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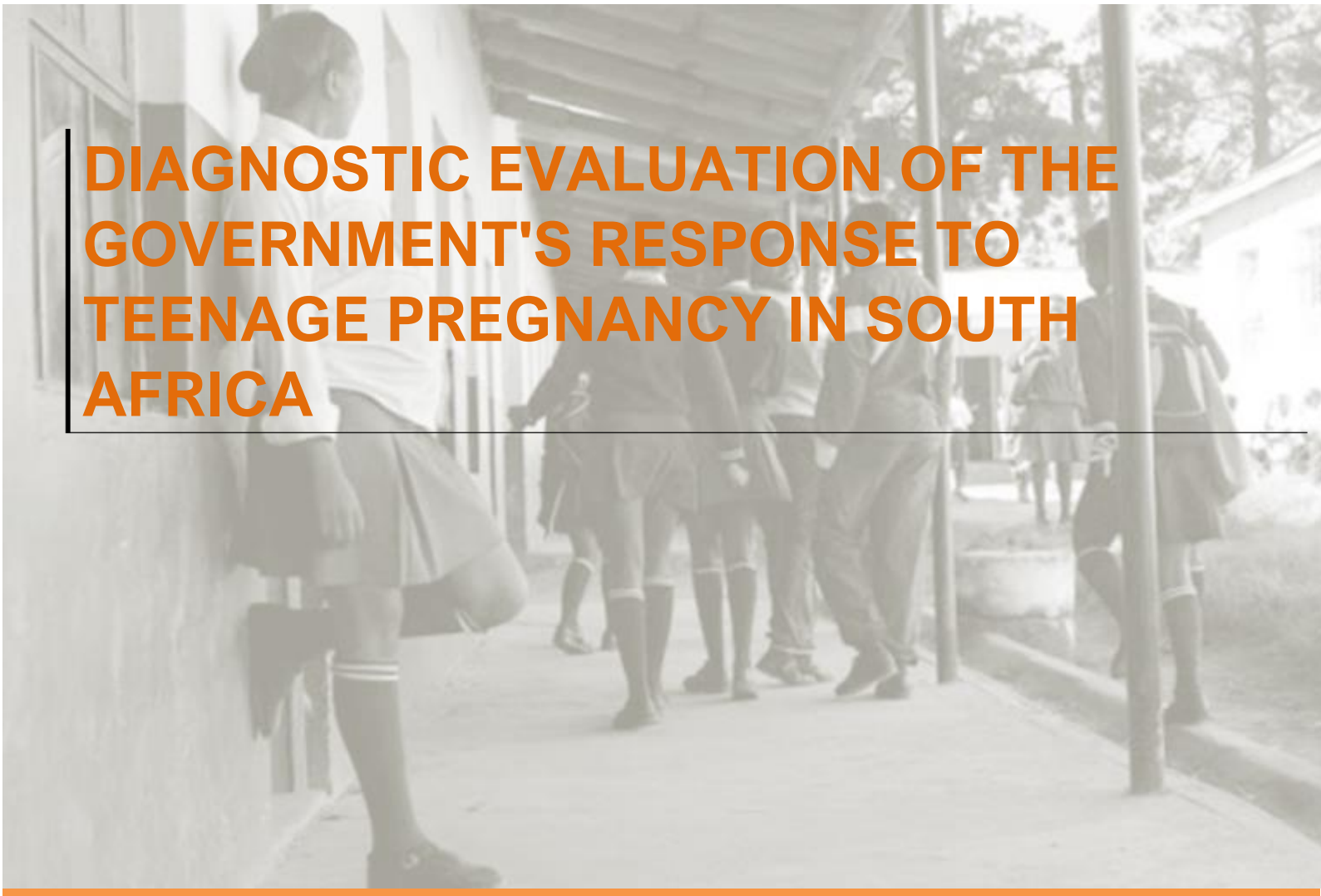

DIAGNOSTIC EVALUATION OF THE GOVERNMENT'S RESPONSE TO TEENAGE PREGNANCY IN SOUTH AFRICA

FINAL REPORT
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Submitted by:	Submitted to:
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STRUCTURE OF THE EVALUATION REPORT

Chapter	Description	Purpose
	Acknowledgements	In this section we express gratitude and recognize the individuals, organizations, or resources that supported or contributed to the creation of the report.
	Policy Summary	The policy summary is to distill the findings of a project or evaluation into clear, actionable insights for decision-makers. Significantly, policy summary highlights policy implications - both existing strengths and areas where adjustments or new considerations might be necessary.
	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	Diagnostic Evaluation Design and 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 Summary	This section reviews the policy problem of teenage pregnancy, its prevalence, its aetiology (factors, determinants and predictors), and Government's main policy, legislative and programme (services and interventions) responses
4	Findings by Evaluation Questions and Themes	This section organizes and presents results clearly, aligning them with the evaluation's objectives. By grouping findings under specific questions and themes, it offers structured insights, aiding in decision-making by highlighting actionable implications, recurring patterns, challenges, and gaps. This enhances clarity and supports evidence-based decisions.
5	Key Literature Review Findings	This section presents key insights from existing research on a specific topic. It highlights current knowledge, major trends, gaps, theoretical frameworks, methodologies, and areas of agreement or debate. It provide context, identify unresolved issues, and show how new research can address these gaps, forming the basis for further investigation or policy action.
6	KEY RECOMMENDATIONS	
	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

This section provides a general introduction to this report of the diagnostic study of the South African Government's response to teenage pregnancy in South Africa.

Teenage pregnancy in South Africa can be viewed within the broader context of children and adolescents in the country in 2024. South Africa faces significant challenges in terms of adolescent health and well-being, with teenage pregnancy being a critical issue. At the outset, the prevalence of teenage pregnancy in the country is influenced by various factors, such as poverty, inadequate access to comprehensive sexual education, and limited sexual and reproductive health services.

The situation of children and adolescents in South Africa is marked by a mix of challenges and opportunities. While there have been improvements in areas such as education and healthcare access in general, issues like high rates of violence, widespread poverty, and mass youth unemployment persist.

As the custodian institution of social development in South Africa, and in particular of the Children's Act (2005), the Department of Social Development (DSD) commissioned this independent study: A Diagnostic Evaluation to understand the Government's Response to Teenage Pregnancy.

1.1 PURPOSE OF THE DIAGNOSTIC EVALUATION TO UNDERSTAND THE GOVERNMENT'S RESPONSE TO TEENAGE PREGNANCY

The purpose of this diagnostic evaluation is to assess the relevance and responsiveness of government interventions (both programmes and services) in addressing the direct determinants of teenage pregnancies. In addition, the study aims to provide empirical evidence on appropriate interventions, policies and guidelines to manage teenage pregnancy in the country.

As a technical background, the DPME released a guideline on diagnostic evaluations, "A Guideline on Diagnostic Evaluation 2.2.10" in 2014, to provide technical guidance on undertaking and managing this kind of evaluation. This is in line with the DSD departmental policy on evaluations. Diagnostic evaluations establish what the current situation is (the policy problem), the policy response, the institutional environment and capacity (including funding), evident gaps, and policy options, leading to an identification of preferred policy options. There is a heavy emphasis on the conceptualization of the policy problem and the policy response, and then a tangible assessment of the actual response and its mechanics as it currently exists. This assessment is overlaid with a comparative assessment of the country's response against that of the international community, leading to the identification of preferred policy options.

1.2 HIGHLIGHTS FROM THE TERMS OF REFERENCE

The key evaluation questions are:

(1) **What is the prevalence of teenage pregnancy in South Africa?** What is the demographic profile, and what are the trends (statistics)?

What are current government and NPO programmes and services for teenage pregnancy? What are the existing government services provided to adolescents concerning teenage pregnancy? What are the institutional priorities, commitments and capabilities for delivering programmes and services concerning teenage pregnancy? What are the roles and responsibilities of different stakeholders? What are the gaps? 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)?

(2) **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 multifaceted issue influenced by socio-economic, cultural, and structural factors. According to Statistics South Africa (StatsSA, 2023), the country has seen a gradual decline in teenage birth rates over the past two decades, yet the problem remains significant, particularly among older adolescents (15-19 years). In 2022, there were 101,569 births recorded among teenagers aged 15-19, accounting for 11.1% of all births in the country. Additionally, 3,598 births were recorded among girls aged 10-14, highlighting the critical issue of very young teenage pregnancies, which are often associated with higher medical and social risks (StatsSA, 2023).

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. However, this rate remains high compared to global standards, particularly in low- and middle-income countries (LMICs), where the median ASFR for this age group is approximately 60 births per 1,000 (StatsSA, 2024). Sub-Saharan Africa, in particular, has some of the highest adolescent birth rates globally, with South Africa's rates being lower than the

regional average but still concerning (UNFPA, 2021).

Provincial disparities in teenage pregnancy rates are evident, with the Northern Cape and KwaZulu-Natal reporting the highest ASFRs for girls aged 15-19 (65.7 and 60.6 births per 1,000, respectively) in 2022. In contrast, Gauteng and the Western Cape consistently report the lowest rates (27.6 and 33.3 births per 1,000, respectively) (StatsSA, 2024). These disparities underscore the need for targeted interventions that address the unique socio-economic and cultural contexts of each province.

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 behavior 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 counseling. 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 influenced by socio-economic, cultural, and structural factors. While the government has made significant strides in developing policies and interventions to address this challenge, gaps in implementation, resource allocation, and coordination remain. A comprehensive, multi-sectoral approach is needed to effectively reduce teenage pregnancy rates and improve outcomes for adolescent girls. This includes strengthening coordination between government departments, addressing resource disparities, and improving access to youth-friendly SRH services. Additionally, targeted interventions that address the unique needs of high-risk provinces and populations are essential for achieving meaningful progress in reducing teenage pregnancy in South Africa.

