

Demographic Profile of Adolescents in South Africa

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Statistician-General

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Preface

The National Development Plan (NDP) Vision 2030, amongst other frameworks, emphasise harnessing of the demographic dividend through investments in the youth population. It is the goal of this report to provide an analysis on the state of the adolescent population in South Africa with specific reference to its age and sex composition, fertility, mortality and migration. Information from this thematic report used data from Censuses 1996, 2001 and 2011, Community Survey 2016, Mortality and Causes of Death 2015, and the General Household Survey 2016.

A handwritten signature in black ink, appearing to read 'Risenga Maluleke', is centered on the page. The signature is fluid and cursive, with a large initial 'R'.

Risenga Maluleke
Statistician-General

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EXECUTIVE SUMMARY

This thematic report employed data from Censuses 1996, 2001 and 2011, Community Survey 2016, Mortality and Causes of Death 2015, and the General Household Survey 2016 to provide data on the state of the adolescent population in South Africa.

The findings indicate that adolescents made up 18,5% of the total population of South Africa in 2016. Eastern Cape (22,7%), Limpopo (21,4%) and KwaZulu-Natal (20,7%) are the provinces where adolescents made up the largest number of the adolescent population, whilst the lowest numbers were recorded in Gauteng and Western Cape. The results show that the majority of adolescents are amongst the black African (19,3%) and coloured (18%) population groups. The Indian/Asian (14%) and white (12%) population groups constituted the lowest proportion of adolescents in the country. Across all the provinces there was a slight increase in the adolescent population from 1996 to 2001, which later showed a decreasing pattern between 2001 and 2011. In 2016, Eastern Cape, Western Cape and North West observed a steady increase in the adolescent population. The median age of adolescents over time was approximately 14 years.

The report revealed that adolescent fertility increased in 2011 (72 births per 1 000 women aged 15–19) after reaching low levels in 2001 (65 births per 1 000 women aged 15–19). Data from SADHS 2016 show a consistent level of adolescent fertility of 71 births per 1 000 women aged 15–19. The pattern of adolescent fertility follows the overall fertility dynamics of the country. Similar to the total fertility rate, adolescent fertility is much higher amongst black Africans and coloureds and lower amongst Indian/Asian and white adolescent women. Rural provinces such as Northern Cape, Eastern Cape and Limpopo reveal high adolescent fertility.

The observation on adolescent mortality showed that there has been a decline in the proportion of deaths amongst adolescents in the country. Of the ten leading causes of death amongst adolescents in 2015, Tuberculosis (A15-A19), followed by Human immunodeficiency virus [HIV] disease (B20-B24), other viral diseases (B25-B34), and Influenza and pneumonia (J09-J18), were ranked top four causes of death amongst both sexes.

Gauteng was home to the majority of foreign-born adolescents (45,4%). About 51% of all foreign-born adolescents were female, and the majority of foreign-born adolescents in South Africa are black African (88,3%). Almost three-quarters of foreign-born adolescents are not South African citizens. Only 66,2% of migrants in this cohort are currently attending an educational institution. Almost three times as many foreign-born adolescents (21,1%) than South African-born adolescents live in informal dwellings. About ten per cent of migrant adolescents were concerned about violence and crime in the municipality where they lived. Nearly 10,54% of migrant adolescents were victims of crime in the year before the survey.

The report is organised into five chapters. The first chapter presents an overview of the adolescent age composition and structure. Chapter two presents the adolescent fertility whilst chapter three presents the adolescent mortality and causes of death. In chapter four, an analysis of foreign-born adolescents in South Africa is presented. The last chapter presents discussions and conclusions.

ABBREVIATIONS AND ACRONYMS

ABR	Adolescent Birth Rate
ADR	Adolescent Death Rate
AIDS	Acquired immune deficiency syndrome
DHA	Department of Home Affairs
DoH	Department of Health
HIV	Human immunodeficiency virus
NDP	National Development Plan
NYP	National Youth Policy
PAF	Proportion of Fertility in Adolescence
PRB	Population Reference Bureau
SADHS	South Africa Demographic and Health Survey
SAHRC	South African Human Rights Commission
SAMRC	South African Medical Research Council
SDGs	Sustainable Development Goals
TFR	Total Fertility Rate
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNDESA-PD	United Nations Department of Economic and Social Affairs, Population Division
WHO	World Health Organization

DEFINITIONS OF TERMS

- **Adolescent:** The term adolescent refers to the population aged 10–19.
- **Adolescent birth rate:** The rate measures the annual number of births to women aged 15–19 per 1 000 women in that age group.
- **Adolescent death rate:** The rate measures the number of deaths amongst persons aged 10–19 per 100 000 population in that age group.
- **Foreign-born adolescent:** Population aged 10–19 who were born outside South Africa.
- **South African-born adolescent:** Population aged 10–19 who were born in South Africa.
- **Lifetime migrant:** A lifetime migrant is defined as a person who was not born in South Africa, but who was enumerated within the borders of South Africa on the night of Community Survey 2016.

CHAPTER 1: ADOLESCENT COMPOSITION AND STRUCTURE

1.1 Overview

African states emphasise harnessing of the demographic dividend through investments in the youth population (Population Reference Bureau, 2017). As such, the youth population has been prioritised by the African Union Agenda 2063 – Aspiration 6, which seeks to ensure that opportunities are available for self-realisation of youth, and this can be achieved by enabling access to health, education and jobs, amongst others (African Union Commission, 2015). The same vision is shared by the South African National Policy instruments such as the National Development Plan (NDP) Vision 2030 and the National Youth Policy (NYP) 2015–2020, which additionally puts emphasis on the protection of young people from sexually transmitted diseases and unplanned teenage pregnancies. Also related to youth is the adolescent birth rate, which is prioritised as one of the indicators to monitor progress towards the achievement of Goal 3 of the Sustainable Development Goals (SDGs). This goal aims to ensure healthy lives and promote well-being for all at all ages. The goal target is to ensure universal access to sexual and reproductive health-care services, including family planning, information and education, and the integration of reproductive health into national strategies and programmes (World Health Organization, 2016).

About 1,2 billion adolescents (10–19 years old) make up sixteen per cent of the world's population and nearly 90% of this population live in developing countries (UNICEF, 2017). In recent times, adolescents have benefited from the gains in child survival, improved education, access to safe water, and other areas of development that were driven to meet the Millennium Development Goals and the human development targets at the core of the Declaration (UNICEF, 2011). Adolescents are protected under the Convention on the Rights of the Child, yet, their vulnerabilities and needs often remain unaddressed compared to other segments of the children population (UNICEF, 2012). These vulnerabilities includes teenage pregnancy, mortality, migration, HIV and AIDS, and sexual reproductive health.

Globally, almost 16 million girls aged 15–19 years give birth each year; the majority of these girls live in sub-Saharan Africa (Christiansen et al., 2013). Nearly one in five girls worldwide becomes a mother before her 18th birthday, accounting for almost 11% of all births globally (ibid). A large number of these young women undergo unsafe abortions, where risks of dying from pregnancy-related causes are very high (WHO, 2011).

The decline in the adolescent birth rate since 1990 is almost universal. Africa has the highest adolescent birth rate and the decline over time has been slow (UN, 2015). In South Africa, 16% of women aged 15–19 have begun childbearing, 12% have given birth, and another 3% were pregnant with their first child at the time of the interview (NDoH, Stats SA, SAMRC and ICF, 2017).

Also, an estimated 1,3 million deaths occurred worldwide amongst adolescents (10–19 years) (WHO, 2014). Empirical evidence indicates that road injuries, AIDS-related causes, suicide, lower respiratory infections and interpersonal violence were the top five leading causes of death in adolescents and young

people in 2012 (ibid). In 2012, an estimated 1,3 million deaths occurred worldwide amongst 10–19-year-olds; however, there has been a drop in the adolescent mortality rate from 126 deaths per 100 000 in 2000 to 111 per 100 000 in 2012 (ibid). Despite this overall decline in mortality, the estimated number of global AIDS-related deaths amongst adolescents aged 10–19 has nearly tripled from 21 000 in 2000 to 60 000 in 2014 (UNAIDS, 2014).

South Africa, much like the rest of Africa, remains plagued by the burden of disease and mortality. Available data indicate that 26 new infections occur every hour amongst adolescents and about half of those living with HIV are in just six countries: South Africa, Nigeria, Kenya, India, Mozambique and Tanzania (SAHRC and UNICEF, 2016).

The migration process also confronts young people under the age of 20 and confers to them certain vulnerabilities. These vulnerabilities include discrimination based on gender, migration status and poor working conditions (UN, 2016). Amongst the migrants under 20 years of age, the group of 15–19 years is the largest one, accounting for some 33 % of all migrants under the age of 20, followed by the age group 10–14, which represents around 27% of the total migrant population under 20 years of age (UNICEF, 2010)

Bennett (2013) in her longitudinal study of teens on the move in South Africa, observed that by age 18, 42% of adolescents who were 12 years old had migrated at least once. Adolescents who shared household membership with both parents were significantly less likely to move than those who were co-members with one or neither parent. Almost half (45%) of all movers moved alone, and girls were significantly more likely to be engaged in unaccompanied migration than boys.

World leaders made a promise to children to help them fulfil their human potential. To date, adolescents are alive as a result of the significant drop in the child mortality rate and globally, more children are enrolled in school than any generation of children before them (UNICEF, 2012). However, the adolescent situation analysis in South Africa suggests that their needs and risky behaviours remain unaddressed. Based on these contexts, this report is aimed at establishing the current state of adolescents in South Africa.

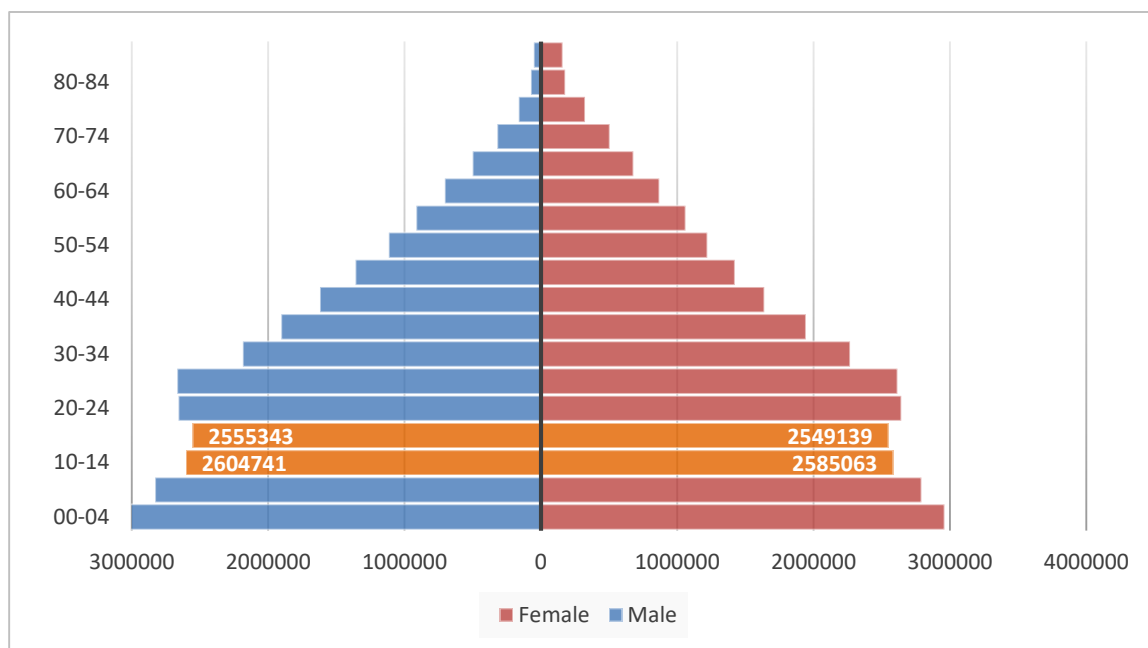
1.2 Adolescents composition and structure

1.2.1 Size and distribution of the adolescent population in South Africa

The adolescent population are cohorts of people aged 10–19 years in a given population structure. According to literature, the adolescent population structure can be classified into two groups. These are the early adolescent population aged 10–14 years and the late adolescent population comprising those aged 15–19 years (Makiwane and Chimere-Dan, 2009; UNFPA, 2009).

Figure 1.1 below shows a pyramid of the South African population by age and sex, 2016. The figure indicates that 10 294 894 adolescents (10–19) were living in South Africa in 2016. Of these adolescents, 9,3% constituted 10–14 year-olds and 9,1% comprised 15–19 year-olds. These adolescents made up 18,5% of the total population in 2016 (Figure 1.2). In this adolescent population, 5 160 084 (18,9%) were males and 5 134 202 (18,1%) were females.

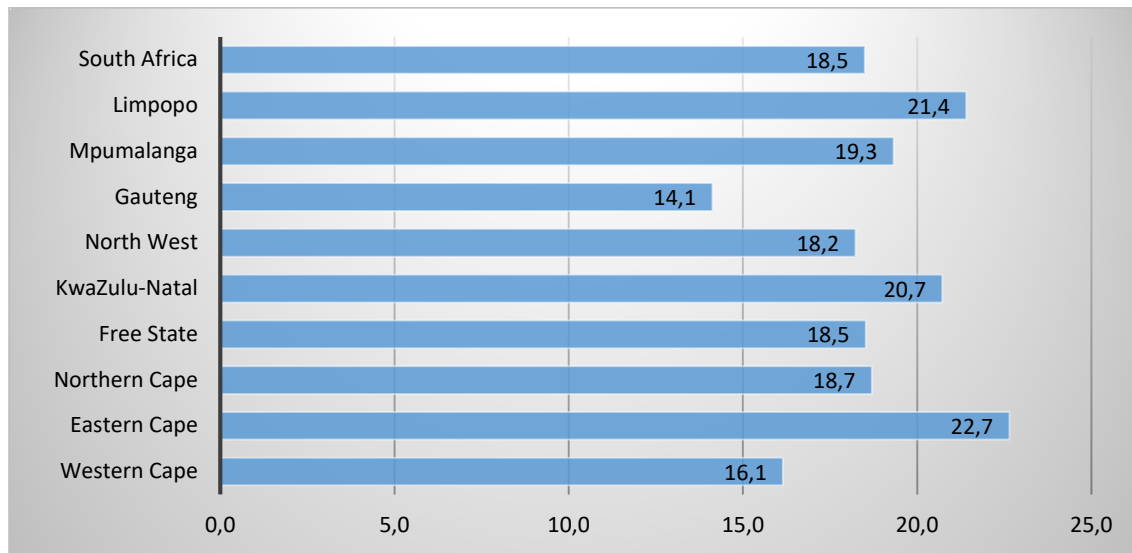
Figure 1.1: South African population by age and sex, 2016



1.2.2 Percentage of adolescents 10–19 years by province, 2016

In 2016, Eastern Cape (22,7%), Limpopo (21,4%) and KwaZulu-Natal (20,7%) were the provinces with the largest number of adolescents aged 10–19. Gauteng had the least number of adolescents (14,1%), followed by Western Cape (16,1%).

Figure 1.2: Percentage of adolescents aged 10–19 years, by province



1.2.3 Percentage of adolescents 10–19 by population group and place of residence

Results in Figure 1.3 show that in 2016, the majority of adolescents were found amongst the black African (19,3%) and coloured (18%) population groups. Adolescents were more likely to reside in rural (22,5%) areas than urban areas (16,2%). Between 1996 and 2001, there were slightly more female than male adolescents; however, in 2011 and 2016, the number of male and female adolescents appeared to be consistent (Figure 1.4).

Figure 1.3: Percentage of adolescents aged 10–19 years by population group and geographical type, 2016

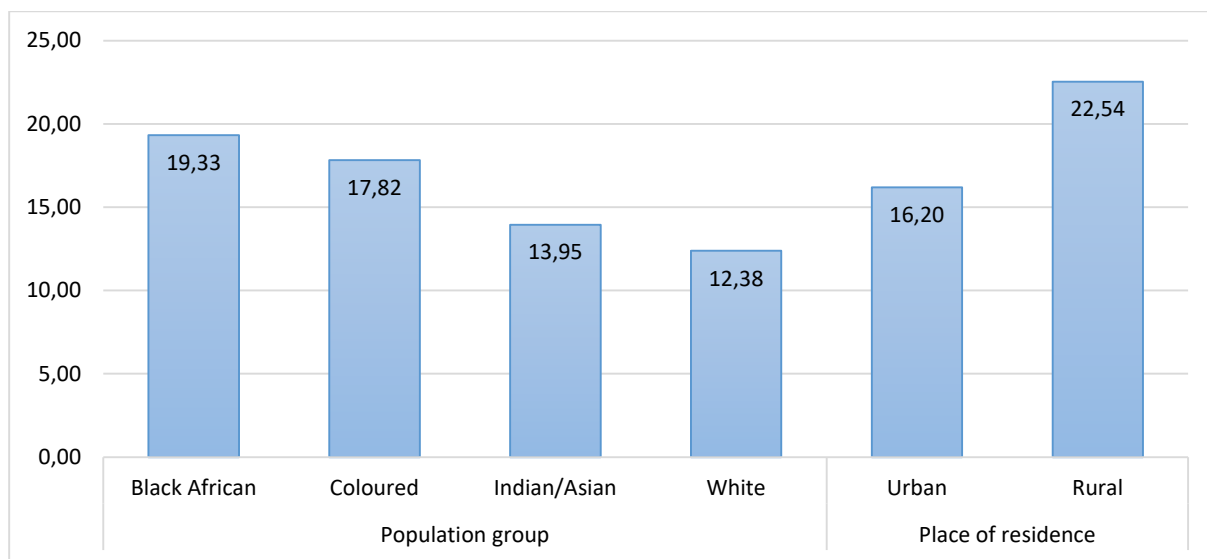
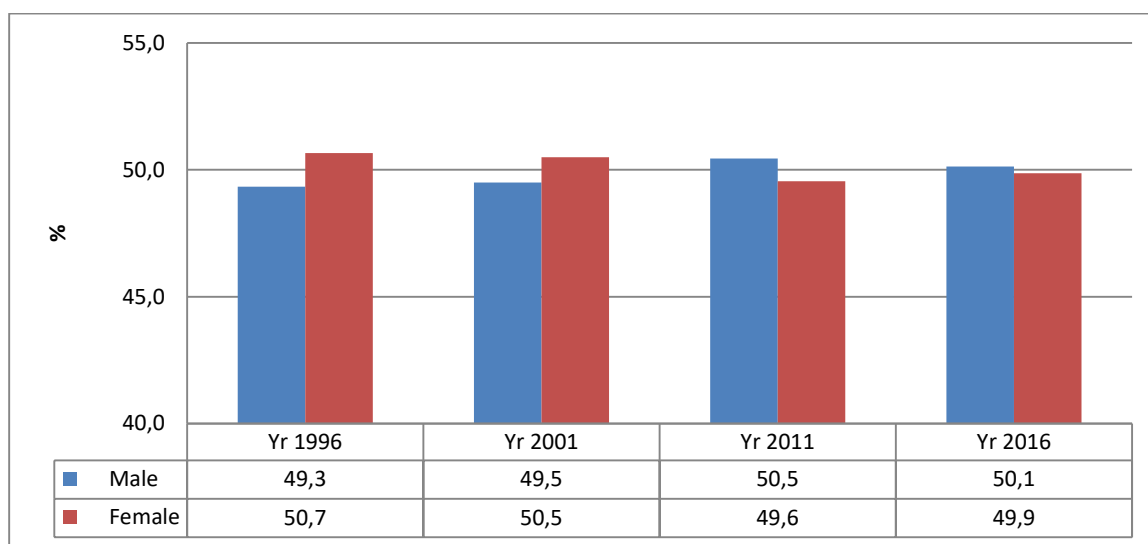


Figure 1.4: Percentage distribution of adolescents in South Africa by sex, 1996–2016



1.2.4 Annual percentage change in the adolescent population in South Africa

Table 1.1 shows the annual percentage change in the adolescent population both nationally and by province from 1996 to 2016. The results indicate that there have been variations in the annual percentage change amongst the adolescent population across the provinces and over time. Between 1996 and 2001, the adolescent population had grown in almost all the provinces, with the exception of Northern Cape (-0.89%). During the period 2001–2011, Gauteng and Western Cape had the highest increase in the proportion of adolescent population (1.22%) and (0.58%), respectively). Between 2011 and 2016, all the provinces showed an increase in the adolescent population. This increase was more pronounced in Eastern Cape (2.25%), Western Cape (2.07), and North West (2.03%).

