Morbidity and mortality patterns among the youth of South Africa, 2013

Statistics South Africa

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Preface

The report is part of a series of thematic health reports produced by Stats SA using health information available from Stats SA's household surveys, administrative data and other Stats SA publications. It presents information on the morbidity and mortality status of the youth of South Africa in 2013. The report is based on information gathered from respondents who participated in the General Household Survey that was conducted by Statistics South Africa during the months of January to December 2013 and the Mortality and causes of death data from the South African civil registration system for deaths that occurred between January and December 2013.

The report highlights information on the distribution and characteristics of the youth. It further presents information on their healthcare-seeking practices (which includes medical aid coverage and health care worker consultation) and perceived health status. It outlines self-reported illnesses that the youth suffered a month before the survey. Information on mortality and causes of death including deaths due to natural and non-natural causes is also provided. In addition, deaths due to communicable and non-communicable diseases as well as the leading natural causes of death are discussed.

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List of abbreviations/acronyms

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti-Retroviral Treatment
ARTI	Acute Respiratory Tract Infection
GDP	Gross Domestic Product
GHS	General Household Survey
HBP	High Blood Pressure
HIV	Human Immunodeficiency Virus
HSRC	Health Sciences Research Council
KZN	KwaZulu-Natal
MDGs	Millennium Development Goals
NDP	National Development Plan
SAS	Statistical Analysis Software
SADHS	South African Demographic and Health Survey
Stats SA	Statistics South Africa
TB	Tuberculosis
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

1. Introduction

1.1. Background

Worldwide, the youth are faced by greater health risks including physical and psychological trauma from sexual abuse, gender-based violence and other forms of accidents. They still face substantial challenges such as high unemployment rates, high HIV infection rates and a number of them heading households (UNFPA, 2015). They also have risks such as sexually transmitted diseases, unwanted pregnancies and other related complications (United Nations, 2015).

Young people in the sub-Saharan African region face a number of challenges, including growing up in poverty, high rates of unemployment, limited educational opportunities and rapid socio-cultural transformations characterised by weakening social controls and breakdown of traditional norms (Kabiru, 2013). These challenges have implications for the health and wellbeing of the youth and for the contributions of youthful populations to the economies of African nations (Kabiru, 2013). Education has been positively linked to good health, economic growth and fewer social conflicts even though millions of the youth remain without access to formal education (Kabiru, 2013). A large number of under-educated youth in a context of rapid population growth and poor economies is a threat to development, health and security in the region (Kabiru, 2013).

In the South African case, the Constitution provides for the right of access to health care services and for other health-related rights. According to Section 24 of the Constitution, “everyone (young people included) has the right to an environment that is not harmful to their health or wellbeing”. The State therefore has an obligation to ensure that its conduct, whether by way of legislation or policies, does not create an environment that is harmful to people's health (The 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 South African youth. The NDP prioritises policies that will improve the capabilities and life chances of the country’s large youthful population. It emphasises that young people deserve better educational and economic opportunities. Promoting greater opportunities for the youth is also part of this plan (The Presidency, 2011).

The “Youth and Adolescent Health Policy” is a policy specifically aimed at improving long-term health outcomes of the South African youth. It was also developed to support and provide direction to efforts with regard to the prevention and response to health problems by promoting health improvement amongst adolescents and youth (Department of Health, 2012). The policy advocates for a long and healthy life for all South Africans, and has identified the ten health priorities for the adolescent and youth in South Africa. Among these health priorities are HIV and AIDS, tuberculosis (TB), chronic diseases, disability, sexual and reproductive health (Department of Health, 2012). In addition, the department committed itself to regularly monitor a set of health outcome indicators for the youth, such as HIV and AIDS and TB, chronic diseases and disability, violence and injuries, to mention a few (Department of Health, 2012).

The South African youth population (14–35 years) was estimated to be about 37% of the total population in 2010 (The Presidency, 2011). This population has been growing at a faster rate when compared to the national annual growth rate (The Presidency, 2011). These higher growth rates are expected to be sustained into the next decade (Statistics South Africa, 2011). South African youth are faced with a number of challenges related to their wellbeing, poverty, social determinants of health such housing, clean water and sanitation, healthy environments as well as food security (The Presidency, 2011).

A report on the status of the youth produced by the Human Sciences Research Council provided a picture of young people in the areas of education, labour market participation, inequality, health and disability, crime and violence, and social integration. Their education may be shortened because of lack of funds to continue schooling and they may wait a very long time to obtain even low paid and insecure informal employment. A large number of the youth don’t make it to adulthood, while others continue in an impoverished marginal state, little different from that of their families of origin (Human Sciences Research Council, 2005).

Others die young of injuries and/or HIV infection (HSRC, 2005). The health status of the South African population does not match the improved health system the country has. It is ranked low in health system performance compared to other middle income countries and even some lower income countries (SADHS, 2003). The 2003 South African Demographic and Health Survey (SADHS) found that South Africans are not very healthy, even though the country is classified as a middle income country (SADHS, 2003).

Kabiru (2013) found that in 2010 the youth population in Africa were at the centre of the HIV/AIDS epidemic, those in the age group 15–24 years contributed 42% of new HIV infections and young women were particularly at risk. However, many young people in Africa still lack wide-ranging and correct HIV knowledge and their access to sexual and reproductive health services is often inadequate (Kabiru, 2013).

South Africa is in the middle of an HIV/AIDS epidemic of profound proportions and young people will continue to fuel the epidemic as newly sexually active cohorts become part of this pool (Bradshaw, 2003). The overall HIV prevalence for the youth (15–24 years) of South Africa was 7,1% in 2012, a decrease from 8,7% established in 2008. The black African population group had an HIV prevalence of 7,6 times higher than that of the coloured population group. The use of population group as a means of stratifying the population given the country's history has been accepted as the best measure of previous socio-economic deprivation (Dorrington, 2004). Besides, this classification is also used in censuses and death registration, though not in the registration of births. This is so because variations in demographics and economic development are still observable within the democratic era. The four distinct population groups in the case of South Africa are black Africans, coloureds, Indians/Asians and whites.

Health-seeking practice is defined as the activity undertaken by individuals who perceive themselves to be ill for the purpose of finding an appropriate remedy (Afolabi et al 2013). Health seeking behaviour is not one event, but part of a person's, a family's or a community's identity, resulting from social, personal, cultural and experiential factors (MacKian, 2003). Seeking behaviour for a health problem can be planned or a focussed behaviour relating to an interaction with a health care practitioner (Moodley, 2013). Health seeking comprises multiple steps and can rarely be explained by a single model of health seeking behaviour (MacKian, 2003). It can infer seeking health options in the absence of an actual health problem, such as health promotion involving lifestyle changes in preventing diseases (Moodley, 2013). Health seeking can occur in a healthy state and does not always need an external source for help. A health problem firstly needs to be recognised and sometimes self-help or alternative assistance sought out prior to formal health care. An essential step to health seeking behaviour is the planned action of actually selecting the source of help (Moodley, 2013).

Most studies into health-seeking behaviour in South Africa have focussed on gender differences in health seeking behaviour. In their study of masculinity and health seeking behaviours in South Africa, Letsela and Ratele (2009) found that some men do seek health-related help by going for health check-ups while the majority of men are still reluctant except in extreme cases or of chronic illness About 60% (63%) of men never go for health care check-ups, while 37% indicated that they do not (Letsela and Ratele, 2009). Leichliter, (2011) found that public health services do not reflect and respond to men's needs, hence inability to encourage men to access health care services and receive appropriate treatment (Leichliter, 2011). In KwaZulu-Natal, Moodley (2013) found that disclosure and stigma around partners and the fear of abandonment and isolation from friends and family was also an issue among men. A study done between men and women in South Africa indicated that men are significantly less likely than women to use voluntary counselling and testing (VCT) services and account for only 21% of all clients receiving VCT (Peacock, 2008). Results of a study done among TB patients revealed that delay to seek formal health care in designated health facilities is due to fear of stigma that is associated with TB. When the patients realised that they were sick, 81,4% of them sought informal remedies from private practitioners or self-medicated, 50,9% bought drugs, 24,6% visited a private doctor, 3,4% bought herbal medicine, while 1,5% visited a witchdoctor, and 59 visited a government health facility, 0,6% did nothing. (Mutinda, Kabiru and Mwaniki, 2014).

A study done in Mpumalanga on young STI patients (16–23 years) showed that 99% of participants sought help for their symptoms, mostly within one week. This may be due to the easy and equitable accessibility to primary healthcare facilities. The majority of 97,9% did not use self-treatment. About half (54,2%) of the participants talked to someone about their problem. The study further indicated that influence of family, friends and partners were important factors that motivated the health-seeking behaviour of respondents (Govender and Eche, 2012).

In Nigeria a study on health-seeking behaviour and student perception of health care services showed that self-treatment was the most common form of care by respondents. The first choice of care in ill health was self-medication with medicines purchased over the counter or obtained through friends or neighbours, followed by visits to the health centre, patent medicine dealers, the community pharmacy, consultation with students in health related academic programmes and use of herbal remedies (Afolabi et al, 2013).

Worldwide, 1.3 million young people die from preventable or treatable causes in 2012 (World Health Organization, 2014). The leading causes of death are road traffic injuries, with some 330 adolescents dying every day, this is followed by deaths due to transport and other accidents for both sexes, then assault for males and neoplasms for female (Wasserman, 2005). Suicidal behaviour is also a major health concern in developed and developing countries (World Health Organization, 2014). About a million people are estimated to die annually from suicide worldwide (World Health Organization, 2014). It is one of the leading causes of death among young persons of both sexes (Wasserman, 2005). Other main causes of death among the adolescent include HIV, suicide, lower respiratory infections and interpersonal violence (World Health Organization, 2014).

The main cause of death among the youth in Africa is HIV and AIDS (53%), followed by maternal conditions (16,7%), tuberculosis (4,5%), sexually transmitted diseases excluding HIV/AIDS (1,7%), and malaria (1,5%) (United Nations, 2011). Yet, research shows low levels of HIV testing among youth, particularly among males (Kabiru, 2013). Acquired immunodeficiency syndrome (AIDS) is the predominant cause of death among the youth, but maternal mortality is still a major risk of death for the youth in some countries in the sub-Saharan region (Sommer, 2011).

The mortality and causes of death report indicated that the death rate due to HIV/AIDS among 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, 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 race against time' epidemiologic transition noted by (Leeder *et al*. 2004) where cardiovascular diseases would affect younger adults in developing countries relative to their developed countries counterparts.

The Government of South Africa has made efforts towards improving access to health care for all and reducing inequity in access to health care. The assessment of the health status of individuals would require a medical examination. In the absence of this examination, perceived health status provides a good indication of health status. Perceived health status is based on how respondents described the health status of household members in terms of five categories: excellent, good, average, poor and very poor (Statistics South Africa, 2004).

Improvement in the health of the youth is prioritised in the context of multi-sectoral approach at all levels of the governance structure. The burden of disease among South African youth has taken a particular character, 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 wellbeing (The Presidency, 2009). In South Africa, the youth is defined as people aged between 14 and 35 years (The Presidency, 1996). In view of the fact that there are altering definitions of the youth across countries, this report will mainly focus on the South African definition "persons between 15 and 34 years of age". It is a definition that embraces varied categories of the youth, which have been exposed to different socio-political and historical experiences (The Presidency, 1996).

It is on this basis that Statistics South Africa prepared this report as it is imperative for government policy makers and those working with youth programmes to be guided by accurate information regarding the population size and distribution of the youth and their health status.

1.2. Purpose of the report

The report is part of a series of thematic health reports produced by Statistics South Africa (Stats SA) using health information available from Stats SA's household surveys, administrative data and other Stats SA publications. This report is undertaken so that the youth's health needs are well documented in order to inform youth health programmes for future policy making.

1.3. Objectives of the report

The report is aimed at achieving the following objectives:

- To assess the health-seeking practices and medical aid coverage among the youth;
- To present information on the health status and consultation with a health worker; and
- To outline levels of morbidity for selected health conditions, mortality and causes of death among the youth.

1.4. Outline of the report

The report is divided into five chapters. The first chapter presents the introduction, purpose and objectives of the report. Data sources and methods used to analyse the data are outlined in the second chapter. The third chapter provides the youth's perceived health status and their health-seeking behaviour, which includes medical aid coverage and health worker consultation. The fourth chapter highlights illnesses reported a month before the survey, while mortality and causes of death is outlined in the fifth chapter.

2. Data and methods

This chapter presents information on sources of data and methods used in this report. It further highlights methods used in the analysis of data for both sources. Issues of data quality regarding information analysed in this report are also covered in this chapter.

2.1. Data sources

This report is based on data from two sources: the 2013 GHS that was conducted by Stats SA between January and December 2013; and the Mortality and causes of death 2013 data set.

2.1.1. General Household Survey

The primary purpose of the GHS is for the South African Government to measure service delivery, demand for service as well as the improvement in the living conditions of individuals and households.

The survey collected data on a wide range of areas, namely health and social development, housing, education, household access to services and facilities, food security, and agriculture. The health module attached to this survey collected information covering health worker consultation, medical aid coverage, injuries, access to health facilities, utilisation of health facilities and satisfaction with health services; communicable diseases suffered in the month before the survey; and non-communicable diseases as diagnosed by a health worker. Communicable diseases included flu or acute respiratory tract infections, diarrhoea, TB or severe cough with blood, sexually transmitted diseases, HIV and AIDS. Information for the following non-communicable diseases was also collected: asthma, diabetes, cancer, hypertension and arthritis. Other health conditions on which information was collected were depression or mental illness, motor vehicle accident injuries and severe trauma due to violence, assault and beating.

There were 19 368 523 (36,6%) individuals falling within the age group 15–34 years in 2013; of these 9 760 706 were male and 9 607 817 were female. Almost 10% of those in this age range were in the age group 15–19 and 9,5% were aged 20–24 while 9,0% and 8,3% were aged 25–29 and 30–34 years respectively. Black African youth constituted about 38% of those in this age group and the white population had the least proportion in this group with 26,2% aged 15–34. Limpopo had the highest proportion of the youth in South Africa in 2013 (39,0%), followed by Mpumalanga (38,2%), Eastern Cape and Free State (both at 37,3%). Western Cape had relatively fewer youth (34,0%).

The first part of this report is based on responses to health-related questions that were provided by those in the age group 15–35 years. Respondents were asked a number of questions including whether they were ill a month before the survey and if ill, to specify the illness. Overall, a total of 1 035 459 youth indicated that they suffered an illness a month before the survey, representing 5,3% of the total youth population. Those that indicated sickness in the period specified were further asked whether they consulted and those that did not consult were asked to indicate the reason for not consulting. The analysis will also look at medical aid coverage among the youth and profile those without coverage.

2.1.2. Mortality and causes of death data

The last part of this report is based on data from death notification forms used to register deaths in South Africa at the Department of Home Affairs (DHA). The information in this report is based on all deaths that occurred in 2013, and were processed and published by Stats SA in 2014. 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 Stats SA 2013 (Stats SA Report P0309.3, 2013).

A total of 458 933 deaths that occurred in 2013 were registered at DHA and reached Stats SA in time for the 2014 reporting period. Of these deaths, 77 822 deaths occurred among the youth. This report will cover patterns and death trends and also causes of death among the youth in 2013.

2.2. Data quality

The General Household Survey collects information from respondents through face to face interviews. Data quality for variables used in this survey was measured by the response rate for each question. The response rate for variables used in the preparation of this report are shown in Table 2.1; this shows that for all variables relevant for this report the response rate was above 99%.

Table 2.1: Response rate per variable from the final 2013 GHS data set

Label	Percentages
Health status	99,7
Consult a health worker as a result of illness	99,7
Suffer from any illness	99,9
Reason for not consulting a health worker	99,6
Medical aid scheme	99,8

The quality of mortality and causes of death data can be affected by the completeness of death registration in a country; the timeliness of registering the death; the timeliness of publishing the statistics on deaths; accuracy of information provided; ill-defined causes of death; and misreporting of causes of death (Stats SA, 2014). Less than 1% of data on age and sex of the deceased in the 2013 deaths registered at DHA and processed by Stats SA, had unknown or unspecified information. Data on causes of deaths on the other hand usually have a sizeable number of ill-defined cause. Ill-defined cause indicates diagnoses that is vague, non-specific and not detailed enough for disease control and prevention programmes (Stats SA, 2014).

Table 2.2: Response rate per variable from the 2013 Mortality and causes of death data set

Label	Percentage
Sex	99,5
Population group	86,9
Residential province	98,7
Underlying broad group	100,0

3. Distribution of the youth and health-seeking practices

3.1. Introduction

This section presents information on healthcare-seeking practices and perceived health status of the youth. Information is based on responses provided by the youth with regard to consultation for those that were ill a month before the survey, reasons provided for not consulting a health care worker, how they perceive their health in general and if they have access to medical aid. Perceived health is subjective and depends entirely on the respondents, therefore results need to be interpreted with caution.

3.2. Health-care-seeking practices

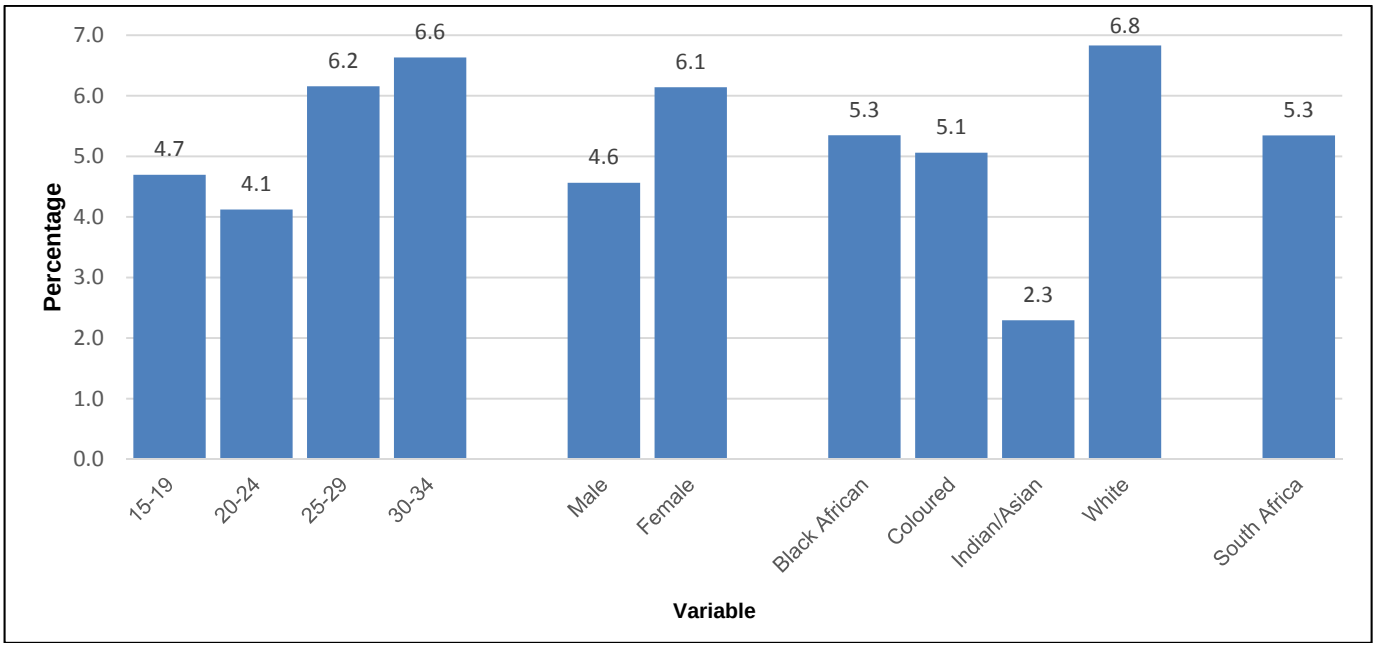
Information on health-seeking behaviour and health care utilisation has important policy implications in health system development (Afolabi et al 2013). Health-seeking behaviour is influenced by a group of factors that can be classified according to cultural and socio-demographic influences, economic conditions, physical and financial accessibility, healthcare services and the degree of women's autonomy (Govender et al 2012).

