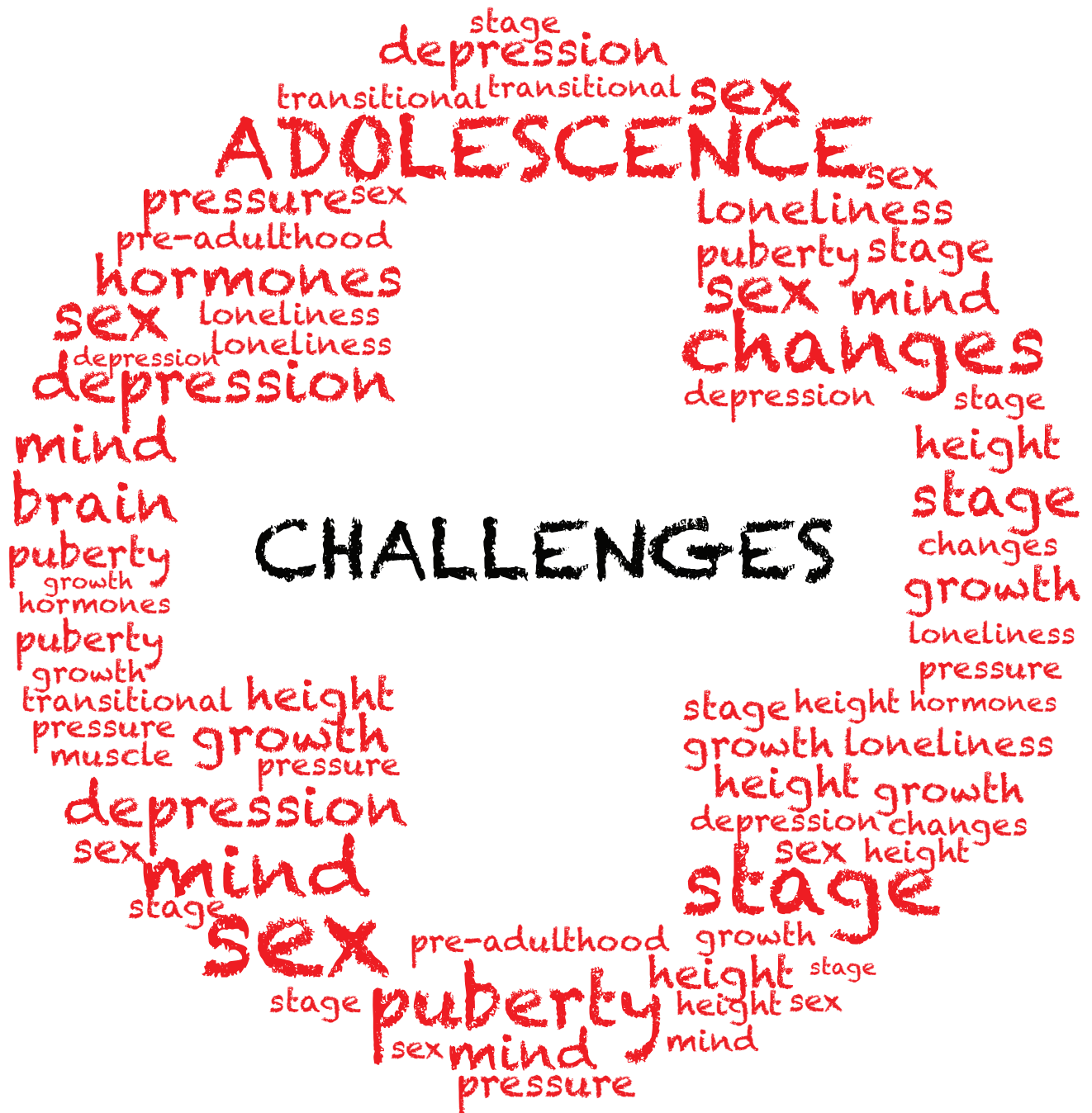


Profiling health challenges faced by adolescents (10-19 years) in South Africa

Report 03-09-15



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Profiling health challenges faced by adolescents (10-19 years) in South Africa

Statistics South Africa

**Risenga Maluleke
Statistician General**

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Preface

Thematic health reports are compiled by the Health component of the Health and Vital Statistics. This health report focuses on health challenges faced by adolescents aged 10-19 years in South Africa.

Information used to compile this report was from sources such as: household surveys (General Household Survey), Stats SA outputs like the Mid-Year Population Estimates and Poverty Trends Report. Other information included in this report was from administrative data (Recorded Live Births and Causes of Death both from the Department of Home Affairs). Additional data providers were the National Cancer Registry, District Health Information System and the Road Traffic Management Corporation.

Health challenges among adolescents described in this report include teenage pregnancy, termination of pregnancy, cancers, circumcision and mental health issues. It also highlights unintentional injuries, interpersonal violence, and traffic fatalities as some of the leading causes of death and disability among adolescents. Infectious diseases such as tuberculosis, HIV and intestinal infectious diseases are among health challenges faced by adolescents. Although cancer is rare among adolescents, leukaemia and lymphoma were among the leading adolescent cancers.

The thematic health report provides an insight into adolescent the health issues in South Africa. The information will inform health planning and programmes to address the burden of disease, allocate resources appropriately and implement adolescent friendly health services.



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Statistician-General

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Statistics South Africa also extends a special gratitude to the following data providers, namely: the National Cancer Registry (NCR), the District Health Information System (DHIS) and the Road Transport Management Corporation (RTMC).

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ALHIV	Adolescents Living with Human Immunodeficiency Virus
ANC	Antenatal Care
CDC	Centres for Disease Control and Prevention
CHoCOR	Culpable Homicide Crash Observation Report
CMS	Council for Medical Schemes
COGTA	Department of Cooperative Governance and Traditional Affairs
COVID	Coronavirus Disease
DBE	Department of Basic Education
DHET	Department of Higher Education and Training
DHIS	District Health Information System
GHS	General Household Survey
HEAIDS	Higher Education and Training for HIV and AIDS
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
HPV	Human Papilloma Virus
MACOD	Mortality and Causes of Death
MODA	Multiple Overlapping Deprivation Analysis
MYPE	Mid-Year Population Estimates
NCR	National Cancer Registry
NDOH	National Department of Health
NHA	National Health Act
NHI	National Health Insurance
NHLS	National Health Laboratory Services
NICD	National Institute for Communicable Diseases
NIOH	National Institute for Occupational Health
Pap-smear	Papanicolaou (Pap) smears
PTSD	Post-Traumatic Stress Disorder
RSA	Republic of South Africa
RTMC	Road Traffic Management Corporation
SSA	Sub Saharan Africa
Stats SA	Statistics South Africa
SDG	Sustainable Development Goals
STIs	Sexual Transmitted Infections
TB	Tuberculosis
VMMC	Voluntary Medical Male Circumcision

Key Findings

Births among adolescent girls

KwaZulu-Natal reported a higher percentage for both births registered at Home Affairs as well as those that were delivered in public health facilities. Northern Cape was the lowest in both births registered at the Department of Home Affairs and those that were delivered in public health facilities.

Termination of pregnancy

Limpopo reported higher rates of termination of pregnancy (TOP) for 2017, 2018 and 2019. Rates of TOP increased consistently in the Western Cape, Free State, North West and Limpopo.

Cancers

Deaths due to cancer fluctuated, with the highest observed in 2017. Most adolescents were diagnosed with leukaemia, Hodgkin's lymphoma and bone cancer.

Medical male circumcision

Medical male circumcision (MMC) was reported more in Gauteng and less performed in Western Cape, Eastern Cape and North West.

Mental health

Gauteng recorded higher proportions of adolescents who visited a mental health facility in 2019 and 2020. Eastern Cape, Northern Cape and Limpopo had lower proportions of adolescents who visited a mental health facility for both reporting years.

Road traffic fatalities

More males died from road traffic accidents than their female counterparts. Road traffic fatalities were the highest among adolescents from the black African population group. KwaZulu-Natal and Eastern Cape recorded more road traffic fatalities than other provinces. Approximately 90% of fatalities involved adolescents categorised as pedestrians and passengers.

Mortality

External causes, which included accidents occurring at places of residence, assault and other injuries accounted for most deaths among adolescents. Illnesses that contributed to mortality include tuberculosis, HIV, intestinal infections, influenza and pneumonia. More males died from external causes/non-natural causes than females.

Chapter 1

1.1 Introduction

The health report is part of a series of thematic reports published annually by the Health Statistics component within the Health and Vital Statistics Division of Statistics South Africa (Stats SA).

1.2 Background

Adolescent stage is a very critical stage where majority of people tend to experience or see life in a different light. It is categorised by emotional, biological, and social development and a time to develop the capabilities needed for a productive, healthy, and satisfying life. Health and wellbeing of adolescents is linked to health outcomes later in adult life (Patton et al, 2016).

Improving the health and well-being of adolescents is crucial for their well-being today, and for their future economic productivity. This is because their behaviour and health developed during these stages of life are future predictors of the burden of diseases in adulthood (Diane Cooper, 2015). Therefore, adolescents require specific needs and health systems with access to health education, including education on sexuality, quality and friendly health services (sexual and reproductive health). They need a productive, healthy, and satisfying life that is critical to attain the sustainable development agenda priorities for action outlined in the Sustainable Development Goals (SDGs) (United Nations, 2020). Better youth health means provision and access of high quality health services, and other factors such as all dimensions of poverty (Diane Cooper, 2015).

A lot needs to be invested for this age group in order to prepare them for adulthood and have a productive and healthy population in the future (Diane Cooper, 2015). Investment on adolescent health is vital to the achievement of the 17 Sustainable Development Goals (SDGs) and their 169 targets, directly or indirectly related to adolescent development, health or well-being. Investing in the health of adolescents and young adults gives a right to life and development, as supported by the global human rights instrument (WHO, 2021).

There are 18 SDG indicators explicitly calling for disaggregation by gender and adolescent- or youth-specific age categories, but there is still little data on young girls' and boys' lives, which means that their specific needs are invisible to policy and programme designers. Although the years between age 10 and 19 are increasingly recognised as a critical time in which to accelerate progress against poverty, inequity and discrimination and to foster positive development trajectories, this global data is not covered in the SDGs (Nicola Jones, 2020).

1.3 Purpose of the report

The Health Statistics component within the Health and Vital Division at Stats SA has a mandate of producing and publishing an annual thematic health report. It has the responsibility for producing these thematic health reports with information that will assist in health policy making and monitoring of health programmes within the public health system.

1.4 Objectives of the report

The current report presents information on the health seeking behaviour of adolescents (health worker consultation and reason for not consulting). It further highlights the health determinants they face such as access to water, sanitation and poverty. The overall health and challenges also include: medical aid coverage, teenage pregnancy, termination of pregnancy, male circumcision, cancer, mental health, disability, road traffic fatalities and causes of death.

1.5 Outline of the report

Information in this report is presented in the form of chapters as follows: The first chapter presents the background and introduction, purpose, objectives and outline of the report. Data sources, analysis and quality of data are included in the second chapter. The third chapter highlights the demographic characteristics of adolescents.

The fourth chapter presents information on the determinants of health (access to water, sanitation and poverty). Medical aid coverage is included in the fifth chapter, while health seeking behaviour (health worker consultation) is covered in the sixth chapter. Births among adolescents' girls (recorded live births and those that took place in public health facilities) are included in Chapter 7. The eighth chapter highlights termination of pregnancy, while cancers and circumcision are covered in Chapters 9 and 10, respectively. Chapter 11 presents mental health. Traffic accident fatalities are covered in Chapter 12, while causes of death and 10-year mortality trend are covered in Chapter 13 and 14, respectively. Chapter 15 summarises the whole report.

Chapter 2: Data sources, analysis and the quality

This section of the report presents information on data sources, method used for data analysis and data limitations used to compile this report.

2.1 Sources of data

This report is based on information from secondary data. Data sources used in this health report are as follows:

Mid-Year Population Estimates, 2020

The Mid-Year Population Estimates (MYPE) is an output produced annually by Statistics South Africa. It provided information on demographic characteristics of the adolescents towards the compilation of this report.

Poverty Trends Report, 2017

Poverty Trends Report is one of the reports published by Statistics South Africa. Information on poverty among children below 18 years was retrieved from data in the report.

Recorded Live Births, 2019

Recorded live births among adolescents were registered and captured by the Department of Home Affairs. An electronic copy of the information is sent to Statistics South Africa to produce a report on recorded live births.

General Household Survey, 2019

The General Household Survey (GHS) is an annual survey that collects information to measure service delivery, demand for services and also improvement in the living conditions of individuals and households. It collects information on health and social development, education, access to health services and facilities among others. The following variables are retrieved from the GHS, namely: access to water and sanitation, medical aid coverage; non-consultation and consultation with a health care worker.

National Cancer Registry, 2016-2018

This report uses morbidity data on cancers as recorded in the National Cancer Registry (NCR) managed by the National Health Laboratory Services. The NCR collates and analyses cancer cases diagnosed in pathology laboratories (public and private) and reports on cancer incidence rates annually.

District Health Information System, 2017-2020

The District Health Information System (DHIS) is a collection system managed by the Department of Health. It provides information on teenage births in facilities, medical male circumcision, mental health and termination of pregnancy.

Road Transport Management Corporation, 2017-2020

Information on road traffic fatalities is retrieved from Road Traffic Management Corporation (RTMC) managed by the Department of Transport. Information is collected by the South African Police Services and sent to RTMC for capturing and compilation of a report on road accidents and fatalities.

Mortality and Causes of Death, 2018

Data used in this report are based on deaths registered by the Department of Home Affairs for the deaths that occurred among adolescents in 2018.

2.2 Data analysis

The report follows a description form of analyses where results are presented as tables and figures. Data used to compile this report was analysed using SAS to create and exported those tables and figures to an Excel spreadsheet.

2.3 Data quality

This report was compiled using secondary data collected for different purposes. Data from the DHIS, MACOD and RTMC were collected for administrative purposes while GHS data was collected for survey purposes in order to measure service delivery rather than for health purposes. Data from DHIS only includes people who attended public health facilities and variables from this system could not be analysed by sex and population group.

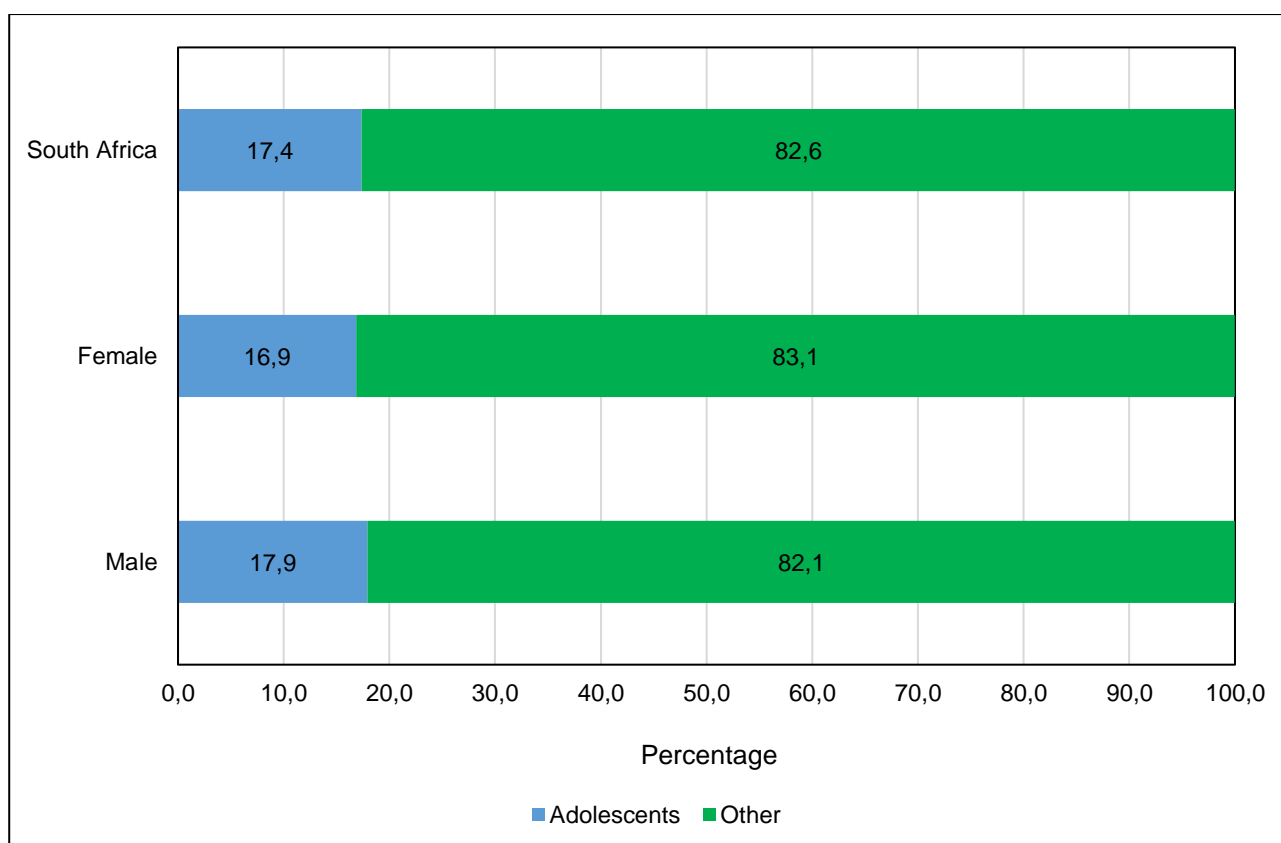
Chapter 3: Demographic characteristics

This chapter presents the demographic information of adolescents aged 10-19 years for 2020. Demographics are the classifiable characteristics of a given population. In this report, the focus is on sex, population group and province. The demographic information is important to government for developing policies and the private sector use this information to develop business strategies.

3.1 Population distribution by sex

Figure 3.1 highlights the population distribution of adolescents by sex and results shows that adolescents comprise 17,4% to the total population of South Africa. The percentage between males and females are not very different, with males at 17,9% and females at 16,9%.

Figure 3.1: Proportion of adolescents by sex

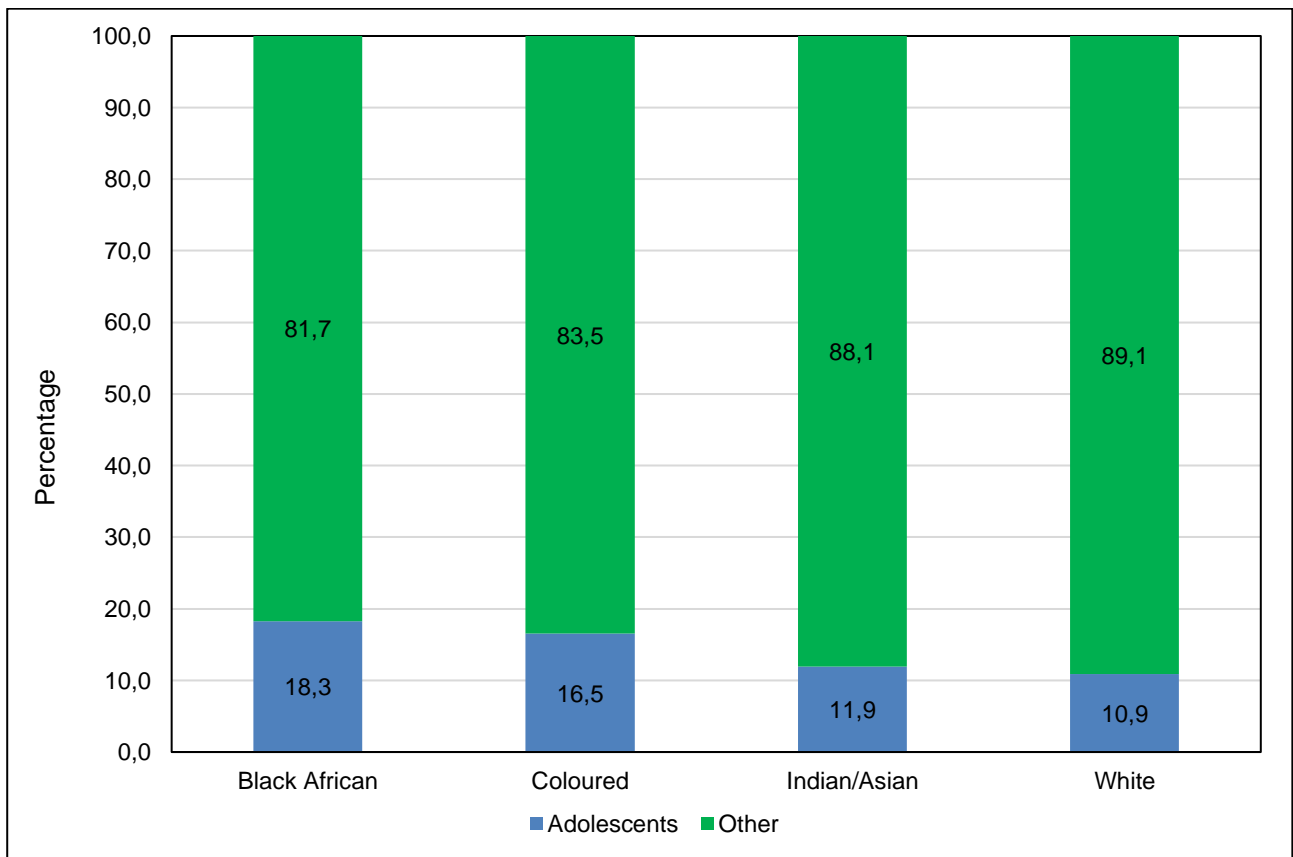


Source: Mid-Year Population Estimates, 2020

3.2 Population distribution by population group

Figure 3.2 presents the demographic profile of adolescents by population group. Results show that adolescents constituted almost a fifth (18,3%) of the black African population and 16,5% of the Coloured population. Adolescents constituted 11,9% and 10,9% of the Indian/Asian and white population groups respectively.

Figure 3.2: Proportion of adolescents by population group

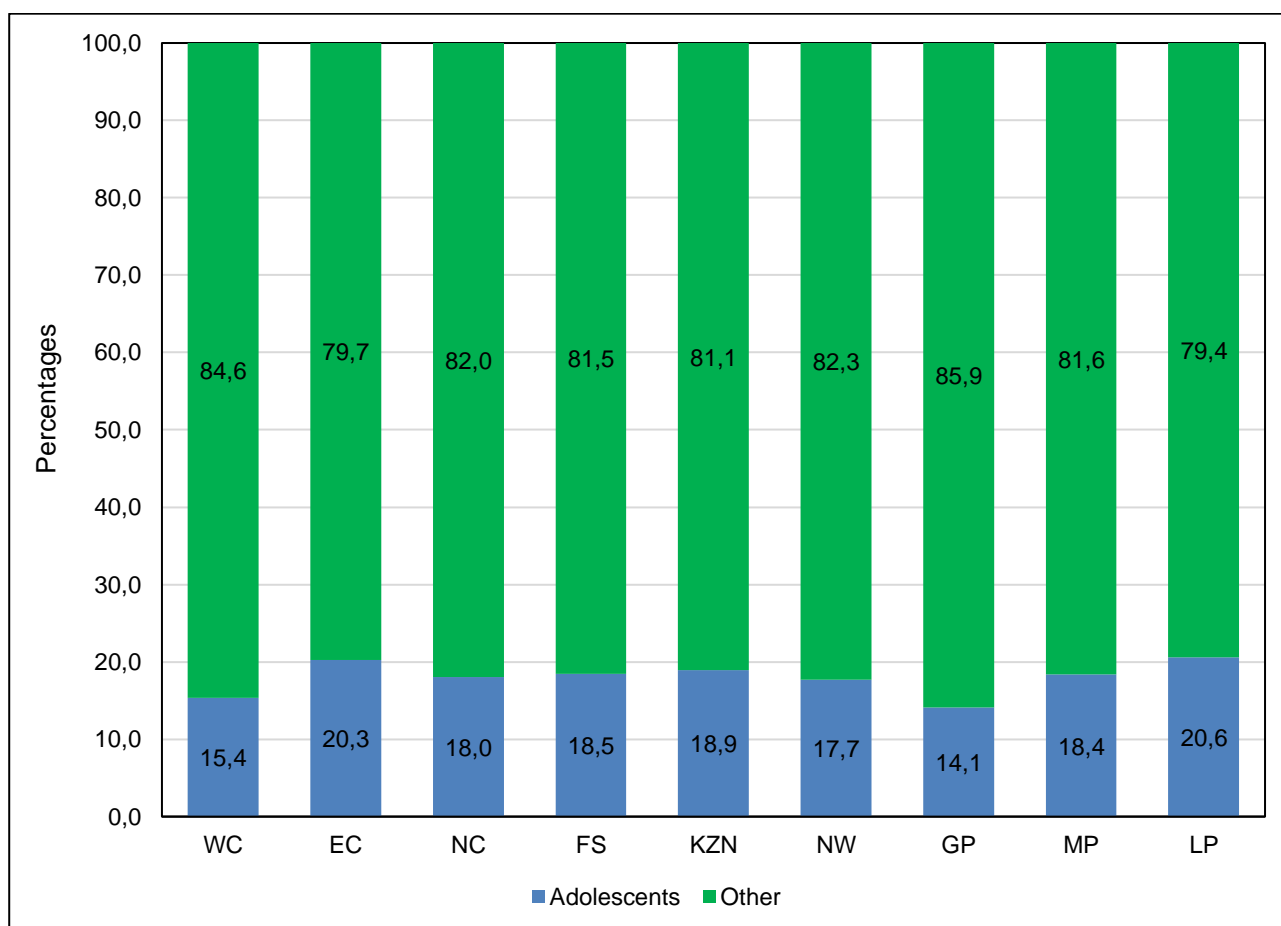


Source: Mid-Year Population Estimates, 2020

3.3 Population distribution by province

Figure 3.3 presents the demographic profile of adolescents by province. Results show that two provinces namely Limpopo (20,6%) and Eastern Cape (20,3%) had almost a fifth of their population as adolescents. Provinces with lowest proportions of adolescents were Western Cape and Gauteng at 15,4% and 14,1%, respectively. The proportions of adolescents for the rest of the provinces ranged from 17,7% to 18,9%.

Figure 3.3: Proportion of adolescents by province



Source: Mid-Year Population Estimates, 2020

3.4 Summary of adolescent’s population

The sex distribution shows that both males and females contributed less than 20% to the total population of South Africa. All population groups had percentages less than 20%. This applies to all provinces with the exception of Eastern Cape and Limpopo.

Chapter 4: Determinants of health

This chapter covers the determinants of health, which are factors that influence the health status of individuals. Health is determined by complex interactions between social and economic factors, the physical environment and individual behaviour. This report covers access to safe water, access to improved sanitation and poverty.