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 1: 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

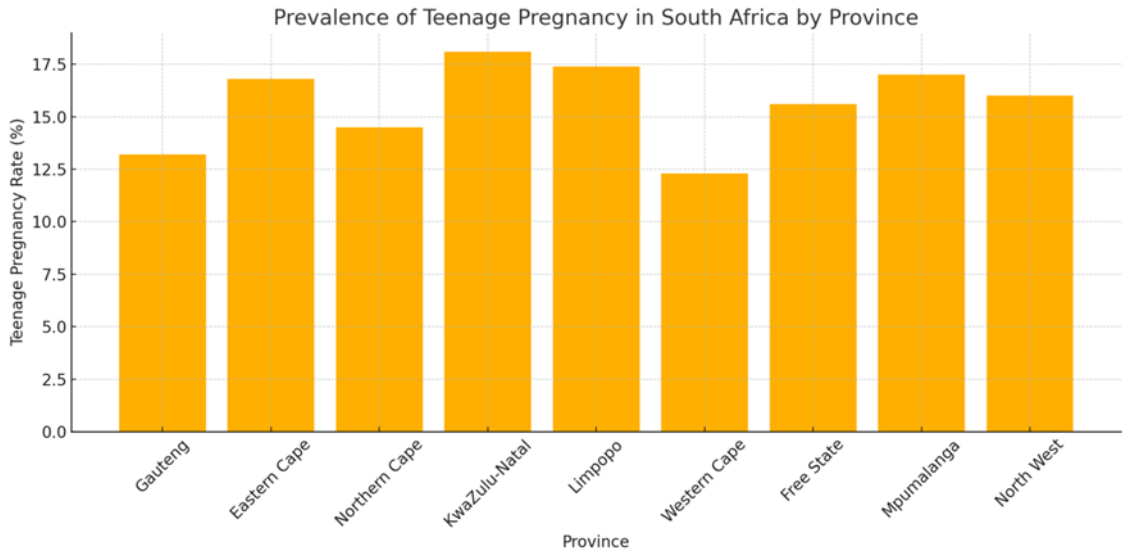


Figure 1: Prevalence of teenage pregnancy in South Africa by province

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).

i. 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).

ii. 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)

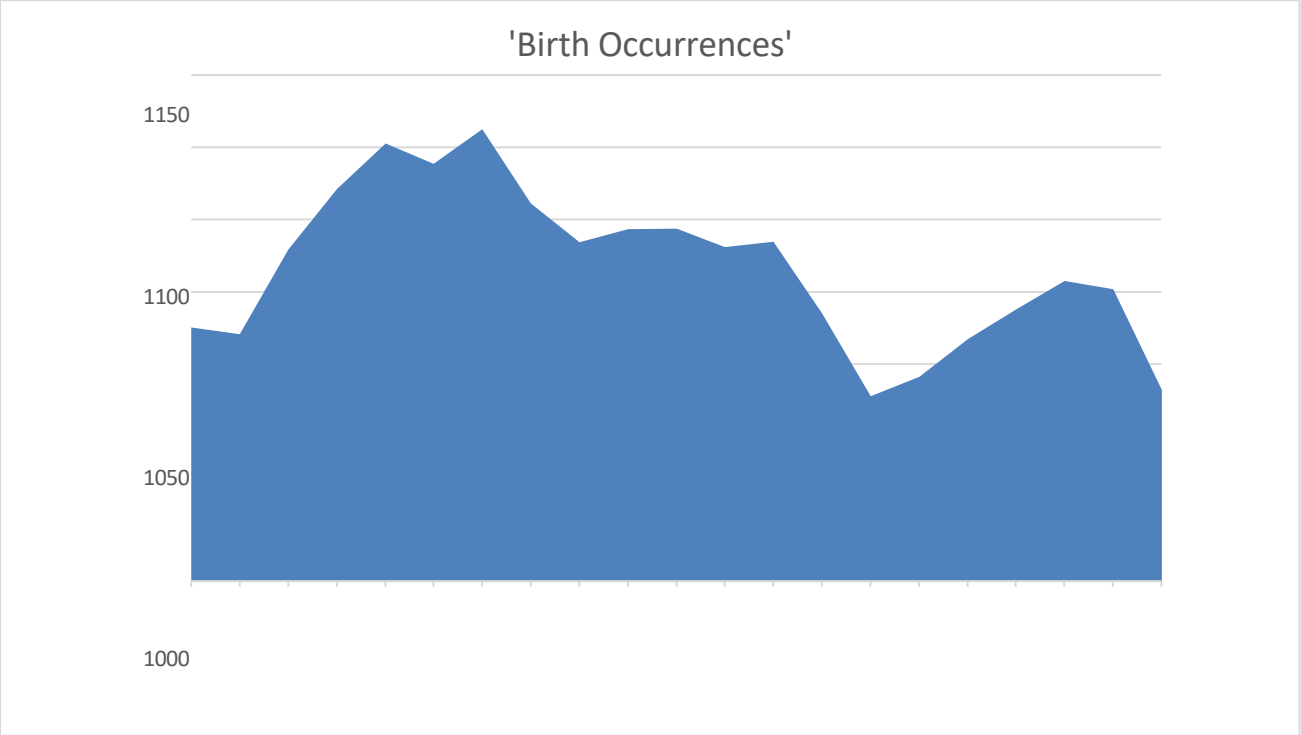


Figure 2. Birth occurrences from 2002 to 2022. Source: StatsSA (2023:25)

iii. Provincial Patterns and Disparities

The distribution of births across South Africa's provinces reveals significant demographic variations that influence the dynamics of teenage pregnancy. Gauteng and KwaZulu-Natal each accounted for 21.7% of the total registered births, reflecting their large population sizes and urban settings. Limpopo followed with 13.2% of total births, while the Northern Cape and Free State reported the lowest proportions, with 2.6% and 4.9%, respectively. Notably, in provinces such as Limpopo and North West, the majority of births were registered within 30 days of occurrence, indicating stronger early registration practices and improved civil registration systems (StatsSA, 2023a). These provincial differences highlight the need for context-specific strategies to effectively address teenage pregnancy, taking into account the unique socio-economic and demographic characteristics of each region. Figure 2 below shows the distribution of Female Adolescents aged 10-14 and 15-19 years (2016-2022) as a proportion (%) of the female population.

iv. Prevalence of Teenage Pregnancy: Latest Data Insights

In 2022, a total of 998,362 births were registered in South Africa. Of these, 911,986 births, representing 91.3%, occurred within the same year, while 86,376, or 8.7%, were classified as late

registrations. The majority of these births were attributed to women aged 20–29 years. However, among the late registrations, adolescents aged 15–19 years accounted for the largest share, with 26,497 births recorded in this age group (StatsSA, 2023a).

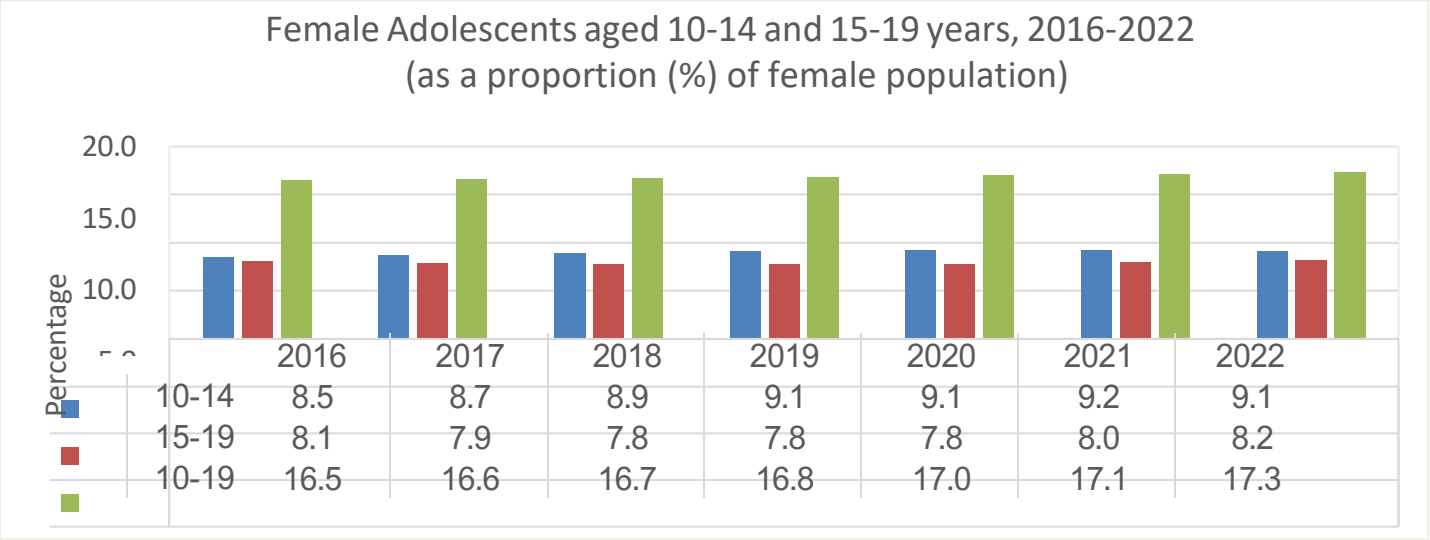
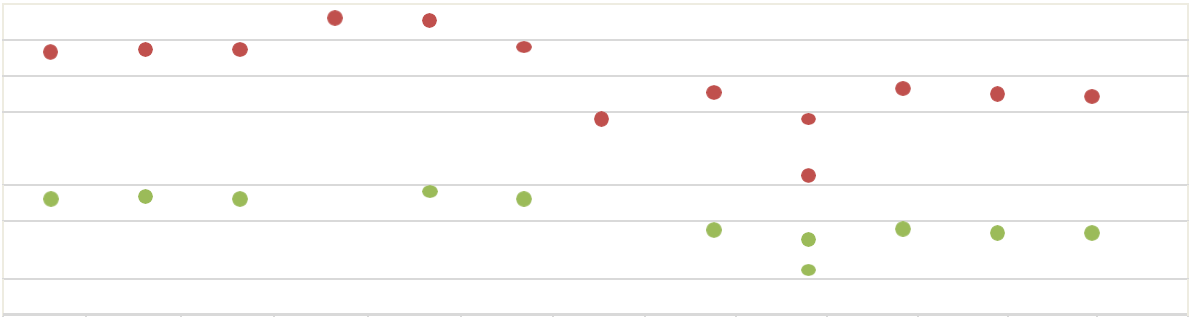


Figure 3. Distribution of Female Adolescents aged 10-14 and 15-19 years (2016-2022) (source: SSA (2023b:4)

Between 2016 and 2022, the provincial distribution of female adolescents aged 10–14 years, expressed as a proportion of the population, displayed notable variations across South Africa's provinces. According to StatsSA (2023b), Gauteng and the Western Cape consistently recorded the lowest proportions of adolescents in this age group, while the Eastern Cape and Limpopo reported the highest proportions. Although there was a slight increase in the proportion of adolescents across all provinces during this period, the year 2022 marked an exception, showing a slight decline or stagnation in some regions.

The Age-Specific Fertility Rates (ASFRs) represent the number of births occurring to women within a specific age group per 1,000 women in that group during a defined period. ASFRs are typically calculated for women aged 15–49, segmented into five-year age intervals. However, data from StatsSA (2024) also includes ASFRs specifically for adolescent girls aged 10–19 years, with further disaggregation for girls aged 10–14 years and those aged 15–19 years. This detailed breakdown allows for a more precise understanding of fertility trends among adolescents and helps in tailoring interventions to the specific needs of different age subgroups within the adolescent population.



