# Nkosi Johnson Memorial Lecture, June 7th 2011

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**This speech is dedicated to the Ministers of Basic Education and Social Development in South Africa with the hope that it might influence them to meaningfully address the pain, loss of life and thwarted possibility it describes.**

## THE IMPORTANCE OF BEING ANGRY

## GROWING UP IN A VORTEX OF VIOLENCE AND DEPRIVATION - WE OWE IT TO SOUTH AFRICA'S YOUNG PEOPLE TO BREAK THEIR SPIRAL OF RISK

### *Introduction:*

It is a privilege to speak this evening in the name of one of South Africa's bravest young people and in the presence of another. Nkosi left us almost exactly ten years ago, he would have been 22 if still alive; Mandisa is full of life and true grit. Their lives overlapped. As she has just described, Mandisa was a 14 year old finding her difficult way as an orphan when Nkosi lost his 12 year old life on June 1 2001.

Although they did not meet each other their lives intersected, and had more in common that we dare think:

- Both had biological mothers who were ensnared in poverty;
- Both had fathers who deserted their mothers;
- Both had mothers who died of HIV, one naturally, the other unnaturally;
- Both found mothers who loved, cared for and empowered them; we must acknowledge Gail Johnson and Khosi Alma Mashego for their love and principle.
- Nkosi had HIV. Mandisa was spared HIV, but has by her own account been frighteningly close to the risk of infection.

But regrettably, as I will show in this lecture, these are characteristics they share with millions of other young people in South Africa.

There is a lot that could and should be said about both individual lives. But today I want to reflect primarily on the lot of young boys/men, girls/women in SA today, and ask whether anything has changed from ten years ago? And if not, why not?

## *2001 and 2011: A comparison*

## *The political environment is transformed:*

The political environment around HIV has been transformed and is unrecognisable. It is now three years since, in September 2008, Manto Tshabalala Msimang was removed as Minister of Health, and Thabo Mbeki as President. We are now living in the third year of an unambiguous political will to tackle HIV and TB, led outstandingly by Health Minister Dr Motsoaledi, which is yielding results.

- In 2001: Nobody was on ARV treatment in the public sector; today the latest statistics claim that over 1.4million people have been initiated onto treatment since 2004;
- In 2001: there was a +-30% rate of vertical transmission amongst pregnant women with HIV; today, vertical transmission at six weeks post partum is reportedly down to 3.5% countrywide, which means that far fewer children like Nkosi are being born with HIV[1];
- In 2002/03 only 2.1% of eligible children had started ART. By 2007/2008 the figure was reported to be 36.9%[2]. Today it is reported that over 100,000 children have started treatment; this is still only 30% of the children in need of treatment.[3]

## *But the social and economic environment that drives the HIV epidemic has got worse*

There are, however, still many negatives and many many challenges faced by South Africa. These challenges require a greater, broader and deeper political will, together with an understanding of how HIV impacts on other areas of life and vice versa, than we have at present:

- In 2001 there were high levels of stigma. In 2011 we have still not found a way to monitor or measure stigma, meaning that we know little of the lives of the many Mandisa's and Nkosi's of today;
- The violent behaviour of the young men who killed Gugu Dlamini remains unabated, both against other young men and women. We have to face the fact that the socially created penchant for violence amongst young men that led to the murder of Gugu Dlamini on 17 December 1998 is the same violence that murdered Noxolo Nogwaza on Sunday 24 April 2011, and before her Eudy Simelane, Nokuthtula Radebe, Nqobile Khumalo and others.[4]

[1] An Evaluation of the Effectiveness of the PMTCT Programme at Six Weeks Post Partum, (Medical Research Council, National Department of Health, unpublished MRC report, 2011)
[2] Children's Institute, HIV and Health, Children Starting ART, updated July 2010
[3] According to statistics released by the Department of Health (Health Epidemiology, Evaluation and Research) by August 2010 there were 105 123 children initiated on treatment.
[4] For the names of more women raped and murdered, see *Act to End Rape*, Lesbian and Gay Equality Project.

