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Malawi Vital Statistics Report 2022

Findings from Civil Registration Records

National Statistical Office, National Registration Bureau and Ministry of Health. Malawi Vital Statistics Report 2022: Findings from Civil Registration Records. Zomba, Malawi.

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Preface



Civil registration is one of the important sources of vital statistics which provides demographic and epidemiological data needed for policy direction, decision making, planning and resource allocation among others by government, private sector, and the civil society.

For a long time, Malawi has relied on censuses, surveys and facility-based Health Information Management System (HIMS) to produce vital statistics for use and reporting at national and international level, in the absence of a fully functional Civil Registration and Vital

Statistics (CRVS) system.

The government of Malawi is fully aware of the need for quality statistics in policy formulation, planning, decision making, targeting of resources and monitoring and evaluation of the Malawi 2063 Vision and Sustainable Development Goals (SDGs) and other development initiatives. A fully operational civil registration system will provide accurate and timely information on births and deaths which are essential for national planning and appropriate resource allocation to reduce health inequalities using population-based indicators. This report will feed directly into public health interventions and planning.

Vital statistics from the civil registration system are also very critical to measuring attainment of Sustainable Development Goals (SGDs). Twelve of the seventeen SDGs require population-based targets for which civil registration data can provide the relevant denominator. Additionally, 67 of the 232 SDG indicators can directly be computed from civil registration data.

This Malawi's first official vital statistics report from civil registration data provides information for monitoring trends of key population indicators, such as, numbers, rates and characteristics of births and deaths such as births by gender, sex, age, location, maternal age, birth weight, location and cause of deaths and trends in deaths (etiology and epidemiology).

On the other hand, the report provides an opportunity to learn from experience and inform investment efforts to improving the civil registration system in the country. It brings to the fore challenges in completeness, total coverage, quality of data, timeliness, reliability and disaggregation of the data, all of which need to be improved by increasing investment for improving CRVS system in

the country including coordination among key players. This will also help build trust and confidence in data use.

This report reaffirms Malawi's commitment to recommendations from the Conference of African Ministers responsible for Civil Registration in Côte d'Ivoire in 2014. The recommendation encourages member countries to produce vital statistics based on civil registration data regardless of the level of completeness to establish the state of the system and its development.

The National Statistical Office, National Registration Bureau and the Ministry of Health therefore commit to producing quality vital statistics report annually and at any time needed for use by all stakeholders.

The report is produced based on the births, deaths and causes of deaths registered from 2015 to 2022 for births and 2017 to 2022 for deaths.

Mphatso SAMBO

Principal Secretary – National Registration Bureau

Acknowledgements



This report is a joint effort by the National Statistics Office (NSO), National Registration Bureau (NRB) and the Ministry of Health (MoH) with support from development partners particularly, the United States Centre for Disease Control and Prevention (CDC), UNFPA, UNICEF and UNECA.

The NSO, NRB and MoH wish to acknowledge the efforts of various institutions that contributed in different ways in the development of the civil registration system in the country which is the source of the data used to produce this vital statistics report. They include CDC, UNICEF, Community of St. Egidio, UNDP, UNECA, Elizabeth Glaser Paediatric Aids Foundation (EGPAF), BHT, and Vital Strategies among others. These have been key in developing and strengthening the civil registration and vital statistics system in the country.

A word of appreciation goes to NSO, NRB and MOH CRVS technical team who worked tirelessly in the compilation, data alignment and analysis to come up with this report which is the first of its kind for Malawi. The following contributed immensely in putting this report together at the NSO: Deputy Director: Isaac CHIRWA; Chief Statistician, Richard PHIRI; Principal Statisticians Atusaye MWAMBYALE, Glory MSHALI and Lusungu CHISESA; and Statistician, Chisomo SINGANO. From MoH, Dr. Amos NYAKA and Dr. Yankho LUWE, Central Coding Unit supervisor and acting Deputy Director respectively. From NRB, the following were instrumental in the compilation of this report: Chief Registration Officer, Rhodric LANGWE; Principal Registration Officers Daniel MANDA and John CHILENGA; Principal Economist, Francis MUKHUPA; and Project Officers Masauso MUSSA and Charles KATCHEREKHWANYA. Special thanks to the CRVS Technical Advisor, Pierre DINDI who coordinated the data analysis and report writing exercise.

Finally, special thank you goes to the United Nations Economic Commission for Africa (UNECA) for providing the technical support through training, guidelines and lay out of the report; and the Norwegian Statistics Bureau (SSB) for providing a comprehensive technical review of the draft report.

Shelton KANYANDA
Commissioner of Statistics

Acronyms and abbreviations

ASFR	Age-specific fertility rate
ASMR	Age-specific mortality rate
CBR	Crude birth rate
CDR	Crude death rate
CRVS	Civil registration and vital statistics
CSMF	Cause-specific mortality fraction
D4H	Bloomberg Philanthropies Data for Health Initiative
DHS	Demographic and Health Survey
ECA	(United Nations) Economic Commission for Africa
ESCAP	(United Nations) Economic and Social Commission for Asia and the Pacific
IMR	Infant mortality rate
MMR	Maternal mortality ratio
MCCD	Medical certification of cause of death
NMR	Neonatal mortality rate
TFR	Total fertility rate
UN	United Nations
US CDC	United States Centers for Disease Control and Prevention
U5MR	Under-5 mortality rate
VA	Verbal autopsy
VS	Vital statistics
WHO	World Health Organization

Definitions

These definitions are based on the United Nations *Principles and Recommendations for a Vital Statistics System*, Revision 3 (2014)¹, *Essentials of Demographic Analysis for Africa*, *Fundamentals of Demographic Analysis*, *Concepts, Measures and Methods*, and *Demography: An Introduction to Population Studies*:

Age-specific fertility rate (ASFR): The annual number of births to women of a particular age group per 1,000 women in that age group.

Age-specific mortality rate (ASMR): A mortality rate limited to a particular age group. The numerator is the number of deaths in that age group; the denominator is the number of persons in that age group in the population.

Cause of death: ‘All those diseases, morbid conditions or injuries which either resulted in or contributed to death and the circumstances of the accident or violence which produced any such injuries.’² Symptoms and modes of dying, such as heart failure or respiratory failure, are not considered to be causes of death for statistical purposes (see ‘ill-defined cause of death’).

Completeness of registration: The proportion of vital events that are registered. It is the number of registered vital events divided by an estimate of the actual number of vital events that occurred in the same population during a specific period of time.

Crude birth rate (CBR): The number of live births relative to the size of that population during a given period, usually one year. It is expressed as the number of live births per 1,000 population per year.

Crude death rate (CDR): The number of deaths relative to the size of that population during a given period, usually one year. It is expressed as the number of deaths per 1,000 population per year.

Date of occurrence is the exact date when the event occurred, and should be expressed in terms of day, month and year. Total numbers of registered live births, deaths, foetal deaths, marriages and divorces should be based on date of *occurrence*, which is the recommended basis for the time reference of all vital statistics tabulations.

¹ Available at: <https://unstats.un.org/unsd/demographic/standmeth/principles/M19Rev3en.pdf>

² United Nations (2014). *Principles and recommendations for a vital statistics system*. Revision 3. Department of Economic and Social Affairs, Statistics Division Statistical Papers, Series M No. 19/Rev.3, New York.

Date of registration of a vital event is the day, month and year when the entry in the civil registration system was made. The time of day, i.e., hour and minutes, may also be recorded if required by the registration law.

Death: The permanent disappearance of all evidence of life at any time after live birth has taken place (postnatal cessation of vital functions without capability of resuscitation). This definition excludes foetal deaths, which are defined separately.

Ill-defined cause of death: Any code that cannot or should not be used for the underlying cause of death (generally referring to 'R codes'). For instance, a 'mode of death' such as heart failure or kidney failure, symptoms such as back pain or depression, and risk factors such as high blood pressure are all uninformative, ill-defined codes for public health purposes.

Infant mortality rate (IMR): Probability (expressed as a rate per 1,000 live births) of a child born in a specific year or period dying before reaching the age of 1, if subject to age-specific mortality rates of that period.

Life expectancy at birth: The average number of years that a newborn could expect to live, if he or she were to pass through life exposed to the sex- and age-specific death rates prevailing at the time of his or her birth, for a specific year, in a given country, territory, or geographic area.

Live birth: 'The complete expulsion or extraction from the mother of a product of conception, irrespective of the duration of pregnancy, which, after such 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 (all live-born infants should be registered and counted as such, irrespective of gestational age or whether alive or dead at the time of registration, and if they die at any time following birth, they should also be registered and counted as deaths).'

³

³ United Nations (2014). Principles and recommendations for a vital statistics system. Revision 3. Department of Economic and Social Affairs, Statistics Division Statistical Papers, Series M No. 19/Rev.3, New York.

Maternal death: 'The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.'⁴

Maternal mortality ratio (MMR): The number of maternal deaths during a given time period per 100,000 live births during the same time period.

Neonatal mortality rate (NMR): Probability (expressed as a rate per 1,000 live births) of a child born in a specific year or period dying in the first 30 days of life, if subject to age-specific mortality rates of that period.

Place of occurrence is the geographical location in the country: (a) locality and (b) major division or other geographical place in which the locality is situated, where the live birth, death, delivery of a dead foetus, marriage or divorce occurred. In this report the place of occurrence (and registration and usual residence) is usually the *district* of occurrence (and registration). Counts of the numbers of vital events by place of occurrence are useful for the planning and evaluation of various medical, health and social programmes. For example, data on the number of live births or deaths by place of occurrence are useful in the planning and evaluation of medical facilities and manpower, and in monitoring the workload and performance of the civil registration system in each civil division.

Place of registration is the geographical location in the country: (a) locality and (b) major civil division or other geographical place, where the live birth, death, delivery of a dead foetus, marriage or divorce is registered in the civil registration system. This information should be provided in enough detail to enable each specific registration office to be identified for a variety of administrative purposes, including backtracking for clarification of registration and statistical reporting problems, for local registration office workload analyses, and for optimal geographical distribution of registration points with reasonable proximity to where vital events are occurring.

Place of usual residence is the geographical location in the country, locality or civil division, or foreign country, where the specified person usually resides. This need not be the same as either the place where he or she was found at the time of the occurrence of the event or inquiry, or his or her legal residence. For vital statistics purposes, the place of usual residence of a live birth, a foetal death or

⁴ World Health Organisation (2004). ICD-10. International Statistical Classification of Diseases and Related Health Problems., Tenth revision, second edition. Geneva.

an infant death is the place where the mother usually resides. Most tables and graphs should be based on the place of usual residence.

Sex ratio at birth: The number of male births for a specific area and during a specified period divided by the number of female births for the same area and period. The sex ratio is an important demographic indicator of the distribution of boys and girls at birth.

Total fertility rate (TFR): The sum of age-specific fertility rates for females aged between 15 and 49 years during a specified period, usually one year. It is an estimate of the average number of children a cohort of women would bear if they went through their childbearing years experiencing the same age-specific fertility rates.

Under-5 mortality rate (U5MR): The probability of a child born in a specific year or period dying before reaching the age of 5, if subject to age-specific mortality rates of that period. The under-5 mortality rate as defined here is strictly speaking not a rate (i.e. the number of deaths divided by the number of population at risk during a certain period of time) but a probability of death derived from a life table and expressed as rate per 1,000 live births.

Underlying cause of death: The cause of death to be used for primary statistical tabulation purposes has been designated as the underlying cause of death. The underlying cause of death is defined as '(a) the disease or injury which initiated the train of events leading directly to death, or (b) the circumstances of the accident or violence which produced the fatal injury.'⁵

Urban and rural is a derived topic of high priority in a vital statistics system which is based on geographical information obtained from place of occurrence and place of usual residence. Because of national differences in the characteristics that distinguish urban from rural areas, the distinction between the urban and rural populations is not yet amenable to a single definition that would be applicable to all countries or, for the most part, even to the countries within a region. Where there are no regional recommendations on the matter, countries must establish their own definitions in accordance with their own needs. Most countries base their definition of urban and rural on administrative areas, while a few countries use population density as the basis.

⁵ United Nations (2014). Principles and recommendations for a vital statistics system. Revision 3. Department of Economic and Social Affairs, Statistics Division Statistical Papers, Series M No. 19/Rev.3, New York.

Executive summary

The Malawi Government through the National Registration Bureau has set up a strong foundation for its National Identification and Registration Systems (NIRS) as a basis for generation official vital statistics. CRVS data is useful for assessment of programs and monitoring progress towards attainment of the goals outlined in the Malawi Implementation Plan (MIP-1) of the Malawi Agenda 2063, as well as tracking of international obligations that Malawi is a signatory to such as the Sustainable Development Goals.

Births

Overall, the annual number of deaths registered depicts an increasing trend from just over 15,000 births at the time of initiating mandatory birth registration in 2015 to 205,069 in 2022. This has been mainly attributed to expansion in geographical coverage from four districts in 2015 to all districts in 2018. Subsequently, there has been an increase in the timeliness of registration of births from 2.2% in 2015 to 32.8% in 2022. The completeness of birth registration is higher among males than females.

Weighted results indicate an overall higher sex ratio for all years except for 2018. The sex ratio was 100.8 boys per 100 girls in 2019 and 2020, 101.8 in 2021, and 103.3 in 2022, which is in line with the observations for all countries of the world. The weighted crude birth rate from CRVS data confirms that reported in the census reports. CBR has shown a decreasing trend from 34 births per a 1,000 population in 2019 to 32.3 births per a 1,000 population in 2022. Similarly, the total fertility rate (TFR) shows comparable patterns to that from other sources, e.g. the census and MICS reports. Civil registration data estimate TFR to 4.1 children per woman in 2018, with a decreasing trend to 4.0, 3.9, 3.8 and 3.7 children per woman in later years.

Deaths

Generally, the total annual number of deaths registered has steadily increased from 6,277 at the launch of mandatory death registration in 2018 to 13,653 in 2022. This signifies a 118% increase over the period. The years 2020 and 2021 had the highest death registration numbers at 17,409 and 17,479, respectively, as a result of a backlog clearing exercise that saw data being entered enmasse. There were more male deaths registered than females across each year translating to a relatively higher completeness of death registration among males than females. Male completeness rose from

6.7% to 13.1% between 2018 and 2022, and female completeness of death registration from 3.5% to about 10.2% within the same period.

Weighted results show that crude death rate has dropped steadily from 7.1 to 6.5 deaths per 1,000 population from 2018 to 2022. This drop is similar to population projections assumptions. CRVS results indicate an increasing under-5 mortality rate from 4.2 deaths per 1,000 live births in 2018 to 17.5 deaths per 1,000 live births in 2022. This could be due to the increase in completeness of death registration. These findings are quite different from the UNICEF-reported under-5 mortality rate of 40.1 deaths per 1,000 live births, most likely due to the low completeness of death registration. Nevertheless, actual registered deaths during pregnancy ranged from 28 in 2018 to 92 deaths in 2022.

Leading causes of death

The top four leading causes of deaths among infants of both sexes were prematurity/low birth weight, birth asphyxia/birth trauma, lower respiratory infections and malaria. While HIV was the 5th leading cause of death among female infants, male infants had endocrine disorders at the 5th leading cause of death. HIV was the least cause of mortality in infant males, whereas protein-energy malnutrition was the least cause among female infants.

Malaria and protein-energy malnutrition are the first and second leading causes of death among children aged between 1 and 14 years old. While lower respiratory infections are the third leading cause among those aged 1 and 4 years old, older children from age 5 years up to 14 years succumbed to endocrine disorders. Drowning is the least (10th) cause of death among male children aged 1 – 4 years, whereas HIV is the least cause of death among this demographic. Among children aged between 5 and 14 years, lower respiratory infections were the least cause of death.

HIV is the leading cause of death among the adult population aged between 15 and 69 years followed by cerebrovascular disease, and diabetes mellitus. Tuberculosis and malaria are the fourth and fifth leading cause of deaths in this age group. On the other hand, alcohol use disorders and road traffic accidents were the least causes of deaths among the adult population. Old age mortality (70+ years) was predominantly caused by cerebrovascular disease, diabetes mellitus and lower respiratory infections as the top three leading causes.

Leading causes of death by broad age group and sex (only for years below 5 years), 2022

	Males	Females
0 – 1 years	1 Prematurity and low birth weight	1 Prematurity and low birth weight
	2 Birth asphyxia and birth trauma	2 Birth asphyxia and birth trauma
	3 Lower respiratory infections	3 Lower respiratory infections
	4 Malaria	4 Malaria
	5 Endocrine disorders	5 HIV
	6 Congenital heart anomalies	6 Diarrhoeal diseases
	7 Diarrheal diseases	7 Congenital heart anomalies
	8 Tuberculosis	8 Endocrine disorders
	9 Iron deficiency Anaemia	9 Meningitis
	10 HIV	10 Protein-energy malnutrition
1 – 4 years	1 Malaria	1 Malaria
	2 Protein-energy malnutrition	2 Protein-energy malnutrition
	3 Lower respiratory infections	3 Lower respiratory infections
	4 Iron deficiency Anaemia	4 Diarrhoeal diseases
	5 Diarrhoeal diseases	5 Endocrine disorders
	6 Endocrine disorders	6 Iron deficiency Anaemia
	7 HIV	7 Meningitis
	8 Congenital heart anomalies	8 Tuberculosis
	9 Nephritis and nephrosis	9 Leukaemia
	10 Drownings	10 HIV
5-14 years	1 Malaria	
	2 Protein-energy malnutrition	
	3 Endocrine disorders	
	4 Road traffic accidents	
	5 Iron deficiency Anaemia	
	6 HIV	
	7 Rheumatic heart disease	
	8 Meningitis	
	9 Nephritis and nephrosis	

	10 Lower respiratory infections
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15–69 years	1	HIV
	2	Cerebrovascular disease
	3	Diabetes mellitus
	4	Tuberculosis
	5	Malaria
	6	Endocrine disorders
	7	Nephritis and nephrosis
	8	Lower respiratory infections
	9	Road traffic accidents
	10	Alcohol use disorders

70+ years	1	Cerebrovascular disease
	2	Diabetes mellitus
	3	Lower respiratory infections
	4	Hypertensive disease
	5	Malaria
	6	Nephritis and nephrosis
	7	COVID-19
	8	Endocrine disorders
	9	HIV
	10	Diarrhoeal diseases

Chapter 1.

Introduction and methodology

1.1 Introduction

The UN Statistics Commission defines Civil Registration as “the continuous, permanent, compulsory, confidential and universal recording of the occurrence and characteristics of vital events (live births, deaths, foetal deaths, marriages, and divorces) and other civil status events pertaining to the population as provided by decree, law or regulation, in accordance with the legal requirements in each country.”⁶ Vital statistics constitute the collection of statistics on vital events in a lifetime of a person, including relevant characteristics of the events themselves and of the person and persons concerned.

This report presents statistics pertaining to vital events namely births and deaths as recorded in the National Population Register. Vital statistics on births, deaths and cause of deaths are used to provide fundamental demographic and epidemiological measures needed in national planning for efficient and effective provision of social services. The report will also help Malawi to monitor progress in achievement of the Sustainable Development Goals (SDGs) by 2030. This includes tracking improvements in child protection rights and evaluating the success of programs enacted to combat communicable diseases (CDs) and non-communicable diseases (NCDs) as major public health concerns in the region. The report is particularly useful for ministries, departments, and agencies such as the National Planning Commission, Ministry of Health, Ministry of Education, Ministry responsible for child protection and welfare, among others. The report could also trigger a policy dialogue that will enable the National Statistics Office, National Registration Bureau, the Ministry of Health and stakeholders to put in place mechanisms for improving the civil registration system in Malawi to achieve desired coverage and completeness.

This is the first report for Malawi and covers the period from 2015 to 2022. It was compiled by the National Statistics Office in collaboration with the National Registration Bureau (NRB) and the Ministry of Health (MoH) with support the Government of Malawi and partners including CDC, UNFPA

⁶ Principles and recommendations for a vital statistics system, revision 3

and UNICEF. This compilation uses a reporting framework provided by the United Nations Economic Commission for Africa (ECA) with technical support from the Economic and Social Commission for Asia and the Pacific (ESCAP), Statistics Norway, Bloomberg Philanthropies, Data for Health Initiatives and Vital Strategies.

The report is organised in the following main chapters:

Chapter 1: Introduction and methodology

Chapter 2: Malawi's Civil Registration System

Chapter 3 Data quality, timeliness, and completeness of registration

Chapter 4 Births

Chapter 5 Deaths

Chapter 6 Causes of Death

Chapter 7 Summary tables

1.2 Data sources and methodology

This report has used data from the civil registration system, and the 2008 and 2018 census reports from the NSO. The data were analysed using SPSS, Stata, and Excel. The data analysis process involved consolidating/merging data from different years to create one CSV and DTA (Stata) file. Data cleaning including deduplication, imputation of missing data where information was unavailable, and correction of data inconsistencies. Given the low completeness of registration (Table 3.4 and Table 3.6), survey weights were generated for each district against the reported census population numbers. However, during tabulation, weights were not applied for selected sensitive indicators e.g., under-5 mortality due to the large variance.

For mortality and cause of death data, ANACoD, a tool developed by the World Health Organisation to perform comprehensive and systematic analysis of mortality and cause of death data, was used. This tool allowed for the automated tabulation and presentation of basic mortality measures in tables and figures.

The major data limitations that were faced during the compilation of this report include;

- Missing values for variables such as sex, year of birth and death.
- Missing variables between system upgrades
- Inconsistent data formats between system upgrades.
- Differences in variable naming between system upgrades.

Chapter 2. Malawi's Civil Registration System

2.1. History

The Government of Malawi established the National Registration Bureau (NRB) in 2003 to implement, coordinate, manage and maintain the National Registration and Identification System (NRIS) with Civil Registration Systems as a major component. The NRIS functions within the domain of National Registration Act (NRA)⁷ promulgated by the Government in 2010 that makes, inter alia, the registration of births and deaths compulsory. The procedures, roles and responsibilities of different functionaries associated with the administration of Civil Registration and Vital Statistics (CRVS) have been gazetted in the Regulations to the Act that became functional from 1st August 2015. A central objective of a functioning CRVS system, is to yield accurate and timely information on births and deaths, which is essential for national development and public health service delivery planning.

Civil Registration in Malawi started in 2015 with facility birth registration on a pilot basis involving four districts and then was gradually rolled out to the rest of the districts reaching full district coverage in November 2017. In February 2018, facility death registration was also introduced in the same pilot districts and was gradually rolled out to the rest of the districts and at the time of writing this report in 2023 the roll-out had reached all districts. Community birth and death registration started on a pilot basis in the two districts Balaka and Ntcheu in 2018 and is still being rolled out to the rest of the districts. At the time of writing this report, community registration had been implemented in 18 of the 28 districts in the country.

The major improvement has been the integration of Civil Registration and the ID management system for real time verification of records and deduplication. The centralized system has also incorporated the scanning of the reporting forms to be stored in the system. Coupled with this, there has been a decentralization of printing of deaths and births certificates within districts, such that we are now able to issue certificates of new-borns to mothers at discharge after delivery.

⁷ National Registration Act, 2010

The CRVS improvement in Malawi is technically and financially supported by the Government of Malawi with support from CDC, EGPAF, Community of Saint Egidio and United Nations particularly UNECA, UNICEF, UNDP, UNFPA and WHO.

2.2. Legal and administrative issues

2.2.1. Legal Framework

The National Registration Act (2010) makes registration of births, deaths and marriages compulsory. In 2015, national regulations were added and in accordance with the legal framework both births and deaths are to be registered within six weeks of the occurrence. Events registered within six weeks are categorised as *current* registrations, whereas those registered between six weeks and one year are regarded as *late* registrations. Those beyond one year are regarded as *delayed* registrations. For late registration there is a penalty fee, which should be paid before registration.

Both the Act and the Regulations are currently under review to incorporate among others, the classification of registration of births and deaths. The Act and Regulations place the duty to register the vital events with the civil registration officers, health officers and parents/guardians/relatives. Non-registration is also penalized in the legal framework. Both the Act and Regulations specify the forms required to process registration of vital events, which are to be completed before registration. There is no restriction of who can be registered, Foreign citizens, refugees, asylum seekers and stateless persons are included so long as the vital event occurs within the borders of Malawi. The law provides for registration of vital events of Malawians in diaspora through Embassies, Consulates and High Commission Offices, although Malawi is yet to start this type of registration. The law specifies that parents and immediate relatives should be the informants in the registration process.

The law prohibits disclosure of personal information recorded in any register, document, or proof of registration, except for the purposes of the Act or any judicial proceedings or the performance of its functions. The law gives the responsible Minister discretion to share information recorded in the civil register for official use. The law provides for registration of cause of death although this is not a requirement for death registration. The law requires that a report of a death that occurred as a result of a road accident, violent physical act or any other unnatural cause shall be accompanied by a Police report after investigation. The Civil Registration system and the ID System are linked for the generation of unique identity numbers as well for identification of individuals in the CR System and

other systems. The National Statistics Act assigns the overall responsibility for official vital statistics production to the Commissioner for Statistics but does not specify the periodicity of production of vital statistics.

