



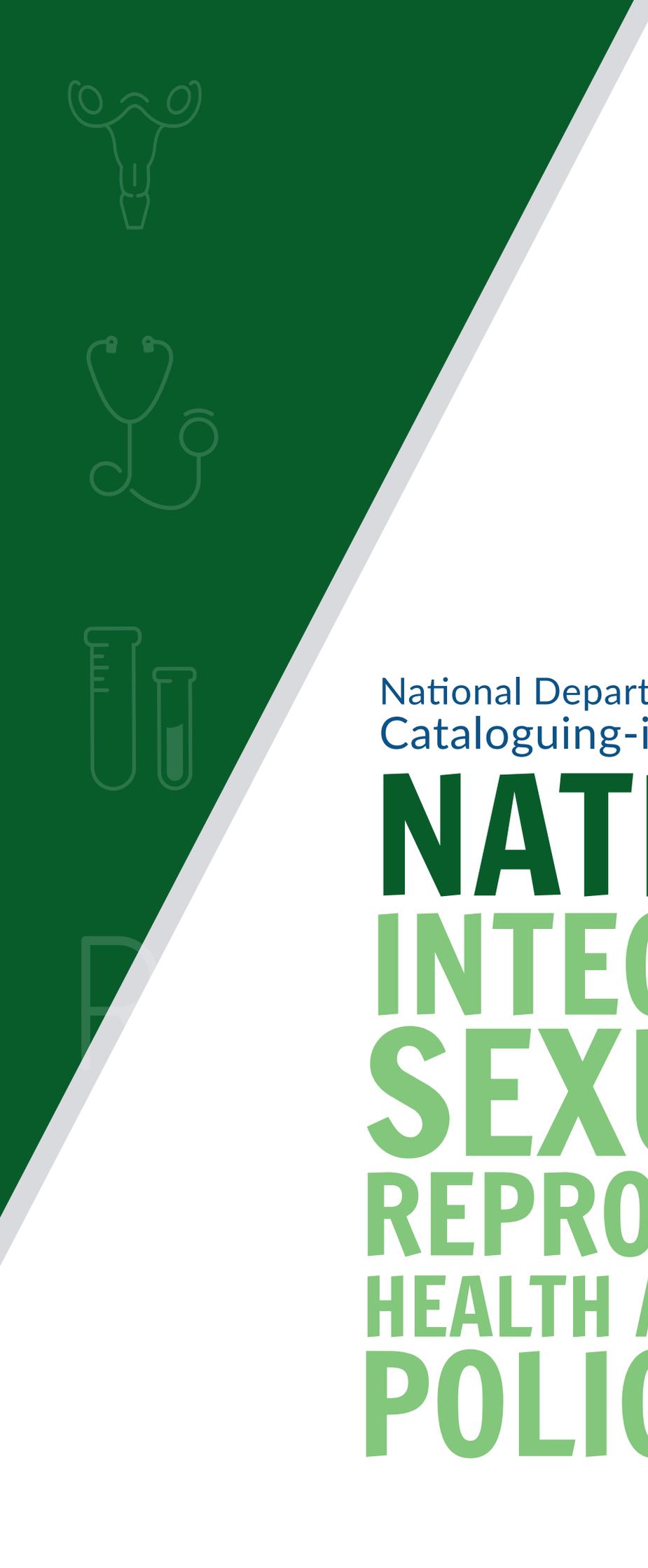
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# NATIONAL INTEGRATED SEXUAL & REPRODUCTIVE HEALTH AND RIGHTS POLICY ED. 1





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# NATIONAL INTEGRATED SEXUAL & REPRODUCTIVE HEALTH AND RIGHTS POLICY ED. 1

# 1 FOREWARD

The consolidation of the various service guidelines presented in the National Integrated Sexual and Reproductive Health and Rights Policy provides an opportunity to define a package of service benefits for women throughout their reproductive lifecycle. The package of services will form a basis for the implementation of the National Health Insurance. The policy will respond to women's needs on agency and choice in a rights-based approach.

This policy is a demonstration of the Department of Health's commitment to provide comprehensive sexual and reproductive health services with a rights-based approach, in order to achieve health for all. Embedded in the principles of equity and equality, this policy emphasises the autonomy and agency of clients seeking sexual reproductive health and rights (SRHR) services. Legal guidance in this policy has been taken from important statutes that govern the advancement of SRHR, the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 and the Choice on Termination of Pregnancy **Act 92 of 1996, amongst others.**

This document consolidates several clinical and policy guidelines on various aspects of SRHR; including the National Contraception Clinical Guidelines; National Clinical Guidelines for Safe Conception and Infertility; National Guidelines for Implementation of Choice on Termination of Pregnancy; the Sexually Transmitted Infections Management Guidelines; National Clinical Guidelines for Cervical Cancer Control and management; National Clinical Guidelines for Breast Cancer Control and management; and the Guidelines on the Management of Post-Exposure Prophylaxis (PEP) in Occupational and Non-Occupational Exposures.

In addition, reference is made to other documents that advance adolescent health and that address underserved and key populations with a focus on the reduction of gender-based violence. These documents include the National Adolescent and Youth Health Policy; National HIV Testing Services (HTS) Policy; National Strategic Plan for HIV, TB and STIs; Department Basic Education National Policy on HIV, STIs and TB; Prevention and Management of Learner Pregnancy in Schools; South African National LGBTI HIV Plan; and the South African National Sex Worker HIV Plan.

International and regional policies and strategies that advance the SRHR agenda are not only acknowledged but guided the thinking behind this policy. The National Integrated Sexual and Reproductive Health and Rights Policy is drawn from the Department of Health commitment to achieving the Sustainable Development Goals (SDGs), the South African Development Community (SADC) minimum package for SRHR services, and the SADC SRHR strategy. Many issues have emerged since the adoption of the SDGs, and in line with the Department of Health's plan to further reduce maternal mortality and

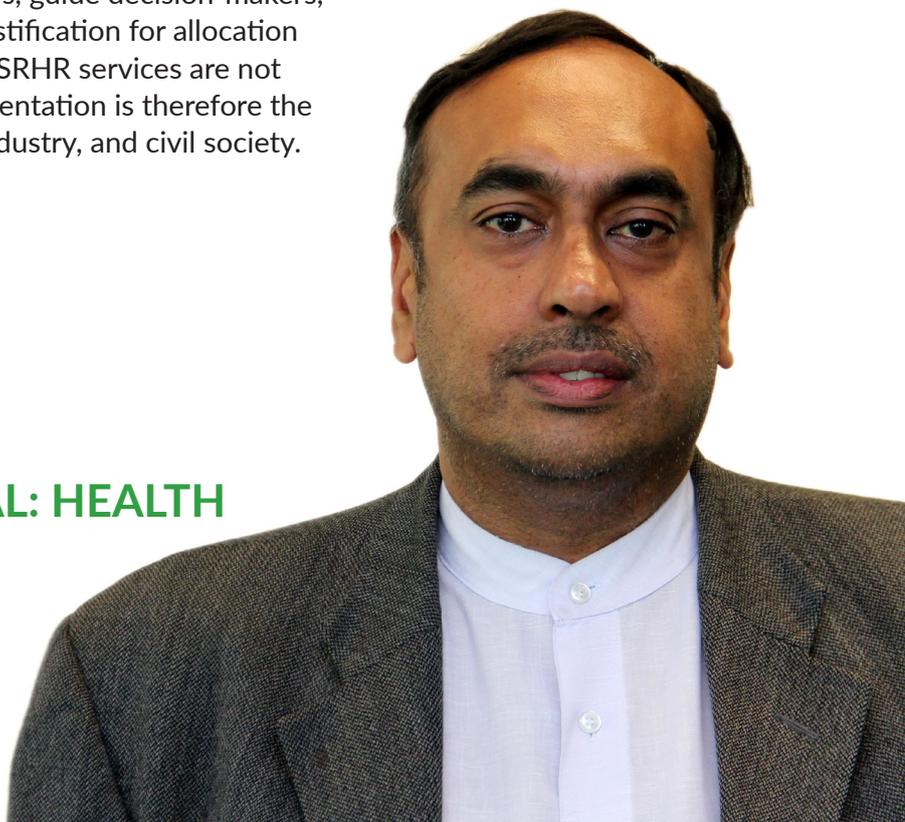


morbidity, this policy couldn't have come at a better time, creating further momentum for achieving the goals. The global Family Planning 2020 framework including the International Conference on Population and Development (ICPD) of 1994, the Beijing Platform for Action and the Maputo Plan of Action (2006) particularly advance our global collaboration for the advancement of SRHR.

The goal of this policy is to promote high quality and safer reproductive health services and practices by women, men, and youth through informed choice and with a rights based approach. It is positioned to facilitate coordination between all stakeholders, guide decision-makers, protect clients and providers, and provide a justification for allocation of resources – noting that implementation of SRHR services are not only restricted to the health sector. Its implementation is therefore the prerogative of all government departments, industry, and civil society.



**DR A PILLAY**  
**ACTING DIRECTOR GENERAL: HEALTH**  
**NOVEMBER 2019**



# TABLE OF CONTENTS

vi	/ LIST OF FIGURES AND TABLES
vii	/ ACRONYMS
viii	/ DEFINITION OF TERMS
1	<b>Guiding principles and values</b>
2	<b>Overview of the sections</b>
3	<b>Section 1 / Introduction</b>
4	1.1 / Vision
4	1.2 / Mission
4	1.3 / Policy Objectives
6	<b>Section 2 / Key considerations in the organisation of SRHR services</b>
6	2.1 / SRHR in the context of South Africa's modern history
7	2.2 / Influence of social, cultural, and economic factors on SRHR in South Africa
8	2.3 / Adolescent girls and young women
11	2.4 / Influence of key SRHR indicators
15	<b>Section 3 / Policy components and alignment</b>
15	3.1 / Alignment with global strategies and statutes
16	3.2 / Alignment with national policies and strategies
18	3.3 / Key focus areas

## 20 **Section 4** / The national integrated SRHR policy objectives

- 22 **OBJECTIVE 1** / Equip all people to make informed decisions about their SRHR and ensure that their SRH rights are respected, protected, and fulfilled
- 23 **OBJECTIVE 2** / Increase the quality of and access to comprehensive and integrated SRHR care and treatment services across all life stages
- 29 **OBJECTIVE 3** / Ensure access to respectful and non-judgmental SRHR services for priority groups
- 33 **OBJECTIVE 4** / Strengthen the health system to deliver integrated SRHR services at the lowest feasible level in the healthcare system
- 38 **OBJECTIVE 5** / Promote multisectoral engagement and shared accountability for a sustainable and rights based service delivery

## 39 / **ACKNOWLEDGEMENTS**

## 40 / **REFERENCES**

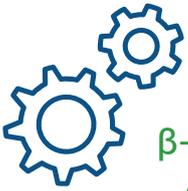
# LIST OF FIGURES AND TABLES

*page*   *figure*

- 5**   **Figure 1** / The SRHR policy encompasses several guidelines and complements the maternal, neonatal, and child health (MNCH) policies
  - 8**   **Figure 2** / Unmet need for contraception among youth under 25 years old
  - 9**   **Figure 3** / Types of contraception used among 15-29 and 20-24 year olds
  - 10**   **Figure 4** / Percentage of young women, age 15-19 years, who have begun childbearing
  - 12**   **Figure 5** / Maternal deaths reported to the National Committee for the Confidential Enquiries into Maternal Deaths between 1998 and 2016<sup>16</sup>
  - 13**   **Figure 6** / Unmet need for contraception (15-49) across the Provinces
- 

*page*   *table*

- 10**   **Table 1** / Birth registrations by age of the mother, 2017
- 11**   **Table 2** / Selected SRHR indicators against national targets
- 15**   **Table 3** / SDGs related to the SRHR Policy
- 17**   **Table 4** / Alignment with national health policies, laws, and plans
- 18**   **Table 5** / Alignment with national service-specific guidelines
- 21**   **Table 6** / SRHR policy objectives, sub-objectives, and intended results



## ACRONYMS

$\beta$ -hCG	Beta-human chorionic gonadotrophin
CBO	Community-based organization
CTOP	Choice on Termination of Pregnancy
D&E	Dilatation and evacuation
D&C	Dilatation and sharp curettage
DBE	Department of Basic Education
DHE	Department of Higher Education
DHIS	District health information system
DoH	Department of Health
DSD	Department of Social Development
EVA	Electric vacuum aspiration
FBO	Faith-based organisations
Hb	Haemoglobin
hCG	Human chorionic gonadotrophin
HIV	Human Immunodeficiency Virus
ICD	International statistical classification of diseases
ICPD	International Conference on Population and Development
IM	Intramuscular
IUD	Intrauterine device
IV	Intravenous
LMP	Last menstrual period
MNCWH	Maternal, neonatal, child, and women health
MVA	Manual vacuum aspiration
M&E	Monitoring and evaluation
NGO	Non-governmental organization
NDoH	National Department of Health
NSAIDs	Non-steroidal anti-inflammatory drugs
PHC	Primary Health Care Facility
POC	Products of conception
PPH	Postpartum haemorrhage
Rh	Rhesus
SGBV	Sexual and gender-based violence
SRH&R	Sexual and reproductive health and rights
STI	Sexually transmitted infection
TOP	Termination of pregnancy
WHO	World Health Organization



# DEFINITION OF TERMS

TERM	DEFINITION
<b>Accessible and equitable health services</b>	Accessible health services are services that are available to all people who need them and are free from any form of discrimination, irrespective of where a person was born, which language they speak, their cultural or religious background, their abilities, sex, or gender. Equitable health services mean that all people are treated fairly based on their need.
<b>Adolescent</b>	Any person between the ages of 10 and 19.
<b>Adolescent and youth-friendly health services</b>	Health services that are both responsive and acceptable to the needs of adolescents and youth and which are provided in a non-judgmental, confidential, and private environment, in times and locations that are convenient for adolescents and youth.
<b>Comprehensive</b>	In healthcare, the term “comprehensive” refers to services that comprise many elements of care such as promotive, preventive, curative, and rehabilitative services. Comprehensive SRHR services bring together all the elements of SRHR to prevent and manage conditions.
<b>Comprehensive sexuality education (CSE)</b>	This refers to the provision of age-appropriate, culturally relevant, scientifically accurate, realistic, non-judgmental information about sex and relationships. Sexuality education provides opportunities to explore one’s values and attitudes and to build decision-making, communication, and risk-reduction skills about many aspects of sexuality.
<b>Counselling</b>	A confidential two-way discussion between a client and trained counsellor to help the client to cope with stress and concerns and make informed decisions (e.g. about a medical sterilisation procedure).
<b>Early Adolescent</b>	Any person between the ages of 10 to 14 years.
<b>Gender equality</b>	The freedom of human beings to develop themselves and make their own choices and that the different behaviours and needs of individuals are valued and are equal. When genders are equal, they get the same treatment, the same access to services, and they have equal power in relationships.
<b>Gender-based violence (GBV)</b>	All acts perpetrated against women, men, boys, and girls on the basis of their sex, which causes or could cause them physical, sexual, psychological, emotional, or economic harm. This includes the threat to take such acts, or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peacetime and during situations of armed or other forms of conflict. It also includes domestic violence, sexual harassment in the workplace, human trafficking, and sexual and emotional abuse.
<b>Gestational age or duration of pregnancy</b>	The number of days or weeks since the first day of the client’s last normal menstrual period in clients with regular cycles. The first trimester is generally considered to consist of the first 12 weeks of pregnancy. Throughout this document, gestational age is defined in both weeks and days, reflecting its definition in the international statistical classification of diseases (ICD).

