Child health and nutrition

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Section 27 of the Constitution of South Africa provides that everyone has the right to have access to healthcare services. In addition, section 28 (1)(c) gives children "the right to basic nutrition and basic healthcare services".[1]

Article 14 (1) of the African Charter on the Rights and Welfare of the Child states that "every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health", and article 14 (2)(c) says that States Parties shall take measures "to ensure the provision of adequate nutrition…".[2]

Article 24 of the United Nations (UN) Convention on the Rights of a Child says that State Parties should recognise "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health". It obliges the state to take measures "to diminish infant and child mortality" and "to combat disease and malnutrition".[3]

Infant, under-five and neonatal mortality

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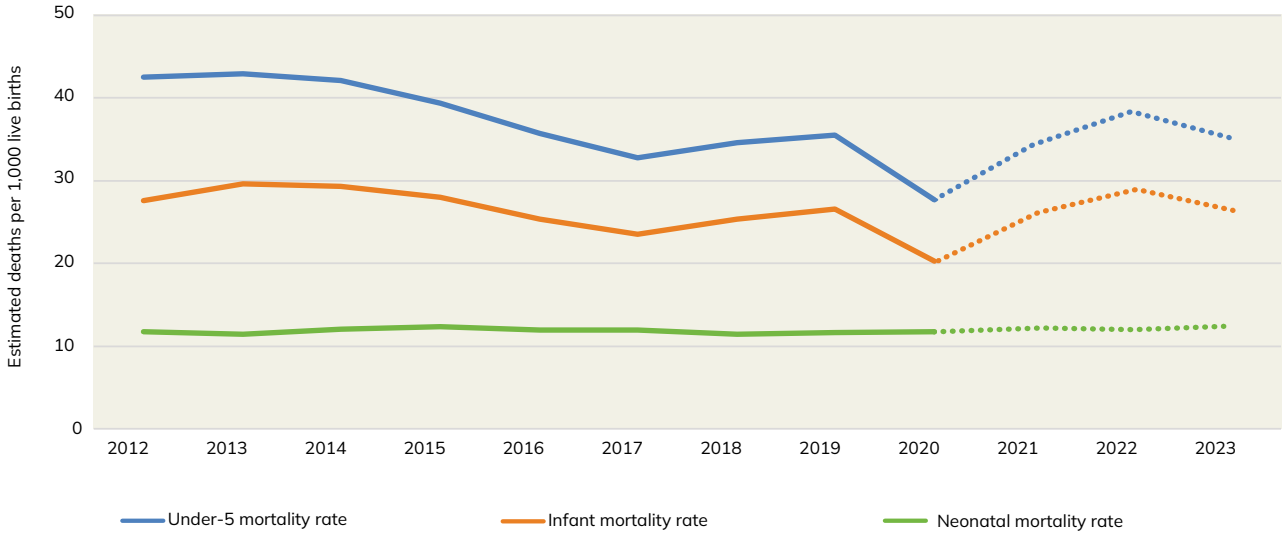
The infant and under-five mortality rates are key indicators of heath and development. They are associated with a broad range of bio-demographic, health and environmental factors which are not only important determinants of child health but are also informative about the health status of the broader population.

The infant mortality rate (IMR) is defined as the probability of dying within the first year of life and is estimated by the number of deaths of infants aged less than one year at death per 1,000 of births in that year. The under-five mortality rate (U5MR) is defined as the probability of a child dying before their fifth birthday.

Ideally this information is obtained from vital registration systems. However, as in many middle- and lower-income countries, the under-reporting of births and deaths renders the South African system inadequate for monitoring directly. South Africa is therefore reliant on alternative methods, such as survey and census data, and modelling (particularly given the

Figure 3a: Child mortality rates, 2012 – 2023



Source: UN Inter-agency Group for Child Mortality Estimation (IGME) https://childmortality.org/all-cause-mortality/data?refArea=ZAF&indicator=MRY0T4.

Notes:
1. U5MR and IMR from Rapid Mortality Surveillance Estimates (2023 series, preliminary) as published by the UN-IGME. RMS estimates are provided to the UN-IGME by the Burden of Disease Research Unit, SA Medical Research Council.
2. Neonatal mortality estimates are referenced on the UN-IGME site as "DHIS direct" but are also those provided by the MRC RMS team. They are published on UN-IGME without a decimal place. To provide a more realistic progression of the rate over time, the estimates used in the figure include a further significant digit provided directly by the RMS team.
3. The estimates represented by dotted lines are preliminary, given absence of survey and vital registration data.

lateness in release of registration data), to determine the extent of the deficiency in the registered deaths. Unfortunately, the most recent survey data that can be used date back to 2016/7 and the most recent data on deaths released by Statistics South Africa (Stats SA) is four years out of date.[i]

An alternative approach to monitoring age-specific mortality nationally since 2009 is the rapid mortality surveillance system (RMS) based on the deaths recorded on the population register by the Department of Home Affairs.[4]

These data have been corrected for known biases. In other words, the trends shown in Figure 3a are based on nationally representative numbers. The RMS reports vital registration data adjusted for under-reporting which allows for the evaluation of annual trends.

Trends since 2000 show that the IMR peaked in 2003 at 54 per 1,000 and decreased to 24 per 1,000 in 2017, after which the IMR rose again slightly before a sudden drop to 20 in 2020. During the same period the U5MR decreased from 81 per 1,000 in 2003 to 33 per 1,000 in 2017, rising again slightly to 36 in 2019 and then dropping to 28 in 2020.[5]

With reference to the substantial drop in infant and under-five mortality in 2020, the authors of the Rapid Mortality Surveillance Report note that "the lack of seasonal increases in the numbers of registered deaths suggest that the winter increases in respiratory syncytial virus (RSV) and other pneumonias as well as seasonal outbreaks of diarrhoea were absent in 2020".[5]

This was possibly due to the effects of lockdown with "unusually low" monthly deaths in April and May 2020, and "no seasonal trend in the following [winter] months".[5]

In other words, while the hard lockdown of 2020 was devastating for the economy and society in many ways, an unexpected benefit was that the restrictions on socialising and travel may have protected young children from infectious diseases that contribute to high mortality rates.