Table 1.1: Adolescent (10–19 years) population annual percentage change by province in South Africa, 1996–2016

Province	1996	2001	1996–2001 annual % change	2011	2001–2011 annual % change	2016	2011–2016 annual % change
Western Cape	733 225	868 198	3,68	918 965	0,58	1 013 917	2,07
Eastern Cape	1 554 932	1 651 146	1,24	1 424 797	-1,37	1 584 818	2,25
Northern Cape	225 843	215 787	-0,89	217 124	0,06	223 237	0,56
Free State	560 834	608 436	1,70	503 395	-1,73	525 088	0,86
KwaZulu-Natal	1 974 695	2 316 548	3,46	2 158 392	-0,68	2 292 973	1,25
North West	590 281	643 742	1,81	620 245	-0,37	683 179	2,03
Gauteng	1 260 487	1 547 691	4,56	1 736 601	1,22	1 891 947	1,79
Mpumalanga	730 137	829 642	2,73	820 626	-0,11	837 848	0,42
Limpopo	1 204 382	1 362 449	2,62	1 198 219	-1,21	1 241 278	0,72
Total	8 834 816	10 043 638	2,74	9 598 364	-0,44	10 294 285	1,45

1.2.5 Historical trends of the adolescent population

Figure 1.5 indicates a somewhat consistent trend of the proportion of adolescents from 1996 to 2001. In 1996 and 2001, the adolescent population made up almost 22% of the total population. This segment of the population decreased gradually from 2001 to 18,5% in 2016. The national trend is consistent with the provincial patterns, as shown in Figure 1.6. Across all the provinces there was a slight increase in the adolescent population from 1996 to 2001, followed by a decreasing pattern from 2001 to 2011. In 2016, Eastern Cape, Western Cape and North West observed a steady increase in their adolescent population.

Figure 1.5: Trends in the proportion of the adolescent population (10–19 years) in South Africa, 1996-2016

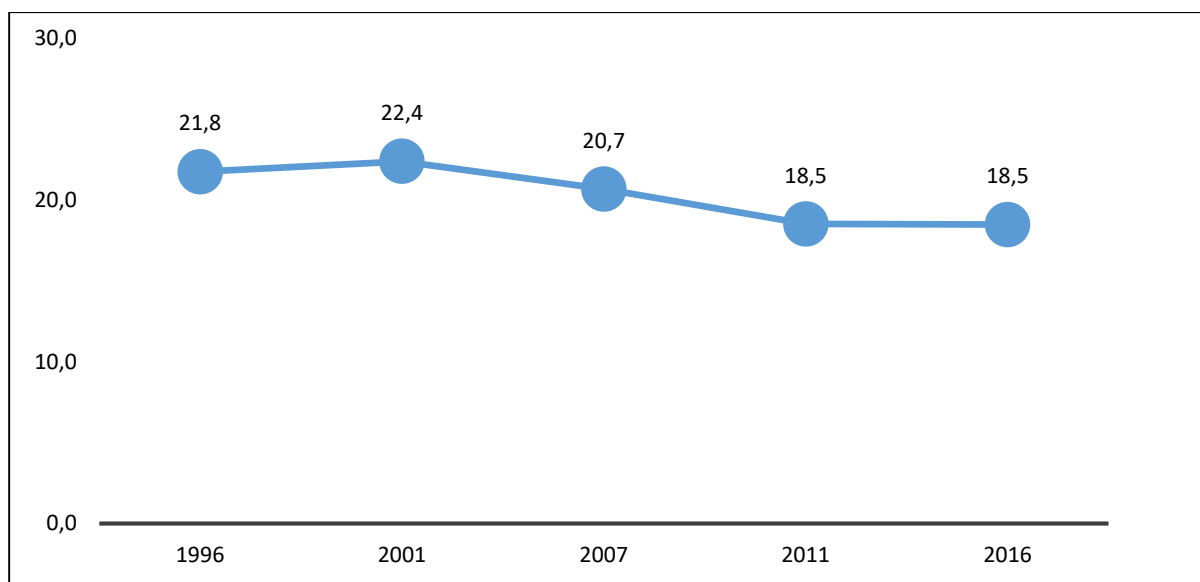
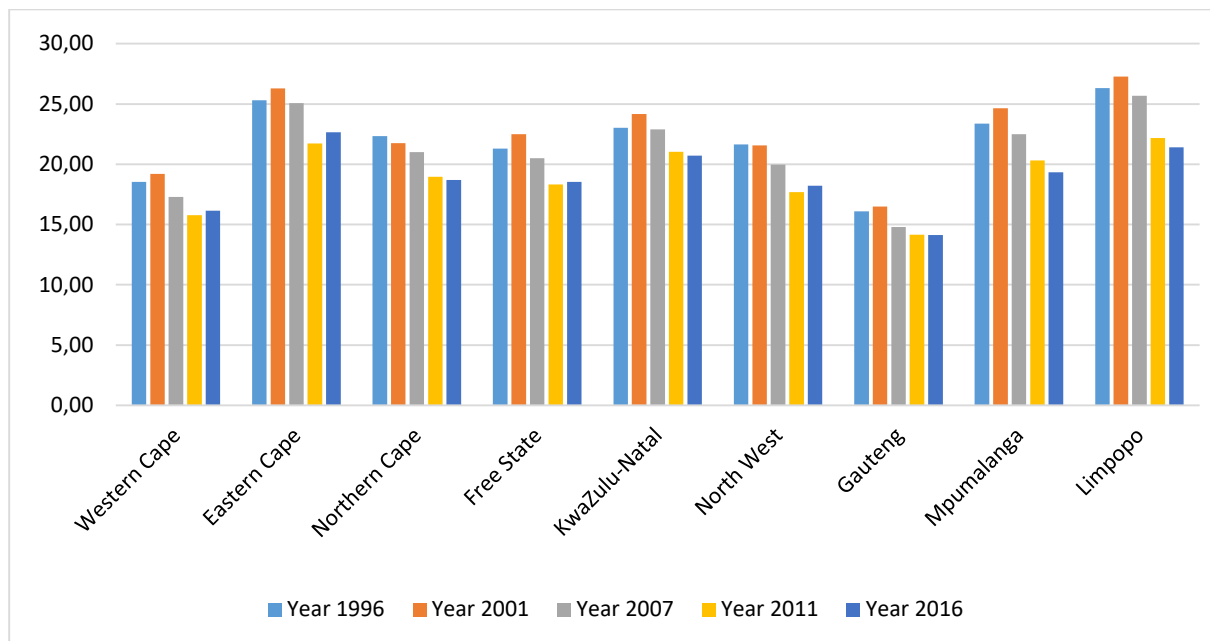


Figure 1.6: Trends in the adolescent population (10–19 years) as a proportion of the total population, by province



1.3 Median age and sex ratio of the adolescent population

Over time, the median age of adolescents revolved around 14 years. It increased to 15 years between 2001 and 2011. In 2016, half of the population of adolescents were 14 years old (Figure 1.7). Figure 1.8 indicates that the adolescent population has been dominated by females from 1996 to 2001. The sex ratios of 102 and 101 males per 100 females suggest that there were more male than female adolescents from 2011 to 2016 in South Africa.

Figure 1.7: Median age of adolescents

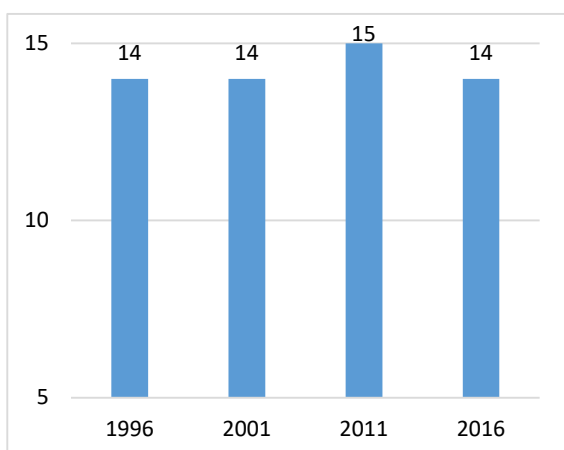
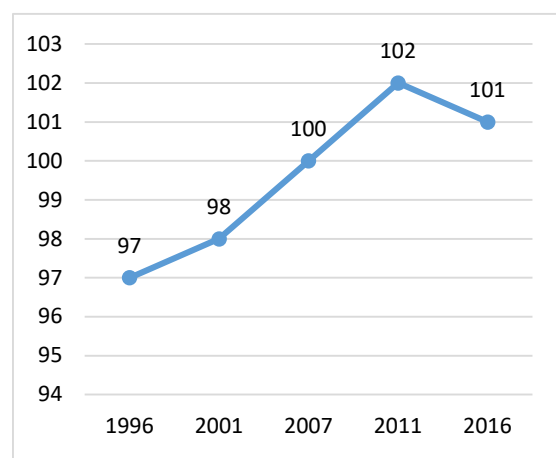


Figure 1.8: Sex ratios of adolescents



1.4 Summary of findings

There has been a gradual decrease in the number of adolescents from 1996 to 2011, which remained consistent between 2011 and 2016. The pattern also manifests geographically across all the provinces. Eastern Cape, North West and Western Cape had a noticeable positive gain of adolescents in 2016. The sex ratios have been steadily increasing over time, and the median age (14 years) remained constant except for 2011.

CHAPTER 2: ADOLESCENT FERTILITY

2.1 Introduction

Teenage or adolescent pregnancy is simply understood as a pregnancy that occurs amongst young women under the age of 20 years (UNICEF, 2008). A wide range of factors, including economic and social factors, have been associated with teenage pregnancy. However, the provision of necessary health services, preventing the risk of early marriage and ensuring that adolescents remain in school are some of the key elements of inhibiting unplanned adolescent pregnancies (UNFPA, 2015). Adolescent fertility receives wide attention due to the undesirable consequences it has on adolescent girls and their babies (Garenne et al., 2001; Kaufman et al., 2001; UNFPA, 2013). According to UNFPA (2015), the life of a girl who falls pregnant at an early age changes negatively, and is less likely to change for the better, because her health and that of the baby are compromised, her educational and future employment prospects become blurred and her vulnerability to poverty multiplies. Outcomes associated with childbearing adolescents include maternal and child morbidity and mortality and exposure to sexually transmitted infections such as HIV/AIDS (Leclerc–Madlala, 2002; Kara and Maharaj, 2015; UNFPA, 2015).

Globally, sub-Saharan Africa remains one of the regions with the highest proportion of adolescent births. The Population Reference Bureau (PRB) (2017) recorded a birth rate of 119 per 1 000 adolescent girls in the region. Data from demographic and health surveys reveal an adolescent birth rate (ABR) of 94 in Lesotho, 82 in Namibia and 141 in Zambia (Ministry of Health [Lesotho] and ICF International, 2016; The Namibia Ministry of Health and Social Services (MoHSS) and ICF International, 2014; Central Statistical Office (CSO) [Zambia], Ministry of Health (MOH) [Zambia], and ICF International, 2014). An analysis of adolescent childbearing in South Africa shows declining trends. However, the decline is not consistent over time (Panday et al., 2009). The 1998 South Africa Demographic and Health Survey (SADHS) reported that 13,2% of adolescent aged 15–19 years had a live birth. This percentage declined slightly to 12,4% based on the 2016 SADHS. Furthermore, 16,4% of adolescent women were recorded to have been pregnant in 1998, while 15,6% were revealed to have commenced childbearing in 2016 (DoH/South Africa and Macro International, 2002; NDoH, Stats SA, SAMRC and ICF, 2017).

The adolescent birth rate dropped from 76 births per 1 000 women aged 15–19 years in 1998 to 71 births per 1 000 women aged 15–19 in 2016 (DoH/South Africa and Macro International, 2002; NDoH, Stats SA, SAMRC and ICF, 2017). Other sources of data highlight the ABR as an indicator that fluctuates over time (Panday et al., 2009; Moultrie and McGrath, 2007). Nonetheless, research has shown that in the South African context, fertility (including adolescent childbearing) varies by population group, geographical location, age, education and marital status (Jewkes et al., 2001; Palamuleni et al., 2007; Panday et al., 2009; Mkhwanazi, 2010; Udjo, 2001; UNFPA, 2015; NDoH, Stats SA, SAMRC and ICF, 2017).

The causes of adolescent fertility are multifaceted, and its dynamics call for a holistic approach in attempting to reduce adolescent fertility levels in South Africa. An analysis of recent adolescent fertility levels remains imperative in assessing the successes of national commitments towards the prevention of adolescent childbearing in South Africa. Understanding the current patterns of adolescent childbearing is

important to redirect attention towards subpopulations which are mostly at risk and those whose future potentials are likely to be compromised.

2.2 Data and methods

The report uses data from Census 2001, Census 2011 and the 2016 Community Survey (CS). Published indicators from census reports and the 2016 South Africa Demographic Health Survey (SADHS) Key Indicator Report are also employed for comparisons. Key parameters reported in this section include:

- **Adolescent birth rate:** Adolescent birth rate is used as a summary indicator of childbearing in young women. The rate measures the annual number of births to women aged 15–19 years per 1 000 women in that age group. It is computed as a ratio where the total number of births to young women aged 15–19 years as a numerator is divided by the total number of women aged 15–19 years, which is the denominator. The rate is expressed as births per 1 000 women (UNDESA-PD, 2009).
- **Contribution of adolescent birth rate to total fertility or proportion of fertility in adolescence (PAF):** This indicator summarises fertility attributed to adolescent women. Since all women of childbearing age (15–49 years) contribute to TFR, and seeing that ABR is a fraction of TFR, PAF quantifies the percentage of total fertility that would occur at ages 15–19 amongst a hypothetical cohort experiencing the current age-specific fertility rates over its reproductive lifetime (UNDESA-PD, 2013). It is estimated as ABR multiplied by 5 and divided by total fertility. Adolescent birth rates and contribution of ABR to total fertility indicators are derived from published fertility estimates from census data.
- **Percentage of adolescent women who have given birth:** The percentage of adolescent women who have given birth shows the number of young women who have entered motherhood. The numerator is the number of women aged 15–19 who are reported to have given birth to a child in their lives, divided by the total number of women in the same age group.
- **Percentage of women who have never married:** In demography, marriage signifies the onset of childbearing in women and is used as a determinant of fertility. The percentage of women who are never married is an indicator of the magnitude with less risk of adolescent fertility. All never married women (15–19 years) are divided by the total population of adolescent females to give the percentage.
- **School attendance by adolescent women who are already mothers:** The percentage of adolescent women who have given birth and are attending school is calculated as young mothers who are attending school divided by total adolescents aged 15–19. This report acknowledges that non-attendance can still promote adolescent fertility. In all calculations, 'don't know' and unspecified cases are excluded in the denominator.

Assessment of data quality highlighted that a lower proportion of adolescent women aged 12-14 years have given birth, therefore analysis focused on adolescent women aged 15-19 years.

2.3 Results

2.3.1 Motherhood by age, CS 2016 and SADHS 2016

Most censuses and demographic surveys often ask childbearing women aged 12–50 years if they had ever given birth to a live child even if the child died soon after birth. From this information the percentage of young women who are mothers can be calculated. Figure 2.1 shows that the percentage of adolescents who are mothers increases with age. Motherhood started from 1,4% amongst 15-year-old adolescents to 25,0% amongst 19-year-olds. Equally, calculations from 2016 SADHS data indicate that motherhood was lower at 2,4% amongst women aged 15 years and higher (24,5%) amongst women aged 19 years.

Differentials of motherhood by population group and province are presented in Table 2.1. A higher percentage of the black African (12,5%) and coloured (11,1%) population groups had a live birth in 2016. Conversely, motherhood was lower amongst the Indian/Asian and white population. Adolescent motherhood was predominant at 14,2% and 14,0% in Eastern Cape and Northern Cape, respectively. Low levels of motherhood in 2016 were noticeable in Western Cape (9,6%) and Gauteng (8,1%).

