SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS:

REVIEWING THE EVIDENCE

Literature review and situation analysis undertaken to inform:
Sexual and Reproductive Health: Fulfilling our Commitments

July 2011
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<td>Acquired Immune Deficiency Syndrome</td>
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<td>AIS</td>
<td>Androgen Insensitivity Syndrome</td>
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<td>A-Plan</td>
<td>Accelerated Plan</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>ASRH</td>
<td>Adolescent Sexual and Reproductive Health</td>
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<tr>
<td>BCS</td>
<td>Balanced Counselling Strategy Plus Toolkit</td>
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<td>CACK</td>
<td>Carcinoma of the Cervix</td>
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<td>CBO</td>
<td>Community-based Organisation</td>
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<td>CBVCT</td>
<td>Community-based Voluntary Counselling and Testing</td>
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<td>C&amp;T</td>
<td>Counselling and Testing</td>
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<td>CCC</td>
<td>Comprehensive Care Centres</td>
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<td>CHAMP</td>
<td>Collaborative HIV Prevention and Adolescent Mental Health Programme</td>
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<td>ChildPIP</td>
<td>Child Healthcare Problem Identification Programme</td>
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<td>CHW</td>
<td>Community Health Worker</td>
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<td>CM</td>
<td>Community Mobilization</td>
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<td>CTOP</td>
<td>Choice on Termination of Pregnancy Act 1996</td>
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<td>DHIS</td>
<td>District Health Information System</td>
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<td>DHS</td>
<td>District Health System</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>EPI</td>
<td>Expanded Programme on Immunisations</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>FtM</td>
<td>Female to Male</td>
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<td>GBV</td>
<td>Gender-based Violence</td>
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<td>GHI</td>
<td>Global Health Initiative</td>
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<td>HAART</td>
<td>Highly Active Antiretroviral Treatment</td>
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<td>HCT</td>
<td>HIV Counselling and Testing</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HPV</td>
<td>Human Papilloma Virus</td>
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<td>HSV-2</td>
<td>Herpes Simplex Virus 2</td>
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<td>HWFC</td>
<td>Health Workers for Change</td>
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<tr>
<td>ICPD</td>
<td>International Conference on Population Development</td>
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<td>ICW</td>
<td>International Community of Women Living with HIV/AIDS</td>
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<td>IEC</td>
<td>Information, Education, and Communication</td>
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<td>IMAGE</td>
<td>Intervention with Microfinance for AIDS and Gender Equity</td>
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<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
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<td>IPC</td>
<td>Interpersonal Communications</td>
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<td>IPV</td>
<td>Intimate Partner Violence</td>
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<td>ISOFI</td>
<td>Inner Spaces Outer Faces Initiative</td>
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<td>IUD</td>
<td>Intrauterine Device</td>
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<td>LGA</td>
<td>Local Government Authorities</td>
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<td>LR</td>
<td>Lifetime Risk</td>
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<td>MARP</td>
<td>Most-at-Risk Population</td>
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<td>MCWHS</td>
<td>Mother, Child, and Women's Health</td>
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<td>MKV</td>
<td>MEMA Kwa Viljana (Good Things for Young People)</td>
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<td>MfT</td>
<td>Male to Female</td>
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<td>MVA</td>
<td>Manual Vacuum Aspiration</td>
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<td>NAFCI</td>
<td>National Adolescent-friendly Clinic Initiatives</td>
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<td>NDOH</td>
<td>National Department of Health</td>
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<td>NGOs</td>
<td>Nongovernmental Organisations</td>
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<td>NIMART</td>
<td>Nurse Initiated and Managed ART</td>
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<td>NSP</td>
<td>National Strategic Plan</td>
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<td>NYRBS</td>
<td>National Youth Risk Behaviour Survey</td>
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<td>M2M</td>
<td>Mothers2Mothers</td>
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<td>MACH</td>
<td>Mpumalanga Maternal and Child Health Integration</td>
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<td>MAP</td>
<td>Men as Partners</td>
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<td>MC</td>
<td>Male Circumcision</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MCWH</td>
<td>Maternal, Child, and Women's Health</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MOU</td>
<td>Midwifery Obstetric Unit</td>
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<td>MSCL</td>
<td>Marie Stopes Clinic Society</td>
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<td>MSM</td>
<td>Men who have Sex with Men</td>
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<tr>
<td>MTCT</td>
<td>Mother-to-Child Transmission; Maternal-to-Child-Transmission</td>
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<tr>
<td>MfF</td>
<td>Male to Female</td>
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<tr>
<td>MVA</td>
<td>Manual Vacuum Aspiration</td>
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<td>OI</td>
<td>Opportunistic Infections</td>
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<td>OVC</td>
<td>Orphaned and Vulnerable Children</td>
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<td>PCR</td>
<td>Polymerase Chain Reaction</td>
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<tr>
<td>PEP</td>
<td>Post-exposure Prophylaxis</td>
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<td>PEMFRA</td>
<td>President’s Emergency Plan on AIDS Relief</td>
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<td>PHC</td>
<td>Primary Healthcare</td>
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<td>PLWHA</td>
<td>People Living with HIV</td>
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<td>PMHP</td>
<td>Perinatal Mental Health Project</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission of HIV</td>
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<td>PSA</td>
<td>Prostate-specific Antigen</td>
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<td>PTSD</td>
<td>Post-traumatic Stress Disorder</td>
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<td>PTSS</td>
<td>Post-test Support Services</td>
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<td>RHRU</td>
<td>Reproductive Health and HIV Research Unit</td>
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<td>RHS</td>
<td>Reproductive Health Services</td>
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<td>RRA</td>
<td>Reproductive Rights Alliance</td>
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<tr>
<td>RTI</td>
<td>Reproductive Tract Infection</td>
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<td>SAFOD</td>
<td>South African Federation of the Disabled</td>
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<tr>
<td>SAG</td>
<td>South African Government</td>
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<tr>
<td>SALIN</td>
<td>Strategic Alliances with International NGOs</td>
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<td>SAPS</td>
<td>South African Police Service</td>
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<tr>
<td>SASL</td>
<td>South African Sign Language</td>
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<tr>
<td>SETA</td>
<td>Sector Education and Training Authority</td>
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<td>SEF</td>
<td>Small Enterprise Foundation</td>
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<td>SFL</td>
<td>Sisters for Life</td>
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<td>SGBV</td>
<td>Sexual and Gender-based Violence</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>SRHR</td>
<td>Sexual and Reproductive Health and Rights</td>
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<td>STG</td>
<td>Standard Treatment Guidelines</td>
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<td>STIs</td>
<td>Sexually Transmitted Infections</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>TOP</td>
<td>Termination of Pregnancy</td>
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<td>USMR</td>
<td>Under Five Mortality Rate</td>
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<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNCRPD</td>
<td>UN Convention on the Rights of Persons with Disabilities</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<td>URC</td>
<td>University Research Co.</td>
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<tr>
<td>VAW</td>
<td>Violence Against Women</td>
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<td>VC</td>
<td>Values Clarification</td>
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<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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A note on language:

We have used the concept of ‘fertility management’ to capture three different components of care – contraception, abortion, and infertility – all of which are pertinent to people’s efforts to make decisions about if, when, and how many children they would like to have.

While we would prefer to use the term “contraception” to describe methods used to avoid pregnancy, historically the word “family planning” has been used to name such services. As a result, we use these terms interchangeably.

National law uses the term ‘termination of pregnancy’ for what is commonly known as abortion. Both terms are used in this document.

We have used the term ‘miscarriage’ to refer to spontaneous abortion, and ‘termination of pregnancy’ to refer to a planned abortion.
HIV, sexual and gender-based violence, and unwanted pregnancy together undermine the health and well-being of large numbers of our population, with young people, and particularly young women—the future generation—being most vulnerable. Sexual relationships and sexual decisionmaking, are at the source of all three challenges. The Department of Health (DOH) can play a key role in supporting individuals and couples in maximising their health and their contribution to society through the information and services it provides in health facilities and, in collaboration with partners, in communities. High rates of HIV transmission, sexual and gender-based violence, and unwanted pregnancy challenge society to start talking about sexual and reproductive decisionmaking, promoting sexual relationships that are mutually respectful, free of coercion, discrimination and violence, where people can enjoy their sexuality safely, and ensuring that every child is a wanted child. To do this requires a public conversation about sexual development, sexual relationships, and sexual decisionmaking—all things that our society finds hard to discuss. Yet discuss them we must, in health facilities, in communities, and in public spaces if we are to lower the rates of HIV transmission, teenage pregnancy, sexual and gender-based violence, and indeed, maternal mortality. Unless there is a fundamental change in the way in which the health sector functions and how it addresses sexual and reproductive health and rights (SRHR), South Africa will not achieve its commitments to the Millennium Development Goals (MDGs) as laid out in the presidential priorities: increasing life expectancy at birth, increasing the contraceptive prevalence rate, reducing maternal and child mortality, combating HIV and TB, and strengthening health system effectiveness.

To reaffirm and clarify its commitment to promoting sexual and reproductive rights as the basis for reducing rates of HIV, teenage pregnancy, sexual and gender-based violence, and maternal mortality, among other things, DOH has produced a strategic framework: Sexual and Reproductive Health and Rights: Fulfilling our Commitments (2011), a framework that integrates South Africa’s policies and strategies for achieving sexual and reproductive health and rights.

This review was undertaken to provide insights to the team involved in the development of Sexual and Reproductive Health and Rights: Fulfilling our Commitments. It is being published to share the evidence base and information for use in the field.

It was necessary to review the literature and interview key informants at provincial and district levels to identify the following:

- To what extent current laws, policies, and guidelines are being implemented;
- What factors are facilitating or undermining implementation of existing SRHR laws, policies, and guidelines in diverse settings, in particular what challenges may be specific to sexual and reproductive health and rights rather than general challenges facing the health system;
- Whether there are any gaps or limitations in existing SRHR laws, policies, and guidelines; and
- Whether provision of an integrated policy framework would help foster clarity for health system managers and health providers.
In addition to supporting the development of *Sexual and Reproductive Health and Rights: Fulfilling our Commitments*, the findings of this review resulted in the identification of a range of gaps in policy, strategies, and guidelines which the Department of Health is addressing during the process initiating the Reengineering Primary Health Care Approach in 2011. The review also identifies gaps in both pre- and in-service training curricula and knowledge needed to inform community, educational, and health initiatives. It is hoped that these will serve to alert training institutions and researchers to the work that needs to be done to support South Africa’s efforts towards achieving the sexual and reproductive health and rights of our population.
CHAPTER 1: INTRODUCTION

Sexual and reproductive health and rights (SRHR) are manifest in the extent to which people feel comfortable about their sexuality and gender identity and are able to make decisions about their sexual and reproductive lives, including if, when, and how to engage in sexual relationships and if, when, and how to have children in a social, cultural, and interpersonal context free of coercion, discrimination, and violence. The personal, social, cultural, economic, and health service factors that influence sexual behaviours result in wanted and unwanted pregnancies; protection from or lack of protection from sexually transmitted infections (STIs), including HIV; and both safe and satisfying sexual relationships, as well as abusive sexual relationships, including intimate partner violence. It is impossible to separate out the diverse dimensions of sexual and reproductive health and rights because the trajectories of different dimensions interact—cervical cancer with HIV; maternal health and child survival; and gender-based violence with HIV, miscarriage, termination of pregnancy, and maternal morbidity and mortality. Health education and healthcare responses that address only single dimensions of sexual and reproductive health thus miss opportunities for addressing people’s needs and experiences holistically and may be rendered ineffective. For this reason, this review gives substantial attention to experiences of integrated responses in prevention, treatment, and care.

Chapter 1 outlines the methodology and background of this review. It defines the concept of sexual and reproductive health and rights and outlines how these are framed in international treaties, which South Africa is obliged to implement, and in South Africa’s own constitutional commitments. It also outlines barriers to achieving sexual and reproductive health and rights.

Chapter 2 gives an overview of the South African health system as a basis for understanding the delivery of sexual and reproductive health and rights. It considers the current efforts to provide integrated services and outlines key issues regarding healthcare provider training in relation to sexual and reproductive health and rights.

Chapter 3 describes the essential package of sexual and reproductive health and rights services, dividing it up into the components that comprise it, and that currently are presented in separate laws, policies, strategies and guidelines. In relation to each component, by way of context, the review briefly considers the current sexual and reproductive health status of South Africans, then presents existing South African laws, policies or guidelines, and finally briefly reviews the status of public health services or public outreach programmes. The focus of the literature search was on best practices in policy and services, and these are incorporated in relation to each component. The information is elaborated through conversations with key informants.

Chapter 4 describes current sexual and reproductive cultures. It identifies the ways in which stigma and discrimination in public and community life and health services undermine the sexual and reproductive health and rights of diverse populations. It then identifies effective approaches to changing these stigmatising cultures, both in health services and in society generally, again, where possible, identifying lessons to learn from effective interventions.

Chapter 5 concludes the review by drawing out key themes and challenges that emerged from the literature review and interviews with key informants.
Methodology

The review brings together the findings of a policy and literature review and interviews with key informants in four provinces, including health managers at provincial, district, and clinic levels; researchers; and nongovernmental organisations (NGOs) organising healthcare providers, providing services, or undertaking advocacy.

Literature review

Information searches were conducted using electronic databases, searching the websites of relevant South African and international organisations, and networking with service provision, policy, and research groups; donors; and United Nations agencies to identify grey literature or material due to be published. Electronic database searches included MEDLINE, PUBMED, GOOGLE, and SCIUCS. Search criteria included peer-reviewed journal articles published between 2000 and 2011 (while recognising that a few interventions tested prior to 2000 may still remain pertinent). World Health Organisation, UNFPA, and UNICEF strategies, resolutions, standard-setting guidelines, and recommendations also were reviewed. Emphasis was placed on local (South Africa), regional (Southern Africa), and international literature, policies, and frameworks and programme implementation at the hospital, clinic, and community levels.

The primary questions the literature review sought to answer were the following:

- Are there any gaps in existing South African national laws, policies, strategies, and guidelines that pertain to aspects of sexual and reproductive health and rights, and what would need to be done to fill them?
- How can synergy between laws, policies, and guidelines be created in implementation?
- Are there lessons or best practice models on how to improve services or community/public outreach to shift sexual and reproductive cultures and behaviours that could serve as guidance to strengthen implementation of existing laws, policies, and guidelines?

Key informant interviews

Key informant interviews were conducted to draw lessons from good practices and approaches identified as most effective by provincial, district, and clinic managers, while also identifying current barriers to providing high-quality services. The interviews followed the requirements of the Human Research Ethics Committee of the University of the Witwatersrand.

The key informants were identified from four provinces: Gauteng, Mpumalanga, KwaZulu-Natal, and the Western Cape. In each province, a district that seemed to be doing well was identified using 2008 Barometer health service indicators. Two rural and two urban sites were identified. The rural sites were Ehlanzeni district in Mpumalanga and Umkhanyakude district in KwaZulu-Natal, and the urban sites were City of Cape Town in Western Cape and City of Johannesburg in Gauteng. Since provincial and local authorities are responsible for the management of their own primary health facilities, it was important to ensure that the situation analysis included key informants from both the provincial and local authorities’ structures.
Three different data collection tools were designed to facilitate conversations with provincial managers from the Mother, Child and Women directorates, district managers, and managers of health facilities. Ultimately, two provincial managers and eight district/subdistrict managers were consulted and seven healthcare facilities were visited. Detailed notes were taken during the conversations and site visits. Some key informants gave permission to use a voice recorder. Thirteen conversations were voice recorded and later transcribed for analysis. Analysis was performed by identifying the four themes of organisational issues, policy gaps, delivery of sexual and reproductive health and rights services, and challenges and recommendations.

In addition, we had informal conversations with four experts, purposefully selected because they are supporting service delivery in the identified districts, researchers and activists working in the health system, research institutions and nongovernmental organisations with expertise on the various components of sexual and reproductive rights, health and health services and the diverse populations requiring sexual and reproductive healthcare. A first draft of the review was sent out to approximately 400 individuals, who responded with additional published and grey literature, as well as commentary from their experiences in service provision and community engagement. In this way, they, too, became key informants and are referenced in the text as ‘researcher,’ ‘service provider,’ or ‘nongovernmental organisation activist.’

One of the methodological challenges in conducting this review was the paucity of information. Many issues were raised repeatedly by diverse informants but could not be assessed against existing literature because of the lack of research, an issue addressed in the concluding chapter.

**Definitions and Scope**

The 1994 International Conference on Population and Development (ICPD) in Cairo was responsible for expanding the understanding of reproductive health from family planning and maternal health to include the right to sexual and reproductive health, including the human rights associated with sexuality and reproduction such as rights to information, education, dignity, and respect for bodily integrity. Since then, more knowledge has been generated, particularly regarding sexuality and gender identity, which has required an extension of the definitions and scope of the concepts. The following internationally recognised definitions shape the approach in this document:

**Sexuality**

Sexuality is a central aspect of being human and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships. Although sexuality can include all of these dimensions, not all are always experienced or expressed. Sexuality is affected by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious, and spiritual factors.
Sexual rights
Sexual rights embrace human rights already recognised in national laws, international human rights documents, and other consensus statements. They include the right of all individuals, free of coercion, discrimination and violence, to

- The highest attainable standard of sexual health, including access to sexual and reproductive healthcare services;
- Seek, receive, and impart information related to sexuality;
- Sexuality education;
- Respect for bodily integrity;
- Choose their partner;
- Decide whether or not to be sexually active;
- Consensual sexual relations;
- Consensual marriage;
- Decide whether or not, and when, to have children; and
- Pursue a satisfying, safe, and pleasurable sexual life.

The responsible exercise of human rights requires that all individuals respect the rights of others (World Association for Sexual Health, no date).

Sexual health
Sexual health is a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health needs a positive and respectful approach to sexuality and sexual relationships, and the possibility of having pleasurable and safe sexual experiences that are free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all individuals must be respected, protected, and satisfied (WHO 2010, pp. 4).

Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of reproductive and sexual health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion, and violence as expressed in human rights documents (United Nations, 1994, para 7.3).

Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, as well as to safe termination of pregnancy, and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (United Nations, 1994, para 7.2; Department of Health Choice on Termination of Pregnancy Act 92, 1996).
Sex and gender

The word “sex” refers to the biological and physiological characteristics that define people. While society tends to believe that people are either “men” or “women,” science shows that these characteristics, in fact, form a continuum. Biologically, there are people who are born with characteristics (chromosomal, gonadal, or genital) that do not conform to the expected patterns of ‘male’ or ‘female,’ often described as ‘intersex’ people. The causes of intersex conditions are diverse, including genetic and hormonal influences during foetal development, many of which are discovered shortly after birth or during childhood. Intersex people can suffer severe stigmatisation because of cultural assumptions that people should be either “male” or “female.” They also may need specialist medical interventions to protect their health and well-being.

The word “gender” is used to describe the roles, behaviours, activities, and attributes that a particular society considers appropriate for men and women.

Culturally, there is fluidity in gender identities and expression within and across cultures. This is evident in the existence of indigenous terms for a wide and diverse range of sex/gender categories in many cultures. Despite the social assumption that all people’s gender matches their biological sex, this is not the case: some people’s experience of their gender (“gender identity”) and behaviour (“gender expression”) does not correspond with the gendered social and cultural norms associated with their biological sex. Hence, someone with the biological characteristics of a woman may appear more like a man or may, in fact, live life as a man. The word “transgender” is used to describe people whose gender characteristics do not match their biological sex. The lack of social recognition of this reality can lead to stigmatisation and lack of access to appropriate health services for transgender people.

While many people have sexual relationships with people of the opposite gender, some also have sexual relationships with people of the same gender. A person’s sexual orientation is defined by the gender to which the person is sexually attracted, which may be to one or both genders.

The World Health Organisation has identified five core aspects of sexual and reproductive health: improving antenatal, perinatal, postpartum, and newborn care; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating sexually transmitted infections, including HIV, reproductive tract infections, cervical cancer, and other gynaecological morbidities; and promoting sexual health. They note that “because of the close links between the different aspects of reproductive and sexual health, interventions in one area are likely to have a positive impact on the others” (WHO, 2004, p. 21).

This review builds upon these concepts to organise the assessment in relation to the following areas, all of which include prevention, diagnosis, counselling, treatment, and care services.
Table 1. Components of sexual and reproductive health and rights services

<table>
<thead>
<tr>
<th>Component</th>
<th>Summary of all services</th>
</tr>
</thead>
</table>
| Sexuality: desire, pleasure, and function | ● Provide age-appropriate sexual health information, education, and counselling for safe and satisfying sexuality, including coverage of sexual development, sexual function and pleasure, mutually respectful sexual and reproductive decisionmaking, and all dimensions of the essential sexual and reproductive health and rights package  
● Provide community education on cultural values that foster sexual and reproductive health and rights and positive health-seeking behaviours, and support these values |
| Sexual and gender-based violence | ● Prevent and manage sexual and gender-based violence  
● Promote cultural values that decrease the incidence of sexual and gender-based violence |
| Fertility | ● Provide comprehensive contraception services  
● Provide safe termination of pregnancy  
● Address infertility |
| Maternal, perinatal, and newborn health | ● Provide antenatal care  
● Prevent mother-to-child transmission of HIV  
● Provide safe delivery care  
● Provide postpartum care  
● Provide postnatal care |
| Sexually transmitted infections, including HIV and AIDS | ● Prevent and manage sexually transmitted infections  
● Initiate HIV counselling and testing (HCT)  
● Manage HIV and AIDS  
● Initiate antiretroviral treatment (ART)  
● Follow up with clients on antiretroviral treatment  
● Provide adherence and self-management support |
| Cancers of the reproductive system | ● Prevent and manage cervical cancer  
● Prevent and manage breast cancer  
● Prevent and manage male reproductive tract cancers |
| Additional SRHR issues | ● Determined on an as-needed basis at specialist or sub-specialist services |

Most of these services are contained implicitly in the National Package of Essential Health Care Interventions for South Africa (not yet published), although they are not always described or organised using the terms listed above. The review did not examine services available in the private sector.

Legal Framework

International commitments

A human rights approach to sexuality and reproduction also is reflected in international treaties that South Africa has signed and ratified, including the United Nations Convention on the Rights of the Child (1989), Convention on the Elimination of All Forms of Discrimination Against Women (1979), and Convention on the Rights of Persons with Disabilities (2006), as well as international consensus agreements, such as the Programme of Action of the International Conference on Population and Development (United Nations, 1994) and the Platform for Action of the Fourth World Conference on Women (United Nations, 1995). The South African delegation in Cairo in 1994 contributed to the clarification of the definitions of reproductive health and rights and the acknowledgement in Beijing in 1995 that human rights must be applied to issues of sexuality (Klugman, 2000). In June 2011,
at the Human Rights Council, South Africa expressed grave concern about acts of violence and discrimination committed in all regions of the world against individuals because of their sexual orientation and gender identity. South Africa therefore called on the Council to study the issue and identify how international human rights law can be used to end violence and related human rights violations based on sexual orientation and gender identity.

The Millennium Development Goals

The Millennium Development Goals (MDGs), adopted in 2000 by world leaders with targets set to be achieved by 2015, are the focus of current global development efforts. They include a range of goals linked directly to sexual and reproductive health and rights, which are described in the table below. Other MDG goals also have a bearing on sexual and reproductive health and rights—Goal 1 on eradicating extreme poverty and hunger, Goal 7 on ensuring environmental sustainability, and Goal 8 on global partnerships.

Table 2. MDG indicators that affect sexual and reproductive health and rights directly

<table>
<thead>
<tr>
<th>MDG</th>
<th>Indicator</th>
</tr>
</thead>
</table>
| MDG 2: Achieve universal primary education | • Net enrolment ratio in primary education  
• Proportion of pupils starting grade 1 who reach grade 5  
• Literacy rate of 15- to 24-year-olds |
| MDG 3: Promote gender equality and empower women | • Ratio of girls to boys in primary, secondary, and tertiary education  
• Ratio of literate women to men, 15–24 years old  
• Share of women in wage employment in the non-agricultural sector  
• Proportion of seats held by women in national parliament |
| MDG 4: Reduce child mortality | • Under-five mortality rate  
• Infant mortality rate  
• Proportion of one-year-old children immunised against measles |
| MDG 5: Improve maternal health | • Maternal mortality ratio  
• Proportion of births attended by skilled health personnel  
• Contraceptive prevalence rate  
• Adolescent birth rate  
• Antenatal care coverage  
• Unmet need for family planning |
| MDG 6: Combat HIV | • HIV prevalence among pregnant women ages 15–24 years  
• Condom use at last high-risk sex  
• Proportion of population ages 15–24 years with comprehensive correct knowledge of HIV and AIDS  
• Contraceptive prevalence rate  
• Ratio of school attendance of orphans to school attendance of non-orphans ages 10–14 years |

Constitutional commitments

The South African Constitution has a human rights approach to sexuality and reproduction. It guarantees the following:

- The right to equality;
- The right to freedom from discrimination on the basis of race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language, and birth;
- The right to be treated with dignity and respect;
- The right to life;
- The right to freedom and security, including the right to be free from all forms of violence from either public or private sources, and not to be treated or punished in a cruel, inhuman, or degrading way; and
- The right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction, the right to security in and control over one’s own body, and the right to not be subjected to medical or scientific experiments without informed consent.

The Constitution also guarantees the right to healthcare services, including sexual and reproductive healthcare, for everyone.

Why Sexual and Reproductive Health and Rights?

The Millennium Development Goals have been translated into ‘Presidential Priorities’ in South Africa and are listed in the table below.

Table 3. Presidential priorities: Required improvements in health outcomes

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>BASELINE 2009</th>
<th>TARGET 2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth</td>
<td>53.5 years for males</td>
<td>58–60 years</td>
</tr>
<tr>
<td></td>
<td>57.2 years for females</td>
<td></td>
</tr>
<tr>
<td>Child mortality</td>
<td>69 per 1,000 live births</td>
<td>30–40 per 1,000 live births</td>
</tr>
<tr>
<td>HIV prevalence (among 15–24-year-old pregnant women)</td>
<td>21.7%</td>
<td>Improved quality of life of people living with HIV/AIDS</td>
</tr>
<tr>
<td>Mother-to-child transmission rate of HIV</td>
<td>10%</td>
<td>0% – &lt;5%</td>
</tr>
<tr>
<td>Percentage of eligible HIV-positive women initiated on ART</td>
<td>37%</td>
<td>All eligible pregnant women to be initiated on ART at a CD4 count of ≤350 or WHO stage iii or iv</td>
</tr>
<tr>
<td>TB cure rate</td>
<td>64%</td>
<td>85%</td>
</tr>
</tbody>
</table>
The 2010 report, *Progress Towards the Millennium Development Goals*, presents South Africa’s situation as follows:

**Table 4. Progress towards achieving MDG 5 on maternal mortality**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Current status (2010)</th>
<th>Target</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality ratio</td>
<td>369</td>
<td>625</td>
<td>38</td>
<td>Unlikely to achieve target</td>
</tr>
<tr>
<td>Proportion of births attended by skilled birth attendant</td>
<td>76.6</td>
<td>94.3</td>
<td>100</td>
<td>Possible to achieve target</td>
</tr>
<tr>
<td>Contraceptive prevalence rate (couple year protection rate)</td>
<td>25.2</td>
<td>33.4</td>
<td>100</td>
<td>Unlikely to achieve target</td>
</tr>
<tr>
<td>Adolescent birth rate</td>
<td>no data</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antenatal care coverage</td>
<td>76.6</td>
<td>102.8</td>
<td>100</td>
<td>Achieved target</td>
</tr>
<tr>
<td>Unmet need for family planning</td>
<td>no data</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Republic of South Africa, 2010)

It will be difficult for South Africa to reach its targets for MDGs 4, 5, and 6 without improving access to and the quality of sexual and reproductive health services. “Although cheap, effective interventions are available for many sexual and reproductive health problems, according to WHO, unsafe sex is the second most important risk factor leading to disability, disease or death in developing countries and the ninth most important in developed countries” (Glasier et al., 2006). Key issues that should be addressed to achieve the MDGs in South Africa include maternal mortality, which is the leading cause of death for women of reproductive age and is largely preventable; addressing HIV prevention, treatment, and care; and the prevention and treatment of all other STIs, which often result in healthy life years lost (Griffin, 2008). In his State of the Nation Address of 10 February 2011, President Zuma stated that

“*Given our emphasis on women’s health, we will broaden the scope of reproductive health rights and provide services related to, amongst others, contraception, sexually transmitted infections, teenage pregnancy and sanitary towels for the indigent. On the fight against HIV and AIDS, we have revitalised our programmes and promote various prevention measures, including medical male circumcision, prevention of mother to child transmission and the promotion of HIV testing*” (Zuma, 2011).
The trajectories of different components of sexual and reproductive health interact—cervical cancer with HIV; maternal health and child survival with HIV; and gender-based violence with HIV, miscarriage, termination of pregnancy, and maternal morbidity and mortality. Health education and healthcare responses that address only single dimensions of sexual and reproductive health thus miss opportunities for addressing people’s needs and experiences holistically and may be rendered ineffective. As the President’s State of the Nation Address indicates, there is growing recognition that addressing issues related to sexuality and reproduction in a piecemeal way does not reach the heart of the problem. Issues are interconnected and need to be addressed coherently together and with a human rights approach. For this reason, this review is using the integrated concept of “sexual and reproductive health and rights” as its framework, taking as its starting point the government’s commitment to provide integrated responses in prevention, treatment, and care. The use of this terminology aims to bring together the different components that often are organised separately in health services, with separate names, such as ‘maternal and child health,’ and ‘sexually transmitted infections,’ and often leave out the human rights dimensions of dignity and respect that are at the heart of sexual and reproductive well-being.

One of the questions this review seeks to assess is to what extent sexual and reproductive health services are being delivered effectively by the health system, with a human rights approach in line with the South African Constitution and international treaties. This begs the question of how services are delivered and the degree to which they are available at one place at one time to any person needing them, irrespective of age, gender, social status, or HIV status.

**Barriers to Achieving Sexual and Reproductive Health and Rights**

Key factors contributing to South Africa’s burden of disease and undermining the human rights of many South Africans include the following:

- Poverty
- Gender inequity and other sources of prejudice
- Violence
- Lack of stewardship and poor management of the district health system
- Lack of information for planning, monitoring, and decisionmaking

**Poverty**

Poverty, including poor nutrition, affects people’s physical and mental development and safe childbirth. Poverty can be responsible for a lack of privacy for exploring and enjoying sexual relationships. It can mean that people lack money for transport to health services and that they are unable to take time from work or childcare to access health services (Ramkissoon et al., 2010). In addition, poverty often motivates people to have sexual relationships in exchange for resources for themselves or their families. Using their sexuality in this way increases people’s vulnerability to sexual ill health and unwanted pregnancies (Sen et al., 2007).

**Gender inequity and other sources of prejudice**

Gender inequity refers to inequitable power relationships and inequitable control over resources between men and women, and the consequences of these inequities for their lives, health, and well-being. Society’s assumptions that women are not equal to men and that they therefore do not have the right to make decisions about their sexual and reproductive lives make women more vulnerable to unwanted pregnancies, sexual and gender-based violence,
and sexually transmitted infections, including HIV. Early pregnancy can also limit their education and employment opportunities. Not having the right to make these decisions limits women’s opportunities to enjoy safe and satisfying sex lives, an essential dimension of their human rights, sexual health and well-being. Stigmatisation of any kind—whether on the basis of disability, sexual orientation, HIV status, gender identity, gender expression, or employment in sex work—can undermine people’s sense of self-worth. This increases their vulnerability; they feel unable to protect themselves, including their sexual and reproductive health and rights (Sen et al., 2007).