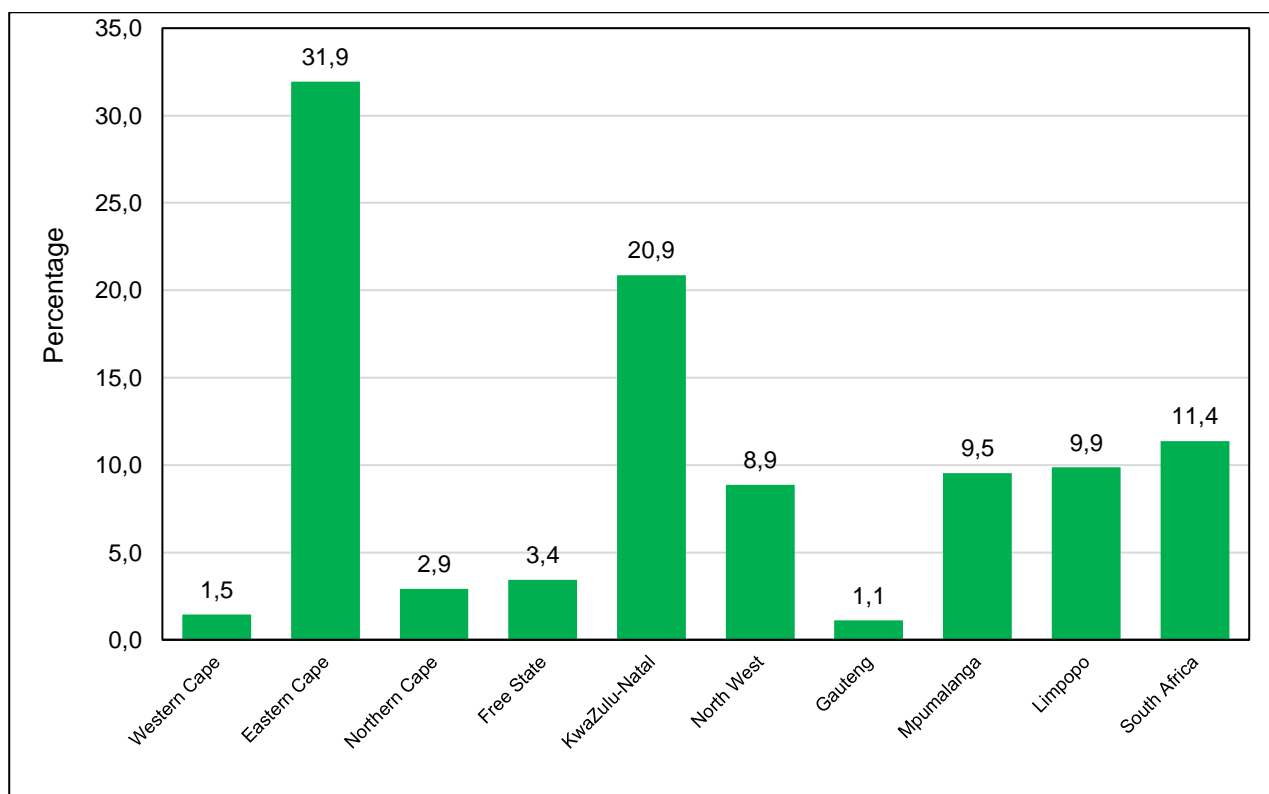
Access to safe or improved water

Safe/improved drinking water is defined as piped (tap) water in dwelling/house/piped (tap) water in yard/borehole in yard/neighbour's tap/public/communal tap/borehole outside yard.

4.1 Results on safe or improved drinking water

Figure 4.1 presents results of households with adolescents that reported no access to safe/improved drinking water in South Africa. Nationally, the percentage of households without safe/improved drinking water was 11,4% in 2019. About 30% of households in Eastern Cape (31,9%) reported that they had no access to safe/improved water, followed by KwaZulu-Natal (20,9). The lowest percentages of households occupied by adolescents with no access to safe/improved water were in Western Cape (1,5%) and Gauteng (1,1%).

Figure 4.1: Percentage of households with adolescents without access to safe drinking water by province



Source: General Household Survey, 2019

4.2 Summary of access to water

Nationally, just above 10% of households do not have access to safe/improved drinking water. The more affluent provinces, Western Cape and Gauteng recorded lower percentages of households without access to drinking water while the less resourced provinces such as Eastern Cape and KwaZulu-Natal still higher percentages of households with no access to safe/ and improved drinking water.

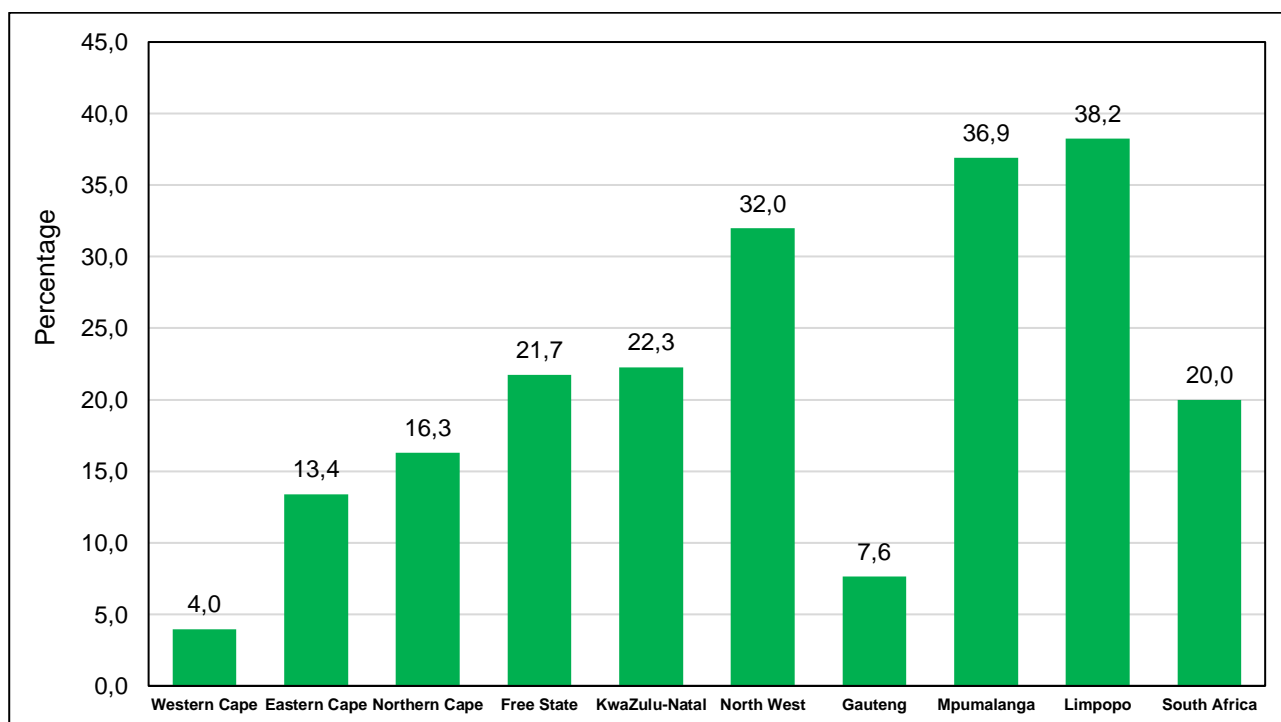
Access to acceptable/improved sanitation

Acceptable/improved sanitation is defined as access to flush toilet connected to a public sewerage system/flush toilet connected to a septic tank. This includes a conservancy tank/pour flush toilet connected to a septic tank (or septic pit)/pit latrine/toilet with a ventilation pipe.

4.3 Results on acceptable or improved sanitation

Figure 4.2 presents results of households with adolescents that reported no access to acceptable/improved sanitation in South Africa. Nationally, the percentage of households without access to acceptable/improved sanitation was 20,0% in 2019. Higher percentages of households with adolescents without access to acceptable/ improved sanitation were reported in Limpopo (38,2%), Mpumalanga (36,9%) and North West (32,0%). Gauteng and Western Cape recorded lowest percentages of households with no access to acceptable/improved sanitation (7,6% and 4,0%, respectively).

Figure 4.2: Percentage of households with adolescents without access to acceptable sanitation by province



Source: General Household Survey, 2019

4.4 Summary of access to sanitation

Nationally, there were 20% of households without access to acceptable/improved sanitation. No access to acceptable/improved sanitation was higher in households from Limpopo, Mpumalanga and North West. Gauteng and Western Cape were the only provinces that recorded less than 10% of households without access to acceptable/improved sanitation.

Poverty

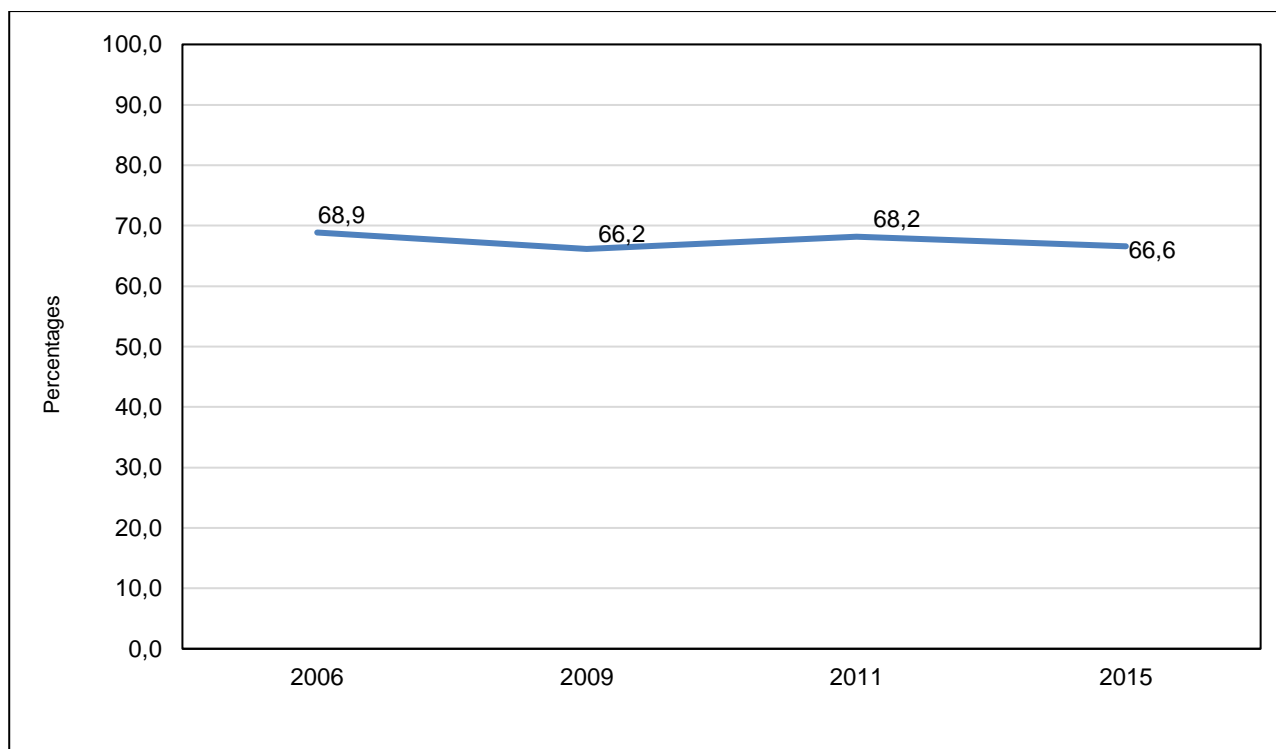
This section of the report presents information on poverty, as defined in terms of monetary or material deprivation. All households with an income below the national median income are defined as poor in this report.

South Africa is still facing a challenge regarding child poverty, with children below 18 years from the black African population group more likely to live in poverty (68,3%) compared to other population groups. Children below 18 years with no parents have higher multidimensional poverty rates compared to other children. In addition, children that are single orphans where only a mother is alive have higher poverty rates compared to single orphans where only a father is alive (Stats SA, 2020). Northern Cape and KwaZulu-Natal had higher percentages of households experiencing poverty. More than half of households with children under 18 years going hungry is observed in urban areas. Children living in rural areas (88,4%) and in non-metropolitan areas (73,7%) as compared to 41,3% of adolescents residing in urban areas and 39,6% in metropolitan areas are experiencing poverty (Stats SA, 2020).

4.5 Poverty in South Africa

Figure 4.3 highlights the percentage of children below the age of 18 years in South Africa who ever experienced poverty for 2006, 2009, 2011 and 2015. Nationally, household experiencing poverty fluctuated between 68,9% and 66,6%; with 2009 recording the lowest at 66,2%.

Figure 4.3: Percentage of children below 18 years in households living below the national median income



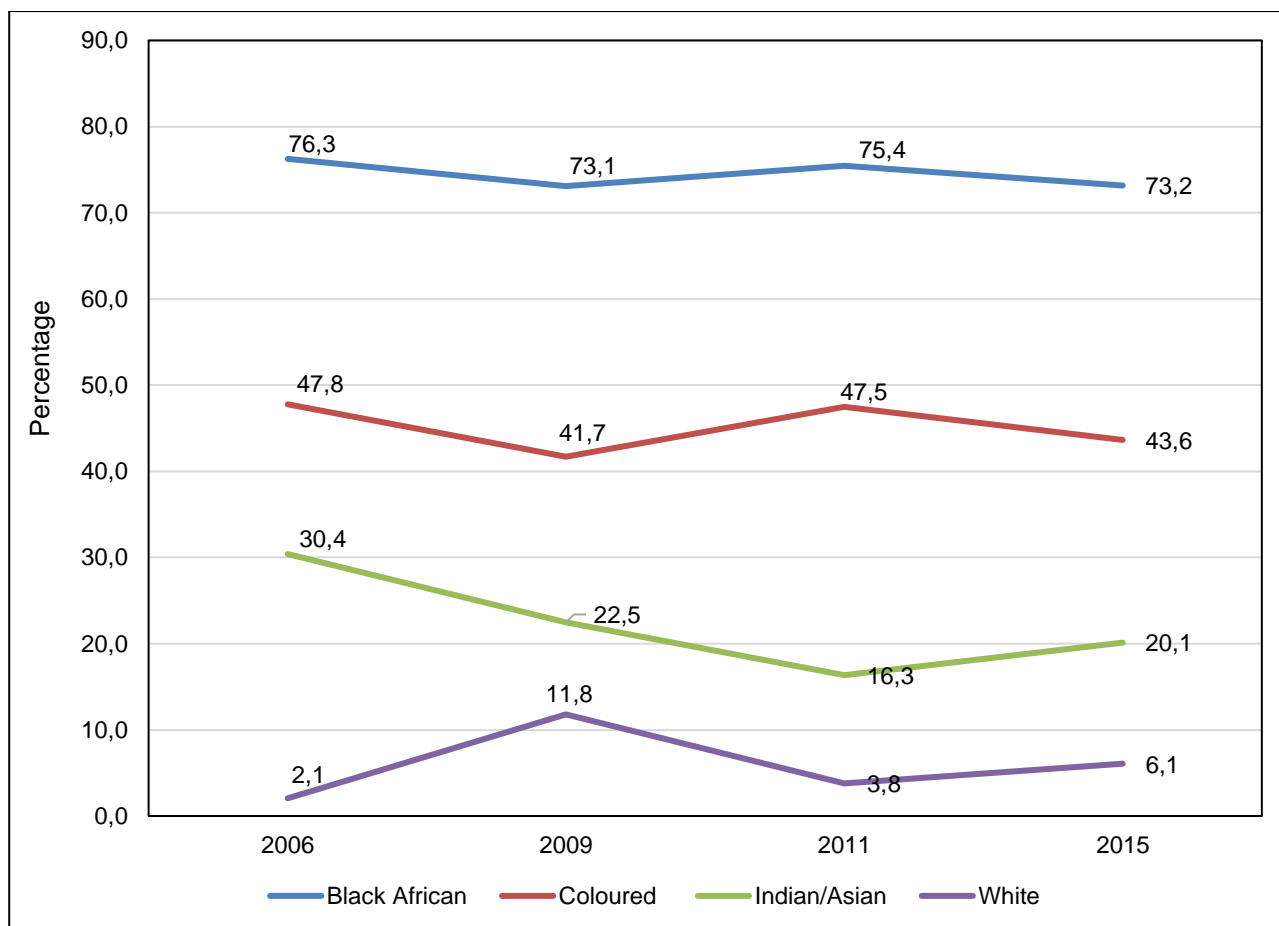
Source: Poverty trends report, Stats SA, 2017

4.6 Poverty by population group

Figure 4.4 presents the percentage of children below 18 years living in households with an income that is below the median national household income by population group between 2006 and 2015. The black African population group had more children living in households with an income below the median national household income than other population groups for the reporting years, followed by those from the coloured population group. Children from the Indian/Asian population group experienced poverty the least as compared to blacks and coloureds. The white population group recorded single digit percentage for all the years with an exception 2009 (11,8%).

Among the black African population group, poverty fluctuated between the years, where it showed a slight decrease from 76,3% in 2006 to 73,2% in 2015. The same fluctuating trend is seen among the coloured population group (47,8% to 43,6%). There was a decrease among the Indian/Asian population group for 2006 to 2011 (30,4% to 16,3%) and then an increase thereafter to 20,1%.

Figure 4.4: Percentage of children below 18 years in households living below national median income by population group



Source: Poverty trends report, Stats SA, 2017

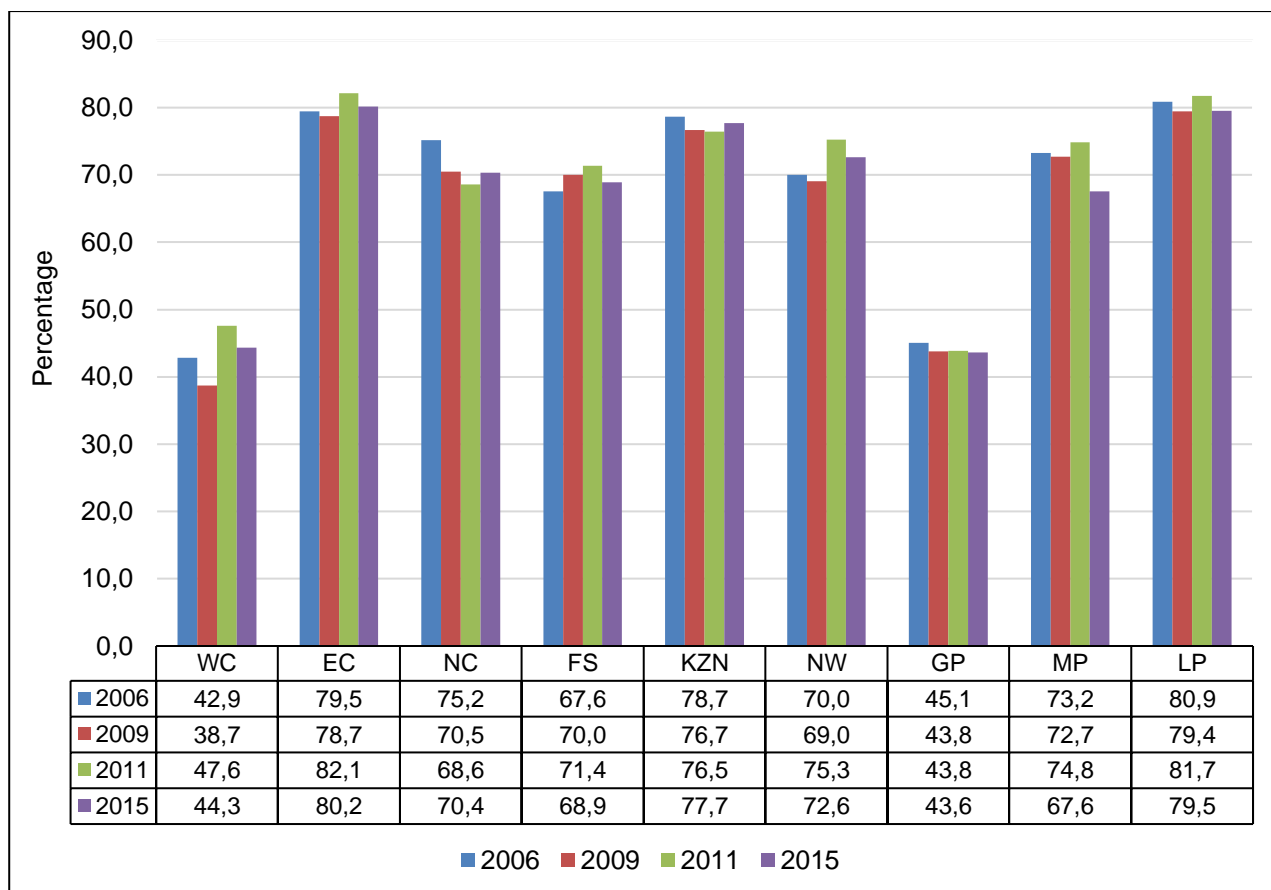
4.7 Poverty by province

Figure 4.5 highlights the percentage of children below 18 years in South Africa living in households that have ever experienced poverty by province in 2006, 2009, 2011 and 2015. The least affected provinces in terms of poverty were Western Cape and Gauteng.

The worst affected provinces included Limpopo, followed by Eastern Cape until 2011, where there was an exchange between the two provinces where Eastern Cape was the leading worst affected province. The third worst affected province was KwaZulu-Natal, followed by Mpumalanga.

When it comes to the poverty trend, Limpopo had a slight increase in 2011 before it declined in 2015, which was the same trend by Eastern Cape, Mpumalanga, North West and Free State. Northern Cape highlighted a decrease from 2006 until 2011 and then a rise in 2015, whereas KwaZulu-Natal followed a different trend of a steady flat curve, which is the same curve followed by Gauteng. Western Cape had a sharp decrease in 2009, an increase in 2011, then another sharp decrease in 2015.

Figure 4.5: Percentage of children below 18 years in household living below national median income by province



Source: Poverty trends report, Stats SA, 2017

4.8 Summary of poverty

Nationally, households experiencing poverty decreased from 68,9% in 2006 to 66,6% in 2015. Racial differences showed that poverty was higher among the black African and coloured population groups. The Indian/Asian and white population groups were better off in terms of experiencing poverty. Provinces experiencing poverty were Eastern Cape, Limpopo, KwaZulu-Natal, North West and Northern Cape. Western Cape and Gauteng recorded less than 50% of children below 18 years living below the poverty line.

Chapter 5: Medical aid coverage

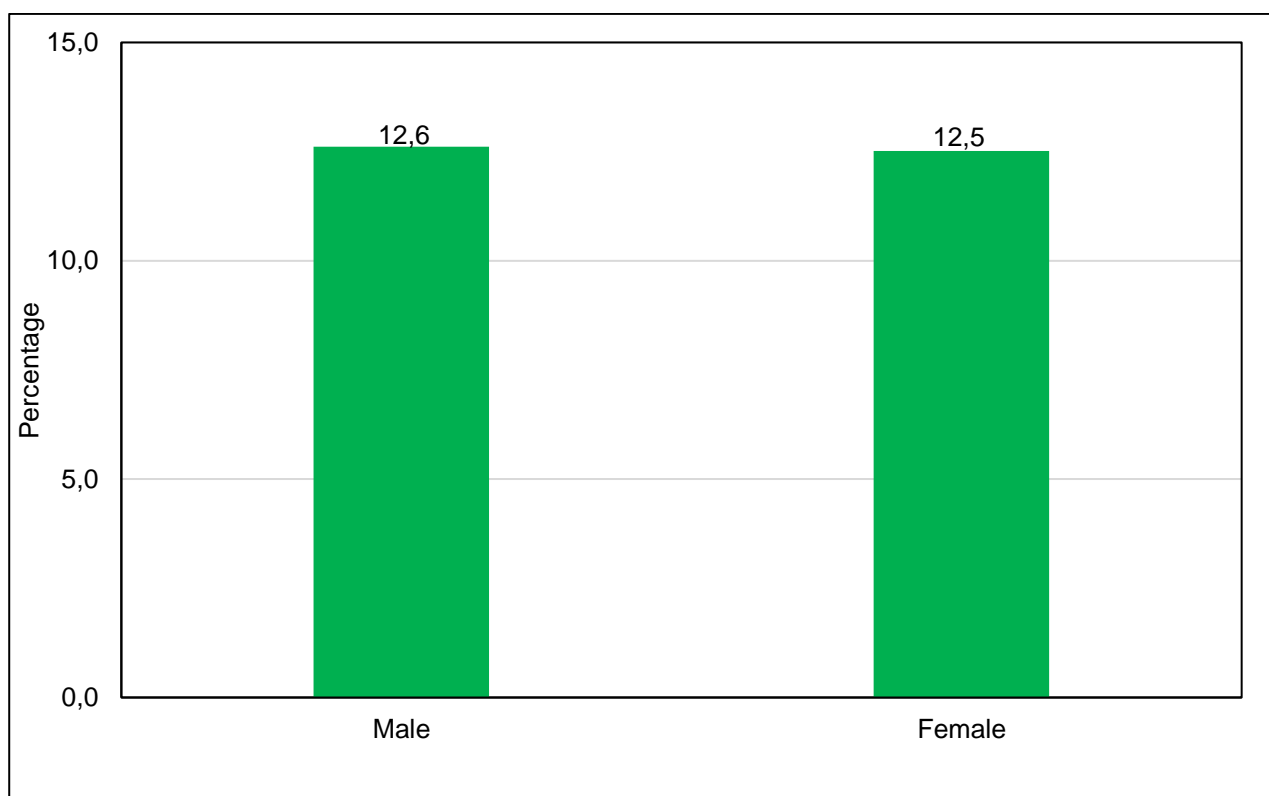
This chapter presents information on medical aid coverage among adolescents. All medical schemes in South Africa are governed in accordance with the Medical Schemes Act 131 of 1998, and are regulated by the Council of Medical Schemes (CMS). Currently in South Africa, there are more than 20 different open medical schemes, where citizens are offered an opportunity to choose and pay for the cover they can afford. Most adolescents are dependants (beneficiaries) on their parents’ medical aid schemes (Council for Medical schemes, 2020).

A question was asked in the GHS 2019 questionnaire regarding medical aid coverage as follows: “Is..... covered by medical aid or medical benefit scheme or other private health insurance?”

5.1 Medical aid coverage by sex

Figure 5.1 shows medical aid coverage among adolescents by sex. There was no difference in medical aid coverage between males and females at 12,6% and 12,5%, respectively.