2.3 Organisational structure, registration processes and information flows

This section outlines the current (As-Is) Business Process for the CRVS System in Malawi focussing on the registration process and information flows for births and deaths.

2.3.1. Birth Registration

The reporting of birth and death takes place at health facilities, and District Registration Offices (DROs). Once a birth has taken place, a responsible person captures the child's details on a registration form (NR8). The data in the form is then entered into the electronic birth registration system (eBRS) located at the health facility or district registration office. Once data entry is done and has gone through all the quality checks in the eBRS, the record is electronically sent to NRB headquarters to be approved for certificate printing.

NRB successfully integrated the birth registration system and the National ID system such that once a birth is registered, a unique number (ID number) is generated and assigned to the child. This number remains valid throughout the life of the individual and appears on the printed birth certificate. When the child turns 16, the same number is used during the production of the national ID card. For children born to foreign citizens, the unique ID number is not generated. Instead a birth registration number (BRN) is generated by the system and printed on the certificate.

2.3.2. Death Registration

The system captures information on deaths in the health facilities by completing a death report form (NR10). Section-1 of the death report captures information on bio data of the deceased along with details of the parents required for the production of a legal death certificate. Section-2 is completed by the attending clinician and is used for documenting the underlying cause of death and for the assignment of ICD-10 codes.

Similarly, for the community death registration, the village head, as the local registrar, issues an NR10C form to the household where the death occurred, assists in completing the form, and checks

its completeness before issuing an acknowledgment slip. The completed forms are sent to the DRO through the Traditional Authority (TA) for data entry and further processing. The current business processes in birth and death registration in Malawi for both facility and community registration are provided in the Annex.

2.3.3 Late or delayed registration

As previously mentioned, the Act and Regulations are currently being reviewed to include, among other things, the classification of registration for births and deaths. Registration within six weeks of its occurrence is considered current, between six weeks and one year is deemed late, and after one year is categorized as delayed registration. Any vital event registered after six weeks from its occurrence incurs a penalty fee as stipulated in the regulations.

2.3.4 Issuance of documentation

Upon completion of a birth or death reporting form, informants are issued with an acknowledgement receipt as evidence of reporting the vital event to the civil registration office. After data processing the certificates are printed and issued to informants by the civil registration officials. While birth certificates are printed and issued on a rolling basis, death certificates are only issued on demand.

2.3.5 Transfer of records

The transfer of records is done by manual or electronic methods. At facilities with electronic birth or death registration systems, records are electronically transmitted to the District Registration Office (DRO) for data validation and approval. DROs and Civil Registration Headquarters are online and transmission of all records to them is done electronically. For health facilities and communities where an electronic system is absent, forms are manually taken to the DRO for data entry, quality checks and registration.

2.4 Organisation of vital statistics production and dissemination

By law, the National Statistics Office is responsible for national-level processing, publishing, and dissemination of vital statistics in collaboration with NRB and MoH. NRB transfers records of vital events registered within a particular period (usually a year) to NSO for data cleaning, analysis and dissemination.

2.5 Incentives and disincentives for registration

Currently, the incentives for collecting and using birth and death certificates do not seem adequate, which is indicated by the fact that most printed certificates remain uncollected at the civil registration offices. Most people do not feel that it is important to have the certificates. However, there some changes may be introduced to encourage registration of vital events such as free registration of births and deaths, linking birth certificates to issuance of passports and to cross-border movement of children under 16 years, registration of births and deaths immediately after occurrence in the health facilities. Also, distribution of the estate of a deceased person to children and other heirs may require that they can have a birth certificate.

In the future, Malawi may be linking access to education, health and mobile telecommunication services for children, among others. This is expected to create demand for birth registration. The major disincentive is that currently, birth certificates are not linked to social services such that many people do not see the importance having birth certificate. Printing of certificates is also done only at district office and very few health facilities such that many people need to travel long distances to get the certificates. Inadequate awareness of birth and death registration and importance of birth and death certificates also contributes to non-registration.

Chapter 3. Data quality, timeliness, and completeness of registration

This chapter provides an overview of the data quality, timeliness of registration, and its completeness. It demonstrates some of the steps undertaken by NRB and NSO to ensure that the civil registration data are of good quality. The data show there has been an improvement in the proportion of deaths registered within six weeks of occurrence, increasing from 14.7% in 2017 to 81.8% in 2022.

3.1 Data quality

During the registration of a vital event, NRB officials or informants use the NR8 and NR10 forms for birth and death registration, respectively. These forms are part of the standard regulations for national registration such that anyone who provides false information is liable for legal prosecution. The forms have clear instructions on how to complete them to ensure correct recording of the data.

The NRB in collaboration with MoH, has trained all health workers and community leaders in the correct completion of the forms. Refresher trainings are also conducted to ensure consistency, sustained practice, and accommodate new staff. During the form collection for data entry, the NRB officials check each form for correct completion, and returns incomplete forms or those with inaccuracies.

During data entry, the electronic system has mandatory fields for data entry without which the process cannot be completed. Once entered, the records undergo deduplication at the district and national level to ensure that no multiple registration of the same record occurs. During data analysis, the NSO subjects the data to rigorous cleaning and imputation prior to the tabulation and reporting of vital statistics.

3.2 Timeliness of registration

Timeliness depicts the timeframe within which a vital event is reported and processed. In Malawi, a current vital event is one which is registered within six weeks from the time of occurrence.

Table 3.1 provides the percentage distribution of births and deaths registered within and outside the recommended time frame from 2017 to 2022. The statistics show there has been an improvement in

the proportion of deaths registered within six weeks of occurrence. In 2017, current registrations were at 14.7%, compared to delayed and late at 45.9% and 39.5% respectively. This figure increased to 81.8% (current) in 2022, compared to 7.3% (delayed) and 10.9% (late). Improvements in current registration are attributed to increased coverage, awareness on mandatory registration within facilities and communities, and increasing incentives associated with death certificates.

In terms of birth registration in 2022, current registration was at 48 percent with delayed and late being at 12 and 40 percent respectively. The time trend could not be established as data are not available for previous years. The variable on date of registration was missing from all datasets before 2022.

Table 3.1 Percentage of vital events by registration timeliness, 2017 – 2022

Registration timeliness	2017		2018		2019		2020		2021		2022	
	Live Births	Deaths	Live Births	Deaths	Live Births	Deaths	Live Births	Deaths	Live Births	Deaths	Live Births	Deaths
Current	-	14.70%	-	31.90%	-	63.70%	-	77.90%	-	76.30%	48%	81.80%
Delayed	-	45.90%	-	32.10%	-	14.90%	-	7.50%	-	7.20%	12%	7.30%
Late	-	39.50%	-	35.90%	-	21.40%	-	14.60%	-	16.50%	40%	10.90%
Total number registered	-	100%	-	100%	-	100%	-	100%	-	100%	100%	100%

Figure 3.1 shows the comparison of current, delayed and late registration of births and deaths. Overall, the figure shows that deaths are reported timelier than births. Again, the timeliness of current birth and death registrations (48% births and 81.8% deaths) far exceed the rest of the registration timeliness. Events registered after a year of their occurrence constituted the least proportion of registered events (12% births and 7.3% deaths).

Figure 3.1 Proportion (%) of live births and deaths by registration timeliness, 2022

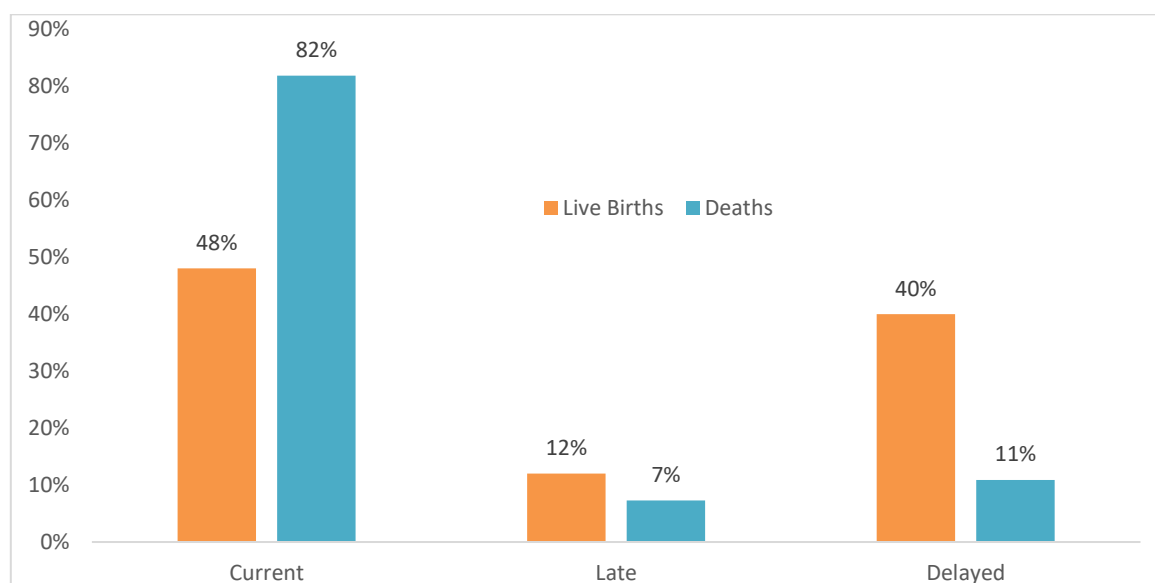


Table 3.2 shows the number of births by year of occurrence and year of registration. The number of births is increasing by both year of occurrence and year of registration. The highlighted section shows the number of births registered in the same year as the occurrence. The numbers in this table show an increasing trend, except for 2021 and 2022. The notable increase in 2019 and 2020 can be attributed to the Mass Birth Registration exercise, which took place in 2018 and 2019 in Ntcheu and Balaka. The table also shows that many events were registered after the year of occurrence.

Table 3.2 Number of live births by year of registration and year of occurrence

Year of registration	Year of Birth									Total
	Before 2015	2015	2016	2017	2018	2019	2020	2021	2022	
2015	1,298	15,657	0	0	0	0	0	0	0	16,955
2016	5,358	5,154	51,719	0	0	0	0	0	0	62,231
2017	9,564	936	18,326	128,278	0	0	0	0	0	157,104
2018	100,368	8,346	15,608	72,476	138,884	0	0	0	0	335,682
2019	225,335	16,997	19,369	37,376	108,713	148,145	0	0	0	555,935
2020	86,142	7,432	10,118	21,218	59,473	152,384	225,806	0	0	562,573
2021	5,505	483	954	3,039	5,153	18,453	77,286	213,102	0	323,975
2022	13,067	1,722	4,487	5,176	6,204	11,451	16,411	79,959	205,069	343,546
Grand total	446,637	56,727	120,581	267,563	318,427	330,433	319,503	293,061	205,069	2,358,001

Table 3.3 shows the number of deaths by year of occurrence and year of registration. The number of deaths is increasing by both year of occurrence and year of registration. The highlighted section shows the number of deaths registered in the same year of occurrence. The numbers in the table show an increasing trend of registered deaths. Out of the 22,481 deaths that were registered in 2022, 13,653 occurred in the same calendar year, constituting a 60.7 percent timely registration access.

Table 3.3 Number of deaths by year of registration and year of occurrence

Year of registration	Year of occurrence							Total
	Before 2017	2017	2018	2019	2020	2021	2022	
2017	2,803	910	0	0	0	0	0	3,713
2018	1,179	1,123	2,096	0	0	0	0	4,398
2019	882	380	3,442	4,779	0	0	0	9,483
2020	812	151	536	7,320	10,157	0	0	18,976
2021	705	75	137	683	4,730	12,350	0	18,680
2022	534	44	66	533	2,522	5,129	13,653	22,481
Grand total	7,134	2,683	6,277	13,315	17,409	17,479	13,653	77,950

3.3 Completeness of registration

Calculating the completeness of registration can be used to monitor the performance of the CRVS system in capturing the vital events and allows for adjustment of incomplete statistical indicators. The completeness is defined as the number of vital events in a population that are registered, divided by the estimated number of vital events that occurred in the same period⁸. The value is multiplied by 100 to express completeness as a percent:

$$\text{Completeness (\%)} = \frac{\text{Number of vital events registered}}{\text{Estimated number of vital events}} \times 100$$

3.3.1 Birth registration

The estimated number of births for each of the years were official estimates from NSO⁹. The completeness of birth registration has increased from 2.2 percent in 2015 to 36.7 percent in 2020, before decreasing to 34.4 and 32.8 percent in 2021 and 2022, respectively, as shown in Table 3.4.

⁸ Principles and recommendations for a vital statistics system, revision 3

⁹ Malawi Population and Housing Census, 2018

The low levels of completeness in the early years denote the period when the CRVS system in Malawi was established. The steady increase in completeness of birth registration over the years is attributed to gradual rolling out. For instance, the expansion of birth registration from the four pilot districts to many more districts in 2017, more than doubled the completeness rate from 7.3 to 17.7 percent. The lower completeness of birth registration in 2021 and 2022 can be attributed to a backlog in the data entry exercise implemented in 2020, which increased the completeness to 36.7% in that year. There was a higher completeness for males than females in all years (Table 3.4).

Table 3.4 Birth registration completeness by year of occurrence and sex of newborn

Year of occurrence	Registered live births			Estimated total live births			Completeness		
	Male	Female	Total*	Male	Female	Total	Male	Female	Total
2015	7,727	7,930	15,657	349,705	369,277	718,982	2.21%	2.15%	2.2%
2016	25,721	25,998	51,719	346,816	366,226	713,042	7.42%	7.10%	7.3%
2017	63,571	64,707	128,278	352,611	372,345	724,956	18.03%	17.38%	17.7%
2018	69,075	69,809	138,884	294,957	313,117	608,074	23.42%	22.29%	22.8%
2019	73,902	74,243	148,145	296,674	314,940	611,614	24.91%	23.57%	24.2%
2020	112,498	113,308	225,806	298,156	316,514	614,670	37.73%	35.80%	36.7%
2021	105,295	107,807	213,102	300,909	319,437	620,346	34.99%	33.75%	34.4%
2022	101,135	103,934	205,069	303,377	322,057	625,434	33.34%	32.27%	32.8%

Note: The estimated total births were sourced from the 2008 and 2018 population and housing census projections made by NSO

* These numbers depict the births that occurred in the year of registration. Refer to Table 3.2 for all births registered in that year.

Table 3.5a below shows the birth registration completeness for 2022 by usual place of residence of mother. The completeness ranges from 100 percent for Mwanza District to 6.8% percent for Phalombe District. Only seven districts registered at least half of all births. Fourteen districts (half of the districts in Malawi) registered less than the national completeness of 32.8 percent.

Table 3.5a Birth registration completeness by place occurrence, 2022

Place of Occurrence	Total Registered births born in 2022	Estimated total live births, 2022	Completeness (%)
Mwanza	4,541	4,522	100.4
Rumphi	5,719	7,913	72.3
Balaka	10,104	16,082	62.8
Mangochi	30,484	49,575	61.5
Neno	3,105	5,223	59.4
Chitipa	4,299	7,605	56.5
Ntcheu	12,308	23,487	52.4
Nsanje	5,754	11,622	49.5
Nkhata Bay	4,709	9,830	47.9
Mchinji	8,313	20,797	40
Mzimba	14,527	37,896	38.3
Kasungu	10,781	29,106	37
Karonga	4,291	11,817	36.3
Likoma	122	361	33.8
Lilongwe	29,349	93,171	31.5
Blantyre	12,971	41,862	31
Chikwawa	6,114	21,935	27.9
Nkhotakota	3,881	15,269	25.4
Zomba	6,835	28,956	23.6
Thyolo	5,271	23,354	22.6
Dowa	5,717	25,842	22.1
Salima	4,100	18,581	22.1
Chiradzulu	1,947	11,553	16.9
Mulanje	2,877	23,990	12
Machinga	2,717	29,362	9.3
Dedza	2,340	28,677	8.2
Ntchisi	792	11,291	7
Phalombe	1,076	15,755	6.8
Outside Malawi	25	-	-
Grand Total	205,069	625,434	32.8

Note: The estimated total births were sourced from calculations based on the 2018 Population and Housing Census & projections (NSO 2020).

Table 3.5b shows the total number and proportion of births ever registered by year of registration for 2015-2022. It shows the cumulative totals of all births that were registered in those years. Cumulatively, the number of births registered has been increasing from 15,657 in 2015 to 1,911,364 in 2022. This translates to 2.2% and 36.5%, respectively, of the total number of births.

Table 3.5b Births ever registered by year of registration

Year of Registration (A)	Registered births (B)	Births occurring Before 2015 (C)	Births occurring from 2015 and later (B-C)	Estimated births (D)	Cumulative births (from B-C) (E)	Cumulative estimated births (from D) (F)	Births ever registered (%) (E/F)
2015	16,955	1,298	15,657	718,982	15,657	718,982	2.2
2016	62,231	5,358	56,873	713,042	72,530	1,432,024	5.1
2017	157,102	9,564	147,538	724,956	220,068	2,156,980	10.2
2018	335,682	100,368	235,314	608,074	455,382	2,765,054	16.5
2019	555,937	225,335	330,602	611,614	785,984	3,376,668	23.3
2020	562,573	86,142	476,431	614,670	1,262,415	3,991,338	31.6
2021	323,975	5,505	318,470	620,346	1,580,885	4,611,684	34.3
2022	343,546	13,067	330,479	625,434	1,911,364	5,237,118	36.5

3.3.2 Death registration

Death registration completeness was calculated by dividing the number of registered deaths occurring in a particular year by the estimated total deaths for that year multiplied by 100. The estimated number of deaths were taken from NSO population projected from the censuses in 2008 and 2018. From Table 3.6 it can be seen that the completeness has been increasing over the years, except from 2020 to 2021 when it stagnated at 13.9% for both sexes combined. In 2018, at the start of mandatory death registration, the registration was 5% complete, increasing 10.6%. By 2022, death registration completeness was 10.8%, which was lower than the preceding year (13.9%). Death registration completeness was higher for males than females (Refer to Table 3.6).

Table 3.6 Death registration completeness by year of occurrence and sex of decedent

Year of occurrence	Registered deaths			Estimated total deaths			Completeness (%)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
2018	4,206	2,071	6,277	60,541	64,242	124,783	6.70%	3.50%	5.00%
2019	8,115	5,200	13,315	60,721	64,462	125,183	13.40%	8.10%	10.60%
2020	10,362	7,047	17,409	60,761	64,535	125,296	17.10%	10.90%	13.90%
2021	10,838	6,641	17,479	60,995	64,815	125,810	17.80%	10.20%	13.90%
2022	8,020	5,633	13,653	61,258	65,126	126,384	13.10%	8.60%	10.80%

Note: The estimated total deaths were taken from NSO census projections for 2008 and 2018

Table 3.7 shows the distribution of registered deaths in 2022 broken down by place of residence of the decedent and sex. The data shows that the district of Mchinji had the highest completeness of death registration at 30.6%, followed by Mwanza (24.0%), Lilongwe (21.1%), Likoma (17.2%) and Karonga (17.0%). In contrast, the districts with the *lowest* completeness were Thyolo (2.0%), Mulanje

(2.5%), Machinga (3.1%) Chiradzulu (3.5%) and Nkhatakota (3.5%). Eleven of the 28 districts (39%) had a completeness of death registration equal to or above the average, whereas the rest had a below-average completeness.

Table 3.7 Death registration completeness by place of usual residence of decedent, 2022

District of residence	Registered deaths			Estimated total deaths			Completeness (%)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Mchinji	722	539	1,261	2,096	2,025	4,122	34.40%	26.60%	30.60%
Mwanza	131	90	221	472	448	921	27.80%	20.10%	24.00%
Lilongwe	1,942	1,356	3,298	7,968	7,665	15,633	24.40%	17.70%	21.10%
Likoma	9	2	11	32	32	64	28.10%	6.30%	17.20%
Karonga	266	180	446	1,370	1,260	2,629	19.40%	14.30%	17.00%
Ntchisi	204	113	317	961	919	1,881	21.20%	12.30%	16.90%
Mangochi	980	757	1,737	5,513	4,976	10,488	17.80%	15.20%	16.60%
Chitipa	118	73	191	696	656	1,352	17.00%	11.10%	14.10%
Nsanje	143	120	263	996	907	1,904	14.40%	13.20%	13.80%
Blantyre	671	389	1,060	4,033	3,925	7,958	16.60%	9.90%	13.30%
Ntcheu	316	289	605	2,870	2,729	5,599	11.00%	10.60%	10.80%
Mzimba	457	297	754	4,200	3,913	8,113	10.90%	7.60%	9.30%
Salima	184	120	304	1,893	1,781	3,673	9.70%	6.70%	8.30%
Zomba	299	231	530	3,345	3,086	6,431	8.90%	7.50%	8.20%
Nkhata Bay	126	103	229	1,472	1,398	2,870	8.60%	7.40%	8.00%
Balaka	173	154	327	2,261	2,065	4,326	7.70%	7.50%	7.60%
Phalombe	125	113	238	1,632	1,538	3,169	7.70%	7.30%	7.50%
Chikwawa	122	82	204	1,670	1,595	3,265	7.30%	5.10%	6.20%
Dowa	199	132	331	2,837	2,724	5,561	7.00%	4.80%	6.00%
Kasungu	188	107	295	2,518	2,464	4,981	7.50%	4.30%	5.90%
Dedza	158	97	255	3,263	2,978	6,241	4.80%	3.30%	4.10%
Rumphi	39	21	60	829	790	1,619	4.70%	2.70%	3.70%
Neno	18	11	29	408	390	798	4.40%	2.80%	3.60%
Nkhatakota	65	30	95	1,388	1,329	2,717	4.70%	2.30%	3.50%
Chiradzulu	58	34	92	1,378	1,261	2,639	4.20%	2.70%	3.50%
Machinga	95	76	171	2,911	2,649	5,560	3.30%	2.90%	3.10%
Mulanje	94	49	143	2,981	2,726	5,707	3.20%	1.80%	2.50%
Thyolo	72	51	123	3,255	2,908	6,163	2.20%	1.80%	2.00%
Missing	46	17	63	-	-	-	-	-	-
Total	8,020	5,633	13,653	65,248	61,137	126,384	13.10%	8.60%	10.80%

Note: estimated total deaths were sourced from NSO census projections

Chapter 4. Births

Overall, the registered number of deaths has been increasing from over 15,000 births in 2015 to 205,069 in 2022. This has been mainly attributed to the expansion in coverage from four districts in 2022 to the current universal coverage at district level. Subsequently, this has translated to an increase in the completeness of birth registration from 2.2% to 32.8%. The completeness of birth registration is higher among males than females.

Weighted sex ratios showed more males being born than females for all years except 2018. The total fertility rate (TFR) shows comparable trends to those derived from other sources such as the census and MICS.

Table xx. Summary statistics on fertility by year of occurrence, 2015-2022

Indicator	2015	2016	2017	2018	2019	2020	2021	2022
Registered live births	15,657	51,719	128,278	138,884	148,145	225,806	213,102	205,069
<i>Males</i>	7,727	25,721	63,571	69,075	73,902	112,498	105,295	101,135
<i>Females</i>	7,930	25,998	64,707	69,809	74,243	113,308	107,807	103,934
Registration completeness (%)	2.20%	7.30%	17.70%	22.80%	24.20%	36.70%	34.40%	32.80%
<i>Males</i>	2.21%	7.42%	18.03%	23.42%	24.91%	37.73%	34.99%	33.34%
<i>Females</i>	2.15%	7.10%	17.38%	22.29%	23.57%	35.80%	33.75%	32.27%
Sex ratio at birth				99.5	100.8	100.8	101.8	103.3
Crude birth rate (per 1,000 population)					34	33.3	32.8	32.3
Total fertility rate (births per woman)				4.1	4.0	3.9	3.8	3.7

4.1 Births by place of occurrence

Table 4.2 shows registered weighted live births by district of occurrence by sex of the child and the sex ratio differentials across districts. Overall, the data shows that Malawi had more male births than female in 2022, with the exception being in nine districts, namely: Mzimba, Phalombe, Chitipa, Mulanje, Karonga, Ntcheu, Rumphi, Likoma and Ntchisi. In contrast, about thirteen districts had a higher sex ratio at birth than the national average of 103.3 males per 100 females. The most male

births were reported in Machinga District at 117.2 males per 100 females, whereas Ntchisi had the least number of male births at 91.3 males per 100 females.