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
	ABR												
10-14	1.3	1.5	1.6	1.9	1.6	1.8	1.2	1.0	0.9	1.5	1.3	1.3	1.4
15 - 19	66.1	67.3	66.5	75.9	74.6	68.5	60.2	54.5	48.7	56.3	54.4	53.7	44.6
10-19	35.1	35.8	35.4	40.0	38.7	35.1	30.0	26.5	23.1	26.8	25.7	25.6	21.9

Table 2. Patterns of adolescent births rates (ABR) South Africa, (source: StatsSA (2024:7)71 from CRVS 2010-2022)

According to StatsSA (2024:7), an analysis of Civil Registration and Vital Statistics (CRVS) data from 2010 to 2022 reveals notable trends in adolescent fertility rates in South Africa. The Age-Specific Fertility Rate (ASFR) among girls aged 15–19 years declined steadily over this period, decreasing from 66.1 births per 1,000 women in 2010 to 60.2 in 2016, and further dropping to 44.6 in 2022. For girls aged 10–19 years, the highest ASFR was recorded in 2013 at 40 births per 1,000 women. However, this figure declined to 23.1 by 2018 and further to 21.9 in 2022. A significant disparity remains between different adolescent age groups, with the ASFR for girls aged 15–19 years at 44.6 in 2022 compared to a much lower rate of 1.4 for girls aged 10–14 years. Overall, the data indicates a consistent decline in adolescent fertility rates in South Africa, with the ASFR for girls aged 10–19 years standing at 21.9 in 2022.

Further analysis from StatsSA (2024:8), based on CRVS data between 2010 and 2022, provides a provincial breakdown of fertility rates among girls aged 10–14 years. While some provinces, such as the Eastern Cape and Northern Cape, have shown a notable decline in ASFR10–14 over time, others like Limpopo and KwaZulu-Natal have exhibited more fluctuation.

In Limpopo, the ASFR10–14 peaked at 2.2 in both 2015 and 2019, followed by notable declines in subsequent years. However, the rate increased again in 2022 to 2.0, making it the highest provincial ASFR10–14 that year. The lowest rate recorded in the province was in 2018, at 0.7.

Mpumalanga showed similar variations, with ASFR10–14 peaking at 2.2 in 2012, 2013, and 2015. Although the rate fluctuated over the years, it generally remained above 1.5. The lowest point was in 2018, with a rate of 1.2, while the second-highest provincial rate in 2022 stood at 1.8.

In the Northern Cape, the ASFR10–14 also peaked at 2.2 in both 2013 and 2019, accompanied by significant fluctuations over the period. The province recorded its lowest rate in 2018 at 0.5, and by 2022, it had the third-highest ASFR10–14 at 1.7.

The Eastern Cape consistently had the highest ASFR10–14 in the country throughout the 2010–

2022 periods, reaching a peak of 3.3 in 2013. However, the rate has generally declined since then, dropping to 1.6 in 2022, ranking it fourth among provinces for that year.

KwaZulu-Natal recorded its highest ASFR10–14 in 2015 at 2.2. In most other years, the rate remained relatively stable, fluctuating between 1.5 and 1.8. The lowest rate in the province was observed in 2010 at 1.3, with a rate of 1.6 recorded in 2022, placing it fifth in provincial rankings for that year.

These provincial trends highlight significant regional variations in adolescent fertility patterns and emphasize the importance of localized, data-driven approaches in addressing early childbearing in South Africa. 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

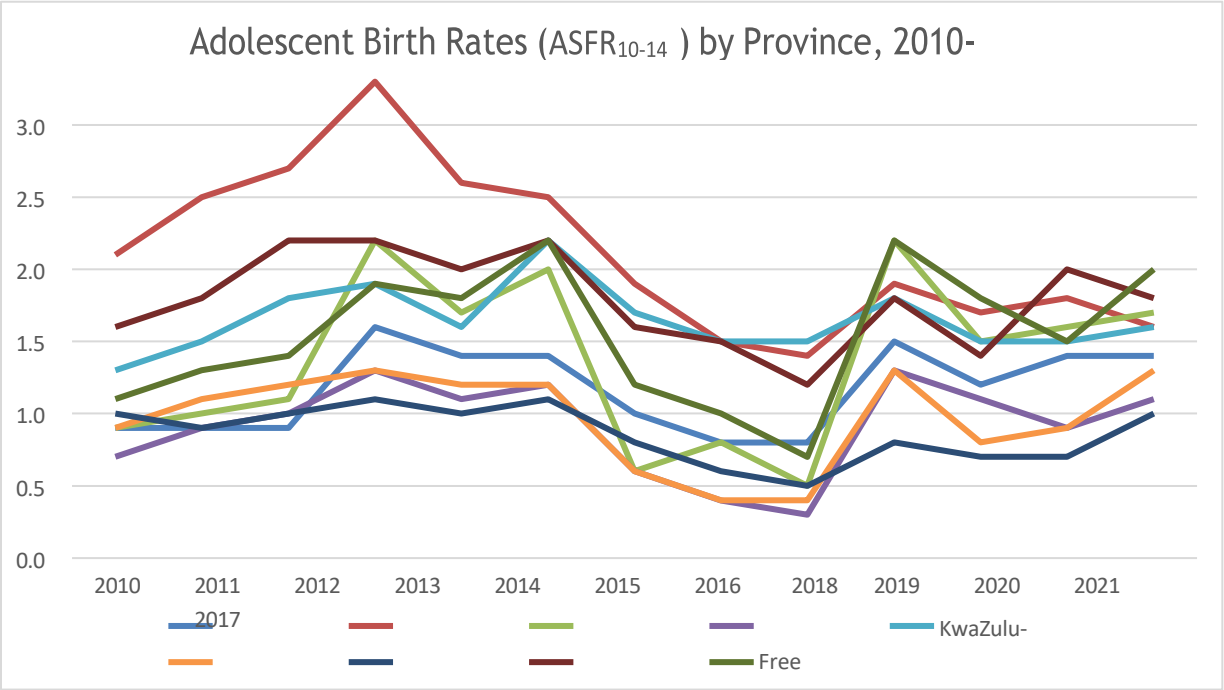


Figure 4. Adolescent Birth Rates (ASFR10-14) by Province, 2010-2022 (CRVS), (source: StatsSA (2024:7)72 from CRVS 2010-2022)73

The Age-Specific Fertility Rate (ASFR) for girls aged 10–14 years across South Africa's provinces reveals a range of fluctuating trends from 2010 to 2022, reflecting varying patterns in early adolescent fertility.

In the Western Cape, ASFR10–14 demonstrated periodic fluctuations, with the highest rates observed in 2013 (1.6) and 2019 (1.5). A notable decline occurred in 2017, when the rate dropped to its lowest point at 0.8. By 2022, the province recorded an ASFR10–14 of 1.4, ranking sixth nationally.

The North-West province experienced significant variation, with peak rates in 2013 and again in 2022, both at 1.3. The lowest rates were recorded in 2017 and 2018, with an ASFR10–14 of just 0.4. In 2022, North-West had the seventh highest ASFR10–14 at 1.3.

In the Free State, ASFR10–14 remained relatively low throughout the period. The province recorded peak values of 1.3 in both 2013 and 2019, while the lowest rate was noted in 2018 at 0.3.

The 2022 figure stood at 1.1, placing it eighth among all provinces.

Gauteng consistently maintained one of the lowest adolescent fertility rates in the country. The ASFR10–14 peaked in 2013 at 1.1 and reached a low in 2018 at 0.5. In 2022, Gauteng recorded the lowest provincial ASFR10–14 at 1.0.

These trends underscore the significant provincial disparities in early adolescent fertility and reinforce the need for region-specific responses. Addressing these disparities requires a nuanced understanding of localized socio-economic conditions, cultural dynamics, and access to reproductive health services. Targeted policies and interventions that reflect provincial contexts are critical in effectively reducing early adolescent pregnancies across

South Africa. Figure 5 below provides provincial ranking of adolescent ASFRs15-19 for 2022 (StatsSA (2024) CRVS data for 2022)

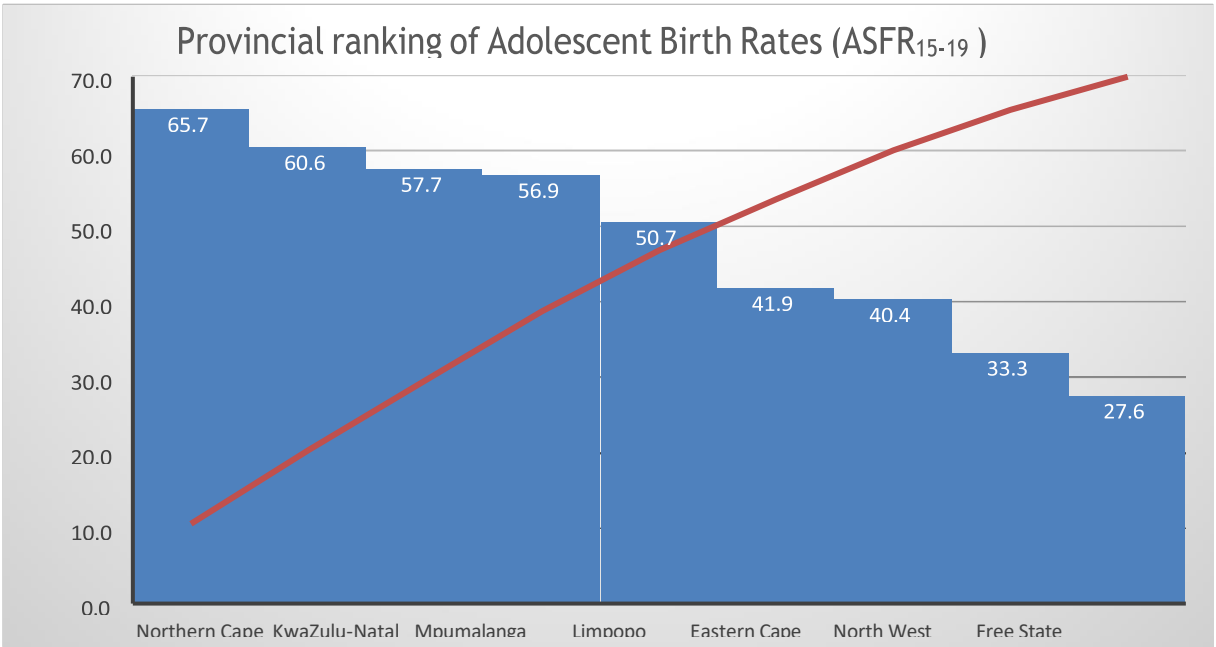


Figure 5: Provincial ranking of Adolescent Birth Rates (ASFR15-19) 2022 (source: StatsSA (2024) CRVS data)

According to StatsSA (2024:9), an analysis of Civil Registration and Vital Statistics (CRVS) data from 2010 to 2022 provides valuable insights into provincial trends in the Age-Specific Fertility Rate (ASFR) for adolescent girls aged 15–19 years. In 2022, the highest ASFR15–19 was recorded in the Northern Cape and KwaZulu-Natal, with rates of 65.7 and 60.6 births per 1,000 girls aged 15–19 years, respectively. In total, five provinces reported ASFR15–19 values exceeding 50 births per 1,000 girls, highlighting areas with a relatively higher prevalence of adolescent pregnancies.

Across all provinces, a general downward trend in ASFR15–19 was observed over the 12 years, reflecting progress in adolescent reproductive health and the possible impact of interventions aimed at reducing teenage pregnancies. Despite this overall decline, several provinces exhibited notable fluctuations in their ASFR15–19 rates, suggesting periods of increased adolescent pregnancy or potential inconsistencies in data reporting and collection.