**Sexual and gender-based violence**

In South Africa, there is a culture of silence around interpersonal violence, and high levels of interpersonal violence are accepted in our society. This puts all people at risk. People who already are undervalued or stigmatised become more marginalised because they are perpetually vulnerable to violence. Criminalisation makes sex workers even more vulnerable to violence. Abusive and violent experiences in childhood not only undermine children’s rights, but can also be significant risk factors for unhealthy and violent behaviours and health problems later in life.

Violence is widely associated with masculinity. This association undermines men’s ability to establish mutually respectful sexual relations and increases their vulnerability to unsatisfying emotional relationships, sexually transmitted infections—including HIV—and unwanted parenthood.

**Lack of stewardship and poor management of the District Health System**

"We need to urgently re-engineer our health system, which is characterized by four negatives... It is unsustainable, it is destructive, it is costly, and does not put emphasis on preventing" (Health Minister Aaron Motsoaledi, 24 May 2011).

Service delivery in the public sector is not as good as it should be. There are substantial inequities across the country in both the availability and the quality of services. Strong stewardship and good management are needed to recruit, support, and retain appropriately trained staff. Sexual and reproductive health and rights depend on this.

Providing quality services is undermined by several factors: the impact of poor implementation of existing norms and standards on SRHR; the failure to use information for planning, monitoring, and improving service delivery; the lack of service integration and effective referral systems between levels of care; and the inadequate infrastructure and technology. In addition, both healthcare providers and clients complain of disrespect and abuse.

Sexual and reproductive health and rights services tend to focus on women of reproductive age and children. They are not oriented to meet the different needs of men, transgender people, people with disabilities, people living with HIV (PLHIV), adolescents and young people, women not of reproductive age, sex workers, or people with diverse sexual orientations, among others. Healthcare providers tend to equate sexual and reproductive health with maternal and child health. They lack knowledge about the full scope of sexual and reproductive health and rights.
Lack of information for planning, monitoring, and decisionmaking
This review will show that information on the social determinants of poor sexual and reproductive health and rights is limited to what small subnational studies provide. There are considerable gaps in data on critical aspects of sexual and reproductive health and rights, such as sexuality, teenage pregnancy, and sexual and gender-based violence. There are also gaps in data on sexual and reproductive health and rights experiences, needs and services in relation to specific groups of people, such as disabled people and transgender people or, more specifically, on HIV prevalence among vulnerable groups, such as men who have sex with men (MSM).

Information on the performance of the healthcare system in relation to sexual and reproductive health and rights is limited to a few routinely collected indicators, which are of suboptimal quality and not easily available. Information on healthcare outcomes does not reflect the impact of health service interventions that aim to improve sexual and reproductive health and rights. There is a lack of applied research that evaluates interventions to strengthen the public and community commitment to gender equality and sexual and reproductive rights, including the impact of such interventions on adolescents. Public sector efforts to strengthen the quality of integrated sexual and reproductive health services also need to be evaluated.

This review focuses only on those barriers to achieving sexual and reproductive health and rights for which the DOH has direct legal, policy and service responsibilities.
CHAPTER 2: HEALTH SYSTEM ORGANISATION

Historical Perspective

Prior to 1994, the South African healthcare system was highly fragmented and the healthcare services to which South Africans had access were determined largely by where they lived, their socioeconomic status, and their race. Ethnic “homelands” were established as semi-autonomous administrative entities and each homeland was charged with the provision of health and other public services. These services were poorly organised, inefficient, and often ineffectively managed, and many of the homeland health services struggled to provide adequate medical and public healthcare.

After the first democratic elections in South Africa, these fragmented health services were consolidated into one South African healthcare system. A unified national department of health (DOH) was created, bringing together all of these previously separate administrations.

The vision of the newly created DOH was a healthcare system based on the primary healthcare approach. This approach to the delivery of healthcare was proposed in the 1978 WHO Alma Ata Declaration (WHO, 1978) — a philosophy and a set of principles and strategies for organising healthcare services. The values of primary healthcare include health as a fundamental right, based on the principles of equity and social justice. The strategies of this approach include providing access to good quality healthcare as well as preventive and promotive services for priority health needs, intersectoral action at the local level to address the root causes of ill-health, and enhanced community participation and accountability (Schneider and Barron, 2008).

To ensure the delivery of the primary healthcare approach, South Africa organised the healthcare system around a district health system (DHS). Districts, the most decentralised structures responsible for the governance and management of the health system, were established by the National Health Act (61 of 2003) along the boundaries of District and Metropolitan Municipalities. Where appropriate, districts were subdivided into subdistricts.

<table>
<thead>
<tr>
<th>Advantages of a district health system</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Equity</td>
</tr>
<tr>
<td>2. Access to services</td>
</tr>
<tr>
<td>3. Quality</td>
</tr>
<tr>
<td>4. Overcoming fragmentation</td>
</tr>
<tr>
<td>5. Comprehensive services</td>
</tr>
<tr>
<td>6. Effectiveness</td>
</tr>
<tr>
<td>7. Efficiency</td>
</tr>
<tr>
<td>8. Local accountability</td>
</tr>
<tr>
<td>9. Community participation</td>
</tr>
<tr>
<td>10. Developmental and intersectoral approach</td>
</tr>
<tr>
<td>11. Sustainability</td>
</tr>
</tbody>
</table>
The National Health Act vested governance of the DHS with the provincial government. Provinces needed to pass subsidiary legislation, which would establish district health councils. In turn, the councils would promote cooperative governance with local government and the coordinated planning, budgeting, delivery, and monitoring of all health services in the district. Districts would then function as decentralised autonomous units. As decentralised units, the advantages of a DHS would be realised—equity, responsiveness to local needs, and accountability to communities (see box above). The establishment of a DHS organised healthcare in such a way that services would be delivered at four levels:

1. Household and community level;
2. District level—primary healthcare in district hospitals, community health centres, and clinics, delivered by generalist healthcare workers;
3. Secondary level—specialist care in regional hospitals; and

Since 1994, a number of initiatives have supported the delivery of primary healthcare and the development of the DHS in South Africa (Schneider and Barron, 2008; Harrison, 2010):

- Primary healthcare services were made free for pregnant women and children under the age of six. User fees then were removed for everyone at primary healthcare facilities, and hospital fees were removed for pregnant women and children under the age of 6 years.
- A clinic construction and upgrading programme was initiated, involving more than 1,600 facilities and ensuring the geographical availability of services within five kilometres to more than 90 percent of the population.
- The Essential Drugs List and Standard Treatment Guidelines for Primary Health Care was developed and implemented for mandatory use in all public sector facilities.
- The system formulated an essential Primary Healthcare package (PHC package) in 2001, which defined a core package of healthcare services to be delivered in clinics and community health centres (DOH, 2001).
- The District Health Information System (DHIS) was implemented. Most facilities now submit information through the DHIS on a monthly basis, and these data are computerised and aggregated at subdistrict, district, provincial, and national levels.
- Human resource policies were initiated to support the delivery of primary healthcare, including the following:
  - Mandatory one-year community service for healthcare professionals, which has improved the availability of doctors in the public sector at the district level;
  - Growth and diversification of primary healthcare providers beyond traditional categories such as nurses to include an increased number of mid-level workers, such as clinical associates, pharmacy assistants, and new types of support staff, such as data capturers; and
  - The recruitment of a wide variety of lay/community health workers (also referred to as lay counsellors, community-based workers, caregivers, home-based carers), estimated at 65,000 in 2008 (Schneider and Barron, 2008).
- A number of policy initiatives have created an enabling health environment—including tobacco legislation and initiatives outside of the healthcare sector, such as the primary school feeding programme and child support grant.
- There have been a number of successful public health programmes
  - Expanded Programme of Immunisation (EPI);
  - Malaria control—house spraying and improved surveillance; and
Prevention, treatment, and care of people living with HIV and AIDS.

The following table reflects major findings of an assessment of the South African public health system undertaken by Harrison (2010).

**Table 5. Accomplishments and shortcomings of the South African health sector**

<table>
<thead>
<tr>
<th>Accomplishments</th>
<th>Shortcomings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legislation and policy</td>
<td>Insufficient prevention and control of epidemics</td>
</tr>
<tr>
<td>• Free primary healthcare</td>
<td>• Limited effort to curtail HIV / AIDS</td>
</tr>
<tr>
<td>• Essential drugs programme</td>
<td>• Emergence of multi-drug resistant TB</td>
</tr>
<tr>
<td>• Choice on termination of pregnancy</td>
<td>• Lack of attention to the epidemic of alcohol</td>
</tr>
<tr>
<td>• Anti-tobacco legislation</td>
<td>• Persistently skewed allocation of resources between public and private sector</td>
</tr>
<tr>
<td>• Community services for graduating health professionals</td>
<td>• Inequitable spending patterns between the public and private sector</td>
</tr>
<tr>
<td></td>
<td>• Insufficient health professionals in public sector</td>
</tr>
<tr>
<td>Better health systems management</td>
<td>Weaknesses in health systems management</td>
</tr>
<tr>
<td>• Greater parity in district expenditure</td>
<td>• Poor quality of care in key programmes</td>
</tr>
<tr>
<td>• Clinic expansion and improvement</td>
<td>• Operational inefficiencies</td>
</tr>
<tr>
<td>• Hospital revitalisation programme</td>
<td>• Insufficient delegation of authority</td>
</tr>
<tr>
<td>• Improved immunisation programme</td>
<td>• Persistently low health worker morale</td>
</tr>
<tr>
<td>• Improved malaria control</td>
<td>• Insufficient leadership and governance</td>
</tr>
<tr>
<td></td>
<td>(Harrison, 2010)</td>
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</tbody>
</table>

Figure 1 illustrates that there has been a substantial increase in public expenditures on primary healthcare and the district health system over the last few years, and that differences in public sector spending between districts have been reduced—using 2007/2008 prices.

**Figure 1. Public spending per capita on district-level healthcare, 2001–2007**
Healthcare Sector in 2010–2011

In recent years, a number of documents have reviewed the successes and challenges facing the South African healthcare system (Department of Health, 2010a, 2010b; Political Leadership in Health, 2010; Barron, 2011; Harrison, 2010; Schneider and Barron, 2008). The Negotiated Service Delivery Agreement (2011), signed by the current Minister of Health, recognises that, despite the aforementioned investments in health services, health outcomes in South Africa remain poor, and South Africa is unlikely to meet any of the health-related MDGs. In fact, some health indicators—namely infant mortality—are actually increasing.

These documents identify a number of challenges that have undermined the gains South Africa could have made since 1994. It is recognised that the South African people and health system face a quadruple burden of disease:

- HIV and AIDS and tuberculosis
- Non-communicable diseases
- Injuries and violence
- High child and maternal mortality

Despite these burdens, the reviews suggest that healthcare outcomes should be better. One particular concern is that, to date, most health districts do not function as envisaged in the National Health Act. The fact that a functional DHS has not been established is a serious impediment to the delivery of primary healthcare, including sexual and reproductive health and rights services. However, none of the provinces has passed the legislation required to ensure that governance rests with district health councils. District management teams have been appointed in most districts but the districts are functioning as smaller subsidiary provincial units, with no autonomy or authority to function as intended. In many places, district hospitals still function separately from and are poorly coordinated with community health centres and clinics, and formal mechanisms of accountability, such as district councils and clinic/community health centre committees, are either absent or do not play a meaningful role. As a result of the structures of the health system there is some duplication in policy development, with provincial government and local government each developing policies for their areas and for implementation in their facilities.

“... We’ve got lots of local government clinics that I don’t have jurisdiction over but we do communicate. We can involve them but they will have to take the process forward themselves. We can arrange that we meet with them because we can’t just focus on provincial clinics and neglect local government because patients don’t know which is local and which is provincial policies and guidelines because they also provide primary healthcare and they also provide women’s health and children’s health. They need to be included.” (Provincial manager, 2010)

“Basically, all of the stuff that we do is normally guided, obviously by national and provincial policy, and on top of that we also have our own policies or policy working group. We also look at the policies and standard operating procedures which are then written down, confirmed, and reviewed on an annual or biannual basis and those are then communicated out into the clinics and the working areas so that all staff members are aware of any new policies or standard operating procedures.” (District manager, 2010)
Other challenges highlighted in a number of reviews of the public sector are as follows:

- Lack of financial, human, and infrastructural resources—and in particular, a lack of management skills;
- Poor quality of care in many public sector facilities; and
- Lack of leadership and governance in the healthcare sector as a whole.

In 2010, in the National Service Delivery Agreement (Department of Health, 2010c), the Minister of Health committed himself to ensuring “a long and healthy life for all South Africans” and in particular to the following:

- Increase life expectancy;
- Reduce maternal and child mortality—a number of strategies to reduce maternal mortality are proposed, including “improved access to contraception services” and a commitment to increase the percentage of health facilities providing contraceptive services to 90 percent by 2014/15;
- Combat HIV / AIDS and decrease the burden of disease from tuberculosis; and
- Strengthen health system effectiveness—with a shift in the service delivery platform from one that focuses on the provision of curative services to the primary healthcare approach that focuses on health promotion, prevention, and community involvement.

In the past six months, a number of documents have been circulated on the process of “re-engineering” primary healthcare in South Africa (Barron, 2011; Department of Health, 2010a, 2010b). This process will involve the following:

- Ensuring that districts are fully functional;
- Delivering a well-defined core package of services that focuses on reducing mortality and morbidity (see Table 6);
- Focusing the efforts of the healthcare sector on populations, prevention, and promotion, and reaching households and communities, rather than individuals;
- Establishing integrated, efficient, and well-supported Primary Health Care (PHC) teams, guided by and accountable to communities; these teams are represented diagrammatically below, and this model of delivery is based on the Family Health Care Teams in Brazil.

This remodelled primary healthcare system (depicted in Figure 2) will extend healthcare into communities and households. Community health workers will go out into communities and homes. Through improved health promotion and prevention, PHC teams will try to keep people healthy in their own homes, as well as getting those who need healthcare into health facilities as early as possible.
Some progress has been made with this process. In 2000, South Africa articulated a comprehensive primary healthcare package. The document outlines the primary healthcare services that should be delivered in clinics and community health centres in South Africa. In 2010, this package was revised as A National Package of Essential Health Care Interventions for South Africa (2010) (Table 7). The new primary healthcare package has been designed to

- Address priority health problems;
- Improve health status;
- Focus on both prevention and promotive services for each of the priority areas;
- Be implemented at the community, clinic, and community health centre levels;
- Target vulnerable populations, such as disabled people;
- Provide for services that are practical, essential, and comprehensive;
- Provide for cost-effective services;
- Promote equity; and
- Respond to the demands of the population.

Financial allocations for the establishment of primary care teams and, in particular, for expanding the number of community healthcare workers, have been made in the budget for 2010 / 2011. It is envisaged that there will be one community health worker per 250 families (1,000 people) and one team per 1,500 families.
Table 6: Proposed primary healthcare services

<table>
<thead>
<tr>
<th>Health personnel</th>
<th>Services provided</th>
<th>Sexual and reproductive health and rights</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Household</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| • Community health workers  
• Health promoters  
• Social workers | • Provide screening, assessment, and referral across the life cycle (all age groups)  
• Provide information and support for healthy behaviours and home care  
• Provide psychosocial support  
• Identify and manage (including provide adherence support for) common health problems |                                          |
| **Community**    |                   |                                          |
| • Community health workers  
• Health promoters  
• Social workers | • Community assessment of causes of ill health (such as water and sanitation, substance abuse, poor nutrition)  
• Assessment of community resources, including service providers  
• Community-based interventions, including intersectoral action |                                          |
| **Primary healthcare clinic** |                   |                                          |
| • Professional nurses, some of whom will have primary healthcare training, and some IMCI training  
• Enrolled nurses  
• Assistant nurses  
• Support staff  
• Visiting medical officer (possibly)  
• Visiting specialised services (possibly) | • Provide general primary health services 8 hours/day as per the current primary healthcare package  
• All basic services provided daily | • Maternal – antenatal, postnatal, family planning  
• Child – immunisation, growth monitoring, IMCI  
• Treatment of all common conditions, including STIs and TB  
• HIV testing and counselling  
• HIV care and management |
| **Community health centre** |                   |                                          |
| • Professional nurses, some of whom will have primary healthcare training or IMCI training  
• Nurses may work in specific areas, such as the termination of pregnancy (TOP) or HIV clinics  
• Medical officers  
• Family physicians (may work throughout the district)  
• Pharmacists  
• Social workers  
• Oral hygienists  
• Occupational therapist  
• Physiotherapist  
• Environmental health officer | Usually 24-hour centres providing all services provided in clinics, as well as:  
• Maternity (for normal labour)  
• Emergencies  
• X-ray, laboratory services, physiotherapy  
• Occupational health  
• Medico-legal services  
• Minor operations  
• Dental services  
• Rehabilitation – occupational therapist and physiotherapist  
• Specialised services – ophthalmology, dermatology | • All primary healthcare services provided in clinics  
• HIV counselling and testing  
• Male medical circumcision (in some facilities)  
• ART (in some facilities)  
• TOP (if accredited) |
Community Health Workers (CHWs) are part of the primary care team and are envisaged to form part of community outreach teams headed by a professional nurse. They are also an important component of community-based PHC services, which encompass activities in communities and households. The generic roles of CHWs include the following:

- Conduct structured and comprehensive household screening and assessment relating to health priorities and refer appropriately;
- Provide education and information and support preventive action (e.g., through condom distribution);
- Provide psychosocial support across the life cycle, including an integrated approach to adherence support for TB, Highly Active Antiretroviral Therapy (HAART), and other chronic diseases;
- Provide basic home management of common health problems—e.g., oral rehydration therapy in diarrhoea, foot care in diabetes, and first aid; and
- Support community assessments, campaigns, and intersectoral action.

The proposed community-based services are listed in Table 6.

**Table 7. Proposed community-based primary healthcare services**

<table>
<thead>
<tr>
<th>Sites</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community</strong></td>
<td>Community assessment of causes of ill-health (e.g., water and sanitation, substance abuse, poor nutrition)</td>
</tr>
<tr>
<td></td>
<td>Assessment of community resources, including service providers</td>
</tr>
<tr>
<td></td>
<td>Community-based interventions, including intersectoral action</td>
</tr>
<tr>
<td><strong>Household</strong></td>
<td>Screening, assessment, and referral across the life cycle (all age groups)</td>
</tr>
<tr>
<td></td>
<td>Provide information and support for healthy behaviours and home care</td>
</tr>
<tr>
<td></td>
<td>Provide psychosocial support</td>
</tr>
<tr>
<td></td>
<td>Identify and manage (including provide adherence support for) common health problems</td>
</tr>
<tr>
<td><strong>Schools &amp; early childhood centres</strong></td>
<td>Screening, assessment, and referral</td>
</tr>
<tr>
<td></td>
<td>Targeted interventions (e.g., educational programmes, vitamin A, de-worming, and immunisation campaigns)</td>
</tr>
<tr>
<td><strong>Other health and social providers: (through referral and linking)</strong></td>
<td>Referral and coordination with other sectors for services provided in households (in particular social development and early childhood development) by nonprofit organisations, community centres, and any other service providers</td>
</tr>
<tr>
<td></td>
<td>Focus on orphaned and vulnerable children (OVC), elderly, mental health, and substance abuse services, step-down care</td>
</tr>
</tbody>
</table>
The advantages of this model of service delivery are that the unit of intervention will be the family rather than individuals, the focus of health interventions will shift from curative to promotive and preventive, and a single package of services will be fully integrated. There will be significant outreach to communities, who will participate fully in service planning and monitoring.

Other initiatives to support the delivery of primary healthcare are described briefly here.

**National health insurance.** The implementation of national health insurance will aim to ensure universal access to a defined comprehensive package of services and improve the quality of care.

**Improving the quality of care in facilities.** The Office of Standards Compliance will be an independent body established to accredit healthcare facilities—including primary healthcare facilities. This body will establish standards for the delivery of healthcare and ensure compliance with these standards.

**Improving infrastructure.** Funds will be allocated to improve infrastructure in the public health system—including technology and Information and Communication Technology.

**Strengthening financial management and health information systems** also has been prioritised.

**The draft PHC Facility Supervision Policy (2009)** highlights that primary healthcare facility supervision is believed to be a cornerstone in providing quality primary healthcare services. In the past, most clinics were expected to receive a visit by a supervisor once a month. However, the role of these visits appeared to be predominantly administrative, with little or no attention paid to monitoring service quality. A situation analysis revealed that, in many cases, these supervision visits did not occur. This policy attempts to ensure that supportive supervision is provided to community health centres and clinic facilities on a monthly basis, with poorly performing clinics being visited more frequently during the month. In addition, the policy allocates a minimum of four hours for a supervisory visit, during which the clinic should be organised to ensure that services remain available. To accomplish this, a clinic supervisor visits the facility, evaluates elements of service delivery in line with the **National Primary Health Care Norms and Standards**, and takes remedial actions to close the gaps identified for improving quality of care. The policy recognizes that numerous authorities oversee the work of these health facilities, and that these facilities vary in size, complexity, staffing, patient load, and range of activities. This diversity of responsibility makes a uniform policy on supervision all the more important for ensuring that all health facilities receive the support, encouragement, and guidance a supervisor can and must provide.

During onsite visits, managers should focus on the following areas:

- ** Clinic Administration Review**
  This is a review of certain administrative aspects, such as staff matters; infrastructural aspects of the facility (building, water supplies, electricity, grounds); equipment; supplies; and legal issues (e.g., collection of vital statistics).
- **Financial Management**
This is a review of every line item of a health facility’s budget and expenditure trends, and involves identifying cost drivers and major over-expenditures and supporting the facility manager in dealing with these issues.

- **Information System Review**
This is a review of health facility registers, completed monthly PHC reports, graphs of important data, and the use of data for planning and monitoring accomplishments at the facility level.

- **Referral System Review**
This is a review of referral systems between health facilities—any problems with referrals, both in terms of patient movement and communication between health facilities—and between community-based structures.

- **Quality of Clinical Care Review**
This is a review of the correct application of Standard Treatment Guidelines (STGs) and use of the approved list of essential drugs to ensure high-quality care. The supervisor/area manager will concentrate on the correct use of the STGs by health facility staff, reinforcing correct practices and ensuring adherence to established standards.

- **Community Involvement Review**
This review focuses on community involvement, regularity and participation of health facility staff in Community Health/Clinic Committee meetings, Community Health/Clinic Committee concerns, and any community problems needing urgent attention (malnutrition, disease outbreaks, etc.).

- **In-depth Programme Review**
The in-depth programme review of all health programmes will be conducted annually and in consultation with programme managers or coordinators. Key programmes for review include TB, STIs, Expanded Programme on Immunization (EPI), Integrated Management of Childhood Illnesses (IMCI), maternal and perinatal care, chronic diseases (including AIDS), reproductive health services¹, and the Essential Drug Programme. Standard review lists will be provided for each of these programmes.

- **Training**
The supervisor or area manager has a major responsibility to ensure that health facility staff is updated, trained, and appropriately coached. At each visit, educational sessions should be conducted addressing the specific needs of facility staff and cover elements of clinical service provision, staff management, and facility administration.

- **Managing people and problem solving**
In this process, the supervisor or area manager should follow the appropriate channels of communication. Many problems can be dealt with on the spot at the health facility, whilst others will have to be taken to the district or other responsible areas. A note will be made of problems requiring solutions at a higher level, and actions taken will be reviewed at the subsequent supervisory visit. The supervisor or area manager will be authorised to contact relevant authorities on behalf of the health facility.

The actual process of supervision should be conducted in a supportive, participatory style with the following characteristics:

- It should be a support visit rather than fault finding;
- It should be a learning situation;

¹ This terminology reflects the current separation between services as already discussed. Reproductive health by definition includes maternal health but in the current organisation of services the inextricable links between diverse sexual and reproductive health services are undermined.
• It should be a planned and announced visit, taking into account staff coverage. However, periodic spot checks (unannounced visits) also should be performed;
• It should have an evaluation tool;
• There should be a feedback system indicating strengths and weaknesses;
• Follow-up is imperative for effective problem-solving;
• Praise should be given for work well done;
• Corrections should be objective;
• Time should be allotted to listen to the problems of individuals as well as the group, and to solve them. Problems that cannot be solved should be referred to a higher authority, and a contact list should be provided for relevant officers;
• The programme managers/coordinators also should visit health facilities with the knowledge of their respective area manager;
• Facilities should be able to request additional visits by the area manager; and
• The importance of accountability should be stressed throughout this process.

Organisation of Sexual and Reproductive Health and Rights Services

To date, the functions of the National Department of Health (NDoH) have been divided into clusters, sometimes along disease lines (communicable diseases; maternal, women’s and child health; HIV and AIDS; and TB) and sometimes by broad functions (monitoring, evaluation, and quality). At the national level, there is more than one chief directorate responsible for developing policies, norms, and standards pertinent to SRHR. (The current organogram of the NDoH is in the process of being changed and is no longer available on the NDoH website.)

This rather fragmented and verticalised approach to management is reflected at the provincial level, although most health programmes are in one chief directorate. In all provinces visited, organograms were being reviewed but, to date, disease-specific programme managers remain in the following areas:
• In the Western Cape, HIV, AIDS, and TB are in one division, separate from other health programmes. Comprehensive health and public health programmes are separate directorates.
• In Mpumalanga, the four priority programmes are HIV and AIDS, MCWH (mother, child, and women’s health), and mental health and rehabilitation. All are managed separately.
• In KwaZulu-Natal, a number of different directorates exist at the provincial level, including those for gender issues, MCWH, HIV and AIDS, health promotion, and mental health.
• In Gauteng, the chief directorate of health programmes includes MCWH, but not HIV and AIDS, health promotion, or mental health.

Across all provinces, HIV and AIDS, TB, health promotion, mental health, and MCWH are always the responsibility of different people. Consequently, no one person is responsible for SRHR.

“Sexual reproductive health services – I do not think that it is grouped in terms of people’s areas or responsibility or specific input.” (District manager, 2010)
At the district level, district managers have been appointed in most districts and are responsible for service delivery in their area. Although there are generic programme managers for primary healthcare in most districts, HIV and AIDS, as well as TB, tend to remain separate programmes, with dedicated programme managers, training, data collection systems, and supervision, although there have been attempts to integrate HIV and TB management as per policy guidelines.

At a facility level, service delivery is to a large degree integrated, in that the same nurse will provide all healthcare services to each client. Information on most services delivered is captured for the DHIS. Some services, however—for example, HIV and AIDS, TB, Termination of Pregnancy, and some others—actually may be provided in a separate section of the facility by staff with dedicated training. Data on these services are collected separately and reported to dedicated programme managers.

**Service delivery and the integration of services**

There are many factors that inhibit the implementation of an essential package of SRHR services. These include the lack of commitment from stakeholders; non-sustainable funding; understaffed clinics; low morale, high turnover, or inadequate training of healthcare providers; inadequate infrastructure, equipment, and commodities; and poor programme management and supervision (WHO/ HIV et al., 2008). There are also underlying determinants of sexual and reproductive health (SRH), such as a lack of male partner participation, women not being sufficiently empowered to make SRH decisions, cultural and literacy issues, adverse social events/domestic violence incidence, and stigma preventing clients from utilizing services (WHO/ HIV et al., 2008). These issues are discussed further in Chapter 4 of this review: “A Culture of Sexual and Reproductive Health and Rights.”

To ensure the implementation of a comprehensive essential package of SRHR services, programmatic interventions need to address the inhibiting factors at both a policy and service delivery level. This section discusses the current situation and some of the challenges to comprehensive SRHR services within the health system.

Integrated services are believed to promote more efficient use of resources, be better from the service user’s perspective, and improve quality of care. Integration requires “a holistic approach that addresses the interconnectedness of supply-demand-advocacy interventions, based on the facility’s capacity to provide a level of integration that meets clients’ needs without compromising existing services” (Searing, et al., 2008, p. xi).

In the context of district health services and primary healthcare in South Africa, services are intended to be fully integrated. Clients should receive the mix of services they may require at one place on the same day, so that they do not have to come back for certain services thereby incurring additional costs in terms of transport and time or losing the opportunities for health information and care that a visit to a health centre implies.

**The importance of integration for SRHR**

Achieving SRHR requires providing access to a broad range of services. The target groups for many individual SRHR programmes are largely the same, and the services intersect in many ways. For example, to be effective, messages about the risk of exposure to HIV should take a holistic approach that meets people’s SRH needs and respects their rights, irrespective of HIV status. Achieving these rights also means addressing underlying gender norms related
to sexuality, masculinity, and femininity, as well as harmful practices that influence sexual and reproductive health and HIV status (e.g., violence against women and widow inheritance).

Those engaged in non-reproductive sex similarly may need a mix of services. For example, HIV-positive transgender persons may be using hormonal contraceptives to alter body shape, and thus need HIV services that take into consideration the interactions of HIV-related drugs with hormonal contraceptives.

It is impossible for individuals to separate out their sexual behaviours and the consequences of these into “HIV,” “pregnancy,” and “other sexually transmitted infections.” Unsafe sex can put people at risk for HIV, other STIs, and unwanted pregnancies. Adolescents are the target of sex education and life skills programmes to delay sexual debut, have healthy relationships, prevent unplanned pregnancies, and prevent STIs, including HIV. Pregnant women are the key target group for antenatal care and safe delivery and are also one of the primary target groups for HIV testing and counselling. In addition, pregnant women who test positive for HIV are the target group for services to prevent mother-to-child transmission (MTCT) of HIV. Interventions to prevent vertical transmission of HIV during delivery, as well as those to promote newborn health, already reside within maternal and reproductive health programmes. Such integration makes sense to the pregnant women who access maternity care.

Are sexual and reproductive health and rights services integrated?

Understanding of integration

Even though most key informants proposed an integrated approach to the provision of SRHR service, their definitions of integration ranged from providing STI diagnosis and treatment with HIV services, to more inclusive approaches—such as a one-stop shop or supermarket approach.

“This means that a woman gets into my room for whatever complaint and she must get all services that are related to her as a woman. If she needs counselling, I must be able to give it her, even pap smear—I should not go out to get another sister to do it. If she needs nutritional advice I must be the one who also does that. However, there are challenges to this approach.” (District manager, 2010)

Integration was perceived to be a good thing—sometimes—but with benefits for clients.

“In practice, you will find that to integrate services around TB and HIV makes a lot more operational sense, whereas linking cervical cancer screening would not make sense. For an example, if you want to look at women’s health as a specific thing, you could then link cervical cancer screening with family planning, that type of thing…” (District manager, 2010)

Interviewees in an earlier study also identified pros and cons of integration, one noting that

“People do not want others to know that they are receiving these services. For example, teenagers do not want others to know that they are using contraceptives. If everybody sits in
one queue, only the health worker and the client know the reason for the visit.” (Health service provider in KZN focus group discussion cited in Maharaj and Cleland, 2005, p.313)

While another argued from a different perspective that

“The problem is that we lose many family planning clients. They leave before receiving their contraceptives because they don’t want to wait for a long time before receiving services. If there were more staff, we could have a fast queue.” (Health service provider in urban focus group discussion cited in Maharaj and Cleland, 2005, p. 314)

Interviews for this review highlighted a number of areas in which services clearly were not integrated at all and identified a number of constraints to service delivery integration.