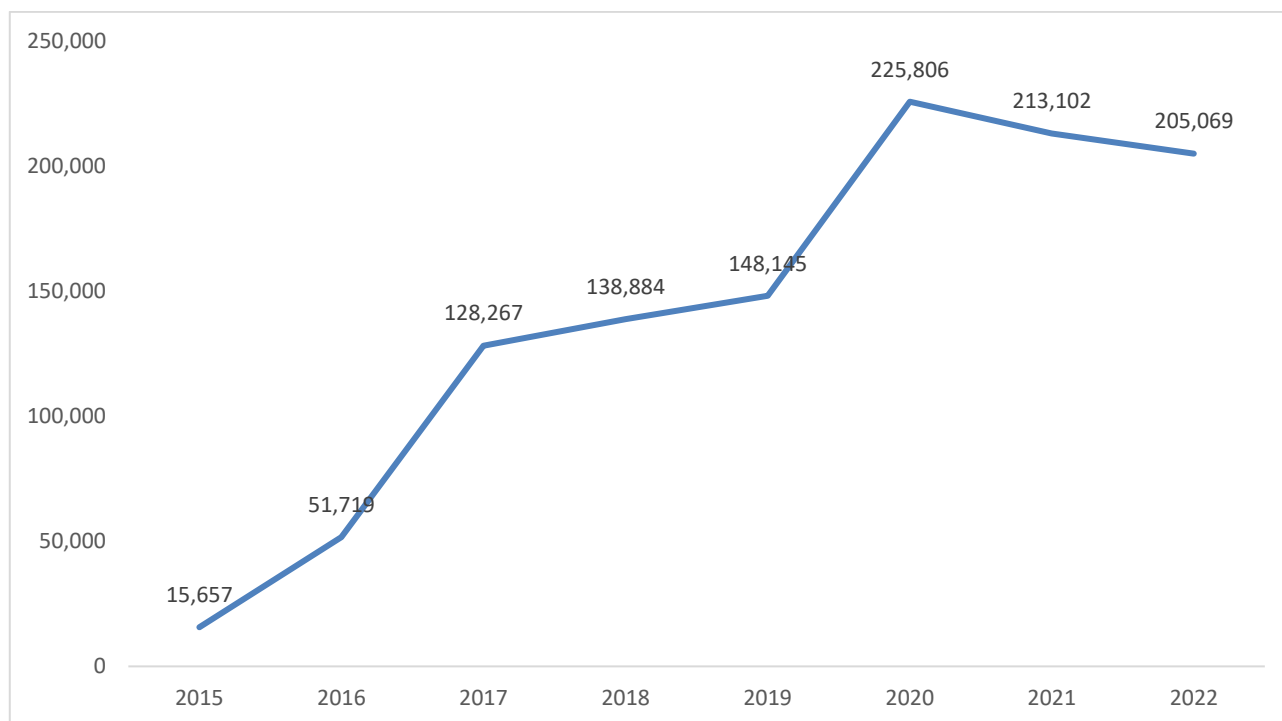
Table 4.1 Place of occurrence of births by sex and sex ratio (weighted), 2022

District of Birth	Weighted Live Births			Sex ratio at Birth
	Female	Male	Total	
Machinga	13,519	15,843	29,362	117.2
Salima	8,801	9,780	18,581	111.1
Dowa	12,358	13,484	25,842	109.1
Kasungu	14,079	15,027	29,106	106.7
Mwanza	2,195	2,327	4,522	106
Nsanje	5,643	5,979	11,622	105.9
Chiradzulu	5,619	5,934	11,553	105.6
Chikwawa	10,684	11,251	21,935	105.3
Mchinji	10,155	10,642	20,797	104.8
Zomba	14,179	14,777	28,956	104.2
Lilongwe	45,695	47,476	93,171	103.9
Mangochi	24,326	25,249	49,575	103.8
Nkhotakota	7,499	7,770	15,269	103.6
Dedza	14,130	14,547	28,677	102.9
Blantyre	20,629	21,233	41,862	102.9
Nkhata Bay	4,845	4,985	9,830	102.9
Thyolo	11,524	11,830	23,354	102.7
Neno	2,592	2,631	5,223	101.5
Balaka	8,028	8,054	16,082	100.3
Mzimba	19,064	18,832	37,896	98.8
Phalombe	7,936	7,819	15,755	98.5
Chitipa	3,839	3,766	7,605	98.1
Mulanje	12,191	11,799	23,990	96.8
Karonga	6,017	5,800	11,817	96.4
Ntcheu	11,972	11,515	23,487	96.2
Rumphi	4,043	3,870	7,913	95.7
Likoma	186	175	361	93.7
Ntchisi	5,902	5,389	11,291	91.3
Total	307,653	317,781	625,434	103.3

Figure 4.1 shows the total number of live births that was registered in the year of occurrence from 2015 to 2022. The steady increase in the number of registered births is attributed to an increase in coverage of registration services in the country, mass birth registration exercises, and improved

system performance, particularly through automated record checking and completion. The reduced number of registered births in 2021 and 2022 emanates from the non-inclusion of mass birth registration data from the analysis, as the data on this were not ready at the time of analysis.

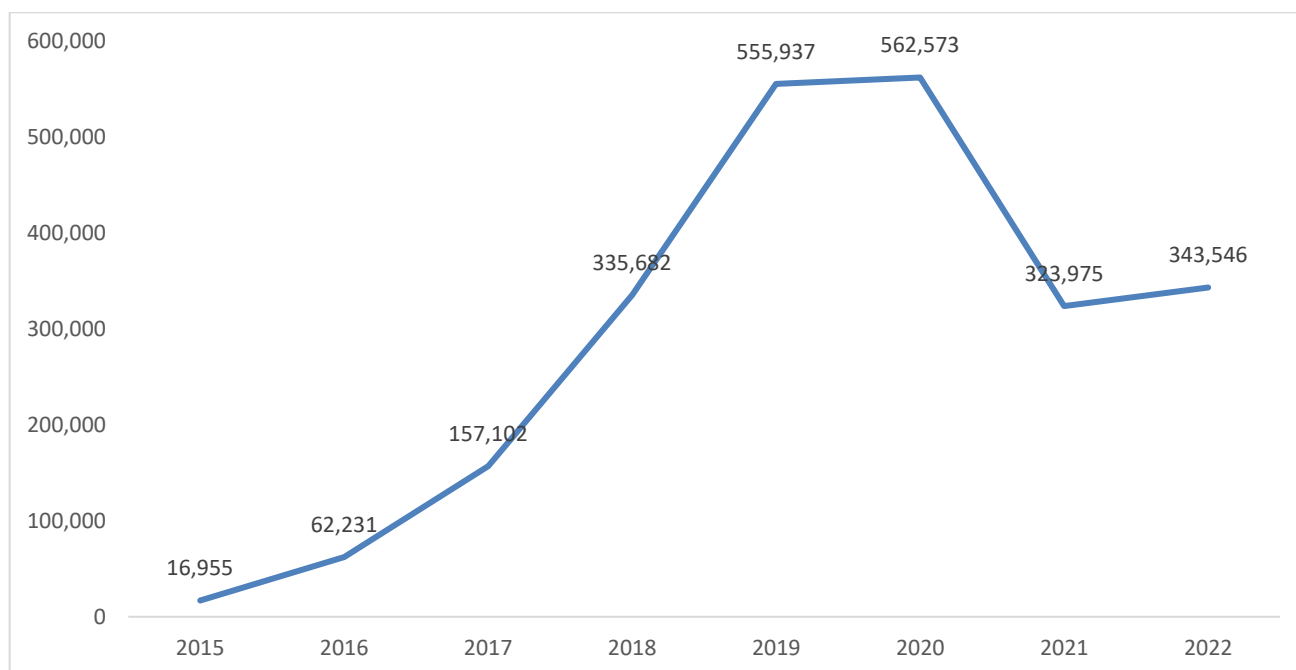
Figure 4.1 Live births by year of occurrence, 2015 – 2022



*Note: Mass Birth Registration data for 2022 are not included

Figure 4.2 shows the total number of live births that were registered from 2015 to 2022, regardless of the year of birth. Notably, the figure shows that there was a sharp increase in the number of registered births between 2017 and , which is not appearing in figure 4.1. The reason for this is that the NRBs registration campaigns registered many past births that had not been registered, which explains the flattening of the graph on current births between the years 2017 and 2019 in figure 4.1.

Figure 4.2 Live births by year of registration, 2015 – 2022



4.2 Births by district of occurrence and district of usual residence of mother

Table 4.2 shows the total number of live births by district of occurrence against district of usual residence of the mother in 2022. Overall, the proportion of live births that did not occur at the mother's usual district of residence was 9 percent. Women residing in Machinga had the highest occurrence of births outside the district (49.7%), signifying higher mobility. This was followed by Rumphi (21.4%), Chiradzulu (18.9%), Mwanza (17.4%) and Balaka (15.2%). Cumulatively, these five districts accounted for 38.2 percent of all births that occur outside the district of residence of the mother. In contrast, Mchinji, Mulanje, Chitipa, Nkhata Bay and Karonga account for the lowest proportion of births occurring outside mother's district of usual residence with proportions ranging from 0.4% for Mchinji District to 2.8% in Karonga.

Table 4.2 Live births by district of occurrence and district of usual residence of mother, 2022

District of Occurrence of Birth	Mother's district of usual residence		Total number of live births (B)	Different District of Birth (A/B%)
	Same as district of occurrence of Birth	Not the same as district of occurrence of Birth (A)		
Machinga	4,291	4,238	8,529	49.7
Rumphi	6,675	1,821	8,496	21.4
Chiradzulu	5,858	1,367	7,225	18.9
Mwanza	4,346	913	5,259	17.4
Balaka	20,121	3,618	23,739	15.2
Nsanje	13,205	2,373	15,578	15.2
Likoma	121	18	139	12.9
Ntchisi	1,618	212	1,830	11.6
Zomba	10,927	1,353	12,280	11
Salima	5,173	531	5,704	9.3
Blantyre	21,524	2,068	23,592	8.8
Kasungu	13,804	1,273	15,077	8.4
Lilongwe	45,086	4,087	49,173	8.3
Dedza	7,442	623	8,065	7.7
Chikwawa	7,075	545	7,620	7.2
Mzimba	23,160	1,488	24,648	6
Neno	7,850	493	8,343	5.9
Phalombe	3,478	188	3,666	5.1
Thyolo	7,204	382	7,586	5
Nkhotakota	4,633	187	4,820	3.9
Mangochi	35,894	1,398	37,292	3.7
Ntcheu	15,209	546	15,755	3.5
Dowa	8,723	299	9,022	3.3
Mulanje	9,150	306	9,456	3.2
Chitipa	5,681	174	5,855	3
Nkhata Bay	6,935	211	7,146	3
Karonga	6,579	192	6,771	2.8
Mchinji	10,497	41	10,538	0.4
OUTSIDE	24	318	342	93
Total	312,283	31,263	343,546	9.1

4.3 Births by age of mother

Table 4.5 compares the registered and weighted number of births in 2022 by age group of the mother. Weighted birth figures estimate the true total registered births in the population if the data were 100% complete by generating weights from completeness data. Notably, due to the lack of an age-specific distribution for registered births in the data sources, a weighting factor is applied to estimate age-specific values for the year. The analysis reveals that women aged 20-24 age group had the highest proportion of births in 2022. This was followed by adolescents a15-19 years.

Table 4.5. Number of registered and weighted births by age of mother, 2022

Age group	Registered births	Weighted births
10-14	343	1,077
15-19	40,705	127,557
20-24	49,339	152,317
25-25	34,278	105,563
30-34	20,699	64,106
35-39	12,933	39,691
40-44	3,699	11,366
45-49	302	929
50+	1,048	2,659
Missing age	41,723	120,170
Total	205,069	625,434

Table 4.3 Registered births by the mother's district of usual residence, marital status and age, 2022

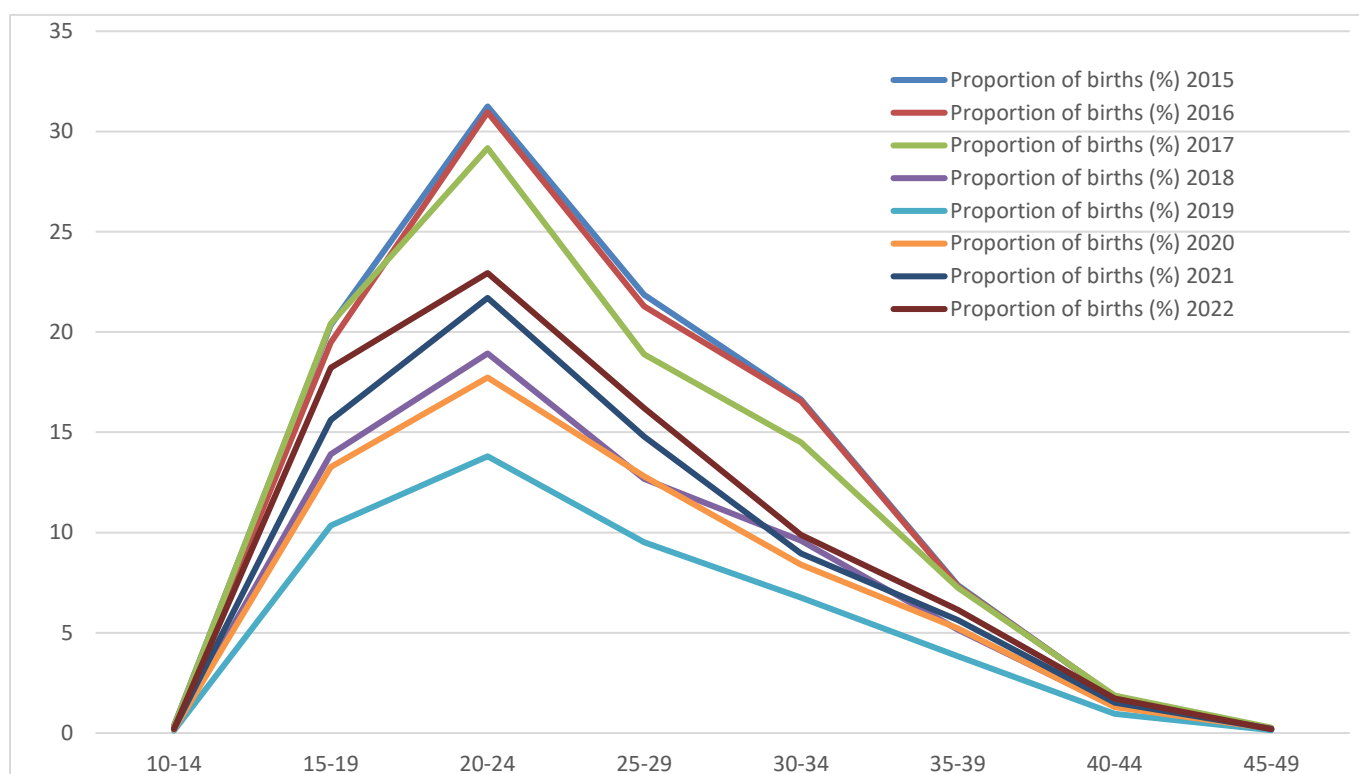
District of Residence of		Mother's Age (Years)												
Mother		Mother Married	< 10	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50 and above	Missing age	Total
Balaka		No	0	10	593	351	154	90	72	21	2	3	1846	3142
		Yes	10	39	3490	4243	2897	1674	1206	333	54	16	9365	23327
Blantyre		No	1	16	657	359	174	110	51	23	2	0	277	1670
		Yes	4	28	2683	4343	3734	2531	1444	395	27	6	6275	21470
Chikwawa		No	1	1	73	79	34	33	24	12	0	0	45	302
		Yes	1	19	1666	2541	1702	1080	728	283	33	10	1154	9217
Chiradzulu		No	0	5	162	76	53	34	24	10	1	0	80	445
		Yes	1	10	1241	1268	896	554	383	104	16	4	1390	5867
Chitipa		No	0	4	160	72	31	21	14	2	0	0	168	472
		Yes	0	3	588	786	586	372	248	51	8	1	2752	5395
Dedza		No	0	11	290	174	77	51	16	5	1	0	43	668
		Yes	0	8	1409	2410	1761	1011	618	173	26	6	516	7938
Dowa		No	0	6	207	105	69	27	24	11	1	0	189	639
		Yes	0	9	1763	2415	1875	1002	590	153	12	3	2441	10263
Karonga		No	1	7	138	105	36	27	23	6	0	0	102	445
		Yes	17	18	1222	1456	1091	670	400	74	3	1	1456	6408
Kasungu		No	0	10	358	196	72	50	22	9	1	0	45	763
		Yes	2	4	2768	4232	2797	1649	1067	296	31	8	626	13480
Likoma		No	0	0	14	13	5	2	3	0	0	0	1	38
		Yes	0	0	11	23	29	16	10	1	0	0	8	98
Lilongwe		No	1	36	1001	577	300	141	71	27	1	1	300	2456

District of Residence of Mother	Mother's Age (Years)												
	Mother Married	< 10	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50 and above	Missing age	Total
Machinga	Yes	4	41	6418	11567	9970	5988	3202	640	42	14	5740	43626
	No	0	1	44	31	19	8	4	2	0	0	82	191
Mangochi	Yes	1	8	571	707	414	241	152	39	9	2	2525	4669
	No	2	17	658	485	240	160	106	42	5	2	1563	3280
Mchinji	Yes	5	55	4393	6468	4047	2490	1594	505	61	35	14135	33788
	No	51	19	714	714	493	282	196	44	4	22	508	3047
Mulanje	Yes	94	23	1466	1900	1434	795	459	111	17	1153	357	7809
	No	0	3	88	48	31	22	18	6	0	0	986	1202
Mwanza	Yes	1	7	1022	890	506	358	228	83	7	2	5819	8923
	No	0	0	53	26	14	5	6	1	0	0	38	143
Mzimba	Yes	0	1	767	984	663	414	275	112	7	0	1099	4322
	No	0	15	349	165	96	53	37	4	1	0	198	918
Neno	Yes	4	25	4849	5774	3914	2304	1298	260	21	2	6363	24814
	No	1	18	504	338	217	153	115	48	2	1	210	1607
Nkhata Bay	Yes	0	7	1405	1860	1197	774	540	153	16	0	789	6741
	No	0	3	194	107	33	26	16	3	0	0	175	557
Nkhotakota	Yes	1	8	1268	1434	955	578	378	89	2	1	2621	7335
	No	0	3	116	53	23	10	9	3	2	0	77	296
Nsanje	Yes	1	2	702	993	792	429	261	76	2	1	1549	4808
	No	0	13	310	213	115	63	57	25	7	2	55	860
Ntcheu	Yes	15	33	2423	3594	2421	1640	1080	468	108	40	672	12494
	No	0	31	959	347	133	72	38	10	1	1	272	1864

District of Residence of Mother		Mother's Age (Years)											
	Mother Married	< 10	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50 and above	Missing age	Total
Ntchisi	Yes	0	27	3763	4243	2905	1765	1072	296	36	5	2541	16653
	No	0	2	62	34	9	5	3	1	1	0	9	126
	Yes	0	1	316	481	350	261	132	23	2	0	107	1673
Outside Malawi	No	0	0	29	12	8	4	1	1	0	0	22	77
	Yes	0	4	225	286	184	112	71	13	0	1	290	1186
Phalombe	No	0	0	45	31	20	7	9	2	0	0	26	140
	Yes	0	5	676	735	418	289	201	65	8	0	1116	3513
Rumphi	No	0	8	175	78	30	14	9	5	0	0	17	336
	Yes	0	13	1600	1903	1284	792	525	133	14	1	316	6581
Salima	No	0	7	192	81	35	24	19	5	0	0	82	445
	Yes	0	12	986	1112	780	481	376	115	18	3	1030	4913
Thyolo	No	0	5	251	149	76	41	37	11	1	0	97	668
	Yes	0	29	2082	1939	1246	757	513	157	20	5	913	7661
Zomba	No	0	13	342	156	65	51	48	18	2	0	52	747
	Yes	2	15	2466	2944	2099	1278	919	294	22	12	979	11030
GRAND TOTAL		221	718	62,977	78,706	55,609	33,891	21,042	5,852	657	1,364	82,509	343,546

Figure 4.3 below illustrates the proportion of live births by the age of the mother. Women aged 20-24 years have the highest fertility compared to the rest of the age groups. This pattern is the same across the years. Thus, the proportional contribution to overall fertility increases with age from adolescence until age group of 20 -24 where it reaches its peak. Thereafter the proportion decreases, reaching a minimum for the age group 45-49.

Figure 4.3 Percentage of Registered births by age of mother, 2015-2022



4.4 Births by site of delivery

Table 4.7 below summarises the occurrence of live births by district and site of delivery (e.g. health facility, home, or other). Overall, the results show that over 95 percent of the births registered in 2022 occurred at health facilities. About 2.8% of births occurred at home and the remaining 1.9% of births occurred at other places. This finding aligns well with the results from the 2019/20 Multiple Indicator Cluster Survey (MICS), where 97% of births were reported to be delivered in health facilities. At district-level, institutional delivery is almost universal with about twenty-five districts (89% of all districts) reporting over 97 percent of births occurring in health facilities. The three remaining districts with below average institutional delivery were Balaka, Machinga and Mulanje, which reported 80.5%, 62.9% and 62.3% facility birth occurrence, respectively. Dowa had the highest proportion of births occurring in health facilities at 99.9%.

Table 4.4 Live births by place of occurrence and site of delivery, 2022

District of Occurrence	Total Births	Percentage of Births by Site of Delivery		
		Health facility	Home	Other
Dowa	9,022	99.86	0.13	0.01
Rumphi	8,496	99.84	0.16	0
Kasungu	15,077	99.76	0.23	0.01
Chitipa	5,855	99.74	0.17	0.09
Dedza	8,065	99.71	0.17	0.11
Mwanza	5,259	99.7	0.3	0
Nsanje	15,578	99.65	0.26	0.09
Nkhata Bay	7,146	99.59	0.36	0.04
Mzimba	24,648	99.52	0.4	0.08
Ntcheu	15,755	99.47	0.5	0.03
Salima	5,704	99.47	0.51	0.02
Chikwawa	7,620	99.46	0.43	0.1
Lilongwe	49,173	99.4	0.33	0.27
Mchinji	10,538	99.4	0.54	0.06
Nkhotakota	4,820	99.36	0.6	0.04
Karonga	6,771	99.34	0.56	0.1
Likoma	139	99.28	0.72	0
Mangochi	37,292	99.21	0.77	0.02
Chiradzulu	7,225	99.11	0.69	0.19
Thyolo	7,586	99.08	0.62	0.3
Phalombe	3,666	98.96	0.87	0.16
Neno	8,343	98.69	1.02	0.29
Ntchisi	1,830	98.52	0.77	0.71
Blantyre	23,592	97.99	1.25	0.76
Zomba	12,280	97.74	2.12	0.14
Balaka	23,739	80.51	19.45	0.04
Machinga	8,529	62.86	37.07	0.07
Mulanje	9,456	62.28	37.3	0.42
Outside Malawi	342	84.21	0.88	14.91
Total	343,204	95.33	2.79	1.88

4.5 Crude birth rate

The crude birth rate (CBR) is the number of live births per 1,000 population over a given period, usually one year. The total number of births can help with planning and resource allocation by providing important information such as how many children will be entering school in the coming years, or how many adults will be entering the workforce.

Table 4.8 shows the CBR calculated from CR data and that weighted against district-level expected number of births. The results show that the national CBR from CR data was 10.6 births per 1,000 population in 2022.

