DEPUTY MINISTER IN THE PRESIDENCY FOR WOMEN, YOUTH AND PERSONS WITH DISABILITIES

REPUBLIC OF SOUTH AFRICA

DRAFT MESSAGE

BY

MS MMAPASEKA STEVE LETSIKE, MP

AT THE

CONTRACEPTION TRAINING AND OUTREACH FOR GP HEALTHCARE WORKERS

ON

23 MAY 2026 | VIRTUAL | 09:00

Programme Director,
Professor Zozo Nene,
Distinguished clinicians, nurses, specialists, community health practitioners, educators, students, partners in public health,
Representatives from government, academia and civil society,
And all those who have dedicated their lives to protecting the dignity and health of our people,

Good morning.

Let me begin by expressing my sincere regret that I could not join you in person today. I had every intention of being physically present among you, but unfortunately, I am writing an exam later this morning and could not be released from that responsibility.

Nevertheless, I felt very strongly that I could not allow this gathering to proceed without lending my voice, my solidarity, and the support of the Office of the Deputy Minister in the Presidency for Women, Youth and Persons with Disabilities to this important work.

I am passionate about this work because what you are shaping here is not simply a conversation about sexual and reproductive health and rights. You are helping shape the lived experience of the next generation in all its diversity. You are helping shape whether a young girl gets to finish school or becomes another statistic too soon. You are shaping whether a young boy grows into a man who understands responsibility, bodily autonomy and dignity. You are shaping whether a young person can make

informed decisions about their own future. And in doing so, you are shaping the developmental trajectory of our country itself.

Professor Zozo Nene, let me thank you sincerely for inviting the Office of the Deputy Minister to once again be part of this journey. Over the past few months, in different provinces, we have seen your commitment to taking these conversations beyond lecture halls and policy papers, and into communities where the stakes are real and urgent. We appreciate your leadership, your courage, and your insistence that sexual and reproductive health must remain a matter of justice, dignity and public accountability.

Allow me to begin my reflections with a story.

Somewhere in South Africa this morning, a 15-year-old girl is sitting quietly in her home, or perhaps spending time with friends, carrying a fear she cannot share. While the world around her moves on as though everything is normal, her mind may be racing with questions she does not yet know how to answer.

Her body is changing in ways she does not fully understand. She may already suspect that she is pregnant. She may not know where to go. She may fear being judged by a nurse, punished by her family, abandoned by a partner, laughed at by peers, or treated like a problem rather than a child in need of care. She may disappear from school in the next few weeks. She may become one more silent statistic in a country that often measures crisis but does not always feel its human cost.

And yet that girl is not a statistic.

She is a future teacher, engineer, scientist, entrepreneur, artist, activist, mother if and when she chooses, a citizen with dreams that deserve protection.

That is why SRHR cannot be treated as a niche policy issue. It is a developmental issue. It is an equality issue. It is an education issue. It is a health systems issue. It is an economic issue. It is a constitutional issue. And above all, it is a human dignity issue.

We know the scale of the challenge before us.

South Africa continues to grapple with an unacceptably high rate of adolescent pregnancy. We have repeatedly reflected as government that there are more than 130,000 girls who give birth every year in this country. Behind that number are disrupted educational pathways, increased vulnerability to poverty, higher health risks, and in many cases, exposure to gender-based violence, coercion, and cycles of social exclusion.

And let us be honest with ourselves: pregnancy is often the visible outcome. It is not always the root problem.

The root problem may be poverty. It may be unequal gender relations. It may be sexual violence. It may be poor access to contraception. It may be stigma in clinics. It may be misinformation. It may be intergenerational silence around sexuality. It may be a health system that technically exists but emotionally excludes.

This is why South Africa's policy architecture on sexual and reproductive health is actually far more progressive than many countries in the world.

Our Constitution recognises dignity, bodily autonomy, equality and access to healthcare as rights. Our National Adolescent and Youth Health Policy provides a framework for youth-friendly services. Our health sector has contraception and family planning guidelines. Our education system has Comprehensive Sexuality Education frameworks. Our HIV and STI policies increasingly integrate adolescent prevention and SRHR interventions. We have a National Strategic Plan on GBVF that recognises bodily integrity and protection. We have youth development frameworks and social protection mechanisms that intersect with these realities.

So the truth is this: South Africa does not suffer from a lack of policy. At times, we suffer from a painful gap between policy and lived reality.

The Constitution may promise dignity, but dignity must still arrive in the clinic. Policy may promise confidentiality, but confidentiality must still be felt by a teenager sitting in front of a healthcare worker. National frameworks may promise access, but access must still reach rural communities, township clinics, school-based interventions, informal settlements and homes where silence and stigma still dominate.

This is why, in our Budget Vote discussions in Parliament this year, we reflected very clearly on the need to intensify interventions around adolescent pregnancy, youth vulnerability, gender-responsive planning, district-level accountability, and mainstreaming coordinated prevention work across sectors. We cannot continue to respond to teenage

pregnancy only when it happens. We must build systems that prevent vulnerability before crisis.

International best practice teaches us valuable lessons here.

In Rwanda, community health worker networks have played a critical role in extending reproductive health services into communities and improving access to contraception and maternal care. In Ethiopia, youth-friendly health corners created dedicated safe access points for adolescents seeking SRHR information and services. In countries like Sweden and the Netherlands, adolescent reproductive health outcomes improved not because of silence, but because of openness, education, integrated services, and trust between young people and health systems.

Closer to home, we know that where young people are treated with dignity, where contraception is accessible, where information is honest, and where healthcare workers create trust instead of fear, outcomes improve.

