6 Protecting the vulnerable

Human and health security beyond citizenship, exploring the rationale and the possibilities for adolescents

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Introduction

Contemporary pressures of climate change and migration are abetting the spread of infectious diseases including HIV, Ebola and tuberculosis (TB). As such, HIV is one of a series of re-emerging infectious diseases (EIDs) that pose significant external threats to health security in Eastern and Southern Africa (ESA). Additional internal health threats include detrimental social determinants of health and exclusionary practices, such as denial of treatment and care to non-citizens (CDC, 2018; WHO, 2018). Taking this into account, this chapter develops a threefold proposal for improved HIV prevention and treatment. First, it identifies how a human-centric approach beyond citizenship would better capture the intermingled risks and vulnerabilities that impact individual and population health security. Second, the chapter develops initial ideas towards targeted prevention and treatment interventions aimed at addressing adolescent vulnerabilities. Third, it offers policy sketches aimed at supporting health claims across borders in ESA, reaching beyond citizenship to provide and protect human health security in the region.

While the biological fact remains that any person can become infected with any of these diseases, those most affected are vulnerable populations. In ESA these include marginalized groups such as people who sell sex, LGBTI and MSM, but more widely also adolescents, who represent a particularly vulnerable group. Members of such marginalized and vulnerable communities are excluded from access to provisions and protections of health as part of the paradigm of human security (Paris, 2001), whether out of apathy, fear or jurisdiction or through (deliberate) neglect. On the brink of adulthood, adolescents represent a doubly vulnerable group, both biologically as well as legally, as they often lack the full rights accorded to them by adult citizenship. Likewise caught in such a double vulnerability are migrants and refugees. As Kofi Annan once said, adolescents are inarguably at the

forefront of global change and innovation. Empowered, they can be key agents for development and peace. If, however, they are left on

society's margins, all of us will be impoverished. Let us ensure that all young people have every opportunity to participate fully in the lives of their societies.

(2014)¹

Yet such adolescent success is not a foregone conclusion.

Adolescents face inclusion challenges in reaching their potential, faced as they are with twin challenges of particular biological vulnerability to EIDs and limited access to legal (and thereby medical) access to prevention measures and provisions to protect themselves. As such, adolescents represent a particularly vulnerable group, caught on the cusp between child protections and adult citizenship claims, including to health and educational provisions and protections. Without, or with incomplete claims, members of marginalized and vulnerable communities, among them adolescents, are excluded from access to provisions and protections of health as part of human security.

Against that backdrop, this chapter analyzes the unique challenges of vulnerable adolescent populations as these relate to HIV prevention and treatment access. It pays special heed to the “double vulnerability” of non-citizenship and compromised citizenship among this cohort.

This chapter asks three questions: What role(s) might citizenship status play in adolescent vulnerability? Might (lack of) formal citizenship make adolescents doubly vulnerable, legally and socially, to HIV, because (non-) citizenship enables or alternatively thwarts access to preventive and curative health services? How might it be possible to protect the health of vulnerable adolescent populations across borders and “beyond citizenship”?

The chapter rests on the theoretical pillar of human security. Human security puts the security of individuals at the centre of its analysis. This stands in contrast to the 1990s securitization argument, which framed HIV as a threat to state security (Buzan et al., 1998). Human security prioritizes individual security, rendered in access to adequate food, health and environmental protection among other elements, above those of territorial integrity traditionally used to define state security. The human security lens brings not just citizens in designated territories into focus but also the vulnerable, including non-citizens, beyond borders. By invoking the human security paradigm and adapting it to the particular situation facing adolescents contending with HIV in ESA, this chapter aims to analyze and offer initial responses to provide for and protect vulnerable populations beyond borders.

The chapter proceeds as follows: The background section introduces the framework of human and health security in more detail. This includes a discussion of the limits to the reach of the human security paradigm posed by age as well as by citizenship, where full citizenship is gained upon legal maturity (18 years of age in some countries, and 21 in others). This has significant ramifications in terms of the legal residency status of immigrants from Zimbabwe to South Africa and, for adolescents in South Africa, rights of access to education and healthcare services. The following sections

present an analysis of the intersection of health security, marginalization, HIV vulnerability and adolescents in ESA, foremost in South Africa and Zimbabwe. These take into account the threat of the rising burden of infectious disease in the region and the inherent, biological vulnerability of adolescents and young adults (AYA), as well as the legal and social risks posed by (non-)citizenship. Finally, the chapter offers initial operational ideas to address the “double vulnerability” of adolescents and (non-)citizenship.

