

The Status of Women's Health in South Africa: Evidence from selected indicators



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The Status of Women's Health in South Africa: Evidence from selected indicators

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Abbreviations

ART	Anti-Retroviral Therapy
DHIS	District Health Management Information System
GHS	General Household Survey
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IPV	Intimate Partner Violence
IUCD	Intrauterine Contraceptive Device
MMR	Maternal Mortality Ratio
MSP	Multiple Sexual Partner
MTCT	Mother-to-Child Transmission
NDoH	National Department of Health
NDP	National Development Plan
NICD	National Infection and Communicable Diseases
NIDS-CRAM	National Income Dynamics Study – Coronavirus Rapid Mobile Survey
RMS	Rapid Mortality Surveillance Report
SADHS	South African Demographic and Health
SDG	Sustainable Development Goal
SRDF	Social Relieve Distress Fund
TOP	Termination of Pregnancy

Executive Summary

The study revealed that with the exception of antenatal first visit before 20 weeks – which observed a drop in 2020 and neonatal death in facility rate that was consistent from 2019 to 2020; other maternal and neonatal indicators showed improvement in 2020. However, there were variations in these indicators by province. For example, Northern Cape and North West witnessed an increase in early neonatal death in facility rate between 2019 and 2020, while the Free State experienced a decline in the same period.

Late adolescent/teenage (15–19 years) pregnancy has been increasing with age. Also, with the pattern increasing in South Africa, the Northern Cape, closely followed by Mpumalanga province reported the highest rate among women who terminated pregnancy between 0–12 weeks. Termination in the 13–20 weeks presented a declining pattern between 2019 and 2020, while Limpopo province presented the highest proportion of terminations by women under 20 years. Delivery in facility rate among adolescents (10–19 years) was highest in Northern Cape and lowest in Gauteng province in 2020. However, with the exception of Western Cape, most women in South Africa tend to deliver in the public sector hospitals. The injection and male condom are common modern contraceptive methods used. Although, the norethisterone injection reported the highest percentage change in distribution between 2018/19 and 2019/20.

Overall, the proportion of women who ever experienced physical violence by any partner were higher than those who ever experienced sexual violence by any partner. Divorced women, women living together with a partner and those widowed were more likely to experience physical violence compared to those who had never been married; and those married. The prevalence of physical violence by any partner was evident in Eastern Cape, North West and Mpumalanga. The majority of women reported incidences of being slapped, pushed, shaken or had an object thrown to them by their partners.

Women endure the most of the Human Immunodeficiency Virus (HIV) epidemic relative to men in South Africa. HIV incidence and infection were evident among female youth aged 15–24 years. The proportion of young women who engage in sexual relationships with men who are five or more years older than themselves increased over time. Women in the age group 15–24 were more likely to have multiple sex partners. Almost all the provinces show a decreasing HIV re-test positive rate among antenatal client over time. The rate of women who were on Anti-Retroviral Therapy (ART) at 1st antenatal visit increased in all the provinces and at national level. Women in the middle age group (35–39) had the highest number of COVID-19 cumulative cases. They are also more likely to vaccinate against the pandemic.



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Chapter 1: Introduction

1.1 Background

The democratic South African government has put in place several transformative policies and legislations aimed at advancing women's empowerment and gender equality. As such, there has been some notable progress in some indicators suggesting improvement in the quality of life of women over the years. However, women are still faced with adverse health outcomes such as poor neonatal and maternal experiences, sexually transmitted illnesses, termination of pregnancies, gender-based violence, leading to health complications and other unfavourable socio-demographic outcomes (Stats SA, 2015; United Nations, 2015).

The Sustainable Development Goals (SDGs) are documented blueprint meant to achieve a broader and more sustainable future for all across the globe (Stats SA, 2019). Specifically, the SDG Goal three (3) seeks to "ensure healthy lives and promote well-being for all at all ages, through the promotion of related targets" (Massyn et al., 2020:1). Others include the targets to reduce maternal mortality ratio (MMR) to at least 70 per 100 000 live births, to end HIV epidemic by 2030, to reduce by one third premature mortality from non-communicable diseases through prevention and treatment and to promote mental health and well-being (Stats SA, 2019). Also, to eliminate all forms of violence against women and girls in both public and private spheres, including trafficking, sexual and other types of exploitation (ibid).

South Africa carries the largest share of the global HIV burden (HRSC, 2017). Studies highlight that HIV&AIDS prevalence is higher among the female population compared to the male population in the country (HRSC, 2017; Zuma et al., 2014). New maternal HIV infections among pregnant women contributes significantly to mother to child transmission (MTCT) of HIV in South Africa (CDC, 2014). The early initiation of ART for newly infected HIV pregnant women may reduce maternal viral load and subsequent risk of MTCT in newly acquired maternal HIV infections. As such, it is ideal for all pregnant women who tested negative to HIV at the initial ANC visitation to repeat the testing every three months to ensure timely identification and treatment of new infections (CDC, 2014; NDoH, 2019).

Furthermore, whilst the country continues to promote healthy lives for all and the fight against HIV, the emergence of COVID-19 pandemic has created a shock and a possible impact on women's health and well-being of many vulnerable groups (OECD, 2020). Nationally, the pattern of COVID-19 infections suggests that women are more vulnerable to the infections than their male counterparts. However, available evidence suggests that men are more likely to die from the pandemic relative to women (Stats SA, 2020).

Despite the many frameworks, strategies and policies put forward to address these concerns, empirical evidence suggests that South Africa still needs to strengthen its efforts in order to realise the commitments and targets in promoting women's health. This report, seeks to unpack the status of women's health in South Africa. It highlights the patterns and trajectories of selected indicators such as maternal and neonatal health, pregnancy, termination and delivery-related issues, including gender-based violence, HIV epidemic and hunger during COVID-19.

1.2 Data and methods

1.2.1 Data sources

The vision of Statistics South Africa (Stats SA) is to improve life through data ecosystems (Stats SA, 2020). This notion implies that Stats SA should begin to integrate data generated by the organisation with data from other sources, for informed decision-making and to improve the well-being of the nation. In advancing this vision, this report employed administrative data and surveys produced by other organisations to achieve the objectives of this report. Whilst these may not be official statistics, they do provide rich information worth considering, especially on subjects related to women's health. Data sources used in the study includes: District Health Information System (DHIS) (2018–2020), South African Demographic and Health Survey (SADHS) (2016), Mortality and Causes of Death in South Africa (2018), General Household Survey (GHS) (2016–2019), National Income Dynamics Study – Coronavirus Rapid Mobile Survey (NIDS-CRAM), National HIV Prevalence, Incidence, Behaviour & Communication Survey (2017) and National Infection and Communicable Diseases (NICD). The DHIS and NICD data are administrative data collected and updated on a continuous basis. The NIDS – CRAM is a National Income Dynamics Study that investigated the socio-economic impact of the national lockdown in South Africa, 2020. The survey was conducted in five waves as shown in Table 1.1. Results of all indicators in the current study are presented in charts and tables. They are also expressed in numbers, percentages, rates and ratios. Appendix 1 in the report provides definitions of some of the indicators and the formula for estimation.

Table 1.1: Tables showing the National Income Dynamics Study – Coronavirus Rapid Mobile Survey (NIDS-CRAM) waves, start and end date (2020-2021).

Waves	Start date	End date
1	07-May-20	27-Jun-20
2	13-Jul-20	13-Aug-20
3	02-Nov-20	13-Dec-20
4	02-Feb-21	10-Mar-21
5	06-Apr-21	11-May-21

1.2.2 Study limitations

This study was subject to various limitations. For instance, the DHIS data was not disaggregated by key variables such as age. This data source only covers individuals who utilise the public health facilities. In addition, the NIDS data presented inconsistencies in data variables over time. Real time data relating to relevant subjects of interest are not available in some cases and administrative data is generally designed to meet the objectives of data owners.

Chapter 2: Maternal and neonatal health

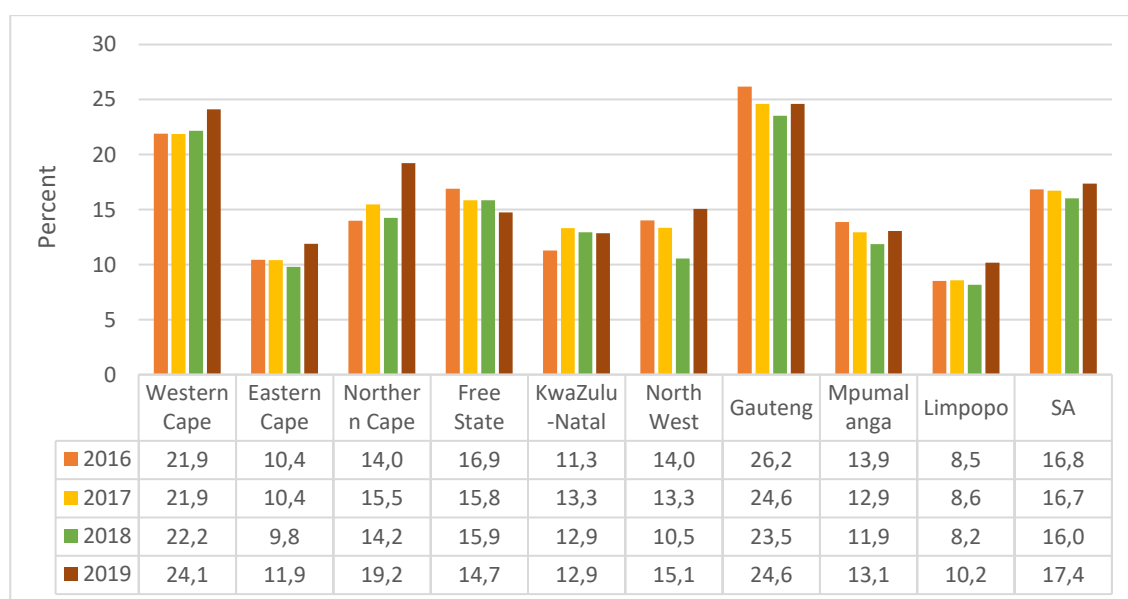
2.1 Introduction

Maternal health during pregnancy, childbirth and post-natal period is worth consideration as part of promoting the best possible outcomes for women. Equally, a positive maternal experience ensures that babies reach their full potential for health (WHO, 2016). South Africa has made noticeable reductions in the area of maternal and neonatal mortality. However, it remains key to establish if the country continues to make progress in eliminating maternal and neonatal deaths especially given the recent COVID-19 pandemic. This section presents some selected findings on maternal and neonatal indicators; these among others, include antenatal 1st visit before 20 weeks rate, maternal mortality in facility ratio, stillbirth in facility rate, neonatal and early neonatal death in facility rate, delivery by caesarean section rate and percentage of females on medical aid.

2.2 Percentage of females (aged 15–49 years) on medical aid

Nationally, Figure 2.1 shows that the percentage of females 15–49 years covered by medical aid increased from 16,8% in 2018 to 17,4% in 2019. The percentage of women on medical aid was consistent at 16,8% on average in 2016 and 2017. From 2016 to 2019, findings indicate that Western Cape and Gauteng had the highest percentage of females who were on medical aid. In 2019 medical aid coverage was at 24,1% and 24,6% for the two provinces respectively. Across all the years, Eastern Cape and Limpopo had the lowest percentages of females on medical aid. However, except for Free State, all the provinces are showing an improvement in coverage between 2018 and 2019.

Figure 2.1: Percentage of females on medical aid, province and national (2016–2019)



Source: GHS, 2016-2019

2.3 Antenatal 1st visit before 20 weeks' rate

Antenatal 1st visit before 20 weeks' rate refers to women who had a first visit before they are 20 weeks into pregnancy as a proportion of all antenatal 1st visits (NDoH, 2021). Table 2.1 indicates that in 2020 about 68,3% of women had their first visit before they are 20 weeks into pregnancy, suggesting a drop from 69,7% observed in 2019. All the provinces observed a decline in the percentage of women seeking their 1st antenatal visit before 20 weeks in 2020. This is with the exception of KwaZulu-Natal which had a slight increase of 74,6% in 2020 from 74,4% in 2019.

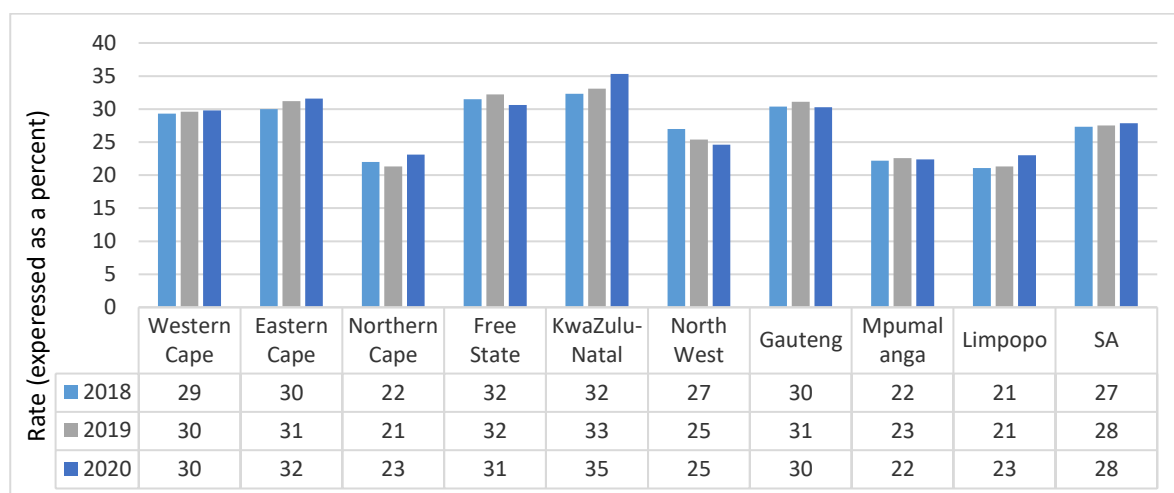
Table 2.1 Antenatal 1st visit before 20 weeks rate, province and national, 2018–2020

Antenatal 1 st visit before 20 weeks' rate (Expressed as a per cent)			
Province	2018	2019	2020
Western Cape	70,2	71,7	70,7
Eastern Cape	62,4	63,4	63,2
Northern Cape	63,2	65,6	60,7
Free State	65,2	66,6	62,2
KwaZulu-Natal	72,8	74,4	74,6
North West	68,4	71,3	68,1
Gauteng	64,0	66,4	63,9
Mpumalanga	75,2	77,0	75,1
Limpopo	66,8	68,8	67,5
RSA	67,8	69,7	68,3

Source: DHIS (2018-2020)

2.4 Delivery by caesarean section rate

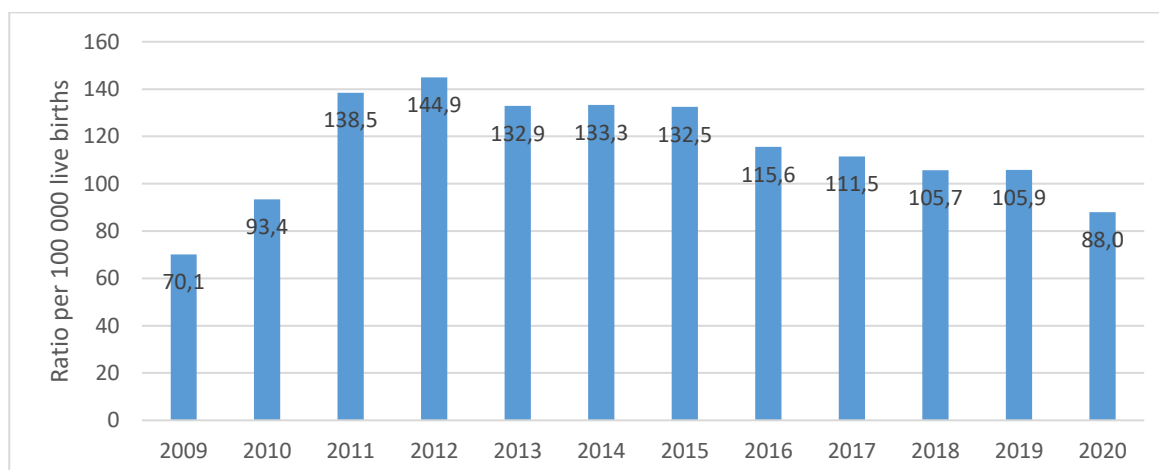
Figure 2.2 presents delivery by caesarean section rate as a proportion of total deliveries in health facilities for the period 2018–2020. Nationally, delivery by caesarean section rate between 2018 and 2020 was 28% on average. Apart from Eastern Cape and KwaZulu-Natal, none of the provinces showed consistent increasing patterns in percentage of women who delivered by caesarean section between 2018 and 2020. The rate of delivery by caesarean section ranges from 22% in Mpumalanga to 35% in KwaZulu-Natal in 2020.