Figure 5.1: Percentage of adolescents with access to medical aid coverage by sex

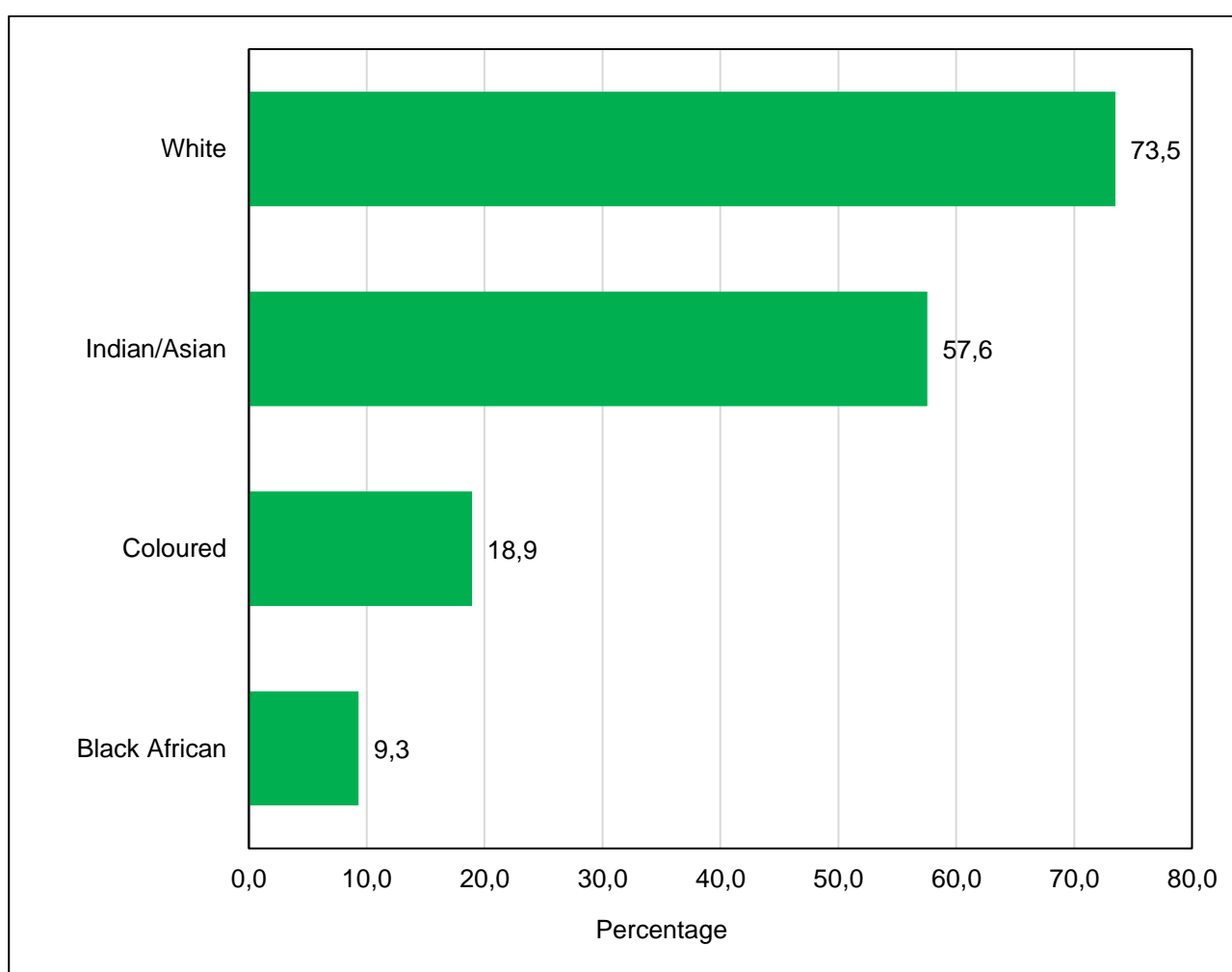


Source: General Household Survey, 2019

5.2 Medical aid coverage by population group

Figure 5.2 shows medical aid coverage among adolescents by population group. Almost three quarters (73,5%) of adolescents from the white population group were covered by a medical aid/scheme while almost six out of ten (57,3%) adolescents from the Indian/Asian population were covered by a medical/scheme. Adolescents from both coloured and black African population groups had low medical aid coverage at 18,8% and 9,3%, respectively.

Figure 5.2: Percentage of adolescents with access to medical aid coverage by population group

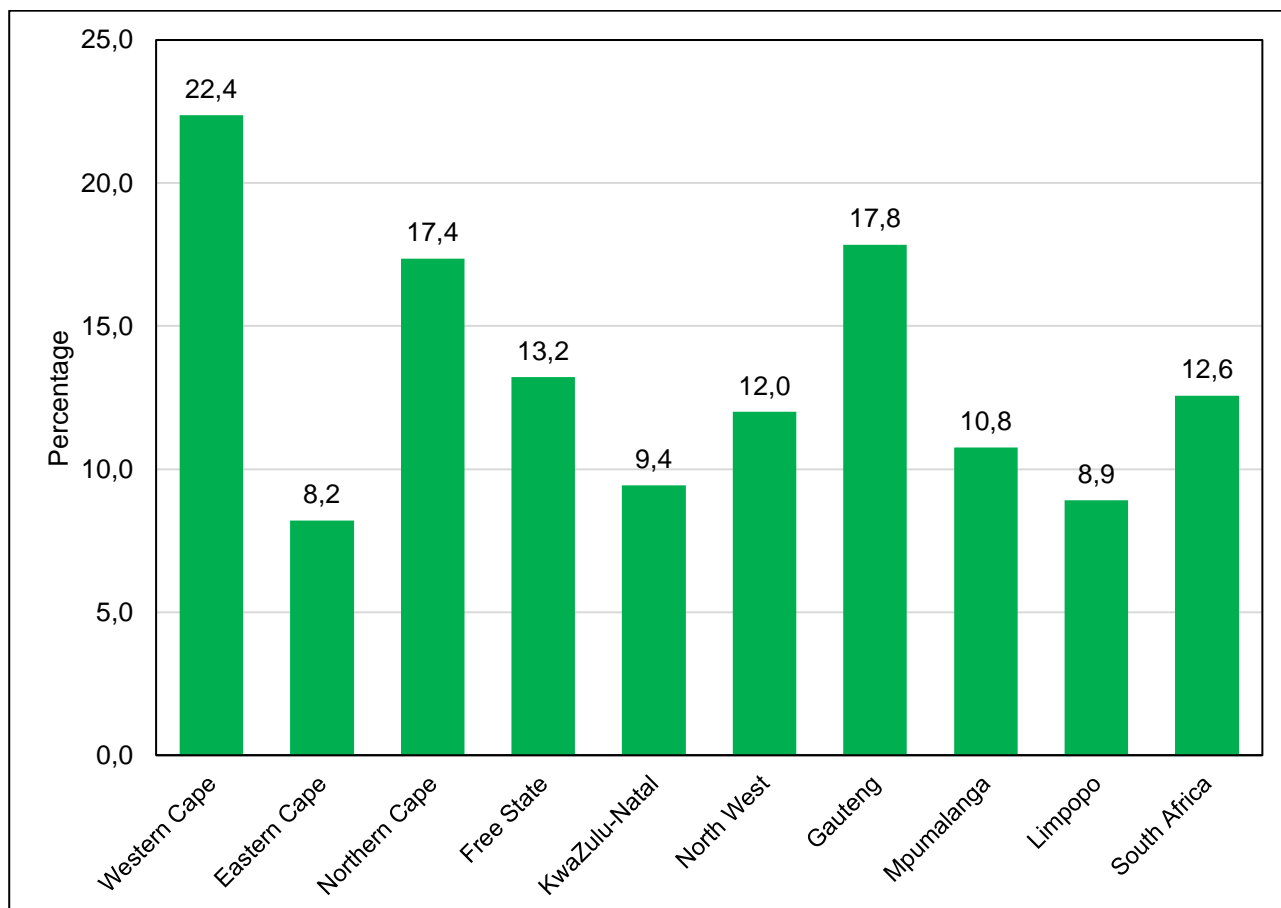


Source: General Household Survey, 2019

5.3 Medical aid coverage by province

Figure 5.3 shows medical aid coverage among adolescents by province from the GHS 2019 survey. Nationally, only 12,6% of adolescents had medical aid in 2019, with the highest percentage in Western Cape (22,4%), followed by Gauteng and Northern Cape (17,8% and 17,4%, respectively). Provinces with less than 10% of adolescents covered by medical aid were KwaZulu-Natal (9,4%), Limpopo (8,9%), and Eastern Cape (8,2%).

Figure 5.3: Percentage of adolescents with access to medical aid coverage by province



Source: General Household Survey, 2019

5.4 Summary of medical aid coverage

Nationally, just above 10% of the adolescents had medical aid in 2019, with no difference in medical aid coverage between males and females. Medical aid coverage was higher among adolescents from the white and Indian/Asian population groups. Provinces with higher medical aid coverage were the Western Cape, Gauteng and Northern Cape, while those with lower coverage were KwaZulu-Natal, Limpopo, and Eastern Cape.

Chapter 6: Health seeking behaviour

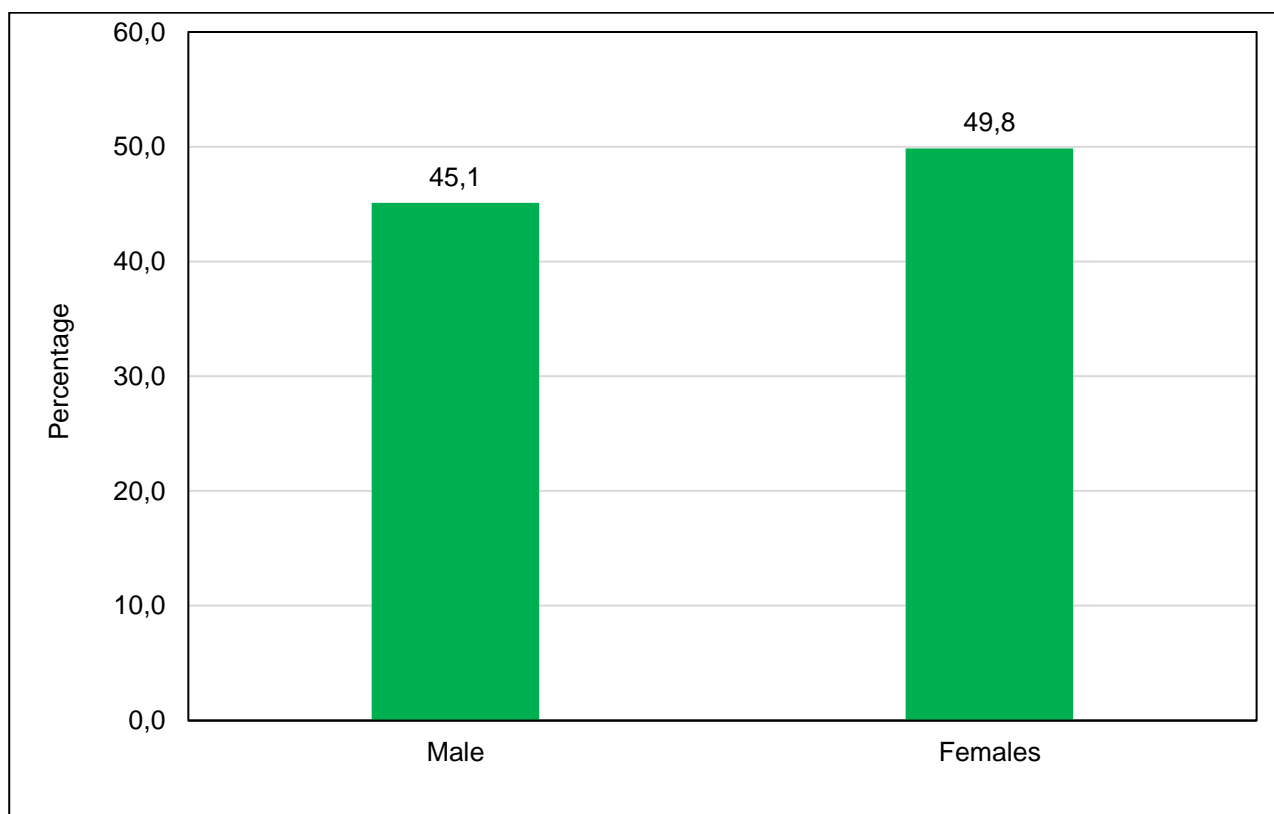
This chapter presents information on health seeking behaviour among adolescents. Healthcare-seeking behaviour is defined as an act taken by individuals who perceived themselves to be ill for purpose of finding an appropriate treatment. It covers issues of consulting a health care worker or any profession for help when sick and reasons for not consulting when sick.

Respondents were asked in the GHS question if they suffered selected illnesses during the past three months before the interview date. Respondents who answered “yes” to the above question were further asked the following question: “Did consult a health worker such as a nurse, doctor or traditional healer as a result of this illness?” The following results will be on adolescents who answered “yes” to that question.

6.1 Health worker consultation by sex

This section shows health care worker consultations among adolescents by sex for the GHS 2019 data. Results show that almost half of female adolescents consulted a health worker when they were sick as compared to their male counterparts (49,8% versus 45,1%).

Figure 6.1: Percentage of adolescents who consulted a health worker when they were ill by sex

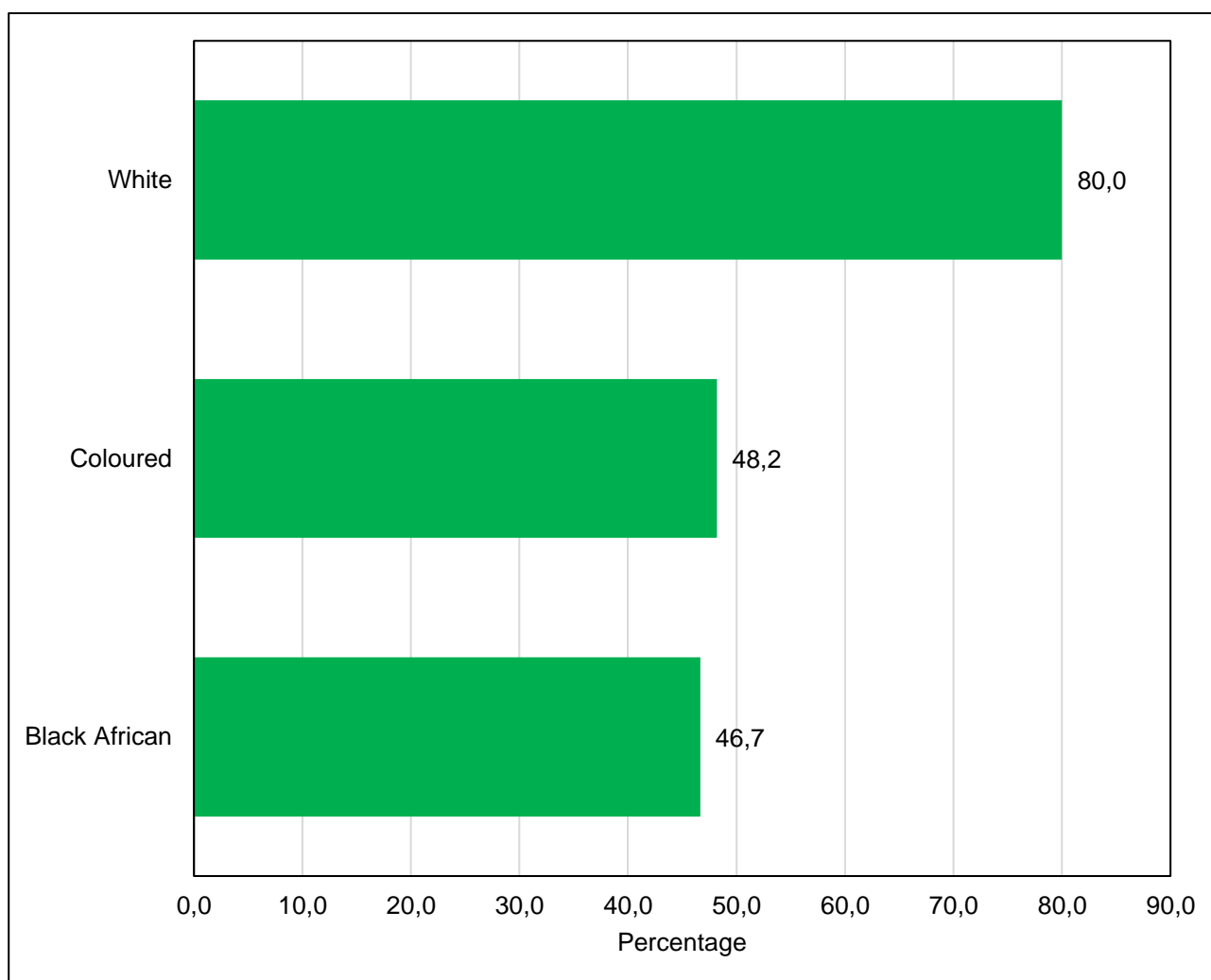


Source: General Household Survey, 2019

6.2 Health worker consultation by population group

Figure 6.2 presents results of health worker consultation among adolescents by population group for the GHS 2019 data. Results show 80% of adolescents from the white population group who consulted a health worker when they were sick, followed by the coloured and the black population groups with percentages just below 50%.

Figure 6.2: Percentage of adolescents who consulted a health worker when they were ill by population group*



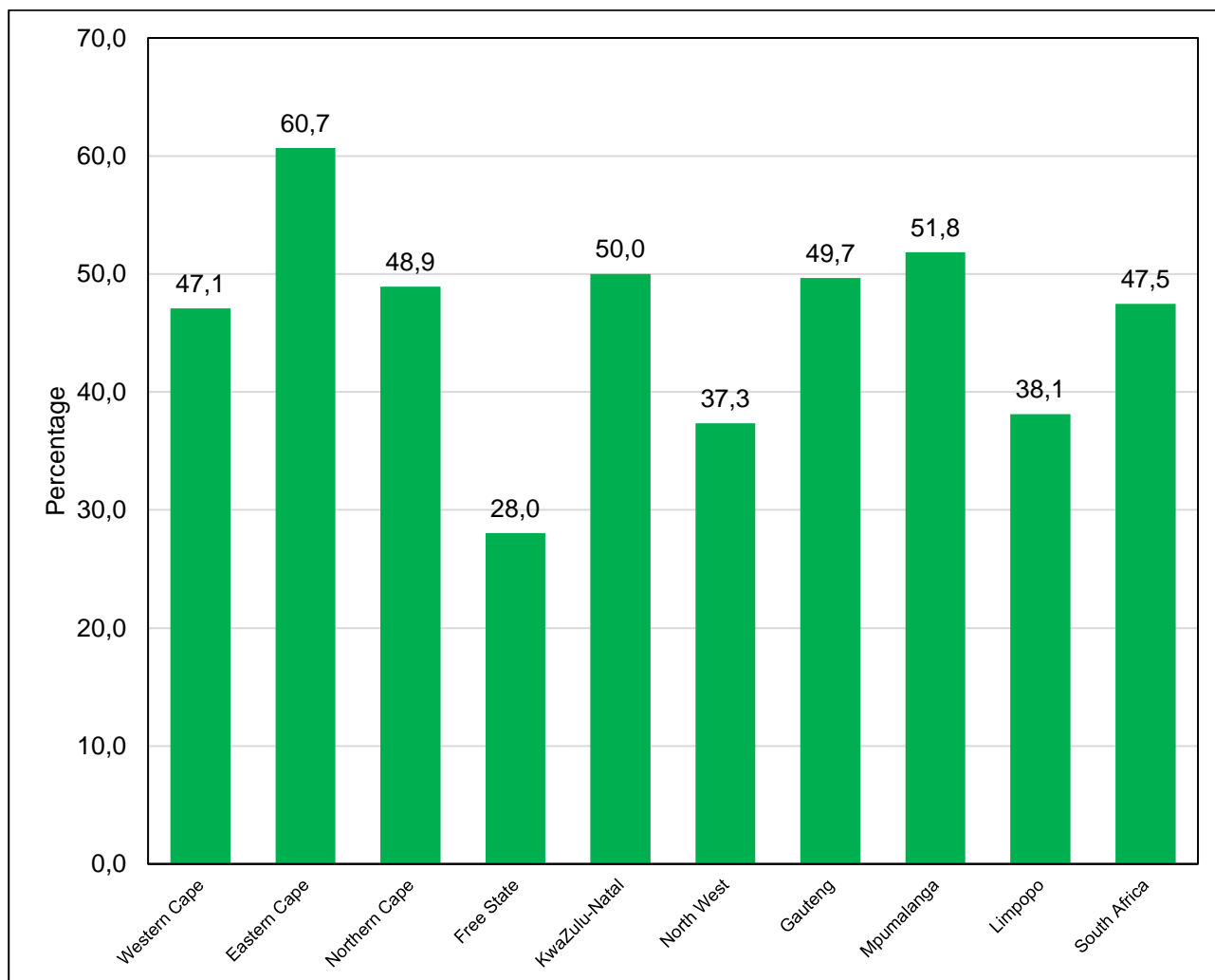
Source: General Household Survey, 2019

*Indian/Asian population group were excluded in the analysis due to few unweighted cases.

6.3 Health worker consultation by province

Figure 6.3 shows health worker consultations among adolescents by province for the GHS 2019 data. Results show that Eastern Cape had a higher percentage of adolescents who consulted (60,7%) when they were ill. It was followed by Mpumalanga and KwaZulu-Natal with percentages just above 50%. Free State was the only province with a percentage below 30%.

Figure 6.3: Percentage of adolescents who consulted a health worker when they were ill by province



Source: General Household Survey, 2019

6.4 Reasons for non-consultation

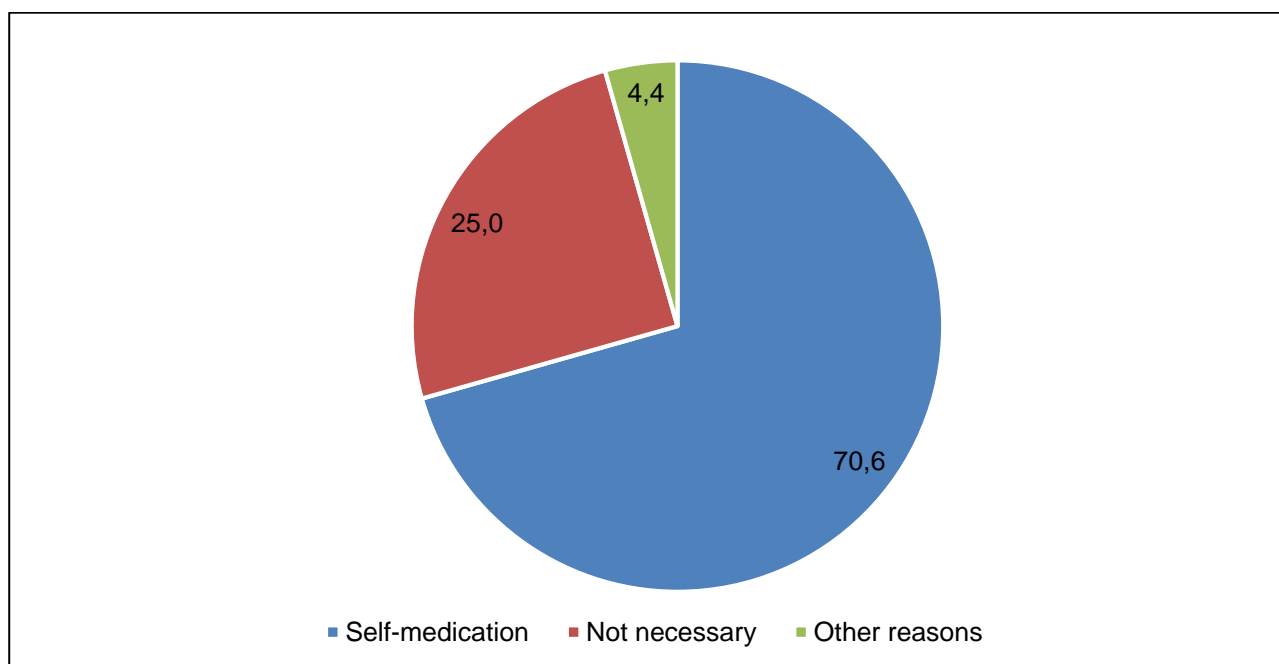
This section presents information on reasons provided by adolescents on why they did not consult a health worker when they were ill three months before the interview date.

Mistreatment or negative attitudes of healthcare workers (HCWs) and school teachers have been identified as barriers to access healthcare by pregnant adolescents (Michelle Olivia Erasmus et al, 2020). This was evident and cause for the introduction of the National Strategy for Maternal Care, 2015, which outlines how health workers administering care to pregnant women must demonstrate respect and a genuine interest in their clients and avoid an arrogant, rude or judgmental attitude (Department of Health, 2015).

A question regarding health worker consultation when a person was ill has been asked as follows in the GHS questionnaire: “Did consult a health worker such as a nurse, doctor or traditional healer as a result of this illness?” The following results will be on adolescents who answered “no” to that question.

If respondents answered with a “no” to the previous question on consultation, were further asked as follows: “What is the MAIN reason, why did not consult any health worker? Results from the responses show that self-medication (70,6%) was the main reason adolescents do not consult a health worker when they are ill. Self-medication is a human behaviour in which an individual uses over-the-counter drugs and dietary supplements, which are used to treat common health issues at home. It is followed by not necessary to consult (25%).

Figure 6.4: Percentage distributions of adolescents who were ill and did not consult by reasons for not consulting*



Source: General Household Survey, 2019

*Other reasons include Queues too long, fear of stigmatisation, etc

6.5 Summary of health seeking behaviour

Self-medication was the main reason adolescents did not consult a health worker when they were ill, followed by adolescents who thought it was not necessary to consult. More female adolescents consulted a health worker when they suffered a specific illness. Adolescents from the white population group were more likely to consult a health worker as compared to black Africans and coloured. More than half of adolescents from Eastern Cape, Mpumalanga and KwaZulu-Natal consulted a health worker when they had a specific illness during the previous three months. Free State had the lowest percentage of adolescents who consulted when they were sick.

Chapter 7: Births among adolescents

The chapter presents information on recorded lives from births that are registered at the Department of Home Affairs. It also highlights births among adolescents that occurred in a health facility as recorded in the District Health Information System of the National Department of Health.

Teenage pregnancy is one of the major public health issues across the whole world. Determinants of teenage pregnancy in a study employed in developing countries included the following, lack of knowledge on sexuality education, ineffective utilisation of modern contraceptives, cultural obedience, socioeconomic dependence of females on males, and peer influence. Teenage pregnancy is greatly associated with negative outcomes such as pre-eclampsia, anaemia, obstructed labour, operative deliveries, endometriosis, postpartum haemorrhage, low birth weight, preterm delivery, and perinatal death among others [Ayele Mamo Abebe et al, 2020].

There are still births that occur among the adolescents, hence they are included in this chapter of births. In South Africa, the right to birth registration is protected in the amended Births and Deaths Registration Amendment Act, 2010 (Act No. 18 of 2010), where all children born in South Africa must be registered within 30 days of their birth.

Registration of vital events has greatly improved in South Africa and the increase arises from a number of concerted efforts aimed at improving registration rates such as an increase in civil registration service delivery points (e.g. hospitals, mobile units, Thusong centres), national campaigns and outreach programmes mobilising the nation to adhere to civil registration laws, institutionalisation of key role players (traditional authorities and funeral undertakers) and demand for registration documents to access social services.

7.1 Recorded live births

The following section highlights information on births that occurred among adolescents and registered at Department of Home Affairs. Table 7.1 shows that a total of 106 383 registered live births occurred among adolescents in 2019. Among registered live births that occurred among adolescents, KwaZulu-Natal recorded a higher percentage than other provinces (24,7%). It was the only province with registered live births above 20%. KwaZulu-Natal was followed by Eastern Cape and Limpopo (both at 14,4%), then Gauteng at 13,7 and Mpumalanga at 10,0%. The remaining provinces reported less than 10% of registered live births: Western Cape at 8,3%, Free State at 4,8%, North West at 6,3% and Northern Cape with the lowest percentage of 3,2%.