Background

Substantial research has gone into the nexus of state and human and health security outlined earlier (Šehović, 2018). Its argument rests on a centuries-long tradition of Westphalian sovereignty theory in which the state increasingly acquired responsibilities for human rights and human security. Human security was first explicitly named in the 1994 United Nations Development Programme Report: *New Dimensions of Human Security* (UNDP, 1994).

While this chapter prioritizes human security and health security, their relationship to state security is worth mentioning for two reasons. First, population health affects the integrity of the state (Howell, 2014). Second, as introduced earlier, health risks can emerge both externally and internally, and by definition then state security from both within and outside. In addition, among these risks, and significant for the analysis presented here, EIDs, while adversely affecting vulnerable populations, make no distinction between citizens and non-citizens, that is, those within or outside of the state. Instead, the insecurities and the social determinants of health are paramount both to vulnerability and to its countermeasures. This makes rethinking health security beyond borders and as applied to (non-)citizens so necessary. Since adolescents constitute an (over-)represented population both at territorial (as migrants and refugees) and at legal (between childhood and adulthood) borders, and as part of a “youth bulge” – a critical component of the future human and state health in ESA – this chapter focuses on their unique vulnerabilities to HIV infection and interventions.

**Population at risk categories: human health security/
adolescents and HIV**

The following matrix illustrates the categories of analysis focusing on the first question this chapter addresses: What role(s) might citizenship status play in adolescent vulnerability?

Citizen adolescents	Non-citizen adolescents
Citizen adolescents/HIV	Non-citizen adolescents/HIV

In order to shed light on these categories, the following two sub-sections outline human and health security in more detail.

Human security

As outlined earlier, human security is a human-centric focus of security. It emphasizes the duality of individual and universal human rights. The premise that all individuals everywhere have the same human rights underpins the UN Charter and the WHO Constitution. However, states – and member states of these international organizations – are those tasked with providing and protecting human rights and thus human security.

The 1994 UNDP report and Jorge Nef (1999) identify seven dimensions of human security, each of them with echoes in the UN definitions of human as well as political and social, cultural and economic rights (Nef, 1999). These seven dimensions are economic security, food security, health security, environmental security, personal security, community security and political security. Many of these components have only vague conceptualizations, let alone legal definitions. The sole exception pertains to provisions of asylum for refugees, but only in relation to political conflicts such as civil wars. Economic or health insecurities, including those of people forced to migrate due to climatic catastrophes, are not protected under current international laws governing refugees. Some countries in ESA including South Africa, do have human security-inspired protections that include, for example, the rights to health and education (Constitution of South Africa, 1996). However, while the scope of human rights has seemingly expanded, their realization remains inextricably tied to the state (Šehović, 2018).

This is evident in the response to HIV and AIDS. AIDS activists expanded the claims of human health rights to include those of men who have sex with men (MSM), babies exposed to the virus in utero and during birth, and mothers through prevention of mother-to-child transmission (PMTCT). Yet, as a rule, non-citizens are not summarily afforded such protections.

Historically with regard to state responsibilities, “vulnerable populations” have been conceived of as widows and orphans. This conception informed the anticipation of millions of “orphans and vulnerable children” (OVC) at the outset of the HIV epidemic. Though these numbers have not emerged as a threat to state stabilization, the idea of vulnerable populations has broadened its cache. Initially including primarily girls and young women, and OVCs, vulnerable populations now includes adolescents more broadly. This chapter argues further that non-citizens constitute another vulnerable group as they lack the ability to claim their human rights and human security from a(ny) state. Turning this human security lens on health security makes it possible to highlight the vulnerabilities of adolescents to assess the exclusions of sub-populations, including adolescents and non-citizens, from state responsibilities for health security.

Health security

Health security refers to the availability of and access to means of health at the population level. It invokes protection in the form of prevention from

external but also internal risks. It can also include provision of treatment and care in the case of disease infection. Health security is not a guarantee of health or *carte blanche* for all care, treatment and intervention. It is a strong foundation for promoting the right to health for all who reside in a country. Health security is also increasingly embedded in national constitutional provisions, such as in the Constitution of the Republic of South Africa (Constitution, 1996), as well as in international regulations aimed towards securing health for all. Against the backdrop of both rising levels of EIDs and of the burden of disease, growing recognition of the roles played by the social determinants of health, and ever-increasing capabilities (medical as well as political and economic) to respond to global disease threats, health security has started to evolve from a strategic concept to a policy priority.

