/Refusal (06) | Indispine behaviour /Expulsion (07) | To work/looking for work (08) | Caring for the sick/children (09) | Marriage (10) | Difficulty/dangerous environment (11) | Unfriendly infrastructure (12) | Not started school (13)	► ASK IF F02 CODED 1, 2 OR 3 What level of education has [NAME] completed or is currently attending? WRITE THE APPROPRIATE CODE
01					
02					
03					
04					
05					
06					
07					
08					

CODES FOR F03

Education level	Code
Pre Primary	00
Std 1	01
Std 2	02
Std 3	03
Std 4	04
Std 5	05
Std 6	06
Std 7	07
Std 8	08

Secondary Education

Education level	Code
Pre form one	18
Form 1	09
Form 2	10
Form 3	11
Form 4	12
Form 5	13
Form 6	14

Education after Primary/Secondary School

Education level	Code
University and other related	15
Training after Primary Education	16
Training after secondary education	17
Unit (People with mental disabilities/mental health disabilities)	19

SECTION A: IDENTIFICATION

Region	District	Council	Constituency	Division/Wadi	Ward/Shehia	Village/Mtaa	Hamlet/Enumeration Area (EA)	Household Number	CONFIDENTIAL

SECTION G: INFORMATION ON ECONOMIC ACTIVITY - ALL PERSONS AGED 5 YEARS OR ABOVE

B01	G05 OCCUPATION		G06 OWNER OF THE ENTERPRISE											G07 MAIN ECONOMIC ACTIVITY		G08 MINING AND QUARRYING ACTIVITY								G09 EMPLOYMENT STATUS				
No.	ENUMERATOR: THE FOLLOWING QUESTIONS ARE ABOUT [NAME'S] MAIN JOB OR BUSINESS. YOUR MAIN JOB IS THE ONE ON WHICH YOU USUALLY SPEND MOST OF YOUR WORKING TIME INCLUDING THOSE WHO WERE TEMPORARY ABSENT In main job, what kind of work does [NAME] usually do? WRITE OCCUPATION FULLY OR AT LEAST IN TWO WORDS		In your main work, who is the owner of the enterprise?											What is the main activity of the business or place where [NAME] work[s]? WRITE ACTIVITY FULLY OR AT LEAST IN TWO WORDS		During the period of 12 Months that is from August 2021 to the day before the census Night, Did [YOU/NAME] work on the following mining or quarrying activities? ► IF CODE "Z" SKIP TO QN. G10 READ RESPONSES								In [YOUR/NAME's] job, [do/does] [YOU/NAME] work as....?				
	DESCRIPTION	TASCO CODES	Central Government	Local Government	Parastatal Organization	NGO,religious organisation, political party, Non-profit institution	International organization or foreign embassy	Private business (non-farm)	Registered partnership or cooperative	Own or familily farm	Household(s) domestic worker	Household - Other economic activities	Other Private	DESCRIPTION	ISIC CODES	Tanzanite	Gold	Diamond	Sands	stone/gravel	Other precious gems	Other non-precious gems	Not Applicable	Paid Employee	Self Emplyed without employees	Self employed with employees	casual worker	Workers not clasifiable by status
			01	02	03	04	05	06	07	08	09	10	11			A	B	C	D	E	F	G	Z	1	2	3	4	5
01																												
02																												
03																												
04																												
05																												
06																												
07																												
08																												

SECTION A: IDENTIFICATION

Region	District	Council	Constituency	Division/Wadi	Ward/Shehia	Village/Mtaa	Hamlet/Enumeration Area (EA)	Household Number	CONFIDENTIAL