Part of the challenge is that existing policies (presented in Chapter 3 of this review: “The Essential Package of Sexual and Reproductive Health and Rights”) are not integrated. A number of key informants felt strongly that, although policies existed, there was a need to link them. Policies are introduced one by one in a vertical manner that does not encourage providers to look at patients holistically. A number of examples, such as the following, were given of instances in which policies are perceived to conflict with each other. According to the Sexual Assault Act, sex with a child 14 years of age is statutory rape. However, this same child does not need parental permission to terminate a pregnancy. Some healthcare workers seemingly are confused as to whether they should inform anyone about the rape and, if so, whom.

“I think that we’ve got policies on contraception, cervical cancer—pap smears, and we’ve got something on breast cancer, even though there’s not a huge amount we can do in that area, we’ve got TOP, we’ve got PMTCT, I could name all of them. I think that the policies are good. I think that the issue is to look at, first of all, how they talk to each other and link up with each other.” (Researcher, 2010)

“….my worry is that the female condom is mostly promoted for HIV/AIDS. It should form part and parcel of the whole reproductive health service.” (Senior provincial manager, 2011)

Vertical programming

Vertical programming does not promote collaborations that support districts in providing a comprehensive service package. District managers suggested that provincial structures were redundant and often hindered service delivery. Disease-specific programme managers at the provincial level have duplicated planning, budgeting, supervision, data collection, and monitoring.

“The bit that is my responsibility at the district level is giving support to the implementation of STI, HIV/AIDS, and TB. So that is where we have integrated.” (Programme manager, 2010)

One of the major obstacles to integration identified by key informants was that vertical programme managers do not work together, even though implementation of their programmes depends on the same healthcare provider.
“At the same time, all these four people will be speaking to the same nurse, who is supposed to do all these things. This is what is crippling our implementation in most cases. There are more people to one nurse.” (District manager, 2010)

“...what is worse in vertical programmes, you will find this manager asks for information, two weeks down the line another manager asks for more or less the same information, and you end up really quarrelling with everyone around.” (District manager, 2010)

“Another challenge is the national and provincial. Those people still run vertical programmes and it becomes very difficult for us to integrate at a district level. I'm sure this is at all levels. Like you are here today, the subject is not far from what the team from strategic information under John Snow is doing, where they are looking at PMTCT, and that is also a national project. This is also a national project. It becomes very difficult for us to integrate the planning.” (District manager, 2010)

Furthermore, management and procurement issues cut across programme areas. Management and commodities are two of the weakest links in health programmes.

**Human and infrastructural resource constraints**

Some policies are less well implemented than others, and there is a perception from the key informant interviews that implementation varies considerably between districts, provinces, and even different groups of people. For example, the situation analysis in one province revealed a perception that the Choice on Termination of Pregnancy Act is better implemented than the cervical screening policy, except with respect to the implementation of the cervical screening policy in HIV-positive women. Not only was the policy being fully implemented but, in some provinces, women were being tested annually from the age of 20. The consequences of this do need to be examined more closely, but the suggestion is that policies can be implemented if people choose to do so. In contrast, in a subdistrict in another province, the Choice on Termination of Pregnancy Act had not been implemented at all, and two nurses had been trained only recently.

The reasons for these differences in SRHR across provinces range from leadership and management to the resource base. During consultations with key informants, substantial inequalities in service provision were reported across provinces and districts, and sometimes within the same district. Such inequalities were cited in service delivery, access to healthcare, and the working environment for service providers in the public sector. For example, one urban district facility not only boasted state-of-the-art scanning information technology equipment, but also had personnel responsible for data collection and management. By comparison, a rural-based facility did not even have proper registers to record their services, and reconciling daily statistics remained the responsibility of the overburdened nursing personnel. Key informants bemoaned the fact that policies were written without considering that challenges to implementation vary from place to place, depending on the availability of resources.

“I know what is the right thing to do, but if I do not have the resources, then it’s useless for me—I can’t follow it.” (Subdistrict manager, 2010)

They also spoke of a lack of privacy in facilities.
“Counselling is done in toilets ... the structure is not a standard structure for a clinic.”
(Subdistrict manager 2010)

Key informants suggested that available human and infrastructural resources did not foster integrated service delivery, which is critical to implementation of SRHR policies at the primary level. In some cases, the physical layout of the facility limited opportunities to integrate services. Yet even with the existing limitations, most facilities could change how their services are organised to improve patient flow, if given some external support. However, there was no evidence of such capability on site.

Most facility managers felt that they did not have enough staff with the necessary skills and mindset to implement an integrated approach.

“Staff attitude is a challenge. Sometimes when you try to introduce something for them to work smartly, they see it as additional work and distance themselves.” (District manager, 2010)

Integration of HIV prevention, management and care with other SRHR services

Key informant interviews suggest that, with the exception of HIV and TB services, primary healthcare services at the service delivery level are integrated—although some logistical challenges impede full integration. The National HIV and STI Strategic Plan recognises the importance of providing a range of SRHR services but does not call for integration of HIV testing and management services with primary healthcare; consequently, many services continue to operate vertically. Even within primary care services, despite the realisation of clients’ needs for integrated SRHR services, donors, funders, and government have responded to the HIV epidemic in such a way that the focus has shifted from delivery of the essential SRHR package to a specific emphasis on HIV treatment, care, support and—to a lesser degree—prevention. This degree of verticalisation undoubtedly accounts for some of the successes of the HIV programme—and there are lessons to be learnt from the roll-out of the national antiretroviral (ARV) treatment programme that can be applied to SRHR programme implementation; namely, patient empowerment strategies and supply chain management. The challenge with verticalisation is that it does not resolve the question of how to provide comprehensive SRHR services, including HIV services, over the long run, let alone how to offer them at the same time as other essential services, whether for TB, diabetes, or acute health needs. There have also been concerns about the negative impact of vertical programmes on the rest of primary healthcare.

One of the biggest strains on the public health system is its need for highly skilled healthcare providers. As HIV programmes are scaled up to provide ever higher levels of coverage, it is essential not to overburden healthcare providers from the general health services. Furthermore, since many of the core skills are common to both services, it is not cost-effective to duplicate the training of healthcare workers in both of these areas. Rather, healthcare workers need to be supported, offered reasonable working conditions, and provided with information and training about HIV as well as SRHR as part of their general training and continuous in-service education. One of the concerns is that resources are not allocated in line with the increased scope and complexity of services, particularly when HIV services are integrated into existing services.

“Clinics are now providing more sophisticated services and you therefore cannot continue doing business as usual.” (District manager, 2010)
The Delivery Agreement for Outcome 2: A Long and Healthy Life for All South Africans (October 2010) commits the Minister of Health and the NDoH to integrate HIV, AIDS, and TB services, irrespective of the level of the healthcare system at which they are rendered.

Lessons from efforts at integrating components of SRHR

Research has shown that successful implementation of contraception and HIV services is possible and will significantly address both the unmet family planning need of HIV-positive women and the HIV counselling and testing needs of family planning clients. Successful integration can be achieved by following a combination of steps laid out by FHI and Engender Health’s ACQUIRE Project, discussed below. In addition, the experiences of the Frontiers project in North West Province and the FHI Kenyan example illustrate that proper training of healthcare workers and targeted materials and job aids will ensure improvements in quality of care. Similarly, linking and/or integration of family planning services into programmes for prevention of mother-to-child transmission (PMTCT) of HIV, as envisaged by the A-Plan (discussed in Chapter 3 of this report) would substantially enhance maternal and child health.

Family Health International’s (FHI) ACQUIRE Project, a pilot intervention in Mbale, Uganda, identified a number of steps for achieving successful integration of family planning services into HIV services.

- Step 1 – Identify/refine level of integration that can be adopted.
- Step 2 – Assess ART centre’s capacity to support family planning.
- Step 3 – Tailor technical assistance interventions to build or strengthen systems to support new and existing services, so as to avoid destabilization of existing service delivery systems.
- Step 4 – Identify and support partnerships needing capacity building to further contribute to the integration process.
- Step 5 – Monitor service delivery performance and use the data to determine the need for expanding the method mix or improving the current level of FP integration (Searing et. al., 2008).

A South African example of integrating HIV treatment and care into family planning services—the Frontiers Project.

Two models of integration were compared:

- Model 1: Counselling and testing services were provided at the same time as a family planning consultation.
- Model 2: Family planning clients received HIV pre-test counselling and referral for further counselling and testing to another part of the clinic or another, nearby clinic, if they so desired.

Findings indicated that integrating HIV counselling and testing into family planning was feasible and acceptable to clients and providers and that there was no significant difference between the two models piloted. The quality of counselling improved in both models for all indicator categories. The intervention evaluation showed that the proportion of providers mentioning counselling and testing services during family planning doubled in model 1, which led to significant increases in the proportion of clients who accepted testing (Population Council, 2008).
An example of intersectoral collaboration

Key informants participating in the situation analysis identified the Premier’s Flagship project in KwaZulu-Natal as one positive approach to integration across different government departments. The Flagship team is composed of senior personnel from different departments and sectors, including social development, health, agriculture, and home affairs, as well as NGOs. The team profiles households, in particular vulnerable ones, by conducting field visits. Various governmental departments use the information collected by the team to provide these households with certain services. For example, the Department of Home Affairs provides the household with identity documents. The Department of Social Development provides social grants, the Department of Agriculture delivers nutritional packages, and the NDOH identifies and addresses gaps in specific health services (e.g., immunization).

The limitation of the service integration described in these examples is that they do not address the needs of men and do not promote a culture of responsibility for reproductive decisionmaking among both men and women; nor do they reach women who are not in search of contraception. It is thus not enough only to integrate HIV services into existing contraception services. Instead, a comprehensive sexual and reproductive health and rights service targeting both men and women, should be offered as part of primary healthcare.

Intersectoral Collaboration

One of the key challenges to the implementation of programmes within the DOH’s priority areas is that many of the indicators mentioned in the table above are not solely the responsibility of the department—for example HIV prevalence. However, there are few mechanisms for intersectoral collaboration.

Many of the activities proposed in the new PHC package, particularly the intersectoral activities, should be indicative only. They are meant to highlight an approach to service delivery. A definitive package of services is best developed through subdistrict- and district level-priority setting and planning processes that take an integrated approach to disease burdens and their causes. This also will allow for the incorporation of specific priorities (such as malaria) where they affect particular regions of the country. Similarly, decisions on emphasis and sequencing within priorities should be made locally, based on the particular profile of need in that area.
Training of Healthcare Providers

The need for pre-service and in-service training in SRHR is mentioned by most policies reviewed for this document. SRHR training has the following three broad dimensions:

- Management skills of diverse kinds—for example, in quality improvement or collation and use of facility data;
- Technical knowledge of diverse kinds, covering all of the policies described in this review. This is particularly challenging, given that new policies, technologies, and drug regimens constantly are being introduced. It is also a challenge where healthcare providers need to understand the interactions between different health issues and drug regimens; and
- Communication capacity, so that interactions with clients are respectful and non-judgemental, and information is provided in a manner that is meaningful to clients, despite their differences in age, sex, and other characteristics.

Pre-service training

Undergraduate healthcare provider training gives little attention to the SRHR approach (Ramkissoon et al 2010). In particular, nurses, who are the key professionals at the district level, are not trained appropriately for the kind of work that is expected of them. While much of the clinical content exists in current curricula, it is not always taught well. (key informant, Nursing College Principal, 2010) It is essential that teachers and tutors receive orientation and training so they can understand issues of sexuality and reproduction from a human rights perspective. This would enable them to integrate a sexual and reproductive rights approach into the curriculum. There is also a major gap in development of curricula and training of cadres of healthcare providers so that they can provide the psychosocial support outlined in many SRHR policies.

Regulatory bodies, such as the Health Professions Council of South Africa and the South African Nursing Council, play a critical role in determining the content of training of health professionals. For example South African Nursing Council (SANC) Regulations Government Notice No. 425 of 22 February 1985 and Notice No. R212 of 19 February 1993 provide some guidance about the requirements for training nurses and primary healthcare nurses. These regulations are open to different interpretations by different institutions and different tutors within the same institution. The current regulations prescribe only the number of training hours that should be spent on the clinical area but are not based on core competencies. Core competencies will, however, be introduced in the 2012 implementation of a proposed new nursing qualification training.
Some nursing colleges—for example, Limpopo Nursing College—have developed a curriculum on SRH for nurses. There are also a number of initiatives across the country considering the integration of reproductive health with HIV/AIDS training.

“Some of the learning or teaching materials show a limited understanding of how to incorporate rights.” (Key informant, Nursing Organisation, May 2011)

Many policies require healthcare providers to offer psychosocial support or counselling. Unfortunately, this service is noticeably absent from current training curricula. The issue of a human rights orientation to healthcare provider training is discussed further in Chapter 4. Suffice it to say that there is no requirement that healthcare providers understand and are able to operationalise South Africa’s obligations under international human rights treaties and the Constitution in relation to creating a culture of professionalism and respect. Current training does incorporate ethics, which should provide an entry point to a discussion of these issues. (Key informant, Nursing Organisation, May 2011)
A new cadre of middle-level health worker—the clinical associate—is being trained to provide comprehensive district-based primary healthcare services, including routine gynaecological problems (including STIs) and emergency obstetrics. (Prof. Ian Couper, Wits Family Medicine, Personal communication, May 2011) While this cadre of health worker will be based in district hospitals, their role could improve access to some SRHR services. However, training institutions currently are not required to include termination of pregnancy in their training. (Key informant, Nursing Organisation, May 2011)

Postgraduate training

Some postgraduate courses and degrees, such as the Master of Public Health at the Universities of Cape Town, Western Cape, and the Witwatersrand, include elective modules such as “Gender and Health” and “Sexual and Reproductive Health and Rights.”

In-service training

Newly qualified doctors and nurses require extra training before they are confident enough to work alone (Ross, 2002). Given the scope and complexity of their work, having insufficiently equipped staff is a challenge. Currently, each programme (HIV/AIDS, maternal health, etc.) provides separate trainings. The new primary healthcare approach aims to change this so that programme managers are replaced by generic primary healthcare managers who will be able to plan and supervise integrated interventions, whether healthcare provider training, community-based interventions, or integrated service provision.

Models of training suggested by key informants include the following:

- Trainers could come to the healthcare facilities. They could choose days and times when facilities have a low patient load, and communities could be informed that the staff will be in training at a particular time.
- Visiting doctors could also be used to impart skills to nurses.
- Training should be provided by trainers or programme managers who will have training as a primary responsibility and be based at district hospitals.

Gaps in pre-service and in-service healthcare provider training

- Nursing curricula do not prepare nurses adequately for their responsibilities in implementing existing SRHR policies in relation to the clinical and the values dimensions of these policies.
- There is no mechanism for integrated in-service training that covers all of the new policies or clinical interventions together.
- Healthcare providers lack the capacity to provide the psychosocial support outlined in many SRHR policies and to distinguish between their own values in relation to sexuality and the sexual and reproductive rights of their clients.
- Those engaged in community outreach, including the new cadres of health workers to be established, are not trained in the methodologies needed to promote dialogue and skills building so as to shift public norms and values, as well as individual behaviour.
- There are not enough trained counsellors.
CHAPTER 3: THE ESSENTIAL PACKAGE OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

This section provides an overview of the health status of South Africans; the laws, policies, strategies, and guidelines regarding health and health services; and implementation of SRH services, to the extent that there is information available in the literature or through interviews with key informants. It should be noted, however, that the reviews of health status and health services are not comprehensive, but rather aim to give a sense of the current situation in relation to the goals of achieving SRHR for all people in South Africa.

It should be noted that SRH services, except for HIV and AIDS services, predominantly target adult women of reproductive age. Most of the information presented in this review therefore focuses on them, although some aspects of men’s SRH also are addressed. However, while there is some research on masculinity in South Africa and there are nongovernmental organisations, such as Sonke Gender Justice, working with men, the literature review was not able to identify material on men’s experiences or preferences in relation to SRH services or what kind of services would be appropriate for diverse groups of men. Hence, there is no evidence that public health services are meeting men’s specific SRH needs. These needs could relate, among others, to service provision regarding sexuality, sexual dysfunction, and psychosexual problems; sexual abuse; contraception or infertility; the prevention and treatment of STIs, including HIV; and prostate and testicular cancers and urologic conditions.

A similar lack of information about SRH needs was found for other populations that have specific SRHR challenges, such as adolescents, disabled people, or transgender people. These populations are discussed in Chapter 4. Given the high prevalence of HIV in South Africa, the review does not address the HIV positive population as a separate population but rather ‘mainstreams’ the SRHR needs of people living with HIV in relation to each component discussed below.

In addition to the Constitution, the following laws, policies, strategies, and guidelines define the provision of SRHR services in South Africa:

Table 8. Laws, policies, strategies, and guidelines reviewed

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<td>Choice on Termination of Pregnancy Act 92 (1996); Amendment Acts</td>
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<td>Children’s Act 38 (2005)</td>
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<td>Sterilisation Act 44 (1988); Sterilisation Amendment Act 3 (2005)</td>
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<td>Promotion of Equality and Prevention of Unfair Discrimination Act</td>
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<td>National Health Act 61 (2003)</td>
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<td>Alteration of Sex Description and Sex Status Act 49 (2003)</td>
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<td>Criminal Law (Sexual Offences and Related Matters) Amendment Act 32</td>
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<td>National Directives and Instructions on Conducting a Forensic</td>
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<td>Examination on Survivors of Sexual Offence Cases in Terms of the</td>
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<td>Criminal Law (Sexual Offences and Related Matters) Amendment Act</td>
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<td>Government Notice 223, 6 March 2009</td>
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### Policies
- A Comprehensive Primary Health Care Package for South Africa (2001); Core Package for Four Levels of Care: A Discussion Document (2007)
- National Contraception Policy: Guidelines within a Reproductive Health Framework (2001) (currently being revised)
- National Youth Policy 2008–2013
- National Service Delivery Agreement for Outcome 2: A Long and Healthy Life for All South Africans (October 2010)
- National Policy on Rape, Sexual Assault and Other Related Sexual Crimes (2010 draft, drawing on the National Sexual Assault Policy 2005)
- Sexual and Reproductive Health and Rights: Fulfilling our Commitments, final draft (2011)

### Guidelines
- National Guidelines for Cervical Screening Programme (2000) (currently being revised)
- Policy Guidelines for Youth and Adolescent Health (2001) (forthcoming updated draft)
- Gender Guidelines for Public Health (2002)
- National Contraceptive Service Delivery Guidelines within a Reproductive Health Framework (2003) (currently being revised)
- Guidelines for the Management of HIV and AIDS in Adults (2010)
- Guidelines for Tuberculosis Preventive Therapy among HIV-infected Individuals in South Africa (2010)
- National Condom Policy and Management Guidelines (2011)
Components of Sexual and Reproductive Health and Rights

Sexuality: Sexual desire, pleasure, and function

Status
Concerns related to sexual functioning are universal but take culturally specific forms. Generally, between 8 percent and 33 percent of the adult population in developed countries, where more research has been undertaken, are estimated to experience some kind of sexual dysfunction in their lifetime, although some studies suggest that the true figure may be higher (Laumann et al., 1999). Sexual problems include low sexual desire, male erectile dysfunction, inability to achieve orgasm, premature ejaculation, pain during intercourse, and vaginismus. These concerns are relatively common but seldom are diagnosed or treated by the public sector. Etiological and epidemiological factors have only recently begun to be explored in any depth. The most researched area is erectile dysfunction in men, a condition common in all societies in which studies have been conducted (Prins et al., 2002). In a number of countries (Egypt, Islamic Republic of Iran, Morocco, Nigeria, and Pakistan), the likelihood of men reporting erectile dysfunction was found to be associated with various characteristics, most commonly increasing age (Berrada et al., 2003; Seyam et al., 2003; Shaeer et al., 2003).

According to studies conducted in Egypt, Nigeria, and Pakistan, sexual dysfunction is associated with common mental illnesses, including depression, and with low quality of life. It also can be exacerbated by certain drugs, including anti-depressants (Outhoff, 2009). Sexual function also is linked to dominant societal expectations (of what it means to be a man, a woman, or transgender, for example) and cultural mores and beliefs (Berrada et al., 2003; Seyam et al., 2003; Shaeer et al., 2003).

Sexual dysfunction can cause considerable suffering, damaging an individual’s ability to form or sustain intimate relationships. In a broader sense, discomfort with sexuality may reduce an individual’s ability to set appropriate boundaries personally and within relationships (Robinson et al., 2002). Drawing attention to sexuality within the concept of ‘sexual and reproductive health and rights’ implies recognizing the critical role that sexual function and dysfunction play in maintaining positive sexual relationships.

Our literature search found that no data exist on the nature or magnitude of sexuality, sexual development, and sexual-function problems in South Africa.

Policy
There is no stand-alone policy or guideline on this issue, although a healthy lifestyle strategy that includes promoting safer sexual practices is apparently in development. Most of the SRHR-orientated policies reviewed explicitly aim to promote human rights and positive sexual and reproductive relationships but do not specifically cover sexuality, sexual development and desire, pleasure, or function. Rather, they focus on sexuality-related issues, for example, in relation to adolescents, on condoms or delaying sexual debut (see “Policy guidelines for youth and adolescent health 2001” below). Nor do they provide guidance to healthcare providers on how to provide information and counselling on these key elements of

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Vaginismus is a condition in which there is involuntary tightness of the vagina during attempted intercourse. The tightness is actually caused by involuntary contractions of the pelvic floor muscles surrounding the vagina. The woman does not directly control or 'will' the tightness to occur; it is an involuntary pelvic response. She may not even have any awareness that the muscle response is causing the tightness or penetration problem (http://www.vaginismus.com).
sexual health and well-being, except in clinical terms; for example, loss of libido as a result of diabetes.

Services
Anecdotal conversations with programme implementers and policymakers and a review of the limited literature all indicate that healthcare providers are embarrassed in dealing with questions of sexuality. They may not welcome people whose sexual cultures or practices may not ‘fit’ with their own; for example, young people, transgender people, sex workers, and people who engage in same-sex practices (Stadler and Delaney, 2006; Wojcicki and Malala, 2001; Tallis, 2009). Similar complaints from disabled people are that others treat them as if they are asexual (Basson, 1998).

There are no public sector programmes addressing sexual dysfunction or questions of desire and pleasure. The review did not examine private sector services.

Key informant interviews reinforced the lack of attention to sexual health.

“I think the issue of sexual health sort of just falls by the wayside. And I think that it’s important because it can affect your other messages. For example, if you urge people to use condoms and to get STDs treated but you don’t look at why that might be difficult, then you’re not going to be very successful in those—in the implementation of those things—so if you don’t look at the sexual problems people have, the sexual issues they have, negotiation issues, do they like condoms?” (Provincial manager, situation analysis)

One respondent commented that the problem is not only the absence of sexual health services for men, but also that most policies see women only as mothers.

“Policies don’t incorporate the [sexual health] needs of women, men, in their own right rather than as carers of children or whatever, or as partners of each other. And they don’t bring a rights approach.” (District manager, situation analysis)

Gaps in policies, strategies, guidelines, and services regarding sexuality

- There is a lack of information in relation to different age groups and populations about
  - Sexual cultures and practices;
  - Sexual pleasure, desire, and function; and
  - Health service capacity in addressing sexuality and sexual health and well-being.
- There is a lack of healthcare provider training using a life-cycle approach to sexuality, including in relation to
  - The evolving capacities of young people to understand and make sexual and reproductive decisions;
  - Menopause and aging;
  - The diversity of sexual practices among both opposite sex and same sex practising people and the health implications of these practices;
  - How various drug regimens impact libido and sexual function; and
  - How to communicate effectively with clients about their sexual development and how to address sexual problems.
- There is a lack of sexuality information that discusses sexual desire, pleasure, and function.
- Counselling clients about their sexuality is not part of the health service package.
- Co-morbidities of depression, addiction, and sexual function have not been addressed.
Sexual and Gender-based Violence

Status

“South Africa has some of the highest levels of both HIV and gender-based violence (GBV) worldwide” (Ghanotakis et al., 2009, p. 357; Jewkes et al., 2009; Matthews et al., 2004). Although it is difficult to measure the prevalence of intimate partner violence, a few studies in South Africa have attempted to do so. For example, one study conducted in Cape Town in 2006 found that 42.3 percent of the 1,378 men interviewed reported using physical violence against their partners (Abrahams et al., 2006, p. 250). After adjusting for age, occupational group, and race, the study identified several factors associated with the use of intimate partner violence: having no post-school training, witnessing parental violence in childhood, being involved in fights at work or in communities, drug and alcohol use, perceiving hitting women to be acceptable, and frequent conflict (including about sex and infidelity). Another study was conducted in 1998 in three South African provinces to measure the prevalence of physical, sexual, and emotional abuse of women and identify risk factors and associated health problems and health service usage. It found that lifetime prevalence of experiencing physical violence from a current or ex-partner was 24.6 percent and that 9.5 percent of women interviewed had been assaulted in the previous year (Jewkes, Levin et al., 2002, p. 1607). It also found that domestic violence was significantly associated with violence in a woman’s childhood, her lack of education, her level of alcohol consumption, having another partner in that year, having a confidante, her partner’s preference for sons, conflict over his drinking, either partner financially supporting the home, and living outside of the Northern Province (Jewkes, Levin et al., 2002).

A study of men across age, class, and ethnicity in two provinces found that 27.6 percent of the men interviewed had raped a woman or girl (Jewkes et al., 2009, p. 1). It found that “parental absence was significantly associated with raping, as was the quality of affective relationships with parents. ... Rape was associated with significantly greater degrees of exposure to trauma in childhood.” In addition, “men who disclosed violence were very much more likely to have engaged in a range of risky sexual behaviour, as well as to have raped and been raped”; “men who are physically violent towards their intimate partners are more likely to have HIV” (ibid, p. 2).

Domestic violence generally is understood to include physical, sexual, and psychological abuse by and of intimate partners. The literature suggests that both normative use of violence in society—that is, social acceptance of violence—and gender inequality are associated with the use of violence against intimate partners (Jewkes, 2002; Abrahams et al., 2006). “Male superiority is manifested, for example, in distinct gender roles, a low social value and status of women, and ideas of manhood linked to the control of women and male sexual entitlement...Lack of family and social support, low levels of education, and poor opportunities for employment may prevent women from leaving abusive relationships, thus prolonging their risk of abuse” (Abrahams et al., 2006, p. 248).

Sexual abuse is happening due to the fact that if you refused to have sex with a man he will beat you and tear your clothes. Surprisingly, you are in love and there is no time for protection. We become pregnant unexpectedly and get HIV/AIDS or STI. Because of this, I ask myself how many of his girlfriends he forced? (Female informal settlement dweller, cited in Parker and Hajiyiannis, 2008, p. 14)
Sexual and gender-based violence (SGBV) undermines women’s and girls’ human rights to dignity and autonomy. The impact of SGBV is also linked to many serious health problems for women, both at the time the violence occurs and throughout their lives. Health consequences include injuries, gynaecological disorders, mental health problems, sexual dysfunction, adverse pregnancy outcomes, and STIs. In addition, a review conducted by Garcia-Moreno and others for the World Health Organisation identified the following conditions as being associated with physical and sexual abuse: irritable bowel syndrome; sexually transmitted diseases; gastrointestinal disorders; gynaecological problems, including vaginal bleeding and vaginal infections; urinary tract infections; chronic pelvic pain; and serious mental health problems, such as depression, anxiety, post-traumatic stress disorder, and risk of suicide (Garcia-Moreno and Stöckl, 2009). SGBV, including intimate partner violence, can have severe physical and mental health consequences, including serious SRHR consequences. In addition, intimate partner violence is a barrier to the use of contraceptives and condoms by women, and denies them their reproductive and sexual rights. It increases the risk of forced sex and makes it harder for women to negotiate condom use with their partners (Programme on International Health and Human Rights, 2009).

“Violence, and the fear of violence, severely limits women’s contribution to social and economic development, thereby hindering achievement of the Millennium Development Goals and other national and international development goals” (Population Council, 2008, p. 6).

There is a growing body of evidence showing that women who have experienced power inequities in their relationships with men and GVB are at greater risk of HIV (Jewkes, Sikweyiya et al., 2009). Since men who have been violent are more likely to be infected, women in relationships with violent men are particularly vulnerable to HIV infection (Jewkes and Morrell, 2010).

“While girls are the most visible survivors of sexual violence, they are far from being the only ones who suffer from the consequences: children of both sexes constitute the majority of abuse survivors, and adult men and the handicapped are minority groups who are often neglected in research and interventions” (Population Council, 2008, p. 1). In addition, the Boksburg Kidz Clinic and the Teddy Bear Clinic indicates that the number of boys seeking services has been increasing annually. However, national data is not available.

Policies that address sexual and gender-based violence

The forthcoming National Policy on Rape, Sexual Assault and Other Related Sexual Crimes (2010) builds upon the National Sexual Assault Policy of 2005 and aims to improve healthcare after sexual assault and rape for women, children, and men. In particular, it will

- Establish an institutional framework within the NDoH to guide collaboration and cooperation between different directorates;
- Establish designated, specialised, accessible, 24-hour healthcare services for the holistic management of patients to improve their health status after sexual assault or rape;
- Operate as part of an intersectoral service, establishing and maintaining links with the community and key stakeholders at all levels of government and service provision—for example the Department of Safety and Security, the South African Police Service (SAPS), the Department of Justice, and the Department of Social Development;
• Provide training structures, guidelines, and standards; and
• Utilise monitoring and evaluation (M&E) as a tool to ensure the quality of sexual assault services.

The NDoH’s maternal, child, and women’s health and nutrition cluster is responsible for overall coordination and management of the implementation of sexual assault and post-rape services. A number of other clusters and directorates within the NDoH also have a role to play in the implementation of this policy, however. This is notable insofar as it assumes an integrated approach—for example, to provide post-exposure prophylaxis and STI treatment, to ensure that sexual violence is addressed in life-skills programmes within HIV prevention programmes, and to ensure that training includes the relevant aspects of mental healthcare. Indeed, the policy clarifies the links along various lines of responsibility within the NDoH, from chronic diseases to pharmaceuticals to communications.

Specific strategies for the provision of medical care in the policy are the following:
• Providing healthcare after sexual assault
• Providing the proper treatment of injuries
• Preventing unwanted pregnancy
• Providing post-exposure prophylaxis for HIV
• Preventing and treating other infections, including STIs and hepatitis B
• Preventing and treating psychological distress
• Providing access to psychological and psychiatric care
• Providing medical certificates for sick leave
• Ensuring that proper follow-up arrangements are in place on discharging the patient
• Providing information to the patient
• Providing the appropriate and complete documentation of injuries

The medico-legal service strategies are the following:
• Reporting forensic evidence
• Collecting forensic evidence in an appropriate and complete manner
• Ensuring that sexual assault examination kits are available at facilities that provide sexual assault services
• Ensuring the integrity of the evidence chain
• Giving evidence in court
• Meeting the legal obligation to report certain sexual offences
• Testing alleged offenders for HIV

Strategies for minimising the impact on staff of vicarious trauma are vital for sustaining post-rape care service provision, including the following:
• Monitoring the psychological well-being of staff involved in post-rape care and providing counselling for them; and
• Monitoring and managing the work loads of staff involved in post-rape care to prevent excessive exposure to vicarious trauma.