Figure 2.2: Delivery by caesarean section rate, province and national, 2018–2020

Source: DHIS (2018-2020)

2.5 Maternal mortality in facility ratio

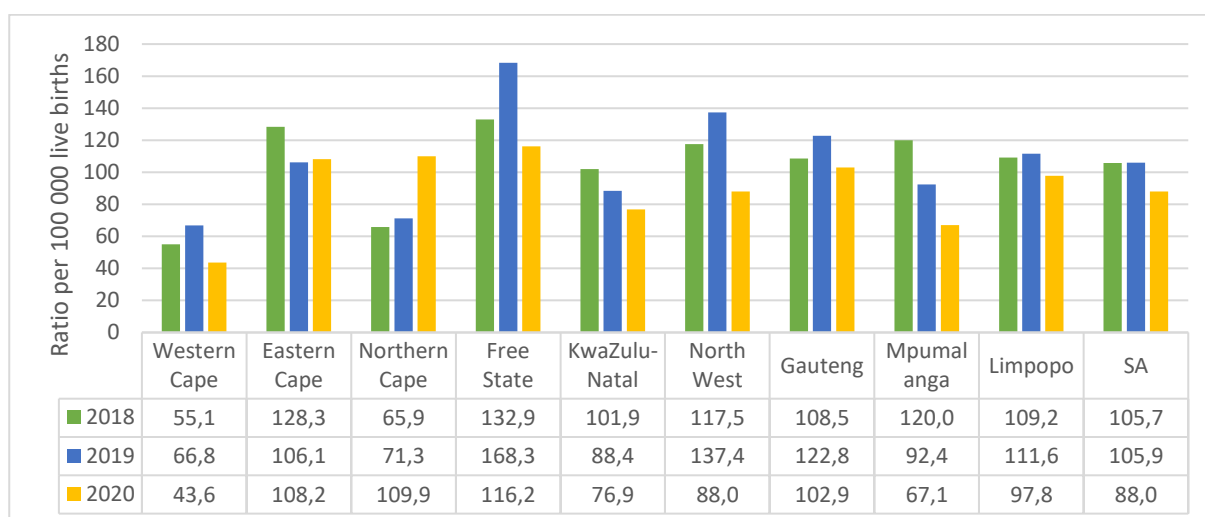
Maternal mortality in facility ratio (MMFR) refers to death occurring during pregnancy, childbirth and approximately 6 weeks after delivery or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and the cause of death. The indicator is measured per 100 000 live births that occurred in a facility (NDoH, 2021). Analysis in Figure 2.3 reveals that South Africa is experiencing a decrease in MMFR. The ratio peaked in 2012 at 144,9 deaths per 100 000 live births and the country has since observed a gradual decline to 88,0 deaths per 100 000 live births in 2020. The level of decline in 2020 is noticeably steeper from that observed in 2019.

Figure 2.3: Trends in maternal mortality in facility ratio, 2009–2020

Source: Massyn et al., 2020

2.6 Maternal mortality in facility ratio by province

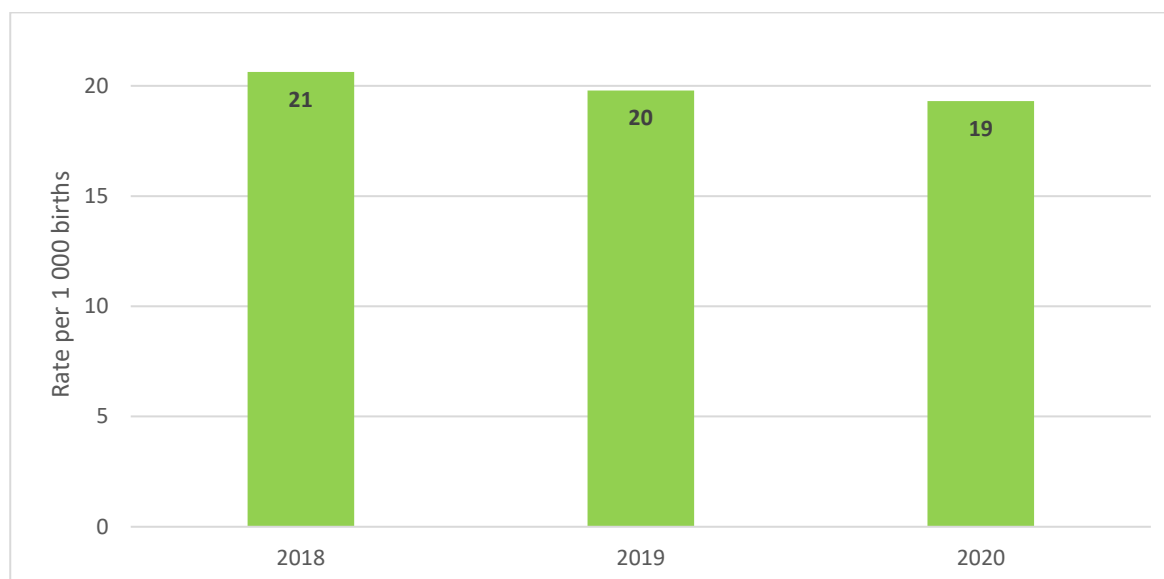
Figure 2.4 shows that Free State (116,2 deaths per 100 000 live births); followed by Northern Cape (109,9 deaths per 100 000 live births), Eastern Cape (108,2 deaths per 100 000 live births) and Gauteng (102,9 deaths per 100 000 live births) had MMFR that is higher than the national average of 88,0 deaths per 100 000 live births in 2020. The lowest MMFR in 2020 was recorded in Western Cape (43,6 deaths per 100 000 live births) followed by Mpumalanga (67,1 deaths per 100 000 live births). The Eastern Cape and Northern Cape provinces showed an increase in maternal mortality in facility ratio between 2019 and 2020. All other provinces showed decreasing patterns, which is also reflected in the national pattern.

Figure 2.4: Maternal mortality in facility ratio, province and national, 2018-2020

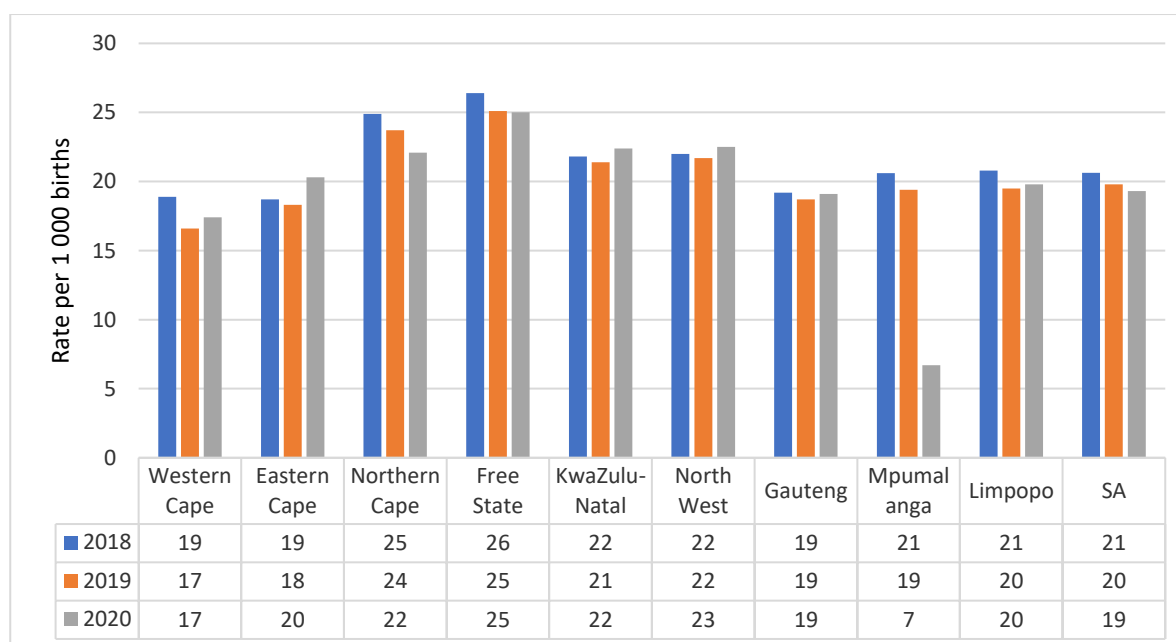
Source: DHIS (2018-2020)

2.7 Stillbirth in facility rate

Figure 2.5 presents stillbirth in facility rate per 1 000 births and is presented as a proportion of total infants born in health facilities. Stillbirth refers to a foetus that had at least 26 weeks of intra-uterine existence but showed no sign of life after complete birth (Republic of South Africa, 1992). At the national level, stillbirth in facility rate declined from 21 per 1 000 births in 2018 to 20 per 1 000 births in 2019 and was 19 per 1 000 births in 2020. Provincial patterns in Figure 2.6 showed a sharp decline from 19 per 1 000 births in Mpumalanga to 7 per 1 000 births in 2020. Eastern Cape, KwaZulu-Natal and North West observed an increase between 2019 and 2020.

Figure 2.5: Stillbirth in facility rate, 2018–2020

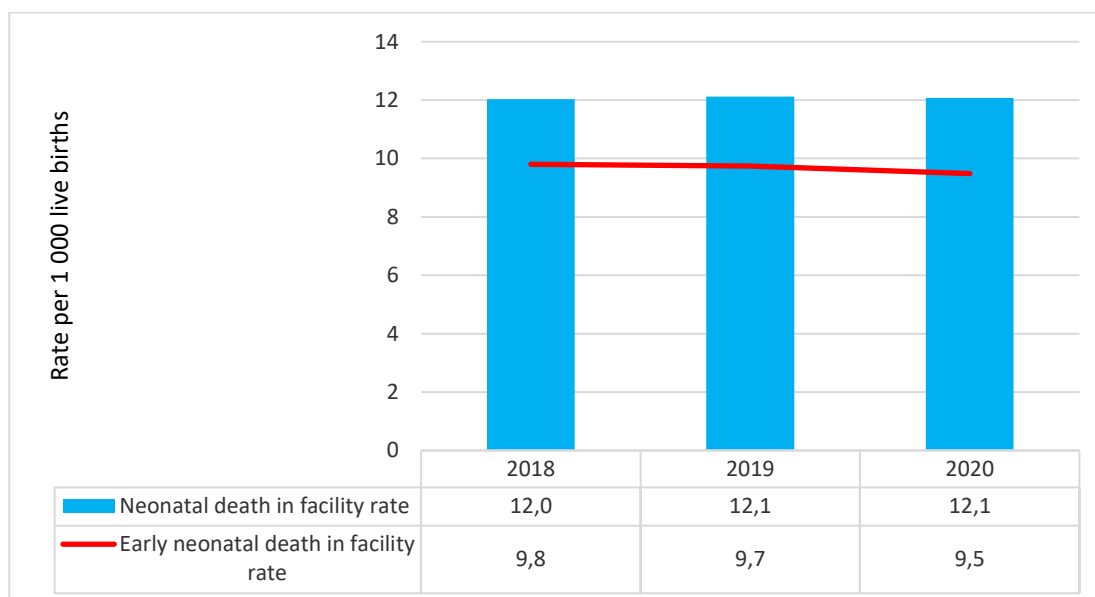
Source: DHIS (2018–2020)

Figure 2.6: Stillbirth in facility rate, province and national, 2018–2020

Source: DHIS (2018–2020)

2.8 Neonatal and early neonatal death in facility rate

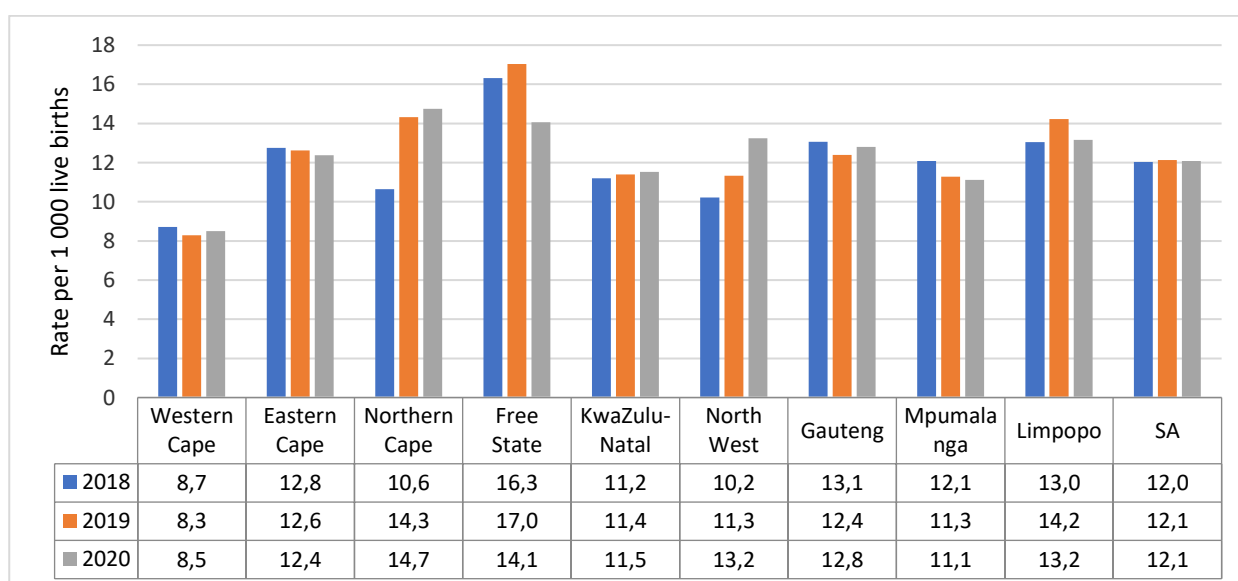
Early neonatal death in facility rate covers death of infants in a facility within 0–6 days of life, whilst neonatal refers to all deaths in a facility within 0–28 days of life (NDoH, 2021). Figure 2.7 indicates that neonatal death in facility rate stabilised at 12,1 deaths per 1 000 live births between 2018 and 2020, whereas early neonatal death decreased from 9,8 deaths per 1 000 live births to 9,5 deaths per 1 000 live births in the same period.

Figure 2.7: Neonatal and early neonatal death in facility rate, 2018-2020

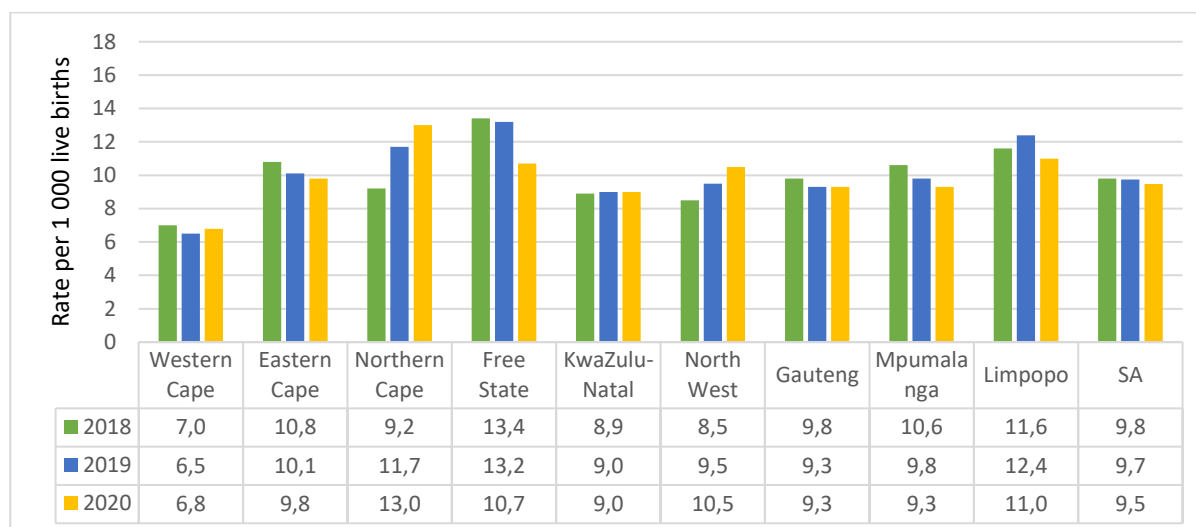
Source: DHIS (2018–2020)

2.9 Neonatal death in facility rate and early neonatal deaths in facility rate by province

Neonatal death in facility rate in 2020 was highest at 14,7 deaths per 1 000 live births in Northern Cape followed by 14,1 deaths per 1 000 live births in Free State, whilst it was lowest in Western Cape at 8,5 deaths per 1 000 live births. North West showed a noticeable increase between 2019 and 2020 (figure 2.8). Northern Cape still observed the highest early neonatal death in facility rate at 13,0 deaths per 1 000 live births in 2020. Northern Cape and North West had an increasing pattern in early neonatal death in facility rate between 2018 and 2020. Western Cape had the lowest early neonatal death in facility rate overtime (Figure 2.9).