Preliminary estimates by the MRC suggest that infant mortality rates rose sharply in 2021 and 2022, with a corresponding increase in under-five mortality. The revised estimate for IMR in 2022 is 29 deaths per 1,000 live births. Despite slight recovery (to 26 in 2023) the estimated probability of dying in the first year of life remains above pre-COVID levels. The U5MR increased to 39 in 2022, declining slightly to 35 in 2023 – also above pre-COVID rates. The reasons for rising child mortality after lockdown are unclear as there have been long delays in the release of Causes of Death data by Stats SA. Mortality estimates beyond 2019 are extrapolations from the National Population Register (NPR), which is more prone to error because not all deaths are reported, and even if they are, they are not captured in the NPR if the birth was not registered prior to death. The NPR also does not record births and deaths for individuals who are not South African. In addition, there is quite a bit of uncertainty around the population estimates for children, and for infants in particular. This is partly due to problems with the high undercount of the 2022 census and subsequent adjustments to correct for that. In addition, administrative data on births, recorded in the Department of Health's District Health Information System (DHIS), shows an inexplicable decline to 2016 and rise to 2020 followed by an improbable decline in the number of live births from 2021 onwards, calling into question the integrity of the system.

It is partly due to these data delays, gaps and quality concerns that the MRC has not formally published its child mortality estimates since 2020, although the estimates have been shared with the United Nations Inter-agency Group for Child Mortality Estimation (UN-IGME) and inform the UN models.

Given the lack of recent data on causes of death, it is not possible to determine what is driving the estimated increase in mortality between 2020 and 2023. The leading causes of under-five mortality (other than neonatal causes) are generally diarrhoea, and lower respiratory infections, while malnutrition is often an underlying cause of death in young children.

The neonatal mortality rate (NMR) is the probability of dying within the first 28 days of life per 1,000 live births. The NMR has remained stable, at around 12 deaths per 1,000 live births. Estimates of the NMR are taken from the UN-IGME model, which is in turn derived from neonatal deaths and live births recorded in the DHIS. The NMR estimates therefore exclude deaths that occur at home or in the many private sector health facilities that are not included in the DHIS. Unlike the live birth trend, the DHIS reflects no substantial change in neonatal deaths.

The DHIS also records the in-facility neonatal death rate – ie the number of infants aged 0 – 28 days who died during their stay in the facility, per 1,000 live births in public health facilities. The recorded rates were also around 12 in the years leading up to COVID-19 but increased after 2020, reaching 13.4 per 1,000 live births in 2023.[6]

Children living in households where there is reported child hunger

This indicator shows the number and proportion of children living in households where children are reported to go hungry 'sometimes', 'often' or 'always' because there isn't enough food.

Child hunger is emotive and subjective, and this is likely to undermine the reliability of estimates on the extent and frequency of reported hunger, but it is assumed that variation and reporting error will be reasonably consistent so that it is possible to monitor trends from year to year.

In 2024, 14% of children in South Africa (approximately 2.9 million) lived in households that reported child hunger. Reported child hunger rates in the years 2021 to 2024 have remained slightly higher than they were in the pre-COVID lockdown year of 2019, when child hunger rates reached a low of 10%. However, the long-term trend is that reported child hunger has declined substantially since 2002 when 30% of children (5.5 million) lived in households that reported child hunger. The largest declines have been in the Eastern Cape, and Limpopo, followed by Free State, Mpumalanga and KwaZulu-Natal.

One of the main contributors to the long-term decline is the expansion of the Child Support Grant which steadily increased its coverage, reaching over 13 million children in 2024. [7] Another possible contributor to declining child hunger

i Stats SA decided the data on fertility and mortality from the most recent 2022 population census were too unreliable to be shared, even with researchers.

is the National School Nutrition Programme (NSNP), which reaches an estimated nine million learners in approximately 20,000 schools.[8] However, the NSNP only operates during the school term and does not include children who are too young to attend. Despite having the smallest child population, the Northern Cape appears to have the highest rates of hunger, with 22% of children living in households that report children going hungry. KwaZulu-Natal households report slightly lower rates of child hunger (19% of children), but because of its large child population it accounts for nearly a third (29%) of children reported to suffer hunger. The Western Cape has relatively low rates of child hunger (15%) but is also the only province where child hunger rates have not reduced in the past two decades. Given population growth, the estimated number of children reported to be hungry in that province has increased from 275,000 in 2002 to around 330,000 in 2024.[9]

