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DIAGNOSTIC EVALUATION OF THE GOVERNMENT'S RESPONSE TO TEENAGE PREGNANCY IN SOUTH AFRICA

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STRUCTURE OF THE EVALUATION REPORT

Chapter	Description	Purpose
	Executive Summary	Presents a summary of the background to the evaluation, the methodology followed as well as the main findings, conclusions and insights.
1	Introduction	Provides the essential background to Teenage Pregnancy in South Africa
2	Methodology	This Chapter presents details of the diagnostic evaluation literature review specifically; its approach and design, methodology and instrumentation, the execution of data collection, and data analysis undertaken. This section also highlights the limitations of this evaluation.
3	Literature Review	This section reviews the policy problem of teenage pregnancy, its prevalence, its aetiology (factors, determinants and predictors), and the Government's main policy, legislative and programme (services and interventions) responses
4	Key Literature Review Findings	This section of the report describes the findings of the literature review and includes a related discussion and analysis.
5	Summary and Conclusion	This section draws inferences from the diagnostic evaluation and draws overall conclusions based on the main evaluation findings and discussions.
	Reference List	This section provides the details of the sources of literature and other information referred to in the report.
	Annexures	Provide additional details or information to support the content that is covered in the report.

ABBREVIATIONS AND ACRONYMS

Abbreviation	Description
AIDS	Acquired Immune Deficiency Syndrome
AU	African Union
BCC	Behaviour Change Communication
COVID-19	Coronavirus disease 2019
CPR	Contraceptive Prevalence Rate
CYCC	Child and Youth Care Centres
DPME	Department of Planning, Monitoring and Evaluation
DSD	National Department of Social Development
ECA	Economic Commission for Africa
ECD	Early Childhood Development
ENE	Estimates of National Expenditure
EPWP	Expanded Public Works Program
FGM	Female Genital Mutilation
FWCW	Fourth World Conference on Women
GP	Gauteng Province
HIV	Human Immunodeficiency Virus
HSRC	Human Science Research Council
ICPD	International Conference on Population and Development
ICPD/PoA	ICPD Programme of Action
IDP	Integrated Development Plan
IDT	Independent Development Trust
IMR	Infant Mortality Rate
IPPF	International Planned Parenthood Federation
IPPF/ARO	IPPF Africa Regional Office
KZN	KwaZulu-Natal Province
M&E	Monitoring and Evaluation
MCH	Mother and Child Health
MCT	Mother-to-Child Transmission
MDGs	Millennium Development Goals
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
MTSF	Medium Term Strategic Framework
NDA	National Development Agency
NDP	National Development Plan
NEPAD	New Partnership for Africa's Development
NEPF	National Evaluation Policy Framework

NGO	Non-Governmental Organisation
NGO	Non-Government Organization
NPO	Non-Profit Organisations
NW	North-West Province
ODA	Official Development Assistance
OECD	Organization for Economic Cooperation and Development
OHS	Occupational Health and Safety
OHSA	Occupational Health and Safety Act No. 85 of 1993
OVC	Orphans and Vulnerable Children
PFMA	Public Finance Management Act
PLWHA	People Living With HIV/AIDS
PPP	Public-Private Partnership
REC	Research Ethics Committee
SASSA	South Africa Social Security Agency
SIP	Sector Infrastructure Programme
SRHR	Sexual and Reproductive Health and Rights
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
ToC	Theory of Change
ToR	Terms of Reference
UNAIDS	Joint UN Programme on HIV/AIDS
UNFPA	United Nations Population Fund
WHO	World Health Organization

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POLICY SUMMARY

The diagnostic evaluation underscores the complex and multidimensional nature of teenage pregnancy in South Africa. While various policy, legislative, and programmatic responses have been introduced by the social development, health, and education sectors, their effectiveness is hampered by fragmented service delivery and weak interdepartmental coordination. Teenage pregnancy is a cross-sectoral issue, yet poor collaboration and siloed implementation significantly undermine progress. The Programme of Action on Teenage Pregnancy provides a potential framework for coordinated intervention, but it lacks strong leadership, defined accountability mechanisms, and adequate financial resourcing.

Despite notable policy strides, such as the Children's Act, the Adolescent Sexual and Reproductive Health and Rights (ASRH&R) Framework, and the Department of Basic Education's Learner Pregnancy Policy, implementation remains inconsistent, particularly in provinces with limited infrastructure and workforce capacity. Bridging the gap between policy intent and practical delivery requires clearer operational guidance, equitable resource allocation, and stronger monitoring and evaluation mechanisms.

The evaluation highlights weaknesses in data and information management systems. The lack of disaggregated real-time data, particularly at the sub-district level, undermines targeted planning and evidence-based decision-making. Simultaneously, adolescents continue to face significant barriers to accessing sexual and reproductive health (SRH) services, often due to stigma, judgmental provider attitudes, and inconsistent availability of services. Expanding adolescent-friendly clinics, integrating SRH education in schools, and ensuring confidential, youth-centred services are key to improving access.

Structural drivers such as poverty, gender inequality, and lack of opportunity continue to fuel teenage pregnancy. Effective policy responses must go beyond health services and address these root causes through social protection programmes, economic empowerment, and inclusive development strategies. Within the education system, enhancing comprehensive sexuality education (CSE), supporting pregnant learners to remain in school, and increasing psychosocial support is critical, especially considering the implications of the Basic Education Laws Amendment (BELA) Bill.

Teenage pregnancy remains a pressing concern, with 18.2% of girls becoming mothers by age 18. Although adolescent birth rates have gradually declined since 1996, pregnancies among very young adolescents (10–14 years) are increasing, often involving statutory rape and delayed birth registration, limiting access to necessary services.

While South Africa's policy framework is commendable, translating it into impact requires enhanced coordination, improved service delivery, robust data systems, and adolescent empowerment through community-based approaches.

EXECUTIVE SUMMARY

South Africa's Department of Social Development conducted a national evaluation to assess current policies and programs addressing teenage pregnancy. The study found KwaZulu-Natal and Limpopo had the highest rates, attributed to socio-economic vulnerability, cultural norms, contraceptive access, and ineffective sex education. The evaluation recommends stronger coordination, improved service delivery, and integrated health programming to reduce teenage pregnancy and support South Africa's youth.

Background to the evaluation

The Department of Social Development (DSD) is working to address teenage pregnancy through early intervention programs like ChommY and YOLO, fostering intergenerational communication and improving health data sharing. The National Adolescent Sexual and Reproductive Health and Rights Framework Strategy was established in 2015 to address service delivery gaps. The DBE has proposed a revised policy to enhance sexual education in schools and improve access to reproductive health services.

Methodology

This study used an Evaluation Analysis Framework to categorize responses from the literature into policy, legislation, and programmatic areas. Sources included administrative documents and peer-reviewed research. Methods combined secondary analysis, interviews, and focus groups with over 50 stakeholders from government and partners like UNICEF and UNFPA. Fieldwork was done in four provinces excluding the Eastern Cape due to constraints. Data analysis involved thematic coding and statistical tools, ensuring ethical compliance per UNEG guidelines and national protocols.

Findings by evaluation questions and themes

What is the prevalence of teenage pregnancy in South Africa?

The table and chart below illustrate the prevalence of teenage pregnancy across South Africa's nine provinces. This data allows for comparative analysis to understand regional disparities and more effectively target interventions.

No.	Province	Teenage Pregnancy Rate	Primary Data Source
1.	Gauteng	13.2	DHIS, StatsSA (2023)
2.	Eastern Cape	16.8	Thembisa Model, StatsSA (2023)
3.	Northern Cape	14.5	DHA, Lifestyle Publications (2023)
4.	KwaZulu-Natal	18.1	DHIS, Naomi Model (2023)
5.	Limpopo	17.4	Thembisa Model, StatsSA (2023)
6.	Western Cape	12.3	DHIS, Lifestyle Publications (2023)
7.	Free State	15.6	DHA, StatsSA (2023)
8.	Mpumalanga	17.0	Naomi Model, DHIS (2023)
9.	North West	16.0	Thembisa Model, Lifestyle Publications (2023)

According to available data and model estimations from sources such as the Thembisa and Naomi models, the District Health Information System (DHIS), and Statistics South Africa (StatsSA 2023), the prevalence of teenage pregnancy varies notably across provinces. KwaZulu-Natal exhibits the highest rate at 18.1%, followed by Limpopo at 17.4%. These elevated rates can be attributed to factors such as limited access to sexual and reproductive health services, cultural norms, and high school dropout rates. Mpumalanga (17.0%), Eastern Cape (16.8%), and North-West (16.0%) also report significant figures, indicating systemic challenges related to adolescent health education and contraceptive access.

Demographic Trends and Contributing Factors

Teenage pregnancy in South Africa remains a significant public health issue, with 13-18% of adolescent girls reporting pregnancy, especially in rural areas. Factors include inadequate contraception access, limited reproductive health knowledge, gender-based violence, and cultural pressures. Initiatives like ISP and AYFS face implementation gaps in under-resourced areas.

The Policy Problem: Teenage Pregnancy in South Africa

South Africa faces a significant public health issue of teenage pregnancy, with 11.1% of births in 2022 occurring to 15-19-year-olds. Despite a decline in birth rates, rates remain higher than in high-income countries, particularly in Northern Cape, KwaZulu-Natal, Mpumalanga, and Limpopo. To address this, improve sexual and reproductive health education, enhance youth-friendly services, and strengthen data systems.

Determinants and Predictors of Teenage Pregnancy

Teenage pregnancy in South Africa is influenced by various factors including socio-structural, economic, cultural, educational, and policy-related influences. Economic deprivation, low contraceptive availability, and COVID-19 have exacerbated the issue. Adolescent girls often view health facilities as unwelcome, and mistrust of teachers hinders prevention efforts. Adolescent pregnancy is linked to early marriage and inadequate access to sexual and reproductive health rights services. Substance abuse among mothers can also increase pregnancy risks in children.

Government Policy and Legislative Response

South Africa's social development sector has implemented policies to address teenage pregnancy, focusing on poverty and inequality. Key documents include the White Paper for Social Welfare and the National Child Care Policy. Legislative measures like the Children's Act and Social Assistance Act provide essential services for teenage mothers. However, implementation challenges persist due to resource distribution and accessibility issues.

Summary of South Africa's Multi-Sectoral Response to Teenage Pregnancy

South Africa's approach to teenage pregnancy is shaped by various national and international policies, including CEDAW and the Convention on the Rights of the Child. However, there is no comprehensive strategy specifically targeting teenage pregnancy. A 2022 evaluation of the National Adolescent Sexual and Reproductive Health and Rights Framework (2014–2019) identified mixed effectiveness, noting progress in stakeholder coordination and sexuality education but ongoing challenges in service delivery, community support, and monitoring.