SECTION G: INFORMATION ON ECONOMIC ACTIVITY - ALL PERSONS AGED 5 YEARS OR ABOVE

B01	G10 AGRICULTURAL ACTIVITIES						G11 TYPES OF CROPS		G11A LEGAL RIGHT OVER THE OWNERSHIP								G12 TYPES OF LIVESTOCK				G13 TYPES OF FISHERY AND ACQUACULTURE		G14 TYPES OF FOREST TREES	
No.	Does [NAME] involved in agricultural activities during 2021/22 agricultural year? MULTIPLE RESPONCE IS ALLOWED ► IF CODE Z SKIP TO QN. G15						Fill Crop Type Codes (At most two)		What legal right do you have over the ownership of the land used for crop production in the aagricultural year 2021/22?								Fill Livestock Type Codes (At most two)				Fill Capture Fishery, Acquaculture Activity and Sea Weeds production Codes (At most two)		Fill Forestry/Tree Activity Type Codes (At most two)	
	Crop Farming	Livestock Keeping	Capture Fishery and Acquaculture (Fish farming, Crab, Sea Weeds production etc)	Forestry/Tree Activity	Not Applicable			Title deed	Customary law	Contract	Rented	Share cropped	Land under other forms of tenure	Doesnot own	Don't know									
	A	B	C	D	Z	FIRST CROP	SECOND CROP	A	B	C	D	E	F	G	Z	1st LIVESTOCK	2nd LIVESTOCK			1st ACTIVITY	2nd ACTIVITY	1st ACTIVITY	2nd ACTIVITY
0 1																								
0 2																								
0 3																								
0 4																								
0 5																								
0 6																								
0 7																								
0 8																								

Codes for COL. G11

Maize	11	Field peas	37	Banana	71	soursop	215	Seaweed	19	Cassava	21	Soyabeans	47
Paddy	12	Fiwi	101	Avocado	72	Rassberry	216	Cashew nut	46	Sweet Potatoes	22	Caster seed	48
Sorghum	13	Sunflower	41	Mango	73	flower	217	Tobacco	51	Irish potatoes	23	Cotton	50
Bulrush Millet	14	Sesame	42	Papaw	74	Lime	851	Pyrethrum	52	Yams	24	Malay apple	38
Finger Millet	15	Groundnut	43	Pineapple	75	Lemon	852	Sisal	53	Cocoyams	25	Bread fruit	67
Wheat	16	Palm Oil	44	Orange	76	Cabbage	86	Coffee	54	Onions	26	Jack fruit	69
Barley	17	Coconut	45	Grapes	78	Spinach	88	Tea	55	Ginger	27	Passion Fruit	70
				Mandarin	79	Carrot	89	Cocoa	56	Garlic	28	Solanum Nigrum	903
				Guava	80	Chilies	90	Rubber	57	Beans	31	collard greens	904
				Plums	81	Amaranths	91	Sugar cane	60	Cowpeas	32	Grapefruit	77
				Apples	82	Pumpkins	92	Cardamom	61	Green gram	33	Pomelo	68
				Pears	83	Cucumber	93	Jute	62	Pigeon pea	34	Bilimbi	98
				Peaches	84	Egg Plant	94	Cinnamon	64	Lentils	35	Star fruit	39
				Durian	97	Water Mellon	95	Clove	66	Bambara nuts	36	Nutmeg	65
				Rambutan	99	Cauliflower	96	Olive	110				
				Custard Apple	200	Okra	100	Green Tomato	300				
				God Fruit	201	Coriander seed	102	Lemon grass	307				
				Plum	203	Tomatoes	871	Other	998				
				Date	210	White eggplant	872	Pumpkin leaves	906				
				Vanilla	212	Green pepper	901	Black Pepper	18				
				Strawberry	213	Brocol	905	Not applicable	999				

Codes for COL. G12

Cattle	1
Goat	2
Sheep	3
Pig	4
Horse	5
Donkey	6
Chicken	7
Duck	8
Turkey	9
Rabbit	10
Other livestock	98
Not Applicable	99

Codes for COL. G13

Capture Fishery	1
Acquaculture (fish farming, crab, etc exclude sea weed)	2
Sea Weed Production	3
Not Applicable	9

Codes for COL. G14

Bee Keeping	1
Production of Seedling	2
Tree Plantation	3
Forest Product	4
Gathering and Hunting	5
Other forestry activities	8
Not Applicable	9

SECTION A: IDENTIFICATION

Region	District	Council	Constituency	Division/Wadi	Ward/Shehia	Village/Mtaa	Hamlet/Enumeration Area (EA)	Household Number	CONFIDENTIAL