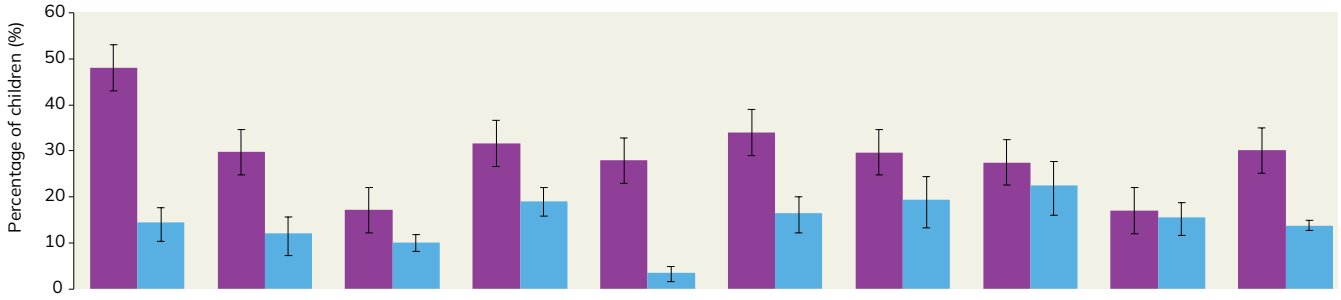
The lowest reported hunger rates were in Limpopo (4%). Despite high poverty rates, Limpopo has always reported child hunger rates well below the national average, perhaps because of the relatively fertile and productive land in rural areas where most of the population lives. However, there is no clear explanation for the dramatic decline in reported hunger in the Eastern Cape. Over the period 2002 to 2024, reported child hunger rates in that province fell from 48% (higher than any other province) to 14%, despite the Eastern Cape having the highest poverty rates in the country, with half of the children in that province living below the food poverty line.

There are no differences in reported child hunger across gender or age groups. However, as with many other indicators, child hunger is highly racialised: 15% of African children and 12% of Coloured children live in households that reported child hunger, compared with less than 3% of Indian and White children. Differences are even more pronounced across income quintiles. While one in five children living in the poorest 20% of households experienced hunger, only 1% of children in quintile 5 (the richest 20%) lived in households where child hunger was reported. Over half of all those who reported child hunger were in the poorest income quintile and nearly 90% were in the poorest two quintiles. For many years, reported hunger rates were higher in the former homelands than in urban areas, but the difference has reduced over time and in 2024 food insecurity was equally prevalent in urban and rural areas.

Children who suffer from hunger are at risk of various forms of malnutrition, including wasting, stunting, overweight and micronutrient deficiencies. The 2016 Demographic and Health Survey recorded the stunting rate among children under five years at 27% – a figure that has remained persistently high since the 1990s and indicates high rates of chronic undernutrition.[10] The more recent National Food and Nutrition Security Survey conducted by the Human Sciences Research Council between 2021 and 2023 found similarly high levels of malnutrition, with under-five stunting estimated at 29% nationally.[11] This suggests that chronic malnutrition has remained persistently high, and even may have worsened in the last decade.

It must be recognised that child hunger is a subjective indicator and does not capture other important aspects of food security such as dietary diversity and consumption of nutrient-rich foods, both of which are important for children's healthy growth especially in early childhood. Children living in households that do not report hunger may still not have access to sufficient nutritious food and be at risk of malnutrition. In 2024, for example, nearly 80% of children who lived in households with incomes below the food poverty line were not reported to have suffered hunger. Food poverty is an indicator that households lack the financial resources needed to meet minimum dietary requirements for children and other household members. Other measures of food insecurity also suggest a more serious challenge than the subjective hunger indicator. For example, in 2024, 22% of children lived in households that reported running out of food due to lack of money, while 27% lived in households that had been forced to cut the range of foods they could afford to buy.[12]

Figure 3b: Children living in households with reported child hunger, 2002 & 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	48%	30%	17%	32%	28%	34%	30%	27%	17%	30%
	1,407,000	297,000	503,000	1,314,000	675,000	518,000	346,000	109,000	275,000	5,455,000
2024	14%	12%	10%	19%	4%	17%	19%	22%	15%	14%
	361,000	126,000	483,000	830,000	91,000	296,000	280,000	99,000	331,000	2,899,000

Source: Statistics South Africa (2003; 2025) *General Household Survey 2002; General Household Survey 2024.* Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

Children living far from their health facility

This indicator reflects the distance from a child's household to the health facility that they normally attend. Distance is measured as the length of time travelled to reach the health facility, by whatever form of transport is usually used. The health facility is classified as 'far' if a child would have to travel more than 30 minutes to reach it, irrespective of mode of transport.

A review of international evidence suggests that universal access to key preventive and treatment interventions could avert up to two-thirds of deaths of children below age five in developing countries.[13] Preventative measures include the promotion of breast- and complementary feeding, micronutrient supplements (vitamin A and zinc), immunisation, and the prevention of mother-to-child transmission of HIV, among others. Curative interventions provided through the government's Integrated Management of Childhood Illness Strategy include oral rehydration, infant resuscitation and the dispensing of medication.

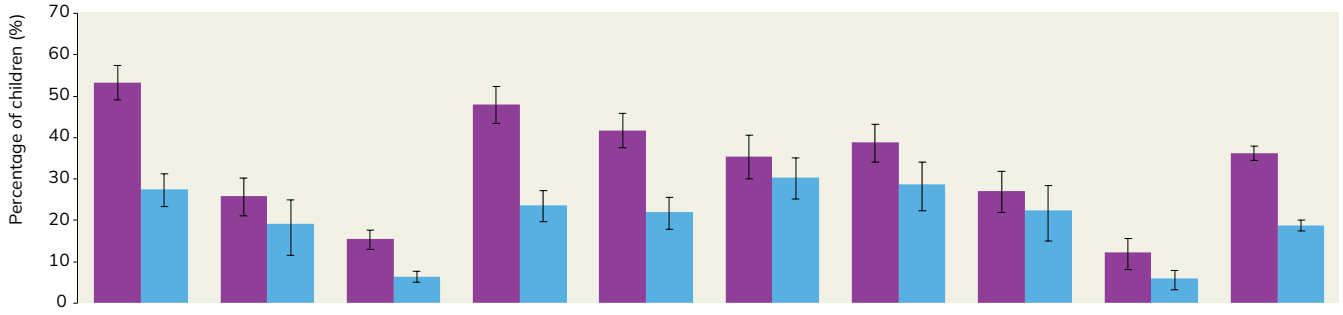
According to the UN Committee on Economic, Social and Cultural Rights, primary healthcare should be available (in sufficient supply), accessible (easily reached and affordable), acceptable and of good quality.[14] In 1996, primary level care was made free to everyone in South Africa, but the availability and physical accessibility of healthcare services remain a problem, particularly for people living in remote areas.