Among the most prominent health security policies are the International Health Regulations (IHR; 2005), under which states pledge to upgrade their health facilities and capabilities. However, though ostensibly binding, the IHRs have few enforcement mechanisms beyond shaming noncompliant states. Individuals can sue their governments in states where provisions for health (security) have been rendered in law. This has been done most famously in Brazil, South Africa and Thailand. The lack of these mechanisms highlight the citizen-state relationship and expose the lack of rights and health security claims available to non-citizens.

At times, non-state actors (NSAs) can step into a void left between citizens and states failing to live up to their responsibilities. NSAs can also take measures to include non-citizens. This has been the case during some of the response to the HIV epidemics in ESA. NSAs have provided care and treatment until public pressure and donor financing stepped in to bridge the gap between states and their infected and affected citizens' needs and their treasuries. Non-citizens with access to identity documents or selectively targeted as belonging to identified and prioritized groups also benefitted. Yet a larger effort to include non-citizens did not emerge and remains a blind spot. Two developments emphasize this: first, according to interviews with the director of the German Chamber of Commerce in South Africa, a consensus seems to exist that private actors will "never again" mobilize a response such as they did to HIV in the 1990s.² This reinforces the state as the only actor responsible for health security, which threatens to exclude non-citizens from its provisions and protections. Second, as resident non-citizens are embedded in the society of where they live, the health security of the citizen population is intrinsically and inextricably tied to theirs. Arguing for the inclusion of non-citizens among vulnerable populations with regard to HIV and health security is not meant to be a case for the medicalization of security (Elbe, 2010), wherein security issues, including migrants and refugees framed as such, are met with medical responses. Instead, it is an argument for reconceiving vulnerability to include not only medical but also legal elements of human security. The next section applies this analysis to adolescents in ESA.

Analysis: the critical case of adolescents

As noted earlier, adolescents in ESA today are coming of age in a rapidly changing world. They are part of the change. The challenges they face include a demographic bulge, climate change, economic and educational constraints and the promise and pressures of migration, both outward and inward – to stay or to go. In the midst of all of these transitions, adolescents are uniquely exposed and vulnerable to the risks of EIDs. In order for adolescents to cope and adapt, they need information pertinent to counter their vulnerabilities and also to claim their rights, including their right to health security. This makes their health dependent upon themselves but also upon the institutional structures, including their citizenship status and their claimant state.

This section explores the intersection of biological vulnerabilities of adolescence and the risk posed by the ongoing HIV epidemic in the region vis-à-vis the additional factor of non-citizenship or compromised citizenship. In doing so, it seeks to answer the second question posed earlier in the chapter: Might (lack of) formal citizenship make adolescents doubly vulnerable, legally and socially, to HIV because (non-)citizenship enables or alternatively thwarts access to preventive and curative health services? First, the section outlines the status of adolescents and young adults in ESA and their biological vulnerability to HIV infection, and then seeks to answer the key questions posed above. It is imperative at the outset to recognize that adolescents, by virtue of their biological and social vulnerability, are uniquely susceptible to EID and especially HIV infection. Second, the section focuses on their “double vulnerability” with the additional risk of non-citizenship or compromised citizenship. In 2016, UNAIDS estimated the adolescent population of ESA at 1.3 million.³ UNICEF’s estimate for the same year was 1.48 million young people (aged 20–24) living with HIV in the region. The definitions are at times overlapping and at times exclusive. Among these there are an estimated 610,000 new HIV infections among young people between the ages of 15 and 24, and 260,000 new infections among adolescents between the ages of 15 and 19 (UNICEF, 2017a, 2017b). Some of these will migrate within the region; others will belong to communities with many migrants. This movement has both social impacts and health consequences, including in the form of the spread of disease. Indeed, the initial spread of HIV from Eastern to Southern Africa can be traced back to migration from the trading ports in Kinshasa in Congo, down the Zambezi River, to the mines in South Africa (Iliffe, 2006). Likewise in a contemporary comparison, in South America, incidences of malaria, measles, diphtheria and tuberculosis are on the rise, especially at the borders of Venezuela. As an estimated 1.6 million people (World Migration Report, 2015), many of them young people, migrate into neighbouring countries such as Colombia, Ecuador, Peru, and Brazil, without provisions for access to medical care to contain and treat these diseases, they are likely to spread.