TERM	DEFINITION
<b>Health system</b>	The total of all the organizations, institutions, and resources whose primary purpose is to ensure delivery of quality services to all people, when and where they need them. The World Health Organization (WHO) identifies six core components or 'building blocks' of a health system: (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, and (vi) leadership/governance.
<b>Informed decision-making</b>	Informed decision-making means that the client decides what is appropriate in a given situation, based on the advice received by a health professional, and taking into account the personal circumstances, belief system, and priorities. It may mean that the client either accepts or declines advice and recommendation from a health professional. The client's decision is paramount and must be respected.
<b>Integration</b>	The process of bringing together, holistically, different kinds of related SRHR and HIV interventions at the levels of legislation, policy, programming, and service delivery to ensure access to comprehensive services efficiently and effectively.
<b>Key populations</b>	Groups of people who are more likely to transmit or be exposed to HIV and whose engagement is critical to a successful HIV response. These include young women, sex workers, mobile and displaced populations, injecting drug users, prisoners, and sexual minorities, or as defined by the Member States in alignment with international and regional standards.
<b>Late adolescent</b>	Any person between the ages of 15 to 19 years. Requires programmatic emphasis over and above the Department of Basic Education (DBE) CSE program, including contraception.
<b>Person-centred services and care</b>	When individuals have control over their health care and receive it as close as possible to where they live. This includes care focused on each client's needs to improve health and wellbeing. In a person-centred approach, people are seen as the experts of their lives and have the right to choose their own health professional and, together with health professionals, decide the most appropriate course of action. This takes into account their own desires, values, social and personal circumstances, and health-related behaviours, as well as a medical or alternative treatment and management options. This empowers people to understand their condition and how they can get better.
<b>Pregnancy</b>	The period from implantation to birth. After the egg is fertilised by a sperm and then implanted in the lining of the uterus, it develops into the placenta and embryo, and later into a foetus. Pregnancy usually lasts 40 weeks, beginning from the first day of the last menstrual period, and is divided into three trimesters, each lasting approximately three months.
<b>Reproductive health</b>	Reproductive health implies that people have the capability to reproduce, and the freedom to decide if, when, and how often to do so. Implicit in this are the rights of all people to be informed and to have access to safe, effective, affordable, and acceptable methods of contraception of their choice, as well as to safe termination of pregnancy. People have the right to access appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.
<b>Sexual and gender-based violence (SGBV)</b>	SGBV includes any physical, sexual, or emotional harm, including threats, bullying, or removals of rights in your public or private life, due to gender.

## TERM

## DEFINITION

### Sexual and Reproductive Health (SRH)

Sexual health and reproductive health overlap and, in addition to supporting normal physiological functions such as pregnancy and childbirth, aim to reduce adverse outcomes of sexual activity and reproduction. They are also about enabling people of all ages, including adolescents and those older than the reproductive years, to have safe and satisfying sexual relationships by tackling obstacles such as gender discrimination, inequalities in access to health services, restrictive laws, sexual coercion, exploitation, and gender-based violence.

The five core components of SRH are 1) improvement of antenatal, perinatal, postpartum, and newborn care; 2) provision of high-quality services for contraception and infertility services; 3) elimination of unsafe abortions; 4) prevention and treatment of STIs, including HIV, reproductive tract infections, cervical cancer, and other gynaecological morbidities; and 5) promotion of healthy sexuality.

### Sexual and Reproductive Health and Rights (SRHR)

SRHR is defined as a state of physical, emotional, mental, and social wellbeing concerning all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity<sup>1</sup>. Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy, and personal autonomy respected
- freely define their own sexuality, including sexual orientation, gender identity, and expression
- decide whether and when to be sexually active
- choose their sexual partners
- have safe and pleasurable sexual experiences
- decide whether, when, and whom to marry
- decide whether, when, and by what means to have a child or children, and how many children to have
- have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence

### Sexual consent

In South Africa, the age of consent for all sexual acts is 16 years. The law prohibits sex with a child who is between 12 and 16 years and forbids any act of sexual violation with a child who is between 12 and 16 years. Sex between two children who are both between 12 and 16, or where one is under 16 and the other is less than two years older, is not a criminal act.

### Sexual health

Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected, and fulfilled.

### Unwanted Pregnancy

Unwanted pregnancies are pregnancies that are not desired for myriad reasons, including relationship status, economic hardship, mistiming, unplanned or unintended at the time of conception. Unwanted pregnancies may result from lack of contraception, contraception not being effective or not being used correctly, or from non-consensual sex such as rape and sexual abuse.

# GUIDING PRINCIPLES AND VALUES

The SRHR Policy prescribes that all norms, standards, and clinical practices related to SRH services should promote:

**EQUITY** Reaffirming national commitment to reducing gender and other inequalities borne from health disparities.

**COHESTION** Bringing together diverse efforts that share common goals.

**UNIFICATION** Linkage and alignment with related national and international policies.

**QUALITY** Delivering comprehensive, evidence-backed SRHR services.

**INTEGRATION** Integrating SRHR and HIV services is a key focus area and SRHR services will be integrated with all other service delivery platforms at the community, primary care (including school health), secondary, and tertiary care levels.

**RIGHTS-BASED APPROACHES** Affirming choice, confidentiality, and individual agency in a non-discriminatory manner while seeking, accessing, and receiving all SRH related services at community levels and health facilities.

In addition, the values espoused in the National Health Strategy are an essential thread of this document. These are:

- universal access to health
- informed, autonomous, and voluntary decision-making
- evidence-based and evidence-informed practices
- person-centred differentiated care in service delivery
- rights-based approach characterised by equality, confidentiality, and non-discrimination
- life cycle approach
- strong and visible stewardship for SRHR policy implementation
- multi-sectoral collaboration between HIV and SRH

# OVERVIEW OF THE SECTIONS

## SECTION 1

Provides a specific vision and mission of the integrated sexual and reproductive health and right (SRHR) policy, which aims to consolidate and give policy direction for all the initiatives relating to SRHR in South Africa. This policy document becomes the superior policy reference document for all issues relating to SRHR in the country. This section also provides guiding principles, with reference to the human rights approach that governs the policy, embedded in the need to improve access, equity, and quality in the delivery of services. The consultation and participation process for the development of this policy is also highlighted in this section.

## SECTION 2

Provides the key considerations and rationale for this policy, whose implementation relies on strengthened health systems, improved socio-cultural norms, and a strong economic landscape. As such, effective implementation of such a policy calls for multi-stakeholder engagements that include government and both the public and private sectors. This section also outlines key areas of focus on adolescent SRHR and concludes by providing various SRHR indicators that need to be collected in the implementation of this policy.

## SECTION 3

Delves into the various policy components and how they align with other national and international strategies and policy directions. These include the National Department of Health Strategy, the National Health Insurance Policy, and other national policies and laws governing SRHR. Additionally, this section defines how the policy document aligns with regional and global initiatives including the SADC SRHR strategy, Family Planning 2020 strategy, the Guttmacher–Lancet Commission report, the Sustainable Development Goals, and the Beijing Platform of Action. The policy recognises the need account for the holistic view of an individual’s life, acknowledging sexual desire and function, and confronting sexual and gender-based violence (SGBV) while zeroing in on key issues that have emerged in South Africa’s SRHR landscape. These issues include contraception, improving safe conception while addressing fertility and subfertility, access to safe choice on termination of pregnancy services, ensuring comprehensive packages for HIV, TB, and STI prevention and management, addressing reproductive cancers, specifically cervical and breast cancer, covering all aspects of the reproductive life cycle, including menopause, and in the management of Post-Exposure Prophylaxis (PEP) in occupational and non-occupational exposures.

## SECTION 4

Provides an in-depth overview of the five policy objectives in this document:

1. to enable all people to make informed decisions about their SRH and ensure that their human rights are respected, protected, and fulfilled
2. to increase the quality and uptake of SRHR care and treatment services across all life stages
3. to ensure access to respectful and non-judgemental SRHR services for priority groups
4. to strengthen the health system to deliver integrated SRHR services at the lowest feasible level in the health care system
5. to promote multi-sectoral engagement and shared accountability for a sustainable response

# 1 INTRODUCTION

The South African National Integrated Sexual and Reproductive Health and Rights Policy, 2019 (SRHR Policy 2019) creates the conditions under which South Africans are able to enjoy quality SRH across their lifespan.

Sexual health encompasses aspects of reproductive health, such as contraception, fertility, and choice on termination of pregnancy, and includes many aspects of sexual health – including reproductive tract infections, sexual pleasure or dysfunction, and the health consequences of violence – which may not be directly associated with reproduction.<sup>2</sup> The definition of SRHR suggests that people have satisfying, safe sexual lives, and can make a choice as to whether, when, and how they would like to have children. It is the intention of this policy to acknowledge the breadth of SRHR services, unifying the inseparable link between sexual health, human rights, individual autonomy, and reproduction.

Given the burden of disease on the health and socio-economic systems in South Africa and the social determinants of health and sociocultural norms that affect SRHR services, this policy intends to highlight these issues and seek ways of tackling the multifaceted nature of SRHR service delivery. However, the implementation of the various programs is facilitated by the separate guidelines that anchor this policy document.

Quality SRH services are organized and delivered with respect for individual agency, ability, and right to undertake SRH decisions, underpinned by a rights-based approach. Sexuality, gender, and the economy are interconnected: SRHR cannot be achieved without the recognition, respect, protection, and fulfilment of sexual and reproductive rights within human rights, essential for social justice, sustainable development, and public health.<sup>3,4</sup>

This policy exists to serve the people of South Africa through the leadership of the National Department of Health (NDoH). The integrated SRHR Policy provides a concise reference for the administrators, financiers, managers, and health workers who dedicate their professional efforts to improving health outcomes for all South Africans.

## A comprehensive definition of SRHR

“A state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right”.<sup>1</sup>

Efficient health systems are a prerequisite for effective service integration and require strengthening of six key components from the WHO Health Systems Framework<sup>5</sup>:

- quality service delivery
- essential medicines and supplies
- human resources for health
- health information systems
- health care financing
- leadership and governance

## 1.1 Vision

Attainment by all South Africans of the highest possible level of comprehensive and integrated SRHR services by 2030.

## 1.2 Mission

Accelerate the equitable delivery of a comprehensive range of quality, integrated, and rights-based SRHR services that are available, accessible, acceptable, effective, and safe to individuals, couples, and communities in South Africa.

## 1.3 Policy Objectives

There are **five SRHR Policy Objectives**, with accompanying policy statements to direct their implementation, as follows:

- OBJECTIVE 1** Equip all people to make informed decisions about their SRHR and ensure that their SRH rights are respected, protected, and fulfilled
- OBJECTIVE 2** Increase the quality of and access to comprehensive and integrated SRHR care and treatment services across all life stages
- OBJECTIVE 3** Ensure access to respectful and non-judgemental SRHR services for priority groups.
- OBJECTIVE 4** Strengthen the health system to deliver integrated SRHR services at the lowest feasible level in the health care system.
- OBJECTIVE 5** Promote multi-sectoral engagement and shared accountability for sustainable and rights-based service delivery.

This policy consolidates various guidelines and aligns to various policies on SRHR in South Africa, thereby providing a broad framework for the provision of quality and comprehensive SRHR services recognising individual autonomy, enabling informed choice, and advancing human rights in the context of SRHR.

These services are also included in the following guideline documents:

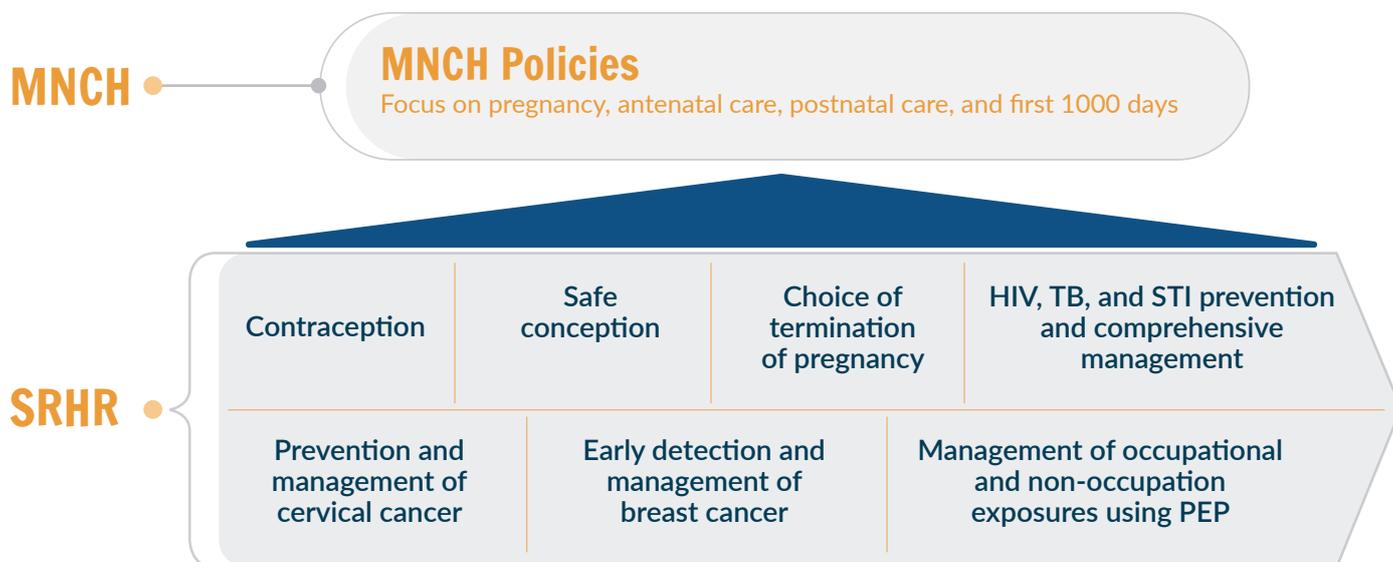
- National Clinical Guideline for Contraception (2019)
- National Guideline for Implementation of Choice on Termination of Pregnancy Act (2019)
- National Clinical Guideline for Safe Conception and Infertility (2019)
- Sexually Transmitted Infections Management Guidelines (2015)
- National Guideline on the Management of Post-Exposure Prophylaxis (PEP) in Occupational and Non-Occupational Exposures (2019)
- National Clinical Guideline for Cervical Cancer Control and Management (2019)
- National Clinical Guideline for Breast Cancer Control and Management (2019)
- National Clinical Guidelines on Genetics Services (2018)
- National Guideline for the Prevention of Mother to Child Transmission of Communicable Infections (HIV, Hepatitis, Listeriosis, Malaria, Syphilis and TB) (2019)

This document articulates the narrative for SRHR and seeks to harmonize the coordination and service delivery for a comprehensive SRHR program in South Africa. It is yet another crucial pillar towards achieving the National Health Strategy and contributes to the country’s socio-economic development as set out in the National Development Plan. The integrated policy presents a cohesive framework that outlines the priorities, structure, and governance for SRHR service delivery in South Africa. This high-level policy aims to positively impact sexual health outcomes at a population level.

The SRHR policy advocates keen attention and inclusion, including all adolescents, young women and girls, sex workers, LGBTQI+, migrants, people with disabilities, young men and male partners of women seeking SRHR services, and survivors of sexual violence. By calling attention to the spectrum of needs of the population, iterating the resources and guidance available within SRHR, prioritizing essential areas of SRHR service delivery, and illustrating comprehensive care, quality care is championed.

The diagram below articulates the lifecycle approach to reproductive health. It is appropriate therefore to read and implement this policy in conjunction with the Maternal, Neonatal and Child Policies and Programs.

Figure 1 / The SRHR policy encompasses several guidelines and complements the maternal, neonatal, and child health (MNCH) policies



# 2 KEY CONSIDERATIONS IN THE ORGANISATION OF SRHR SERVICES

The context in which SRHR services are designed in South Africa needs to include an understanding of South Africa's modern history in relation to SRHR, the current socio-cultural and economic dynamics that drive SRHR service delivery, the performance of the SRHR program in general, as illustrated in the indicators to date, and, given the high incidence of HIV and teenage pregnancy, the need to have a sharpened focus on adolescents, young women, and girls.