Physical inaccessibility poses particular challenges when it comes to health services because the people who need these services are often unwell or injured or need to be carried because they are too young, too old or too weak to walk. Physical inaccessibility can be related to distance, transport options and costs, or road infrastructure. Physical distance and poor roads also make it difficult for mobile clinics and emergency services to reach outlying areas. Within South Africa, the extent to which patients use healthcare services is influenced by the distance to the health service provider: those who live further from their nearest health facility are less likely to use the facility. This 'distance decay' is found even in the uptake of services that are required for all children, including immunisation and maintaining the Road to Health Book.[15]

In 2024, almost 20% of South Africa's children lived far from the primary healthcare facility they normally use. Our analyses from previous years of the General Household Survey (GHS) showed that over 90% of children live in households where members attended the health facility closest to their home. Among those who do not, the main reasons for attending a more remote health service relate to perceptions of service quality: a preference for private health services (36%), and other specific quality complaints including long waiting times (19%); the unavailability of medication (8%) and rude or uncaring staff (4%). Cost considerations also inform choices, and 12% of households that did not use their nearest facility chose to travel further in order to access cheaper medical care or free government health services.[16] Unfortunately these questions were dropped from the GHS in 2020 and were not reinstated in more recent years.

In total, four million children (one in five children) travel more than 30 minutes to reach their usual healthcare service provider. This is a significant improvement since 2002, when 36% (or 6.6 million children) lived far from their nearest health facility. Improvements in the accessibility of health services are probably related both to the roll out of additional facilities since 2002, and to increased urbanisation and greater population density in the areas around existing health infrastructure. While it is easier to deliver services in areas of greater population density, it may lead to greater pressure on health facilities if their capacity is not increased alongside a growing client population.

Figure 3c: Children living far from their health facility, by province, 2002 & 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2002	53%	26%	15%	48%	42%	35%	39%	27%	12%	36%
	1,559,000	259,000	453,000	1,988,000	1,010,000	538,000	451,000	108,000	199,000	6,568,000
2024	27%	19%	6%	24%	22%	30%	29%	22%	6%	19%
	687,000	199,000	309,000	1,027,000	556,000	544,000	412,000	100,000	128,000	3,960,000

Source: Statistics South Africa (2003; 2025) *General Household Survey 2002; General Household Survey 2024.* Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

It is encouraging that the greatest improvements in health facility accessibility have been made in provinces which performed worst in 2002: the Eastern Cape (where the share of children with poor access to health facilities dropped from 53% in 2002 to 25% in 2022, increasing again slightly to 27% in 2024), KwaZulu-Natal (down from 48% to 24%), and Limpopo (from 42% to 22%). Provinces with the highest rates of access are the largely metropolitan provinces of the Western Cape and Gauteng, where only 6% of children live more than 30 minutes from their usual healthcare service.

Over 20% of African children travel far to reach their usual healthcare facility, compared with between 4% and 9% of Coloured, Indian and White children. Racial inequalities are amplified by access to transport: if in need of medical attention, 95% of White children would be transported to their health facility in a private car, compared with only 14% of African children. Only 3% of the poorest children (quintile 1) travel to their health facility in a private car, while 60% walk.

Poor children tend to bear the greatest burden of disease, due to undernutrition, poorer living conditions and lower levels of access to basic services such as water and sanitation. Yet health facilities are least accessible to the poor. A quarter of children (26%) in the poorest 20% of households travel far to access healthcare, compared with 8% of children in the richest quintile.

There are no significant differences in patterns of access to health facilities when comparing children of different sex and age groups.