3.2.1. Self-reported illnesses

What people do when they have symptoms of illness has major implications for morbidity and progression of the illness and consequences for creating a healthy community (Afolabi *et al,* 2013). Information on the types of illnesses suffered by the youth a month before the survey is presented in this chapter. The denominator of the analyses undertaken in this chapter is the total number of the youth who were ill with specific illnesses. As indicated in previous chapters, a total of 1 035 459 youth reported being ill a month before the survey. Among those who were ill, 63,9% consulted a health care worker while 30,3% did not consult. About 5,8% of those that reported illness did not specify whether or not they consulted a health worker.

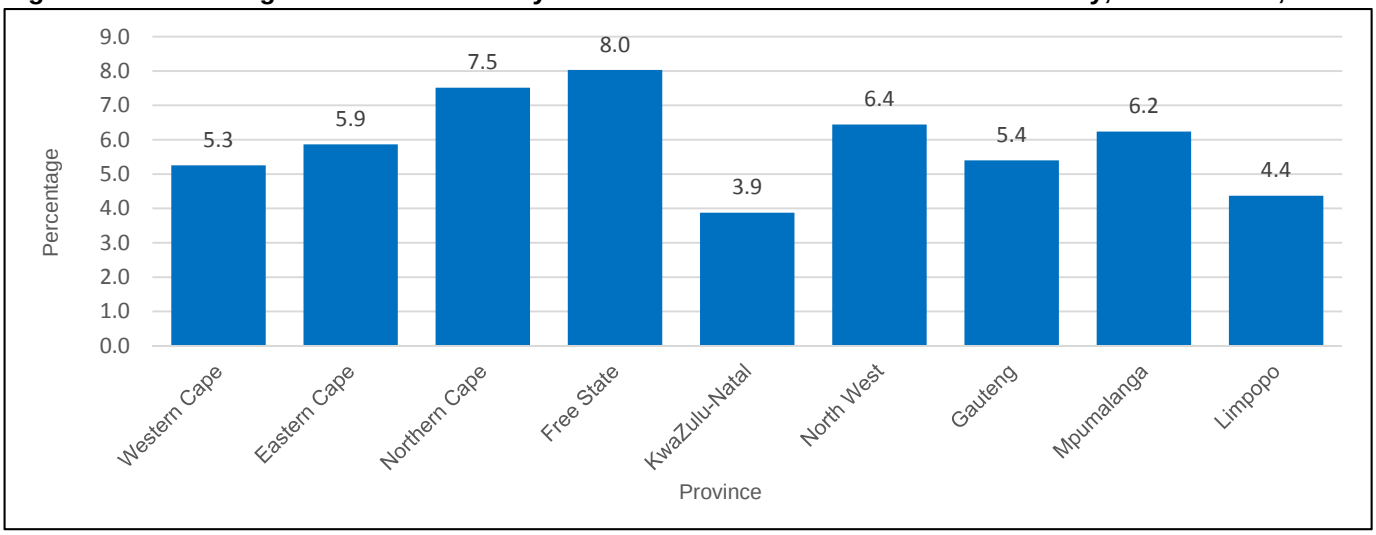
Figure 3.1 shows the percentage of youth that were ill a month before the survey, by age, sex and population group. The age groups 30–34 and 25-29 years had the highest proportion reporting illness a month prior to the survey, at 6,6% and 6,2% respectively. More females (6,1%) than males (4,6%) were ill a month before the survey. Almost seven percent of white youth reported illness a month before the survey, while those from the Indian/Asian population group had the lowest proportion ill (2,3%).

Figure 3.1: Percentage distribution of the youth who were ill a month before the survey, South Africa, 2013



The provincial distribution of reported illness is shown in Figure 3.2. The distribution was derived from the denominator of the total youth population who were ill a month before the survey. The percentage reporting illness a month before the survey was below 10% across all Free State followed by Northern Cape had the highest proportion of those who were ill a month before the survey. The lowest percentage of the youth who were ill a month before the survey was recorded in KwaZulu-Natal (3,9%).

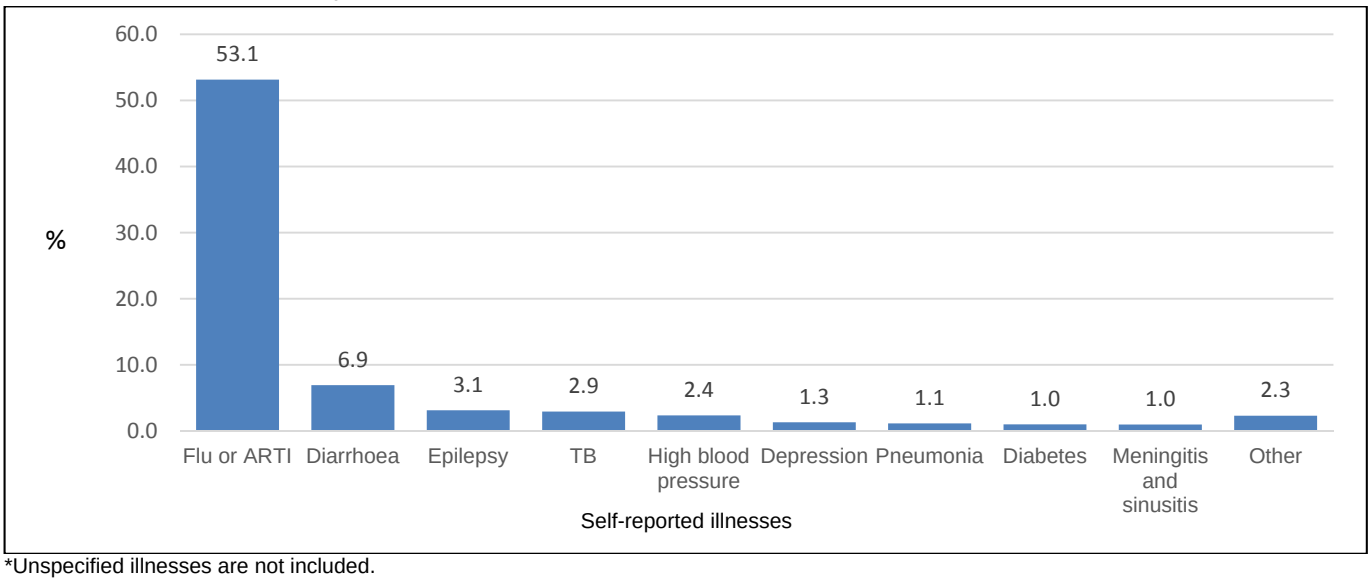
Figure 3.2: Percentage distribution of the youth who were ill a month before the survey, South Africa, 2013



Those that indicated illness in the month prior to the survey were further asked to indicate which illness they suffered. Figure 3.3 presents the percentage distribution of those who said they suffered a specific illness. Figures were arranged from the most frequently reported illnesses to the least reported illnesses.

Flu or acute respiratory tract infection (ARTI) was the most commonly reported illness suffered by the youth a month before the survey. Above half of those that reported illness were affected by *flu or acute respiratory tract infection*, followed by *diarrhoea* which affected 6,9% of the youth. Other illnesses were *epilepsy* (3,1%), *tuberculosis* (2,9%) and *high blood pressure* (2,4%). Illnesses less than 1% were categorised as “other” and they included sexually transmitted diseases, abuse of alcohol or drugs, bronchitis, osteoporosis, cholesterol and cancer. Further analyses will only focus the first five illnesses, namely: flu or acute respiratory tract infections (ARTI), diarrhoea, epilepsy, Tuberculosis (TB) and high blood pressure due to limited numbers of other illnesses.

Figure 3.3: Percentage distribution of the youth by type of illness suffered a month before the survey, South Africa, 2013

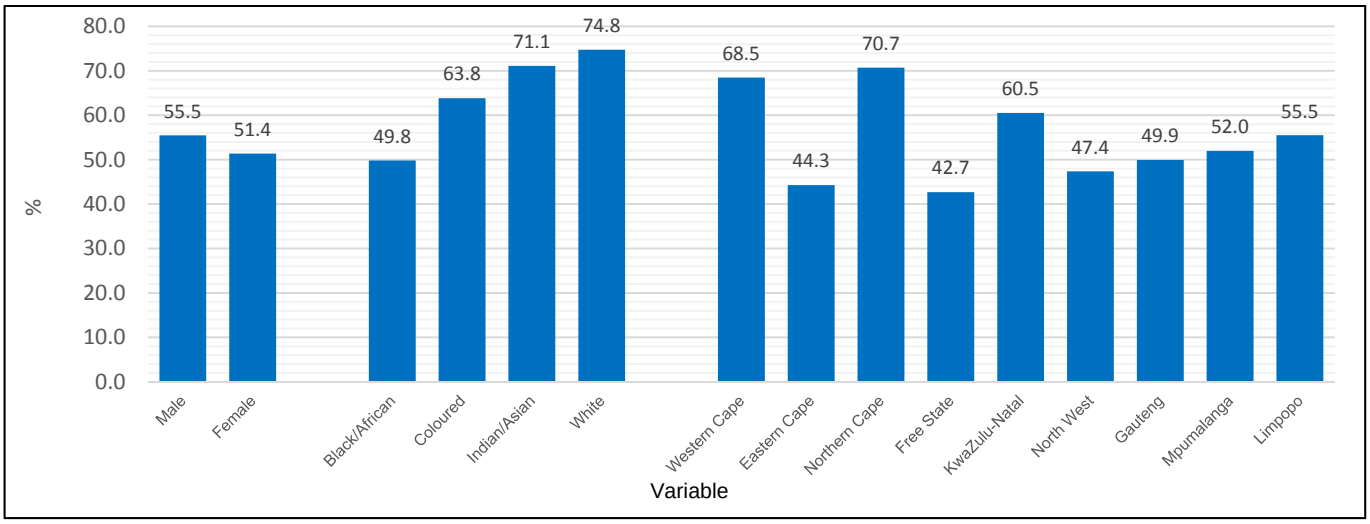


*Unspecified illnesses are not included.
*Other include abuse of alcohols or drugs, STD, bronchitis, cholesterol, cancer and osteoporosis.

3.2.2. Flu or acute respiratory tract infection

Figure 3.4 presents the distribution of the youth who suffered from *flu or acute respiratory tract infection (ARTI)* a month before the survey. More males suffered from *flu or ARTI* a month before the survey than females. Population group distribution indicate that whites followed by Indians/Asians had higher proportions of the youth who suffered from *flu or ARTI*. The black African population group (49,8%) had the least proportion of the youth who suffered from *flu or ARTI* a month before the survey. Provincially, Northern Cape (70,7%) and Western Cape (68,5%) had higher proportions of the youth who suffered from *flu or ARTI* a month before the survey. Eastern Cape (44,3%) and Free State (42,7%) had the lowest proportion of those who suffered from *flu or ARTI* a month before the survey.

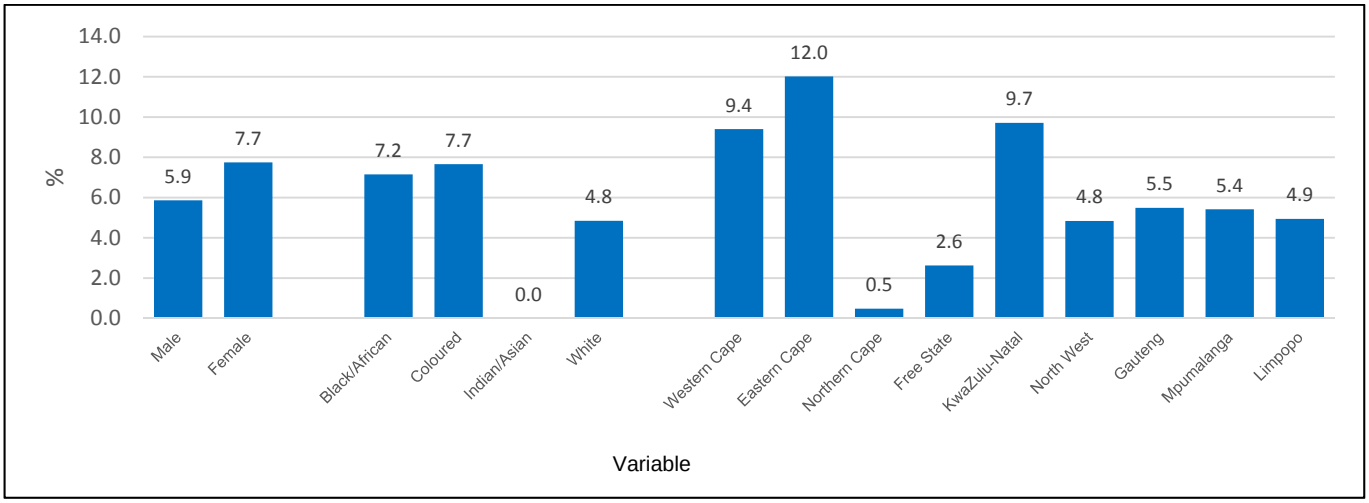
Figure 3.4: Percentage distribution of the youth who were ill a month before the survey and suffered from flu or ARTI, South Africa, 2013



3.2.3. Diarrhoea

Differences in the proportions of the youth who suffered from *diarrhoea* a month before the survey by sex, population group and province of usual residence are shown in Figure 3.5. More females (7,7%) suffered from *diarrhoea* than males (5,9%). The coloured population group had a higher proportion followed by the black African population group. Provincial distribution shows that those residing in Eastern Cape (12,0%), KwaZulu-Natal (9,7%) and Western Cape (9,4%) had a higher proportion of the youth that reported having suffered from *diarrhoea* respectively, while those in Northern Cape reported the lowest.

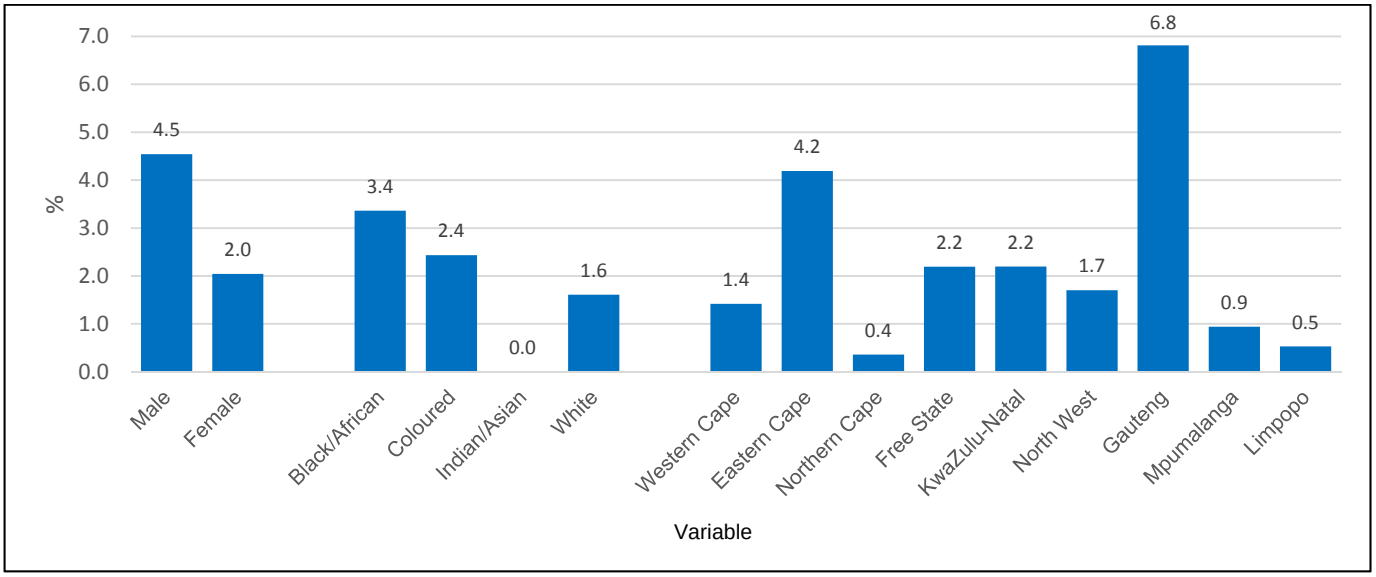
Figure 3.5: Percentage distribution of the youth who were ill a month before the survey and suffered from diarrhoea, South Africa, 2013



3.2.4. Epilepsy

Relatively more males than females suffered from *epilepsy* a month before the survey. Differences were also observed by population group where the black African population group recorded a higher proportion (3,4%). Provincial distribution show that the youth residing in Gauteng (6,8%) had a higher proportion, while less than one percent of those in Northern Cape and Limpopo reported suffering from epilepsy.