The Northern Cape and Eastern Cape stand out as the provinces with the highest peak ASFR15–

19 values over the review period, indicating persistent challenges in managing adolescent fertility in these areas. In contrast, Gauteng consistently recorded the lowest ASFR15-19 rates from 2010 to 2022, indicating better outcomes in adolescent reproductive health or more effective implementation of prevention strategies in this province.

These trends underscore the importance of continued investment in adolescent sexual and reproductive health programmes, with a strong emphasis on targeted, province-specific interventions to address regional disparities and further reduce teenage pregnancy rates across South Africa. Figure 6 below shows the Adolescent Birth Rates (ASFR15-19) by Province, 2010-2022 (CRVS), (source: StatsSA (2024:7)74 from CRVS 2010-2022)75

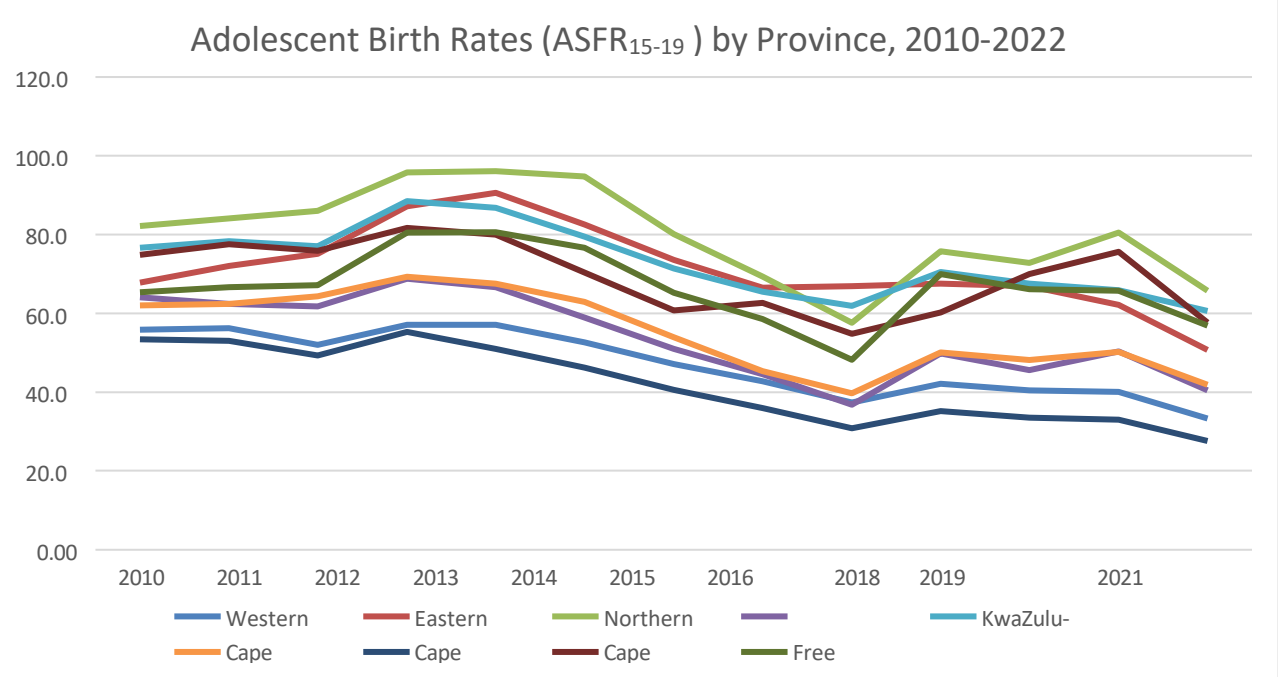


Figure 6. Adolescent Birth Rates (ASFR15-19) by Province, 2010-2022 (CRVS), (source: StatsSA (2024:7)[74] from CRVS 2010-2022)[75]

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.

Using additional data sources, particularly from the Census 1996–2011 and Community Survey (CS) 2016, StatsSA (2023b) reported an ASFR15–19 of 71 births per 1,000 adolescent girls in 2016. The long-term trend shows a general decline from 78 in 1996 to 71 in 2016. The steepest reduction occurred between 1998 and 2001, when the ASFR15–19 dropped from 76 to 65 births per 1,000. However, there is no clear evidence explaining this sharp decline during that period.

These observations reflect both progress and challenges in adolescent reproductive health across South Africa, emphasizing the importance of sustained, evidence-based interventions and province-specific strategies to reduce teenage pregnancy and support youth development. Figure 7 shows the Adolescent birth rates (ASFR15-19), 1996-2016, (source: StatsSA (2023b:10) Census 1996–2011 and CS 2016 data)

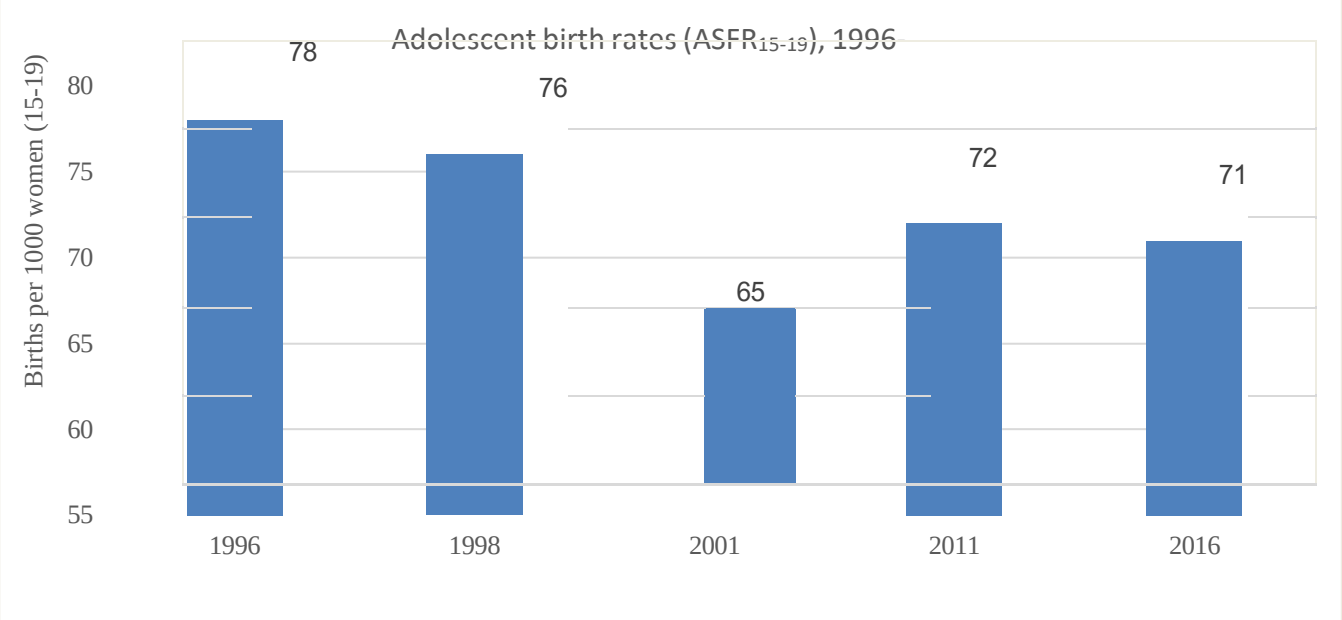


Figure 7. Adolescent births rates (ASFR15-19), 1996-2016, (source: StatsSA (2023b:10) Census 1996–2011 and CS 2016 data)

In conclusion, teenage pregnancy continues to present a complex and multifaceted policy challenge in South Africa, with profound implications for adolescent health, education, and overall social development. A nuanced and data-driven understanding of its prevalence, root causes, and geographical distribution is essential for the design of effective interventions. Government stakeholders must enhance inter-sectoral collaboration, implement targeted programmes, and strengthen responsive service delivery mechanisms to reduce adolescent pregnancies and support improved long-term outcomes for the country's youth

v. National Trends and ASFR Indicators

The Age-Specific Fertility Rate (ASFR) serves as a critical metric for evaluating teenage fertility patterns. According to data from StatsSA (2024), the ASFR for adolescent girls aged 15–19 years declined from 66.1 per 1,000 in 2010 to 44.6 per 1,000 in 2022. The ASFR for the 10–14 age group remained significantly lower at 1.4 per 1,000 girls in 2022. Although this trend reflects a gradual decline, fluctuations have been observed, particularly during the COVID-19 lockdown period between 2019 and 2021, when school closures and reduced access to contraceptive services likely contributed to increases in adolescent pregnancies (StatsSA, 2023; StatsSA, 2024).

vi. Birth Registrations and Demographic Insights

Analysis of birth registration data reveals a considerable proportion of births among adolescents. In 2022, 101,569 births were recorded among girls aged 15–19, constituting 11.1 percent of all live births in the country, while 3,598 births were registered to girls aged 10–14, making up 0.4 percent of total births (StatsSA, 2023). Late birth registration remains prevalent in younger age groups, particularly among girls aged 10–14, where 35.6 percent of births were registered after the standard period, suggesting barriers such as social stigma, lack of access, or inadequate information about birth registration processes (StatsSA, 2023b).

vii. Provincial Variation in Teenage Pregnancy Rates

The prevalence of teenage pregnancy varies widely across provinces. StatsSA's Civil Registration and Vital Statistics (CRVS) system data indicates that the highest ASFRs for girls aged 15–19 in 2022 were found in the Northern Cape (65.7 per 1,000), KwaZulu-Natal (60.6), and Mpumalanga (57.7), while Gauteng (27.6) and the Western Cape (33.3) reported the lowest rates (StatsSA, 2024). These disparities point to uneven access to reproductive health services and broader structural inequalities.

viii. DHIS Insights

The District Health Information System (DHIS) contributes further understanding by tracking adolescent service utilization in public health facilities. In 2020, the delivery-in-facility rate for girls aged 10–19 stood at 14.2 percent. Provincial variations mirror ASFR trends, with the Northern Cape recording the highest delivery rate at 18.4 percent, followed by KwaZulu-Natal at 16.4 percent and Eastern Cape at 16.9 percent. These statistics demonstrate varying levels of adolescent access to maternal health services across provinces (DHIS, 2020).

ix. DHA and Integrated Vital Registration Systems

The DHA, working in conjunction with the State Information Technology Agency (SITA), has

enhanced birth registration processes by integrating direct data capture systems in health and administrative facilities. This collaboration enables more comprehensive tracking of adolescent births and improves timely registration, especially in underserved areas (StatsSA, 2023b).

x. Thembisa and Naomi Model Projections

The Thembisa model, which estimates HIV and reproductive health dynamics, indicates a strong association between teenage pregnancy and HIV incidence among adolescent girls. The model shows that risk factors such as low contraceptive uptake, unprotected sex, and engagement in transactional relationships significantly contribute to teenage pregnancies, especially in socio-economically disadvantaged areas (Johnson & Dorrington, 2021). Similarly, the Naomi model offers sub-national HIV estimates and service delivery projections, supporting targeted planning and enabling policymakers to design district-specific interventions that address the reproductive health needs of adolescents (UNAIDS, 2022).

xi. International and Regional Context

In comparative terms, South Africa's ASFR for girls aged 15–19, although lower than the Sub-Saharan Africa regional average of approximately 90 births per 1,000, remains considerably higher than that of high-income countries, where the rate often falls below 20 per 1,000 (UNFPA, 2021; UNICEF, 2022). The ASFR for girls aged 10–14 is also below the low- and middle-income countries (LMIC) median of 4.5 per 1,000, positioning South Africa in a unique intermediate category globally (IHME, 2020).

xii. 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 remains a complex and multifaceted policy challenge in South Africa, with significant implications for adolescent health, education, and social development. Despite a decline in Adolescent Specific Fertility Rates (ASFRs) over time, persistent provincial disparities, limited access to youth-friendly sexual and reproductive health and rights (SRHR) services, and entrenched socio-economic and structural barriers continue to hinder progress.