## 2.1 SRHR in the context of South Africa's modern history

**THIS POLICY IS A PROGRESSIVE MOVEMENT TOWARDS ENSURING ACCESS TO QUALITY AND EQUITABLE SRHR SERVICES IN THE COUNTRY.**

The first democratic elections in 1994 ushered in a new era in South Africa, with the concepts of human rights and equity installed as the cornerstones of the new constitution. South Africa's democratic transition provided unique opportunities to address racially-based political, socio-economic, and health inequalities.<sup>6</sup> While major investments to transform the health system into an integrated, comprehensive national health system have been made, there are several systemic challenges that the implementation of this policy faces, categorised into four themes:

### **The complex burden of disease**

maternal, newborn and child health, HIV/AIDS, TB, non-communicable diseases, violence, and injury

### **Quality concerns**

related to health care in general

### **An ineffective and inefficient, overburdened health system**

resulting in inefficiencies in service delivery and inequities in care delivery in both the public and private sectors

### **Costs**

spiralling health care costs, particularly in the private health care environment

Tackling these challenges is not necessarily the focus of this policy document, however, policy and health systems initiatives specific to SRHR are acknowledged and have produced results:

- At the higher levels of policy and law, the country has strengthened rights-based youth SRH legislation and policies, introduced new progressive sexual offences laws, related matters, and amended the Choice on Termination of Pregnancy (CTOP) act to ensure more effective implementation.
- At the systems level, the state has sustained well-established data collection systems, such as the Confidential Enquiry into Maternal Deaths Reviews and a strong civil registration and vital statistics system, made progress in the ideal clinic framework, and advanced the setting up of the National Health Insurance Fund.
- Specific SRHR programs are commendable. For example, the Human Papilloma Virus (HPV) vaccine, which will significantly reduce the incidence of cervical cancer, has been introduced for young girls. Additionally, SRHR programs expands the focus on the reduction of new HIV infections among young women and girls.

These successes benefit all South Africans and must be scaled, especially among more vulnerable groups such as women in rural areas, teenagers, the marginalised, and key populations.<sup>7</sup>

## 2.2 Influence of social, cultural, and economic factors on SRHR in South Africa

A variety of factors affect people's access to and utilisation of SRHR services. These factors influence the patterns of use, the continuation and interruption of services, and affect the quality of services clients receive. This policy acknowledges these factors as they affect outcomes. While this policy does not go into detail on how to overcome such challenges, legislative and implementation measures (in the form of guidelines) have been put in place to help address some of these challenges. However, broader views are needed that acknowledge the negative effect that the health economy, systemic inequities, and levels of educational attainment have on access and adherence to SRHR services.

A number of key factors highlight the need to take a considered and collaborative approach when implementing this policy, including:

### **Socioeconomic status and rural residence**

Women living in poor socioeconomic conditions, especially in rural areas and informal settlements, tend to have less access to SRHR services (i.e. safe choice of termination of pregnancy), higher in-facility maternal mortality, and lower delivery in the facility.<sup>8</sup>

### **Educational attainment**

Education has a strong positive link with contraceptive and SRHR service use, improved employment opportunities, and economic independence. Higher levels of education, comprehensive sexual education, and retaining learners in school are also associated with lower levels of teenage pregnancy, HIV, and other STIs.

### **Gender norms and entrenched cultural practices**

Interventions to increase agency among women and efforts in engaging their male partners, men, and boys in fostering equitable SRHR in South Africa have been ongoing. However, more are necessary, particularly linking existing initiatives to communities through multisector involvement to achieve sufficient scale and coverage. Changing attitudes embedded in socio-cultural and political structures are important to promote contraceptive use and other proactive SRHR choices.

### **Gender-based violence**

High levels of gender-based, and intimate partner violence affects South Africa, denying many women, including adolescents, the full enjoyment and attainment of SRHR services. This undermines development efforts and increases women's vulnerability to poor health and social outcomes. Various strategies have been deployed through multisector collaboration, but these need more strategic implementation and enforcement.

### **Partner, family, and community expectations around fertility**

Teenagers, young and older women often face pressure to 'prove their love' by childbearing, face troubled negotiations between partners concerning condom and contraceptive use, and are subject to societal and familial expectations for women to have children.

### **Knowledge about conception**

Many people do not have sufficient understanding of the fertile period and when pregnancy is most likely to occur. This influences their choices around contraception and can result in an unwanted pregnancy. There are important missed opportunities in a variety of health and educational settings to provide information on reproduction.

## Knowledge about contraceptive methods

Although almost all South Africans know of at least one type of contraceptive, most have limited knowledge of the range of contraceptive methods available. This hampers the ability to make informed choices and limits community experience with newer methods. Misinformation about methods may also negatively affect uptake.

## Stigma and discrimination

Women who are not in a formal union such as unmarried or widowed women, often face stigma when accessing sexual health services. Therefore, a non-discriminatory approach is needed when addressing their specific needs.

Due consideration should be made to advance the rights of sex-workers, LGBTQI+ people, disabled people and refugees to ensure they enjoy a meaningful sex life. As such, reference should be made to some documents that have been put forward to advance the individual rights of sex workers and the LGBTQI+ rights, such as the South African National Sex Worker HIV Plan, 2016–2019 and the South African National LGBTI HIV Plan, 2017–2022.<sup>10, 11</sup>

## 2.3 Adolescent girls and young women

### UNMET NEED FOR CONTRACEPTION AMONG YOUTH

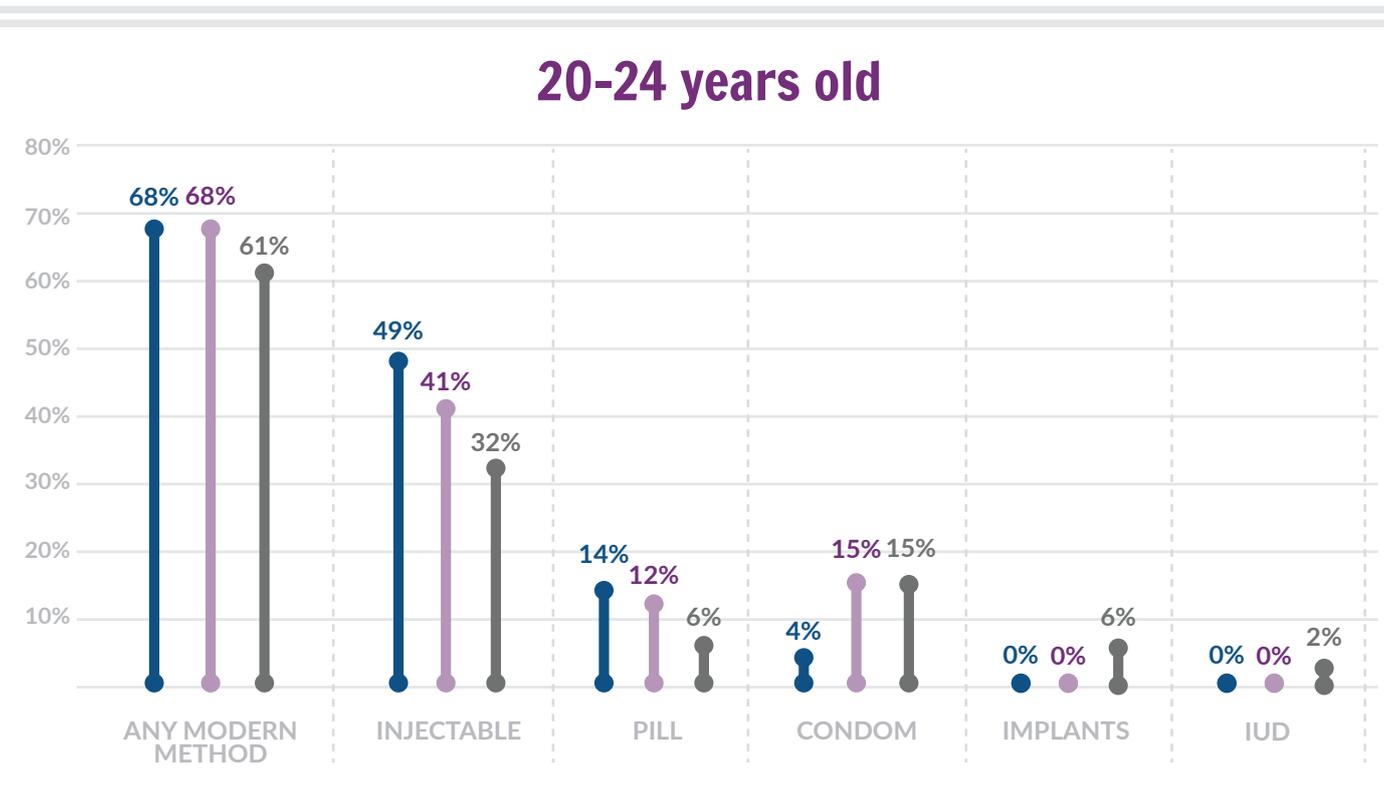
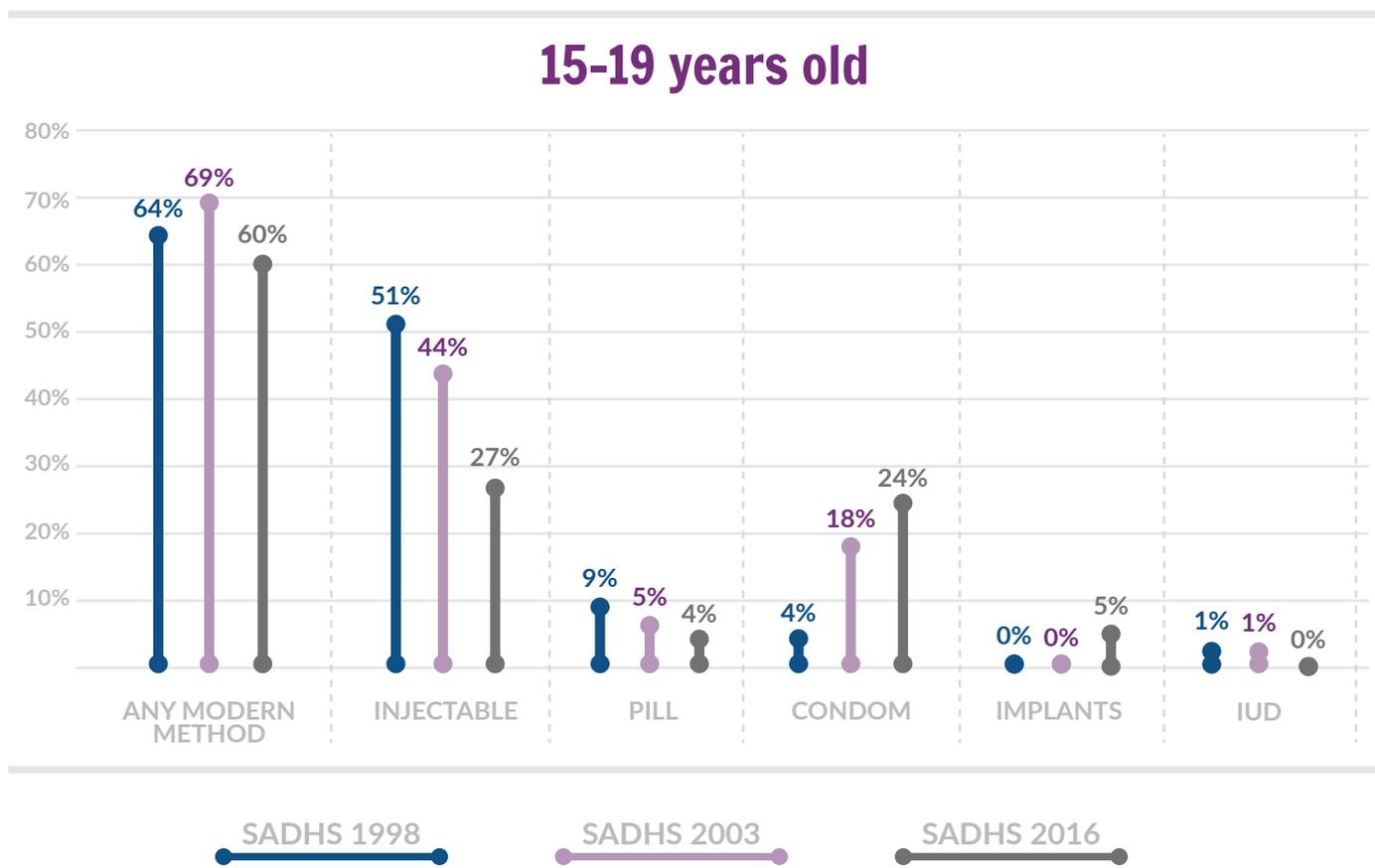
Adolescents girls and young women (AGYW) exhibit a high incidence of HIV and high levels of unmet need for contraception (around 30%).<sup>12</sup> This has been demonstrated consistently from the demographic health surveys as shown in Figure 2.

Figure 2 / Unmet need for contraception among youth under 25 years old



The mix of methods of contraception used by young women is also uneven. For example, the popularity of progestin-only injectable contraception in South Africa, specifically among AGYW, is attributed to its convenience, high acceptability among clients and health providers, and cost-effectiveness.<sup>13</sup> This has resulted in a poor contraceptive mix among young women.

Figure 3 / Types of contraception used among 15-29 and 20-24 year olds



## HIV ACQUISITION RISK AMONG YOUTH

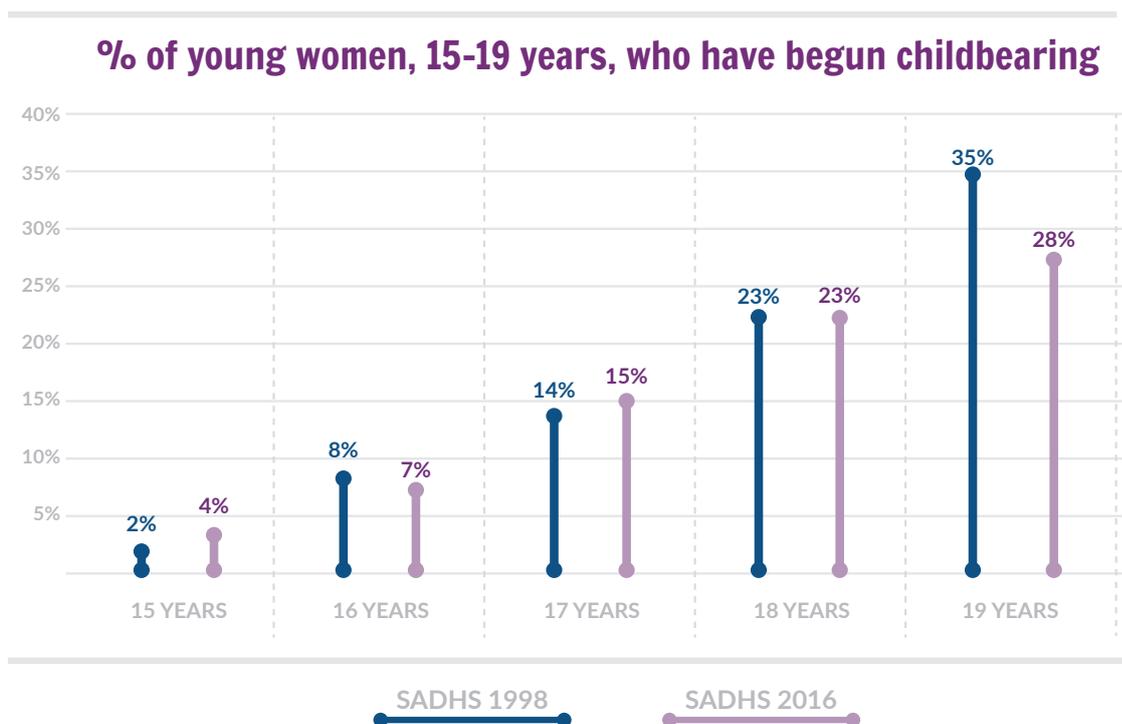
Many South African youth are sexually active and practice risky sexual behaviour. There is a need to accelerate the implementation of strategies that specifically address HIV among young people, where the incidence of unwanted pregnancies and HIV displays worrying trends. When asked about sexual behaviour in the past 12 months, youth aged 15-24 years reported<sup>12</sup> the following.