Figure 2.1: Percentage of adolescents who gave birth by age, CS 2016 and SADHS 2016

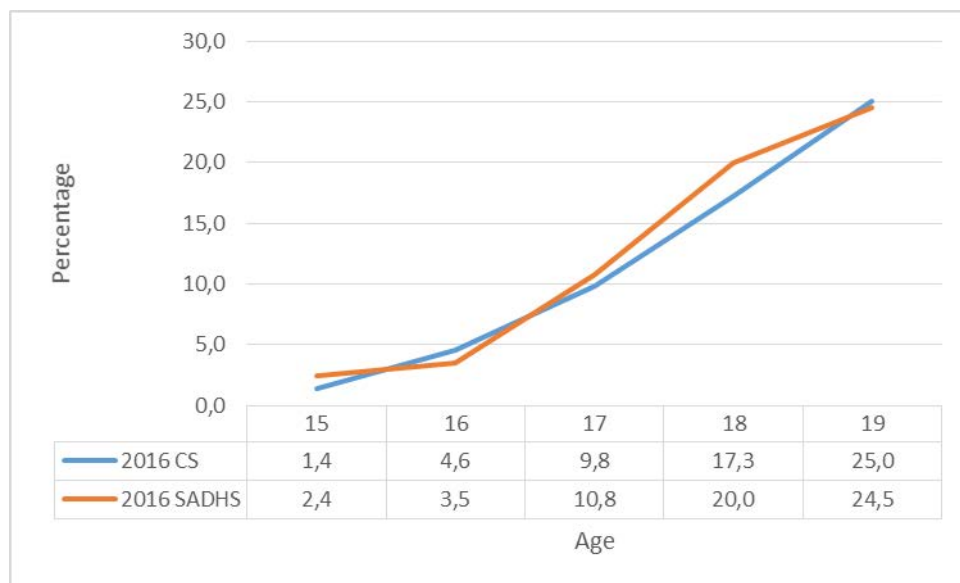
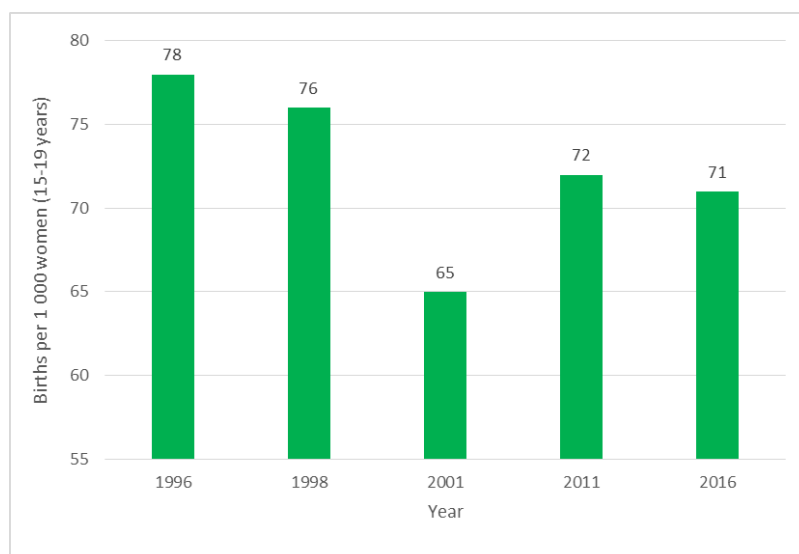


Table 2.1: Percentage of adolescents who gave birth by population group and province, CS 2016

Percentage of adolescents who gave birth	
Population group	
Black African	12,5
Coloured	11,1
Indian/Asian	2,4
White	1,8
Province	
Western Cape	9,6
Eastern Cape	14,2
Northern Cape	14,0
Free State	10,3
KwaZulu-Natal	12,6
North West	11,9
Gauteng	8,1
Mpumalanga	12,8
Limpopo	12,2
South Africa	11,6

2.3.2 Trends in adolescent birth rate, 1996–2016

Historical trends presented in Figure 2.2 show that ABR was much higher in 1996 at 78 births per 1 000 women aged 15–19 before declining to 65 births per 1 000 women aged 15–19 in 2001. Census 2011 recorded an increase in the ABR to 72 births per 1 000 women aged 15–19, and this rate is almost consistent with the ABR of 71 births per 1 000 women aged 15–19, as reported by the 2016 SADHS (NDoH, Stats SA, SAMRC and ICF, 2017).

Figure 2.2: Trends in adolescent birth rate, 1996–2016

Source: DoH/South Africa and Macro International, 2002; Moultrie and Timaeus, 2003; Moultrie and Dorrington, 2004; Stats SA, 2015; NDoH, Stats SA, SAMRC and ICF, 2017

2.3.3 Adolescent birth rate by population group and province, Census 2001 and Census 2011

Fertility dynamics in South Africa have been documented to differ by population group and province of residence. Table 2.2 shows that in both the 2001 and 2011 censuses, the ABR was high amongst black African (71 and 76, respectively) and coloured (60 and 71, respectively) women. However, between 2001 and 2011, the ABR for the coloured population increased by 11 births per 1 000 women, while a reduction of 5 births per 1 000 women was observed for black Africans. Adolescent childbearing is generally low amongst the white and Indian/Asian population groups; over the 2001–2011 period, the ABR for white adolescent women remained unchanged at 14 births per 1 000 women while the birth rate amongst Indian/Asian women slightly decreased from 22 births per 1 000 women in 2001 to 20 in 2011.

Differentials in ABR are also observed by province of residence. Results indicate that the ABR has increased from 2001 to 2011 in all the provinces, except Mpumalanga and Limpopo. In 2001, Mpumalanga (88), Limpopo (85) and KwaZulu-Natal (77) had the highest ABRs. However, in 2011, the highest ABR was 82 births per 1 000 women for both Mpumalanga and Northern Cape. The two census years are marked by a lower ABR for Gauteng (48 and 57, respectively), followed by Western Cape (50 and 60, respectively).

Table 2.2: Adolescent birth rate by population group and province, Census 2001 and Census 2011

	Adolescent birth rate per 1 000 women (15–19 years)	
	2001	2011
Population group		
Black African	71	76
Coloured	60	71
Indian/Asian	22	20
White	14	14
Province		
Western Cape	50	60
Eastern Cape	60	76
Northern Cape	61	82
Free State	56	71
KwaZulu-Natal	77	78
North West	62	78
Gauteng	48	57
Mpumalanga	88	82
Limpopo	85	76
South Africa	65	72

Source: Estimates derived from published fertility rates by Moultrie and Dorrington, 2004; Stats SA, 2015

2.3.4 Contribution of adolescent birth rate to total fertility, Census 2001 and Census 2011

The contribution of the adolescent birth rate (ABR) to total fertility or the proportion of fertility in adolescence (PAF) is another distinct indicator of adolescent childbearing. Table 2.3 indicates that PAF for black Africans and coloureds was equal at 12% in 2001. However, in 2011, coloured adolescents contributed more (14%) to total fertility than other population groups. Over the 2001–2011 period, the contribution of ABR to total fertility was consistent at 4% amongst white adolescent women, while the PAF for Indian/Asian women decreased marginally from 6% in 2001 to 5% in 2011.

Provincial differentials indicate that in 2011, the contribution of ABR to total fertility was 14% for four provinces (Mpumalanga, North West, KwaZulu-Natal and Free State). The highest contribution of 15% was recorded in Northern Cape. In 2001, a high PAF of 14% was recorded in Mpumalanga, followed by KwaZulu-Natal (13%) and Northern Cape (13%). An increase of four percentage points in the contribution of ABR to total fertility was observed in Eastern Cape. In the two census years, the contribution of ABR to total fertility was constant at 14% and 12% for Mpumalanga and Limpopo, respectively.

Table 2.3: Contribution of adolescent birth rate to total fertility by population group and province (%), Census 2001 and Census 2011

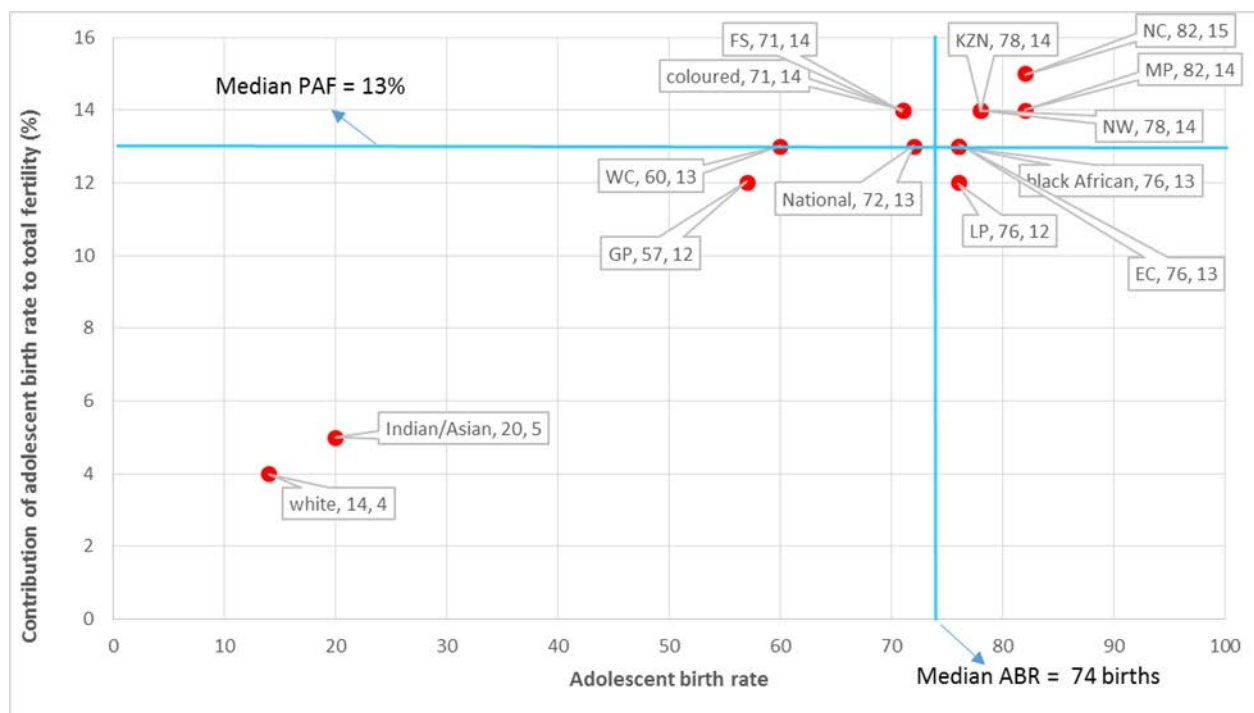
	Contribution of adolescent birth rate to total fertility (PAF)	
	2001	2011
Population group		
Black African	12	13
Coloured	12	14
Indian/Asian	6	5
White	4	4
Province		
Western Cape	10	13
Eastern Cape	9	13
Northern Cape	13	15
Free State	11	14
KwaZulu-Natal	13	14
North West	11	14
Gauteng	10	12
Mpumalanga	14	14
Limpopo	12	12
South Africa	11	13

Estimates derived from published fertility rates by Moultrie and Dorrington, 2004; Stats SA, 2015

2.3.5 Distribution of subpopulations according to adolescent birth rate and contribution of adolescent birth rate to total fertility, 2011

Associations are often made between ABR and the contribution of ABR to total fertility. Therefore, Figure 2.3 shows this association as well as median values of ABR and the contribution of ABR to total fertility in South Africa. The figure presents the fertility indicators in two clusters, which is high and low. For the purposes of this report, a PAF that is lower than the median is classified as a low contribution of ABR to total fertility; equally, birth rates lower than the median are regarded as low ABR. The low fertility subpopulations in terms of ABR and the contribution of ABR to total fertility are shown to be the white and Indian/Asian populations. Figure 2.3 show that the PAF and ABR of Western Cape and Gauteng is lower or equal to the median PAF of 13% and median ABR of 74 births per 1 000 women aged 15-19 years. Provinces such as Northern Cape, KwaZulu-Natal, North West and Mpumalanga are classified in the high fertility cluster in terms of adolescent childbearing. Worth noting is that the PAF can be low, even in the context of a high ABR. This is because the PAF is also influenced by the overall distribution of fertility across all reproductive ages (UNDESA-PD, 2013).

Figure 2.3: Median adolescent birth rate and contribution of adolescent birth rate to total fertility by population group and province, Census 2011



2.3.6 Marriage as a risk factor for adolescent childbearing, Census 2001, Census 2011 and CS 2016

Child marriage has been associated with adolescent childbearing – especially in developing countries (UNFPA, 2015). In South Africa, marriage is less common, and where a marital union is formed, it is usually late in reproductive life (Panday et al., 2009; Palamuleni, 2010). Table 2.4 shows that the percentage of adolescent women who have never been married was 95,6% in 2001, 93,8% in 2011 and then slightly increased to 95,1% in 2016. With the exception of Limpopo and Eastern Cape, subpopulations mirror the patterns of increases and decreases observed at national level between 2001 and 2016. In 2011, the black African population group recorded the highest number of adolescents who have never been married (93,9%).

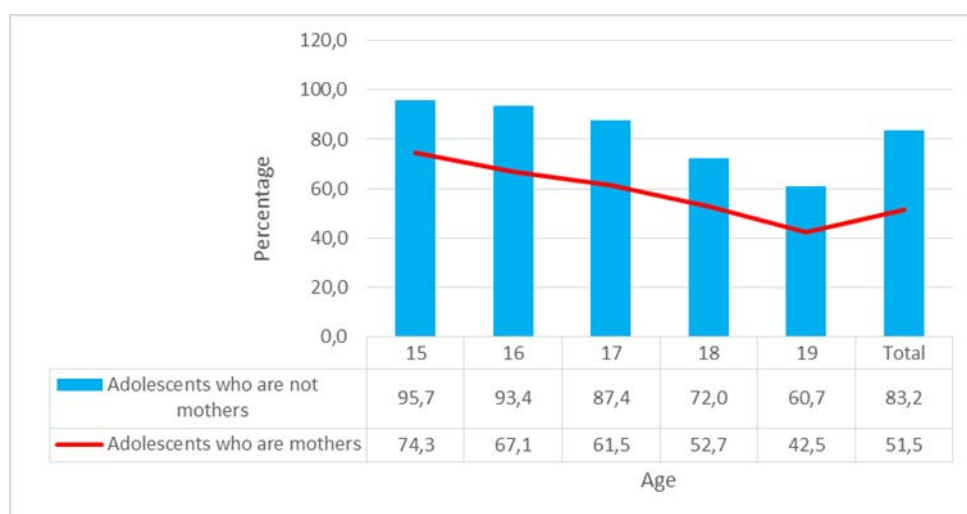
Table 2.4: Percentage of adolescents who have never been married by population group and province, 2001–2016

	Percentage of adolescents who have never been married		
	2001	2011	2016
Population group			
Black African	95,6	93,9	95,2
Coloured	96,0	93,7	95,3
Indian/Asian	95,2	92,2	94,5
White	95,6	92,5	92,6
Province			
Western Cape	96,4	93,6	94,9
Eastern Cape	94,5	94,6	96,3
Northern Cape	94,4	94,0	95,5
Free State	96,7	93,4	95,9
KwaZulu-Natal	94,4	94,3	95,1
North West	95,1	93,7	95,0
Gauteng	95,3	91,8	94,9
Mpumalanga	96,8	94,0	94,6
Limpopo	95,8	94,7	94,1
South Africa	95,6	93,8	95,1

2.3.7 Motherhood and school attendance, CS 2016

Early childbearing by adolescent women is widely known to impede schooling by young women, mainly because the majority do not return to school after having given birth. However, even in contexts where young women continue with education, they strive to find a balance between schooling and nurturing infants (Gyan, 2013). Figure 2.4 below highlights a marked difference in school attendance by adolescents who are mothers and adolescents who have not given birth to a child. Only 51,5% of adolescents who are mothers were reported to be attending school. Comparatively, 83,2% of childless adolescents in the same age group were reported to be attending school in 2016.

Figure 2.4: Percentage of adolescent mothers who were attending school by age, CS 2016



Findings presented in Table 2.5 do not show a significant difference in school attendance by sex. Overall, the pattern and level of school attendance is almost similar for both males and females.

Table 2.5: Percentage of adolescents who were attending school by age and sex, CS 2016

Percentage of adolescents attending school			
Age	Male	Female	South Africa
15	94,9	95,4	95,2
16	92,1	92,2	92,2
17	85,9	84,8	85,4
18	72,6	68,7	70,6
19	59,4	56,1	57,7
Total	81,1	79,5	80,3

2.4 Summary of findings

The adolescent birth rate decreased in 2001 before increasing in 2011 to 72 births per 1 000 women aged 15–19. The pattern of adolescent fertility follows the overall fertility dynamics of the country. Adolescent fertility is much higher amongst the black African and coloured population groups, and lower amongst the Indian/Asian and white adolescent population groups. In 2011, a high ABR was observed in Mpumalanga (82) and Northern Cape (82). In terms of contribution of ABR to total fertility, the coloured adolescent population contributed more to total fertility (14%) than other adolescent population groups. Results from CS 2016 indicated that motherhood increases with age. In 2016, Eastern Cape had the highest percentage of adolescents who were mothers. The percentage of adolescents who have never been married was 95,6%, 93,8% and 95,1% in 2001, 2011 and 2016, respectively. The percentage of adolescent mothers who were attending school was lower compared to that of adolescents who have never given birth.

CHAPTER 3: ADOLESCENT MORTALITY

3.1 Introduction

Most studies on mortality focus on infant, under-five and adult mortality; however, between these age groups lies the population of adolescents. The SDG Goal 3 addresses all major health priorities, including reproductive, maternal and child health; communicable, non-communicable and environmental diseases; universal health coverage; and access to safe, effective, quality and affordable medicines and vaccines (United Nations, 2016).

In South Africa, the Constitution provides for the right of access to health care services and for other health-related rights (Constitution of South Africa, 1996). In addition to the Constitution, the National Development Plan (NDP) 2030 highlights plans to build a better future for the young people of South Africa. The NDP prioritises policies that will improve the capabilities and life chances of the country's youthful population (The Presidency, 2011).

The National Adolescent and Youth Health Policy 2017 aims for a realistic, practical approach to health programming. It identifies stakeholders involved in the promotion of health amongst youth and emphasises the commitments of the Department of Health (DoH). It foregrounds the critical role of various government departments and agencies in supporting and streamlining the successful implementation of health programmes. The policy advocate for a long and healthy life has identified health priorities for adolescents. Amongst the priorities are adolescent and youth-friendly services; elimination of drug and substance abuse; HIV/AIDS and TB prevention; mental health/illness; sexual and reproductive health; and violence prevention (Department of Health, 2017).

The World Health Organization estimated that in 2012, an estimated 1,3 million deaths occurred worldwide amongst adolescents (WHO, 2012). Road injuries, HIV-related causes, suicide, lower respiratory infections, and interpersonal violence were the top five leading causes of death amongst adolescents and young people in 2012. Globally there has been a modest decline in the adolescent mortality rate from 126 deaths per 100 000 in 2000 to 111 per 100 000 in 2012 (WHO, 2012). Despite this overall decline in mortality, the estimated number of global HIV-related deaths amongst adolescents aged 10–19 has nearly tripled from 21 000 in 2000 to 60 000 in 2014, despite a decrease amongst all other age groups (UNAIDS, 2015).

During adolescence, particularly amongst older ages, mortality patterns often differ by sex with environmental and behavioural factors beginning to play a central role amongst both boys and girls (Viner, 2011). For instance, the proportion of deaths due to intentional injuries amongst boys rises from 6% at age 10–14 to 22% at age 15–19, while it increases amongst girls from 5 per cent to 14 per cent across the same age groups. For girls between the ages of 15 and 19, however, complications related to pregnancy and childbirth are the second leading cause of death (after self-harm) globally, with little change in the ranking since 2000 (UNICEF, 2014). However, there has been a significant drop in the

number of deaths from maternal causes amongst 15–19-year-old adolescent girls in all regions of the world between 2000 and 2012 (WHO, 2014).