Social Development Sector Response

The Department of Social Development (DSD) has responded through various policy initiatives aimed at broader social issues. However, teenage pregnancy interventions are often subsumed under HIV, TB, STIs, and substance abuse programmes. Despite a legislative foundation, a distinct

sector strategy specifically for teenage pregnancy is absent. Service delivery is fragmented, heavily donor-dependent, and marred by weak information systems and inadequate provincial funding. This limits the effectiveness and coordination of interventions across the country.

Health Sector Response

The DOH has developed and implemented policies like the National Adolescent and Youth Health Policy and Sexual and Reproductive Health Rights Policy to improve adolescent health and prevent teenage pregnancy. However, progress is limited, requiring robust health information systems for effective service delivery.

Basic Education Sector Response

The DBE has implemented policies to promote Comprehensive Sexuality Education (CSE) and prevent HIV, STIs, TB, and learner pregnancy, but implementation is inconsistent due to donor funding and challenges like lack of social service practitioners and underdeveloped monitoring systems.

Cross-Sectoral Government Response

The National Youth Policy and Strategic Plan aim to empower youth, address poverty, and improve adolescent health and rights. However, effective implementation requires better data systems and targeted resources.

Overall Conclusion

Despite social development policies, a cohesive strategy for teenage pregnancy is still developing. Current efforts depend on donor funding, resulting in fragmented services. Improved coordination, youth-friendly services, school support systems, and strong data systems are crucial. The new POA offers a promising platform for the prevention and empowerment of adolescent girls affected by teenage pregnancy.

Government and NPO Programmes for Teenage Pregnancy in South Africa

South African government and non-profits tackle teenage pregnancy through the National Adolescent Health Policy and Integrated School Health Programme, but rural areas need learning from successful models like Kenya and Ethiopia.

International Best Practices for Integrated Service Delivery

Drawing from international literature and best practices, various integrated service delivery methods have proven effective in tackling teenage pregnancy. These approaches can be adapted to fit the South African context when creating a comprehensive framework for program planning. Below is a summary of the relevant practices:

Comprehensive Sexuality Education (CSE)

Comprehensive Sexuality Education (CSE) is crucial for preventing teenage pregnancy. The UNESCO International Technical Guidance highlights the importance of age-appropriate, culturally sensitive education in schools and communities. Data from the Netherlands and Sweden indicate that early and continuous CSE delays sexual debut and boosts contraceptive use among adolescents.

Youth-Friendly Health Services (YFHS)

The World Health Organization advocates accessible youth-friendly health services (WHO, 2021). Kenya and Ethiopia have integrated these services into primary health care, offering non-judgmental sexual and reproductive health (SRH) support.

Multi-sectoral Coordination

Best practice frameworks highlight the importance of collaboration across sectors such as education, health, social development, and justice. For example, the UK's "Teenage Pregnancy Strategy" combined local government, education, and health services with clear accountability and outcome targets. A similar coordination mechanism could be integrated into South Africa's District Development Model.

Community and Parental Involvement

Global interventions like those in Latin America and sub-Saharan Africa underscore the importance of community engagement and parental communication programmes. The “Families Matter!” programme, for example, implemented in Kenya and Zambia, improved parent-child communication and delayed adolescent sexual activity (Markham et al., 2010).

Integration of SRH Services in Schools and Mobile Clinics

Mobile SRH clinics and school-based health centres in Ghana and Thailand have enhanced access to contraception and health education in underserved areas, especially when connected with social protection services and referral pathways (Chandra-Mouli et al., 2015).

Data-driven planning and Monitoring

International best practices emphasize disaggregated data and real-time monitoring. The WHO's “Accelerated Action for the Health of Adolescents (AA-HA!)” framework facilitates the planning and monitoring of adolescent programs through participatory methods and continuous feedback (WHO, 2017).

KEY RECOMMENDATIONS

Below are the consolidated and Action-Oriented Recommendations on Teenage Pregnancy organised and structured around key thematic areas, specific recommendations, responsible actors, proposed timeframes, and indicators of success where applicable.

A. CROSS-CUTTING STRATEGIC RECOMMENDATIONS

To address systemic gaps and enhance the coherence of the national response to teenage pregnancy:

- **Recommendation 1:** Strengthen cross-sectoral and intra-sectoral leadership. This includes clearly defining coordination roles and institutional responsibilities among DSD, DOH, DBE, provincial governments, and municipalities, to establish functional coordination forums within 6 to 12 months.
- **Recommendation 2**: Strengthen Data systems. This is to ensure integrated information management and regular reporting on teenage pregnancy indicators. This should be implemented by DSD, DOH, DBE, and Stats SA within 12 to 18 months.
- **Recommendation 3**: DSD, NYDA, and youth-focused CSOs should facilitate ongoing youth-led consultations to ensure meaningful youth engagement in programme design and monitoring is critical.
- **Recommendation 4:** Expand Preventive behaviour change programmes in schools and communities, led by DBE, DSD, and NGOs, with implementation within 6 to 12 months.
- **Recommendation 5**: Enforce statutory rape laws, especially for girls aged 10–14, by SAPS, DOJ, DSD, and community structures.

- **Recommendation 6**: Use GIS mapping for resource and service planning, led by DSD, DOH, DBE, and local government within 12 months.

B. PREVALENCE-FOCUSED RECOMMENDATIONS

To reduce prevalence rates among 15–19-year-olds, DOH, DBE, and DSD should expand targeted SRHR education and services. SAPS, DOJ, and DSD must protect girls aged 10–14. DHA and DSD should enhance birth registration outreach. Stats SA, DSD, and DOH need to improve sub-district data collection within a year. A national framework for intersectoral coordination and a comprehensive National Teenage Pregnancy Strategy should be developed immediately. With performance tracking and budget allocations by DOH, DBE, and DSD.

C. TARGETED INTERVENTIONS – ADDRESSING FACTORS AND PREDICTORS

The Department of Social Development, local government, and SEDA are urged to enhance social protection and economic empowerment programs within the next 12 to 24 months. It is also recommended that age-appropriate social behaviour change programs be developed within 6 to 18 months. Furthermore, Comprehensive Sex Education for out-of-school youth should be improved within 12 months, with a focus on enhancing training and supervision to ensure the effective delivery of this education.

D. SECTOR-SPECIFIC RECOMMENDATIONS

1) Social Development Sector

DSD should develop an integrated teenage pregnancy strategy with clearly defined accountability mechanisms within 6 to 12 months. The recruitment and deployment of additional social workers should be prioritised by DSD and provincial governments within 12 to 18 months. Additionally, the ASRH&R Framework Strategy should be reviewed and updated within 6 months.

2) Health Sector

The DOH and NGOs should scale up youth-friendly services and outreach programmes over the next 12 months. SRHR indicators must be delineated in national health data systems, with enhanced disaggregation and reporting by DOH and Stats SA within 6 to 12 months.

3) Education Sector

DBE and NGO partners should improve tracking of learner participation and outreach to out-of-school youth within 12 months. The institutionalisation of sustainable curriculum-integrated prevention programmes must replace donor dependency over the next 12 to 24 months.

4) Cross-Cutting Institutional Strengthening

Youth participation should be institutionalized via advisory boards facilitated by DSD, DBE, DOH, and youth agencies in the short to medium term. DSD, DBE, and Treasury should ensure permanent social worker employment and reduce donor reliance.

- Government departments must secure long-term funding for SRHR and CSE programs.
- Monitoring systems need enhancement through integrating DHIS, CRVS, Naomi, and Thembisa models.
- DSD, DOJCD, and SAPS should prioritize stronger enforcement of statutory rape laws and integration with child protection systems.

1. CHAPTER ONE: INTRODUCTION

1.1 CONTEXTUALISING THE TEENAGE PREGNANCY PROBLEM IN SOUTH AFRICA

Teenage pregnancy is a significant global public health and developmental challenge, affecting countries across all income levels. In South Africa, high rates of adolescent pregnancy have far-reaching health, social, and economic implications for young mothers and their children. Evidence consistently highlights the importance of keeping girls in school as a key determinant for improving socio-economic outcomes and breaking intergenerational cycles of poverty.

In South Africa, 16% of young women aged 15-19 have begun childbearing, with a prevalence rate of 11% in urban areas and 19% in rural areas. The COVID-19 pandemic exacerbated the issue, with school closures and restricted access to sexual and reproductive health services contributing significantly to the spike in teenage pregnancies. Approximately 31% of girls aged 15-19 report unmet needs for contraceptive services, highlighting systemic barriers within the healthcare system and a broader neglect of adolescents' sexual and reproductive health rights. Adolescent pregnancy is associated with increased susceptibility to HIV/AIDS, higher rates of maternal mortality and miscarriage, and complications stemming from inadequate pre-and postnatal care.

1.2 BACKGROUND TO THE EVALUATION

The issue of teenage pregnancy in South Africa must be viewed in the context of adolescent health and child development in 2024. Despite improvements in education and healthcare access, adolescent girls still face vulnerabilities like poverty and limited access to sexuality education (DSD, 2024).

The Department of Social Development (DSD) has commissioned an evaluation to assess the government's response to teenage pregnancy, focusing on prevention and early intervention initiatives. A multi-sectoral approach is essential, with collaboration among various government departments, civil society, and development partners.

Intervention initiatives include:

- Ezabasha Dialogues and Risiha – community-based social behaviour change programmes.
- ChommY (targeting ages 10–14) and YOLO – You Only Live Once (targeting ages 15–24), which promote positive youth development and responsible decision-making.
- Intergenerational dialogues on Sexual and Reproductive Health and Rights (SRHR).
- Training programmes on intergenerational communication and comprehensive sexuality education (CSE), particularly for out-of-school youth.
- Advocacy for replicating successful models such as the Nzululwazi Model, which promotes SRHR in schools with high learner pregnancy rates.

Additionally, the National Adolescent Sexual and Reproductive Health and Rights Framework Strategy, approved in 2015, guides these efforts, aiming to improve policy and service delivery for adolescent SRHR. The Department of Basic Education (DBE) has also proposed a new policy to enhance sexuality education and health service access for learners.

1.3 PURPOSE

The primary objective of this diagnostic evaluation is to assess the relevance, responsiveness, and effectiveness of government interventions aimed at addressing the root causes of teenage pregnancy in South Africa.

1.4 OUR INTERPRETATION OF THE PURPOSE OF THE DIAGNOSTIC EVALUATION

The evaluation seeks to:

- Determine the extent to which existing programmes and services are aligned with the needs and rights of adolescents.
- Identify strengths and gaps in current government efforts.
- Provide evidence-based recommendations for improving policies, programme design, and service delivery mechanisms.
- Promote coordinated, integrated, and multisectoral strategies to reduce adolescent pregnancy and enhance adolescent well-being.