SECTION G: INFORMATION ON ECONOMIC ACTIVITY - ALL PERSONS AGED 5 YEARS OR ABOVE

B01	G15	G16		G17	G18	G19								G20											
No.	Does [NAME] engage in any informal economic activitiy? Yes = 1 | No = 2 ►IF CODE 2 SKIP TO H01	What is the main activity of [NAME]'s business? WRITE ACTIVITY FULLY OR AT LEAST IN TWO WORDS		In which area does [NAME] mostly work?	Is [NAME] a member of Machinga Union Federation (SHIUMA)? Yes = 1 | No = 2	Currently, how much capital does [NAME] have?								What is the main source of [NAME]'s capital?											
	INFORMAL ECONOMIC ACTIVITIES	DESCRIPTION	ISIC CODE		MACHINGA UNION FEDERATION - SHIUMA MEMBERSHIP	Less than 10,000	10,000 - 49,999	50,000 - 99,999	100,000 - 199,999	200,000 - 499,999	500,000 - 999,999	1,000,000 - 9,999,999	10,000,000 or more	Own sources (Personal savings from salary/crops	Government assistance	Loan from Government	TASAF	Private persons assistance (friends,	Donor Assistance/Loan	Loan from Banks	Loan from Pension Funds (PSSSF, NSSSF, etc)	Loan from Cooperatives associations	Employer Assistance	Loan from Employer	Loan from SACCOS/VICOBA	Loan from SHIUMA
						1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8	9	10	11	12	13
01																									
02																									
03																									
04																									
05																									
06																									
07																									
08																									

CODES FOR QUESTION G17

WITHOUT PERMANENT PRIMISES

Hawking/mobile	01
Improvised post on the roadside	02
Permanent post on the roadside	03
Vehicle, motor bike, Tricycle, Bicycle	04
Customer's home	05
In my own/partner's home without special installation	06
Online bussiness	07
Improvised post in a market	08
Garbage area	09
Construction sites	10
Other without permanent premises	11

WITH PERMANENT PRIMISES

Permanent premises in a market (shop, kiosk, shed)	12
Workshop, shop, restaurant, hotel	13
Taxi station in permanent structure/ Public transport with fixed route	14
Bicycle /Boda boda/ Tricycle stations	15
Mining site	16
Farm/fishing or grazing area	17
Industrial area	18
Other area with permanent premises	19
In my own/partner's home with special installation	20

SECTION A: IDENTIFICATION

Region	District	Council	Constituency	Division/Wadi	Ward/Shehia	Village/Mtaa	Hamlet/Enumeration Area (EA)	Household Number	CONFIDENTIAL

SECTION H: LAND OWNERSHIP AND INFORMATION REGARDING ICT

B01	LAND OWNERSHIP - ALL PERSONS									INFORMATION REGARDING ICT - 4 YEARS OR ABOVE													
No.	H01 OWNERSHIP OF LAND					H02 TITLE DEED					H03 EQUIPMENTS OWNERSHIP				H04 EQUIPMENTS USED				H05 EQUIPMENT USE					
	Does [NAME] own any agricultural or non agricultural land either alone or jointly with someone else? ► IF THE ANSWER IS 4 OR 9 SKIP TO H03					Does [NAME] have title deed with his/her name on it?					Did [NAME] own the following equipments in the past 3 months? YES = 1 | NO = 2 | Don't Know = 9				Did [NAME] use the following equipments in the past 3 months? Yes = 1 | No = 2 | Don't Know = 9 ► IF CODE 2 OR/AND 9 FOR ALL, SKIP TO QN. I01				In which of the following activities did [YOU/NAME] you use the equipments? Yes = 1 | No = 2 | Don't Know = 9 READ ALL CATEGORIES					
	Alone	Jointly	Both alone and jointly	Does not own	Don't Know	Alone	Jointly	Both alone and jointly	No title deed	Don't Know	Smart phone/Tablet	Mobile phone	Desktop	Laptop	Smart phone/Tablet	Mobile phone	Desktop	Laptop	Communication	Search/receive information	Online buisness	Learning	Playing games/Entertainment	Sending and receiving money
	1	2	3	4	9	1	2	3	4	9	A	B	C	D	A	B	C	D	A	B	C	D	E	F
01																								
02																								
03																								
04																								
05																								
06																								
07																								
08																								

SECTION A: IDENTIFICATION

Region	District	Council	Constituency	Division/Wadi	Ward/Shehia	Village/Mtaa	Hamlet/Enumeration Area (EA)	Household Number	CONFIDENTIAL