Figure 2.8: Neonatal death in facility rate, province and national, 2018-2020

Source: DHIS (2018-2020)

Figure 2.9: Early neonatal deaths in facility rate, province and national, 2018-2020

Source: DHIS (2018–2020)

Chapter 3: Pregnancy, Termination (Abortion) and Deliveries

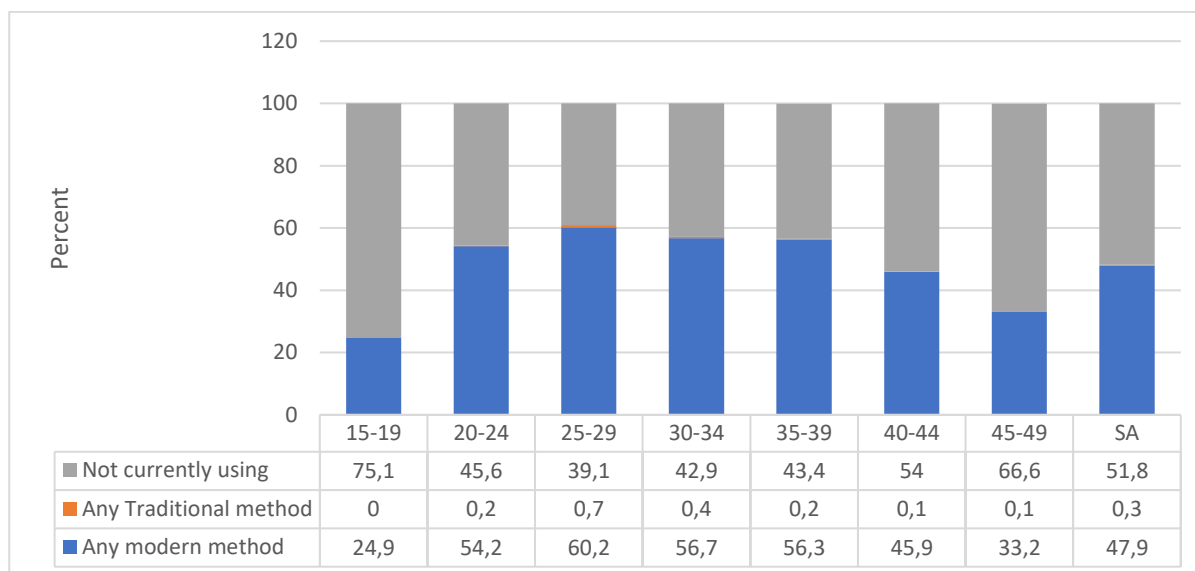
3.1 Introduction

The proportion of pregnancy, rate of terminations (abortions) and other delivery-related issues are of concern to the government and other stakeholders. These are so, as they are important indicators in the measure of reproductive health status of women. This chapter explores the dynamics of selected pregnancy, termination and delivery related indicators in South Africa, highlighting their patterns and trajectories, especially among women and adolescents between 2016 and 2020.

3.2 Contraceptive methods currently used by age group

The results presented in Figure 3.1 show that the majority of the women in the age groups 20–39 years used any modern method of contraceptive. The highest proportion of those not currently using were in the age group 15–19 years (75,1%), followed by those in the age group 45–49 (66,6%). A slightly higher proportion of women are not currently using any (51,8%) compared to those using modern methods (47,9%). An insignificant proportion of women used any traditional methods in the year of study.

Figure 3.1: Distribution of all women by any contraceptive method currently used by age group 15–49 years, 2016

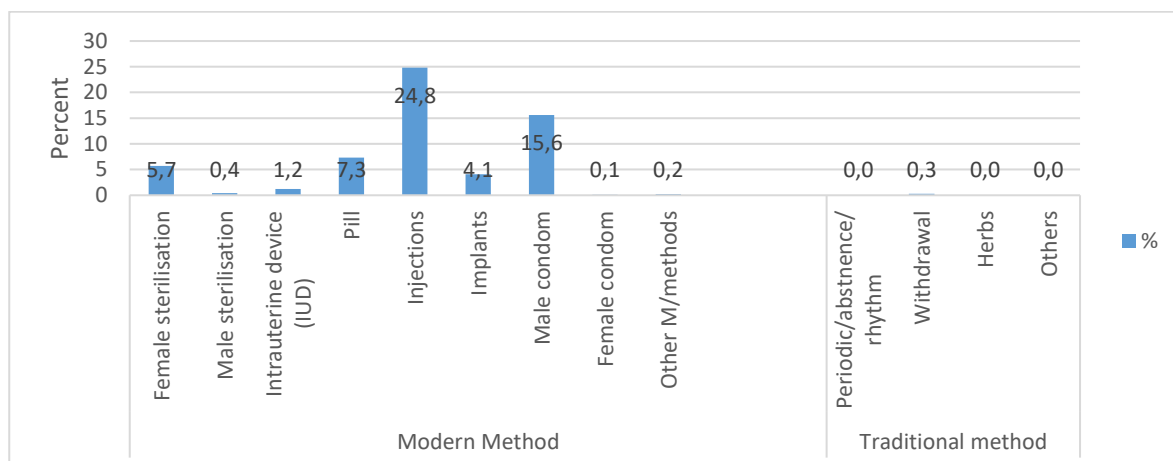


Source: SADHS, 2019

3.3 Modern and traditional contraceptive methods used

The results show that the majority of sexually active women in the country were using modern contraceptive methods such as injections (24,8%) and the male condom (15,6%), while the least prefer using the female condom (0,1%). An insignificant proportion of 0,3% were using the withdrawal method (Figure 3.2).

Figure 3.2: Modern and traditional contraceptive methods currently used among sexually active women (15–49 years), 2016



Source: SADHS (2019).

3.4 Change in contraceptive distribution

Table 3.1 presents the changes of contraceptive distribution (numbers and percentages) in 2018–2020. The results show positive percentage change in the distribution of norethisterone enanthate injection (47,9%) and female sterilisation (7,3%) contraceptive methods. Other contraceptive elements reported negative percentage change in distribution. Specifically, sub-dermal contraceptive implant (-28,9) oral pill cycle (-12,6%) followed by male condom distribution (-11%) presented the highest negative percentage change, while the male sterilisation (-1,2%) had the least.

Table 3.1: Changes in contraceptive distribution (numbers and percentage), 2018–2020

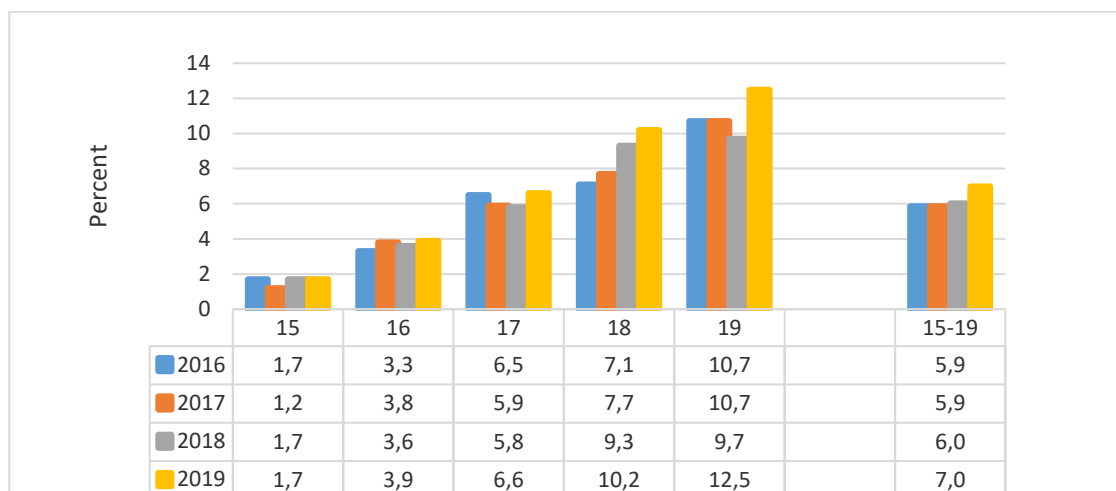
Data elements	2018/19	2019/20	% change
Female condoms distribution	17 658 915	16 562 153	-6,2
Male condoms distribution	726 202 616	646 587 444	-11
Depot medroxyprogesterone acetate injection	6 206 245	5574653	-10,2
Norethisterone enanthate injection	1 939 006	2 868 579	47,9
Oral pill cycle	4 257 198	3 719 328	-12,6
Female sterilisation	45 372	48 703	7,3
Male sterilisation	1 366	1 349	-1,2
IUCD	51 334	56 391	9,9
Sub-dermal contraceptive implant	213 260	151 615	-28,9

Source: Massyn et al., (2020)

3.5 Late adolescent (15–19 years) pregnancy (2016–2019)

Late adolescent pregnancy refers to pregnancy to teenage girls between the ages of 15 and 19 years (Stats SA, 2018). Figure 3.3 shows that the proportions generally increased with age over the years. The proportions maintained a consistent increasing pattern among those aged 18 years (7,1% to 10,2%). The national proportion increased between 2018 (6%) and 2019 (7%).

Figure 3.3: Distribution of late adolescents (15–19 years) pregnant during the year preceding the survey in single years, 2016–2019

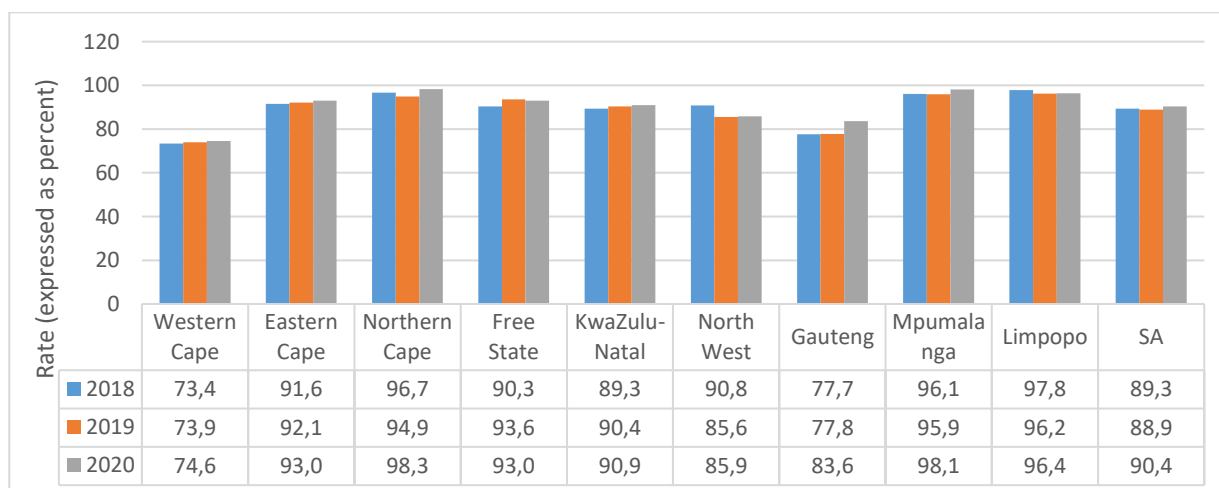


Source: GHS, 2016–2019

3.6 Termination of pregnancy 0–12 weeks rate

Termination of pregnancy 0-12 weeks rate refers to pregnancies terminated at health facilities in the first 12 weeks of pregnancy as a proportion of total termination of pregnancies (NDoH, 2021). With the exception of provinces such as Western Cape (74,6%), North West (85,9%) and Gauteng (83,6%), all other provinces presented rates above 90% in 2020. The proportion increased from 91,6% to 93,0% in Eastern Cape between 2018 and 2020. It also increased between 88,9% to 90,4% in the same period nationally. These rates suggest an average of 89,5% over the three years in the country (Figure 3.4).

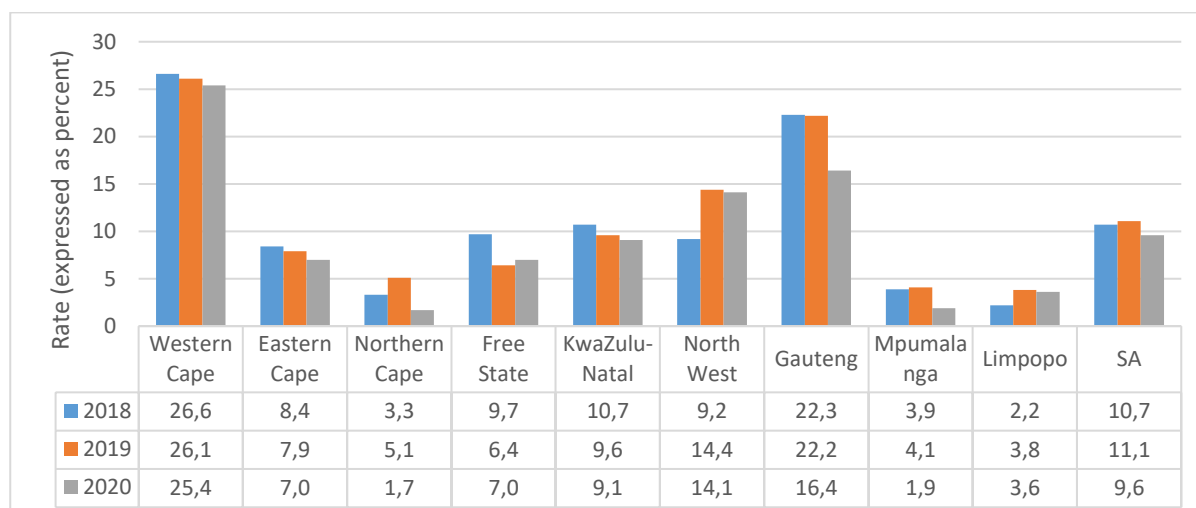
Figure 3.4: Termination of pregnancy 0–12 weeks' rate, province and national, 2018–2020



Source: DHIS (2018–2020)

3.7 Termination of pregnancy 13–20 weeks rate

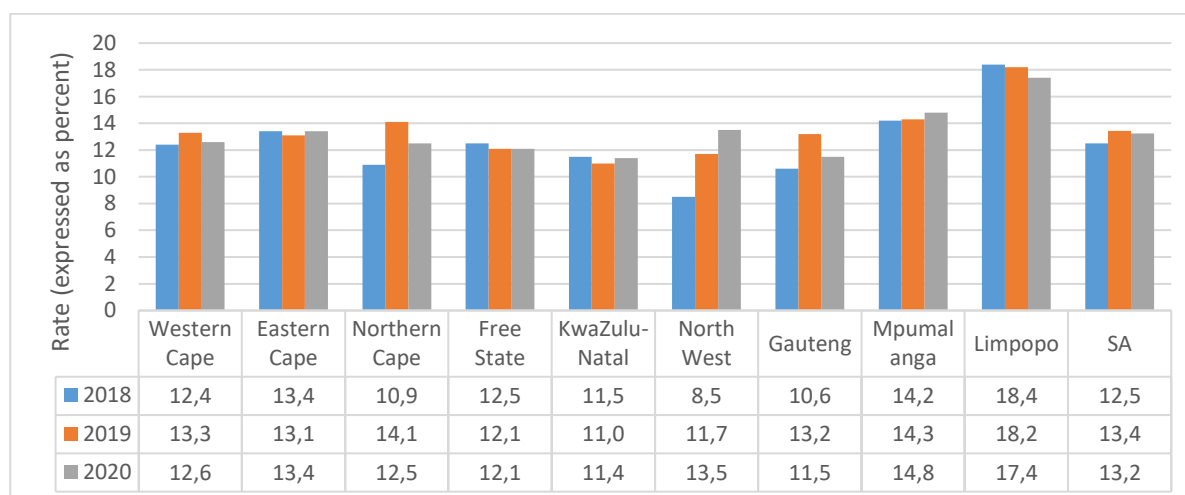
Termination of pregnancy 13–20 weeks rate refers to pregnancies terminated at health facilities at 13–20 weeks of pregnancy as a proportion of total termination of pregnancies (NDoH, 2021). Figure 3.5 suggests that Western Cape and Gauteng reported the highest termination rate across the years, while the Northern Cape, Limpopo and Mpumalanga had the least rates in the study period. Gauteng province shows a significant decrease from 22,2% in 2019 to 16,4% in 2020. The rate of termination of pregnancy at 13–20 weeks dropped slightly from 11,1% in 2019 to 9,6% in 2020 in South Africa.

Figure 3.5: Termination of pregnancy 13–20 weeks rate, province and national, 2018–2020

Source: DHIS (2018–2020)

3.8 Termination of pregnancy under 20 years rate

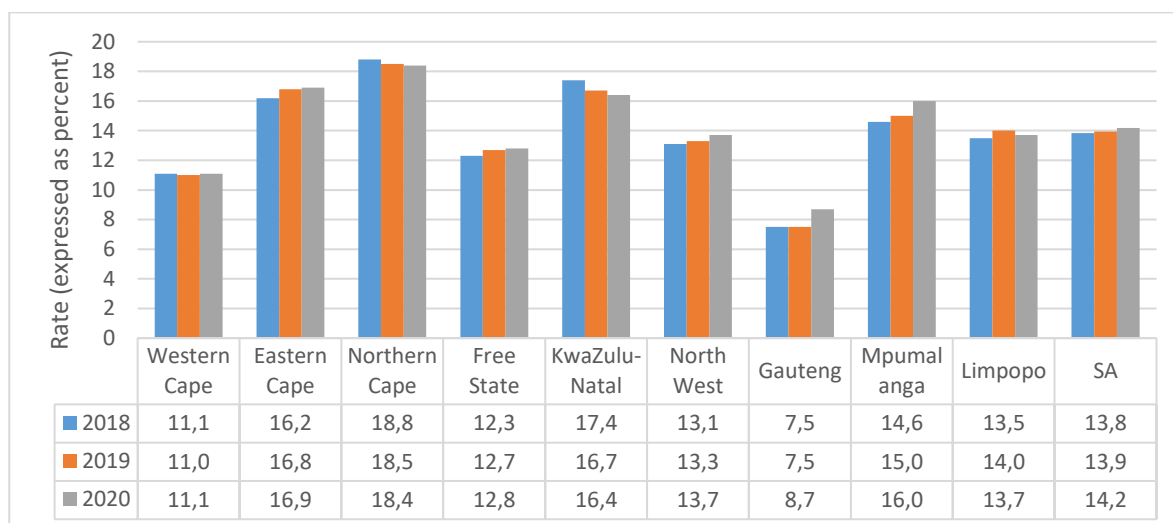
Termination of pregnancy under 20 years rate refers to termination of pregnancy among women under 20 years as a proportion of total of deliveries under 20 years at health facilities (NDoH, 2021). The results in Figure 3.6 show that Limpopo, followed by Mpumalanga recorded the highest termination rates among these women over time. North West showed a noticeable increase in the proportions (rates). The rates increased between 8,5% and 13,5% in North West and was almost consistent at an average of 13% in the country.