Table 7.1: Number and percentage distributions of recorded live births among adolescents by province

Province	Number of recorded live births	Percentage
Western Cape	8 828	8,3
Eastern Cape	15 348	14,4
Northern Cape	3 441	3,2
Free State	5 131	4,8
KwaZulu-Natal	26 296	24,7
North West	6 730	6,3
Gauteng	14 577	13,7
Mpumalanga	10 667	10,0
Limpopo	15 365	14,4
South Africa	106 383	100,0

Source: Recorded live births, 2019

7.2 Births in public health facilities

This section presents information on births that were delivered by adolescents in the public health facility recorded in the DHIS for 2019. A total of 129 223 births were delivered by adolescents in a public health facility. KwaZulu-Natal presented a higher percentage of births (28,0%), followed by Limpopo (14,0%), Eastern Cape (13,8%) and Gauteng at 12,1%. The other provinces such as Western Cape, North West, and Mpumalanga had percentages above 5% but still less than 10%. Free State and Western Cape recorded less than 5% of births delivered in a public health facility (4,7% and 3,1%, respectively).

Table 7.2: Number and percentage distributions of births delivered by adolescents in a public health facility

Province	Number of births in public health facilities	Percentage
Western Cape	11 195	8,7
Eastern Cape	17 802	13,8
Northern Cape	4 057	3,1
Free State	6 117	4,7
KwaZulu-Natal	36 236	28,0
North West	8 044	6,2
Gauteng	15 596	12,1
Mpumalanga	12 141	9,4
Limpopo	18 035	14,0
South Africa	129 223	100,0

Source: District Health Information System, 2019

7.3 Summary of adolescent births

KwaZulu-Natal reported higher percentages of both births registered at Home Affairs and those that were delivered in public health facilities. Northern Cape was the lowest in both births registered at the Department of Home Affairs and those that were delivered in public health facilities.

Chapter 8: Termination of pregnancy

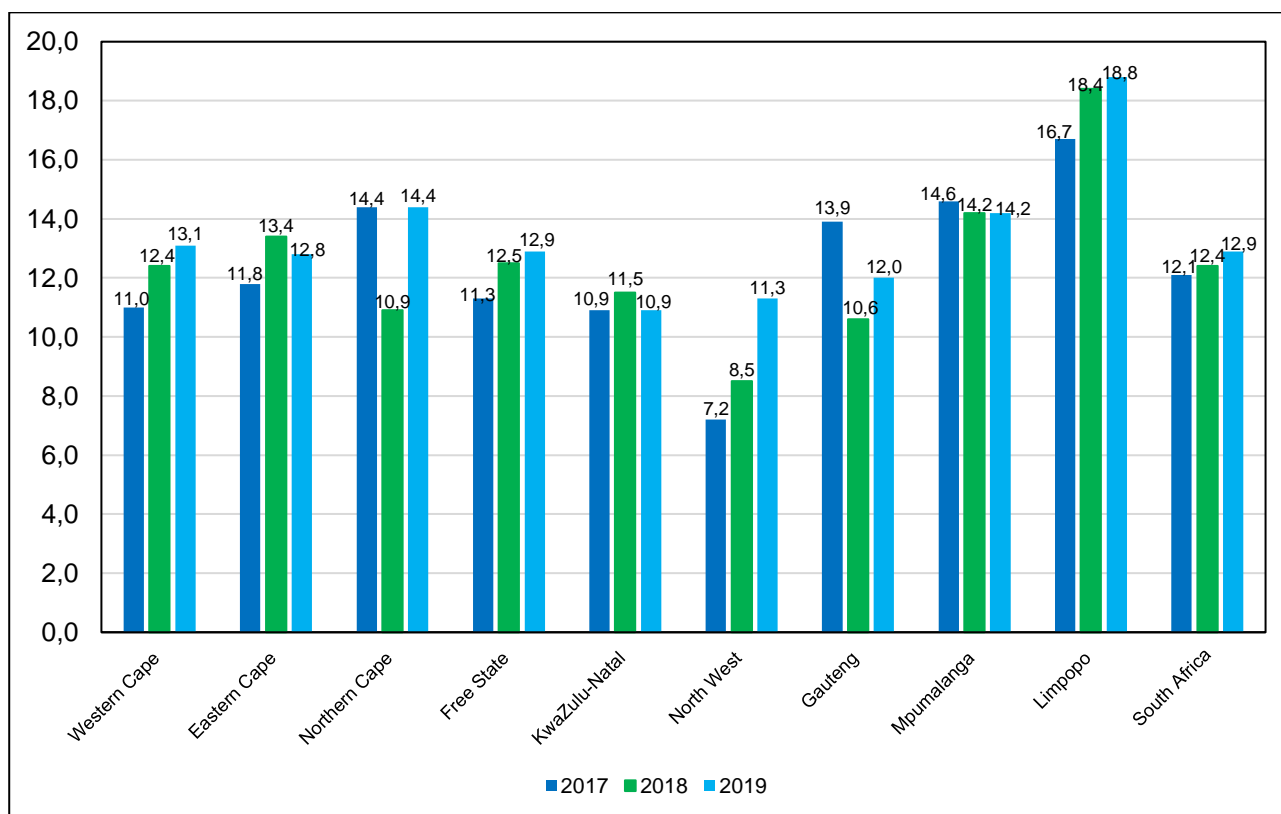
This chapter presents information on termination of pregnancy among women aged below 20 years for 2017, 2018 and 2019 as retrieved from the DHIS of the Department of Health. Termination of pregnancy is referred to as the decision by a woman to end her pregnancy by medical procedure before the foetus/baby reaches full term. TOP was legal under very limited circumstances until 1 February 1997, when the Choice on Termination of Pregnancy Act (Act No. 92 of 1996) came into effect, providing abortion on demand (Republic of South Africa, 1996).

Termination of pregnancy under 20 years is calculated as a proportion of total deliveries among women under 20 years in a public health facility.

8.1 Results on termination of pregnancy

Nationally, the rate of TOP was around 12% for all the reporting years, showing a slight increase from 2017 (12,1%) to 12,9% in 2019. Limpopo had the highest percentage of TOPs being performed for the three-year period. In 2017, Limpopo (16,7%) had the highest rates of TOPs, followed by Mpumalanga and Northern Cape (14,6% and 14,4%, respectively).

Figure 8.1: Rate of termination of pregnancy among women aged less than 20 years



Source: District Health Information System, 2017-2019

The lowest rate of TOPs performed in 2017 was in North West at 7,2%. The highest rate of TOPs in 2018 was again observed in Limpopo at 18,4%, followed by Mpumalanga at 14,2% and Eastern Cape at 13,4%. The lowest rate of TOPs in 2018 was recorded in North West at 8,5%. In 2019, Limpopo was also the highest in terms of rates of TOP (18,8%), this time followed by Northern Cape (14,4%). The lowest rate of TOPs in 2019 was in KwaZulu-Natal (10,9%).

Provinces that recorded a consistent increase in the proportion of TOPs between the three years (2017, 2018 and 2019) are Western Cape (11,0% to 13,1%), Free State (11,3% to 12,9%), North West (7,2% to 11,3%) and Limpopo (16,7% to 18,8%). Provinces showing a decrease between 2018 and 2019 were Eastern Cape (13,4% to 12,8%) and KwaZulu-Natal (11,5% to 10,9%). North West was the only province with TOP rates less than 10% for 2017 (7,2%) and 2018 (8,5%).

8.2 Summary on termination of pregnancy

Over three years 2017-2020, the highest rates of TOP were observed in Limpopo. In 2017 and 2018, North West had the lowest proportions of TOPs, whilst for 2019, the lowest rate was recorded in KwaZulu-Natal. There was a consistent increase in termination of pregnancy rates in the Western Cape, Free State, North West and Limpopo.

Chapter 9: Cancer

The chapter presents cancers diagnosed as recorded in the National Cancer Registry managed by the National Health Laboratory Services and deaths due to cancer from the Mortality and Causes of Death managed by Statistics South Africa.

South Africa has a pathology-based National Cancer Register (NCR), which was established in 1986 and is the main source of cancer statistics. It collates and analyses cancer cases diagnosed in pathology laboratories (public and private) and reports annual cancer incidence rates stratified by age, sex and population groups.

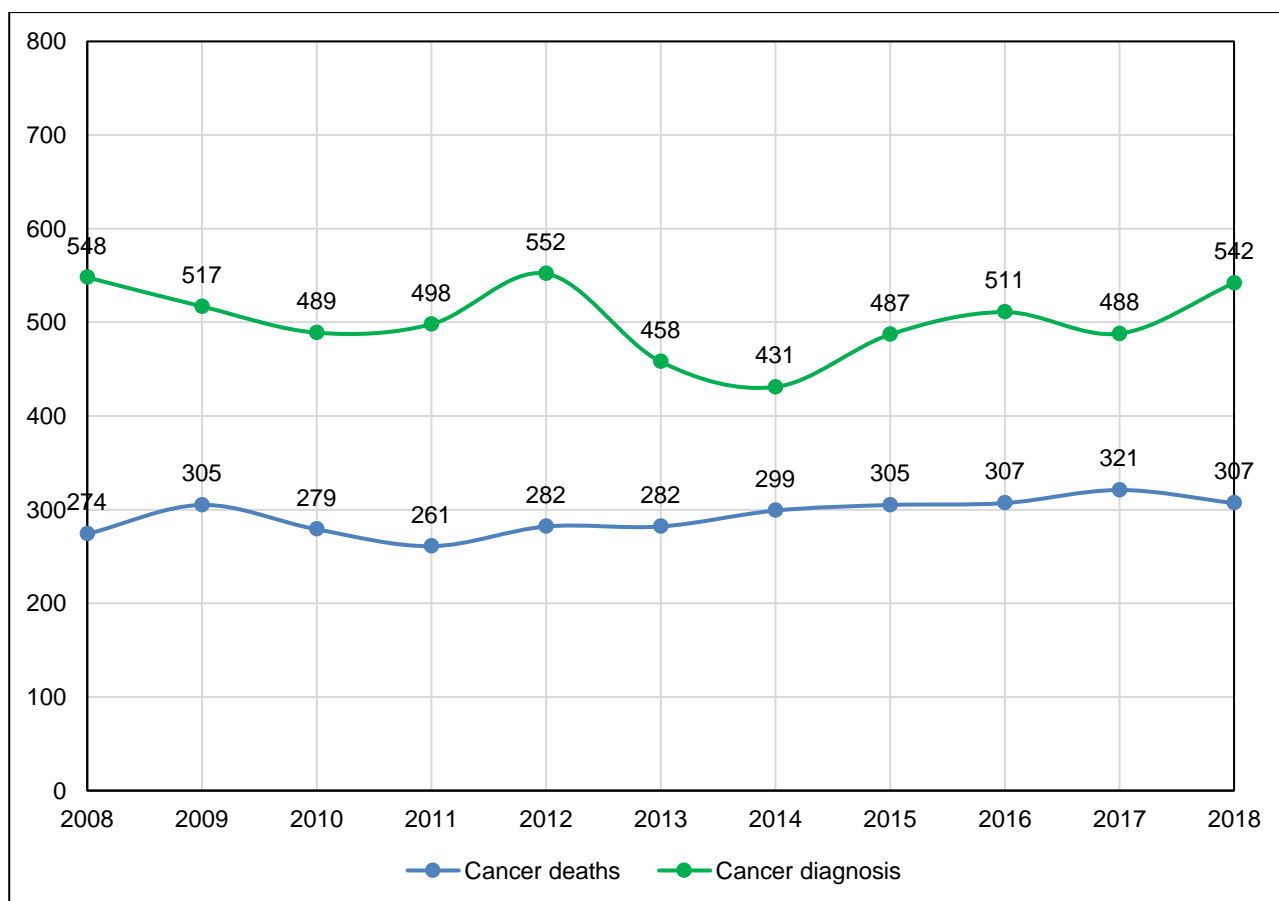
Teenagers are not well-documented in the NCR and the South African Children's Cancer Registry, so the true status of their incidence is still unknown. Hodgkin and Non-Hodgkin Lymphoma remain two leading cancers among teenagers (10 to 19 years), accounting for nearly a quarter (24%) of all the cancers affecting teenagers with a five-year survival rate of 79% in South Africa (Cancer Association of South Africa, 2018).

The following sections on results presents 10-year trends of both cancer diagnoses and cancer deaths among adolescents for 2008 and 2018. Furthermore, cancer diagnoses were analysed for the years 2016 to 2018 as retrieved from the National Cancer Registry. Cancer deaths were also highlighted for 2016 to 2018 as retrieved from the Mortality and Causes of Death.

9.1 Cancer trends

This section presents the trends of cancer diagnoses and deaths that occurred due to cancer among adolescents for the period 2008 and 2018. Generally, there was almost the same number of cancer diagnoses in 2008 (548) and those in 2018 (542). There was fluctuation in the number of cancer diagnoses between 2008 and 2018. Slight decreases were observed in 2012 and 2014 (552 to 431) but an increase from 488 to 542 between 2017 and 2018. In terms of cancer deaths, there was a more levelled trend during the reporting years, with a slight increase from the starting number of 274 in 2008 to 307 in 2018.

Figure 9.1: Trends of cancer diagnoses and deaths among adolescents, 2008-2018



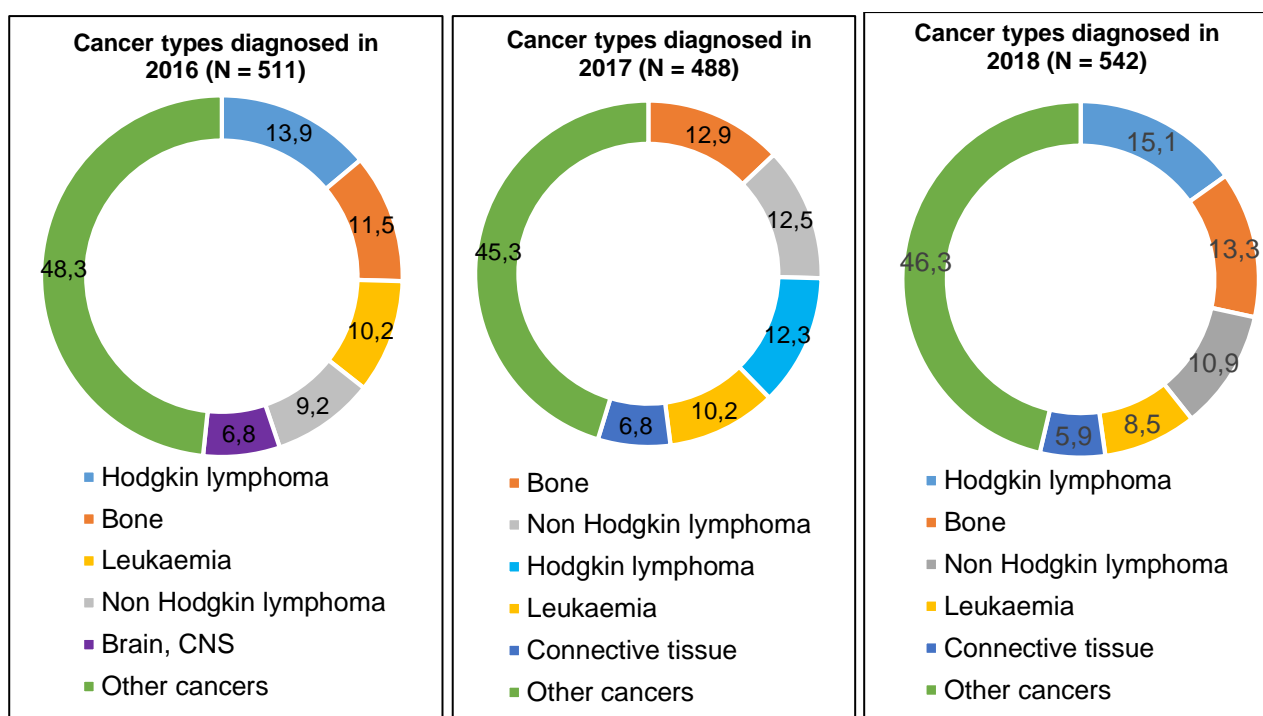
Source: National Cancer Registry and Mortality and Causes of Death, 2008-2018

9.2 Morbidity from cancers

This section presents adolescents that were diagnosed with certain types of cancer in 2016, 2017 and 2018. The top leading types of cancers among adolescents (not in any particular order) were: Hodgkin’s lymphoma, non-Hodgkin’s lymphoma, bone, leukaemia, brain or central nervous system and connective tissue cancers.

Non-Hodgkin’s lymphoma was the leading type of cancer in 2016 (13,9%) and in 2018 (15,1%). It was followed by bone cancer which accounted for 11,5% in 2016 and 13,3% in 2018. The year 2017 was vice versa to the years 2016 and 2018. Leukaemia was the cancer that follows bone and non-Hodgkin’s lymphoma for 2016 and 2018. In 2017, Hodgkin’s lymphoma was ranked third at 12,3% among adolescents.

Figure 9.2: Percentage distribution of adolescents diagnosed with cancer by site



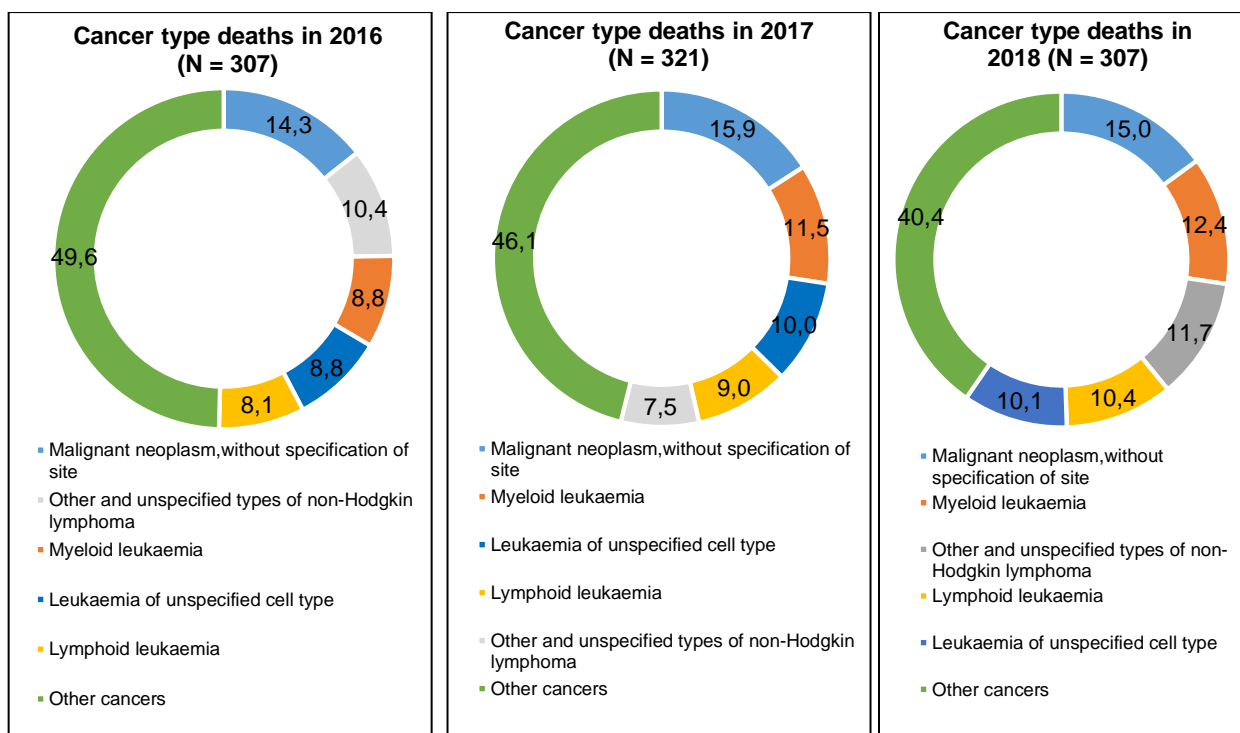
Source: National Cancer Registry, 2016-2018

9.3 Mortality from cancers

This section presents information on adolescents who died from certain types of cancers in 2016, 2017 and 2018. The leading cause of death among adolescents were malignant neoplasm without specification site, myeloma leukaemia, other and unspecified types of non-Hodgkin’s lymphoma, leukaemia and lymphoid leukaemia.

Malignant neoplasm without specification site was the leading cause of death among adolescents across all reporting years, while myeloma was the second cause of deaths in 2017 and 2018, but third in 2016. Other and unspecified types of non-Hodgkin’s lymphoma was ranked second for 2016, fifth for 2017 and third for 2018. Lymphoid leukaemia was ranked third for both 2016 and 2017 and ranked fifth for 2018.

Figure 9.3: Percentage distribution of adolescents who died from cancer by site



Source: Mortality and Causes of Death, 2016-2018

9.4 Summary of cancer morbidity and mortality

A slight decrease in cancer diagnoses were reported between 2012 and 2014 with an increase between 2017 and 2018. Cancer deaths remained at an average of 455 per years between 2008 and 2018. Hodgkin’s lymphoma and bone cancer were the leading causes of morbidity among adolescents in 2016 to 2018.

Chapter 10: Male circumcision

The chapter presents information on male circumcision for adolescents 10-14 years. Male circumcision (MC) is regarded as one of the oldest and most common surgical procedures performed worldwide. It is performed throughout the world for medical, ritual, traditional, and cosmetic reasons (Andrea Wilcken, 2010).

Male circumcision around initiation schools in South Africa is part of the culture practiced by many populations. However, there is still lack of understanding and acceptability regarding the integration of medical male circumcision with traditional manhood initiation rituals. South Africa has moderate prevalence of circumcision performed among students in higher institutions of learning (Sam Mndzebele, 2019).

Results from the Higher Education and Training HIV and AIDS Programme (HEAIDS) study showed that 66% of the students were circumcised, 79% preferred Voluntary Medical Male Circumcision (VMMC) and that students were willing to encourage others to opt for circumcision. The prevalence was due to massive scale-up of VMMC in different communities and mobilisation through media platforms targeting young people and peer- pressure among students. It was shown that 250 000 VMMC were done between 2012 and 2015 in South Africa. About 70% of the men fear the stigma of following the medical circumcision in South Africa (Sam Mndzebele, 2019).

A number of organisations are partnering with Higher Education and Training HIV and AIDS Programme (HEAIDS) to assist with comprehensive HIV prevention services by motivating all male students to get circumcised. About 40% of new HIV infections are from young people aged 15–24 years (Sam Mndzebele, 2019).

10.1 Morbidity from male circumcision

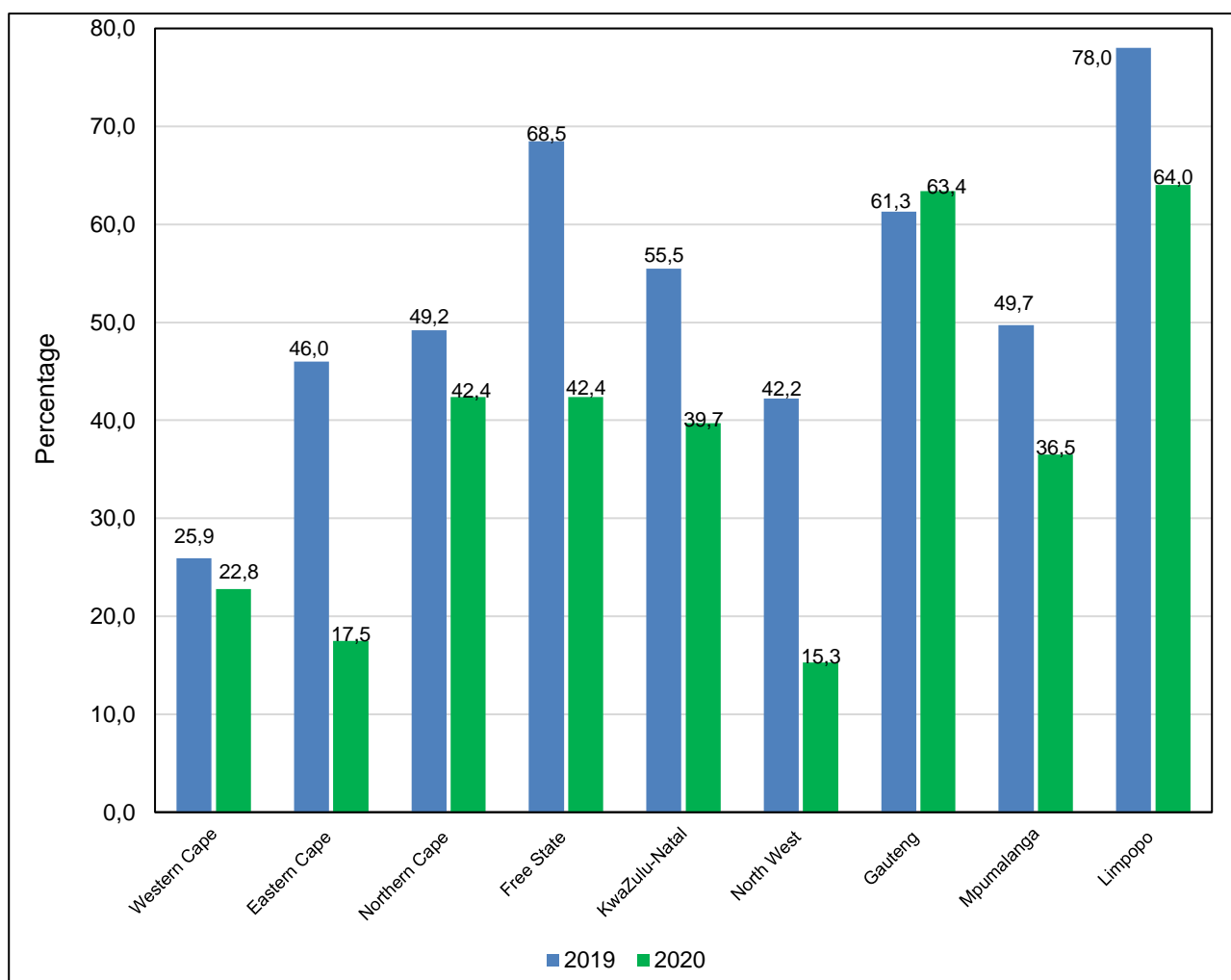
This section highlights information on the morbidity regarding male circumcision among adolescents (10–14 years). Data on mortality for male circumcision were not included in this report because of low number of deaths among adolescents.

Medical male circumcision

Figure 10.1 presents results of adolescents (10–14 years) who performed medical male circumcision (MMC) as a proportion of the total medical male circumcisions performed for the years 2019 and 2020. In 2019, Limpopo recorded a higher percentage of adolescents 10-14 years who went for MMC at 78%, followed by Free State and Gauteng (68,5% and 61,3%, respectively). Lower percentage of male circumcision was seen in Western Cape (25,9%).