SECTION I:INFORMATION ON FERTILITY - FEMALES AGED 10 YEARS OR ABOVE

B01		CHILDREN EVER BORN - CHILDREN SURVIVING			FERTILITY IN LAST 12 MONTHS FOR WOMEN AGED 10 TO 49 YEARS
No.	I01 BIRTH	I02 BORN ALIVE IN HOUSEHOLD	I03 BORN ALIVE LIVING ELSEWHERE	I04 CHILDREN DIED	I05 CHILDREN BORN ALIVE
	Have you ever given live birth? Yes = 1 | No = 2 ► IF CODE "2" SKIP TO I04	How many male/female children were born alive to [NAME] and are now living with you/her in this household? IF SHE IS NOT LIVING WITH ANY OF HER CHILDREN WRITE "00"	How many male/female children were born alive to [NAME] and are now living elsewhere? IF SHE HAS NO CHILDREN LIVING ELSEWHERE WRITE "00"	How many male/female children were born alive to [NAME] and are now unfortunately dead? IF NONE OF HER CHILDREN HAS DIED WRITE "00" ► IF QN 101 = 2 AND IO4 = 0 SKIP TO J01	How many of the male/female children who were born alive to [NAME] in the last 12 months? (22 AGOST, 2022 BACK TO 23 AGOST, 2021) IF THERE IS NO CHILD SURVIVING WRITE "0" ► IF THERE IS NO CHILD BORN ALIVE IN THE LAST 12 MONTHS WRITE "0" THEN GO SECTION J. DON'T ASK FEMALES AGED 50 YEARS OR ABOVE
		MALE FEMALE	MALE FEMALE	MALE FEMALE	MALE FEMALE
0 1					
0 2					
0 3					
0 4					
0 5					
0 6					
0 7					
0 8					

SECTION A: IDENTIFICATION

Region	District	Council	Constituency	Division/Wadi	Ward/Shehia	Hamlet/Enumeration Area (EA)	Kitongoji/Eneo la Kuhesabia Watu (EA)	Household Number	CONFIDENTIAL

SECTION J: INFORMATION ON GENERAL AND MATERNAL DEATHS IN THE HOUSEHOLD

PLEASE RECORD INFORMATION ON DEATHS THAT OCCURRED IN THE HOUSEHOLD DURING THE LAST 12 MONTHS. DO NOT FORGET CHILDHOOD MORTALITY

J01 Was there any death which occurred in this household during the last 12 months? (i.e. 22 AUGUST 2022 - 23 AUGUST 2021)

Yes = 1 | No= 2 ☐

► IF THE ANSWER IS NO, SKIP TO SECTION K

J02 How many number of death occurred in this household during the last 12 months

RECORD THE NUMBER OF DEATHS ☐☐

J03	SEX AND AGE OF DECEASED; AND CAUSE OF DEATH			IF DEATH IS OF A WOMAN AGED 10 TO 49 YEARS			
Death Serial Number	J04 SEX OF DECEASED	J05 AGE OF DECEASED	J06 CAUSE OF DEATH	J07 DURING PREGNANCY	J08 DURING CHILDBIRTH	J09 DURING SIX WEEKS	J10 PLACE OF DEATH
	Was the deceased a male or a female? Male =1 Female =2	How old was the deceased at the time of death? WRITE AGE IN COMPLETE YEARS. IF UNDER ONE YEAR WRITE "00" IF 97 YEARS OR ABOVE WRITE '97'	What was the main cause of death?	Did the death occur during pregnancy? Yes = 1 No = 2 ► IF CODE 1 SKIP TO QUESTION J10	Did the death occur during childbirth? Yes = 1 No = 2 ► IF CODE 1 SKIP TO QUESTION J10	Did the death occur during the 6 weeks period following the end of pregnancy, irrespective of the way the pregnancy ended? Yes = 1 No = 2	ASK IF QJ07 OR J08 OR J09 = 1 Did this death occurred at home or in health facility? Home = 1 Health facility = 2 On the way = 3
			Road Accident (1) / Other Accidents (2) / Suicide (3) / Domestic Violence/Homicide (4) / Sickness/Disease (5) / Martenal Death (6) / Killed (7) / Unspecified reasons (8)				
01							
02							
03							
04							
05							
06							
07							
08							

SECTION A: IDENTIFICATION

Region	District	Council	Constituency	Division/Wadi	Ward/Shehia	Village/Mtaa	Hamlet/Enumeration Area (EA)	Household Number	CONFIDENTIAL

SECTION K: HOUSING OWNERSHIP, CONDITIONS, CHARACTERISTICS AND ASSETS

K01 OWNERSHIP OF THE HOUSE/BUILDING

What is the ownership status of the main dwelling used by this household?

► IF CODE 2 or ABOVE SKIP TO K03

1	2	3	4	5	6	7
Owned by household	Lived in without paying any rent	Rented privately	Rented by employer	Rented by Government at susdize rent	Owned by employefr - free of charge	Owned by employer - with rent

K02 LEGAL RIGHT OVER THE OWNERSHIP

What legal right do you have over the ownership of this land where your house is built?