Ultimately, this study aims to inform national and provincial policy development processes and ensure that interventions are evidence-driven, rights-based, and responsive to the lived realities of young people in South Africa.

1.5 KEY EVALUATION QUESTIONS

The key evaluation and sub-questions to be addressed by the study include the following:

Table 1: Key Evaluation Questions

KEY EVALUATION QUESTIONS	SUB-QUESTIONS
a) What is the prevalence of teenage pregnancy in South Africa?	i. What is the demographic profile and what are the trends (statistics)?
b) What are current government and NPO programmes and services for teenage pregnancy?	1) What are the existing government services provided to adolescents in relation to teenage pregnancy? 2) What are the institutional priorities, commitments and capabilities for delivering programmes and services in relation to teenage pregnancy. 3) What are the roles and responsibilities of different stakeholders? 4) What are the gaps? 5) What are relevant international best practices for integrated service delivery which could work in the South African context in developing a framework for an effective country response (i.e. programme planning)?
c) What evidence from other countries exists on solutions that are working? Are there lessons that can be learned from these countries to develop workable solutions?	

2. CHAPTER 2: DIAGNOSTIC EVALUATION DESIGN AND METHODOLOGY

2.1 OVERALL DIAGNOSTIC EVALUATION DESIGN

The diagnostic evaluation followed a methodological approach based on an Evaluation Analysis Framework, which outlined the key evaluation questions, sub-questions, and the specific research methods employed. This framework guided the structure and direction of the evaluation, ensuring alignment with the Terms of Reference and the study's objectives.

2.2 LITERATURE REVIEW CONCEPTUALIZATION AND THEMATIC ANALYSIS

The literature review formed a critical component of the evaluation, aimed at establishing a strong foundation of existing knowledge on teenage pregnancy. It began by identifying available evidence, how teenage pregnancy is defined, and how this definition is applied in operational terms within government departments. The review then mapped the core dimensions of this body of evidence, focusing particularly on sectoral responses within social development, health, and basic education. These responses were grouped into three categories: policies, legislation, and programmes or interventions. In addition, cross-cutting initiatives spanning multiple sectors were identified and analysed.

The design of the study integrated evidence assessment and thematic analysis, drawing from a wide range of research sources, including grey literature. While exhaustive academic searches and hand-searching of journals were excluded, selected studies were chosen based on relevance, methodological rigour, data quality, and recency. Preference was given to large datasets, systematic reviews, and multi-study meta-analyses, while smaller qualitative studies and localised findings were mostly excluded.

2.3 DATA SOURCES AND METHODS

The evaluation methodology included two key components: a review of administrative documents such as management and programme reports from selected institutions and provinces and a literature review of policies, legislation, and evaluations. The literature review addressed the core evaluation questions, focusing on the prevalence of teenage pregnancy, government and civil society responses, institutional frameworks, gaps and opportunities, and comparative international insights to strengthen South Africa's national response.

2.4 METHODOLOGY

This evaluation adopted a mixed-methods approach, drawing on both secondary evidence and primary data collection. The primary data collection consisted of document reviews, key informant interviews, and focus group discussions, aligned with the Terms of Reference.

Primary data collection involved interviews and focus groups with key stakeholders from institutions such as the Departments of Social Development (DSD), Health (DoH), Basic Education (DBE), Women, Youth and Persons with Disabilities (DWYPD), as well as the National Youth Development Agency (NYDA), Non-Profit Organisations (NPOs), UNICEF, UNFPA, and other development partners. Interviewees from DSD included officials overseeing community-based interventions,

support services for pregnant teenagers and young mothers, child protection, and social welfare programmes like the Child Support Grant (CSG). DoH participants included professionals responsible for adolescent health programmes and family planning services, while DBE respondents included those involved in implementing the Comprehensive Sexuality Education (CSE) curriculum and managing learner pregnancy policies.

3. CHAPTER 3: LITERATURE REVIEW SUMMARY

3.1 INTRODUCTION

Teenage pregnancy remains a critical public health and social issue in South Africa, with significant implications for adolescent health, education, and socio-economic outcomes. The Department of Social Development (DSD) commissioned a diagnostic evaluation to assess the government's response to teenage pregnancy, focusing on the prevalence, determinants, and effectiveness of interventions. This literature review synthesizes existing evidence on teenage pregnancy in South Africa, examining its prevalence, underlying factors, and the government's policy, legislative, and service delivery responses. The review also highlights gaps and opportunities for improving the national response to this persistent challenge.

3.2 PREVALENCE OF TEENAGE PREGNANCY IN SOUTH AFRICA

Teenage pregnancy in South Africa is a significant issue influenced by socio-economic, cultural, and structural factors. Despite a gradual decline in teenage birth rates over the past two decades, the problem remains significant, especially among older adolescents (15-19 years). In 2022, 101,569 births were recorded among teenagers aged 15-19, accounting for 11.1% of all births in the country. However, very young teenage pregnancies are often associated with higher medical and social risks. The Age-Specific Fertility Rate (ASFR) for girls aged 15-19 was 44.6 births per 1,000 in 2022, a decline from 66.1 in 2010. Provincial disparities in teenage pregnancy rates are evident, with the Northern Cape and KwaZulu-Natal reporting the highest ASFRs, while Gauteng and the Western Cape consistently report the lowest rates.

3.3 FACTORS, DETERMINANTS, AND PREDICTORS OF TEENAGE PREGNANCY

Teenage pregnancy in South Africa is influenced by a complex interplay of socio-economic, cultural, and individual factors. Research highlights several key determinants:

3.3.1 Socio-Economic Factors:

Poverty, unemployment, and limited access to education are significant drivers of teenage pregnancy. Adolescents from low-income households are more likely to engage in transactional sex, which increases the risk of unintended pregnancies and sexually transmitted infections (STIs) (Duby et al., 2022c). The COVID-19 pandemic exacerbated these challenges, with lockdowns leading to increased food insecurity, economic strain, and mental health stressors, further heightening the vulnerability of adolescent girls (Duby et al., 2022d).

3.3.2 Cultural Norms and Practices:

Cultural attitudes that normalize early sexual activity and transactional relationships

contribute to high rates of teenage pregnancy. In some communities, early pregnancy is seen as a marker of fertility and maturity, leading to social pressure on young girls to engage in sexual relationships (DSD, 2017).

3.3.3 Education and Awareness:

Limited access to comprehensive sexuality education (CSE) and reproductive health services is a critical factor. Many adolescents lack accurate information about contraception and safe sexual practices, leading to high rates of unprotected sex and unintended pregnancies (Duby et al., 2022f).

3.3.4 Individual and Relationship Dynamics:

Power imbalances in relationships, particularly age-disparate relationships, often result in adolescent girls having limited control over sexual decision-making. This dynamic increases the risk of coerced sex and unintended pregnancies (Duby et al., 2022c).

3.3.5 Health Service Accessibility:

Barriers to accessing youth-friendly sexual and reproductive health (SRH) services, including stigma, long waiting times, and judgmental attitudes from healthcare providers, further exacerbate the problem (Mathews et al., 2022).

3.4 GOVERNMENT POLICY AND LEGISLATIVE RESPONSE

The South African government has developed a range of policies and legislative frameworks to address teenage pregnancy, primarily through the Department of Social Development (DSD), the Department of Health (DOH), and the Department of Basic Education (DBE).

3.4.1 Social Development Sector:

3.4.1.1 Policies:

The DSD has implemented several policies aimed at addressing the social determinants of teenage pregnancy, including the White Paper for Social Welfare (1997), the White Paper on Families (2012), and the National Child Care and Protection Policy (2019). These policies emphasize poverty alleviation, family support, and the protection of vulnerable children, indirectly addressing the root causes of teenage pregnancy (DSD, 2017).

3.4.1.2 Legislation:

Key legislation includes the Children's Act (2005), which provides a comprehensive framework for the care and protection of children, including pregnant teenagers. The Act allows minors over the age of 12 to access contraceptives and consent to medical treatment, including termination of pregnancy, without parental consent (DSD, 2023). The Criminal Law (Sexual Offences and Related Matters) Amendment Act (2015) addresses statutory rape and consensual sex among minors, aiming to protect adolescents from sexual exploitation while recognizing their sexual autonomy (Setlhako, 2023).

3.4.2 Health Sector:

3.4.2.1 Policies:

The DOH has developed the National Adolescent and Youth Health Policy (2017) and the

National Integrated Sexual and Reproductive Health Rights Policy (2019), which aim to improve access to SRH services for adolescents. These policies emphasize the importance of youth-friendly health services, including contraception, HIV testing, and counselling (DOH, 2017).

3.4.2.2 Legislation:

The Choice on Termination of Pregnancy Act (1996) allows minors to access safe abortion services, while the National Health Act (2003) provides a legal framework for the delivery of comprehensive healthcare services, including SRH services for adolescents (DOH, 2003).

3.4.3 Basic Education Sector:

3.4.3.1 Policies:

The DBE's Policy on the Prevention and Management of Learner Pregnancy in Schools (2022) aims to ensure that pregnant learners can continue their education without discrimination. The policy also emphasizes the importance of comprehensive sexuality education (CSE) in preventing teenage pregnancy (DBE, 2022).

3.4.3.2 Legislation:

The South African Schools Act (1996) ensures that pregnant learners have the right to remain in school, while the Employment of Educators Act (1998) outlines the responsibilities of educators in supporting pregnant learners (DBE, 1996).

3.5 SERVICE DELIVERY AND INTERVENTIONS

The government's response to teenage pregnancy includes a range of service delivery interventions across the social development, health, and education sectors.

3.5.1 Social Development Services:

3.5.1.1 Psychosocial support

The DSD provides psychosocial support, family preservation services, and early intervention programs through its network of social workers and social service practitioners (SSPs). In 2022, the DSD reported reaching over 2.5 million beneficiaries through its social behaviour change and substance abuse programs, which indirectly address the determinants of teenage pregnancy (DSD, 2023).

3.5.1.2 Social grants,

Social grants such as the Child Support Grant (CSG) play a critical role in alleviating poverty among teenage mothers and their children. In 2023, over 11.9 million children received CSG, highlighting the scale of poverty and its impact on teenage pregnancy (SASSA, 2023).

3.5.2 Health Services:

The DOH has expanded access to adolescent-friendly SRH services, including contraception, HIV testing, and counselling. The Integrated School Health Programme (ISHP), implemented in collaboration with the DBE, aims to provide SRH services in schools, although its implementation has been inconsistent across provinces (DOH, 2012). The rollout of youth-friendly zones in primary healthcare clinics has improved access to SRH services for adolescents, with approximately 18% of adolescents aged 10-19 visiting these facilities monthly (DOH, 2023).