Figure 3.6: Termination of pregnancy under 20 years rate, province and national, 2018–2020

Source: DHIS (2018–2020)

3.9 Delivery 10–19 years in facility rate by province

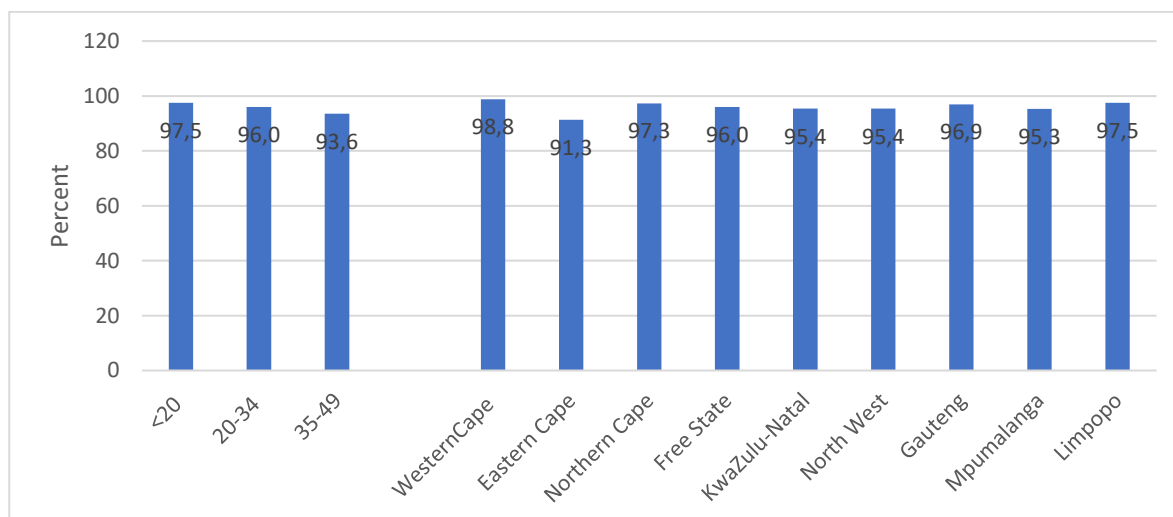
Delivery in 10–19 years (adolescents) in facility rate refers to deliveries to women under the age of 20 years as a proportion of total deliveries in health facilities (NDoH, 2021). Northern Cape, Eastern Cape and KwaZulu-Natal provinces recorded the highest delivery in facility rates among adolescents (10–19 years). Gauteng had the least rate between 2018 and 2020. The rate was almost consistent in the three-year period, at an average of 14% in the country (Figure 3.7).

Figure 3.7: Delivery in 10–19 year in facility rate, province and national, 2018–2020

Source: DHIS (2018-2020)

3.10 Delivery in health facilities rate by mother's age at birth and province

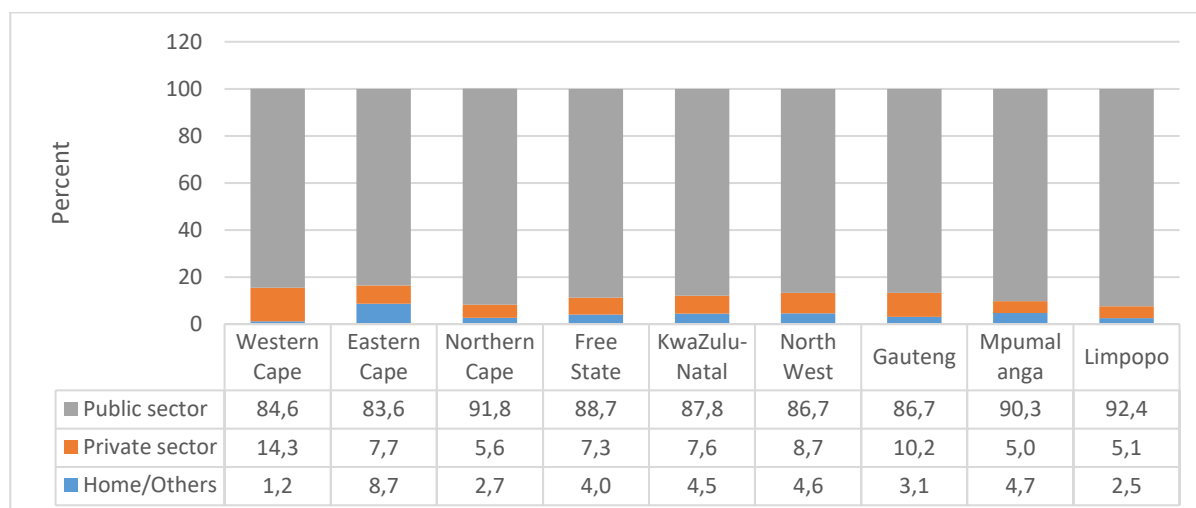
The results show that delivery in health facility rates was high by mother's age at birth and province in the study period. The proportion also declined slightly with the age of women. Women below 20 years' age (<20) had the highest proportion of deliveries at health facilities (97,5%). The proportions in all the provinces was above 90% in 2016. Western Cape province recorded the highest proportion (98,8%), while Eastern Cape province recorded the least (91,3%) (Figure 3.8).

Figure 3.8: Delivery in health facility by mother's age at birth and province, 2016

Source: SADHS (2019)

3.11 Deliveries in types of facilities

Figure 3.9 indicates that a majority of women in all provinces delivered in public facilities. Those in Limpopo (92,4%), closely followed by those in Northern Cape (91,8%) presented the highest proportions. The percentage of women who delivered in private facilities ranged from as low as 5% in Mpumalanga to 14,3% in Western Cape. Those in Eastern Cape (8,7%) presented the highest proportion among those who delivered at home or other facilities.

Figure 3.9: Deliveries in types of facilities, 2016

Source: SADHS (2019)

Chapter 4: Gender-based violence (GBV)

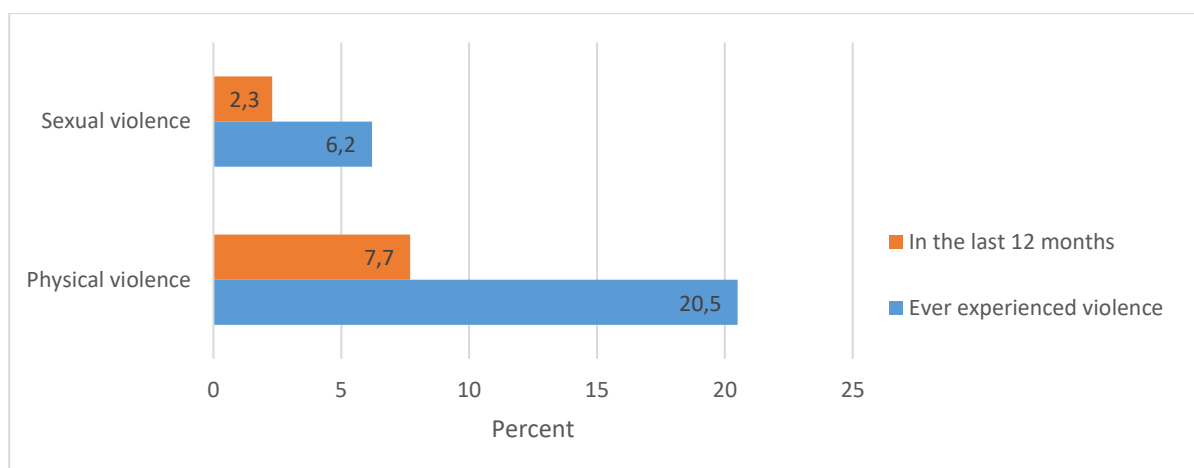
4.1 Introduction

According to the National Strategic Plan on Gender-Based Violence and Femicide (2020–2030), violence against women refers to any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life (Jansen, 2016). South Africa has made great strides in empowering women. Despite the progress made so far, GBV against women still persists. GBV disproportionately affects women and girls. It is systematic and deeply entrenched in institutions, cultures and traditions (Enaifoghe, 2019). Therefore, this chapter seeks to explore some selected GBV indicators such as sexual and physical violence against women.

4.2 Experience of violence, ever partnered women 18 years and older

The results show that one in five (20,5%) ever partnered woman reported to have ever experienced physical violence by a partner while 6,2% experienced sexual violence. In 12 months before the survey, 7,7% of women reported that they experienced physical violence (Figure 4.1).

Figure 4.1: Percentage distribution of ever partnered women 18 years and older who experienced violence (ever and in the last 12 months) by any partner

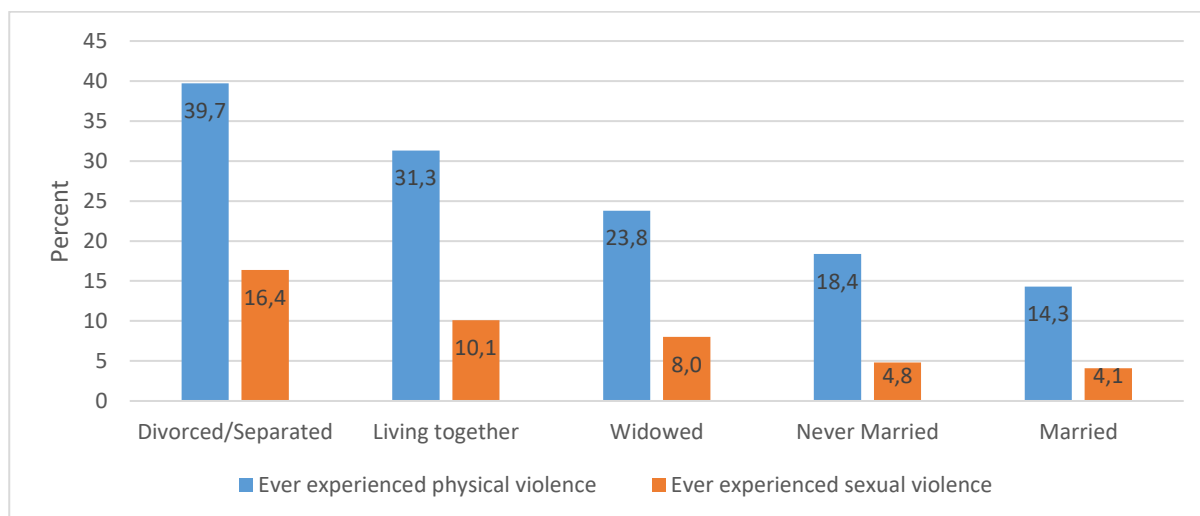


Source: SADHS (2019)

4.3 Experience of violence, ever partnered women 18 years and older by marital status

The results show that 39,7% of ever partnered women who are divorced ever experienced physical violence. The proportion is lowest among ever partnered women who were married (14,3%) at the time of the survey. These patterns were consistent among those who ever experienced sexual violence in the country (Figure 4.2).

Figure 4.2: Percentage distribution of ever partnered women 18 years and older who experienced violence (physical and sexual) by marital status

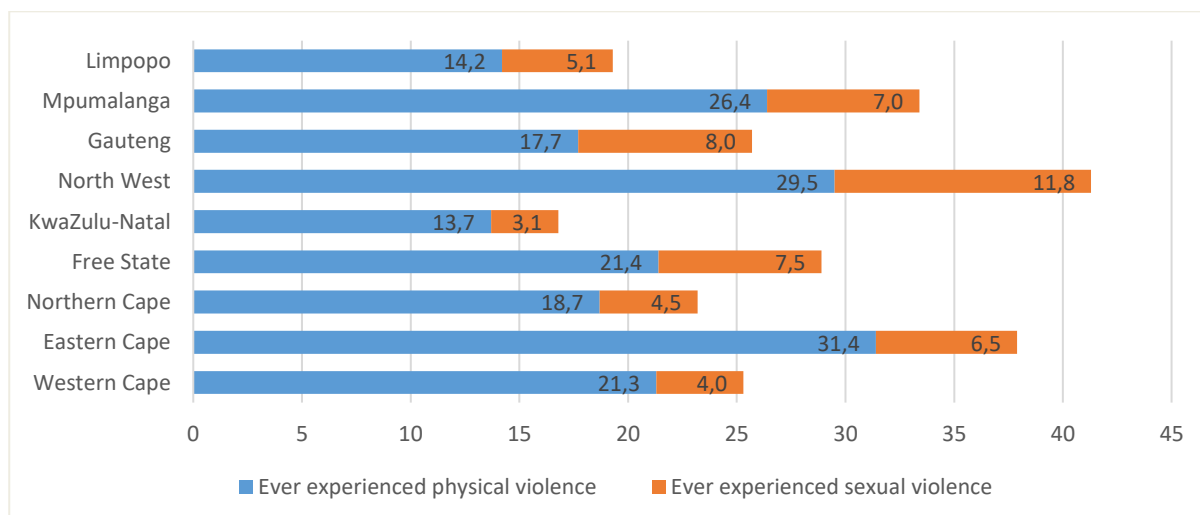


Source: SADHS (2019)

4.4 Experience of violence, ever partnered women 18 years older by province

Results presented in Figure 4.3 indicate that Eastern Cape (31,4%), followed by North West (29,5%) and Mpumalanga (26,4%) presented the highest proportions among women who ever experienced physical violence. Women in KwaZulu-Natal and Limpopo recorded the least proportion of physical violence at 13,7% and 14,2% respectively. North West at 11,8% recorded the highest percentage among those who ever experienced sexual violence.

Figure 4.3: Percentage distribution of ever partnered women 18 years and older who experienced violence (physical and sexual) by province

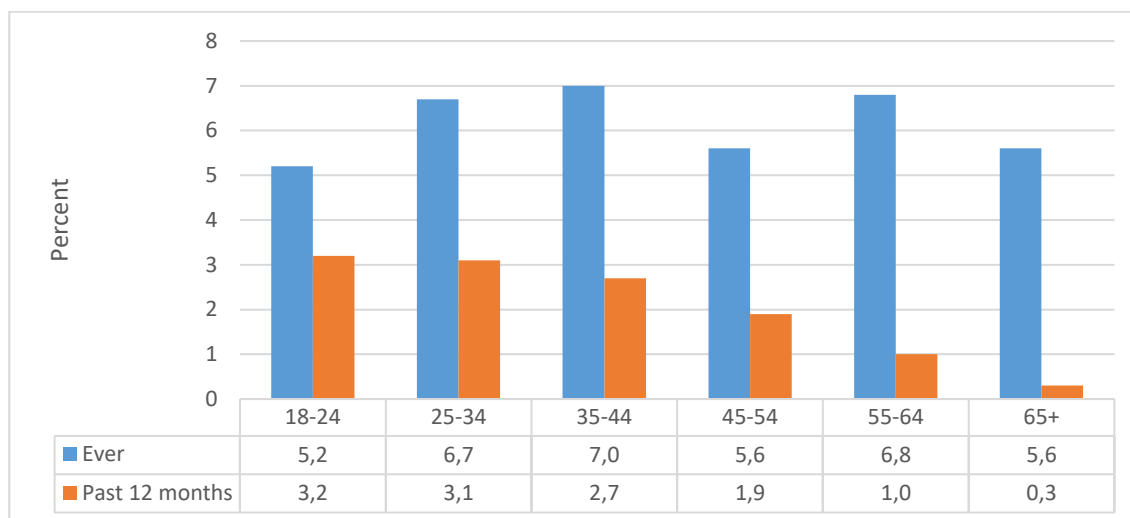


Source: SADHS (2019)

4.5 Experience of violence, ever partnered women 18 years older by age groups

The results in Figure 4.4 show that the proportions of ever partnered women who ever-experienced sexual violence were higher, compared to those that experienced such in the last 12 months before the survey. The proportions were highest among those in the age groups 35–44 (7,0%) and 55–64 (6,8%). The proportion of ever partnered women who experienced sexual violence in the past 12 months from any partner show a decreasing trend with increasing age.

Figure 4.4: Distribution of ever partnered women 18 years and older who experienced sexual violence (ever and in the past 12 months) from any partner by age groups

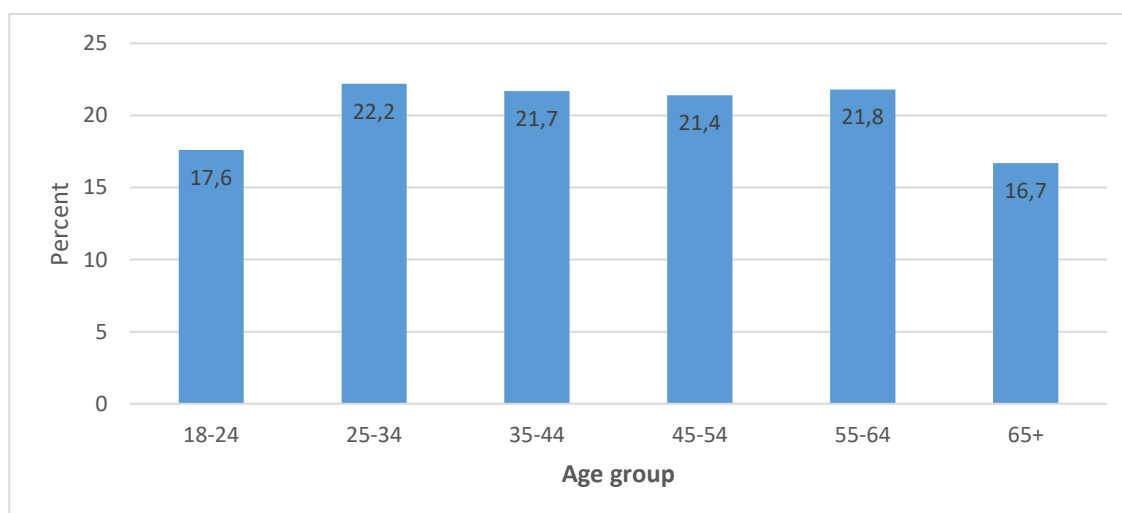


Source: SADHS (2019)

4.6 Lifetime experience of violence, ever partnered women 18 years and older by age group

Figure 4.5 presents the distribution of ever partnered women 18 years and older who experienced physical violence from any partner in their lifetime by age group. The results show that women in the age groups 25–34 to 55–64 reported the highest proportion of physical violence from any partner in the year of study. At a proportion of 16,7%, those aged 65+ years reported the least.