1	2	3	4	5	6	7	8
Title deed	Residential licence	Letter of offer/Acknoleggement of payments	Customary ownership	Contract	Land Registration Card (Zanzibar)	Official document from Mtaa/Kijiji/Shehia	No legal right

K03 ROOFING MATERIALS

What is the main roofing material used for the main building of this household?

1	2	3	4	5	6	7	8
Iron sheets	Tiles	Concrete	Asbestos	Grass/Leaves	Mud and Leaves	Plastics/Box	Tent

K04 FLOORING MATERIALS

What is the main flooring material used for the main building of this household?

1	2	3	4	5	6	7	8	9	10
Cement	Ceramic tiles	Parquet or Polished wood	Terazzo	Vinyl or Asphalt strips	Wood Planks	Palm/Bamboo	Earth/Sand	Dung	Tent/Containers

K05 WALL MATERIALS

What is the main wall material used for the main building of this household?

1	2	3	4	5	6	7	8	9	10
Stones	Cement bricks/rock bricks	Sundried bricks	Burnt bricks	Timber	Timber and Sheets	Poles and mud	Grass	Glass/Aluminium	Tent/Containers

K06 ROOMS FOR SLEEPING

How many rooms are available for sleeping in this household?

RECORD NUMBER OF ROOMS FOR SLEEPING

K07 MAIN SOURCE OF DRINKING WATER

What is the main source of drinking water for this household?

01	02	03	04	05	06	07	08	09	10	11	12	13	14
Piped water into dwelling	Piped water in the yard/plot	Public tap/standpipe	Neighbours tap/standpipe	Tubewell/borehole	Protected dug well	Unprotected dug well	Protected spring	Unprotected spring	Rain water	Bottled water	Bicycle/Motorcycle/Cart with small tank/drum	Tanker truck	Surface water (river, dam, lake, pond, stream,charco, canal, irrigation channels)

K08 MAIN SOURCE OF ENERGY FOR COOKING

What is the main source of energy used by this household for cooking?

01	02	03	04	05	06	07	08	09	10	11	12	13	99
Electricity (TANESCO/ZECO)	Solar	Generator/private sources	Gas	Biogas	Wind generated Electricity	Paraffin	Coal	Charcoal	Firewood	Wood/ residuals	Animal residuals	Charcoal briquette	Not Applicable

SECTION A: IDENTIFICATION

Region	District	Council	Constituency	Division/Wadi	Ward/Shehia	Village/Mtaa	Hamlet/Enumeration Area (EA)	Household Number	CONFIDENTIAL

SECTION K: HOUSING OWNERSHIP, CONDITIONS, CHARACTERISTICS AND ASSETS

K09 What is the main source of energy used by this household for lighting?

Electricity (TANESCO/ZECO)	Solar	Generator (private source)	Gas (Industrial)	Gas (Biogas)	Wind generated Electricity	Acetylene lamp	Kerosene (lantern/chimney)	Kerosene (Wick lamps)	Candles	Firewood	Torch/Chines lamp	Electricity (Generated from plant residues)
01	02	03	04	05	06	07	08	09	10	11	12	13

K10 What is the main type of toilet facility used by this household?

Flush/pour flush to piped sewer system	Flush/pour flush to septic tank	Flush/pour flush to covered pit	Flush/pour flush to somewhere else	Ventilated improved pit (VIP) latrine	Pit latrine with washable slab and with lid	Pit latrine with washable slab without lid	Pit latrine with not-washable/ soil slab	Pit latrine without slab/ open pit	Bucket	No facility/bush/field/ beach
01	02	03	04	05	06	07	08	09	10	11

K11 How does the household dispose solid waste?

► IF RESPONSE IS CODE 3-9 SKIP TO K13

Regularly collected	Irregularly collected	Burnt	Roadside dumping	Burying/pit	Open space	Ocean/Lake/River/Shores	In the farm/manure	Bush/ravine
01	02	03	04	05	06	07	08	09

K12 Which authorities usually collect waste from your household?

Contractor	Waste collecting groups	Council	Private Individual(s)
1	2	3	4

K13 Does your household usually sort kitchen waste, plastic waste, glass waste, metal waste and electronic waste?

YES = 1 | NO = 2

K14 What is the main method that is used by your household to dispose E-Waste?