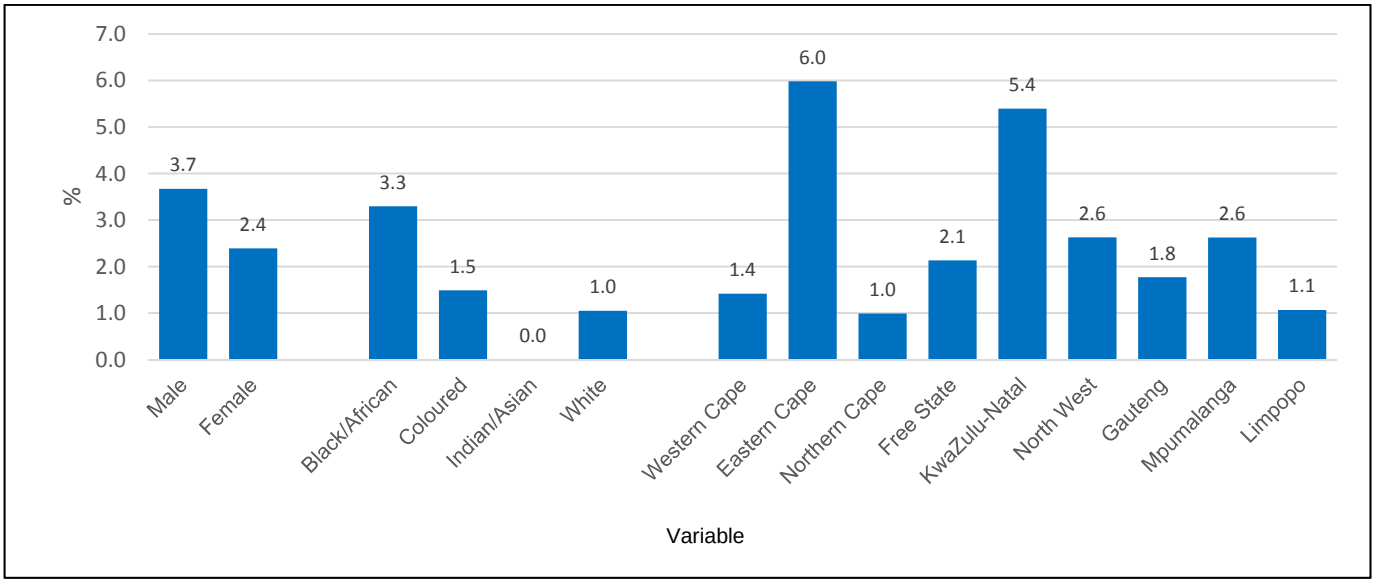
Figure 3.6: Percentage distribution of the youth who were ill a month before the survey and suffered from epilepsy, South Africa, 2013



3.2.5. Tuberculosis

Figure 3.7 presents the distribution of the youth who were ill a month before the survey and suffered from *tuberculosis*. Relatively more males than females suffered from *tuberculosis* a month before the survey. The black African population group recorded a higher proportion while the white population group had the lowest (1,0%). The youth residing in Eastern Cape suffered from *tuberculosis* more than the youth in other provinces, while those in Limpopo (1,1%) and Northern Cape (1,0%).

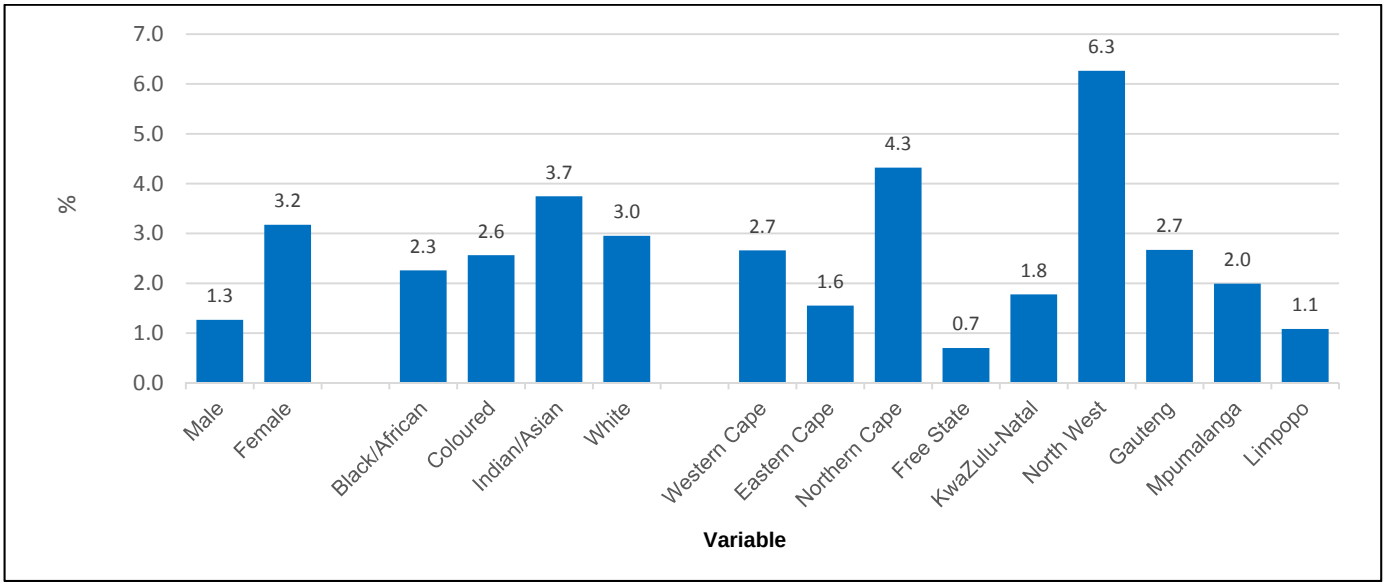
Figure 3.7: Percentage distribution of the youth who were ill a month before the survey and suffered from tuberculosis, South Africa, 2013



3.2.6. High blood pressure

Three times more females reported suffering from *high blood pressure* a month before the survey than males (see Figure 3.8). Indian/Asian population group (3,7%) had higher proportions of those who were ill a month before the survey and suffered from *high blood pressure* compared to other population groups. *High blood pressure* was less commonly reported by the youth in Limpopo and Free State but more commonly seen in North West (6,3%).

Figure 3.8: Percentage distribution of the youth who were ill a month before the survey and suffered from high blood pressure, South Africa, 2013

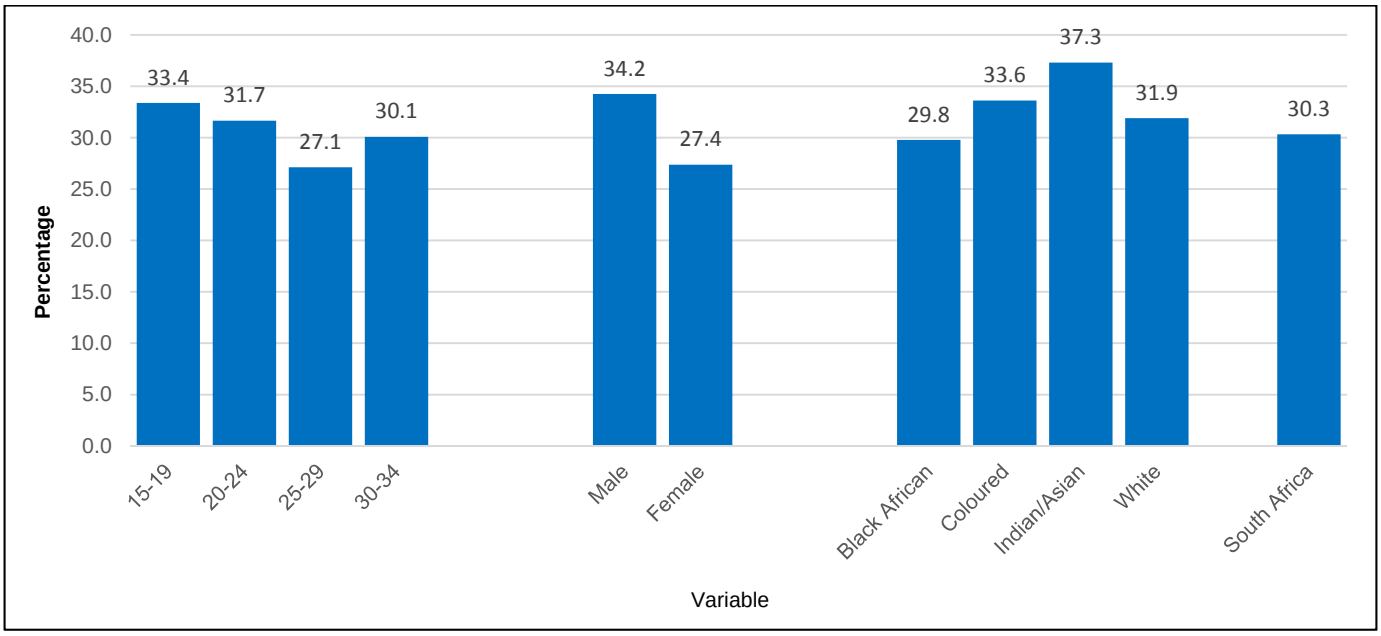


3.2.7. Consultation with a health care worker

Respondents who indicated that they suffered from an illness were asked if they consulted a health worker such as a nurse, doctor or traditional healer as a result of the illness. If not, they were asked to indicate the main reasons for not consulting a health worker. Results were calculated from the youth who did not consult a health worker by the total of the youth who were ill a month before the survey. The main reasons were calculated from the youth that did not consult a health worker.

This section will present information only on the youth who did not consult a health care worker when ill. Information in this section is presented by age group, sex and population group and shown in Figure 3.9. Overall 30% of young people indicated that they did not consult when they were ill during the month before the survey; of these the highest percentage (33,4%) was in the 15–19 age group, with the lowest percentage in the 25–29 age group. More males (34,2%) than females (27,4%) reported being ill and did not consult a health worker. Across the four population groups over a third of young people did not consult a health care worker.

Figure 3.9: Percentage distribution of the youth who did not consult a health care worker when ill, South Africa, 2013

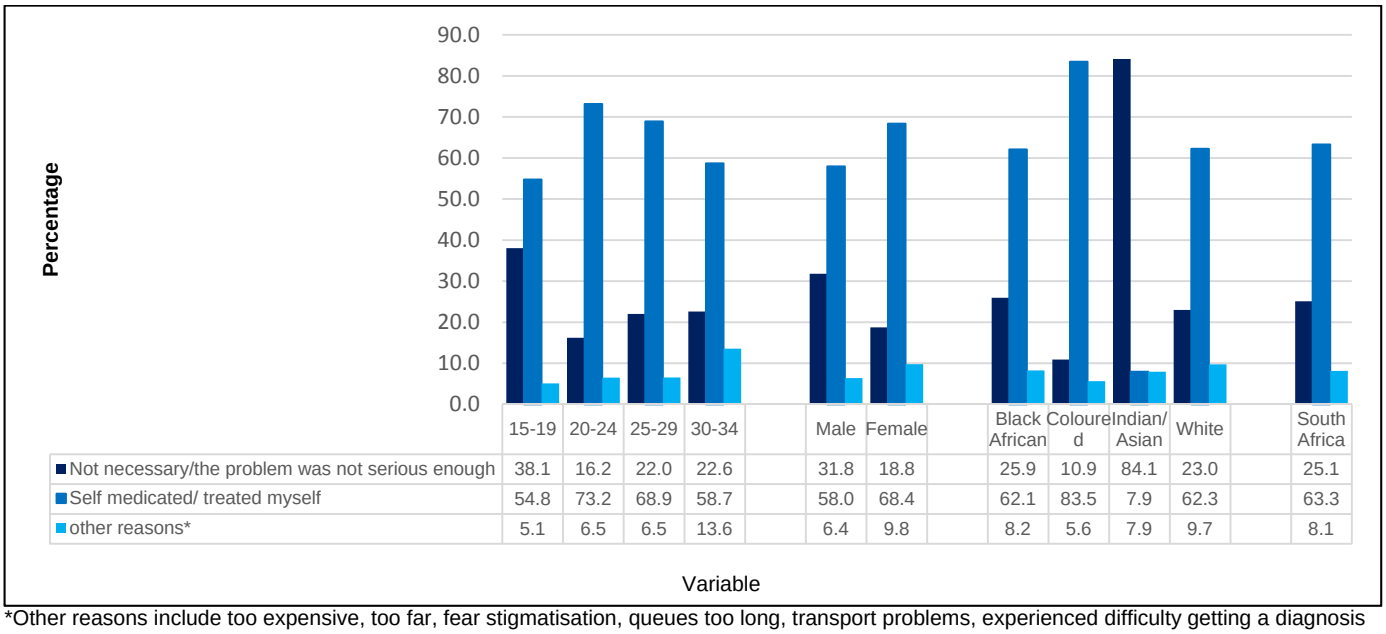


Reasons for not consulting health care worker

Respondents who did not consult a health care worker were further asked to provide reasons for not consulting. Self-medication and the seriousness of the illness constituted over 80 per cent of reasons given by respondents. Figure 3.10 shows the results of the analysis. Of the total of 314 028 (30,3%) that did not consult a health care worker, 63,3% indicated that they self-medicated, with only one third indicating that it was not necessary/serious enough to warrant consultation. Among those who used self-medication, 73,2% were in the age group 20–24, mainly male (58,0%) and the Coloured population group (83,5%). The highest proportion for the youth who thought it was not necessary was in the 15–19 age groups (about 38,1%); males (31,8%) had a higher percentage in this group. Among population groups, Indians/Asians had the highest proportion that indicated that the illness was not serious enough to warrant consultation, while Coloureds had the highest percentage of those that self-medicated.

Some of the reasons were significantly low; they were combined and classified as other reasons. They include too expensive, too far, fear stigmatisation, queues too long, transport problems, experienced difficulty getting a diagnosis before and other.

Figure 3.10: Percentage distribution of the youth who were ill a month before the survey and did not consult a health care worker classified by age group, sex, population group, South Africa, 2013



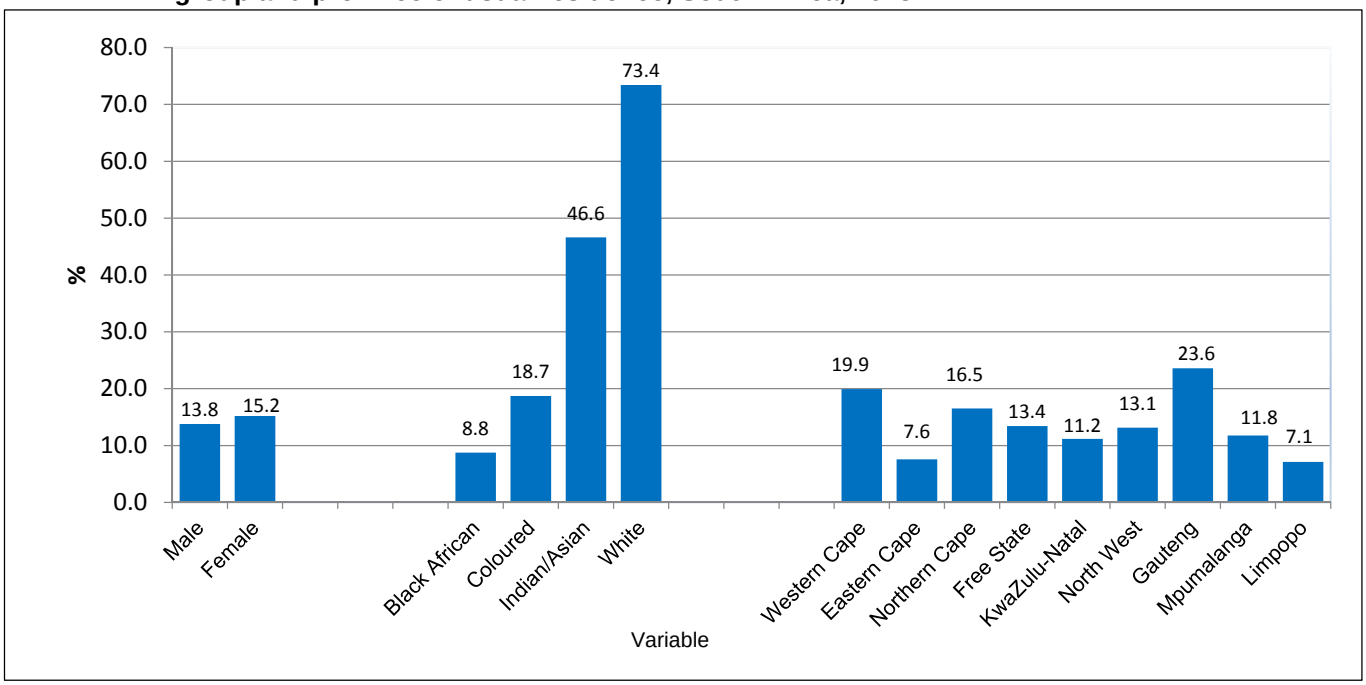
	15-19	20-24	25-29	30-34	Male	Female	Black African	Coloured	Indian/ Asian	White	South Africa
Not necessary/the problem was not serious enough	38.1	16.2	22.0	22.6	31.8	18.8	25.9	10.9	84.1	23.0	25.1
Self medicated/ treated myself	54.8	73.2	68.9	58.7	58.0	68.4	62.1	83.5	7.9	62.3	63.3
other reasons*	5.1	6.5	6.5	13.6	6.4	9.8	8.2	5.6	7.9	9.7	8.1

*Other reasons include too expensive, too far, fear stigmatisation, queues too long, transport problems, experienced difficulty getting a diagnosis before and other.

3.2.8. Medical aid coverage

In general, the percentage of the youth covered by medical aid in the country was less than 15%, with slightly more females (15,2%) than males (13,8%) covered by medical aid. A relatively higher proportion of the youth from the white population group (73,4%) were covered by medical aid while 46,6% of the Indian/Asian population group, 18,7% of the coloured population group and only 8,8% of the black African population were covered. A much higher proportion of the youth from Gauteng (23,6%) and Western Cape (19,9%) was covered by medical aid (see Figure 3.11). The lowest proportions of the youth covered by medical aid were residing in Eastern Cape (7,6%) and Limpopo (7,1%), the only provinces with figures below 10%. The medical aid coverage pattern seen among the youth is similar to the pattern seen for the general population (Stats SA, 2013).

Figure 3.11: Percentage distribution of the youth covered by medical aid classified by sex, population group and province of usual residence, South Africa, 2013



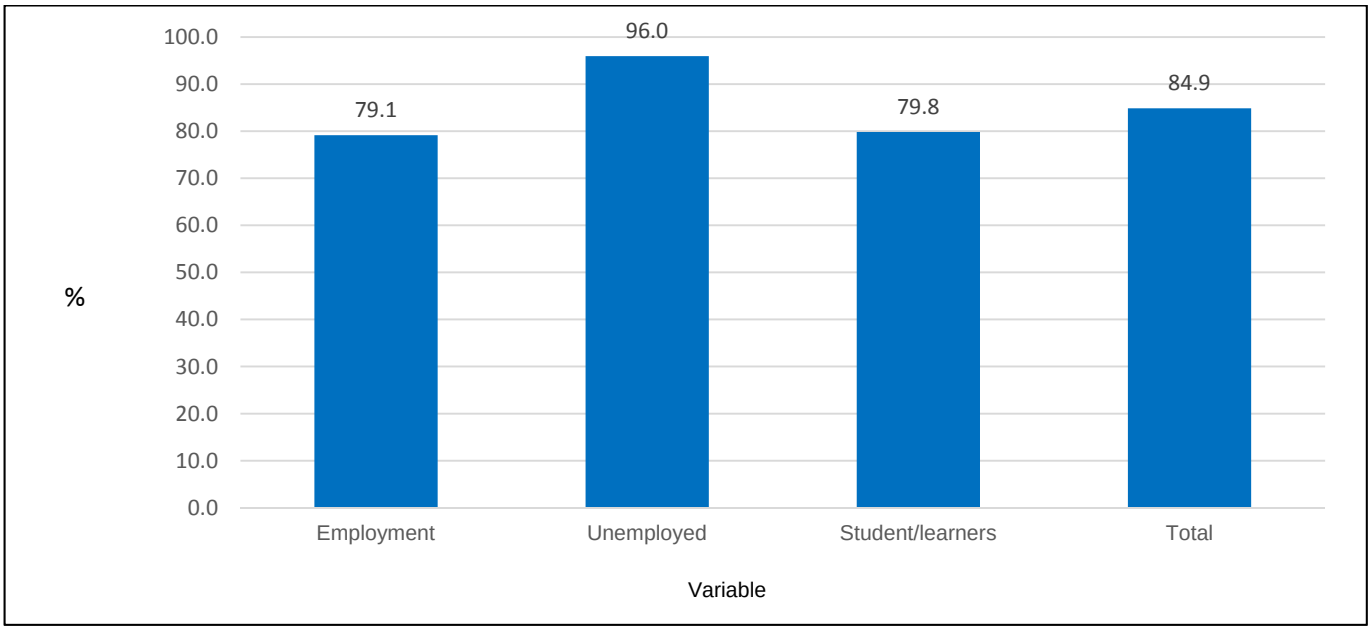
3.2.9. Medical aid coverage by health care worker consultation and economic status

Analysis in this section is based on respondents who were ill a month before the survey, did not consult a health care worker and were not covered by medical aid. This group were further categorised by whether they were employed, unemployed or student/learner. Results presented by age group, sex and population group show that 266 514 (84,9%) of the youth who were ill and did not consult were not covered by medical aid and only 14,9% were covered by medical aid.