- There is an epidemic of violence amongst young people that leads to maiming and early death for far too many. According to a Statistics South Africa report released last year:

> "The age group most affected by non-natural causes of death was 15–19. 43,1% of recorded deaths in this age group were due to non-natural causes." Within this age group: "11,8% of male non-natural deaths were due to assault, while 5,6% of female deaths were due to the same cause."[5]

It is a tragedy that in the shadow of a Constitution that is pioneering on gender and sexual equality that :

## *In South Africa being young and a woman is a risk factor for unwanted pregnancy, rape, HIV and death:*

Below is some of the evidence:

*Rising rates of HIV Infection:*

- Although there is some evidence of improved condom use among young men and women[6], there are still "desperately high" rates of HIV infection, particularly in women of Mandisa's age and younger;
- In this regard, what we have established of the facts about new HIV infections among young women remains disturbing:

| In a recently published study of HIV incidence among young women in KwaZulu Natal[7] with a median age of 22, HIV incidence was: |
|---|
| • 6.5/100 person years amongst rural women<br>• 6.4/100 person years amongst urban women<br>• 17.2/100 person years amongst urban women under 20 |

According to the authors of the study: "Several studies and this study confirm the persistently high steady state HIV incidence rates, demonstrating the underlying

[5] Statistics South Africa, Report on *Mortality and causes of Death in South Africa in 2008: Findings from death Notification*, 2010 (http://www.statssa.gov.za/publications/P03093/P030932008.pdf)
[6] *South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008. A Tide Turning Among Teenagers?* p 66: "A key finding of this study is that there has been a dramatic increase in the number of people reporting using condoms at last sex. The greatest improvement was seen among youth (15–24 years), adult males, and even among females who have traditionally had low rates of reported condom use, where we have seen an improvement in 2008."
[7] Karim et al, Stabilising HIV Prevalence Masks High HIV incidence Rates amongst Rural and Urban Women in KwaZulu-Natal, South Africa, *Int J Epidemiol*, 2010;1-9. It is admitted that South Africa doesn't know enough about HIV incidence. This is one of the challenges for the next NSP. However, the trends reported by Karim et al are confirmed in other studies. See SANAC, *The HIV Epidemic in South Africa, What do We Know and How Has It Changed?* April 2011.

transmission dynamics despite the scaled-up prevention and treatment efforts, which have failed to address the HIV prevention needs of young women."

*High rates of teenage pregnancy:*

- In 2007, nearly 50 000 pupils fell pregnant while in school, a 151% increase since 2003 (including 53 pupils in grade 3)
- According to the General Housing Survey (2010)[8], 4.9% of females between the ages of 13 and 19 reported being pregnant in the year preceding the survey.
- In the 2009 ante-natal survey, 13.7% of pregnant women surveyed between the ages of 15 and 19 were HIV positive; between 15 and 24 this figures rises to 21.7%.
- About 50% of the women in the survey were aged between 15 and 24 which means that this is the average age for most births in South Africa.

*High maternal mortality:*

Whilst we've learnt how to protect the child from vertical HIV transmission, we are not protecting the mother, due to the exceedingly high rates of maternal mortality, closely associated with HIV infection.

- Between 2005-2007 there was been a 20.1% increase in the number of deaths reported compared with the previous triennium (2002-2004).
- The largest cause of maternal death was AIDS (43.7%). [9]

In the middle of the nineteenth century Charles Dickens penned a permanent lament to the death of Pip, a young orphaned street sweeper, saying.

> "Dead, your Majesty. Dead, my lords and gentlemen. Dead, Right Reverends and Wrong Reverends of every order. Dead, men and women, born with Heavenly compassion in your hearts. And dying thus around us every day."