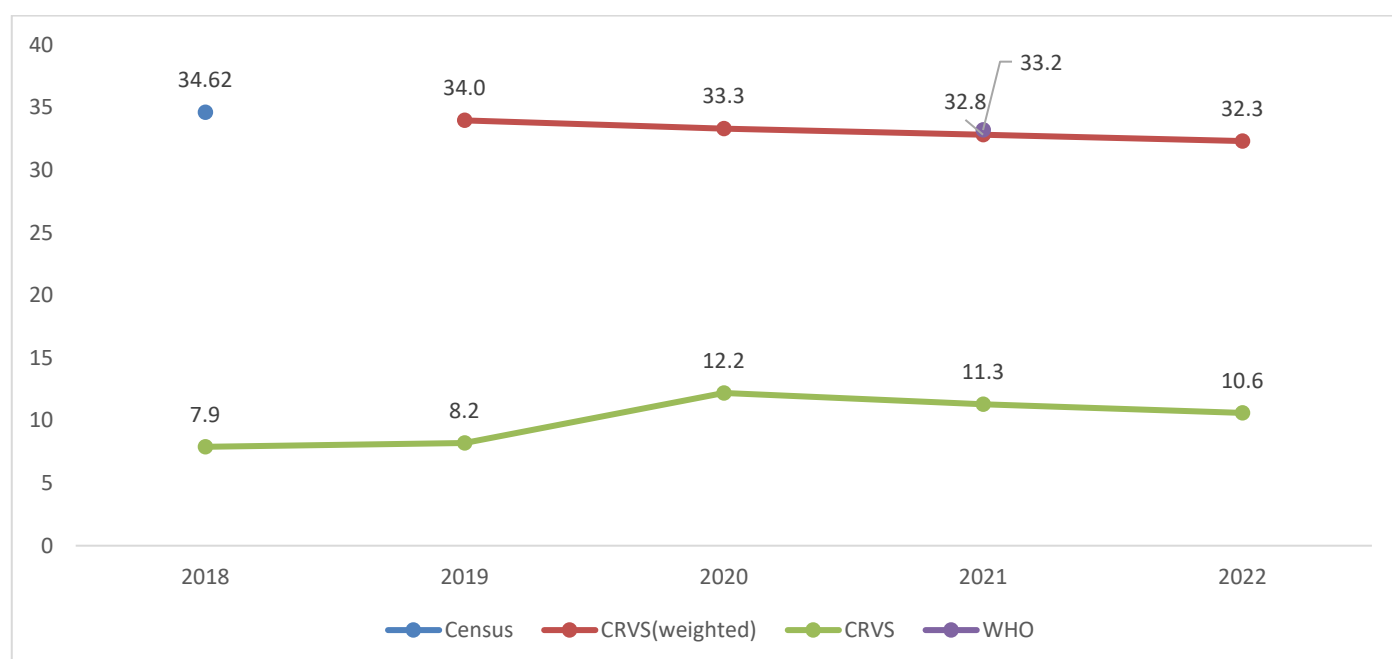
When adjusted for completeness, the CBR is 32.2 births per 1,000 population. The weighted CBR results correspond with estimates from census reports. At the district-level, unweighted CBR ranged from 30.7 births per 1,000 population in Mwanza to 2.3 births per a 1,000 population in Phalombe. The highest weighted birth rate was reported in Nsanje (36.1 births per 1,000 population), and the lowest in Likoma (23 births per a 1,000 population). What is interesting to note is that Mwanza, a district with 100% completeness of birth registration, has the same weighted and unweighted CBR values. Thus, improving the completeness of registration improves the accuracy of the corresponding vital statistics indicator.

Table 4.5 Crude birth rate (CBR) by district of occurrence of birth, 2022

District of Occurrence	Total Population	Registered of live births	Weighted live births	Crude Birth Rate (per 1,000 population)	
				CRVS	Weighted CBR
Balaka	490,804	10,104	16,082	20.6	32.8
Blantyre	1,355,665	12,971	41,862	9.6	30.9
Chikwawa	615,685	6,114	21,935	9.9	35.6
Chiradzulu	383,559	1,947	11,553	5.1	30.1
Chitipa	251,830	4,299	7,605	17.1	30.2
Dedza	908,487	2,340	28,677	2.6	31.6
Dowa	857,510	5,717	25,842	6.7	30.1
Karonga	397,097	4,291	11,817	10.8	29.8
Kasungu	928,471	10,781	29,106	11.6	31.3
Likoma	15,691	122	361	7.8	23
Lilongwe	2,917,964	29,349	93,171	10.1	31.9
Machinga	845,076	2,717	29,362	3.2	34.7
Mangochi	1,305,432	30,484	49,575	23.4	38
Mchinji	658,470	8,313	20,797	12.6	31.6
Mulanje	749,359	2,877	23,990	3.8	32
Mwanza	147,976	4,541	4,522	30.7	30.6
Mzimba	1,263,507	14,527	37,896	11.5	30
Neno	150,211	3,105	5,223	20.7	34.8
Nkhatabay	304,556	4,709	9,830	15.5	32.3
Nkhotakota	428,355	3,881	15,269	9.1	35.6
Nsanje	321,535	5,754	11,622	17.9	36.1
Ntcheu	735,941	12,308	23,487	16.7	31.9
Ntchisi	356,232	792	11,291	2.2	31.7
Phalombe	477,929	1,076	15,755	2.3	33
Rumphi	248,930	5,719	7,913	23	31.8
Salima	535,981	4,100	18,581	7.6	34.7
Thyolo	770,860	5,271	23,354	6.8	30.3
Zomba	928,779	6,835	28,956	7.4	31.2
Missing	-	25	-	-	-
Grand Total	19,351,892	205,069	625,434	10.6	32.3

Figure 4.4 shows the weighted and unweighted crude birth rate by year of occurrence with comparable data from the 2018 Malawi Population and Housing Census, and WHO's population estimates. Overall, the unweighted CBR is lower than the weighted CBR and that from the 2018 Malawi Population and Housing Census and WHO data. The reason for this can be attributed to the limitations of CRVS data stemming from the low completeness of registration (32.8%). However, when examining the weighted CBR over a four-year period, the trend that emerges points towards a declining CBR, dropping from 34.0 in 2019 to 32.3 in 2022, representing a 5% decrease over a four-year period. The weighted CBR also corresponds well with the results from other data sources. For instance, WHO reported a CBR of 33.2 births per 1,000 population in 2021, whereas the weighted CBR estimates is 32.8.

Figure 4.4 Crude birth rate by year of occurrence derived from different data sources



4.6 Age-specific fertility rates

Fertility rates by the mothers' age, or age-specific fertility rates (ASFRs), are the number of births occurring to mothers of a certain age group per 1,000 women in that age group in a given period (usually one year). Table 4.6 provides a comparison between CRVS and weighted Age-Specific Fertility Rates (ASFRs) for the year 2022. As the data reveal, women in their early and mid-twenties exhibit the highest weighted fertility rates at 193.2 and 160.6 children per 1000 women aged 20-24 and 25-29 years, respectively. Thereafter, the ASFR steadily declines with increasing age.

However, a noteworthy concern arises from the findings. Women aged 15-19 have the third-highest fertility rate at 140.3 children per 1,000 women in that age group, compared to 101 according to the census results for 2018. The **2022 CRVS** data suggest a higher adolescent fertility **rate** compared to 2018 **MPHC** results, this could be due to improvement in registration of births. The TFR of 1 in the CRVS data signifies the low birth registration coverage in the country (Table 4.6).

Table 4.6 Age-specific fertility rates, 2022 (consider annexing for TFR calculation)

Mother's age group (years)	Number of Women	Registered live births	Weighted births	ASFR (CRVS)	Weighted ASFR
10–14	1,221,797	343	1340	0.3	1.1
15–19	1,131,129	40,705	158730	36	140.3
20–24	981,091	49,339	189541	50.3	193.2
25–29	818,101	34,278	131361	41.9	160.6
30–34	678,369	20,699	79772	30.5	117.6
35–39	548,413	12,933	49391	23.6	90.1
40–44	445,570	3,699	14144	8.3	31.7
45–49	347,301	302	1156	0.9	3.3
TFR				1.0	3.7

Note: Population numbers were taken from the 2018 Census projections

ASFR for women aged 10-14 not included in TFR calculation.

42,771 of births occurred to women aged 50+ years.

Figure 4.5a illustrates the variations in age-specific fertility rates by year of occurrence over time between 2018 and 2022 as calculated from weighted CR data. Notably, across all years, fertility is negligible for age group 10-14 and very low for those aged 45-49 years. There is decreasing fertility for women aged 20-24 years with the ASFR declining from 212 per 1000 in 2018 to 193 in 2022. The declining fertility over time can also be observed in age groups 25-29, 30-34 and 35-39. Unlike the age group 15-19 years, which experienced a drop in fertility in 2020, there was an increase in the ASFR among women aged 25-29 in that year.

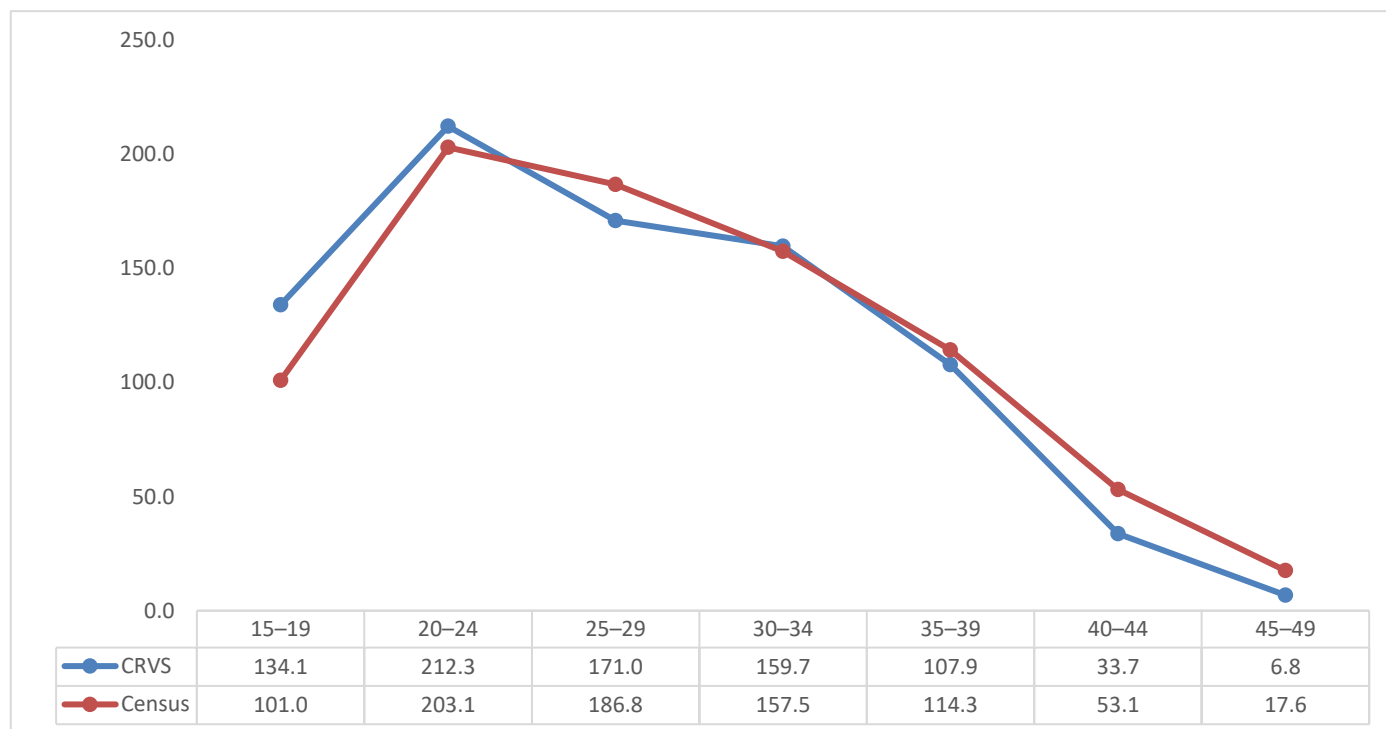
Figure 4.5a Age-specific fertility rates (ASFRs) by year of occurrence of birth, 2018 - 2022



The most recent comparable ASFRs were obtained from the 2018 population and housing census, which only estimated ASFRs for that year. Figure 4.5b compares the ASFR computed from census results to the weighted

ASFR calculated from civil registration data for 2018. We note some differences in the age distribution of fertility despite similar levels of fertility. ASFR from CRVS data is higher than census fertility between ages 15 and 24 years, and it is lower in age groups 25-29, 35-39, and 40-49. CRVS based fertility rates are higher for younger women and lower for older women, compared with 2018 MPHC data.

Figure 4.5b Comparison between census ASFR and weighted ASFR from CRVS, 2018



4.7 Total fertility rate

The total fertility rate (TFR) is the average number of children a woman would give birth to during her lifetime if she were to pass through her childbearing years experiencing present-day age-specific fertility rates, and not dying before the end of that period. Both census and civil registration data show a decreasing trend in TFR. From CRVS records the weighted TFR dropped from 4.1 in 2018 to 3.7 in 2022. The difference between the TFR based on 2018 MPHC projections and CR data is only 0.1- 0.2 over the period. The results are also similar to the MICS¹⁰ estimate for 2020.

¹⁰ Malawi Multiple Indicator Cluster Survey 2019-20

Figure 4.6 Total fertility rate by year of occurrence of birth based on different data sources

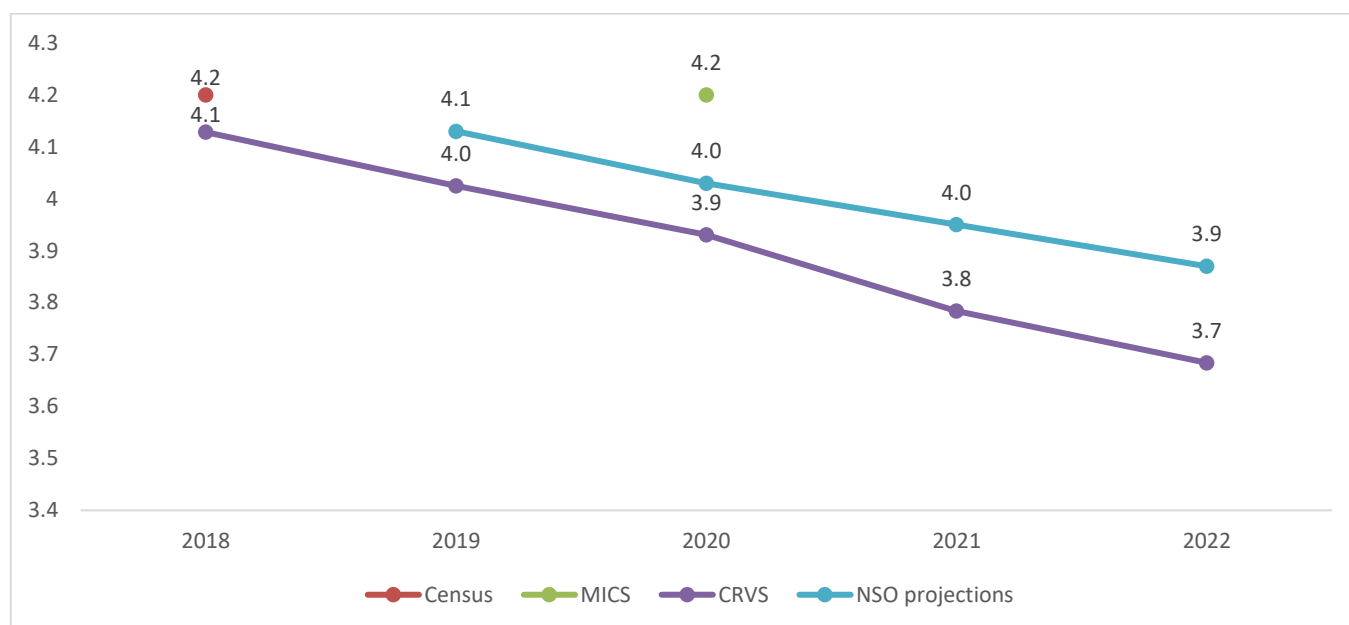
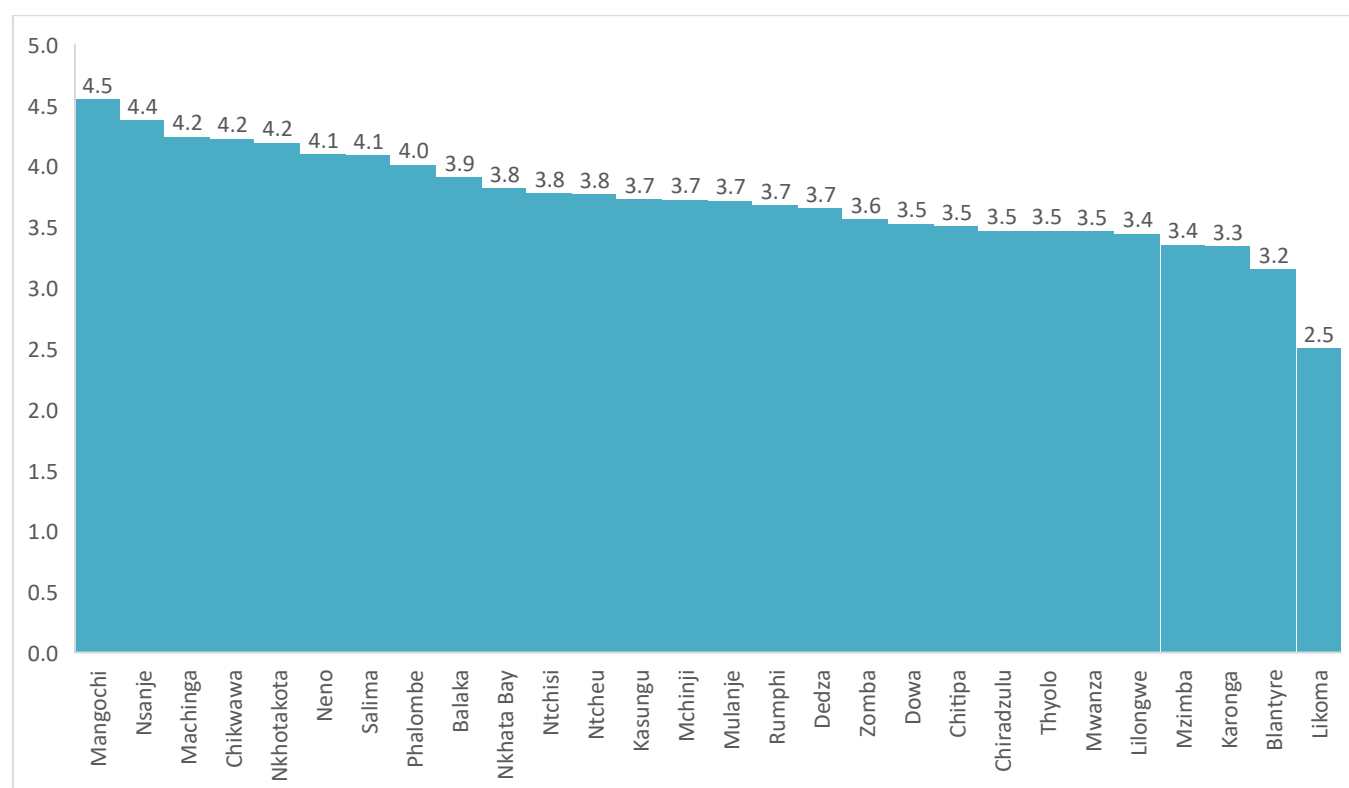


Figure 4.8 shows the TFR for by district of delivery in 2022. The findings indicate that despite a national average TFR of 3.7 children per woman, the district levels range from 4.5 children woman in Mangochi to 2.5 children in Likoma.

Figure 4.8: Total fertility rate (TFR) by district of delivery, 2022



Note: The number of women in the reproductive age groups were taken from NSO census projections.

Chapter 5. Deaths

Generally, the total number of deaths registered annually has steadily increased, from 6,277 at the launch of mandatory death registration in 2018 to 13,653 in 2022. This signifies a 118% increase over the period. The years 2020 and 2021 had the highest death registration numbers at 17,409 and 17,479 respectively as a result of a backlog clearing exercise that saw data being entered en masse.

There were more male deaths registered than females for each year suggesting to a relatively higher completeness of death registration among males than females. Male completeness rose from 6.7% to 13.1% between 2018 and 2022, while the female completeness rose from 3.5% to 10.2%.

Weighted results show that the crude death rate dropped steadily from 7.1 in 2018 to 6.5 in 2022. This drop corresponds to the 2018 MPHC population projections that depict the decreasing crude death rate. Due to the sensitivity of the indicator on under-5 mortality, the results were not weighted, due to strong variance in the results, as there were a too few registered records. The CRVS data indicate an increasing under-5 mortality rate from 4.2 in 2018 to 17.5 deaths per 1,000 live births in 2022. These findings are far from the UNICEF-reported under-5 mortality rate of 40.1 deaths per 1,000 live births as a result of low completeness of death registration. Deaths among pregnant women follow an irregular pattern.

Table 5.1. Summary statistics on mortality by year of occurrence

Indicator	2018	2019	2020	2021	2022
Registered deaths (number)	6,277	13,315	17,409	17,479	13,653
<i>Males</i>	4,046	8,552	11,015	10,813	8,490
<i>Females</i>	2,231	4,763	6,394	6,666	5,163
MPHC Projected deaths (number)	124,783	125,183	125,296	125,810	126,384
<i>Males</i>	60,541	60,721	60,761	60,995	61,258
<i>Females</i>	64,242	64,462	64,535	64,815	65,126
Registration completeness (%)	5	10.6	13.9	13.9	10.8
<i>Males</i>	6.7	13.4	17.1	17.8	13.1
<i>Females</i>	3.5	8.1	10.9	10.2	8.6
Crude death rate (per 1,000 population)	7.1	7	6.8	6.7	6.5
Under-5 mortality rate (per 1,000 live births) CRVS	4.2	19.1	21.3	16.3	17.5
Deaths during pregnancy and delivery (actual registered)	28	88	115	106	92

5.1 Deaths by place of usual residence and sex of decedent

Table 5.1 shows registered deaths by district of usual residence and sex in 2022. It also breaks down the deaths by district of residence and registration. That is to say, deaths registered in 2022 include records of persons that died before 2022, whereas registration by occurrence only comprises deaths that occurred in

2022. The findings indicate that a total of 22,481 deaths were registered in 2022, out of which 13,228 (59%) were males and 9,253 (41%) were females. Of the registered deaths, only 13,653 (61%) deaths occurred in 2022, and the rest before 2022. Of the 13,653 of registered deaths, 8,020 (59%) were males and 5,633 (41%) were females.

Table 5.1 Registered deaths by district of usual residence and sex of decedent, 2022

District of usual residence of decedent	All deaths registered in 2022			Registered deaths occurred in 2022		
	Male	Female	Total Deaths	Male	Female	Total Deaths
All deaths	13,228	9,253	22,481	8,020	5,633	13,653
Balaka	496	447	943	173	154	327
Blantyre	936	559	1,495	671	389	1,060
Chikwawa	248	152	400	122	82	204
Chiradzulu	95	45	140	58	34	92
Chitipa	173	94	267	118	73	191
Dedza	248	140	388	158	97	255
Dowa	262	161	423	199	132	331
Karonga	381	238	619	266	180	446
Kasungu	242	133	375	188	107	295
Likoma	9	3	12	9	2	11
Lilongwe	2,756	1,863	4,619	1,942	1,356	3,298
Machinga	223	165	388	95	76	171
Mangochi	1,281	1,037	2,318	980	757	1,737
Mchinji	2,369	1,885	4,254	722	539	1,261
Missing	115	59	174	46	17	63
Mulanje	126	67	193	94	49	143
Mwanza	162	116	278	131	90	221
Mzimba	659	395	1,054	457	297	754
Neno	24	14	38	18	11	29
Nkhata Bay	168	119	287	126	103	229
Nkhotakota	99	43	142	65	30	95
Nsanje	258	230	488	143	120	263
Ntcheu	433	359	792	316	289	605
Ntchisi	360	205	565	204	113	317
Phalombe	215	185	400	125	113	238
Rumphi	70	37	107	39	21	60
Salima	246	137	383	184	120	304
Thyolo	112	73	185	72	51	123
Zomba	462	292	754	299	231	530

Figure 5.1a below shows the trend in registered deaths among those that occurred in the year of registration. Out of the 22,481 deaths registered, about 9,817 occurred before 2018 (prior to the commencement of death registration), thereby implying on-demand death registration. Most of the registered deaths occurred in 2020 (17,209) and 2021 (17,479), respectively. There was a significant decrease in the number of registered deaths from 2021 to 2022 as Covid-19 resounded.

