Determinants of health among the youth aged 15–34 years in South Africa

Embargoed until:
11 March 2020
12:00

Statistics South Africa

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Report No. 03-00-15

Determinants of health among the youth aged 15–34 years in South Africa / Statistics South Africa

Published by Statistics South Africa, Private Bag X44, Pretoria 0001

Stats SA Library Cataloguing-in-Publication (CIP) Data
Determinants of health among the youth aged 15–34 years in South Africa / Statistics South Africa. Pretoria: Statistics South Africa, 2020

Report no. 03-00-15
pp62

ISBN 978-0-621-48110-5

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Preface

This annual report focuses on determinants of health and causes of death among the South African youth aged 15–34 using the health information available from household surveys, administrative data, Stats SA outputs and other external sources. The South Africa Demographic and Health Survey (SADHS) 2016, General Household Survey (GHS) 2018, and Mortality and Causes of Death (MACOD) 2016 are the main sources used in preparing the report.

Determinants of health are defined as factors that affect people's chances of maintaining good health (WHO, 2017 and Viner, 2012). Determinants that are known to affect young people's health and well-being among others are education, income, population group, employment and sexual orientation (WHO, 2017). In addition, health behaviour and risk behaviour are among key aspects affecting the health of young people (WHO, 2012). Health aspects pertaining to the youth mostly focus on the communicable disease profile as well as behavioural aspects that impact on their health, as shown by the causes of death among the youth.

Young people are often neglected in the area of health statistics, as they are sometimes categorised as younger children or as young adults (WHO, 2012). The statistics presented in this report are critical in informing health planners and programmes focusing on health promotion as the country strives to address the burden of diseases among the youth. Using statistics for evidence-based decision-making, efforts need to be commissioned with regard to prevention programmes and the promotion of a healthy lifestyle, targeted at persons of all ages.

Findings from this report will provide insights into the burden of diseases among the youth population in South Africa. The report will also provide a deeper understanding on the impact of selected determinants affecting the well-being of young people in South Africa. In addition, this analytical work will contribute to intellectual debates and discourse on the youth and their health, which are critical for policy review and interventions.

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Statistician-General

Abbreviations and acronyms

AIDS	Acquired immunodeficiency syndrome
AU	African Union
AYC	African Youth Charter
CHoCOR	Culpable Homicide Crash Observation Report
DHA	Department of Home Affairs
DHET	Department of Higher Education and Training
DHIMS	District Health Information Management System
DoE	Department of Basic Education
GHS	General Household Survey
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
IHME	Institute for Health Metrics and Evaluation
ILO	International Labour Organization
IOM	Institute of Medicine
IQ	Intelligence Quotient
IUD	Intrauterine Device
MACOD	Mortality and Causes of Death
MYPE	Mid-Year Population Estimates
NDoH	National Department of Health
NDP	National Development Plan
NIDA	National Institute on Drug Abuse
NIDS	National Indicator Data Set
NIMSS	National Injury Mortality Surveillance System
NRC	National Research Council
NSC	National Senior Certificate
NYDA	National Youth Development Agency
NYP	National Youth Policy
RTMC	Road Traffic Management Corporation
SADHS	South Africa Demographic and Health Survey
SAFMH	South African Federation for Mental Health
SAMHSA	Substance Abuse and Mental Health Services Administration
SAMJ	South African Medical Journal
SAMRC	South African Medical Research Council
SAPS	South African Police Service
SDGs	Sustainable Development Goals
SMME	Small, Medium and Micro-Enterprise
SSA	Sub-Saharan Africa
STATS SA	Statistics South Africa
STI	Sexually Transmitted Infection
TOP	Termination of Pregnancy
UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organization
YES	Youth Employment Service

Chapter 1: Introduction

1.1 Background

Thematic reports form part of a series of health reports produced by Statistics South Africa (Stats SA) on an annual basis. This particular report is one of the annual thematic reports and it focuses on the youth. The United Nations defines the youth as people between the ages of 15 and 24 years (United Nations, 2018), while the African Union and many other African nations define youth as those aged between 15 and 35 years (African Union, 2006). In the case of South Africa, the National Youth Policy (NYP) defines the youth as every person between the ages of 14 and 35 years (Presidency, 2015). The NYP is informed by the Constitution of South Africa, the United Nations World Programme of Action for Youth (1995), the African Youth Charter (2006) and the National Development Plan (NDP) (2012).

The United Nations (UN) further refers to the youth as the "torchbearers" of the 2030 Agenda for Sustainable Development Goals (SDGs). They have an essential role to play both as beneficiaries of actions and policies under the Agenda and as partners in its implementation. The role of youth is critical to the success of the 2030 Agenda in engaging with local and national government in delivering on policies and programmes on the ground (United Nations, 2018).

The African Union (AU) developed a policy framework called the African Youth Charter (AYC), which prescribes responsibilities of member states with regard to the development of youth. The Summit of Heads of State and Government adopted this Charter in 2006. The framework provides governments, youth, civil society and international partners with a regional framework that underlines the rights, duties and freedom of the youth. The AYC outlines the development of national programmes and strategic plans for their empowerment and ensuring involvement of the youth in the development agenda of Africa. The charter enables policymakers to mainstream youth issues in all developmental policies and programmes, providing important guidelines to and responsibilities of member states for the empowerment of the youth in key strategic areas. Key areas include education and skills development, poverty eradication and socio-economic integration of youth, sustainable livelihoods and youth employment, health, peace and security, law enforcement, sustainable development, and protection of the environment (African Union, 2006).

South Africa has developed a National Development Plan (NDP), which is aligned to the UN Sustainable Development Goals (SDGs). Goals contained in the NDP are a universal call of action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity. The two SDGs relevant to this thematic report are SDG 3 and SDG 4. SDG 3 is *"to ensure healthy lives and promote wellbeing for all people at all ages."* SDG 4 is *"to ensure inclusive and equitable quality education and promote lifelong learning opportunities for all"* (United Nations, 2015).

In South Africa, the youth forms a significant part of developmental human resources, serving as key agents for social change, economic expansion and innovation. The plan recognises the role of the youth in building South Africa, pursuing to develop their capabilities as part of a long-term solution. The NYP will in turn open opportunities for the youth to participate in and take advantage of what South Africa has to offer. Hence, the NYP aims at achieving its goals by 2020 (Presidency, 2015).

1.2 Purpose of the report

The purpose of this report is to provide analyses on demographic and health information collected by different sources in order to increase the statistical information base. Although the SADHS 2016 data are among those utilised for analysis, such data were analysed according to the ages 15-34 years in alignment with the focus of this report.

1.3 Objectives of the report

The main goal of this thematic health report is to provide information on aspects that affect the health of the youth (15–34) in South Africa. The report is aimed at achieving the following objectives among the youth:

- To outline their sexual activity;
- To highlight awareness and use of contraception;
- To describe information on termination of pregnancy;
- To present data on substance use and abuse;
- To highlight information on crashes and fatalities; and
- To describe deaths due to natural and non-natural causes.

1.4 Data sources and methods

The following internal and external sources were used to compile this thematic report:

- The Mid-year population estimates 2019 from Statistics South Africa and the South Africa Demographic and Health Survey 2016 to outline the demographics of the youth;
- The General Household Survey 2018 from Statistics South Africa for information on education;
- South Africa Demographic and Health Survey 2016 to provide a synopsis on the youth's sexual activity, contraception and abortion, substance use and abuse;
- A desktop research by the South African Federation for Mental Health 2018;
- Information on the rate of termination of pregnancy from the District Health Management Information System managed by the National Department of Health;
- Road Traffic Management Corporation 2018 for information on fatalities from motor vehicle accidents; and
- Mortality and causes of death 2016 data for information on deaths.

1.5 Presentation of the report

This section presents a broad outline of the content of the report in terms of background, purpose, objectives; and data sources and methods. Literature review is provided in Chapter 2, highlighting overview on literature related to the health aspects affecting the youth. Demographic profile and education attainment are presented in Chapter 3 whilst health determinants are explained in Chapter 4. Chapter 5 provides information on the use and abuse of substances, while crashes and fatalities are highlighted in Chapter 6. Deaths due to natural and non-natural causes of death are provided in Chapter 7, followed by conclusion in Chapter 8.

Chapter 2: Literature review

This chapter presents literature review related to aspects that affect the health of the youth, such as education, sexual behaviour, family planning and contraceptive use, substance use and abuse, state of mental health, violence, injuries and accidents; and causes of death.

2.1 Youth population

Worldwide there are currently 1,2 billion young people aged 15–24 years, accounting for 16% of the global population (UN World Youth Report, 2019). This global number of the youth (15–24 years) is projected to increase by 42% in 2030. The youth face challenges that need to be prioritised the world over. Areas that need to be addressed include amongst others, education, employment, hunger and poverty, health, environment, substance abuse, juvenile justice, leisure-time activities, girls and young women, full and effective participation of youth in the life of society and in decision-making, globalisation, information and communication technologies, HIV/AIDS, armed conflict, and intergenerational issues (UN World Youth Report, 2019).

Africa has 226 million of the youth aged 15–24, accounting for 19% of the global population (UN Population Facts, 2015). The African youth population is expected to continue to grow throughout the remainder of the 21st century, doubling from current levels by 2055 (UN Population Facts, 2015).

South Africa's population as a whole is quite young. However, South Africa is experiencing a decline in growth rates year-on-year among young people aged 15–34 (NYDA, 2008). The mid-year population estimates for South Africa that were released in July 2019 estimated that there were 20,6 million youth aged 15–34 years. As a result the youth population constituted approximately 35,1% of the total population of 58,8 million in South Africa (Stats SA, 2019).

2.2 Education

Education is key to development and to improvement of the lives of young people. Hence, it is a priority area in the international development goals, such as the Millennium Development Goals and the World Programme of Action for Youth. The United Nations in 2010 estimated that worldwide, 10,6% of the youth (15–24 years) are illiterate, with no basic reading and numerical skills, leading to lack of skills for full and decent employment (United Nations, 2013). There are still unacceptably high numbers of young people experiencing poor education and employment outcomes (United Nations, 2010).

Currently, there are 142 million of the youth of upper secondary age out of school globally. About 30% of the poorest 12–14-year-olds have never attended school, and many of the youth are still unable to obtain an acceptable primary education. Young women still face problems in terms of securing and completing an education (UN World Youth Report, 2019).

Education is a key factor in the wellbeing of the youth since school attendance has significant and positive associations with the health outcomes of the youth. It is therefore significant that the health of adolescents and youth be improved for their current well-being and future economic productivity (Diane Cooper et al., 2015). A good quality education is therefore important to prepare the youth’s participation in the economy, educating them to make correct decisions regarding their health and improving their quality of life (United Nations, 2013).

Studies have shown that education is also a key factor in the well-being of the youth because school attendance has a significant and positive association with the health of the youth. It is therefore significant that the health of adolescents and youth be improved for their current well-being and future economic productivity (Diane Cooper, 2015). A good quality education is therefore important to prepare the youth for participation in the economy, educating them to make correct decisions regarding their health and improving their quality of life (United Nations, 2013).

2.3 Sexual behaviour

Sexual behaviour is defined as a person's choice of sexual practice or activity. Sexual behaviour includes unprotected sexual intercourse, having multiple sexual partners, early sexual initiation, sexual intercourse with commercial sex workers and bartering sex for money, goods or other favours.

Globally, unwanted pregnancies among the youth and complications of induced abortions are some of the important health problems in the world. About a third (38%) of all pregnancies are unintended and studies have indicated that risk factors for unintended pregnancy in Arab countries include early marriage, low socio-economic status, low education and certain local socio-cultural factors. In addition, unwanted pregnancies (either mistimed when they occur or unwanted at all) in the Middle East and North Africa countries were estimated between 15% and 58%. About 20 million abortions are performed worldwide each year, of which 95% are practised in developing countries (Fetene and Mekonnen, 2018).

Reported risky sexual behaviours are a common practice among youth in sub-Saharan Africa (SSA). Youth in SSA were frequently engaged in pre-marital sexual intercourse, with ill consequences such as unwanted pregnancy, sexually transmitted infections (STIs), and HIV/AIDS. The youth also tend to engage in having multiple sexual partners, concurrent sexual partners and unprotected sexual intercourse. Groups of people who engage in these high-risk sexual behaviours are considered as being vulnerable to HIV infection (Fetene and Mekonnen, 2018).

The majority of the youth in the SSA have multiple sexual partners in their lives and that puts them at risk for STIs and unintended pregnancies. A study conducted in secondary schools in Tanzania in 2013 showed that 29% of study participants were sexually active. Among those who were sexually active, 47,7% have had more than one sexual partner. Studies conducted in 2015 in different parts of Ethiopia also showed that among those who have had sexual intercourse, more than 45% of them have had two and more than two sexual partners in the past 12 months. Further studies conducted in 2014 among the youth and university students in Ethiopia showed that 25,0% and 42,1%, respectively, of the respondents from those who ever had sexual intercourse, had intercourse with multiple sexual partners. Another study conducted in 2013 among high school students in Ethiopia showed that 70,5% of the respondents had two or more sexual partners in the past one year prior to the survey (Fetene and Mekonnen, 2018).

In South Africa, behaviour developed during the adolescent stages of life are key predictors of the burden of disease during the adult stages (Cooper, 2015). It was shown that young male and female students who continue with school during their teens are less likely to have had sex than their non-enrolled peers (Marteleto, 2008). The behaviour of abstinence from sex prevents the youth from contracting sexually transmitted infections and other diseases, thus prolonging their good health (Marteleto, 2008). Unplanned pregnancies resulting from early sexual behaviour affect the health and wellbeing of adolescents, putting them at risk of morbidity and mortality related to unsafe abortion and childbirth (Beksinska, 2014).

The South African youth are at risk for unprotected sex, unhealthy eating habits and violence, all of which start in their youthful years and continues into adulthood. This sexual behaviour simultaneously results in social and educational problems, such as failure to complete high school, unemployment, crime, morbidity and sometimes mortality (HSRC, 2013).

About 40% of learners in South Africa who participated in the study reported ever having had sex and 12% of them have had sex before they turned 14 years old. Among the above-mentioned 40% of learners that had ever had sex, 47% have had two or more sexual partners in their lifetime. More than half (58%) had sex in the three months before the survey. One in five (18%) had sex after consuming alcohol. One in ten (13%) had a sexual activity after taking drugs. About a third (33%) of the youth practised consistent condom use, and 18% fell pregnant or made someone pregnant (HSRC, 2013).

2.4 Family planning and contraceptive use

The World Health Organization (WHO) defines family planning as a service that allows people to anticipate and achieve their desire on the number of children they want, including spacing and timing of their births. Globally, family planning services are being strengthened and the range of contraceptive choices expanded to cover a variety to choose from (Chersich, 2017). Knowledge and use of family planning (FP) methods can contribute to a substantial reduction in fertility and reduce the proportion of unwanted pregnancies as well as maternal deaths that would occur in the absence of contraceptive use (Galla Alege et al., 2016). Contraceptive use is the intentional prevention of conception by means of various devices, sexual practices, chemicals, drugs, or surgical procedures (Jain, 2011). Contraceptive use has profound benefits for women and society, including reduced maternal and infant mortality and morbidity, empowerment of women to make informed choices about fertility, economic advancement, and a reduction in the number of children infected with HIV (Chersich, 2017).

The global use of modern contraception has risen from 54,0% in 1990 to 57,4% in 2015. In Africa, the figure for contraceptive use rose from 23,6% to 28,5%, while it has risen slightly from 60,9% to 61,8% in Asia. In Latin America and the Caribbean it has remained stable at 66,7% (Mutumba, 2018). Contraceptive use among young women aged 15–24, whether married or unmarried, is lower as compared to that among the older women in the developing world. Among individual countries, contraceptive use is highest among young married women in Senegal (69,5%) and lowest in Ukraine (7,3%). For the unmarried young women, it is highest in Ghana (45,7%) and Haiti (44,8%) and lowest in Egypt (8,8%) and Indonesia (8,0%) (Mutumba, 2018).

Research shows that about a quarter of women in sub-Saharan Africa currently use modern contraceptive methods, with levels highest in southern Africa (Darroch JE, 2013). In South Africa, estimates of the proportion of women of reproductive age using modern contraceptive methods have increased steadily from 26,3% in 2002/2003 to 37,3% in 2013/2014 (Chersich, 2017).

The fourth SA National HIV Prevalence, Incidence and Behaviour Survey that took place in 2012 indicates that 46,2% of women aged 15–49 years had ever used injectable contraception and a quarter had ever used oral contraception (25,6%). The current contraceptive prevalence was 49,1%, and 41,8% of women were using modern, non-barrier methods. Injectable contraception was by far the most common method (25,0%). Other methods were several-fold less commonly used (Chersich et al., 2017). Only about a third of women aged 15–19 years were using modern contraception, only 5,0% were using oral contraception, and 0,4% were on an intrauterine device (IUD). More women aged 20–34 or 35–49 years were using modern contraception (42,7% and 41,8%, respectively). A significant proportion of women aged 35–49 years old had undergone sterilisation (16,4%); and 16,2% use injectables, which was much lower than that of women aged 15–19 years (26,1%) and those aged 20–34 years (30,5%) (Chersich et al., 2017).