- 5% of young women reported two or more sexual partners
- 52% of young women reported sex with a partner who is not their spouse or living with them
- 62% of young, unmarried women not living with a partner used a condom at last sex
- Only 38% of young women 15-19 and 67% aged 20-24 years reported that they tested for HIV
- Only 29% of young men 15-19 and 49% of men 20-24 years reported that they tested for HIV

## TEEN PREGNANCY AND MOTHERHOOD

South Africa's teenage pregnancy rate has shown little change since 1998.

Figure 4 / Percentage of young women, age 15-19 years, who have begun childbearing<sup>12</sup>



Overall, 12% of teens between the ages of 15 and 19 years have begun childbearing, indicated by the red box in Table 1.

Table 1 / Birth registration by age of the mother<sup>14</sup>

Age of mother	Number birth occurrences	Percentage
10-14	3 261	0,3%
15-19	119 645	12,1%
20-24	244 190	24,7%
25-29	247 507	25,0%
30-34	200 490	20,3%
35-40	108 362	11,0%
40-44	32 737	3,3%
45-49	2 679	0,3%
50-54	340	0,0%
Unspecified	30 107	3,0%
<b>Total</b>	<b>989 318</b>	<b>100%</b>

Teens between the ages of 10 and 19 contributed 12,4% to registered childbirths in 2017. In an attempt to stem learner pregnancy in South African schools, the DBE included the reduction of unwanted teen pregnancy as a separate objective in its HIV, STI, and TB Policy.<sup>15</sup>

## 2.4 Influence of key SRHR indicators

Current trends in key SRHR indicators, which may suggest both wide access to primary healthcare for improving quality of care, are considered in this policy. Observing change in indicator measurement over time and in relation to national targets highlights areas of achievement and those in need of extra support. Table 2 below summarizes:

Table 2 / Selected SRHR indicators against national targets

Category	Indicator	2011	2012	2013	2014	2015	2016	Target
Facility Delivery	Delivery in facility under 18 years rate (%)	8,1	7,7	7,8	7,4	7,1	6,8	N/A
	Maternal mortality in facility ratio (iMMR) (per 100,000 live births)	144,9	132,9	133,3	132,5	119,1	116,9	120
Prevention of mother-to-child-transmission (PMTCT)	ANC 1st visit before 20 weeks rate	40,2	44,0	50,0	53,9	61,2	65,2	62
	ANC client initiated on ART rate	80,4	81,6	76,3	91,2	93,0	95,1	95
Sexual Health	Cervical cancer screening coverage	50,2	50,3	54,1	54,5	56,6	61,5	62
	Couple year protection rate (CYPR)	-	-	-	63,4	66,7	70,2	50
HIV	HIV testing coverage (including ANC)	-	-	26,1	32,1	34,5	35,9	90
	Male condom distribution	15,7	21,8	27,9	38,4	44,4	47,5	3 billion

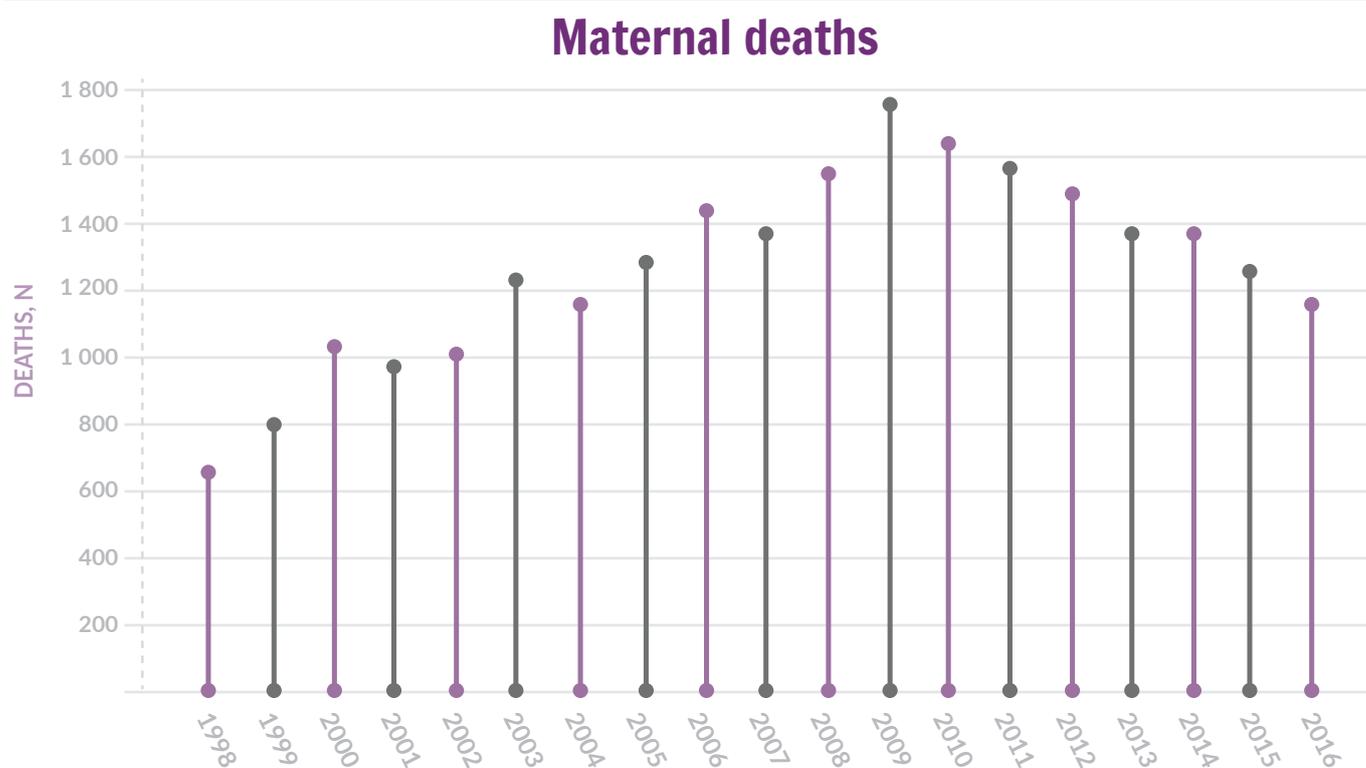
### Facility delivery rates for under 18 years

The proportion of in-facility deliveries to women under 18 years old can be used as a proxy for the adolescent birth rate. There was a downward trend from 7,7% in 2012–13 to 6,8% in 2016–17.<sup>15</sup> While the decline is commendable, strategies encompassed in this policy call for accelerated multi-stakeholder approaches from the National Departments of Health, Basic Education, and Social Development for multisector solutions.

### Institutional Maternal Mortality Ratio (iMMR)

South Africa has shown a decreasing trend in the iMMR over the past five years. The national iMMR in 2016-17 met the target of 120 per 100 000 live births with 116,9 per 100 000 live births, down from 132,9 in 2012–13. The target for 2019 is less than 100/100 000 live births and is on track for the SDG targets on maternal mortality reduction. Since 2015, 84% of women with a live birth received a postnatal check during the first 2 days after birth, compared with only 63% in 2014.<sup>16</sup>

Figure 5 / Maternal deaths reported to the National Committee for the Confidential Enquiries into Maternal Deaths between 1996 and 2016<sup>16</sup>



### Fertility trends

Fertility is on the decline in South Africa, the number of children born per woman in 2016 was 2,6, compared to 2,9 from 1996 – 98 [16]. A current challenge, however, is that more than two-thirds of births, particularly among 20-29 year-olds, do not contain information on fathers.<sup>17</sup>

### First antenatal visit before 20 weeks

The NDoH aims to have 66.0% of first antenatal visits before 20 weeks gestation by 2019–20. In 2016–17, the rate in South Africa was 65,2%, 3,2 percentage points above the current target of 62%.<sup>12</sup> Focused interventions by the Department to improve early antenatal care (ANC) booking rates contributed to this improvement through:

- implementation of the 90-90-90 strategies<sup>18</sup>
- announcement of the Last Mile Plan<sup>19</sup>
- launch of ward-based community outreach teams<sup>20</sup>
- implementation of the 2015 National Consolidated Guidelines<sup>21</sup>
- annual PMTCT stock-take workshops

### ANC client-initiated on antiretroviral treatment (ACOA) rate

The 2014–15 move to option B+ and the introduction of 90-90-90<sup>18</sup> in 2016 have ensured a high coverage of antiretroviral therapy (ART) to pregnant women accessing ANC services. In 2016–17, the ACOA rate in South Africa was 95,1% only 0.1 percentage points above the national target of 95% for this year.<sup>22</sup>

### Cervical cancer screening coverage

Data collection prescribed by the National Policy on Cervical Cancer was implemented in April 2017. Before April 2017, cervical cancer screening was monitored only once within a 10-year interval. National cervical cancer screening coverage has increased over the past three years (to 61,5%), nearly reaching the national target of 62% in 2016–17.<sup>22</sup>

## Couple year protection rate (CYPR) and Contraception Protection Rate (CPR)

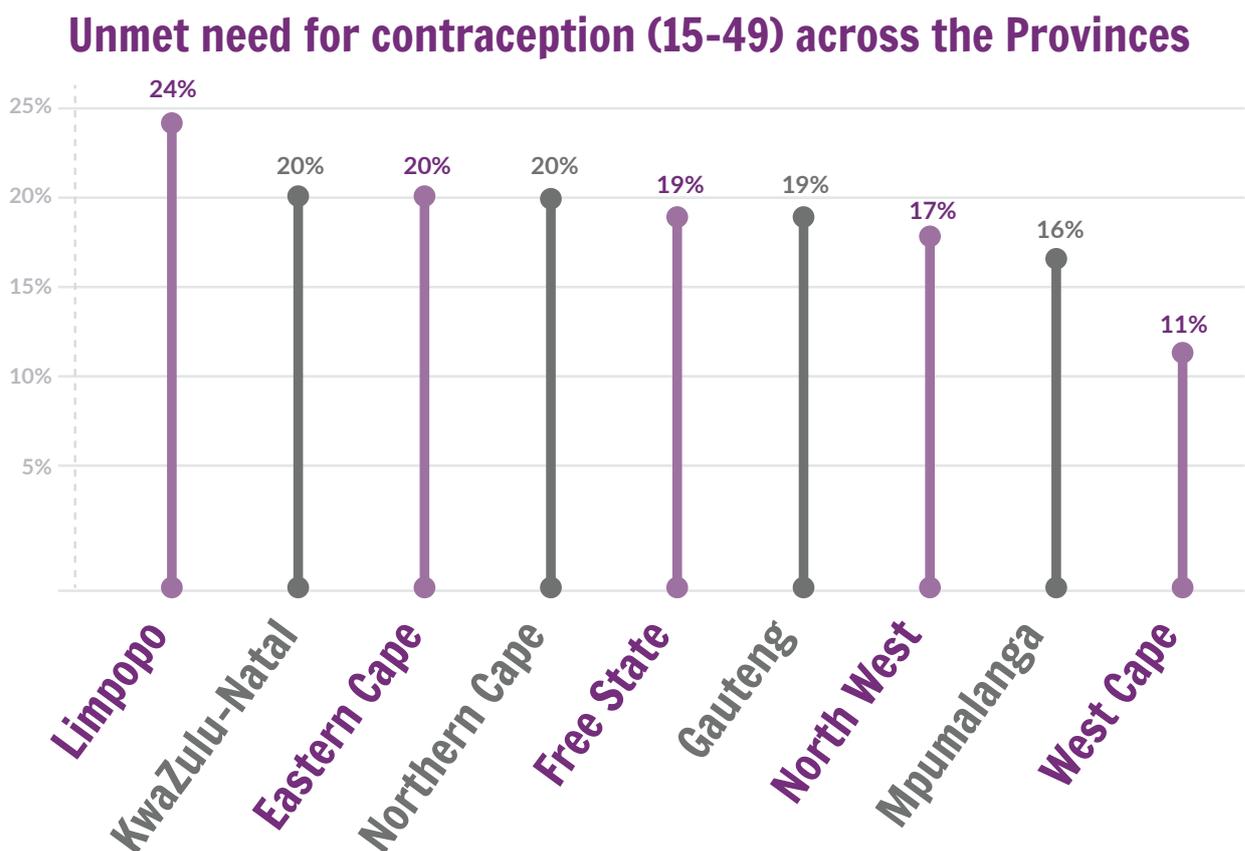
The CYPR measures the proportion of women protected against pregnancy by using modern contraceptive methods, which is currently estimated at 59,3%, considerably higher than the national target of 50% for the country.<sup>12</sup>

Contraceptive use has risen at a much slower pace with a high unmet need for contraception. The district health information system (DHIS) reported the 2016–17 CYPR at 70,2%. When comparing 1998 data with the 2016 data, modern CPR among married women in South Africa remained almost unchanged at 55% and 54%, respectively. From 1998 to 2016, modern CPR among sexually active unmarried women has declined (68% vs. 64%).<sup>22</sup> The shift in methods used is notable, even though comprehensive data is not readily available:

- use of oral and injectable contraceptives has decreased
- use of condoms for contraception has increased
- modest uptake of contraceptive implants (5-6% in 2016) was observed
- unmet need for contraception has increased

Unmet need for contraception varies between 11% and 24% across provinces, as shown in Figure 6. This issue needs more attention as it demonstrates there has not been much improvement over the years, with an average of 18% among married and sexually active women of 15-49 years; and 30% of married or sexually active women 15-24 years.<sup>12</sup>

Figure 6 / Unmet need for contraception (15-49) across the Provinces<sup>12</sup>



## **HIV testing coverage**

The average HIV testing coverage rate (including ANC) for the country has been increasing steadily from 26,1% in 2013–14 to 35,9% in 2016–17 translating to more than 10 million HIV tests annually. HIV testing coverage reports on testing done within public health facilities and those in non-medical sites that report data to the DHIS. South Africa's target is to ensure that 90% of all persons and 95% of ANC clients living with HIV know their HIV status.<sup>23</sup> In terms of the national effort to increase HIV testing to 90% of people living with HIV, 59% of women and 44% of men aged 15-49 years reported that they were tested for HIV and received their result in the past 12 months.<sup>12</sup>

## **Access to safe termination of pregnancy (TOP)**

Data on the availability of abortion services is still limited. However, since the CTOP Amendment Act in 2002 trends indicate an increase in the rate of safe abortion, a proxy for access.<sup>24</sup> However, more needs to be done. Many facilities are still not providing abortions, even though they have the capacity to, with some districts not providing any abortion services at all. With an abortion rate of approximately 31 per 1000 women aged 15-44, it is estimated that the public sector provides 20% of all abortions while the illegal sector provides 26% unsafe abortions, which burdens the public sector when the resulting morbidity has to be managed.<sup>25</sup> The reasons for so many illegal abortions are multifaceted, including mere lack of knowledge, skills paucity among frontline health care workers, conscientious objections, and stigma that is often associated with seeking such services.<sup>26</sup>

## **Male condom distribution**

This indicator monitors the distribution of male condoms for prevention of HIV and other STIs, as well as contraception. A steady increase in the number of condoms distributed is shown in Table 2. More effort is still required to ensure utilisation.

# 3 POLICY COMPONENTS & ALIGNMENT

South Africa's laws and policies support a rights-based framework for SRH – aligned with regional and international frameworks, including the 1994 International Conference on Population and Programme of Action, 1995 Beijing Fourth Conference on Women, the SDGs, the Guttmacher–Lancet Commission report on SRHR, Family planning 2020, and the SADC SRH strategy.<sup>27-31</sup> SRHR improvement, prevention, diagnosis, treatment, and care should be evidence-based and in line with global and national policies, protocols, and clinical guidelines.