3.5.3 *Education Services:*

The DBE's CSE program, delivered through Life Orientation and Life Skills subjects, aims to equip learners with knowledge about sexual and reproductive health. However, the reach and effectiveness of CSE remain limited, with only 294,970 learners reached in 2022/2023 (DBE, 2023). School-based support teams and social workers provide psychosocial support to pregnant learners, although the number of social workers in schools remains insufficient, with only 760 social workers employed by the education sector in 2023 (DBE, 2023).

3.6 CROSS-SECTORAL INITIATIVES

The government has also implemented cross-sectoral initiatives to address teenage pregnancy, including the National Strategic Plan (NSP) for HIV, STIs, and TB (2023-2028), which includes targeted interventions for adolescents at risk of unintended pregnancies. The Integrated Programme of Action (POA) on Teenage Pregnancy, led by the Department of Women, Youth, and Persons with Disabilities (DWYPD), aims to coordinate efforts across government departments to reduce teenage pregnancy through prevention, early intervention, and evidence-based interventions (DWYPD, 2023).

3.7 CHALLENGES AND GAPS IN THE GOVERNMENT'S RESPONSE

Despite these efforts, several challenges and gaps remain in the government's response to teenage pregnancy:

3.7.1 *Fragmentation of Services*: The lack of a centralized strategy to address teenage pregnancy has resulted in fragmented service delivery across sectors. There is limited coordination between the DSD, DOH, and DBE, leading to gaps in the implementation of interventions (DSD, 2023).

3.7.2 *Resource Constraints*: Provincial disparities in resource allocation and capacity have hindered the effective implementation of programs. Provinces with higher rates of teenage pregnancy, such as the Northern Cape and KwaZulu-Natal, often lack the necessary resources to deliver comprehensive services (StatsSA, 2024).

3.7.3 *Data Gaps*: Limited availability of sub-district level data on teenage pregnancy hampers the development of targeted interventions. Improved data collection and monitoring are needed to inform evidence-based policy and program design (StatsSA, 2023).

3.7.4 *Stigma and Access Barriers*: Stigma surrounding teenage pregnancy and SRH services continues to deter adolescents from accessing care. Youth-friendly services are often underutilized due to negative perceptions and logistical barriers (Mathews et al., 2022).

3.8 CONCLUSION

Teenage pregnancy in South Africa is a complex issue shaped by socio-economic, cultural, and structural factors. While the government has made progress in policies and interventions, gaps in implementation and resource allocation persist. A comprehensive, multi-sectoral approach is essential to effectively reduce teenage pregnancy rates. This includes improved coordination among government departments, addressing resource disparities, and enhancing access to youth-friendly sexual and reproductive health services. Targeted interventions for high-risk provinces are also crucial for meaningful progress.

4. CHAPTER 4: FINDINGS BY EVALUATION QUESTIONS AND THEMES

4.1 WHAT IS THE PREVALENCE OF TEENAGE PREGNANCY IN SOUTH AFRICA?

Teenage pregnancy remains a significant public health and developmental concern in South Africa, with considerable social and economic consequences. It disproportionately affects adolescent girls' health, education, and life opportunities. To understand the scope of this challenge, a diagnostic evaluation incorporating data from various sources such as StatsSA, the District Health Information System (DHIS), the Department of Home Affairs (DHA), the Thembisa and Naomi models, and Age-Specific Fertility Rates (ASFRs) was conducted to examine prevalence patterns and inform government responses.

The table and chart below illustrate the prevalence of teenage pregnancy across South Africa's nine provinces. This data allows for comparative analysis to understand regional disparities and target interventions more effectively.

Table 2: Prevalence of teenage pregnancy across South Africa's nine provinces

No.	Province	Teenage Pregnancy Rate	Primary Data Source
1.	Gauteng	13.2	DHIS, StatsSA (2023)
2.	Eastern Cape	16.8	Thembisa Model, StatsSA (2023)
3.	Northern Cape	14.5	DHA, Lifestyle Publications (2023)
4.	KwaZulu-Natal	18.1	DHIS, Naomi Model (2023)
5.	Limpopo	17.4	Thembisa Model, StatsSA (2023)
6.	Western Cape	12.3	DHIS, Lifestyle Publications (2023)
7.	Free State	15.6	DHA, StatsSA (2023)
8.	Mpumalanga	17.0	Naomi Model, DHIS (2023)
9.	North West	16.0	Thembisa Model, Lifestyle Publications (2023)

According to available data and model estimations from sources such as the Thembisa and Naomi models, the District Health Information System (DHIS), and Statistics South Africa (StatsSA 2023), the prevalence of teenage pregnancy varies notably across provinces

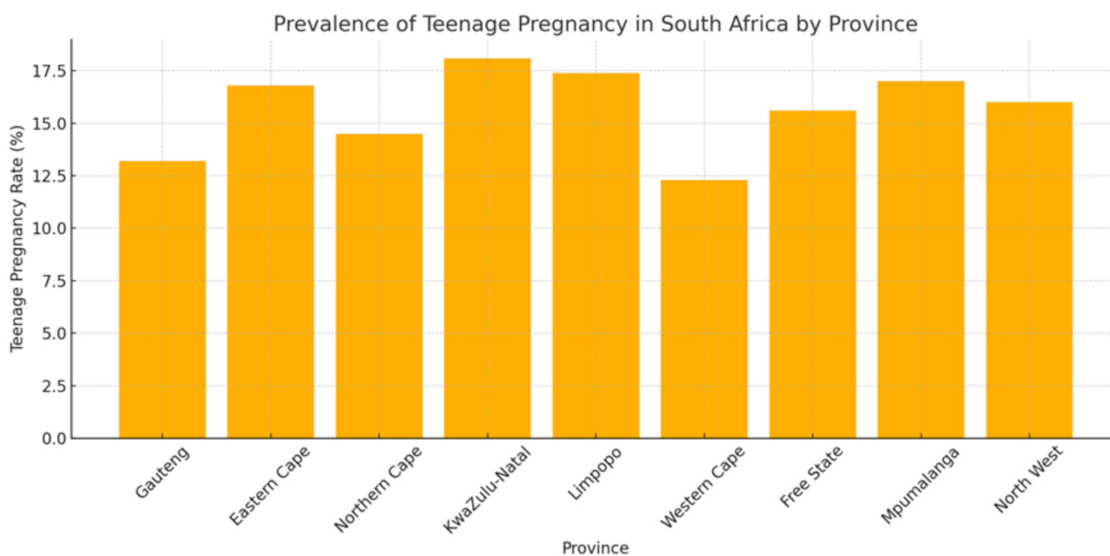


Figure 1: Prevalence of teenage pregnancy in South Africa by province

The above figure shows that the prevalence of teenage pregnancy varies significantly across South Africa's nine provinces, as illustrated by data sourced from the Thembisa and Naomi models, the District Health Information System (DHIS), the Department of Home Affairs (DHA), Statistics South Africa (StatsSA, 2023), and Lifestyle Publications (2023). Among the provinces, KwaZulu-Natal records the highest teenage pregnancy rate at 18.1%, followed closely by Limpopo at 17.4%. These elevated figures are largely attributed to limited access to sexual and reproductive health services, prevailing cultural norms, and high school dropout rates.

Similarly, provinces such as Mpumalanga (17.0%), Eastern Cape (16.8%), and North West (16.0%) also experience high teenage pregnancy rates. These figures highlight persistent systemic challenges, particularly in adolescent health education and the accessibility of contraceptives.

On the other hand, the Western Cape (12.3%) and Gauteng (13.2%) report comparatively lower teenage pregnancy rates. This trend is often linked to stronger health infrastructure, the implementation of comprehensive sex education programs, and active community-based health interventions.

The Free State, with a rate of 15.6%, and the Northern Cape, at 14.5%, fall within a mid-range prevalence. These figures suggest mixed outcomes in the effectiveness of adolescent reproductive health services in these provinces. Understanding these provincial variations is vital for developing tailored policies and targeted interventions. Such strategies should focus on improving education, expanding access to healthcare services, and enhancing community engagement programs to effectively address and reduce the incidence of teenage pregnancy across the country.

In LMICs, adolescent pregnancies are predominantly concentrated among rural and poorer populations, exacerbating health inequalities and contributing to the intergenerational cycle of poverty (Ganchimeg et al., 2014).

Understanding the Indicators of Teenage Pregnancy Prevalence

A comprehensive understanding of the prevalence of teenage pregnancy necessitates the examination of several key statistical indicators. One such indicator is the number of birth occurrences, which refers to the total number of births recorded within a specific time frame, regardless of the mother's age. This metric is essential for identifying reproductive trends and guiding relevant interventions, as highlighted by StatsSA (2023a). Another important measure is the number of live births, which denotes births where the infant exhibits signs of life post-delivery. This indicator is particularly critical for assessing both adolescent maternal and neonatal health outcomes, according to the World Health Organization (2022).

Additionally, the proportion of the adolescent population plays a significant role in understanding teenage pregnancy patterns. In South Africa, adolescents consistently make up approximately 17% of the female population, with 9% aged between 15 and 19 years and 8% between 10 and 14 years, as reported by StatsSA (2023b). The distribution of female adolescents further illustrates the geographical and socio-economic patterns across provinces. For instance, provinces such as the Eastern Cape and Limpopo report the highest proportions of adolescent girls, while Gauteng and the Western Cape report the lowest. These distribution patterns have implications for access to reproductive health services and the development of regionally targeted interventions (StatsSA, 2023b).

Age-specific fertility Rates (ASFRs) offer another crucial measure, calculating the number of births per 1,000 females in a specific age group each year. ASFR is regarded as the most reliable indicator for evaluating adolescent fertility trends and assessing the effectiveness of efforts aimed at reducing teenage pregnancy (StatsSA, 2024). Lastly, the delivery in facility rate, which reflects the percentage of births occurring within health facilities, serves as an important measure of access to quality maternal healthcare. This is particularly relevant in the context of adolescent mothers, as emphasized by StatsSA (2023a).

4.1.1 What is the demographic profile and what are the trends (statistics)?

Teenage pregnancy continues to pose a significant demographic and public health challenge in South Africa, closely linked to persistent patterns of social inequality, limited access to sexual and reproductive health services, and entrenched gender norms. Adolescents aged 10 to 19 represent a substantial segment of the female population, and their reproductive health outcomes serve as critical indicators of broader developmental progress and equity in service provision.

According to Statistics South Africa, adolescents in the 10–19 age group account for approximately 17% of the total female population, with 9% in the 15–19 cohort and 8% in the 10–14 age group (StatsSA, 2023a). The Mid-Year Population Estimates further highlight spatial disparities, showing that provinces such as Limpopo and the Eastern Cape have a higher proportion of adolescent females compared to more urbanised regions like Gauteng and the Western Cape (StatsSA, 2023b). These demographic patterns contribute to the uneven distribution of teenage pregnancy prevalence across the country.