Even in their own countries, adolescents and young adults (AYA) often have circumscribed citizenship rights: neither children nor adults, they exist on the cusp of child rights' protections and adult citizenship. They are socially, educationally and economically dependent upon both familial and state ties for their preparation and protection into adulthood. This vulnerability is even more pronounced among foreigners or non-citizens, and is magnified by the lack of and difficulties in securing citizenship, which curbs their access to the protections and provisions of citizenship.

The intersection of adolescent biological and social vulnerability

Adolescent vulnerability is accentuated by biology and social position. Biologically, adolescents are at their prime both in terms of physical fitness and their immune response (Govender et al., 2017). They are also at a moment of experimentation, sexually and otherwise, putting them at heightened risk of HIV infection among other sexually transmitted illnesses.

It is worth noting that this biological and social moment of transition and experimentation can promote a certain nonchalance with regard to an unseen and unknown risk of infection. Exacerbating vulnerabilities are the lack of sexual education, non-use of condoms, inter-generational sexual relationships (known to introduce HIV into adolescent populations), and experience of peer and cross-generational violence. This moment coincides with and can be reinforced both by the access and availability of treatments and by the lack thereof.

Evidence of an attitude of nonchalance can be found in high rates of adolescent abuse of anti-retroviral drugs (ARVs), including the recreational combination of various drugs, including ARVs, especially among migrant adolescents (Timol, 2017).⁴ Pupils, including marginalized, non-citizen adolescents, many of them migrants from as far north as Djibouti, Sudan and South Sudan into the outskirts of Cape Town, South Africa, attempt to learn in schoolrooms of 30 pupils speaking 13 languages (Timol, Cape Town, 2017). As non-citizens, their access to the matriculation exam is uncertain – and with it, their future. Consequently, HIV prevalence, nonchalance and future insecurity contrive to create a situation of exacerbated vulnerabilities. That has consequences for the HIV epidemics, but also for the human and health security of the ESA region.

Indeed, despite a broad range and decades of intervention efforts, including increased access to biomedicine and continual efforts to normalize HIV infection as a chronic condition, the HIV epidemics in ESA continue to rage. On the one hand, this might be attributed to the course of HIV infection and prevalence between Eastern and Southern Africa. The earlier peak of the epidemic in eastern Africa reduced the populations of HIV-positive persons in those countries before national treatment programmes were implemented, drastically reducing prevalence rates (WHO, 2017; compare UNAIDS, 2008). In contrast, in southern and especially South Africa, HIV

epidemics peaked later and closer to initial campaigns for access to treatment arrived (ca. 2004), resulting in higher prevalence rates (Kharsany et al., 2018). Setting the stage for complications to come, however, rates of tuberculosis infection and (co-)infection with HIV have been climbing especially in South and Southern Africa.⁵

Adolescents' abilities to address these deficiencies – in information, in education, in physical protection – are dependent upon the adults' as well as adolescents' social and political power, which is limited by their lack of adult citizenship. Adolescents and young adults (AYA) can formally engage – contributing to and benefiting from – the societies in which they come of age only if legally recognized and afforded practical and legal access to health, education, economic and political systems. If and where such access is not available, AYA knowledge, access and uptake of health-care, and of associated social support mechanisms to improve their social determinants of health, including educational and employment opportunities, is substantially limited. The consequences, notably infection with HIV, impact both AYA individually and the communities in which they reside, affecting citizens and non-citizens alike.

The situation of those without citizenship, foreign as opposed to adolescent citizens, is that they are left outside of the citizen-state responsibility nexus. Yet many such AYAs have only ever known one community. For example, over notably the last decade, young Zimbabweans have been migrating to South Africa and raising their non-citizen families there. In other cases, children and adolescents have been crossing the porous border into South Africa with and without legal and legally resident guardians. For the duration of time that these children and adolescents are under the age of 18 and reside with a legal guardian who is a legal resident in South Africa, they can remain and they can access educational and health services, with one caveat that has concrete implications on their future: these adolescents and young people cannot take the matriculation examination – the gateway to higher education – before first resolving their own legal residency status.⁶

This process can involve relinquishing, for example, Zimbabwean citizenship (assuming it can be established in the first instance) and applying for refugee status in South Africa. The decision of such a process can take years.⁷ In the interim, adolescents faced with such a “choice” are left in legal limbo with a cascade of consequences that reinforce their marginalization and vulnerabilities. Without legal status, such adolescents cannot complete their secondary education and, therefore, cannot pursue tertiary education, nor can they legally work. When they turn 18, the legal protections they were entitled to as minors are rescinded, leaving them in legal, social and economic limbo.