A data-driven and context-specific understanding of the root causes, prevalence, and geographical distribution of teenage pregnancy is essential for designing effective interventions. Evidence from sources such as the Civil Registration and Vital Statistics (CRVS), District Health Information System (DHIS), Department of Home Affairs (DHA), and models like Thembisa and Naomi highlights the urgent need for coordinated, evidence-based responses.

To address this challenge effectively, government stakeholders must prioritize inter-sectoral collaboration, strengthen responsive service delivery mechanisms, and enhance access to adolescent-friendly health services. Furthermore, the use of disaggregated data for localized policy planning is critical to ensuring targeted and impactful interventions that improve long-term outcomes for South Africa's youth.

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 establishes that the South African Government provides a range of policy-driven services and sector-specific interventions aimed at addressing adolescent sexual and reproductive health and reducing teenage pregnancy. These services are delivered across multiple sectors, primarily social development, health, and basic education, and are increasingly being supported by integrated planning tools such as DHIS, DHA birth registration systems, and predictive models like Thembisa and Naomi to enhance evidence-based service delivery.

From the perspective of the Department of Social Development (DSD), several policies and programmes directly or indirectly respond to the needs of adolescents at risk of or affected by teenage pregnancy. These include the National Child Care and Protection Policy (2019), the White Paper on Families (2021), and the Social Assistance Act (2004). Through these frameworks, the DSD provides psychosocial support services, early intervention programmes, and social behaviour change communication (SBCC) initiatives. These services are facilitated by social service practitioners (SSPs), including social workers, auxiliary workers, and community caregivers. According to DSD data, over 610,911 adolescents received psychosocial support services in 2023, often integrated within HIV, TB, and substance abuse prevention programmes (DSD, 2023c). Additionally, through its social assistance programmes, the DSD ensures access to child support grants (CSG) and food security support, which indirectly mitigates some of the structural drivers of teenage pregnancy, such as poverty and social exclusion.

In the health sector, the Department of Health (DOH) plays a pivotal role in the provision of sexual and reproductive health and rights (SRHR) services tailored for adolescents. This is operationalized through policies such as the National Adolescent and Youth Health Policy (2017) and the Integrated SRHR Policy (2019). The DHIS data reveals that adolescents form a significant proportion of healthcare users, with an estimated 18% of adolescents aged 10–19 accessing public primary healthcare facilities monthly, many for SRHR-related services (DHIS, 2022). The sector also promotes adolescent-friendly health services, including youth-friendly zones at public clinics, contraceptive services, pregnancy counselling, and antenatal care for pregnant teenagers. The Choice on Termination of Pregnancy Act (1996) enables adolescents to access safe abortion services without parental consent, reinforcing reproductive autonomy and contributing to harm reduction strategies.

Further support services include the revitalized Integrated School Health Programme (ISHP), jointly implemented by the DOH, DSD, and the Department of Basic Education (DBE). This programme, although disrupted during the COVID-19 pandemic, provides on-site screening, SRHR education, and contraceptive services in schools and is increasingly being repositioned as a critical service platform for adolescent health promotion (DOH & DBE, 2012).

Within the education sector, the DBE provides adolescent-targeted services under frameworks

such as the DBE Policy on HIV, STIs and TB (2017) and the Policy on the Prevention and Management of Learner Pregnancy in Schools (2022). The central pillar of this sector's response is the provision of Comprehensive Sexuality Education (CSE) through Life Skills (Grades 4–6) and Life Orientation (Grades 7–12) curricula. The implementation of scripted lesson plans (SLPs) and digital interventions such as the AMAZE video series, in partnership with UNFPA, has improved adolescent access to accurate SRHR information. Furthermore, school social workers and school-based support teams (SBSTs) provide essential psychosocial and academic support to pregnant learners and young mothers. However, data shows that only a fraction of schools currently employ dedicated social workers, and many rely on donor-funded SSPs (DBE, 2023).

Cross-sectoral efforts are reinforced through integrated government programmes such as the National Strategic Plan (NSP) on HIV, TB, and STIs (2023–2028), which addresses structural determinants of teenage pregnancy. The NSP facilitates targeted interventions for key adolescent populations, improves SRHR service delivery, and supports community-level advocacy. Similarly, the Programme of Action (POA) on Teenage Pregnancy (2023) represents a multi-sectoral initiative involving DSD, DOH, DBE, and the Department of Women, Youth and Persons with Disabilities, aiming to strengthen the coordinated delivery of adolescent services, especially in high-prevalence districts (DWYPD, 2023).

The Department of Home Affairs (DHA), through its integration with the State Information Technology Agency (SITA), supports service provision through its role in birth registration and documentation. Timely birth registration allows pregnant adolescents and young mothers to access social grants and other government services. Enhanced digital registration systems have contributed to improved tracking of adolescent births and better identification of vulnerable groups (StatsSA, 2023b).

Complementing these services are predictive and planning tools such as the Thembisa and Naomi models, which provide insights into adolescent reproductive behaviour, service needs, and risk profiles. The Thembisa model highlights correlations between teenage pregnancy and HIV infection among adolescent girls, offering valuable projections for integrated HIV and SRHR programming (Johnson & Dorrington, 2021). The Naomi model helps local governments plan resource allocation and optimize service coverage at the sub-district level by estimating unmet SRHR needs (UNAIDS, 2022).

Overall, while a comprehensive service architecture exists across government sectors to support adolescents in relation to teenage pregnancy, the diagnostic evaluation reveals significant implementation gaps, funding shortages, and intersectoral coordination challenges. Strengthening youth-centred delivery systems, ensuring equitable access across provinces, and improving monitoring and evaluation mechanisms remain essential to enhancing the impact of government services in addressing adolescent pregnancy.

4.2.2 Government Policy and Legislative Response

South Africa's social development sector has developed a broad set of policies, legislation, and service delivery responses aimed at addressing the structural and social factors contributing to teenage pregnancy. Though not always designed explicitly to combat teenage pregnancy, these frameworks collectively address underlying issues such as poverty, inequality, and limited access to social protection and services, thereby indirectly supporting vulnerable adolescents and teenage

mothers.

The sector's policy response includes foundational documents such as the White Paper for Social Welfare (1997), the White Paper on Population (1998), the Policy Framework for Orphans and Vulnerable Children (2005), the National Child Care and Protection Policy (2019), and the White Paper on Families (2012), later revised in 2021. These policies focus on strengthening family structures, supporting vulnerable children, and mitigating the socio-economic factors that often lead to early childbearing.

Legislative instruments such as the National Welfare Act (1978), the Welfare Laws Amendment Act (1997), the National Development Agency Act (1998), the Social Assistance Act (2004), and the Prevention of and Treatment for Substance Abuse Act (2008) further reinforce the sector's response. While not originally targeting teenage pregnancy, these laws provide the framework for essential services, including social assistance and substance abuse support, which help improve outcomes for teenage mothers.

Comprehensive legal protection for children is provided through critical legislation such as the Children's Act (2005), the Children's Amendment Act (2022), and the Criminal Law (Sexual Offenses and Related Matters) Amendment Act (2015), which defines the legal boundaries for child protection, sexual consent, and statutory rape, ensuring safeguards for adolescents.

In terms of service delivery, the social development sector has implemented various interventions, including psychosocial support, early intervention programs, family preservation services, and community outreach initiatives targeting social behaviour change, HIV, TB, and substance abuse. Social assistance programs like child support grant, food parcels, and shelter services respond to broader social vulnerabilities linked to teenage pregnancy. Notably, while the sector does not operate a dedicated teenage pregnancy intervention on a large scale, existing programmes addressing HIV and substance abuse indirectly address key drivers of early pregnancies.

The DSD's Adolescent Sexual and Reproductive Health and Rights (ASRH&R) Framework Strategy (2014–2019) reflects a targeted approach to adolescent health, although its current implementation status remains unclear. The sector also aligns with international treaties promoting adolescent rights and well-being. Despite a sizeable network of social service professionals, capacity remains uneven across provinces, with resource distribution challenges affecting service accessibility. Ultimately, while the legislative and policy architecture is robust, implementation gaps and the lack of targeted programming highlight the need for a more coordinated and adolescent-specific response to teenage pregnancy.

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, in collaboration with non-profit organisations (NPOs), has implemented various programmes and services to address teenage pregnancy among adolescents. These initiatives span across the education, health, and social development sectors and are guided by policy frameworks such as the National Adolescent and Youth Health Policy (2017–2022) and the Integrated School Health Programme (ISHP). A number of integrated services are provided to adolescents to reduce teenage pregnancy and enhance reproductive health outcomes. Central among these is the ISHP, which delivers sexual and reproductive health education, access to contraceptives, and referral services directly within schools (Department of Basic Education, 2023). The Department of Health's Adolescent and Youth-Friendly Services (AYFS) further contributes by offering confidential care through clinics, including contraception, antenatal support, and counselling (Department of Health, 2023). Complementing these efforts, Comprehensive Sexuality Education (CSE) is taught in schools to empower adolescents with knowledge around reproductive health, consent, and life skills (DBE, 2023). The Department of Social Development (DSD) supports adolescent mothers through psychosocial counselling and teen parenting support programmes, while the Department of Home Affairs (DHA) plays a supportive role by facilitating birth registration and demographic tracking essential for service planning.

Institutional priorities in this area are guided by strategies such as the National Adolescent Sexual and Reproductive Health and Rights Framework Strategy (2015–2020), which continues to inform current interventions. Central to the institutional response is multi-sectoral collaboration, involving Health, Education, Social Development, and Home Affairs. Capacities have been enhanced through the training of healthcare workers in youth-friendly services, the deployment of mobile health units, and improved availability of contraceptives and safe abortion services (Department of Health, 2023). The broader health sector response has also been strengthened through the National Strategic Plan on HIV, TB and STIs (2023–2028), which recognizes teenage pregnancy as a key vulnerability intersecting with HIV risk and incorporates related interventions as part of broader health system improvements (SANAC, 2023).