That is why I want to say something directly to the boots on the ground in the health sector.

To the nurses, the doctors, clinical associates, the counsellors, our community health workers and all the frontline practitioners who may never stand behind a podium but who stand every day at the point where policy meets a human being.

You are not simply dispensing contraceptives.
You are not simply filling forms.

You are not simply conducting consultations.

You are often the difference between fear and hope, the light between silence and information, the bridge between stigma and dignity, the solution between crisis and prevention and our hope between a child dropping out and a young person staying on course.

You are the frontline custodians of reproductive justice.

Reproductive justice demands more than clinical competence. It demands empathy, confidentiality, non-judgment, accessibility, and cultural intelligence. Reproductive justice demands that we see the whole human being in front of us, not simply the clinical issue they present with.

A teenager seeking contraception is not asking for permission to become irresponsible. They may be asking for protection. They may be asking for information. They may be asking for agency over their own future.

A young woman seeking reproductive care is not asking to be judged. She is asking to be treated with dignity.

A person with a disability seeking SRHR services is not asking for special treatment. They are asking for equal access to healthcare systems that too often forget they exist.

A queer young person navigating sexual health is not asking for ideology. They are asking for care.

This vision is not alien to our constitutional tradition. Our Constitution is an intersectional document, born at the meeting point of race, gender, class, geography and culture. It promises not only formal equality, but substantive equality that takes account of context, history and the deep wounds of exclusion.

And so our engagement today must be intersectional in its practice, because the lived experience of sexual and reproductive health and rights is never neutral, never abstract, and never the same for everyone.

A poor rural girl navigating puberty, sexuality and reproductive vulnerability does not encounter the health system in the same way as a middle-class urban girl with financial resources, supportive networks and easier access to services.

A young person with a disability may confront not only the ordinary anxieties of seeking healthcare, but inaccessible facilities, communication barriers, assumptions about their sexuality, and systems that too often erase their existence altogether.

A survivor of violence does not walk into a clinic carrying only a medical concern; they often arrive carrying trauma, fear, shame, fractured trust, and the invisible emotional burden of harm that no clinical chart can fully capture.

A teenager navigating poverty may experience reproductive vulnerability long before they ever encounter a healthcare worker, because economic desperation, transactional relationships, food insecurity, unsafe

environments and limited access to information often shape choices in ways that policy frameworks alone cannot account for.

This is why our response cannot be simplistic, fragmented or one-dimensional; it must be layered enough to understand context, integrated enough to address structural realities, and human enough to recognise that behind every intervention is a life, a future and a dignity worth protecting.

When we understand this, we begin to see that our work here is not merely about preventing pregnancy or reducing numbers on a dashboard, important as those indicators may be.

Our work is about expanding possibility for young people whose futures are too often narrowed by preventable crises; it is about protecting educational continuity so that motherhood does not become the premature end of a girl's learning journey; it is about strengthening agency so that young people can make informed decisions about their bodies and futures; it is about interrupting intergenerational cycles of poverty that are reinforced when vulnerability is left unattended; it is about reducing maternal and adolescent health risks that continue to burden families and communities; and it is, in the deepest democratic sense, about making democracy visible in the lives of young people who are still waiting to feel the full promise of freedom in the most intimate parts of their lives.

And so let me end with this call to action, not as a ceremonial closing, but as an urgent appeal to conscience and practice. We must become the generation that closes the painful distance between policy and lived reality, moving deliberately from policy to practice, from information to

meaningful access, from fragmented intervention to integrated prevention, from judgement to dignity, and from reactive crisis management to systems that are intelligent enough, compassionate enough and coordinated enough to prevent harm before it happens.

To the health workers in this room and those leading the charge from clinics, hospitals, community health centres and rural outposts across our country, never underestimate the quiet but extraordinary power of your everyday practice, because what may feel routine to you can alter the trajectory of a life for someone else.

A conversation in a clinic can change a future. A compassionate consultation can restore dignity where shame once lived. A moment of listening can rebuild trust where fear has taken root. A young person who feels seen, respected and informed may return to seek care again, while one who feels judged, humiliated or dismissed may disappear from the health system altogether, carrying consequences that could have been prevented.

And to all of us gathered here, let us remember that the future of South Africa is not built only in Cabinet rooms, parliamentary chambers, leacture halls, court judgments or policy documents, important as those spaces are.

Our future is also constructed in clinics where a nurse chooses compassion over judgement, in schools where young people receive honest information instead of silence, in community halls where difficult conversations become pathways to healing, in homes where dignity is taught and protected, in encounters where reproductive choices are

supported rather than shamed, and in health systems that understand that care is not simply the treatment of illness, but the protection of human possibility.

Hope, after all, is not a candle we admire from a distance while darkness continues its work around us. Hope is a fire we are responsible for feeding, through science, through care, through dignity, through courage, through accountability, and through the daily decisions we make in service of others.

As we feed that fire with enough honesty, enough compassion and enough determination, then the next generation of South Africans will inherit not only better health outcomes, but a freer, fairer and more dignified future in which their bodies, their choices, their aspirations and their humanity are all treated as worthy of protection.

As the highly respected Egyptian obstetrician-gynaecologist and reproductive health scholar, Dr Mahmoud Fathalla once reminded the world, and I quote: ***"Women are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving."***

Today, our task is to make that decision again in our clinics, in our policies, in our communities, and in our daily practice so that every young person in South Africa may know that their life, their body, their dignity and their future are indeed worth protecting.

Let us continue doing that important work together toward ensuring that our Constitution becomes a lived reality for all in our diversity in the Republic.

I thank you.