If an AYA can establish legal residency via either one of these routes, though (s)he remains a non-citizen, (s)he can access most health and other benefits afforded the citizen population. Adolescents without legal

guardians become wards of the state with access to health and education until they turn 18. Such adolescents are often assigned to social services' communal residences, which can raise their vulnerability to sexual exploitation and inconsistent educational access and oversight (Blignaut, 2017). Overall, without legal protections, the incentive to study is reduced and the incentive to practice safe sex is lowered (Interviews with female secondary students, Pretoria, April 2017).

Combined, all these elements increase the risk of adolescent HIV infection. They challenge current prevention and intervention policies and protocols to take into account not only adolescent biological and social vulnerabilities but also the "double vulnerability" contained in citizenship status. This creates a "perfect storm" contributing to making HIV prevention and treatment for adolescents – and especially non-citizen adolescents – an uphill battle.

Double vulnerability: adolescents/citizenship/HIV prevention

The protection and preparation of adolescents and young adults for their and their societies' future against the backdrop of ongoing HIV epidemics and EIDs in ESA depends to a large extent on state responsibility and citizenship claims which facilitate access to health provisions and protections. States, delineated by political boundaries yet with porous borders, are increasingly faced with the task of assessing rights, including health rights, to (non-)citizens. This makes it imperative to address the health vulnerabilities of adolescents beyond borders.

The case for doing so can be broken down into four counts:

- 1 People under age 15 constitute 40% of the continent's population (AU, 2017), and as such the single largest sub-population of national populations in most countries in the region. Including different definitions of young adults, even when restricting consideration to adolescents and young adults (10–24 years), this key population likely makes up the largest sub-population on the continent (Katz et al., 2013).
- 2 Adolescents and young adults are now recognized as a key population in the sense of being one of the several populations most at risk of HIV infection (others are people who sell sex, MSM and migrants, many of which also include large proportions of AYA).
- 3 External state and NSA actors are unlikely to commit again to a multi-generational investment in response to a health crisis. This is due to lower levels of international funding support since the 2008 financial crisis and also to a shift in focus after the "grand decade of global health" (2000–2010). Making up for this loss requires state action, including enabling adolescents to take ownership of their health rights and responsibilities. Ideally, this ownership would be matched by a guarantee of access across the region.

- 4 Despite major investments in education over the past few decades, major challenges remain, especially in the areas of tertiary education and vocational training. Removing the structural impediments to access to health and education is critical to harnessing the potential of AYAs.

As evidenced, adolescents are a distinct and yet communal cohort: still dependent, but not children; almost adult, but without full citizenship rights in their own countries or a claim in countries not their own. For citizen and non-citizen adolescents alike, they are supported by legal frameworks and mechanisms extended from the protections for children but which do not take fully into account the particular human and health security needs of adolescents (Grossman and Stangl, 2013; Pantelic et al., 2015). Adolescents must be given the tools, among them access to legal citizenship, to access their health security and thereby to contribute to that of their communities (International HIV/AIDS Alliance: Together to End AIDS, 2016; Li et al., 2013; Marten and Smith, 2018; Mburu et al., 2013; Gruskin et al., 2013; Christensen et al., 2013; Risher et al., 2013).

Such an approach could have positive reverberations for HIV prevention. It re-invigorates the debate for prevention that goes beyond individualized risk management approaches and current social determinants of health-based programming (e.g. combination HIV prevention) and brings human security into the heart of the debate.

A case for cross-border adolescent HIV and health access

Human and health security can influence the design of HIV interventions tailored to AYA against a backdrop of continual and intensifying population movements. Indeed, the case of HIV and AIDS illustrates that the question of the right to health and human security is less in dispute than before the eruption of that global epidemic. However, as treatment resistance and co-infections, notably of TB (including multi-drug-resistant and extremely drug-resistant TB strains, as well), and cross-border claims to access health-care have increased,⁸ the schism between the right and its realization has again widened. However, not meeting the demand for the right to health poses a risk to infection to both sedentary citizen as well as resident and migratory non-citizen populations (Šehović, 2018). This section focuses on answering the question: How might it be possible to protect the health of vulnerable adolescent populations across borders, including citizens and non-citizens?

That movements of disease as well as people are likely to increase reinforces the case for facilitated access to healthcare. Two scenarios, and three concrete options developed under the second scenario, present themselves as possible responses.