The delivery of these services involves multiple stakeholders with distinct roles. Government departments are chiefly responsible for policy development, service provision, and implementation. NPOs and NGOs, including LoveLife, Soul City Institute, and Marie Stopes South Africa, offer vital supplementary services, such as peer education, mobile outreach, and counselling. Community-based organisations and traditional leaders often contribute by fostering

behavioural change and addressing cultural barriers. Parents and caregivers are expected to offer support and guidance, though research indicates that communication gaps between them and adolescents pose a significant barrier (SAMRC, 2023). International partners like UNFPA and UNICEF provide technical expertise, financial assistance, and support in shaping policy frameworks.

Despite these efforts, there remain critical gaps in programme delivery and service provision. Adolescents, especially in rural areas, still experience limited access to contraceptives due to stigma, supply shortages, and a lack of youth-friendly environments (DHIS, 2023). The roll-out of Comprehensive Sexuality Education is inconsistent across provinces, often hindered by community resistance and inadequate training for educators (DBE, 2023). Coordination among sectors is often disjointed, leading to duplicated efforts and inefficient resource use. Moreover, adolescent fathers are frequently excluded from programme design and implementation, and there is insufficient focus on engaging boys and young men in prevention strategies. The limited use of digital tools and real-time data for adolescent health planning also represents a significant shortfall (StatsSA, 2023).

Looking at international best practices, several models provide valuable insights for strengthening South Africa's response. For instance, Kenya and Ethiopia's "One-Stop Youth Centers" deliver integrated services, including healthcare, counselling, legal aid, and skills training, in a single location, improving accessibility and uptake (UNFPA, 2021). In Rwanda, "Youth-Friendly Corners" within health facilities have proven successful in reducing adolescent pregnancy rates by offering services that are confidential and responsive to youth needs (WHO, 2022). The United Kingdom's "Whole School Approach" integrates health education, parental involvement, school-based services, and community engagement directly into school operations (OECD, 2020).

Adopting a similar multi-sectoral model in South Africa, one that combines school-based health services, digital health technologies, targeted community outreach, and social protection measures, could significantly improve outcomes. Enhanced investment in service provider cross-training, real-time data systems and youth participation in programme design and implementation would be crucial in developing a contextually relevant and effective response to teenage pregnancy.

4.3 WHAT ARE THE ROLES AND RESPONSIBILITIES OF DIFFERENT STAKEHOLDERS?

4.3.1 Roles and Responsibilities of Different Stakeholders

South Africa's institutional response to teenage pregnancy reflects a formal commitment across multiple sectors, primarily Social Development, Health, and Basic Education. These sectors have articulated clear policy priorities and strategic commitments aimed at reducing adolescent fertility rates, improving sexual and reproductive health rights (SRHR), and supporting pregnant adolescents and adolescent mothers. However, the extent to which these priorities have translated into effective, coordinated implementation is uneven and varies by province and institutional capacity.

The Department of Social Development (DSD) takes a developmental approach to tackle the root causes of teenage pregnancy. Key policies include the White Paper on Social Welfare (1997), the

Policy Framework for Orphans and Vulnerable Children (2005), the National Child Care and Protection Policy (2019), and the Revised White Paper on Families (2021). These demonstrate the government's commitment to family well-being and supporting vulnerable adolescents. The Children's Act (2005) and the Children's Amendment Act (2022) further enhance the legal framework for the protection and development of children, including adolescent mothers.

DSD's operational capability to deliver on these priorities, however, is constrained by resource limitations. As of 2022, the department reported employing 17,508 social service practitioners (SSPs), supplemented by 3,473 contract social workers and 25,492 auxiliary social workers (DSD, 2023c). While this workforce underpins the delivery of psychosocial and behavioural services, the national average ratio of SSPs to the population, estimated at 1:6,096, falls short of international norms (DSD, 2017). Furthermore, provincial disparities persist, with Gauteng reporting the lowest SSP coverage (2.7 per 100,000 population), compared to the Northern Cape's higher ratio (11.6 per 100,000) (DSD, 2017). Despite these capacity challenges, DSD programmes such as social grants, food parcel distribution, gender-based violence response services, and the National Adolescent Sexual and Reproductive Health and Rights (ASRH&R) Framework Strategy (2014–2019) remain central to the institutional response. However, a 2022 evaluation of the ASRH&R Strategy identified significant implementation gaps, especially in interdepartmental coordination, monitoring and evaluation, and sustainable service delivery systems (DPME, 2022).

In the health sector, institutional priorities are guided by the National Adolescent and Youth Health Policy (2017) and the Integrated SRHR Policy (2019). These frameworks align with the country's commitment to universal access to SRHR services and adolescent-friendly healthcare. The Choice on Termination of Pregnancy Act (1996) and the National Health Act (2003) also affirm adolescents' rights to reproductive health services, including access to contraceptives and safe abortion. The health sector's capabilities to meet these commitments are evidenced through adolescent-friendly clinics, youth-friendly zones, and integrated services under the Ideal Clinic Programme. However, DHIS data reveals that while approximately 18 percent of adolescents visit primary healthcare facilities monthly, service quality and contraceptive accessibility remain inconsistent across provinces (DHIS, 2022).

Institutionally, the Department of Health (DOH) is also responsible for the revitalisation of the Integrated School Health Programme (ISHP), implemented in collaboration with DBE and DSD. This programme represents a critical commitment to providing school-based SRHR services, but it has suffered from implementation setbacks due to staffing shortages, funding gaps, and disruptions caused by the COVID-19 pandemic (DOH & DBE, 2012). The Naomi and Thembisa models, used by DOH and planning agencies, offer vital support for sub-national resource allocation and identification of adolescent service needs. These tools help translate institutional priorities into data-informed service planning, particularly in underserved districts (Johnson & Dorrington, 2021; UNAIDS, 2022).

In the education sector, institutional commitments are anchored in the DBE Policy on HIV, STIs and TB (2017) and the Policy on the Prevention and Management of Learner Pregnancy in Schools (2022). These policies position schools as primary sites for preventive intervention through Comprehensive Sexuality Education (CSE) and psychosocial support services. The South African Schools Act (1996) and the SACE Code of Ethics (2000) provide the legislative foundation for learner protection and service delivery. In practice, the implementation of CSE remains inconsistent. The Scripted Lesson Plans (SLPs) and newer digital tools, such as the AMAZE video

series, have helped enhance delivery, yet coverage is limited, and educator training is uneven across provinces (DBE, 2023).

The DBE's capacity to deliver adolescent services is constrained by an insufficient number of school-based social workers, with only 760 full-time social workers employed nationally and 1,154 supported by donor funding (DBE, 2023). Moreover, 85 percent of the sector's SSPs are funded externally, exposing systemic under-resourcing. This funding model undermines the institutional sustainability of adolescent support programmes in schools. The department is currently exploring a model of one social worker per 20 schools, but implementation remains at an early stage.

Cross-sectoral coordination represents a critical institutional priority but also a persistent gap. Recent initiatives, such as the Programme of Action (POA) on Teenage Pregnancy (2023), led by DSD, DBE, DOH, and the Department of Women, Youth and Persons with Disabilities (DWYPD), aim to address these systemic weaknesses. The POA reflects a strategic shift towards integrated, evidence-based programming and seeks to consolidate fragmented efforts across sectors (DWYPD, 2023). Similarly, the National Strategic Plan (NSP) on HIV, TB and STIs (2023–2028) incorporates teenage pregnancy as a cross-cutting issue, highlighting the influence of structural determinants such as poverty, inequality, and limited SRHR access (DSD, 2023c).

Finally, institutional commitments to data-driven service delivery have improved through enhancements in birth registration systems by DHA, supported by the State Information Technology Agency (SITA). These systems enable better identification of adolescent mothers and facilitate timely service linkage. However, gaps remain in harmonising data systems across departments, which affects service integration and monitoring.

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.

4.4 WHAT ARE THE GAPS?

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

Despite the existence of a broad policy framework and the efforts of multiple government departments to address teenage pregnancy, significant implementation and systemic gaps continue to undermine the effectiveness and impact of the response. These gaps are evident across strategic planning, service delivery, data management, inter-sectoral coordination, and resource allocation, limiting the government's ability to deliver holistic and integrated adolescent sexual and reproductive health and rights (SRHR) services (DSD, 2023; DPME, 2022).

One of the most persistent gaps is the lack of consistent interdepartmental coordination and integration of services despite well-defined institutional mandates. Although the Programme of Action (POA) on Teenage Pregnancy (2023) and the National Adolescent Sexual and

Reproductive Health and Rights (ASRH&R) Framework Strategy (2014–2019) were intended to foster multi-sectoral collaboration, evaluations show that fragmented implementation and unclear role delineation continue to affect their operationalisation (DSD, 2023c). Departments often work in silos, which results in duplication of efforts, inefficient resource utilisation, and uneven service coverage, particularly at the provincial and district levels (DPME, 2014).

Another critical gap relates to the inadequate provision and quality of adolescent-friendly SRHR services. While the Department of Health has rolled out youth-friendly zones and ideal clinics, these services are not uniformly available across all provinces. DHIS data indicates disparities in service utilisation, with rural areas and poorer provinces such as Eastern Cape, Limpopo, and KwaZulu-Natal having limited access to contraceptive services, counselling, and termination of pregnancy options (DHIS, 2022). In addition, adolescents often perceive health services as judgmental and unwelcoming, which discourages early health-seeking behaviour (DSD, 2023; Barron et al., 2022).

The education sector faces substantial gaps in the implementation of Comprehensive Sexuality Education (CSE). Although Scripted Lesson Plans (SLPs) and digital content such as AMAZE videos have been introduced in schools, their rollout remains inconsistent and heavily dependent on external support and teacher capacity (DBE, 2022). There are also challenges in training educators, ensuring fidelity to curriculum content, and integrating life skills into broader SRHR messaging. Moreover, school-based social support services are critically under-resourced, with only a small proportion of schools employing full-time social workers, most of whom are funded by donors (DBE, 2023).

A further systemic gap is the insufficient psychosocial support and reintegration services for pregnant learners and adolescent mothers. While DBE's Policy on the Prevention and Management of Learner Pregnancy in Schools (2022) mandates that schools support learners before and after delivery, implementation remains weak. Many schools lack clear reintegration protocols or the capacity to provide counselling, parenting support, or flexible learning options for young mothers (DBE, 2022; DSD, 2023).

There are also data and information management limitations, which hinder effective planning and monitoring. Although StatsSA's Civil Registration and Vital Statistics (CRVS) system, DHIS, and DHA registration platforms provide valuable data, their integration remains inadequate. Delays in birth registrations, particularly for girls aged 10–14, limit the availability of real-time data and impede the government's ability to track adolescent pregnancy trends accurately (StatsSA, 2023b). In 2022, 35.6% of births among 10–14-year-olds were registered late, indicating systemic bottlenecks in data capture and service linkage (StatsSA, 2024).