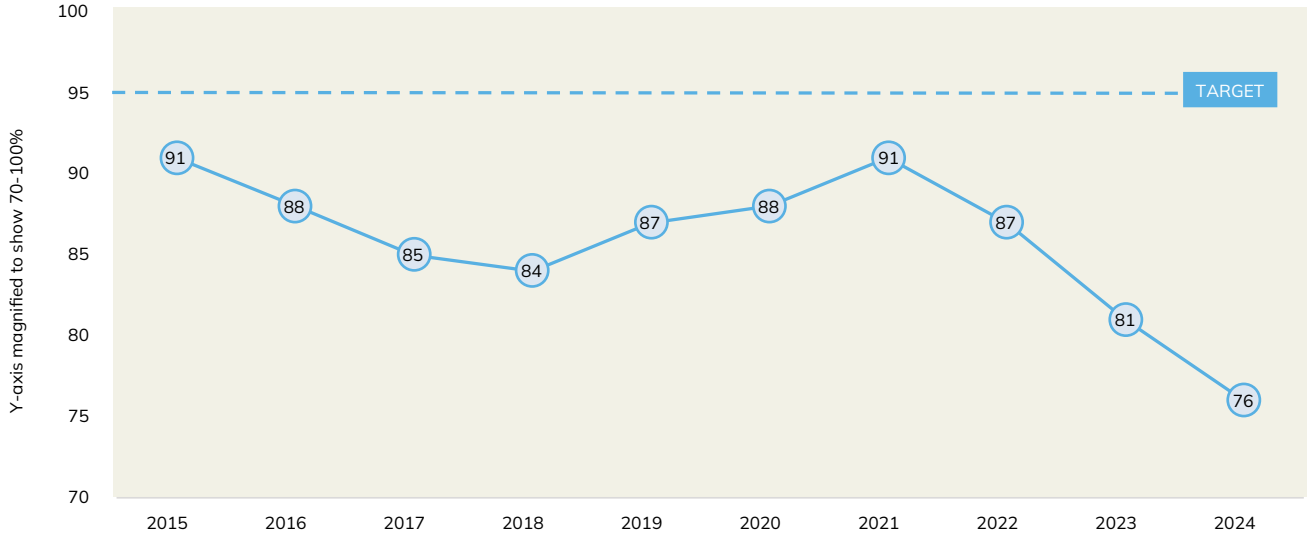
Immunisation coverage of children

This indicator reflects the percentage of children younger than one year who are fully immunised. 'Full immunisation' refers to children having received all the required doses of vaccines administered in the first year of life. The primary course of immunisation in the first year includes BCG and OPV 0 (administered at birth); OPV 1; DTaP-IPVHib-HBV 1, 2 and 3; PCV 1, 2 and 3; RV 1 and 2, and the measles and rubella vaccine (usually administered at six months).

Vaccination is one of the most effective interventions to prevent serious illnesses and death in young children. It entails giving injections or drops to young children, to protect them against potentially life-threatening illnesses such as tuberculosis, polio, hepatitis and measles. Since the introduction of the Expanded Programme on Immunisation (EPI) over 50 years ago, an estimated 154 million lives have been saved globally, of which 101 million were infants. In Africa alone, the EPI has reduced infant deaths by more than 50%.[17] In keeping with world standards, South Africa has an up-to-date immunisation programme which was last revised in 2024.

The revised EPI schedule for public health facilities includes immunisation at birth, and then at six weeks, 10 weeks, 14 weeks, six months and nine months.[18] Thus, by the time of their first birthday, all babies should have visited a health facility at least five times after birth for immunisation services, and these immunisations should be recorded in the child's Road to Health Book. However, many children do not receive their scheduled immunisations. Low coverage is driven by both supply side issues, such as vaccine stockouts and a reluctance to administer multiple vaccines at once, and demand side barriers, including transport challenges, long distances to health facilities, a lack of information or fear of vaccine adverse effects. Those children are classified as 'zero-dose' – meaning that they have not received

Figure 3d: National estimates of DTP1 vaccine dose coverage in babies younger than one year, 2015 – 2024



Source: WHO/UNICEF Estimates of National Immunization Coverage, 2024 Revision (completed 15 July 2025). Available at: https://worldhealthorg.shinyapps.io/wuenic-trends/

Notes:

1. Immunisation coverage estimates may not fully account for vaccines administered to children in the private sector, since data from the private sector are only partially collected in all provinces.
2. There has been no nationally representative household survey in the last five years to verify the reported coverage levels.

any doses of the BCG, polio, hexavalent or measles vaccines. Some children could also be classified as 'penta-zero' dose which, in a South African context, means that they haven't received the hexavalent (DTaP-IPV-Hib-HBV) vaccine – a marker of successful access to primary healthcare facilities.[19] A study using Demographic and Health Survey data of non-immunised children between 2010 and 2020 found that 5.8% of children aged 12 – 23 months were zero-dose, while 10.8% of children were penta-zero dose.[20]

In 2023, approximately 220,000 children in South Africa were considered zero-dose based on whether they had achieved access to the first dose of diphtheria, tetanus and pertussis (DTP) vaccine.[21] WHO and UNICEF estimates of National Immunisation Coverage show that coverage of DTP1 in babies younger than one year declined from 91% in 2021 to 76% in 2024. This amounts to a 15% drop in coverage of this lifesaving vaccine, far below the 95% target. The Immunisation Agenda 2030 aims to reduce the number of zero-dose children by 50%, prioritising equity in healthcare.

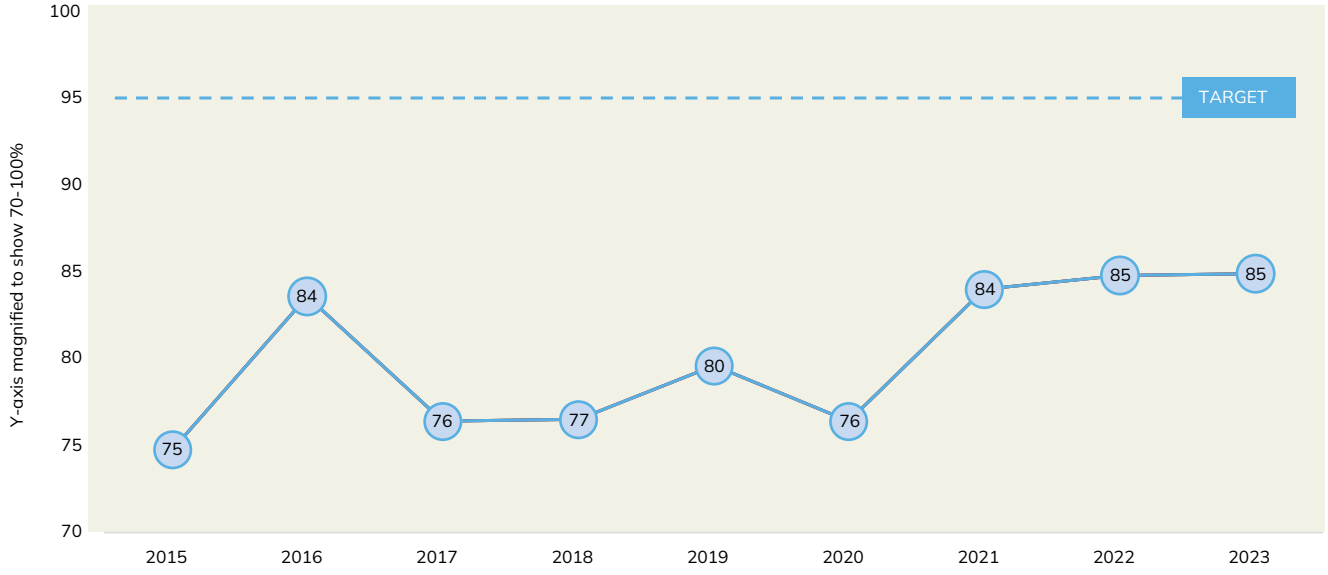
Immunisation coverage serves as a strong indicator of the extent to which young children access primary healthcare services. Immunisation coverage is also a proxy for the extent to which children access other health services, as the immunisation schedule provides a point of contact for identifying other health problems and for scheduling preventative child health interventions. Examples of these are the vitamin A supplementation programme, developmental screening, and prophylaxis for babies born to HIV-positive mothers.