Figure 5.1a Deaths by year of occurrence, 2017 - 2022

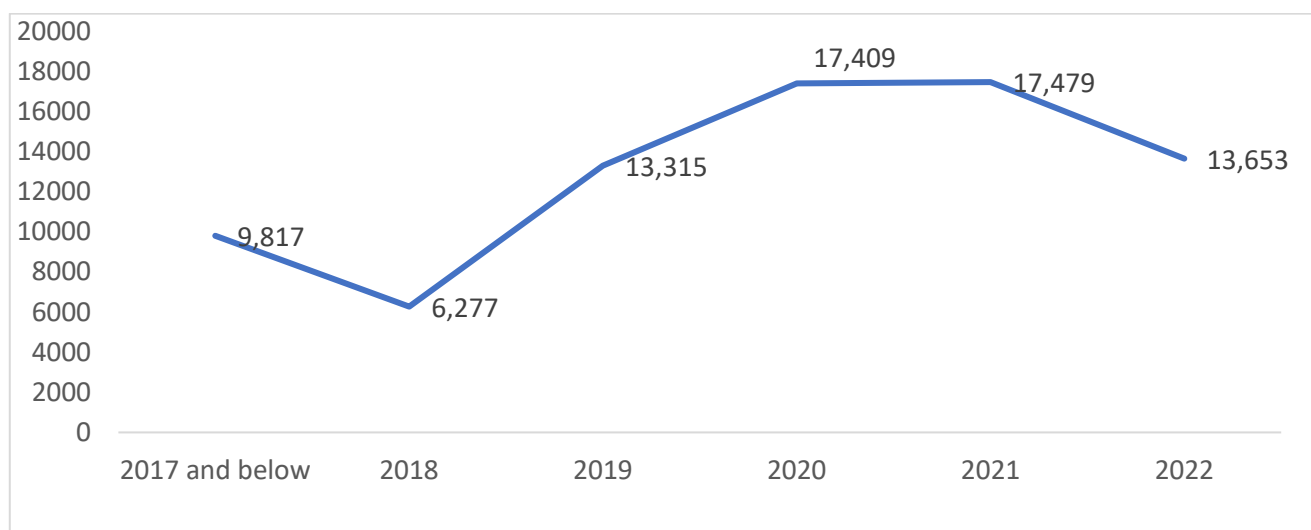
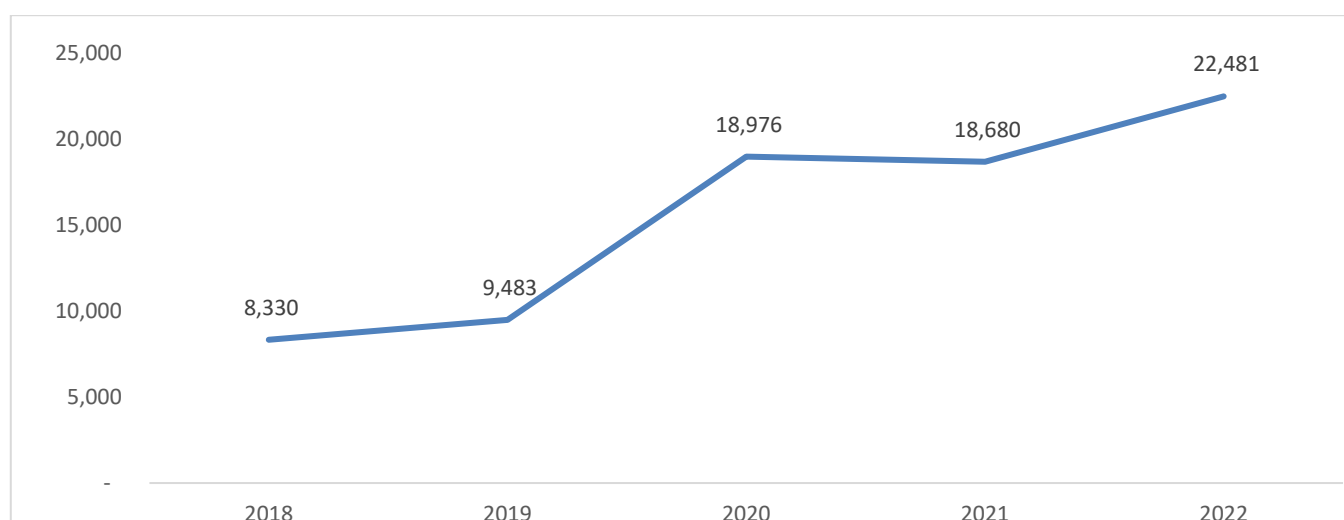


Figure 5.2b shows annual registered deaths from 2018 to 2019. In the year 2018, NRB registered 8,330 deaths, which increased to 9,483 in 2019. Increased coverage coupled with improved data entry increased the figures further to 18,976 and 18,680 in 2020 and 2021, before rising sharply to 22,481 in 2022. These figures, however, comprise deaths that occurred in previous years as well.

Figure 5.2b Deaths by year of registration, 2017 – 2022



5.2 Deaths by district of occurrence, district of usual residence, and sex of decedent

Table 4.3 shows the total number of deaths by district of occurrence against the district of usual residence of the deceased in 2022. Overall, the proportion of deaths that occurred outside the decedent's usual district of residence was 13 percent. The population residing in Chiradzulu had the highest occurrence of deaths outside this district (57%). This was followed by Dedza (42%), Neno (41%), Blantyre (32%), Machinga (26%) and Lilongwe (20%). Cumulatively, these six districts accounted for 72 percent of all births that occurred outside the district residence of the decedent. In contract, Likoma, Mchinji, Mangochi, Nsanje and Ntcheu

accounted for the lowest proportion of deaths occurring outside the district of residence of the deceased with proportions ranging from 0% for Likoma District to 3% in Ntcheu respectively.

Table 5.2 Registered deaths by district of occurrence and district of usual residence of decedent, segregated by sex, 2022

District of Occurrence of Death (District)	District of Usual Residence						Total Number of Deaths (B)			Different district of residence (A/B%)		
	Same as district of occurrence of death			Not the same as district of occurrence of death (A)								
	F	M	Total	F	M	Total	F	M	Total	F	M	Total
Chiradzulu	0	0	0	8	49	57	15	85	100	53%	58%	57%
Dedza	0	0	0	10	13	23	20	35	55	50%	37%	42%
Neno	4	11	15	2	10	12	6	23	29	33%	43%	41%
Blantyre	605	966	1571	428	600	1028	1263	1954	3217	34%	31%	32%
Machinga	99	170	269	39	66	105	145	260	405	27%	25%	26%
Lilongwe	1216	1963	3179	304	561	865	1631	2754	4385	19%	20%	20%
Rumphi	8	33	41	3	10	13	11	58	69	27%	17%	19%
Phalombe	184	252	436	38	49	87	224	315	539	17%	16%	16%
Balaka	354	384	738	61	77	138	427	480	907	14%	16%	15%
Kasungu	19	88	107	6	19	25	28	139	167	21%	14%	15%
Dowa	16	57	73	3	13	16	25	91	116	12%	14%	14%
Salima	41	124	165	9	15	24	57	160	217	16%	9%	11%
Chitipa	0	0	0	0	4	4	8	33	41	0%	12%	10%
Zomba	193	406	599	36	76	112	316	858	1174	11%	9%	10%
Chikwawa	47	86	133	6	13	19	59	143	202	10%	9%	9%
Ntchisi	129	190	319	9	20	29	141	221	362	6%	9%	8%
Mulanje	83	325	408	7	24	31	100	364	464	7%	7%	7%
Mzimba	386	900	1286	26	55	81	421	993	1414	6%	6%	6%
Thyolo	101	336	437	7	30	37	134	529	663	5%	6%	6%
Nkhotakota	17	58	75	2	3	5	22	73	95	9%	4%	5%
Nkhata-bay	25	70	95	1	3	4	27	77	104	4%	4%	4%
Karonga	63	123	186	2	7	9	73	162	235	3%	4%	4%
Mwanza	125	222	347	5	9	14	132	262	394	4%	3%	4%
Ntcheu	581	651	1232	21	22	43	615	708	1323	3%	3%	3%
Nsanje	121	167	288	3	6	9	131	187	318	2%	3%	3%
Mangochi	1250	1427	2677	24	39	63	1288	1486	2774	2%	3%	2%
Mchinji	808	1136	1944	3	13	16	1102	1532	2634	0%	1%	1%
Likoma	0	1	1	0	0	0	1	2	3	0%	0%	0%
Not Stated	0	0	0	0	0	0	18	36	54	0%	0%	0%
Totals	6,475	10,148	16,623	1,070	1,817	2,887	8,448	14,033	22,481	13%	13%	13%

5.3 Deaths by district and site of occurrence

Table 5.4 below summarises the occurrence of deaths by district and site of occurrence (e.g. health facility, home or other). Overall, the results show that over 64 percent of deaths registered in 2022 occurred in health facilities, whereas 33% and 2% of deaths occurred at home and other places, respectively. This finding however, deviates from estimates from the Malaria Vaccine Implementation Programme, which shows a prevalence of non-facility deaths of about 70%. This may be the case because this report is based on data with limited community registration coverage.

Table 5.3 Percentage of Deaths by district and site of occurrence, 2022

District of Occurrence	Health Facility			Home			Other			Grand Total
	F	M	Total	F	M	Total	F	M	Total	
Blantyre	36	54	89	3	6	9	1	1	2	100
Ntcheu	41	43	84	5	9	14	1	2	3	100
Rumphi	14	68	83	1	13	14	0	3	3	100
Karonga	27	55	82	3	12	15	1	2	3	100
Chiradzulu	13	68	81	2	16	18	0	1	1	100
Chitipa	20	61	80	0	15	15	0	5	5	100
Mzimba	25	55	80	4	14	17	1	2	3	100
Lilongwe	29	51	79	8	11	18	1	1	2	100
Neno	14	66	79	7	10	17	0	3	3	100
Nkhata-bay	21	54	75	5	19	24	0	1	1	100
Kasungu	14	60	74	2	20	22	1	4	4	100
Nkhotakota	19	55	74	2	16	18	2	6	8	100
Dedza	25	45	71	5	16	22	5	2	7	100
Salima	18	53	71	7	18	25	1	3	4	100
Dowa	15	53	67	6	22	28	1	4	5	100
Mwanza	23	43	65	11	22	33	0	2	2	100
Zomba	21	45	65	6	27	33	0	2	2	100
Machinga	23	39	62	12	24	36	0	1	1	100
Nsanje	23	36	59	18	22	40	1	1	2	100
Phalombe	24	33	57	18	24	42	0	1	1	100
Ntchisi	23	33	56	15	24	39	1	4	6	100
Thyolo	13	42	55	7	35	42	0	3	3	100
Mulanje	13	41	54	7	36	44	1	1	2	100
Chikwawa	11	40	51	17	28	46	0	2	3	100
Mangochi	17	20	37	29	33	63	0	0	1	100
Mchinji	15	21	35	27	37	64	0	1	1	100
Balaka	14	19	33	32	33	65	1	1	2	100
Likoma	33	0	33	0	67	67	0	0	0	100
Totals	24	40	64	13	21	33	1	2	2	100

5.4 Deaths by district of usual residence, age, and sex of decedent

The age and sex distribution of deaths varies considerably depending on the overall level of mortality in a country, which determines the risk of dying at each age, and the size of the population currently alive at each age. Irrespective of level of mortality, the number of deaths usually increases by age from the age of 5-9 years onwards. Table 5.5 summarises the occurrence of deaths by age of the deceased over time between years 2019 and 2022. Across all the years, the occurrence of deaths shows comparable age patterns starting with higher mortality in younger ages (0-4 years), and stabilising between 5-9 years before gradually rising with age. A sharp rise in mortality is observed from age 79 years and older. Given that these results are unweighted, we cannot make comparisons on the absolute magnitudes of mortality across the years due to varying levels of completeness in the data.

Figure 5.3 Deaths by age of decedent and year of occurrence (unweighted), 2019-2022

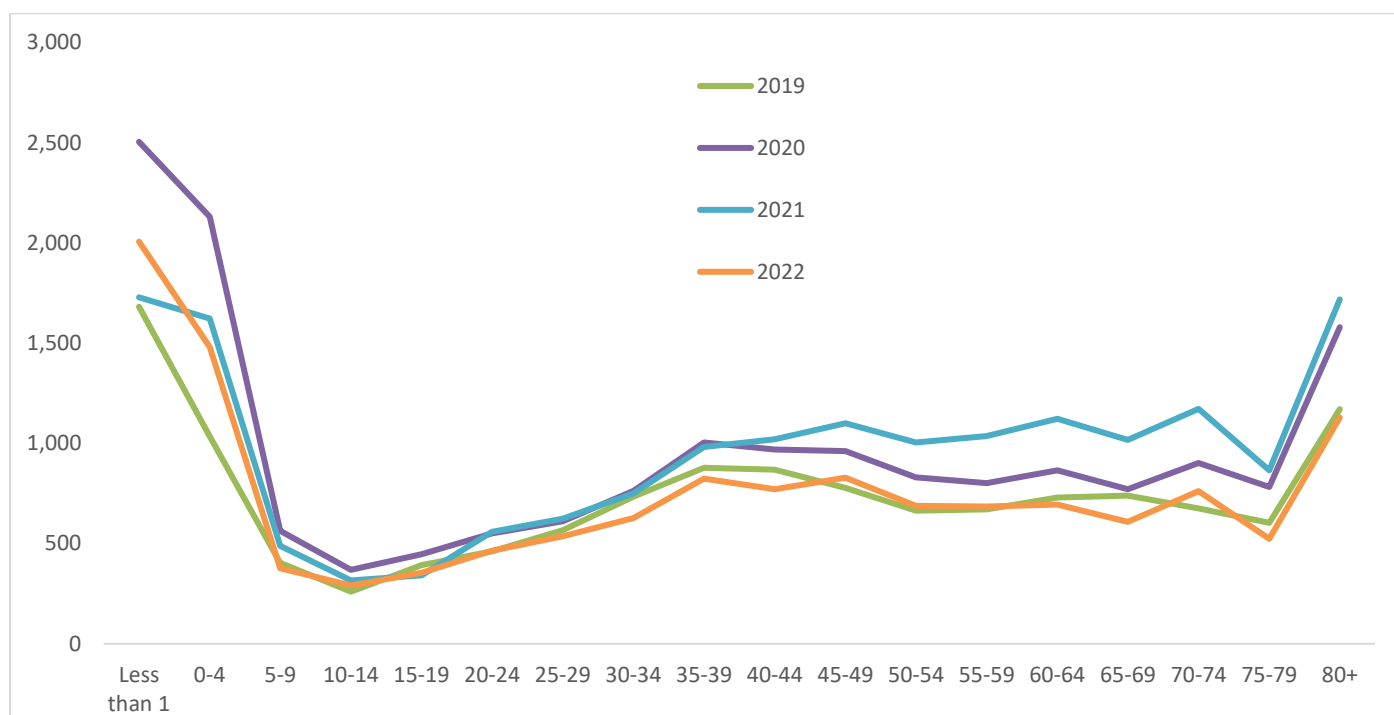
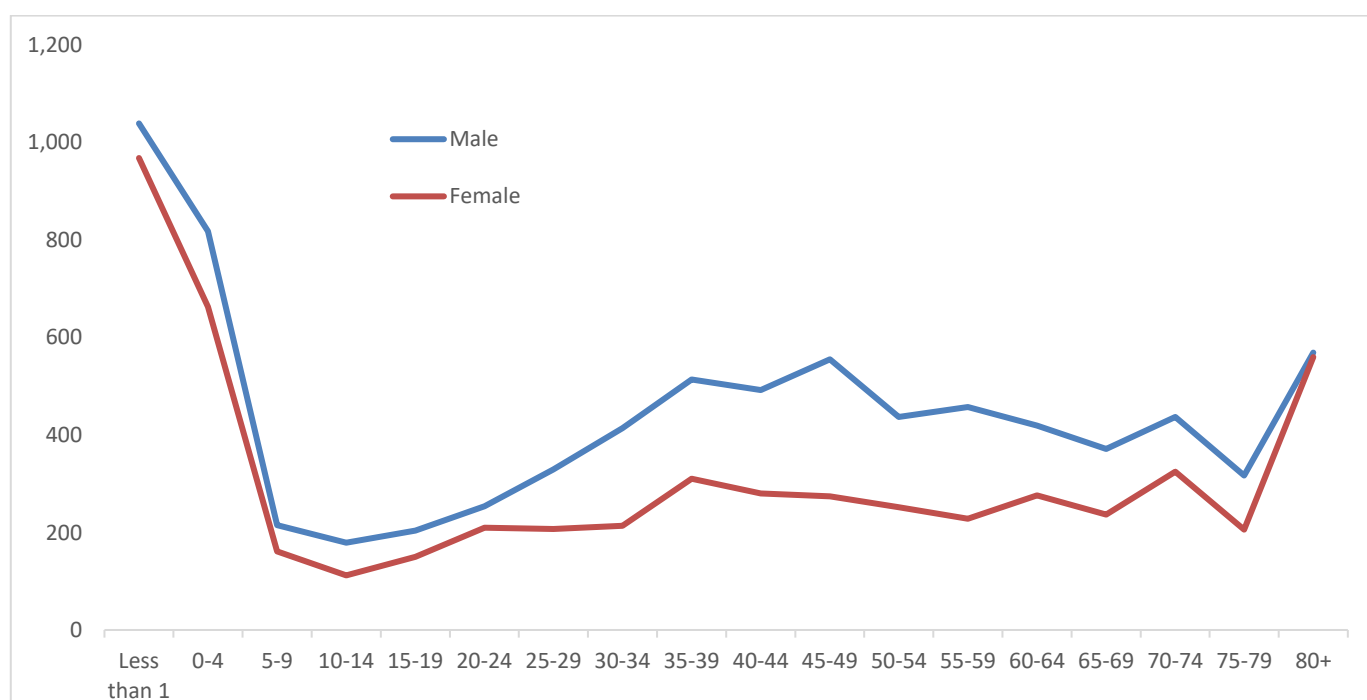


Figure 5.4 shows the age and sex comparison of mortality based on civil registration data. Comparison between male and female mortality shows a higher mortality among males for all age groups. The difference, however, arises with respect to the magnitude of deaths. Nevertheless, these findings alone may not be conclusive unless the data are adjusted for completeness.

Figure 5.4 Deaths by sex and age of decedent (unweighted), 2022



5.5 Crude death rate

As a mortality indicator, the crude death rate (CDR) is the simplest measure of population health status. It is a measure of the number of deaths relative to the size of that population during a given period, usually one year. It is expressed in numbers of deaths per 1,000 population per year. Table 5.6 shows the CDR calculated from civil registration data and the weighted CDR against district-level expected number of deaths¹¹ in 2022.

Results indicate that the national CDR from CR data was 0.7 deaths per 1,000 population in 2022. When adjusted for completeness, the national CDR rises to 6.5 deaths per 1,000 population. This weighted CDR corresponds with estimates from census reports.

At the district-level, the unweighted CDR ranged from 0.07 deaths per 1,000 population in Dedza District to 1.75 deaths per a 1,000 population in Mchinji. When weighted for completeness, the highest death rate was reported in Nkhata Bay at 9.4 deaths per 1,000 population.

The lowest crude death rate was reported in Likoma (4.1 deaths per 1,000 population), followed by Ntchisi, Neno and Chikwawa districts, which all stood at 5.3 deaths per 1,000 population. Lilongwe, Kasungu and Chitipa all had a crude death rate of 5.3 deaths per 1,000 population.

Just as the case with birth registration, Mchinji, a district with the highest completeness of death registration (30%) has its unweighted death rate value (1.75) closer to the true/weighted death rate. Thus, improving completeness of registration improves the accuracy of the corresponding vital statistics to be computed.

Table 5.5 Crude death rate (CDR) by district of occurrence of death, 2022

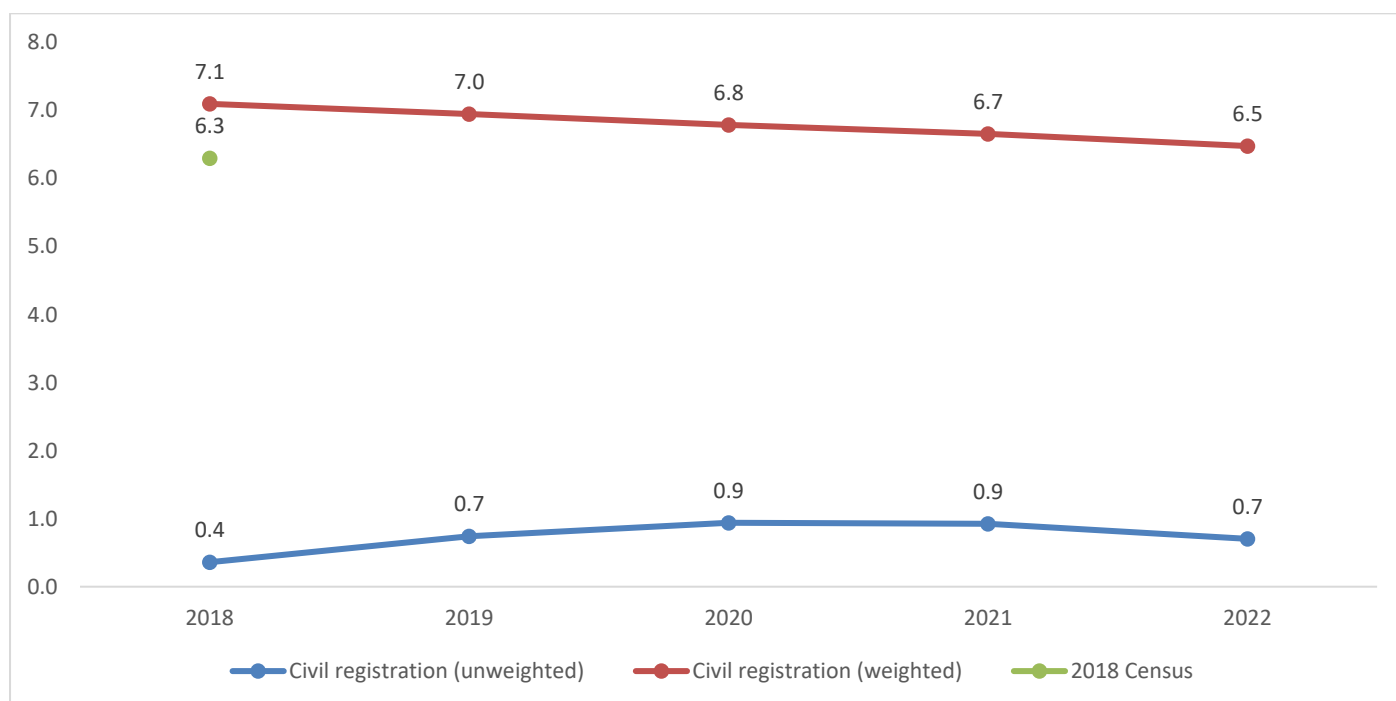
District of Occurrence	Registered deaths	Weighted deaths	Total Population	Crude Death Rate (per 1,000 population)	
				CRVS	Weighted CDR
Nkhatabay	156	2,870	304,556	0.51	9.4
Balaka	347	4,326	490,804	0.71	8.8
Mangochi	1,727	10,488	1,305,432	1.32	8
Thyolo	74	6,163	770,860	0.10	8
Mulanje	73	5,707	749,359	0.10	7.6
Ntcheu	463	5,599	735,941	0.63	7.6
Chiradzulu	60	2,639	383,559	0.16	6.9
Dedza	61	6,241	908,487	0.07	6.9
Salima	255	3,673	535,981	0.48	6.9
Zomba	623	6,431	928,779	0.67	6.9
Karonga	419	2,629	397,097	1.06	6.6
Machinga	146	5,560	845,076	0.17	6.6
Phalombe	228	3,169	477,929	0.48	6.6
Dowa	103	5,561	857,510	0.12	6.5
Rumphi	24	1,619	248,930	0.10	6.5

¹¹ 2018 MPHIC

District of Occurrence	Registered deaths	Weighted deaths	Total Population	Crude Death Rate (per 1,000 population)	
				CRVS	Weighted CDR
Mzimba	870	8,113	1,263,507	0.69	6.4
Mchinji	1,152	4,122	658,470	1.75	6.3
Nkhotakota	37	2,717	428,355	0.09	6.3
Mwanza	259	921	147,976	1.75	6.2
Blantyre	1,262	7,958	1,355,665	0.93	5.9
Nsanje	242	1,904	321,535	0.75	5.9
Chitipa	176	1,352	251,830	0.70	5.4
Kasungu	216	4,981	928,471	0.23	5.4
Lilongwe	4,142	15,633	2,917,964	1.42	5.4
Chikwawa	154	3,265	615,685	0.25	5.3
Neno	15	798	150,211	0.10	5.3
Ntchisi	321	1,881	356,232	0.90	5.3
Likoma	8	64	15,691	0.51	4.1
Missing	40	-	-	-	-
Total	13,613	126,384	19,351,892	0.70	6.5

Figure 5.4 shows the weighted and unweighted crude death rate by year of occurrence compared with the CBR based on projections of the 2018 population and housing census. Overall, the unweighted CDR is lower than the weighted CDR and that from the census. The reason for this can be attributed to the limitations of CRVS data stemming from its low completeness of registration (10.8%). However, when examining the weighted CBR over a four-year period, the trend that emerges points towards a declining death rate, dropping from 7.1 deaths per 1,000 population in 2018 to 6.5 deaths per 1,000 population in 2022. This represents a 20% decrease over a four-year period. The weighted CDR also corresponds well with other data sources. For instance, the 2018 population and housing census reported a CDR of 6.3 deaths per a 1,000 population in 2018.