The Age-Specific Fertility Rate (ASFR), commonly used to measure teenage pregnancy, reveals a declining trend at the national level, with the ASFR for females aged 15–19 falling from 66.1 births per 1,000 in 2010 to 44.6 in 2022 (StatsSA, 2024). Nonetheless, significant provincial disparities persist. The Northern Cape, KwaZulu-Natal, and Limpopo report considerably higher adolescent fertility rates, with ASFRs of 65.7, 60.6, and 56.9 respectively, in contrast to Gauteng's rate of 27.6 per 1,000. These differences reflect underlying socio-economic conditions, disparities in access to healthcare services, and variations in education quality across provinces.

The THEMBISA model, South Africa's principal demographic and HIV simulation tool, further contextualises these trends by linking teenage fertility to factors such as HIV risk exposure, contraceptive access, and antenatal service uptake (Johnson & Dorrington, 2023). The model shows that while contraceptive coverage among adolescents has improved, it remains insufficient to substantially reduce adolescent pregnancy, particularly in underserved rural areas. Many pregnancies are unintended, often a result of inconsistent contraceptive use and poor service continuation.

Complementing this, the NAOMI model (National Adolescent Outcomes Model for Impact) indicates that adolescent pregnancy trends are strongly influenced by social determinants such as poverty, school dropout, and gender-based violence. The model underscores that adolescents with access to formal education and youth-friendly health services are less likely to fall pregnant, while those with limited support face heightened vulnerability (Dorrington et al., 2022).

Administrative data from the District Health Information System confirms an increase in antenatal visits among girls aged 15–19, indicating either improved reporting or rising pregnancy rates (DHIS, 2023). However, births to girls aged 10–14 remain a serious concern. Gauteng's Department of Health recorded 934 such births between April 2020 and March 2021, alongside over 19,000 births among older adolescents (Gauteng DOH, 2021).

The Department of Home Affairs reports that 35.6% of births among girls aged 10–14 in 2022 were registered late, reflecting access barriers, stigma, and systemic inefficiencies (StatsSA, 2023a). These late registrations hinder access to critical services such as social grants and healthcare. While ASFR trends are declining, the absolute number of adolescent pregnancies remains high, particularly in poverty-stricken areas with weak institutional support.

In conclusion, teenage pregnancy in South Africa is shaped by a complex interplay of demographic, socio-economic, and systemic factors. Although there has been some progress in reducing adolescent fertility, achieving meaningful improvements will require better access to adolescent-friendly services, stronger surveillance systems, and a focused approach to addressing the root causes of early childbearing.

Trends in Birth Occurrences and Registrations (2002–2022)

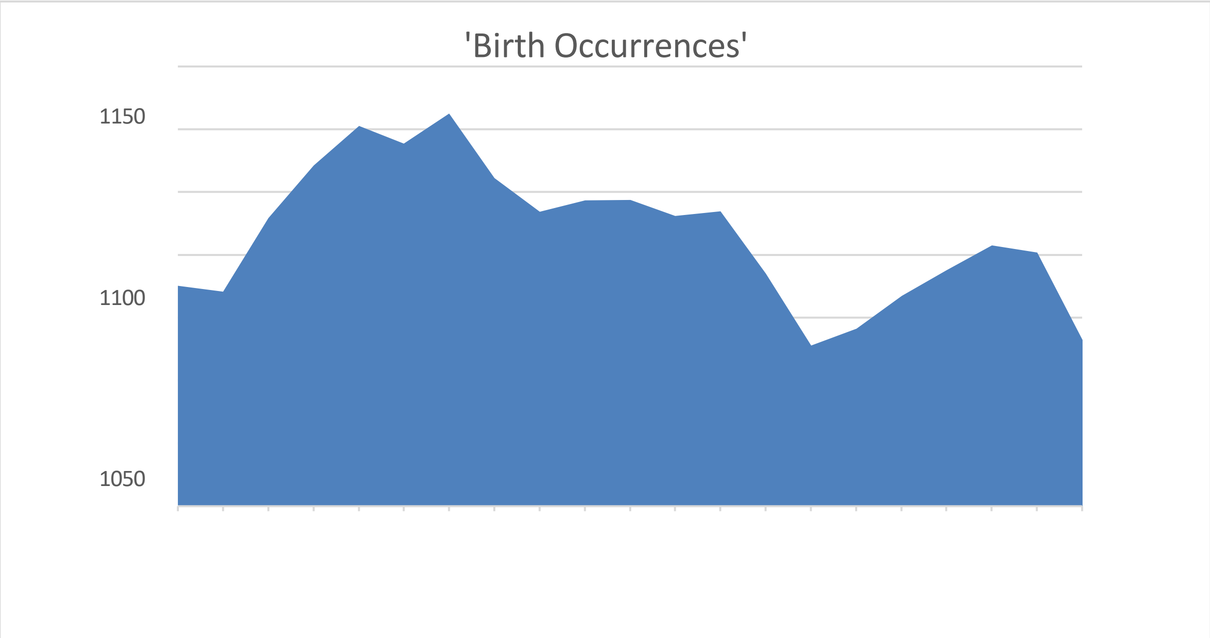
According to StatsSA (2023a), birth occurrences in South Africa have exhibited a fluctuating pattern over the past two decades. The number of births reached its highest point in 2008, followed by a period of decline and relative stability between 2009 and 2014. After this period, a gradual downward trend emerged, culminating in the lowest number of births recorded in

2016, with a total of 927,879. However, birth occurrences began to rise again between 2017 and 2020 before declining once more in 2021 and 2022. The year 2022 recorded the lowest number of births since 2016. An important development observed during this period is the reduction in late birth registrations, alongside an increase in registrations completed within the same year of birth. This shift indicates an improvement in the efficiency and effectiveness of the country's civil registration systems. Figure 1 shows the country's Birth occurrences from 2002 to 2022. Source: StatsSA (2023:25).

Provincial Patterns and Disparities

The distribution of births in South Africa shows significant demographic differences affecting teenage pregnancy. Gauteng and KwaZulu-Natal accounted for 21.7% of total births each, due to their large populations and urban environments, while Limpopo had 13.2%. The Northern Cape and Free State had the lowest at 2.6% and 4.9%, respectively. Provinces like Limpopo and North West showed strong early registration practices, with a majority of births registered within 30 days (StatsSA, 2023a).

These variations emphasize the need for targeted strategies to address teenage pregnancy, considering each region's unique socio-economic and demographic factors. Figure 2 illustrates the distribution of females aged 10-14 and 15-19 years (2016-2022) as a percentage of the female population.



Prevalence of Teenage Pregnancy: Latest Data Insights

In 2022, South Africa recorded a total of 998,362 registered births, with 911,986 of these—equating to 91.3 percent—occurring within the same year, while 86,376 or 8.7 percent were classified as late registrations. Although the majority of these births were attributed to women aged 20–29 years, adolescent girls aged 15–19 accounted for the largest share among late registrations, with 26,497 births recorded in this age group (StatsSA, 2023a). Between 2016 and 2022, provincial distribution data revealed notable variation in the proportion of female adolescents aged 10–14 across South Africa's provinces. Gauteng and the Western Cape

consistently reported the lowest proportions of adolescents in this age cohort, while the Eastern Cape and Limpopo had the highest. Although most provinces showed slight increases in adolescent population shares over time, the year 2022 marked a slight decline or stagnation in some regions (StatsSA, 2023b).

Age-Specific Fertility Rates (ASFRs), which measure the number of births per 1,000 females within specific age groups, are essential indicators of adolescent fertility trends. StatsSA (2024) includes disaggregated ASFR data for adolescents aged 10–14 and 15–19, enabling a more detailed analysis of early childbearing. From 2010 to 2022, ASFR for girls aged 15–19 declined steadily, from 66.1 per 1,000 in 2010 to 60.2 in 2016 and 44.6 in 2022. Among girls aged 10–19, the ASFR peaked at 40 in 2013 but dropped to 23.1 in 2018 and further to 21.9 by 2022. However, substantial differences persist between age groups, with an ASFR of 44.6 recorded in 2022 for those aged 15–19 compared to only 1.4 among girls aged 10–14, reflecting a significant concentration of adolescent births among older teens.

Provincial analyses reveal further variation in ASFR10–14 across time and geography. In Limpopo, the ASFR10–14 peaked at 2.2 in both 2015 and 2019 before declining, although it rose again to 2.0 in 2022—the highest provincial rate for that year. Mpumalanga showed similar trends, with highs of 2.2 in earlier years and a second-highest rate of 1.8 in 2022. The Northern Cape reached 2.2 in 2013 and 2019 but dropped to 1.7 by 2022. The Eastern Cape, despite having historically high ASFR10–14 rates, saw a decline from a peak of 3.3 in 2013 to 1.6 in 2022. KwaZulu-Natal's ASFR10–14 remained stable between 1.5 and 1.8 across most years, recording 1.6 in 2022. These patterns highlight the critical importance of regionalised, data-driven strategies to address early childbearing effectively across South Africa (StatsSA, 2024). Figure 4 below shows the Adolescent Birth Rates (ASFR10-14) by Province, 2010-2022 (CRVS), (source: StatsSA (2024:7)72 from CRVS 2010-2022)73

Figure 2. Adolescent Birth Rates (ASFR10-14) by Province, 2010-2022 (CRVS), (source: StatsSA (2024:7)72 from CRVS 2010-2022)73

The Age-Specific Fertility Rate (ASFR) for girls aged 10–14 in South Africa from 2010 to 2022 reveals fluctuating trends across provinces. In the Western Cape, peak rates were 1.6 in 2013 and 1.5 in 2019, with a low of 0.8 in 2017. By 2022, it was 1.4, ranking sixth nationally.

North-West saw peaks of 1.3 in 2013 and 2022 but dropped to 0.4 in 2017 and 2018. The 2022 ASFR was 1.3, placing it seventh. The Free State remained low, with peaks of 1.3 in 2013 and 2019, and a low of 0.3 in 2018. It recorded an ASFR of 1.1 in 2022, ranking eighth.

Gauteng had the lowest rates nationally, peaking at 1.1 in 2013 and dropping to 0.5 in 2018. In 2022, it recorded an ASFR of 1.0. These disparities highlight the need for targeted, region-specific policies that consider local socio-economic conditions and access to reproductive health services to effectively reduce early adolescent pregnancies in South Africa.