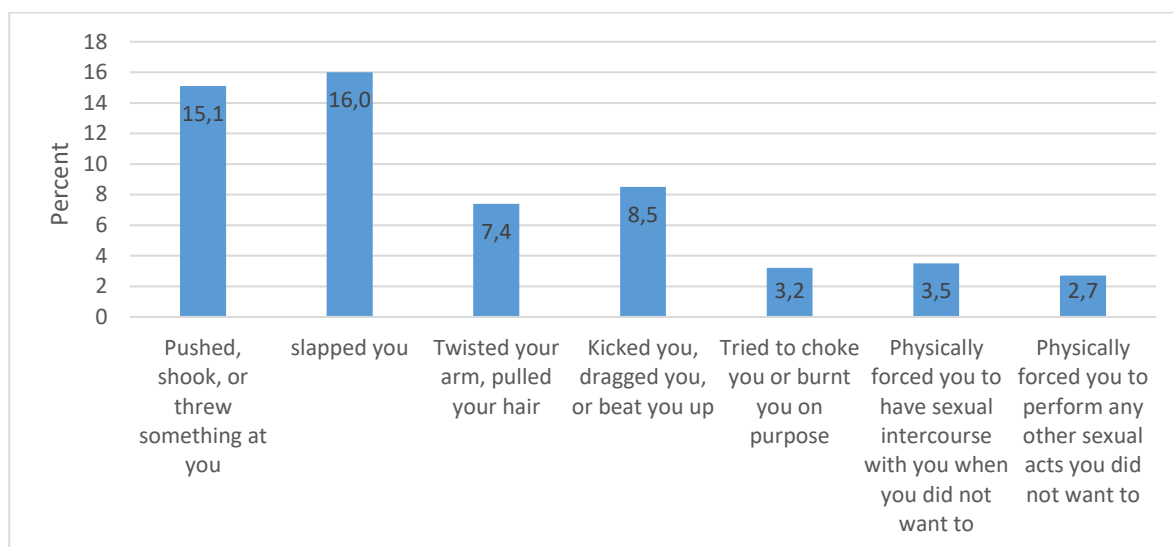
Figure 4.5: Distribution of women 18+ years who ever experienced physical violence from any partner in their lifetime by age group



Source: SADHS (2019)

4.7 Women's experiences of intimate partner violence

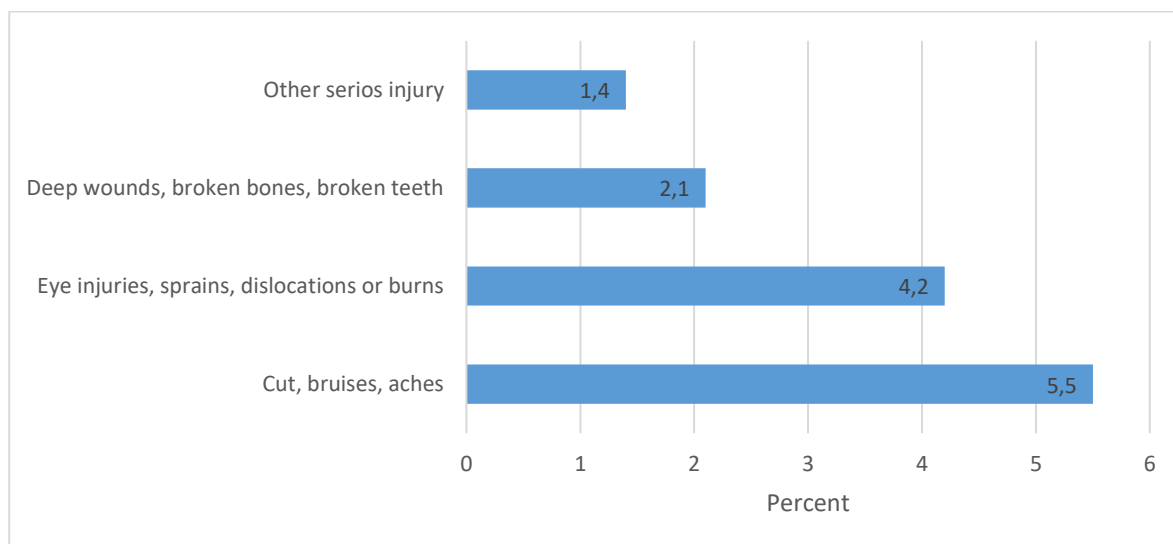
The most common reported act of intimate partner violence (IPV) among women include being slapped (16%), closely followed by being pushed, shaken or having an object thrown at them (15,1%). Women who were physically forced to perform any other sexual acts (2,7%) reported the least (Figure 4.6).

Figure 4.6: Distribution of women on experiences of intimate partner violence, 2017

Source: South African National HIV Prevalence, Incidence, Behaviour & Communication Survey (2017)

4.8 Injury types experienced by women as a result of intimate partner violence (IPV)

Figure 4.7 shows the types of injury women sustained due to IPV. Cuts, bruises and aches were the main injuries experienced as a result of intimate partner violence (5,5%). These are followed by eye injuries, sprains, dislocations or burns (4,2%). Women with injuries of deep wounds, broken bones, and broken teeth reported a proportion of 2,1%. Women with injuries of deep wounds, broken bones, and broken teeth reported a proportion of 2,1%.

Figure 4.7: Distribution of injury types experienced by females

Source: South African National HIV Prevalence, Incidence, Behaviour & Communication Survey (2017)

Chapter 5: HIV/AIDS and related indicators

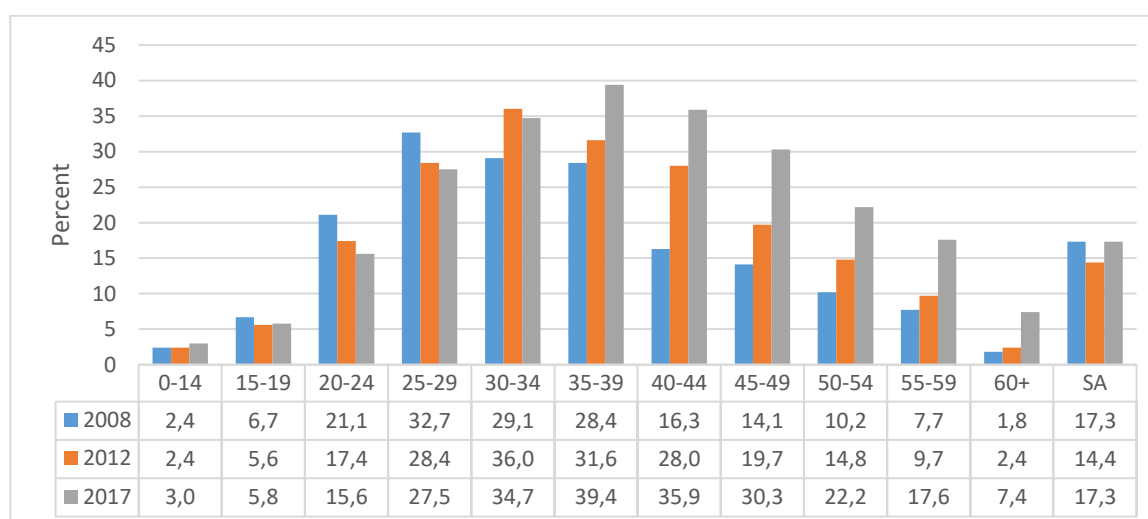
5.1 Introduction

The persistence of HIV epidemic and associated gender disparities is a major concern in South Africa (Mabaso et al., 2019). Empirical evidence suggest that new HIV infections during pre-conception and pregnancy is a significant contributor of mother-to-child transmissions in the country (MTCT). This section presents HIV prevalence and incidences, including other related indicators among women in South Africa.

5.2 HIV prevalence in South Africa

Findings in Figure 5.1 indicate that women still bear the brunt of the HIV epidemic. The results show that HIV prevalence was highest among sexually active women in the age groups 25–29 to 45–49. Over the years, prevalence has been decreasing among those aged 20–29 and increasing among those 35 years and above.

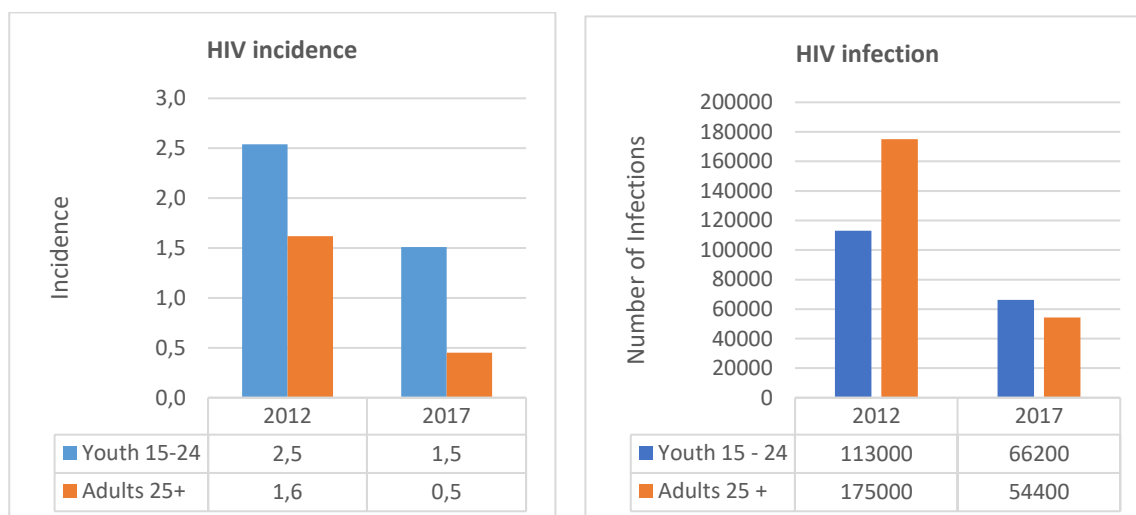
Figure 5.1: HIV prevalence among women by age group in South Africa, 2008-2017



Source: South African National HIV Prevalence, Incidence, Behaviour & Communication Survey (2017)

5.3 HIV incidence and infection 2012 and 2017

Figures 5.2 indicate HIV incidences among women, 2012 and 2017. The results show that HIV incidence amongst the youths are higher, compared to the adults in both years. The proportions have also been declining between the years among the age cohorts. The incidence declined from 2,5 to 1,5 among youths 15–24 years between 2012 and 2017. In terms of new infections, both adults 25+ and youth 15–24 observed a decline from 2012 to 2017. Youth 15–24 had the highest infections (66200) compared to adults 25+ (54 400) in 2017 (Figure 5.2).

Figure 5.2: HIV incidence and infection among women, 2012 and 2017

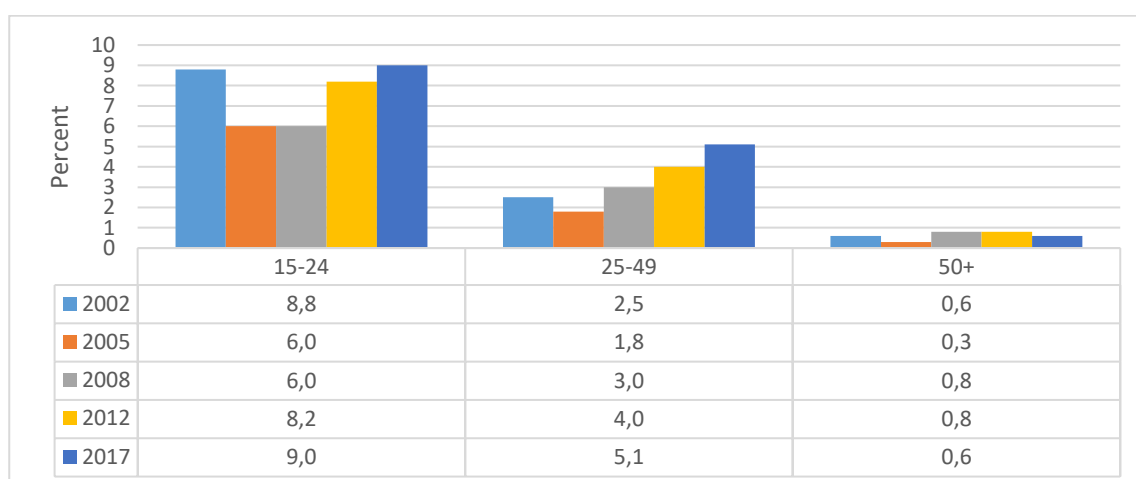
Source: South African National HIV Prevalence, Incidence, behaviour & Communication Survey (2017)

5.4 Women's vulnerability to risk of contracting HIV

In South Africa, some behavioral factors have been associated with HIV. This section presents behavioral factors such as sexual debut, age-desperate relationships and multiple sexual partners that increases the risk of women to contract the epidemic.

5.4.1 Multiple sexual partners

Multiple sexual partners (MSPs) have been shown to increase the spread of HIV during the early infection phases (Pines et al., 2016; UNAIDS, 2015). The results in Figure 5.3 indicate that 9% of women aged 15–24 had more than one sexual partners, compared to 5,1% among those aged 25–49 in 2017. The proportion increased among those aged 25–49 years who reported having more than one sexual partner between 2005 and 2017.

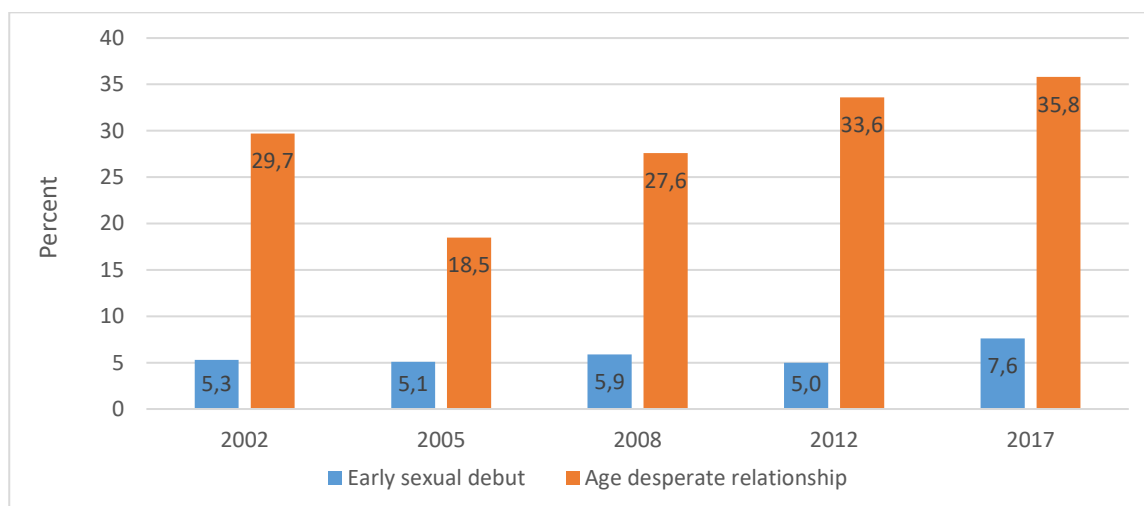
Figure 5.3: Sexually active women aged 15 years and older who reported having more than one sexual partner in the year preceding the survey

Source: South African National HIV Prevalence, Incidence, Behaviour & Communication Survey (2017)

5.4.2 Early sexual debut

Women who have their sexual intercourse before the age of 15 are associated with high risks of sexual reproductive issues (Richter et al., 2015). Figure 5.4 indicates that higher proportions of women 15-24 were involved in age desperate relationships over time. The behavior shows an increase from 2005 (18,5%) to 2017 (35,8%). Those who had early sexual debut reported a proportion of 7,6% in 2017.