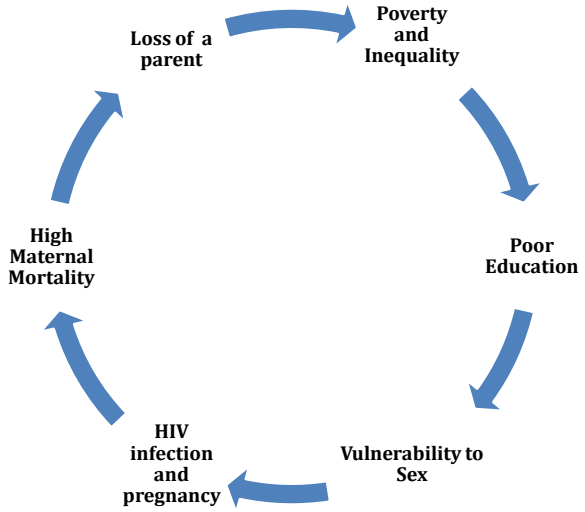
The same words apply 150 years later to women losing their lives as a result of pregnancy.

In reality, these 'different' issues are closely connected in a vicious circle.

[8] Statistics South Africa, General Household Survey, 2010.

[9] Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa, 2005-2007.

# THE RISK CYCLE OF A YOUNG AFRICAN WOMAN IN SOUTH AFRICA




For social and economic reasons girls and young women are vulnerable to early consensual and non-consensual sex; this contributes to high rates of HIV infection; HIV infection is a major cause of maternal mortality; the death of young mothers, leaves another generation of young men and women, prey to the behaviours and social forces that restart the cycle.

**It is this cycle that must be broken.**

For a combination of reasons whilst in their teenage years young women are more vulnerable to HIV infection than men of the same age. [10] However whilst men have lower HIV infection rates in their teens, they 'catch up' in their twenties.[11]

Unfortunately this cycle is not something that people escape after passing through the corridor of childhood, because...

## *Adult Risk behaviours are often Determined in Adolescence:*

The WHO estimates that up to 70% of premature deaths in adults can be attributed to behaviour initiated in adolescence.[12] If true, this is not good for South Africa.

Most young people in South Africa do not have quality lives. According to a compilation of research issued by the South African Institute of Race Relations (SAIRR)[13], in SA there are:

[10] See SANAC Epidemic report at p 70: "In young women aged 15-24 it was estimated that HIV incidence was over 8 times higher than in young men aged 15-24."; at p71 "Holding other factors constant in multiple regression, women faced a 53% higher hazard of sero-conversion than men."
[11] Check Prevalence statistics at 20 and 25
[12] WHO, 2001, The Second Decade: Improving Adolescent Health and development
[13] SAIRR, *First Steps to Healing the South African Family*, March 2011

| SAIRR Summary of Findings | | |
|---|---|---|
| Double orphans | 859 000 | |
| Paternal orphans | 2,468 000 | |
| Maternal orphans | 624 000 | |
| Total orphans | 3.95 million | |
| AIDS Orphans | 1.4 million | |
| Number/proportion of children in child-headed households 98 000 (0.5%) | 98 000 (0.5%) | |
| Proportion of children with absent, living fathers | 42% (1996) | 48% (2009) |
| Proportion of children with present fathers | 49% (1996) | 36% (2009) |
| Proportion of children with present fathers: | African<br>Coloured<br>Indian<br>White | 30%<br>53%<br>85%<br>83% |
| Proportion of children with absent fathers | African up from 46% (1996) to 52% (2009)<br>Coloured up from 34% (1996) to 41% (2009)<br>Indian Down from 17% (1996%) to 12% (2009)<br>White Up from 13% (1996%) to 15% (2009) | |

## *Not surprisingly this, and a range of other factors, affects young people's attitudes to life and mental health:*

"Many South African children are not growing up in safe and secure families. Some are affected by poverty, while others are burdened by the effects of the HIV/AIDS pandemic. This pandemic has resulted in an epidemic of orphanhood and child-headed households, which has left many children having to fend for themselves."