Results for 2020 should be interpreted with caution as it was a year of COVID lockdown. In that year, higher percentages were again in Limpopo (64,0%) and Gauteng (63,7%), while Eastern Cape and North West recorded lower percentage of adolescents who did MMC (17,5% and 15,3%, respectively). When 2019 and 2020 are compared, results show that 2019 recorded higher percentages of male circumcision among 10–14 years for all provinces than in 2020.

Figure 10.1: Percentage of adolescents (10-14 years) who underwent medical male circumcision



Source: National Department of Health, 2019-2020

10.2 Summary of male circumcision

Medical male circumcision (MMC) was mostly practised in Limpopo, Free State and Gauteng in 2019 but in 2020 it was practiced only in Gauteng and Limpopo. MMC was less practised in Western Cape for 2019 and Eastern Cape and North West for 2020.

Chapter 11: Mental health visits

The chapter presents information on children below 18 years who visited a mental health facility in 2019 and 2020 from the DHIS data.

In South Africa, about 20% of teenagers have a detected or untreated mental health disorders. Results lead to catastrophic situations: common psychiatric disorders in adolescents include anxiety-, mood-, trauma- and stress- disorders, which are all associated with an increased suicide risk. The South African National Youth Risk Behaviour Survey (SANYRBS) recently investigated a number of key risk behaviours, including intentional and unintentional injuries, violence and traffic safety, suicide-related behaviours, behaviours related to substance abuse (tobacco, alcohol and other drugs), sexual behaviour, nutrition and dietary behaviours, physical activity and hygiene related behaviours (Netcare, 2018).

Results of the South African National Youth Risk Behaviour Survey showed that 24% of youths surveyed between Grade 8 to Grade 11 had experienced feelings of depression, hopelessness and sadness, while a further 21% had attempted suicide at least once. Another recent study, among school-attendees aged 14 to 15 years in Cape Town, reported that adolescents experienced a high prevalence of depression (41%), anxiety (16%) and Post Traumatic Stress Disorder (PTSD) (21%) (Jayati Das-Munshi, 2016).

11.1 Results on mental health visits

This section presents results on children under 18 years who visited a mental health service/facility for 2019 and 2020.

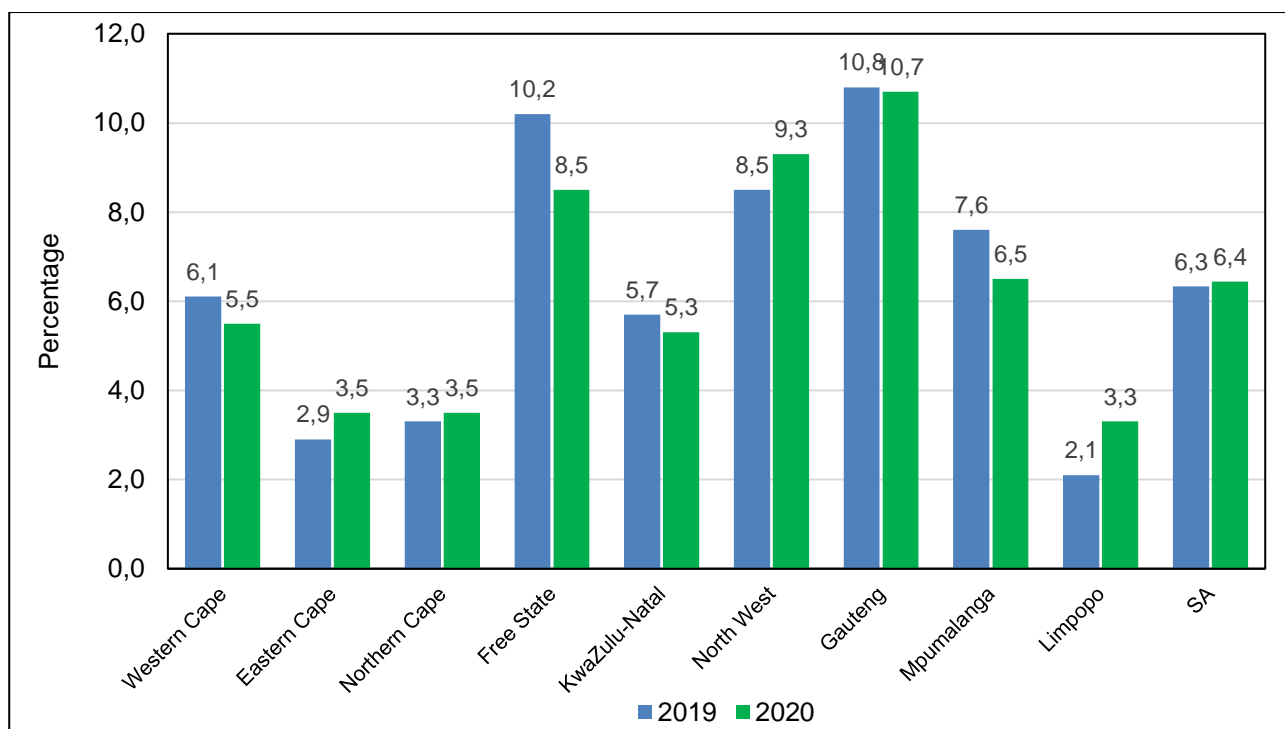
In 2019, about 6% of children below 18 years visited a mental health service/facility. Gauteng and Free State were the only provinces that reported a double-digit figure of 10,8% and 10,2%, respectively. They were followed by 8,5% for North West, 7,6% for Mpumalanga, 6,1% for Western Cape and 5,7% for KwaZulu-Natal. The remaining provinces reported proportions less than 5% of children below 18 years who visited a mental health facility for 2019.

Out of people who visited the mental health facility in 2020, a figure of 6,4% were children below 18 years. Provinces with the highest proportions of children under the age of 18 who attended a mental health facility were Gauteng (10,7%), followed by North West (9,3%), then Free State at 8,5% for Mpumalanga. Lower percentages were recorded in Eastern Cape and Northern Cape (both at 3,5%) and Limpopo at 3,3%.

Nationally, almost six percent of children below 18 years attended mental health services in 2019 and 2020. There was a slight increase from 6,3% to 6,4%. The following provinces recorded a decrease in proportions in mental health visits between 2019 and 2020, namely: Western Cape (6,1% to 5,5%), Free State (10,2% to 8,5%), KwaZulu-Natal (5,7% to 5,3%), Gauteng (10,8% to 10,7%) and Mpumalanga (7,6% to 6,5%). Free State recorded the highest decrease with 1,7 percentage points and Gauteng recorded the lowest decrease of 0,1 percentage points.

The following provinces recorded an increase in proportions between 2019 and 2020, namely: Eastern Cape (2,9% to 3,5%), North West (8,5% to 9,3%) and Limpopo (2,1% to 3,3%). Limpopo observed the highest increase of 1,2 percentage points.

Figure 11.1: Proportions of children below 18 years who visited a public mental health facility



Source: National Department of Health, 2019 and 2020

11.2 Summary of mental health visits

Gauteng recorded higher proportions for both 2019 and 2020. Eastern Cape, Northern Cape and Limpopo had lower proportions of adolescents who visited a mental health service or facility for both reporting years. Decreases were seen in Western Cape, Free State, KwaZulu-Natal, Gauteng and Mpumalanga while increases were in Eastern Cape, North West and Limpopo.

Chapter 12: Road traffic fatalities

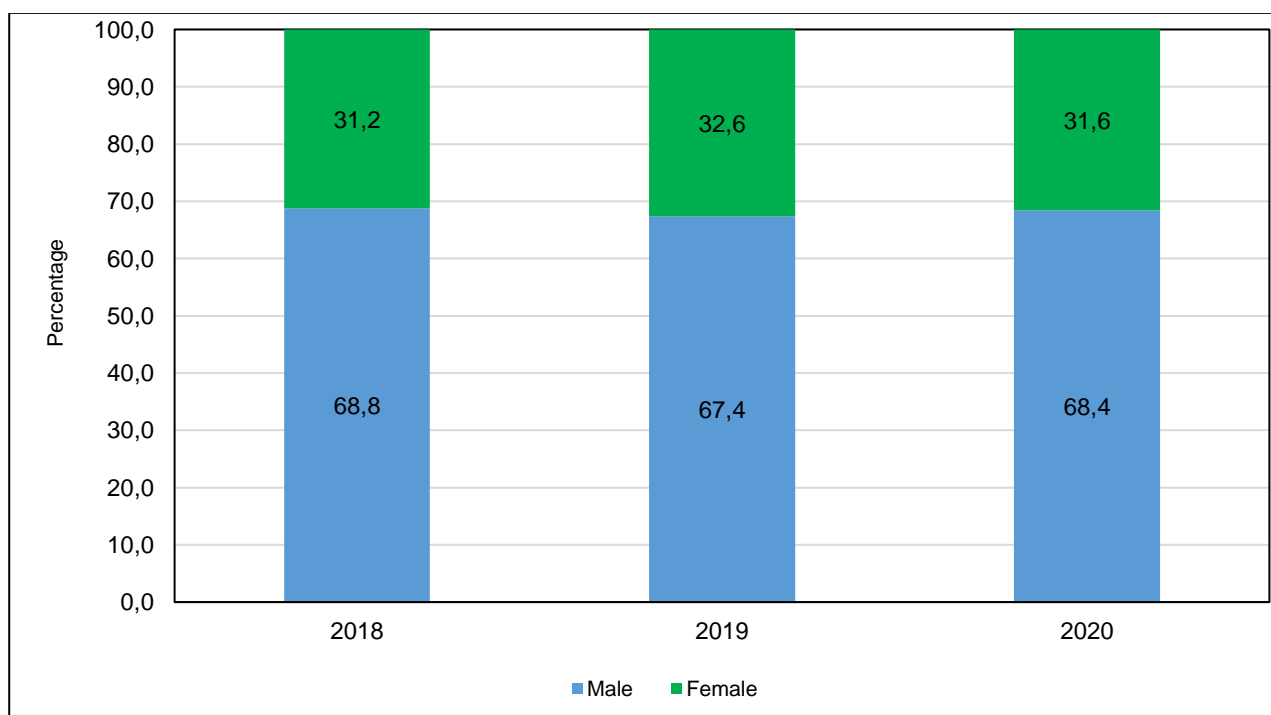
The chapter presents information on road traffic accidents that led to deaths among adolescents during 2018 to 2020. Road accidents affect families and society as a whole and are the leading cause of disability. Recent statistics highlight that youth contribute the highest number of road fatalities annually when compared to other age groups. In 2019, youth aged 20–24 years constituted 11,5% of total fatalities, while those aged 25–29 years contributed 21,8% and those aged 30–34 years constituted 9,0% (RTMC, 2021).

Information on road accidents experienced by adolescents is analysed from the Road Traffic Management Corporation (RTMC) managed by the Department of Transport (DOT). Data on road accidents is collected on a daily basis by the South African Police Service (SAPS), using Culpable Homicide Crash Observation Report (CHoCOR). Forms are then sent to the RTMC to be captured, processed and verified to compile a report on these occurrences. All accidents must be reported as and when they occur as required by the National Road Traffic Act, 1996 and the Road Traffic Management Corporation Act. 1999.

12.1 Road traffic fatalities by sex

Figure 12.1. below present road traffic fatalities among adolescents by sex for 2018 to 2020. In general, there were more male fatalities than female ones for all the reporting years. The proportions of male road fatalities has remained around 69% overtime.

Figure 12.1: Percentage distribution of road traffic fatalities among adolescents by sex and year

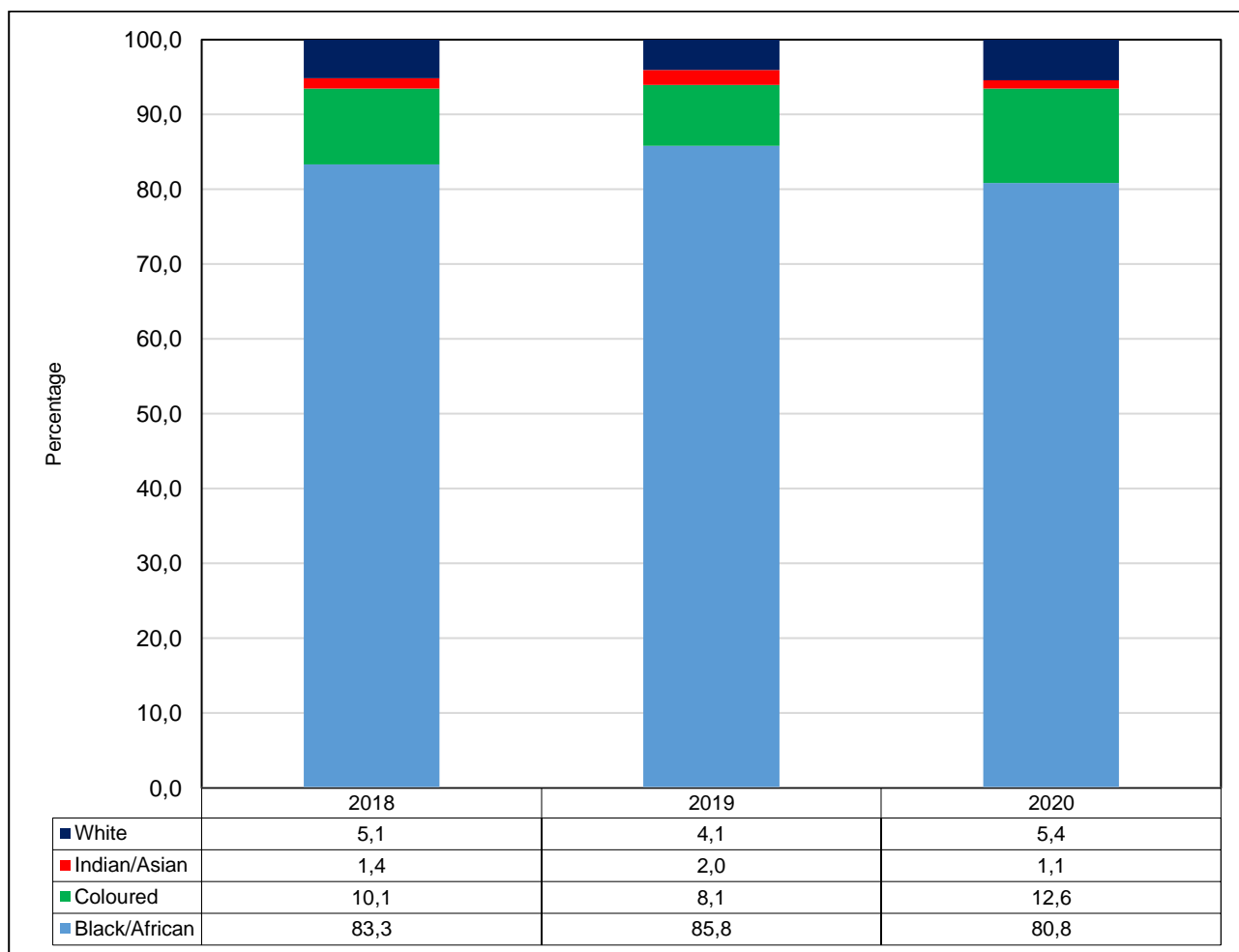


Source: Road Traffic Management Corporation, 2018-2020

12.2 Road traffic fatalities by population group

Figure 12.2 below shows road traffic fatalities by population group between 2018 and 2020. In general, adolescents from the black African population group had higher percentages across all years (around 80%), followed by those from the coloured population. The white and the Indian/Asian population groups were less affected by road accidents with percentages less than 10%.

Figure 12.2: Percentage distribution of road traffic fatalities among adolescents by population group and year



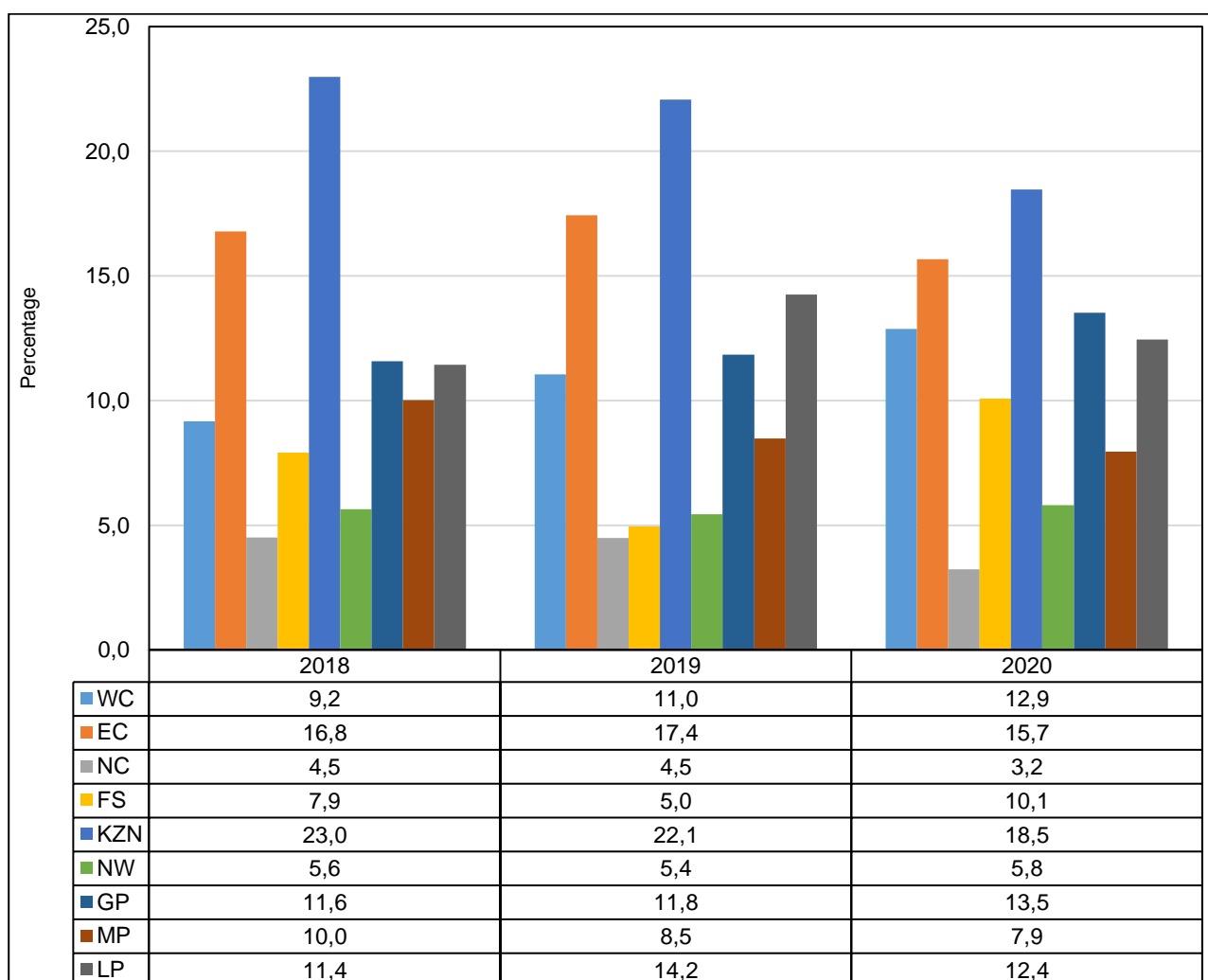
Source: Road Traffic Management Corporation, 2018-2020

12.3 Road traffic fatalities by province

Figure 12.3 below presents results of road traffic fatalities among adolescents by province for 2018–2020. Western Cape recorded an upward trend in adolescent’s fatalities between 2018 and 2020 (9,2% to 12,9%). KwaZulu-Natal showed a consistent decrease in fatalities among adolescents between 2018 and 2020 (23,0% to 18,5%).

A steady upward trend in road traffic fatalities among adolescents was seen in Gauteng where it recorded 11,6% in 2018 and 13,5% in 2020. The remaining other provinces showed fluctuations in percentages between the reporting years.

Figure 12.3: Percentage distribution of road traffic fatalities among adolescents by province and year



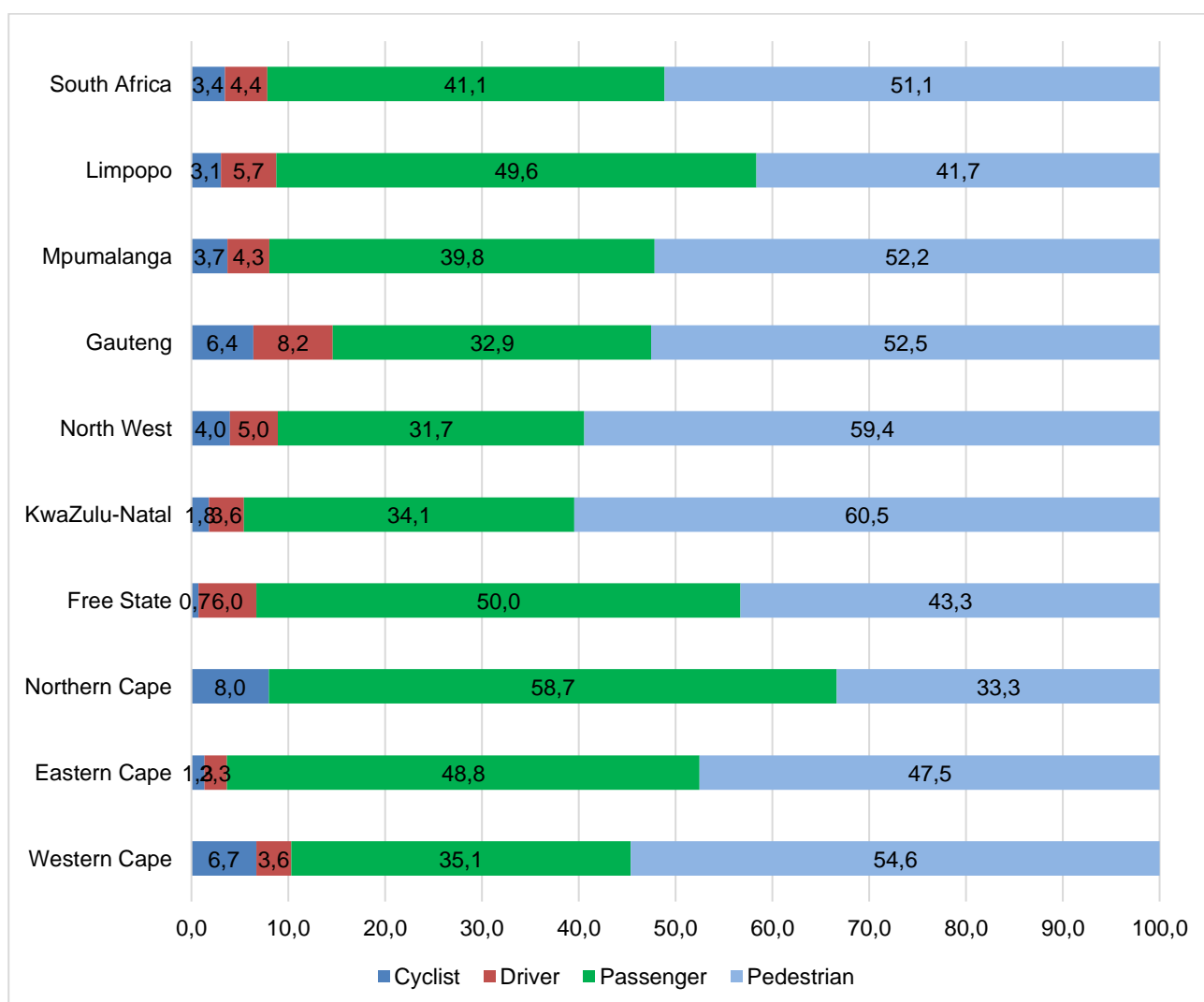
Source: Road Traffic Management Corporation, 2018-2020

12.4 Road traffic fatalities by type of road users

This section presents information of the type of road users that died due to traffic accidents among adolescents. Figures present results of road traffic fatalities among adolescents by road user for the years 2018–2020. Adolescents were divided into four categories of road user, namely: cyclist, driver, passenger and pedestrian.

Nationally, just above half (51%) of road fatalities among adolescents were passengers, followed by those who are categorised as passengers (41,1), then cyclists and drivers recording less than 5% of road fatalities among adolescents (3,4% and 4,6%, respectively). Provincially, adolescents who died as passengers and pedestrians contributed about 90% of road traffic fatalities.

Figure 12.4: Percentage distribution of road traffic fatalities among adolescents by type of road user and province



Source: Road Traffic Management Corporation, 2018-2020

Among adolescents who died as pedestrians, a higher percentage of road traffic fatalities were reported in KwaZulu-Natal (60,5%), followed by North West at 59,4% and Western Cape at 54,2%. The lowest percentage of road traffic fatalities among pedestrians were seen in Northern Cape (33,3%). Adolescents who died as passengers, higher percentages of road fatalities were in Northern Cape (58,7%) and Free State at 50,0%, while lower percentage was recorded in North West (31,7%). Categories of cyclists and drivers contributed less than 10% each of road traffic fatalities of both provincial and national figures. Northern Cape is the only provinces with no adolescents who died as drivers.

12.5 Summary of road traffic fatalities

More males died due to road traffic accidents than their female counterparts, with more black Africans dying more than other population groups. More fatalities were reported in KwaZulu-Natal and Eastern Cape. Increases were recorded in Western Cape, Eastern Cape, Gauteng but decreased in KwaZulu-Natal and Mpumalanga. Lowest percentages of fatalities were recorded in Northern Cape and North West.

Nationally, just above half of road traffic fatalities among adolescents were passengers and less cyclists and drivers. Adolescents who died as pedestrians were recorded in KwaZulu-Natal, North West and Western Cape, with those categorised as passengers reported more in Northern Cape and Free State. Gauteng was the only province with about 10% of adolescents who died as drivers.

Chapter 13: Mortality among adolescents

The five leading causes of death among teenagers in South Africa for 2017 were accidents (unintentional injuries), homicide, suicide, cancer, and heart disease. Road traffic accidents account for nearly one-half of all teenage deaths (Stats SA, 2020).