Immunisation rates are tracked in the District Health Information System and are calculated as the number of children under one year who have received their complete primary course of immunisation divided by the child population under one year. Immunisation rates at district level are calculated in a similar way, by dividing immunisations administered by the infant population for a district. The percentages obtained in this way may be influenced by population movement in health seeking behaviour – for example, if children from one district or province are taken to a health facility in a neighbouring district or province. Currently, estimates of immunisation uptake are also compromised by the uncertainty around infant numbers at the national, provincial and district levels.

The 2015 immunisation rate, as reported in the 2016 District Health Barometer, reflected high levels of immunisation for infants under a year, at 89.2% [22] but the population model for the country had under-estimated the number of children. Stats SA subsequently revised its population model and released a new series of mid-year population estimates[23] and the 2015 immunisation rate was revised downwards to 79.4%. The 2016 rate dropped to 71% after retrospective adjustment to the revised population estimates. The lower immunisation rate for that year was attributed to a global shortage of Hexavalent vaccine.[18] In 2017 the immunisation rate picked up to 77%, increasing further to 82% in 2018 and 83.5% in 2019. In 2020, the immunisation rate dropped to 79.5% nationally as a result of the COVID-19 lockdown, and as low as 61% in Limpopo. These fluctuations illustrate how the immunisation programme, which generally has high levels of compliance, is highly sensitive to disruptions in vaccine supply (as in 2016) or service delivery (as in 2020).

Immunisation rates improved significantly to 85.5% in 2021, dropping back slightly to 82.2% in 2022. This increase in the year following the hard lockdown, followed by a slight decline the next year, occurred across all provinces and might have been the result of a catch-up in delayed infant immunisations. When comparing the baseline immunisation rates in 2015 with those in 2023, the overall rates are quite similar despite some volatility in the intervening years.[ii] The average rate for the

Figure 3e: National estimates of measles second vaccine dose coverage of babies younger than one year, 2015 – 2023



Source: Health Systems Trust (2025) District Health Barometer 2024 data file (derived from Department of Health District Health Information System – DHIS). Available at www.hst.org.za.

ii The immunisation rates in the District Health Barometer have not been adjusted to the revised population model before 2015, and so it is not possible to determine historical trends in immunisation uptake before 2015.

country was slightly higher in 2023 (83%) than in 2015 (79%). Underlying the overall increase between 2015 and 2023 are contrasting patterns between provinces. Immunisation rates over the period increased substantially in KwaZulu-Natal and, to a lesser extent, in the Eastern Cape, Free State, Mpumalanga and North West. At the same time, immunisation rates dropped in the Northern and Western Cape, Limpopo and Gauteng.

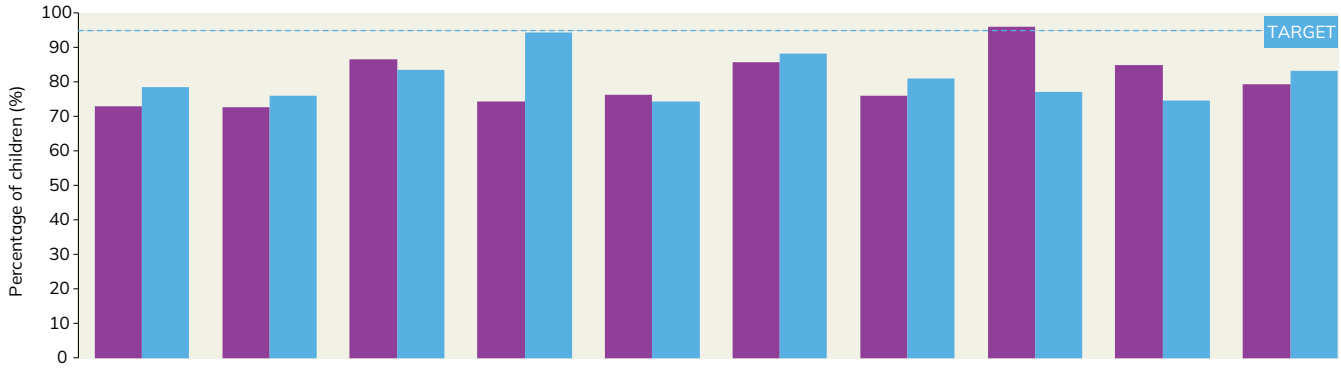
Provinces that experienced a notable increase from 2022 to 2023 were Limpopo (+6.8%) and North West (+7.1%). While provinces who experienced a significant decline in immunisation coverage were the Eastern Cape (-3.7%) and Free State (-3.5%). The highest immunisation rates for 2023 were in KwaZulu-Natal (94.5%) and Mpumalanga (88.2%), while the lowest rates were in Limpopo (74.3%), Western Cape (74.8%) and the Free State (76.2%). Effective immunisation requires high levels of coverage to achieve a certain level of immunity within the broader community. This is known as 'herd immunity' and it means that, if immunisation coverage has reached a high enough level, even the most vulnerable who have not been immunised in that community will be protected – including young children and those with low immunity. Herd immunity depends on the disease's reproductive number: the higher the reproductive number (that is, the more people one infected person can transmit the disease to) the larger the proportion of the population that needs to be immune to achieve herd immunity. The World Health Organization recommends a target of 95% coverage to achieve herd immunity and eliminate infectious childhood diseases. While no province was able to achieve this target, KwaZulu-Natal came relatively close.