- The National Youth Risk Behaviour Survey (2008) of grade 8-11 learners found in the six months before the survey, 24% of youth had sad or hopeless feelings; 21% admitted to suicidal thoughts; 17% had a suicide plan; 21% had made at least one suicide attempt;
- Western Cape study: 17% of children and adolescents suffer psychiatric problems, major depressive disorder (8%) and post traumatic stress disorder (8%).[14]

## *And mental health is directly connected to physical health and risk of HIV:*

According to researchers:

> "Mental health disorders are accompanied by a considerable amount of impairment, suffering, stigma and family financial strain. There is also a high degree of continuity between psychiatric disorders in childhood and adolescence and those in adulthood.

[14] Kleintjies S et al, The Prevalence of Mental Disorders amongst children, adolescents and adults in the Western Cape, South Africa. *South African Psychiatry Review*, 9: 157-60 (2006)

> Seventy five per cent of adults with mental health problems experience the first onset before the age of 24 years.
> "Finally, mental ill-health is associated with physical ill-health. One good example of this is HIV infection. Young people with a psychiatric disorder are more likely to contract HIV infection than those without such a disorder. There are a number of possible reasons for this increased risk, such as inadequate sexual communication skills, susceptibility to negative peer norms, low self efficacy, decreased assertiveness, and reduced ability to negotiate safer sex."[15]

This environmental assault on people when they are too young to understand it or fend it off helps to explain the cavalier attitude many young people are reported to have towards HIV and other risks to their lives. The evidence in this regard is complex and at times contradictory. It should not be over-simplified. Behaviour is mixed up with culture and context, both of which are changing. But:

- Despite risks of HIV many youth report a preference for prefer 'skin to skin'. Ironically, knowledge of HIV has deteriorated among young people in recent years.
- Condom use among young people is reported to be improving, but so are rates of teenage pregnancy
- Young women are simultaneously victims and agents of their own risk.[16]

**In the words of respected anthropologist Suzanne Leclerc-Madlala there is a need "to engage with the dis-enabling context that gives sustenance to dis-enabling attitudinal and behavioural codes that continue to drive the HIV/AIDS epidemic."[17]**

Where to start?

## *The central importance of basic education and a functional school to reduction of vulnerability to HIV amongst young people*

It is well established that the higher and better the educational attainment, the lower the risk of HIV infection.[18] According to one research study:

> The relationship between educational attainment and HIV prevalence appears to change as epidemics mature. As educated individuals tend to have more control over

[15] A Fischer at al, Mental Health and Risk Behaviour, South African Child Gauge, 2009/2010, Children's Institute, University of Cape Town. See also, L Lake and L Reynolds, Addressing the Social Determinants of Health, where it is recorded that infant mortality is 46/1000 live births in mothers with a matric education and higher and 84/1000 where a mother has no education. Also, Children's Institute, HIV and Health – Distance to Nearest Clinic, July 2010, 40.4% of children (7,588,000) live "far" (more than 30 mins irrespective of mode of transport) from nearest clinic.

[16] Read Mark Hunter, Love in the Time of AIDS, Inequality, Gender and Rights in South Africa, UKZN Press 2010. @ p 6 "... We must pay more attention to how the coming together of low marriage rates and wealth and poverty in close proximity can today drive gender relations and material sexual relationships that fuel AIDS."