The age group 20–24 years (89,7%) had the highest percentage of those who were ill and were not covered by medical aid, while those aged 15–19 years (82,2%) had the lowest percentage. There were slightly more males (85,0%) than females (84,8%) that were ill and were not covered by medical aid. A relatively higher proportion of the youth from the black African population group (91,3%) were not covered by medical aid while 78,4%, 36.8 and 29,8 respectively of the coloured, white and Indian/Asian population groups, were not covered by medical aid.

Respondents who were ill a month before the survey and did not consult a health care worker were further categorised into medical aid coverage and their economic status (student/learner, employed and unemployed). The unemployed category includes the youth that are neither working nor students/scholars. Results in Figure 3.12 show that employed youth and those who were students had the same percentage of those without a medical aid. Those that were neither employed nor in school had the highest percentage not covered by medical aid.

Figure 3.12: Percentage distribution of the youth not covered by medical aid classified by their economic status, South Africa, 2013

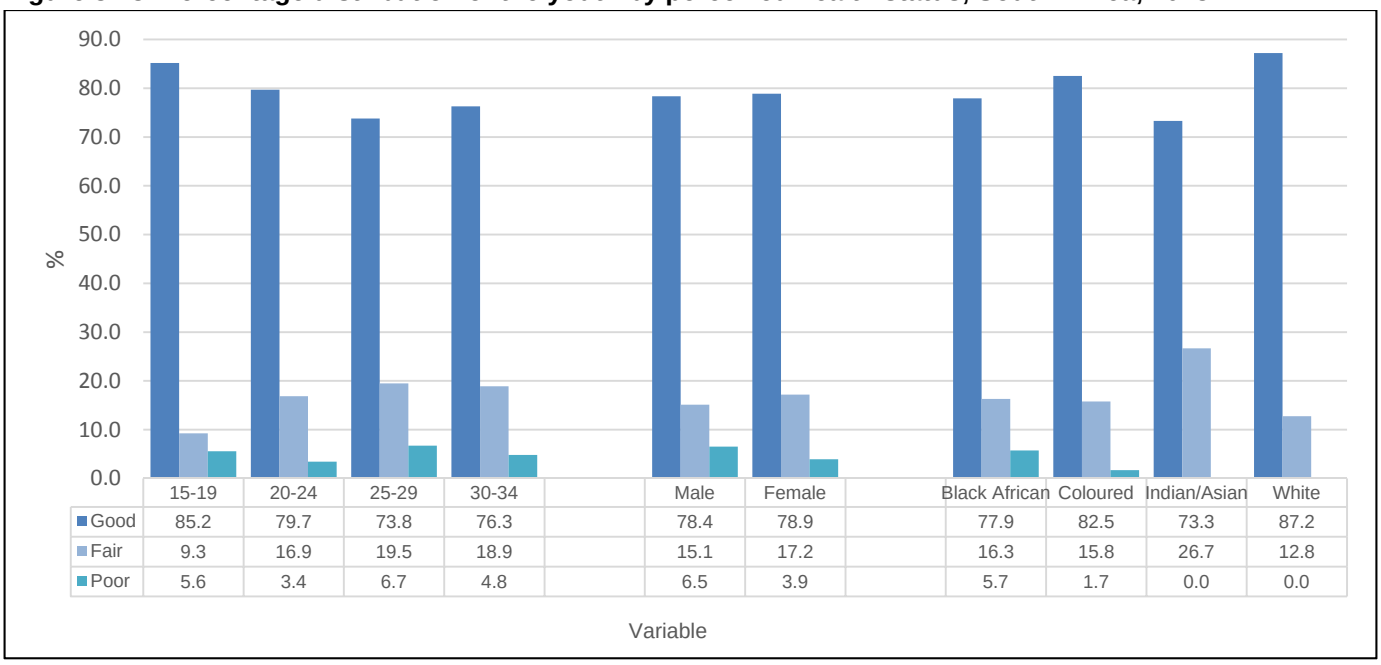


3.2.10. Perceived health by health care worker consultation and medical aid coverage

Those that were ill a month before the survey, did not consult a health care worker and were not covered by medical aid, were further asked how they perceived their own health. Among the four sub-age groups, those aged 15–19 years had the highest percentage that perceived their health as good (85,2%) while those aged 25-29 had the lowest proportions. There was no noticeable difference by sex, however, males had higher proportion perceiving their health as poor than females. Young white people also had the highest percentage that perceived their health as good (87,2%) despite being ill, not consulting a health care worker and not having a medical aid.

Results on perceived health presented in this report are consistent with results the October Household Survey conducted by Statistics South Africa showing that the white population was are more likely to perceived their health status as good than the other population group. Individuals with medical benefits were also perceived their health status as better than of those without access to medical aid.

Figure 3.13: Percentage distribution of the youth by perceived health status, South Africa, 2013



	15-19	20-24	25-29	30-34	Male	Female	Black African	Coloured	Indian/Asian	White
Good	85.2	79.7	73.8	76.3	78.4	78.9	77.9	82.5	73.3	87.2
Fair	9.3	16.9	19.5	18.9	15.1	17.2	16.3	15.8	26.7	12.8
Poor	5.6	3.4	6.7	4.8	6.5	3.9	5.7	1.7	0.0	0.0

3.2.11. Summary

The youth in age group 30–34 had higher percentage reporting illness a month prior to the survey, followed by those in the 25–29 age group. Females, white youth those residing in the Free State and Northern Cape had a higher proportion of those who were ill a month before the survey.

Flu or acute respiratory tract infection (ARTI) was the most common illness reported by those ill a month before the survey, affecting above half of the youth. Male, whites and Indians/Asians had higher proportions suffering from *flu or ARTI*. This was also the case for youths residing Northern Cape and Western Cape. A higher proportion of females than males, coloureds and those residing in Eastern Cape, KwaZulu-Natal and Western Cape suffered from *diarrhoea.*

Overall 30% of the youth did not consult when they were ill during the month before the survey; with the highest percentage in the 15–19 age group, more males who were ill and did not consult a health worker. Of the total youth that did not consult a health care worker, above 60% indicated they used self-medication, the highest percentage was in the age group 20–24, mainly male and the coloured population group.

Less than 15% of the youth were covered by medical aid, with slightly more females than males. The white population group had highest percentage covered by medical aid than other population groups. More youth in Gauteng and Western Cape were covered by medical aid. The youth in the 15–19 age group perceived their health as good among the youth who were ill, did not consult a health care worker and did not have a medical aid. Young white people also perceived their health as good despite being ill, not consulting a health care worker and not having a medical aid.

4. Mortality and causes of death

4.1. Introduction

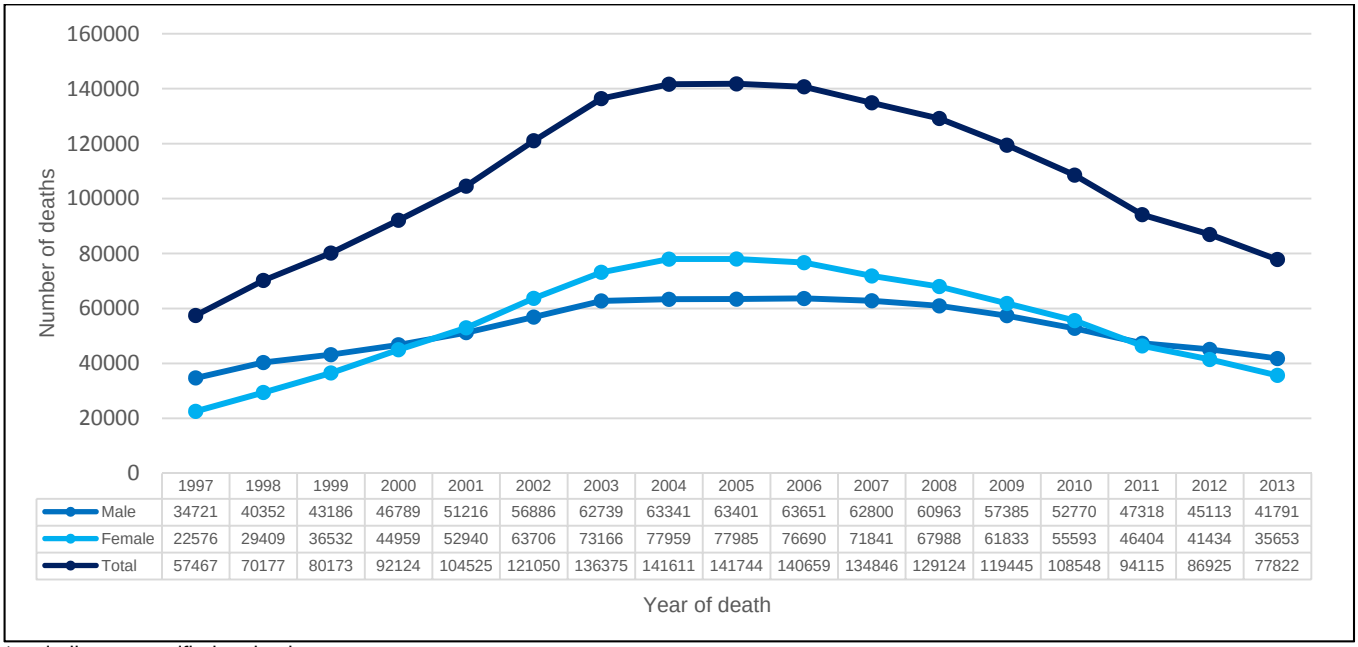
This section covers analysis based on mortality and causes of death data 2013. It looks at patterns and trends of mortality among the youth that died in 2013; analysis of leading causes of death among the youth is also presented. Trends data cover the period 1997 to 2013.

4.2. Mortality

4.2.1. Trends in number of deaths

Figure 4.1 shows trends in the number of deaths among South African youth between 1997 and 2013. The number of deaths among the youth increased consistently from around 57 000 in 1997 and peaked in 2005. After this period there was a consistent decline to 77 822 observed in 2013. The levels observed in 2013 were still higher than those that were seen in 1997 but were almost consistent with those seen in 1999, when 79 718 deaths were registered. Prior to 2001 there were more male than female deaths; when changes in the trends were observed, this trend (where there were more female deaths than male deaths) continued until 2011, when female deaths declined to levels last seen in 2000. However, these levels among the sexes were also still above those observed in 1997. Female deaths contributed the highest to the total deaths during the era of increasing mortality (1997-2005) and the biggest contributor to the decline observed in the period 2006-2013. This pattern was consistent with patterns observed in the general population, and consistent with increasing mortality related to HIV/AIDS in the country.

Figure 4.1: Number of deaths among the youth by sex and year of death, South Africa, 1997–2013*



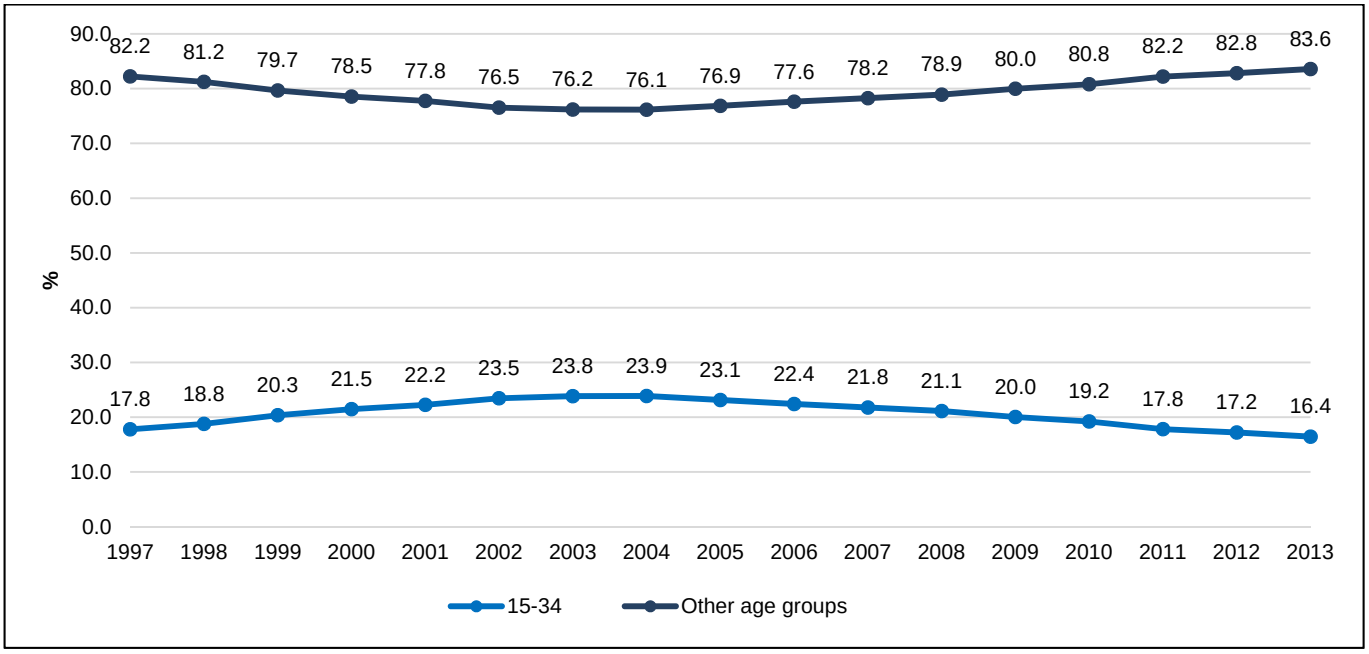
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Male	34721	40352	43186	46789	51216	56886	62739	63341	63401	63651	62800	60963	57385	52770	47318	45113	41791
Female	22576	29409	36532	44959	52940	63706	73166	77959	77985	76690	71841	67988	61833	55593	46404	41434	35653
Total	57467	70177	80173	92124	104525	121050	136375	141611	141744	140659	134846	129124	119445	108548	94115	86925	77822

*excluding unspecified and unknown sex

4.2.2. Contribution of deaths among the youth to the overall mortality

Figure 4.2 presents trends showing the contribution of deaths among the youth and those deaths that occurred in other age groups to the overall deaths. Other age groups include people aged 0–14 years and those aged 35 years and above that died between 1997 and 2013. Deaths among the youth contributed 16,4% of all deaths that occurred in the country in 2013. It is observed that for the period 1997–2004, the proportion of deaths occurring among the youth increased from 18% in 1997 and peaked at 24% in 2004 before declining gradually to current levels. Deaths among the rest of the population also decreased and peaked in 2005, but had started to increase gradually again in direct contrast to youth deaths.

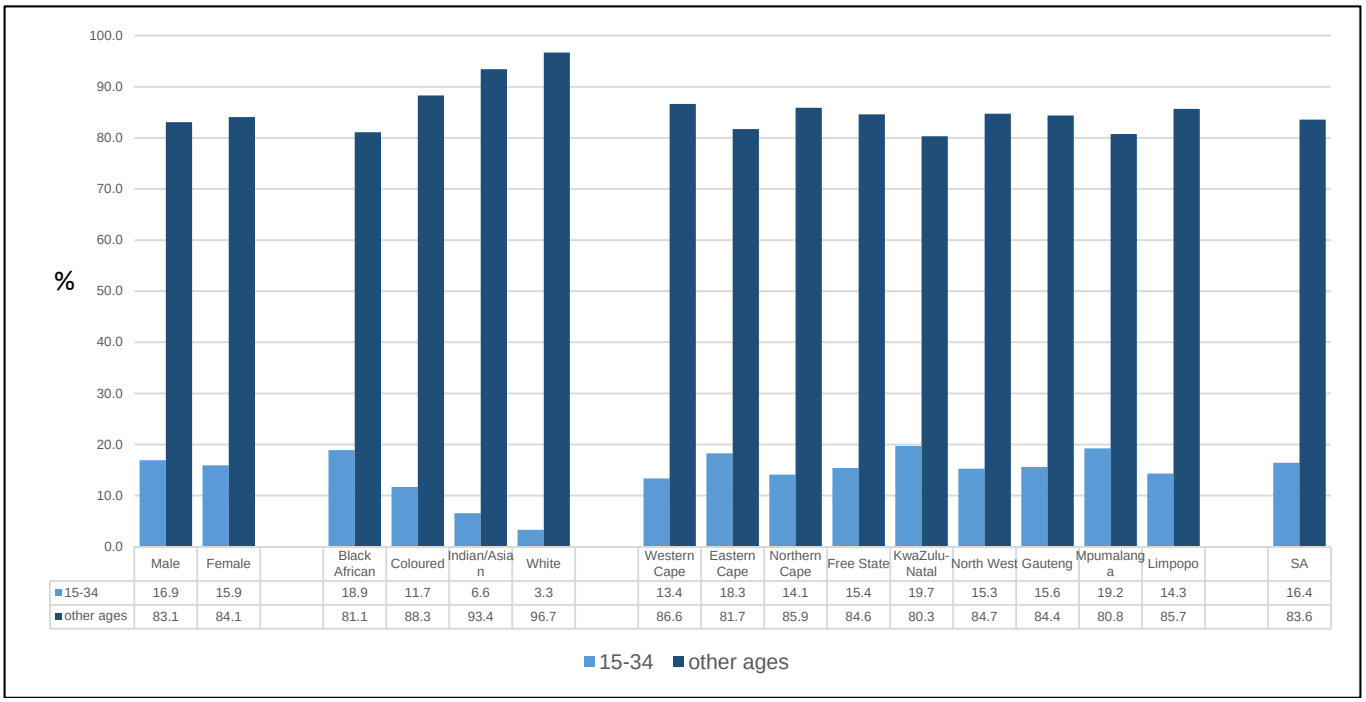
Figure 4.2: Percentage distribution of deaths among the youth by age and year of death, South Africa, 1997–2013



The proportion of deaths occurring among the youth as compared to deaths occurring in other age groups by sex, population group and province of usual residence are presented in Figure 4.3. Young males had a slightly higher mortality than young females (17% and 16% respectively). Youth from the white population group had much fewer deaths than other groups within this population group. Black African and the coloured youth had higher mortality relative to the other two population groups. Black Africans mortality was five times that of the white population group.