## 3.1 Alignment with global strategies and statutes

### SUSTAINABLE DEVELOPMENT GOALS

Although they exclude explicit mention of sexual rights, several SDGs are inclusive of SRHR goals for health, education, and gender equality, incorporating certain key SRHR aspects into the targets, such as access to SRHR services, CSE, and the ability to make decisions about one's health.<sup>32</sup>

Table 3 / SDGs related to the SRHR Policy

<b>GOAL 3: ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AT ALL AGES</b>	
<b>TARGET 3.1</b>	By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
<b>TARGET 3.3</b>	By 2030, end the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases, and combat hepatitis, water-borne diseases, and other communicable diseases
<b>TARGET 3.7</b>	By 2030, ensure universal access to sexual and reproductive health-care services, including for contraception, information and education, and the integration of reproductive health into national strategies and programmes
<b>GOAL 5: ACHIEVE GENDER EQUALITY AND EMPOWER ALL WOMEN AND GIRLS</b>	
<b>TARGET 5.1</b>	End all forms of discrimination against all women and girls everywhere
<b>TARGET 5.2</b>	Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation
<b>TARGET 5.3</b>	Eliminate all harmful practices, such as child, early, and forced marriage and female genital mutilation
<b>TARGET 5.6</b>	Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences
<b>GOAL 10: REDUCE INEQUALITY WITHIN AND AMONG COUNTRIES, RELATES TO ACHIEVING SRHR FOR PRIORITY POPULATIONS MOST AFFECTED BY HIV, DISCRIMINATION, AND FULFILLING THE RIGHT TO DEVELOPMENT</b>	

## GUTTMACHER-LANCET COMMISSION

The 2018 Guttmacher–Lancet Commission report proposes a comprehensive and integrated definition of SRHR, recommending an essential package of SRHR services and a positive, progressive, evidence-based agenda for progress on SRHR to 2030 and beyond.<sup>30</sup>

## REGIONAL GUIDANCE, INCLUDING SADC

The SRHR Policy is aligned with global clinical and service delivery guidance, and reference is made in several areas of this document:

- WHO Clinical practise handbook for safe abortion<sup>33</sup>
- Family planning: A global handbook for providers<sup>34</sup>
- Selected Practice Recommendations for Contraceptive Use<sup>35</sup>
- Global Health Sector Strategy on STIs<sup>36</sup>
- The Global Family Planning 2020 framework<sup>37</sup>
- Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region<sup>38</sup>
- SADC Protocol on Health, Article 16<sup>39</sup>
- Sexual and Reproductive Health Strategy for the SADC Region 2006-2015<sup>40</sup>

## 3.2 Alignment with national policies

This SRHR Policy is aligned with the following key documents, strategies, and approaches:

### National Department of Health Strategic Plan 2015-16 to 2019-20

The SRHR Policy implementation supports, and is also dependent on, the efficient execution of the National Department of Health’s five-year strategic goals for 2015 – 16 to 2019 – 20, with key objectives as follows<sup>41</sup>:

1. **Prevent disease and reduce its burden and promote health**
2. Make progress towards **universal health coverage** through the development of the National Health Insurance scheme, and improve the readiness of health facilities for its implementation
3. **Re-engineer primary healthcare** by increasing the number of ward-based outreach teams, contracting general practitioners, and district specialist teams, as well as expanding school health services
4. Improve **health facility planning** by implementing norms and standards
5. Improve **financial management** by improving capacity, contract management, revenue collection, and supply chain management reforms
6. Develop an efficient **health management information system (HMIS)** for improved decision-making
7. Improve the **quality of care** by setting and monitoring national norms and standards, improving the system for user feedback, increasing safety in health care, and by improving clinical governance
8. Improve **human resources for health** by ensuring appropriate appointments, adequate training, and accountability measures

## National Strategic Plan for HIV, TB and STI's 2017-2022

This SRHR Policy also supports cross-cutting goals of the National Strategic Plan for HIV, TB and STI's 2017–2022.<sup>42</sup> Fostering an enabling policy environment to accelerate prevention of HIV and STIs, reducing associated morbidity and mortality, reaching key populations, and grounding policy in human rights, are all key alignments between the SRHR Policy and the HIV, TB, and STI strategic plan.

## Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011-2022

SRHR: Fulfilling our Commitments 2011–2022<sup>43</sup> created the platform for a multi-sectoral framework, further informed by the CTOP Act, in which SRHR are recognised and valued for delivery of equitable and accessible SRH services in South Africa.

## National Health Insurance

The NHI, as one of the mechanisms to facilitate universal health coverage, will offer all South Africans and residents' access to a defined package of comprehensive health services, including SRHR services. The NHI seeks to create a health financing system that ensures that all citizens of South Africa, as well as legal long-term residents, are provided with essential healthcare, regardless of their employment status and ability to make a direct monetary contribution to the NHI Fund. The first phase of NHI is underway, with full implementation expected in the financial year 2025/26.<sup>44</sup>

## Other National Policies, Laws, and Guidelines

Table 4, below, lists a summary of additional relevant South African policies, plans, and laws.

*Table 4 / Alignment with national health policies, laws, and plans*

### **SOUTH AFRICAN POLICIES AND LAWS INFORMING THE SRHR POLICY NATIONAL ADOLESCENT SRHR FRAMEWORK STRATEGY (ASRH&R), 2014-201945**

National Adolescent and Youth Health Policy 2016-2020<sup>9</sup>

National HIV Testing Services (HTS) Policy<sup>23</sup>

National Strategic Plan for HIV, TB and STIs, 2017-2022<sup>46</sup>

Department Basic Education National Policy on HIV, STIs and TB<sup>15</sup> and the National Policy on the Prevention and Management of Learner Pregnancy in Schools<sup>47</sup>

The South African National LGBTI HIV Plan, 2017-2022<sup>11</sup>

The South African National Sex Worker HIV Plan, 2016-2019<sup>10</sup>

National Breast Cancer Prevention and Control Policy<sup>48</sup>

National Cervical Cancer and Control Policy<sup>49</sup>

Health Sector HIV Prevention Strategy 2016<sup>50</sup>

Choice on Termination of Pregnancy Act and CTOP Amendment Bill 2004<sup>51</sup>

Building upon the 2011 NDOH Sexual and Reproductive Health and Rights: Fulfilling our commitments 2011-2022, 43 components of SRHR services will focus on the key focus areas detailed in Section 3.4 below.

This SRHR Policy provides an overarching foundation for the SRHR service specific clinical guidelines listed in the following table.

Table 5 / Alignment with national services-specific guidelines

<b>SOUTH AFRICAN NATIONAL SERVICE-SPECIFIC GUIDELINES</b>
National Clinical Guideline for Contraception (2019)
National Guideline for Implementation of Choice on Termination of Pregnancy Act (2019)
National Clinical Guideline for Safe Conception and Infertility (2019)
Sexually Transmitted Infections Management Guidelines (2015)
National Guideline on the Management of Post-Exposure Prophylaxis (PEP) in Occupational and Non-Occupational Exposures (2019)
National Clinical Guideline for Cervical Cancer Control and Management (2019)
National Clinical Guideline for Breast Cancer Control and Management (2019)
National Clinical Guidelines on Genetics Services (2018)
National Guideline for the Prevention of Mother to Child Transmission of Communicable Infections (HIV, Hepatitis, Listeriosis, Malaria, Syphilis and TB) (2019)

In addition, there are several other documents which are relevant to the healthcare provider:

- National Policy on HIV Pre-Exposure Prophylaxis (PrEP) and Test and Treat (T&T) (2016)
- Guidelines for Expanding Combination Prevention and Treatment Options: Oral Pre-Exposure Prophylaxis (PrEP) and Test and Treat (T&T) (2017)
- Guidelines for Maternity Care in South Africa (2015)
- Ideal Clinic Manual (2018)
- The Integrated Clinical Services Management Manual (ICSM)

### 3.3 Key focus areas

This SRHR Policy is aligned with the following key documents, strategies, and approaches:

#### SEXUAL HEALTH – SEXUAL DESIRE, PLEASURE AND FUNCTION

- promote healthy sexuality, including self-acceptance, sexual orientation, gender identity, sexual function and pleasure, and sexuality throughout the human lifecycle
- comprehensive sexuality education and friendly services for youth, community, and individual education on and support for cultural values that foster SRHR, and positive health-seeking behaviours
- counselling and support in relation to all dimensions of the SRHR package

## **CONFRONTING SEXUAL AND GENDER-BASED VIOLENCE**

- promote individual and cultural values that decrease SGBV
- provide comprehensive clinical management of SGBV

## **CHOICE ON TERMINATION OF PREGNANCY**

- ensure that every woman who seeks an abortion can access the service without delay
  - no woman should have to wait more than seven days from the first request to access services
- enable all abortion clients to make informed decisions and ensure their human rights are respected, protected, and fulfilled
- provide a standardised approach to CTOP services in all regions of South Africa
- increase access and uptake of CTOP services
- deliver integrated CTOP services at the lowest appropriate level of care
- promote multi-sectoral collaboration and shared accountability related to the provision of abortion within the context of SRHR services

## **REDUCING THE UNMET NEED FOR CONTRACEPTION**

- improve access to modern methods of contraception
- improve the method mix for contraception

## **SAFE CONCEPTION AND FERTILITY MANAGEMENT**

- increase access to, management of, and provision of psychosocial care for safer conception services
- increase access to, management of, and provision of psychosocial care for people seeking infertility treatment
- provide uniformity, standardisation of care, and cost-effective treatment for infertile patients

## **PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV AND OTHER TRANSMITTABLE INFECTIONS**

- provide comprehensive ANC services
- increase the number of pregnant women who attend the first ANC visit before 20 weeks
- eliminate mother-to-child transmission of HIV with interventions like retesting of HIV-negative pregnant and breastfeeding women, adherence support, and monitoring viral load for HIV-positive pregnant and breastfeeding women
- provide safe delivery care
- provide postpartum care, including post-partum contraception counselling and service

## **HIV AND OTHER STIS**

- prevention, detection, and treatment of HIV and other STIs, with emphasis on elimination of congenital syphilis

## **CANCERS OF THE REPRODUCTIVE SYSTEM**

- prevention and management of cervical cancer
- early detection and management of breast cancer

## **MENOPAUSE**

- management of SRHR beyond child-bearing years

## **OCCUPATIONAL AND NON-OCCUPATION EXPOSURE RISK**

- prevention and management of exposures to HIV, STI, pregnancy, hepatitis, and tetanus

# 4 THE NATIONAL INTEGRATED SRHR POLICY OBJECTIVES

The follow table summarizes the five SRHR policy objectives and sub-components.

Table 6 / SRHR policy objectives, sub-objectives, and intended results

SRHR POLICY OBJECTIVES	INTENDED RESULTS
<b>OBJECTIVE 1: Equip all people to make informed decisions about their SRHR and ensure that their SRH rights are respected, protected, and fulfilled</b>	
<p><b>1.1</b> Disseminate the SRHR Policy to all levels in the Department of Health and collaborating implementing partners</p> <p><b>1.2</b> Create awareness and improve SRHR knowledge to stimulate demand for SRHR services in the general population</p> <p><b>1.3</b> Offer person-centred counselling to all clients who access SRHR services</p>	<p>Informed and autonomous decision-making at provincial, district and individual levels.</p>
<b>OBJECTIVE 2: Increase the quality of and access to comprehensive and integrated SRHR care and treatment services across all life stages</b>	
<p><b>2.1</b> Offer a range of modern contraceptive methods, together with counselling and information to encourage informed choice</p> <p><b>2.2</b> Provide safer conception and infertility services to all clients, including prevention, diagnostics and treatment for all clients who experience difficulty with conception</p> <p><b>2.3</b> Safe CTOP services: Provide safe TOP-related services at all health facilities</p> <p><b>2.4</b> HIV and other STIs: Prevent, diagnose, and treat HIV and other STIs</p> <p><b>2.5</b> Provide programmes for the prevention, detection, and early management of cervical cancer and breast cancer</p> <p><b>2.6</b> Provide management of Post-Exposure Prophylaxis (PEP) in Occupational and Non-Occupational Exposures within 72 hours</p>	<p>A comprehensive and integrated package of SRHR services is provided in an equitable, accessible and rights-based manner for all South Africans.</p>
<b>OBJECTIVE 3: Ensure access to respectful and non-judgmental SRHR services for priority groups</b>	
<p><b>3.1</b> Adolescents and young people (10-24 years)</p> <p><b>3.2</b> Ensure SRHR well-being of clients after child-bearing age, peri- and post-menopausal</p> <p><b>3.3</b> LGBTQI+ people</p> <p><b>3.4</b> Female sex workers</p> <p><b>3.5</b> People with disabilities</p>	<p>Rights-based approach characterised by non-discrimination, confidentiality, and privacy.</p>

<p><b>3.6</b> Migrants and asylum seekers</p>	
<p><b>3.7</b> Promoting SRHR services to support male involvement</p>	

**OBJECTIVE 4: Strengthen the health system to deliver integrated SRHR services at the lowest feasible level in the healthcare system**

<p><b>4.1</b> Provide quality SRHR services at primary health care level or the lowest level possible</p> <p><b>4.2</b> Ensure uninterrupted supply of commodities and drugs in all facilities</p> <p><b>4.3</b> Ensure healthcare providers have the skills and knowledge to deliver integrated SRHR services</p> <p><b>4.4</b> Maximise the use of programmatic data and research to improve service provision and increase the impact</p> <p><b>4.5</b> Mobilise financial resources and maximise efficiencies to support implementation</p> <p><b>4.6</b> Promote strong leadership and management to enforce the SRHR Policy</p>	<p>Enabling environment for high-quality services delivered by trained providers</p>
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**OBJECTIVE 5: Promote multi-sectoral engagement and shared accountability for a sustainable and rights-based service delivery**

<p><b>5.1</b> Strengthen stakeholder engagement and partnerships to enforce and implement the SRHR Policy</p> <p><b>5.2</b> Improve collaboration and co-operation between government departments, civil society, development and implementing partners, and the private sector</p>	<p>Coordinated implementation for a sustainable response</p>
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## OBJECTIVE 1:

Equip all people to make informed decisions about their SRHR and ensure that their SRH rights are respected, protected, and fulfilled

### POLICY STATEMENT

Cooperation and collaboration of intergovernmental departments. All provinces, district health systems, and other collaborating partners are required for full implementation.

#### 1.1 Disseminate the SRHR Policy to all levels in the Department of Health and collaborating implementing partners

##### 1.1.1 Ensure the policy is incorporated into provincial and district health plans through stakeholder engagement and alignment

- host provincial workshops to introduce the SRHR Policy and get buy-in
- use existing channels and create new channels to distribute policy documents to all districts in the country
- conduct value clarification workshops with provider groups and other implementers to ensure equitable comprehensive SRHR service delivery to all clients, specifically priority populations
  - » the workshops should result in policy planning reflected in provincial and district planning

### POLICY STATEMENT

Through innovative use of media and communication strategies, populations (especially the underserved) must have information related to services they need in order to generate increased demand.

#### 1.2 Create awareness and improve SRHR knowledge to stimulate demand for SRHR services in the general population

##### 1.2.1 Inform the general population about available SRHR services through a robust demand generation strategy

- establish and implement a communication and advocacy plan for demand generation and information sharing across all levels
- use a variety of communication channels, including technology-based channels, to inform the public of available SRHR services
- reduce stigma and discrimination through community dialogues and mass media
- provide comprehensive sexuality education in all schools

##### 1.2.2 Provide knowledge and information to clients accessing SRHR services

- develop and share information, education, and communication (IEC) materials at points of SRH service delivery
- make IEC materials available at other potential entry points
  - » for example, voluntary medical male circumcision (VMMC), outreach HTS, family planning outreach services, and any other mobile services

## POLICY STATEMENT

All clients seeking SRHR services should receive appropriate counselling and informed consent.

## POLICY STATEMENT

SRHR services must focus on attracting new users, improving continuation rates, and encouraging past users who still want to avoid pregnancy to resume use, using effective, non-coercive counselling as a primary tool.

### 1.3 Offer person-centred counselling to all clients who access SRHR services

#### 1.3.1 Offer person-centred counselling

- to provide accurate, evidence-informed information to all clients accessing SRHR services
- to learn about the lived experience of the client through non-judgemental, open-ended questions to inform SRHR service choices
- to avoid coercion, emphasizing non-directive communication
- to provide clients with information to make healthy choices about their bodies and sexuality, and services that could mitigate social, political, and economic challenges
- to avoid stigmatisation, undermining autonomy, or compounding inequalities<sup>52</sup>

## OBJECTIVE 2:

**Increase the quality of and access to comprehensive and integrated SRHR care and treatment services across all life stages**

*This objective should be read in coordination with the national service-specific guidelines detailed in Table 5.*

The SRHR Policy provides for a comprehensive package of services that is available and accessible to all. A sustained increase in the uptake of, demand for, and access to SRHR services is only possible if service delivery meets the demand and the needs of individual clients.