Results from the 4th SA National HIV Prevalence, Incidence and Behaviour Survey that took place in 2012 also show that contraceptive coverage in South Africa was the highest in the Western Cape (54,0%), Eastern Cape (50,7%) and KwaZulu-Natal (50,1%) and lowest in the Northern Cape (42,2%) and Mpumalanga (45,0%). The prevalence of any contraceptive use differed by population group: 47,2% black Africans, 52,4% coloureds, 61,1% Indians/Asians, and 61,9% of the white population group used any form of contraception. Whilst 27,5% of black African and 23,8% of coloured women were using injectables, the method is only used by 6,8% of Indians/Asians, and 4,8% of white women. The use of oral contraception and IUDs was more common among white and Indian/Asian women (22,8% and 22,5%, respectively). Female sterilisation among Indian/Asian women (27,9%) was considerably more common than among other population groups, while 16,6% of white women had been sterilised, and 13,0% of their male partners were sterilised (Chersich et al., 2017).

2.5 Substance use and abuse

Substance abuse refers to the use or abuse of harmful or hazardous substances such as tobacco, alcohol and illicit drugs (World Health Organization, 2019). Substance abuse has been used by learners as a mechanism to help cope with amongst others, bullying at school (World Health Organization, 2019).

Globally, 150 million young people make use of tobacco smoking, with one in every ten girls aged 13–15 years and one in every five boys in this age group using tobacco (Reddy, 2013). Approximately 4,9 million middle and high school students in the USA were current tobacco users in 2018. Tobacco use by adolescents has declined substantially in the last 40 years. Less than 1 in 25 high school seniors were daily smokers in 2018 (Johnston et al., 2019). Products used by adolescents include cigarettes (both store-bought and hand-rolled), cigars, pipes, hookahs, smokeless tobacco, and newer oral products such as e-cigarettes, pouches, lozenges, strips, and sticks: Nearly 90% of adult smokers in the USA began smoking before age 18 years and 9,7% of high school seniors reported smoking in the month before the study. Use of smokeless tobacco among adolescents is less common than cigarette smoking. Hookahs are no safer than other forms of tobacco smoking and may deliver even higher levels of toxic substances (Johnston et al., 2019). Flavoured cigars were used by more than 60% of middle and high school students who used tobacco products in 2014 (Corey et al., 2015).

Tobacco was the second most frequently reported substance used, with 47,4% of learners reporting lifetime use of this substance. Among learners who reported lifetime use of tobacco, more than half had used tobacco in the year before the survey (50,7%), about 40% were current (past 30-day) tobacco users, and more than a quarter (27,6%) reported daily smoking. About 40% (37,5%) of the learners had first tried cigarettes before the age of 13 years. Males were more likely to report lifetime smoking than females (51,3% vs 44,5%), and among smokers, males were more likely than females to report daily smoking (30,6% vs 25,1%), as well as smoking more than ten cigarettes per day (13,1% vs 6,7%) (Morojele, 2016).

A South African study done among learners in Grades 8, 9 and 10 in public schools across the eight districts of the Western Cape in 2011 shows that the use of tobacco, alcohol and cannabis (dagga) were the three most frequently reported substances used by Grade 8–10 learners in the Western Cape (Morojele et al., 2013). Alcohol was the most regularly reported substance used, with 66% of learners reporting ever having used alcohol. Among learners who reported lifetime use of alcohol, more than 33,3% reported current use, almost 25% reported alcohol use in the week before the study, and almost 25% reported indulge-drinking in the two weeks prior to the study. Among those who drank alcohol, almost 33,3% reported early initiation of alcohol use (before the age of 13 years), with 10% reporting using alcohol on a weekly basis. A small percentage (2%) reported being drunk on a daily or (10%) on a weekly basis. Males were more likely than females to report indulge-drinking (25,4% vs 19,8%), weekly alcohol use (12,2% vs 8,3%) and weekly drunkenness (11,6% vs 7,9%). There was no difference between males and females on lifetime (66,6% vs 65,6%) and past year (59,3% vs 59,0%) drinking or on initiation of alcohol before the age of 13 years (28,9% vs 27,2%) (Morojele et al., 2013).

Cannabis is the drug that was the third most regularly reported substance used, with almost a quarter of learners (23,6%) reporting ever having used this drug. Cannabis users reported high levels of use the year before the survey (52,1%), current (34,6%), past week (29,6%) and daily use (13,8%); 14% reported initiation before the age of 13 years. Males had higher prevalence rates than females on all measures of cannabis use (28,4% and 20,0%) for lifetime use. Among lifetime users there were 55,2% males and 48,7% females who used cannabis in the past year; and 39,0% males and 30,0% females for current use. The use of cocaine, mandrax, ecstasy, heroin and methamphetamine, and drug injecting had percentages of less than 5% for each one of them, respectively (Morojele, N. et al., 2013). Codeine is a drug found in prescription pain medication used to treat mild to moderate pain (SAMHSA, 2019). Treatment records from the South African Stress and Health study show that heroin/opiates was used by 7,9% of those who consulted for treatment of misusing prescription/over-the-counter drugs (2,0%), and cannabis/mandrax (1,7%) (Peltzer, 2018).

2.6 State of mental health

The World Health Organization (WHO) defines mental health as a state of well-being where an individual realizes their own potential, coping with the normal stresses of life, being able to work productively and fruitfully, and being able to make a contribution to their community (South African Federation for Mental Health, 2018).

The WHO indicates that 10–20% of all children and adolescents have some type of a mental illness, with 50% of these disorders occurring by the age of 14 years, and 75% by the age of 20 years. Research shows that 37% of students aged 14 years and older drop out of school because of a mental health condition. Results from a desktop research conducted by the South African Federation for Mental Health (SAFMH) in 2018 highlight that 25% of learners (15–19 years) reported having experienced feelings of sadness or hopelessness, 18% had considered suicide and 18% had attempted suicide; 32% of those who attempted suicide required medical treatment (South African Federation for Mental Health, 2018).

Suicide is defined as the intentional act of ending one's life. Suicide is the third leading cause of death among the youth aged 10–24 years; 11% of youth live with a mood disorder, 10% with a behaviour or conduct disorder. Twenty per cent of youth aged 13–18 years live with a mental health condition, with 8% of them having an anxiety disorder (National Alliance on Mental Illness, 2015).

Suicide has become a significant public health problem in South Africa. The average rate of suicide in South Africa in 2012 was 17,2 per 100 000, accounting for 8% of all deaths. Results from a survey conducted by the South African Medical Research Council in 2013 highlighted that one in five adolescents considered suicide. The 2015 Mortality and causes of death report showed that 125 deaths of young people aged 15–24 years were due to intentional self-harm, including self-poisoning, drowning, strangulation and jumping from a high place (Khuzwayo, 2018).

A study on the association between traumatic events and suicidal behaviour in South Africa found that hanging was the most frequently employed method of suicide, followed by shooting, gassing and burning. A study that aimed to identify the levels and sex-specific determinants of self-harm mortality among youth in South Africa found higher rates among males than females, and noted that the prevalence of self-harm mortality among pregnant females was of concern (Khuzwayo, 2018).

Research on risk behaviours indicated that many factors influence suicide attempts among young people, including alcohol abuse, being threatened by someone with a weapon, bullying and previous suicide attempts, which have all been associated with a high prevalence of suicide and suicidal ideation among adolescents (Khuzwayo, 2018).

A survey on substance use, risk behaviour and mental health among Grade 8–10 learners in Western Cape indicated that 41,4% of the learners were categorised as being at ‘medium risk’ and 14,9% as ‘high risk’ for mental health problems; similar proportions were found across the grades and districts. Female learners (18,5%) were more likely than male learners (10,1%) to fall into the ‘high risk’ category for mental health problems. Almost two-thirds (63,9%) of learners were in the ‘medium risk’ and 6,9% were in the ‘high risk’ category for aggressive behaviour. This was a consistent trend across the grades, districts and sex groups (Morojele, 2016).

2.7 Violence, injuries and accident incidences

Injuries remain a growing problem in some countries and are regarded as an important public health concern. The leading causes of death due to injury are road traffic injuries and falls. Road traffic injuries are among the leading causes of death and life-long disability globally (Adeloye, 2016) and the leading cause of death among young people aged 15–29 years. It is also among the top three causes of mortality among people aged 15-44 years (Adeloye, 2016). About 1,24 million people die annually on the world's roads, with 20–50 million sustaining non-fatal injuries (World Health Organization, 2013).

According to the Institute for Health Metrics and Evaluation (IHME), about 907 900 deaths in 1990, 1,3 million in 2010 and 1,4 million in 2013 were from road accidents. About 90% of injuries that occur among the adolescents are as a consequence of unintentional or "accidental" incidents (Adeloye, 2016).

Information on violence in South Africa shows that adolescents who are involved in bullying, either as victims or as perpetrators, are more likely to be socially isolated than those who are not involved, since they may lack a sense of belonging. A national survey of violence at school conducted in 2013 indicated that 24% of learners were bullied on school property. Another survey conducted in uMgungundlovu District of KwaZulu-Natal in 2016 showed similar results (Khuzwayo, 2018).

The National Injury Mortality Surveillance System (NIMSS) registered a total of 14 678 adult homicide deaths in Johannesburg – a major city of South Africa – between 2001 and 2010. Among those 14 678 deaths, the majority (58,4%) were young adult homicides (Swart et al., 2019). Violence, injuries and traffic accidents affect the youth in general but mostly young men; hence, it is vital that these challenges be looked at in order to improve the health of the youth (Swart et al., 2019).

Chapter 3: Demographic profile and education

This chapter presents the demographic profile of the youth aged 15–34 years in South Africa. Analysis accommodated the age breakdowns as per definition of the United Nations, the National Youth Commission and the African Youth Commission. These are: a) United Nations 15–24 years, b) African Youth Commission 15–35 years and c) National Youth Commission 14–35 years. For the purpose of this report, the definition of youth are those aged 15–34 years and will be used for all analyses.

Demographic dividend in broad terms refers to accelerated economic growth that starts with changes in the age structure of a country as it transitions from high to low birth and death rates. Many policymakers, however mistakenly thinks that a demographic dividend follows automatically from a large population of young people relative to the working age population. Large investments into human capital (health and education, particularly) is needed for a nation to achieve the demographic dividend. Hence this report's focus on the demographic profile, education status and health determinants of the youth in South Africa.

Data are analysed for each of the respective 5-year intervals, e.g. 15–19 years, to highlight health problems and challenges faced by adolescents, 20–24 years for issues affecting young adults and also for the 15–24-year-old group due to its significance as a group in line with the UN definition.

3.1 Demographic characteristics

The demographic characteristics of the youth in this report are retrieved from the mid-year population estimates (MYPE) released in July 2019. The MYPE estimated that there are 20 640 722 young people aged 15–34 years, accounting for 35,1% of the total population of South Africa (Statistics South Africa, 2019). The majority of the youth (approximately 11,5 million) are between the ages of 25 and 34 years and constitute 53,6% of the youth population. There are 10,5 million males (constituting 50,6% of the youth population) and slightly higher than females at 10,2 million.

Table 1: Number and percentage distribution of the youth (15–34) by age and sex, MYPE 2019

Age group	Male		Female		Total	
	Number	% of male youth	Number	% of female youth	Number	% of total youth
15–19	2 343 975	22,4	2 316 027	22,7	4 660 002	22,6
20–24	2 475 396	23,7	2 438 790	23,9	4 914 186	23,8
25–29	2 805 676	26,8	2 722 896	26,7	5 528 571	26,8
30–34	2 826 623	27,0	2 711 340	26,6	5 537 963	26,8
Total	**10 451 670**	**100,0**	**10 189 052**	**100,0**	**20 640 722**	**100,0**

Source: Mid-year population estimates 2019

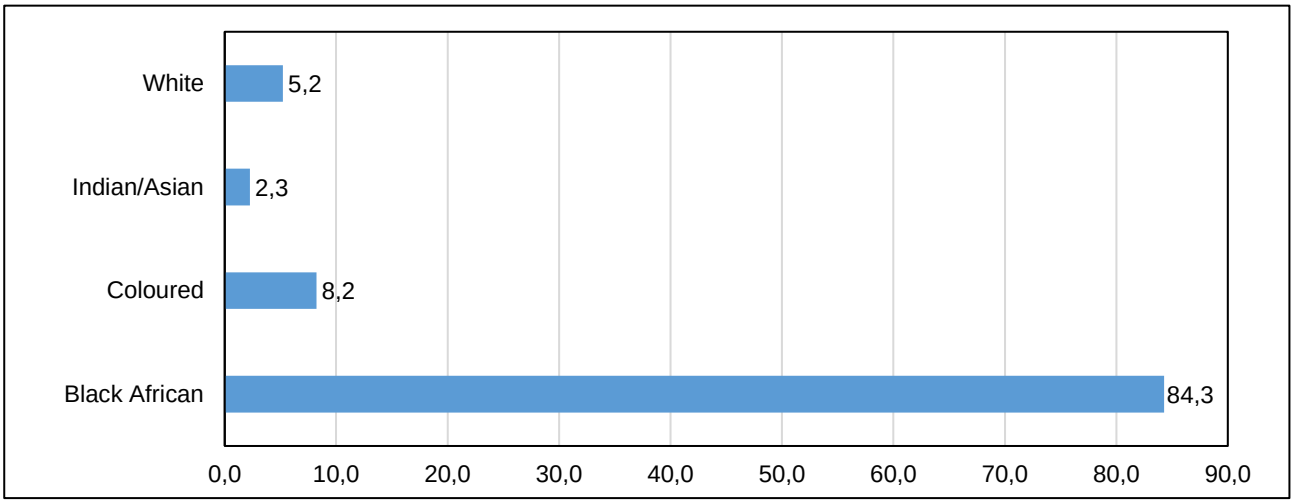
Table 2 and Figure 1 below show that 17,4 million of the youth are black African, which constitutes 84,3% of the total youth population in the country, with the Indian/Asian population group being in the minority at 2,3%. When percentages are calculated within each population group, 36,7% of the black African population group are youth, the highest when compared to other population groups, implying that the black African population has a very youthful population. In contrast, the white population group has the smallest proportion of their population being youth at 23,2% (Table 3).

Table 2: Number and percentage distribution of the youth (15–34) by population group and sex, MYPE 2019

Population group	Male		Female		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
Black African	8 803 602	84,2	8 596 218	84,4	17 399 819	84,3
Coloured	851 459	8,1	845 662	8,3	1 697 121	8,2
Indian/Asian	252 089	2,4	212 922	2,1	465 011	2,3
White	544 520	5,2	534 251	5,2	1 078 771	5,2
Total	**10 451 670**	**100,0**	**10 189 052**	**100,0**	**20 640 722**	**100,0**

Source: Mid-year population estimates, 2019

Figure 1: Percentage distribution of the youth (15–34) years by population group, 2019



Source: Mid-year population estimates, 2019

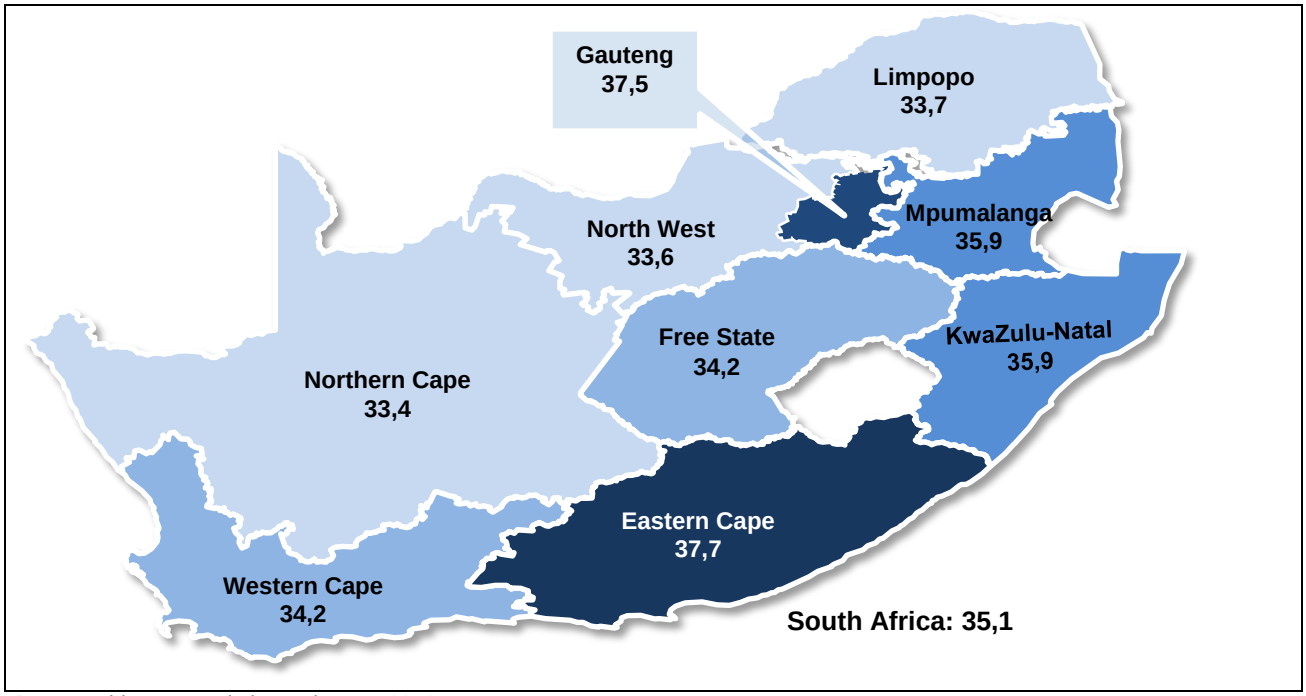
Table 3: Percentage distribution of the youth (15–34) within each population group by age group and sex

Age group	Black African			Coloured			Indian/Asian			White		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
15–19	8,5	8,0	**8,3**	8,2	7,7	**7,9**	5,8	5,8	**5,8**	5,5	5,0	**5,3**
20–24	9,0	8,4	**8,7**	8,5	8,0	**8,2**	7,2	6,6	**6,9**	5,8	5,4	**5,6**
25–29	10,3	9,5	**9,9**	8,7	8,2	**8,5**	9,4	7,9	**8,7**	6,1	5,7	**5,9**
30–34	10,3	9,4	**9,8**	8,4	7,9	**8,2**	10,3	8,6	**9,5**	6,7	6,3	**6,5**
Total	**38,1**	**35,3**	**36,7**	**33,9**	**31,7**	**32,8**	**32,8**	**29**	**30,9**	**24**	**22,4**	**23,2**

Source: Mid-year population estimates, 2019

The percentage distribution of the youth calculated within each province is shown in Map 1. Results indicate that Eastern Cape (37,7%) and Gauteng (37,5%) have the largest proportions of their population classified as youth. The three provinces that have the smallest proportions of their population classified as being youth are: Northern Cape (33,4%), North West (33,6%) and Limpopo (33,7%). Table 4 shows that Gauteng (27,6%) and KwaZulu-Natal (19,7%) have higher percentages of the youth when percentages are calculated across provinces.