The mortality and causes of death report indicated that death due to HIV/AIDS amongst young adults in South Africa has been declining, with the female death rate declining at a faster rate than that of males (Statistics South Africa, 2011). While deaths from HIV and injuries peak in the youthful years (15–35), the risk factors for death from non-communicable disease are also noticed during adolescence and early adulthood (Department of Education, 2009). This finding confirms the epidemiological transition noted by Leeder et al. (2004), where cardiovascular diseases would affect younger adults in developing countries relative to their counterparts in developed countries. The burden of disease amongst South African youth has assumed a worrisome dimension, where teenage pregnancies, maternal mortality, reproductive and sexual health, HIV and AIDS, and non-communicable diseases such as cancer, diabetes, and hypertension are key health challenges facing young people and affecting their well-being (The Presidency, 2009).

It is on this basis that this section of the report has been prepared, as it is imperative for government policymakers and those working with adolescents to make informed decisions using current statistics on adolescent mortality and causes of death. The purpose of this chapter is therefore to outline adolescent deaths rates, the proportion of adolescents by parental survival status, adolescent medical aid coverage, and to present the mortality and causes of death data amongst adolescents in South Africa.

3.2 Data and methods

The report uses data obtained from Census 1996, Census 2001, Census 2011 and the 2016 Community Survey. For causes of death, the report uses the 2015 Mortality and Causes of Death data to identify the leading causes of death amongst adolescents. Most importantly, the age and sex characteristics of the deceased were collected in all censuses and the 2016 Community Survey. The mortality and causes of death data provide detailed information about the deceased's cause of death. The 2016 General Household Survey was used to analyse the proportion of adolescents covered by medical aid in South Africa. The adolescent death rates are expressed per 100 000 population of adolescents. The rate is disaggregated by sex, age, province, and population group.

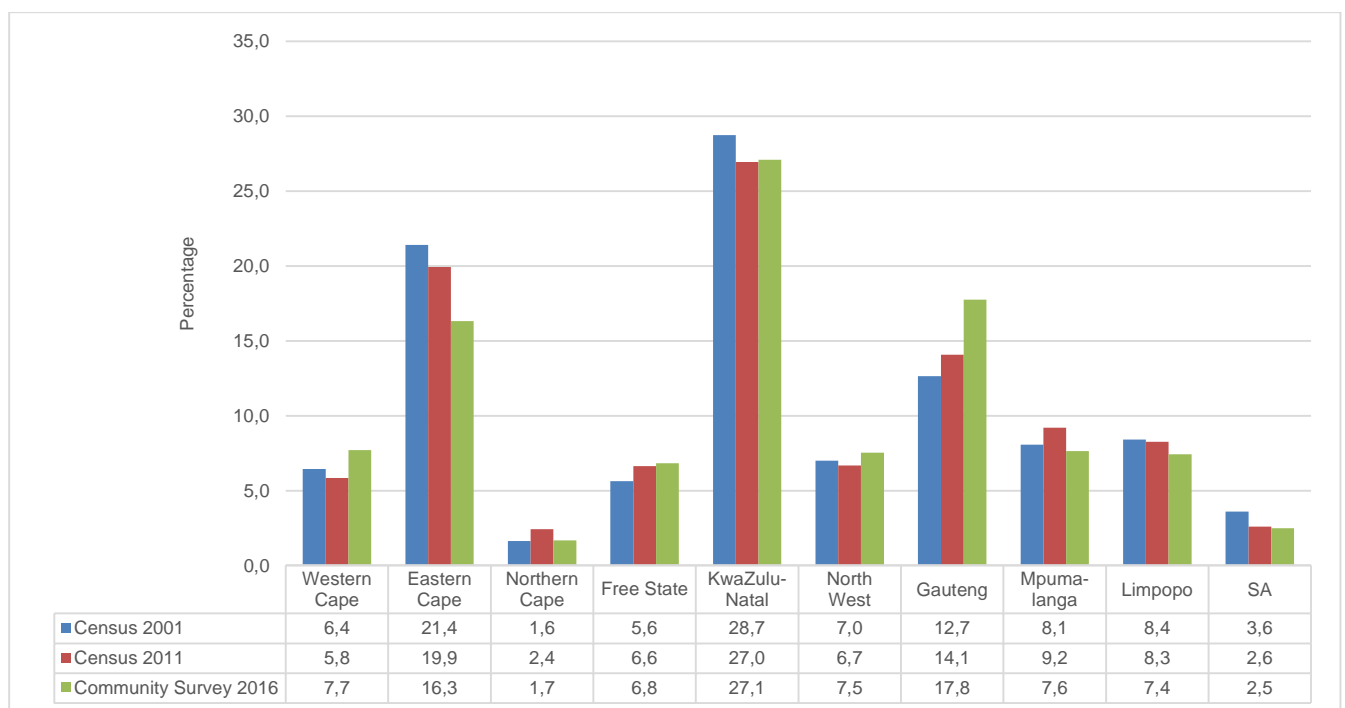
3.3 Results

3.3.1 Distribution of adolescent deaths reported by households from censuses and surveys, 2001–2016

This section provides an analysis of the unadjusted adolescent deaths as reported by households from Census 2001 and Census 2011 as well as the Community Survey 2016 data. Findings indicate that mortality rates are low amongst adolescents compared with other age groups. Despite the rates being relatively low, mortality figures are still significant during the adolescent years. Deaths amongst persons aged 10–19 constituted 3,6% in 2001, 2,6% in 2011 and 2,5% in 2016 of the total number of household deaths reported in South Africa.

Figure 3.1 shows the percentage distribution of deaths reported by households for adolescents by province. The provincial patterns are consistent with the general mortality patterns in the country. KwaZulu-Natal reported the highest percentage distribution of deaths (28,7% in 2001 to 27,1% in 2016). Northern Cape had a relatively low number of deaths amongst adolescents (1,6% in 2001 to 1,7% in 2016). The percentage distribution of deaths could be linked to the age distribution of the population.

Figure 3.1: Distribution of deceased adolescents by province, 2001–2016



The percentage distribution of deceased adolescents is presented in Figure 3.2 below by actual age at death. The figure shows that mortality was much higher amongst older adolescents (15–19 years) than amongst younger adolescents (10–14 years). This is seen for the 2001, 2011 and 2016 periods.

Figure 3.2: Distribution of deceased adolescents by age, 2001–2016

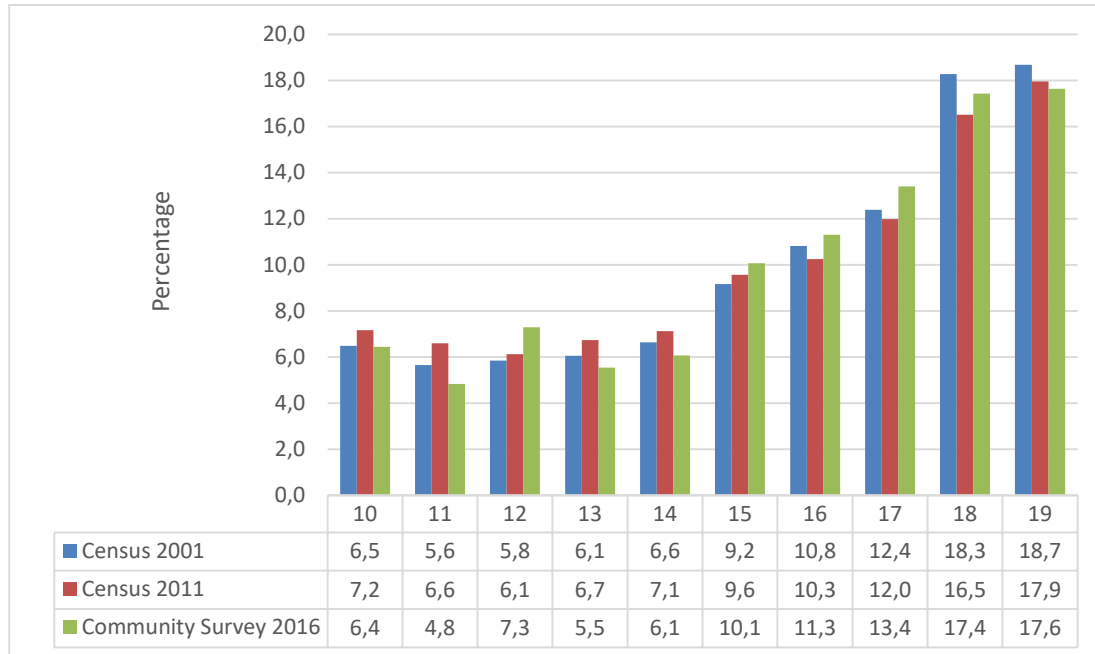


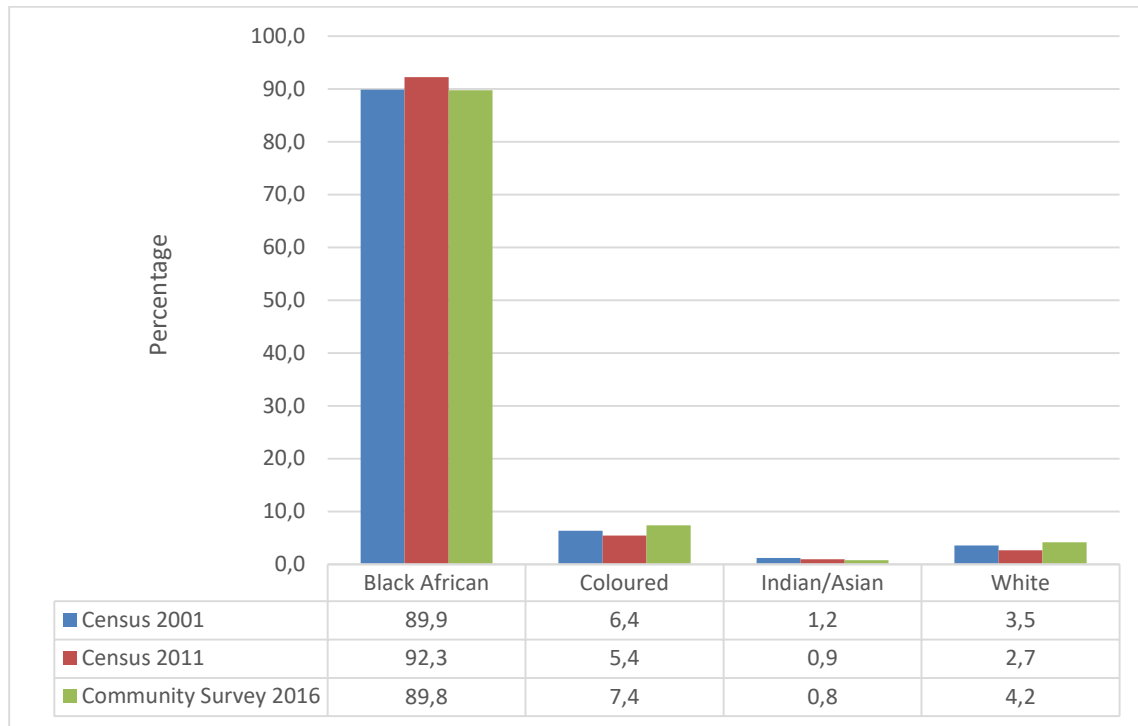
Figure 3.3 offers a broad overview of the percentage distribution of deaths amongst adolescents by sex for 2001, 2011 and 2016. The figure shows that in 2001, 2011 and 2016, male mortality was higher compared to that of female adolescents. Female adolescent mortality declined slightly from 47,6% in 2001 to 40% in 2016. For all three periods, mortality was higher amongst male adolescents when compared to female adolescents. There was an approximate 8% decrease in the distribution of adolescent female deaths from 2001 to 2016. Overall, mortality amongst males was higher than that amongst females.

Figure 3.3: Distribution of deceased adolescents by sex, 2001–2016



Figure 3.4 shows the percentage distribution of deaths amongst adolescents by population group. Results show that overall, mortality amongst the black African population was the highest (80,9% in 2001 and 89,8% in 2016), followed by the coloured population group at 6,4% in 2001 and 7,4% in 2016, while the white and Indian/Asian population groups had the lowest proportion of deaths reported. This is consistent with the dynamics of the different population groups in the country (Stats SA, 2011).

Figure 3.4: Distribution of deceased adolescents by population group, 2001–2016



3.3.2 Adolescent death rates

This section presents estimates of adolescent death rates by population group and province. The adolescent death rate refers to the number of deaths for persons aged 10–19 years per 100 000 population in that age group. The adolescent death rate (ADR) was estimated at 131 in 2001 and 111 in 2011 per 100 000 in South Africa. Figure 3.5 shows the ADR by population group in 2001 to 2011. The ADR was high amongst black African adolescents. Mortality rates amongst Indian/Asian adolescents and that of White adolescents are lower.

Figure 3.5: Adolescent death rates by population group, 2001–2011

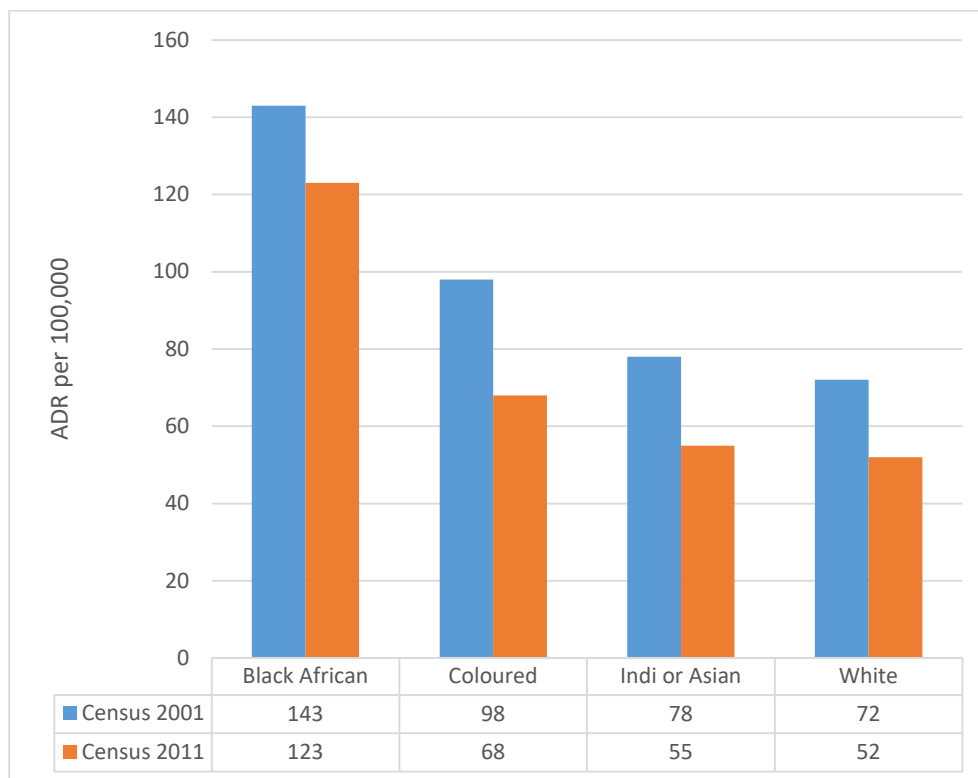
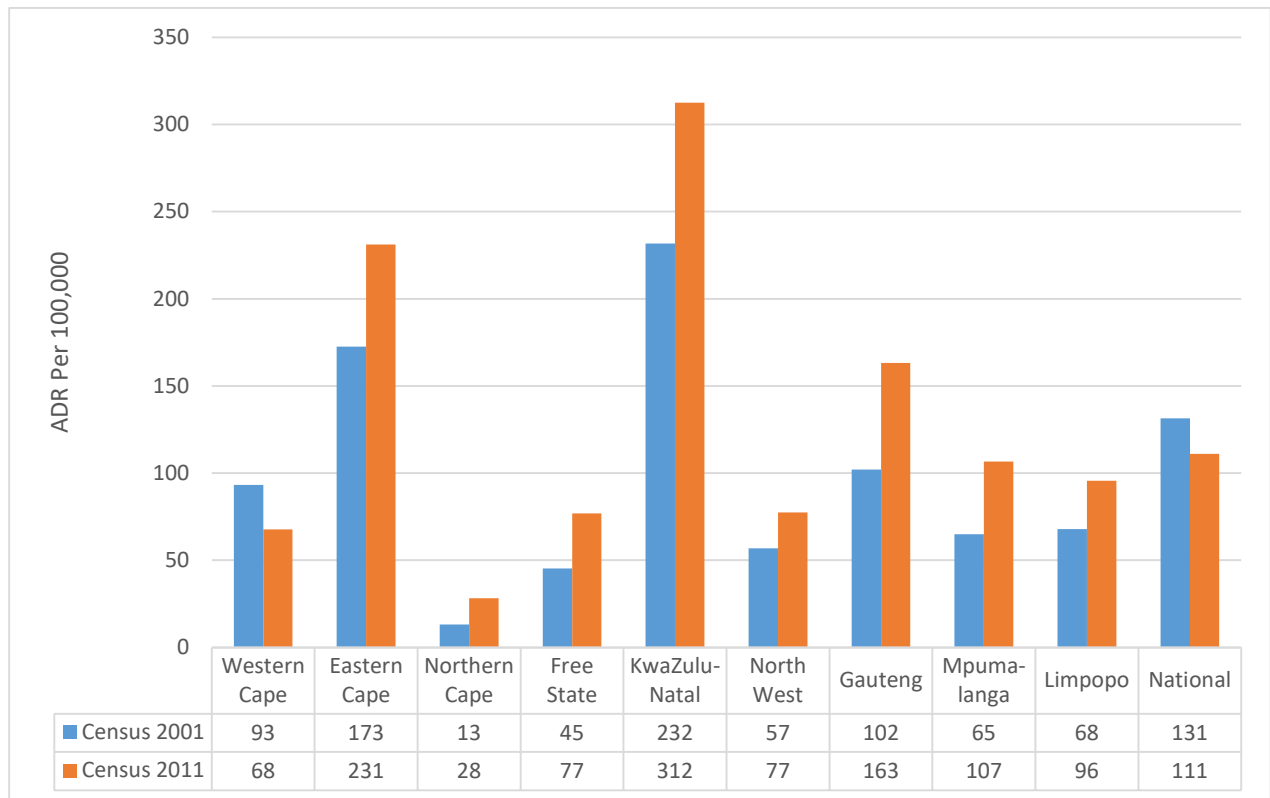


Figure 3.6 offers a broad overview of ADR by province for 2001 and 2011. The figure shows that KwaZulu-Natal had the highest ADR. This is followed by Eastern Cape and Gauteng. Northern Cape recorded the lowest ADR.