The Policy Guidelines for Youth and Adolescent Health 2001 describes the following strategies for addressing violence, including SGBV, in this population:
• Prioritise parents who are at risk of abusing their infants by performing more clinic or home visits, before and after the birth;
• Train healthcare professionals to identify, manage, and refer clients who have been abused physically and/or psychologically; and
• Provide 24-hour, youth-friendly emergency services that include psychological counselling for adolescents and youth who have been victims or perpetrators of abuse and violence.

**Services that address sexual and gender-based violence**

The literature review revealed that there is a large body of evidence in South Africa and elsewhere about what works and does not work in programmes that address GBV. Unfortunately, despite the multitude of tested interventions, not much progress has been made. For example, a study of community health centres in the Western Cape found that women visited the centres for a variety of reasons, some of which should alert healthcare providers to the possibility of intimate partner violence—assault, headache, request for psychiatric medication, sleep disturbance, dizziness, feeling anxious, depressed, or fatigued. Hypertension was a frequently cited reason for attending the clinic; depression was the most common diagnosis. Yet intimate partner violence rarely was identified as a possible causal factor, indicating a low standard of care despite the existing policy (Joyner and Mash, 2010).

There is little integration between services addressing GBV and broader SRHR programmes. The *National Policy on Rape, Sexual Assault and Other Related Sexual Crimes (2010)* describes GBV services as specialist services, but there is still a need to integrate GBV and HIV service delivery, particularly in a country like South Africa, where the two epidemics co-exist (Ghanotakis et al., 2009). A systemic approach to the implementation of GBV services should include the following:

- Changes in norms, policies, and protocols;
- Infrastructure upgrades to ensure private consultations;
- Training of all staff (including managers) on screening for GBV, safety planning for victims, and the provision of emotional support;
- Increased availability of emergency voluntary testing and counselling services (HIV, STI, pregnancy); HIV post-exposure prophylaxis (PEP); treatment of STIs, emergency contraception; and treatment for other common health consequences of GBV; and
- Strengthening the referral system by linking GBV-related services with other services, such as legal advice, psychosocial support, and shelter (Bott et al., 2005; Betron et al., 2006, cited in UNFPA, 2010).

This approach is reflected in the *National Policy on Rape, Sexual Assault and Other Related Sexual Crimes (2010)*; however, this policy was still a draft as of July 2011 and so has not yet been implemented. Despite this, victims of sexual assault are receiving some services, as indicated by the NDoH’s Annual Report, which states that 64 percent of health facilities are rendering services for survivors of sexual assault (NDoH, 2010d, p. 33).
A best practice model in Thuthuzela care centres, South Africa

The Thuthuzela care centres are a unique, one-stop, integrated response to addressing GBV against women and children, as well as HIV and AIDS. The Thuthuzelas (from a Xhosa word meaning “comforting”) operate in some communities where the incidence of rape is high. They are linked to Sexual Offence Courts, which are staffed by a committed team of prosecutors, social workers, investigating officers, magistrates, health professionals, and police and are located in close proximity to the Thuthuzela. The centres are managed by an interdepartmental team composed of the departments of justice, health, education, correctional services, safety and security, local government, home affairs, social development, the Treasury, and designated civil society organisations. The centres have been working to develop best practices and policies to reduce the victimisation of women and children while improving prosecution, particularly in the areas of sexual offences, maintenance, child justice, and domestic violence. The Thuthuzelas’ approach to rape care is one that involves restoring dignity to the victim and ensuring justice for children and women who are victims of sexual violence.

Services offered at the Thuthuzela care centres include the following:
- Psychosocial support from a coordinator or nurse
- Information about the medical examination and how evidence of rape will be collected
- Seeking the victim’s consent for medical examination before the procedure is undertaken by a doctor
- Presence of a (female) nurse during the examination
- Use of bath and shower facilities
- An interview conducted by the investigation officer
- Immediate and long-term counselling services
- A follow-up visit for treatment
- Medication for STIs and HIV
- Transportation between clinic and residence
- Shelter, if desired by the victim
- Consultations with a specialist prosecutor before the court case
- Information about the outcome of the trial process

(National Prosecuting Authority, 2009)

The Thuthuzela model has been evaluated but findings have not yet been released. Although the model is well regarded for its innovative approach to dealing with GBV, it has several limitations. First, the centres offer services only during office hours, during which an average of only 25 percent of victims report their assault. Services for victims needing support after hours, (the other 75%) are not included in the model. Instead, these clients are seen as the responsibility of nongovernmental organisations, most of which do not receive any governmental financial support to provide such services, or hospitals, where healthcare workers do not have the capacity to provide the kind of care and support needed by these clients. Second, this model requires multisectoral coordination; however, obtaining this collaboration between different governmental departments often is difficult. As a result, some services are not implemented—for example, providing the victim with transport home might only occur if the police have a vehicle available. Also, follow-up of PEP often is not done because staff do not have transportation for making the follow-up visit. (Key informant, NGO service provider)
Gaps in policies, strategies, or guidelines on sexual and gender-based violence

- The Thuthuzela model has operated as a vertical program, with the majority of funding for the program coming from donors. The new primary healthcare approach (described in Chapter 2) requires integration with other dimensions of SRHR.
- There are not enough primary healthcare providers trained to detect and manage individuals affected by SGBV and to take forensic evidence.
- Systems of support for providers are not institutionalised.
- Sustained public outreach programmes that challenge current values and attitudes about masculinity and societal acceptance of GBV and that build the capacity of individuals to take a stand against such beliefs (see Chapter 4 for examples of such programmes) have not been institutionalised.

Harmful practices

Internal ‘cleansing’, drying, and tightening of the vagina are believed to increase women’s risk of acquiring HIV and STIs (Smit et al., 2007). A household survey in KwaZulu-Natal using multistage cluster sampling of women ages 18 to 60 years (n=867) tried to determine the prevalence of practices such as internal cleansing, ingestion, application or insertion of substances, that aim to cleanse, dry or tighten the vagina. The survey found that the majority of women currently follow one or more of these practices (90.2%), with 34.8 percent reporting using two practices and 16.3 percent reporting following more than three. Internal cleansing was the most common practice performed (63% of women) and was undertaken frequently (61.6% cleansing twice daily; 20% using more than two products). Fewer report application (10.1%), insertion (11.6%), or ingestion (14.3%) practices (Smit et al., 2007). There is limited understanding of what these practices entail, what motivates women to undertake them, and their sociocultural and historical meanings (Scorgie et al., 2009). In a study conducted in KwaZulu-Natal (Scorgie et al., 2009), the majority of the participants believed that vaginal practices were widespread among sexually active women in rural and urban areas. Strong motivations for such practices included women’s desire to enhance men’s sexual pleasure and fidelity and obtain control in their relationships. “Both women and men revealed intricate expectations about the nature and quality of sexual intercourse and it is these expectations that largely motivate women’s vaginal practices” (Scorgie et al., 2009, p. 274). Any intervention to change women’s reliance on such vaginal practices must recognise and attend to the broader social contexts in which these are embedded (Scorgie et al., 2009).

Other harmful practices, such as ukuthwala, a custom practiced mostly by Xhosa speakers in the Eastern Cape Province and some parts of KwaZulu Natal, involves a man and his peers forcing young girls and their families into marriage negotiations by making them partake in sexual acts, mostly against their will. Young girls from as young as 10 years of age are taken to a man’s house against their will and forced to be a man’s wife and have sex with him. In most cases, the men are up to 20 years older than the girl being forced to marry them. The large age difference, more extensive sexual history of the men, and coercive circumstances make negotiating safer sex options for the girls very difficult (Parliamentary Monitoring Group, 2009).

Traditional male circumcision can be considered a harmful practice in light of high morbidity levels in South Africa. It is addressed in the section on HIV and AIDS, in which medical male circumcision is also discussed.
**Gaps in policies, guidelines, or services regarding harmful practices**

- There are no systematically funded public outreach programmes to build understanding of the dangers of vaginal cleansing practices.
- Healthcare providers do not have guidelines to help manage the consequences of harmful practices.
- There are no systematically funded public outreach programmes to shift cultural values towards accepting girls’ and women’s right to autonomy and dignity in sexual decisionmaking and relationships.

**Fertility management**

*Contraception*

*Status*
The United Nation’s Population Fund’s (UNFPA’s) 2003 *South African Country Profile* indicates that contraceptive use is high, with 61 percent of sexually active women (15–49 year olds) using a modern contraceptive method. Both the two-month (NET-EN) and the three-month (DMPA) injectables are offered widely throughout the country and account for 49 percent of current contraceptive use nationally and up to 90 percent in some settings. According to the *National Condom Policy and Management Guidelines (2011)*, 308 million male condoms were distributed through the public sector to primary sites in 2007/08, 283 million in 2008/09, and 445 million in 2009/10. This translates to 70 percent of all condoms distributed by the public sector. In addition, 122,000 female condoms were sold at subsidized rates as part of the national condom social marketing program conducted by the Society for Family Health (NDoH, 2011).

The *National Condom Policy and Management Guidelines* highlight obstacles to effective and widespread condom usage. These include social and cultural beliefs and norms that restrict or stigmatize condom use; the lack of control over male condom use as a result of unequal gender power relations; lack of negotiating skills; incompatibility of regular condom use with people’s need for procreation; fear that insisting on condom use will be interpreted as a lack of trust in their partner or that female condoms are linked to female promiscuity; difficulties in obtaining condoms due to high prices, restricted availability, or lack of privacy at the point of sale or distribution; the belief that condoms reduce sensitivity or are uncomfortable or disruptive to spontaneous love-making; inability to use condoms correctly and handle condom failures; and inappropriate quality or design of condoms that raise public concerns about safety (NDoH, 2011). There have also been occasional stock outs of condoms.

Using the 2001 national census as the sampling frame, a nationally representative survey of South African 15- to 24-year-old sexually active women was undertaken. Participants completed a questionnaire on sexual behaviour and provided an oral fluid sample for HIV testing. Findings from the survey indicated that two-thirds of adolescent women reported that they had been sexually active, of which 87 percent had been sexually active in the previous 12 months. Among women who reported being sexually active currently, only 52.2 percent reported using contraceptives. “Amongst those women who reported that they were currently using a contraceptive 26.5% (95% CI: 20.9–33.1%) were using condoms only; 8% (95% CI: 4.4–10.4%) were using dual method (barrier and hormonal); and 66.6% (95% CI: 57.5–74.7%) were using only a hormonal method of contraception. A small percentage of women reported using less reliable methods (1.1% of contraceptive users) such as natural, rhythm,
withdrawal or safe period. These women were excluded from later analysis. Half of sexually experienced women reported having ever been pregnant (95% CI: 46.4–52.7%), of whom 65% indicated that their pregnancy had been unwanted. Despite this, only 2.6% reported having accessed termination of pregnancy” (MacPhail et al., 2007, p. 3). Although condom distribution is a component of the HIV strategic plan, HIV-positive women in South Africa “may receive little information on contraceptive options or find it difficult to use contraceptive methods of their choice” (de Bruyn, 2004). A study of childbearing intentions of HIV-positive women identified a range of fertility goals among them, which indicates their need for information and support in managing their fertility (Kaida et al., 2010).

Policy and guidelines

National Contraception Policy Guidelines—Within a Reproductive Health Framework (NDoH, 2001) and The National Contraception Service Delivery Guidelines (NDoH, 2003), (currently being revised)

Objective: Enable all people to exercise their contraceptive choice safely and freely.

The guidelines address the following issues:

Health service

- Remove barriers that restrict access to contraceptive services.
- Train service providers and educators to increase public knowledge on contraception.
- Utilise all opportunities to provide information, education, and communication (IEC) materials about contraception and reproductive health.
- Increase the accessibility of client-acceptable contraceptive methods.
- Provide high-quality contraceptive services.
- Provide contraceptive services during other PHC consultations, as appropriate.
- Provide contraceptive methods safely and correctly in accordance with standardised contraceptive clinical practice guidelines and infection prevention protocols.
- Provide effective counselling in a private and comfortable environment and ensure confidentiality.

Methods

- More extensive use of barrier methods should be promoted urgently in view of the STI/HIV epidemic. At least one female-initiated barrier method should be made available. Promote dual-protection approaches for protection against pregnancy and STI/HIV infection.
- High-dose oral contraceptives should be phased out.
- Address the use of hormonal contraception for women living with HIV and ensure that they use dual protection and not just condoms.
- Core methods that should always be available in stock at all health facilities include male condoms, low-dose combined and progestogen-only pills, progestogen-only injectables, and emergency contraception.
- Methods that may require referral and will be provided by specially trained providers include intrauterine device (IUD), female and male sterilisation services, female condom (at selected facilities), and natural family planning approaches. Postpartum: on discharge from health facility and at the six-week postnatal check-up, all women should be counselled about contraception and supplied with a suitable method of their choice. The same applies to post-abortion.
Training

- Revise or develop contraceptive training curricula for the different categories of service providers and students, including the following:
  - Values clarification, anti-stigma training, and the development of client-centred approaches to care\(^3\) to help ensure that providers uphold clients’ rights and provide services to all people, irrespective of age, race, sex, social status, and disability in a respectful, understanding, and nonjudgemental manner;
  - Provision of IEC materials and counselling to the public and clients;
  - Technical knowledge and skills on contraceptive technologies, method provision, and follow-up; infection prevention; special sexual and reproductive healthcare needs of priority groups; and prevention and management of interrelated SRH priority areas (such as STI/HIV infection, infertility, cervical cancer, breast cancer, violence against women, teenage pregnancy); and
  - Management skills, including quality improvement methods; the recording of client information; and the collection, collation, and use of data routinely collected for the District Health Information System.

**National Condom Policy and Management Guidelines (2011)**

Objective: To provide a framework for the Condom Procurement and Distribution Program, which deals with the distribution of male and female condoms by the public sector. The framework is based on gaps identified within the programme.

The policy’s target group is policymakers and provincial and district-level programme managers. It describes several strategies for

- Fostering an enabling policy environment for condom promotion and distribution;
- Ensuring adequate funding/financing for condoms;
- Ensuring smoothly operating supply-chain management of condoms;
- Ensuring correct estimation of condom needs;
- Ensuring that condoms are purchased at the lowest available price;
- Ensuring that only high-quality condoms are made available to the public;
- Ensuring effective distribution, warehousing, and issuing of condoms at PDS/SDS;
- Removing barriers that restrict access and use of condoms;
- Ensuring the monitoring and evaluation of condom management program activities; and
- Ensuring that relevant operational research is conducted to inform policy and practices.

**Sterilisation Act 44 of 1998; Sterilisation Amendment Act No 3 of 2005**

- The Act recognises that women and men have the right to be informed of and have access to safe, effective, affordable, and acceptable methods of fertility regulation.

\(^3\) These are described further in Chapter 4: A Culture of Sexual and Reproductive Health and Rights – Health services: respecting and protecting health providers’ and clients’ human rights
The Act provides the right to sterilisation and the right to determine the circumstances under which sterilisation may be performed.

The Act identifies who can consent (over 18; capable of consenting) to sterilisation and stipulates when sterilisation can be performed on persons incapable of consenting or incompetent to consent due to mental disability.

Sterilisation may not be performed on a person who is under 18 unless failure to sterilise would jeopardise his or her health or life.

Sterilisation may be performed on any person who is incapable of consenting or incompetent to consent, on request to the person in charge of a hospital and with the consent of a parent, spouse, guardian or curator; if the person is mentally disabled to such an extent that they are incapable of making their own decision about contraception or sterilisation; if the person is developed mentally to a sufficient degree to make an informed judgement about contraception or sterilisation; and if the person can fulfil the parental responsibility associated with giving birth.

The Amendment Act calls for obtaining additional medical advice in certain circumstances when sterilisation is being contemplated.

**Contraception Policy in the Children’s Act**

Act 38 of 2005 was enacted in 2006 and promulgated in 2010.

**Objectives:**
- To regulate children’s access to contraceptives;
- To strengthen the autonomy of children in making decisions that affect them. Based on this, the Act stipulates that “contraceptives other than condoms may be provided to a child on request by the child and without the consent of the parent or care-giver of the child if the child is at least 12 years of age”;
- To ensure confidentiality for children who receive condoms, contraceptives, or contraceptive advice; and
- To require healthcare providers to report sexual abuse.

The Southern African HIV Clinicians Society published a **Guideline on Safer Conception in Fertile HIV-Infected Individuals and Couples** (Bekker et al., 2011) in June 2011 which will inform the forthcoming revision of Department of Health guidelines on fertility management. These propose a planned approach, including counselling of seroconcordant and serodiscordant couples to identify the safest and most effective conception methods; for example:

- Seroconcordant couples should ensure that the viral load in both partners is as low as possible and have unprotected sex only during the woman’s most fertile period;
- Serodiscordant couples in which the male partner is HIV positive can use sperm washing, in which the fertilizing sperm is separated from the infectious seminal fluid, thus reducing the risk of HIV infection of the woman and her unborn child; and
- Serodiscordant couples in which the female is HIV infected can use manual self-insemination with the partner’s sperm.

The guidelines also provide guidance to healthcare providers on how to manage AIDS in seroconcordant and serodiscordant couples who desire a pregnancy.
I went to the doctor at my clinic in Groote Schuur in Cape Town and I told them I’m pregnant … he told me there is a trial [ARVs], I can have a healthy child. I told him … I want to have an abortion. He referred me to the other clinic and they told me… “you are not supposed to fall pregnant when you are HIV positive, you can die any time. If you must want an abortion you must sign for sterilization.” …I will say that I signed it because of the pressure that the doctors put on me…My boyfriend is leaving me because I cannot have a child.” (Workshop participant, cited in Le Roux and Stevens, 2011, p. 33)
More people now have access to female condoms, of which more than 4 million are distributed annually. However, female condoms still are not as easily available as male condoms, since they cannot be found in all existing distribution sites (Susser et al., 2009). People face additional barriers to contraception. For example, few healthcare providers are trained in insertion of IUDs, and male sterilisation is barely promoted (Ross, 2002).

Although injectable contraceptives make up a large percentage of the contraceptive method mix, many women discontinue their use, either by choice (Beksinska et al., 2001) or because they return too late for reinjection. A comparative study found that “only 1% of continuing clients in the Western Cape who arrived during the two-week grace period did not receive a reinjection; however, 36% of similar clients in the Eastern Cape did not receive a reinjection” (Baumgartner, 2007, pp. 66), reinforcing differences in service quality across the country.

Several key informants talked about pressure put on women, particularly those who are HIV positive, to be sterilised, and that some women make such decisions while in labour. There is no scientific evidence of these claims, but these anecdotal reports from women again reflect the failure to implement the current contraception policy. A number of studies note lack of effective contraceptive counselling and mixed experiences of nurses’ attitudes, with adolescents in particular experiencing scolding by nurses. (Gatsinzi and Maharaj, 2008; Wood and Jewkes, 2006).

**Gaps in contraception policies, guidelines, and services regarding contraception**

- Healthcare professionals are mandated by the Children’s Act to report sexual child abuse (Section 110) and by the Sexual Offenses Act to report consensual sex between teenagers under the age of 16 (i.e., statutory rape). The Children’s Act, however, also requires providers to offer confidential reproductive health services to children, including contraceptives to children 12 years and older who request them. These duties are inconsistent, and healthcare workers are thus faced with opposing legal obligations.

- The contraceptive policy focuses predominantly on women of reproductive age. Some subgroups in this target population, however (e.g., women living with HIV, disabled women, and sex workers), may experience disrespect and stigmatisation, which undermines their ability to manage their fertility effectively. There is a lack of sustained and institutionalised interventions to promote an understanding of reproductive rights among healthcare providers. Such an understanding is important to enable providers to deliver high-quality counselling and other services so that their clients, including adolescents and women living with HIV, can make informed decisions about their reproductive health.

- The policy also does not adequately address men.

- The increasing use of hormonal methods of contraception particularly injectable progestins rather than the promotion of a broad range of contraceptives is of concern.

- Decreasing numbers of family planning nurses are trained to insert IUDs (Ross, 2002). There is insufficient training, lack of provision in clinics, and a lack of advertisements about IUDs.

- The numbers of male condoms distributed is insufficient for HIV prevention and fertility management; the National Condom Policy and Management Guidelines do not address condom distribution outside of the health sector and are not linked to health information messages about correct and consistent condom use.
Female condoms are not universally available, costs per unit are still high, and public awareness and promotion of female condoms are limited. There is a growing demand from women’s organisations and from people living with HIV for greater access to them.

There is a lack of public awareness about the availability of male sterilisation, and such services are not widely available (Ross, 2002).

Community health workers are not enabled legally or trained adequately to distribute contraceptives other than condoms.

Public outreach programmes that aim to increase the knowledge and capacity of all individuals to manage their reproductive health and rights are lacking. Failure to address these issues as part of HIV public education is a missed opportunity.

Guidelines exist on contraception for people living with HIV, people on antiretrovirals, and people infected with TB. However, they have not been disseminated widely and are out of date in relation to current research. The issue of contraceptive provision in the context of high HIV prevalence has been neglected. A key mandate of the National Fertility and Contraception Policy Expert Group is to consider contraceptive provision and fertility counselling in the context of high HIV prevalence both for women known to be infected with HIV, on or off treatment, and for those exposed to HIV infection who are HIV negative. In addition, the new policy will provide guidance for safer conception for HIV positive and negative women and discordant couples who wish to become pregnant (Bekker et al., 2011). Whilst the revision of the policy is a work in progress at the time of publication of this review, the Fertility and Contraceptive Policy Working Group has been deliberating on the relevance of recent research related to HIV acquisition, transmission and HIV disease progression in relation to hormonal contraception, in particular DMPA, the long acting progestin injectable (Kleinschmidt et al., 2007; Morrison et al., 2010; Heffron et al., 2011). Recommendations include the need for further research, and expanding the contraceptive mix, including long acting reversible contraceptives (e.g. Intrauterine Contraceptive Devices (IUCD); Intrauterine Systems (IUS); and subdermal hormonal implants). Improved contraceptive training for all categories of healthcare workers including IUCD training and promotion is recommended. Continued promotion of consistent and correct condom use is also recommended. All the recommendations relating to contraception and fertility management in both this review, and in SRHR: Fulfilling Our Commitments (NDoH, 2011) inform the revised draft policy.

Once the new guidelines are out, the challenge will be to ensure that providers know what to do, and that women are unaware that services are available to them.

Many of these gaps are being addressed in the redrafting of contraceptive policy guidelines during 2011.

Gaps in relation to use of hormonal contraception for non-contraceptive purposes

There is widespread use of hormonal contraceptives by transgender people, despite an absence of any guidelines on appropriate use of hormones. Furthermore, neither health workers nor transgender people are informed fully about the proper regimens to use, side effects, and long-term implications of hormone use. (This issue is discussed further in the section on gender identity below.)

Post and perimenopausal women’s need for hormone replacement therapy is similarly not addressed in existing policies. Appropriate support for women through
menopause, with its associated training needs for healthcare providers, and information dissemination to women also need attention.

Infertility

*Status*
Infertility is a major problem in South Africa (Stewart-Smythe, 2003). However, the availability and quality of public sector data on infertility is problematic, primarily because of insufficiently large sample sizes; or failure to collect data at all.

HIV infection results in reduced fertility and poor pregnancy outcomes (Basu et al., 2010). Also, a history of STIs often can predispose men and women to decreased fertility.

*Services*
Although infertility is an SRHR challenge facing many men and women, healthcare providers frequently are not trained to recognise infertility and provide appropriate information (Dyer et al., 2001). Very few public sector infertility treatment options are available. If they were, they would have to be provided at the tertiary level. Even in the private sector, such services are expensive and not covered by medical aid schemes.

Gaps in infertility policies, guidelines, and services

- Policies and guidelines on how to address male and female infertility in the public sector are absent. Public health nurses do not have IEC materials that provide clients with general information on infertility, its symptoms, locations of available services, and when services might be needed.
- Information for men and women who want to conceive is not provided at most health services.

Abortion

*Status*
During the 10-year period (1997 to 2006) since the introduction of the Choice on Termination of Pregnancy Act (CTOP Act), a half-million safe and legal pregnancy terminations were performed. This, in turn, led to a 90 percent reduction in abortion-related maternal mortality (NDoH, 2003a). The legislation had a particularly positive impact on abortion-related morbidity in young women (Jewkes, Rees et al., 2005a).

The number of abortions provided in public health facilities has declined dramatically. The Department of Health has provided contradictory figures – it’s published report says a decline from 77660 in 2009 to 66274 in 2010 (NDoH, 2010d:33) while in a response to a question in parliament it provided the figures in Table 10. This discrepancy reinforces the issue of poor quality of the District Health Information System. The Department also reports a decline from 45% of Community Health Centres providing termination of pregnancy services in 2008/9 to 25% in 2009/10 in part as a result of a shortage of nurses trained to
perform first trimester terminations (NDoH, 2010d, p. 33). 2010 data indicates that 70% of abortions are performed by nurses and midwives (Stevens 2011, pp. 41).

Table 10: Number of abortions performed in state facilities

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Abortions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>86,074</td>
</tr>
<tr>
<td>2005</td>
<td>89,850</td>
</tr>
<tr>
<td>2006</td>
<td>86,891</td>
</tr>
<tr>
<td>2007</td>
<td>69,243</td>
</tr>
<tr>
<td>2008</td>
<td>90,668</td>
</tr>
<tr>
<td>2009</td>
<td>84,478</td>
</tr>
<tr>
<td>2010</td>
<td>38,321</td>
</tr>
</tbody>
</table>

(Mclea 2011, citing Department of Health response to a question in Parliament)

This declining trend in abortions is in stark contrast to that in the private sector, where the numbers of abortions have been rising by 10 percent annually since 1997, with Marie Stopes reporting that it performed 51,185 abortions around the country during 2010 (Stevens 2011, pp. 40).

Policy and guidelines

Choice on Termination of Pregnancy Act No. 92 of 1996

Objective: The Act sets out conditions for surgical termination of a pregnancy before 12 weeks, between 13 and 20 weeks, and after 20 weeks of gestation.

Highlights:
- The Act allows for the termination of pregnancy if a woman chooses to do so before 12 weeks or, in consultation with a medical practitioner, between 13 and 20 weeks. After the 20th week of the gestation period, termination is allowed if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy would (1) endanger the woman's life, (2) result in a severe malformation of the foetus, or (3) pose a risk of injury to the foetus.
- In the case of a pregnant minor, a medical practitioner or a registered midwife advises the minor to consult with her parents, guardian, family members, or friends before the pregnancy is terminated. However, if the minor chooses not to consult them, she still has the right to have the termination.
- The procedure can be done by a medical practitioner or, if the woman’s gestation period is less than 12 weeks, by a midwife who has been specifically trained.
- The procedure can be done at any facility designated by the Minister of Health. Informed consent is required only from the woman concerned, even if she is a minor.
- The state shall promote the provision of voluntary and non-directive counselling before and after the termination of a pregnancy.
- Any person who prevents the lawful termination of a pregnancy or obstructs access to a facility for the termination of a pregnancy shall be guilty of an offence and liable on conviction to a fine or imprisonment for a period not exceeding 10 years.

Choice on Termination of Pregnancy Amendment Act 2004 and 2008

Highlights:
- Empowers a member of the Executive Council to approve facilities where a termination of pregnancy may take place;
• Exempts a facility offering a 24-hour maternity service from having to obtain approval for termination of pregnancy services under certain circumstances;
• Provides for the recording of information and the submission of statistics; and
• Enables a member of the Executive Council to make regulations.

The 2008 amendment to the Act allows registered and trained nurses to perform manual vacuum aspirations (MVAs) in the first 12 weeks of gestation. Thereafter, until 20 weeks, MVAs must be performed by doctors. Prior to this amendment, all MVAs had to be performed by doctors.

Objective: To provide acceptable, accessible, affordable, cost-effective, safe, and user-friendly termination of pregnancy services for women with unwanted pregnancies as part of the RHS programmes, integrate them into comprehensive health services, and eventually reduce the number of unwanted pregnancies, the need for pregnancy termination, and maternal mortality and morbidity.

Strategies:
• Promote reproductive choice as a fundamental human right;
• Promote positive attitudes and behaviour towards providing termination of pregnancy services;
• Build capacity of managers to organise termination of pregnancy services and support service providers;
• Build sustained commitment towards the effective, efficient delivery of integrated SRHR services, including termination of pregnancy services;
• Manage compliance with the Act’s stipulations;
• Promote pro-choice healthcare provider initiatives;
• Increase the number of appropriately designated and newly designated primary healthcare facilities and ensure that they are functional and deliver good quality services;
• Increase the number of trained, motivated termination of pregnancy practitioners rendering good quality services in the public and private sectors;
• Support providers in delivering client-friendly services using values clarification or Health Workers for Change workshops and provide services that treat clients with respect and dignity;
• Provide client-friendly termination of pregnancy services that treat youth with respect and dignity; and
• Provide for a wider choice of termination of pregnancy techniques.

The overall plan includes an action plan that operationalises these strategies.

The Policy Guidelines for Youth and Adolescent Health 2001 provide similar guidelines to those laid out by the Choice of Termination on Pregnancy Act.

• The Delivery Agreement for Outcome 2: A Long and Healthy Life for All South Africans (October 2010) commits the Minister of Health and the NDoH to strengthening the provision of termination of pregnancy services within the public sector, with a focus on eliminating the stigma associated with the use of such services.
Abortion services have least priority

“They had women on a waiting list for at least three weeks and many were pushed into the second trimester. The first day I worked there I noticed that women had been on the waiting list for three weeks already, and as a result one was 20 weeks pregnant. Yet when she came for the ultrasound she was 17 weeks! The others were in the first trimester when the ultrasound was done, but because of the delay they were now second trimesters. I was furious and had a discussion with the people responsible.” (Alblas, abortion provider, 2009)

The National Policy for Conscientious Objection in the Implementation of the CTOP Act of 1996 (draft, August 2007)

Objective: “To establish uniform policy guidelines throughout the Republic of South Africa that deal with the rights of patients, health care providers and health professionals in a manner that ensures that constitutional rights of conscience, belief, thought and opinion and reproductive autonomy are balanced in a manner which upholds the values of the Constitution.”

The document lays out the circumstances under which conscientious objection does not apply:

- In an emergency situation where a patient’s life or physical or mental health can be preserved only by medical intervention, and the health professional cannot refer the patient in a timely fashion;
- Where healthcare providers are not directly involved in the actual procedure of termination of pregnancy – for example, the right to conscientious objection does not extend to health professionals involved in preparing patients for termination of pregnancy or post-operative care, or to medical students at institutions of higher learning insofar as they are required to be trained in termination of pregnancy related procedures; and
- If the objection is made because of the number of terminations of pregnancy previously rendered to a client, because the Choice on Termination of Pregnancy Act does not place any limits on the number of terminations a woman may undergo.

Health professionals who object to performing a termination of pregnancy and are not covered by the above circumstances must provide a written declaration to the health facility management. A prescribed form for the declaration of conscientious objection is provided in the policy document. In any legal proceedings, the medical provider is presumed not to have a conscientious objection to providing termination of pregnancy. The burden of proof of conscientious objection rests on the person claiming it.

A health professional who refuses to perform a termination of pregnancy is obligated to inform women of their rights under the Choice on Termination of Pregnancy Act, including the location of facilities that perform abortions, and to refer the patient to such a facility. The right to conscientious objection never can be exercised in a way that infringes upon a patient’s dignity and autonomy or that of the healthcare provider who works at the facility that will perform the abortion.