## POLICY STATEMENT

Provision of contraception services must be guided by the principle of informed choice, non-coercion, and availability of a varied method mix.

## POLICY STATEMENT

Multiple contraceptive methods, including sterilisation, must be offered to meet the individual needs of clients.

## POLICY STATEMENT

Encourage all sexually active clients to practice dual protection – contraception plus HIV and STI prevention.

## POLICY STATEMENT

Emergency contraception shall be made available to all women needing or requesting it.

## 2.1 Create awareness and improve SRHR knowledge to stimulate demand for SRHR services in the general population

The following modern contraceptive methods are available in public health facilities:

- subdermal hormonal implants
- female sterilisation
- male sterilisation
- levonorgestrel intrauterine device (LNG-IUD)
- copper-bearing intrauterine devices (Cu-IUD)
- progestin-only injectables
- combined oral contraceptives
- progestin-only pills
- male and female condoms and lubrication
- emergency contraception

### POLICY STATEMENT

**Childbearing decisions are the right of the client, irrespective of HIV status, and service providers must not interfere with those decisions.**

## 2.2 Provide safe conception and infertility services to all clients, including prevention, diagnostics and treatment for all clients who experience difficulty with conception

### 2.2.1 All clients who desire a child and are planning a pregnancy should be advised about preparing for safe conception, pregnancy, delivery, having a healthy child, and contraception for purposes of birth spacing and deciding when their family is complete.

- ensure a holistic reproductive lifespan for all women, rather than focusing only on the prevention of pregnancy
- ensure availability of pregnancy tests at all levels of care, including within appropriate community settings such as mobile clinics
- provide IEC to promote:
  - » the importance of planning for a healthy conception, the healthy spacing of pregnancies, and contraception
  - » dual protection for both HIV and pregnancy prevention
  - » available methods and the relative advantages of respective methods
  - » issues such as choice, informed decision-making, and shared responsibility
  - » HIV testing at ANC visits
- include future fertility plans as part of the history-taking for all clients
- provide timely access to safe delivery, post-partum contraceptives, and prevention, detection, and treatment of infections to reduce secondary infertility
- motivate pregnant clients to attend ANC early in pregnancy, ideally before week 12

### POLICY STATEMENT

**Services for subfertility and infertility management are provided at the tertiary level and are not included in the free service for maternal and childcare package.**

### 2.2.2 Fertility and subfertility treatment

Healthcare providers should use every opportunity to identify the clients at risk of infertility and subfertility, and manage the risk appropriately:

- provide basic fertility services at the primary care level
- primary health care clinics, general practitioners, and urologists to perform an initial assessment of fertility and evaluate patients prior to referral to a gynaecologist
- refer complicated cases for specialist services at secondary and tertiary level institutions

Preconception counselling is important to all clients seeking fertility treatment to optimise pregnancy outcomes. Communication strategies should be in place to support clients emotionally to manage the psychological effects of infertility, and otherwise be in accordance with the WHO preconception care package of preconception care interventions and the European Society of Human Reproduction and Embryology (ESHRE) Guidelines for Routine Psychosocial care in infertility and medically assisted reproduction.<sup>53</sup>

## POLICY STATEMENT

Health care providers must provide appropriate guidance about safe conception to clients in HIV serodiscordant relationships planning a pregnancy.

### 2.2.3 Safe conception for HIV serodiscordant couples

A couple can safely conceive a child if one partner has HIV while the other does not (a serodiscordant couple):

- The HIV-positive partner should take ART consistently and correctly until viral load is undetectable.
- If the HIV-positive partner is not virally suppressed on ART, the HIV-negative partner can consider taking PrEP during the period when they are trying to conceive.
- Where available, a safe option for conception is artificial insemination with the HIV-negative partner's sperm. Other options include self-insemination or timed ovulatory intercourse.
- Both partners should be screened and treated for any STIs before trying for conception.

## POLICY STATEMENT

Safe termination of pregnancy services should be available in every facility that performs deliveries and at the lowest level possible; as stipulated in the guidelines

### 2.3 Safe TOP services: Provide safe CTOP-related services at all health facilities

#### 2.3.1 Access to safe TOP

- ensure pregnancy testing is available at all public and private health facilities, including community settings such as mobile clinics
- all clients presenting for TOPs must be welcomed, supported, and given care
- if the facility is unable to provide medical or surgical abortion, the client should be provided with a clear list of facilities that will be able to accommodate her

#### 2.3.2 Pre-TOP care

- provide information in a way that the client can understand, enabling her to make informed decisions about her pregnancy, and what method of TOP to choose, if appropriate
- give an opportunity to discuss contraception choices for the future, and affirm that consent to contraception is not a prerequisite to accessing a CTOP
- all clients who need TOP services should enter the health system at the primary health care level irrespective of whether the facility provides TOP services
- in most cases, TOP care can and should be offered in an outpatient setting
- facilities providing TOP services, which currently are all facilities that can perform a delivery, should have trained staff, appropriate equipment, and communication available so that emergency care is available 24 hours

#### 2.3.3 Pain management

- clients undergoing a TOP have the right to pain relief, which should be provided proactively<sup>54, 55</sup>
- following the principle that experience of pain varies by individual, by gestational age, and maternal age and parity, estimate the client's pain perception and evaluate pain treatment given to achieve optimal pain relief

#### 2.3.4 Medical TOP

- TOPs through the first trimester may be performed by a registered nurse or midwife in primary healthcare clinics, using medical or surgical methods

#### 2.3.5 Surgical TOP

- surgical TOP can be performed by either manual vacuum aspiration (MVA) up to 14 weeks gestation, or dilation & evacuation (D&E) after 12 to 14 weeks gestation
- clients who cannot tolerate the surgical TOP can be referred to theatre for the procedure

### 2.3.6 Post-TOP Care

- women receiving TOPs should be provided clear instructions on signs and symptoms of excessive bleeding post-procedure and how to get help should that occur
- provide access to comprehensive SRHR services including for HIV and other STIs, cervical cancer screening, and contraception

#### **POLICY STATEMENT**

**No health care worker has the right to refuse client access to TOP services, directly or indirectly, by not providing information about the facilities or providers where abortions services are available or by providing erroneous information, including in an emergency situations.**

### 2.3.7 Conscientious objection

Access to abortion under the CTOP Act is regarded as a constitutional right grounded in human rights. This right needs to be balanced with other individual rights and moral objections, but never to the detriment of the client seeking a TOP.

- Access to abortion under the CTOP Act is regarded as a constitutional right grounded in human rights. This right needs to be balanced with other individual rights and moral objections, but never to the detriment of the client seeking a TOP.
- All health professionals are under legal and ethical obligation to provide care for patients presenting with complications arising from abortion, regardless of whether the abortion was induced or spontaneous, or how or by whom it was performed.
- In non-emergency cases, health providers who believe that their religious or moral beliefs may affect the treatment or the advice that they provide may refuse to participate in abortion but must fulfil the requirements stipulated in the National Abortion Guidelines (under development).
- A conscientious objection should not be invoked by persons not directly conducting TOP procedures, such as support personnel.
- Management of public sector facilities are obliged to ensure that clients have access to the services to which they are legally entitled. Conscientious objection may not be the basis for facility staff to limit or deny access to safe TOP at that facility.
- Refusal only applies to trained health professionals and not to groups, institutions, support personnel, or complementary services.
- The clients' right to information and access to health care services must always be respected.<sup>56</sup>
- At a minimum, information and facilitation of referral about where to obtain a safe TOP must be provided respectfully to the client seeking a TOP.<sup>57</sup>
- Health professionals not willing to conduct TOPs must document their unwillingness in writing, and address this with the facility manager when applying for a position.
- Facility managers need to confirm whether a staff member is fit for purpose in terms of providing abortion services when appointing staff.
- Each objecting staff member must be dealt with individually; never in a group, or through group action at facilities.

#### **POLICY STATEMENT**

**No health worker can deny TOP or post-TOP services to any client in an emergency situation**

### 2.3.8 Obligations in emergency settings

When the continuation of pregnancy poses a danger to the life or health of a client or the foetus, regardless of gestational age, health workers cannot recuse themselves from their duties.

- A health care worker cannot legally or ethically object to the rendering of care in cases of life-or health-endangering emergencies, including suicidality, where TOP or post TOP service provision is part of addressing the emergency.
- If a health care worker denies access to TOP services under such circumstances, she or he may be charged with negligence where disciplinary steps may need to be taken.
- Where a health professional refuses to assist in performing the TOP in emergency circumstances, she or he will be disciplined for misconduct or failure to carry out instructions as per the CTOP Act and may be vulnerable to legal action taken by the client or her family.

## POLICY STATEMENT

Lifelong ART is recommended for all adults and children from the time their HIV-positive status is known

### 2.4 HIV and other STIs: Prevent, diagnose, and treat HIV and other STIs

#### 2.4.1 Increase access to HIV and STI services for vulnerable groups including young women and girls

Young people are especially susceptible to HIV and other STIs, but all sexually active people can be at risk of infection at any age.

- inform clients about their risk for HIV and other STIs and how to protect themselves and others
- inform clients of behaviours and situations that could increase risk
- offer HTS to all clients
- offer treatment to all clients who test positive for HIV and other STIs

#### 2.4.2 Contraceptives for clients living with HIV and other STIs

- People with HIV and other STIs can start and continue to use most contraceptive methods safely.

#### 2.4.3 PMTCT for pregnant HIV positive clients

- PMTCT has been accelerated in South Africa through various elimination strategies. This policy emphasises the need to offer HTS to all pregnant clients reporting for ANC. Those who are infected with HIV must have access to start treatment and those who are not infected must have access to continued HIV prevention services.
- Offer and start clients on ART immediately after a positive HIV diagnosis to reduce the chances that she will become ill or that baby will be infected with HIV in utero, during delivery, or postpartum and during breastfeeding
- Offer and start clients at high risk of HIV infection on oral pre-exposure prophylaxis (PrEP) containing tenofovir (TDF) immediately after a negative HIV diagnosis
- Newborns of mothers living with HIV should receive newborn PEP to further reduce the chances of HIV transmission in the period around birth in accordance with PMTCT clinical guidance<sup>28</sup>

## POLICY STATEMENT

The HPV vaccine must be offered to all girls aged nine to 12 years, as primary prevention of cervical cancer.

## POLICY STATEMENT

Secondary cervical cancer prevention, screening, and treatment of cervical lesions, is a national priority and must be offered by the public healthcare system free of charge to all eligible clients.

### 2.5 Provide programmes for the prevention, detection and early management of cervical cancer and breast cancer

#### 2.5.1 Cervical cancer

- comprehensive cervical cancer prevention and control requires equitable and affordable access to care
  - » provide access to 4 key interventions, along with IEC:
  - » primary prevention with HPV vaccination for girls aged nine to 12 years
  - » secondary prevention with cervical screening, diagnosis, and treatment of precancerous lesions
  - » treatment for invasive cervical cancer
  - » palliative care<sup>58</sup>
- screen all clients 30 to 50 years for cervical cancer once every three years, as prescribed in the Cervical Cancer Prevention and Control Policy
- screen all clients with HIV at time of diagnosis and repeat as per HIV treatment guidelines.
- offer all clients found with High Grade Squamous Intraepithelial Lesion (HG-SIL) or Cervical Intraepithelial Neoplasia (CIN 2/3) appropriate pre-cancer treatment using ablative or excisional methods
- all clients with histologically diagnosed cervical cancer must undergo staging before any treatment is initiated

## **POLICY STATEMENT**

All clients attending primary health care (PHC) clinics will be taught breast self-examination and given printed educational material, while female clients over 40 years attending a PHC clinic will have clinical breast examination as well.

### **2.5.2 Breast cancer**

It is critical to improve the survival of clients by decreasing time to presentation so that cancers are identified at earlier stages and time to treatment is decreased.

- perform a clinical breast examination on all clients with breast symptoms and refer immediately to a designated specialised breast unit as per protocol
- diagnose all eligible patients using triple assessment (clinical examination, imaging, and histological confirmation), followed by staging and referral to appropriate services
- all clients with early breast cancer should undergo breast cancer surgery, mastectomy (with or without reconstruction), or treatment to obtain cancer clearance at an appropriate facility including access to life-saving treatment, such as Herceptin, for those who qualify for such treatment
- palliative care services should be available to every eligible patient (Stage 4 disease)
- all clients should receive an appropriate cost-effective strategy for follow-up

## **POLICY STATEMENT**

The comprehensive PEP for HIV, PEP, and package should be available at all levels of care

### **2.6 Provide management of Post-Exposure Prophylaxis (PEP) in Occupational and Non-Occupational Exposures within 72 hours**

Provide a comprehensive PEP package to all exposed clients in occupational and non-occupational settings:

- provide information, advocacy, and social mobilisation on PEP
- provide appropriate counselling and psychosocial support
- supply comprehensive PEP services including referral at all health facilities
- recognise the additional needs of children and people with disabilities
- identify possible abuse and protection from ongoing abuse
- adhere to medico-legal responsibilities, if indicated
- record, monitor, and evaluate all incidents of potential exposure

#### **2.6.1 Occupational exposure**

- provide comprehensive PEP services to all healthcare providers exposed to body fluids, semen, and vaginal secretions through percutaneous injury or contact of mucous membranes or non-intact skin
- all employers to enforce and all employees to practise universal precautions to prevent exposure

#### **2.7.1 Non-Occupational exposure**

- provide comprehensive PEP services to all individuals exposed to rape, sexual assault, condom burst during sexual activities, condomless sex, human bite, abandoned babies within 72 hours of birth, and any unintended exposure to blood or other body fluids

## OBJECTIVE 3:

### Ensure access to respectful and non-judgemental SRHR services for priority groups

People who do not fit gender stereotypes, people living with HIV, adolescent girls, sex workers, and LGBTQI+ people (priority groups) experience unique barriers to accessing services and may require additional services tailored to their needs.

#### POLICY STATEMENT

All clients must be treated equally and promptly regardless of age, ethnicity, socioeconomic, marital status, or similar characteristic.

#### 3.1 Safe TOP services: Provide safe TOP-related services at all health facilities

Adolescents, especially girls, are a key population for nearly all SRHR services, including prevention, detection, and treatment of HIV and other STIs. Adolescents and young people must have access to youth-friendly services and school-based services, including comprehensive sexuality education, the prevention of unwanted pregnancies and risks associated with teen pregnancy, prevention of HIV and other STIs, and access to safe TOP.

Facilities should remove barriers to accessing SRHR services by:

- refraining from moral judgement and discrimination by health workers
- welcoming adolescents to access SRHR services and information
- promoting personal choice in decisions guided by friendly, non-judgemental, and empathetic health workers, social workers, and community workers with the support of family
- challenging taboos, myths, misperceptions, stereotypes, and discrimination on sexuality, culture, and traditional practices, as well as against certain groupings with positivity, facts, and openness
- informing adolescents of risky sexual behaviours, such as early sexual debut, intergenerational sex and multiple concurrent partners, often driven by patriarchal gender norms and poverty

#### PRIORITY GROUPS

- » adolescents and young people (10 to 24 years)
- » LGBTQI+ people
- » sex workers
- » people with disabilities
- » migrants
- » male partners of women

#### POLICY STATEMENT

The menopausal transition must be utilised as a window of opportunity to assess and manage specific SRHR and general health matters

#### 3.2 Ensure SRHR well-being of clients after child-bearing age, peri- and post-menopausal

*This section references the Primary Care 101: Symptom-based integrated approach to the adult in primary care<sup>59</sup>*

For clients older than 35 years:

- if younger than 50 years, continue contraception for 2 years after the last period
- take a medical history at every visit and perform general breast and gynaecological examinations at first visit and when due according to guidelines
- order special investigations, if indicated (for example, for bleeding between periods or after sex)
- initiate hormone replacement therapy (HRT) for proven indications, provided there are no contraindications, and individualise according to each client's needs
- inform clients of all risks and benefits regarding HRT [60]
- provide advice on lifestyle modifications such as cessation of smoking, adjustment of diet, maintenance of a healthy weight, adequate exercise, and stress control
- provide psychosocial support if necessary

## POLICY STATEMENT

Five interlinked peer-led service packages shall be implemented to serve the needs of LGBTQI+ groups in the areas of health, empowerment, psychosocial services, human rights, and strategic information as outlined in the National LGBTI HIV Plan.