Even though the pattern observed provincially was consistent with that observed in the other analysis, we also observed that youths in KZN, Mpumalanga and Eastern Cape had higher mortality relative to other age groups within their respective provinces as compared to youths in other provinces. The opposite was true for youth deaths in Western Cape, Northern Cape and Limpopo.

Figure 4.3: Percentage distribution of deaths among the youth, South Africa, 2013



	Male	Female		Black African	Coloured	Indian/Asian	White		Western Cape	Eastern Cape	Northern Cape	Free State	KwaZulu-Natal	North West	Gauteng	Mpumalanga	Limpopo		SA
15-34	16.9	15.9		18.9	11.7	6.6	3.3		13.4	18.3	14.1	15.4	19.7	15.3	15.6	19.2	14.3		16.4
other ages	83.1	84.1		81.1	88.3	93.4	96.7		86.6	81.7	85.9	84.6	80.3	84.7	84.4	80.8	85.7		83.6

4.3. Causes of death

This subsection presents information on causes of death among youth in South Africa in 2013. Deaths are classified according to natural and non-natural causes of death; deaths due to communicable and non-communicable diseases and their trends; and the ten leading causes of death based on broad groups of causes of death.

Natural causes are deaths that are primarily attributed to an illness or an internal malfunction of the body not directly influenced by external forces (Stats SA, 2014). Non-natural causes on the other hand are those that are not from natural causes, such as deaths from homicide, suicide, workplace accidents, motor vehicle accidents, air accidents, violent deaths, falls, poisoning or overdoses (both intentional and unintentional) and drowning or water deaths (Stats SA, 2014).

Deaths were further categorised into communicable and non-communicable diseases. Communicable diseases are those due to illnesses or infections that can be spread from person to person, animal to person, animal to animal or person to animal. Deaths due to non-communicable diseases, also known as chronic diseases, are those that cannot be passed from person to person, of long duration and generally slow progression (Stats SA, 2014).

4.3.1. Deaths due to natural and non-natural causes

Natural causes were the most common cause of death, contributing 71,9% to the total deaths that occurred among the youth in 2013. Non-natural causes of death were attributable to about 29% of all deaths. Figure 4.4 show natural and non-natural causes of death among the youth by sex and population group. Noticeable differences are observed by sex where, among young males, 43,2% of deaths were due to non-natural causes, compared to 10,4% for females. Young females had a higher proportion dying from natural causes (89,6%) than young males (56,8%). Further analysis done to highlight the leading cause of death among females shows that tuberculosis was the leading cause of death and the percentage was higher than that for males (16,8% and 11,8% respectively).

The white and Indian/Asian youth had higher proportions of deaths due to non-natural causes (57,8% and 54,8% respectively). The leading non-natural cause of death for both the Indian/Asian (33,1%) and white population group (32,5%) was other external causes of accidental injury. The youth from the black African population group (73,4%) had a higher proportion of deaths due to natural causes. This high proportion due to natural cause of death among the black African youth was driven by deaths due to tuberculosis (15,2%).

Figure 4.4: Percentage distribution of deaths among the youth by type of death, South Africa, 2013*

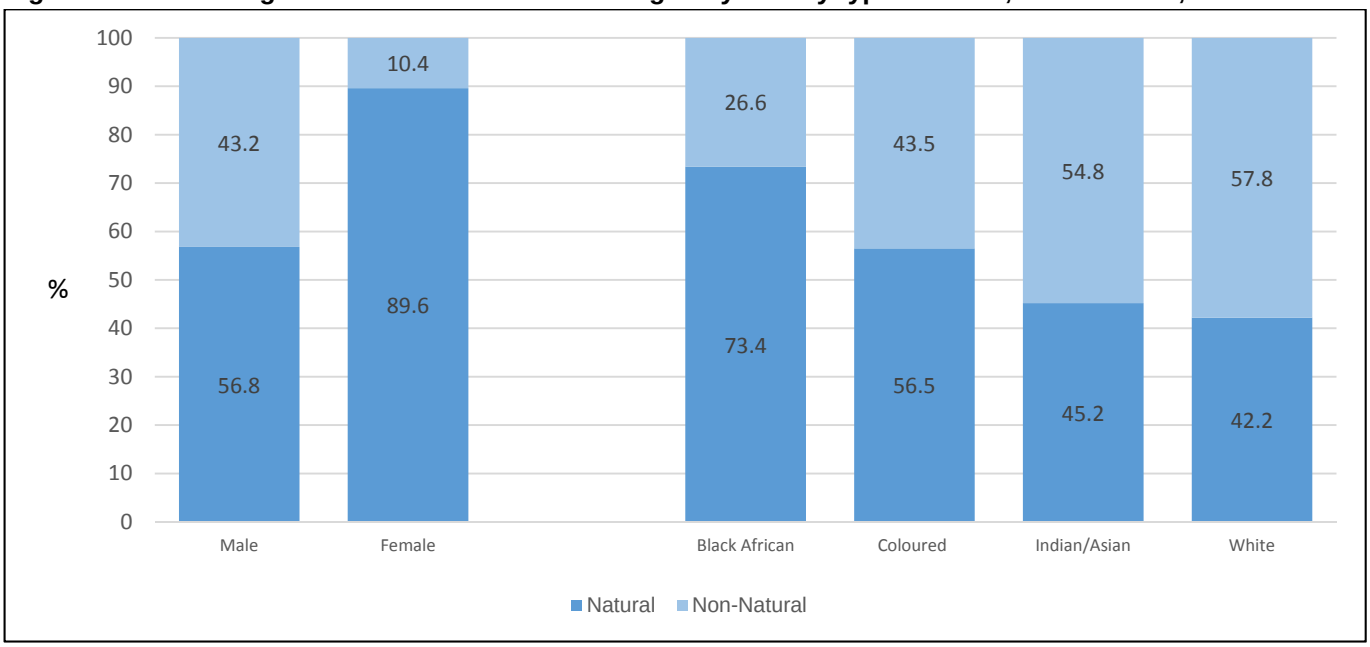
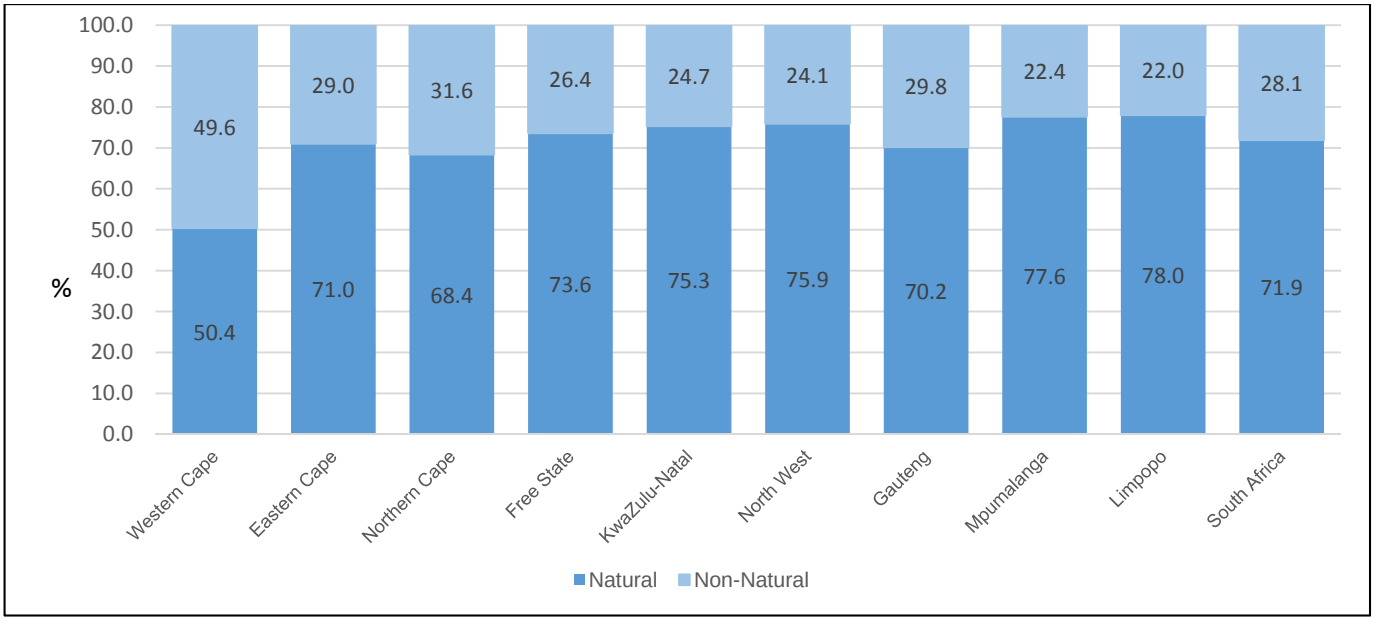


Figure 4.5 shows provincial distribution by natural and non-natural causes of death among the youth. Western Cape had the highest percentage of non-natural deaths. There was almost a 50% spread between natural and non-natural causes of death among the youth in this province and the only one with this pattern (50,4% and 49,6%, respectively). The leading natural cause of death in Western Cape was human immunodeficiency virus (14,6%) while the leading non-natural cause of death was other external causes of accidental injury constituting 25,3% of all non-natural causes of death. Northern Cape had the second highest proportion of deaths due to non-natural causes (32%) while Limpopo had the lowest percentage (22,0%). Deaths due to natural causes were highest in Limpopo followed by Mpumalanga, at 78,0% and 77,6% respectively.

Figure 4.5: Percentage distribution of deaths among the youth by type of death, South Africa, 2013*



4.3.2. Deaths due to communicable and non-communicable diseases

Natural causes were categorised into communicable and non-communicable diseases and are presented in this subsection. Communicable diseases are those diseases that are infectious and include, among others, diseases such as *tuberculosis, intestinal infectious diseases* and *influenza and pneumonia* (Stats SA, 2014). Non-communicable diseases are defined as diseases that are non-infectious, are of long duration and generally slow progression; they include among others, *cerebrovascular diseases, diabetes mellitus* and *ischaemic heart diseases* (Stats SA, 2014). External causes of deaths are deaths due to such causes as *accidents, homicides,* and *assault,* among others.

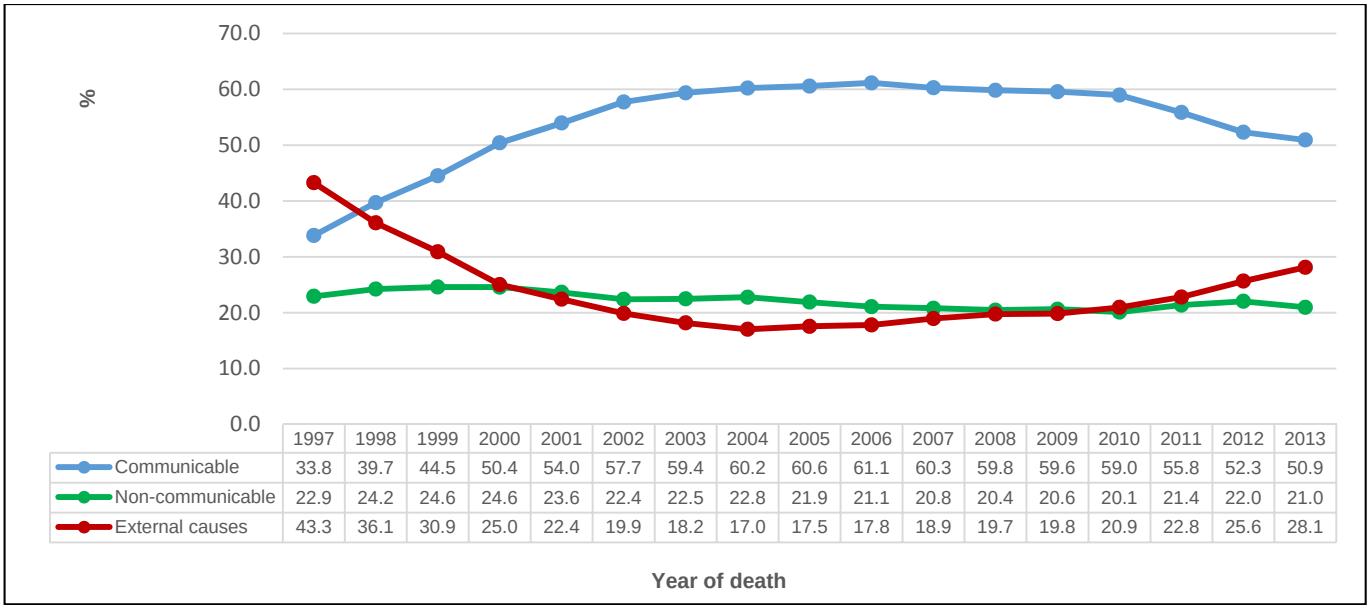
This section presents the general distribution of communicable, non-communicable and external causes of deaths by sex, population group and province of usual residence. It further highlights trends and distribution of deaths from communicable, non-communicable diseases and other external causes of accidental injury between 1997 and 2013.

The majority of deaths (50,9%) among the youth were due to communicable diseases in 2013. Deaths due to communicable diseases were more prevalent among females (64,7%) than males (39,2%), and black African population group (52,9%). Youth from the coloured population group (36,6%) were also more likely to die from communicable diseases than other causes. Deaths due to non-communicable diseases were relatively common among females (24,9%), and the white population group (33,7%). The provincial distribution of deaths due to communicable diseases shows that the highest proportion was among the youth residing in KwaZulu-Natal (58,1%) and the lowest in Western Cape (34,0%). Deaths due to non-communicable diseases were higher in Gauteng (24,9%) and lower in Western Cape (16,4%).

Figure 4.6 presents trends in communicable, non-communicable diseases and other external causes of accidental injury from 1997 to 2013. There are three important periods to be observed from Figure 4.6. The first period is at the beginning of the trend, where deaths due to external causes started to decline to levels below those of communicable diseases, while communicable diseases started to be the most dominant cause of death post-1998, accounting for more than 50% of all deaths between 2000 and 2013. Trends in communicable diseases have started showing a declining trend since 2010.

The second period was the post-2000 period where deaths due to external causes declined to levels lower than those of non-communicable diseases. Declines in external causes occurred consistently until 2004, and then there was a steady increase which can still be observed in 2013. The last period is after 2010 when external causes increased to levels above those of non-communicable diseases and represent a period of increasing mortality from external causes for the youth. Deaths due to non-communicable diseases have not shown any distinct trends over the years, staying around the 20% level throughout the period.

Figure 4.6: Trends in the number of deaths due to communicable, non-communicable and external causes of mortality among the youth, South Africa, 1997-2013*

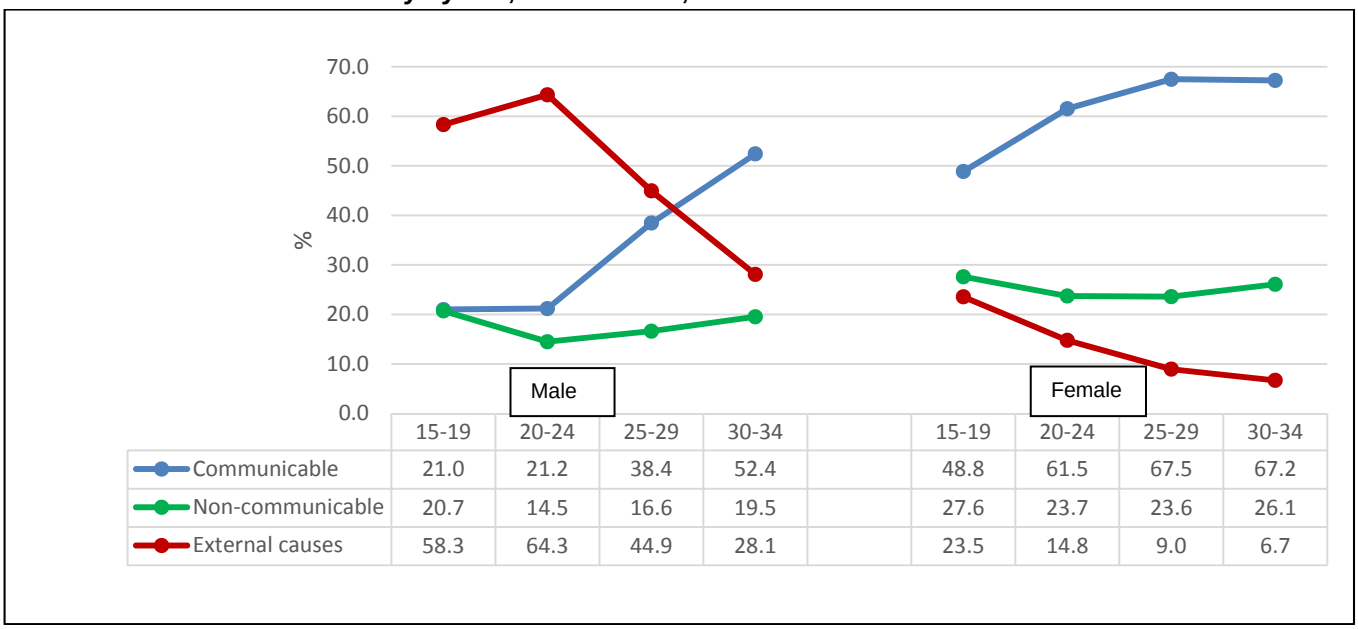


	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Communicable	33.8	39.7	44.5	50.4	54.0	57.7	59.4	60.2	60.6	61.1	60.3	59.8	59.6	59.0	55.8	52.3	50.9
Non-communicable	22.9	24.2	24.6	24.6	23.6	22.4	22.5	22.8	21.9	21.1	20.8	20.4	20.6	20.1	21.4	22.0	21.0
External causes	43.3	36.1	30.9	25.0	22.4	19.9	18.2	17.0	17.5	17.8	18.9	19.7	19.8	20.9	22.8	25.6	28.1

*Redistributed ill-defined diseases R00 - R99 proportionally to causes to communicable and non-communicable diseases.

Information on the distribution of deaths due to communicable, non-communicable diseases and external causes by age groups, sex and population group is presented in Figures 4.7 to 4.9. The general pattern depicted in Figure 4.7 shows that young males aged 15–29 years were more likely to die from external causes, while those above age group 30–34 years were more likely to die from communicable diseases than the other two causes of death. Deaths due to external causes peaked at ages 20–24 and declined rapidly with increasing age for males. For young men in the ages 15–24 years, communicable diseases accounted for just around 20% of all deaths; the proportion dying from communicable diseases increased with increasing age among males. Above half of those that died in the ages 30–34 years died from communicable diseases. Among young females the pattern was different; deaths due to communicable diseases were higher, accounting for more than 40% of all deaths across all age groups. Communicable diseases for females increased with age and peaked at ages 25–29 years before declining at ages 30–34 years. For young females, deaths due to external causes were fewer and tended to start at lower levels and declined with increasing age. Deaths from non-communicable diseases were lower for both males and females but slightly higher for females with levels above 20% observed across all youth sub-age groups. For young males, deaths from non-communicable diseases were lower than those observed for females but increased gradually with increasing age.