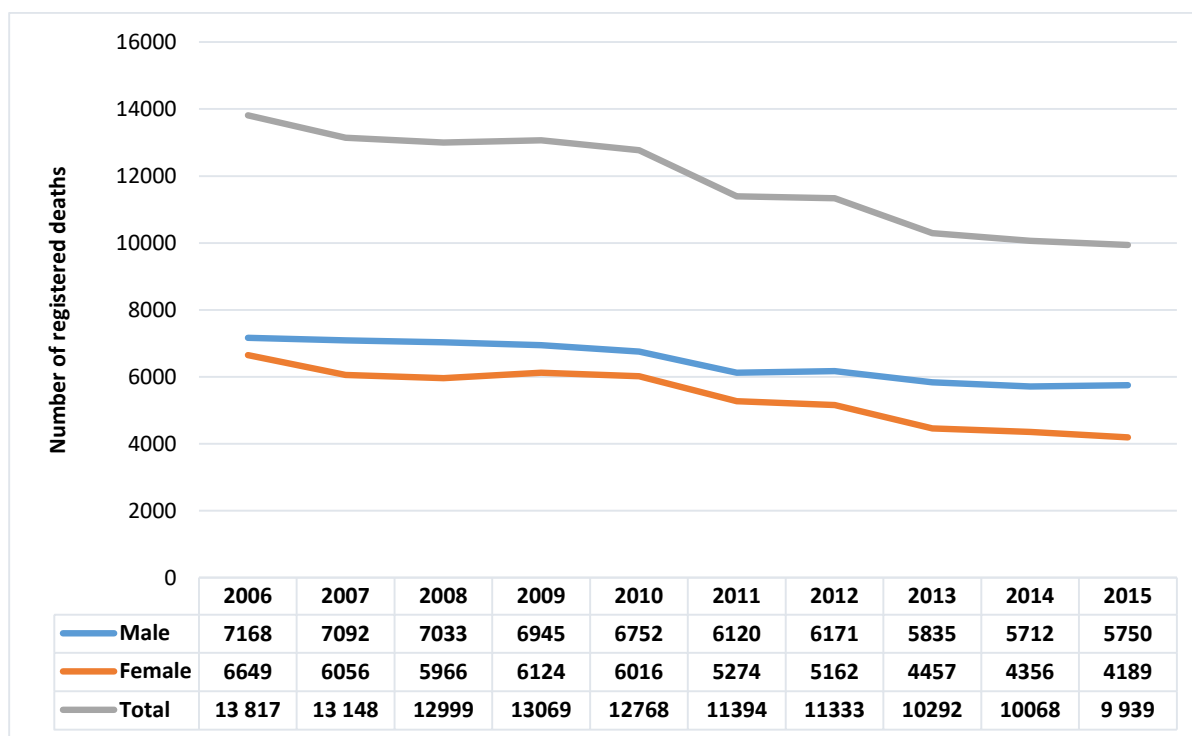
Figure 3.6: Adolescent death rates by province 2001–2011



3.4 Mortality and causes of death amongst adolescents, 2015

This section is based on data from the death notification forms used to register deaths in South Africa at the Department of Home Affairs (DHA). The information in this section is based on all deaths that occurred in 2015, and that were processed and published by Stats SA. For more information on the methods used for data validation, data quality assessment and completeness of reporting on mortality and causes of death data, see the Stats SA report, *Mortality and causes of death in South Africa, 2015: Findings from death notification* (Stats SA Report P0309.3, 2015). A total of 460 236 deaths that occurred in 2015 were registered at DHA and reached Stats SA in time for the 2015 reporting period. Of these deaths, 9 939 occurred amongst adolescents (adolescent mortality contributed 2,2% to the overall number of deaths in 2015). This section will cover death trends and also causes of death amongst adolescents in 2015. Figure 3.7 shows trends in the number of deaths amongst South African adolescents between 2006 and 2015. The number of deaths amongst adolescents declined consistently over the ten-year period; however, in 2008 and 2009 there was a slight peak in the number of adolescent deaths. There were more male adolescent deaths compared to female adolescent deaths.

Figure 3.7: Trends in the number of registered deaths amongst adolescents, 2006–2015*



*excludes unspecified ages and unknown sex

3.4.1 The leading causes of death amongst adolescents in South Africa

In this section, the ten leading causes of death are ranked according to the most frequently reported causes of death. The rankings exclude deaths due to symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified (Stats SA, 2015).

Table 3.1 presents the ten leading causes of death for female adolescents in 2015 in South Africa. The figure shows that the most common causes of death amongst female adolescents were tuberculosis (8,2%), followed by the human immunodeficiency virus (HIV) disease (6,2%), and other viral diseases (5,6%). Non-natural causes of death amongst female adolescents constituted 25,8% of all deaths recorded amongst female adolescents.

Table 3.1: Distribution of the ten leading causes of death amongst adolescent females, 2015

Underlying broad group	Rank	Number	Percentage
Tuberculosis (A15-A19)	1	343	8,2
Human immunodeficiency virus [HIV] disease (B20-B24)	2	258	6,2
Other viral diseases (B25-B34)	3	233	5,6
Influenza and pneumonia (J09-J18)	4	190	4,5
Certain disorders involving the immune mechanism (D80-D89)	5	124	3,0
Other forms of heart disease (I30-I52)	6	122	2,9
Intestinal infectious diseases (A00-A09)	7	119	2,8
Inflammatory diseases of the central nervous system (G00-G09)	8	90	2,1
Episodic and paroxysmal disorders (G40-G47)	9	88	2,1
Cerebral palsy and other paralytic syndromes (G80-G83)	10	81	1,9
Other natural causes		1 462	34,9
Non-natural causes		1 079	25,8
All causes		4 189	100,0

Source: Mortality and causes of death in South Africa, 2015

Table 3.2 presents the ten leading underlying causes of death for male adolescents in 2015. It shows that tuberculosis (5%) was the leading cause of death amongst adolescent males in South Africa. It was followed by the human immunodeficiency virus [HIV] disease (3,2%). Amongst male adolescents, non-natural causes contributed to 50,8% of deaths.

Table 3.2: Distribution of the ten leading causes of death amongst adolescent males, 2015

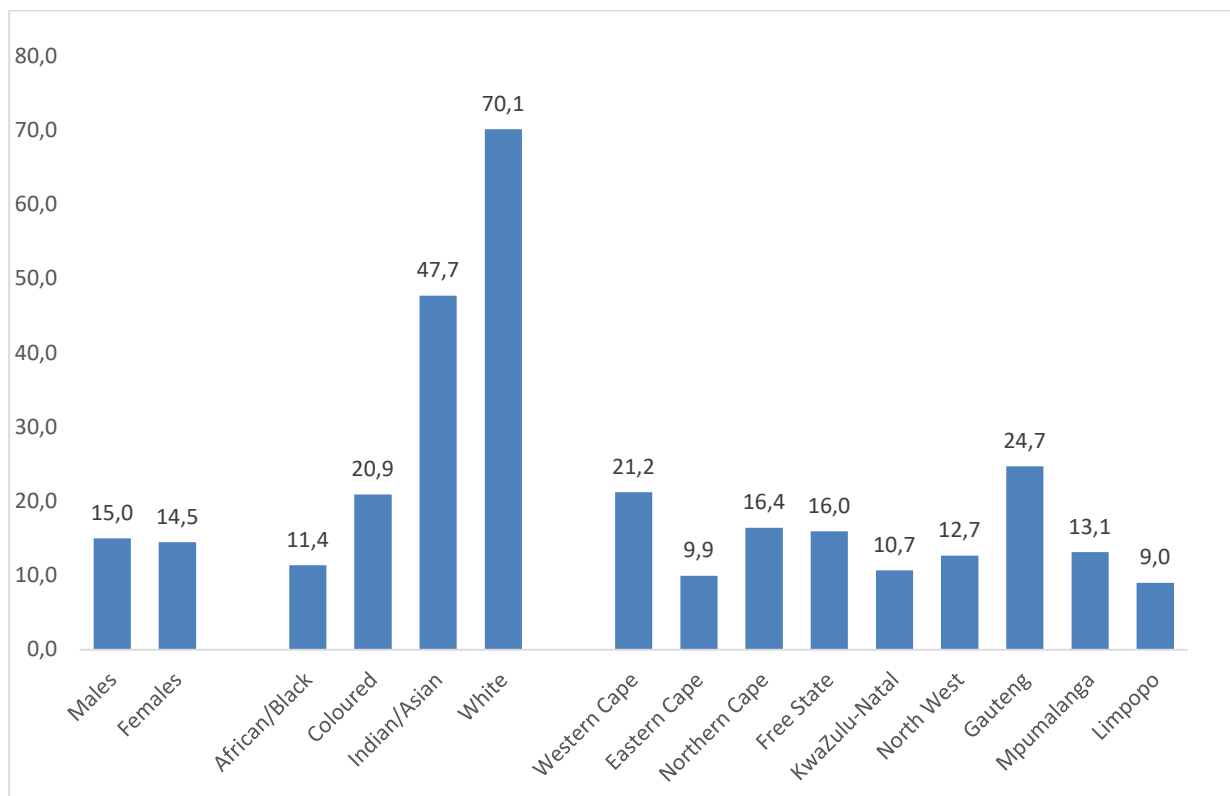
Underlying broad group	Rank	Frequency	Percentage
Tuberculosis (A15-A19)	1	288	5,0
Human immunodeficiency virus [HIV] disease (B20-B24)	2	185	3,2
Other viral diseases (B25-B34)	3	174	3,0
Influenza and pneumonia (J09-J18)	4	172	3,0
Episodic and paroxysmal disorders (G40-G47)	5	137	2,4
Cerebral palsy and other paralytic syndromes (G80-G83)	6	114	2,0
Intestinal infectious diseases (A00-A09)	7	107	1,9
Inflammatory diseases of the central nervous system (G00-G09)	8	105	1,8
Certain disorders involving the immune mechanism (D80-D89)	9	99	1,7
Other forms of heart disease (I30-I52)	10	95	1,7
Other natural causes		1 355	23,6
Non-natural causes		2 919	50,8
All causes		5 750	100,0

Source: Mortality and causes of death in South Africa, 2015

3.5 Adolescent medical aid coverage

Figure 3.8 shows the percentage distribution of adolescents covered by medical aid by population group, sex and province of usual residence, based on the 2017 General Household Survey data. The results indicate that a relatively high proportion of adolescents from the white population group (70,1%) were covered by medical aid, while only 11,4% of the black African population were covered. A much higher proportion of adolescents from Gauteng (24,7%) and Western Cape (21,2%) were covered by medical aid. The lowest proportions of adolescents covered by medical aid were residing in Eastern Cape (9,9%) and Limpopo (9,0%). The medical aid coverage pattern seen amongst the youth is similar to the pattern seen for the general population as reported in the General Household Survey (Stats SA, 2017).

Figure 3.8: Distribution of adolescents covered by medical aid by sex, population group and province of usual residence, 2016

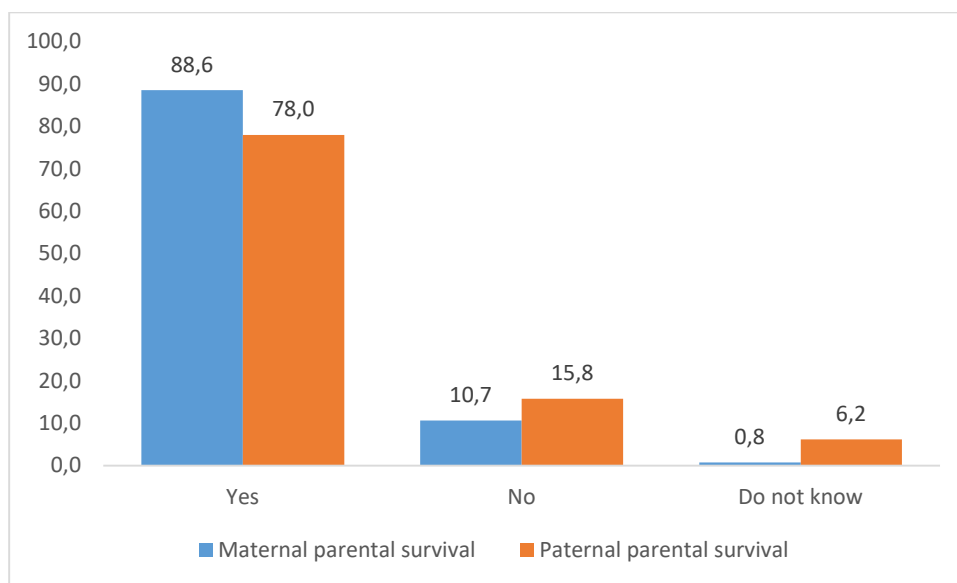


General Household Survey, 2017

3.6 Distribution of adolescents by parental survival status, CS 2016

In this section, parental survival data from the 2016 Community Survey were used to analyse the distribution of adolescents by maternal and paternal survival status. The set of parental survival questions employed in South Africa's 2016 Community Survey were different from the questions in the previous surveys and censuses; hence, no comparison was made amongst the different sources. According to Figure 3.9 below, 88,6% of adolescents' mothers were still alive, while 78% of adolescents' fathers were still alive. In addition to this, 15,8% of adolescents had no father alive, while 6,2% of adolescents did not know their father's survival status.

Figure 3.9: Distribution of adolescents by maternal parental and paternal parental survival status, CS 2016



3.7 Summary of findings

The observation on adolescent mortality showed that there has been a decline in the percentage distribution of death amongst adolescents in the country. This is also linked to a decline in the overall number of deaths in the country. Findings from this chapter showed that mortality was much higher amongst adolescents 15-19 years than amongst younger adolescents 10-14 years. Adolescent male mortality was higher compared to that of female adolescents. Mortality amongst black African adolescents was the highest, while the white and Indian/Asian population groups has the lowest distribution of adolescent deaths. This findings are consistent with the available literature regarding the mortality dynamics of the different population groups in the country.

CHAPTER 4: PROFILE OF FOREIGN-BORN ADOLESCENTS IN SOUTH AFRICA

4.1 Introduction

Migration is perceived as one of the three components of population growth (in addition to fertility and mortality), and is an important phenomenon as it plays a crucial role in population distribution and contributes to shaping the demographic structure of a country (Simelane, 1999; Stats SA 2017). Globally, international migration continues to grow rapidly, increasing from 154 million in 1990 to 244 million in 2015 (Global Migration Group, 2014; IOM, 2015). With respect to adolescents, countries show an increase in this cohort, with migration increasing from 82,3 million in 1990 to 135 million in 2013, (Global Migration Group, 2014). The migrant population residing in South Africa was estimated to be 2,2 million in 2011 (Statistics South Africa, 2011). The International Migration Report estimated that South Africa was home to 3,14 million migrants by the middle of 2015 (United Nations, 2015). The Global Migration Group (2014) states that although human mobility has gained increasing international attention in recent years, migration by young people has been mostly absent from global policy debates and national policies. This chapter adds to the discourse on international migration and adolescents.

Adolescence is defined as a transitional stage from childhood to adulthood. This transitional period can bring up issues of independence and self-identity (Thenmozhi, 2015). It is during this period that adolescents make decisions on how they want to live their lives in preparation for adulthood. Migration may be one of these decisions. In addition to this, the decision may be made by parents or guardians, and the adolescent moves according to these decisions. Hence, the migration of adolescents differs from adult migration as it is interconnected with other changes that this age group may experience. Adolescents are expected to attend an educational institution between the ages of 10 and 19 years. However, some join the labour force whilst others enter a marital union or commence childbearing. Some adolescents may begin to take control of their lives and want to be independent from family and the community. Juarez et al. (2013) argued that migration introduces another layer of complexity to the condition of entry into adulthood, as it is an additional step on the path to adulthood and it modifies the social and physical environment for many adolescents. The motivation for adolescents to move is often linked to the search for sustainable livelihoods, due to a lack of employment and/or under-employment, absence of decent working conditions, and poor economic prospects in the countries of origin. Furthering education, family reunification or formation, and escaping from regions affected by war, persecution, humanitarian crises, or natural disasters are important drivers (Global Migration Group, 2014).

The choices made by adolescents have a significant impact not only on their own lives and opportunities for human development, but also on the lives of their societies and communities, both in the medium and long term. The youth years pose both challenges and opportunities. They represent a period during which the efficiency of interventions throughout childhood and adolescence can be tested, assessed and, as a result, further improved or reconsidered. A positive migration experience can set young migrants on a successful path towards capitalising on their accomplishments and developing economic and social assets for their future. However, if the circumstances are negative, migration can have particularly dire and traumatic consequences for young people's short- and long-term future. Not only do they lose a

valuable opportunity for full human development, but their countries of birth and destination stand to lose an enormous potential contribution to social, economic and cultural development (Global Migration Group, 2014). It is in this stead that the purpose of this chapter is to provide a spatial sociodemographic and housing profile of adolescents with specific emphasis on foreign-born adolescents residing in South Africa.

4.2 Data source

This study uses data from the South African Community Survey (CS) 2016. This is the most recent data available on migration in South Africa. Whilst the migration data in CS 2016 produced unexpected results, there is still a wealth of information to be ascertained from the data (Stats South Africa, 2016). All results are presented as percentages and not as absolute numbers.

4.3 Results

Like any demographic phenomenon, the measurement of migration can be undertaken utilising different methods. This chapter focuses on lifetime migration. A lifetime migrant is defined as a person who was not born in South Africa, but who was enumerated in South Africa on the night of Community Survey (CS) 2016. The results are presented on spatial, sociodemographic and housing characteristics of adolescents.

4.3.1 Spatial profile of foreign-born adolescents

Spatial analysis provides the background of positioning where foreign-born adolescents are located in South Africa. The purpose of this is to determine where foreign-born adolescents reside after having moved to South Africa. This section focuses on the nine provinces in South Africa. From these results, the focus will be on the province which is most populous with foreign-born adolescents. In addition, data will be disaggregated at district municipality level within the most populous province.

Province of enumeration

Figure 4.1 illustrates the provincial distribution of foreign-born adolescents who were enumerated in South Africa. Gauteng was home to the majority of foreign-born adolescents (45,4%), followed by Western Cape (14,2%), Limpopo (9,9%) and Mpumalanga (9,7%). Free State (3,6%) and Northern Cape (0,8%) were the provinces with the fewest foreign-born adolescents.

District municipality/metropolitan area of enumeration

As indicated in Figure 4.1, Gauteng is the province with the most foreign-born adolescents (45,4%). Gauteng consists of three metropolitan areas (Ekurhuleni, City of Johannesburg, and City of Tshwane) as well as two district municipalities (Sedibeng and West Rand). Figure 4.2 indicates that in Gauteng, the majority of foreign-born adolescents resided in the metropolitan areas: City of Johannesburg (47,7%), City of Tshwane (20,2%) and Ekurhuleni (20,3%). This was followed by West Rand (7,5%) and Sedibeng (4,3%).