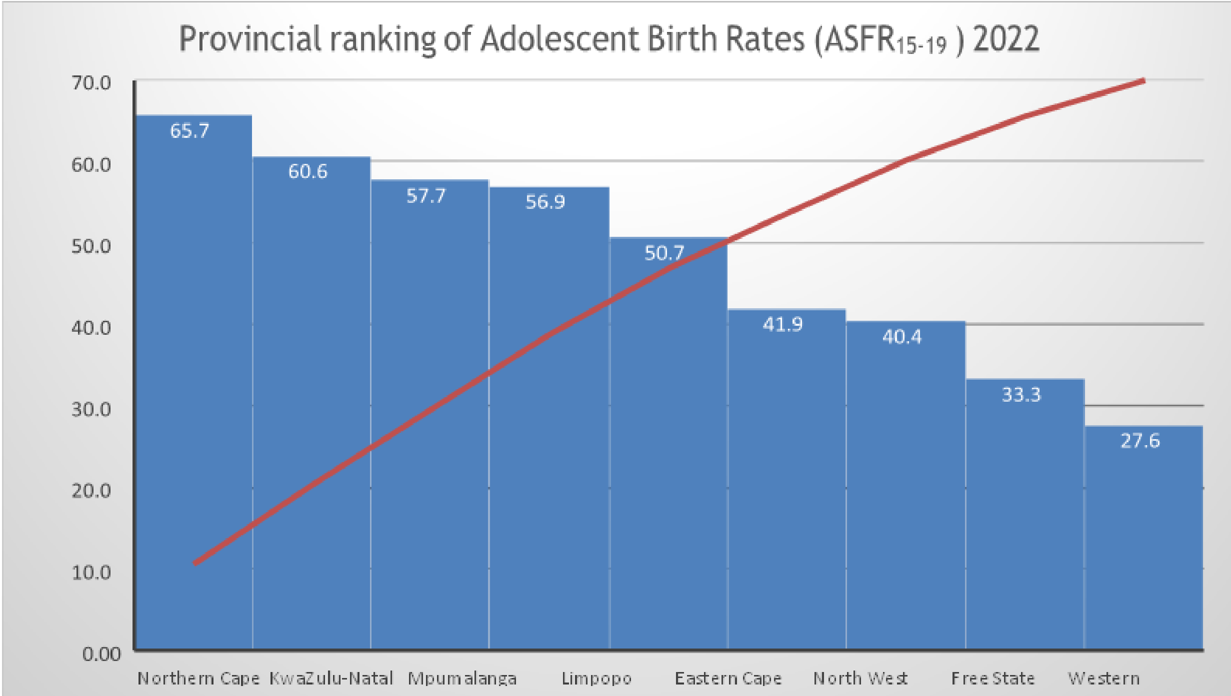


Figure 3: Provincial ranking of Adolescent Birth Rates (ASFR15-19) 2022 (source: StatsSA (2024) CRVS data)

The Age-Specific Fertility Rate (ASFR) for adolescent girls aged 15-19 in South Africa has shown a downward trend over the past 12 years, with the Northern Cape and KwaZulu-Natal recording the highest rates. However, several provinces experienced fluctuations, suggesting periods of increased adolescent pregnancy or data inconsistencies. The Northern Cape and Eastern Cape have the highest peak ASFR values, while Gauteng consistently recorded the lowest rates. These trends highlight the need for continued investment in adolescent sexual and reproductive health programs.

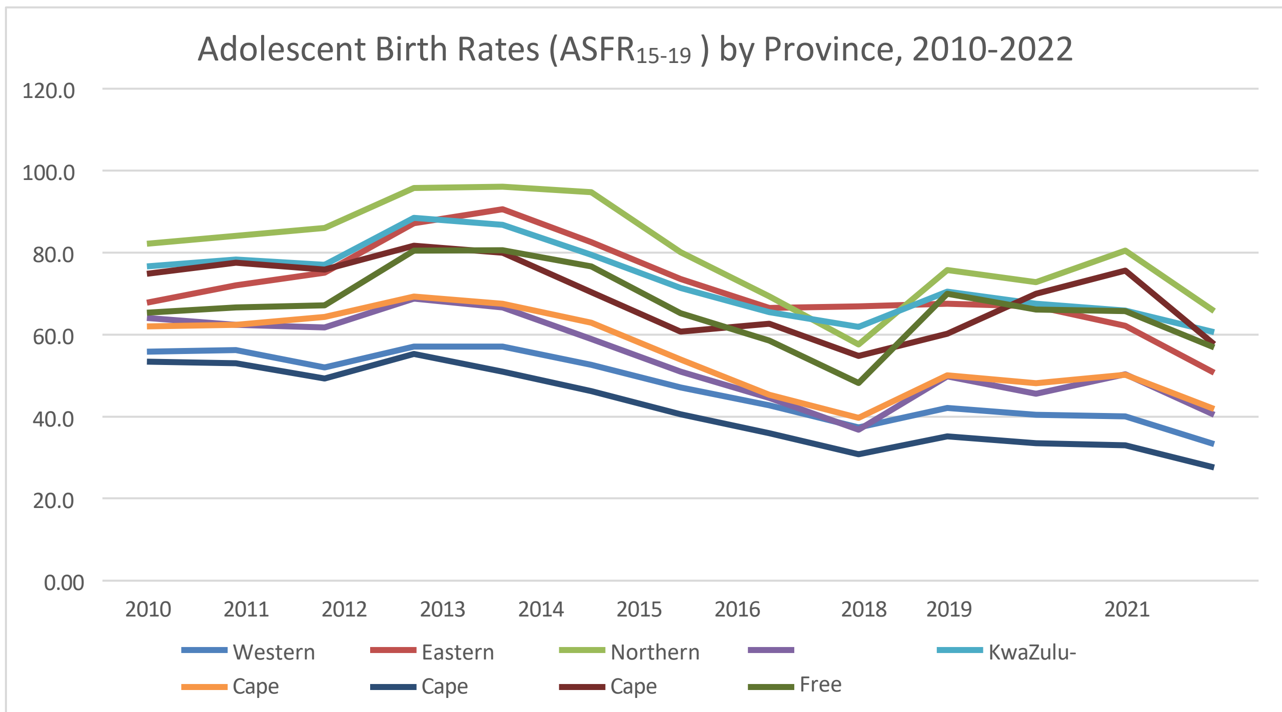


Figure 4. Adolescent Birth Rates by Province, 2010-2022 (CRVS), (source: StatsSA (2024:7)[74] from CRVS 2010-2022)[75]

Specific provincial observations from StatsSA (2024) highlight significant trends and disparities in the Age-Specific Fertility Rate (ASFR) for adolescent girls aged 15–19 years across South Africa between 2010 and 2022.

In the **Northern Cape**, the ASFR15–19 was consistently among the highest, peaking at 96.1 in 2014 and 94.8 in 2013. Despite some fluctuations, the rate declined to 65.7 in 2022, which still represented the highest ASFR15–19 across all provinces that year.

KwaZulu-Natal followed closely with high rates, recording a peak of 88.5 in 2013 and 83.0 in 2014. A steady downward trend has been observed since then, with the rate declining to 60.6 in 2022, the second-highest provincial ASFR15–19.

In **Mpumalanga**, the ASFR15–19 decreased from 74.8 in 2010 to 57.7 in 2022, with significant fluctuations over the years. The highest rate was 81.7 in 2013, while the lowest was 54.8 in 2018, placing it third in the 2022 rankings.

Limpopo experienced a general downward trend from 65.3 in 2010 to 56.9 in 2022. The ASFR15–19 reached its highest levels in 2014 and 2015, at 80.5 and 80.6, respectively, ranking it the fourth highest in 2022.

The **Eastern Cape** recorded high fertility rates in earlier years, with peaks in 2013 (87.2) and 2014 (90.6), but a gradual decline brought the rate down to 50.7 in 2022, placing the province fifth in the national ranking.

In the **North-West**, ASFR15–19 reached 69.3 in 2013 before declining to 41.9 in 2022. The province recorded its lowest rate in 2018 at 39.7, ranking it sixth in 2022.

The **Free State's ASFR15–19 decreased** from 64.1 in 2010 to 40.4 in 2022, with a significant

drop in 2018 to 36.8. The peak was recorded in 2013 at 68.8, placing the province seventh in the 2022 rankings.

In the **Western Cape**, the ASFR15-–19 declined from 55.9 in 2010 to 33.3 in 2022. The highest rate occurred in 2011 at 56.3, and despite minor fluctuations, the province maintained relatively low rates, ranking eighth in 2022.

Gauteng recorded the lowest ASFR15-19 throughout the period, starting at 53.4 in 2010 and steadily declining to 27.6 in 2022. This consistent downward trend highlights Gauteng's success in managing adolescent fertility compared to other provinces.

The South African Census 1996-2011 and Community Survey 2016 reported an ASFR15-19 of 71 births per 1,000 adolescent girls in 2016, with a general decline from 78 in 1996 to 71 in 2016. The steepest decline occurred between 1998 and 2001, but no clear evidence explains it. These observations highlight progress and challenges in adolescent reproductive health, emphasizing the need for sustained interventions and province-specific strategies.

Key Observations

Research findings show that while South Africa has made progress in reducing teenage pregnancy, the rates remain unacceptably high in certain provinces and among specific population groups. Adolescent girls from African and Coloured communities exhibit higher fertility rates compared to their Indian/Asian and White counterparts (StatsSA, 2023b). Additionally, data from the South African Demographic and Health Survey (SADHS, 2016) illustrates a progressive increase in pregnancy prevalence with age, culminating in a 27.8 percent pregnancy rate among 19-year-olds. These patterns emphasize that the burden of teenage pregnancy increases significantly in the latter teenage years and is aggravated by systemic inequalities and service delivery gaps.

Conclusion

Teenage pregnancy in South Africa remains a complex policy challenge with serious implications for adolescent health, education, and social development. Although Adolescent Specific Fertility Rates have declined, provincial disparities, limited access to youth-friendly SRHR services, and persistent socio-economic barriers continue to impede progress. A data-driven, context-specific understanding of the issue is crucial for effective intervention. Insights from sources like CRVS, DHIS, DHA, and models such as Thembisa and Naomi underscore the need for coordinated, evidence-based responses. Strengthening inter-sectoral collaboration, enhancing service delivery, and using disaggregated data is key to improving outcomes for adolescents nationwide.

4.2 WHAT ARE CURRENT GOVERNMENT AND NPO PROGRAMMES AND SERVICES FOR TEENAGE PREGNANCY?

4.2.1 Government services for Adolescents in relation to Teenage Pregnancy in South Africa

The study confirms that the South African government has established a broad range of policy-driven services and sector-specific interventions aimed at improving adolescent sexual and reproductive health and reducing teenage pregnancy. These efforts are primarily

delivered through the social development, health, and basic education sectors and are increasingly supported by integrated planning and data management systems such as the District Health Information System (DHIS), Department of Home Affairs (DHA) birth registration systems, and predictive models like THEMBISA and NAOMI, which guide evidence-based service delivery.