The indicator used to estimate coverage of the second dose of the measles vaccine administered at 12 months was derived from the 2025 edition of the District Health Barometer. Over the past decade, at global and national level, there have been numerous outbreaks of measles, emphasising how important it is to administer this booster dose. In South Africa, coverage of the second measles dose in children has varied between 2015 and 2023. After a peak in 2016 (83.6%), coverage dropped and stayed around 76% between 2017 and 2020 with a slight deviation of 79.6% in 2019. Coverage increased sharply to 84% in 2021 and remained at that level in 2022 and 2023. Measles coverage has consistently been the lowest in the North West and Limpopo provinces, the very same provinces that were most severely affected by the 2023 measles outbreak. To prevent outbreaks of this nature and protect children from preventable infectious diseases, we need to advocate for increased uptake of both the first and second measles dose to more than 95%.

Even though immunisation is freely available, and the goal is for it to be universal, it is voluntary and there is growing evidence that some parents choose not to immunise their children. A "worldwide increase in vaccine hesitancy and refusal" has been described as a threat to the public health achievements in controlling and preventing infectious diseases.[24] Internationally, vaccine sentiment and voluntary compliance is inversely correlated with socio-economic status (ie compliance is lower in wealthy countries than in poorer ones).[24] Following a campaign of misinformation about vaccines during the COVID-19 pandemic, a concerted effort needs to be made to ensure that all mothers and caregivers are educated about the importance of immunising their children.

The completion rates for 'basic immunisation' in the South African Demographic and Health Survey of 2016 were substantially lower than those recorded in the District Health Information System for the same year (at 61%, compared with 77%). The reason for this discrepancy is not clear, but it is important to note that compliance was highest in the poorest wealth quintile (66%) while the richest quintile was lower, at 60%.[10] This suggests that there is also an inverse correlation between socio-economic status and immunisation in South Africa, a highly unequal country.

Figure 3f: Immunisation coverage of babies younger than one year, by province, 2015 & 2023



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2015	73%	73%	87%	74%	76%	86%	76%	96%	85%	79%
2023	79%	76%	84%	95%	74%	88%	81%	77%	75%	83%

Source: Health Systems Trust (2025) District Health Barometer 2024 data file (derived from Department of Health District Health Information System – DHIS). Available at www.hst.org.za.

Notes:

1. The numerator (immunisations) comes from the NDoH's District Health Information System for April 2023 – March 2024.
2. The denominator (population under one) was derived from the 2023 mid-year population estimate.

Teenage pregnancy

This indicator shows the number and proportion of young women aged 15 – 24 who are reported to have given birth in the past year.

Teenage pregnancy rates are difficult to calculate directly because it is hard to determine how many pregnancies end in miscarriage, still-birth or abortion: these are not necessarily known to the respondent, or accurately reported. In the absence of reliable data on pregnancy, researchers tend to rely on childbearing data (ie the percentage of women in an age group who have given birth to a live child).

Despite widespread assumptions that teen pregnancy in South Africa is an escalating problem, the available data suggest that the percentage of teenage mothers is not increasing. A number of studies have suggested a levelling off and even a decrease in fertility rates among teenagers in South Africa.[25-27] Teenage fertility rates declined after the 1996 census from 78 births per 1,000 women aged 15 – 19 years, to 65 births per 1,000 adolescents in 2001. The adolescent birth rate recorded in the 2011 population census suggested an increase to 72 per 1,000, and the 2016 SA Demographic and Health Survey recorded a similar (slightly lower) rate of 71. These patterns (the decline, increase and stability over the past two decades) are not exclusive to adolescents but follow the overall fertility trends for the country.[28]

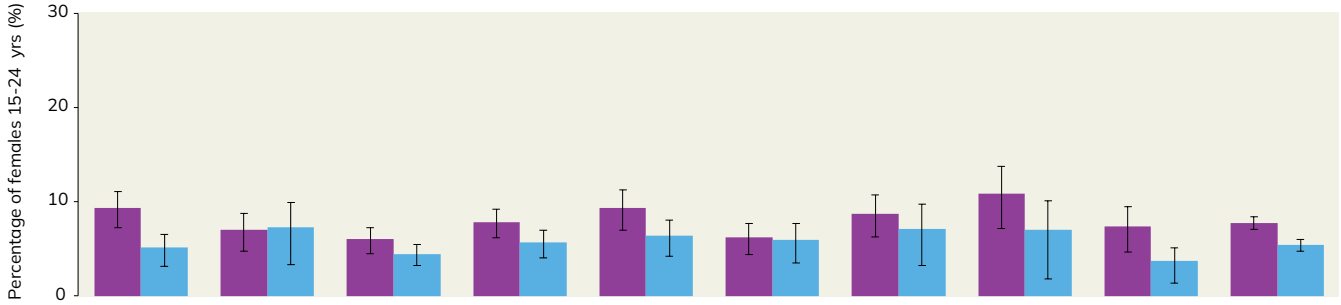
Stats SA regularly reports the number of 'recorded live births', using vital statistics data. The pattern over the past decade (from 2011) has been a decrease in adolescent births, this decrease being reflected in both the rate of current year birth registrations and late birth registrations. In 2023, out of 950,000 current-year births registered, 100,000 were registered to the mothers of adolescents aged 19 or younger.[29] The share of all births registered to teens up to 19 years was 12%, down from 16% of births that occurred a decade before.