Map 1: Percentage distribution of the youth (15-34) within each province, 2019



Source: Mid-year population estimates, 2019

Table 4: Number and percentage distribution of the youth (15–34) across provinces

Province	Number	Percentage
Western Cape	2 338 600	11,3
Eastern Cape	2 125 226	10,3
Northern Cape	421 895	2,0
Free State	987 673	4,8
KwaZulu-Natal	4 056 250	19,7
North West	1 351 353	6,5
Gauteng	5 695 021	27,6
Mpumalanga	1 650 549	8,0
Limpopo	2 014 156	9,8
Total	**20 640 722**	**100,0**

Source: Mid-year population estimates, 2019

Summary of demographic characteristics

The youth population constitutes 35,1% of the overall population in South Africa, with higher percentages of the youth in Gauteng and KwaZulu-Natal.

3.2 Education

This section presents on data elements collected by the General Household Survey (GHS) conducted annually by Statistics South Africa. The GHS 2018 collected data on all the respondents' demographic information; current educational activities and highest educational qualification attained; health and general functioning; social security; economic activities; general household information and service delivery; communication and transport; welfare and food security; and household livelihoods.

3.2.1 Method

Analysis for this section focuses only on the highest level of educational attainment defined as the highest level of grade or standard completed. The analysis is done for the youth by 5-year age groups, sex, population group and province.

3.2.2 Results

Table 5 below shows that 42,6% (32,7% for Grade 12 and 9,9% for post-secondary) of the youth population aged 15–34 years attained Grade 12 or a post-secondary qualification while 48,4% completed some secondary schooling. Overall, only 0,6% of the youth have never attended school. Educational attainment for males is similar to that for females. Almost 89,0% of males have at least attended some secondary schooling or higher and a slightly higher proportion (93%) of females have completed some secondary schooling or higher.

Almost 74,1% of the 15–19-year-old youths attended some secondary schooling, 40,4% of the youths aged 25–29 and 30–34 attended some secondary schooling, while 43,1% of the youths aged 20–24 completed Grade 12. A high percentage of youths with no schooling or incomplete primary education is observed within the age group 15–19 at 5,7% (0,6% for no schooling and 5,1% for some primary education). The age group 20–24 years has the lowest proportion of youth with no schooling or incomplete primary education at 3,4% (0,4% for no schooling and 3,0% for some primary education).

A higher percentage of the youths in the white population group (31,0%) completed a post-secondary level education. Among the Indian/Asian population group, 22,2% of youths had a post-secondary level education. Lower percentages of youths who completed a post-secondary level of education are observed amongst the black African (8,6%) and coloured (6,8%) population groups.

Provincial differentials show that Gauteng and Western Cape have more of their youths who completed a post-secondary level of education at 16,1% and 11,8%, respectively. In contrast, Limpopo and Mpumalanga had the highest proportion of their youth who have never attended school (both at 0,9%). Within all the provinces, the majority of the youths have attended some secondary schooling ranging between 39,5% in Gauteng and 59,7% in Limpopo.

Table 5: Percentage distribution of the youth (15–34) by the highest level of schooling completed

Variable	No schooling	Some primary	Completed primary	Some secondary	NSC/Grade 12	Post-secondary	Other
Sex							
Male	0,8	4,7	4,9	49,5	30,6	8,9	0,7
Female	0,5	2,9	3,2	47,3	34,8	10,9	0,5
Age group							
15–19	0,6	5,1	8,9	74,1	10,6	0,3	0,4
20–24	0,4	3,0	2,3	42,2	43,1	8,1	0,8
25–29	0,6	3,4	2,6	40,4	38,3	14,0	0,6
30–34	1,0	3,8	2,9	40,4	36,1	15,4	0,4
Population group							
Black African	0,6	4,2	4,3	49,9	31,9	8,6	0,6
Coloured	0,7	3,3	4,3	50,8	33,3	6,8	0,7
Indian/Asian	1,2	0,1	0,0	28,5	48,1	22,2	0,0
White	0,2	0,2	1,0	28,1	38,8	31,0	0,7
Province							
Western Cape	0,5	2,2	3,4	49,2	31,9	11,8	0,8
Eastern Cape	0,8	8,0	6,0	56,0	22,8	6,0	0,3
Northern Cape	0,8	5,8	6,6	51,0	29,4	5,8	0,6
Free State	0,5	4,8	5,4	48,4	33,5	7,1	0,2
KwaZulu-Natal	0,4	4,1	3,8	48,3	36,1	7,1	0,3
North West	0,8	5,2	7,1	50,3	29,2	7,1	0,3
Gauteng	0,6	1,7	2,2	39,5	38,8	16,1	1,0
Mpumalanga	0,9	3,9	3,7	50,3	34,0	6,7	0,6
Limpopo	0,9	4,2	4,9	59,7	22,5	7,6	0,1
Total	**0,6**	**3,8**	**4,0**	**48,4**	**32,7**	**9,9**	**0,6**

Source: General Household Survey, 2018

Summary of education

There are generally high proportions of youth that attended school primary level and attained some secondary education. However, only one in ten learners completed post-secondary schooling. The youths from the white and Indian/Asian population groups are more likely to complete post-secondary schooling than those from the coloured and black African population groups. Youth in Gauteng and KwaZulu-Natal are more likely to have completed matric as compared to the youth in other provinces.

Studies have shown that education is also a key factor in the well-being of the youth because school attendance has a significant and positive association with the health of the youth. It is therefore significant that the health of adolescents and youth be improved for their current well-being and future economic productivity (Diane Cooper, 2015). A good quality education is therefore important to prepare the youth for participation in the economy, educating them to make correct decisions regarding their health and improving their quality of life (United Nations, 2013).

Chapter 4: Sexual activity

This chapter presents information on the sexual activity among the youth aged 15–34 years. Sexual activity determines the extent to which women are exposed to the risk of becoming pregnant. Early sexual activities also increase the risks for individuals to contract sexually transmitted infections. This chapter covers information on sexual debut, sexual partners and condom use.

4.1 Sexual debut

Sexual debut is defined as the age at first sexual intercourse as reported by respondents aged 15-34 years, who participated in the SADHS 2016.

4.1.1 Method

Respondents participating in the SADHS 2016 were asked for their age at first sexual intercourse and the median age was calculated from the information received. Information on multiple sexual partners was retrieved from questions that asked respondents on the number of sexual partners they had during the 12 months before the survey and also over their lifetime. The use of a condom with a recent partner is also presented.

4.1.2 Results

This section covers information collected by the SADHS 2016 for sexual activity among women and men aged 15–49 years. For the purpose of this report, only information from respondents aged between 15 and 34 years is analysed. Results on age at first intercourse for both sexes are grouped into the following broad categories: before the age of 16 years, 16–20 years and 21–32 years.

4.1.2.1 Sexual debut among women

This sub-section presents information on age at first intercourse as reported among women aged 15–34 years from the SADHS 2016. More than half (58,1%) of young women aged 15–34 reported that they had their first intercourse when they were between the ages of 16 and 20 years (Table 6). Approximately 16,2% of this group of women reported to have started sexual intercourse before the age of 16 years and less than 10% of women had their first sexual intercourse when they were between 21 and 32 years (8,2%). The remaining 17,5% of female respondents reported that they never had sexual intercourse. A higher percentage of women reported that they had their first intercourse between the ages of 16 and 20 years, ranging from 27,4% for women aged 15–19 years to 72,3% for women aged 25–29 years. Almost 6 in 10 women aged 15–19 years (56,7%) had never had sexual intercourse.

Although the results show that only 3,8% of the Indian/Asian women aged 15–34 had their first sexual intercourse before the age of 16 years, this information should be interpreted with caution, due to the small number of respondents in this group. Six (6,1%) of women from the white population had their first sexual intercourse before the age of 16 years. Seventeen (17,1%) of the black African and 10,5% of the coloured population had their sexual debut before age 16 years. Women with higher of levels of education delay their sexual debut as opposed to women with lower levels of education. Table 6 indicates that 24,5% of women who have attained more than secondary level education, only had their first sexual intercourse between the ages of 21 and 32. Only 2,1% of women who had completed primary school education delayed their first intercourse to between the ages 21 and 32 years. Almost a third of the youth in Eastern Cape (27,4%) had their sexual intercourse debut before the age of 16. In all the provinces, more than half of the women experienced their sexual debut between the ages of 16 and 20 years, ranging from 52,2% in Western Cape to 69,5% in North West.

Table 6: Percentage distribution of women (15–34) on their sexual debut, SADHS 2016

Variable	Sexual debut			Never had sex	Number of young women
	Before 16 years	16–20 years	21–32 years		
All	**16,2**	**58,1**	**8,2**	**17,5**	**5 618**
Age group					
15–19	15,9	27,4	0,0	56,7	1 427
20–24	17,0	67,6	6,1	9,2	1 415
25–29	14,3	72,3	11,1	2,2	1 444
30–34	17,6	65,4	15,9	1,1	1 333
Population group					
Black African	17,1	58,7	7,8	16,3	5 000
White	6,1	52,9	15,9	25,2	124
Coloured	10,5	53,9	9,3	26,2	423
Indian/Asian	(3,8)	(45,4)	(13,4)	(37,3)	68
Marital status					
Never married	15,3	53,3	6,7	24,8	3 961
Married or living together as married	18,4	69,5	11,9	0,2	1 658
Education					
No schooling	(28,6)	(55,3)	(9,6)	(6,5)	39
Primary incomplete	32,9	47,1	5,3	14,7	181
Primary complete	25,3	51,5	2,1	21,2	219
Secondary incomplete	18,9	52,6	4,1	24,4	2 968
Secondary complete	10,5	69,8	11,3	8,4	1 684
More than secondary	8,6	58,4	24,5	8,5	528
Province					
Western Cape	14,3	52,2	9,7	23,8	587
Eastern Cape	27,4	55,4	4,4	12,8	609
Northern Cape	13,9	57,2	10,4	18,5	106
Free State	14,5	56,4	8,5	20,5	287
KwaZulu-Natal	11,2	55,0	10,7	23,0	1 137
North West	14,2	69,5	5,1	11,1	369
Gauteng	17,4	59,4	9,7	13,5	1 511
Mpumalanga	17,3	63,7	5,7	13,2	474
Limpopo	14,5	58,4	5,0	22,2	537

'Other' population group is excluded
Figures in parentheses are based on 25–49 unweighted cases
Asterisk indicates that a figure is based on fewer than 25 unweighted cases

4.1.2.2 Sexual debut among men

This sub-section presents information on age of first sexual intercourse among young men aged 15–34 years from the SADHS 2016. Overall, almost half of the men (49,2%) aged 15–34 years made their sexual debut whilst they were between 16 and 20 years (Table 7). A quarter of the men aged 15–34 years (26,7%) had their sexual debut whilst they were younger than 16 years. Almost one in five (17,7%) of young men aged 15–34 years indicated that they never had sex at the time of the survey.

Within the five-year age groups, the majority of men had their first intercourse between the ages of 16 and 20 years, with the exception of the group aged 15–19. Men aged 15–19 years (27,8%) had their sexual debut before age 16 years, while 23,1% had their first sexual intercourse at age 16 to 20 years. For the remainder of the groups, the majority of men had their first intercourse between the ages of 16 and 20 years, ranging from 55,9% for those aged 30–34 to 62,7% for men aged 25–29 years. Roughly half of the men (49,1%) aged between 15 and 19 years indicated that they never had sex.

More than a third of men in both Eastern Cape (34,7%) and Mpumalanga (34,4%) had their sexual intercourse debut before the age of 16 years. In all the provinces, most of the men experienced their sexual debut between the ages of 16 and 20 years, ranging from 44,9% in the Western Cape to 62,9% in North West.

Table 7: Percentage distribution of men (15–34) on their sexual debut, SADHS 2016

Variable	Sexual debut			Never had sex	Number of young men
	Before 16 years	16–20 years	21–32 years		
All	**26,7**	**49,2**	**6,4**	**17,7**	**2 189**
Age					
15–19	27,8	23,1	0,0	49,1	647
20–24	28,3	61,3	2,2	8,2	588
25–29	25,0	62,7	8,5	3,9	506
30–34	24,7	55,9	18,8	0,5	448
Population group					
Black African	28,3	49,5	6,2	16,0	1 955
Coloured	17,1	53,0	1,7	28,2	146
Indian/Asian	*	*	*	*	30
White	(6,9)	(40,1)	(20,3)	(32,8)	58
Marital status					
Never married	27,7	46,9	3,3	22,1	438
Married or living together as married	22,4	58,7	19,0	0,0	438
Education attainment					
No schooling	*	*	*	*	16
Primary incomplete	22,2	39,4	8,8	29,6	126
Primary complete	27,8	31,6	9,3	31,3	115
Secondary incomplete	27,5	45,0	5,3	22,2	1 214
Secondary complete	25,8	59,6	7,6	7,0	546
More than secondary	26,5	62,9	7,2	3,5	172
Province					
Western Cape	26,4	44,9	6,8	21,9	201
Eastern Cape	34,7	45,3	3,3	16,7	270
Northern Cape	19,8	53,5	4,1	22,7	39
Free State	29,5	46,7	2,2	21,6	119
KwaZulu-Natal	22,9	47,6	5,4	24,2	392
North West	19,8	62,9	2,0	15,3	153
Gauteng	25,0	51,2	12,1	11,7	602
Mpumalanga	34,4	49,5	2,8	13,3	183
Limpopo	26,3	46,7	4,8	22,2	230

'Other' population group is excluded
Figures in parentheses are based on 25–49 unweighted cases
Asterisk indicates that a figure is based on fewer than 25 unweighted cases

4.2. Multiple sexual partners and condom use among women

Information on the proportion of women aged 15–34 years who had two or more sexual partners in the 12 months before the survey is discussed in this section of the report. In addition, respondents were asked to indicate the total number of different people whom they had sexual intercourse with in their lifetime.

Overall, 5,4% of young women between the ages 15–34 years responded that they had two or more different sexual partners in the 12 months before the survey, and 59,2% of them used a condom with their recent partner. Table 8 highlights that women (aged 15–34) had four sexual partners on average in their lifetime.

Among women aged 25–29 years, 6,9% reported to have had two or more sexual partners in the 12 months before the survey than any of the other five-year age groups, followed by women aged 20–24 at 6,6%. On average, women in the older age categories had more sexual partners in their lifetime than women in their early ages. Women aged 15–19 had two sexual partners on average, whilst women aged 30–34 had an average of five sexual partners in their lifetime.

Close to six (5,7%) of black African women aged 15–34 had multiple partners in the 12 months before the survey, whilst three per cent of white (3,2%) and coloured (3,1%) women aged 15–34 had multiple partners in the 12 months before the survey. The number of respondents for the Indian/Asian female population was too small to deduce any meaningful interpretations.

In the 12 months prior to the survey, never married women (6,2%) were more likely to have had multiple partners than married women or women living together as married or divorced/widowed women (3,5%). There is no meaningful difference in terms of the average sexual partners they had in their lifetime between never married and married/divorced/widowed women at 3,9 partners and 3,8 partners, respectively.