The health facility manager at any designated facility bears the responsibility for ensuring the implementation of both the Choice on Termination of Pregnancy Act and the National Policy for Conscientious Objection. Termination of pregnancy provision should be part of the performance agreement of the health facility. When advertising for positions for health professionals at designated facilities, management
"I want a baby with all my heart. My boyfriend said he doesn’t have money for a child and that I’m trying to hold him down with a child. I told him again and again that I won’t need his help but he said I want to trick him. We fought until I gave up. He inserted a pencil under me and said I will thank him. He poked until I started bleeding. I have never been in so much pain.” (33-year-old cited in Jewkes et al., 2005b, p. 1239)
Abortion services also are available in the private sector and through NGOs. Marie Stopes, the primary NGO provider, currently has 40 clinics structured according to the client base which it serves; its ‘commercial’ clinics are in urban areas, and income from them helps to fund its ‘social’ clinics, which are in lower-income and rural areas and have a lower price base. Marie Stopes also runs six rural clinics that offer free services, since they are fully funded by the European Commission. The organisation is using social franchising to expand its services—for example, by contracting with doctors in Limpopo and Mpumalanga to offer certain services at highly subsidized prices to under-served areas under the name “BlueStar Franchise.”

Research indicates that women living with HIV are treated negatively or judgementally by healthcare workers regarding their reproductive intentions (Harries, et al., 2007; Cooper et al., 2007; Orner et al., 2010 cited in Orner et al., 2011). These negative experiences are compounded further for HIV-positive women seeking safe, legal abortions because HIV services are not integrated with abortion services and, accordingly, HIV healthcare workers lack the capacity to counsel women on abortion (Orner et al., 2011). Orner notes that the unavailability or inaccessibility of abortion services at many public health sector facilities, lack of client-centred abortion information at numerous clinics, and lack of integration all affect HIV-positive women’s decisionmaking about abortion (de Bruyn, 2004; Magome, 2010 cited in Orner, 2011).

Gaps in policy, strategy, guidelines, and services on abortion

The policy is fairly comprehensive. However, it fails to address both how to shift negative attitudes towards women needing abortions and healthcare providers performing abortions, and how to offer quality services in context of these attitudes. It similarly does not adequately address the logistics involved in implementing it.

- Clear guidance on standards of pain relief for women post-abortion have not been developed.
- Medical abortion guidelines for the public sector have not been implemented uniformly across the country.
- Mifepristone, essential for performing medical abortion, has not been registered for use in the public sector by the Medical Control Council.
- The law and strategic plan do not include any guidance for HIV testing of women presenting for abortion, or for the integration of HIV and abortion care (Stevens, 2008).
- Training on termination of pregnancy, including medical termination, has not been incorporated into all midwifery training.
- The policy on conscientious objection and referral guidelines is still in draft.
- There are no criteria against which to assess counselling services the government funds to ensure that it only funds counselling that is delivered in an unbiased manner.
- Post-abortion care must be provided and integrated with cervical screening programmes (Women’s Health Gauge, 2010).
• There is inadequate post-abortion follow-up to ensure that women who develop post-abortion sepsis can receive treatment and other medical or counselling services. (Key informant, nongovernmental organisation researcher)

• Programmes to build healthcare provider understanding of the need for safe abortions are not institutionalised.

• Support services for providers performing abortions have not been institutionalised. (Key informant, nongovernmental organisation, 2010)

• Client information on what to expect and the actual abortion procedures is not always available (Orner et al., 2011).

• Lack of public outreach services to address stigmatisation by communities of healthcare providers and women seeking abortions.

• Women’s lack of knowledge about their rights under the Choice on Termination of Pregnancy Act and how to access services in a timely manner.

Maternal, perinatal, and newborn care, including PMTCT and Maternal Mental Health Status

Maternal death

The World Bank estimates that 74 percent of maternal deaths could be averted if all women had access to interventions that address the complications of pregnancy and childbirth, especially emergency obstetric care (World Health Report, 2006 cited in HST report, no date). According to this report, the package of interventions that would prevent these deaths includes good nutrition; access to contraception and family planning counselling; care during pregnancy, delivery, and the postpartum period; and referral services for obstetric complications. All of these form part of the essential package of services offered through the South African public health service. Yet a situation analysis of maternal health services in the public sector in South Africa indicates that “South Africa performs poorly for a middle-income country with a considerable health infrastructure, available staff, legal abortion, free health care for pregnant women and high levels of utilisation of delivery services (92% in the 1993 Demographic and Health Survey). Key explanatory factors identified included high levels of inequality, the impact of HIV, and problems with provider practice and motivation” (Penn-Kekana et al., 2007, p. 31).

According to the Saving Mothers 2005–2007: Fourth Report on Confidential Inquiries into Maternal Deaths in South Africa, during the triennium (2005–2007), there was a 20.1 percent increase in maternal deaths from the previous triennium (2002–2004). The report highlighted a 14 percent decrease in the institutional maternal mortality ratio for complications of hypertension and a 21 percent increase in deaths due to non-pregnancy-related infections (including HIV). The report also found that young pregnant women under the age of 20 were at increased risk of dying as a result of hypertension, and pregnant women over the age of 35 were at greater risk of dying as a result of obstetric haemorrhage, ectopic pregnancies, embolism, acute collapse, and pre-existing medical disease. Furthermore, the assessors classified 38.4 percent of deaths as avoidable within the healthcare system, with the most frequent healthcare provider-avoidable factors being failure to follow standard protocols and inability to recognise problems and assess patients properly. In addition, administrative factors contributing to maternal deaths included poor transport facilities, lack of healthcare facilities, and lack of appropriately trained staff (NCCEMD, 2008).

Although the maternal mortality rate in South Africa varies by source, the best estimates indicate that approximately 2,600 women and girls die each year as a result of pregnancy-
related complications, and approximately 52,000 women and girls suffer from pregnancy-related injuries, disabilities, or complications (MNPI, 2005).

Table 11. Death, cause of death, and avoidable factors

<table>
<thead>
<tr>
<th></th>
<th>Maternal</th>
<th>Perinatal</th>
<th>Children under 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual number of deaths (estimated)</strong></td>
<td>1,400</td>
<td>22,000</td>
<td>60,000</td>
</tr>
<tr>
<td><strong>Direct causes of death</strong></td>
<td>Hypertension 15.7%</td>
<td>Immaturity-related 46%</td>
<td>Gastroenteritis</td>
</tr>
<tr>
<td></td>
<td>Haemorrhage 12.4%</td>
<td>Acute respiratory infection</td>
<td>Acute</td>
</tr>
<tr>
<td></td>
<td>Ectopic pregnancy 1.4%</td>
<td>Asphyxia-hypoxia 29%</td>
<td>TB</td>
</tr>
<tr>
<td></td>
<td>Abortion 3.4%</td>
<td>Infection 10%</td>
<td>HIV</td>
</tr>
<tr>
<td></td>
<td>Pregnancy-related sepsis 5.6%</td>
<td>Congenital abnormalities 8%</td>
<td>Neonatal conditions</td>
</tr>
<tr>
<td></td>
<td>Anaesthetic-related 2.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acute collapse 3.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Indirect or underlying causes of death</strong></td>
<td>AIDS 23.1%</td>
<td>Malnutrition and HIV were underlying causes in 60% and 50%, respectively, of all under-five deaths</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other non-pregnancy-related infections 20.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pre-existing maternal disease 6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Avoidable deaths – modifiable factors, missed opportunities, and sub-standard care</strong></td>
<td>38.4% of all deaths clearly avoidable</td>
<td>43% of neonatal deaths probably avoidable</td>
<td>Location of modifiable factors:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Home – 36.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PHC – 13.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ambulance &amp; Emergency – 17.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Wards – 27.7%</td>
</tr>
</tbody>
</table>

(Report of the MCWH Summit, 2009)

To reduce maternal mortality and pregnancy-related disability, injuries, and complications, improvements must be made to strengthen family planning and sexually transmitted infection (including HIV) prevention and treatment services; ensure adequate access to appropriate antenatal care; strengthen emergency obstetric care; and ensure adequate postpartum care and follow-up for both mothers and babies. Furthermore, programmes to reduce maternal mortality must be supported by strong policies; capacity building of healthcare workers; logistical service delivery (Maternal and neonatal program effort: South Africa, 2005); ensuring adequate screening and treatment of the major causes of maternal death; improving quality and coverage of SRHS (including TOP services); and community involvement and empowerment regarding maternal, neonatal, and reproductive health in general (NCCEMD, 2008).

Motherhood in context of HIV

The intention of HIV-positive women to have children cannot be ignored. A study conducted in Soweto to investigate the childbearing intentions of HIV-positive women of reproductive age found that 44 percent of all women reported their intent to have children; within this group, there was significant variation by HIV status; 31 percent of women using HAART expressed intention to bear children; 29 percent of HIV positive women who have never been on any antiretroviral treatment wanted to have children, and 68 percent of HIV-negative women intended to have children. Despite the fact that the study reported that HIV-positive
women were nearly 60 percent less likely to report their childbearing intention, it showed that women living with HIV cannot be ignored in fertility management. The study concluded that there was a need for the integration of HIV, HAART, and reproductive health services for all women to achieve their fertility goals safely (Kaida et al., 2010).

Infant and child death
More than 260 infant and child deaths every day result from five major health challenges: pregnancy and childbirth complications, newborn illness, childhood illness, HIV and AIDS, and malnutrition. According to the Every Death Counts report, South Africa needs to address these health challenges to meet the MDGs for maternal, newborn, and child survival and for combating HIV by 2015. Poverty is an important underlying cause of death.

In South Africa, the number of babies born annually is approximately 1,200,000 (Human Sciences Research Council, 2008). Since HIV prevalence among pregnant women in 2009 was 29.3 percent (NDoH, 2008), this translates to almost 360,000 babies born exposed to HIV every year. Without the assistance of any intervention, approximately 30 percent (around 108,000) of these babies would become infected with HIV. Both international and local literature highlights that since HIV transmission from mothers to children is largely preventable, the provision of effective PMTCT care provides an opportunity to reduce infant and maternal mortality in South Africa. Previously, transmission rates for the national PMTCT programme were difficult to measure due to the high rate of loss to follow-up of mother-baby pairs (Key informant, NGO service provider, 2010); however, data from a national survey conducted by the Medical Research Council from June to December 2010 to evaluate the effectiveness of the South African Prevention of Mother To Child Transmission (SA PMTCT) programme at six weeks postpartum show that, out of a sample size of 9,915 infants, 31.4 percent were HIV exposed. The national HIV transmission rate from mother to child, measured in these 9,915 infants (ages 4–8 weeks, attending public sector clinics for their immunisation) was 3.5 percent (MRC press release, 2011). Despite these promising results, the survey highlighted a number of gaps in postnatal care and infant follow-up and the need to follow infants until 18 months of age to measure the total effectiveness of the sample.

“There is considerable uncertainty about the current levels of child mortality in South Africa. Despite efforts to improve vital registration, and the investment in census and surveys, the actual mortality rate remains elusive” (Saunders et al., cited in Kibel et al., 2010, p. 30). In 1990, the estimated under-five mortality rate was 60 deaths per 1,000 live births (UNICEF, 2009). By 2005, the rate showed no improvement, as indicated by several estimates from different data sources (ASSA, 2003; IGME, 2008; DHS, 2003; UN Population Division, 2006; UN Mortality Group, 2008; U.S. Census Bureau, 2009, cited by Saunders et al., cited in Kibel et al., 2010, p. 30). These data sources estimate the under-five mortality rate to be between 67 and 75 per 1,000 live births. “Instead of the expected decrease in mortality, there is an increase due to more child deaths from HIV/AIDS” (Lawn, 2008, p. 45). The leading causes of under-five mortality can be found in Figure 3.

The underlying causes of childhood illness and injury include poverty and the poor delivery of essential services, such as housing, water, and sanitation. In addition, unsafe sex, alcohol abuse, and violence against women and children significantly impact child health (Kibel et al., 2010, p. 21).
Figure 3. Causes of death in newborns and children under five years, 2000–2005

(Saunders et al., cited in Kibel et al., 2010, p. 31)

Policy and guidelines

Guidelines for Maternity Care in South Africa 2007: A manual for community health centres and district hospitals

Objective: Guidance for healthcare providers (doctors and midwives) providing obstetric, surgical, and anaesthetic services for pregnant women in district clinics, health centres, and hospitals having limited access to specialist services.

This is a detailed manual that cannot be summarised adequately here, so only the major areas are outlined.

The guidelines define levels of care and the content of each dimension of care with regard to antenatal, labour and the puerperium, anaesthesia, and resuscitation; hypertensive disorders of pregnancy; pregnancy problems; medical disorders in pregnancy; infections in pregnancy; PMTCT and management of HIV-positive pregnant women; and data audit.

Regarding the integration of services so that maternal and neonatal services address HIV and AIDS:

- Primary prevention of HIV—advise women on safer sexual practices, including condom use during pregnancy and breastfeeding; effective treatment of sexually transmitted infections and any other genital infections to reduce the likelihood of chorioamnionitis and thus the risk for mother to child transmission; and
- Medical interventions for HIV-positive pregnant women, including ARV treatment, the management of opportunistic infections, PMTCT dosing, post-delivery care, etc.

Levels of care:

- Emergency transport—appropriately staffed and equipped vehicles available 24 hours a day in all health districts to move women with emergencies from one health facility to another, or from their homes to a health facility; appropriate communications in place, whether radio or telephone, so that ambulances can be called to transport such women as rapidly as possible;
Clinics—antenatal care for low- and intermediate-risk women, including on-site blood testing; postnatal checks, including contraception, referral of problems to hospital, and the management of emergencies;

Community health centres—as above, as well as the treatment of the common problems of pregnancy, 24-hour labour and delivery service for low-risk women, and vacuum extraction;

Level 1 hospitals—genetic screening and counselling services; counselling and support; antenatal care for high-risk women, ultrasound service, treatment of pregnancy problems, including admission to hospital, 24-hour labour and delivery service for intermediate- and high-risk women, vacuum extraction, caesarean section and manual removal of placenta, regional and general anaesthesia, blood transfusion, and essential special investigations; postnatal care, including complications and postoperative care and postpartum sterilisation; referral centre for clinics and community health centres in the district and their supervision; referral of complicated problems to level 2 or 3 hospitals;

Level 2 hospitals—all level 1 functions, plus management of severely ill pregnant women, specialist supervision of the care of pregnant women, prenatal diagnosis, such as genetic amniocentesis; multidisciplinary care—other specialities, physiotherapy, etc.; referral centre and supervision for level 1 hospitals; and

Level 3 hospitals (central or tertiary hospitals)—all level 1 and 2 functions, plus specialist combined clinics, such as cardiac and diabetic pregnancy clinics; advanced prenatal diagnosis such as chorion villus sampling and cordocentesis; management of extremely ill or difficult obstetric patients; supervision and support for level 1 and 2 hospitals; responsibility for policy and protocols in the regions served.

Saving Mothers: Essential steps in the management of common conditions associated with maternal mortality (NDoH, 2007)

Objective: Improve the quality of care for some of the common conditions which cause maternal deaths.

The document opens with the following “general points”:

All healthcare should be based on the following standards:

- Women treated with respect
- Care based on best available current evidence and practice
- Health professionals committed to improving care through adherence to standard protocols of clinical management

To achieve the above

- Acquire and practice effective communication skills
- Ensure confidentiality and privacy in all contacts with the woman and any accompanying people
- Ensure knowledge of referral patterns
- Prioritise order of treatment—record all observations

In addition to providing algorithms for typical challenges associated with pregnancy and childbirth—pre-eclampsia and eclampsia, obstetric anaesthesia, cardiac arrest, neonatal
resuscitation, breech presentation, cord prolapsed, shoulder dystocia, and pregnancy-related sepsis—the document also covers HIV and abortion.

In October 2010, Minister of Health Aaron Motsoaledi signed the Delivery Agreement for Outcome 2: A Long and Healthy Life for All South Africans. This commits the DOH to a number of outputs, including Output 2: Decreasing Maternal and Child Mortality.

In addition to the broad policy points already covered in this section, the delivery agreement states the following:

- An ambulance for emergency maternity and child cases will be available to avoid delays in providing medical attention. An ambulance must respond within 30 minutes to an hour of having been called to attend to an obstetric emergency.
- Some facilities must be redesigned to ensure that maternity waiting homes and rooms are available so that women do not have to travel far while in labour, especially those with complicated pregnancies.
- All facilities will institute infection control measures.
- Regular training exercises (“fire drills”) on dealing with pregnancy-related haemorrhage will be conducted, along with perinatal and maternal mortality meetings in each facility.
- Community healthcare workers linked to facilities will conduct postnatal care home visits to identify problems with the mother and her baby and assist in promoting appropriate feeding and the prevention of neonatal sepsis.

In relation to prevention of mother to child transmission (PMTCT), the National HIV and STI Strategic Plan (NSP) 2007–2011 (see under STIs and HIV and AIDS below) sets an ambitious target of reducing mother to child transmission to less than 5 percent by 2011 (NDoH, 2007).

The strategy aims to

- Broaden existing mother to child transmission (MTCT) services to include other related services and target groups.
- Scale up the coverage and improve the quality of PMTCT to reduce MTCT to less than 5 percent.
- In February 2008, the NDoH reviewed and improved the existing PMTCT policy. In addition to testing all women attending antenatal care, all HIV positive women would have CD4 counts measured. The revised policy provided for HAART for all eligible women and improved methods of early infant diagnosis of HIV in all exposed or symptomatic infants before their six week immunization visit.
- Following an announcement by the South African president on World AIDS Day 2009, the above policy changes were followed by further improvements to ensure alignment with the WHO-revised PMTCT guidelines. Improvements included drug regimen changes for PMTCT and an increased eligibility threshold to 350 CD4 count for the initiation of pregnant women on HAART. Implementation of the policy is currently underway, and it is expected that these changes will result in a reduction in country-level MTCT rates.
- The implementation of the PMTCT policy includes the prevention of unintended pregnancies, and the plan specifically refers to the implementation of medical abortion guidelines.
Clinical PMTCT Guidelines

These guidelines are an update of the 2008 national PMTCT Policy and Guidelines. The objective is to provide continued guidance towards a reduction in the vertical transmission of HIV, building on work done since the inception of the programme and the 2008 Policy and Guideline document. The clinical guidelines serve as a revised guide to health practitioners for the comprehensive management of pregnant women who are HIV positive and/or with an unknown HIV status. The clinical guidelines are divided into the provision of PMTCT services during antenatal care, labour and delivery, and the postpartum period. The guidelines provide detailed algorithms for the clinical management of HIV-positive pregnant women, including the following:

- Routine offer and provision of provider-initiated HIV counselling and testing for all pregnant women attending antenatal care;
- Provision of appropriate regimens to prevent MTCT of HIV according to the risk profile based on the HIV test, CD4 cell count, and clinical staging;
- Provision of other appropriate treatments, such as those for OI management and nutritional support;
- Provision of psychosocial support to HIV-positive pregnant women;
- Provision of quality, objective, and individualized counselling on safe infant feeding practices for HIV-positive women;
- Strengthened obstetric practices which reduce MTCT;
- Provision of antiretroviral (ARV) prophylaxis to infants;
- Integrated follow-up of infants born to HIV-positive women through routine child health services and the Integrated Management of Childhood Illness (IMCI) Strategy; and
- Early infant HIV testing at six weeks of age for all infants born to HIV-positive women (integrated with the Expanded Programme on Immunizations (EPI) six-week visit), irrespective of feeding option.

In an attempt to strengthen implementation and achieve better results for the PMTCT programme and related SRHR indicators, the NDoH developed a methodology, known as The Accelerated Plan or “A-Plan,” to strengthen PMTCT implementation.

The A-plan serves as a tool to enforce implementation of the four prongs of PMTCT, described by the WHO as

- The delivery of primary prevention interventions within services related to reproductive health, including working with community structures;
- The importance of providing appropriate counselling and support to women living with HIV, enabling informed decisionmaking about their future reproductive life, giving special attention to preventing unintended pregnancies;
- Targeting pregnant women already infected and demanding integration of HIV testing into maternal child and women’s health; and
- Better integration of care, treatment, and support for HIV-positive people and their families (WHO, 2009).

Through use of this approach, the plan hopes to:

- Improve early antenatal booking, early HIV testing, and access to care;
• Fast track initiation of HAART during pregnancy and improved follow-up for mother-baby pairs, including community-based interventions;
• Facilitate the integration of services, including family planning; and
• Encourage the involvement of men and families in maternal care and support.

The A-Plan is unique in that it links the demand for quality PMTCT services through social mobilization with the supply side to increase access. The A-Plan has been designed via a wide consultation process with multilateral, bilateral, technical, and civil society partners who have been funding and working in support of health and PMTCT programmes. It builds on a wealth of research and best practices. The A-Plan is based on a comprehensive analysis of bottlenecks and gaps in PMTCT implementation and aims to employ a range of evaluated sustainable quality improvement methodologies and accurate data capture and analysis to help healthcare providers improve service delivery. It involves working with the district management team and facilities to determine the areas that need strengthening and designing interventions that the districts and facilities can implement with support from stakeholder organisations and local nongovernmental organisations.

Community-based delivery of health and nutrition services and mother-baby pair follow-up are highlighted, with emphasis on the three-day postnatal check. In essence, the A-Plan provides practical guidance that covers the four prongs of PMTCT. It aims to ensure the delivery of a package of quality PMTCT services integrated with maternal, newborn, and child health, ARV treatment, family planning, HIV counselling and testing, and male involvement.

In relation to children, the data from the 2006 Child Healthcare Problem Identification Programme, which audits hospital deaths of children under five in approximately 35 facilities around the country (with the aim of general implementation over time), outlined five priority areas that, if addressed, would impact the under-five mortality rate. These included the following:
• HIV and AIDS – reduce MTCT and give parents and children universal access to ARV treatment;
• Nutrition – manage underweight children and refer and provide emergency treatment and effective case management to severely malnourished children;
• Gold standards – identify and manage sick children correctly, strengthen and sustain the integrated management of childhood illnesses (IMCI), and implement paediatric guidelines and protocols;
• Establish and implement norms and standards – according to staffing levels and level of care and transport; and

Services
During 2005–2007, 76.1 percent of women who died during or within six weeks of pregnancy had received antenatal care (NCCEMD, 2008). During the same period, in the general population, 95 percent of pregnant women received antenatal care. Although the majority of maternal deaths occurred in women who attended antenatal care, the attendance rate is substantially lower than the general population and the data illustrate the importance of early and regular antenatal care that can identify risk factors and manage complications effectively. Furthermore, since the majority of women who died attended antenatal care, such care provides an opportunity for early intervention to prevent death (NCCEMD, 2008).
An audit of antenatal care in Empangeni District (KwaZulu Natal) found that, although the majority of pregnant women attend antenatal care services, the quality of these services is not optimal. For example, screening for syphilis at the first antenatal visit was at 18 percent and at 36 weeks gestation was 2 percent. Only 46 percent of women received the required three-dose vaccination for tetanus. Both examples illustrate that antenatal care providers are not offering an adequate quality of care, and that instructions given in official guidelines were carried out infrequently. The assessment makes the point that approaches to improve the quality of antenatal care should be based on regular training, supporting staff, quality assessments, and additional operational research activities (Hoque et al., 2008). In addition, the study found that the mean gestational age for the first visit was 22 weeks (Hoque et al., 2008, p. 66b). This late attendance at antenatal care results in numerous missed opportunities for early intervention to deal with complications and highlights the need for community interventions aimed at educating women about early signs and symptoms of pregnancy and the importance of early attendance to antenatal care (Myer and Harrison, 2003).

Furthermore, most women do not perceive significant health threats during pregnancy, and often view more than one antenatal care visit as unnecessary (Myer and Harrison, 2003), perceiving that the primary purpose of attendance is to receive the antenatal attendance card required for health facility delivery. This again highlights the need for community-level health education programmes that promote antenatal care attendance.

The NDoH describes its strategy for the improvement of maternal and child health services as prioritizing the following within the NDoH-defined 18 priority districts:

- Normalisation of HIV infection as a chronic disease;
- Clinical skills improvement;
- Training and education;
- The implementation of national maternal and neonatal guidelines;
- Postnatal care;
- Regional clinicians appointed to establish, run, and monitor and evaluate outreach programmes for maternal and neonatal health (positions that have been advertised in 2011 as part of the Re-engineering Primary Healthcare vision);
- Auditing, monitoring, and evaluation;
- Constant health messages conveyed to all and understood by all;
- Staffing, equipment, and facilities; and
- Transport and referral routes (Sempe-Masasa, 2008).

In 2009, in an attempt to improve maternal and child outcomes, the NDoH identified and prioritized 18 subdistricts in 18 districts across South Africa as focus areas for interventions. These subdistricts are known as the 18 priority districts. The selection of the districts was based on an assessment of key maternal and child healthcare indicators and an evaluation of the deprivation index (described in the 2006/07 District Health Barometer and updated using

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“I went to the Johannesburg hospital. I was admitted to have a caesarian. The nurse there was questioning me, saying I am a foreigner, what am I doing in South Africa? She said I should go back to my own country and have my baby there. I was in pain and I was screaming and crying but she didn't mind that I was in pain. She was a healthcare worker but she was careless. I was in pain and I was bleeding but she didn't help me. I was admitted to ICU. I was in so much pain that I can't remember her name but till now I remember her face.” (Immigrant from the DRC, wife of NGO organiser, personal communication, Tuesday, 2011)
the 2007 Community Survey). The deprivation index was used, since many health outcomes, in particular those related to women and children, are sensitive to socioeconomic conditions.

At the time of the writing this report, data on the impact of the intervention in the 18 priority districts were not publicly available. However, substantial resources from both government and donor funding have been used to implement interventions based on the priorities identified above to improve maternal and health status.

If HIV-positive women choose to become pregnant, they may face highly negative attitudes and stigma and discrimination in their communities as well as the healthcare sector (United Nations, 2004 cited by Cooper et al., 2007). “While … health risks … deter some HIV-positive individuals from considering reproduction, these concerns may be overridden for others by strong personal desires to experience biological parenthood, which are influenced by social values that encourage childbearing” (Cooper et al., 2007, p. 275). However, the stigma associated with HIV and the role healthcare workers play in blaming clients for perinatal transmission makes it difficult for women to discuss fertility desires with healthcare providers. This speaks to the lack of dignity and human rights accorded to women living with HIV, which in turn reflects the lack of effective interventions to build an enabling environment within the health services. There are real challenges for HIV-positive people who want to have children, given that unprotected sexual activities increase the risks of sexual transmission, reinfection with different viral strains of HIV, and perinatal HIV transmission. The NDoH’s Annual Report for 2009/10 indicates that no headway had been made in training HIV support groups in stigma mitigation (NDoH, 2010d, p. 46).

According to the DOH Annual Report, 92.7 percent of pregnant women were tested for HIV in 2009; 48.7 percent of HIV-positive pregnant women were on AZT, 99.1 percent were administered Nevaripine, and 76.9 percent were on HAART (NDoH, 2010d, p. 33). Women frequently do not present themselves early for ARV treatment (Black et al., 2009; Hargrove, 2010), and opportunities for HIV testing are missed in antenatal care, which results in a diminished continuum of care (Sprague et al., 2010). In addition, shortage of staff and supplies, including low staff morale and absenteeism, delays in payment for lay counsellors, delays in receiving CD4 cell counts resulting in women being unable to commence ART, are all barriers to service delivery in PMTCT antenatal care (Sprague et al., 2010, Black et al., 2009). A study by Sprague and colleagues (2010) study found that barriers to postnatal care PMTCT include lack of healthcare worker knowledge regarding safe infant feeding, which shows that one of the weakest aspects of the PMTCT programme is infant feeding counselling. Other barriers to care include stigma, inadequate health personnel-patient interaction, lack of psychosocial support, and inadequacy of data and information systems for monitoring and evaluation. (Sprague et al., 2010).

A large number of pregnant women attend antenatal care for the first time later than is desirable, with less than 30 percent booking before 20 weeks gestation and a large number accessing services later in pregnancy. Furthermore, as a result of large variations among districts, not all pregnant women are tested for HIV. This results in more than 40 percent of women being missed at the facility level and not receiving ARV prophylaxis or undergoing diagnostic testing to assess treatment eligibility. Current data indicate that approximately 27 percent of treatment-eligible HIV-positive pregnant women are referred and initiated on HAART (DHIS data, extracted March 2010). In the Kouga local service area of the Eastern Cape, although clinic staff have high levels of awareness of HIV and AIDS policies and the majority have received the relevant training, Nevirapine uptake (administered to HIV-
positive women at 28 weeks gestation to self-administer at the onset of labour) was around 56 percent. There were many missed opportunities for PMTCT, with only 67 percent of pregnant women tested for HIV and only 6 percent of HIV-positive women reporting support group participation (Rispel et al., 2009). “Despite 83% of HIV infected pregnant women receiving antiretroviral therapy in 2009 to prevent HIV transmission to newborns, the annual number of newly infected children (59,000 in 2009) remains very high and contributes substantially to under five mortality” (Kibel et al., 2010, p. 41).

Reasons for PMTCT programme ineffectiveness include poor marketing of services, inadequate community involvement, and poor quality of care.

Although PMTCT gains have been made, they have not been accompanied by similar gains in the primary healthcare programme, such as the increased use of contraception or uptake of abortion. This is due primarily to the implementation of PMTCT as a vertical programme, which resulted in a lack of integration and a decline in routine care indicators. (Provincial PMTCT implementers, personal communication, August 2010)

The A-Plan was developed to try to overcome existing obstacles. To date, an evaluation of the A-Plan has not occurred. However, key informants and DHIS data indicate that significant improvements to PMTCT service delivery are evident as a result of the implementation of the methodology.

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**An effort to improve MCH interventions: Mpumalanga Maternal and Child Health Integration (MACH 1) project, 2009–present**

To strengthen maternal and child health (MCH) services, UNICEF, in partnership with the provincial and district DOH and the University of Pretoria MRC Maternal and Infant Health Care Strategies Research Unit, implemented the Mpumalanga Maternal and Child Health Integration (MACH 1) project. The project is a district-based health initiative founded on the premise that improving the integration of MCH services, using antenatal care and PMTCT as an entry point, will lead to better quality of care. Therefore, interventions to prevent maternal and child deaths can and should be performed during routine antenatal care. Antenatal care is only part of the continuum of care that a mother and her child receive from the primary healthcare system. Although antenatal care is often the entry point of the maternal-child health dyad, services, care, and follow-up are required during pregnancy, labour, delivery, and beyond to improve the overall health status of mothers and their children.

The Mpumalanga integration model places the “human face” of the healthcare user or patient in the centre, and the focus is on the interface between healthcare user and healthcare provider at all points in the health system. This approach is called “participatory interactive care,” and can be applied at the individual consultation level as well as a systems level. It also ensures that joint knowledge creation and sharing; respectful interaction to build trust, feedback, and inclusiveness; networking; and referral are all central to quality care provision.

A mother and her child will access the health system and obtain services at various points. The initial point of contact will more than likely be pregnancy, but service delivery will continue long after the child has been born. Interactions with the health system usually occur at both the public health clinic level and higher levels of care. These levels of care need to be integrated fully within the PHC level, and referrals and communication between them must be effective.
Gaps in policy, guidelines, and services for maternal, perinatal, and newborn health

- Clinic and community outreach and education aimed at encouraging women and men to include men and partners in the process of antenatal care, PMTCT, and labour have not been institutionalised;
- The proportion of pregnant women tested for HIV and provided with ARV treatment early is low (Black et al., 2009; Hargrove, 2010);
- PMTCT as practised is not yet oriented toward following all of the components of the A-Plan in addressing women’s health and tends to focus only on prevention of vertical transmission;
- Healthcare provider capacity to address the needs of HIV-positive pregnant women in relation to postpartum counselling and contraception is not developed systematically;
- Guidelines and training that would aim to prevent forced sterilisation at the time of childbirth have not been developed and institutionalised (Stevens and Le Roux, 2010); and
- Programmes to build health worker communication skills and the ability to work respectfully with all pregnant women, including adolescents, disabled women, and women living with HIV, have not been institutionalised.