[17] S Leclerc Madlala, Youth, HIV/AIDS and the Importance of Sexual Culture and Context, *Social Dynamics* 28:1 (2002): 20-41

[18] See The HIV Epidemic in South Africa, pp 51-54

> their sexual behavior, the association between education and HIV depends crucially on behavioral intentions. In the absence of information about HIV transmission, many individuals may intend to have several sexual partners, increasing their risk of HIV infection. However, educated individuals are more likely to be exposed to HIV prevention messages and more likely to understand them. Given that HIV prevention messages become more prevalent with epidemic maturity, this leads to a hypothesis about the changing relationship between HIV and education. In the early stages of an epidemic, education is a risk factor for HIV infection. As an epidemic matures and prevention messages become more common, education is a protective factor against HIV infection.[19]

Given this knowledge South African youth should be well protected, because section 29(1)(a) of the Constitution reads as follows:

> **29. Education.—**(1) Everyone has the right-
> *(a)* to a basic education, including adult basic education;

And, as Chief Justice Ncgobo knows well, our right to education is founded in an international consensus on the importance of education and the duty on the state to provide it that is expressed as follows in the UN Committee on Economic Social and Cultural Rights (CESCR) 's *General Comment on Education*[20]:

> Education is both a human right in itself and an indispensable means of realizing other human rights. As *an empowerment right*, education is the primary vehicle by which economically and socially marginalized adults and children can lift themselves out of poverty and obtain the means to participate fully in their communities. Education has a vital role in empowering women, safeguarding children from exploitative and hazardous labour and sexual exploitation, promoting human rights and democracy, protecting the environment, and controlling population growth. Increasingly, education is recognized as one of the best financial investments States can make. But *the importance of education is not just practical: a well-educated, enlightened and active mind, able to wander freely and widely, is one of the joys and rewards of human existence*.

[19] Joint Learning Initiative on Children and HIV/AIDS, Learning Group 3: Expanding Access to Services and Protecting Human Rights, Educational access and HIV prevention: Making the case for education as a health priority in sub-Saharan Africa, M Jukes, S Simmons, M Smith Fawzi

[20] UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment No. 13 (The Right to Education)

## *But our government is failing dismally in its duties to provide basic education to children:*

- Of the 1 207 996 Grade 1 learners who started school in 2005 only 948 213 made it to Grade 6;
- In 2005, 951 641 learners started grade 7. Six years later only 364 513 passed matric;
- In 2009, 662,000 children were out of primary (80,000) or secondary (582,000) school;
- In October 2009 the Department of Basic Education conducted an audit to establish the number of Quintile 1 (poorest) schools that had access to basic resources for grades R to 6. The majority did not have the most basic resources to teach literacy and numeracy.

This conference should think deeply about this issue. We cannot afford to be selfish & siloed in our approach to rights. The imperatives of HIV been not sufficiently linked to other major social challenges. Education rights are health rights. We should demand libraries in schools, and enforceable minimum norms and standards for schools.

> (some political will seen in taking over of schools in Eastern Cape, settlement in mud schools matter, but this needs to happen across the board, be monitored and sustained)

What lawyers would call a *sine qua non* for HIV prevention amongst young people is the fulfilment of their right to basic education, including:

- Effective quality education
- Proper life skills education (which is not happening and must be addressed urgently by the Departments of Health and Basic Education)
- Access to condoms in schools

## *Conclusion: the National Strategic Plan on HIV & TB (2012-2016) must genuinely focus on Young People*

In the current NSP 2007-2011 it is stated:

> "Continued investment in and expansion of carefully targeted evidence-based programmes and services focusing on this age group remain as critical as ever. Young people represent the main focus for altering the course of this epidemic. "

Yet this has not happened. Whilst there have been effective programmes such as Soul City & Beat it! which talk to young people, these programmes have not been scaled up or sufficiently supported. They now also face threats due to the global pull back on promises to challenge HIV.

So in conclusion, so questions to think about:

1. How do we address young people in the NSP and not just pay lip service?
2. How do we use the schools HIV Counselling and Testing campaign and the Minister's School Health campaign to genuinely empower young people?
3. How do we bring young people into society as citizen activists for change and their own lives?

Mandisa and Nkosi Johnson have shown us a way. Old people cannot speak for young people! Young people need to genuinely become policy makers and implementers in HIV prevention.

**ENDS**