Mixed with other Refused	Collected by Government	Collected by Private Company	Dumped in the compound/street	Dumped in the Latrine	Burnt in open/pit	Buried	Sold/given as gift	Collected by individual (s)
1	2	3	4	5	6	7	8	9

K15 OWNERSHIP OF EQUIPMENTS/ASSETS

Does your household have/own the following assets?

Yes = 1 | No = 2

FOR CODE 1, ASSETS SHOULD BE IN WORKING CONDITION. SELECT THE APPROPRIATE ANSWER FOR EACH ITEM

Radio	Telephone (Land Line)	Mobile Phone	Bicycle	Motor vehicle	Motorcycle/Vespa	Tricycle (Guta)	Tri motorcycle (Bajaj)	Television	Electric Iron	Charcoal Iron	Cooker (Electric or Gas)	Refrigerator/Freezer	Computer /Laptop	Internet Facility	Plough	Power tiller	Hand hoe	Wheelbarrow	Oxen	Draft animals (Donkey/Camel)	House	Land/Farm	Tractor	Don't have/own
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y

SECTION A: IDENTIFICATION

Region	District	Council	Constituency	Division/Wadi	Ward/Shehia	Village/Mtaa	Hamlet/Enumeration Area (EA)	Household Number	CONFIDENTIAL

SECTION L: INFORMATION ON AGRICULTURE, LIVESTOCK, FISHERIES AND FORESTRY

L01 AGRICULTURE

Did this household use the land for crop production in the agricultural year 2021/22?

Yes = 1 | No = 2 ☐

► IF CODE 2 SKIP TO L03

IF CODE 1, how many acres is the land used for agriculture?

LAND FOR CROP PRODUCTION SHOULD BE AT LEAST 25 SQUARE METERS

L02 CROPS

Which of the following crops did the household grow during 2021/22 agricultural year?

MULTIPLE RESPONSE IS ALLOWED

Yes = 1 | No = 2

Maize	Paddy	Cassava	Banana	Sunflower	Other food crops	Cash crops
A	B	C	D	E	F	G

L03 LIVESTOCK

Did this household raise or care cattle, goats, sheep or poultry for the agricultural year 2021/22?

Yes = 1 | No = 2 ☐

► IF CODE 2 SKIP TO L06

L04 NUMBER OF LIVESTOCK

How many cattle, goats, sheep, pig, donkey or poultry were available during the Census night

IF NO LIVESTOCK , WRITE CODE "00000"

Cattle	
Goat	
Sheep	
Pig	
Donkey	
Poultry	

L05 TYPE OF GRAZING

What type of grazing is practiced in this household?

Free range = 1
Zero grazing = 2
Ranch = 3
Pastoralism = 4

THIS QUESTION SHOULD BE ASKED FOR EACH TYPE OF LIVESTOCK MENTIONED IN QUESTION L04

Cattle	
Goat	
Sheep	
Pig	
Donkey	
Poultry	

L06 FISHING/SEAWEED FARMING

Did this household engaged in fishing/fish farming/Sericulture/crabs/seaweed farming activities for the agricultural year of 2021/22?

MULTIPLE RESPONSE ALLOWED

Yes = 1 | No = 2

A	Fishing	
B	Fish farming/Sericulture/Crabs	
C	Seaweed farming	

L07 OWNERSHIP OF PLANTATION

Did this household operate any land for woodlot(s) during 2021/22 agricultural year?

Yes = 1 | No = 2 ☐

LAND FOR WOODLOTS SHOULD BE AT LEAST 0.5 ACRES

L08 BEEKEEPING

Is there any person in this household involved in beekeeping business/activity?

Yes, individually = 1 | Yes, in groups = 2 I No= 3 ☐

SECTION A: IDENTIFICATION

Region	District	Council	Constituency	Division/Wadi	Ward/Shehia	Vilage/Mtaa	Hamlet/Enumeration Area (EA)	Household Number	CONFIDENTIAL

INFORMATION ON PHYSICAL ADDRESS

A01A	Does this household have a physical address?	Yes = 1 | No = 2	▶ IF CODE 2 SKIP TO SECTION Z
A01B	Please, state the Physical Address Number		
A01C	Name of the Road/Hamlet		

SECTION Z: TOTAL NUMBER OF HOUSEHOLD MEMBERS

Male	
Female	
Total	

Date of Interview	D	D	M	M	Y	Y	Y	Y