The Department of Social Development (DSD) plays a key role through a variety of policies and programmes targeting adolescents affected by or at risk of teenage pregnancy. These include the National Child Care and Protection Policy (2019), the White Paper on Families (2021), and the Social Assistance Act (2004). DSD provides psychosocial support, early intervention services, and social behaviour change programmes, facilitated by social service practitioners including social workers and community caregivers. In 2023, over 610,000 adolescents accessed psychosocial support services, often linked to broader HIV, TB, and substance abuse initiatives. Social assistance programmes such as child support grants and food parcels also help mitigate poverty and other structural drivers of teenage pregnancy.

The Department of Health (DOH) delivers adolescent sexual and reproductive health and rights (SRHR) services guided by the National Adolescent and Youth Health Policy (2017) and the Integrated SRHR Policy (2019). DHIS data indicates that approximately 18 percent of adolescents aged 10–19 use public primary healthcare services monthly, many for SRHR needs. The sector promotes adolescent-friendly health services including contraceptive access, antenatal care, counselling, and safe abortion services under the Choice on Termination of Pregnancy Act (1996).

Additional support is provided through the Integrated School Health Programme (ISHP), jointly run by DOH, DSD, and the Department of Basic Education (DBE). Despite disruptions during the COVID-19 pandemic, ISHP remains a key platform for school-based screenings and contraceptive distribution. DBE also advances adolescent services through policies such as the DBE Policy on HIV, STIs and TB (2017) and the Learner Pregnancy Policy (2022). Comprehensive Sexuality Education (CSE), delivered via Life Skills and Life Orientation curricula, forms the foundation of prevention efforts, supported by tools like scripted lesson plans and the AMAZE video series. However, school-based psychosocial services remain underfunded and often rely on donor support.

Cross-sectoral initiatives such as the National Strategic Plan on HIV, TB and STIs (2023–2028) and the Programme of Action on Teenage Pregnancy (2023) aim to strengthen coordination, particularly in high-prevalence areas. The DHA and SITA ensure timely birth registration, which supports access to grants and services. Planning tools like THEMBISA and NAOMI further aid the strategic targeting of SRHR interventions. Nonetheless, implementation gaps, resource constraints, and weak coordination continue to undermine progress. Strengthening youth-centred service delivery, ensuring equitable access across provinces, and improving monitoring systems are critical to advancing the national response to teenage pregnancy.

4.2.2 Government Policy and Legislative Response

South Africa's social development sector has implemented policies and legislation to address the structural and social conditions contributing to teenage pregnancy. These frameworks aim to reduce poverty, inequality, and limited access to social protection and services, which

disproportionately affect vulnerable adolescents and teenage mothers. Foundational policy documents promote stronger family structures and improved social support systems, indirectly helping to prevent early childbearing. Legislative instruments like the National Welfare Act, Welfare Laws Amendment Act, National Development Agency Act, Social Assistance Act, and Prevention of and Treatment for Substance Abuse Act reinforce service delivery, particularly in areas like social assistance and substance abuse prevention. The sector delivers psychosocial support, early intervention programs, family preservation services, and social behaviour change initiatives, often integrated with HIV, TB, and substance abuse programs.

4.2.3 South Africa's Multi-Sectoral Response to Teenage Pregnancy

South Africa's response to teenage pregnancy is shaped by various national and international policy frameworks and commitments, including CEDAW, the Convention on the Rights of the Child, the ICPD Programme of Action, and regional strategies such as the Maputo Plan of Action. While efforts have been made across sectors, a comprehensive and unified strategy specifically targeting teenage pregnancy remains lacking.

A 2022 evaluation of the National Adolescent Sexual and Reproductive Health and Rights (ASRHR) Framework (2014–2019) found that although key activities aligned with its priorities, implementation effectiveness was mixed. Progress was made in stakeholder coordination and the development of comprehensive sexuality education (CSE), but challenges persisted in service delivery, community support structures, and policy refinement. Inadequate monitoring and evaluation mechanisms further hampered the ability to assess progress effectively.

4.2.3.1 Social Development Sector Response

The Department of Social Development (DSD) has responded through various policy initiatives aimed at broader social issues. However, teenage pregnancy interventions are often subsumed under HIV, TB, STIs, and substance abuse programmes. Despite a legislative foundation, a distinct sector strategy specifically for teenage pregnancy is absent. Service delivery is fragmented, heavily donor-dependent, and marred by weak information systems and inadequate provincial funding. This limits the effectiveness and coordination of interventions across the country.

4.2.3.2 Health Sector Response

The Department of Health (DOH) has developed key policies such as the National Adolescent and Youth Health Policy (2017), the Sexual and Reproductive Health Rights Policy (2019), and the Maternal and Neonatal Health Policy (2021). These frameworks support adolescent health and access to contraception and prenatal care, which are crucial for preventing and managing teenage pregnancy. Legislation like the National Health Act and the Choice on Termination of Pregnancy Act underpins these services.

The health sector has made strides in expanding adolescent-friendly services, with many adolescents accessing SRHR, mental health, and HIV-related services at primary healthcare facilities. However, despite these improvements, the sector still faces limitations in effectively reaching all adolescents. Nevertheless, relatively strong health information systems support

evidence-based service delivery and continuous improvement in response efforts.

4.2.3.3 Basic Education Sector Response

The Department of Basic Education (DBE) has introduced policies such as the 2017 National Policy on HIV, STIs, and TB, and the 2022 Policy on the Prevention and Management of Learner Pregnancy. These aim to ensure that pregnant learners are not excluded from education and to promote prevention through CSE. The approach is grounded in a rights-based framework emphasizing equality, health, and access. While the integration of CSE through the curriculum and co-curricular activities has expanded, supported by initiatives like the AMAZE video series, implementation remains inconsistent. Most interventions are embedded within HIV and TB programmes, often driven by donor funding. Despite training efforts, there is still insufficient deployment of social service practitioners in schools, with a significant proportion of social workers funded by donors and unevenly distributed across institutions. Moreover, information systems and systematic monitoring remain underdeveloped, hindering targeted responses.

4.2.3.4 Cross-Sectoral Government Response

A broader cross-sectoral response is being pursued through mechanisms like the National Youth Policy (2009–2030), which adopts a holistic, youth-centred approach to empowerment and development. This policy aligns with broader development goals and emphasizes young people’s participation, including in SRHR programmes.

The National Strategic Plan (NSP) for HIV, TB, and STIs (2023–2028) also plays a vital role by addressing the structural determinants of teenage pregnancy, such as poverty and inequality. Other initiatives include the Integrated School Health Programme (ISHP), the Programme of Action on Teenage Pregnancy (POA), and the National Plan of Action for Children (NPAC), which collectively aim to promote adolescent health, well-being, and rights through a multi-sectoral, evidence-based strategy.

The POA represents a renewed effort to consolidate interdepartmental coordination involving DSD, DBE, DOH, and other key departments. It seeks to enhance leadership, align programmes, and focus interventions in high-risk areas. However, successful implementation depends heavily on improved data systems, strategic coordination, and targeted resourcing.

4.2.4 Government and NPO Programmes for Teenage Pregnancy in South Africa

South Africa's government, along with non-profits, has introduced various programs to address teenage pregnancy. Key initiatives include the National Adolescent and Youth Health Policy (2017–2022) and the Integrated School Health Programme (ISHP), which provides sexual and reproductive health education and contraceptive access in schools. The Department of Health offers confidential contraception and counselling through Adolescent and Youth-Friendly Services (AYFS). Schools deliver Comprehensive Sexuality Education (CSE), though inconsistently across provinces. The Department of Social Development supports adolescent mothers with psychosocial counselling and parenting support, while the Department of Home Affairs manages birth registration for better service planning. Despite

these efforts, challenges remain, such as limited contraceptive access in rural areas and weak intersectoral coordination. Including boys in prevention and adopting youth-responsive service models could enhance the response. Non-profits like LoveLife, Soul City Institute, and Marie Stopes South Africa contribute through peer education and outreach programs.

4.3 WHAT ARE THE INSTITUTIONAL PRIORITIES, COMMITMENTS AND CAPABILITIES FOR DELIVERING PROGRAMMES AND SERVICES IN RELATION TO TEENAGE PREGNANCY?

4.3.1 Institutional Priorities, Commitments and Capabilities

South Africa's response to teenage pregnancy is a multi-sectoral effort, primarily within the Departments of Social Development, Health, and Basic Education. The DSD uses developmental policies, but implementation varies across provinces. The health sector employs over 17,500 practitioners, but the national practitioner-to-population ratio is below international standards. The Department of Education's policies aim to integrate Comprehensive Sexuality Education and psychosocial. Support, but implementation remains inconsistent due to limited training and inadequate school-based social workers.

4.4 WHAT ARE THE ROLES AND RESPONSIBILITIES OF DIFFERENT STAKEHOLDERS?

4.4.1 Roles and Responsibilities of Different Stakeholders

South Africa's response to teenage pregnancy is a multi-sectoral effort involving various stakeholders at various levels of government and civil society. The Department of Social Development (DSD) leads the response by addressing the social and economic drivers of teenage pregnancy through a developmental approach. Key policies include the National Adolescent Sexual and Reproductive Health and Rights Framework Strategy and the National Child Care and Protection Policy. The DSD manages social assistance programs like the Child Support Grant and Foster Care Grant to alleviate the economic burden on adolescent mothers. The Department of Health (DOH) delivers adolescent-focused health services, including sexual and reproductive health and rights (SRHR), contraception, maternal care, and HIV prevention. The DBE promotes Comprehensive Sexuality Education through policies like the DBE Policy on HIV, STIs and TB and the Learner Pregnancy Policy. The Department of Home Affairs supports service linkage through improved birth registration systems and the Programme of Action on Teenage Pregnancy. The Department of Planning, Monitoring and Evaluation (DPME) supports strategic alignment with the National Development Plan and oversees programme evaluations.

Conclusion

The institutional landscape addressing teenage pregnancy in South Africa is characterised by a broad and complex array of stakeholders, each with defined but interdependent roles and responsibilities. While policy frameworks and strategic plans articulate strong mandates, implementation success is often hindered by resource limitations, interdepartmental silos, and uneven capacity. Enhanced collaboration, improved M&E systems, and sustained investment in adolescent-focused services are critical to strengthening these stakeholder contributions

and improving outcomes in teenage pregnancy prevention and support.

4.5 WHAT ARE THE GAPS?

4.5.1 Gaps in the South African Government's Response to Teenage Pregnancy

South Africa's response to teenage pregnancy is facing systemic and implementation challenges, including inconsistent coordination, uneven distribution of adolescent-friendly sexual and reproductive health (SRHR) services, and inadequate data systems. These issues have led to duplication of efforts and uneven service coverage. In the education sector, Comprehensive Sexuality Education faces delivery challenges due to inconsistent rollout, insufficient educator training, and dependence on donor support. School-based psychosocial services are also under-resourced, causing concerns about programme sustainability. Data systems pose barriers to effective planning and monitoring, and socio-cultural and legal barriers restrict service uptake, particularly for younger adolescents. Addressing these systemic issues is crucial for reducing teenage pregnancy and promoting adolescent well-being in South Africa.