Figure 4.7: Percentage distribution of youth deaths due to communicable, non-communicable and external causes of mortality by sex, South Africa, 2013*



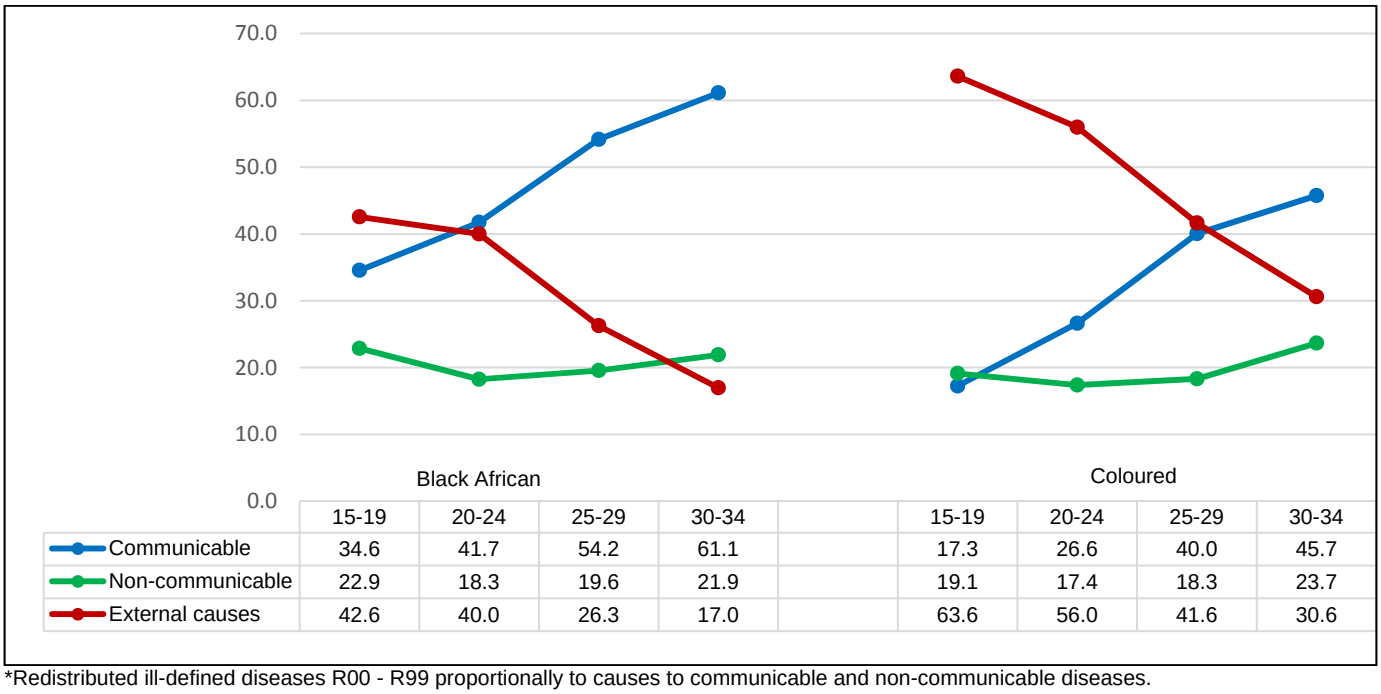
	Male				Female			
	15-19	20-24	25-29	30-34	15-19	20-24	25-29	30-34
Communicable	21.0	21.2	38.4	52.4	48.8	61.5	67.5	67.2
Non-communicable	20.7	14.5	16.6	19.5	27.6	23.7	23.6	26.1
External causes	58.3	64.3	44.9	28.1	23.5	14.8	9.0	6.7

*Redistributed ill-defined diseases R00 - R99 proportionally to causes to communicable and non-communicable diseases.
**Excluding unknown and unspecified sex.

Figure 4.8 shows the percentage distribution of deaths due to communicable diseases, non-communicable diseases and external causes of mortality among the black African and coloured youth by age group in 2013. For black African youth, the highest percentage of deaths due to communicable diseases was noted in the age groups 25–29 and 30–34. For those aged 20–24 years, almost the same proportion died from external causes of mortality as those dying from communicable diseases (40% and 41,7% respectively). Deaths due to external causes of mortality were dominant for those aged 15–19 years. Deaths due to non-communicable diseases for the black African population group were the lowest between ages 15–29; by age 30 most young black Africans were more likely to die from non-communicable diseases than from external causes of mortality. Deaths due to external causes declined with increasing age among young black Africans.

Deaths due to external causes of mortality were higher among the coloured youth between the ages of 15–29 years, accounting for well above half of all deaths in these age groups. Below 20% of the coloured youth in the age group 15–19 died from communicable and non-communicable diseases. From age group 30–34, deaths due to communicable diseases became dominant among the coloured youth. Deaths due to non-communicable diseases started showing any noticeable pattern at ages 25–29 and above.

Figure 4.8: Percentage distribution of youth deaths due to communicable, non-communicable and external causes of mortality among the black African and the coloured population groups, South Africa, 2013*



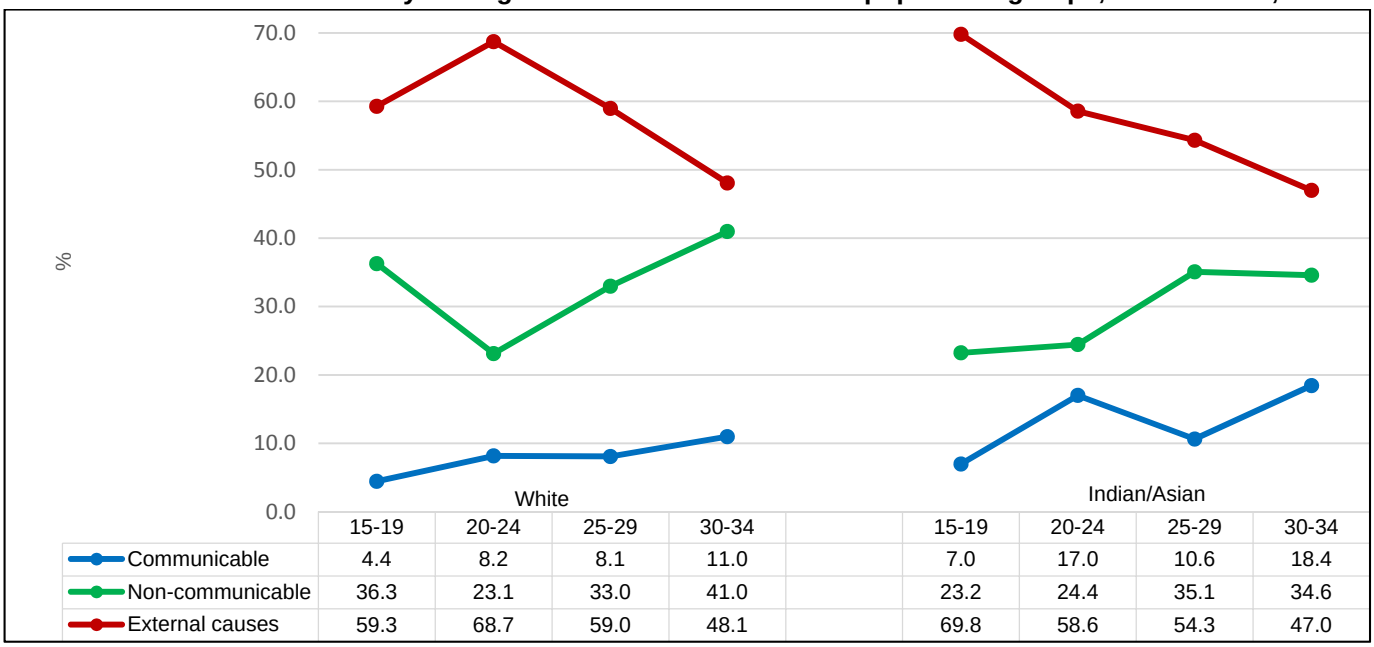
	Black African					Coloured			
	15-19	20-24	25-29	30-34		15-19	20-24	25-29	30-34
Communicable	34.6	41.7	54.2	61.1		17.3	26.6	40.0	45.7
Non-communicable	22.9	18.3	19.6	21.9		19.1	17.4	18.3	23.7
External causes	42.6	40.0	26.3	17.0		63.6	56.0	41.6	30.6

*Redistributed ill-defined diseases R00 - R99 proportionally to causes to communicable and non-communicable diseases.

Figure 4.9 shows the percentage distribution of deaths due to communicable diseases, non-communicable diseases and external causes of mortality among white and Indian/Asian youth by age group in 2013. Indian/Asian and white youth were more likely to die from external causes of mortality than any other cause across all age groups. Deaths due to external causes of mortality peaked at ages 20–24 for whites (accounting for 8,2% of all deaths in this age group) and declined rapidly as age increased, while for young Indians/Asians deaths due to external causes are highest at ages 15–19 and decline at higher ages.

Deaths due to non-communicable diseases start higher at younger ages for white youth; there is a slight decline at ages 20–24 before increasing steeply with age. Only less than 10% of white youth died from communicable diseases in 2013. Deaths due to non-communicable diseases represent the second highest cause of death for Indian/Asian youths. Although less than 20% of deaths were due to communicable diseases within the Indian/Asian population, the levels at ages 30–34 seem to indicate increasing proportions with age.

Figure 4.9: Percentage distribution of youth deaths due to communicable, non-communicable and external causes of mortality among the white and Indian/Asian population groups, South Africa, 2013*



	White				Indian/Asian			
	15-19	20-24	25-29	30-34	15-19	20-24	25-29	30-34
Communicable	4.4	8.2	8.1	11.0	7.0	17.0	10.6	18.4
Non-communicable	36.3	23.1	33.0	41.0	23.2	24.4	35.1	34.6
External causes	59.3	68.7	59.0	48.1	69.8	58.6	54.3	47.0

*Redistributed ill-defined diseases R00 - R99 proportionally to causes to communicable and non-communicable diseases.

Figure 4.10 shows changes in disease patterns overtime for deaths due to communicable diseases, non-communicable diseases and external causes of mortality by province of usual residence and Figure 4.11 for the year 2013. We observe that for all provinces there was a decline in deaths due to other external causes and noticeable increase in deaths due to communicable diseases. The biggest increase was observed in both Western Cape and Gauteng, this mainly due to the fact that these provinces had the biggest proportion of deaths due to external causes of mortality in 1997.

Deaths due to communicable diseases were higher in Free State (44,5%) for 1997, followed by KwaZulu-Natal (40,4%). There was a slight decline in deaths from non-communicable diseases in seven of the nine provinces, the exceptions were Free State and Gauteng where there was a slight increase in both.

Figure 4.10: Percentage distribution of youth deaths due to communicable, non-communicable and external causes of mortality, South Africa, 1997*

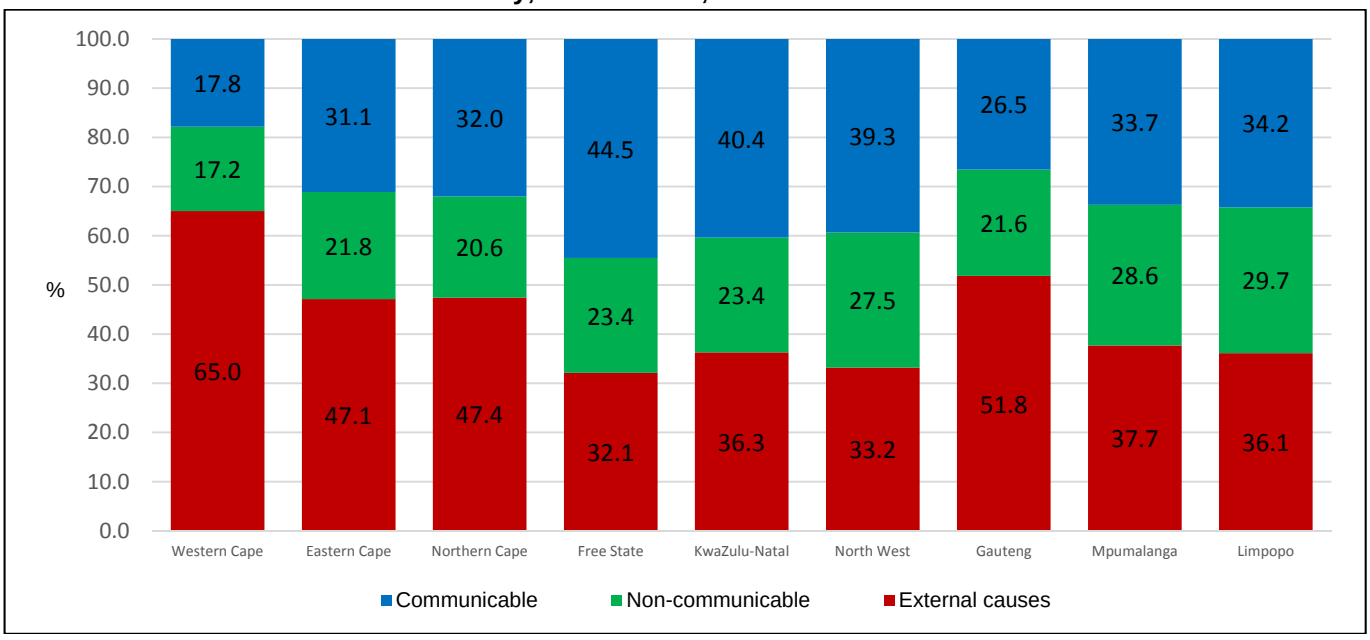
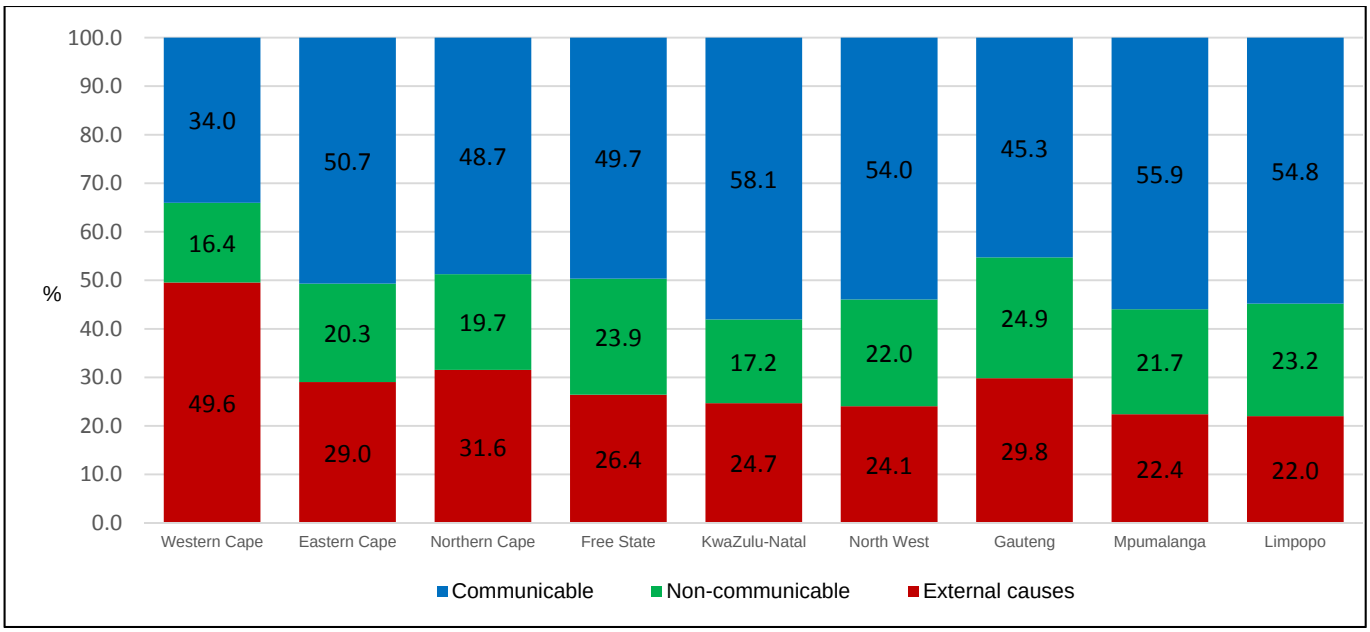


Figure 4.11: Percentage distribution of youth deaths due to communicable, non-communicable and external causes of mortality, South Africa, 2013*



4.4. The ten leading causes of death

In this section the ten leading causes of death are ranked according to the most frequently reported cause of death. The rankings excluded deaths due to *symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified.* This subsection has been divided according to the three variables of interest (sex, population group and province).

4.4.1. Leading cause of deaths among all youth

Table 4.1 presents the ten leading underlying causes of death for the youth in 2013; it shows that *tuberculosis* (14,1%) was the leading cause of death among the youth. It was followed by *human immunodeficiency virus (HIV) disease* and *other viral diseases*. The remaining underlying causes of death contributed less than 5% to the overall deaths. *Intestinal infectious diseases,* which was ranked third for the overall deaths in 2013, was ranked the sixth underlying cause of death for the youth.

Table 4.1: Distribution of the ten leading causes of death among the youth, South Africa, 2013

Causes of death (Based on ICD-10)	Rank	Number	%
Tuberculosis (A15-A19)	1	10 962	14,1
Human immunodeficiency virus [HIV] disease (B20-B24)	2	7 890	10,1
Other viral diseases (B25-B34)	3	4 400	5,7
Influenza and pneumonia (J09-J18)	4	3 603	4,6
Certain disorders involving the immune mechanism (D80-D89)	5	2 351	3,0
Intestinal infectious diseases (A00-A09)	6	2 030	2,6
Other forms of heart disease (I30-I52)	7	1 448	1,9
Inflammatory diseases of the central nervous system (G00-G09)	8	1 374	1,8
Protozoal diseases (B50-B64)	9	916	1,2
Other acute lower respiratory infections (J20-J22)	10	797	1,0
Other natural causes		20 167	25,9
Non-natural causes		21 884	28,1
All deaths		**77 822**	**100,0**

4.4.2. Leading causes of death by sex, 2013

The ten leading underlying causes of death by sex are shown in Table 4.2. The ranking of the leading causes of death for both sexes were the same for the first six causes of death. *Tuberculosis* was the first leading underlying cause of death, followed by *human immunodeficiency virus [HIV] disease, other viral diseases, influenza and pneumonia* and *certain disorders involving the immune mechanism*. *Inflammatory diseases of the central nervous system* was ranked the seventh and eighth for males and females, respectively. *Episodic and paroxysmal disorders* were ranked ninth for males while *protozoal diseases* were ranked ninth for females. The contribution of all the leading causes of death to overall number of deaths for each sex was higher for females as compared to males.