As far as provincial differentials with regard to women who had multiple partners in the 12 months before the survey are concerned, the largest proportion were those in North West (8,5%), followed by those in Mpumalanga (8,3%) and Eastern Cape (7,9%). In a third of the provinces, among those women who reported having had multiple partners, more than half of them utilised condoms with the recent partner: KwaZulu-Natal (60,1%), Eastern Cape (53,3%) and Mpumalanga (52,5%). In the remainder of the provinces, the numbers of respondents were too small to deduce any meaningful information.

On average, women in the inland provinces had four sexual partners in their lifetime: North West and Gauteng recorded an average of 4,6 partners, Free State and Mpumalanga recorded 4,3 partners and Northern Cape 4,1 partners. Limpopo was the only exception in this regard with women in this province having an average of 2,8 partners in their lifetime.

Table 8: Percentage distribution of women (15–34) on their lifetime sexual activity, sexual partners and condom use in the past 12 months, SADHS 2016

Variable	All women		Women who had 2+ partners in the past 12 months		All women	
	% of women who had 2+ partners in the past 12 months	No. of women	Condom used with recent partner	No. of women	Mean number of sexual partners in lifetime	No. of women
All	**5,4**	**5 618**	**59,2**	**304**	**3,9**	**4 507**
Age group						
15–19	2,7	1 427	54,8	38	1,9	618
20–24	6,6	1 415	64,0	94	3,4	1 256
25–29	6,9	1 444	63,3	99	4,0	1 360
30–34	5,4	1 333	49,8	72	5,2	1 273
Population group						
Black African	5,7	5 000	59,7	287	3,9	4 064
White	3,2	124	*	4	4,6	91
Coloured	3,1	423	*	13	3,1	307
Indian/Asian	(0,0)	68	N/A	0	(1,8)	43
Marital status						
Never married	6,2	3 961	62,4	246	3,9	3 032
Married/living together as married	3,5	1 658	46,0	58	3,8	1 475
Education						
No schooling	(2,1)	39	*	1	(8,2)	35
Primary incomplete	6,1	181	*	11	3,1	149
Primary complete	3,2	219	*	7	3,8	167
Secondary incomplete	5,6	2 968	61,4	165	4,0	2 182
Secondary complete	5,0	1 684	64,9	84	3,4	1 501
More than secondary	6,7	528	(31,1)	35	4,7	473
Province						
Western Cape	3,0	587	*	18	3,4	441
Eastern Cape	7,9	609	53,3	48	3,6	525
Northern Cape	2,4	106	*	3	4,1	83
Free State	4,8	287	(51,3)	14	4,3	221
KwaZulu-Natal	6,4	1 137	60,1	73	3,1	849
North West	8,5	369	(67,1)	31	4,6	322
Gauteng	3,9	1 511	*	59	4,6	1 264
Mpumalanga	8,3	474	52,5	39	4,3	393
Limpopo	3,7	537	(57,8)	20	2,8	410

'Other' population group is excluded
Figures in parentheses are based on 25–49 unweighted cases
Asterisk indicates that a figure is based on fewer than 25 unweighted cases

4.3. Multiple sexual partners and condom use among men

This section presents information on men aged 15–34 years who had two or more sexual partners in the 12 months before the survey. In addition, respondents were asked to indicate the total number of different people whom they had sexual intercourse with in their lifetime and if a condom was used with a recent partner.

Nationally, 20,2% of young men between the ages 15–34 years indicated that they had two or more partners in the 12 months prior to the survey. About seventy per cent (68,3%) of them used a condom with their recent partners and had 13 sexual partners on average in their lifetime.

More than a quarter of men (26,2%) aged 20–24 years had two or more sexual partners in the 12 months before the survey and one in five in the age groups 25–29 years (19,8%) and 30–34 years (19,1%) had two or more sexual partners in the 12 months before the survey. One in six men in the age group 15–19 years (15,7%) had two or more sexual partners in the 12 months before the survey. Condom use with the recent partner varied from 57,6% for men aged 30–34 years to 87,9% for those men aged 15–19 years.

Men in the older ages (30-34 years) had on average more sexual partners than men in their early ages, with almost 18 sexual partners on average while those aged 15–19 years had 6 partners on average in their lifetime. On average, black African men had 13,1 sexual partners while Indian/Asian men had 2,4 sexual partners in their lifetime.

In the 12 months prior the survey, never married men (20,7%) were more likely to have had multiple partners than married men or men living together as married or divorced/widowed men (18,3%). Married or men living together as married or divorced/widowed men have on average had more sexual partners (17,6 partners) than never married men who had 11 sexual partners.

A quarter of men in Limpopo (25,7%) and Free State (25,4%) had two or more partners in the 12 months prior the survey. Men who had multiple partners in the 12 months before the survey, 74,5% in Free State, 73,2% in Mpumalanga, 73,1% in Gauteng and 72,2% in KwaZulu-Natal used a condom with the recent partner. On average, men in Gauteng had 20 sexual partners whilst on average men in Limpopo and KwaZulu-Natal had 8 sexual partners (see Table 9).

Summary of sexual activity

On average, men had three times the number of sexual partners than their women counterparts. Educated women start their sexual activities at older ages than their less educated counterparts. One in three women in the Eastern Cape had their first sexual intercourse before their 16th birthday. Among youth women, less than 10% had multiple sexual partners, and condom use was at 60%. Condom use was also lower among both women and men aged 30–34 years. Generally among the youth men, a quarter had multiple sexual partners in the 12 months before the survey, while condom use was low among those aged 30–34 years. A quarter of the youth men who had never married also had multiple sexual partners, while the percentage of condom use was less for those men who were married.

Research shows that the behaviour of abstinence from sex prevents the youth from contracting sexually transmitted infections and other diseases, thus prolonging their good health (HSRC, 2015). Unplanned pregnancies resulting from early sexual behaviour affect the health and well-being of adolescents, putting them at risk for morbidity and mortality related to unsafe abortion and childbirth (Beksinska, 2014). This sexual behaviour simultaneously results in social and educational problems, such as failure to complete high school, unemployment, crime, morbidity and sometimes mortality (HSRC, 2013).

Table 9: Percentage distribution of men (15–34) on their lifetime sexual activity, sexual partners and condom use in the past 12 months, SADHS 2016

Variable	All men		Men who had 2+ partners in the past 12 months		All men who ever had sexual intercourse	
	% of men who had 2+ partners in the past 12 months	No. of men	Condom used with recent partner	No. of men	Mean number of sexual partners in lifetime	No. of men
All	**20,2**	**2 189**	**68,3**	**442**	**12,6**	**1 646**
Age group						
15–19	15,7	647	87,9	101	5,7	322
20–24	26,2	588	63,0	154	11,0	502
25–29	19,8	506	66,0	100	15,0	429
30–34	19,1	448	57,6	86	17,9	392
Population group						
Black African	21,6	1 955	68,2	423	13,1	1 499
White	(8,5)	58	*	5	8,0	38
Coloured	9,4	146	*	14	9,0	96
Indian/Asian	*	30	NC	NC	2,4	13
Marital status						
Never married	20,7	1 752	71,3	362	11,0	1 247
Married/living together as married	18,3	438	54,8	80	17,6	399
Education						
No schooling	*	16	*	2	6,1	14
Primary incomplete	10,9	126	*	14	12,1	80
Primary complete	12,7	115	*	15	6,8	75
Secondary incomplete	21,0	1 214	46,2	254	12,5	885
Secondary complete	21,5	546	71,5	118	13,1	453
More than secondary	22,7	172	(66,5)	39	16,0	139
Province						
Western Cape	15,0	201	*	30	8,5	148
Eastern Cape	20,0	270	65,1	54	8,2	206
Northern Cape	12,5	39	*	5	10,7	27
Free State	25,4	119	74,5	30	13,9	83
KwaZulu-Natal	15,0	392	72,2	59	8,0	257
North West	20,9	153	(54,3)	32	11,9	127
Gauteng	22,9	602	73,1	138	20,0	478
Mpumalanga	19,0	183	73,2	35	13,0	157
Limpopo	25,7	230	60,0	59	7,8	163

'Other' population group is excluded
Figures in parentheses are based on 25–49 unweighted cases
Asterisk indicates that a figure is based on fewer than 25 unweighted cases
NC means there were no cases

4.4 Contraceptive use

This section presents information on contraceptive knowledge and use among women aged 15–34 years. The South African National Contraception Policy Guidelines were developed in 2001. The aim of the policy was to focus on the rights of people to select a method of choice to prevent pregnancy. These guidelines were updated in 2012 and led to the publication of the National Contraception and Fertility Planning Policy. The guidelines were again revised and culminated in the Service Delivery Guidelines and the National Contraceptive Clinical Guidelines (NDoH, 2013a).

Contraceptive methods available in the public health sector at no cost to clients who need contraceptives are: injectables (3-month and 2-month), contraceptive pills, male and female condoms, intrauterine devices (IUDs), male and female sterilisation, and emergency contraceptive pills. In 2014, implants were added to the list of contraceptives that are available in the public sector.

4.4.1 Method

The knowledge about contraceptive methods was tested among all women 15–49 (those in-union women and sexually active women but not in-union) in the SADHS 2016. The question in the SADHS 2016 was phrased as follows: “Which ways or methods have you heard about?” Information on contraceptive use is retrieved from the SADHS 2016 question: “Are you or your partner currently doing something or using any method to delay or avoid getting pregnant?”

4.4.2 Results

Results on the findings from the SADHS 2016 on contraception are presented in three subsections: knowledge of contraceptives, distribution of different methods of contraceptives, and the use of at least one contraceptive method.

According to the results of the SADHS 2016, knowledge of contraceptives is universal in South Africa, with almost all the youth aged 15–34 years having heard of at least one method of contraception (data not shown), ranging between 98,8% among those aged 15–19 years to 100% for those aged 25–29 years.

Table 10 below shows the distribution of each contraceptive method used by the youth broken down by age group, population group, marital status, education and province. The most common method of contraception used among women aged 15–19 years is the injection (57,9%), followed by condoms (both male and female) at 29,2%, then the implant (8,7%). The least commonly used method of contraceptives among this group was the IUD and traditional methods (both at 0,2%). Similarly, those aged 20–24 years do not commonly use sterilisation (0,6%) and traditional methods (0,3%), but also most frequently use injectables (56,0%). Women aged 25–29 years again prefer the use of injectables (51,4%), condoms (25,0%) and the pill (13,0%); they prefer not to use the IUD (1,3%) and traditional methods (1,2%). The age group 30–34 years use injectables (48,7%) and 22,4% using condoms as contraceptives.

The distribution of contraceptive use among the black Africans population group shows that the majority prefer the use of the injection (53,5%), followed by condom use at 25,6% and a pill at 9,4%. Almost two-thirds of the coloured population group use the injection (62,6%), followed by the implant (12,8%) and the condom (10,2%). The least commonly used method of contraceptives were IUDs and traditional methods for both the black African and the coloured population groups. The most common method of contraceptives used among the never married group was the injection (52,7%), followed by the condom (29,2%). For women in-union the pattern is largely the same as the one for single women, with the majority using injectables (52,8%). The second preferred method being used by this group is the pill (16,3%), followed by condom use (15,1%).

As far as contraceptive use in relation to educational attainment is concerned, the pattern of contraceptive use is common for all educational levels, except for those who have attained more than secondary level education. The most commonly used method is injectables, ranging between 47,1% for those who completed secondary education to 65,0% for those who completed primary level education. Youth who had attained more than secondary level education had higher use of the condom as the contraceptive method (33,6%).

The provincial distribution shows that women aged 15–34 years in all provinces prefer to use the injection as their first method of contraception, followed by condom use. In the Eastern Cape, 67,2% of women use injectables whilst only 43,4% of women in North West use injectables. Condom use is the second preferred method of contraception in all provinces.

The third most commonly used method among women aged 15–34 years is the implant, with Western Cape (14,7%), Free State (10,4%), Northern Cape (8,7%) and Eastern Cape (8,6%). For North West (17,0%), Gauteng (16,0%), and Limpopo (11,0%), the third most commonly used method is the pill.

Table 10: Distribution of contraceptive methods used among women (15–34) by age group, population group, marital status, education and province, SADHS 2016

Variable	Condom	IUD	Implant	Injection	Other modern methods	Pill	Sterilisation	Traditional	Total	Number of women
Age group										
15–19	29,2	0,2	8,7	57,9	0,0	3,8	0,0	0,2	**100,0**	356
20–24	23,1	2,4	8,9	56,0	0,0	8,7	0,6	0,3	**100,0**	768
25–29	25,0	1,3	6,6	51,4	0,0	13,0	1,6	1,2	**100,0**	880
30–34	22,4	2,2	7,2	48,7	0,2	11,8	7,1	0,4	**100,0**	759
Population group										
Black African	25,6	1,7	7,3	53,5	0,0	9,4	2,1	0,4	**100,0**	2 496
White	(20,8)	(1,9)	(7,8)	(8,0)	(0,0)	(42,1)	(14,0)	(5,4)	**100,0**	57
Coloured	10,2	1,3	12,8	62,6	0,0	7,5	4,7	0,9	**100,0**	180
Indian/Asian	*	*	*	*	*	*	*	*	*	29
Marital status										
Never married	29,2	1,7	7,7	52,7	0,1	7,1	1,4	0,2	**100,0**	1 810
Married or living together as married/divorced/widowed	15,1	1,7	7,6	52,9	0,0	16,3	5,1	1,4	**100,0**	953
Education										
No schooling	*	*	*	*	*	*	*	*	*	22
Primary incomplete	21,8	0,8	3,9	60,1	0,0	8,1	5,3	0,0	**100,0**	86
Primary complete	16,6	0,9	8,3	65,0	0,0	8,9	0,2	0,0	**100,0**	98
Secondary incomplete	21,6	1,2	8,2	59,9	0,0	6,2	2,3	0,6	**100,0**	1 341
Secondary complete	26,4	2,6	7,1	47,1	0,0	13,1	3,2	0,5	**100,0**	916
More than secondary	33,6	1,5	8,4	30,8	0,4	22,0	2,2	1,1	**100,0**	300
Province										
Western Cape	20,7	2,7	14,7	47,4	0,0	8,4	5,5	0,6	**100,0**	286
Eastern Cape	13,7	1,6	8,6	67,2	0,3	4,6	4,0	0,0	**100,0**	343
Northern Cape	17,2	0,5	8,7	64,7	0,0	7,3	1,6	0,0	**100,0**	50
Free State	18,9	0,0	10,4	63,4	0,0	4,5	2,8	0,0	**100,0**	124
KwaZulu-Natal	28,1	2,1	7,4	51,3	0,0	7,0	3,6	0,5	**100,0**	555
North West	31,4	1,0	5,8	43,4	0,0	17,0	1,2	0,3	**100,0**	205
Gauteng	27,6	2,3	5,7	45,9	0,0	16,0	1,6	1,0	**100,0**	730
Mpumalanga	29,1	0,7	4,8	55,0	0,0	8,3	1,6	0,5	**100,0**	248
Limpopo	17,8	0,7	7,4	61,3	0,0	11,0	0,7	1,1	**100,0**	221
Total	**24,3**	**1,7**	**7,7**	**52,8**	**0,0**	**10,3**	**2,6**	**0,6**	**100,0**	**2 763**

'Other' population group is excluded Figures in parentheses are based on 25–49 unweighted cases
Asterisk indicates that a figure is based on fewer than 25 unweighted cases

The use of at least one contraceptive is presented in Table 11 below, based on results from the SADHS 2016. Results show that about half (49,2%) of women aged 15–34 years reported to use at least one contraceptive method. About a quarter (24,9%) of women aged 15–19 years use a contraceptive method, while 54,3% of those aged 20–24 years, 60,9% of those aged 25–29 years and 56,9% of women aged 30–34 years use of at least one contraceptive.

Racial differentials show that about half of the women from the black African (49,9%) population group, 45,7% of the white population group and 42,6% of the coloured population group are using contraceptives. More than half of the women in-union (57,5%) use at least one contraceptive, whilst only 45,7% of never married women use at least one contraceptive.

About 60% (56,8%) of women with more than secondary level education used at least one contraceptive method, whilst only 44,6% of those who completed primary level education used at least one contraceptive method.

Provincially, about half of women are using at least one method of contraceptive in three provinces: Eastern Cape (56,4%), followed by North West (55,6%) and Mpumalanga (52,4%). KwaZulu-Natal (48,8%), Western Cape (48,7%), Gauteng (48,3%) and Northern Cape (47,1%) have percentages above 45% but less than 50%. Free State (43,3%) and Limpopo (41,2%) have percentages below 45% of women who use at least one method of contraceptive.

Summary of contraceptive use

Overall, the most commonly used method of contraceptives is the injection, followed by the condom, while the least used method is the IUD for modern contraceptive methods. Traditional methods of contraception are rarely used. Contraceptive use has profound benefits for women and society, including reduced maternal and infant mortality and morbidity, empowerment of women to make informed choices about fertility, economic advancement and a reduction in the number of children infected with HIV (Chersich, 2017).