4.6 WHAT ARE RELEVANT INTERNATIONAL BEST PRACTICES FOR INTEGRATED SERVICE DELIVERY WHICH COULD WORK IN THE SOUTH AFRICAN CONTEXT IN DEVELOPING A FRAMEWORK FOR AN EFFECTIVE COUNTRY RESPONSE (I.E. PROGRAMME PLANNING)?

4.6.1.1 International Best Practices for Integrated Service Delivery in Adolescent Pregnancy Prevention: Relevance to the South African Context

Integrated service delivery is crucial in global adolescent sexual and reproductive health and rights (ASRHR) programming, with international best practices proving effective in reducing teenage pregnancy and improving health outcomes. South Africa could enhance its policy and programme response by strengthening collaboration between the Department of Basic Education, Health, and Social Development. Finland and other Nordic countries embed SRHR services within primary healthcare systems, promoting access to non-judgmental counselling, contraception, mental health care, and parenting advice without parental consent. South Africa could maximize its Integrated School Health Programme (ISHP) by improving data integration between Civil Registration and Vital Statistics (CRVS), DHIS, and DHA systems.

Conclusion

International best practices suggest that reducing teenage pregnancy requires integrated, adolescent-centered service delivery models that link schools, communities, clinics, and families. South Africa must align its programme planning with global models focusing on service convergence, youth empowerment, data-driven planning, and inclusive governance structures. Integrating these principles within national frameworks like the Programme of Action on Teenage Pregnancy will transform the country's response into a holistic and sustainable adolescent development framework.

4.7 WHAT EVIDENCE FROM OTHER COUNTRIES EXISTS ON SOLUTIONS THAT ARE WORKING? ARE THERE LESSONS THAT CAN BE LEARNED FROM THESE COUNTRIES TO DEVELOP WORKABLE SOLUTIONS?

4.7.1 Evidence from Other Countries on Solutions That Work: Lessons for the South African Context

Countries worldwide have implemented multi-sectoral interventions to reduce teenage pregnancy rates and improve adolescent health. South Africa can learn from these experiences to develop a more integrated framework. Chile's Friendly Spaces for Adolescents and Youth improves access to sexual and reproductive health services. Finland, Sweden, the Netherlands, Rwanda, Kenya, Thailand, and Bangladesh have all implemented comprehensive sexuality education, youth empowerment programs, and low-barrier contraception access. South Africa can better utilize data integration and digital platforms for planning and cross-sectoral collaboration.

Conclusion

International experience demonstrates that reducing teenage pregnancy requires strong policies, effective integration of education, health, and social services, youth-friendly environments, and community engagement. South Africa should strengthen school-based SRHR programmes, expand adolescent-friendly health facilities, improve data integration, engage adolescents in planning, and ensure continuous monitoring. Adapting global best practices to local contexts can enhance a youth-centered strategy.

5. CHAPTER 5: KEY RECOMMENDATIONS

Below is the consolidated and Action-Oriented Recommendations on Teenage Pregnancy organised and structured around key thematic areas, specific recommendations, responsible actors, proposed timeframes, and indicators of success where applicable.

A. CROSS-CUTTING STRATEGIC RECOMMENDATIONS

Table 2: Cross-Cutting Strategic Recommendations

Recommendation	Responsible Stakeholders	Timeframe	Success Indicators
1. Strengthen cross-sectoral and intra-sectoral leadership, coordination, and implementation	DSD, DOH, DBE, Provinces, Municipalities	6-12 months	Functional coordination forums; clear roles/responsibilities
2. Strengthen data systems, including integrated information management across sectors	DSD, DOH, DBE, Stats SA	12-18 months	Operational data systems; regular reporting on TP indicators
3. Ensure meaningful youth engagement in programme design and monitoring	DSD, NYDA, Youth CSOs	Immediate, ongoing	Number of youth-led consultations and participation reports
4. Expand early prevention and behaviour change programmes in schools and communities	DBE, DSD, NGOs	6-12 months	Increased programme coverage and adolescent reach
5. Enforce statutory rape laws, especially for girls aged 10–14	SAPS, DOJ, DSD, Community Structures	Immediate, ongoing	Number of prosecutions; community awareness campaigns
6. Use GIS mapping for resource and service planning	DSD, DOH, DBE, Local Government	Within 12 months	Maps published and used in programme planning

B. PREVALENCE-FOCUSED RECOMMENDATIONS

Table 3: Prevalence-Focused Recommendations

Issue Identified	Recommendations	Responsible Stakeholders	Timeframe	Success Indicators
High prevalence in the 15–19 age group	Target SRHR education and services for 15–19 age group	DOH, DBE, DSD	6-12 months	Reduced ASFR (15–19); improved access to SRHR services
Rising concern over very young pregnancies (10–14)	Prioritize law enforcement, community buy-in, and special protection measures	SAPS, DOJ, DSD	Immediate	Prosecution rates; increased community reporting
Late birth registrations for 10–14s	Improve birth registration education and outreach	DHA, DSD	6 Months	Reduced late registration rates
Need for better localized data.	Improve sub-district level data collection	Stats SA, DSD, DOH	12 Months	Availability of disaggregated data by age/location
Fragmented intersectoral coordination	Establish a unified national framework for teenage pregnancy response integrating all sectors.	DSD, DBE, DOH, DWYPD	Short to Medium Term	Operational intersectoral plan; joint programme reports
Need for national strategic coordination	Develop a National Teenage Pregnancy Strategy with cross-sectoral leadership.	DSD, DBE, DOH, DWYPD	Immediate	Adoption of strategy; sectoral alignment to strategic goals

Uneven delivery of Integrated School Health Programme (ISHP)	Revitalize ISHP with clear budget allocations, performance tracking, and cross-sector support.	DOH, DBE, DSD	Immediate to Medium Term	Number of functional ISHP units; improved school SRHR access rates

C. FACTORS AND PREDICTORS – TARGETED INTERVENTIONS

Table 4: Factors and Predictors – Targeted Interventions

Key Determinants	Recommendations	Responsible Stakeholders	Timeframe	Success Indicators
Socio-structural and economic determinants	Expand social protection and local economic empowerment programmes	DSD, Local Govt, SEDA	12–24 months	Coverage of social protection for vulnerable girls
Socio-cultural and personal factors	Develop localised, age-appropriate social behaviour change programmes	DSD, DBE, Traditional Leaders	6–18 months	No. of local SBC interventions implemented
Questionable SBC data quality	Improve monitoring and evaluation of SBC programmes	DSD, DBE	12 months	Regular publication of outcome-based data
Comprehensive Sexuality Education (CSE) efficacy	Conduct research on CSE reach and impact; ensure out-of-school youth are included	DBE, Research Institutions	12 months	Evaluation reports produced; learner reach data
Personal relationships dynamics	Incorporate adolescent relationship education in CSE and community programmes.	DBE, DSD	Ongoing	Curriculum content revised and delivered
Insufficient adolescent access to SRHR services	Expand youth-friendly clinics and SRHR services across provinces, prioritising rural areas.	DOH, Provincial Health Departments	Immediate to Medium Term	Number of clinics meeting youth-friendly standards; increased contraceptive uptake
Weak implementation of CSE in schools	Strengthen educator training, supervision and fidelity checks on CSE delivery.	DBE, Provincial Education Departments	Short Term	Percentage of schools with trained educators delivering CSE; learner satisfaction surveys

D. SECTOR-SPECIFIC RECOMMENDATIONS

1. Social Development Sector

Table 5: Sector-Specific Recommendations

Key Issue	Recommendations	Responsible Stakeholders	Timeframe	Success Indicators
Fragmented services and weak strategy	Develop an integrated teenage pregnancy strategy with clear accountability	DSD	6–12 months	Approved strategy document; implementation plans
Inadequate social workforce	Recruit more social workers and optimize the current workforce for SBC outreach	DSD, Provincial Govts	12–18 months	Number of social workers hired; reach of interventions
Weak monitoring and outdated frameworks	Review and update ASRH&R Framework Strategy 2014–2019	DSD	6 months	Revised framework and operational plan

E. HEALTH SECTOR

Table 6: Health Sector

Key Issue	Recommendations	Responsible Stakeholders	Timeframe	Success Indicators
Adolescent SRHR services underutilized	Scale up youth-friendly health services and outreach	DOH, NGOs	12 months	Number of youth accessing services
Data limitations on SRHR	Distinguish SRHR indicators in health data systems	DOH, Stats SA	6–12 months	Enhanced SRHR reporting and disaggregation

F. EDUCATION SECTOR

Table 7: Education Sector

Key Issue	Recommendations	Responsible Stakeholders	Timeframe	Success Indicators
CSE under-evaluation and low school retention	Strengthen tracking of learner participation and out-of-school reach	DBE, NGOs	12 months	Learner reach data; dropout rate reduction
Reliance on donor-supported co-curricular programmes	Institutionalize sustainable, curriculum-integrated prevention efforts	DBE	12–24 months	Budget allocation and programme integration status

2. DSD, DBE, DOH, StatsSA, DHIS, DOJCD, SAPS & Youth Agencies

Table 7: Education Sector

Key Issue	Recommendations	Responsible Stakeholders	Timeframe	Success Indicators
Limited adolescent engagement in programme design	Establish youth advisory boards to participate in programme design and review.	DSD, DBE, DOH, Youth Agencies	Short to Medium Term	Number of youth consultations conducted; youth inclusion in policy evaluations
Under-resourced social service workforce	Invest in permanent employment of social workers and increase coverage per school.	DSD, DBE, Treasury	Immediate to Medium Term	Improved social worker-to-school ratio; reduction in learner dropout due to pregnancy
Heavy reliance on donor funding	Secure sustainable government funding for SRHR and CSE programmes, reducing donor dependency.	DSD, DBE, DOH, Treasury	Medium Term	Increased public sector budget allocations; reduced donor funding ratio
Inadequate data integration and M&E systems	Strengthen DHIS, CRVS, and school data systems; ensure Naomi and Thembisa models are used at sub-national levels.	StatsSA, DHIS, DBE, DSD, DOH	Medium to Long Term	Improved data availability; evidence of model use in planning reports
Limited enforcement of statutory rape and child protection laws	Enhance enforcement of statutory rape laws and integrate child protection services.	DSD, DOJCD, SAPS	Immediate to Short Term	Increase in prosecutions; reduced 10-14 pregnancy incidence

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