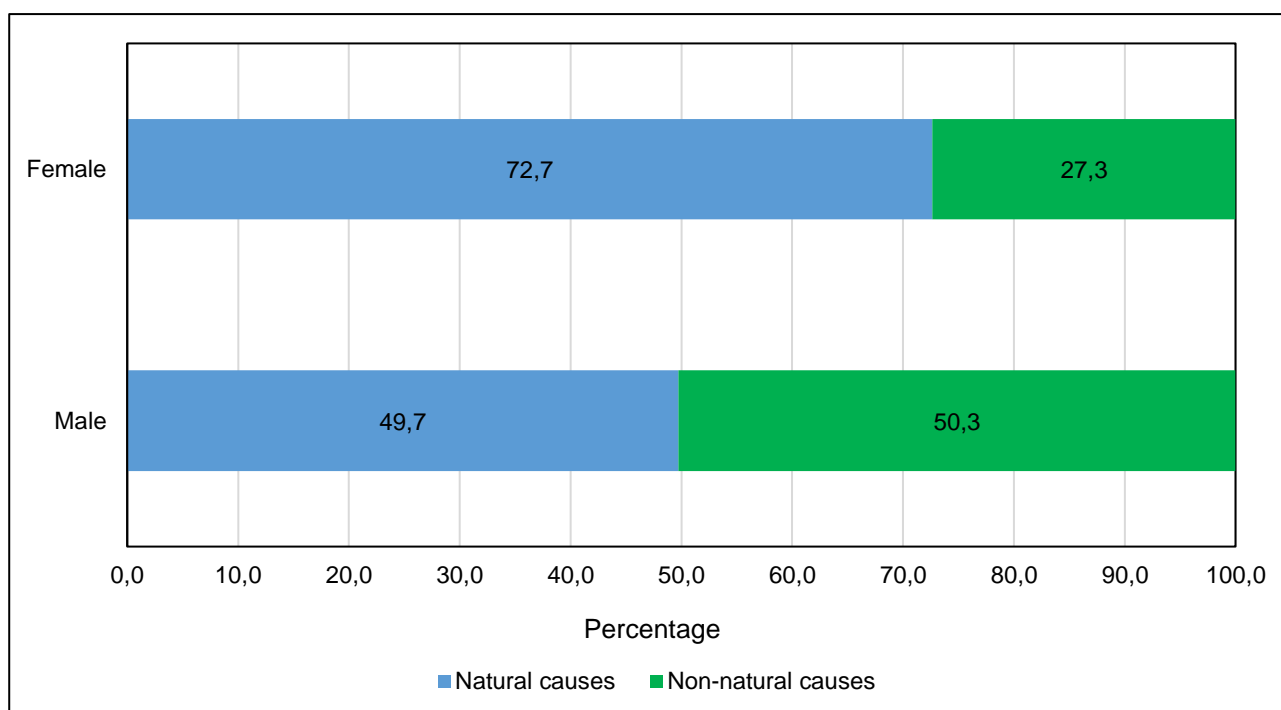
Type of death

This section presents information on the type of death (natural or non-natural cause) by sex, population group and province. All causes of death included in chapters 1 to 18 are classified according to the International Classification of Disease, Tenth Revision (ICD-10) codebook as natural causes (deaths due to natural causes) and those in chapter 20 (V01-Y98) as non-natural causes (deaths due to all external causes of morbidity and mortality). Information on non-natural causes of death is critical for informing policy and planning in the country regarding adolescents, hence the need to be included in this report. Information used to compile this chapter is retrieved from the mortality and causes of death 2018 dataset processed by Statistics South Africa.

13.1 Type of death by sex

Figure 13.1 below shows distribution of deaths among adolescents by the type of death (natural or non-natural) and sex for deaths that occurred in 2018. Results show that seven out of ten (72,7%) female adolescents died from natural causes. Half (50,3%) of the male adolescents' deaths were due to non-natural causes.

Figure 13.1: Percentage distribution of deaths among adolescents by type of death and sex



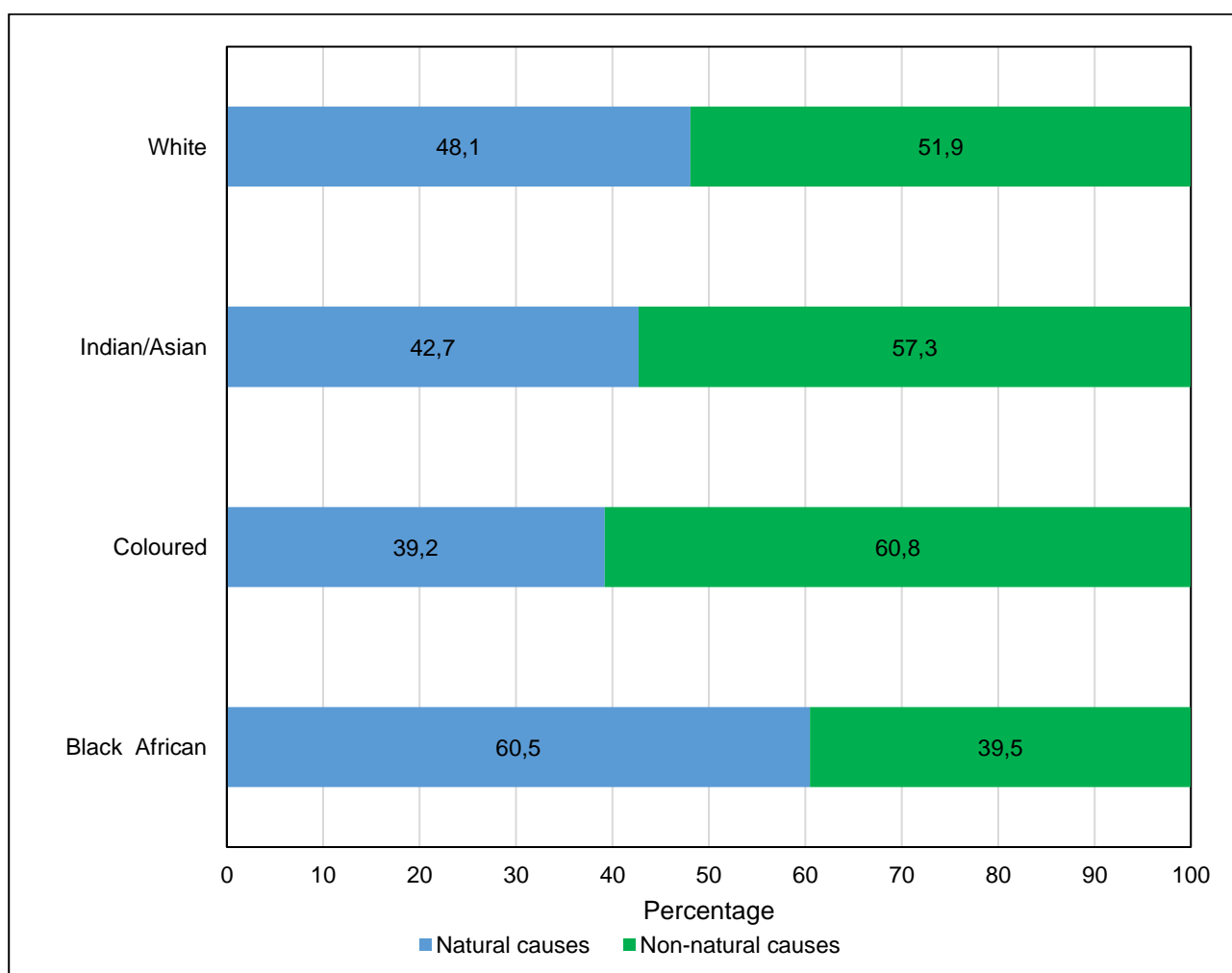
Source: Mortality and causes of death, 2018

13.2 Type of death by population group

Figure 13.2 below presents distribution of deaths among adolescents by the type of death and population group. Generally, results show that adolescents in all population groups died from non-natural causes than natural causes across with the exception of those from the black African population group who died more from natural causes.

A higher percentage of deaths from non-natural causes was observed among adolescents from the coloured population group (60,8%), followed by those from the Indian/Asian population group (57,3%). Adolescents from the white population group contributed 51,9% of deaths from non-natural causes while those from the black African population group recorded 39,5% of deaths from non-natural causes.

Figure 13.2: Percentage distribution of deaths among adolescents by type of death and population group



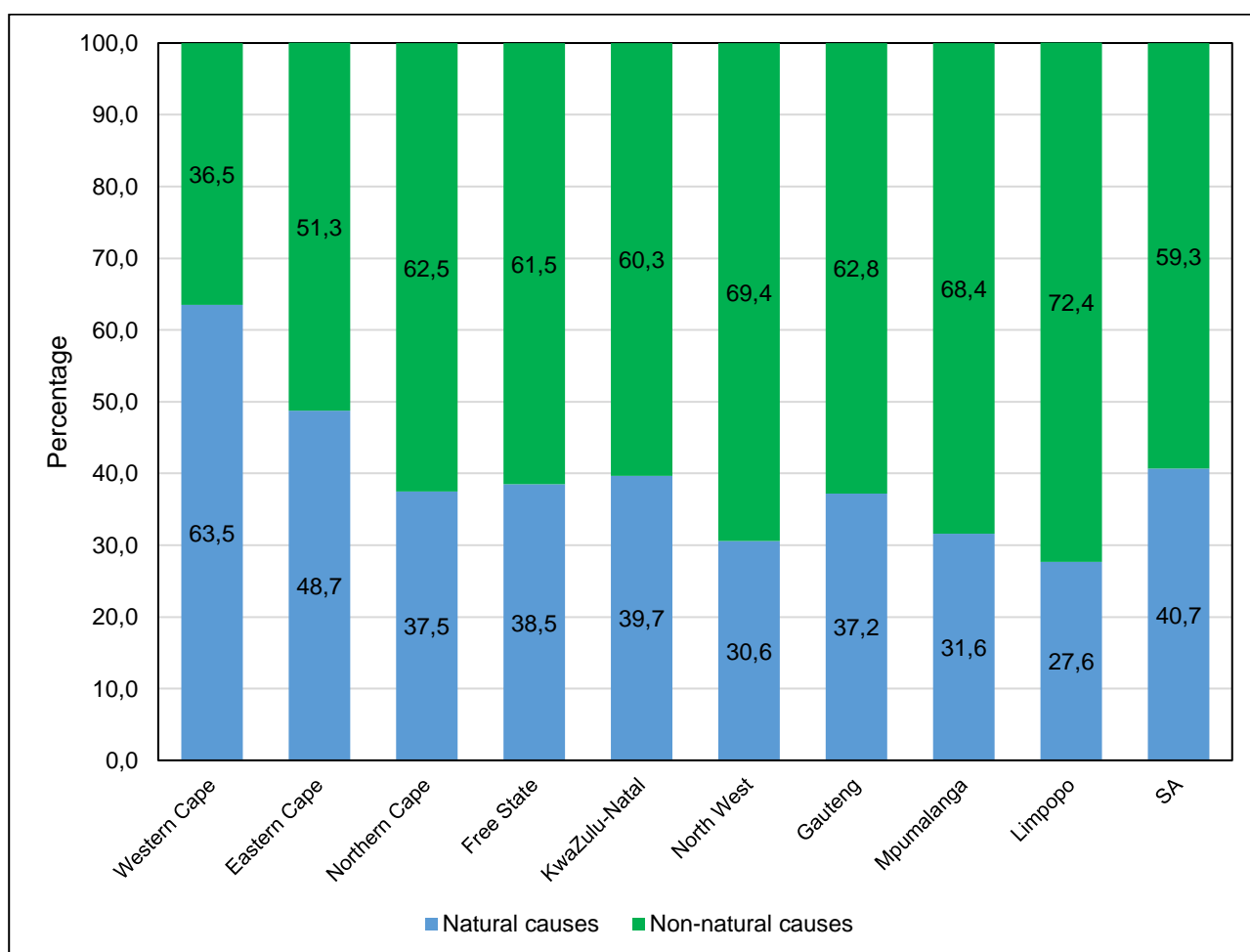
Source: Mortality and causes of death, 2018

13.3 Type of death by province

Figure 13.3 below shows distribution of deaths among adolescents by the type of death (natural or non-natural) and province.

Adolescents died from non-natural causes than natural causes across in South Africa (59,3% vs. 40,7%). Higher percentages of adolescents who died from non-natural causes were observed in Limpopo (72,4%), followed by those in North West at 69,4% and Mpumalanga at 68,4%. Western Cape recorded a lower percentage of those who died from non-natural causes than other provinces at 36,5%.

Figure 13.3: Percentage distribution of deaths among adolescents by type of death and province

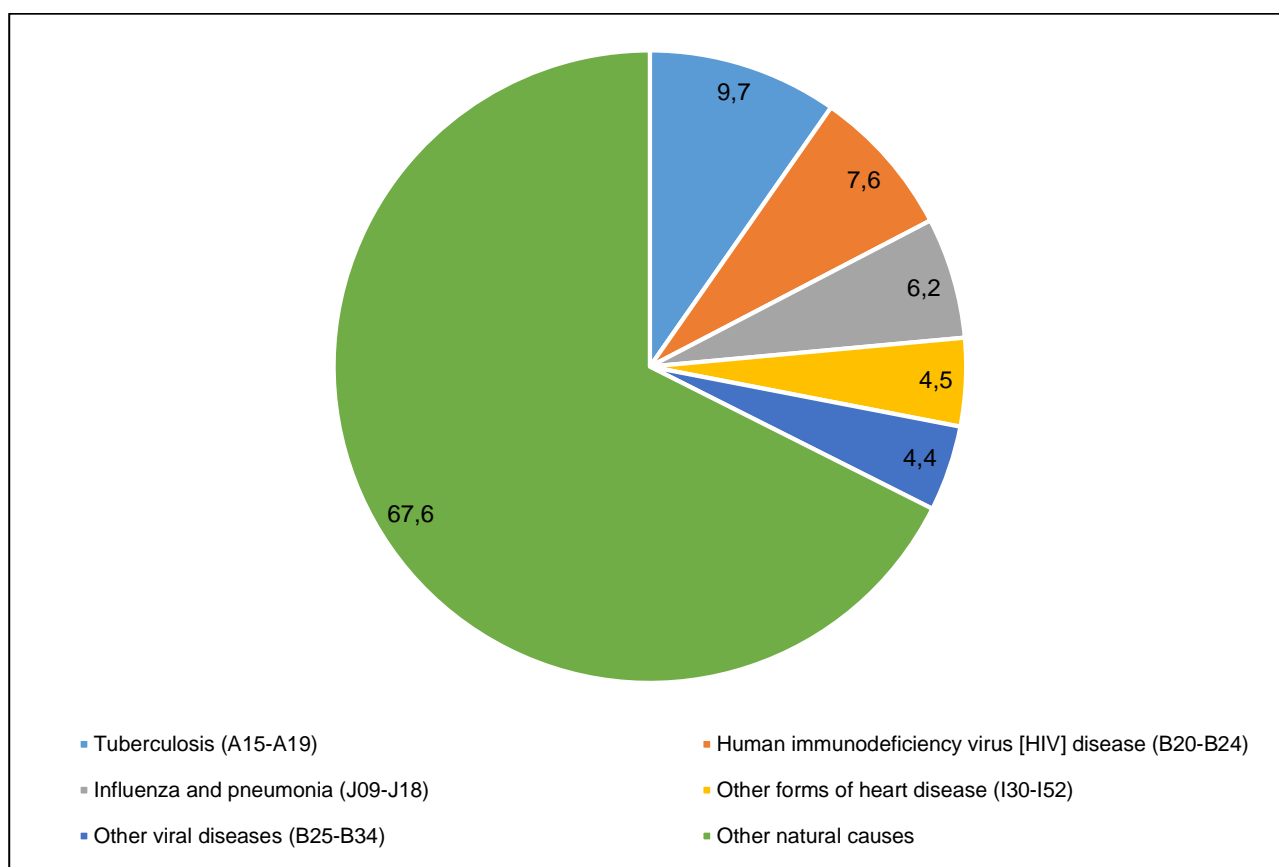


Source: Mortality and causes of death, 2018

13.4 The leading natural causes of death

Figure 13.4 presents the top five leading natural causes of death among adolescents for deaths that occurred in 2018. According to the results, the leading cause of death was tuberculosis (9,5%), followed by human immunodeficiency virus (7,6%), then influenza and pneumonia at 6,2%. Other forms of heart diseases were fourth at 4,5% while other viral diseases were ranked fifth at 4,4%. Other natural causes of death contributed 67,6% to overall adolescent mortality in 2018.

Figure 13.4: The five leading natural causes of death among adolescents (n = 5 820)

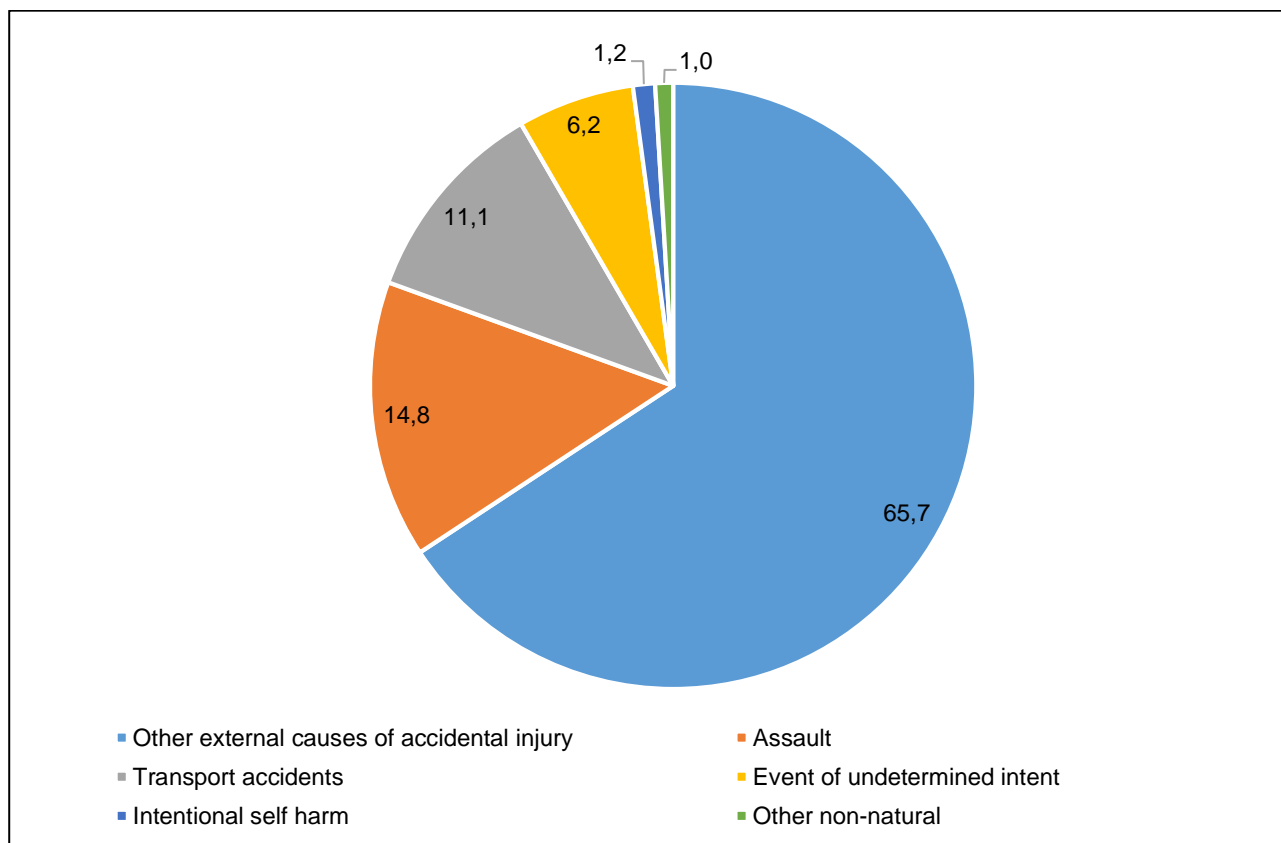


Source: Mortality and causes of death, 2018

13.5 The leading non-natural causes of death

Figure 13.5 presents the top five leading non-natural causes of death among adolescents for deaths that occurred in 2018. The leading non-natural causes of death were other external causes of injury (65,7%), followed by assault (14,8%), transport accidents (11,1%) and event of undetermined intent at 6,2%. Intentional self-harm contributed 1,2% to the non-natural causes of death among adolescents.

Figure 13.5: The five leading non-natural causes of death among adolescents (n = 3 990)



Source: Mortality and causes of death, 2018

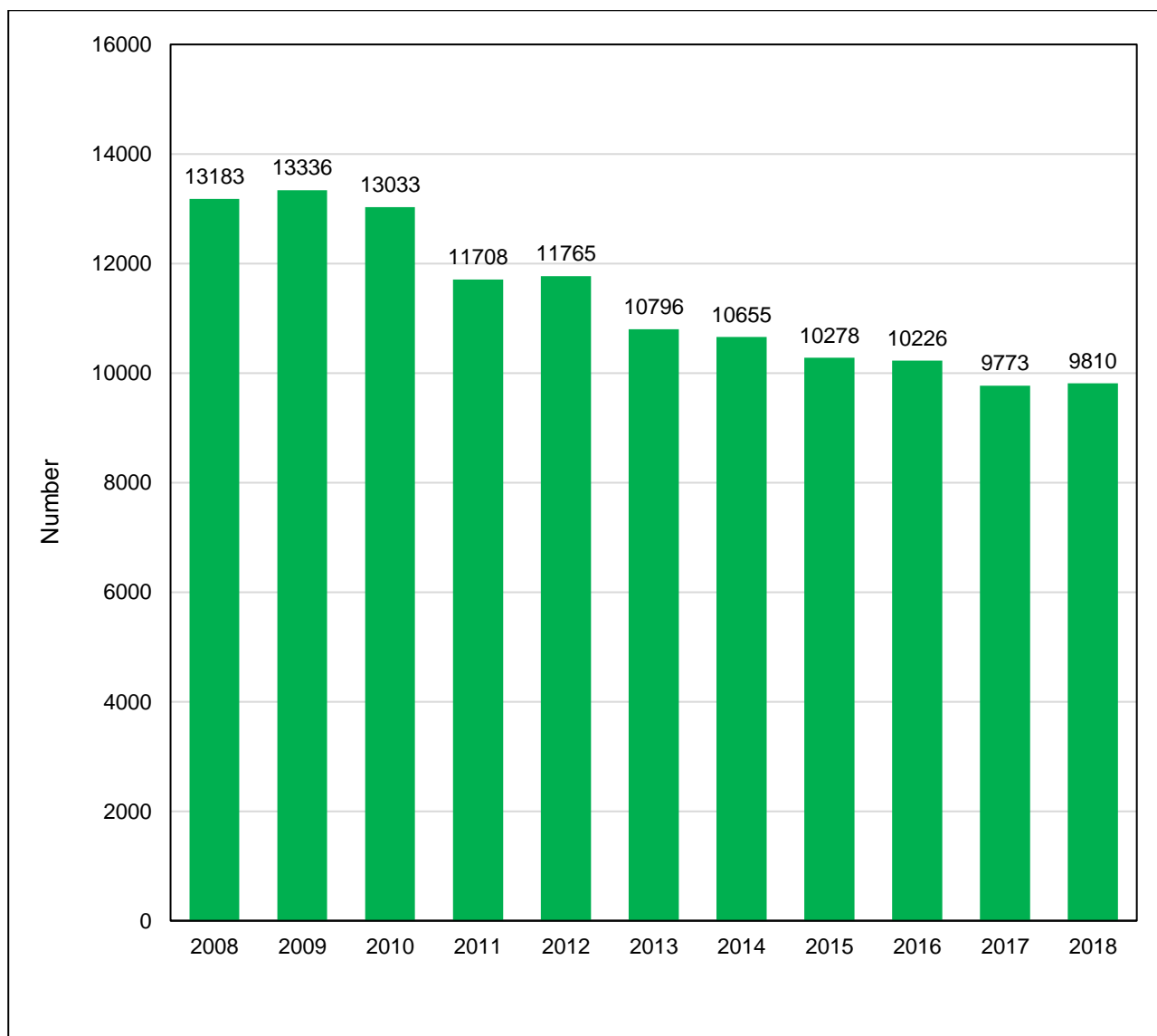
13.6 Summary of mortality

Males died from non-natural causes more than females. Adolescents from all population groups died of non-natural causes with the exception of black Africans. Adolescents in North West, Mpumalanga and Limpopo died of non-natural causes than other provinces. Western Cape was the only province where majority of adolescents died natural causes. The leading natural causes of death among adolescents were tuberculosis, intestinal infections, HIV, influenza and pneumonia, other forms of heart diseases and other viral diseases. The leading non-natural causes of deaths were other external causes of injury, assault, transport accidents, event of undetermined intent and intentional self-harm.

Chapter 14: Trend in mortality

This chapter highlights the total number of deaths among adolescents for the deaths that occurred between 2008 and 2018. Adolescents deaths accounted for 2,1% of all deaths. The trend suggests a decline in adolescent deaths from 13 183 in 2008 to 9 810 in 2018. This represents a 25,5% drop in adolescent deaths over the ten-year period.

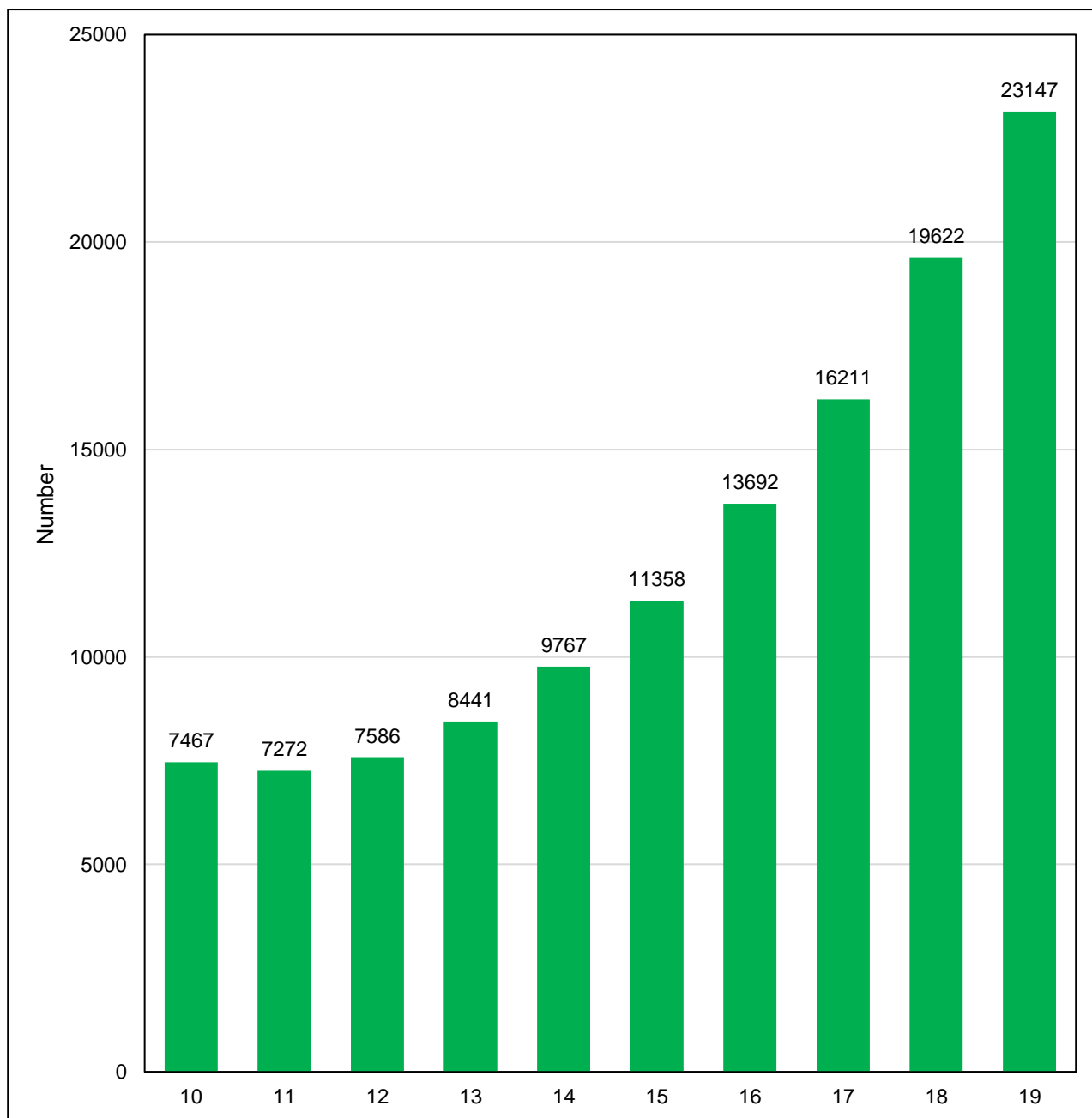
Figure 14.1: Total number of deaths among adolescents by year



Source: Mortality and causes of death, 2008-2018

Figure 14.2 shows the total number of deaths among adolescents in single years between 2008 and 2018. Generally, the number of deaths increased with age from 10 to 19 years, with the highest number occurring among those aged 19 years at 23 147 deaths. At 70%, adolescents aged 15 to 19 years accounted for most adolescent deaths.