Table 11: Percentage distribution of women (15–34) who use at least one contraceptive method, SADHS 2016

Variable	Percentage of women who use at least one contraceptive method	Number of women
All	**49,2**	**5 618**
Age group		
15–19	24,9	**1 427**
20–24	54,3	**1 415**
25–29	60,9	**1 444**
30–34	56,9	**1 333**
Population group		
Black African	49,9	**5 000**
Coloured	42,6	**423**
Indian/Asian	(42,1)	**68**
White	45,7	**124**
Marital status		
Never married	45,7	**3 961**
Married or living together as married	57,5	**1 658**
Educational attainment		
No schooling	(55,8)	**39**
Primary incomplete	47,6	**181**
Primary complete	44,6	**219**
Secondary incomplete	45,2	**2 968**
Secondary complete	54,4	**1 684**
More than secondary	56,8	**528**
Province		
Western Cape	48,7	**587**
Eastern Cape	56,4	**609**
Northern Cape	47,1	**106**
Free State	43,3	**287**
KwaZulu-Natal	48,8	**1 137**
North West	55,6	**369**
Gauteng	48,3	**1 511**
Mpumalanga	52,4	**474**
Limpopo	41,2	**537**

'Other' population group is excluded
Figures in parentheses are based on 25–49 unweighted cases
Asterisk indicates that a figure is based on fewer than 25 unweighted cases

4.5 Termination of pregnancy

This section highlights information on termination of pregnancy, referred to as the decision by a woman to end her pregnancy by medical procedure before the foetus/ baby reaches full term for women aged 15–34 years. Termination of pregnancy (TOP) was legal only 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.

In South Africa, any woman of any age can get a legal abortion on demand, when she is less than 13 weeks pregnant. If a woman is between 13 and 20 weeks pregnant, she can choose for a legal abortion if her own physical or mental health is at stake; if the baby is at risk to have severe mental or physical abnormalities; if she is pregnant because of incest; or if she is pregnant because of rape. If a woman is more than 20 weeks pregnant, she can only terminate the pregnancy if her life or the foetus's life is in danger or there are likely to be serious birth defects in the baby.

Any woman under the age of 18 is advised to consult her parents about termination of her pregnancy, but she can decide not to inform or consult them if she so chooses. A woman who is married or in a life-partner relationship is advised to consult her partner; she can, however, decide not to inform or consult him. In the case where a woman is severely mentally ill or has been unconscious for a long time, consent of a life-partner, parent or legal guardian is required.

4.5.1 Method

The first part of the results on pregnancies that did not result in a live birth for women aged 15-34 years, is retrieved from the SADHS 2016. Respondents were asked the question: "Have you ever had a pregnancy that miscarried, was terminated, or ended in a stillbirth?" If the answer to the question was "Yes", a follow-up question was asked: "Did that pregnancy end in a spontaneous miscarriage, an induced abortion, or a stillbirth?"

The second part of the results is analysed from the District Health Management Information System (DHMIS) managed by the National Department of Health. The DHMIS is an information system developed and implemented to collect data from all public health service delivery points in all districts of the nine provinces (NDoH, 2011).

The service delivery points include mobile clinics, which are linked to fixed clinics (buildings), and information for the mobile clinics is captured on the system at the fixed clinics. Data is received from district facilities on a monthly basis and made available the following day on the national system for facilities that have internet access. In the case of facilities without internet access, data is captured on paper (form) and then captured electronically on the system once a month at sub district offices. The captured data feeds into the data elements within the National Indicator Data Set (NIDS).

The data comprises information on a group of indicators that each public health facility is required to collect, use and report on. Health facilities are required to report only on indicators for a particular service they render, according to their service package. The purpose of the data elements within the NIDS is to monitor and track progress with regard to the implementation of the national health strategic goals, objectives and priority health programmes. The data set also assists the NDoH to identify needs in the health care system and delegate managers to guide programme development and budgeting, provide support to improve the health care system, and demonstrate national commitment to globally accepted measures of care.

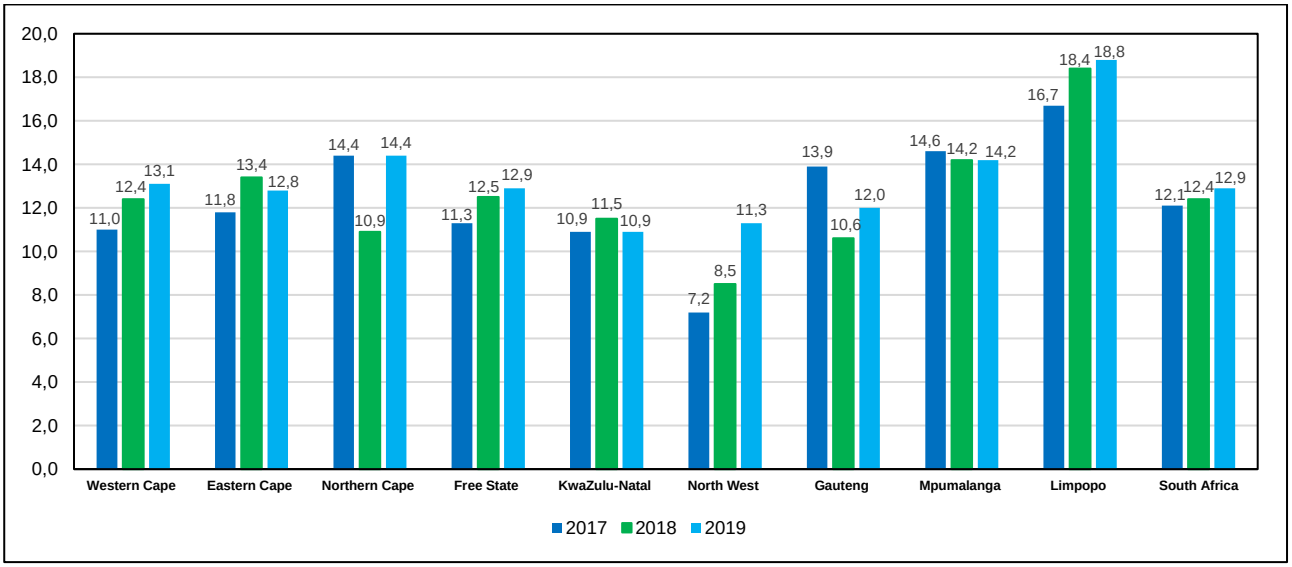
4.5.2 Results

The SADHS 2016 provides data on the number of women who experienced a pregnancy that did not result in a live birth. Results show that a total of 374 (6,7%) women aged 15–34 years experienced terminated pregnancies in their lifetime. A total of 228 (4,8%) women experienced these terminated pregnancies between 2011 and 2016. Of those pregnancies, 28 were terminated deliberately by means of induced abortions.

Results presented in Figure 2 as retrieved from the DHMIS show the rate of induced termination of pregnancy (TOP) or abortions for the years 2017, 2018 and 2019. Due to the limitation on data provided by NDoH, only TOP's experienced by women younger than 20 years is reported on. 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 overall for the three-year period (2017 to 2019). In 2017, Limpopo (16,7%) had the highest rates of TOPs, followed by Mpumalanga and Northern Cape (14,6% and 14,4%, respectively). 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 show 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 are Eastern Cape (13,4% to 12,8%) and KwaZulu-Natal (11,5% to 10,9%). North West is the only province with TOP rates less than 10% for 2017 (7,2%) and 2018 (8,5%).

Figure 2: Rate of termination of pregnancy (TOP) for women aged less than 20 years, DHMIS, 2017–2019



Summary on termination of pregnancy

In the three reporting years, 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. Termination of pregnancy rates were seen to consistently increase in the Western Cape, Free State, North West and Limpopo. Research showed that termination of pregnancy does not have any health benefits to women who undergo the procedure. On the contrary, women who had an abortion are more likely to experience mental health problems than those who complete their pregnancy full term (National Health Services, 2019).

Chapter 5: Substance use and abuse

The following chapter covers information on the use and abuse of tobacco, alcohol and codeine-containing medications. Tobacco and alcohol use and misuse contributes to the burden of disease in South Africa by increasing the risk of cardiovascular disease, respiratory disease and cancer in people. Alcohol in particular contributes to the additional risk of accidents and violence. The management of alcohol abuse is one of the areas covered in the National Department of Health's National Strategic Plan for Non-Communicable Diseases targeted to be reduced by 2020. Information on this section is analysed using data collected during the SADHS 2016.

The misuse of prescription medications is a growing health concern in South Africa. Codeine in particular is one of the ingredients contained in a number of prescription medications which have been misused and abused in recent years. Among the numerous misused opioids, codeine is most commonly consumed worldwide (Van Hout, 2014).

The use and/or misuse of codeine-containing medications in South Africa has been understudied, given that there is no system of recording or monitoring either over-the-counter or prescription medications purchased at pharmacies and retail stores (SADHS, 2016). The only recorded data comes from specialised substance abuse treatment centres; however, treatment centre data do not provide information on patterns of use and/or misuse of codeine-containing medications in the general population (SADHS, 2016).

5.1. Method

Information on tobacco, alcohol and codeine use and abuse is retrieved from the SADHS 2016 data. The survey included questions on tobacco use in the form of smoking, alcohol consumption, and on the use and misuse of codeine-containing medications in the adult health module administered to respondents aged 15 years and older. For the purpose of this report, only information pertaining to the youth aged 15–34 years is analysed and reported on.

5.2. Results

Results on codeine misuse or abuse are highlighted only at national level due to the limited number of respondents who responded to the question (see Table 12). Information on tobacco smoking and alcohol consumption is presented by age group, population group, marital status, level of education and province.

5.2.1 Codeine misuse or abuse

Information on codeine misuse is analysed from a question that was phrased as follows in the SADHS 2016: “In the last 12 months, have you used any of these codeine-containing medications for the experience or feeling it gave you rather than for their medicinal effect?” The response to this question was used to classify misuse in the context of the SADHS. A total of 58 (2,1%) of young women and 35 (1,6%) young men aged 15–34 years reported they have used codeine for the feeling it gave in the 12 months before the survey in the SADHS 2016.

The majority of respondents indicated that the question was not applicable to them. Although only a small number of respondents reported the abuse of codeine. It is a matter of concern that there was a proportion of the youth that was willing to answer honestly about the fact that they took medication containing codeine for the feeling or experience, rather than for the medicinal effect.

Table 12: Percentage of the youth (15–34) who used codeine-containing medication in the 12 months before the survey for the experience or feeling rather than its medicinal effect

Variable	Percentage of the youth who used codeine-containing medication in the 12 months before the survey for the experience or feeling rather than its medicinal effect			
	Women		Men	
	Number	Percentage	Number	Percentage
Yes	58	2,1	35	1,6
No	295	12,0	235	10,7
Not applicable	2 466	87,5	1 921	87,7
Total	**2 820**	**100,0**	**2 191**	**100,0**

5.2.2 Tobacco smoking

Information on tobacco smoking is presented in Table 13 below and it shows only for those respondents who answered “Yes” to the two questions in the SADHS 2016, namely: “Do you currently smoke tobacco every day, some days or not at all?”, and “In the past, have you ever smoked tobacco every day, some days, or not at all?”

Nationally, 7,7% of women and 40,1% men between the ages 15–34 years who participated in the survey reported that they are currently smoking tobacco or that they have smoked tobacco in the past. A percentage of 5,3% of women and almost a quarter (22,6%) of men aged 15–19 years have ever smoked tobacco. Among those aged 20–24 years, 8,2% women and 44,6% men reported that they are currently smoking tobacco or that they have smoked tobacco in the past, Among the group aged 25–29 years, 7,8% of women and one in every two (50,1%) men had indicated that they are currently smoking tobacco or that they have smoked tobacco in the past. One in every ten (9,8%) of the women and almost one in every two (48,2%) of the men aged 30–34 years indicated that they ever smoked tobacco or are currently smoking.

With regard to analysis on racial differentials, only those for the black African population are reported on, since the numbers for the other population groups were too small to deduce any useful information. Amongst the black African population, 4,3% of women aged 15–34 and almost four in every ten men (38,9%) indicated that they ever smoked tobacco.

Provincial differentials indicate much higher proportions of smoking amongst men versus their female counterparts in all provinces. The Western Cape (49,3%) and Eastern Cape (48,0%) were the two provinces that had the highest proportions of men who had ever smoked tobacco. The Western Cape (29,4%) and Northern Cape (21,1%) were the two provinces who had the highest proportions of women who had ever smoked tobacco. KwaZulu-Natal had the lowest percentage (2,5%) of women who had ever smoked tobacco. The lowest percentage of men who had ever smoked tobacco was seen in Limpopo (28,5%), although this still means almost one in every three men in the province had ever smoked.

Summary of tobacco use

Generally, more men use tobacco than their female counterparts for all age groups and provinces. Research on the use of tobacco has shown to have negative effects on people’s health as it affects the lungs, leading to respiratory disease and could cause amongst others cancer. Tobacco use contributes to the burden of disease and could even lead to death from tobacco-related diseases (SADHS, 2016).

Table 13: Percentage distribution of the youth (15–34) who indulge in tobacco smoking, SADHS 2016

Variable	% of women who ever smoked tobacco	Number of women	% of men who ever smoked tobacco	Number of men
All	**7,7**	**2 819**	**40,1**	**2 191**
Age group				
15–19	5,3	721	22,6	647
20–24	8,2	708	44,6	588
25–29	7,8	754	50,1	506
30–34	9,8	637	48,2	450
Population group				
Black African	4,3	2 536	38,9	1 957
Coloured	44,4	192	(39,2)	58
White	(22,7)	59	59,0	146
Indian/Asian	*	33	*	30
Marital status				
Never married	6,5	1 992	39,3	1 753
Married or living together as married	10,7	828	43,7	438
Education				
No schooling	*	16	*	16
Primary incomplete	5,1	98	43,1	126
Primary complete	5,3	110	34,5	115
Secondary incomplete	8,4	1 491	40,0	1 216
Secondary complete	8,0	847	39,5	546
More than secondary	5,6	257	45,1	172
Province				
Western Cape	29,4	258	49,3	203
Eastern Cape	7,6	286	48,0	270
Northern Cape	21,1	54	44,4	(39)
Free State	6,8	142	42,6	119
KwaZulu-Natal	2,5	578	37,2	392
North West	4,9	193	33,2	153
Gauteng	6,2	781	40,7	602
Mpumalanga	7,6	247	40,8	183
Limpopo	2,6	279	28,5	230

'Other' population group is excluded
Figures in parentheses are based on 25–49 unweighted cases
Asterisk indicates that a figure is based on fewer than 25 unweighted cases

5.2.3 Alcohol consumption

This part of the report presents information on alcohol consumption among young people as obtained from the SADHS 2016. Information on alcohol consumption and risky drinking among the youth is based on the CAGE test (Concern/Cut-down, Anger, Guilt, and Eye-Opener). This is a test used to screen for possible problem drinking and alcoholism. Two “Yes” responses to the following questions indicate the possibility of problem drinking: “Have you ever felt you should cut down your drinking?”, “Have people annoyed you by criticising your drinking?”, “Have you ever felt bad or guilty about your drinking?”, “Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?”.

Results shown in Table 14 indicate that 29,3% of women and 60,3% men aged 15–34 years who participated in the survey reported that they have consumed a drink that contains alcohol in the past. Among the youth aged 15–19 years, one in five (23,4%) women and almost one in two (45,5%) men ever consumed a drink that contains alcohol, while those aged 20–24 years comprised one in three (35,2%) women and seven out of every ten (68,3%) men who ever consumed a drink that contains alcohol. Men aged 25–29 years had more than double the proportion (66,3%) versus women (31,6%) who ever consumed a drink that contains alcohol. Among the women and men aged 30–34 years, 26,4% and 64,6%, respectively were among those who ever consumed a drink that contains alcohol.

With regard to analysis on racial differentials, only those for the black African population are reported on, since the numbers for the other population groups were too small to deduce any useful information. Amongst the black African population, one in four (26,6%) women aged 15–34 and more than double the proportion of men (60,7%) indicated that they ever consumed alcohol.

The provincial profile for persons who ever consumed a drink that contains alcohol varies widely, as much as 78,4% of men in North West ever consumed a drink that contains alcohol. In the Western Cape, 44,7% women and 54,0% men ever consumed a drink that contains alcohol. In the Northern Cape, a similar picture is seen with 48,2% women and 56,7% men who ever consumed a drink that contains alcohol. The provinces with the highest percentages of men who ever consumed a drink that contains alcohol were North West (78,4%) and Mpumalanga (64,7%). The provincial profile for women who ever consumed a drink that contains alcohol shows that almost one in every two women (48,2%) in Northern Cape and 44,7% in Western Cape had consumed alcohol.

Summary of alcohol assumption

Alcohol consumption was found to be more prevalent among men when compared to their female counterparts. The age group with the highest consumption for both women and men who ever consumed a drink that contains alcohol is those persons aged 20–24 years. Provincially, North West had more men and Northern Cape more women who ever consumed a drink that contains alcohol. Research over time has shown that the abuse of alcohol contributes to the additional burden of accidents and violence in the country, thus making these results a cause for concern. (SADHS, 2016).