Furthermore, resource constraints and the inequitable distribution of services remain pervasive. The Department of Social Development (DSD) has limited capacity to scale its psychosocial and social protection services due to shortages in the social service workforce. With an average ratio of 1 social service practitioner per 6,096 people and vast disparities across provinces, many adolescents are left without access to vital support systems (DSD, 2017; DSD, 2023c).

Funding gaps and reliance on donor-supported programmes pose additional challenges. For instance, over 85% of social support personnel in schools are funded externally, raising questions about sustainability and long-term integration into public service structures (DBE, 2023). The lack

of secure, government-funded positions for social workers, community outreach workers, and SRHR educators hinders the continuity and scalability of services.

Importantly, existing policy documents and programmes often lack effective monitoring and evaluation (M&E) frameworks. The evaluation of the ASRH&R Strategy (2014–2019) and other sectoral policies revealed weak performance indicators, poor data feedback loops, and limited accountability mechanisms (DPME, 2022). Tools such as the Thembisa and Naomi models, while valuable for sub-national planning, are underutilised in many provinces due to a lack of technical capacity or integration into routine programme planning cycles (Johnson & Dorrington, 2021; UNAIDS, 2022).

Lastly, socio-cultural and legal barriers continue to inhibit service uptake, especially for younger adolescents. Adolescents under 18 often experience stigma and discriminatory attitudes from service providers, and while legal instruments such as the Children's Act (2005) and the Choice on Termination of Pregnancy Act (1996) protect adolescent rights, many service providers are unaware of or reluctant to uphold these protections (DSD, 2023).

Conclusion

While South Africa has made commendable policy and institutional progress in addressing teenage pregnancy, several critical gaps persist across coordination, service delivery, resource allocation, data systems, and community engagement. These shortcomings continue to compromise adolescent access to equitable, comprehensive, and youth-friendly SRHR services. Strengthening integrated service delivery platforms, enhancing provider training, ensuring sustainable financing, and improving M&E systems remain essential to closing these gaps and achieving meaningful reductions in teenage pregnancy.

4.5 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)?

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

In the global public health landscape, integrated service delivery has emerged as a key principle in adolescent sexual and reproductive health and rights (ASRHR) programming. Several countries have successfully operationalised multisectoral and youth-centred approaches that effectively reduce teenage pregnancy and improve adolescent health outcomes. These international best practices offer valuable guidance for strengthening South Africa's policy and programme framework, particularly in the context of the diagnostic evaluation of the government's response to teenage pregnancy.

One of the most widely acknowledged models is the "Whole School, Whole Community, Whole Child (WSCC)" framework developed in the United States, which integrates health, education, and community services in a coordinated manner. This model emphasises the importance of health-promoting school environments, comprehensive health education, youth engagement, and strong linkages between schools and health services (Centers for Disease Control and Prevention [CDC], 2019). In adapting this model, South African schools could enhance

coordination between the Department of Basic Education (DBE), Department of Health (DOH), and Department of Social Development (DSD) by ensuring that learners receive SRHR services, psychosocial support, and health education under one unified structure.

In Finland and the Nordic countries, the successful integration of SRHR services within primary healthcare has proven highly effective. These systems offer adolescent-friendly clinics within local primary healthcare centres, equipped with trained professionals who provide contraception, mental health support, sexual counselling, and parenting advice without stigma or parental consent barriers (World Health Organization [WHO], 2022). Such an approach could strengthen South Africa's existing Ideal Clinic Realisation and Maintenance Programme by enhancing youth-friendly service standards, increasing the presence of dedicated adolescent health nurses, and extending mobile outreach clinics, particularly in rural and underserved areas.

The Philippines' Adolescent Health and Development Programme (AHDP) presents another best practice, where the national government implemented multi-level coordination platforms, combining education, health, and social services with community-based peer education and youth empowerment initiatives (UNFPA Philippines, 2020). Adapting this to South Africa could involve embedding peer educators within existing school support teams and community structures to increase SRHR literacy, improve service uptake, and build adolescent agency.

In Rwanda, the School-Based Health Programme (SBHP) is a noteworthy example of leveraging school infrastructure as primary access points for SRHR services, offering immunisations, contraceptives, counselling, and health promotion through collaborative partnerships between Ministries of Education and Health. A similar strategy in South Africa could be aligned with the Integrated School Health Programme (ISHP), which already exists but remains underutilised due to poor funding and weak interdepartmental collaboration (DOH & DBE, 2012; DHIS, 2022).

In Chile, the Friendly Spaces Programme for Adolescents and Youth operates within public health facilities and provides holistic, rights-based health services for young people, focusing on privacy, accessibility, and non-judgmental service environments. Facilities are evaluated and certified based on their youth-friendliness using measurable performance standards (WHO, 2022). South Africa's adaptation could involve scaling up adolescent-friendly facility certification within the Ideal Clinic Framework, supported by Naomi and Thembisa models to identify areas with the highest service gaps and unmet adolescent SRHR needs (Johnson & Dorrington, 2021; UNAIDS, 2022).

Another replicable model is Kenya's National Adolescent Sexual and Reproductive Health Policy, which institutionalised interministerial steering committees, decentralised budgeting, and created performance-based monitoring frameworks. The Kenyan model also established youth health advisory boards to ensure adolescent voices in programme design and evaluation (Kenya MoH, 2015). A similar governance structure in South Africa could enhance accountability and foster youth participation in the Programme of Action on Teenage Pregnancy (2023) and related policy initiatives.

Globally, best practices also stress the need for robust monitoring and evaluation systems. Countries like Thailand and Bangladesh have adopted data integration systems that link SRHR indicators across health, education, and social protection databases. This has facilitated more

effective tracking of teenage pregnancy, service uptake, and programme performance. For South Africa, improving integration between CRVS, DHIS, and DHA registration systems, as well as optimising the use of modelling tools such as Thembisa and Naomi, would enhance evidence-informed programme planning and real-time response.

Furthermore, many international programmes are anchored in life-course approaches, addressing adolescent pregnancy not as a standalone issue but in relation to broader determinants like poverty, violence, and early marriage. UNICEF's multi-sectoral adolescent framework promotes cross-cutting programming that integrates nutrition, education, protection, and mental health with SRHR (UNICEF, 2022). Applying a similar life-course lens in South Africa would necessitate better convergence between DSD's child protection systems, DBE's learner support services, and DOH's adolescent health programmes.

Conclusion

International best practices underscore that reducing teenage pregnancy requires more than isolated sectoral interventions. Integrated, adolescent-centred service delivery models that link schools, communities, clinics, and families through coordinated structures yield the most sustainable outcomes. South Africa has already laid a strong policy foundation but must now align its programme planning with global models that emphasise service convergence, youth empowerment, data-driven planning, and inclusive governance structures. Embedding these principles within national frameworks such as the Programme of Action on Teenage Pregnancy, ASRH&R strategies, and the Integrated School Health Programme will be critical to transforming the country's response into a holistic and sustainable adolescent development framework.

4.6 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?

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

Globally, countries grappling with adolescent pregnancy have implemented a range of multi-sectoral, evidence-based interventions that have led to significant reductions in teenage fertility rates and improved adolescent health outcomes. These international experiences provide valuable insights for South Africa, particularly as it seeks to develop a more integrated, effective, and sustainable framework for addressing teenage pregnancy through the current diagnostic evaluation.

One of the most compelling examples is from Chile, where the government's implementation of Friendly Spaces for Adolescents and Youth within public health facilities has resulted in improved access to sexual and reproductive health services for young people. These centres are characterised by their emphasis on non-discriminatory service delivery, trained adolescent health personnel, and confidentiality assurances (World Health Organization [WHO], 2022). The programme also incorporates feedback mechanisms whereby adolescents rate services and inform service improvements. For South Africa, this model offers a clear pathway to strengthening its youth-friendly zones under the Ideal Clinic Framework, especially in provinces with high adolescent birth rates (DHIS, 2022; StatsSA, 2023).

In Finland and Sweden, success in reducing teenage pregnancies has been largely attributed to comprehensive, age-appropriate sexuality education integrated early into the school curriculum and supported by a strong national SRHR policy framework. In Finland, for instance, sexuality education is compulsory from early grades and reinforced by easy access to adolescent-focused health services in local primary care settings (European Expert Group on Sexuality Education, 2020). The South African education system, while promoting Comprehensive Sexuality Education (CSE) through Life Orientation and Life Skills, struggles with inconsistent rollout and insufficient teacher training (DBE, 2022). Finland's model underscores the importance of integrating CSE into national curricula with strong institutional backing, ongoing capacity-building for educators, and clear accountability mechanisms.

In the Netherlands, a combination of universal CSE, youth empowerment programming, and low-barrier access to contraception has resulted in one of the world's lowest adolescent fertility rates. A hallmark of their approach is the Youth Clinic model, where adolescents can access confidential counselling and contraception without parental consent or judgment. Furthermore, school-based SRHR programmes in the Netherlands engage adolescents in open conversations about values, relationships, and gender equity—factors often neglected in South African interventions (UNFPA, 2019). South Africa could strengthen its service environment by integrating similar confidentiality assurances and participatory methods into its adolescent health services and school-based programmes.

From Rwanda, the School-Based Health Programme (SBHP) has been instrumental in delivering integrated SRHR services to in-school youth, including contraceptive counselling, HIV testing, mental health support, and early pregnancy referrals. The programme is built on strong collaboration between the Ministries of Health and Education and uses school infrastructure as a service delivery platform. Importantly, SBHP has been linked with performance-based financing to ensure quality and accountability (UNESCO, 2021). Given South Africa's existing Integrated School Health Programme (ISHP), the Rwandan experience offers a model for strengthening school-based service delivery through clear funding mechanisms and interdepartmental collaboration.

In Kenya, the Adolescent Sexual and Reproductive Health Policy (2015) has made headway in ensuring SRHR integration into primary health care and education systems. Key lessons from Kenya include the establishment of adolescent health coordinators at the county level, a national adolescent health M&E framework, and youth advisory boards that actively participate in programme development and implementation (Kenya MoH, 2015). These strategies offer replicable governance models for South Africa, particularly in terms of enhancing decentralised coordination and engaging young people in decision-making processes within the Programme of Action (POA) on Teenage Pregnancy (DWYPD, 2023).

Thailand's Life Skills and Peer Education Programme, implemented nationally through the Ministry of Education, has contributed to behavioural change and reduced teenage pregnancies. The programme trains peer educators who conduct school-based workshops, build life skills, and link adolescents to SRHR services. Evaluations show high uptake and improved knowledge among youth (UNESCO, 2020). For South Africa, this highlights the importance of youth-led initiatives and peer education within schools, complementing existing interventions such as Scripted Lesson Plans (SLPs) and AMAZE video content (DBE, 2022).

Another important model comes from Bangladesh, where the government integrates community health workers (CHWs) into adolescent reproductive health programmes. These workers conduct door-to-door SRHR education, identify high-risk cases early, and connect adolescents to formal health facilities. In South Africa, Community Health Workers (CHWs) already exist under the DOH structure, but their potential to address teenage pregnancy remains underutilised. Lessons from Bangladesh point to the value of capacitating CHWs with adolescent-specific training and expanding their scope to include SRHR service delivery (WHO, 2022).