Figure 4.1: Distribution of foreign-born adolescents by province of enumeration, CS 2016

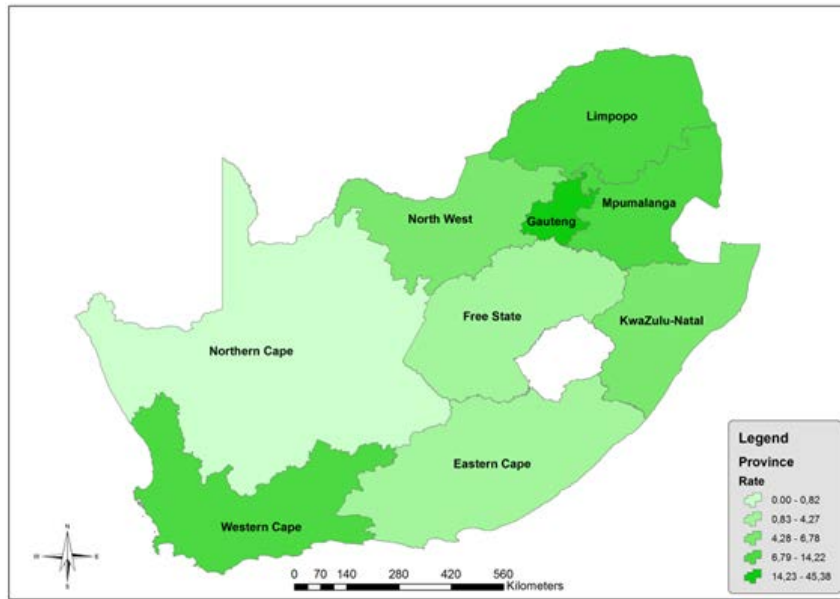
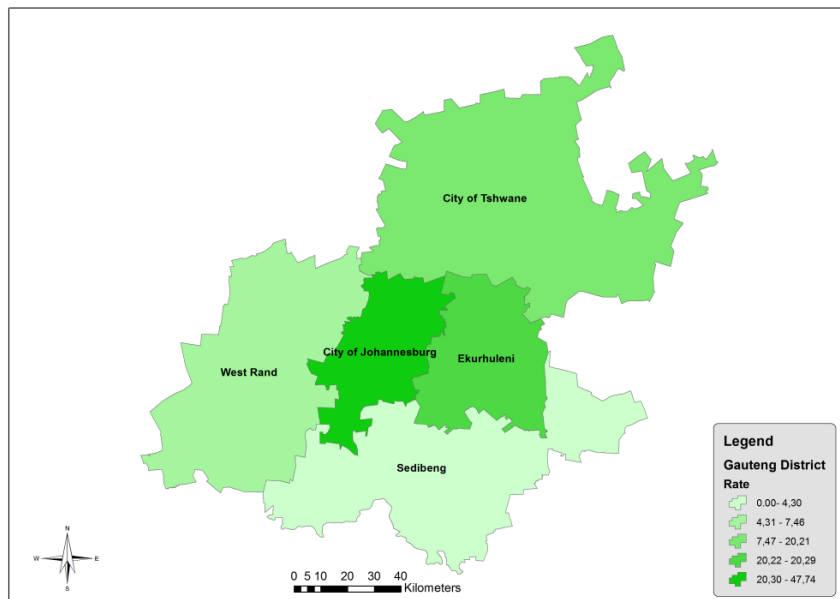


Figure 4.2: Distribution of foreign-born adolescents by district of enumeration in Gauteng, CS 2016



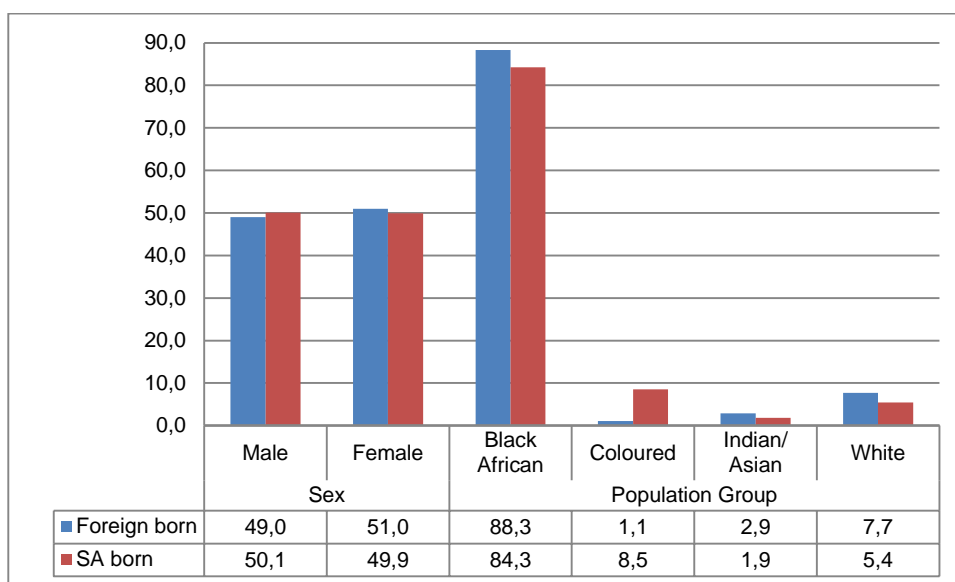
4.3.2 Sociodemographic profile of adolescents

Risks faced by migrants are exacerbated in the case of adolescents, particularly when they are in irregular situations and face threats of exploitation, trafficking, exclusion, detection, detention and deportation. Young migrants, especially girls and young women, are vulnerable to human rights violations such as child marriage, sexual exploitation, violence and unpaid labour. Many young migrants face deskilling and precarious employment in so-called 3-D jobs (dirty, dangerous and degrading), despite having higher educational or skills-training qualifications (Global Migration Group, 2014). The sociodemographic profile considers the sex selectivity, population group, citizenship status, religious affiliation, parental survival, living arrangement, fertility status, and education of both foreign-born and South African-born adolescents.

Sex selectivity and population group

Figure 4.3 indicates the sex selectivity of adolescents in South Africa. The number of female (51,0%) foreign-born adolescents (51,0%) was slightly higher than the number of male foreign-born adolescents (49,0%). This is compared to South African-born adolescents, where the number of males (50,1%) was slightly higher than the number of females (49,9%). Analysis by population group is a unique feature in the South African landscape and context, shaped by the country’s history. The majority of foreign-born adolescents in South Africa are black African (88,3%). According to Figure 4.3, there are more white and Indian/Asian foreign-born adolescents (7,7% and 2,9%, respectively) than there are white and Indian/Asian South African-born adolescents (5,4% and 1,9%, respectively).

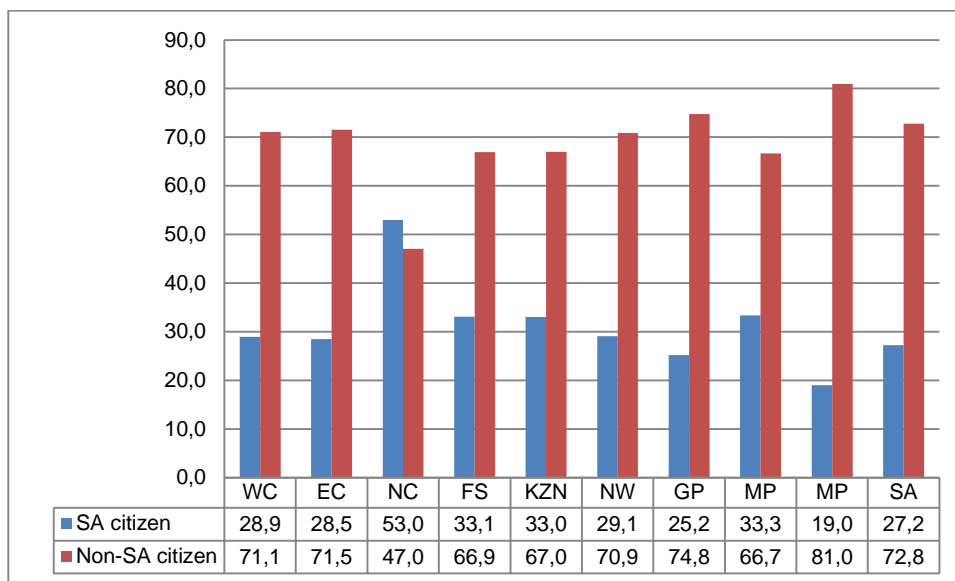
Figure 4.3: Distribution of adolescents by sex selectivity and population group, CS 2016



Foreign-born adolescents by their citizenship status

Figure 4.4 indicates the distribution of foreign-born adolescents by province of enumeration and by citizenship status. Regarding citizenship in South Africa, 27,2% of foreign-born adolescents reported having acquired South African citizenship. However, almost three-quarters of foreign-born adolescents (72,8%) are not South African citizens. Northern Cape (53,0%) recorded the highest percentage of foreign-born adolescents who are South African citizens (53,0%). Despite Gauteng having the highest percentage of foreign-born adolescent residents, only a quarter (25,2%) are South African citizens.

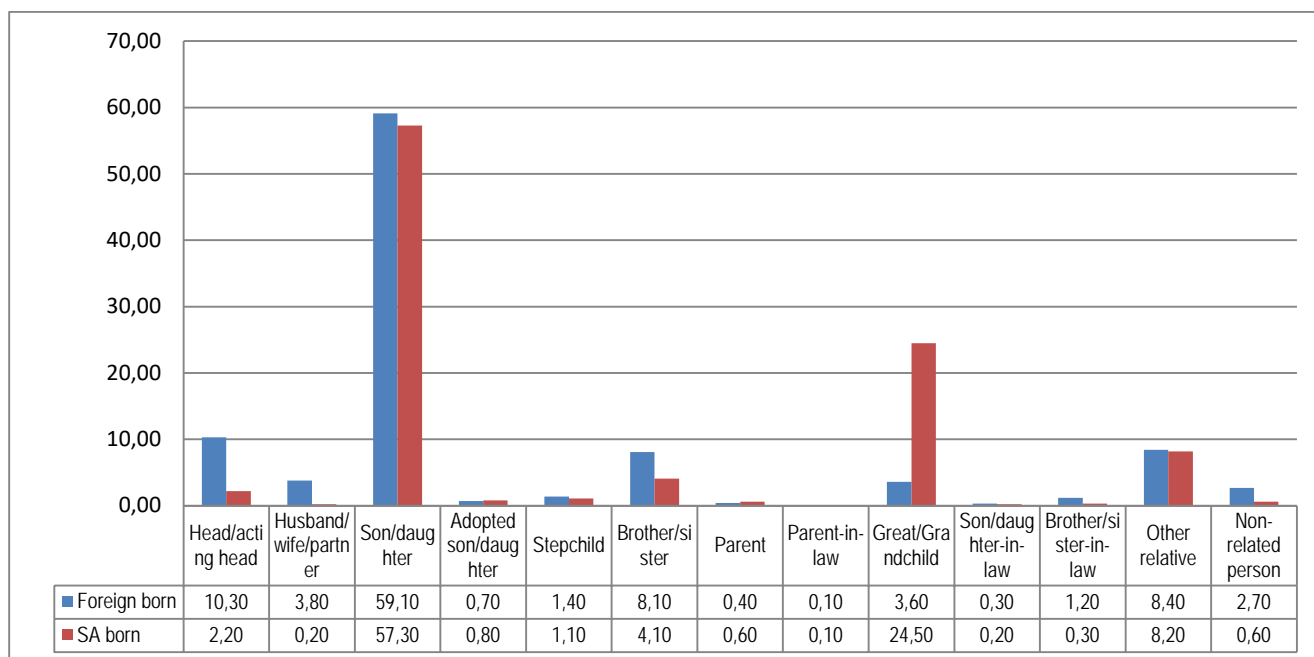
Figure 4.4: Percentage of foreign-born adolescents by citizenship status, CS 2016



Distribution of adolescents by family structure

During the migration process, adolescents can lose their social networks and may also be without parents or family members to provide guidance and care (Global Migration Group, 2014). Analysis of the relationship of adolescents to the household head was conducted to determine patterns of family structure. This was to determine who adolescents live with. Bennet et al. (2015) state that family networks in migration decision-making and behaviour have highlighted the importance of family structure and family ties to the place of origin and destination in determining whether children accompany migrant parents. Figure 4.5 indicates that there were more foreign-born adolescent household heads (10,3%) than South African-born adolescent household heads (2,2%). Results also indicate that a higher percentage of foreign-born adolescents (3,8%) lived with a spouse/partner than South African-born adolescents (0,2%). A higher percentage of foreign-born adolescents (8,1%) lived with a sibling than South African-born adolescents (4,1%). Significantly more South African-born adolescents (24,5%) than foreign-born adolescents (3,6%) lived with a grandparent. Similarly, more South African-born adolescents than foreign-born adolescents lived with their parents. A higher percentage of foreign-born adolescents lived with a non-related person (2,7%). The majority of both adolescent groups (foreign-born or South African-born) lived with their parents (Figure 4.5).

Figure 4.5: Distribution of adolescents by relationship to household head, CS 2016

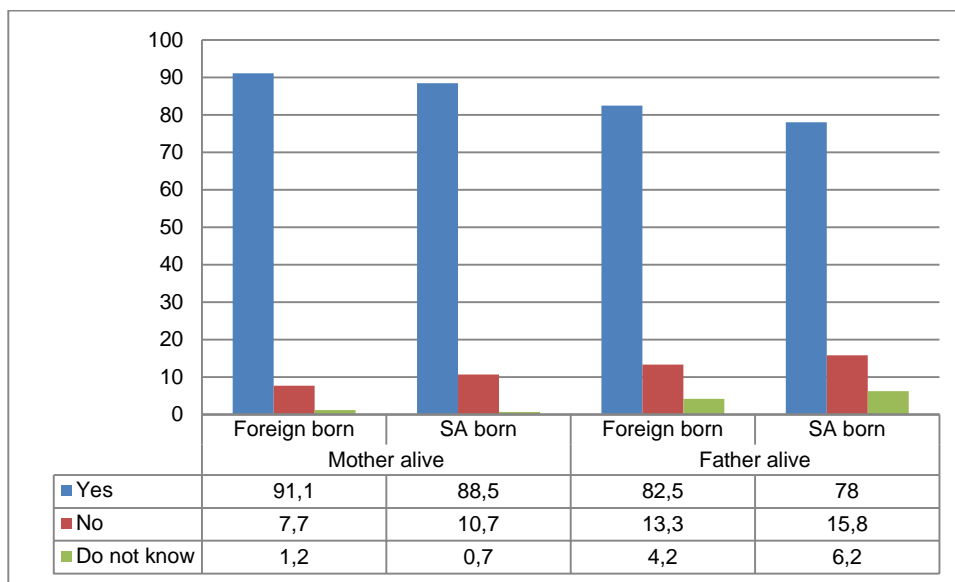


Parental survival

Figure 4.6 indicates the knowledge that adolescents have of their parents’ survival status. Knowledge of their parents’ survival status can be used to assess links to family, particularly in the case of migration, where people move and invariably lose touch with their family. This was ascertained by analysis of the “do not know” option when responding. Parental survival is divided into maternal and paternal parental survival.

Figure 4.6 illustrates that more foreign-born adolescents (1,2%) than South African-born adolescents (0,7%) did not know the status of their mother’s survival. However, more South African-born adolescents (6,2%) did not know the status of their father’s survival.

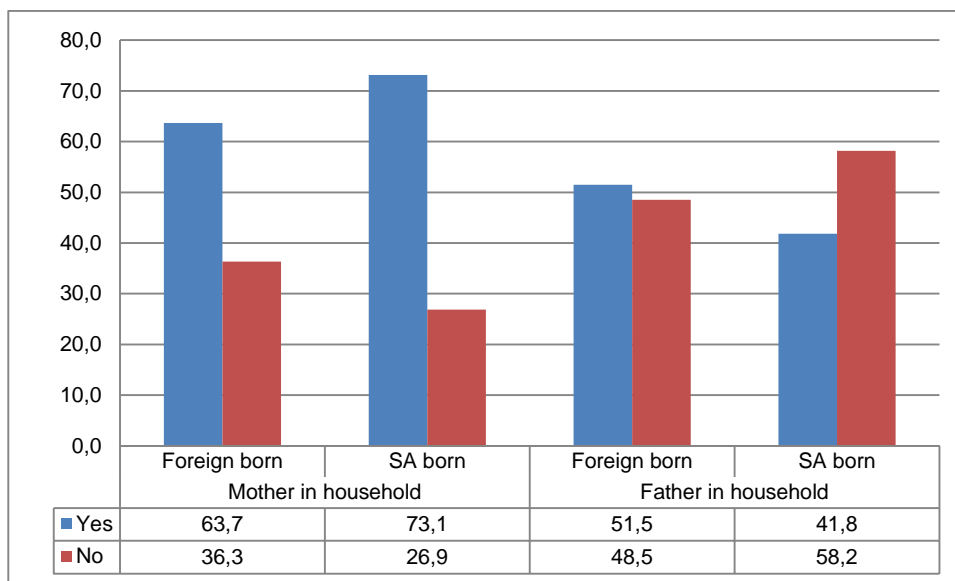
Figure 4.6: Distribution of adolescents by parental survival, CS 2016



Living arrangements

Whilst Figure 4.6 illustrated parental survival status, Figure 4.7 indicates the living arrangements of adolescents. Typically, children of migrants remain resident in the area of origin and in the care of family members, and may not move to area of destination with their parents (Bennet et al., 2015). Figure 4.7 illustrates the distribution of adolescents who lived in the household with their mother or with their father. More South African-born adolescents (73,1%) than foreign-born adolescents (63,7%) lived in households with their mothers. However, more foreign-born adolescents (51,5%) than South African-born adolescents (41,8%) lived in households with their fathers.

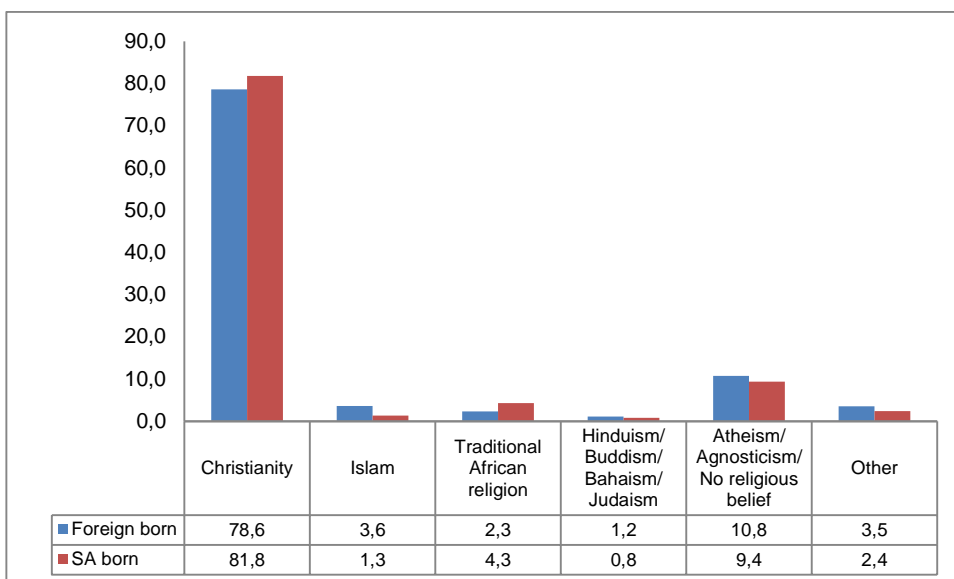
Figure 4.7: Distribution of adolescents by mother or father residing in household, CS 2016



Religious affiliation

The CS 2016 questionnaire included a question on religious affiliation. Figure 4.8 indicates that there were more Christian South African-born adolescents (81,8%) than foreign-born adolescents (78,6%). This trend is similar for Traditional African Religion. However, there were more foreign-born adolescents who practised Islam (3,6%) compared to South African-born adolescents. More foreign-born adolescents than South African-born adolescents also had no religious affiliation or who were Atheists or Agnostic (10,8%).