Table 14: Percentage distribution of the youth (15–34) who indulge in alcohol consumption, SADHS 2016

Variable	% of women who ever consumed drink that contains alcohol	Number of women	% of men who ever consumed alcohol	Number of men
All	**29,3**	**2 819**	**60,3**	**2 191**
Age group				
15–19	23,4	721	45,5	647
20–24	35,2	708	68,3	588
25–29	31,6	754	66,3	506
30–34	26,4	637	64,6	450
Population group				
Black African	26,6	2 536	60,7	1 957
Coloured	52,7	192	(81,7)	58
White	(65,6)	59	51,4	146
Indian/Asian	*	33	*	30
Marital status				
Never married	28,5	1 992	59,1	1753
Married or living together married	31,2	828	65,2	438
Education				
No schooling	*	16	69,1	172
Primary incomplete	20,8	98	*	16
Primary complete	24,7	110	47,0	115
Secondary incomplete	26,9	1 491	53,1	126
Secondary complete	30,9	847	65,5	546
More than secondary	42,6	257	58,7	1 216
Province				
Western Cape	44,7	258	54,0	203
Eastern Cape	34,1	286	56,2	270
Northern Cape	48,2	54	56,7	39
Free State	32,7	142	46,9	119
KwaZulu-Natal	14.0	578	55,6	392
North West	30,9	193	78,4	153
Gauteng	33,5	781	63,5	602
Mpumalanga	40,7	247	64,7	183
Limpopo	13,0	279	62,7	230

'Other' population group is excluded
Figures in parentheses are based on 25–49 unweighted cases
Asterisk indicates that a figure is based on fewer than 25 unweighted cases

Chapter 6: Crashes and fatalities

Information on injuries and road accidents that the youth experience is analysed from information retrieved from the Road Traffic Management Corporation (RTMC) managed by the Department of Transport. Fatalities are defined as deaths that occurred as a result of road accidents (referred in this report as crashes). This section presents information based on data collected for administrative purposes thus caution should be excised when interpreting such data.

6.1 Method

Information on fatal crashes is collected by the South African Police Service (SAPS) in all nine provinces using the culpable homicide crash observation report (CHoCOR) forms. The forms are then sent to the RTMC to be captured, processed and verified to compile a report on these occurrences. All fatal crashes 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.

6.2. Results

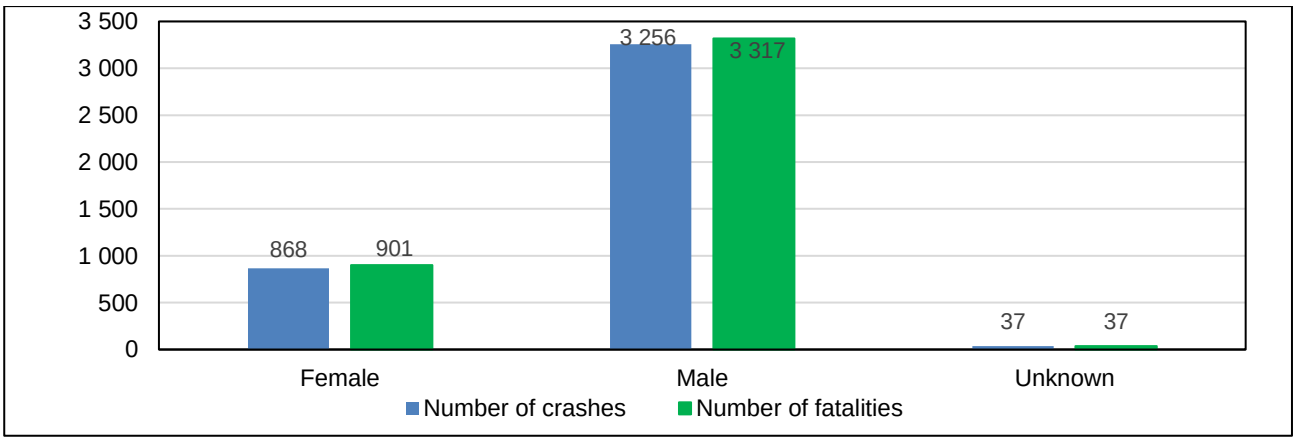
Table 15 and Figure 3 below present information on crashes and fatalities among the youth by sex. Results show that a total of 4 161 crashes occurred on the roads between January and December 2018, resulting in 4 255 fatalities among the youth aged 15–34 years. Crashes and fatalities are more prevalent among males than females (78,0% and 21,0%, respectively). As can be expected, since all fatalities due to accidents must be investigated and reported, the percentages of crashes and fatalities are nearly the same. In absolute numbers, more fatalities than crashes are reported, i.e. 868 crashes occurred that involved females but 901 women were killed in these crashes. Similarly, 3 256 crashes occurred in which 3 317 men lost their lives in 2018.

Table 15: Number and percentage of crashes and fatalities among the youth (15–34) by sex, 2018

Sex	Number of crashes	Percentage of crashes	Number of fatalities	Percentage of fatalities
Female	868	21,0	**901**	21,0
Male	3 256	78,0	**3 317**	78,0
Unknown	37	1,0	**37**	1,0
Total	**4 161**	**100,0**	**4 255**	**100,0**

Source: Road Traffic Management Corporation

Figure 3: Number of crashes and fatalities among the youth aged 15–34 by sex, 2018



Source: Road Traffic Management Corporation

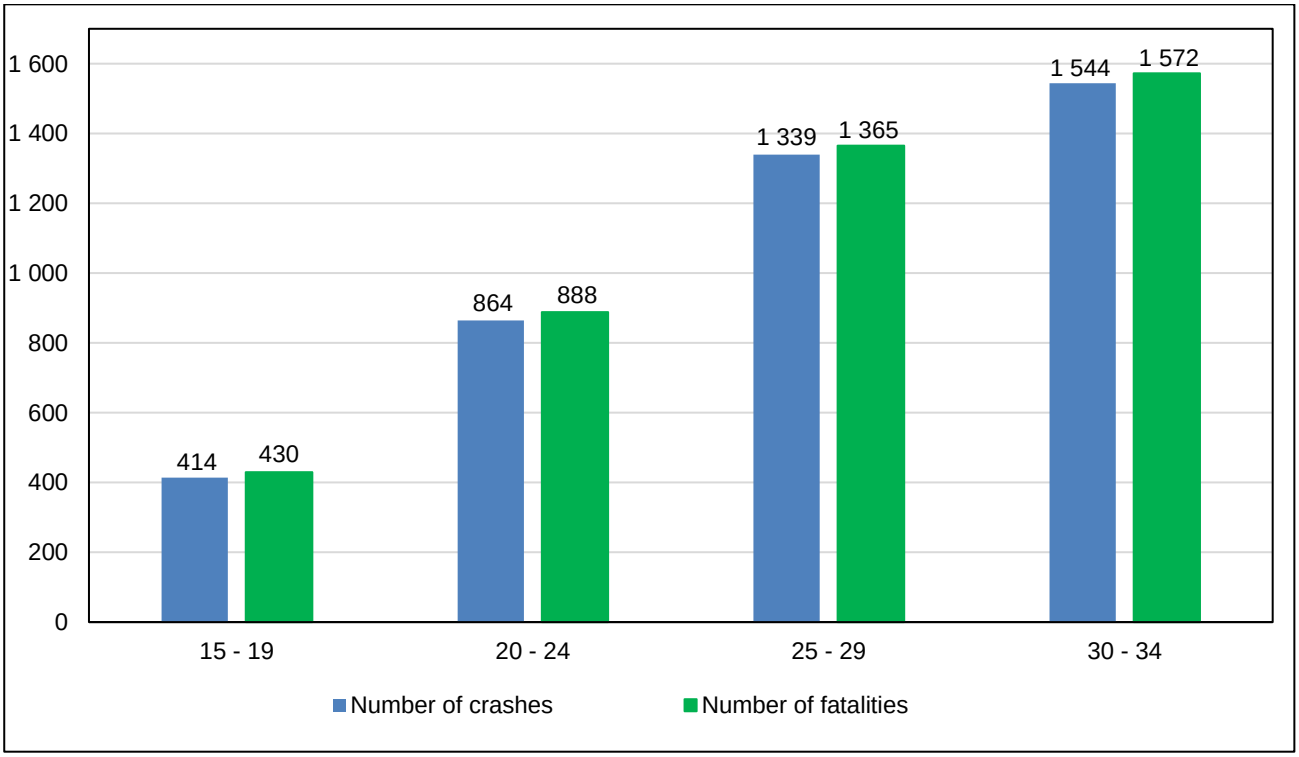
Table 16 and Figure 4 below presents the number and proportions of crashes and fatalities that occurred in 2018 among the youth by age group. Results show that those aged 30–34 years (1 544 crashes and 1 572 fatalities) were mostly affected by crashes and fatalities as a result thereof. Those people aged 25–29 years (1 339 accidents and 1 365 fatalities) were the second most affected. The least affected age group was those aged 15–19 years for both crashes (414) and fatalities (430).

Table 16: Number and percentages of crashes and fatalities among the youth (15–34) by age group

Age group	Number of crashes	Percentage of crashes	Number of fatalities	Percentage of fatalities
15–19	414	10,0	430	10,0
20–24	864	21,0	888	21,0
25–29	1 339	32,0	1 365	32,0
30–34	1 544	37,0	1 572	37,0
Total	**4 161**	**100,0**	**4 255**	**100,0**

Source: Road Traffic Management Corporation

Figure 4: Number of crashes and fatalities among the youth (15–34) by age group, 2018



Source: Road Traffic Management Corporation

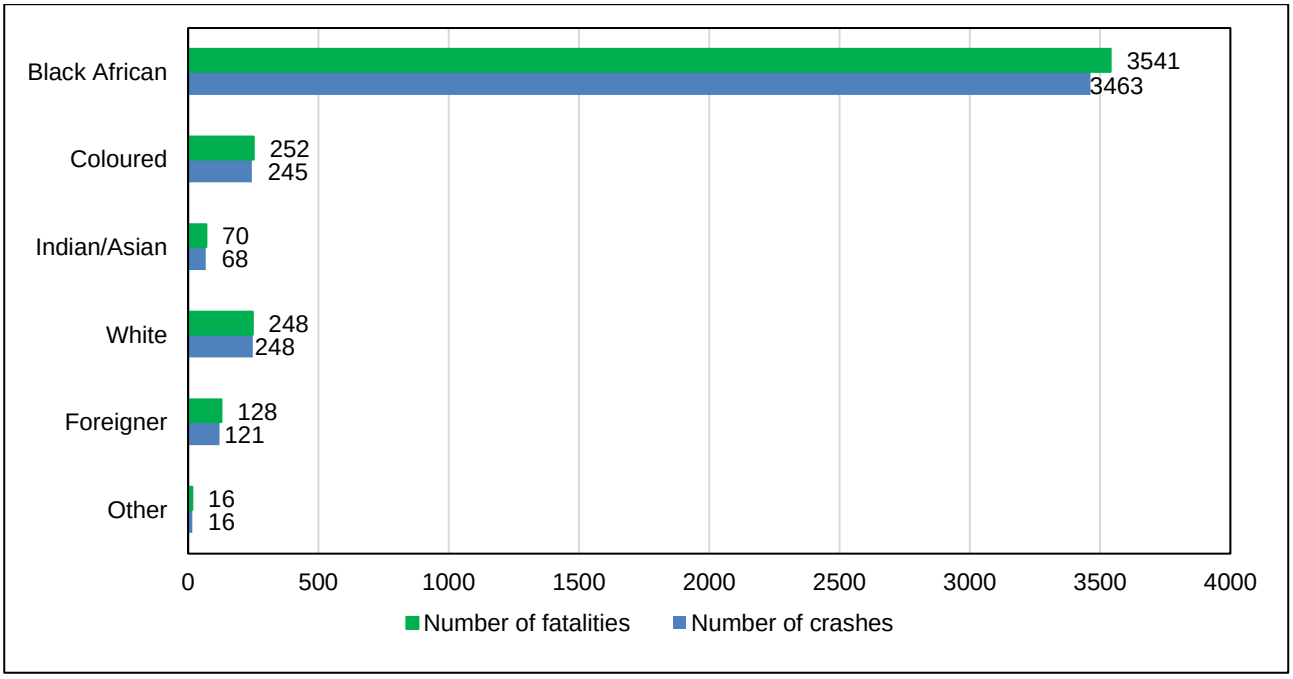
Table 17 and Figure 5 below highlight the number of crashes and fatalities among the youth by population group. Results with regard to crashes and fatalities in terms of population group might be indicative of the population distribution in the country, with the black African population being the largest proportion of the overall population. The largest proportions of crashes and fatalities occurred among the black African population group (3 463 crashes and 3 541 fatalities). The coloured and white population groups had very similar profiles in terms of crashes and fatalities, with percentages around 6,0%. The least affected population group is the Indian/Asian population group with percentages of 2% for crashes and fatalities.

Table 17: Number and percentages of crashes and fatalities for the youth (15–34) by population group, 2018

Population group	Number of crashes	Percentage of crashes	Number of fatalities	Percentage of fatalities
Black African	3 463	83,0	3 541	83,0
Coloured	245	6,0	252	6,0
Indian/Asian	68	2,0	70	2,0
White	248	6,0	248	6,0
Foreign nationals	121	3,0	128	3,0
Other	16	0,0	16	0,0
Total	**4 161**	**100,0**	**4 255**	**100,0**

Source: Road Traffic Management Corporation

Figure 5: Number of crashes and fatalities among the youth (15–34) by population group, 2018



Source: Road Traffic Management Corporation

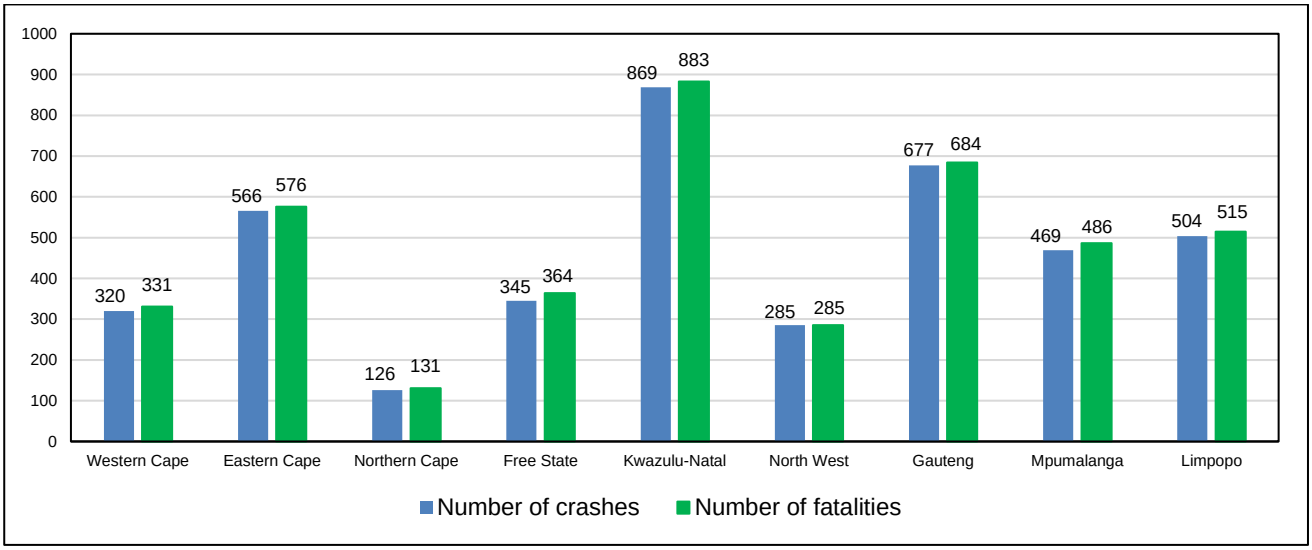
Information in Table 18 and Figure 6 shows the number and percentages of crashes and fatalities among the youth in 2018 by province. The most affected provinces in terms of crashes and fatalities were KwaZulu-Natal (21,0%) and Gauteng (16,0%). The remainder of the provinces all had percentages below 15% for both crashes and fatalities. Northern Cape had the lowest proportions for crashes and fatalities (126 crashes and 131 fatalities) while North West had the second lowest proportions of crashes and fatalities (both at 285).

Table 18: Number and percentages of crashes and fatalities among the youth (15–34) by province, 2018

Province	Number of crashes	Percentage of crashes	Number of fatalities	Percentage of fatalities
Western Cape	320	8,0	331	8,0
Eastern Cape	566	14,0	576	14,0
Northern Cape	126	3,0	131	3,0
Free State	345	8,0	364	9,0
KwaZulu-Natal	869	21,0	883	21,0
North West	285	7,0	285	7,0
Gauteng	677	16,0	684	16,0
Mpumalanga	469	11,0	486	11,0
Limpopo	504	12,0	515	12,0
Total	**4 161**	**100,0**	**4 255**	**100,0**

Source: Road Traffic Management Corporation

Figure 6: Number of crashes and fatalities among the youth (15–34) by province, 2018



Source: Road Traffic Management Corporation

Summary of crashes and fatalities

Males are more likely to be involved in crashes and resultant fatalities than females. Results show that those in the age category 30–34 years are more prone to crashes. In terms of population profile, the black African group has the highest proportions of crashes and fatalities. Provincial differences indicate more accidents take place in KwaZulu-Natal and least in Northern Cape. Road traffic injuries are among the leading causes of death and life-long disability globally (Adeloye, 2016) and the leading cause of death among young people aged 15–29 years and also among the top three causes of mortality among people aged 15–34 years (Adeloye, 2016). A similar picture is found with regards to accidents and mortality in South Africa as described above.