Table 4.2: Distribution of the ten leading causes of death among the youth by sex, South Africa, 2013

Causes of death (Based on ICD-10)	Male			Female		
	Rank	Number	%	Rank	Number	%
Tuberculosis (A15-A19)	1	4 931	11,8	1	5 975	16,8
Human immunodeficiency virus [HIV] disease (B20-B24)	2	3 230	7,7	2	4 635	13,0
Other viral diseases (B25-B34)	3	1 620	3,9	3	2 764	7,8
Influenza and pneumonia (J09-J18)	4	1 422	3,4	4	2 164	6,1
Certain disorders involving the immune mechanism (D80-D89)	5	865	2,1	5	1 478	4,1
Intestinal infectious diseases (A00-A09)	6	758	1,8	6	1 262	3,5
Inflammatory diseases of the central nervous system (G00-G09)	7	645	1,5	8	726	2,0
Other forms of heart disease (I30-I52)	8	643	1,5	7	796	2,2
Episodic and paroxysmal disorders (G40-G47)	9	473	1,1	…	…	…
Other acute lower respiratory infections (J20-J22)	10	357	0,9	10	438	1,2
Protozoal diseases (B50-B64)	…	…	…	9	604	1,7
Other natural causes		8 799	21,1		11 103	31,1
Non-natural causes		18 048	43,2		3 708	10,4
All deaths		**41 791**	**100,0**		**35 653**	**100,0**

*Excluding deaths with unknown and unspecified sex.

4.4.3. Population group

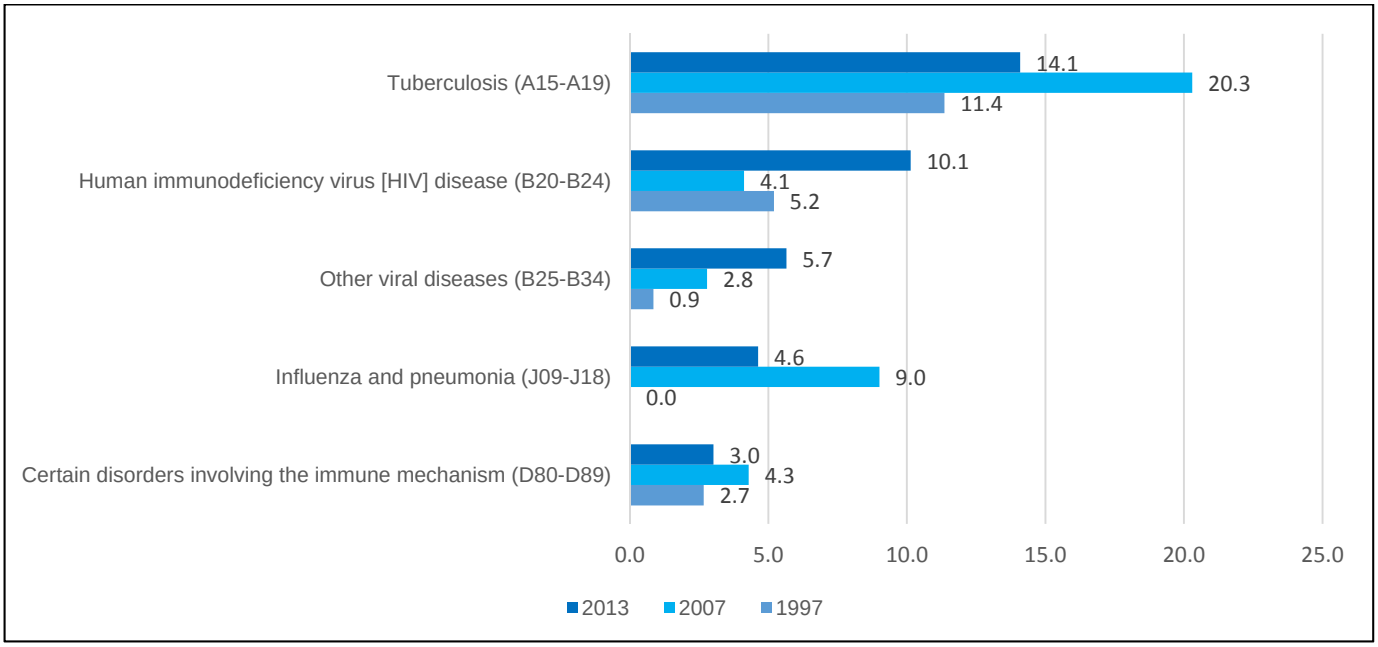
Notable differences in the leading causes of death are observed by population group (See Appendix V). The leading cause of death, *tuberculosis*, was ranked first for the black African and Indian/Asian population groups while it was ranked second for the coloured population group and seventh for the white population group. For the white population, the leading cause of death was *ischaemic heart diseases* and for the coloured population group it was the *human immunodeficiency virus [HIV] disease.*

4.4.4. Province of usual residence

Tuberculosis was the leading cause of death among the youth in seven provinces except for Western Cape and Northern Cape, where the human immunodeficiency virus was the leading cause. Other viral diseases were ranked the third leading cause of death in five provinces, namely: Western Cape, Eastern Cape, KwaZulu-Natal, Mpumalanga and Limpopo, while in the remaining four provinces, namely: Northern Cape, Free State, North West and Gauteng it was ranked the fourth (see Appendix W).

Figure 4.12 shows trends of the five leading causes of deaths among the youth for 1997, 2007 and 2013. There were three causes of death where there was an upward trends to 2007, then reversal between 2007 and 2013. Deaths due to *tuberculosis, influenza and pneumonia; and certain disorder involving the immune mechanism* increased from 1997 to 2007 then declined in 2013. A different pattern was seen for *human immunodeficiency virus [HIV] disease*, where a decrease was observed between 1997 and 2007 (5,2% to 4,1%) and an increase to 10,1% in 2013. The observed increase in HIV is likely due to better reporting than from increasing incidence for this disease.

Figure 4.12: Changes in the leading causes of death among the youth, South Africa, 1997, 2007 and 2013*



5. Summary

Statistics South Africa (Stats SA) has a mandate to provide statistical information that meets user requirements and regularly conducts surveys to achieve this. Statistical information is provided in the form of reports, which are part of a series of annual thematic health reports using health information available from Stats SA's household surveys, administrative data and other Stats SA publications. The theme of this report is about the youth (15–34 years) and the health challenges they are facing.

Information on the distribution of the youth from the General Household Survey shows that the youth contributed less than 40% to the total population of South Africa in 2013. There were more males, the youth from the black African population group and those residing in Limpopo.

The health-care seeking practices among the youth show that 5,3% were ill a month before the survey. There were more females who were ill than males and among the youth in the 30–34 age group. The youth from the white population group and those residing in Gauteng suffered an illness a month before the survey.

Respondents were asked if they consulted a health care worker when they were ill a month before the survey; less than half of the youth mentioned that they did not consult a health care worker when they were ill a month before the survey. The main reason for not consulting was self-medication, followed by those that indicated that the illness was not serious enough for consulting. Among the youth who were ill a month before the survey and did not consult a health care worker, the highest proportion was in the 15–19 age group. Males and those from the Indian/Asian population group also did not consult a health care worker when ill a month before the survey. Among the youth who thought it was not necessary, the youth from the 25–34 age group had a higher percentage, which was also higher among females and the youth from the coloured population. Those in the age groups 20–24 years were more likely to use self-medication than other age groups, while females and the youth from the coloured population group had a higher percentage of self-medication.

Less than 15% of the youth were covered by medical aid, with more females than males, the white population group and those in the 30–34 age groups. Western Cape and Gauteng were the provinces with higher percentages of medical aid coverage.

The majority of those that were sick and did not consult a health care worker, were not covered by medical aid. Young males, black African youth, and unemployed youth had a higher percentage of those not covered by medical aid, were ill a month before the survey, and did not consult a health care worker. The highest proportion of those who perceived their health as good, were ill a month before the survey and did not consult a health care worker but were also not covered by medical aid. Also interesting was that the same proportion of employed young people and those still in school were also not covered by medical aid. This might be linked to the perception of good health among the youth, or equally it might point to unaffordability of medical aid coverage for the youth in their early work life.

Flu or acute respiratory tract infection (ARTI) was a common illness, affecting over half of the youth, more males, the white and the Indian/Asian population groups and the youth residing in Northern Cape and Western Cape. *Diarrhoea, epilepsy* and *tuberculosis* accounted for 6,9%, 3,1% and 2,9% of illnesses among the youth respectively. Just over two per cent of young people reported suffering from *high blood pressure*, which affected more females (3,2%) than males.

Results on mortality and causes of death show that 77 822 deaths occurred among the youth in 2013, with more male than female deaths observed between the years 2001 to 2011. Trends in the number of deaths show that as is the case with deaths in the rest of the country, deaths among youth peaked around 2005, and has been declining consistently in later years. There was a decline of 64,3% in mortality between the two periods. Most deaths occurred among the black African and coloured youth. KwaZulu-Natal, Mpumalanga and Eastern Cape had higher proportions of deaths occurring amongst the youth. Female deaths contributed higher to increasing mortality and to the decline.

Natural causes were the most common cause of death, contributing the majority of deaths that occurred in 2013 among the youth, while non-natural causes of death contributed less than 30% of all deaths. Almost half of all male deaths were due to non-natural causes as compared to females. Just over half of deaths to white and Indian/Asian youths were due to non-natural causes, and this figure is 50% as well for those residing in Western Cape.

More than half of the deaths among the youth were due to communicable diseases. More females, youth from the black African and the coloured population groups, and the youth in KwaZulu-Natal died from communicable diseases.

Young males between the ages of 15–29 were more likely to die due to external causes than communicable and non-communicable diseases. Deaths due to external causes among males declined with increasing age while deaths through communicable diseases increase as age increases. Deaths due to communicable diseases were higher among females of all sub-age groups while those due to external causes were the least important for young females.

Most young black Africans aged 15–19 died from external causes in 2013, while coloureds aged between 15 and 25 years died from external causes in 2013. This pattern changed from deaths through external causes to mainly communicable diseases for black African youth in the 20–34 age groups and the coloureds in the 25–34 age group. The youth from the white and the Indian/Asian population groups died mainly from external causes across all sub-age groups and less from communicable diseases.

Of the ten leading natural causes of death among the youth in 2013, half were due to communicable diseases. *Tuberculosis* and *human immunodeficiency virus (HIV) disease* and *other viral diseases* accounted for just over a quarter of all the deaths among the youth in 2013. The top six leading causes of deaths were the same for both sexes. The contribution of all the leading causes of death to overall number of deaths for each sex was higher for females as compared to males.

The leading cause of death for the black African and the Asian/Indian population groups was *tuberculosis*, while *ischaemic heart diseases* was the leading cause among the youth from the white population group, and the *human immunodeficiency virus [HIV] disease* for the youth from the coloured population group. *Tuberculosis* was the leading cause of death among the youth in seven provinces except for Western Cape and Northern Cape, where the *human immunodeficiency virus* was the leading cause. *Other viral diseases* was the third leading cause of death in five provinces, namely: Western Cape, Eastern Cape, KwaZulu-Natal, Mpumalanga and Limpopo, while ranked fourth in the remaining four provinces, namely: Northern Cape, Free State, North West and Gauteng.

The report has clearly indicated that communicable diseases are the main cause of death in the youth. This information can be used by programme managers of the Department of Health responsible for the Adolescent and Youth Health programmes both at national and provincial levels for monitoring the Adolescent and Youth Health Policy.

In conclusion, information in this report has highlighted that there is still a need to intensify efforts to prevent diseases like *tuberculosis* and the *human immunodeficiency virus (HIV) disease* in the youth in South Africa.

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7. Appendices

Appendix A: Number of the youth by age group and sex, population group and province of usual residence, South Africa, 2013

Variables	Total population	Number of youth	Age group			
			15-19	20-24	25-29	30-34
Overall	**52 982 000**	**19 368 523**	**5 168 797**	**5 034 532**	**4 765 661**	**4 399 533**
Sex						
Male	25 823 300	9 760 706	2 588 237	2 539 655	2 406 940	2 225 873
Female	27 158 700	9 607 817	2 580 560	2 494 877	2 358 721	2 173 660
Population group						
Black African	42 284 100	16 094 116	4 302 977	4 190 550	3 975 801	3 624 787
Coloured	4 766 200	1 617 093	449 639	419 741	377 826	369 887
Indian/Asian	1 329 300	452 175	102 946	109 921	118 125	121 184
White	4 602 400	1 205 139	313 235	314 320	293 909	283 675
Province						
Western Cape	6 016 900	2 045 285	488 674	498 105	527 166	531 340
Eastern Cape	6 620 100	2 470 344	796 867	635 078	567 726	470 673
Northern Cape	1 162 900	406 194	113 238	99 641	96 091	97 225
Free State	2 753 200	1 026 854	267 127	289 931	244 482	225 314
KwaZulu-Natal	10 456 900	3 875 821	1 084 393	999 813	918 024	873 591
North West	3 597 600	1 286 734	345 081	315 954	319 807	305 892
Gauteng	12 728 400	4 515 211	966 221	1 205 450	1 202 665	1 140 875
Mpumalanga	4 128 000	1 575 308	415 050	432 662	397 109	330 488
Limpopo	5 551 800	2 166 772	692 145	557 899	492 592	424 7

Appendix B: Number of the youth who were ill a month before the survey classified by age group, sex and population group, South Africa, 2013

Variable	Total	Number of youth who reported ill in the past 30 days	Number of youth who reported not ill in the past 30 days	Do not know
Overall	**19 368 523**	**1 035 459**	**18 332 042**	**1 022**
Age group				
15-19	5 168 797	242 682	4 926 114	0
20-24	5 034 532	207 540	4 826 992	0
25-29	4 765 661	293 455	4 471 184	1 022
30-34	4 399 533	291 781	4 107 752	0
Sex				
Male	9 760 706	445 506	9 315 200	0
Female	9 607 817	589 953	9 016 842	1 022
Population group				
Black African	16 094 116	860 942	15 233 174	0
Coloured	1 617 093	81 819	1 535 274	0
Indian/Asian	452 175	10 375	441 800	0
White	1 205 139	82 323	1 121 795	1 022

Appendix C: Number of the youth who were ill a month before the survey classified by province of usual residence, South Africa, 2013

Province	Total	Number of youth who were ill by province	% distribution of youth who were ill by province
Overall	**19 368 523**	**1 035 459**	**5,4**
Western Cape	2 045 285	107 520	5,3
Eastern Cape	2 470 344	144 887	5,9
Northern Cape	406 194	30 517	7,5
Free State	1 026 854	82 488	8,0
KwaZulu-Natal	3 875 821	150 329	3,9
North West	1 286 734	82 900	6,4
Gauteng	4 515 211	243 875	5,4
Mpumalanga	1 575 308	98 242	6,2
Limpopo	2 166 772	94 702	4,4

Appendix D: Number of the youth by type of illness suffered a month before the survey, South Africa, 2013

Type of illness suffered a month before the survey	Number	Percentage
Flu or ARTI	550 169	53,1
Diarrhoea	71 827	6,9
TB	30 449	2,9
Depression	13 550	1,3
Diabetes	10 265	1,0
High blood pressure	24 361	2,4
Epilepsy	32 280	3,1
Pneumonia	11 838	1,1
Meningitis and sinusitis	10 084	1,0
Other	23 747	2,3
Unspecified	256 888	24,8
Total of illnesses	**1 035 459**	**100,0**

Appendix E: Number of the youth who were ill a month before the survey and suffered from flu or ARTI by sex, population and province of usual residence, South Africa, 2013

Variables	Number of youth	Ill youth	Flu	Percentage
Overall	**19 368 523**	**1 035 459**	**550 169**	**53,1**
Sex				
Male	9 760 706	445 506	247 064	55,5
Female	9 607 817	589 953	303 105	51,4
Population group				
Black African	16 094 116	860 942	429 020	49,8
Coloured	1 617 093	81 819	52 230	63,8
Indian/Asian	452 175	10 375	7 376	71,1
White	1 205 139	82 323	61 543	74,8
Province				
Western Cape	2 045 285	107 520	73 626	68,5
Eastern Cape	2 470 344	144 887	64 146	44,3
Northern Cape	406 194	30 517	21 581	70,7
Free State	1 026 854	82 488	35 201	42,7
KwaZulu-Natal	3 875 821	150 329	90 975	60,5
North West	1 286 734	82 900	39 275	47,4
Gauteng	4 515 211	243 875	121 752	49,9
Mpumalanga	1 575 308	98 242	51 054	52,0
Limpopo	2 166 772	94 702	52 558	55,5

Appendix F: Number of the youth who were ill a month before the survey and suffered from diarrhoea by sex, population group and province of usual residence, South Africa, 2013

Variables	Number of youth	Ill youth	Diarrhoea	Percentage
Overall	**19 368 523**	**1 035 459**	**71 827**	6,9
Sex				
Male	9 760 706	445 506	26 132	5,9
Female	9 607 817	589 953	45 695	7,7
Population group				
Black African	16 094 116	860 942	61 569	7,2
Coloured	1 617 093	81 819	6 265	7,7
Indian/Asian	452 175	10 375	0	0,0
White	1 205 139	82 323	3 992	4,8
Province				
Western Cape	2 045 285	107 520	10 107	9,4
Eastern Cape	2 470 344	144 887	17 413	12,0
Northern Cape	406 194	30 517	147	0,5
Free State	1 026 854	82 488	2 169	2,6
KwaZulu-Natal	3 875 821	150 329	14 595	9,7
North West	1 286 734	82 900	4 009	4,8
Gauteng	4 515 211	243 875	13 382	5,5
Mpumalanga	1 575 308	98 242	5 325	5,4
Limpopo	2 166 772	94 702	4 679	4,9

Appendix G: Number of the youth who were ill a month before the survey and suffered from epilepsy by sex, population group and province of usual residence, South Africa, 2013

Variables	Number of youth	Ill youth	Epilepsy	Percentage
Overall	**19 368 523**	**1 035 459**	**32 280**	3,1
Sex				
Male	9 760 706	445 506	20 231	4,5
Female	9 607 817	589 953	12049	2,0
Population group				
Black African	16 094 116	860 942	28 963	3,4
Coloured	1 617 093	81 819	1991	2,4
Indian/Asian	452 175	10 375	0	0,0
White	1 205 139	82 323	1326	1,6
Province				
Western Cape	2 045 285	107 520	1527	1,4
Eastern Cape	2 470 344	144 887	6074	4,2
Northern Cape	406 194	30 517	110	0,4
Free State	1 026 854	82 488	1810	2,2
KwaZulu-Natal	3 875 821	150 329	3303	2,2
North West	1 286 734	82 900	1413	1,7
Gauteng	4 515 211	243 875	16616	6,8
Mpumalanga	1 575 308	98 242	924	0,9
Limpopo	2 166 772	94 702	503	0,5

Appendix H: Number of the youth who were ill a month before the survey and suffered from tuberculosis by sex, population group and province of usual residence, South Africa, 2013

Variables	Number of youth	Ill youth	Tuberculosis	Percentage
Overall	**19 368 523**	**1 035 459**	**30449**	2,9
Sex				
Male	9 760 706	445 506	16355	3,7
Female	9 607 817	589 953	14094	2,4
Population group				
Black African	16 094 116	860 942	28368	3,3
Coloured	1 617 093	81 819	1219	1,5
Indian/Asian	452 175	10 375	0	0,0
White	1 205 139	82 323	863	1,0
Province				
Western Cape	2 045 285	107 520	1522	1,4
Eastern Cape	2 470 344	144 887	8670	6,0
Northern Cape	406 194	30 517	302	1,0
Free State	1 026 854	82 488	1759	2,1
KwaZulu-Natal	3 875 821	150 329	8110	5,4
North West	1 286 734	82 900	2180	2,6
Gauteng	4 515 211	243 875	4317	1,8
Mpumalanga	1 575 308	98 242	2579	2,6
Limpopo	2 166 772	94 702	1009	1,1