### 3.3 LGBTQI+ people

Although there are many differences between the groups, and further variation within subgroups, LGBTQI+ persons share common challenges. Facilities should remove barriers to accessing SRHR services by:

- addressing negative staff attitudes
- sensitising staff on stereotypical assumptions about the needs of LGBTQI+ persons
- training staff on required knowledge and skills to provide quality SRHR care appropriate to the needs of respective groups
- providing psychosocial support for mental health problems, alcohol, and substance abuse

## POLICY STATEMENT

Six interlinked peer-led packages related to health, social, legal, human rights, social capital, and economic empowerment services addressing the needs of sex workers shall be implemented as outlined in The National Sex Worker HIV Plan.

### 3.4 Female sex workers

Female sex workers are particularly vulnerable to HIV and other STIs. They are exposed to many human rights violations that limit their access to good SRHR interventions.

Facilities should remove barriers to accessing SRHR services by:

- ensuring access and referral to support services for mental health problems, social grants, substance and alcohol use, and legal support
- providing support for sexual-, verbal-, and gender-based violence
- adapting facility opening hours and modes of delivery to suit sex workers
- sensitising staff to the needs of sex workers
- providing the comprehensive package of services described in South African National Sex Worker HIV Plan

## POLICY STATEMENT

People with disabilities will be afforded an opportunity to gain agency, choice, and control over their sexuality and relationships. Emphasis will be placed in reducing vulnerability to sexual and gender-based violence and HIV.

### 3.5 Persons with disabilities

People living with disabilities are an underserved population subjected to harmful stereotypes and myths. They have similar SRHR needs as able-bodied people. However, they are much more likely to be victims of physical and sexual abuse and rape, sometimes even at the hands of their caretakers. They are also more likely to be subjected to forced or coerced procedures, such as sterilisation, abortion, and contraception.<sup>61</sup>

Facilities should remove barriers to accessing SRHR services by<sup>62</sup> ensuring:

- access to information
  - » the availability of information in a range of formats, including sign language and braille
- physical access
  - » the distance between the facility and users' homes, transport, the structure of entrances/exits, passages, and structures within the facility buildings
- financial access
  - » the cost of the health service to an individual, including the hidden cost of transportation and loss of income when going to the health facility
- access to comprehensive SRHR care

- » all SRHR facilities must be accessible to people in wheelchairs
- access to restrooms while in health facilities
  - » a toilet with wheelchair access must be indicated by a pictogram in health facilities
- access to efficient service
  - » fast track people living with disabilities

## POLICY STATEMENT

Offer a basic package of SRHR care in emergency situations.

## POLICY STATEMENT

Build and enhance the capacities of health care providers to render culturally competent, gender-sensitive, age-responsive, and migrant-friendly reproductive health services.

### 3.6 Migrants and asylum seekers

SRHR needs are heightened for displaced people and refugees. All migrants and asylum seekers should receive SRHR services, with full respect for client rights.

- Provide information on contraceptive options, HIV and STI prevention, detection and treatment, abortion, emergency contraception, PMTCT, and antenatal and postnatal services in South Africa. Information is available in a range of languages, especially South African languages. Where necessary, a translator (trained for correct translation and in confidentiality) is engaged for non-English speakers. In the context of SRHR, translators should preferably be the same gender as the client.
- Provide specialist referral services where clinic staff do not have the required skills (for example, provide services for women who have a subdermal implant from their home country). Implement a referral system and training programme for staff.
- Provide all HIV services, including HTS, initiation onto ART, PMTCT, and PEP, where indicated. For some cross-border migrants, this may require the switching of ART regimens. In such cases, national ART guidelines should be followed. Pregnant women on PMTCT should be encouraged to delay moving away from the area until they complete PMTCT treatment to ensure continuity of care and in cases where there is no PMTCT programme where they plan to move. Thereafter, clear referral direction, documentation, and letters should be provided.
- Issue clients with 'health passports' that record information about all contraceptive methods being used, treatment, and testing. Encourage clients to keep these health passports with them, to make relevant notes, and memorise all contraceptive methods, medication, and doses in case they need to move to another location and/or lose their health passport (or other records). Encourage clients to come to the clinic before they relocate and provide sufficient treatment and a referral letter for their next health facility.
- Encourage informed decision-making and provide choice in contraception methods. Methods provided should take into account the client's risk, mobility, and fertility plans for the future.
- Some migrant groups are more vulnerable to violence, sexual assault, and exploitation. The provision of additional counselling may be necessary, given the trauma experienced by some migrants. Such trauma may relate to circumstances and experiences in their home country and during their journey to South Africa, as well as to particular vulnerabilities to which they may be exposed, such as rape, bribes, sexual exploitation and abuse. As with all clients, post-rape management should include PEP, STI management, and emergency contraception.

## POLICY STATEMENT

In implementing partner involvement, a client-centred approach must be adopted that does not limit engagement to legally defined groups such as husband and wife.

## POLICY STATEMENT

Individuals and couples should be empowered to decide freely and responsibly the number, spacing, and timing of children and be provided with the means to do so without coercion.

### 3.7 Promoting SRHR services to support male involvement

Men account for half of the reproductive-age population but are often reluctant to seek care at health facilities that cater primarily to pregnant clients and their infants, leaving them underserved and inhibiting them from playing a greater role in supporting sexual and reproductive health. Men play a key role in bringing about gender equality since, in most societies, men exercise greater power in nearly every sphere of life, ranging from personal decisions regarding the size of families to the policy and programme decisions taken at all levels of government. Yet, most awareness and implementation efforts related to SRHR and HIV prevention disregard the cultural and gender norms that may affect a client's decision-making regarding SRHR issues. Partners often lack information to support their spouses' SRHR decisions and the roles they might play in promoting overall family health. Increased knowledge will also increase partner access to and utilisation of HIV and other SRHR services. Male and male partner involvement provides an opportunity to offer SRHR services to men.

Facilities must promote partner and male involvement by:

- emphasising shared responsibility, gender equality, and active involvement in parenthood and sexual and reproductive behaviour in the delivery of SRHR services
- offering services that cater to the needs of men, ensuring that services are welcoming to all clientele, and that staff are competent to meet everyone's needs
- training competent male and priority population-friendly staff to make male clients more comfortable talking about sensitive subjects
- confronting gender inequality and violence in counselling sessions
- encouraging clients to bring their partners with them to the clinic for joint consultation and testing, to get a mutual commitment to both HIV, STI, and pregnancy prevention and management
- offering alternative HIV testing methods such as HIV self-screening, mobile clinics, workplace testing, and door-to-door testing, which have been shown to increase uptake of services and reduce stigma
- promoting the role of partners as supportive spouses and parents
- developing outreach strategies including community events to engage partners
- actively promoting SRHR services for male partners, which can include provision or referral for the following: condoms, male sterilisation, and counselling about other contraceptive methods; counselling and help for sexual problems; TB prevention and treatment; HIV counselling, prevention, testing and treatment; infertility counselling; screening for penile, testicular and prostate cancer; and VMMC
- using opportunities to appropriately integrate services, such as medical and traditional male circumcision and STI services to promote uptake of SRHR services

## OBJECTIVE 4:

### Strengthen the health system to deliver integrated SRHR services at the lowest feasible level in the health care system

This section should be read with the Ideal Clinic Manual<sup>63</sup>, the Integrated Clinical Services Management Manual<sup>64</sup>, and the Primary Healthcare Laboratory Handbook.<sup>65</sup>

The success of South Africa's health system will depend on a well-functioning primary health care system. Community-based services must be complemented by primary health care facilities that provide equitable access to South Africans, prioritising health services to those most in need. To achieve optimal primary healthcare delivery, the Ideal Clinic Programme provides a framework for implementation, which outlines systematic preparation of optimal conditions to provide quality, integrated services.

#### POLICY STATEMENT

Ensure all clients, including priority populations, receive integrated services tailored to their needs, and that all clients who need additional support are referred and receive follow up care.

#### POLICY STATEMENT

All facilities must adhere to Ideal Clinic standards to ensure all SRHR services are offered, effective referral networks and practices are in place, adequate transport between levels of care are available, and coordination between the units within hospitals and other larger referral facilities are functional.

#### 4.1 Provide quality SRHR services at primary health care level or the lowest level possible

##### 4.1.1 Integrated service delivery

##### 4.1.2 Deliver integrated services within the district health system

- provide SRH services at the appropriate level of care in accordance with the service delivery guidelines
- integrate SRH services with HIV services and other streams of primary care
- establish linkages to ensure complicated cases and emergencies can be accommodated within the district health system

##### 4.1.3 Provide integrated SRH services within a single facility

Integration within a facility requires that all units be well co-coordinated to ensure clients receive appropriate care:

- organise all planned streams of care efficiently
- use a functional patient appointment system
- ensure each client has only one file across their lifespan
- ensure that linkages between facilities provide all elements of the SRHR service package
- establish referral paths for services not available

#### POLICY STATEMENT

Every facility providing SRHR services should adhere to quality standards prescribed in the ideal clinic manual.

#### POLICY STATEMENT

Every effort shall be made to implement effective infection control systems throughout facilities.

## 4.1.4 Quality of care

Ensure quality of care in delivering SRHR services:

- regular clinical audits are conducted (see Clinical Audit Guidelines)
- respectful treatment by technically competent providers
- improved informed choice and empowered individuals and couples make choices in line with their SRHR needs
- clients are satisfied with SRHR services
- clients can complain about the services they receive, to have complaints investigated and receive a full response on investigations

### POLICY STATEMENT

The facility manager and/or person in charge of ordering drugs, supplies and other commodities must deal with the logistics of obtaining necessary equipment and supplies, and supervise its maintenance.

## 4.2 Ensure uninterrupted supply of SRH commodities and drugs in all facilities

Looking at the value chain for commodities, this objective would be fulfilled through a clear coordination framework between the suppliers, the regulatory pathways within the South African Health Products Regulatory Authority (SAHPRA), and the distribution systems to a facility, and eventually to a client level. Building upon existing systems such as the Centralised Chronic Medicines Dispensing and Distribution (CMMDD) program, commodities could equally be distributed through the same mechanism. The following activities need to be accelerated:

- build capacity of responsible health workers to ensure efficient forecasting and procurement of essential SRHR commodities
- develop and implement systems to ensure joint planning, procurement and supply chains for essential SRHR commodities
- develop an efficient procurement, distribution and supply chain management system to enable the consistent and regular provision of essential SRHR commodities
- prevent stock-outs and ensure that SRHR drugs and commodities are always in stock
- pre-pack chronic prescriptions and keep buffer stock of medicines and supplies to pre-empt stock-outs
- include surgical equipment in SRHR commodity supply chains to ensure that adequate equipment is available and that updated clinical techniques are used

“A well-functioning health system ensures equitable access to essential medical products, vaccines, and technologies of assured quality, safety, efficacy, and cost-effectiveness, and their scientifically sound and cost-effective use.”

*The International Covenant on Economic, Social and Cultural Rights: Cases ...By Ben Saul, David Kinley, Jaqueline Mowbray, OUP Oxford, 2014*

### POLICY STATEMENT

Staff must receive adequate training in SRHR service delivery and linked to refresher training, debriefing and continuing professional development.

## 4.3 Ensure healthcare providers have the skills and knowledge to deliver integrated SRHR services

Health workers benefit from continuing education and competency improvement, such as training and capacity building to ensure adequate knowledge, attitude, and skills to provide holistic, quality SRHR services.

The following must be offered according to the staff category's scope of practice, current skills, and the level of care permitted at their home facility:

“A well-performing health workforce is one which works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances, i.e. there are sufficient numbers and mix of staff, fairly distributed; they are competent, responsive and productive.”

*Book Alone: Caring for the Vulnerable, by Mary de Chesnay, Barbara Anderson Jones & Bartlett Publishers, 19 Jul 2011*

- develop a national core curriculum, in line with the SRHR Policy, to provide the basis for all institutions providing training, including universities, further education and training institutions, nursing colleges, provincial training units, non-governmental organisations, and other organisations that provide SRHR training, including a specific focus on training on CTOP care and values clarification
- update the curriculum every five years and include new research findings as addendums to the curriculum in between revisions
- develop a package of in-service and post-qualification/advanced training for the following categories of health professionals: doctors (including specialists with obstetrics/gynaecology training), medical officers, public health practitioners, midwives, nurses, and pharmacists
- strengthen collaboration and liaison with regional training centres
- develop an agreed package of in-service training for the following non-medical staff: social workers, health promoters, HIV support personnel (such as HTS counsellors, ART adherence counsellors), community health and outreach workers
- develop provider or supervisor job aids and distribute at all points of care to standardise policy implementation
- include a rights-based approach into curricula and training with an emphasis on improved access and integrated care

## POLICY STATEMENT

Facilities must record and report accurate client data in the national health information system. All client data are treated as confidential.

## POLICY STATEMENT

The SRHR Policy is underpinned by research evidence to guide best practices, policies, and the legal framework for improving SRHR outcomes for all.

### 4.4 Maximise the use of programmatic data and research to improve service provision and increase the impact

South Africa has a range of information, review, and monitoring systems in place, including routine public health monitoring and evaluation activities, a variety of robust surveillance activities, and rigorous epidemiologic, laboratory, and programmatic research. To improve the ability to fully leverage this capability for progress against targets, improve programmes over time, maximise efficiencies, and close research gaps, health facilities must optimise routinely collected data, monitor and evaluate the implementation and outcomes, and strengthen surveillance and outcomes.

“A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status.”

*The International Covenant on Economic, Social and Cultural Rights: Cases ..by Ben Saul, David Kinley, Jaqueline Mowbray OUP Oxford, 2014*

#### 4.4.1 Optimise routinely collected data to improve planning and management

Data collection needs to be accurate and centralised to guide decision-making:

- review indicators and reporting tools to ensure the correct aspects of implementation are measured
- disaggregate data collection by age, gender, and priority populations
- identify service access gaps and outcomes and report on these indicators
- revise, adapt, or develop tools and standard operating procedures for quality assurance in the provision of comprehensive integrated SRHR services
- revise or develop single or linked registers and tools for integrated SRHR services to facilitate recording, monitoring, and reporting of integration indicators
- clients can complain about the services they receive, to have complaints investigated and receive a full response on investigations

## 4.4.2 Monitor and evaluate the implementation and outcomes of the SRHR Policy

It is essential that multi-sectoral data are collected at all levels and across all stakeholders to reflect the progress of improving SRHR outcomes and service integration.

- develop an M&E framework to track progress against targets
- establish efficient mechanisms to collate, analyse, and use the routine data collected (through the DHIS) for responsive programming at the provincial, district, and sub-district level
- disseminate data to policy-makers and service providers

## 4.4.3 Strengthen surveillance and research activities for improved efficiency and impact

Research helps develop and eventually adopt new technologies and drugs, optimise the delivery of interventions and strategies, and answer key implementation questions not fully addressed through surveillance and surveys.

- include SRHR Policy indicators in routine surveys
- identify research questions aimed at improving SRHR outcomes
- integrate SRHR research questions into the national research agenda
- develop systems for the documentation and sharing of best practices on SRHR and HIV integration
- disseminate data to policy-makers and service providers

### POLICY STATEMENT

Facility managers must plan for comprehensive SRHR services, including effective systems for managing the flow of clients through a facility despite fluctuations in caseload to ensure information flows to the district levels for budgeting purposes.