Perinatal mental health

Status
Approximately 20 percent of women suffer from antenatal depression, while the prevalence of postpartum depression is estimated to be between 12 percent and 16 percent (Leung and Kaplan, 2009). However, these are most likely conservative figures, as maternal depression often goes undiagnosed or unreported. It also has been noted that often there are higher rates of depression among women living in poverty during the antenatal and postnatal periods (Bledsoe and Grote, 2006; Tomlinson et al., 2004). For example, studies in developed countries show that postnatal depression affects 10 percent to 15 percent of women (Warner et al., 1996), whereas research in South Africa indicates rates of 41 percent antenatal depression and 35 percent postnatal depression, respectively (Cooper et al., 1999). The high prevalence of mental illness among pregnant women could be a reflection of the state of affairs in the broader society of women of reproductive age, but there is not enough information about such women to assess this.

In addition to the negative consequences for the woman, mood disturbances during pregnancy and in the postpartum period can have adverse neonatal, physiological, cognitive, emotional, and behavioural outcomes for the child, including fatal infections, stunted growth, poor brain development, and childhood anxiety disorders, and have long-term implications (Sanders, 2010; Heron et al., 2004; Misri et al., 2010; Lusskin et al., 2007; Austin, 2004).

Services
Treatment aimed at reducing maternal distress may offer protective advantages to the woman, child, and family members (Kaplan et al., 2002; Bledsoe and Grote, 2006). The antenatal period presents a unique opportunity to prevent postnatal mental health disorders, as research shows that only 3 percent of women who suffer from postnatal depression or anxiety did not have depression and/or anxiety during pregnancy (Warner et al., 1996). Furthermore, pregnancy is often a time of increased contact with health professionals.

Pragmatic, cost-effective, feasible, and culturally adaptive interventions yield positive corrective and preventative outcomes. Integrating attention to perinatal mental health into
health services through screening and intervention appears to reduce morbidity (Price and Proctor, 2009). Even simple community-based interventions demonstrate positive outcomes. Similarly, a supportive companion during labour decreases intrapartum complications and increases chances of normal delivery (Sanders, 2010). Yet a study on the introduction of birth companions to hospitals in South Africa found an uncondusive environment:

“At baseline, the majority of hospitals did not allow a companion, or access to food or fluids. A third of women were given an episiotomy. Some women were shouted at (17.7%, N = 2085), and a few reported being slapped or struck (4.3%, N = 2080). Despite an initial positive response from staff to the childbirth companion intervention, we detected no difference between intervention and control hospitals in relation to whether a companion was allowed by nursing staff, good obstetric practice or humanity of care” (Brown et al., 2007).

Gaps in guidelines and services

- Perinatal mental health generally is not incorporated into current care. Also, the focus on the foetus, infant, and child may overshadow the need also to address the mother’s health in its own right.

Sexually transmitted infections, including HIV and AIDS

HIV and AIDS

Status

Currently, South Africa accounts for 17 percent of the global burden of HIV infection. This amounts to an estimated 5.7 million people living with HIV in a population of 48.5 million (UNAIDS, 2009). It is estimated that in 2009, 310,000 South Africans died of AIDS (UNAIDS, 2009). Almost one in three women ages 25–29 and more than a quarter of men ages 30–34 are living with HIV (Shisana et al., 2009). The HSRC 2008 National Household Survey estimated that approximately 2.5 percent of children ages 2–14 years were living with HIV (Shisana et al., 2009).
AIDS has become one of the leading causes of death amongst mothers and children in South Africa, accounting for 43.7 percent of maternal deaths (NDoH, 2008) and 35 percent of under-five deaths (Shisana, 2009, p. xvii).

Routine national HIV surveillance does not identify sexual orientation or gender identity; thus, the extent of the epidemic in these groups is not known. The HIV and AIDS National Strategic Plan (NSP) recognised this lack in reliable data, as South Africa was unable to report on MSM for the United Nations General Assembly Special Session (UNGASS) progress report on universal access to HIV treatment and prevention submitted in 2008 (Rispel and Metcalf, 2009). Forward-looking clinical trials, such as anal or vaginal microbicides, pre- and post-exposure prophylaxis, and treatment of herpes simplex virus 2 (HSV-2), should include same-sex practising individuals (Johnson, 2007).

Policy
A large number of HIV and AIDS-related policies exist. Only those that link directly with aspects of sexuality or reproduction are mentioned here.

HIV/AIDS and STI Strategic Plan for South Africa 2007–2011
Objective: Provide continued guidance to all government departments and sectors of civil society to

- Reduce the rate of new HIV infections by 50 percent by 2011; and
- Reduce the impact of HIV and AIDS on individuals, families, communities, and society by expanding access to appropriate treatment, care, and support to 80 percent of all HIV-positive people and their families by 2011.

Community-based treatment, care, and support:
- Mitigate the impacts of AIDS and create an enabling social environment for care, treatment, and support for strengthening programmes aimed at orphaned and vulnerable children;
- Expand and implement community home-based care as part of the expanded public works programme;
- Strengthen the implementation of policies and services for marginalised communities affected by HIV; and
- Ensure community HIV and AIDS competency to facilitate the utilisation of good quality services.

Prevention:
- Develop and integrate a package of SRH and HIV prevention services into all relevant health services;
- Develop a comprehensive package that promotes male sexual health;
- Increase the accessibility and availability of comprehensive sexual assault care, including PEP and psychosocial support; and
- Minimise the risk of HIV transmission through blood and blood products.
(Note: PMTCT is addressed in the section above on maternal, perinatal, and neonatal care)

Health centre treatment, care, and support:
- Increase coverage of voluntary counselling and testing (VCT) and promote regular HIV testing;
• Enable people living with HIV to lead healthy and productive lives through scaling up treatment and increasing their retention on treatment, managing TB/HIV co-infection, and improving quality of life for people with HIV requiring terminal care; and
• Address the special needs of pregnant women and children through a comprehensive package of services addressing HIV- and AIDS-related maternal mortality and by providing wellness care and ART to HIV-affected, -infected, and -exposed children and adolescents.

Research, monitoring, and surveillance:
• Establish and implement a functional M&E system;
• Develop and support a comprehensive research agenda for prevention, treatment, and care that also informs policy;
• Create an enabling environment for research; and
• Support capacity building in research, surveillance, and monitoring among black and women professionals.

Guidelines for the management of HIV and AIDS in Adults (2010)

Objectives: to achieve the best possible health outcomes in the most cost-efficient manner through
• Implementing nurse-initiated ARV treatment;
• Decentralising service delivery to primary healthcare facilities;
• Integrating services for HIV with TB, maternal and child health (including PMTCT), sexual and reproductive health, and wellness programmes;
• Earlier diagnosis of HIV;
• Preventing HIV disease progression;
• Preventing AIDS-related deaths;
• Retaining patients on lifelong therapy;
• Preventing new infections among children, adolescents, and adults; and
• Mitigating the impact of HIV/AIDS.

In April 2010, President Jacob Zuma launched the government’s new and upscaled HIV prevention and treatment plan. Its objectives are to reduce the rate of infection by 50 percent by 2011 and provide ARV treatment to 80 percent of those who need it. The new plan sees a move from VCT to provider-initiated HIV counselling and testing, and a service delivery model that offers testing to all patients at the entry point in all health institutions. This model hopes to achieve the testing of up to 15 million people by June 2011. In addition, the new campaign also will promote healthy lifestyles and increase access to treatment, care, and support, and put greater emphasis on prevention through information, education, the widespread distribution of condoms, and the mobilisation of millions of South Africans to learn their status.


The National HIV Counselling and Testing Policy Guidelines build on The South African National Voluntary Counselling and Testing (VCT) HIV Prevention and Care Strategy 2003 and draw from international practices on HIV counselling and testing. The policy guidelines
seek to provide a framework for all of the HIV Counselling and Testing models being implemented in the country. The guidelines provide a policy framework to assist in the implementation of HIV counselling and testing to ensure that the goals of the NSP are attainable. The policy aims to

- Provide a national framework for the provision of HIV counselling and testing in the public sector for adults and children;
- Provide universal access to good quality, effective HIV counselling and testing and referral services.

The objectives of the HIV counselling and testing Policy Guidelines are to

- Provide core requirements and guidance to ensure the delivery of standardised, high-quality, and ethical HCT services;
- Outline different types of HCT approaches for different circumstances and target groups;
- Ensure compliance with legal and human rights approaches to HCT;
- Expand access to HCT beyond formal healthcare settings into community, private sector, and non-healthcare environments; and
- Ensure appropriate referral to treatment.

The National Condom Policy and Management Guidelines (2011) are discussed above in the section on contraception; PMTCT is discussed above in the section on Maternal and Newborn Health.

Services
This review does not describe the situation of services generally, since they are reviewed amply in the NSP and elsewhere. It focuses only on those aspects of HIV that link to other aspects of SRHR. It is nevertheless notable that the country’s ARV treatment programmes are reaching an increasing number of those in need. The number of patients undergoing ART almost doubled, from 458,951 to 700,500, between 2007 and 2008 (WHO, 2008) to a total of 1.3 million people on treatment by the end of December 2010. This was made possible, amongst other factors, by the health sector’s decision to train and authorise professional nurses to initiate ART. The number of nurses trained in the Nurse Initiated and Managed ART (NIMART) programme increased from 290 at the beginning of 2010 to 2,000 by the end of the same year. In the same period, the number of health institutions able to provide ART increased from 490 to 1,500 (NDoH, 15 Feb 2011).

While HIV and AIDS policy is comprehensive, major challenges in the interfaces with other aspects of SRHR remain, and neither healthcare providers nor the public are informed adequately about them. Part of the challenge is that knowledge is poor globally—for example, regarding the interfaces between hormonal contraception and HIV and AIDS (Expert Working Group on Contraception Guidelines, 2011) and particularly on interfaces between hormonal contraception and ART. An expert group is currently reviewing contraception guidelines to address these gaps to the extent that new research findings are available. Similarly, policy and guidance on other dimensions of SRHR, such as cervical cancer, need to be updated in light of their interface with HIV.

Key informants referenced abundant complaints about healthcare providers stigmatising HIV-positive women and being abusive towards them in relation to their wanting or not wanting to have children. This topic is addressed in other sections of the review.
Gaps in HIV and AIDS policies, strategies, and guidelines

Gaps

- Sexual and reproductive health and rights is referred to only under the prevention section of the NSP and is absent from the rest of the document regarding treatment, care, and support. HIV services remain predominantly vertical.
- HIV incidence cannot be decreased unless sexual cultures change. Yet public outreach programmes to promote cultural values, norms and attitudes that oppose gender inequities and promote mutual respect in sexual relationships and people’s right to sexual autonomy are not systematically funded and institutionalised, rather focusing predominantly and in a more limited way on technical understanding of HIV/AIDS and condom use.
- Healthcare providers lack capacity to provide effective sexuality information and education; help people cope with a positive diagnosis; work out how to engage family, sexual partners, and community members; engage people living with HIV about their fertility intentions; and support them in realising those intentions safely (see sections on maternal and newborn health and contraception).
- Current treatment regimens are contra-indicated in pregnancy—with unclear guidance on which regimens are suitable.
- Guidance on contraception and cervical screening in the context of high HIV prevalence has been developed for the Western Cape, but not nationally.
- Not enough is known about diverse sexual cultures and how these may affect people’s vulnerability to HIV and their uptake of services, in particular in relation to gay men, men who have sex with men (MSM), and lesbians.

Sexually transmitted infections

Status

It is estimated that there are 11 million cases of sexually transmitted infections (STIs) annually. For example, in Hlabisa, a rural area in KwaZulu-Natal, among 321 women attending district antenatal clinics, 52 percent were found to have at least one STI (gonorrhoea, chlamydial infection, trichomoniasis, or syphilis), and 18 percent had more than one infection. Modelling indicates that around 25 percent of all women in the reproductive age group residing in that district have at least one STI on any given day, of which about half are asymptomatic (Moodley, 2002, p. 5).

According to Johnson’s STI and HIV modelling, “HIV/AIDS has brought about modest reductions in the prevalence of most STIs. Two exceptions are herpes simplex virus 2 (HSV-2) and vaginal candidiasis. The prevalence of HSV-2 is expected to rise as a result of HIV/AIDS because HSV-2-infected individuals who are co-infected with HIV are assumed to experience greater frequency of HSV-2 shedding and HSV-2 symptoms, and are thus more likely to transmit HSV-2 than they would be in the absence of HIV infection. The prevalence of vaginal candidiasis is also expected to rise slightly, due to the assumed increase in the frequency of vaginal candidiasis in the later stages of HIV infection” (Johnson, 2008, p. 221).

“Unfortunately, however, there (is) no mechanism in place to monitor whether the syndromic management programme (is) having any impact. South African sexually transmitted infection prevalence data have been—and continue to be—obtained from independently conducted studies in different communities, based on different sampling strategies and different
diagnostic procedures. This makes it difficult to compare sexually transmitted infection prevalence estimates from different studies, and it is even more challenging to establish whether there has been any change in prevalence levels over time. With the exception of the national antenatal clinic survey estimates of syphilis prevalence (NDoH, 2008) there are no nationally representative estimates of the prevalence of sexually transmitted infection STIs other than HIV” (Johnson, 2008, p. 20).

Policy
First-line comprehensive management and control of sexually transmitted infections (STIs): protocol for the management of a person with a sexually transmitted infection according to the essential drug list. 2008.
This DOH manual provides guidance that begins with the following categories under “Improve the Quality of Services”:
- Make services accessible and user friendly, including the following:
  o Offer services during normal working times, but consider extended hours;
  o Conduct health promotion while people are waiting in queues;
  o Offer one-stop services that avoid stigmatising patients by having STI services on a particular day or in a particular room;
  o Ensure confidentiality at the point of registration;
  o Ensure the positive and friendly attitude of all staff; and
  o Aim for adolescent-friendly services and address barriers to service use based on sex, age, or race;
- Ensure the regular supply of drugs and consumables, the availability of equipment, and improved infrastructure;
- Improve access to and availability of laboratory services and quality control;
- Ensure a well-functioning patient referral system;
- Develop communication skills and gain the trust of patients; and
- Monitor and evaluate work.

The rest of the manual discusses the treatment of STIs, including the following:
- The identification and comprehensive management of a patient with a symptomatic STI, involving taking a history; examination; screening for cervical cancer; correct diagnosis; treatment using the syndromic approach; health education; counselling; VCT; partner notification and treatment; condom promotion, demonstration, and provision; referral to other services (contraception, antenatal, PMTCT, TB, AIDS treatment and care); and documentation.
- STIs covered include male urethritis syndrome, vaginal discharge syndrome, lower abdominal pain, genital ulcer syndromes, scrotal swelling, balanitis/balanoposthitis, bubo, genital warts, genital molluscum contagiosum, and neonatal conjunctivitis.
- Syphilis screening of pregnant women.

Services
The prevention and early treatment of STIs are high public health priorities in South Africa. The government recognised that untreated STIs play a significant role in driving the HIV epidemic and introduced syndromic management protocols into the public health sector on a national basis in the mid-1990s. During the initial stages of this approach, treatment guidelines were formulated and widely distributed, and training programmes for implementation were conducted in all provinces. At the same time as syndromic management
protocols were introduced, the government increased the distribution and promotion of male condoms. “[T]he reversal in the prevalence of syphilis among pregnant women in the past five years is an indication of the gains from the introduction of syndromic management of sexually transmitted infections (STIs) in 1995” (HIV/AIDS and STI Strategic Plan for South Africa, 2007–2011, p. 8). Since STIs are major contributors to the HIV epidemic, there is a need to be vigilant in ensuring the optimal management of STIs. “Reductions in HIV incidence could be achieved by promoting patient-initiated treatment of genital herpes, by addressing rising levels of drug resistance in gonococcal isolates, and by encouraging prompt health seeking for STIs” (Johnson, 2008, p. 2). “The main hurdles with STI control relate to the management of ‘partners,’ asymptomatic infections, the emergence of resistant strains of some bacteria, as well as the importance of viral STIs in the spread of HIV” (HIV/AIDS and STI Strategic Plan for South Africa, 2007–2011, p. 8).

Common problems identified include inappropriate treatment, missed opportunities for treatment, and the incomplete examination of patients, leading to failure in diagnosing an STI. The main challenges at the clinic level include partner notification, the lack of skilled staff to manage patients, poor morale and attitudes of healthcare workers, long patient waiting times, lack of privacy in clinic infrastructure, and poor and insufficient STI counselling offered to clients. At the district level, there is a lack of adequate support, supervision, and management (Sonko et al., 2003).

**Gaps in relation to sexually transmitted infection policy, guidelines, and services**

- There are no guidelines for the treatment of genital herpes.
- The syndromic approach does not address the HPV and Hepatitis B co-infections, and there are no guidelines specifically addressing HPV and Hepatitis B co-infection for the management of HIV-infected populations.
- The treatment of vaginal candidiasis is weak.
- There is inadequate guidance to healthcare providers on how to support HIV-positive clients to recognise signs of recurring infections and, for example, have treatment—acyclovir—at home, rather than treating every visit for HSV as a new STI incident.
- Mechanisms for monitoring the impact of treatment are inadequate.

**Medical male circumcision**

**Status**

The biomedical literature suggests that medical male circumcision helps prevent STI and specifically offers some protection for heterosexual men against HIV infection (Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007). Traditional circumcision also may help to reduce HIV infection rates if full circumcision of the foreskin is achieved, as long as the process does not itself transmit HIV or encourage further unprotected sexual activity, and if it is conducted on boys not already infected with HIV.

Circumcision benefits only those who perform insertive sex and is not protective for those receiving receptive sex, whether anal or vaginal.

The 2009 South African National Communication Survey found that there was a low level of knowledge of male circumcision as a method of lowering the risk of HIV transmission (7.5%) and that, of those who were aware of male circumcision’s protective factor, 12–22 percent of men and 12–17 percent of women across age groups (15% in total) also believe that circumcised men do not need to use condoms (Key facts of the National Communication
One of the concerns of mass circumcision is around risk compensation. According to de Bruyn, et al., (2010), circumcised men believe that circumcision provides complete protection and as a result may be more likely to engage in risky sexual behaviours that could offset the effect of circumcision. However, there is incomplete evidence regarding risk compensation in the context of male circumcision. De Bruyn and colleagues argue that, despite inconclusive evidence, “national rollout programmes will have to evaluate risk compensation and messages that place mc [male circumcision] as part of a comprehensive HIV strategy. In such a context, mc should be presented as part of a comprehensive HIV prevention strategy that includes VCT, risk reduction, behaviour counselling, access to condoms, disclosure of HIV status to partners and partner testing” (de Bruyn et al., 2010, p. 25). The decision whether to scale up provision needs to give serious consideration to the potential impact of medical male circumcision on women’s ability to negotiate safer sex with their partners, as men who have been circumcised often refer to having “natural condoms,” also known as “disinhibition” (Myers and Myers, 2007).

Figure 4 shows the highest rate in the Limpopo and Eastern Cape provinces. Circumcision rates are highest among men over the age of 30 (53%) (Draft Policy for Male Circumcision, 2011). Circumcision rates vary by province, with a national prevalence rate of approximately 35 percent.

Research conducted on a sample of 350 Xhosa boys by Peltzer and colleagues (2008) suggests that increased social desirability (and desirability to women) and sexual potency in adulthood are more important than reductions in HIV risk or other health concerns as reasons communities and individuals support traditional male circumcision. Although 37 percent of the boys sampled were fearful about the experience they would have in the initiation school (32% wanted anaesthesia for the procedure, and 74% were concerned about having an inexperienced traditional surgeon), only 17 percent chose to be circumcised by a biomedical doctor (Peltzer et al., 2008, p. 1030).

Figure 4. Percentage of males circumcised in South Africa, by province, 2002

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Note that this draft is not going to be finalised as a policy; rather, medical male circumcision is being built into implementation strategies.
At the same time, introduction of medical male circumcision into communities that practice
traditional circumcision may raise challenges, since traditional circumcision is part of
initiation processes that are linked fundamentally to socialisation of men into a culture of
masculinity and adulthood (Sawires et al., 2006; Ramkissoon et al., 2010).

To gain a better understanding of traditional male circumcision, more and better research is
required. According to a recent systematic review of eight articles (Muula et al., 2007, cited
in Deacon and Thompson, 2010), the literature on complications associated with male
circumcision in sub-Saharan Africa is not very extensive, complications generally are minor,
and there is no firm evidence to suggest higher levels of complications in circumcisions done
either by non-medically trained or medically trained professionals. However, some literature
suggests otherwise, as does the South African experience (Mayatula and Mavundla, 1997;
Mogotlane et al., 2004; Ncayiyana, 2003). Sawires et al. (2007, p. 36) note that “[q]uestions
pertaining to safety, human resources, and adequate medical training in resource-poor
environments remain a high concern ... Studies in Nigeria and Kenya cite complications rates
(of varying severity) ranging from 12–17.5% in hospital settings.” This research is difficult
because traditional male circumcision practices are conducted in private spaces and inviting
outsiders is taboo. This makes it difficult to understand the social context of the ritual itself
and how social context and meaning affect the practice to inform the dialogue about ways to
maximise circumcision’s health benefits and minimise its health risks (see Deacon, 2008 and
Vincent, 2008, cited in Deacon and Thompson, 2010).

Policy
There is no national policy addressing the dangers of traditional circumcision, but provinces
have policies that tend to require some oversight from the DOH.
In March 2007, WHO/UNAIDS recommended that medical male circumcision be promoted as a component of a comprehensive HIV prevention strategy, and that countries with generalized heterosexual epidemics and low rates of male circumcision scale up the intervention (WHO/UNAIDS, 2007). A South African policy was drafted but it was subsequently decided not to issue a stand-alone policy, but rather to incorporate medical male circumcision into HIV implementation processes.

**Services**

The scale-up of medical male circumcision in South Africa has been slow, primarily due to the lack of policy clarity. The National AIDS Council has supported consultations with experts as well as workshops with traditional healers. In addition, a national male circumcision task team has been established. To date, medical male circumcision services are not being offered uniformly or throughout the country. However, there are a number of places where implementation is occurring, including through circumcision camps in KwaZulu-Natal. As part of the circumcision drive in KwaZulu-Natal, the province has held several circumcision camps, where young men gather at a hospital venue and are circumcised. The province intends to use this approach to ensure that a large number of men are circumcised over the next few years.

The DOH’s 15 February 2011 “Progress towards the negotiated service delivery agreement of the health sector” makes the following statement on male medical circumcision:

“Male medical circumcision is one of effective interventions to combat the spread of HIV. In 2010, all nine provinces vigorously promoted and conducted male medical circumcision, with KwaZulu-Natal taking the lead, under the stewardship of the King himself. Since the launch in April last year, they have conducted 17,000 circumcisions.

The beautiful thing about this circumcision campaign is that a lot of counselling of the young men takes place there, with traditional advice imparted to the young people together with technical aspect of HIV and AIDS on male and female sexuality.”

**Lessons on male medical circumcision: The Orange Farm Bophele Project**

The Orange Farm Bophele project can serve as an example for lessons that should be applied on a national scale. The goal of the Bophele project is to extend male circumcision services to the Orange Farm community, where the Agence Nationale de Recherches sur le Sida male circumcision randomized controlled trial was conducted. A community advisory board has been established, composed of local leaders, NGOs, and scientists. Senior male and female community stakeholders also have been targeted through workshops. Mobile recruitment teams have been established to make door-to-door visits, and outreach posts within the communities have been set up for VCT. In addition, substantial time has been spent implementing regularly held information sessions for the whole community that highlight the partial effectiveness of male circumcision and the need to abstain from sex for six weeks after the procedure. Some programmatic challenges include the scarcity of surgical staff, financial costs, and the size of the facilities. The cost for each male circumcision conducted in the Bophele project has been reduced to approximately R245 per circumcision through the use of a disposable surgical kit and electrocautery and by optimizing the use of personnel by, for example, including four beds per surgical bay.
Provision of medical male circumcision outside of integrated primary healthcare services may have the unintended consequence of focusing on the clinical procedure without the community and broader service engagement underway in the Orange Farm model. Specifically, men and women may not be provided with a full understanding of the fact that while medical male circumcision has public health value, it does not provide adequate protection against HIV to men, or any protection for women.

According to the AIDS Vaccine Advocacy Coalition (September 2007), the following should be achieved for medical male circumcision programmes to be effective:

- Medical male circumcision must be offered in addition to the full array of proven HIV prevention strategies.
- Programmes must clearly explain the benefits and limitations of the procedure and what is known and not known about protection for women and men who have sex with men.
- Programmes must be staffed appropriately.
- Programmes must contain clear cultural and context-specific messages to counteract changes in risk behaviour that might follow the procedure.
- Programmes must be sensitive to the different meanings of the procedure, delineating its use as a strategy for HIV risk reduction, separate from its uses as a marker of religious or tribal affiliation and the dangerous and unrelated practice of female circumcision (AVAC, 2007).

Gaps in medical male circumcision policies, guidelines, and services

- No policy, and so no official direction, on the intersection between male medical and traditional male circumcision, including how the health system deals with training of traditional surgeons, making the practice safer, and dealing with complications that may arise as a result of traditional practices;
- The fact that there has been no institutionalisation of counselling for the public and partners of those circumcised to ensure that they understand that male medical circumcision is not fully protective for men and is not protective for women, and hence safer sex practices should be employed;
- No programme of research into the diverse cultural understandings of circumcision and its role in the construction of masculinity to inform understanding of how to communicate about male medical circumcision;
- Little capacity for sexuality counselling that enables people to make fully informed and reflective decisions on male medical circumcision and provides effective information and education on post-male medical circumcision HIV prevention; and
- No male-friendly services to facilitate male medical circumcision expansion within public health services, which means that current services operate vertically, unrelated to broader HIV prevention programmes and messages and contraceptive services.
Cancers of the sexual and reproductive system

Cancer in South Africa is an emerging health problem. Little information is available regarding people’s knowledge of cancers, prevention, and when to seek information, screening, or testing (Maree and Wright, 2010).

Breast cancer
Status
Lifetime risks of developing breast cancer vary from a low of 1 in 81 in African women to a high of 1 in 13 among white women, which is similar to rates in Western countries. Age and stage at diagnosis vary considerably between racially defined groups and populations (urban or rural) living in South Africa (Vorobiof et al., 2001, p. 125). The annual crude incidence rate is 34.3 per 100,000 South African women of all ages (WHO/ICO, 2010).

Women lack knowledge of breast cancer (Pillay, 2002).

Policy
The National Contraception Policy Guidelines (2002) make reference to screening for breast cancer, but mammography is not recommended. There is no policy or routine screening.

Services
There are no cost-effective screening mechanisms, but healthcare workers do need to provide information to women on self-examination for breast cancer and should know when to refer women for signs and symptoms of breast cancer. One key informant suggested that the reference to screening for breast cancer in the absence of methods for screening creates confusion for healthcare providers.

Cervical cancer
Status
Current estimates indicate that every year 5,743 women are diagnosed with cervical cancer and 3,027 die from the disease, with a crude incidence rate of 22.8 per 100,000 South African females of all ages. About 21 percent of women in the general population are estimated to have cervical human papilloma virus (HPV) infection at a given time, and 62.8 percent of invasive cervical cancers are attributed to HPVs 16 or 18 (WHO/ICO, 2010).

Policy
National Guidelines for Cervical Cancer Screening programme 2000
Objectives:
- Reduce the incidence of carcinoma of the cervix (CACX), primarily by detecting and treating the pre-invasive stage of the disease.
- Reduce the morbidity and mortality associated with cervical cancer.
- Ultimately, reduce the current excessive expenditure of scarce health funds on the treatment of invasive cancer of the cervix.
Secondary prevention:
- Three cervical cytology Papanicolaou (pap) smears per lifetime of women ages 30 or over, with a 10-year interval between each smear;
- Only one smear if screened for the first time at age 55 and smear is normal;
- Woman with inadequate smear to be rescreened and, if second smear is inadequate, referred to known competent screening service;
- Follow-up: screened women asked to return to facility to obtain result within four weeks; facility to find patients with positive results who do not return voluntarily;
- Referral to colposcopy clinic if second smear is atypical;
- Treat if positive on colposcopy and cytology; and
- Follow-up: patients who do not keep their appointment at colposcopy clinics to be traced by the original screening institution.

The National HIV&AIDS and STI Strategic Plan for South Africa 2007–2011 commits to “integrated contraceptive, cervical screening and fertility services” and includes under its ‘Wellness Care Package’ “Regular CD4 counts; opportunistic infections prophylaxis and treatment; cervical screening; advice on lifestyle, nutrition, contraceptive use and fertility, positive prevention, social support, and pain and symptom relief.” It does not indicate whether this screening will remain in line with the overall cervical screening policy of three smears per lifetime, and anecdotal reports suggest that younger HIV-positive women are being screened. The Western Cape Department of Health guidelines and related research suggest that, given that cervical cancer is viewed as an opportunistic infection and that HIV-infected women present earlier with cervical lesions, pap smears need to be provided upon HIV diagnosis and then provided annually (Western Cape guidelines, 2008; Harries, 2008; Gaym et al., 2008).

Services
Screening is hampered by women’s limited knowledge of cervical cancer (Heystek et al., 1995; Maree and Wright, 2007). In 2005–2006, 100 percent of primary healthcare clinics in South Africa had health professionals trained to conduct pap smears, yet the screening rate was only 1.3 percent, despite the fact that 1 in 26 South African women will develop cervical cancer (van Schalkwyk et al., 2008, p. 9).

Cervical cancer screening rates in South Africa are low, regardless of HIV status. Pap screening rates are as low as 4 percent among women of 15–65 years of age, with most performed in antenatal or family planning clinics (Cronje and Beyer, 2007 p. 170; Bradley et al., 2004; Fonn et al., 2002; Larney et al., 2003), although the DOH’s Annual Report indicates an increase in screening coverage from 22 percent in 2008/09 to 47.7 percent in 2009/10 (NDoH, 2010d, p. 7). “Primary health centre data on recently diagnosed HIV-positive women revealed that the proportion of patients undergoing at least one pap smear was low (13.1%)” (Batra et al., 2010, p. 41). In Johannesburg Metro District, “the cumulative cervical screening coverage for the period 2000 to 2008 is below target for both the district (30.7%) and the province (21.4%)” (Jassat, 2010, p. 59).

A study on cervical screening loss to follow-up in Johannesburg Metro District found that, of 557 women identified to have pre-cancerous and cancerous lesions via pap smear, only 155 attended diagnostic and treatment facilities. Identifying the point of loss, it found that the notification rate was 57 percent, referral appointment rate was 38 percent, and appointment compliance rate was 28 percent (Jassat, 2010, p. 54). It found that “While provincial clinics (83.9%) referred high proportions of women with high-grade lesions, local government
(48.2%) patients were most likely to make appointments, and provincial (32.3%) patients were most likely to attend colposcopy appointments. NGO-run clinics performed poorest in terms of referral of women to colposcopy services.” Subdistrict, HIV seropositivity, and recording of contact telephone number were associated with attending colposcopy appointments (Jassat, 2010, p. 56).