Figure 14.2: Number of deaths among adolescents in single years, 10-19 years



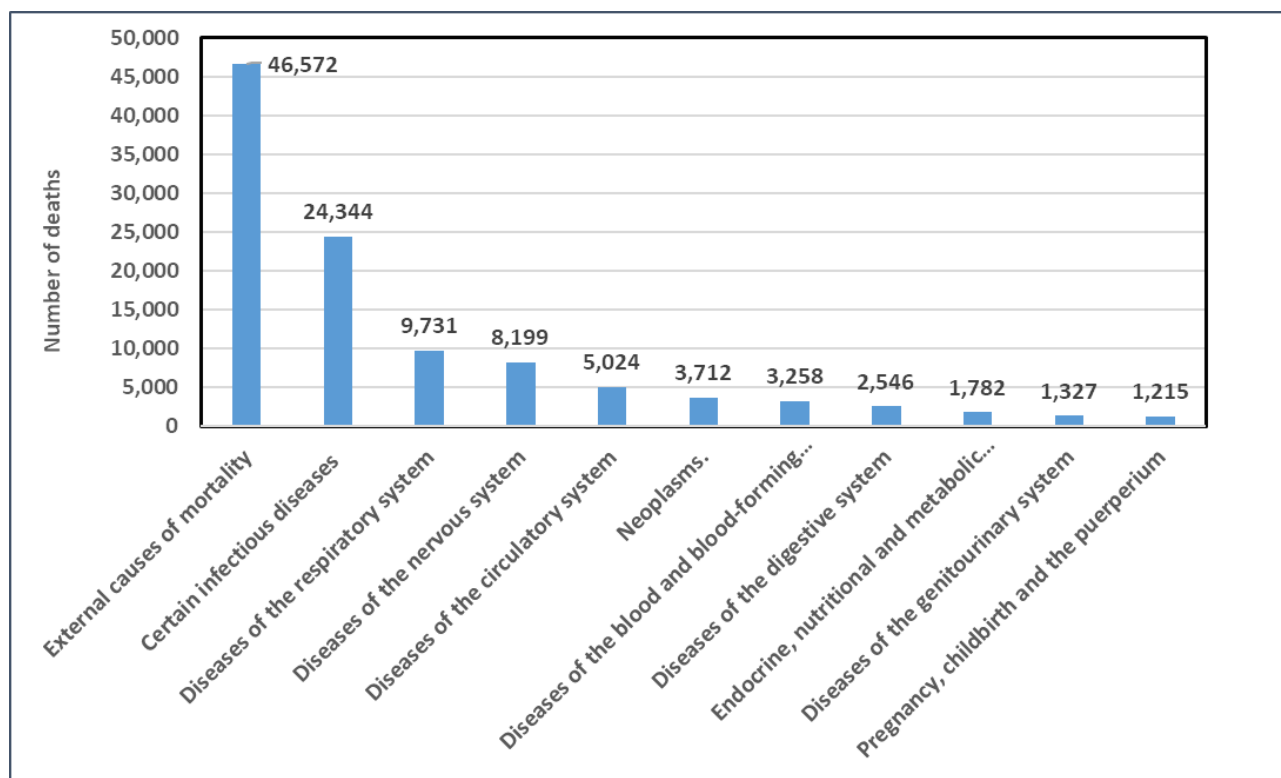
Source: Mortality and causes of death, 2008-2018

Figure 14.3 shows the number of deaths by main group among adolescents between 2008 and 2018. The leading causes of adolescent deaths by main group are external causes of morbidity and mortality (comprising accidents occurring at home or place of residence, assault, contact with an object and traffic accidents). These were followed by certain infectious diseases that included intestinal infectious diseases, tuberculosis and HIV and respiratory system diseases (influenza and pneumonia).

External causes of morbidity and mortality contributed 46 572 deaths (37,4%) to the total number of deaths among adolescents. Certain infectious diseases accounted for 24 344 (19,5%) deaths, and respiratory diseases accounted for 9 731 (7,8%) of adolescent deaths. The highest three main groups of causes of mortality accounted for slightly over 60% of adolescent deaths.

Neoplasms, diseases of the blood and blood forming organs, diseases of the digestive system, endocrine, nutritional diseases of the genitourinary system and those related to pregnancy, childbirth contributed less than 5 000 deaths to the total deaths that occurred to adolescents between 2008 and 2018.

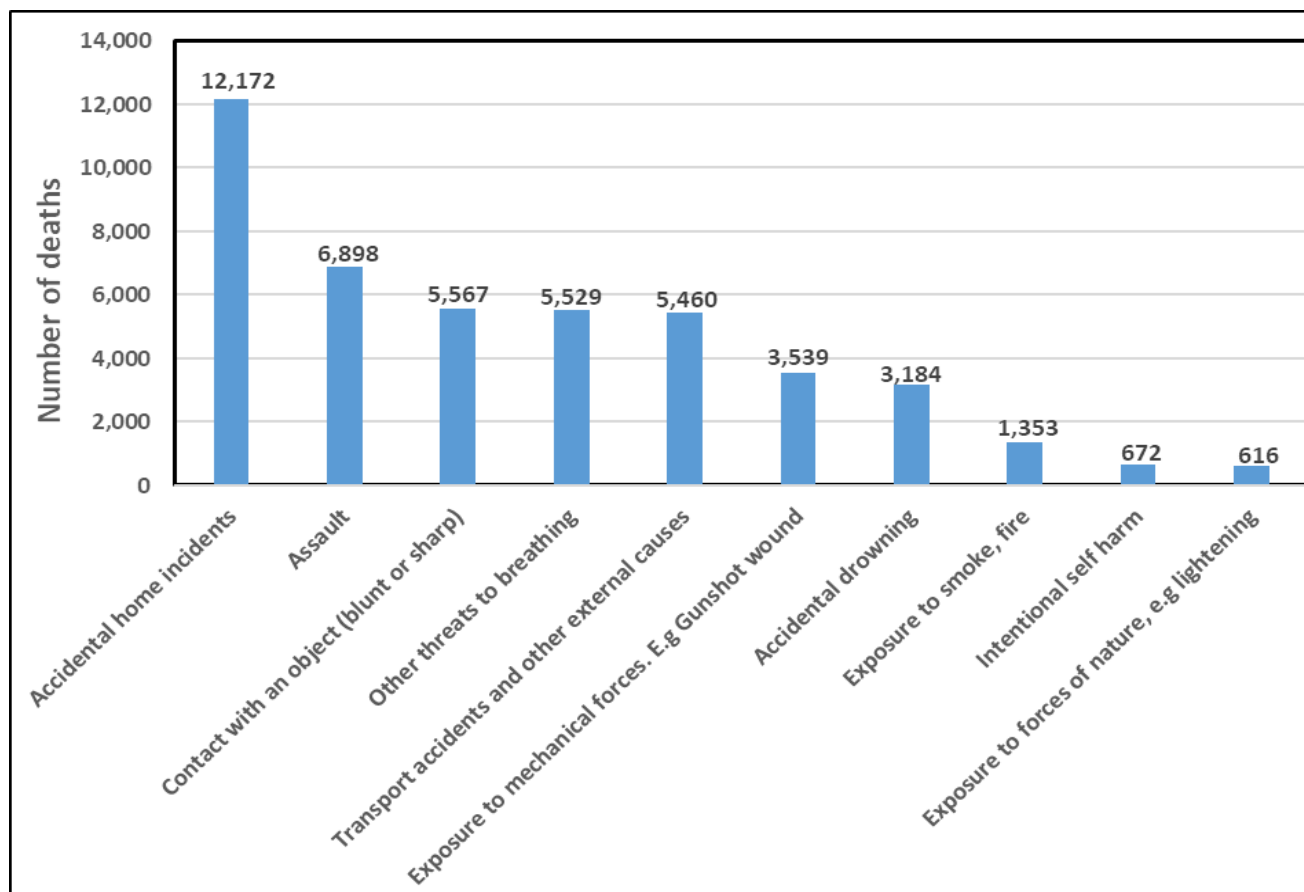
Figure 14.3: Number of deaths among adolescents by main groups



Source: Mortality and causes of death, 2008-2018

Figure 14.4 shows a breakdown of external causes of morbidity and mortality among adolescents. External causes of morbidity and mortality are also classified as non-natural because they are not caused by a medical condition or illness. Accidental incidents occurring at home were the leading external causes of deaths at 12 172 (26,1%), followed by assault at 6 898 (14,8%), contact with an object at 5 529 (11,9%), other threats to breathing at 5 460 (11,7%) and traffic accidents at 3 539 (7,6%). These top five accounted for slightly over 70% of deaths due to external causes of adolescent mortality.

Figure 14.4: Number of deaths from external causes of morbidity and mortality among adolescents



Source: Mortality and causes of death, 2008-2018

Figure 14.5 shows that males accounted for over 80% of deaths due to assault and exposure to mechanical forces such as gunshot wounds.

Figure 14.5: Breakdown of assault and exposure to mechanical forces such as gunshot wounds by sex

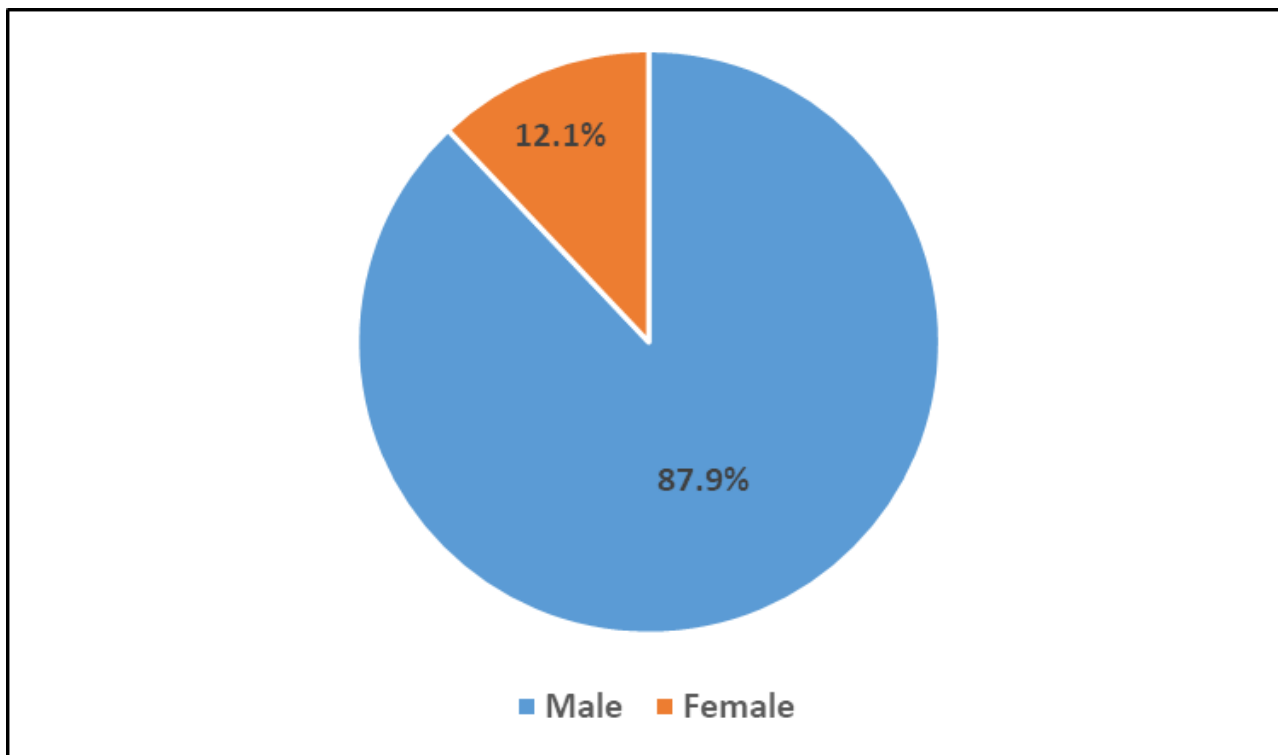
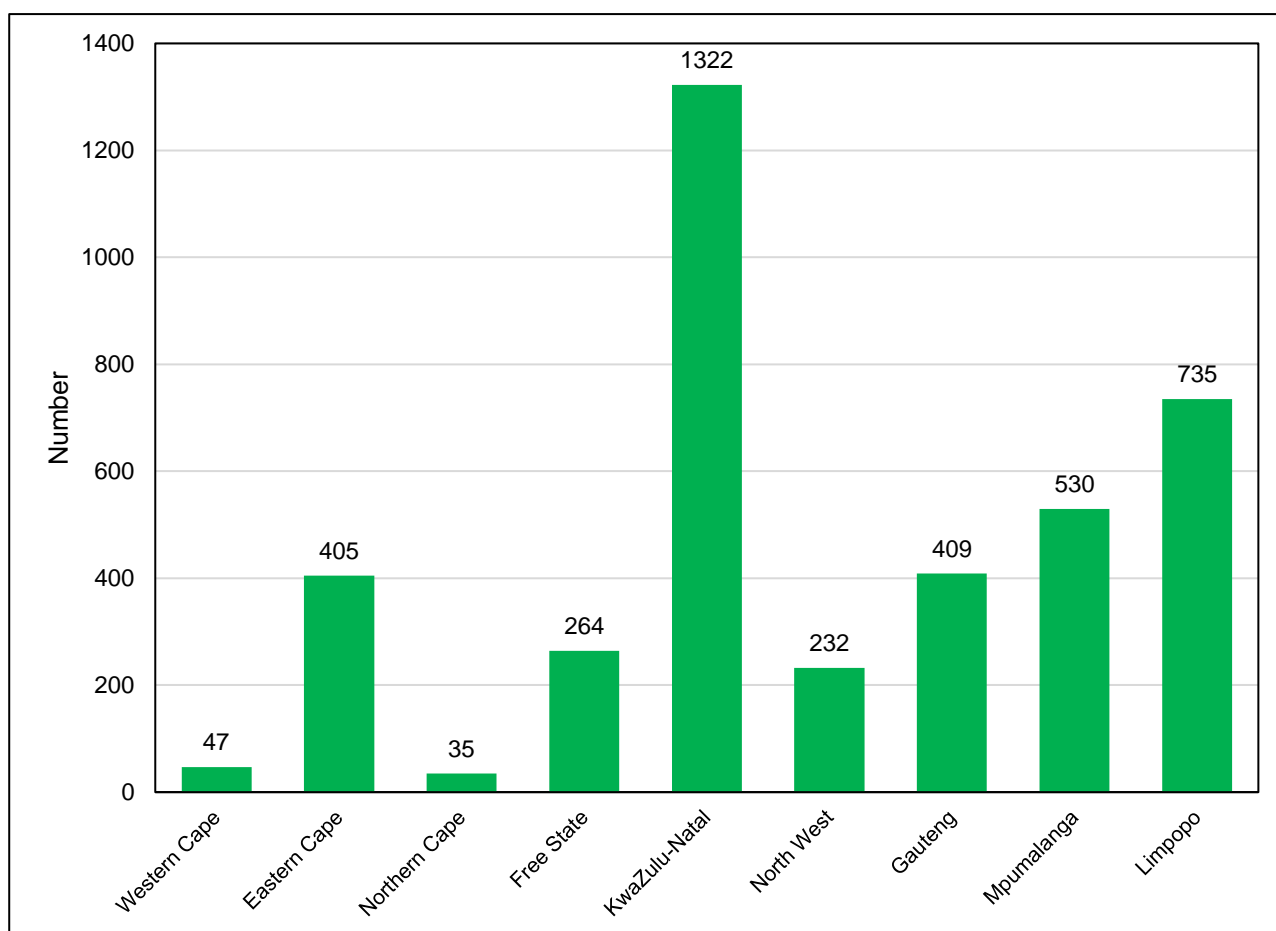


Figure 14.6 shows number of deaths due to intestinal infectious diseases among adolescents between 2008 and 2018. KwaZulu-Natal (1 322), Limpopo (735) and Mpumalanga (530) had the highest number of deaths from intestinal infections, which are largely caused by water-borne diseases. Three provinces were among the leading ones in terms of lack of safe drinking water. Adolescents from Western Cape and Northern Cape had the lowest number of deaths from intestinal infectious diseases.

KwaZulu-Natal is the only province that recorded the number deaths from intestinal infectious diseases above 1 000. It was followed by Limpopo, Mpumalanga, Gauteng and Eastern Cape that reported less than 1 000 but above 500 deaths from intestinal infectious diseases. Western Cape and Northern Cape contributed less than 50 deaths due intestinal infectious diseases among adolescents between 2008 and 2018.

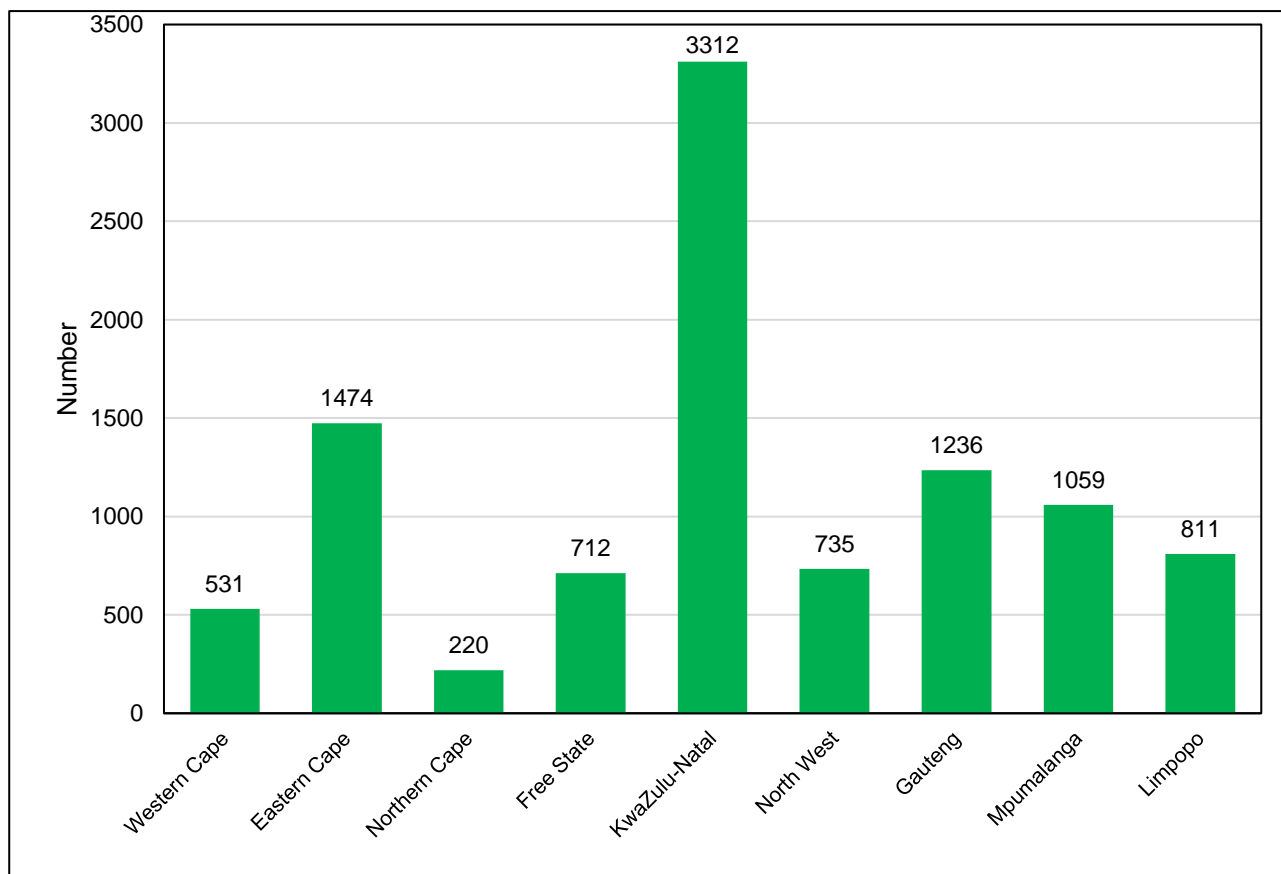
Figure 14.6: Number of deaths from intestinal infectious diseases among adolescents by province



Source: Mortality and causes of death, 2008-2018

Figure 14.7 shows number of deaths due to tuberculosis among adolescents between 2008 and 2018. Tuberculosis was highest in KwaZulu-Natal at 3 312, followed by the Eastern Cape 1 474. Northern Cape had the lowest number was tuberculosis at 220. Tuberculosis deaths in the remaining provinces were less than 1 000.

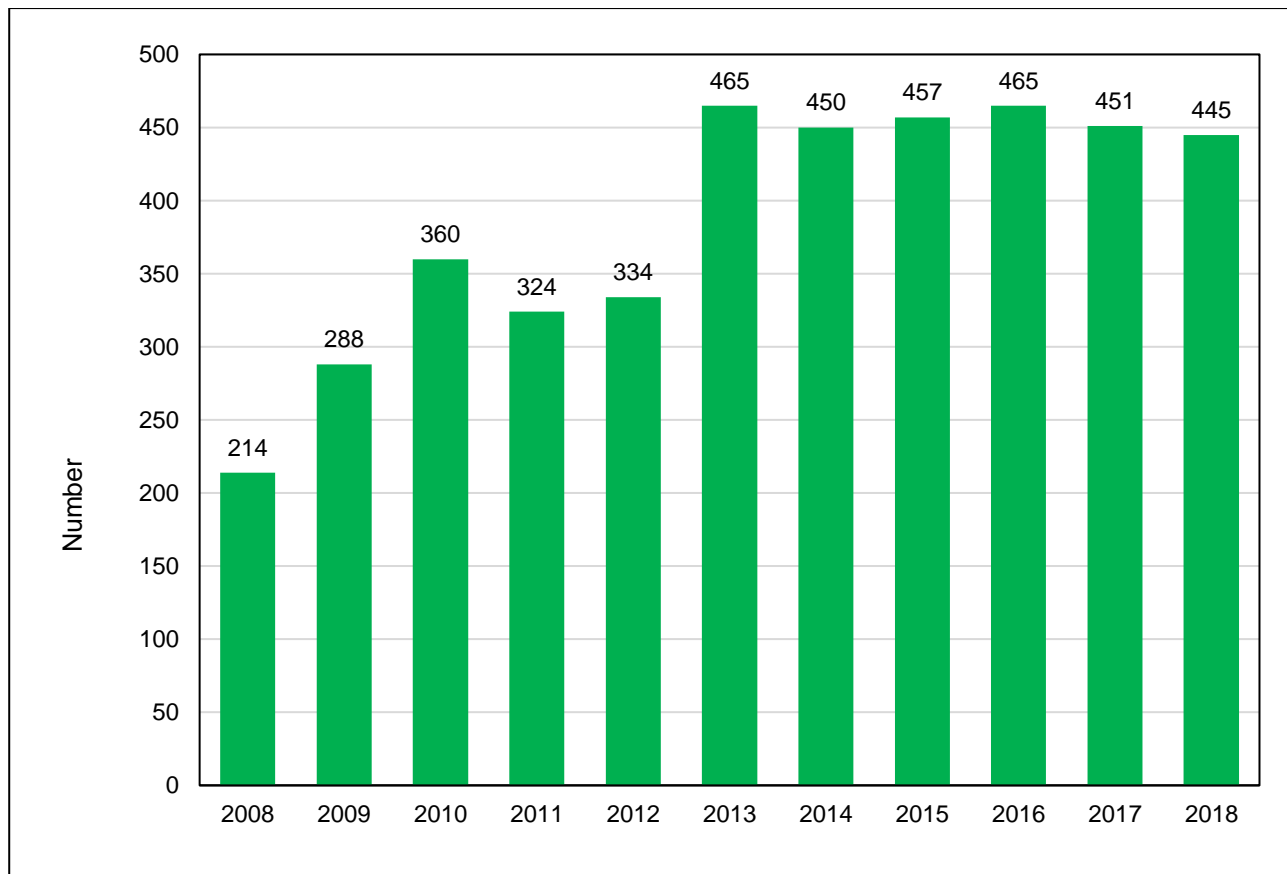
Figure 14.7: Number of deaths from tuberculosis among adolescents by province



Source: Mortality and causes of death, 2008-2018

Figure 14.8 shows number of deaths from Human Immunodeficiency Virus (HIV) among adolescents between 2008 and 2018. There was a steady increase in the number of deaths between 2008 and 2010, from 214 to 360 cases. For the remaining period, deaths due to HIV remained stable at an average of 456 cases per year.