## 4.5 Mobilise financial resources and maximise efficiencies to support implementation

The National Health Insurance will be one of the key levers to improve access to SRHR services without exposing clients to financial vulnerability. The implementation of the policy will further ensure a more effective and efficient use of resources that are already allocated to SRHR-related services. Additionally, the policy will serve as a platform for further resource mobilisation. To ensure adequate financing for the implementation of the SRHR Policy, all responsible implementers at all levels must:

- ensure buy-in from all stakeholders and departments to align existing for resources for integrated service delivery
- develop a resource mobilisation plan, including the reallocation of funds from vertical programmes
- review and revise budget line items, nationally and provincially, in-line with projected needs for both method procurement, training, and communication strategies
- develop costed implementation plans for integration in collaboration with other stakeholders, including civil society organisations, donors, and development partners
- align donor funding with the costed plans for the provision of integrated SRHR services

“A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them.”

*Comparative Health Systems, Johnson, Carleen Stoskopf, Leiyu Shi, Jones & Bartlett Learning, 02 Mar 2017*

### POLICY STATEMENT

Provide oversight, platforms for collaboration, and institutional coordination frameworks that ensure program delivery transparency and accountability.

## 4.6 Promote strong leadership and management to enforce and implement the SRHR Policy

### 4.6.1 National and provincial levels

At a national and provincial level, implementation of integrated services is supported by an enabling environment, which includes strong political support built on the principles of the National Development Plan. Leadership is needed to ensure scopes of practice are aligned with the goals of this policy, that the regulatory pathways that anchor successful programmes, such as SAHPRA, are efficient, and that effective tendering, procurement, and supply systems are established through strong leadership. Leadership is also necessary at various other levels.

“Leadership and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, the provision of appropriate regulations and incentives, attention to system-design, and accountability.”

*Book Alone: Caring for the Vulnerable*  
By Mary de Chesnay, Barbara Anderson  
Jones & Bartlett Publishers, 19 Jul 2011

## POLICY STATEMENT

Provide oversight, platforms for collaboration, and institutional coordination frameworks that ensure program delivery transparency and accountability.

### 4.6.2 Facility levels

Implementation of the SRHR policy requires leadership, management, and accountability at all facilities.<sup>66</sup> Facility managers must:

- monitor current caseload frequently and remain alert to developments that could affect waiting times
- ensure that clients who present for emergency procedures receive care or are quickly referred for services
- train staff members on clients' rights to access to SRHR, ensuring the availability of sufficient staff for rendering comprehensive SRHR services
- match the skills and capacity of the team to implement comprehensive and integrated SRHR and primary healthcare services
- create an enabling environment for staff to perform their work responsibilities
- ensure that staff have access to confidential counselling and debriefing, if needed
- implement the SRHR policy at the facility level in a way that meets the health needs of the community and specific populations served cooperate with schools and school health teams to assist with the removal of health-related barriers to learning
- maintain functional home- and community-based services in the facility, facilitating coordination at district and provincial levels

## OBJECTIVE 5:

### Promote multi-sectoral engagement and shared accountability for a sustainable and rights-based service delivery

The impact of the SRHR Policy will first and foremost be through improved coordination, synergy, and alignment with the programme of government, civil society, and development partners that already work in the area of SRHR. This includes both intragovernmental collaboration and shared accountability, as well as with other sectors such as the private sector and civil society.

#### POLICY STATEMENT

The SRHR Policy implementation framework depends on intergovernmental collaboration, multi-stakeholder engagement, and partnerships that include government, industry, and private sector.

#### 5.1 Strengthen stakeholder engagement and partnerships to enforce and implement the SRHR Policy

To increase access to SRHR services for all through channels other than public sector health facilities, it is necessary to form and strengthen partnerships with other government sectors, the private sector, development partners, non-governmental organisations, and communities. These partnerships may include, for example:

- non-clinic-based delivery systems, such as social marketing and community-based programmes
- community health workers
- school-based clinics
- workplace-based clinics
- public-private partnerships, especially within the context of NHI

#### 5.2 Improve collaboration and cooperation between government, civil society, development partners, and the private sector

- collaborate with the DBE for the provision of SRHR services in schools and the provision of comprehensive sexuality education
- collaborate with the South African Social Security Agency (SASSA) and Department of Housing to align policy implementation
- collaborate with the Department of Justice and police service; for example, Thuthuzela centres became one-stop-shops for survivors of violence seeking legal and medical attention
- put in place systems to ensure the availability of information and commodities in other government departments; for example, condoms and IEC materials
- in collaboration with other stakeholders, develop innovative specific interventions to address economic-related structural factors among priority groups that hinder access to SRHR
- develop strategies to ensure the involvement of adolescents and youth in the design, implementation, monitoring, and evaluation of interventions
- develop strategies that support SRHR programmes in national youth movements and government departments and units
- develop strategies and interventions for the integration of SRHR and other communicable and non-communicable diseases
- establish and strengthen multi-sectoral coordination mechanisms, such as SRH social pacts and structures at all levels, ensuring clear terms of reference
- establish, strengthen, and coordinate effective and seamless referral systems between government facilities and non-governmental organisations
- engage the private sector in hybrid service delivery models; for example, private general practitioners, clinics, retail, and courier pharmacies
- engage civil society groups and others committed to advancing SRHR to hold governments accountable to their commitments to improve health and to uphold human rights
- develop strategies, including supportive supervision and mentorship, for health workers and other service providers, to ensure quality assurance in the provision of integrated services

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It is our sincere hope that this document would advance the sexual and reproductive health and rights of all citizens, thereby improving health and well-being, and an essential ingredient of a thriving economy.

# REFERENCES

- 1 World Health Organization. Sexual and reproductive health: Defining sexual health. Available from: [https://www.who.int/reproductivehealth/topics/sexual\\_health/sh\\_definitions/en/](https://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/).
- 2 World Health Organization. Defining Sexual Health: Report of a technical consultation on sexual health 28-31 January 2002, Geneva. 2006; Available from: [http://www.who.int/reproductivehealth/publications/sexual\\_health/defining\\_sexual\\_health.pdf?ua=1](http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf?ua=1).
- 3 UNAIDS. Sexual and reproductive health and rights of people most affected by HIV: The right to development [Internet]. 2016; Available from: [http://www.unaids.org/sites/default/files/media\\_asset/20160607\\_UNAIDS\\_PCB38\\_16-4\\_PCBNGO\\_Report\\_EN.pdf](http://www.unaids.org/sites/default/files/media_asset/20160607_UNAIDS_PCB38_16-4_PCBNGO_Report_EN.pdf).
- 4 World Health Organization. Developing sexual health programmes. A framework for action. 2010; Available from: [http://apps.who.int/iris/bitstream/10665/70501/1/WHO\\_RHR\\_HRP\\_10.22\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/70501/1/WHO_RHR_HRP_10.22_eng.pdf).
- 5 World Health Organization. The WHO Health Systems Framework. Available from: [http://www.wpro.who.int/health\\_services/health\\_systems\\_framework/en/](http://www.wpro.who.int/health_services/health_systems_framework/en/).
- 6 Cooper, D., Harries, J., Moodley, J., Constant, D., Hodes, R., Mathews, C., et al., Coming of age? Women's sexual and reproductive health after twenty-one years of democracy in South Africa. *Reprod Health Matters*, 2016. 24(48): p. 79-89.
- 7 The South African National Aids Council (SANAC), National Strategic Plan on HIV, STIs and TB 2017-2022. 2017: Pretoria.
- 8 Michalow, J., Chola, L., Mcgee, S., Tugendhaft, A., Pattinson, R., Kerber, K., et al., Triple return on investment: the cost and impact of 13 interventions that could prevent stillbirths and save the lives of mothers and babies in South Africa. *BMC pregnancy and childbirth*, 2015. 15: p. 39-39.
- 9 Government of South Africa, Adolescent and Youth Health Policy, Department of Health, Editor. 2017.
- 10 The South African National Aids Council (SANAC), South African National Sex Worker HIV plan, 2016 – 2019. 2016: Pretoria.
- 11 The South African National Aids Council (SANAC), The South African National LGBTI HIV Plan, 2017-2022. 2017: Pretoria.
- 12 National Department of Health, S.S.A., South African Medical Research Council, and ICF, South Africa Demographic and Health Survey 2016: key indicators. 2017, NDoH, Stats SA, SAMRC and ICF Pretoria, South Africa and Rockville, Maryland.
- 13 National Department of Health, Sexual and reproductive health and rights: Literature review and situation analysis undertaken to inform: Sexual and reproductive health: Fulfilling our Commitments. 2011, Soul City: Pretoria.
- 14 STATSSA, Recorded Live Births, 2017. 2017.
- 15 Government of South Africa, National Policy on HIV, STI, TB, Department of Basic Education, Editor. 2017.

- 16 Saving mothers 2014-2016: seventh triennial report on confidential enquiries into maternal deaths in South Africa: Executive summary. Pretoria: National Department of Health, 2018.
- 17 Recorded live births. 2016; Available from: <http://www.statssa.gov.za/publications/P0305/P03052016.pdf>.
- 18 Joint United Nations Programme on HIV/AIDS , 90-90-90: an ambitious treatment target to help end the AIDS epidemic. October 2014. 2018.
- 19 Sherman, G., Doherty, T., and Barron, P., Eliminating mother-to-child transmission of HIV in South Africa, 2002–2016: progress, challenges and the Last Mile Plan. *South African Heal. Rev.*, 2017: p. 137–46.
- 20 Government of South Africa, Policy Framework and Strategy for Ward Based Primary Healthcare Outreach Teams. 2017, National Department of Health: Pretoria.
- 21 Government of South Africa, National Consolidated Guidelines for the Prevention of Mother-To-Child Transmission of HIV (PMTCT) and the Management of HIV in Children, Adolescents and Adults. 2015, National Department of Health: Pretoria.
- 22 Massyn, N., Padarath, A., and Peer, N., District health barometer 2016/17. 2017: Health Systems Trust.
- 23 Government of South Africa, National HIV Testing Services: Policy, Department of Health, Editor. 2016.
- 24 Vawda, Y. and Gray, A., South African Health Review 2018. 2018, Health Systems Trust.
- 25 Lince-Deroche, N., Harries, J., Constant, D., Morroni, C., Pleaner, M., Fetters, T., et al., Doing more for less: identifying opportunities to expand public sector access to safe abortion in South Africa through budget impact analysis. *Contraception*, 2018. 97(2): p. 167-176.
- 26 Hodes, R., The culture of illegal abortion in South Africa. *Journal of Southern African Studies*, 2016. 42(1): p. 79-93.
- 27 United Nations Population Information Network, Report of the ICPD (94/10/18). 1994: Cairo.
- 28 United Nations Children’s Fund, Beijing Declaration and Platform for Action. Fourth World Conf. Women. 1995: Beijing.
- 29 United Nations. Sustainable Development Goals (SDGs). Available from: <https://www.un.org/sustainabledevelopment/sustainable-development-goals/>.
- 30 Gutmacher–Lancet Commission on Sexual and Reproductive Health and Rights 2018; Available from: <https://www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights>.
- 31 Study, T.I.H.C., The major genetic determinants of HIV-1 control affect HLA class I peptide presentation. *Science (New York, NY)*, 2010. 330(6010): p. 1551.
- 32 Galati, A.J., Onward to 2030: Sexual and Reproductive Health and Rights in the Context of the Sustainable Development Goals, in *Gutmacher Policy Rev.* 2015. p. 77-84.
- 33 World Health Organization, Clinical practice handbook for safe abortion. 2014, WHO: Geneva.

- 34** World Health Organization Department of Reproductive Health and Research (Who/Rhr) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (Ccp) Knowledge for Health Project, Family Planning: A Global Handbook for Providers (2018 update). 2018: Baltimore and Geneva: CCP and WHO.
- 35** World Health Organization, Selected practice recommendations for contraceptive use - 3rd edition. 2016, WHO: Geneva.
- 36** World Health Organization, Global health sector strategy on sexually transmitted infections: Towards ending STIs, 2016-2021. 2016, WHO: Geneva.
- 37** The Lancet., FP2020: accelerating progress in access to family planning. The lancet., 2016. 388(10057): p. 2210-.
- 38** Southern African Development Community (SADC), Minimum Standards for the Integration of HIV and Sexual & Reproductive Health in the SADC Region. 2015.
- 39** Southern African Development Community (SADC), Protocol on Health. 1998.
- 40** Southern African Development Community (SADC), Sexual and Reproductive Health Strategy for the SADC Region 2006-2015. 2008.
- 41** Government of South Africa, Department of Health Strategic Plan 2014/15–2018/19. 2014, National Department of Health: Pretoria.
- 42** Government of South Africa, South Africa's National Strategic Plan on HIV, TB and STIs 2017-2022, Department of Health, Editor. 2017.
- 43** National Department of Health, Sexual and Reproductive Health and Rights: Fulfilling our Commitments, 2011-2021 and Beyond. 2011: Pretoria.
- 44** National Department of Health. NHI White Paper. 2017; Available from: <http://www.health.gov.za/index.php/nhi-documents?download=2257:white-paper-nhi-2017>.
- 45** National Department of Health, National Adolescent Sexual and Reproductive Health and Rights Framework Strategy (ASRH&R), 2014-2019 2015: Pretoria.
- 46** Government of South Africa, National Strategic Plan for HIV, STIs, and TB 2017-2022, National Department of Health, Editor. 2017.
- 47** Government of South Africa, DBE Draft National Policy on the Prevention and Management of Learner Pregnancy in Schools. 2018, Department of Basic Education, : Pretoria.
- 48** Government of South Africa, Breast Cancer Prevention and Control Policy. 2017, National Department of Health: Pretoria.
- 49** Government of South Africa, Cervical Cancer Prevention and Control Policy. 2017, National Department of Health: Pretoria.
- 50** Government of South Africa, Health Sector HIV Prevention Strategy. 2016, National Department of Health: Pretoria.
- 51** The Parliament of South Africa, Choice on Termination of Pregnancy Amendment Act, 2004, A.N.o. 1996, Editor. 1996, Government of South Africa: Pretoria.

- 52** Department of Social Development, Fifteen year progress review of the implementation of the Population Policy for South Africa (1998) and the ICPD programme of action (1994). 2015: Pretoria.
- 53** European Society of Human Reproduction and Embryology, Routine psychosocial care in infertility and medically assisted reproduction – A guide for fertility staff. 2015, ESHRE.
- 54** Livshits, A., Machtinger, R., David, L.B., Spira, M., Moshe-Zahav, A., and Seidman, D.S., Ibuprofen and paracetamol for pain relief during medical abortion: a double-blind randomized controlled study. *Fertil Steril*, 2009. 91(5): p. 1877-80.
- 55** Kapp, N., Pain management in abortion care. FIAPAC, 2014.
- 56** Fiala, C. and Arthur, J.H., There is no defence for 'Conscientious objection' in reproductive health care. *Eur J Obstet Gynecol Reprod Biol*, 2017. 216: p. 254-258.
- 57** Department of Justice and Constitutional Development, Constitution of the Republic of South Africa. 1996.
- 58** World Health Organization, Comprehensive Cervical Cancer Control. 2014: Geneva.
- 59** National Department of Health, Primary Care 101: Symptom-based integrated approach to the adult in primary care. 2014: Pretoria.
- 60** Guidozi, F., Alperstein, A., Bagratee, J.S., Dalmeyer, P., Davey, V., De Villiers, T.J., et al., South African Menopause Society revised consensus position statement on menopausal hormone therapy, 2014. *SAMJ: South African Medical Journal*, 2014. 104: p. 537-543.
- 61** Women Enabled International, Submission to OHCHR Report on Mental Health and Human Rights. 2016: Washington DC.
- 62** Schneider, M., Couper, J., and Swartz, L., Assessment of accessibility of health facilities to persons with disabilities Report submitted to Directorate: Chronic Diseases, Disabilities and Geriatrics. 2010: Cape Town. p. 1-63.
- 63** National Department of Health, Ideal Clinic Manual v18. 2018: Pretoria.
- 64** National Department of Health, Integrated Clinical Services Management Manual 2018: Pretoria.
- 65** National Department of Health, Primary Healthcare Laboratory Handbook. 2017: Pretoria.
- 66** National Department of Health, Human Resources for Health, South Africa: HRH Strategy for the Health Sector: 2012/13 – 2016/17. 2011: Pretoria.