A study from 2002–2003 found that community health workers following up clients could substantially cut loss to follow-up cervical screening (Goldhaber-Fiebert et al., 2005).

According to a qualitative study of 15 women with advanced cervical cancer designed to understand the routes they followed from the first signs and symptoms of the disease to receiving treatment, the women did seek treatment, often more than once, and were not solely responsible for presenting late. The average number of months from first contact with a healthcare professional until diagnosis was 17.3, ranging from 11.8 months for urban participants to 28.4 months for rural participants; for diagnosis to referral for treatment, the average was 3 to 7 months. Lack of knowledge and awareness among healthcare professionals resulted in a low suspicion of cancer and misdiagnosis (van Schalkwyk et al., 2008).

In general, the cervical cancer screening programme is poorly implemented, and even in cases where smears are done, there are no proactive follow-ups of women with positive smears, women wait a long time for colposcopies, and they do not go back for results.

Key informants suggested some confusion about cervical screening in the current context of HIV. The existing cervical screening policy is to start cervical screening at the age of 30. However, HIV clinics are screening much younger women, and doing so annually. A study in the Johannesburg Metro District found that “a high number of Pap smears continue to be performed in women less than 30 years, who are outside the target age group according to the national policy. Despite this, a relatively significant proportion of high-grade lesions and invasive cancers (4.4%) are detected in young women” (Jassat, 2010, p. 59).

“I think with the cervical cancer clinicians have great difficulty buying into the idea of three times in a lifetime, starting at the age of 30. They think you should do it immediately. They don’t understand the public health part of it.” (Key informant, researcher)

Women referred for colposcopy tended to be HIV positive and over the age of 30 years and, in most (70.2%), cytological examination revealed high-grade cervical dysplasia (van Schalkwyk et al., 2008). HIV-positive women treated with excision for precancerous lesions of the cervix were significantly more likely than their HIV-negative counterparts to undergo incomplete excision, experience persistent cervical disease after treatment, and be lost to follow-up (ibid). The study highlights the need for cervical cancer screening efforts to be scaled up for women with HIV. Treatment and surveillance guidelines for cervical intraepithelial neoplasia in HIV-positive women may need to be revised and new interventions developed to reduce incomplete treatment and patient default.

The necessary radiation equipment in the country to treat cervical cancer is lacking. (Personal communication, Prof. Dreyer, University of Pretoria, 2011)
HPV vaccination acceptability studies have started, and the DOH in KwaZulu-Natal has begun implementation in some areas, in partnership with the Department of Education. Greater mobilisation is needed to enable the affordability of HPV vaccines. Thomas (2008) notes the important role of ART in arresting cervical cancer disease progression and suggests that treatment is important in limiting HPV spread and transmission.

**Gaps in cervical screening policy, guidelines, and services**

- The current guidelines are inadequate in light of the interactions between cervical cancer and HIV.
- Implementation of existing guidelines is uneven.
- There is no policy for the provision of the human papilloma virus (HPV) vaccine in the public sector.
- Health providers lack the ability to treat women effectively following a positive Pap smear, including referrals and treatment opportunities.
- Colposcopy services may not be available at district hospitals, and doctors at these institutions may not be trained in colposcopy. The long delays currently seen in women with abnormal cervical cytology lead to a loss of follow-up, and many women develop invasive cancer while waiting to have colposcopy and treatment of their pre-invasive lesions.

**Prostate cancer**

*Status*

The 2000–2001 National Cancer Report shows that males have a lifetime risk of one in six of getting any cancer, with prostate cancer being the most common. However, if prostate cancer is detected early through screening services and treated, it can be managed successfully. The age-adjusted incidence for prostate cancer in South Africa is 90 cases per 100,000 (Bowa, 2010).

“Over 4,000 cases of prostate cancer are diagnosed in South Africa every year and over 2,500 men lose the battle to prostate cancer each year. The lifetime risk for men developing prostate cancer in South Africa is one in 24. One of the contributing factors to these alarming figures is that many men are unaware of the risks they face with regards to this disease and that many are currently diagnosed with advanced stages of the disease. These realities and statistics are directly related to awareness and education programmes available to the public at large” (Prostate Cancer Foundation website, 2010).

*Policy*

There is no national policy on addressing prostate cancer in the public sector.

*Services*

No articles relating to prostate cancer in the public sector were found for this review. The review revealed that prostate cancer screening services are absent from the public sector. One article (Bowa, 2010) was found on the diagnosis and management of prostate cancer in Nigeria. Bowa examined prostate cancer screening and treatment programmes in Africa and determined that generally there are no screening programmes in Africa due to the perceived low prevalence, and that PSA (prostate specific antigen) testing, which is standard practice in the developed world, is expensive and not widely available. As a result, the diagnosis of prostate cancer is limited both by the non-availability of ultrasound-guided biopsy techniques and inadequate pathology services.
Gaps in policy, guidelines, and services for prostate cancer

- There is no national policy on addressing prostate cancer for the public sector, and this may not be a priority.
- Healthcare workers lack information on and understanding of signs and symptoms of prostate cancer so that they can provide healthcare users with referrals and information.
- There is a lack of community awareness of prostate cancer, including signs and symptoms of disease.

Mental health and counselling as it relates to sexual and reproductive health and rights

Status

“Mental health as a component of reproductive health has generally been—and still is—inconspicuous and considered peripheral and marginal. The lack of attention it has received is unfortunate, given the significant contributions of both mental health and reproductive health to the global burden of disease and disability” (WHO and UNAIDS, 2009, p. 1). Furthermore, this literature review revealed that the majority of evidence on reproductive mental health conditions is primarily from middle- and high-income countries. This is misleading, as the perception is that reproductive mental health conditions are not relevant to people in low-income and developing countries. Even in cases where the physical aspects of women’s reproductive health are affected (such as fertility, infertility, childbirth, and lactation), it is only the physical condition that receives attention in the public health system, while the mental health effects of these reproductive health conditions are ignored and often considered an unaffordable luxury for women in resource-poor settings. A variety of social pressures, including violence against women, economic instability, a patriarchal society, the gendered burden of care, and other factors, lead to a higher prevalence of emotional and mental issues in women (Prince et al., 2007). The most debilitating of these are anxiety and depression, which exacerbate any livelihood issues women may be facing (Health Systems Trust, 2011). These mental and emotional issues lead to increased incidences of alcohol or other substance abuse and push women towards addiction (Smit et al., 2006). The mental health and emotional needs of women are seen as outside the scope of reproductive health services, which consequently provide no support or assistance in this regard. Human resources for mental

“...When we had a child together, I again suffered very much from postnatal depression, although I did not know what it was called at the time. The clinic I went to in the township did not know anything about depression. So, I was unable to get help from them.

…I attended Liesbeeck MOU for my antenatal care. There I met with a counsellor as part of the Perinatal Mental Health Project. Finally I was able to get help. It was very good to speak to her about how I was feeling and to just talk out about everything. That was what was killing me, having to keep all my feelings inside of me for a long time. I was so lonely and there were so many things that I needed someone to listen to. I needed to express my feelings and to be heard when I was saying something...They also sent me to a psychiatrist to get medication for my depression. Now I am doing just fine and coping very well with motherhood.

...There are so many women who are dying inside from this thing. They don’t know how to deal with it or how to cope. Everything in their lives is turning upside down. And they need someone who will understand and not judge them. If I could have my way, each and every one of the hospitals would have these kinds of counsellors, especially the government hospitals, which are for everybody. That way, everyone could get help.” (Gloria Mbovu cited in Perinatal Mental Health Project, 2008, p. 5)
healthcare generally are minimal, and there is a general lack of awareness among front-line healthcare providers of mental health and emotional problems and how to detect such problems and intervene (Lazarus and Freeman, 2009).

Policy
As indicated in the policies reviewed here, many SRHR policies include the need for counselling. By way of illustration are the following:

- The National Contraception Policy Guidelines require health services to “provide effective IEC and counselling in a private and comfortable environment and ensure confidentiality.”
- The Choice on Termination of Pregnancy Act 1996 requires the state to “promote the provision of non-mandatory and non-directive counselling, before and after the termination of a pregnancy.”
- The HIV/AIDS and STI Strategic Plan for South Africa 2007–2011 aims to increase coverage to VCT.
- The National Policy on Rape, Sexual Assault and Other Related Sexual Crimes says that “a member of staff of every clinic must have received training in the identification and management of sexual, domestic and gender related violence. The training should include gender sensitivity and counselling.”

Some policies locate counselling at other levels of care, such as the Guideline for Maternity Care in South Africa 2007, which requires Level 1 hospitals to provide genetic screening and counselling services, counselling and support; and some of the services above, such as abortion services, would not be at provided at the clinic level. In addition, even clinics that do not provide services are required to counsel women before referring them for services.

Services
In South Africa, mental healthcare services in resource-poor settings are underdeveloped; where they do exist, they are restricted to urban areas and hospital-based care, making it difficult for rural women to access them. Many mental healthcare services and institutions often are unable or unwilling to deal with broader mental health challenges, such as depression in combination with HIV (Collins, 2006). The review conducted by Lazarus and Freeman (2009) highlights the need for mental health services for HIV-infected people, due to the vulnerability of people with mental disorders and substance abuse to contracting HIV, and because mental ill health is an important health outcome of being infected with HIV. Furthermore, mental health status impacts on the course of the disease in various ways. According to the review, “studies in both more and less developed countries show that just under half of all people living with HIV have a diagnosable mental disorder and in some instances a threefold higher rate of mental disorder. Even with the greater availability of antiretroviral therapy, people living with HIV still often experience high levels of psychological distress and mental disorder. Difficulties include problems and decisions concerning relationships, having children, the side effects of medication and dealing with stigma. Where mental illness and HIV co-occur, there is increasing evidence that the progression of the virus is greater. Mental disorder also affects adherence to medication. Access to mental health services has been shown to decrease AIDS progression and mortality” (Lazarus and Freeman, 2009, p. ix).

The 10 principles for the integration of mental healthcare developed by the WHO and the World Organisation of Family Doctors are the following:

- Policy and plans need to incorporate primary care for mental health.
• Advocacy is required to shift attitudes and behaviour.
• Adequate training of primary care workers is required.
• Primary care tasks must be limited and doable.
• Specialist mental health professionals and facilities must be available to support primary care.
• Patients must have access to essential psychotropic medication in primary care.
• Integration is a process, not an event.
• A mental health service coordinator is crucial.
• Collaboration with other sectors and stakeholders is required.
• Financial and human resources are needed (Lazarus and Freeman, 2009, p. x–xi).

An approach to addressing the mental health needs of HIV-positive pregnant women
Lazarus and Freeman (2009) identify a number of best practice models for addressing reproductive mental health. Of particular note is the South African mothers2mothers (M2M) project. PMTCT programmes have the potential to address the mental health concerns of HIV-positive women, especially in the early stages of parenting. M2M was established in 2001 to fill the healthcare provider shortage gap in relation to the high volume of pregnant women needing care, specifically in relation to HIV infection. M2M works in collaboration with provincial, district, and municipal services. The programme is operational in community health facilities and involves the use of trained mothers living with HIV (mentor mothers) as peer educators and psychosocial care supporters for HIV-positive pregnant women through pregnancy and during the first year of their baby’s life. The programme uses education and empowerment as tools to prevent MTCT of HIV during pregnancy, to combat stigma in families and communities, support a mother’s adherence to medical treatment, and reduce the likelihood of children being orphaned. The programme is seen as contributing to continuing medical and psychosocial care. M2M is unique, in that it has a strong focus on psychosocial issues and the provision of emotional support. The mentor mothers are recruited locally from among women who have gone through PMTCT services themselves. Training for the mentor mothers includes basic medical knowledge about HIV and AIDS and ART, knowledge of PMTCT strategies, safer infant feeding practices, strategies around the disclosure of HIV status, and nutritional guidelines for women living with HIV. Programme activities include health talks in clinic waiting rooms, individual and group education, and regular support group meetings. Mentor mothers also support women in infant feeding choices, promote safer sex and family planning, encourage mothers to return for wellness HIV care or treatment, and ensure that infants return to the clinic for HIV testing and care. Mentor mothers are supervised by site coordinators (who previously were mentor mothers). A formal cross-sectional pre-post quasi-experimental evaluation of the programme (Baek et al., 2007 cited in Lazarus and Freeman, 2009, p. 57) prior to and one year after its introduction in KwaZulu-Natal showed positive medical and psychosocial outcomes. With regard to the latter, pregnant women who had contact with the M2M programme were more likely to report disclosure (usually to their partners) and improved psychosocial well-being (Lazarus and Freeman, 2009, pp. 56–58).

While M2M provides a model to incorporate psychosocial support into the health continua, the quality of the intervention and the way in which it is integrated into the different levels of care and across multiple SRHR programmes will need to be investigated.
Women’s experiences of mental health differ from men’s. Women may experience increased mental health mortality and morbidity due to unaddressed SRHR issues, such as increased sexual violence, reinfection, fertility intentions, partum depression, and depression related to HIV. In addition, repeated trauma and experiences of violence predispose HIV-positive women to depression (Brandt, 2009).

There is little information about South African men’s and transgender people’s mental health in relation to sexuality and reproduction.

**Gaps in policy, guidelines, and services on mental health counselling in relation to sexual and reproductive health and rights**

- Most of the SRHR policies reviewed thus far note the importance of ‘counselling and support’ or ‘psychosocial support.’ However, they do not address the specific mental health dimensions of reproductive and sexual experiences, which range from postpartum depression to coping with gender- or sexuality-related bullying and stigmatisation. There is a lack of specific guidelines on dealing with sexual and reproductive mental health issues, e.g., pre- and postpartum depression and gender identity challenges, among others.
- Some policies reference highly specialised services, for example, those relating to sexual and gender-based violence or HIV counselling, without linking them to other related aspects of SRHR in a health service context where there are not enough trained counsellors to meet the need.
- Mental health guidelines have not been updated to include the specific mental health needs of women, men, and transgender people living with HIV.
- Additional training is needed for healthcare workers in counselling and the recognition of depression, anxiety, and related substance abuse.
• There are no public outreach programmes aimed at building public knowledge of mental health challenges and the possibility of seeking health service support.
• There are gaps in knowledge, policy, and implementation regarding the mental health sequelae of sexual and reproductive health problems and abuses of sexual and reproductive rights in South Africa, as well as regarding the relationships between anxiety, depression, and addiction and SRHR for diverse populations.
CHAPTER 4: A CULTURE OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Chapter 3 focused on the essential package of SRHR services that are the responsibility of the Department of Health. But, as discussed in the introduction to this review, many of the barriers to sexual and reproductive health and rights lie elsewhere. This chapter focuses on other instances of these barriers, such as gender inequity and other sources of prejudice, as well as sexual and gender-based violence. In doing so, it considers how current cultures in South Africa respond to the sexual and gender expression of diverse populations—adolescents, people with disabilities, same-sex practising people, transgender people, intersex people, and migrants—looking in particular at their experiences of stigma and discrimination and how these impact on their sexual and reproductive rights.

The chapter then considers the response of health services working in this cultural context. It reviews current health policy on gender equity, healthcare provider training, and interventions that effectively address stigma and discrimination in health services.

While Chapter 3 identified how many sexual and reproductive health policies call for community outreach and mobilisation, it is Chapter 4 that explores community-based interventions to influence broader cultural values in favour of gender equity and sexual and reproductive rights, including some with specific target groups—adolescents, pre-adolescents, men, and boys. It concludes by reviewing mass outreach programmes to change cultural norms, knowledge, and behaviour.

Stigma and Discrimination

This section explores social and cultural responses to diverse populations that occur due to their sexuality or some other aspect of their lives (such as disability or citizenship) that in turn affect their sense of self, their ability to express and enjoy their sexuality, and their ability to protect and promote their sexual and reproductive health. It does not focus on women, since women are the target of most health services, and hence their experiences and health status were the subject of much of Chapter 3. Similarly it does not focus on people living with HIV as issues facing them have been dealt with above. Here, the focus is on those who are not addressed directly by health policies and services. The exception is adolescents, to whom the health, social development and education systems are paying increasing attention and who, as the largest population in South Africa, require attention in their own right.

Adolescent sexual health

Initiatives for adolescents cover multiple sectors. This section of the review focuses not only on health services, but also on school health programmes and the issues outlined in the White Paper on Population 1998 and the National Youth Policy 2008–2013.

Status

Teenage motherhood is very high in South Africa, with 55 per 1,000 African South African women becoming mothers in 2001 (Gustafsson and Worku, 2007). Teenage mothers are less likely to have completed high school in comparison to all other women and to all mothers. This has a negative impact on their personal development and employment opportunities (ibid, 2007). Adolescents ages 15 to 25, especially young girls, are at increased risk of acquiring STIs (including HIV infection), having unintended pregnancies, and other SRHR challenges, due to an early age of sexual debut, multiple and concurrent partners,
intergenerational sexual relationships with older men, and inequitable gender dynamics that limit their capacity to negotiate safer sexual practices, including condom use. According to the 2008 South African National Youth Risk Behaviour Survey, 38 percent of learners had reported ever having had sex, with 13 percent of them reporting their age of the initiation of sexual activity as being under 14. Of those who had ever had sex, 41 percent had two or more sexual partners in their lifetime (this prevalence increased with grade, with significantly more grade 10s and grade 11s having more than two sexual partners in their lifetime than grade 8s). Of those learners who had ever had sex, 52.3 percent had one or more partner in the past three months. Sixteen percent of learners reported consuming alcohol, and 14 percent reported using drugs prior to having sex. In terms of condom use, 31 percent of learners reported that they practiced consistent condom use. Significantly fewer learners of 13 years of age and under reported using condoms for contraception, compared to 16 year olds. Nineteen percent of learners reported that they had been pregnant or made someone pregnant. The national prevalence of learners who reported having an abortion was 8.2 percent, of whom only 51.5 percent reported that the abortion took place at a hospital or clinic; 20.5 percent reported using a traditional doctor or healer; 10.2 percent reported “another place,” and 5.4 percent reported that they did not know where the abortion took place. HIV and AIDS education was received by 65 percent, and 21.5 percent of learners reported having an HIV test (Reddy et al., 2010, pp. 30–34).

Despite schools being an ideal venue to discuss sexual and reproductive health and rights with learners, it is important to note that for young girls, school also can be a site of sexual harassment (Prinsloo, 2006; Wilson, 2008). In qualitative research, school girls reported being threatened with failing the school year if they did not agree to sex with their teacher (Wood and Jewkes, 1998). In a three-province study, 2 percent of learners disclosed being threatened with exam failure or bad marks if they refused to have sex with their teacher (Jewkes and Abrahams, 2002, p. 1238).

*Education Policy*

The **National Youth Policy 2008–2013** includes the right to participate in policy development, decisionmaking, and leadership; the right to healthcare; the right to protection from all forms of violence and abuse; and the right to privacy, cultural expression, self-determination, and enjoyment of youth.

The **White Paper on Population Policy 1998** commits to the provision of life skills, sexuality and gender sensitive education for adolescents. The **School Health Policy and Implementation Guidelines** (2003) include the provision of health education, the promotion of health, and access to necessary health services.

The Department of Basic Education has developed a **Draft Integrated Strategy on HIV and AIDS 2012–2016** (2010). The strategy is in line with the HIV and AIDS NSP and defines interventions beyond the Life Skills programmes to respond to the HIV epidemic. The target groups for the strategy include senior management within the Department of Basic Education, Heads of Education departments, senior provincial managers, provincial HIV and AIDS coordinators, educator unions, student organisations, and nongovernmental
organisations. The goals of the strategy are threefold, namely to enhance the protective factors of schools and the basic education sector with regard to HIV prevention, support, and mitigation; increase knowledge skills and confidence among learners, educators, school support staff, and officials to take self-appropriate sexual and reproductive decisions; and increase access to sexual and reproductive health services, including HIV services by learners, educators, school support staff, and officials.

In relation to sexual and reproductive health, the **Draft Integrated Strategy on HIV and AIDS 2012-2016** has the following intervention strategies:

- Creating a safe and supportive environment
- Providing information
- Building skills
- Counselling
- Access to health services

Most of these strategies are implemented in schools or within the community and are addressed later in this chapter in the section on adolescent community-based interventions.

**The National Curriculum Statement (2001) (Also known as Curriculum 2005)**

Objectives: The National Curriculum Statement for each grade aims to develop learners’ level of knowledge and skills. It sets up high expectations of what all South African learners can achieve. The National Curriculum Statement specifies the minimum standards of knowledge and skills to be achieved at each grade and sets high, achievable standards in all subjects.

**The Revised National Curriculum Statement (2008)**

The Revised National Curriculum Statement streamlines and strengthens the national curriculum statement and continues to be committed to outcomes-based education. It is a part of the process of transforming education and builds on the vision and values of the Constitution and Curriculum 2005. These principles include outcomes-based education; a high level of skills and knowledge for all; clarity and accessibility; progression and integration; and social justice, a healthy environment, human rights, and inclusivity by paying specific attention to issues of poverty, inequality, race, gender, age, and disability.

Sexuality education is part of the Life Orientations component of the National Curriculum Statement. The aims are that by Grade 12, learners will be able to

- Analyse what other people have done for human rights
- Debate the changing roles of men and women
- Explain life roles
- Apply decisionmaking skills
- Make healthy lifestyle choices

This will enable them to make sense of the various life changes they experience on the path to adulthood; maintain healthy relationships with the opposite gender; create a realistic picture of the responsibilities connected to different life roles; and make informed lifestyle decisions based on long-term consequences of various options.

The current school curriculum, based on the revised national curriculum statement (2008), is implementing ‘life orientation’ as one of its learning areas with specific learning outcomes.
The above mentioned sexuality education is implemented through the life orientation programme. This programme is a “multifaceted programme that consists of several components, including capacity building for educators and school management teams; the development of teaching and learning materials; objective-based lessons within the Life Skills component of the Life Orientation Learning area; peer education programmes; and the establishment of care and support teams that include community-based stakeholders.

The topic areas covered by the programme are sexuality and health education (including HIV and AIDS), substance abuse, child abuse, peer education, assertiveness, peer pressure, anti-bias, gender issues and other relevant skills that would enable learners to deal effectively with difficult situations” (Department of Basic Education, 2010, p. 36). The Life Skills programmes were introduced in schools to increase learner’s knowledge of HIV, improve their skills for engaging in healthy relationships by improving communication skills and decisionmaking ability, and shift attitudes about people living with HIV and AIDS.

**Education programmes**

Sexuality and relationships education is understood to include accurate, age-appropriate, scientifically supported information on sexual health, sexuality, and relationships as aspects of human conduct. It includes knowledge building on information and ideas regarding the effective use of contraception, protection against HIV, protections against sexual violence, understanding of sexual orientation, and information on the diversity of sexual practices in society (UNESCO, 2010; Haberland and Rogow, 2009).

Sexuality and relationships education promotes ideas and values of fairness, human dignity, non-discrimination and equality, tolerance, safety, and respect for the rights of others (UNESCO, 2010; Haberland and Rogow, 2009). It prioritises the acquisition and/or reinforcement of human rights values, such as equality, responsibility and respect, tolerance, reciprocity, and empathy, which are prerequisites for healthy and safer sexual and social relationships. “It is not possible to divorce considerations of values from discussions of sexuality” (UNESCO, 2010, p. 9).

Sexuality and relationships education uses pedagogical methods that provide opportunities to explore one’s own values and attitudes and to build decisionmaking, communication, and risk reduction skills about many aspects of sexuality. This includes skills building in how to understand one’s own sexuality and sexual identity and how to retain one’s personal autonomy in sexual and reproductive decisionmaking in different cultural contexts, including how to negotiate sexual and reproductive relationships in ways that promote equality and respect for oneself and others. It creates opportunities for the participation and contributions of young people, particularly adolescents and older teens (UNESCO, 2010; Haberland and Rogow, 2009).

Sexuality and relationships education must be delivered by trained agents using age- and context-appropriate pedagogical methods. In particular, a rights-based approach to sexuality education requires the participation and contributions of the people it targets, whether young people, disabled people, or any other group (Haberland and Rogow, 2009; Convention on the Rights of the Child, 1989; Signed by SA 29 January 1993; ratified by SA 16 June 1995).

UNESCO’s International Technical Guidelines on Sexuality Education (2009) note that effective programmes can lead to a reduction in misinformation and an increase in
knowledge, and can assist in clarifying and strengthening positive values and attitudes. Furthermore, sexuality education can lead to improved skills to make informed decisions and act upon them, shift social norms, and improve communication with parents or other trusted adults. In additions, programmes can help to ensure that youth abstain from or delay the debut of sexual relations, reduce the frequency of unprotected sexual activity, reduce the number of sexual partners, and increase the use of protection against unintended pregnancy and sexually transmitted infections during sexual intercourse.

“The latest statistics on the education system in South Africa indicate that there are about 5,670 secondary schools accommodating about 3,831,937 learners, which translates to about 70% of young people of school-going age who are in schools” (Department of Education, 2008 cited by Reddy et al., 2010, p. 15). Since the majority of adolescents are learners, schools are an essential venue for disseminating sexuality and health-related information, and implementing programmes to assist in building young people’s sense of self and healthy sexual development and reducing risky sexual and reproductive peer cultures and behaviours (Panday et al., 2009). Over the past few decades, South Africa has used schools to disseminate sexual and reproductive health and rights education and information. In relation to schools, many policies make reference to sexuality education.

Sexuality and relationships education is defined as an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, nonjudgmental information (UNESCO, 2009). Sexuality and relationships education provides the opportunity to equip youth with knowledge and opportunities to make responsible choices with regard to SRHR. Implementation of sexuality and relationship education programmes recognises that all young people need sexuality education. It further recognises that some have specific needs, for example, if they are living with HIV or are more vulnerable to HIV infection than others, if they are already sexually active, have been victims of or are vulnerable to sexual and gender-based violence, are grappling with their gender identity or sexual orientation, or have disabilities that influence their sense of themselves as sexual beings. Effective sexuality and relationships education can provide young people with age-appropriate, culturally relevant, and scientifically accurate information. It provides a platform for young people to explore their attitudes and values and to practise the decisionmaking and other life skills they will need to be able to make informed choices about their sexual lives.

“While it is not realistic to expect that an education programme alone can eliminate the risk of HIV and other STIs, unintended pregnancy, coercive or abusive sexual activity and exploitation, properly designed and implemented programmes can reduce some of these risks and underlying vulnerabilities. Effective sexuality education is important because of the impact of cultural values and religious beliefs on all individuals, and especially on young people, in their understanding of this issue and in managing relationships with their parents, teachers, other adults and their communities” (UNESCO, 2009, p. 2).

A report commissioned by the Department of Basic Education on teenage pregnancy (Panday et al., 2009) reviewed a number of evaluations on sex education programmes in developing countries. This report found that sex education programmes were responsible for increasing participant knowledge, but had little to no impact on improving skills, changing values and norms and behaviours (Panday et al., 2009). This report also cites a systematic review conducted by Kirby and colleagues (2006), of 22 interventions that used either experimental or quasi-experimental designs in order to fill gaps identified in previous evaluation of school-
based sex education programmes. It found that “there was strong evidence for the effect of school-based sex education and HIV education interventions on adolescent sexual behaviour. While the interventions did not increase sexual activity, they did report positive effects in delaying sexual activity, reducing the number of sexual partners, reducing the frequency of sex and increasing condom and contraceptive use. There was also ample evidence for the effect of programmes on knowledge but less consistent effects of the programmes on improving skills or changing values, attitudes and peer norms. The strongest evidence for programmes that had an impact on behaviour was curriculum based and led by adults (either teachers or other adults such as health workers). Only two curriculum-based programmes were implemented by peers, one of which showed some evidence for positive impact on sexual behaviour... Despite the strong effect of intervention on sexual behaviour, only 1 study measured the effect of programmes on STI rates and pregnancy and showed no impact” (Panday et al., 2009, p. 83).

The Department of Basic Education’s Draft Integrated Strategy on HIV and AIDS 2012–2016 (2010) highlights the findings of several evaluation studies that have been undertaken in previous years to examine teachers’ and learners’ perceptions and opinions of the programme and learners attitudes and behaviour of learners. “Several studies have shown that exposure to the Life Skills Programme is associated with improvement in learners’ knowledge about HIV and AIDS, common modes of transmission and prevention methods. The Programme has produced other favourable gains amongst learners that include a heightened level of risk perception for HIV infection, an increased understanding of abstinence as a prevention method and increased approval of abstinence as a behavioural choice for teenagers. However, some studies have found gaps in learners’ knowledge that need to be addressed by the Programme. In a national evaluation of the Programme, learners failed to identify unprotected sex as a mode of HIV transmission, while a small proportion of Gauteng learners showed acceptance of common myths surrounding HIV and AIDS. In terms of impact on learners’ attitudes and behaviours, evaluations have produced mixed results. A national evaluation conducted in 2006 reported that the Life Skills Programme had made a positive impact on learners’ behaviour, on their attitudes towards people different to themselves, and the way in which learners treat and interact with others. A reduction in the number of sexual partners among grade 9 male learners in KwaZulu-Natal was found by Reddy and colleagues while a study by Visser found that increases in learner knowledge had failed to reduce learners’ engagement in high risk sexual behaviours” (Department of Basic Education, 2010, pp. 36–37).

Most striking in this review of evaluations is that it does not seek outcomes in relation to teenage pregnancy, another consequence of unprotected sex.

Significantly, there is a peer education curriculum, Rutanang, which has been developed by the Harvard School of Public Health under the auspices of the Department of Health in a five-year consultative process (Centre for the Support of Peer Education, no date) and is being used as the basis for training NGOs and people within provincial Departments of Education to offer school-based peer education. The process produced a set of guidelines for the development, implementation and evaluation of peer programmes (Panday et al., 2009). Despite these guidelines, efforts to assess their effectiveness indicated that many organisations using them are not implementing them as intended for reasons ranging from donor priorities to lack of school commitment and lack of teacher competence and commitment (Ahmed et al., 2006; Visser, 2005; Ward et al., 2007). A number of departments have contracted out responsibility for training (Centre for the Support of Peer Education, no
It is not what we teach but rather how and by whom the HIV curriculum is delivered....We cannot use the same pedagogy to teach Life Orientation as we do to teach mathematics.” Deputy Minister of Basic Education, Enver Surty, SA Government Information, 2011

The evaluations show that the Life Skills Programme is having limited success which suggests that the current approach is not giving adequate attention to each of the key dimensions of sexuality and relationship education described above—information, ideas, and values and pedagogical methods (UNESCO, 2010; Haberland and Rogow, 2009). In this regard, teachers play a critical role in the implementation of the Life Skills Programmes and their effectiveness impacts on the success of the programme. “Research has shown that the majority of teachers believe in the importance of the life orientation for learners and the responsibility of schools to educate learners about sex and sexuality and HIV and AIDS” (Bhana, et al., 2005 cited in the Department of Basic Education, 2010). Despite this, one of the challenges to implementation of school-based sex education programmes is teachers’ attitudes, skills and preparedness to teach sex education. An evaluation of the impact of the life orientation programme on HIV/AIDS in Gauteng schools found that about half of the teachers had not received materials from the DoE; the majority of teachers had not received training support in the life orientation programme; a third of primary school teachers and three quarters of high school teachers believed that there were insufficient life orientation teachers in school with the ratio of life orientation teachers to learners ranging from 1:131 to 1:550. In addition, the evaluation found that some Gauteng teachers felt that the materials were too explicit and the focus was placed on sex and sexuality and HIV (Bhana et al., 2005, cited in Department of Basic Education, 2010), which illustrates that because teachers themselves are a product of society, their own discomfort with, and possible prejudices regarding sexuality, need to be addressed if they are to teach effectively.