Figure 5.4: Early sexual debut and age desperate relationship among women 15–24 years, 2002–2017

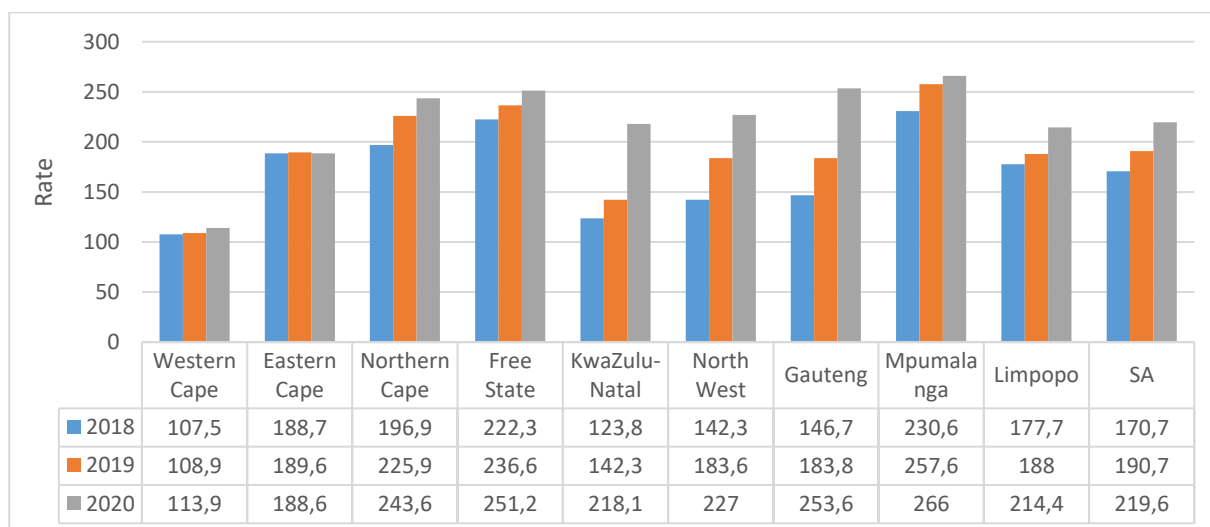


Source: South African National HIV Prevalence, Incidence, Behaviour & Communication Survey (2017)

5.5 Antenatal client HIV re-test rate

The results in Figure 5.5 suggest that with the exception of Eastern Cape, the antenatal client HIV re-test rate has been increasing in all the provinces and South Africa. The rate increased from 146,7 to 253,6 in Gauteng and 222,3 to 251,2 in the Free State in the study period. Nationally, the HIV retest rate among antenatal client increased markedly from 170,7 in 2018 to 219,6 in 2020 (Figure 5.5).

Figure 5.5: Antenatal client HIV re-test rate, province and national

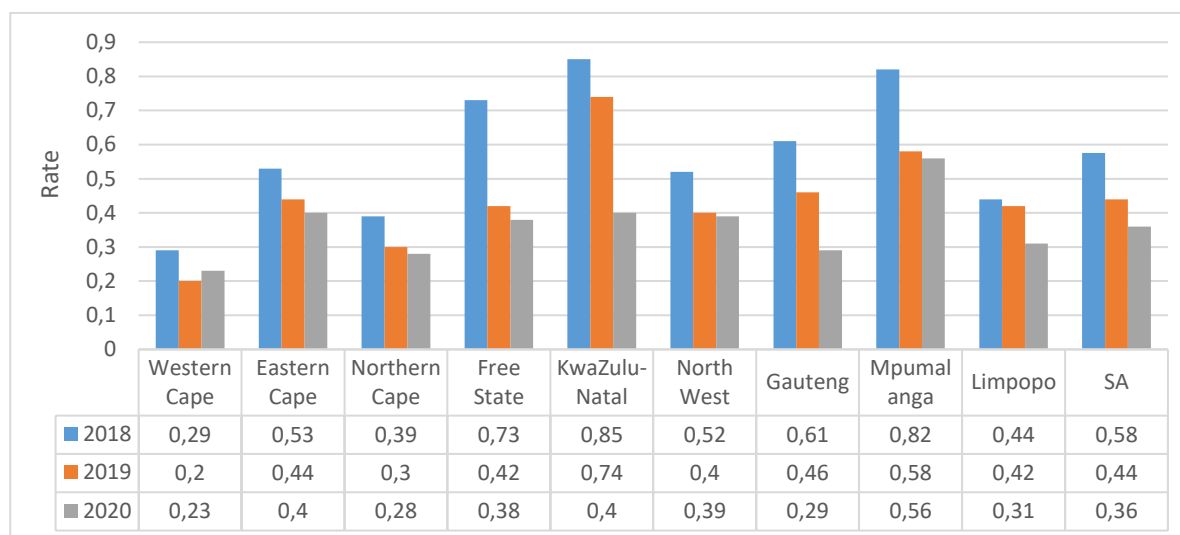


Source: DHIS (2018–2020)

5.6 Antenatal client HIV re-test positive

Figure 5.6 indicates that all the provinces show a decreasing HIV re-test positive rate over time. These are so with the exception of Western Cape, which also had the lowest HIV re-test positive rate across the years. Mpumalanga (0,56) had the highest re-test positive rate across all provinces in 2020. The HIV re-test positive rate decreased noticeably from 0,58 to 0,36 from 2018 to 2020 in South Africa.

Figure 5.6: Antenatal client HIV re-test positive rate, province and national, 2018–2019

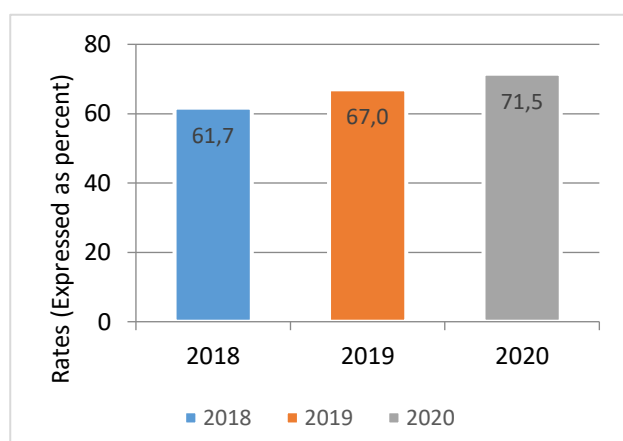


Source: DHIS (2018–2020)

5.7 National antenatal clients on ART and those starting ART rate

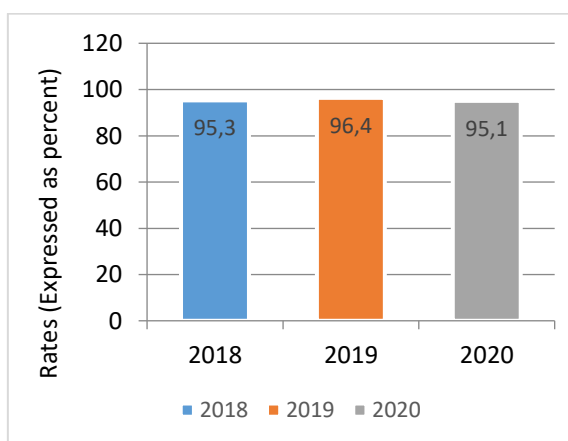
Antenatal client already on ART increased over the period (2018–2020) (as shown in Figure 5.7). The rate was 61,7% in 2018 and this increased to 71,5% in 2020. Across the same period the rate of pregnant women starting on ART stood at almost 95,6% on average (Figure 5.8).

Figure 5.7: Antenatal client already on ART at 1st visit



Source: DHIS (2018–2020)

Figure 5.8: Antenatal start on ART

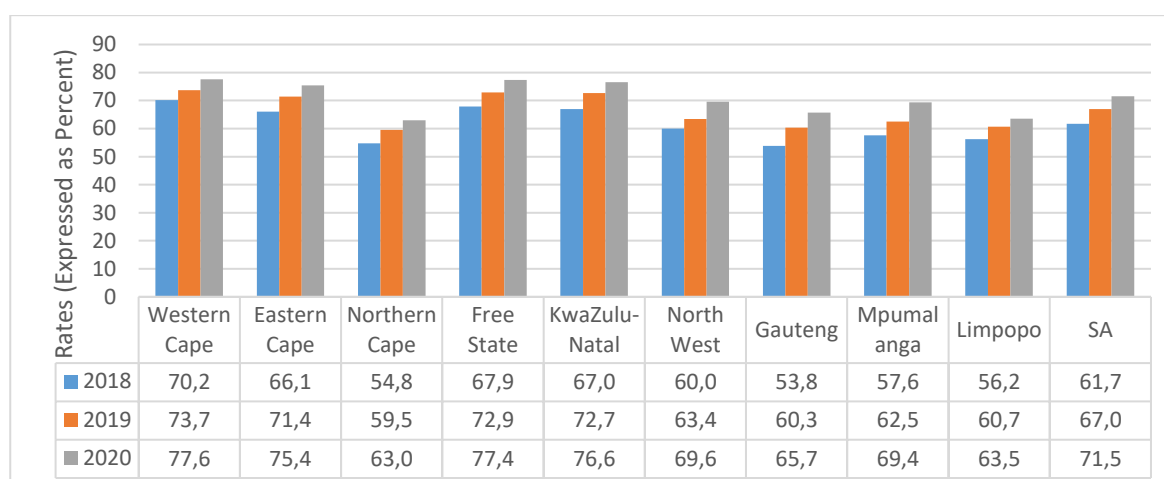


Source: DHIS (2018–2020)

5.8 Antenatal client already on ART at 1st visit rate

The findings in Figure 5.9 indicate that there was an increase in antenatal clients on ART at 1st visit across all the provinces and nationally. The highest rate of clients already on ART at 1st visits was reported in Western Cape (77,6%), followed by Free State (77,4%) and KwaZulu-Natal (76,6%) respectively in 2020. Gauteng had the lowest rate (53,8%) of clients already on ART at 1st visit in 2018. Nationally, the rate increased from 61,7% in 2018 to 71,5% in 2020.

Figure 5.9: Antenatal client already on ART at 1st visit rate, province and national

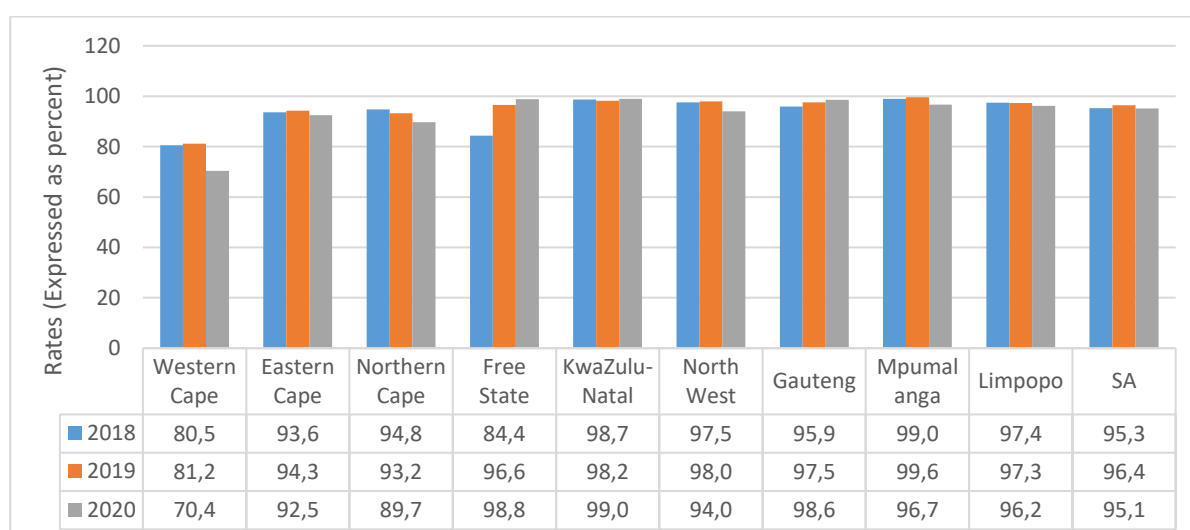


Source: DHIS (2018–2020)

5.9 Antenatal start on ART rate

Western Cape had the lowest antenatal start on ART rate relative to other provinces in the study period. The proportion decreased considerably from 81,2% in 2019 to 70,4% in 2020. Limpopo, KwaZulu-Natal, Mpumalanga and Gauteng had the rate of over 95,0% over the period. The rate of antenatal start on ART increased in Free State from 84,4% to 98,8% in the study period. The proportion decreased slightly between 2019 and 2020 in South Africa (Figure 5.10).

Figure 5.10: Antenatal start on ART rate, province and national

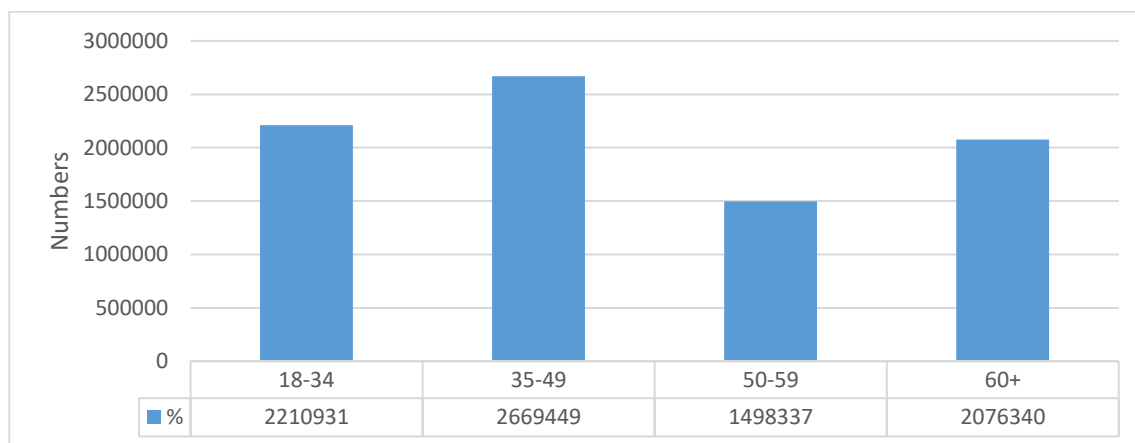


Source: DHIS (2018–2020)

5.10 COVID-19 Vaccination administered¹

The distribution shows that females in the age cohort 35–49 presented the highest number of vaccinations administered, while those in the age cohort 50–59 presented the least. These distributions suggest that those in the age cohort 35–49 years are more likely to vaccinate compared to other cohorts (Figure 5.11).

Figure 5.11: Number of administered vaccination (in numbers) among women (as of 25 October 2021)



Source: National infection and communicable diseases (NICD)

5.11 COVID-19 Cumulative cases (25 October 2021)

Women across all age groups had a higher number of COVID-19 infection cumulative cases. The number of cumulative cases were highest among those in the ages 30–39 years (186 129), closely followed by those in the age group 30–34 years (184 958). Those in the age group 75–79 years had the least.

Table 5.1: Cumulative cases of COVID-19 (25 October 2021)

	Female
15–19	90 897
20–24	106 661
25–29	159 398
30–34	184 958
35–39	186 129
40–44	156 742
45–49	150 373
50–54	138 011
55–59	115 712
60–64	78 785
65–69	53 899
70–74	39 243
75–79	26 327
80+	34 658
Unknown cases	13 966

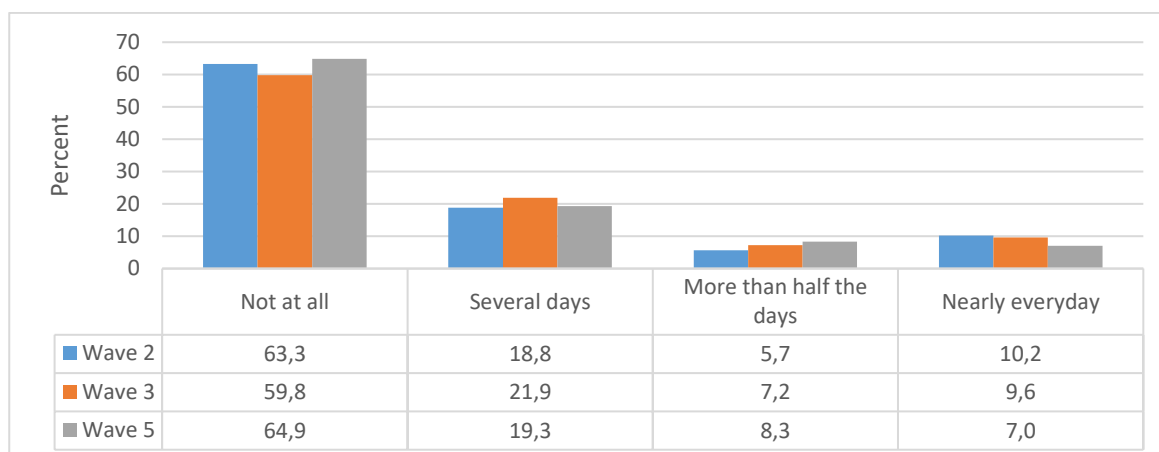
Source: National infection and communicable diseases (NICD)

¹ Vaccinated individuals refer to persons who received one dose of J&J or Pfizer.

5.12 Mental health of women during COVID-19

The distribution shows that a high proportion of women did not feel depressed or hopeless in the last two weeks before the survey across the waves. The proportion has been increasing among those who felt so more than half the days and decreasing among those who felt so nearly every day (Figure 5.12).