A key cross-cutting lesson from these international examples is the critical role of data integration and digital platforms. Countries such as Estonia and Thailand have implemented e-health platforms that allow real-time monitoring of adolescent health indicators, service utilisation, and educational outcomes. These systems support evidence-informed planning and foster cross-sectoral collaboration. In South Africa, while tools such as StatsSA, DHIS, DHA's birth registration systems, and Thembisa and Naomi models are available, they remain under-integrated and underutilised in service planning and performance monitoring (Johnson & Dorrington, 2021; StatsSA, 2023b).

Conclusion

International experience shows that meaningful reductions in teenage pregnancy require not only strong policies but also effective integration of education, health, and social services—anchored in youth-friendly service environments and sustained community engagement. For South Africa, key lessons include the need to strengthen school-based SRHR programmes, expand adolescent-friendly health facilities, improve data integration, engage adolescents in planning processes, and ensure continuous monitoring and accountability. Adopting and adapting these global best practices to the local contexts supported by existing tools such as the Integrated School Health Programme, Ideal Clinic Framework, and Thembisa/Naomi models can significantly enhance the country's capacity to design a responsive, equitable, and youth-centred strategy to reduce teenage pregnancy.

5. CHAPTER 5: DISCUSSION AND CONCLUSIONS

5.1 DISCUSSION

The diagnostic evaluation of the South African Government's response to teenage pregnancy provides a nuanced understanding of the strengths and limitations of existing policies, programmes, and implementation systems. Both the evaluation report and the supporting literature review reveal a comprehensive yet fragmented response, reflecting strong policy intent but inconsistent translation into practice (DSD Evaluation Report, 2024; DSD Literature Review, 2024).

The evaluation underscores the growing concern of teenage pregnancy, especially in the 15–19 age group, which accounted for 11.1% of all births in 2022, representing a significant increase of 17.9% from previous years (StatsSA, 2023b). Despite a gradual decline in age-specific fertility rates (ASFRs), particularly among 10–14-year-olds, the sustained prevalence among older adolescents signals persistent systemic and behavioural gaps in the delivery of adolescent sexual and reproductive health and rights (SRHR) services (StatsSA, 2024; DHIS, 2023).

A key theme arising from both the literature review and fieldwork is the fragmented coordination among government departments. Although national frameworks such as the ASRH&R Framework Strategy (2014–2019) and the Programme of Action (POA) on Teenage Pregnancy (2023) outline multisectoral approaches, implementation often remains siloed. As one official stated during fieldwork, “Each department works in silos; we need a unified plan of action, not isolated policies” (DSD Evaluation Report, 2024:113). This sentiment captures the lack of operational integration across the Departments of Social Development (DSD), Health (DOH), and Basic Education (DBE).

Capacity constraints emerged as a prominent concern. The evaluation confirmed that the availability of social service practitioners (SSPs), especially within schools and clinics, remains well below national demand. The reliance on donor-funded posts—notably, over 85% of school social worker positions—creates programme instability and limits institutional sustainability (DBE, 2023; DSD Evaluation Report, 2024:117). One education manager noted, “We simply do not have enough social workers in schools,” emphasizing systemic human resource shortages that impede service outreach and learner support.

Service delivery gaps are further exacerbated by inconsistencies in the implementation of Comprehensive Sexuality Education (CSE). Although CSE is embedded in the Life Orientation and Life Skills curricula, educators reported discomfort and insufficient training in delivering sensitive content. As one teacher shared during fieldwork, “We often skip those topics because we don’t know how to teach them, and there’s no support” (DSD Literature Review, 2024:84). These challenges directly affect learner awareness, knowledge acquisition, and behavioural outcomes.

The evaluation also revealed barriers in accessing adolescent-friendly health services. Despite the presence of youth-friendly zones and SRHR policies, adolescents perceive healthcare environments as unwelcoming and judgemental. A youth development officer recounted, “Young girls fear being judged by nurses and avoid going to clinics,” highlighting stigma and provider attitudes as deterrents to service uptake (DHIS, 2023; DSD Evaluation Report, 2024:108).

Another cross-cutting issue is the underutilisation of data for decision-making. Although data systems such as CRVS and DHIS and modelling tools like Thembisa and Naomi exist, integration across sectors is weak. Fieldwork participants noted data delays and limited access to real-time district-level data, which constrain effective planning. One district health coordinator remarked, “We don’t have real-time data at the district level—how can we plan effectively?” (DSD Evaluation Report, 2024:122).

Notably, the evaluation also identified a lack of youth engagement in programme design and delivery. While policies aim to empower adolescents, implementation often excludes their voices. As one official noted, “We talk about youth, but we don’t talk with them.” This lack of participatory governance limits the relevance and responsiveness of interventions (DSD Evaluation Report, 2024).

5.2 THEMATIC ANALYSIS OF STAKEHOLDER ENGAGEMENTS

This section presents key insights shared by officials during the fieldwork phase of the evaluation. Although only four of South Africa’s nine provinces were engaged—a recognised research limitation- the perspectives gathered offer valuable insight into how officials perceive and respond to the issue of teenage pregnancy. These insights underscore the complex and multidimensional

nature of the problem, shaped by interrelated socio-economic, cultural, institutional, and service delivery factors. While South Africa has established a comprehensive legislative and policy framework across sectors such as health, education, and social development, significant implementation challenges continue to undermine the effectiveness of adolescent sexual and reproductive health and rights (SRHR) interventions. The fieldwork findings highlight persistent systemic gaps, the impact of broader social dynamics, and the urgent need for coordinated, multi-sectoral responses. Several critical themes emerging from these engagements provide a deeper understanding of current limitations and opportunities for strengthening policy and programme delivery.

Key Discussion Themes:

- **Communication and Awareness Initiatives:**
  Officials stressed the importance of diversified communication strategies, including face-to-face outreach, radio programmes, and community campaigns in local languages, to increase awareness and promote prevention. Effective communication is seen as central to engaging adolescents and their families in efforts to reduce teenage pregnancy.
- **Social Support Programmes for Young Parents:**
  Interventions like the Teenage Parents Programme reflect a growing recognition of the need to support both teenage mothers and fathers. However, stigma and limited access to youth-friendly health services continue to hinder young parents' access to support systems, compromising their well-being.
- **Interconnected Social Challenges:**
  Teenage pregnancy is deeply linked to broader socio-economic issues such as poverty, unemployment, and household instability. The absence of father figures and the prevalence of female-headed households were cited as key contributing factors. Addressing these structural issues is essential for meaningful progress.
- **Educational Gaps in Sexuality Education:**
  A lack of consistent and comprehensive sexuality education (CSE) in schools remains a significant barrier. Many educators lack training or confidence in delivering SRHR content, often omitting critical topics. This gap undermines young people's ability to make informed choices about their sexual health.
- **Limited Access to Mental Health Services:**
  Adolescents face prolonged waiting times and limited access to psychosocial support services. Given the psychological toll associated with unplanned pregnancy and related challenges, there is a pressing need to expand therapeutic support for adolescents.
- **Fragmented Service Delivery:**
  Weak coordination among departments, such as health, basic education, and social development, results in fragmented service provision. Although national initiatives like the Programme of Action on Teenage Pregnancy (2023) exist, poor integration at the implementation level undermines their impact.
- **Cultural Norms and Harmful Practices:**
  Cultural practices such as ukuthwala (forced marriages) are identified as contributors to early pregnancy. Addressing these harmful traditions is critical to creating enabling environments for adolescent girls to thrive.

5.2.1 Insights from Officials: Highlighted Perspectives

- **Inter-sectoral Coordination Deficits:**
  Officials consistently highlighted the lack of cohesive planning across departments. Despite existing frameworks, unclear roles and weak joint accountability mechanisms hamper collaborative efforts.
- **Capacity and Resource Constraints:**
  Disparities in resource allocation, especially in under-resourced provinces, severely limit service delivery. Social service posts in schools are largely donor-funded, making them unsustainable. Healthcare facilities in rural areas also face shortages in trained staff and contraceptive supplies.
- **Inconsistent CSE Implementation:**
  Teachers reported insufficient training and discomfort in teaching SRHR topics. This inconsistency contributes to learner vulnerability and low knowledge levels.
- **Stigma and Unfriendly SRHR Services:**
  Adolescents often avoid clinics due to fear of judgment from healthcare workers, which hinders early help-seeking behavior and limits access to preventive services.
- **Lack of Youth Engagement in Programme Design:**
  Officials acknowledged the absence of meaningful youth participation in designing interventions. Without adolescent input, many programmes fail to resonate with their intended beneficiaries.
- **Weak Data and Monitoring Systems:**
  Inconsistent data integration across systems (CRVS, DHIS, and school records) compromises evidence-based planning. Officials expressed concern over the lack of real-time data at the local level, which constrains responsive service delivery.

Conclusions

This diagnostic evaluation, supported by a comprehensive literature review, confirms that while South Africa has made notable progress in establishing a robust policy and legislative framework to address teenage pregnancy, substantial implementation challenges continue to impede meaningful impact. Structural issues such as weak interdepartmental coordination, insufficiently resourced service systems, and limited adolescent access to sexual and reproductive health and rights (SRHR) services persist as critical barriers to success. Despite strong policy commitments, systemic weaknesses continue to undermine programme outcomes. These include ineffective delivery of comprehensive sexuality education (CSE), insufficient psychosocial and mental health support within schools, and a lack of adolescent-friendly healthcare environments, particularly in rural and under-served areas. Furthermore, the exclusion of adolescent voices from programme design diminishes the relevance and accessibility of services.

Provincial disparities in service provision remain evident, with persistently high adolescent fertility rates in areas such as the Northern Cape and KwaZulu-Natal. Service environments are often hampered by provider bias, limited contraceptive availability, and fragile referral systems. Although CSE has been institutionalised in policy, its actual implementation across schools is uneven, and psychosocial support remains fragmented. The evaluation also highlights gaps in data-driven planning, with limited use of disaggregated sub-district data and predictive modelling tools such as

Thembisa and Naomi, which restrict effective intervention targeting and outcome monitoring.

A strengthened national response requires a unified, adolescent-centred service delivery model that fosters inter-sectoral collaboration with clearly defined roles and accountability structures. SRHR services must be expanded across schools and communities, supported by the training of personnel in adolescent-friendly service provision. Reinforced CSE implementation and improved educator support and monitoring mechanisms are also essential. Institutionalising youth participation platforms is critical to ensure adolescents meaningfully contribute to the development and implementation of services. Additionally, strengthening data integration and using localised planning tools will enhance the precision and responsiveness of interventions. Without addressing these systemic bottlenecks, South Africa's policy efforts will remain aspirational. A cohesive, youth-inclusive, and well-coordinated system is essential to reducing teenage pregnancy and improving adolescent health and well-being.

6. CHAPTER 6: 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.

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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 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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