Figure 5.3 Crude death rate by year of occurrence of death with comparator data



5.6 Age-specific mortality rates

The age-specific mortality rate (ASMR) is the number of deaths for a specific age or age group in a specific area during a specified period divided by the population of the same age or age group in the same area and period. Table 5.6 provides a comparison between unweighted and weighted ASMRs from CRVS data by sex for the year 2022. It also breaks down the age-standardised mortality rates for males and females. As the data reveal, children aged 0-4 years experienced a high mortality rate of 8.9 deaths per 1000 population. By ages 5 through 14 years, the ASMR declined to 1 death per thousand population. From age 15, however, the mortality rate steadily rises reaching 8.9 deaths per 1,000 population at ages 40-44 years, a rate similar to that of the population aged 0-4. The mortality rates continue to sharply increase with age reaching up to 80.4 deaths per 1,000 population among those aged 80 years and older. A comparison of ASMRs between sexes depict higher male mortality than females across all ages.

The population age structure affects the ASMR making comparisons between populations unfeasible. The age-standardized mortality rate is a weighted average of the age-specific mortality rates, where the weights are the proportions of persons in the corresponding age groups of a WHO standard population. Age-standardised mortality is used to compare the mortality rates for countries without being affected by the difference in age distributions from country to country. Without using this standardization, it would be unclear if differing mortality rates were due to age differences or other factors. In order to calculate this, weighted ASMRs from CRVS were multiplied by the age distribution of the WHO standard population. Table 5.9 below also breaks down the age-standardised mortality rates per 1,000 population by sex for the year 2022.

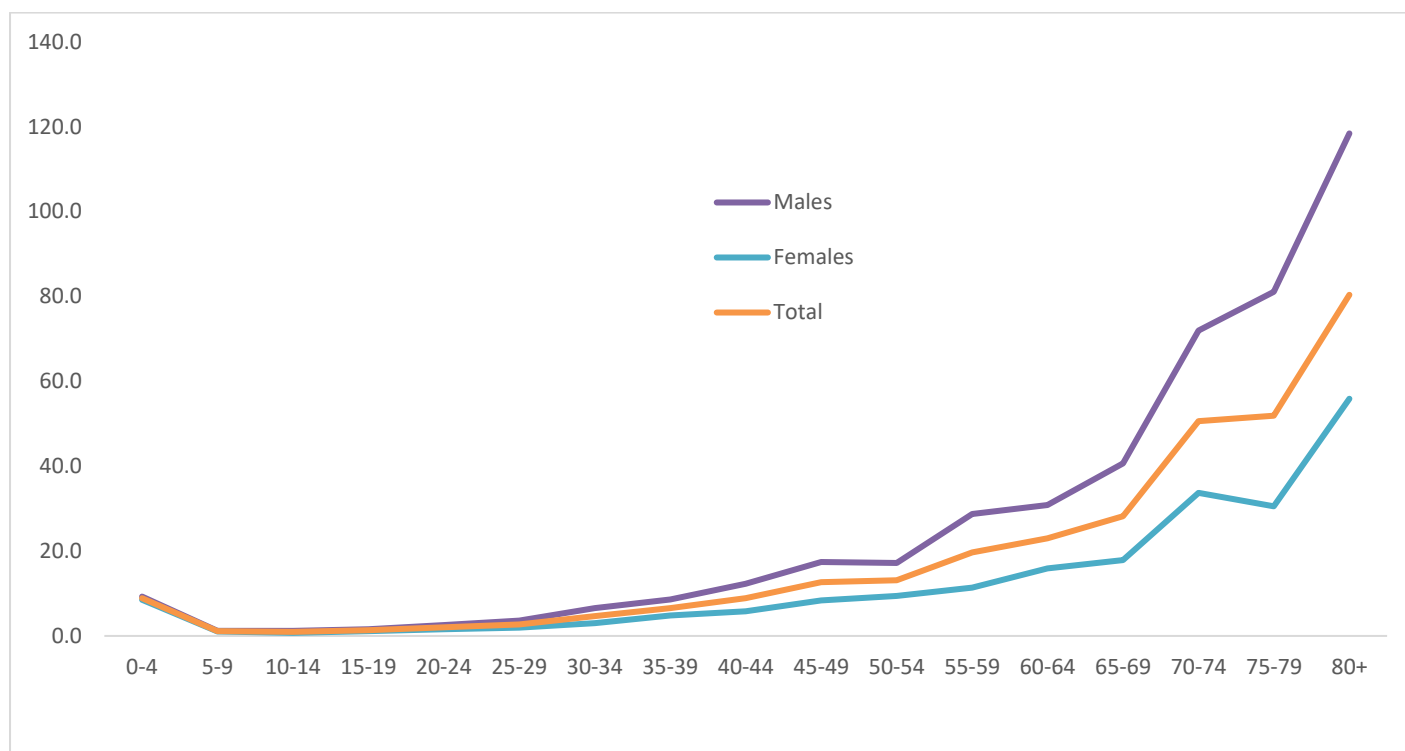
**Table 5.6: Age-Specific Mortality Rates and Age-Standardised Mortality Rates (per 1,000 population),
2022**

Age group	Age-Specific Mortality Rate (Unweighted)			Age-Specific Mortality Rate (weighted)			Age-Standardised Mortality Rate		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
0-4	1.3	1.1	1.2	9.3	8.5	8.9	0.8	0.8	0.8
5-9	0.2	0.1	0.1	1.2	1.1	1.1	0.1	0.1	0.1
10-14	0.1	0.1	0.1	1.2	0.7	1	0.1	0.1	0.1
15-19	0.2	0.1	0.2	1.6	1.1	1.3	0.1	0.1	0.1
20-24	0.3	0.2	0.2	2.5	1.6	2	0.2	0.1	0.2
25-29	0.4	0.3	0.3	3.7	1.9	2.7	0.3	0.2	0.2
30-34	0.7	0.3	0.5	6.5	3	4.7	0.5	0.2	0.4
35-39	1.1	0.6	0.8	8.6	4.8	6.6	0.6	0.3	0.5
40-44	1.2	0.6	0.9	12.3	5.8	8.9	0.8	0.4	0.6
45-49	1.7	0.8	1.2	17.4	8.4	12.7	1.1	0.5	0.8
50-54	1.7	0.9	1.3	17.2	9.4	13.2	0.9	0.5	0.7
55-59	2.5	1.1	1.8	28.7	11.4	19.7	1.3	0.5	0.9
60-64	3	1.7	2.3	30.9	15.9	23	1.1	0.6	0.9
65-69	3.5	1.9	2.6	40.6	17.9	28.2	1.2	0.5	0.8
70-74	5.7	3.4	4.4	71.9	33.7	50.6	1.6	0.7	1.1
75-79	6	2.8	4.2	81.1	30.5	51.9	1.2	0.5	0.8
80+	9.7	6.1	7.5	118.4	55.9	80.4	1.8	0.9	1.2

While there are notable differences in mortality rates between males and females, Figure 5.5 below visualises the magnitude of these differences over the course of life. Noticeable differences are observed from age 25 years and the gap widens with age. From age 55, however, the difference between male and

female mortality exponentially increases, thereby depicting exceptionally higher mortality among males than females.

Figure 5.4 Age-specific mortality rates by sex, 2022



5.7 Infant and child mortality

The infant mortality rate (IMR) is the number of deaths among live-born infants during the first year of life per 1,000 live births over a specified period. Mortality during infancy accounts for a large proportion of deaths and is a useful indicator of maternal and newborn neonatal health and care. Generally, as infant mortality decreases and fewer deaths are attributed to infectious diseases and environmental influences, a greater proportion of infant deaths would be expected to occur in the neonatal period.

Table 5.7 below shows the breakdown of infant mortality and under-five mortality over time based on CR data, which are important indicators of overall population health and well-being. The results in this table have not been weighted for completeness, as adjusted figures had huge variance with the expected rates due to the sensitivity of the indicators (IMR and U5MR). UNICEF estimates Malawi's infant mortality rate at 30 deaths per 1,000 live births. However, based on CR data, out of an estimated 608,074 births that occurred in 2018, about 316 were registered, translating to an unweighted IMR of 0.5 deaths per 1,000 live births. With improving completeness in death registration, CRVS-generated IMR increased to 2.8 in 2019, 4.1 deaths in 2020, and 3.2 deaths in 2022. These findings call for the need to improve death registration, which is currently only 11% complete.

Similarly, under-five mortality rate (unweighted) rose from 1 death per 1,000 population in 2018 to 5.8 deaths per 1,000 population in 2022. Again, this is against the national under-5 mortality estimates of 40 deaths per 1,000 live births.

Table 5.4 Infant and child mortality (deaths per 1,000 live births) by year of occurrence (unweighted)

Year of occurrence	Live births	Infant Mortality		Under-5 Mortality	
		Registered deaths	IMR	Registered deaths	U5MR
2018	608,074	316	2.3	584	1
2019	611,614	1,682	11.4	2,833	4.6
2020	614,670	2,505	11.1	4,811	7.8
2021	620,346	1,729	8.1	3,467	5.6
2022	625,434	2,007	9.8	3,598	5.8

Note: Population data were sourced from NSO census projections

NMR = neonatal mortality rate; IMR = infant mortality rate; U5MR = under-5 mortality rate

5.8 Deaths during pregnancy

A maternal death is defined by WHO as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes. The maternal mortality ratio (MMR) is the ratio of the number of maternal deaths during a given period per 100,000 live births during the same time period (usually one year).

However, this report does not report findings on maternal mortality for the following two reasons: Firstly, NRB collects information on the pregnancy status of the deceased during death registration. This information may be subject to misclassification, therefore introduce bias in the analysis of maternal mortality. Secondly, very low completeness of death registration makes it challenging to produce accurate and comparable estimates of maternal mortality. As such, this report documents finding related to deaths during pregnancy only. For the very same reason, these numbers were not adjusted for completeness, and should, therefore be reported in their absolute terms stemming directly from registered records.

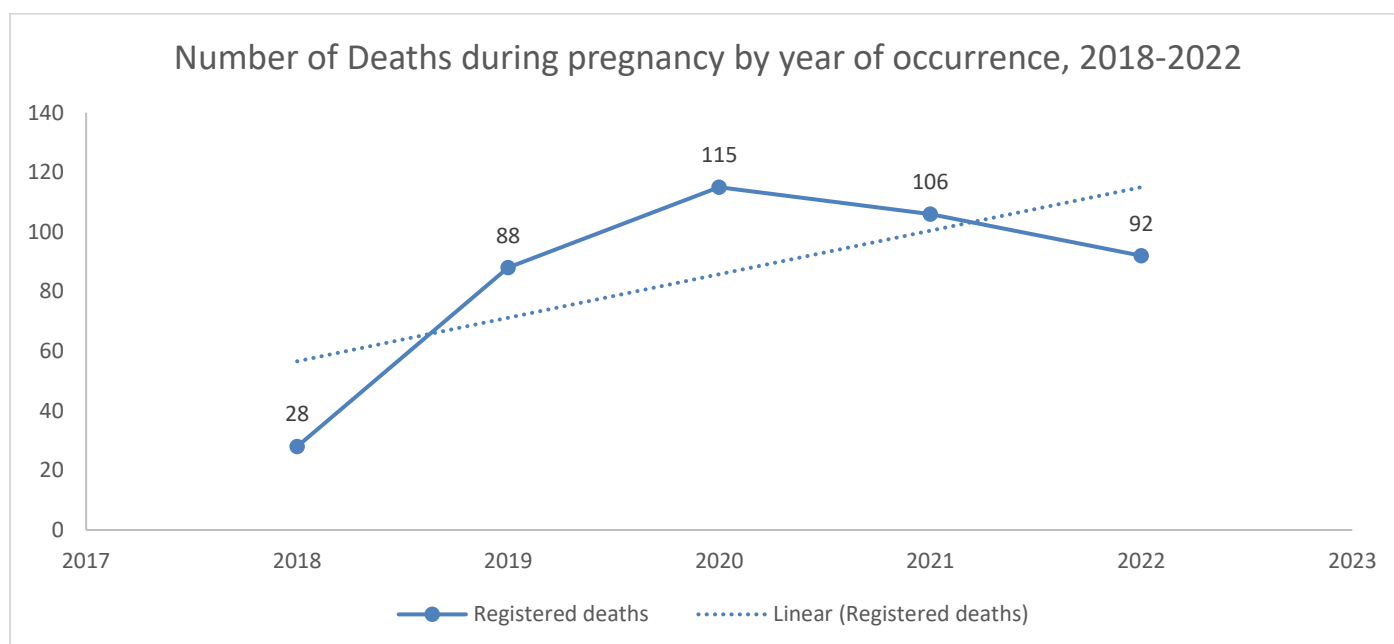
Table 5.8 provides a summary of the number of deaths that occurred during pregnancy among those registered between 2018 and 2022. Deaths during pregnancy were reported at 28 in 2018, 88 deaths in 2019, 115 deaths in 2020, 106 deaths in 2021 and 92 deaths in 2022.

Table 5.5 Number of deaths during pregnancy by year of occurrence

Year of occurrence	Total number of deaths (Unweighted)
2018	28
2019	88
2020	115
2021	106
2022	92

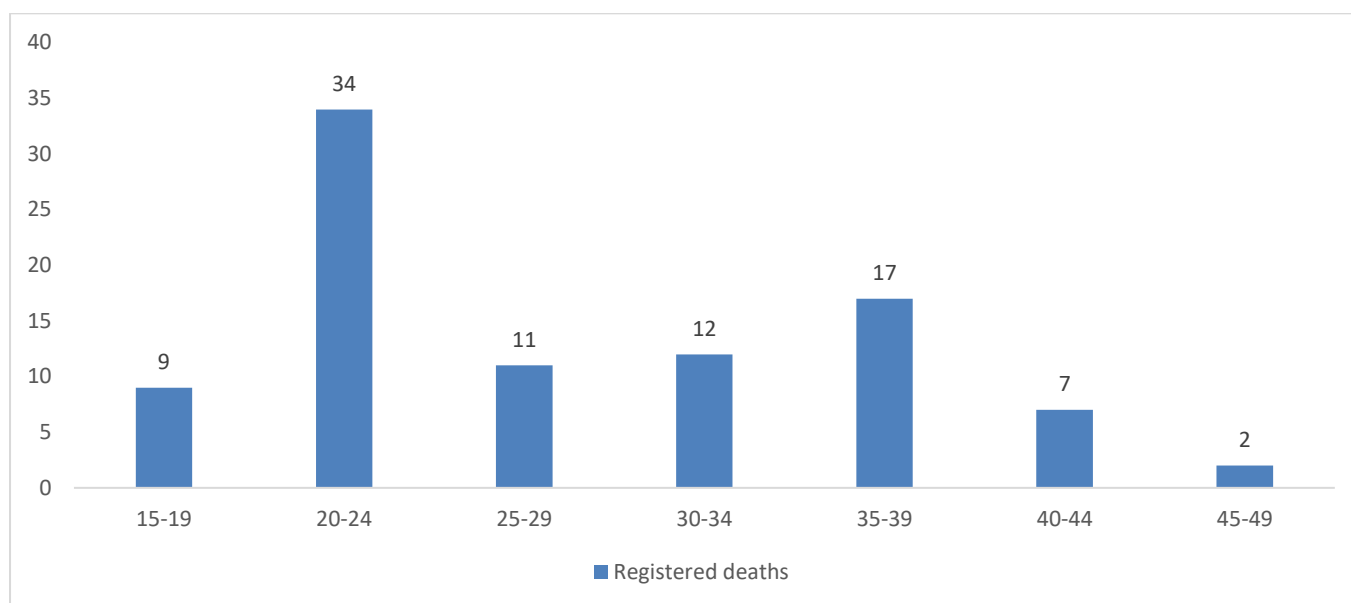
Figure 5.5 provides a visual illustration of the trends in weighted deaths occurring during pregnancy from 2018 through 2022. While the figures indicate a decreasing trend from 2021, the best fit linear interpolation (dotted line) demonstrate an overall increasing trend in deaths during pregnancy among women.

Figure 5.5: Number of deaths during pregnancy by year of occurrence, 2018-2022



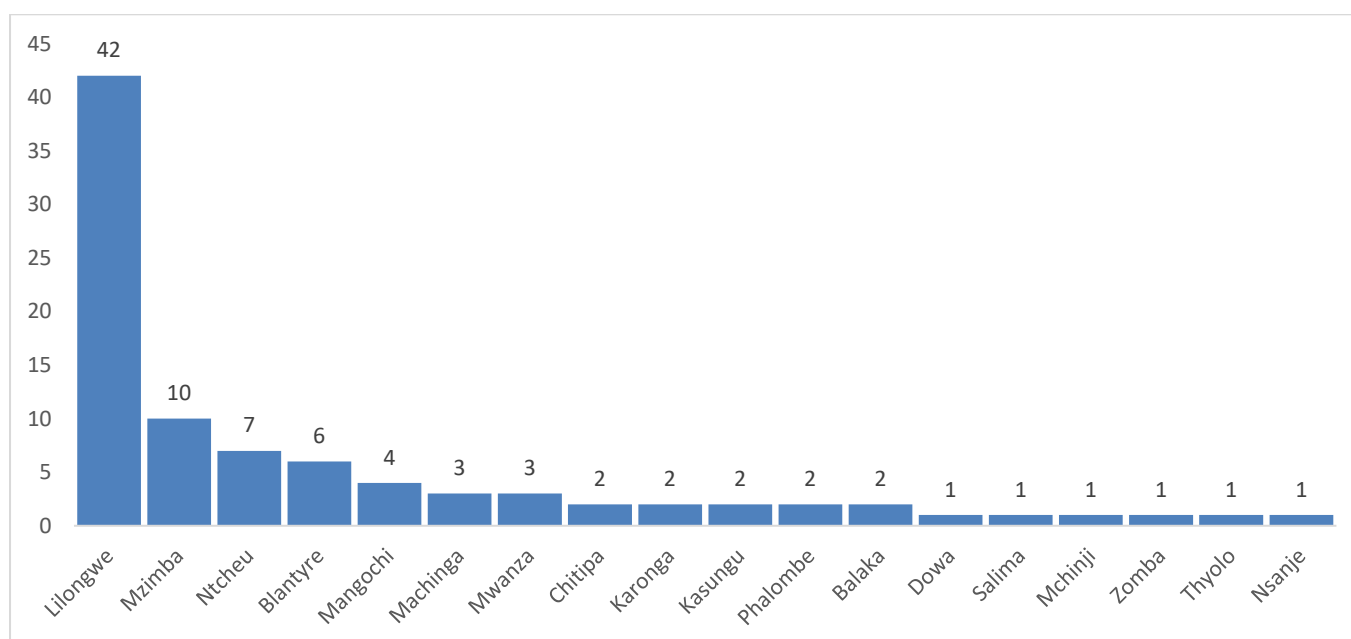
With respect to age of the mother, deaths during pregnancy among those registered occurred most frequently to women aged 20-24 years (34). This was seconded by women aged 35-39 (17). On the other hand, the least number of deaths was reported among women aged 45-49 years (2), 40-44 years (7) and adolescents aged 15-19 years (9).

Figure 5.6 Number of deaths during pregnancy by age group, 2022



In terms of district of death, Lilongwe reported the highest number of deaths among pregnant women at 159 deaths. While Mchinji had the least number of deaths among pregnant women, some districts did not report any such deaths at all.

Figure 5.7 Number of deaths during pregnancy by district of occurrence, 2022



Chapter 6. Causes of death

BEGIN BY DISCUSSING THE METHODOLOGY FOR THIS AND THE CURRENT STATUS OF CoD REGISTRATION IN Malawi, including the completeness and the quality of the data. Apparently, only about 5% of all deaths were classified by CoD in 2022. This is a very low proportion, and the CoD statistics should be discussed against this background.

Table 6.1 shows that the top four leading causes of deaths among infants of both sexes were prematurity/low birth weight, birth asphyxia/birth trauma, lower respiratory infections and malaria. While HIV was the 5th leading cause of death among female infants, male infants had endocrine disorders at the 5th leading cause of death. HIV was the least cause of mortality in infant males, whereas protein-energy malnutrition was the least cause among female infants.

Malaria and protein-energy malnutrition were the first and second leading causes of death among children aged between 1 and 14 years. While lower respiratory infections are the third leading cause among those aged 1 and 4 years old, older children from age 5 years up to 14 years succumbed to endocrine disorders. Drowning is the least (10th) cause of death among male children aged 1 – 4 years, whereas HIV is the least cause of death among this demographic. Among children aged between 5 and 14 years, lower respiratory infections were the least cause of death.

HIV is the leading cause of death among the adult population aged between 15 and 69 years followed by cerebrovascular disease, and diabetes mellitus. Tuberculosis and malaria are the fourth and fifth leading cause of deaths in this age group. On the other hand, alcohol use disorders and road traffic accidents were the least causes of deaths among the adult population. Old age mortality (70+ years) was predominantly caused by cerebrovascular disease, diabetes mellitus and lower respiratory infections as the top three leading causes.

Table 6.1. Leading causes of death by broad age group and sex (only for years below 5 years), 2022

	Males	Females
0 – 1 years	1 Prematurity and low birth weight	1 Prematurity and low birth weight
	2 Birth asphyxia and birth trauma	2 Birth asphyxia and birth trauma
	3 Lower respiratory infections	3 Lower respiratory infections
	4 Malaria	4 Malaria
	5 Endocrine disorders	5 HIV
	6 Congenital heart anomalies	6 Diarrhoeal diseases
	7 Diarrheal diseases	7 Congenital heart anomalies
	8 Tuberculosis	8 Endocrine disorders
	9 Iron deficiency Anaemia	9 Meningitis
	10 HIV	10 Protein-energy malnutrition
1 – 4 years	1 Malaria	1 Malaria
	2 Protein-energy malnutrition	2 Protein-energy malnutrition
	3 Lower respiratory infections	3 Lower respiratory infections
	4 Iron deficiency Anaemia	4 Diarrhoeal diseases

	5	Diarrhoeal diseases	5	Endocrine disorders
	6	Endocrine disorders	6	Iron deficiency Anaemia
	7	HIV	7	Meningitis
	8	Congenital heart anomalies	8	Tuberculosis
	9	Nephritis and nephrosis	9	Leukaemia
	10	Drownings	10	HIV

5-14 years	1	Malaria
	2	Protein-energy malnutrition
	3	Endocrine disorders
	4	Road traffic accidents
	5	Iron deficiency Anaemia
	6	HIV
	7	Rheumatic heart disease
	8	Meningitis
	9	Nephritis and nephrosis
	10	Lower respiratory infections

15-69 years	1	HIV
	2	Cerebrovascular disease
	3	Diabetes mellitus
	4	Tuberculosis
	5	Malaria
	6	Endocrine disorders
	7	Nephritis and nephrosis
	8	Lower respiratory infections
	9	Road traffic accidents
	10	Alcohol use disorders

70+ years	1	Cerebrovascular disease
	2	Diabetes mellitus
	3	Lower respiratory infections
	4	Hypertensive disease
	5	Malaria
	6	Nephritis and nephrosis
	7	COVID-19
	8	Endocrine disorders

	9 HIV
	10 Diarrhoeal diseases

6.2. Overview of Health facility/Hospital deaths

Malawi collects mortality data through various means including censuses, surveys as well as routinely from the hospitals using monthly/periodic reports. The statistics from these sources are entered into the District Health Information Software (DHIS2) platform. The DHIS2 data, however, have limitations. The data are not subjected to MCCoD as per WHO standards. The mandatory health facility death registration with MCCoD commenced in four pilot districts of Blantyre, Chitipa, Lilongwe and Ntcheu from February 2018. The roll out of MCCoD to other districts was undertaken in phases. Majority of MCCoD records pertain to deaths that occurred from January to December 2022. It is only through Civil Registration that Malawi has started reporting Medically Certified Causes of Deaths through the completion of section 2 of the Death Report Form (NR 10).

6.3. Leading Causes of Deaths

A total of 22,481 deaths were registered in the year 2022 in Malawi. Of these, 10,957 deaths had medical certification of cause of death with 4,736 and 6,211 being female and male deaths, respectively. The ten leading causes of deaths that occurred in 2022 for all ages account for 44 percent of all deaths with medical certification of cause of death as shown Table 6.1. Malaria is the leading cause of death (9 percent) followed by Cerebrovascular Disease (6 percent) and HIV (6 percent).

Table 6.2 Leading causes of death for all Ages, 2022

Rank	ICD Code	Disease	Number of deaths	Proportion (%)
1	B50-B54, P37.3, P37.4	Malaria	914	9
2	I60-I69	Cerebrovascular Disease	637	6.2
3	B20-B24	HIV	600	5.9
4	E10-E14	Diabetes mellitus	451	4.4
5	J09-J22, P23, U04	Lower respiratory infections	423	4.1
6	P05, P07, P22, P27-P28	Prematurity and low birth weight	366	3.6
7	A15-A19, B90	Tuberculosis	328	3.2
8	D55-D64 (minus D64.9), D65-D89, E03-E07, E15-E34, E65-E88	Endocrine disorders	321	3.1
9	P03, P10-P15, P20-P21, P24-P26, P29	Birth asphyxia and birth trauma	251	2.5
10	A00, A01, A03, A04, A06-A09	Diarrhoea Diseases	216	2.1
	Total		4,539	44.1

6.4. Deaths by broad cause of death group

The **Global Burden of Disease Study (GBD)** is a comprehensive worldwide research program that provides a systematic scientific assessment of published, publicly available, and contributed data on incidence, prevalence, and mortality for a mutually exclusive and collectively exhaustive list of diseases and injuries. The GBD study uses a **hierarchical classification system** to categorize diseases and injuries into different levels of detail. The classification system has four levels: Level 1, Level 2, Level 3, and Level 4. The Level 1 categories are the broadest and most general, while the Level 4 categories are the most specific and detailed⁴. The classification system is used to help researchers and policymakers understand the global burden of disease and injury, and to identify areas where interventions are needed to improve health outcomes.