Figure 5.12: Percentage distribution of women who felt depressed or hopeless in the last two weeks before the survey

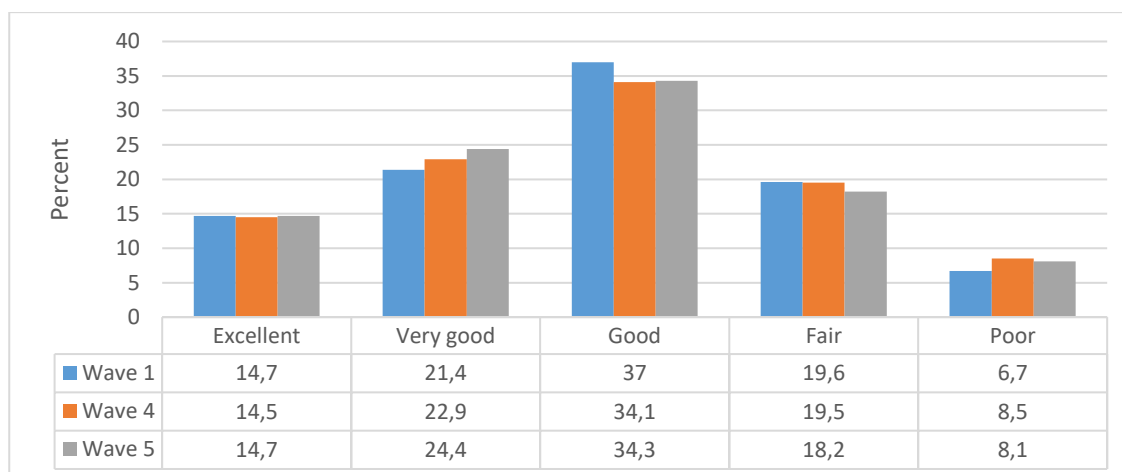


Source: National Income Dynamics Study – Coronavirus Rapid Mobile Survey (NIDS-CRAM), (2020-2021), **Note:** Only Waves 2, 3 and 5 had a question on mental health. See periods of waves in Table 1.1.

5.13 Description of health during COVID-19

The results show that the proportion of those who described their health to be very good has been increasing across the waves. Also, the proportion of those who described their health to be good presented the highest proportion, compared to other categories. Women who described their health as fair declined slightly from 19,5% to 18,2% between wave 4 and wave 5 (Figure 5.13).

Figure 5.13: Percentage distribution of description of health by women, Waves 1, 4 and 5

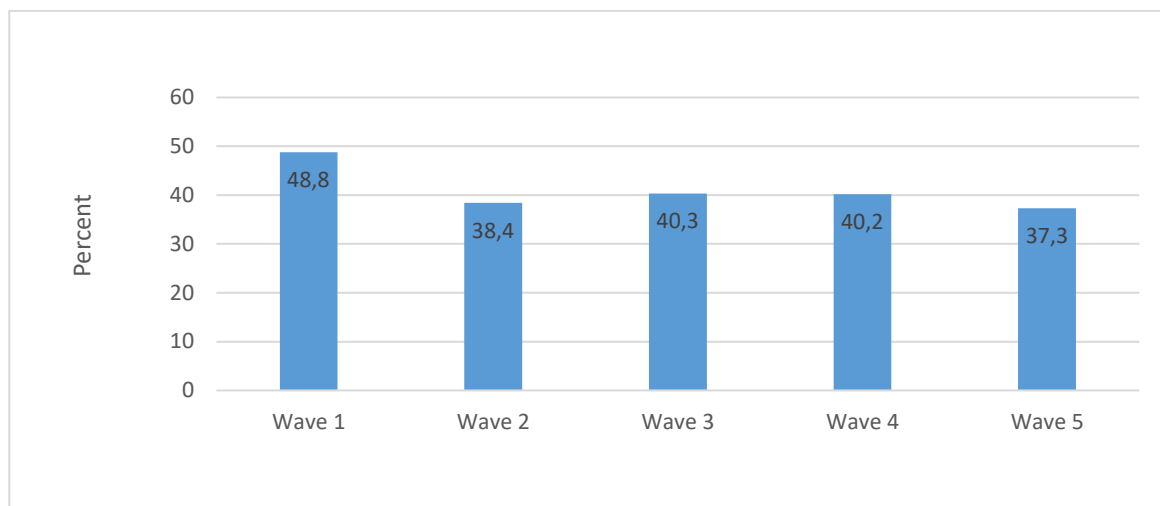


Source: National Income Dynamics Study – Coronavirus Rapid Mobile Survey (NIDS-CRAM), (2020-2021), **Note:** Only Waves 1, 4 and 5 had a question on current description of health. See periods of waves in Table 1.1.

5.14 Households that ran out of money to buy food during COVID-19

Figure 5.14 shows the percentage distribution of female respondents who reported households that ran out of money to buy food 7 days before the survey. The results show that the proportions were highest in Wave 1 (48,8%). This was followed by the females reporting hunger in wave 3 (40,3%) and 4 (40,2%).

Figure 5.14: Percentage distribution of households that ran out of money to buy food in the 7 days before the survey, waves 1–5

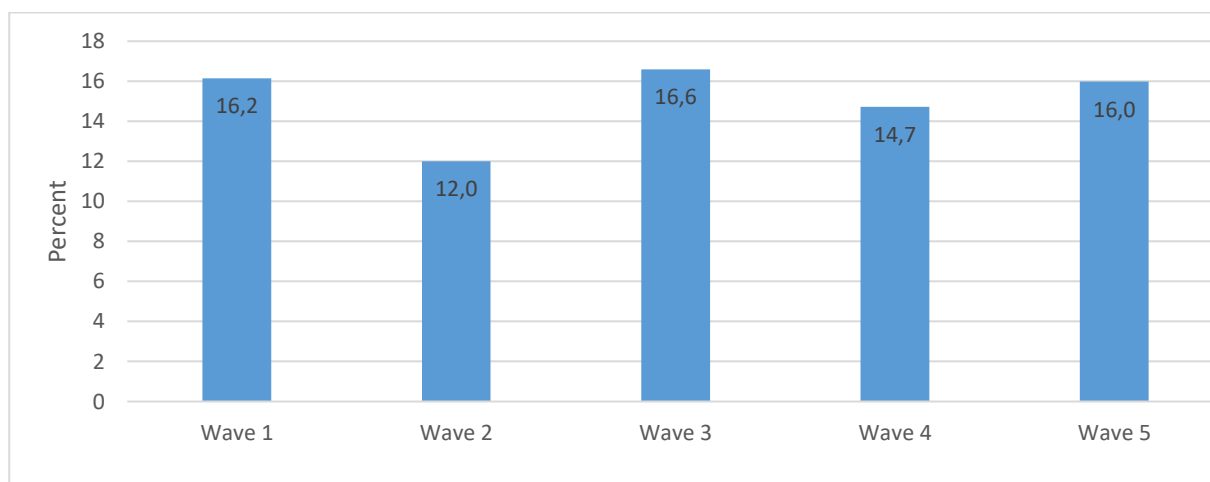


Source: National Income Dynamics Study – Coronavirus Rapid Mobile Survey (NIDS-CRAM), (2020-2021). See periods of waves in Table 1.1.

5.15 Children under 18 years who went hungry 7 days before the survey

The results in Figure 5.15 presents the distribution of women who reported children under 18 years who went hungry due to lack of food in the 7 days before the survey. The results show that a proportion of females who reported child hunger were higher in wave 3 and wave 1 with 16,6% and 16,2% respectively. The proportion of female respondents declined from wave 1 (16,2%) to wave 2 (12%).

Figure 5.15: Percentage distribution of households with children under 18 years who went hungry due to lack of food in the 7 days before the survey, waves 1–5

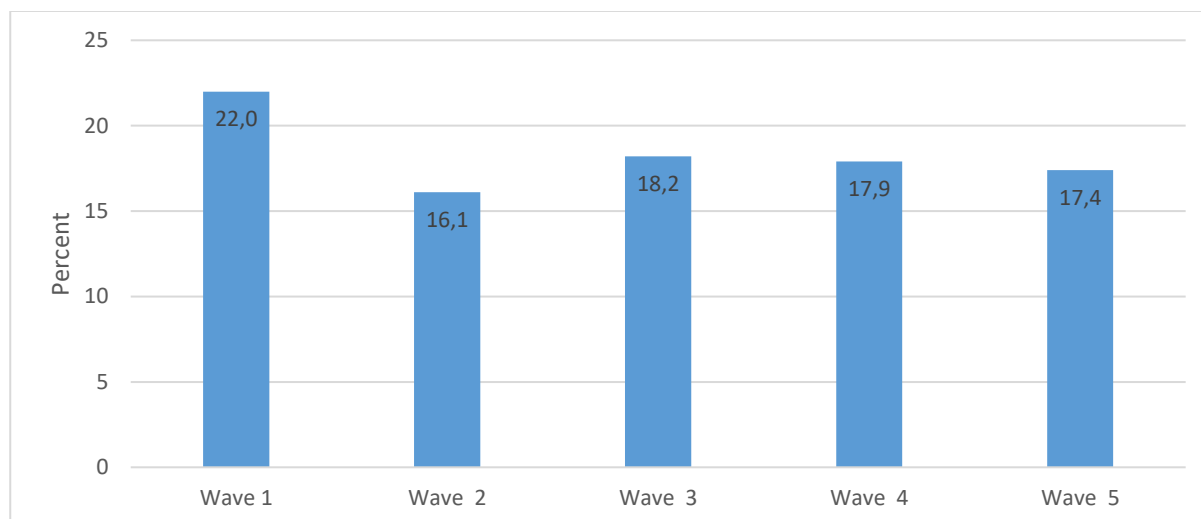


Source: National Income Dynamics Study – Coronavirus Rapid Mobile Survey (NIDS-CRAM), (2020-2021). See periods of waves in Table 1.1.

5.16 Women who reported anyone in the household who went hungry due to lack of food in the 7 days before the survey

The proportion of women who reported anyone in the household who have gone hungry due to lack of food in the week before the survey saw a significant decline from 22% to 16,1% between Waves 1 and 2. A proportion of 17,9% was reported in wave 4, while a proportion of 18,2% was reported in wave 3 (Figure 5.16).

Figure 5.16: Percentage distribution women who reported anyone in the household who went hungry due to lack of food in the 7 days before the survey

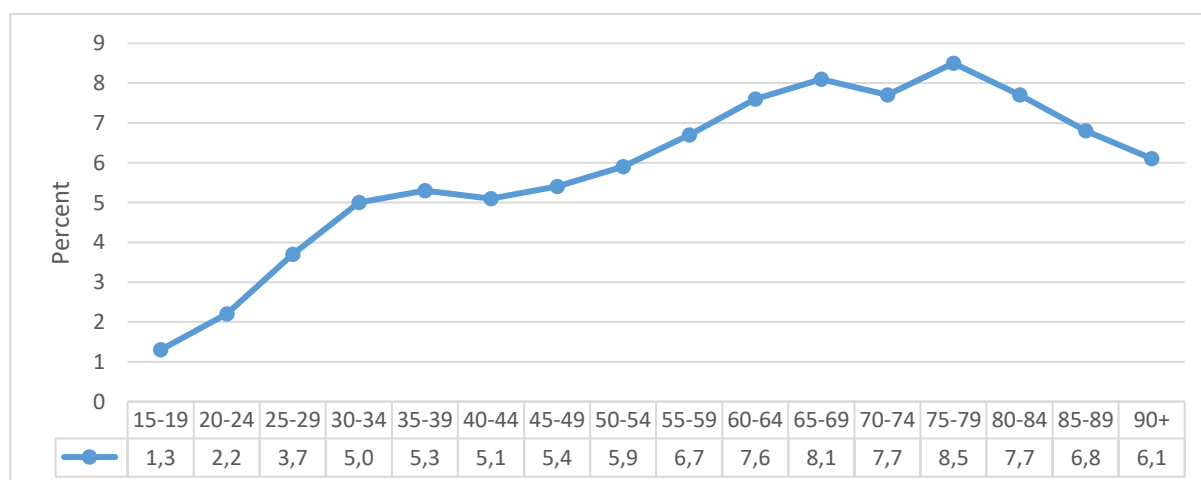


Source: National Income Dynamics Study – Coronavirus Rapid Mobile Survey (NIDS-CRAM) (2020-2021). See periods of waves in Table 1.1

5.17 Distribution of Deaths among women

The distribution of deaths among women (as a result of diseases) showed an increasing pattern from age 15-19 (1,3%). At age 70-74 a sharp decline from 8,1% to 7,7% was observed. There was a notable decline in proportion of deaths of the elderly population from ages 75-79 (8,5%) to 90+ (6,1%).

Figure 5.17: Percentage distribution of deaths by age among female population, 2018*



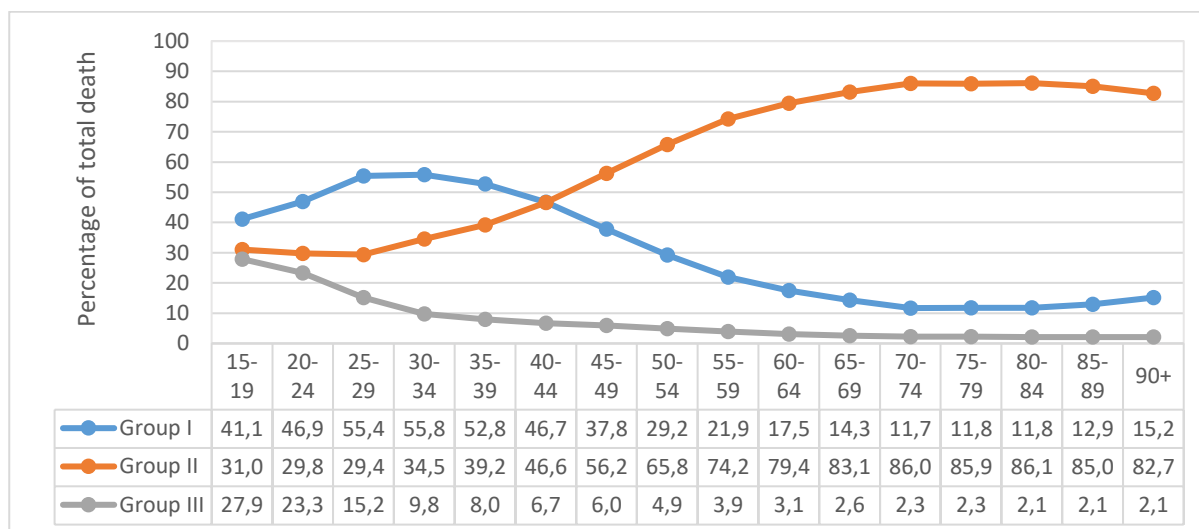
Source: Mortality and causes of death in South Africa: Findings from death notification

*Excluding deaths with unspecified age and sex.

5.18 Deaths due to communicable, non-communicable diseases and injuries

The Figure 5.18 shows the percentage of deaths due to communicable diseases (Group I), non-communicable diseases (Group II) and injuries (Group III) by all age groups, 2018. The distribution shows that those in the age groups 15–19 and 40–44 had the highest proportion of deaths due to communicable diseases, while the deaths due to injuries had the least proportions across all ages. Female from the age group 40–44 (46,6%) and above recorded the highest proportion of deaths due to non-communicable diseases.

Figure 5.18: Percentage of deaths due to communicable diseases (Group I), non-communicable diseases (Group II) and injuries (Group III) by age group among women, 2018*



Source: Mortality and causes of death in South Africa: Findings from death notifications

*Excluding deaths with unspecified age and sex.

5.19 The ten leading underlying causes of death

The distribution shows that Diabetes mellitus (E10-E14) disease (7,7%) was the highest leading underlying cause of death among females. This was followed by Cerebrovascular diseases (I60-I69) and Hypertensive diseases (I10-I15) at 6,1% and 6,0% respectively. Chronic lower respiratory diseases (J40-J47), Malignant neoplasms of female genital organs (C51-C58) and Ischaemic heart diseases (I20-I25) recorded the least proportion at an average of 2,6%.

Table 5.2: The ten leading underlying causes of death among females (all ages), 2018

Causes of death (based on ICD-10)	Rank	Number	%
Diabetes mellitus (E10-E14)	1	16 447	7,7
Cerebrovascular diseases (I60-I69)	2	13 015	6,1
Hypertensive diseases (I10-I15)	3	12 845	6,0
Other forms of heart disease (I30-I52)	4	12 213	5,7
Human immunodeficiency virus [HIV] disease (B20-B24)	5	10 824	5,1
Tuberculosis (A15-A19)	6	10 230	4,8
Influenza and pneumonia (J09-J18)	7	8 442	3,9
Ischaemic heart diseases (I20-I25)	8	5 926	2,8
Malignant neoplasms of female genital organs (C51-C58)	9	5 862	2,7
Chronic lower respiratory diseases (J40-J47)	10	5 393	2,5
Other Natural		100 543	47,0
Non-natural		12 062	5,6
All causes		213 802	100,0

Chapter 6: Discussion and Conclusion

6.1 Discussion

The study revealed that the rate of antenatal 1st visit before 20 weeks of pregnancy was encouraging at 68,6% on average in the study period. However, the rate declined by 1,4% between 2019 and 2020. In support of this finding, Pattinson et al. (2020) noted a reduction in the use of reproductive health services in 2020, after the emergence of the COVID-19 pandemic. Antenatal care is critical in ensuring the best possible pregnancy outcomes as well as improving the overall maternal health of pregnant women and their families (Hlongwane, 2021). Early presentation to antenatal care, especially before 20 weeks of pregnancy assists in timely identification of complications and management during pregnancy (NDoH, 2016). Generally, a minimum of 8 contacts care is recommended by the World Health Organization for each pregnancy term (Massyn et al., 2020). A study by Jinga and others (2019) found that reasons for late presentation for antenatal care includes the unaffordable costs of travel visit to the health centre and possible prior knowledge about pregnancy care, especially amongst older women. The 2016 SADHS report also recorded a drop to 47,6% in the percentage of older women (45–49) who had more than 4 antenatal visits in their most recent birth (Stats SA, 2020).