Chapter 7: Causes of death

This chapter of the report discusses the leading causes of death for deaths that occurred in 2016 among the youth 15–34 years. Information on these deaths is retrieved from Mortality and causes of death 2016 data as produced by Stats SA (MACOD, 2016).

7.1 Method

Statistics South Africa receives death notification forms (DNFs) from the Department of Home Affairs (DHA) for processing on a continuous basis. The DNFs go through a number of processes, e.g. sorting by year of death, coding of demographic information as well as other variables such as place of death occurrence. Classification and generation of underlying causes of death are also processes that the DNFs go through. Capturing of all the variables into the system is done after all variables are coded (Refer to MACOD 2016 report for full method).

Information presented in this section describes the five leading natural and non-natural causes of death among the youth by 5-year age groups. The age categories for the purpose of this report are: 15–19 years, 20–24 years, 25–29 years and 30–34 years. In addition to the above-mentioned age categories, there is a combination of the first two age categories to form the 15–24 years age group.

For statistical purposes, the United Nations defines youth as those persons aged between 15 and 24 years. This definition was prepared during the planning of International Youth Year (1985), and endorsed by the General Assembly. All United Nations statistics on youth follow this definition (DESA, 2019). In addition to age groups, data on causes of death is also analysed by sex, population group and province.

7.2 Results

Overall, there was a total of 71 257 deaths (both natural and non-natural) that occurred among the youth aged 15–34 years in 2016. The number of deaths among the youth by age group were as follows: 6 821 deaths among the youth aged 15–19 years, 13 708 deaths among those aged 20–24 years, 20 529 deaths for those aged 15–24 years, with 22 209 deaths among those aged 25–29 years and 28 519 deaths among those aged 30–34 years.

7.2.1 Natural causes of death

This subsection highlights the leading underlying natural causes of death. The five leading natural causes of death were identified by ranking the natural underlying causes by the number of deaths due to those diseases. In total, there were 46 719 deaths due to natural causes among the youth in 2016.

Natural causes of death by sex

The information shown in Table 19 below presents information on the leading natural causes of death among the youth by sex for deaths that occurred in 2016. Results show that there was a total of 21 219 deaths due to natural causes among males and 25 267 deaths due to natural causes among females aged 15–34 years.

Tuberculosis was the leading cause of death for both males and females (8,5% and 13,6%, respectively). It was followed by the *human immunodeficiency virus* (6,7% for males and 12,3% for females). The third leading natural cause of death was *other viral diseases* for both sexes (4,3% and 9,9%, respectively). *Certain disorders involving the immune mechanism* was ranked the fourth leading cause of death for both sexes (2,7% and 5,6%, respectively), while *influenza and pneumonia* was the fifth leading cause of death for males and females (2,7% and 4,5%, respectively). Deaths due to natural causes were more common among females than males for all the five leading natural causes of death in 2016.

Table 19: The five leading natural causes of death among the youth (15–34) by sex, MACOD 2016

Underlying Broad Group ICD-10	Males			Females		
	Rank	Number	Percentage	Rank	Number	Percentage
Tuberculosis (A15-A19)	1	3 538	8,5	1	3 956	13,6
Human immunodeficiency virus [HIV] disease (B20-B24)	2	2 798	6,7	2	3 600	12,3
Other viral diseases (B25-B34)	3	1 808	4,3	3	2 898	9,9
Certain disorders involving the immune mechanism (D80-D89)	4	1 136	2,7	4	1 622	5,6
Influenza and pneumonia (J09-J18)	5	1 118	2,7	5	1 300	4,5
Other natural causes		10 821	25,9		11 891	40,8
Total natural causes		21 219			25 267	
Non-natural causes		20 520	49,2		3 896	13,4
Total		**41 739**	**100,0**		**29 163**	**100,0**

*Excluding cases with unspecified sex

Natural causes of death by population group

Table 20 shows that *tuberculosis* was the leading cause of death for black Africans (10,8%) and Indian/Asians (3,0%), and second for coloureds (10,2%). *Human immunodeficiency virus* was ranked as the leading cause of death for the coloured population group (11,5%), second for black Africans (10,3%) and fifth for Indians/Asians (1,6%). *Other viral diseases* was third for black Africans (7,5%) and coloureds (2,8%).

Certain disorders involving the immune mechanism was ranked the fourth leading natural causes of death among the black Africans (4,3%) and coloured population group (2,8%). *Influenza and pneumonia* was the fourth leading cause of death for whites and Indians/Asians (both at 1,8%) and ranked fifth for black Africans at 3,7%.

The white population group had a totally different profile in terms of the leading natural causes of death. *Other forms of heart disease* was the leading cause of death (2,7%), followed by *Ischemic heart diseases* (2,0%) in the second place and the third ranking was *malignant neoplasms, stated or presumed to be primary, of lymphoid, hematopoietic and related tissue* (1,9%). *Ischemic heart diseases* was the second ranking natural cause of death for the Indian/Asian population group (3,0%) and also fifth for the coloured population group (1,4%).

Table 20: The five leading natural causes of death among the youth (15–34) by population group, MACOD 2016

Underlying Broad Group ICD-10	Black African			White			Indian or Asian			Coloured		
	Rank	No.	%	Rank	No.	%	Rank	No.	%	Rank	No.	%
Tuberculosis (A15-A19)	**1**	6 200	10,8	**…**	…	…	**1**	15	3,0	**2**	413	10,2
Human immunodeficiency virus [HIV] disease (B20-B24)	**2**	5 913	10,3	**…**	…	…	**5**	8	1,6	**1**	466	11,5
Other viral diseases (B25-B34)	**3**	4 332	7,5	**…**	…	…	**…**	…	…	**3**	114	2,8
Certain disorders involving the immune mechanism (D80-D89)	**4**	2 485	4,3	**…**	…	…	**…**	…	…	**4**	114	2,8
Influenza and pneumonia (J09-J18)	**5**	2 117	3,7	**4**	21	1,8	**4**	9	1,8	**…**	…	…
Other forms of heart disease (I30-I52)	**…**	…	…	**1**	32	2,7	**3**	12	2,4	**…**	…	…
Ischaemic heart diseases (I20-I25)	**…**	…	…	**2**	24	2,0	**2**	15	3,0	**5**	58	1,4
Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue (C81-C96)	**…**	…	…	**3**	23	1,9	**…**	…	…	**…**	…	…
Diabetes mellitus (E10-E14)	**…**	…	…	**5**	20	1,7	**…**	…	…	**…**	…	…
Other natural causes		17 500	30,4		448	37,9		157	31,0		995	24,6
Total natural causes		38 547			568			216			2 160	
Non-Natural causes		18 946	33,0		614	51,9		290	57,3		1 886	46,6
Total		**57 493**	**100,0**		**1 182**	**100,0**		**506**	**100,0**		**4 046**	**100,0**

*Excluding ‘unspecified’, ‘unknown’ and ‘other’ population group

Natural causes of death by age group

Table 21 depicts the five leading natural causes of death among the youth by age groups. There were 3 770 deaths due to natural causes among the youth aged 15–19 years, 7 154 deaths among those aged 20–24 years, 14 255 deaths among those aged 25–29 years and 21 540 deaths among those aged 30–34 years. Among the youth aged 15–24 years, 10 924 deaths due to natural causes were recorded.

In all age groups, *tuberculosis* was the leading natural cause of death for deaths that occurred among the youth in 2016, followed by *human immunodeficiency virus. Other viral diseases* was ranked third for all age groups. *Influenza and pneumonia* was ranked the fourth leading natural cause of death for all age groups with the exception of those aged 30–34 years, where *certain disorders involving the immune mechanisms* was the fourth leading cause of death. The fifth leading natural cause of death was *certain disorders involving the immune mechanism* for all age groups with the exception of those aged 20–24 years and 30–34 years.

Table 21: The top five leading natural causes of death among the youth (15–34) by age group, MACOD 2016

Underlying Broad Group ICD -10	15–19			20–24			15–24			25–29			30–34		
	Rank	Number	%	Rank	Number	%	Rank	Number	%	Rank	Number	%	Rank	Number	%
Tuberculosis (A15-A19)	1	403	5,9	1	1 041	7,6	1	1 444	7,0	1	2 255	10,2	1	3 478	12,2
Human immunodeficiency virus [HIV] disease (B20-B24)	2	300	4,4	2	865	6,3	2	1 165	5,7	2	2 142	9,6	2	3 469	12,2
Other viral diseases (B25-B34)	3	254	3,7	3	636	4,6	3	890	4,3	3	1 495	6,7	3	2 345	8,2
Influenza and pneumonia (J09-J18)	4	215	3,2	4	347	2,5	4	562	2,7	4	888	4,0	5	1 372	4,8
Certain disorders involving the immune mechanism (D80-D89)	5	164	2,4	4	347	2,5	5	511	2,5	5	751	3,4	4	1 119	3,9
Other natural causes		2 434	35,7		3 918	28,6		6 352	30,9		6 724	30,3		9 757	34,2
Total natural causes		3 770			7 154			10 924			14 255			21 540	
Non-natural causes		3 051	44,7		6 554	47,8		9 605	46,8		7 954	35,8		6 979	24,5
Total		**6 821**	**100,0**		**13 708**	**100,0**		**20 529**	**100,0**		**22 209**	**100,0**		**28 519**	**100,0**

*Excluding cases of unspecified age

Natural causes of death by province

Table 22 below presents the underlying natural causes of death among the youth by province. *Human immunodeficiency virus* was the leading cause of death in three of the provinces, namely Western Cape (14,1%), Northern Cape (13,1%) and Eastern Cape (12,0%). It was ranked the second leading natural cause of death for KwaZulu-Natal (12,0%) and Gauteng (5,5%). *Human immunodeficiency virus* was the third leading natural cause of death in Free State (9,2%) and Mpumalanga (8,7%) and ranked fourth in Limpopo (6,7%) and North West (5,5%).

Tuberculosis was the leading cause of death in six of the provinces, namely KwaZulu-Natal (12,1%), North West (11,9%), Mpumalanga (11,4%), Free State (10,0%), Limpopo (9,1%) and Gauteng (7,7%). *Tuberculosis* was the second leading natural cause of death in Northern Cape (11,1%), Eastern Cape (10,3%) and Western Cape (8,3%).

Other viral diseases was ranked the second leading natural cause of death in Free State (9,3%), Limpopo (9,0%), North West (8,8%), and Mpumalanga (8,7%). *Other viral diseases* was the third leading natural cause of death in KwaZulu-Natal (7,1%), Eastern Cape (6,4%), Gauteng (5,2%), and Western Cape (2,3%).

Certain disorders of involving the immune mechanism is ranked the fourth leading cause of death in five provinces with the exception of Northern Cape, North West, Gauteng and Limpopo. *Other forms of heart disease* was the fifth leading cause of death in KwaZulu-Natal (3,0%), Eastern Cape (2,0%) and Western Cape (1,1%).

Influenza and pneumonia was the third leading natural cause of death in Limpopo (6,8%) and fourth in Gauteng (4,5%). It was ranked the fifth natural cause of death in Free State and North West (5,1% and 4,5%, respectively).

Table 22: The five leading natural causes of death among the youth (15–34): Western Cape, Eastern Cape and Northern Cape, MACOD 2016

Western Cape				Eastern Cape				Northern Cape			
Broad group of underlying causes	**Rank**	**Number**	**%**	**Broad group of underlying causes**	**Rank**	**Number**	**%**	**Broad group of underlying causes**	**Rank**	**Number**	**%**
Human immunodeficiency virus [HIV] disease (B20-B24)	1	961	14,1	Human immunodeficiency virus [HIV] disease (B20-B24)	1	1 294	12,0	Human immunodeficiency virus [HIV] disease (B20-B24)	1	260	13,1
Tuberculosis (A15-A19)	2	565	8,3	Tuberculosis (A15-A19)	2	1 113	10,3	Tuberculosis (A15-A19)	2	220	11,1
Other viral diseases (B25-B34)	3	157	2,3	Other viral diseases (B25-B34)	3	689	6,4	Certain disorders involving the immune mechanism (D80-D89)	3	145	7,3
Certain disorders involving the immune mechanism (D80-D89)	4	85	1,3	Certain disorders involving the immune mechanism (D80-D89)	4	339	3,1	Other viral diseases (B25-B34)	4	113	5,7
Other forms of heart disease (I30-I52)	5	78	1,1	Other forms of heart disease (I30-I52)	5	212	2,0	Influenza and pneumonia (J09-J18)	5	57	2,9
Other natural causes		1 461	21,5	Other natural causes		3 339	30,9	Other natural causes		532	26,9
Non-natural causes		3 488	51,3	Non-natural causes		3 818	35,3	Non-natural causes		652	
Total		**6 795**	**100,0**	**Total**		**10 804**	**100,0**	**Total**		**1 979**	**100,0**

Table 22: The five leading natural causes of death among the youth (15–34): Free State, KwaZulu-Natal and North West, MACOD 2016

Free State				KwaZulu-Natal				North West			
Broad group of underlying causes	**Rank**	**Number**	**%**	**Broad group of underlying causes**	**Rank**	**Number**	**%**	**Broad group of underlying causes**	**Rank**	**Number**	**%**
Tuberculosis (A15-A19)	1	470	10,0	Tuberculosis (A15-A19)	1	1 856	12,1	Tuberculosis (A15-A19)	1	594	11,9
Other viral diseases (B25-B34)	2	437	9,3	Human immunodeficiency virus [HIV] disease (B20-B24)	2	1 828	12,0	Other viral diseases (B25-B34)	2	440	8,8
Human immunodeficiency virus [HIV] disease (B20-B24)	3	432	9,2	Other viral diseases (B25-B34)	3	1 078	7,1	Certain disorders involving the immune mechanism (D80-D89)	3	315	6,3
Certain disorders involving the immune mechanism (D80-D89)	4	263	5,6	Certain disorders involving the immune mechanism (D80-D89)	4	477	3,1	Human immunodeficiency virus [HIV] disease (B20-B24)	4	275	5,5
Influenza and pneumonia (J09-J18)	5	239	5,1	Other forms of heart disease (I30-I52)	5	456	3,0	Influenza and pneumonia (J09-J18)	5	225	4,5
		1 440	30,5			4 547	29,8			1 675	33,6
Non-natural causes		1 436	30,4	Non-natural causes		5 042	33,0	Non-natural causes		1 464	29,4
Total		**4 717**	**100,0**	**Total**		**15 284**	**100,0**	**Total**		**4 988**	**100,0**

Table 22: The five leading natural causes of death among the youth (15–34): Gauteng, Mpumalanga and Limpopo, MACOD 2016

Gauteng				Mpumalanga				Limpopo			
Broad group of underlying causes	**Rank**	**Number**	**%**	**Broad group of underlying causes**	**Rank**	**Number**	**%**	**Broad group of underlying causes**	**Rank**	**Number**	**%**
Tuberculosis (A15-A19)	1	1 141	7,7	Tuberculosis (A15-A19)	1	675	11,4	Tuberculosis (A15-A19)	1	542	9,1
Human immunodeficiency virus [HIV] disease (B20-B24)	2	809	5,5	Other viral diseases (B25-B34)	2	517	8,7	Other viral diseases (B25-B34)	2	533	9,0
Other viral diseases (B25-B34)	3	766	5,2	Human immunodeficiency virus [HIV] disease (B20-B24)	3	516	8,7	Influenza and pneumonia (J09-J18)	3	405	6,8
Influenza and pneumonia (J09-J18)	4	663	4,5	Certain disorders involving the immune mechanism (D80-D89)	4	275	4,6	Human immunodeficiency virus [HIV] disease (B20-B24)	4	401	6,7
Certain disorders involving the immune mechanism (D80-D89)	5	636	4,3	Influenza and pneumonia (J09-J18)	5	238	4,0	Certain disorders involving the immune mechanism (D80-D89)	5	234	3,9
		5 717	38,7			1 913	32,3			2 049	34,4
Non-natural causes		5 039	34,1	Non-natural causes		1 794	30,3	Non-natural causes		1 789	30,1
Total		**14 771**	**100,0**	**Total**		**5 928**	**100,0**	**Total**		**5 953**	**100,0**

7.2.2 Non-natural causes of death

In this section the leading underlying non-natural causes of death are discussed. The five leading causes were identified by ranking the non-natural underlying causes by the number of deaths that occurred due to those causes. Overall, there were 24 538 deaths due to non-natural causes among the youth aged 15-34 years in 2016.

Non-natural causes of death by sex

In Table 23 below presents information on the leading non-natural causes of death among the youth by sex for deaths that occurred in 2016. Figures for non-natural deaths are obtained by adding the total of the top five ranked causes of death to the "other non-natural causes" and then subtracting them from the total of all causes among the youth. Results show that there was a total of 20 520 of deaths due to non-natural causes among males and 3 896 deaths due to non-natural causes among females aged 15–34 years.