Figure 4.8: Distribution of adolescents by religious affiliation, CS 2016

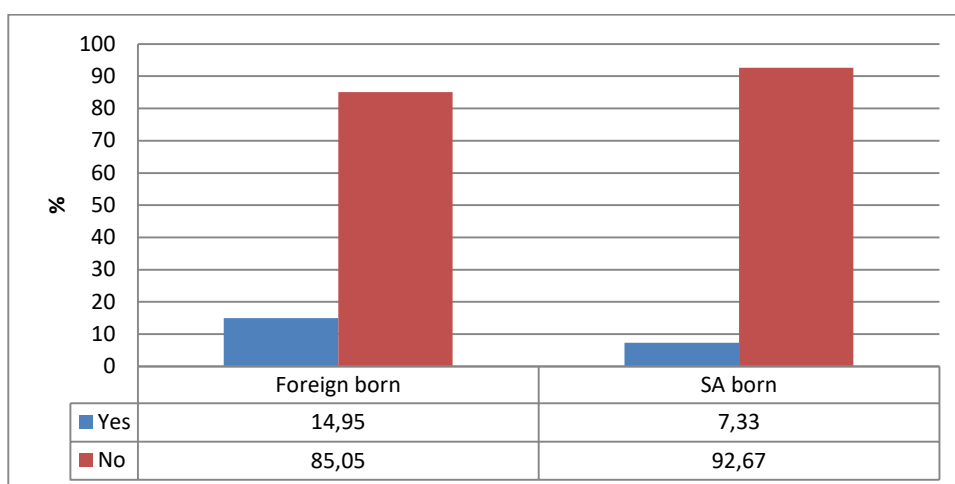


Fertility status (ever given birth)

International migration affects the fertility rate of countries of destination (Genereux, 2008). Immigration of women, especially from a country with a high fertility rate to a country with a low fertility rate, will increase fertility in the host country, if their fertility behaviour is in line with that of their country of origin. Bozon’s typology of African demographic patterns shows how and why the sending country matters for future childbearing decisions post-migration (Bozon, 2001).

Figure 4.9 illustrates the distribution of foreign-born adolescents and South African-born adolescents, by ever giving birth. For this analysis, only women aged 12–19 were considered. This is due to the fertility schedule of questions only being asked to women aged 12–49 years of age. Twice as many foreign-born adolescents (14,9%) have given birth than South African-born adolescents (7,3%).

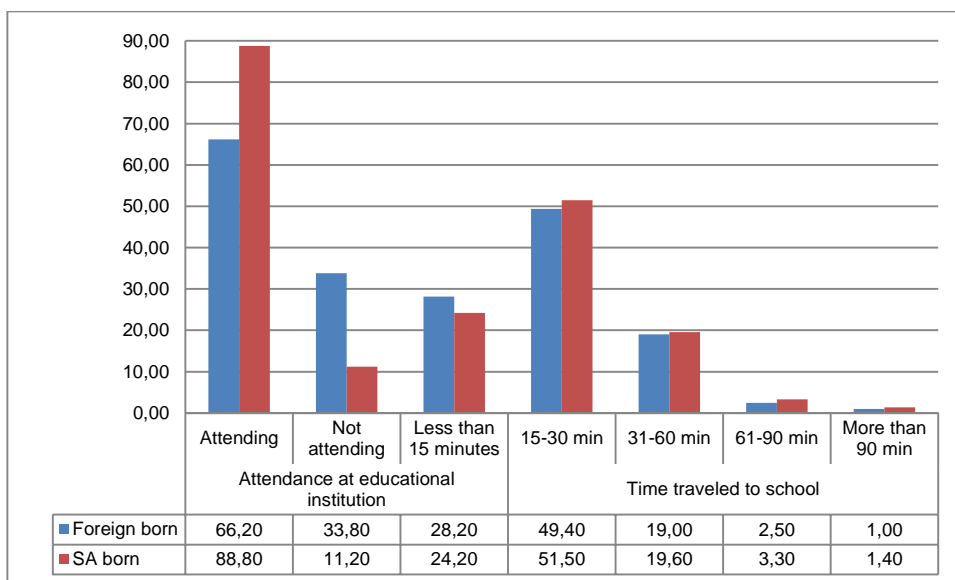
Figure 4.9: Distribution of adolescents by ever giving birth, CS 2016



Education

The decision to migrate may be to seek better socio-economic opportunities and to improve the migrant’s standard of living (Dudley et al., 2010). Some of these socio-economic opportunities may include seeking better educational opportunities for adolescents by parents or adolescents themselves. Figure 4.10 indicates that a higher proportion of South African-born adolescents (88,8%) were attending educational institutions than their foreign-born counterparts (66,2%). An education-related indicator that also links to the socio-economic status of the adolescent is the time travelled to get to the educational institution by the adolescent. Despite fewer foreign-born adolescents currently attending an educational institution (Figure 4.10), foreign-born adolescents seemed to live closer to their place of study (Figure 4.10). A higher proportion of foreign-born adolescents (28,2%) than South African-born adolescents (24,2%) travelled less than 15 minutes to an educational institution.

Figure 4.10: Distribution of adolescents by attendance at educational institution and time travelled to get to educational institution, CS 2016



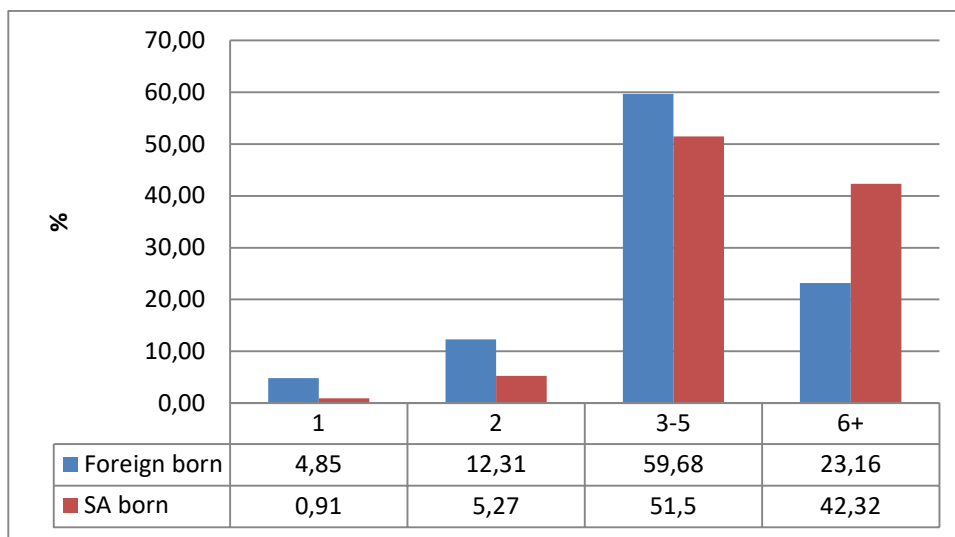
4.3.3 Housing profile of foreign-born adolescents

One of the objectives of CS 2016 is to collect information from households regarding their access to a range of basic services as well as their general living conditions. This section presents selected findings on household size, RDP or government-subsidised dwelling, tenure status, main dwelling that household currently lives in, access to household services (water, electricity, sanitation), household assets, household’s involvement in agricultural activity, food security, household opinions on issues such as difficulties facing municipalities, and a question on being a victim of crime in the past twelve months. Studies have documented poor material conditions for migrant families in their destination community (Bennet et al., 2015). The results are based on households that adolescents reported to live in.

Household size

Results from Figure 4.11 indicate that more foreign-born adolescents (4,9%) than South African-born adolescents (0,9%) lived in single-person households. A higher proportion of South African-born adolescents, however, lived in households of six persons or more (42,3%). This indicates that South African-born adolescents lived in more crowded households than their foreign-born counterparts. It can be deduced then that migrant housing selectivity puts more strain on housing demands.

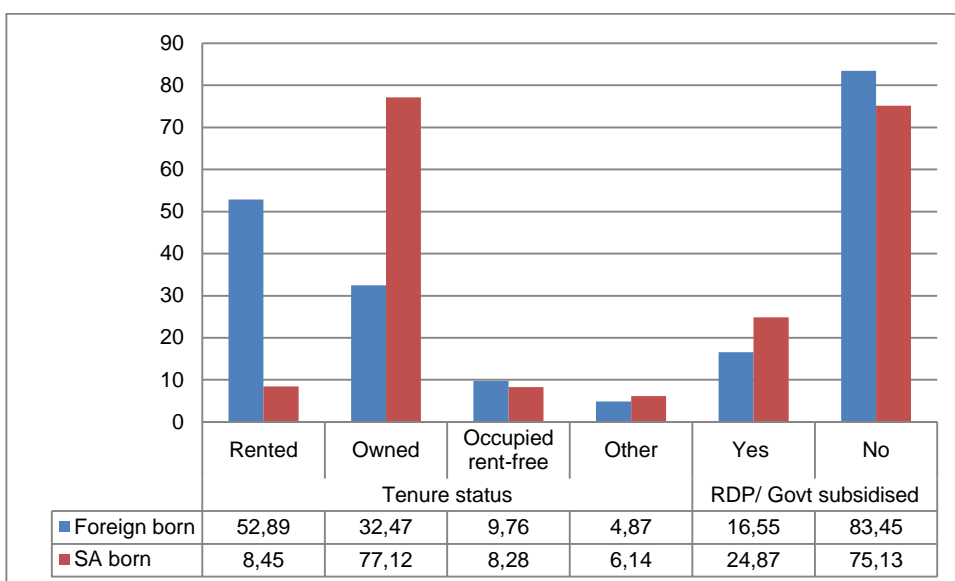
Figure 4.11: Distribution of adolescents by household size, CS 2016



Tenure status and RDP or government-subsidised dwelling

Tenure status indicates if a dwelling is owned, rented or occupied at no cost. Figure 4.12 shows the percentage of households according to their tenure status. The majority of foreign-born adolescents (52,9%) lived in homes that are rented, whilst the majority of South African-born adolescents (77,1%) lived in homes that are owned. Whilst a large proportion of South African-born adolescents (77,1%) lived in households that are owned, a higher proportion (24,9%) than foreign-born adolescents lived in RDP/government-subsidised dwellings (Figure 4.12).

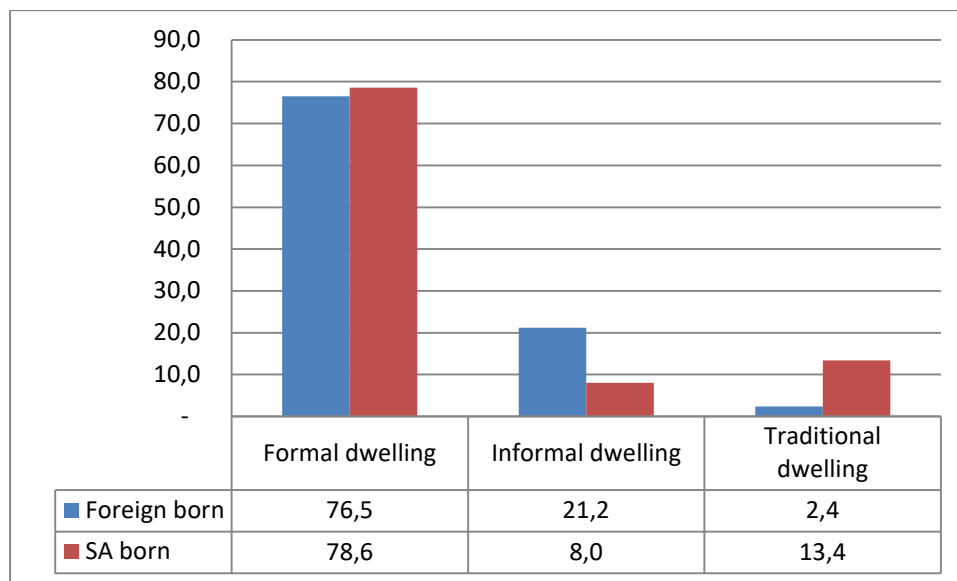
Figure 4.12: Distribution of adolescents by household tenure status, CS 2016



Dwelling type

Figure 4.13 indicates that a slightly higher proportion of South African-born adolescents (78,6%) than foreign-born adolescents (76,5%) lived in formal dwellings. CS 2016 defines informal dwellings as shacks not in a backyard, e.g. in an informal/squatter settlement or on a farm. Almost three times as many foreign-born adolescents (21,2%) than SA-born adolescents (8,0%) lived in informal dwellings.

Figure 4.13: Distribution of adolescents by main dwelling that household currently lives in, CS 2016



Access to household services

In this section, household services consider basic services such as access to safe water supply, household access to electricity and main type of toilet facility used. Table 4.1 indicates that a higher proportion of foreign-born adolescents (89,8%) than South African-born adolescents (80,6%) had access to safe drinking water. Table 4.1 also indicates that with regard to household access to electricity, a higher proportion of South African-born adolescents (89,6%) had access to electricity that is connected in their houses, and a higher proportion of foreign-born adolescents had no access to electricity (12,12%). Considering sanitation, a higher proportion of foreign-born adolescents (68,3%) had access to a flush toilet than South African-born adolescents (50,7%). A higher proportion of South African-born adolescents (36,4%) still utilised pit latrines.

Table 4.1: Distribution of adolescents by household services, CS 2016

Household service	Indicator	Foreign-born	South African-born
Water	Access to safe water	89,8	80,6
Electricity	In-house	80,8	89,6
	Connected to other source	5,9	1,7
	Other	1,2	1,1
	No access to electricity	12,2	7,5
Sanitation	Flush toilet	68,3	50,7
	Chemical toilet	1,8	6,0
	Pit latrine/toilet	22,7	36,4
	Ecological toilet	0,2	0,4
	Bucket toilet	2,7	1,7
	Other	1,4	2,0
	None	2,8	2,8

Household goods

Table 4.2 indicates that a higher proportion of South African-born adolescents lived in households that have refrigerators (84,4%), electric/gas stoves (84,5%), washing machines (40,3%) and microwaves (54,1%). However, a higher proportion of foreign-born adolescents lived in households that have a geyser (35,8%), air conditioner (7,6%) and a motor vehicle(s) (35,7%).

Table 4.2: Distribution of adolescents by household assets, CS 2016

Household goods	Foreign-born adolescents	South African-born adolescents
Refrigerator	76,0	84,4
Electric/gas stove	81,9	84,5
Washing machine	35,8	40,3
Microwave oven	51,2	54,1
Geyser	35,8	22,3
Air conditioner	7,5	5,8
Motor vehicle	35,7	28,3

Telecommunication devices

Table 4.3 indicates that, compared with South African-born adolescents, a higher proportion of foreign-born adolescents owned tablets (29,3%), computers (31,5%), landlines (11,8%), cellphones (95,7%), and had an internet connection in their dwelling (16,8%).

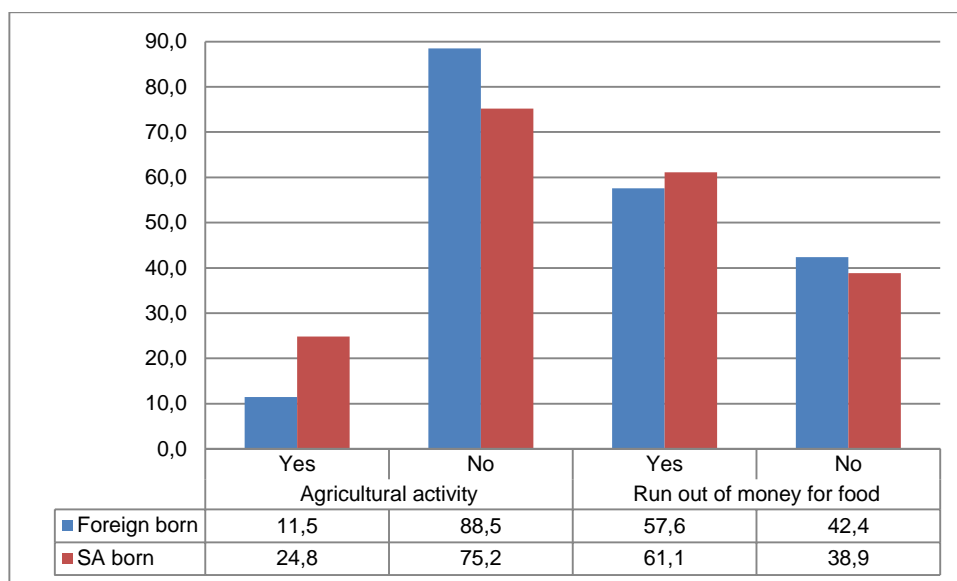
Table 4.3: Distribution of adolescents by telecommunication devices, CS 2016

Telecommunications	Foreign-born adolescents	South African-born adolescents
Tablet	29,34	19,63
Computer	31,50	20,25
Landline	11,75	7,69
Cellphone	95,72	95,52
Internet connection in dwelling	16,82	8,58

Household involved in agricultural activity and food security

Figure 4.14 indicates the agricultural activities of households. A higher proportion of South African-born adolescents (24,8%) than foreign-born adolescents (11,5%) lived in households that are involved in agricultural activities. The CS 2016 questionnaire included a question that asked if respondents had “run out of money to buy food for 5 or more days in past 30 days”. A higher proportion of South African-born adolescents (61,1%) indicated that they had run out of food (Figure 4.14). This indicates that a higher proportion of South African-born adolescents were more vulnerable with regard to food security, despite a higher proportion of SA-born adolescent households involved in agricultural activities.