The first scenario would be to continue to allow migrants to cross territorial and political borders, while failing to formally recognize their human

and health rights or to act on any corresponding citizenship responsibilities. This scenario would marginalize significant numbers of people, putting their own health (and the health of the populations with which they come into contact) at the mercy of NSAs that may or may not provide healthcare services for an uncertain amount of time, jeopardizing both access and continuity of care (Šehović, 2017). This would most certainly further marginalize already vulnerable populations, foremost among them adolescents with legal protections as minors. This would severely undercut the educational and economic and political potential of the individuals, communities and, ultimately, the nation states (Winter and Winter, 2018). The second scenario would be to issue identification documents (at the national or regional level) to document and enable access to state health and education as well as to facilitate participation in the formal economy and tax collection.⁹

The three concrete options are:

- 1 Regional protocols that focus on particular diseases could move beyond harmonization to treatment access. For instance, while the Harmonised Minimum Standards for the Prevention, Treatment and Management of Tuberculosis in the SADC Region (Directorate of Social & Human Development & Special Programs SADC Secretariat, 2010) and the HIV and AIDS Strategic Framework, 2010–2015 (SADC, 2010) seek to standardize treatments for those diseases in SADC, a further step would be for citizens, including those who migrate across borders, to access treatment in any of the participating countries. This would incentivize some to seek treatment and reduce the burden of treatment provision if additional providers are added to the cooperation.
- 2 The SADC Secretariat has expressed interest in the creation of cross-border initiatives for malaria and HIV (Janse van Rensburg and Fourie, 2016). Moving beyond particular disease treatment, cross-border initiatives could eventually could be applied to all health programs in the region.
- 3 The 2006–2015 Sexual and Reproductive Health Strategy for the SADC Region (2008), which included “vulnerable youth” as a unique target group slated for extra outreach and intervention, could be adapted and broadened. Its focus areas could also be integrated into a cross-border program.

Implementing such initiatives would go a long way towards providing for and protecting the health of vulnerable adolescent populations across borders.

Conclusion

This chapter analyzed the biological, social and legal “double vulnerability” of adolescents to HIV and EID infection in Eastern and Southern Africa. By looking through the lens of human security as it intersects with state

security, the chapter made the conceptual case of including individuals, notably citizens and non-citizens, in any analysis of health security. First, it argued that a human-centric approach beyond citizenship would better capture the intermingled threats, risks and vulnerabilities that impact individual and population health security. Second, having made those identifications, the chapter delved into the particular conditions, biological and legal, that confront adolescents. In doing so, it paid particular attention to the added vulnerability of non-citizenship. Finally, it outlined two possible response scenarios and developed three operational ideas to address these vulnerabilities.

The chapter showed that citizenship status, whether existent, non-existent or compromised, constitutes a factor in adolescent access to health provisions and protections. In short, citizenship status is a contributing factor in adolescent marginalization. A “double vulnerability” follows from that, wherein biological vulnerability and legal vulnerability reinforce one another. Responding to this double vulnerability, as this chapter has shown, requires cross-border, regional concepts and operationalization of health interventions that expressly include citizen and non-citizen access to elevate health as a universal human right.

Health is increasingly accepted as a universal human right. More migrants than ever before are on the move. That means that health rights must move across borders. This reality reinforces the imperative to recognize universal health rights and to universally extend them beyond borders.

Notes

- 1 Quoted at the International Day of Democracy, 15 September 2014. Available at: www.way.org.my/press-release-menu/419-international-day-of-democracy.
- 2 Interview with M. Boddenberg, German Chamber of Commerce and Industry, Johannesburg, Republic of South Africa, April 2017.
- 3 The agency defines adolescents as persons between the ages of 10 and 19.
- 4 Interview with S. Timol, former educator in the Western Cape Province, Republic of South Africa, Cape Town, April 2017.
- 5 Interview with S. Timol, former educator in the Western Cape Province, Republic of South Africa, Cape Town, April 2017; also interview with Prof. Dr. Lynne Weber, University of Pretoria, April 2017.
- 6 Šehović, ethnographic notes taken in Pretoria, Republic of South Africa, April 2017.
- 7 Šehović, ethnographic notes taken in Pretoria, Republic of South Africa, April 2017.
- 8 Interview with K. Govender, HEARD, Durban, South Africa, 10 April 2017.
- 9 Tax collection in turn would help finance additional access to health and education services.

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