South Africa observed a decline in maternal mortality in facility ratio from 115,6 to 88,0 deaths (per 100 000 live births) across years. Many studies, using different methodologies, confirm the decline in the country (Moodley and Pattinson, 2018; Damian et al., 2019; Bomela, 2020; Dorrington et al., 2020). The Rapid Mortality Surveillance Report highlights a decline in maternal mortality ratio to 137 per 100 000 live births in 2016 (Dorrington et al., 2021). An investigation into the number of deaths by causes from 1997–2017 noted an overall decrease in deaths by cause (ibid). Generally, progress made in maternal mortality is largely attributed to improvements in the roll out of antiretroviral treatment in the country (Dorrington et al., 2020).

Nationally, stillbirth in facility rate was gradually declining, although some provinces still experience a slight increase in 2020. Most of the identifying causes of stillbirth in South Africa are understood to be treatable or preventable. These include probable foetal compromise, pathological placental conditions, and foetal invasive bacterial infection (Madhi et al., 2019; UN IGME, 2020).

Neonatal mortality in facility rate was consistent at 12,1 (per 1 000 births) between 2019 and 2020. Rhoda et al. (2018) who looked at neonatal mortality in South Africa established that the major causes of neonatal death includes complications of prematurity, intrapartum-related events and infections (Rhoda, et al., 2018). With the exception of 2018, neonatal death in facility rates were consistent with the rates observed from the Rapid Mortality Surveillance report (RMS) (2021). Rates from RMS are computed after the DHIS data is adjusted for under-coverage, relative to the registered deaths and the incompleteness of the vital registration (Dorrington et al., 2021).

Although, evidence suggests that routine and emergency maternal health services may be the hardest hit by COVID-19 as resources are diverted to addressing the pandemic (Hussein, 2020). Findings from the study however showed that indicators such as delivery by caesarean section rate, stillbirth in facility rate, neonatal death in facility rate, among others did not change or were almost consistent in 2020. These patterns are not unique since the study of Riley et al. (2020) on the impact of COVID-19 on maternal and new born mortality offer different results, suggesting that these might be as a result of inconclusive data.

The study revealed that late adolescent pregnancy (14–19 years) remains an issue in South Africa, as the proportions increased with age. Early study suggest that this increase can be associated to high-unmet need of contraceptives, especially in sub-Saharan Africa (UNICEF, 2018). In addition, the study also suggest that adolescent pregnancy has consequences for the mother and child, escalating the chance of death and future health problems (EAC, 2018; UNICEF, 2018).

The rate of early pregnancy termination 0–12 weeks remained high in all provinces in 2020. Most provinces maintained a slightly increasing pattern, with Gauteng province presenting the biggest gap (5,8%) between 2019 and 2020. This difference may be reflecting the high number of pregnancies reported in Gauteng province in recent time, as compared to other provinces. National trajectories over the years indicates a marginal increase of 1,5% between 2019 and 2020. This might be associated to the fact that couples staying indoors during the COVID–19 era gave room for sexual practices, leading to unwanted/unplanned pregnancy (Aassve et al., 2020).

There was a low rate of termination of pregnancy 13–20 weeks in all provinces in 2020. These are pregnancies which may be terminated only under specific conditions (Goh and Thong, 2006; Kapp et al., 2021). The low rate of termination may be associated to the fact that it becomes more risky (life threatening) to terminate at these number of months. However, the Western Cape and Gauteng presented the highest rates, compared to other provinces. There was a decrease of 1,5% between 2019 and 2020 in South Africa. The low termination of pregnancy rates in the more traditional provinces (e.g. Limpopo, Mpumalanga, Northern Cape) may also be associated to cultural practices and norms (Ipas, 2021).

The use of any modern contraceptive methods is significant among sexually active women, with the injection (24,8%) and male condoms (15,6%) being the most used. Chersich, et al. (2017) found these patterns to be almost consistent in their study in South Africa. Although, the use of injection method may be higher because of its convenience of use, studies however suggest that male and female condom use are also very effective in the prevention of HIV and unintended pregnancies when used properly and consistently (Massyn et al., 2020; WHO, 2012). Changes in contraceptive distribution indicates that only norethisterone enanthate injection, female sterilisation and IUCD showed a positive distribution in proportion, while others experienced negative changes, 2018–2020. Earlier studies has also associated this to the COVID-19 lockdown measure, which has caused major disruptions to contraceptive production and supply chains (IPPF, 2020).

Delivery in facility rate among adolescents (10–19 years) revealed almost consistency in recent years. Jonas and Massyn (2020) observed a pattern similar to this in their study in South Africa. Although, significantly high proportion of women of reproductive ages (15–49 years) delivered in health facilities in all provinces. However, there were more women delivering at public health facilities, compared to private health facilities. Empirical evidence suggests that these developments may be linked with high cost of deliveries at private hospitals (Maphumulo, 2019). At a proportion of 14,3%, evidence from the study suggests that women in the Western Cape are more likely to afford deliveries in private health facilities. Early studies have documented series of factors hindering facility sector deliveries. Prominent among these include socio-economic and cultural factors, general educational status, obstetric history and awareness of danger signs, perceived quality of care, physical and financial barriers, etc. (EAC, 2018; Global Health Group, 2014). According to EAC (2018), since “facility deliveries are known to be associated with improved maternal and child health outcomes. A proper referral system is therefore essential in enhancing facility deliveries” (EAC, 2018:19).

Reviews on gender-based violence (GBV) shows that experience of physical violence by a partner is common in South Africa. This development is consistent with earlier studies such as Kaminer (2008), Merten (2017), Mthembu et al. (2021). For example, Kaminer (2008) in his study in South Africa observed that one in eight women experienced intimate partner violence. The study also revealed that divorced and never married women were more likely to have ever experienced physical abuse than other women. Also, Merten (2017) found that “four in 10 divorced or separated women reported physical violence, as has one in three women in the poorest households” (Merten, 2017:1).

Sexual violence from any partner was prevalent in North West and Gauteng and lowest in KwaZulu-Natal in 2016. These findings are almost consistent with that of Merten (2017), who in an earlier study identified KwaZulu-Natal as having the least experience of partner violence. Although, the development in KwaZulu-Natal may be associated to methodological issues. Empirical evidence however suggests that most of women in rural communities in KwaZulu-Natal are victims of domestic violence, but choose not to report their experiences, due to their financial vulnerability and cultural beliefs. Hence, the low prevalence. In support of these notions, CSVR (2009) further observed that reliable statistics on GBV are not regularly reported or published in South Africa (CSVR, 2009).

The study revealed that HIV incidence has been declining in South Africa by age, with the prevalence more pronounced among those in the reproductive ages. Studies suggest that the global acceleration of the AIDS response over the past decade, particularly increased access to antiretroviral for HIV treatment, has resulted in declining HIV incidence in many regions of the world (Salim and Baxter, 2019). This has led to a 33% reduction in AIDS-related deaths between 2010 and 2018 (ibid). Nonetheless, women and young girls are still vulnerable to HIV infections in South Africa. These findings also corroborate with many studies in regions of Africa (Mathur et al., 2020; UNICEF, 2021). Also, the high prevalence observed amongst adolescents and women (of reproductive age) could be qualified by new infections or high incidence observed among this population (Johnson et al., 2017). Furthermore, the systematic pattern of HIV prevalence amongst women have been associated with factors such as multiple sex partners, age desperate relationships and early sexual debut (Evans, et al., 2017; Simbayi and Cloete, 2009).

Over time, Western Cape had the lowest antenatal client HIV re-test rate and re-test positive rate compared to other provinces over time. These patterns may be associated with the lowest HIV prevalence rate observed in the province. On the other hand, Mpumalanga presents the highest rates in 2020. According to the Thembisa estimate model, Mpumalanga recorded a high number of people living with HIV (746 915) and new infections (18 473) in 2020 (Johnson and Dorrington, 2020). The study also revealed that Western Cape experienced the highest rate of clients already on ART across the years, followed by Free State and KwaZulu-Natal. These findings are consistent with that of Woldesenbet et al. (2020), who observed that the highest knowledge of HIV-positive status was in Western Cape and KwaZulu-Natal.

Distribution of females who reported that the household ran out of money to buy food in the 7 days before the survey suggest that below half of the households ran out of money to buy food in the 7 days before the survey. Casale and Posel (2020) in a recent study have associated this to women experiencing much greater job losses than men in both absolute and relative terms during the COVID-19 first strict lockdown phase in April (Casale and Posel, 2020). Also, findings from the study using the NIDS-CRAM data revealed that food insecurity affects female respondents more than male respondents (Casale and Shepherd, 2021).

The dynamics observed across the waves might be associated with the timing of the initiation of government support grants in South Africa. For example, the government support measures, which were implemented to combat the effects of the COVID-19 pandemic, were planned to end in October 2020. However, the severe conditions in the society led to the extension of the COVID-19 SRD grant to the end of January 2021. The increased levels of hunger observed in the Wave 3 data could in part have been due to the phasing out of this government support incentives (Bridgman et al., 2020). The study revealed that women are more vulnerable to COVID-19 infections. This is so, especially among those in the middle ages in South Africa. The finding in South Africa is consistent with global studies such as OECD (2021) and UN (2020). They are also more likely to vaccinate against COVID-19 in all age groups. Studies such as Unger, 2021; Loomba et al., 2021 are also consistent with these patterns in South Africa.

Deaths as result of diseases has been increasing in South Africa, especially after 10-14 years. The most leading causes of death among female include Diabetes mellitus (E10-E14) disease (7,7%), followed by Cerebrovascular diseases (I60-I69) and Hypertensive diseases (I10-I15). Studies such as Macaulay et al. (2018), Pheiffer (2021) and Chivese et al. (2016) have found these to be consistent in their studies in South Africa and Africa respectively. They also suggest that these diseases have increased the burden on the economy due to work absenteeism and decreased productivity.

6.2 Conclusion

In general, the study revealed that some of the indicators analysed in the study showed improvement, while others did not. For example, indicators such as maternal mortality in facility ratio and termination of pregnancy 13–20 week rate declined, while those of antenatal client already on ART at first visit rate and delivery 10–19 years in facility rate reported an increase, especially between 2019 and 2020. Although, provinces of Northern Cape, Free State and North West need more efforts to improve progress in some of the indicators. Overall, findings from this study strongly contribute to the existing knowledge of women's health status in South Africa, especially in the recent time.

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Appendix: Table showing the name, definition, formula and the source of selected indicators used in the study

Indicator Name	Definition	Formula	Indicator type	Source
Antenatal 1 st visit before 20 weeks rate	Women who had a first visit before they are 20 weeks into their pregnancy as proportion of all antenatal 1 st visits.	(Antenatal 1 st visit before 20 weeks)/ (Antenatal 1 st visit 20 weeks or later +Antenatal 1 st visit before 20 weeks).	%	Department of Health
Maternal mortality in facility ratio	Death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100, 000 live births in facility.	(Death in facility)/(live birth in facility + born alive before arrival at facility).	Per 100 000 live births	Department of Health
Females on medical aid	Females in age group 15–49 who are members of medical aid schemes.	(Females who are covered by medical aid in age group 15-49)/ (total number of females in age group 15–49).	%	Statistics South Africa: GHS
Stillbirth in a facility rate	Infants born still as proportion of total infants born in health facilities.	(Still birth in facility)/(Live birth in facility + Stillbirth in facility)	Per 1 000 births	Department of Health
Early neonatal death in facility rate	Infants 0–6 days who died during their stay in the facility per 1000 live births in facility.	(Death in facility 0–6 days)/(Live birth in facility)	Per 1 000 live births	Department of Health
Neonatal death in facility rate	Infants 0–28 days who died during their stay in the facility per 1000 live births in facility.	((Death in facility 0-6 days) + (death in facility 7–28 days))/(live birth in facility)	Per 1 000 live births	Department of Health
Delivery by caesarean section rate	Delivery by caesarean section as proportion of total deliveries in health facility.	(Delivery by caesarean section)/(delivery 10–14years in facility + delivery 15–19 years in facility +delivery 20 years and older in facility)	%	Department of Health
Late Adolescent/Teenage Pregnancy	Percentages of teenage girls who get pregnant with their first child.	(Number of women in age group 14–19 who are pregnant)/ (all women in the age group 14–19)	%	Statistics South Africa: GHS

Indicator Name	Definition	Formula	Indicator type	Source
Termination of pregnancy 0–12 week's rate	Pregnancies terminated in health facilities in the first 12 weeks of pregnancy as a proportion of total termination of pregnancies.	$(\text{Termination of pregnancy 0–12 weeks}) / (\text{termination of pregnancy 0–12 weeks} + \text{termination of pregnancy 13–20 weeks})$	%	Department of Health
Termination of pregnancy 13–20 weeks rate	Pregnancies terminated in health facilities at 13–20 weeks of pregnancy as a proportion of total termination of pregnancies.	$(\text{Termination of pregnancy 13–20 weeks}) / (\text{Termination of pregnancy 0–12 weeks} + \text{termination of pregnancy 13–20 weeks})$	%	Department of Health
Termination of pregnancy under 20 years rate	Termination of pregnancy under 20 years as a proportion of total of deliveries under 20 years in health facilities.	$(\text{Termination of pregnancies 10–19 years}) / (\text{Termination of pregnancy 0–12 weeks} + \text{Termination of pregnancy 13–20 weeks})$	%	Department of Health
Modern and Traditional contraceptive methods currently used among sexually active women (15–49)	Percentage of women who used specific methods/any method/modern method, any traditional method among sexually active women (15–49)	$(\text{Modern} + \text{traditional methods}) / (\text{Number of women in the coverage category})$	%	Demographic and Health Survey: Guide to DHS Statistics
Percentage distribution of all women by contraceptive methods currently used, according to age	Percentage of women who currently use specific methods/ use any methods/ use any modern methods/ use any traditional methods.	$(\text{Specific methods, any methods, modern methods, and traditional methods}) / (\text{Number of women in each of the coverage categories})$	%	Demographic and Health Survey: Guide to DHS Statistics
Delivery in 10–19 years (adolescents) in facility rate	Deliveries to women under the age of 20 as proportion of total deliveries in health facilities.	$(\text{Delivery 10–14 years in facility} + \text{Delivery 15–19 years in facility}) / (\text{Delivery 10–14 years in facility} + \text{Delivery 15–19 years in facility} + \text{Delivery 20 years and older in facility})$	%	Department of Health
Delivery in facility rate	Deliveries in health facilities as proportion of expected deliveries in the population. Expected deliveries are estimated as population under 1 year multiplied by 1.025 to compensate for stillbirths and infant mortality.	$(\text{Delivery 10–14 years in facility} + \text{Delivery 15–19 years in facility} + \text{Delivery 20 years and older in facility}) / (\text{Female under 1 year} + \text{Male under 1 year}) * 1.07$	%	Department of Health

Indicator Name	Definition	Formula	Indicator type	Source
Experience of Sexual Violence	Percentage of women 18 years and older who have ever experienced sexual violence by any partner or non-partner.	Numerator: 1) Number of women who have ever experienced any form of sexual violence. Denominator: Number of women age 18 and older selected and interviewed for the domestic violence module	%	SADHS 2016 report
Experience of Sexual Violence in the last 12 months	Percentage of women 18 years and older who have ever experienced sexual violence by any partner or non-partner.	2) Number of women who have experienced any form of sexual violence in the 12 months preceding the survey. Denominator: Number of women age 18 and older selected and interviewed for the domestic violence module	%	SADHS 2016 report
Distribution of experience of Sexual violence from partner	Percentage of women who ever experienced sexual violence from partner	Numerators: 1) Number of women who have ever experienced any form of sexual violence asked about, as a child or as an adult: Denominator: Number of women selected and interviewed for the domestic violence module	%	SADHS 2016 report
Distribution of women who ever experienced physical violence from any partner	Percentage of woman age 15–49 who have experienced physical violence since age 15 (partner or non-partner)	Numerator: Number of women who have experienced any form of physical violence from Any husband/partner Denominator: Number of women age 15–49 selected and interviewed for the domestic violence module	%	SADHS 2016 report

Indicator Name	Definition	Formula	Indicator type	Source
Distribution of women who ever experienced physical violence from any partner in the last 12 months	Percentage of women age 15–49 who have experienced physical violence in the past 12 months	Number of women who have experienced any physical violence in the 12 months Denominator: Number of women age 15–49 selected and interviewed for the domestic violence module	%	SADHS 2016 report
Antenatal clients already on ART at 1 st visit rate	Antenatal clients already on ART at first visit as a proportion of antenatal clients HIV positive	$\frac{\text{Antenatal already on ART at 1}^{\text{st}} \text{ visit}}{(\text{Antenatal HIV 1}^{\text{st}} \text{ test positive}) + (\text{Antenatal HIV re-test positive}) + (\text{Antenatal already on ART at 1}^{\text{st}} \text{ visit})}$	%	Department of Health
Antenatal start on ART rate	Antenatal clients who started on ART as a proportion of the total number of antenatal clients who are HIV positive and not previously on ART	$\frac{\text{Antenatal start on ART}}{((\text{Antenatal known HIV positive but NOT on ART at first visit}) + (\text{Antenatal HIV 1}^{\text{st}} \text{ first test positive}) + (\text{Antenatal HIV re-test positive}))}$	%	Department of Health