Figure 4.14: Distribution of adolescents by household involvement in agricultural activity and food security, CS 2016



Difficulties facing the municipality presently

The CS 2016 questionnaire included an opinion question on the difficulties facing the municipality. Table 4.4 indicates that more foreign-born adolescents lived in households that expressed difficulties experienced with regard to the reliability of an electricity supply (7,3%), cost of electricity (12,7%), inadequate sanitation/sewerage/toilet services (3,7%), inadequate refuse/waste removal (2,8%), violence and crime (9,9%), gangsterism (1,2%), lack of/inadequate public transport (0,5%), and corruption (1,7%). However, the proportion of foreign-born adolescents who lived in households that indicated that there were no difficulties facing municipalities (10,9%) was also higher than the proportion of South African-born adolescents who lived in such households (5,2%).

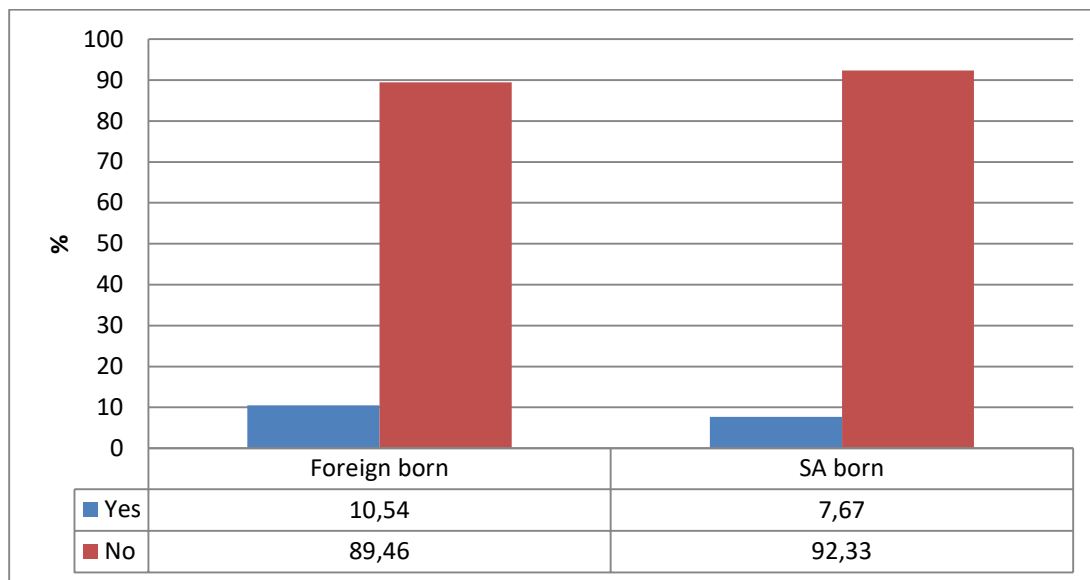
Table 4.4: Distribution of adolescents by difficulties facing the municipality presently, CS 2016

Difficulty facing municipality	Foreign-born	South African-born
Lack of safe and reliable water supply	14,6	24,6
Cost of water	5,5	6,1
Lack of reliable electricity supply	7,3	5,6
Cost of electricity	12,7	8,8
Inadequate sanitation/sewerage/toilet services	3,8	3,1
Inadequate refuse/waste removal	2,8	1,5
Inadequate housing	6,4	8,6
Inadequate roads	6,0	8,9
Inadequate street lights	1,2	1,4
Lack of/inadequate employment opportunities	8,9	12,1
Lack of/inadequate educational facilities	0,7	0,7
Violence and crime	9,9	5,1
Drug abuse	2,2	2,4
Alcohol abuse	0,7	0,7
Gangsterism	1,2	0,9
Lack of/inadequate parks and recreational area	0,5	0,4
Lack of/inadequate healthcare services	0,7	0,9
Lack of/inadequate public transport	0,5	0,4
Corruption	1,7	1,5
Other	1,9	1,2
None	10,9	5,2

Victim of crime in the past 12 months

The CS 2016 questionnaire included a question on having been a victim of crime in the past twelve months. Figure 4.15 indicates that a higher proportion of foreign-born adolescents (10,5%) were from households who were victims of crime in the twelve months preceding the survey.

Figure 4.15: Distribution of adolescents by victim of crime in the past 12 months, CS 2016



4.4 Summary of findings

Although human mobility has gained increasing international attention in recent years, migration by young people has been mostly absent from global policy debates and national policies (Global Migration Group, 2014). It is in this stead that this chapter sought to add to the discourse on international migration and adolescents. The chapter focused on the spatial, sociodemographic and housing profile of foreign-born adolescents in South Africa, using data from CS 2016.

Gauteng was home to the majority of the foreign-born adolescents (45,4%). About 51% of all foreign-born adolescents were female, and the majority of foreign-born adolescents in South Africa were black African (88,3%). Almost three-quarters of foreign-born adolescents were not South African citizens. Only 66,2% of migrants in this cohort were attending an educational institution at the time. Almost three times as many foreign-born adolescents (21,1%) as SA-born adolescents lived in informal dwellings. Almost ten per cent of migrant adolescents were concerned about violence and crime in the municipality they lived in. In this stead, 10,54% of migrant adolescents had been victims of crime in the year before the survey.

CHAPTER 5: DISCUSSIONS

5.1 Age composition

The results indicate that over time, Limpopo and Eastern Cape had the highest proportion of adolescents, while Gauteng and Western Cape had the lowest. This pattern can be attested to the fact that from the post-apartheid era to date, Gauteng and Western Cape have been the most popular migration destinations in the country. The sending provinces who have lost the largest number of adolescents by far have been Limpopo and Eastern Cape. Since migration is age and sex selective, parents often leave children behind for better economic opportunities. The age-sex structure of the sending and receiving provinces also concurs with the levels of the adolescent population across the country. For instance, the child dependency ratio is highest in Limpopo and Eastern Cape, while lowest in Gauteng, followed by Western Cape.

Sex ratio indicates that South Africa has more male adolescents than their female counterparts (101 males per 100 females). Sex ratio at birth is known to revolve around 103 to 105 males per 100 females. Sex ratio depends on mortality rates between the sexes, and age and migration. Therefore, the sex ratio suggests an increase in the birth survival rates amongst male adolescents.

An analysis of the adolescent population size of the provinces indicates declining trends amongst adolescents from 2001 to 2011, but the numbers then increased across all provinces in 2016. The decrease could have been due to a decline amongst the number of children aged 5–14 that was revealed in 2011. The most likely reason for the decline might be that the cohort did not survive the increase in infant and child mortality between 1997 and 2006. HIV/AIDS prevalence in pregnant mothers increased significantly from 1999; however, mother-to-child transmission decreased from 8% to almost 3% in 2011 (Sherman et al., 2012). Notwithstanding the sudden increase in mortality between the late 1990s and the mid-2000s, the country has seen an improvement in life expectancy at birth over time. Although the levels of adolescent migration are low, data on migration appeared to have also contributed to the slight increase in the adolescent population in 2016.

5.2 Fertility

The adolescent birth rate increased in 2011 after reaching low levels in 2001. The increase reflects the proportion of young women who are increasingly becoming vulnerable to the undesirable consequences of adolescent childbearing. No demographic phenomenon could be identified to explain recent increases in adolescent fertility. The notion that child support grants promote adolescent pregnancies in South Africa has been discredited by Makiwane and others (2006) who tried to seek evidence from national surveys and administrative data. Their research arrived at the conclusion that no significant association exists between the child support grant and adolescent fertility in South Africa.

The level of adolescent fertility differed by population group. Findings support previous studies which also observed high adolescent pregnancy amongst black Africans and coloureds (Jewkes et al., 2001; Mkhwanazi, 2010). The socio-economic status in which these subpopulations find themselves are said to be related to the observed fertility levels (Sibanda and Zuberi, 2005). Using education as an example, a study which looked at fertility and childbearing in South Africa highlights that fertility is higher amongst women of lower educational level (Palamuleni et al., 2007). According to the authors, education promotes the postponement of marriage, and educated women who are most likely to be active in the labour force, desire fewer children and have access to information to regulate fertility by using contraceptives. In South Africa, the level of education amongst black Africans and coloureds is lower compared to that of the Indian/Asian and white population groups.

The contribution of ABR to total fertility is said to be associated with the level of ABR (UNDESA-PD, 2013). This is the case for Indians/Asians and whites where the ABR is low and PAF is equally low. A high PAF as indicated for coloureds, and for the Northern Cape and Mpumalanga provinces, amongst others, shows that early childbearing is an important contributor to high fertility amongst these subpopulations. Provincial disparities in adolescent childbearing possibly mirror, amongst others, varying access to sexual and reproductive health information and services and the socio-economic status and dominance of specific groups in the different provinces (Stats SA, 2015). For instance, the black African population, which is characterised by high fertility rates, makes up the majority in Limpopo. The same can be said for Eastern Cape.

Marriage symbolises the onset of childbearing (UNFPA, 2015). Results from this study alluded to the slight increase in the percentage of young women who have never been married from 2011 to 2016. In addition, childbearing is higher amongst the very few women who have ever married (data not shown). Worth noting is that the consequences of adolescent pregnancy are the same for both married and unmarried teen mothers. Poorer health and socio-economic outcomes have been associated with adolescent fertility in South Africa (Kara and Lee, 2012).

Disruption in education has been viewed as one of the causes and consequences of adolescent childbearing (UNFPA, 2015; Timaeus and Moultrie, 2015). The negative impact of motherhood on education in South Africa was reflected in the lower school attendance by adolescent mothers. Since adolescent motherhood increased noticeably after age 15 in 2016, school attendance also decreased noticeably after this age, notwithstanding other factors that may affect school attendance by young women. Using the national income dynamics data of 673 young women between the ages of 15 and 18, Timaeus and Moultrie (2015) who looked at teenage childbearing and educational attainment in South Africa, ascertained that the odds of leaving school were higher at 4,4 for young women who had given birth by the year 2008. The study also concludes that motherhood is central to the failure of teen women to successfully complete their secondary education.

5.3 Mortality

Adolescents like all age groups in South Africa, are greatly affected by the HIV/AIDS pandemic. The national Strategic Plan on HIV/AIDS and Sexually Transmitted infections identifies young people aged 15-24 years as a specific target group for all interventions.

Findings from this study show that household deaths for persons aged 10–19 years contributed 3,6% in 2001; 2,6% in 2011 and 2,5% in 2016 to the overall number of deaths reported by households in South Africa. This finding is linked to the overall mortality decline in the country. The provincial patterns show that KwaZulu-Natal had the highest proportion of adolescent deaths, while Northern Cape had a relatively low number of deaths amongst adolescents reported by households. This could be linked to the population distribution in South Africa. This finding is also linked to the results from Census 2011 on the number of deaths by province where KwaZulu-Natal reported the highest number of deaths (Stats SA, 2011).

The proportion of deaths occurring amongst adolescents by age at death shows that mortality is much higher amongst older adolescents (15–19 years) than amongst younger adolescents (10–14 years). With regard to mortality by sex, male adolescent mortality was higher compared to that of female adolescents. There was an 8% decrease in the proportion of adolescent female deaths from 2001 to 2016. With regard to population group, black Africans reported the highest adolescent mortality. Mortality rates amongst Indian/Asian adolescents have been declining consistently from 2001 to 2011. The findings on mortality by population group are consistent with literature regarding the dynamics of the different population groups in the country.

Results on mortality and causes of death in 2015 indicated that 25,8% of female adolescent deaths were due to non-natural causes, compared to 50,8% non-natural deaths for male adolescents. Of the ten leading causes of death amongst the adolescents in 2015, tuberculosis (A15-A19), followed by the human immunodeficiency virus [HIV] disease (B20-B24), other viral diseases (B25-B34), and influenza and pneumonia (J09-J18), were ranked top four, and they were the same for both adolescent males and females in South Africa. The 2015 mortality and causes of death report also showed that generally, the age groups greatly affected by non-natural deaths were 10–14 (30,2%) and 15–19 (44,7%), which form part of the adolescent population (Stats SA, 2015).

Medical aid coverage is also low amongst adolescents in South Africa. Findings from this study indicate that a relatively higher proportion of adolescents from the white population group were covered by medical aid, followed by the Indian/Asian population group. This pattern is consistent with medical aid coverage for the general population. In terms of province of usual place of residence, a much higher proportion of adolescents from Gauteng and the Western Cape were covered by medical aid.

5.4 Migration

Chapter 4 focused on profiling foreign-born adolescents in South Africa from a spatial, sociodemographic and household perspective. Consideration of migration in this cohort is integral, as development plans such as the Sustainable Development Goals have an emphasis on adolescents and migration. This cohort

represents a specific category of migrants whose unique needs, rights and challenges are not being adequately addressed by the larger migration policy debate (Global Migration Group, 2014). Results indicated that at provincial level, the highest proportion of foreign-born adolescents lived in Gauteng (Figure 4.1). The spatial distribution of foreign-born adolescents at provincial level followed the trends of the foreign-born population as a whole. This is in line with expected findings, where foreign-born adolescents may have moved with family members and reside with family members. In addition to this, foreign-born adolescents who are independent of family also move in the same pattern as the general foreign-born population.

Although some reports indicate that it is difficult to estimate adolescent migration by sex of migrants, the Global Migration Group (2014) and UNHCR (2015) reported that more young males (53,5%) than young females (46,5%) were migrating. However, the South African context is unique in that there were slightly more female migrants (51,0%) than males (Figure 4.3). With regard to population group distribution, the majority of foreign-born adolescents in South Africa were black African (88,3%) (Figure 4.3). This is in line with literature, as the majority of in-migration is from the SADC region (Stats SA, 2014). There are more white and Indian/Asian foreign-born adolescents (7,7% and 2,9%, respectively) than South African-born white and Indian/Asian adolescents (5,4% and 1,9%, respectively) (Figure 4.3). This therefore has implications for the adolescent population of both the Indian/Asian and white population groups, which will be largely influenced by the foreign-born adolescent group.

Citizenship provides access to social services as well as stability in the country of destination. Almost three-quarters (Figure 4.4) of foreign-born adolescents are not South African citizens. This high number has an impact on the services that foreign-born adolescents will be able to access in South Africa. For example, a South African birth certificate, identity document or valid visa is required to enter education institutions or to be eligible for formal employment. Despite Gauteng having the highest percentage of foreign-born adolescents (Figure 4.1), only a quarter are South African citizens (Figure 4.4). Northern Cape, however, which has the lowest percentage of foreign-born adolescents, has the highest percentage of foreign-born adolescents who are South African citizens (Figure 4.4).

All South Africans have a right to basic education, and the Bill of Rights obliges the government to make education available and accessible through reasonable measures (Stats SA, 2016). By tracking education and education-related indicators, particular aspects of the circumstances of adolescents can be analysed. Those under the age of 18 who are impacted by migration in countries of origin, transit and destination, regardless of migration status, are protected by the Convention on the Rights of the Child which accommodates education. However, this right is not extended to migrants, as undocumented migrants will be unable to provide the school with a birth certificate of the migrant child. This may lead to the child not being admitted to the school (Centre for Education Rights and Transformation, 2012). Figure 4.10 is implicit in this regard, as only 66,2% of migrants in this cohort are currently attending an educational institution. This is an area that requires policy intervention.

The chapter further considered adolescent fertility. Migrant adolescent fertility is affected in two ways. First, international migration affects the fertility rate of the countries of destination (Genereux, 2008).

Immigration of women, especially from a country with a high fertility rate to a country with a low fertility rate, will increase fertility in the host country, if their fertility behaviour is in line with that of their country of origin. The typology of African demographic patterns shows how and why the sending country matters for future childbearing decisions post-migration (Bozon, 2001). Second, migrant female adolescents form part of a vulnerable group and may be exposed to rape, assault and violence (Global Migration Group, 2014). Results were in line with the stated literature. Twice as many foreign-born adolescents (14,95%) have given birth than South African-born adolescents (7,3%) (Figure 4.9).

Chapter 4 also measured knowledge of parental survival as a proxy to ascertain family structures which may be affected by migration. Slightly more foreign-born adolescents did not know the survival status of their mothers (Figure 4.6). Figure 4.5 indicated that 10,3% of foreign-born adolescents were head of their household. This indicates an independence from living with a parent as it is assumed that in this cohort, a parent would be the household head. Just over sixty per cent of foreign-born adolescents live with their mother in the household, and approximately half live with their father in the household (Figure 4.7). These statistics are congruent with literature, as Bennet et al. (2015) indicate that only a minority of migrant parents in South Africa include their children in their destination household. This may be indicative of parents without the social or physical resources to have children reside with them in their destination household (Bennet et al., 2015).

Living with a parent is closely linked to household size. Children included in the destination household of migrant parents typically live in small households with both their mother and father (Bennet et al., 2015). Measuring household size is an important phenomenon, as more households require more housing infrastructure. Results indicated that more foreign-born adolescents (4,9%) lived in single-person households than South African-born adolescents (0,9%) (Figure 4.11). This could be due to foreign-born adolescents not migrating with family members and hence, live alone. The increase in single-person households puts a strain on the demand for housing. When people choose to live in fewer-person households, more housing is required. A similar trend follows for two-person and three-to-five-person foreign-born adolescent households (Figure 4.11). Hence, it can be deduced that migrant housing selectivity puts a strain on housing demands.

Migrants from poor backgrounds and who do not have access to social networks are said to be more likely to migrate to informal settlements (Weeks, 2012). Almost three times as many foreign-born adolescents (21,1%) than SA-born adolescents live in informal dwellings (Figure 4.13). Despite the type of dwelling, migrant adolescents live in households that have considerable access to safe water (89,8%) and electricity in the house (80,8%). The availability of a flush toilet, however, is lower (68,3%) (Table 4.1). Household goods are viewed as a proxy for household wealth. Literature says that migrant children live in households that are less likely to have amenities such as a refrigerator, television, washing machine, telephone and motor vehicle (Richter, Norris et al., 2006). The majority of migrant adolescents lived in households that have a stove, refrigerator and microwave oven. Household ownership of a washing machine, geyser, air conditioner and motor vehicle, however, is considerably lower (Table 4.2). The vulnerability of migrants as discussed in the literature is indicative in the South African context, where

almost half of foreign-born adolescents reported that with regard to food security, the household ran out of money to buy food for five or more days in the thirty days before the interview (Figure 4.14).

Due to their age and developmental stage, adolescent migrants are more vulnerable to migration experiences that result in isolation, exclusion and insecurity. They may be particularly affected by xenophobia and discrimination, and suffer further marginalisation due to lack of fluency in the local language, and insufficient information about laws and regulations in their new country. This also indicates that migrant households experience higher levels of crime (Global Migration Group, 2014). This is congruent with results, as Table 4.4 indicated that almost ten per cent of migrant adolescents were concerned about violence and crime in the municipality where they lived. In this stead, 10,54% of migrant adolescents were victims of crime in the year before the survey (Figure 4.15).

Last, all survey data have limitations, and the Community Survey 2016 is not unique. The Community Survey 2016 provided a platform to further understand the demographic profile of adolescents in South Africa. Nonetheless, some indicators from the data showed somewhat lower levels than had been expected. Despite this observation, the patterns from the data concur with those revealed in the historical data.

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