Appendix I: Number of the youth who were ill a month before the survey and suffered from high blood pressure by sex, population group and province of usual residence, South Africa, 2013

Variables	Number of youth	Ill youth	High blood pressure	Percentage
Overall	**19 368 523**	**1 035 459**	**24361**	2,4
Sex				
Male	9 760 706	445 506	5635	1,3
Female	9 607 817	589 953	18725	3,2
Population group				
Black African	16 094 116	860 942	19443	2,3
Coloured	1 617 093	81 819	2097	2,6
Indian/Asian	452 175	10 375	389	3,7
White	1 205 139	82 323	2432	3,0
Province				
Western Cape	2 045 285	107 520	2859	2,7
Eastern Cape	2 470 344	144 887	2251	1,6
Northern Cape	406 194	30 517	1319	4,3
Free State	1 026 854	82 488	577	0,7
KwaZulu-Natal	3 875 821	150 329	2669	1,8
North West	1 286 734	82 900	5193	6,3
Gauteng	4 515 211	243 875	6511	2,7
Mpumalanga	1 575 308	98 242	1957	2,0
Limpopo	2 166 772	94 702	1025	1,1

Appendix J: Number of the youth who were ill a month before the survey by status of consultation with a health care worker and age group, sex and population group, South Africa, 2013

Variable	Total number of youth in the country	Number of youth who reported ill in the past 30 days	Those who consulted	Did not consult	Unspecified
Overall	**19 368 523**	**1 035 459**	**661 407**	**314 028**	**60 024**
Age					
15-19	5 168 797	242 682	151 868	81 002	9 813
20-24	5 034 532	207 540	130 512	65 689	11 339
25-29	4 765 661	293 455	194 978	79 593	18 885
30-34	4 399 533	291 781	184 049	87 744	19 988
Sex					
Male	9 760 706	445 506	262 136	152 552	30 818
Female	9 607 817	589 953	399 271	161 476	29 206
Population group					
Black African	16 094 116	860 942	552 980	256 405	51 556
Coloured	1 617 093	81 819	49 931	27 497	4 391
Indian/Asian	452 175	10 375	5 335	3 870	1 170
White	1 205 139	82 323	53 160	26 255	2 908

Appendix K: Number of the youth who were ill a month before the survey and did not consult classified by reasons of not consulting and age group, sex and population group, South Africa, 2013

Variable	Did not consult	Not necessary/the problem was not serious enough	Self-medicated/ treated myself	Other reasons	Do not know	Unspecified
Overall	**314 028**	**78 819**	**198 804**	**25 524**	**2 296**	**8 585**
Age						
15-19	81 002	30 827	44 374	4 132	0	1 668
20-24	65 689	10 635	48 073	4 273	1 359	1 349
25-29	79 593	17 531	54 865	5 210	620	1 368
30-34	87 744	19 826	51 493	11 909	317	4 200
Sex						
Male	152 552	48 529	88 422	9 759	1 592	4 250
Female	161 476	30 290	110 382	15 765	704	4 336
Population group						
Black African	256 405	66 528	159 195	21 108	2 296	7 278
Coloured	27 497	2 994	22 954	1 549	0	0
Indian/Asian	3 870	3 256	308	307	0	0
White	26 255	6 040	16 348	2 560	0	1 307

Appendix L: Number of the youth covered by medical aid and sex, population group and province of usual residence, South Africa, 2013

Variables	Number of youth	Number of youth covered by medical aid	Percentage
Overall	**19 368 523**	**2 806 647**	14,5
Sex			
Male	9 760 706	1 347 306	13,8
Female	9 607 817	1 459 340	15,2
Population group			
Black African	16 094 116	1 408 294	8,8
Coloured	1 617 093	302 860	18,7
Indian/Asian	452 175	210 745	46,6
White	1 205 139	884 748	73,4
Province			
Western Cape	2 045 285	407 364	19,9
Eastern Cape	2 470 344	187 209	7,6
Northern Cape	406 194	67 132	16,5
Free State	1 026 854	137 811	13,4
KwaZulu-Natal	3 875 821	433 210	11,2
North West	1 286 734	168 953	13,1
Gauteng	4 515 211	1 065 255	23,6
Mpumalanga	1 575 308	185 522	11,8
Limpopo	2 166 772	154 191	7,1

Appendix M: Number of the youth not covered by medical aid classified by, South Africa, 2013

Social activity	Total	Medical aid	No medical aid
Overall (did not consult)	**314 028**	**46 937**	**266 514**
Employed	125 062	25 507	98 978
Inactive	103 417	4 182	99 235
Student/learners	85 549	17 249	68 300

Appendix N: Number of the youth who does not have medical aid by perceived health and age group, sex and population group, South Africa, 2013

Variable	Total number of youth who does not have medical aid	Perceived health		
		Good	Fair	Poor
Overall	**266 514**	**209 568**	**43 132**	**13 814**
Age				
15-19	66 610	56 739	6 162	3 709
20-24	58 942	46 983	9 937	2 022
25-29	67 713	49 973	13 194	4 545
30-34	73 249	55 872	13 839	3 538
Sex				
Male	129 640	101 590	19 607	8 443
Female	136 874	107 978	23 525	5 372
Population group				
Black African	234 141	182 504	38 190	13 447
Coloured	21 568	17 799	3 402	367
Indian/Asian	1 152	845	308	0
White	9 653	8 420	1 233	0

Appendix O: Number of deaths among the youth by age and year of death, South Africa, 2013

Year of death	Total deaths	Number of deaths for 15-34 age group	Other
1997	323 394	57 467	265 927
1998	373 853	70 177	303 676
1999	394 090	80 173	313 917
2000	429 384	92 124	337 260
2001	469 840	104 525	365 315
2002	516 086	121 050	395 036
2003	572 453	136 375	436 078
2004	593 672	141 611	452 061
2005	612 694	141 744	470 950
2006	628 074	140 659	487 415
2007	619 802	134 846	484 956
2008	611 947	129 124	482 823
2009	596 301	119 445	476 856
2010	565 037	108 548	456 489
2011	528 698	94 115	434 583
2012	505 763	86 925	418 838
2013	473 537	77 822	395 715

Appendix P: Number of deaths among the youth due to natural, non-natural and external causes by sex and population group, South Africa, 2013

Variables	Total number of youth deaths	Natural deaths	Non-natural deaths
Overall	77 822	55 938	21 884
Sex			
Male	41 791	23 743	18 048
Female	35 653	31 945	3 708
Unknown/unspecified	378	250	128
Population group			
Black	63 129	46 348	16 781
Coloured	3 544	2 004	1 540
Indian/Asian	429	194	235
White	1 273	537	736
Unknown/unspecified	9 447	6 855	2 592
Province			
Western Cape	6 133	3 094	3 039
Eastern Cape	11 569	8 209	3 360
Northern Cape	1 955	1 338	617
Free State	5 247	3 860	1 387
KwaZulu-Natal	17 044	12 835	4 209
North West	5 596	4 249	1 347
Gauteng	14 985	10 515	4 470
Mpumalanga	7 021	5 448	1 573
Limpopo	6 945	5 417	1 528
Unknown/unspecified/foreign	1 327	973	354

Appendix Q: Number of deaths due to communicable, non-communicable and external causes of morbidity classified by year of death: South Africa, 2013*

Year of death	Total deaths	Communicable diseases	Non-communicable diseases	External causes
1997	57 467	19 431	13 173	24 863
1998	70 177	27 858	17 001	25 318
1999	80 173	35 690	19 706	24 777
2000	92 124	46 434	22 631	23 059
2001	104 525	56 400	24 701	23 424
2002	121 050	69 887	27 105	24 058
2003	136 375	80 957	30 643	24 775
2004	141 611	85 273	32 235	24 103
2005	141 744	85 843	31 027	24 874
2006	140 659	86 006	29 635	25 018
2007	134 846	81 266	28 031	25 549
2008	129 124	77 239	26 390	25 495
2009	119 445	71 152	24 617	23 676
2010	108 548	63 999	21 822	22 727
2011	94 115	52 562	20 107	21 446
2012	86 925	45 474	19 157	22 294
2013	77 822	39 630	16 308	21 884

Appendix R: Number of deaths due to communicable, non-communicable and external causes of mortality classified by year of death, South Africa, 2013*

Variable	Total number of deaths	Number of deaths due to communicable diseases	Number of deaths due to non-communicable diseases	Number of deaths due to external causes
Overall deaths	**77 822**	**39 630**	**16 308**	**21 884**
Overall male**	**41 791**	**16 315**	**7 428**	**18048**
15-19	4 056	851	840	2365
20-24	7 977	1 689	1 156	5132
25-29	13 027	5 008	2 165	5854
30-34	16 731	8 767	3 267	4697
Overall female**	**35 653**	**23 061**	**8 884**	**3708**
15-19	2 981	1 456	823	702
20-24	6 827	4 201	1 618	1008
25-29	11 907	8 034	2 807	1066
30-34	13 938	9 371	3 635	932
Overall black African**	**63 129**	**33 374**	**12 974**	**16 781**
15-19	5 623	1 943	1 287	2 393
20-24	11 860	4 950	2 165	4 745
25-29	20 385	11 041	3 989	5 355
30-34	25 261	15 439	5 534	4 288
Overall coloured**	**3 544**	**1 294**	**710**	**1 540**
15-19	382	66	73	243
20-24	811	216	141	454
25-29	1 119	448	205	466
30-34	1 232	563	292	377
Overall Indian/Asian**	**429**	**62**	**132**	**235**
15-19	53	4	12	37
20-24	111	19	27	65
25-29	116	12	41	63
30-34	149	27	52	70
Overall white**	**1 273**	**109**	**428**	**736**
15-19	167	7	61	99
20-24	307	25	71	211
25-29	385	31	127	227
30-34	414	45	170	199

***Redistributed ill-defined diseases R00 - R99 proportionally to causes to communicable and non-communicable diseases.**

****Excluded unknown and unspecified sex**

Appendix S: Number of deaths due to communicable, non-communicable and external causes of accidental injury classified by province, South Africa, 1997*

Variables	Total deaths	Communicable diseases	Non-communicable diseases	External causes
Overall	39 237	19 431	13 173	24 863
Province				
Western Cape	3 417	609	586	2 222
Eastern Cape	5 396	1 678	1 175	2 543
Northern Cape	1 004	321	207	476
Free State	3 444	1 534	804	1 106
KwaZulu-Natal	9 867	3 983	2 304	3 580
North West	2 662	1 047	731	884
Gauteng	8 889	2 360	1 921	4 608
Mpumalanga	2 260	762	646	852
Limpopo	2 298	786	682	830

Appendix T: Number of deaths due to communicable, non-communicable and external causes of accidental injury classified by province, South Africa, 2013*

Variables	Total deaths	Communicable diseases	Non-communicable diseases	External causes
Overall	77 822	39 630	16 308	21 884
Province				
Western Cape	6 133	2 088	1 006	3 039
Eastern Cape	11 569	5 864	2 345	3 360
Northern Cape	1 955	953	385	617
Free State	5 247	2 606	1 254	1 387
KwaZulu-Natal	17 044	9 899	2 936	4 209
North West	5 596	3 019	1 230	1 347
Gauteng	14 985	6 785	3 730	4 470
Mpumalanga	7 021	3 928	1 520	1 573
Limpopo	6 945	3 806	1 611	1 528

Appendix U: Changes in the leading causes of death among the youth, South Africa, 1997, 2007 and 2013*

Broad group of underlying causes	Year of death		
	1997	2007	2013
Tuberculosis (A15-A19)	6 525	27 371	10 962
Human immunodeficiency virus [HIV] disease (B20-B24)	2 989	5 561	7 890
Other viral diseases (B25-B34)	491	3 757	4 400
Influenza and pneumonia (J09-J18)	10	12 152	3 603
Certain disorders involving the immune mechanism (D80-D89)	1 532	5 782	2 351

Appendix V: Distribution of the ten leading causes of death among the youth by population group, South Africa, 2013

Causes of death (Based on ICD-10)	Population group											
	African Black			Coloured			Indian/Asian			White		
	Rank	Number	%	Rank	Number	%	Rank	Number	%	Rank	Number	%
Tuberculosis (A15-A19)	1	9 627	15,2	2	420	11,9	1	19	4,4	7	15	1,2
Human immunodeficiency virus [HIV] disease (B20-B24)	2	6 900	10,9	1	432	12,2	6	7	1,6	…	…	…
Other viral diseases (B25-B34)	3	4 034	6,4	4	77	2,2	10	6	1,4	…	…	…
Influenza and pneumonia (J09-J18)	4	3 060	4,8	3	82	2,3	4	10	2,3	3	23	1,8
Certain disorders involving the immune mechanism (D80-D89)	5	2 104	3,3	5	56	1,6	…	…	…	…	…	…
Intestinal infectious diseases (A00-A09)	6	1 819	2,9	…	…	…	…	…	…	…	…	…
Inflammatory diseases of the central nervous system (G00-G09)	7	1 233	2,0	…	…	…	…	…	…	…	…	…
Other forms of heart disease (I30-I52)	8	1 211	1,9	6	43	1,2	2	11	2,6	5	18	1,4
Protozoal diseases (B50-B64)	9	842	1,3	…	…	…	…	…	…	…	…	…
Other acute lower respiratory infections (J20-J22)	10	713	1,1	…	…	…	…	…	…	…	…	…
Diabetes mellitus (E10-E14)	…	…	…	7	39	1,1	6	7	1,6	4	22	1,7
Episodic and paroxysmal disorders (G40-G47)	…	…	…	8	37	1,0	…	…	…	10	12	0,9
Cerebrovascular diseases (I60-I69)	…	…	…	9	34	1,0	…	…	…	6	16	1,3
Chronic lower respiratory diseases (J40-J47)	…	…	…	10	30	0,8	6	7	1,6	…	…	…
Ischaemic heart diseases (I20-I25)	…	…	…	…	…	…	3	10	2,3	1	24	1,9
Systemic connective tissue disorders (M30-M36)	…	…	…	…	…	…	5	8	1,9	…	…	…
Cerebral palsy and other paralytic syndromes (G80-G83)	…	…	…	…	…	…	6	7	1,6	…	…	…
Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue (C81-C96)	…	…	…	…	…	…	…	…	…	2	23	1,8
Renal failure (N17-N19)	…	…	…	…	…	…	…	…	…	7	15	1,2
Pulmonary heart disease and diseases of pulmonary circulation (I26-I28)	…	…	…	…	…	…	…	…	…	9	13	1,0
Other natural causes		14 805	23,5		754	21,3		102	23,8		356	28,0
Non-natural causes		16 781	26,6		1 540	43,5		235	54,8		736	57,8
All causes		**63 129**	100,0		**3 544**	100,0		**429**	100,0		**1 273**	100,0

Appendix W: Distribution of the ten leading causes of death among the youth by province of usual residence, South Africa, 2013

Causes of death (Based on ICD-10)	Western Cape			Eastern Cape			Northern Cape			Free State			KwaZulu-Natal			North West			Gauteng			Mpumalanga			Limpopo		
	Rank	Number	%	Rank	Number	%	Rank	Number	%	Rank	Number	%	Rank	Number	%	Rank	Number	%	Rank	Number	%	Rank	Number	%	Rank	Number	%
Human immunodeficiency virus [HIV] disease (B20-B24)	1	895	14,6	2	1 270	11,0	1	355	18,2	2	367	7,0	2	2 351	13,8	2	530	9,5	2	955	6,4	2	638	9,1	5	412	5,9
Tuberculosis (A15-A19)	2	570	9,3	1	1 647	14,2	2	220	11,3	1	724	13,8	1	3 256	19,1	1	783	14,0	1	1 704	11,4	1	1 068	15,2	1	838	12,1
Other viral diseases (B25-B34)	3	89	1,5	3	717	6,2	4	79	4,0	4	305	5,8	3	1 171	6,9	4	335	6,0	4	710	4,7	3	498	7,1	3	441	6,3
Influenza and pneumonia (J09-J18)	4	67	1,1	5	244	2,1	5	69	3,5	3	340	6,5	4	520	3,1	3	453	8,1	3	894	6,0	4	373	5,3	2	564	8,1
Other forms of heart disease (I30-I52)	5	61	1,0	7	199	1,7	7	25	1,3	7	98	1,9	8	246	1,4	7	118	2,1	6	414	2,8	9	122	1,7	8	140	2,0
Certain disorders involving the immune mechanism (D80-D89)	6	53	0,9	4	390	3,4	3	84	4,3	5	241	4,6	6	335	2,0	5	240	4,3	5	435	2,9	5	321	4,6	6	209	3,0
Other bacterial diseases (A30-A49)	7	49	0,8	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Cerebrovascular diseases (I60-I69)	8	46	0,8	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Renal failure (N17-N19)	9	45	0,7	...	...	...	...	...	...	10	68	1,3	...	...	...	...	...	...	10	172	1,1	...	...	...	9	109	1,6
Malignant neoplasms, stated or presumed to be primary, of lymphoid, haematopoietic and related tissue (C81-C96)	10	43	0,7	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...
Intestinal infectious diseases (A00-A09)	...	...	...	6	228	2,0	6	30	1,5	6	160	3,0	5	475	2,8	6	124	2,2	8	273	1,8	6	267	3,8	4	427	6,1
Inflammatory diseases of the central nervous system (G00-G09)	...	...	...	8	168	1,5	9	18	0,9	9	69	1,3	6	335	2,0	8	76	1,4	7	304	2,0	8	149	2,1	7	202	2,9
Episodic and paroxysmal disorders (G40-G47)	...	...	...	9	163	1,4	8	22	1,1	...	...	...	10	163	1,0	...	...	...	...	...	...	...	...	...	...	...	...
Other acute lower respiratory infections (J20-J22)	...	...	...	10	83	0,7	...	...	...	...	...	...	...	...	...	10	64	1,1	...	...	...	7	228	3,2	...	...	...
Chronic lower respiratory diseases (J40-J47)	...	...	...	...	...	...	10	18	0,9	...	...	...	8	246	1,4	...	...	...	...	...	...	...	...	...	...	...	...
Protozoal diseases (B50-B64)	...	...	...	...	...	...	...	...	...	8	79	1,5	...	...	...	...	...	...	9	228	1,5	...	...	...	10	93	1,3
Other bacterial diseases (A30-A49)	...	...	...	...	...	...	...	...	...	...	...	...	...	...	...	9	71	1,3	...	...	...	10	104	1,5	...	...	...
Other natural causes		1 176	19,2		3 100	26,8		418	21,4		1 409	26,9		3 737	21,9		1 455	26,0		4 426	29,5		1 680	23,9		1 982	28,5
Non-natural causes		3 039	49,6		3 360	29,0		617	31,6		1 387	26,4		4 209	24,7		1 347	24,1		4 470	29,8		1 573	22,4		1 528	22,0
All causes		**6 133**	**100,0**		**11 569**	**100**		**1 955**	**100,0**		**5 247**	**100**		**17 044**	**100**		**5 596**	**100,0**		**14 985**	**100**		**7 021**	**100,0**		**6 945**	**100,0**