Figure 6.1 shows the distribution of deaths with medical certification of cause of death by sex and broad cause of death that occurred in 2022. Out of 10,944 deaths with medical certification of cause of death, 4,977 (Female: 2,290 and Male: 2,687) were due to Communicable, maternal, perinatal and nutritional conditions (Group 1) representing 45.5 percent of all death with medical certification of cause of death. Noncommunicable diseases (Group 2) contributed 5,176 (Female: 2,263 and Male: 2,913) deaths while 791 (Female: 202 and Male: 589) deaths were attributable to Injuries (Group 3) representing 47.3 percent and 7.2 percent of deaths with medical certification of cause of death respectively. This is consistent with trends in low-income countries where Malawi falls.

Figure 6.1 Number of deaths by major cause, with deaths of unknown age and ill-defined causes redistributed, by sex 2022

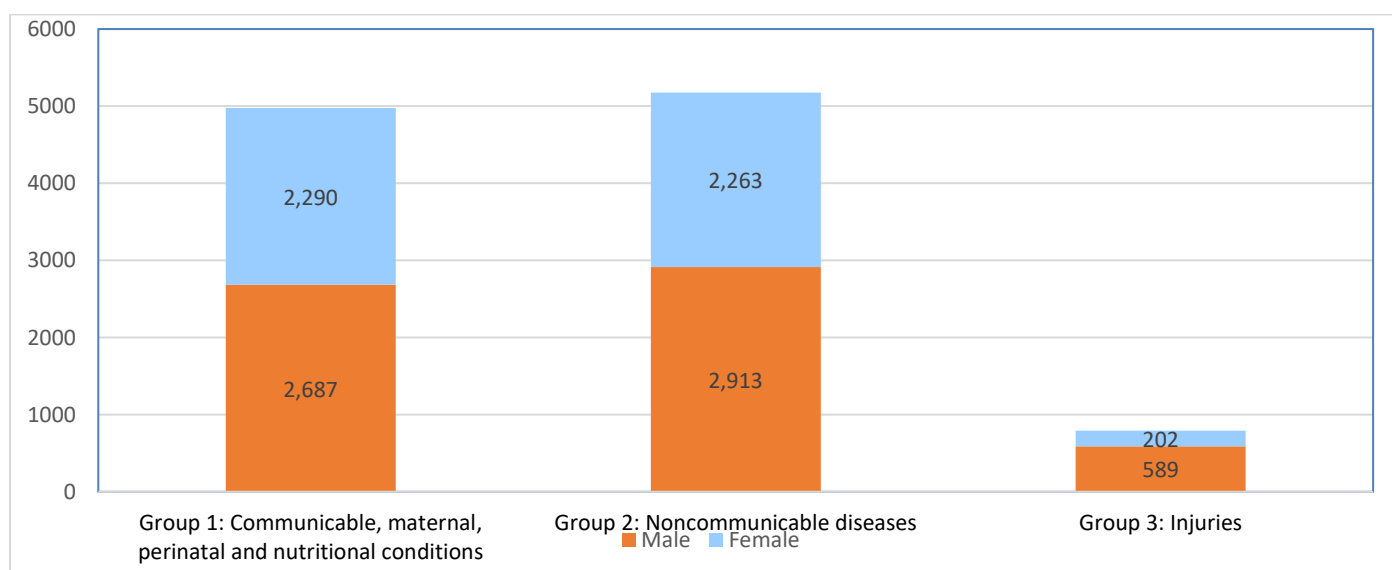


Figure 6.2 and Figure 6.3 show patterns of deaths in 2022 by sex, age groups and broad cause of death. Overall, there is no major disparity between female and male deaths in terms of pattern. Communicable, maternal, perinatal and nutritional conditions are responsible for more deaths for ages below 34 years while

non-communicable diseases contribute to more deaths in ages above 35 years for females. For males, non-communicable diseases are responsible for more deaths for age 25 years and above while communicable, maternal, perinatal and nutritional conditions are responsible for more deaths for ages below 25 years. In the year 2022 Communicable, maternal, perinatal and nutritional conditions caused most deaths in the age group 0-4 while in the age group 65 and above noncommunicable diseases were responsible for most deaths in both female and male. Injuries are responsible for the least number of deaths for both sexes. For females, most deaths due to injuries were in Age Group 0 – 4 years while for males most deaths due to injuries were in the age group 25 – 34 years.

Figure 6.2 Registered Female deaths by Global Burden of Disease (GBD) Listing by Age, 2022

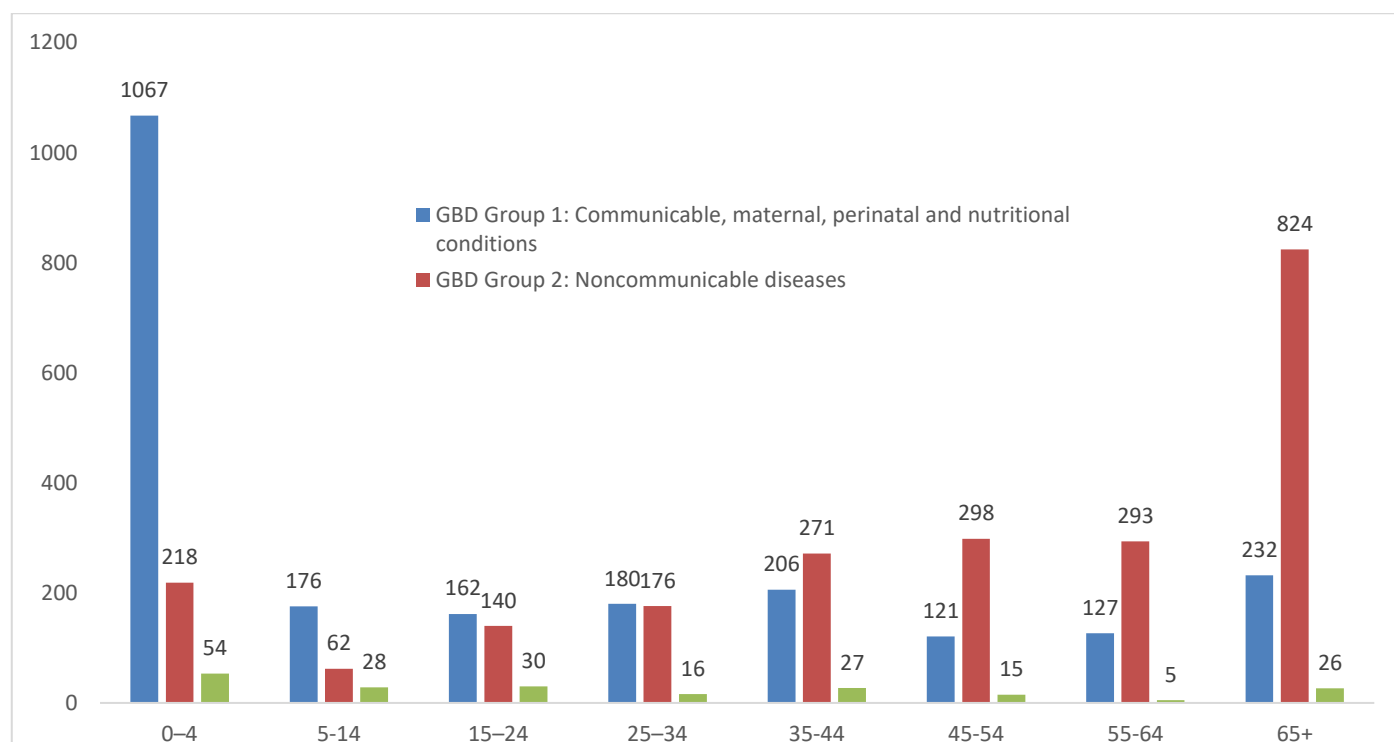
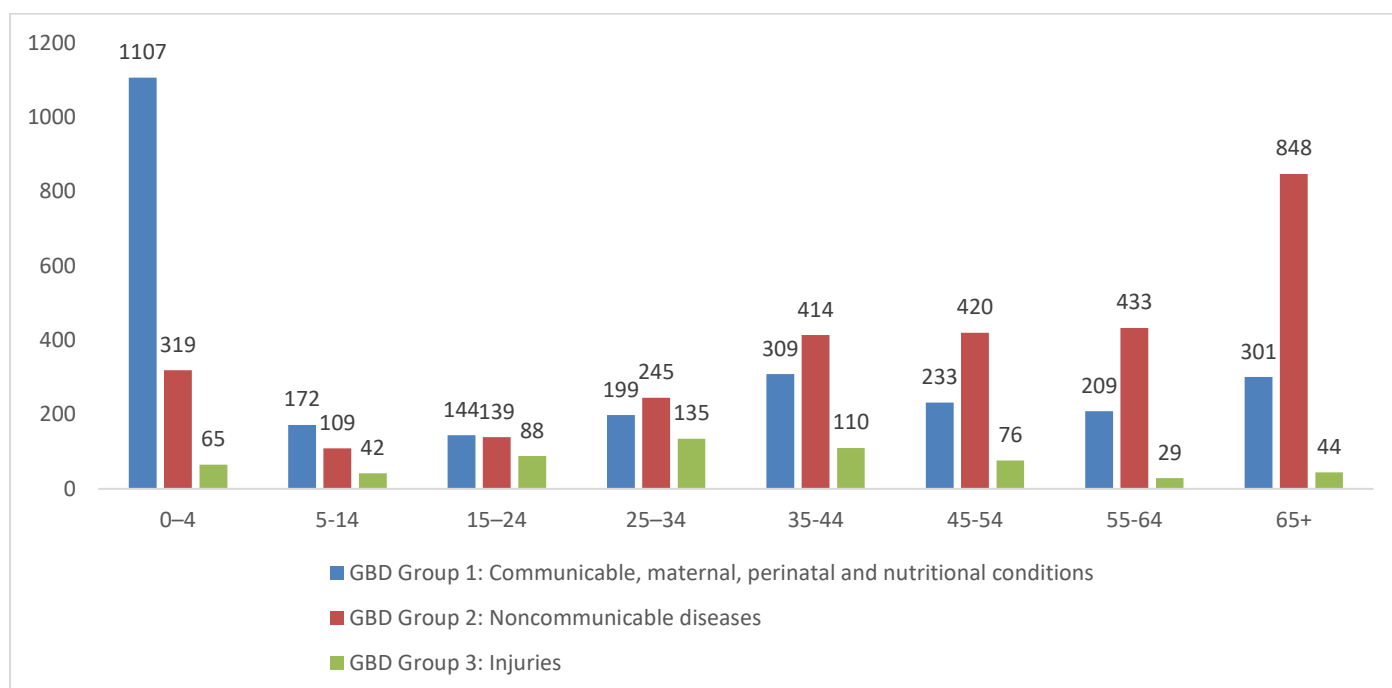


Figure 6.3 Registered Male deaths by Global Burden of Disease (GBD) Listing by Age, 2022



6.5 Leading causes of death by age and sex

From Tables 6.2 and 6.3 it can be seen that for 2022 deaths with medical certification of cause of death, malaria was the leading cause of death for either sex, being responsible for 8.7 percent and 9.3 percent of male and female deaths, respectively. HIV is the second leading cause of deaths in males while it is the third leading cause of deaths in females.

Table 6.2: Ten leading causes of death, males, 2022

Rank	ICD code	Disease	Number of deaths	Proportion (%)
1	B50-B54, P37.3, P37.4	Malaria	496	8.7
2	B20-B24	HIV	326	5.7
3	I60-I69	Cerebrovascular disease	300	5.3
4	J09-J22, P23, U04	Lower respiratory infections	238	4.2
5	E10-E14	Diabetes mellitus	234	4.1
6	A15-A19, B90	Tuberculosis	210	3.7
7	D55-D64 (minus D64.9), D65-D89, E03-E07, E15-E34, E65-E88	Endocrine disorders	196	3.4
8	P05, P07, P22, P27-P28	Prematurity and low birth weight	153	2.7
9	N00-N19	Nephritis and nephrosis	135	2.4
10	A00, A01, A03, A04, A06-A09	Diarrhoeal diseases	133	2.3
	Total		2,421	42.5

Table 6.3: Ten leading causes of death, females, 2022

Rank	ICD code	Disease	Number of deaths	Proportion (%)
1	B50-B54, P37.3, P37.4	Malaria	418	9.3
2	I60-I69	Cerebrovascular disease	337	7.5
3	B20-B24	HIV	274	6.1
4	E10-E14	Diabetes mellitus	217	4.8
5	P05, P07, P22, P27	Prematurity and low birth weight	213	4.8
6	J09-J22, P23, U04	Lower respiratory infections	185	4.1
7	P03, P10-P15, P20-P21, P24-P26, P29	Birth asphyxia and birth trauma	143	3.2
8	D55-D64 (minus D64.9), D65-D89, E03-E07, E15-E34, E65-E88	Endocrine disorders	125	2.8
9	A15-A19, B90	Tuberculosis	118	2.6
10	N00-N19	Nephritis and nephrosis	113	2.5
Total			2,143	47.7

6.5.1 Infants and children (0–4 years)

In children in the Age Group 0 – 4 years Malaria is the leading cause death contributing 17.2 percent of deaths that occurred in 2022 and had medical certification of cause of death seconded by Prematurity and low birth weight at 13.6 percent. For infants (0-1 Years) the leading cause of deaths is Prematurity and low birth weight contributing 19.8 percent seconded by Birth asphyxia and birth trauma responsible for 9.4 percent for both sexes. In age group 1 – 4 years the leading cause of death for both sexes is malaria (40.3 percents) seconded by Protein-energy malnutrition contributing (11.7 percent). Refer to Table 6.4 – 6.6.

Table 6.4: Ten leading causes of death, infants, and children (0–4 years, both sexes combined), 2022

Rank	Disease	Number of deaths	Proportion (%)
1	Malaria	462	17.2
2	Prematurity and low birth weight	365	13.6
3	Birth asphyxia and birth trauma	251	9.4
4	Lower respiratory infections	196	7.3
5	Protein-energy malnutrition	125	4.7
6	Diarrhoeal diseases	78	2.9
7	Endocrine disorders	77	2.9
8	Iron deficiency Anaemia	57	2.1
9	Congenital heart anomalies	56	2.1
10	HIV	50	1.9
Total		1,717	64.1

Table 6.5: Ten leading causes of death, infants, and children (0–1 years, both sexes combined), 2022

Rank	Cause	Number of deaths	% of total deaths*
1	Prematurity and low birth weight	362	19.8
2	Birth asphyxia and birth trauma	249	13.6
3	Lower respiratory infections	159	8.7
4	Malaria	118	6.4
5	Congenital heart anomalies	46	2.5
6	Endocrine disorders	44	2.4
7	Diarrheal diseases	43	2.3
8	HIV	35	1.9
9	Iron deficiency Anemia	30	1.6
10	Tuberculosis	29	1.6
	Totals	1,115	60.8

Table 6.6: Ten leading causes of death, infants, and children (1–4 years, both sexes combined), 2022

Both	Cause	Number of deaths	% of total deaths*
1	Malaria	344	40.3
2	Protein-energy malnutrition	100	11.7
3	Lower respiratory infections	37	4.3
4	Diarrhoeal diseases	35	4.1
5	Endocrine disorders	33	3.9
6	Iron deficiency Anaemia	27	3.2
7	HIV	15	1.8
8	Congenital heart anomalies	10	1.2
9	Meningitis	9	1.1
10	Nephritis and nephrosis	8	0.9
	Totals	618	72.5

Tables 6.7 to 6.10 show the leading causes of deaths in Age Groups 0-1 and 1-4 segregated by sex. The leading cause of death for both female and male in the Age Group 0 – 1 is Prematurity and low birth weight contributing 23.3 percent of female deaths and 16.3 percent of male deaths in the group. Birth asphyxia and birth trauma is the second leading cause of death being responsible for 15.8 percent of the female deaths and 11.4 percent of male deaths in the group. HIV was the fifth cause of death in female deaths while in male deaths it is the tenth cause of death in the age group. The top ten leading causes of female deaths contributed 63.8 percent while for male deaths they contributed 58.9 percent of all deaths with medical certification of death in the age group.

Table 6.7: Ten leading causes of death, infants, and children (0–1 years, Female), 2022

Rank	Cause	Number of deaths	% of total deaths*
1	Prematurity and low birth weight	211	23.3
2	Birth asphyxia and birth trauma	143	15.8
3	Lower respiratory infections	80	8.8
4	Malaria	57	6.3
5	HIV	21	2.3
6	Diarrheal diseases	17	1.9
7	Congenital heart anomalies	15	1.7
8	Endocrine disorders	12	1.3
9	Meningitis	11	1.2
10	Protein-energy malnutrition	11	1.2
	Totals	578	63.8

Table 6.8: Ten leading causes of death, infants, and children (0–1 years, Male), 2022

Rank	Cause	Number of deaths	% of total deaths*
1	Prematurity and low birth weight	151	16.3
2	Birth asphyxia and birth trauma	106	11.4
3	Lower respiratory infections	79	8.5
4	Malaria	61	6.6
5	Endocrine disorders	32	3.5
6	Congenital heart anomalies	31	3.3
7	Diarrheal diseases	26	2.8
8	Tuberculosis	25	2.7
9	Iron deficiency Anemia	21	2.3
10	HIV	14	1.5
	Totals	546	58.9

The leading cause of death for both females and males in age group 1 - 4 is malaria, contributing 44.1 percent of female deaths and 37.3 percent of male deaths in the group. Protein-energy malnutrition is the second leading cause of death being responsible for 10.3 percent of the female deaths and 12.9 percent of male deaths in the age group. HIV was the tenth cause of death in female deaths while in male deaths it is the seventh cause of death in the age group. The top ten leading causes of female deaths contributed 75.2 percent while for male deaths they contributed 71.1 percent of all deaths with medical certification of death in the age group.

Table 6.9: Ten leading causes of death, infants, and children (1–4 years, Female), 2022

Both	Cause	Number of deaths	% of total deaths*
1	Malaria	171	44.1
2	Protein-energy malnutrition	40	10.3
3	Lower respiratory infections	18	4.6
4	Diarrhoeal diseases	18	4.6
5	Endocrine disorders	17	4.4
6	Iron deficiency Anaemia	10	2.6
7	Meningitis	6	1.5
8	Tuberculosis	5	1.3
9	Leukaemia	4	1
10	HIV	3	0.8
	Totals	292	75.2

Table 6.10: Ten leading causes of death, infants, and children (1–4 years, Male), 2022

Both	Cause	Number of deaths	% of total deaths*
1	Malaria	173	37.2
2	Protein-energy malnutrition	60	12.9
3	Lower respiratory infections	19	4.1
4	Iron deficiency Anaemia	17	3.7
5	Diarrhoeal diseases	17	3.7
6	Endocrine disorders	16	3.4
7	HIV	12	2.6
8	Congenital heart anomalies	7	1.5
9	Nephritis and nephrosis	5	1.1
10	Drownings	4	0.9
	Totals	330	71.1

6.3.2 Children (5–14 years old)

The leading cause of death for both sexes in Aae group 5-14 years is malaria, contributing 29.8 percent of the deaths with medical certification of cause of death in the age group seconded by Protein-energy malnutrition being responsible for 5.9 percent of the deaths in the age group. HIV is the sixth cause contributing 3.8 percent of the deaths in the age group. The top ten leading causes of death in the age group are responsible for 64.5 percent of the deaths with medical certification of cause of death in the age group. Refer to Table 6.11 below.

Table 6.11: Ten leading causes of death, children (5–14 years, both sexes combined), year

Rank	Disease	Number of deaths	Proportion (%)
1	Malaria	167	29.8
2	Protein-energy malnutrition	33	5.9
3	Endocrine disorders	25	4.5
4	Road traffic accidents	23	4.1
5	Iron deficiency Anaemia	22	3.9
6	HIV	21	3.8
7	Rheumatic heart disease	19	3.4
8	Meningitis	18	3.2
9	Nephritis and nephrosis	18	3.2
10	Lower respiratory infections	15	2.7
	Total	361	64.5

6.3.3 Adolescents and adults (15–69 years old)

The leading cause of death for both sexes in the Age Group 15-69 Years in HIV contributing 9.3 percent of the deaths with medical certification of cause of death in the age group seconded by Cerebrovascular disease being responsible for 6.3 percent of the deaths in the age group. Malaria is the sixth cause contributing 4.4 percent of the deaths in the age group. The top ten leading causes of death in the age group are responsible for 43.7 percent of the deaths with medical certification of cause of death in the age group. Refer to Table 6.12 below.

Table 6.12: Ten leading causes of death, adolescents, and adults (15–69 years), 2022

Rank	Disease	Number of deaths	Proportion (%)
1	HIV	491	9.3
2	Cerebrovascular disease	332	6.3
3	Diabetes mellitus	310	5.8
4	Tuberculosis	253	4.8
5	Malaria	233	4.4
6	Endocrine disorders	172	3.2
7	Nephritis and nephrosis	158	3
8	Lower respiratory infections	145	2.7
9	Road traffic accidents	114	2.1
10	Alcohol use disorders	110	2.1
	Total	2,318	43.7

6.3.4 Older adults (70+ years old)

The leading cause of death for both sexes in the Age Group 70+ Years in Cerebrovascular disease contributing 18.0 percent of the deaths with medical certification of cause of death in the age group seconded by Diabetes mellitus being responsible for 7.3 percent of the deaths in the age group. HIV is the ninth cause contributing

2.3 percent of the deaths in the age group. The top ten leading causes of death in this age group are responsible for 49.4 percent of the deaths with medical certification of cause of death in the age group. Refer to Table 6.13 below.

Table 6.13: Ten leading causes of death, older adults (70+ years), 2022

Rank	Disease	Number of deaths	Proportion (%)
1	Cerebrovascular disease	296	18
2	Diabetes mellitus	120	7.3
3	Lower respiratory infections	67	4.1
4	Hypertensive disease	58	3.5
5	Malaria	52	3.2
6	Nephritis and nephrosis	49	3
7	COVID-19	48	2.9
8	Endocrine disorders	47	2.9
9	HIV	38	2.3
10	Diarrhoeal diseases	36	2.2
	Total	811	49.4

Annexes

Annex 1: Birth reporting form (NR 8)



NATIONAL REGISTRATION ACT/ LAMULO LA KALEMBERA WA DZIKO

BIRTH REPORT /KALATA YA CHIDZIWIWISO CHA KUBADWA

NR8

WARNING:- In terms of Section 43 of the ACT, any person who furnishes false information or forges any document for the purpose of obtaining registration of Birth of a person shall be guilty of committing an offence. /CHENJEZO:- Malingana ndi gawo 43 ya lamulo la kalembera wadziko, aliyense wopeleka umboni wabodza, kapena makalata achinyengo ndicholinga choti alembetse kubadwa kwa mwana adzaimbidwa mulandu.

NOTE: Please read instructions at the back of the form /Welengani malangizo ali kuseli kwa fomuyi.