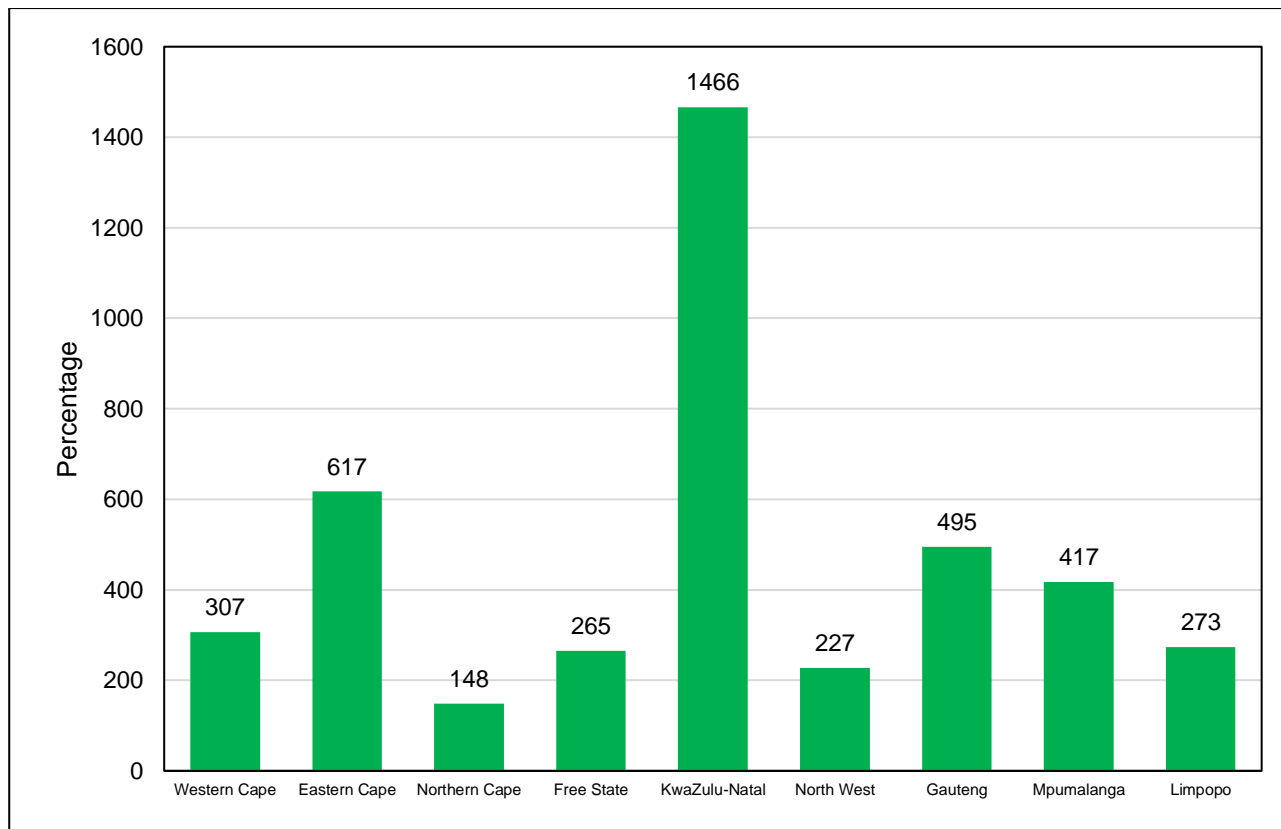
Figure 14.8: Number of deaths from HIV among adolescents by year



Source: Mortality and causes of death, 2008-2018

Figure 14.9 shows the distribution of deaths due to Human Immunodeficiency Virus among adolescents by province. KwaZulu-Natal had higher HIV deaths at 1 466 cases due to HIV, followed by Eastern Cape with 617 cases. Northern Cape recorded low HIV deaths with 148 cases.

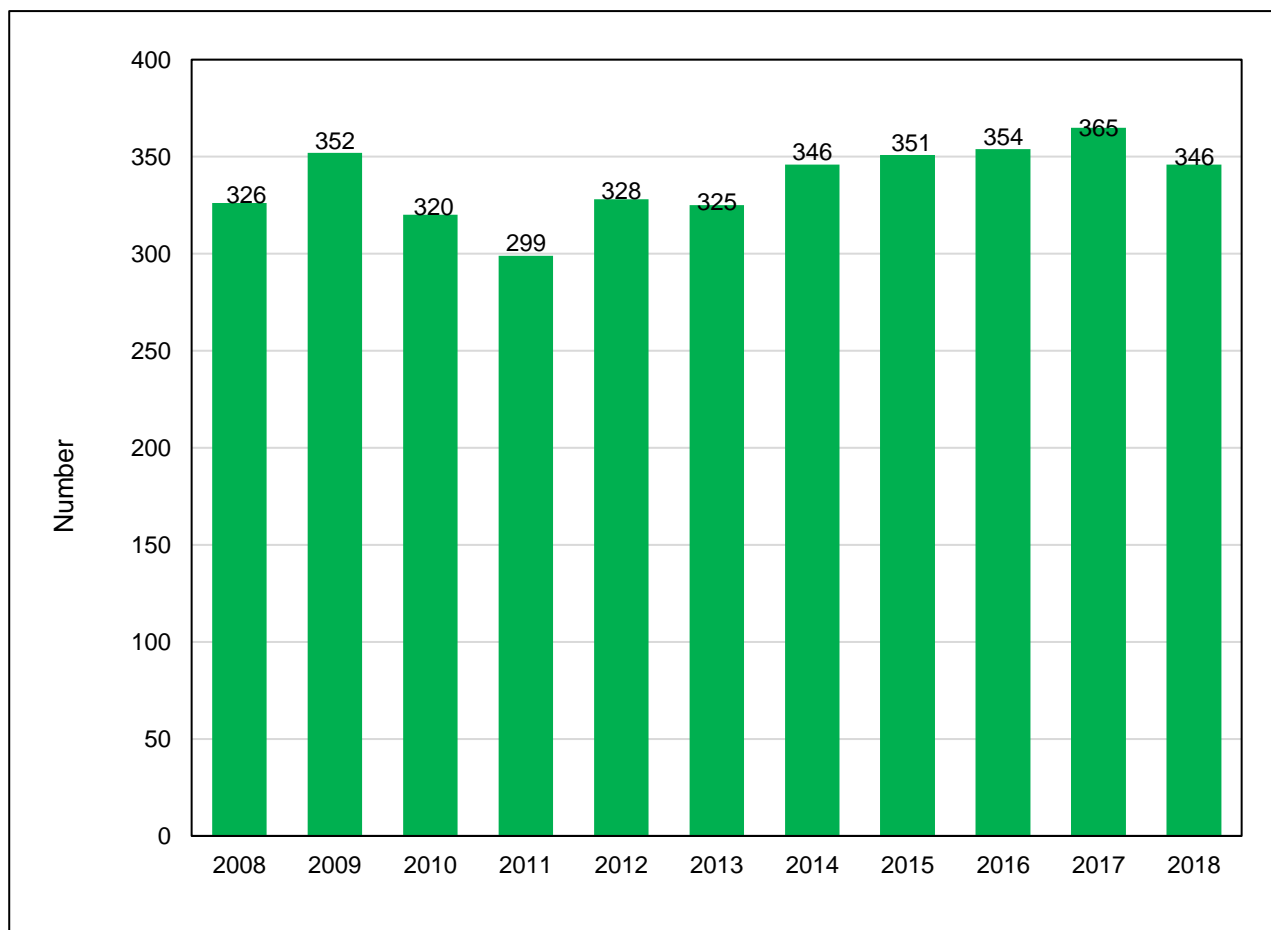
Figure 14.9: Number of deaths from HIV among adolescents by province



Source: Mortality and causes of death, 2008-2018

Figure 14.10 shows number of deaths due to malignant neoplasms among adolescents between 2008 and 2018. A malignant neoplasm is defined as a cancerous tumour, an abnormal growth that can grow uncontrolled and spread to other parts of the body. Deaths due to malignant neoplasms among adolescents have remained below 400 between 2008 and 2018.

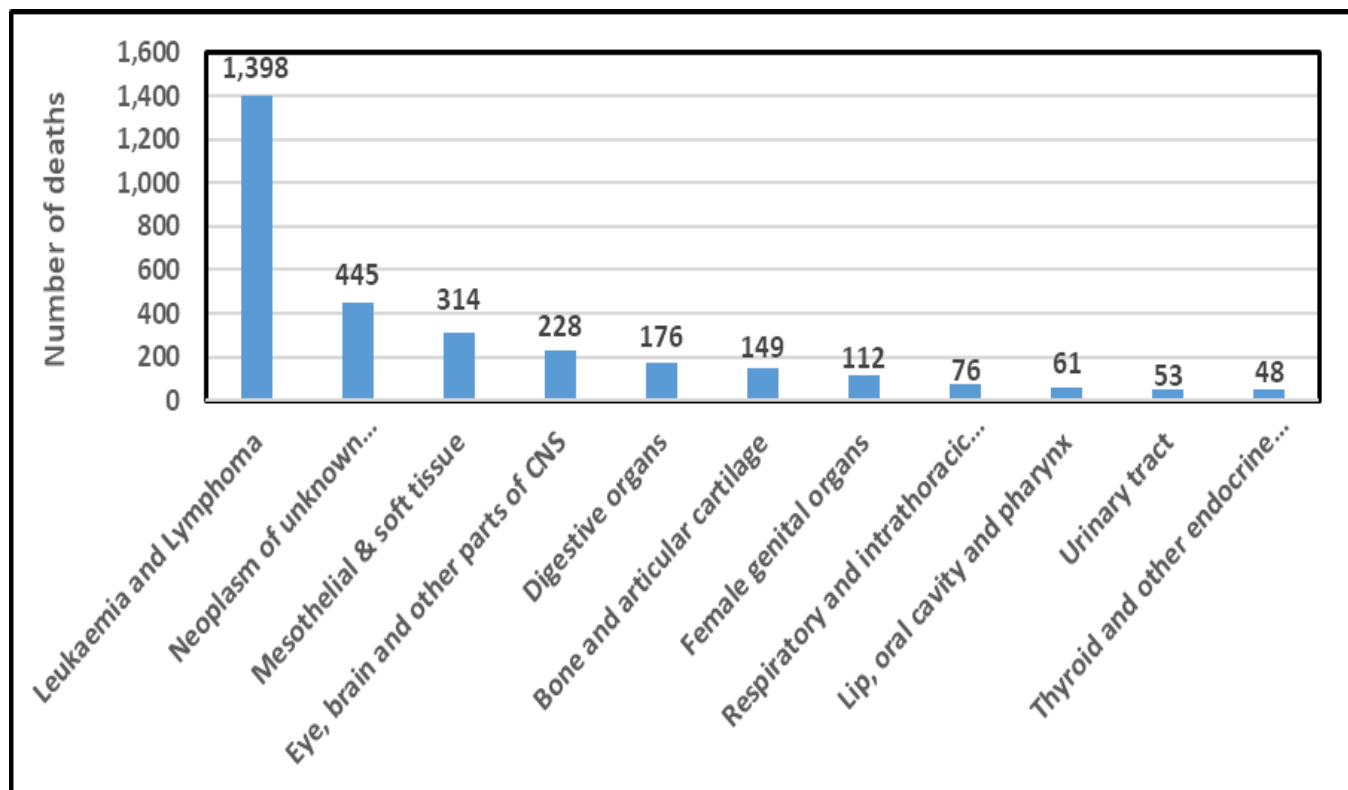
Figure 14.10: Number of deaths from malignant neoplasms among adolescents by year



Source: Mortality and causes of death, 2008-2018

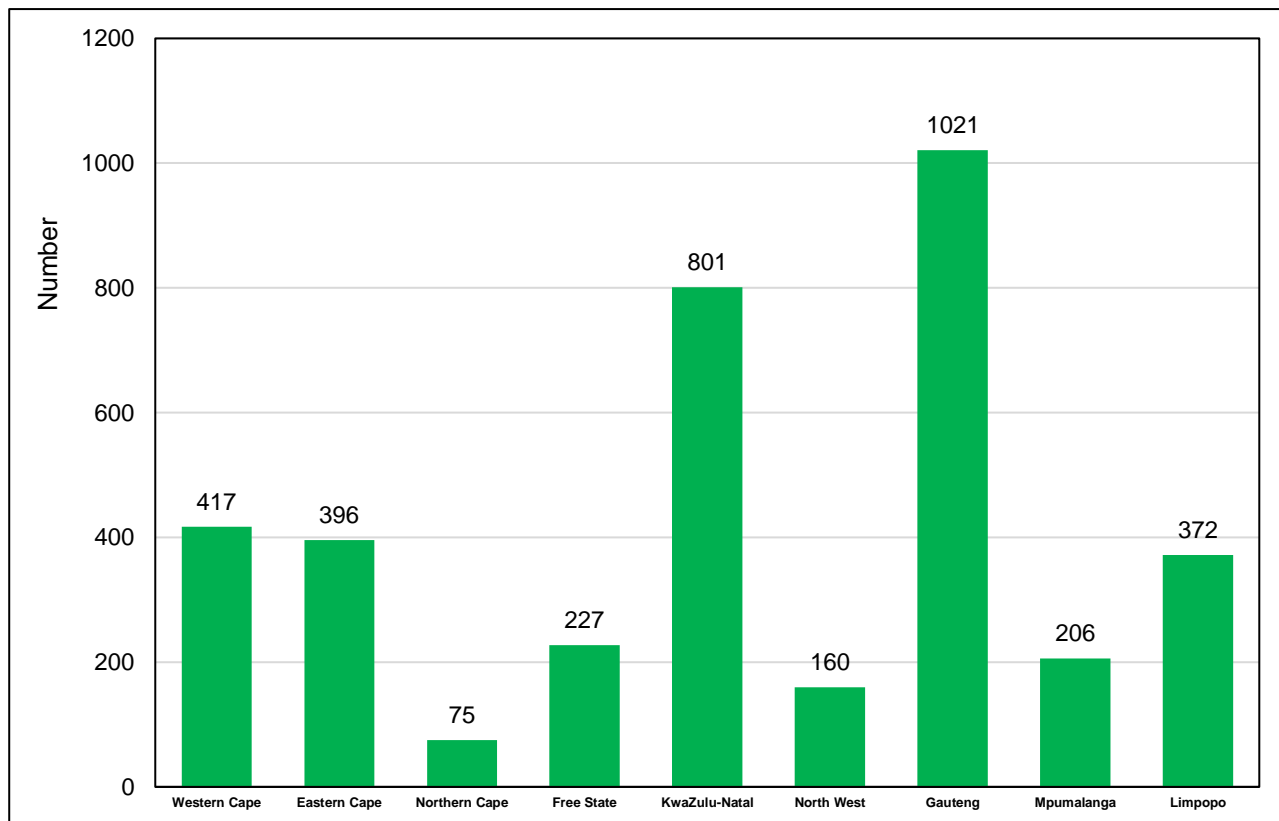
Figure 14.11 gives a breakdown of deaths due to neoplasms among adolescents by site. Neoplasms of the blood and blood-forming organs, leukaemia and lymphoma accounted for the majority, 1 398 (44,3%) of deaths. Neoplasms of unknown origin accounted for 445 (16,2%) and mesothelial and soft tissue, 314 (14,1%). These three groups accounted for slightly over 70% of malignant neoplasms among adolescents.

Figure 14.11: Number of deaths among adolescents from neoplasms by site



Most deaths due to malignant neoplasms occurred in Gauteng and KwaZulu-Natal, which contributed approximately 50% of deaths due to neoplasms among adolescents.

Figure 14.12: Number of deaths from neoplasms among adolescents by province



Source: Mortality and causes of death, 2008-2018

Chapter 15: Overall summary

Annual thematic health reports assist policy makers in the improvement of the well-being and health of people in the country.

Adolescents contributed 17% to the overall population of South Africa but at 2,1%, accounted for a much smaller proportion of deaths, reflecting relatively good health.

In terms of access to water and sanitation, less than 10% of households in South Africa are without access to safe/improved drinking water. Eastern Cape, Limpopo and Mpumalanga have higher than 10% of household with no access to safe/ and improved drinking water. About 20% of households with adolescents in the country do not have access to acceptable/improved sanitation, with Limpopo, Mpumalanga and North West recording higher percentages with no access to acceptable/improved sanitation.

The report indicates that poverty among children less than 18 years decreased between 2006 and 2015. Children less than 18 years from the black African and coloured population groups and provinces such as Eastern Cape, Limpopo, KwaZulu-Natal, North West and Northern Cape live below the national median income.

Less than 20% of the adolescents in South Africa had medical aid in 2019. Adolescents from coloured and black African population groups had the lowest medical aid coverage. A breakdown by province showed that adolescents from KwaZulu-Natal, Limpopo, and Eastern Cape provinces had the lowest medical aid coverage.

The main reason adolescents did not consult a health worker when they were ill was that they self-medicated. Female adolescents and those from the black Africans and coloured population groups had the lowest percentage of adolescents who consulted when they were sick. Free State had the lowest percentage of adolescents who consulted when they were sick.

Adolescent girls are at risk of early pregnancy and motherhood. Due to social and biological factors, adolescent mothers have a higher risk of adverse outcomes. KwaZulu-Natal reported a higher percentage of both births registered at Home Affairs and those that were delivered in public health facilities. Northern Cape was the lowest in terms of births registered at the Department of Home Affairs and those that were delivered in public health facilities.

Termination of pregnancy (TOP) is legal in South Africa, and some adolescents opted to terminate their pregnancies, which suggests an unmet need for contraception among young people. Limpopo reported the highest rates of TOP for 2017, 2018 and 2019. TOP was seen to consistently increase in the Western Cape, Free State, North West and Limpopo.

Hodgkin's lymphoma and bone cancer were among cancers that adolescents were diagnosed with, while malignant neoplasms without specification of site were the leading cause of cancer deaths among adolescents for 2016 to 2018.

Medical male circumcision (MMC) was more common in Gauteng for 2019 and 2020, and less practised in Western Cape for 2019 and Eastern Cape and North West for 2020.

Mental health visits were calculated for children less than 18 years. Gauteng recorded higher percentages of mental health visits for both 2019 and 2020. Eastern Cape, Northern Cape and Limpopo had lower percentages of children less than 18 years who visited a mental health service or facility for both years.

Traffic accidents were the 5th leading cause of mortality among adolescents. Males were more likely to die from road traffic accidents than their female counterparts. KwaZulu-Natal and Eastern Cape accounted for most of the road traffic fatalities. The number of road traffic fatalities increased in the Western Cape, Eastern Cape and Gauteng but decreased in KwaZulu-Natal and Mpumalanga. More than half of fatalities were pedestrians in Western Cape, KwaZulu-Natal, North West, Gauteng and Mpumalanga. There were less road traffic fatalities among adolescents categorised as drivers.

External, or non-natural causes of death accounted for most of the mortality among adolescents. Higher percentages of males than females died from violence-related causes such as assault and gunshot wounds. Adolescents in North West, Mpumalanga and Limpopo died of non-natural causes more than those from other provinces.

Appendices

Appendix A: Demographic information

Appendix A1: Number of adolescents within each sex, MYPE 2020

Sex	Male	Female	Total
Adolescents	5 224 648	5 141 484	10 366 132
Others	23 904 227	25 351 991	49 256 218
Total	29 128 875	30 493 475	59 622 350

Appendix A2: Number of adolescents within each population group, MYPE 2020

Population group	Adolescents	Other	Total
Black African	8 805 474	39 348 253	48 153 727
Coloured	867 769	4 379 971	5 247 740
Indian/Asian	183 415	1 357 698	1 541 113
White	509 474	4 170 296	4 679 770

Appendix A3: Number of adolescents within each province, MYPE 2020

Province	Adolescents	Others	Total
Western Cape	1 077 210	5 928 531	7 005 741
Eastern Cape	1 364 364	5 369 637	6 734 001
Northern Cape	233 095	1 059 691	1 292 786
Free State	540 438	2 388 465	2 928 903
KwaZulu-Natal	2 180 556	9 351 072	11 531 628
North West	726 792	3 382 025	4 108 816
Gauteng	2 180 529	13 307 608	15 488 137
Mpumalanga	858 829	3 820 957	4 679 786
Limpopo	1 204 320	4 648 233	5 852 553

Appendix B: Determinants of health**Appendix B1: Number of households with and without access to safe/improved water, GHS 2019**

Province	Household with access to safe/improved drinking water	Household without access to safe/improved drinking water	Total
Western Cape	934 431	13 786	948 217
Eastern Cape	850 489	398 891	1 249 380
Northern Cape	235 483	7 070	242 553
Free State	551 520	19 503	571 023
KwaZulu-Natal	1 699 018	447 907	2 146 925
North West	658 369	64 019	722 388
Gauteng	2 374 252	26 433	2 400 686
Mpumalanga	883 851	93 182	977 033
Limpopo	1 136 062	124 339	1 260 401
South Africa	9 323 476	1 195 130	10 518 606

Appendix B2: Number of households with and without access to acceptable/improved sanitation, GHS 2019

Province	Households with access to acceptable/improved sanitation	Households without access to acceptable/improved sanitation	Total
Western Cape	910 610	37 607	948 217
Eastern Cape	1 081 983	167 397	1 249 380
Northern Cape	203 050	39 503	242 553
Free State	446 892	124 131	571 023
KwaZulu-Natal	1 668 783	478 142	2 146 925
North West	491 419	230 969	722 388
Gauteng	2 217 214	183 472	2 400 686
Mpumalanga	616 451	360 582	977 033
Limpopo	778 359	482 041	1 260 401
South Africa	8 414 762	2 103 844	10 518 606

Appendix C: Medical aid coverage**Appendix C1: Number of medical aid coverage among adolescents by sex, GHS 2019**

Sex	Medical aid	No medical Aid	Do not know	Total
Male	763 092	4 307 209	3 179	5 073 481
Female	748 491	4 331 976	5 683	5 086 151
South Africa	1 511 584	8 639 186	8 862	10 159 631

Appendix C2: Number of medical aid coverage among adolescents by population group, 2019

Population group	Medical aid	No medical Aid	Do not know	Total
Black African	869 584	7 758 178	8 862	8 636 624
Coloured	174 813	675 772	0	850 585
Indian/Asian	100 336	76 258	0	176 595
White	366 850	128 977	0	495 828
South Africa	1 511 584	8 639 186	8 862	10 159 631

Appendix C3: Number and percentage of medical aid coverage among adolescents by province, 2019

Province	No medical aid		Medical aid		Total per province
Western Cape	798 011	77,8	227 414	22,2	1 025 425
Eastern Cape	1 205 121	91,2	115 960	8,8	1 321 081
Northern Cape	178 215	80,0	44 612	20,0	222 827
Free State	439 193	85,6	73 721	14,4	512 914
KwaZulu-Natal	1 975 660	89,5	231 583	10,5	2 207 243
North West	615 849	87,4	89 114	12,6	704 963
Gauteng	1 629 768	75,9	516 288	24,1	2 146 056
Mpumalanga	749 287	87,9	102 969	12,1	852 256
Limpopo	1 056 944	90,6	109 922	9,4	1 166 866
South Africa	8 648 048	85,1	1 511 583	14,9	10 159 631

Appendix D: Health seeking behaviour

Appendix D1: Number of adolescents who consulted or did not consult by sex, GHS 2019

Sex	Did consult	Did not consult	All
Male	206 218	233 917	440 136
Female	229 247	228 556	457 803
South Africa	435 466	462 473	897 939

Appendix D2: Number of adolescents who consulted or did not consult by population group, GHS 2019

Population group	Did consult	Did not consult	All
Black Africans	375 388	422 325	797 713
Coloured	31 219	33 726	64 945
White	26 691	6 028	32 719
South Africa	435 466	462 473	897 939

Appendix D3: Number of adolescents who consulted or did not consult by province, GHS 2019

Province	Did consult	Did not consult	All
Western Cape	29 871	39 731	69 603
Eastern Cape	66 569	42 550	109 118
Northern Cape	15 940	15 293	31 233
Free State	20 877	45 252	66 129
KwaZulu-Natal	64 264	69 915	134 179
North West	21 800	40 173	61 973
Gauteng	133 143	115 016	248 159
Mpumalanga	49 097	42 842	91 939
Limpopo	33 903	51 703	85 606
South Africa	435 466	462 473	897 939

Appendix D4: Number and percentage of reasons for non-consultation among adolescents, GHS 2019

Reason	Number	Percentage
Self-medication	326 710	70,6
Not necessary	115 650	25,0
Queues too long	5 947	1,3
Too expensive	5 230	1,1
Too far	5 177	1,1
Fear of stigmatization	1 889	0,4
Do not know	961	0,2
Other	702	0,2
Experiencing difficulty getting a diagnosis	208	0,0
Total	462 473	100,0

Appendix E: Mental health visits**Appendix E1: Number of mental health visits among children below 18 years, DHIS 2019–2020**

Province	2019	2020
Western Cape	14 805	11 000
Eastern Cape	10 484	10 621
Northern Cape	1 952	1 859
Free State	17 342	10 039
KwaZulu-Natal	28 661	24 353
North West	9 688	10 079
Gauteng	56 354	52 423
Mpumalanga	12 735	8 103
Limpopo	8 458	9 401
South Africa	160 479	137 878

Appendix F: Road traffic fatalities

Appendix F1: Number of road traffic fatalities among adolescents by sex, RTMC 2018–2020

Sex	2018	2019	2020	Total
Female	220	203	145	568
Male	485	419	314	1 191
Unknown	4	3	7	14
Total	709	625	466	1 800

Appendix F2: Number of road traffic fatalities among adolescents by population group, RTMC 2018–2020

Population group	2018	2019	2020
Black/African	584	527	371
Coloured	71	50	58
White	36	25	25
Asian	10	12	5
Foreigner	6	10	3
Other	2	1	4
South Africa	709	625	466

Appendix F3: Number of road traffic fatalities among adolescents by province, RTMC 2018–2020

Province	2018	2019	2020
Western Cape	65	69	60
Eastern Cape	119	109	73
Northern Cape	32	28	15
Free State	56	31	47
KwaZulu-Natal	163	138	86
North West	40	34	27
Gauteng	82	74	63
Mpumalanga	71	53	37
Limpopo	81	89	58
South Africa	709	625	466

Appendix F4: Number of road traffic fatalities among adolescents by type of road user, RTMC 2018–2020

Province	Cyclist	Driver	Passenger	Pedestrian	Total
Western Cape	13	7	68	106	194
Eastern Cape	4	7	147	143	301
Northern Cape	6	0	44	25	75
Free State	1	8	67	58	134
KwaZulu-Natal	7	14	132	234	387
North West	4	5	32	60	101
Gauteng	14	18	72	115	219
Mpumalanga	6	7	64	84	161
Limpopo	7	13	113	95	228
South Africa	62	79	739	920	1 800

Appendix G: Causes of death

Appendix G1: Number of deaths among adolescents by type of death and sex, MACOD 2018

Type of death	Male	Female
Natural causes	2 833	2 969
Non-natural causes	2 866	1 117
Total	5 699	4 086

Appendix G2: Number of deaths among adolescents by type of death and population group, MACOD 2018

Population group	Natural causes	Non-natural causes	Total
Black African	4 665	3 048	7 713
Coloured	231	358	589
Indian or Asian	38	51	89
White	76	82	158

Appendix G3: Number of deaths among adolescents by type of death and province, MACOD 2018

Province	Natural causes	Non-natural causes	Total
Western Cape	299	520	819
Eastern Cape	796	757	1 553
Northern Cape	162	97	259
Free State	347	217	564
KwaZulu-Natal	1 429	940	2 369
North West	415	183	598
Gauteng	950	563	1 513
Mpumalanga	530	245	775
Limpopo	686	262	948
South Africa	5 820	3 990	9 810

Appendix G4: Number and percentage of deaths among adolescents, MACOD 2008-2018

Year of death	Total number of deaths	Number of adolescents deaths	Percent of deaths
2008	613 508	13 183	2,1
2009	598 697	13 336	2,2
2010	567 074	13 033	2,3
2011	532 575	11 708	2,2
2012	510 624	11 765	2,3
2013	492 826	10 796	2,2
2014	493 027	10 655	2,2
2015	489 077	10 278	2,1
2016	485 396	10 226	2,1
2017	473 044	9 773	2,1
2018	466 927	9 810	2,1

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