Department of Health data between 2004 and 2019 showed a consistent decline in the share of teenagers aged 15 – 19 who attended antenatal clinics and participated in the national HIV sero-prevalence survey.[30] The share remained stable in 2022, with teens aged 15 – 19 representing 13% of participants in the antenatal survey, down from 17.5% in 2013. All of these data sources suggest that pregnancy and fertility rates among teenagers did not increase in last decade.

Fertility rates are, of course, an indicator of possible exposure to HIV. HIV prevalence rates are higher among women in their late twenties and thirties, and lower among teenagers, and the prevalence rate in the 15 – 24 age group has decreased over the past decade. However, prevalence rates are still worryingly high: of the young pregnant women surveyed in antenatal clinics in 2022, 7.6% of those aged 15 – 19 and 16.4% of those aged 20 – 24 were HIV positive.[31] For many years the majority of deaths in young mothers were caused by HIV.[32] Much of the overall decline in maternal deaths since 2011 is attributed to implementation of policies to manage and prevent HIV,[33] but it is still important that safe sexual behaviour is encouraged and practised.

Studies have found that early childbearing – particularly by teenagers and young women who have not completed school – has a significant impact on the education outcomes of both the mother and child, and is also associated with poorer child health and nutritional outcomes.[26, 32, 34] For this reason, it is important to delay childbearing, and to ensure that teenagers who do become pregnant are appropriately supported. This includes ensuring that young mothers can complete their education, and that they have access to parenting support programmes and health services. Although pregnancy is a major cause of school drop-out, some research has also suggested that teenage girls who are already falling behind at school are more likely

Figure 3g: Annual childbearing rates among young women aged 15 – 24 years, by province, 2009 & 2024



	EC	FS	GT	KZN	LP	MP	NW	NC	WC	**SA**
2009	9,3%	7,0%	6,0%	7,8%	9,3%	6,3%	8,7%	10,9%	7,4%	7,7%
	66,000	20,000	66,000	92,000	61,000	28,000	27,000	12,000	39,000	412,000
2024	5,1%	7,3%	4,5%	5,7%	6,4%	5,9%	7,2%	7,0%	3,7%	5,4%
	26,000	18,000	61,000	59,000	34,000	27,000	24,000	8,000	23,000	281,000

Source: Statistics South Africa (2010; 2025) *General Household Survey 2009; General Household Survey 2024*. Pretoria: Stats SA.
Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

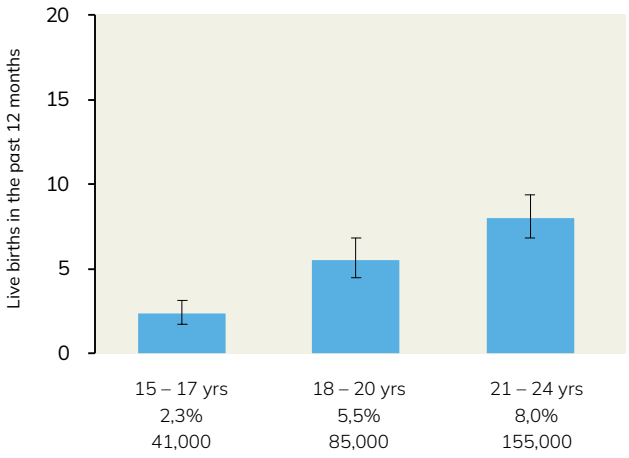
to become pregnant than those who are progressing through school at the expected rate.[35] So efforts to provide educational support for girls who are not coping at school may also help to reduce teenage pregnancies.

Poverty alleviation is important for both the mother and child, but previous studies on take-up of the Child Support Grant (CSG) among teenage mothers have found that access is low compared with older mothers.[27, 36, 37] In 2024, fewer than 1% of the 7.5 million CSG beneficiaries (caregivers) were under 20 years old.[7] This suggests that greater effort should be made to assist young mothers to obtain identity documents for themselves and birth certificates for their babies so that they can apply for CSGs. Ideally, birth registration and social security services should form part of a comprehensive maternal support service at all maternity facilities.

Since 2009 the nationally representative GHS conducted by Stats SA has included questions on pregnancy and fertility. The pregnancy question asks the household respondent: "Has any female household member [between 12 – 50 years] been pregnant during the past 12 months?" For those reported to have been pregnant, a follow-up question asks about the current status of the pregnancy. This indicator calculates the number and percentage of young women who have given birth in the past year.

According to the GHS, the national childbearing rate for young women aged 15 – 24 was 5.4% in 2024. This is equivalent to 281,000 births to young women in this age group, out around one million births per year, according to the population models and represents a statistically significant decline since 7.7% in 2009 when the question was first asked in the survey.

Figure 3h: Childbearing rates among female youth aged 15 – 24 years, by age group, 2024



Source: Statistics South Africa (2025) *General Household Survey 2024*. Pretoria: Stats SA. Analysis by Katharine Hall and Sumaiyah Hendricks, Children's Institute, UCT.

As would be expected, childbearing rates increase with age. Only 2% of girls aged 15 – 17 were reported to have given birth in the previous 12 months (representing 41,000 teenagers in this age group). Childbearing rates rose to 6% among 18 – 20-year-olds (85,000 when weighted), and 8% in the 21 – 24 age group (155,000). This pattern has been been fairly stable over the past decade, and in the group defined as children (under 18) the childbearing rate has never risen above 3.2% (its peak in 2013).

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