PART 1 DETAILS OF CHILD GAWO LOYAMBA MBIRI YA MWANA	1	Surname/Dzina la bambo		First name/Dzina loyamba		Other names/Maina ena		
	2	Date of Birth/Tsiku lobadwa:Month/Mwezi.....Year/Chaka.....				3	Sex: Male/Mwamuna ☐ Female/Mkazi ☐	
	4	Place of birth (Tick the appropriate option and give details)/Malo obadwira (Sankhani malo amodzi oyenerela)						
	a) Hospital/Kuchipatala ☐		Name/Dzina la chipatala.....					
b) Home/Kunyumba ☐		Address/Keyala yake.....						
c) Others/Malo ena ☐		Give details/ Fotokozerani						
PART 2 DETAILS OF MOTHER GAWO LACHIWIRI MBIRI YA MAYI AMWANAYU	5	Birth weight (in Kilograms)/ Kulemera kwa mwana pobadwa (Kg)		6		Type of Birth/Anabadwa ana angati (Tick the appropriate option and give details)		
					a) Single/M'modzi ☐		7	
					b) Twin/Mapasa awiri ☐		Are the parents of the Child Married to each other?/ Kodi makolo a mwanayu adakwatirana? YES/INDE ☐ NO/AYI ☐	
					c) Triplet/Mapasa atatu ☐		If yes, date of marriage/ Ngati adakwatirana, tchulani tsiku laukwati	
					d) Other (specify)/Mapasa oposera atatu (Nenani nambala yake.....)		Day/TsikuMonth/Mwezi.....Year/Chaka.....	
	WOMEN SHOULD USE MAIDEN NAMES / AMAYI GWIRITSANI NTCHITO DZINA LA BAMBO ANU							
	1	Surname/Dzina la bambo anu		First name/Dzina loyamba		Other names/Maina ena		
	2	ID No./Nambala ya chiphaso cha dziko.....						
	3	Date of Birth/Tsiku lobadwa:Month/Mwezi.....Year/Chaka.....				4		
					Nationality/Ndi nzika ya dziko liti?			
	5							
	Physical residential address/Malo amene amakhala District/BomaTA/Mfumu yayikulu.....Village/Town/Mudzi.....							
6								
Home address/Kumudzi kwanu: Village/Town/Mudzi TA/Mfumu yayikulu District/Boma.....								
7				8				
Gestational Age at birth (in weeks)/Mwana anabadwa ndi mimba ya masabata angati				Mode of delivery/Adachira mu njira yanji				
9				a) SVD/Njira ya bwino bwino ☐				
Month of pregnancy prenatal care begun/Anayamba mwezi wachingati kupita kusikelo ya amayi oyembekezera?				b) Vacuum Extraction/Yokoka ndi mpweya ☐				
10				c) Breech/Yotsogaza matako ☐				
Number of prenatal visits/Kusikelo ya amayi oyembekezera anapita kangati?				d) Forceps/Yokoka ndi zitsulo ☐				
11				e) Caesarean Section/Ya opashoni ☐				
Number of children born alive to the mother, including this child / Nambala ya ana amene mayiyu anabadwitsa amoyo, kuphatikizapo mwanayu				13				
12				Level of education (Enter completed level of education)/Maphunziro anamalizira pati: (Changani gawo limene anamaliza bwino bwino)				
Number of children born alive to the mother, and still living/Nambala ya ana amene mayiyu anabeleka ndipo ali moyo mpaka pano.....				a) None/Sanaphunzire ☐ b) Primary/Pulayimale ☐				
				c) Secondary/ Sekondale ☐				
				d) Higher education/Anamaliza maphunziro ena oposera a sekondale ☐				
PART 3 DETAILS OF FATHER (if known) GAWO LACHITATU MBIRI YA BAMBO AMWANAYU (Ngati akudziwika)	1	Surname/Dzina la bambo		First Name/Dzina loyamba		Other Names/Maina ena		
	2	ID No./Nambala ya chiphaso cha dziko.....						
	3	Date of Birth/Tsiku lobadwa:Month/Mwezi.....Year/Chaka.....				4		
					Nationality/Ndi nzika ya dziko liti?			
5								
Physical residential address/Malo amene amakhala District/BomaTA/Mfumu yayikulu.....Village/Town/Mudzi.....								
6								
Home address/Kumudzi kwanu: Village/Town/Mudzi TA/Mfumu yayikulu District/Boma.....								

ACKNOWLEDGEMENT OF RECEIPT (KUVOMEREZA KUTI NDALANDIRA)

Acknowledge the receipt of birth Report of/Ndikutsimikizira kuti ndalandira chidziwitso cha kubadwa kwa

Surname/Dzina la bambo..... First name/ Dzina loyamba.....Other Names/Maina Ena.....
on/pa Day/Tsiku.....Month/Mwezi.....Year/Chaka.....

as reported by /limene lapelekedwa ndi.....

Signature/Sainani.....Day/Tsiku.....Month/Mwezi.....Year/Chaka.....

Official Stamp/Chidindo cha boma

Annex 2: Death reporting form (NR 10)



NATIONAL REGISTRATION ACT / LAMULO LA KALEMBERA WA DZIKO

DEATH REPORT/ KALATA YA CHIDZIWIWITSO CHA IMFA



NRB

WARNING: In terms of section 43 of the ACT, any person, who furnishes false information or forges any document for the purpose of obtaining registration of Death of a person shall be guilty of committing an offence. **CHENJEZO:** Malingana ndi gawo 43 ya lamulo la kalembera wadziko, aliyense wopeleka umboni wabodza, kapena makalata achinyengo ndi cholinga choti alembetse za imfa ya munthu adzaimbidwa mulandu.

NOTE: Please read instructions at the back of the form/Welengani malangizo ali kuseli kwa fomuyi.

NR-10

SECTION-1: Particulars of Deceased / Mbiri ya Omwalira				
PART 1 PERSONAL DETAILS OF DECEASED GAWO LOYAMBA MBIRI YA MUNTHU OMWALIRA	1	Surname/Dzina la bambo		First name/Dzina loyamba
	2	ID No./Nambala ya chiphaso cha dziko/chobadwa		3 Nationality/Ndi nzika ya dziko liti?
	4	Male/Mwamuna ☐ Female/Mkazi ☐		
	6	Date of Death/Tsiku lomwalira : Day/Tsiku Month/Mwezi Year/Chaka		
	7	Place of Death Tick the appropriate option/Malo omwalira (Sankhani malo amodzi oyenera)		
	8	Physical residential address/Malo amene amakhala: District/Boma Village/Town/Mudzi		
	9	Home address/Kumudzi kwao: District/Boma TA/Mfumu yaikulu Village/Location/Mudzi		
	10	In case this is a female death, did the death occur while pregnant, at the time of delivery or within 6 weeks after the end of pregnancy? Ngati omwalira anali wamazizi, panthawi yomwe amamwaliraye anali ndi mimba, kapena anamwalira nthawi yobebeke, kapena pasanathe masabata asanu ndi imodzi (6) kuchokera panthawi imene anabereka kapena pamene mimba inachoka? Yes/Inde ☐ No/Ayi ☐		
	11	Mother's name: Surname/Dzina la bambo First Name/Dzina loyamba Other Names/Maina ena		
	PART 2 DETAILS OF PARENTS GAWO LACHIWIRI MBIRI YA MAKOLO	12	ID No./Nambala ya Chiphaso cha dziko	
14		Father's name: Surname/Dzina la bambo		15 First Name/Dzina loyamba
16		ID No./Nambala ya Chiphaso cha dziko		17 Nationality/ Ndi nzika ya dziko liti?
18		Name: Surname/Dzina la bambo		19 First Name/Dzina loyamba
PART 3 INFORMANTS DETAILS GAWO LACHITATU MBIRI YA WOLEMBETSA	20	ID No./Nambala ya Chiphaso cha dziko		21 Relationship to the deceased/ Ubale ndi munthu omwalira
	22	Address/Keyala District/Boma TA/Mfumu yaikulu Village/Town/Mudzi		23 Telephone No./Nambala ya foni
	24	I certify that the above information is correct and I am aware that I could face criminal prosecution if this information is incorrect in material respect / Ndikuvomereza kuti umboni omwe ndikupelekelawu ndiwoona ndipo ndikudziwa kuti ndidzaimbidwa mlandu ngati umboniwuli wabodza.		
	25	Date: Day/Tsiku Month/Mwezi Year/Chaka Signature/Thumb mark of Informant/Sainani		

SECTION-2 : Medical Certification of Death and Cause of Death (FOR HEALTH FACILITY DEATHS ONLY)

1	Cause of death		Final ICD Code	Approximate interval between onset and death	ICD Code
DEN: _____					
Part I Disease or condition directly leading to death*		(a) _____ Due to (or as a consequence of)			
Antecedent causes Morbid conditions, if any, giving rise to above cause, stating the underlying condition last		(b) _____ Due to (or as a consequence of)			
		(c) _____ Due to (or as a consequence of)			
		(d) _____ Due to (or as a consequence of)			
Part II Other significant conditions contributing to the death, but not related to the disease or condition causing it.				ICD Code	 39123439
				ICD Code	
*This does not mean the mode of dying, e.g. heart failure, respiratory failure. It means the disease, injury, or complication that caused death.					
2	(a) Was an autopsy requested? Yes ☐ No ☐ (b) If yes, were the findings used for certification? Yes ☐ No ☐				
3	Manner of death: Natural ☐ Accident ☐ Homicide ☐ Suicide ☐ Pending investigation ☐ Could not be determined ☐ ; Other ☐ specify _____				
4	If accidental death, how did it occur: Motor vehicle (driver) ☐ Motor vehicle (passenger) ☐ Motor vehicle (Pedestrian) ☐ Drowning ☐ ; Other ☐ specify _____				
5	I certify that to the best of my knowledge and belief, the above named person died on the date and from the cause stated herein: Date/Tsiku: _____ Name _____ Signature _____ MCM Registration No. _____ Designation of medical certifier: Physician ☐ Clinical Officer ☐ Medical Assistant ☐ Other ☐ Specify _____				

SECTION-3

ACKNOWLEDGMENT OF RECEIPT / KUVOMEREZA KUTI NDALANDIRA

Acknowledge the receipt of Death Report of/Ndikutsimikizira kuti ndalandira chidziwitso cha imfa ya:

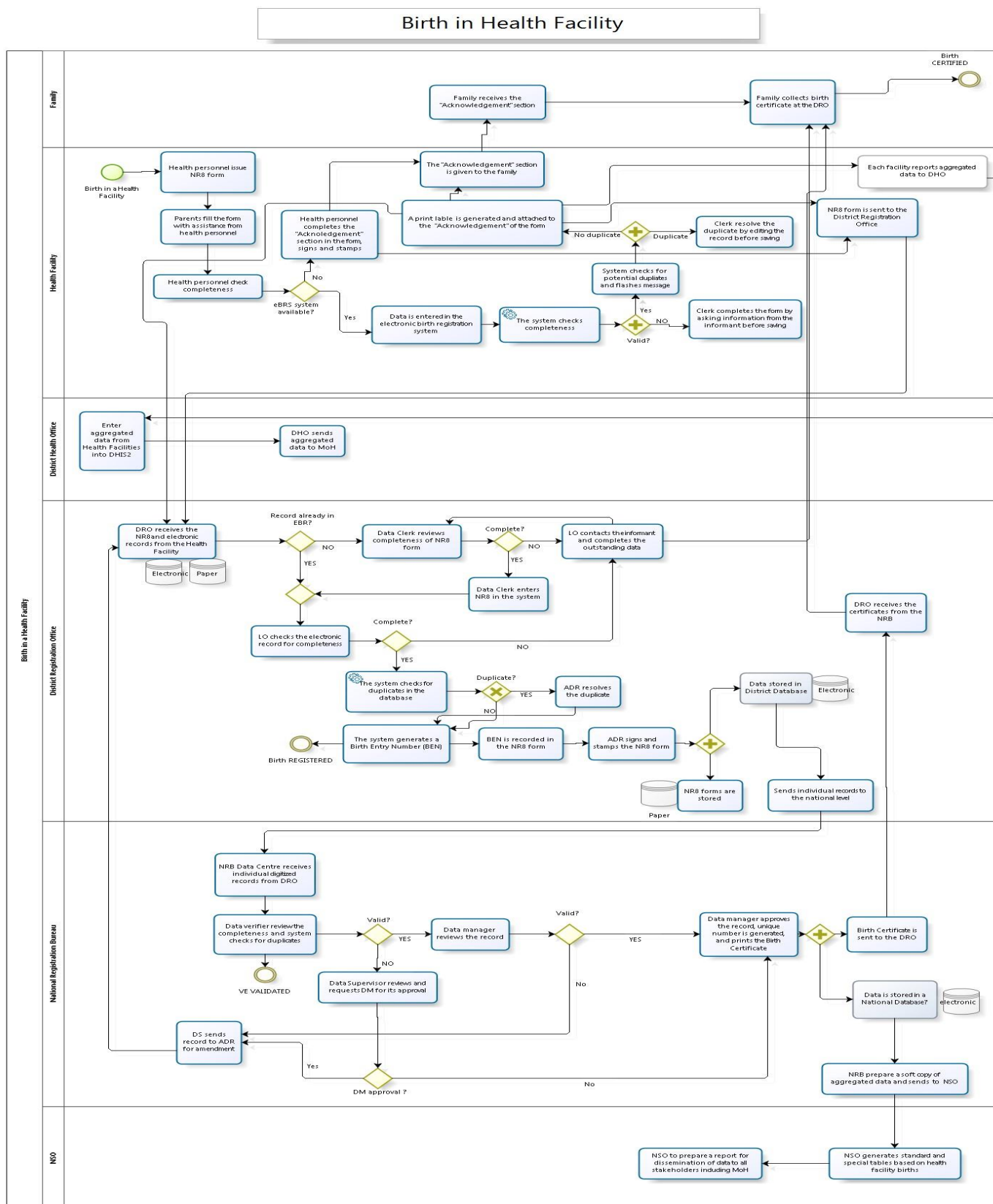
Surname/Dzina la bambo _____ First Name/Dzina loyamba _____ Other Names/Maina ena _____
Date of birth/Tsiku lobadwa: Day/Tsiku _____ Month/Mwezi _____ Year/Chaka _____, Sex _____,
with ID No./Nambala ya chiphaso _____ Date of Death/Anamwalira pa: Day/Tsiku _____ Month/Mwezi _____ Year/Chaka _____
as reported by /Iimene lapelekedwa ndi _____
Signature/Sainani _____ Date/Tsiku _____ Death Register entry No. _____



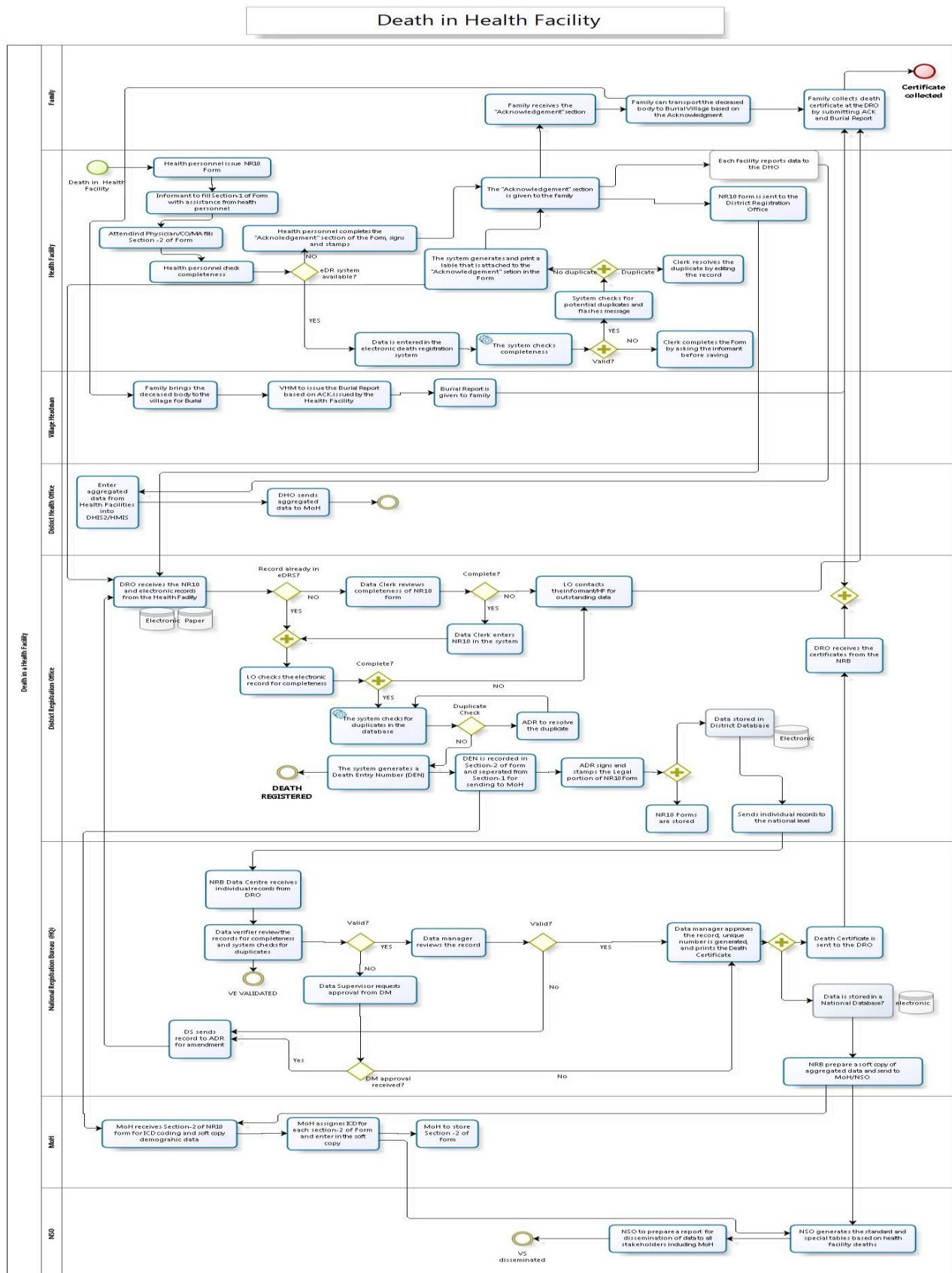
39123439

Official Stamp

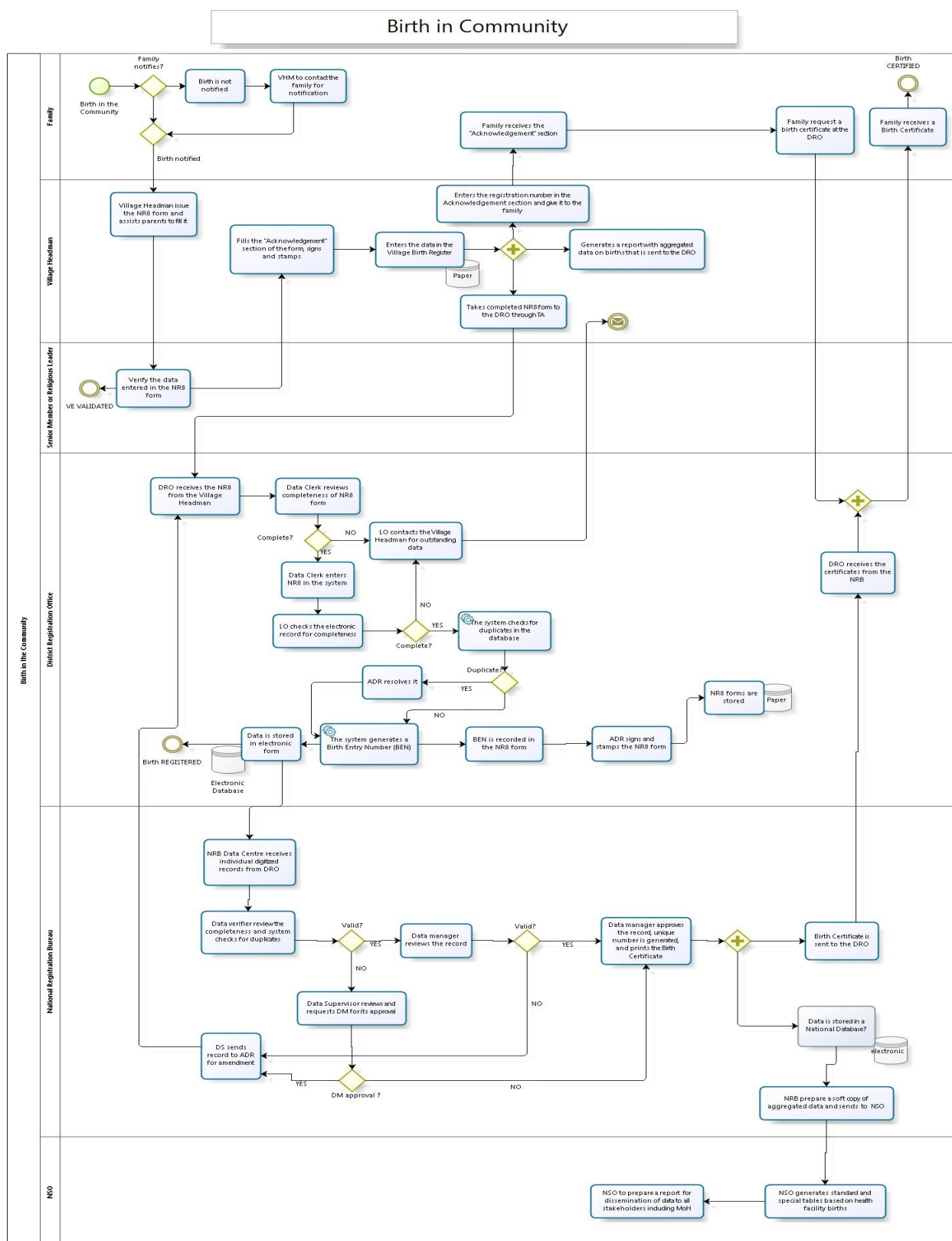
Annex 3: Process flow for facility birth registration



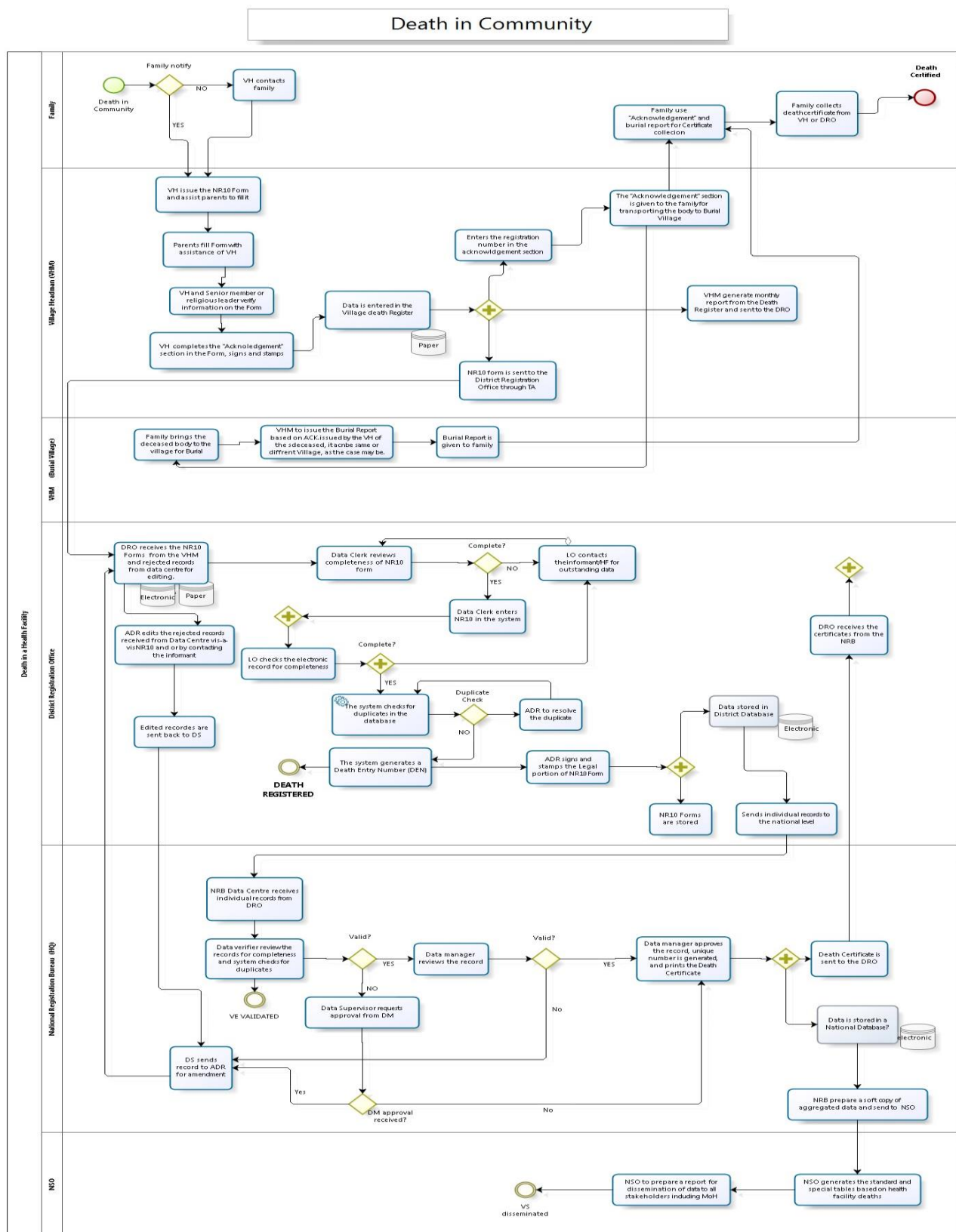
Annex 4: Process flow for facility death registration



Annex 5: Process flow for community birth registration



Annex 6: Process flow for facility death registration



Contact Us

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