Other external causes of accidental injury was the leading non-natural cause of death for males (30,5%) and the second leading non-natural cause of death for females (2,3%). *Assault* was ranked the leading cause of deaths for females (7,9%) and second for males (11,4%). The third leading non-natural cause of death was *Transport accidents* for males (5,5%). *Event of undetermined intent*[1] was ranked the fourth leading cause of deaths for males (1,1%) and third for females (1,5%). *Intentional self-harm* was the fifth leading cause of death for males (0,5%) and fourth for females (1,2%), while *complications of medical and surgical care* was the fifth for females (0,3%).

Table 23: The five leading non-natural causes of death among the youth (15–34) by sex, MACOD 2016

Underlying Broad Group ICD-10	Males			Underlying Broad Group ICD -10	Females		
	Rank	Number	%		Rank	Number	%
Other external causes of accidental injury (W00-X59)	1	12 730	30,5	Other external causes of accidental injury (W00-X59)	2	668	2,3
Assault (X85-Y09)	2	4 742	11,4	Assault (X85-Y09)	1	2 317	7,9
Transport accidents (V01-V99)	3	2 290	5,5	Event of undetermined intent (Y10-Y34)	3	436	1,5
Event of undetermined intent (Y10-Y34)	4	473	1,1	Intentional self-harm (X60-X84)	4	341	1,2
Intentional self-harm (X60-X84)	5	199	0,5	Complications of medical and surgical care (Y40-Y84)	5	88	0,3
Other non-natural causes		86	0,2	Other non-natural causes		46	0,2
Total non-natural causes		20 520		Total non-natural causes		3 896	
Natural causes		21 219	50,8	Natural causes		25 267	86,6
Total		**41 739**	**100,0**	**Total**		**29 163**	**100,0**

*Excluding cases with unspecified sex

[1] Death from undetermined intent is considered as any death reported with an underlying cause of death coded Y10 to Y34 in the 10th revision of ICD (ICD-10). This section covers events where available information is insufficient to enable a medical or legal authority to make a distinction between accident, self-harm and assault. It includes self-inflicted injuries, but not poisoning, when not specified whether accidental or with intent to harm.

Non-natural causes of death by population group

Other external causes of accidental injury was the leading non-natural cause of death for all population groups, with differing proportions (Table 24). *Assault* was the second non-natural cause of death for black Africans (7,2%) and coloureds (11,4%). *Transport accidents* was the second ranking non-natural cause of death for whites (9,0%) and Indians/Asians (6,7%).

Transport accidents was the third ranking non-natural cause of death for black Africans (4,3%) and coloureds (3,9%). *Event of undetermined intent* was ranked third for whites (2,6%), and fourth for black Africans (1,1%) and Indians/Asians (2,4%). *Intentional self-harm* was the fifth ranking non-natural cause of death for black Africans (0,3%) and fourth for coloureds (0,8%).

Table 24: The five leading non-natural causes of death among the youth (15-34) by population group, MACOD 2016

Underlying Broad Group ICD-10	Black African		White		Indian or Asian		Coloured	
	No.	%	No.	%	No.	%	No	%
Other external causes of accidental injury (W00-X59)	11 414	19,9	454	38,4	217	42,9	1 194	29,5
Assault (X85-Y09)	4 127	7,2	10	0,8	21	4,2	462	11,4
Transport accidents (V01-V99)	2 453	4,3	106	9,0	34	6,7	159	3,9
Event of undetermined intent (Y10-Y34)	658	1,1	31	2,6	12	2,4	21	0,5
Intentional self-harm (X60-X84)	171	0,3	5	0,4	2	0,4	31	0,8
Complications of medical and surgical care (Y40-Y84)	115	0,2	7	0,6	4	0,8	16	0,4
Sequelae of external causes of morbidity and mortality (Y85-Y89)	8	0,0	1	0,1	0	0,0	3	0,1

*Excluding 'unspecified', 'unknown' and 'other' population group

Non-natural causes of death by age group

Table 25 presents deaths due to non-natural causes by age group. Non-natural causes are categorized as follows: 3 051 deaths among those aged 15–19 years, 6 554 deaths among the 20–24-year-olds, 9 605 deaths among those aged 15–24 years; 7 954 deaths among the 25–29-year-olds and 6 979 for those aged 30–34 years.

Overall, the pattern of the five leading non-natural causes of death is the same for all age groups, albeit at different proportions (Table 25). The leading cause of death was *other external causes of accidental injury* for all age groups. The second leading non-natural cause of death was *assault*, and *transport accidents* ranking as the third non-natural cause of death. *Event of undetermined intent* was ranked in the fourth place while *intentional self-harm* ranked as the fifth non-natural cause of death for all age groups among the youth in 2016.

Table 25: The five leading non-natural causes of death among the youth (15–34) by age group, MACOD 2016

Underlying cause of death	Age in 5-year age groups									
	15–19		20–24		15–24		25–29		30–34	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Other external causes of accidental injury (W00-X59)	1 762	25,8	3 911	28,5	5 673	27,6	4 977	22,4	4 476	15,7
Assault (X85-Y09)	658	9,6	1 592	11,6	2 250	11,0	1 674	7,5	1 281	4,5
Transport accidents (V01-V99)	367	5,4	700	5,1	1 067	5,2	967	4,4	932	3,3
Event of undetermined intent (Y10-Y34)	168	2,5	230	1,7	398	1,9	228	1,0	194	0,7
Intentional self-harm (X60-X84)	49	0,7	80	0,6	129	0,6	63	0,3	52	0,2
Other non-natural causes	**47**	**0,7**	**41**	**0,3**	**88**	**0,4**	**45**	**0,2**	**44**	**0,2**
Total non-natural causes	**3 051**		**6 554**		**9 605**		**7 954**		**6 979**	
Natural causes	**3 770**	**55,3**	**7 154**	**52,2**	**10 924**	**53,2**	**14 255**	**64,2**	**21 540**	**75,5**
Total	**6 821**	**100,0**	**13 708**	**100,0**	**20 529**	**100,0**	**22 209**	**100,0**	**28 519**	**100,0**

*Excluding cases with unspecified age

Non-natural causes of death by province

Table 26 below presents information on the leading non-natural causes of death among the youth by province for deaths that occurred in 2016. *Other external causes of accidental injury* was the leading non-natural cause of death in all the provinces with the exception of Northern Cape.

Transport accidents was the leading non-natural cause of death in Northern Cape (11,3%), second in Limpopo and Mpumalanga (10,4% and 4,2%, respectively). It was ranked the third leading non-natural cause of death in Free State (5,3%), North West (4,9%), KwaZulu-Natal (4,3%) Eastern Cape (3,7%), and Western Cape (3,0%).

Assault was the second leading non-natural cause in six provinces with the exception of Northern Cape, Mpumalanga and Limpopo. *Transport accidents* was the third leading non-natural cause of death in five provinces except for Northern Cape, Gauteng, Mpumalanga and Limpopo.

Event of undetermined intent was the third leading non-natural cause of death only in Gauteng (1,8%). It was ranked fourth in Free State (1,8%), Eastern Cape (1,5%), North West (1,4%), KwaZulu-Natal (0,8%), and Western Cape (0,3%), and fifth only in Northern Cape (0,8%).

Complications of medical and surgical care and *event of undetermined intent* was the fourth leading non-natural causes of death in Western Cape (both 0,3%). *Complications of medical and surgical care* is ranked fifth in Gauteng (0,3%), Eastern Cape (0,3%), and North West (0,2%).

Table 26: The five leading non-natural causes of death among the youth (15–34): Western Cape, Eastern Cape and Northern Cape, MACOD 2016

Western Cape			Eastern Cape			Northern Cape		
Broad group of underlying causes	**No.**	**%**	**Broad group of underlying causes**	**No.**	**%**	**Broad group of underlying causes**	**No.**	**%**
Transport accidents (V01-V99)	204	3,0	Transport accidents (V01-V99)	398	3,7	Transport accidents (V01-V99)	223	11,3
Other external causes of accidental injury (W00-X59)	2080	30,6	Other external causes of accidental injury (W00-X59)	2 070	19,2	Other external causes of accidental injury (W00-X59)	203	10,3
Intentional self-harm (X60-X84)	12	0,2	Intentional self-harm (X60-X84)	10	0,1	Intentional self-harm (X60-X84)	47	2,4
Assault (X85-Y09)	1148	16,9	Assault (X85-Y09)	1151	10,7	Assault (X85-Y09)	151	7,6
Event of undetermined intent (Y10-Y34)	23	0,3	Event of undetermined intent (Y10-Y34)	157	1,5	Event of undetermined intent (Y10-Y34)	16	0,8
Complications of medical and surgical care (Y40-Y84)	19	0,3	Complications of medical and surgical care (Y40-Y84)	30	0,3	Complications of medical and surgical care (Y40-Y84)	9	0,5
Sequelae of external causes of morbidity and mortality (Y85-Y89)	2	0,0	Sequelae of external causes of morbidity and mortality (Y85-Y89)	2	0,0	Sequelae of external causes of morbidity and mortality (Y85-Y89)	3	0,2
Natural causes	3 307	48,7	Natural causes	6 986	64,7	Natural causes	1327	67,1
Total	**6 795**	**100,0**	**Total**	**10 804**	**100,0**	**Total**	**1979**	**100,0**

Table 26: The five leading non-natural causes of death among the youth (15–34): Free State, KwaZulu-Natal and North West, MACOD 2016

Free State			KwaZulu-Natal			North West		
Broad group of underlying causes	**No.**	**%**	**Broad group of underlying causes**	**No.**	**%**	**Broad group of underlying causes**	**No.**	**%**
Transport accidents (V01-V99)	249	5,3	Transport accidents (V01-V99)	655	4,3	Transport accidents (V01-V99)	246	4,9
Other external causes of accidental injury (W00-X59)	723	15,3	Other external causes of accidental injury (W00-X59)	3158	20,7	Other external causes of accidental injury (W00-X59)	847	17,0
Intentional self-harm (X60-X84)	22	0,5	Intentional self-harm (X60-X84)	123	0,8	Intentional self-harm (X60-X84)	3	0,1
Assault (X85-Y09)	351	7,4	Assault (X85-Y09)	950	6,2	Assault (X85-Y09)	289	5,8
Event of undetermined intent (Y10-Y34)	85	1,8	Event of undetermined intent (Y10-Y34)	127	0,8	Event of undetermined intent (Y10-Y34)	70	1,4
Complications of medical and surgical care (Y40-Y84)	5	0,1	Complications of medical and surgical care (Y40-Y84)	28	0,2	Complications of medical and surgical care (Y40-Y84)	8	0,2
Sequelae of external causes of morbidity and mortality (Y85-Y89)	1	0,0	Sequelae of external causes of morbidity and mortality (Y85-Y89)	1	0,0	Sequelae of external causes of morbidity and mortality (Y85-Y89)	1	0,0
Natural causes	3 281	69,6	Natural causes	10 242	67,0	Natural causes	3 524	70,6
Total	**4 717**	**100,0**	**Total**	**15 284**	**100,0**	**Total**	**4 988**	**100,0**

Table 26: The five leading non-natural causes of death among the youth (15–34): Gauteng, Mpumalanga and Limpopo, MACOD 2016

Gauteng			Mpumalanga			Limpopo		
Broad group of underlying causes	**No.**	**%**	**Broad group of underlying causes**	**No.**	**%**	**Broad group of underlying causes**	**No.**	**%**
Transport accidents (V01-V99)	122	0,8	Transport accidents (V01-V99)	250	4,2	Transport accidents (V01-V99)	617	10,4
Other external causes of accidental injury (W00-X59)	3793	25,7	Other external causes of accidental injury (W00-X59)	1360	22,9	Other external causes of accidental injury (W00-X59)	882	14,8
Intentional self-harm (X60-X84)	7	0,0	Intentional self-harm (X60-X84)	13	0,2	Intentional self-harm (X60-X84)	6	0,1
Assault (X85-Y09)	796	5,4	Assault (X85-Y09)	131	2,2	Assault (X85-Y09)	236	4,0
Event of undetermined intent (Y10-Y34)	273	1,8	Event of undetermined intent (Y10-Y34)	32	0,5	Event of undetermined intent (Y10-Y34)	36	0,6
Complications of medical and surgical care (Y40-Y84)	44	0,3	Complications of medical and surgical care (Y40-Y84)	8	0,1	Complications of medical and surgical care (Y40-Y84)	12	0,2
Sequelae of external causes of morbidity and mortality (Y85-Y89)	4	0,0	Sequelae of external causes of morbidity and mortality (Y85-Y89)	0	0,0	Sequelae of external causes of morbidity and mortality (Y85-Y89)	0	0,0
Natural causes	9 732	65,9	Natural causes	4 134	69,7	Natural causes	4 164	69,9
Total	**14 771**	**100,0**	**Total**	**5 928**	**100,0**	**Total**	**5 953**	**100,0**

Conclusion

A vast number of definitions on what ages constitute the youth are being used by different organisations and institutions. However, for the purpose of this report, the youth is defined as those aged 15–34 years. All the analysis was subsequently done to profile the youth in the five-year age intervals, i.e. 15–19; 20–24; 25–29 and 30-34 years.

South Africa has a youthful population, as shown by the mid-year population estimates. Roughly one in every three people (35,1%) in the country can be classified as being between the ages 15–34 years. The majority of the youth population belongs to the black African population group (84,3%). Almost one in every three people classified as youth can be found in Gauteng (27,6%).

In terms of educational attainment, very similar proportions of those who attained some secondary and those who completed Grade 12 can be seen amongst the three age categories, 20–24, 25–29 and 30–34-year-olds, with approximately one in four having either some form of secondary level of education or Grade 12. Generally, there are high levels of school attendance, but this unfortunately does not translate to a large proportion of those who attain a post-secondary level of education. Nationally, only one in every ten of the youth (9,9%) attain post-secondary level education, with less than 1% of the youth who never attended school.

Being sexually active places women at risk of becoming pregnant, which in turn can have a negative impact on their general functioning and health, e.g. dropping out of school; being exposed to risk at childbearing, etc. For the women (15–34 years) who participated in the SADHS 2016, more than one in every two (58,1%) reported that they had their first sexual intercourse whilst they were between 16 and 20 years. A further 16,2% reported that they had their first sexual intercourse before reaching the age of 16 years. The profile of men with regard to their first sexual intercourse is very similar to that of women with one in every two reporting becoming sexually active between ages 16–20, but unlike with the women, more than one in every four men (26,7%) made their first sexual intercourse before age 16 years.

Risky sexual behaviour in terms of having multiple sexual partners exposes the youth to contracting a number of sexually transmitted diseases, which has a negative impact on their health. Results show that women aged 15–19 years already had an average of two sexual partners, whilst those aged 30–34 on average had five sexual partners in their life. The marital status of these women had little impact on the average number of sexual partners: those who had never been married had on average 3,9 partners while those who were married or who were living together with someone as being married had 3,8 partners on average.

Results among men show that those aged 15–19 years already had six sexual partners on average, whilst those aged 30–34 on average had eighteen sexual partners in their life. The marital status of men showed an interesting picture with regard to the average number of sexual partners. Men who had never been married had an average of eleven partners, whilst those who were married or who were living together with someone as being married had 17,6 partners on average. This behavior also puts those women to whom they are married or with whom they are partnered with at a higher risk of contracting sexually transmitted infections.

Knowledge about contraceptive methods was found to be almost universal, with 98,8% of those aged 15–19 years to 100% for the 25–29-year-olds who have heard of at least one contraceptive method. The use of injectable contraceptives is by far the most popular, with 52,8% of women using this method of contraception. The second most used method of contraception among the youth is the condom (both male and female) with 24,3% of the youth using it as a contraceptive method.

Information on the prevalence of termination of pregnancies performed on women aged less than 20 years of age showed that over the period 2017 to 2019, 12% of women had opted to have an abortion on average. Provincially the profile varies from 10,9% in KwaZulu-Natal to 18,8% in Limpopo for 2019. Limpopo was the province that consistently had the highest rates of TOPs for the three-year period, increasing from 16,7% in 2017 to 18,8% in 2019. This could be an indication that the availability of or access to contraceptives might be a challenge in the province for especially women in the younger ages.

The use of tobacco in the form of smoking tobacco showed that 7,7% of women aged 15–34 had ever smoked tobacco whilst an alarming 40,1% of men had ever smoked. Almost one in every three women in the Western Cape (29,4%) had ever smoked tobacco versus 49,3% of men in this province who had ever smoked.
With regard to the consumption of alcohol, a different profile emerges, with almost one in every two women aged 15-34 who had ever consumed a drink that contained alcohol in the Northern Cape (48,2%). This is in stark contrast with the profile for men, where 78,4% of men in North West had ever consumed alcohol.

Information obtained from the Road Traffic Management Corporation showed that the majority of road accidents involved males, resulting in the same percentages of fatalities. This implies that men are more likely to die as a result of road accidents. The majority of accidents and fatalities occurred among the youth aged 30–34 years and also among the youth in KwaZulu-Natal.

Tuberculosis was the leading natural cause of death for both men and women in 2016, albeit at different levels. *Tuberculosis* was the leading cause of death for the black African and the Indian/Asian population groups as well. It was also the leading natural cause of death in all provinces with the exception of Western Cape, Eastern Cape and Northern Cape.

Other external causes of accidental injury was the leading non-natural cause of death among the youth (15-34) in 2016, ranging from 15,7% among those aged 30–34 to 28,6% among those aged 20–24 years.

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