Another evaluation of teacher training on an AIDS prevention programme in schools found that despite receiving training, the majority of teachers lacked the necessary skills and appropriate levels of knowledge on HIV, struggled with participatory methodologies required for skills development such as role plays, and felt uncomfortable teaching content that conflicted with their own value systems. The study recommended that sexuality education should be integrated into undergraduate teacher training courses to improve their knowledge, skills and comfort in teaching about HIV (Ahmed et al., 2006, cited in Panday et al., 2009).

Despite the above mentioned challenges, sexuality education programmes can be highly cost-effective, especially when compulsory, adapted from existing models and integrated into the mainstream school curriculum. The UNESCO study (not yet published), Cost and cost-effectiveness: Analysis of school-based sexuality education programmes in six countries, examines a range of programmes in Estonia, India, Indonesia, Kenya, the Netherlands and Nigeria. The study shows that compulsory programmes are more cost-effective as they reap the benefits and greater impact of full coverage of the student population. The study highlights Estonia a national sexuality education programme which was introduced and linked with accessible, youth-friendly sexual and reproductive health services. Between 2001 and 2009 some 13,490 ‘health events’ were averted in the country, including nearly 2,000
HIV infections, at a potential lifetime cost of US$67,825 per patient, approximately 4,300
unintended pregnancies and more than 7,000 sexually transmitted infections (UNESCO
Media Statement, April 2011).

In line with the findings of the UNESCO six-country study discussed above, although
evaluation findings of sex education in South Africa are not convincing, sex education should
form a critical component of a comprehensive strategy for sexual and reproductive health
(Panday et al., 2009). To improve the focus, quality and level of implementation of sex
education programmes in South African schools, the following components must be
addressed:

- The programmes must meet most of the 17 criteria (including criteria for the
development of the curriculum, context and implementation) identified for effective
sex education programmes in developed and developing countries\(^6\) (Kirby, 2007, cited
in Panday, 2009).
- Programmes should not focus narrowly only on HIV but rather the broader sexual and
reproductive health and rights affecting adolescents and school-aged learners.
- Programmes should adopt a comprehensive approach that addresses abstinence as
well as safer sexual practices depending on the age and development of the learner,
ensuring that learners receive developmentally appropriate messaging.
- Sex education programmes should focus on biological and social risk factors affecting
sexual and reproductive health and rights.
- Programmes should address barriers to full implementation in schools, including
raising the level of priority sex education assumes within the education system and
the community, and improving the teachers’ willingness and readiness to deliver the
programme.
- Peer educations from community-based organisations (CBOs) should form part of sex
education programmes. This component of the programme should take place outside
of the classroom. “While the benefits of peer education may be greatest to peer
educators themselves, this could make an important contribution to generating a new
cadre of leaders at community level who can serve as role models for among others
positive sexuality and equitable gender relations” (Panday, et al., 2009, p. 15).
- Evaluation should be a component of the programme and evaluation studies should be
implemented using biological measures or distinct outcomes as they relate to sexual
and reproductive health and rights.

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\(^6\) Criteria for the process of curriculum development include the following: involving multiple
people with specific expertise; assessing the relevant needs and assets of the target group;
using a logical model to specify behaviour change and activities to change risk and protective
factors; designing activities consistent with community values and resources; and conducting
pilot testing. For curriculum content, ensure the following: present a clear focus on health goals;
focus narrowly on behaviours leading to goals; address sexual risk and protective factors; create
a safe space; include multiple activities; use age and culturally appropriate methodologies; and
cover topics in a logical sequence. For curriculum implementation, ensure the following: garner
support from authorities; select and train educators with desired characteristics; recruit and retain
adolescent to prevent barriers to participation (if required); and implement all activities with
reasonable fidelity (Kirby, 2007, cited in Panday, 2009, p. 82).
Health Policy


Access to health services includes the following:
- Work towards the integration of sexual and reproductive health services (including termination of pregnancy services) at the primary, secondary and tertiary levels of healthcare.
- Establish transport and communication facilities for effective referrals between health facilities.
- Establish national standards and mechanisms for monitoring standards of care for reproductive health services and an audit system for sexual and reproductive health and rights services.
- Improve the training of doctors, nurses, social workers, and other staff involved in sexual and reproductive health service provision, including for responding to adolescents and youth with empathy and respect, and maintaining confidentiality.
- Ensure that sexual and reproductive health services constitute a central component of youth friendly health facilities.

There is currently a Second Draft of the Policy Guidelines for Youth and Adolescent Health (as of September 2010).

Objectives:
- To improve, prevent, rehabilitate, and treat the health problems faced by young people, particularly vulnerable groups;
- To enhance the role of primary health services in the healthcare system; and
- To ensure that health facilities and services are accessible and available, and provide youth-friendly services to young people.

The policy has two strands—preventing and responding to problems; and promoting healthy adolescent development.

The policy has a range of health service-related strategies. Those relating to sexual and reproductive health and rights include the following:
- Improve access and utilisation of youth-friendly health services and counselling in order to prevent STIs, HIV, AIDS, unwanted pregnancies, nutrition disorders, mental health problems, and suicides;
- Introduce Abstinence, Be Faithful and Condomise (ABC), where adolescents are encouraged to abstain from sexual activities until they are physically and mentally ready, be faithful to their partners, and use condoms;
- Lower the morbidity and mortality rates of adolescents by empowering them about substance abuse, violence, accidents and other risky behaviours;
- Prevent sexually transmitted infections by providing good reproductive health education and education about avoiding premarital sex and using condoms; and
- Lower the burden of sickness, such as chronic diseases, by encouraging a culture of non-smoking, and discouraging the abuse of substances and being overweight.
Child and Adolescent Mental Health Policy Guidelines (2008)
Objectives: to address mental health in the prenatal period (conception to birth), childhood (birth to 9 years), and adolescence (12 to 18 years).
The guidelines adopt a broad definition of child and adolescent mental health—the capacity to achieve and maintain optimal psychological functioning and well-being. It is directly related to the degree of age-appropriate bio-psychosocial development achieved using available resources. The guidelines provide a framework for the development of more specific policy by provincial mental health service managers, taking into account their specific priorities and resources. They
- Highlight risk and protective factors for child and adolescent mental health;
- Commit to appropriate, integrated, comprehensive child and adolescent mental health services inclusive of mental health promotion and prevention of mental problems/illness at primary, secondary and tertiary levels of healthcare;
- Plan to develop a national database on children and adolescents with mental health problems; training and development of human resources, with special focus on addressing the shortage of well-trained child mental health specialists; and
- Protect human rights of children and adolescents with mental disability.

General intervention strategies include the following:
- Promoting a culturally sensitive, safe, and supportive environment;
- Providing information;
- Building skills;
- Counselling; and
- Access to healthcare services.

Services
Healthcare facilities can play an important role for adolescents in preventing health problems, in promoting sexual and reproductive health and rights, and in shaping positive behaviours. However, public health facilities are failing to provide adolescent-friendly health services (Senderowitz, 1999; Wani et al., 2008 in Klepp et al., 2008; Wood and Jewkes, 2006). The need to strengthen adolescent-friendly clinic services where they exist, or to make general health services friendly towards adolescents was perceived to be critical by a number of key informants.

There are a number of factors that make adolescents uncomfortable when it comes to seeking services for their sexual and reproductive healthcare needs. These include, but are not limited to: that they believe that reproductive health services are not intended for them; that they are often embarrassed at being seen at the health centres for reproductive health problems; that they are concerned about a lack of privacy and confidentiality, or are afraid that their parents might find out about their visit; that they fear medical procedures, especially pelvic exams; they might be ashamed of having experienced coercive or abusive sex; and that clinic staff are often hostile and unapproachable (Wani et al., 2008, cited in Klepp et al., 2008, p. 214; Wood and Jewkes, 2006). In addition, there are a number of other obstacles that play a role in preventing youth from obtaining essential sexual and reproductive health services. These include many

“I am 19 years old and in matric. Last year, I had an illegal abortion and I do not think it was done correctly. I went to the hospital and to a private doctor, but was too scared and ashamed to tell them what I did. I told them that I was having problems with my periods. I did not receive any help. I have not had sex since the abortion and I am not using contraceptives. I am so scared because I bleed continuously. Please tell me what to do.” (Too scared, Rosettenville cited in Dudu, 2011)
adolescents being unaware of the risks and signs and symptoms of pregnancy; being unfamiliar with STI symptoms; being unfamiliar with the kinds of services offered; that health facilities are not open at convenient hours; and that transportation to clinics is costly. This has resulted in large number of adolescents not seeking services for contraception, sexually transmitted infections, counselling and testing, antenatal care and prevention of mother to child transmission of HIV (Wani et al., 2008, cited in Klepp et al., 2008).

In relation to health service interventions, the essential components of youth-friendly services are accessibility, privacy, confidentiality, and nonjudgmental, skilled providers (Senderowitz, 1999; Shaw, 2009). Services are said to be youth-friendly if they have policies and attributes that attract young people, are comfortable and appropriate, and meet their various needs. Specific characteristics of youth-friendly services include the following:

- Youth input in the programme design
- Providers have knowledge of the issues and empathy with young people
- Respect for young people and their health needs
- Privacy and confidentiality honoured
- Adequate time for provider and client interactions
- Availability of peer counsellors
- Convenient hours that do not conflict with school times
- Wide range of services available
- Necessary referrals available
- Educational materials available (Senderowitz, 1999)

It is notable that these are not dissimilar from what makes any service friendly to any clients.

By linking community-based services with facility-based services and ensuring that both types of services are youth focused, youth of all ages and all genders obtain essential sexual and reproductive health and rights services. In addition, key messages will be reinforced in multiple settings, such as schools, recreational settings, church settings, and health facilities (Shaw, 2009).

The National Adolescent-Friendly Clinic Initiative
The National Adolescent-Friendly Clinic Initiative (NAFCI) was an accredited government programme designed to improve the quality of adolescent health services at the primary care level and strengthen the public sector’s ability to respond to adolescent health needs. The programme is no longer operational because of resource constraints yet the model highlights what is needed in terms of adolescent-friendly services, even if they are not to be offered in this particular resource-demanding form.

The NAFCI essential service package includes the following:

- Information, education, and counselling on sexual and reproductive health;
- Information, counselling, and appropriate referral for sexual violence and abuse and mental health problems;
- Contraceptive information and counselling, and the provision of contraceptives, including oral contraceptive pills, emergency contraception, injectables, and condoms;
- Pregnancy testing and counselling, antenatal and postnatal care;
- Pre- and post-abortion counselling and referral;
- STI information, including information on dual protection strategies;
- Syndromic management of STIs; and
- HIV information, pre- and post-test counselling and appropriate referral for voluntary testing if services are not available.
Gaps in policy, guidelines, education, and health services

- The Draft Guidelines for Youth and Adolescent Health are very wide ranging, but do not specify who is responsible for taking on the wide ranging roles they lay out.
- They do not address some of the emerging key issues facing adolescents, in particular the need for information and skills building about sexuality, sexual development and personal autonomy; and the vulnerability of particular adolescents including orphans, HIV infected and affected youths.
- The Child and Adolescent Mental Health Policy Guidelines do not give substantial attention to sexual and reproductive health and rights related mental health issues for children and adolescents.
They only deal with home, school, or health facilities. There are a number of other settings that are also important but do not receive attention. These include the youth clubs/groups, street, workplace, CBOs, and residential centres.

Given the decision not to pursue the NAFCI approach, and the likelihood that only well resourced areas will continue to offer adolescent-specific services, there is no clear guidance on the standards and processes that will address the particular needs of diverse groups of adolescents.

Neither teachers nor healthcare providers receive the training and orientation they need in order to be comfortable and competent in addressing adolescent sexuality and sexual and reproductive health.

People with disabilities

Status

In terms of sexuality and reproductive health, disabled people have been subject to several myths. Most notably, they are deemed to be asexual and not part of the world of sexual interchange (Basson, 1998; Nganwa et al., 2003; Swartz et al., 2006; World Bank, 2004), although this myth is contradicted by the literature, which indicates that disabled people are indeed sexually active (Hanass-Hancock, 2009). In this mythical sense, disabled people are construed as innocents who must be protected from sexual knowledge and discouraged from learning about their own sexuality. Parents are often overprotective and withhold knowledge about sexuality from their disabled children in the belief that sex will not be part of their lives (Wazakili et al., 2006).

On the other hand, disabled people are often viewed as sexually promiscuous or oversexed. This applies especially to those with an intellectual disability (Rohleder and Swartz, 2009). In this framework, SRHR issues are avoided for fear of “waking the beast.” The evidence does not support this claim, but rather points to a lack of knowledge about the appropriate and inappropriate conduct of sexual behaviour (Johns, 2007).

Disabled women are subject to beliefs that those who are single are celibate, cannot be mothers, are always heterosexual, and should be grateful for any sexual offers, especially since youth and beauty are seen as essential to sexuality (Basson, 1998). In the South African context, Hanass-Hancock (2009) has noted the vulnerability of disabled women due to sexual exploitation and sexual abuse. She observes that disabled women are viewed as asexual, virgins, sexually overactive, cursed, and either dirty or clean, all of which increase their exposure to abuse and, subsequently, HIV. A recent survey conducted for the Southern Africa Federation of the Disabled (SAFOD) further notes that disabled women are sometimes hidden away as partners in coterminous relationships (SAFOD, unpublished report). Furthermore, there is some indication that the myth that sexual intercourse with a virgin cures HIV can be linked to the rape of disabled women (Groce and Trasi, 2004).

Compounding these specific myths is the general situation of disabled people in the South African context, where they are thought to make up roughly 5–6 percent of the population (approximately 2.5 million people) (Rohleder et al., 2010). The nature of the interaction between HIV and disability is the topic of the Yale/World Bank study on HIV and Disability (World Bank, 2004). In this report, the major themes identified are the following:

- Poverty – disabled people are more likely to be poor and therefore at heightened risk of HIV infection;
- Lack of education – as disabled people have limited access to schools and education, their access to preventive messages is reduced;
• Elevated risk for violence and abuse – this has been noted above, and carries the dangers of non-consensual sex;
• Disabled AIDS orphans – such children are more vulnerable to sexual exploitation;
• Access to care – the physical inaccessibility of health services and the inaccessibility of health promotion messages limit the reach of SRHR services to disabled people (South African National AIDS Council [SANAC], 2008); and
• Stigma – the myths about sexuality and disability noted above maintain the stigmatisation of disability.

While disability is a social issue, it affects people with different impairment types differently regarding their SRHR.

People with an intellectual disability are seen as either oversexed or innocent and childlike. This results in sexuality education being couched in terms of abuse and fear rather than responsible enjoyment of their own sexuality (Rohleder and Swartz, 2009). Women with an intellectual disability are at a high risk of sexual abuse and rape, while men are not immune to abusive sex with other men (Groce, 2005; Kvam and Braathen, 2006). The families of many young women with an intellectual disability often are pressured into considering hysterectomy as a contraception option (Down Syndrome South Africa website), despite the legal provision that this can be done only for persons younger than 18 in life threatening situations or where there is a serious threat to physical health, and not for menstrual management or contraception alone (Sterilisation Act 44 of 1998).

People with physical disabilities contend with perceptions relating to physical perfection as a prerequisite for engagement in sexual activity, which affects women in particular. Their access to SRH services are restricted by the physical inaccessibility of services, especially in conditions of poverty (Wazakili et al., 2006). Furthermore, people with acquired physical impairments, such as spinal cord injuries, may not receive relevant information as to how their impairment affects sexual functioning (Basson, 1998). Deaf people are disadvantaged by their lack of access to information in South African Sign Language. While they have been shown to have some knowledge of HIV and AIDS, incorrect or incomplete information places them at risk of HIV infection (Hanass-Hancock, 2009). Those with visual impairment or who are blind are also disadvantaged by inaccessible health messages presented in a visual format (Hanass-Hancock, 2009). They also report a lack of privacy in seeking SRH services because a family member often escorts them to health services (SAFOD, unpublished report).

People with psychosocial or mental health issues are barely mentioned in the literature but, given the high degree of stigma attached to mental illness, they are likely to be vulnerable. There is, however, a body of work that focuses on the interrelations of mental health and HIV (see for example, Smart, 2009). Along with people with intellectual disability, this group is subject to institutionalisation, a common setting for sexual abuse. They also experience a lack of credibility and recognition in the eyes of the law should they attempt to report such abuse (Dickman et al., 2006). Processes of deinstitutionalisation, when undertaken without sufficient support structures, also compound vulnerability when homelessness and marginalisation result (Kelly, 2006).

The SRHR of disabled people have been ignored in that they often have been denied the right to establish relationships and start families of their own. Hanass-Hancock (2009) reports that very few articles in her review of the literature considered SRHR outside of the context of HIV prevention and treatment. However, many disabled people have been subjected to forced
sterilisations, forced abortions, or forced marriages (Groce et al., 2009). Parenthood often is not considered an option for disabled people. This applies to people with both physical and mental disabilities (O’Toole and Doe, 2002). Antenatal screening counselling often presents an overly negative view of disability, and potential parents are not given a realistic picture of what it means to have a disabled child. To a degree, within existing genetic counselling programmes, they feel pressured to terminate the pregnancy (Wong, 2002).

Policy
The **White Paper on an Integrated National Disability Strategy** encapsulated the vision of early policy development around disability in the transition to democracy (Office of the Deputy President, 1997). It established a particular way of thinking that underpins all subsequent policy development in South Africa around disability. Disability is no longer seen as an individual tragedy requiring medical and welfare intervention, but rather it is on the agenda as a human rights issue. Society’s lack of adaptation to the person’s physical limitation imposes the disability rather than the impairment alone. This is no less the case in issues of SRHR. A number of other policies address disability (for example, on employment equity, labour relations, and social security). Some have been developed specifically for disability—for example the **White Paper on Education 6: Special Needs Education** (Department of Education, 2001)—but there is no policy focusing specifically on SRHR.

The ratification by South Africa of the **UN Convention on the Rights of Persons with Disabilities** (UNCRPD) (United Nations, 2006) further establishes the understanding of disability as a human rights issue. Persons with disabilities are identified as “those who have long-term physical, mental, intellectual, or sensory impairments, which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.” The sections of the UNCRPD relevant to sexual and reproductive health and rights are the following:

- **Article 13** relates to access to justice and is relevant to sexual abuse;
- **Article 22** asserts the equal rights of persons with disabilities to privacy, including privacy of personal health information;
- **Article 23** requires states to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood, and relationships, including in the areas of family planning, fertility, and family life;
- **Article 24** concerns educational issues and is important in relation to sexuality education for persons with disabilities; and
- **Article 25** requires that states ensure equal access to health services for persons with disabilities, with specific mention of SRHR and population-based public health programmes.

> “I went to the local clinic, but could not be assisted because they did not have a Sign Language interpreter. I was then referred to another doctor, who didn’t know Sign Language either. He wrote me a note asking if I understood English. I said yes, so we communicated by exchanging notes. He asked if I wanted to take an HIV test. I agreed… I had to wait for about 15 minutes for my results and then he called me into the consulting room…. and wrote in big bold letters, “YOU ARE HIV-POSITIVE”. I was shocked and devastated.” (Interview cited in de Waal and Manion 2006)

Thus, the UNCRPD establishes the rights of disabled people to their SRHR in the same manner as for all people.
Services
The UNFPA report on promoting SRHR for disabled people makes the following recommendations (Groce et al., 2009):

- Establish partnerships with organisations of persons with disabilities. Policies and programmes are consistently better when organisations of persons with disabilities take part in their development.
- Raise awareness and increase accessibility in-house. Attention to the needs of persons with disabilities should be an integral part of current work. Separate or parallel programmes usually are not needed. However, specific resources and different media might be required to ensure full access to these programmes. Ensure that all SRH programmes reach and serve persons with disabilities.
- Address disability in national SRH policy, laws, and budgets. UNFPA, the WHO, and other reproductive health partner organisations’ staff should work with organisations of persons with disabilities to make sure that all legislation and regulations affecting SRHR reflect the needs of persons with disabilities.
- Promote research on the SRHR of persons with disabilities. A stronger evidence base will help improve SRHR programmes for them.

Furthermore, the UNFPA report identifies 10 key messages to raise awareness around the SRHR of disabled people:

- Disability is everyone’s business.
- Persons with disabilities are not necessarily sick.
- Persons with disabilities have sex too.
- Access means more than ramps.
- Persons with disabilities want the same things in life that everyone wants.
- For persons with disabilities, prejudice can be the biggest barrier.
- Everywhere and always, persons with disabilities are entitled to self-determination, privacy, respect, and dignity.
- It is best and usually easy to mainstream health services that accommodate persons with disabilities.
- Persons with disabilities are a crucial constituency in all programmes.
- Programmes best suit persons with disabilities when persons with disabilities help to design them. “Nothing about us without us” is a key principle.

Current efforts to address the sexual and reproductive rights and health of disabled people
Sexuality education programmes using concrete activities and simple language for people with an intellectual disability are being undertaken to reduce the instances of sexual abuse and encourage the responsible enjoyment of sexuality (Johns, 2007). Johns has recently produced an easy-to-understand booklet with pictures that can be used in one-on-one HIV counselling for people with an intellectual disability. Cape Mental Health has established a support programme for disabled victims of sexual abuse, which constitutes current best practice in the field (Dickman and Roux, 2005). A project conducted by Dr Heap, which pilots the first ever professional South African Sign Language interpreter service in healthcare in Cape Town, is beginning to yield interesting results, but these are not yet written up for publication. Create in KwaZulu-Natal provides sex education for disabled youth as well as sensitisation workshops for VCT counsellors. In addition the Quadriplegic Association South Africa is providing sexuality and HIV education courses for adults.
All of these initiatives are driven by disabled people’s organisations or nongovernmental organisations. The DOH is not providing the necessary services within its overall service delivery programmes. The focus on disability within the South African National AIDS Council has grown over the past few years and is likely to result in a heightened awareness of disability issues with regard to HIV (South African National AIDS Council, 2008).

**Gaps**

- There is no policy or guidance on addressing SRHR needs of people with disabilities including in relation to impairment type, opportunities for parenthood, and specific health risk factors (for example, a high incidence of testicular cancer among men with Down Syndrome and sexual health complications associated with spinal cord injuries).
- Existing interventions have a narrow focus on HIV, as opposed to a sexual and reproductive health and rights approach promoting the attainment of a healthy, responsible enjoyment of sexuality.
- Health services give little attention to the SRHR of people with disabilities. In general, they address people with disabilities as medical cases instead of as individuals with unique needs.
- Healthcare providers do not receive training to challenge the myth of the asexuality of disabled people, as well as their stigmatisation.
- Although the NSP states that clinics and health services need to be physically accessible to disabled people, not all clinics and health services are. In addition, Braille and South African Sign Language health educational messages are not universally available, nor are more creative mediums of communication.

**People with non-conforming sexual orientations**

**Status**

Humans experience sexuality in many ways, using different parts of the body for sexual stimulation. Sexual experience may be via genital-to-genital contact, genital-anal contact, oral-genital contact, oral-anal contact, male-female, or same-sex (Epprecht, 2008). All cultures include people with diverse sexual practices. In many cultures, people at times engage in sex with people of the opposite sex and at times with people of the same sex.

In recent history, the choice of sex of a person’s sexual partner has become something that is named and associated with a personal identity, such as “gay,” “lesbian,” or “bisexual.” In this process, it also has become associated with contemporary Western sexual culture, so that people who have same-sex sexual relationships are accused of going against African culture, despite the long history of these practices in all cultures.

People with non-conforming sexual orientations are identified in this review because they are singled out for extreme social and cultural prejudice as a result of their sexuality, particularly those who are poor. People who see themselves as lesbian, gay, or bisexual frequently are
subject to high levels of discrimination and violence. They may in turn internalise society’s homophobia and develop a negative sense of self which may undermine their mental and emotional health (Reid and Dirsuweit, 2009; Tallis, 2009; Johnson, 2007) and predispose them to alcohol and drug abuse (Tallis, 2009). Violence and stigmatisation can precipitate post-traumatic stress disorder (PTSD), and manifest themselves in suicidal ideation (Reid and Dirsuweit, 2009).

Prejudice against lesbian, gay, and bisexual people, as well as other same-sex-practising people such as ‘men who have sex with men’ (MSM) has been exacerbated during the AIDS pandemic by the early association of HIV with homosexual cultures, coupled with the greater levels of transmission among MSM. (Lane, 2009; Ne, 2009). Intravenous drug use further exacerbates susceptibility to HIV. Similarly, the general experience of social exclusion may lead the most vulnerable members of this population not to take television, radio, and magazine HIV prevention messages seriously, since they do not reflect their realities. This makes them more vulnerable (Johnson, 2007).

Despite these issues, the generalised nature of HIV in South Africa (as opposed to pocketed high-risk groupings) has eclipsed the particular needs of lesbian, gay, and bisexual people (Rispel and Metcalf, 2009). Mainstream SRH research, prevention messaging and technologies, and care and management give little attention to people with non-conforming sexual orientations (Lane, 2009; Tallis, 2009; Epprecht, 2008). For instance, seroprevalence in this group is unknown, but significant enough (as shown by a number of small-scale studies) to merit more attention (Reid and Dirsuweit, 2009; Epprecht, 2008; Johnson, 2007). Lack of epidemiological data undermines planning efforts and vice versa. This results in a lack of appropriate, relevant and responsive, targeted prevention and care initiatives, exposing same-sex practising people to increased risk of HIV and limiting their abilities to protect themselves, their families, and their partners (Tallis, 2009).

**Women who have sex with women**

While the discussion above on sexual orientation also applies to women, some specific issues pertain to women who have sex with women, who may or may not define themselves as lesbian. Lesbians (especially those from poorer areas) are targets of so-called “corrective rape,” which may manifest itself in gang rape (Reid and Dursuweit, 2009). Tucker and Strand report research indicating that 86 percent of black lesbian women in the Western Cape Province live in fear of sexual assault and that Triangle, a gay rights organisation, based in Cape Town, says it works with as many as 10 new cases of “corrective” rape every week (The Telegraph 13 Mar 2009, cited in Tucker and Strand, 2011, p. 12). While the relationship between such sexual violence and HIV infection has not been proven, rape elevates HIV risk for women (Tallis, 2009).

The invisibility of the transmission of HIV through lesbian sex leaves lesbians thinking that lesbian sex is not risky for HIV (Tallis, 2009). From this point of view, lesbians become an at-risk group through sheer neglect. Sexual practices such as digital-vaginal (fingering the vagina) or digital-anal (fingering the anus) contact, as well as sex with shared penetrative
toys, may serve as a means for the transmission of HIV-infected cervicovaginal secretions (Johnson, 2007).

Despite the generalised concern over the lack of healthcare provider understanding and knowledge, some lesbians have reported positive health services experiences. For example, Van Dyk’s study of lesbians in Tshwane describes one person’s experience that “within the public sector, doctors know that she is a lesbian and she feels that she has been treated well being HIV-positive, but that they did not know what advice to give, since they couldn’t understand her positive status either, especially since she had no history of having sex with men” (Van Dyk, 2010, p. 13).

Gay men and MSM

Men who have sex with men (MSM) are listed as a ‘most at risk population’ (MARP) in the NDoH National Strategic Plan for HIV & AIDS and STI 2007–2011 (NDoH, 2007). The NSP highlights the need for more information on the prevalence of HIV in this population. Recent studies appear to confirm the necessity of MSM being listed as at higher risk, with several studies reporting HIV prevalence rates between 14.1 percent and 38.3 percent (Rispel and Metcalf, 2009b; Sandfort et al., 2008; Lane et al., 2009, cited in Jobson, 2010). Gay men and MSM are also targets of so-called “corrective rape,” which, in addition to physical harm, leaves them feeling disempowered. In many such cases, victims have limited legal recourse (Reid and Dirisuweit, 2009). They may harbour misconceptions about anal sex—the receiver of the penis is thought to be more vulnerable to HIV transmission than the inserter (Nel, 2009). Research is also ambiguous on this matter (Nel, 2009). Reported use of lubricants that reduce the protective effect of condoms, such as Vaseline or lotion, is another HIV risk for gay men and MSM. Nel (2009) notes the culture of “bareback” (unprotected anal sex) that co-exists with drug and alcohol abuse among this group. This predisposes them to anal STIs, including anal cancer, with most cases associated with a pre-existing infection with the human papilloma virus (HPV) (Liviston and Nel, no date). Some subcultures of gay men and MSM may also partake in casual sex and sex work (Livingston and Nel, no date), which increases their vulnerability to STIs.

The Soweto Men's Study assessed HIV prevalence and associated risk factors among MSM in Soweto, South Africa. The HIV prevalence in the sample population was estimated at 13.2 percent (95% confidence interval, 12.4–13.9%), with 33.9 percent among gay-identified men, 6.4 percent among bisexual-identified men, and 10.1 percent among straight-identified MSM. Due to stigmatisation of same-sex practice, many of these men will not say they have sex with men or are gay, which puts them at further risk of being neglected in HIV prevention and treatment efforts, as well as in terms of their specific healthcare needs and access to services. The study results indicate that MSM are at high risk for HIV infection, with gay men at highest risk (Lane, et al., 2011, p. 630).

Since MSM also frequently have sex with women, they are often seen as the bridge for the transmission of HIV between homosexual and heterosexual cultures. There is a need from the
sexual health point of view to understand the varying risks to HIV that pertain to each grouping (Tallis, 2009).

Policy
In addition to constitutional protection, the **Promotion of Equality and Prevention of Unfair Discrimination Act** (2000) explicitly prohibits discrimination based on sexual orientation. Same-sex marriages are enshrined in the Civil Union Act of 2006. Under this Act, same-sex couples have the right to found a family.

Services
The lack of targeted education and information, including methods of preventing and managing HIV and other STIs, leave people vulnerable to contracting such STIs, mismanaging them and further transmitting them. For instance, HIV counselling and testing and harm reduction counselling may not be receptive and responsive to the diversity of people’s sexual practices (Nel, 2009). Sexually non-conforming groups face systemic discrimination because healthcare providers assume the heterosexuality of clients, thus effectively silencing lesbian, gay, and bisexual clients and failing to investigate same-sex SRH needs (Wells et al., no date). When clients disclose same-sex sexual practices, they often are met with negative reactions. This results in same-sex practising people delaying seeking healthcare, or, not disclosing their same-sex practices when they do seek healthcare, thus receiving inadequate care (Tallis, 2009). The ignorance of healthcare providers may impede taking a complete sexual history, which may result in inadequate and unresponsive care even when healthcare providers do not harbour negative sentiments against same-sex practising people (Tallis, 2009). As a result, people may delay accessing care and self-medicate (Ghana case in Johnson, 2007) and may not disclose certain sexual behaviours, resulting in inadequate care and untreated STIs; effectively, this means that communities of same-sex practising people may become groups with high STI prevalence (Johnson, 2007).

Lesbians may also experience challenges in accessing assisted pregnancy technologies (Tallis, 2009) and face stigmatisation during pregnancy. Yet they may also face stigmatisation for not having children, given the cultural assumptions that adult women are not fully women if they are not mothers (Goosen and Klugman, 1996; Wood and Jewkes, 2006).

Gaps
- Homophobic violence is not recognised as a hate crime.
- Except for HIV and AIDS, existing policies and guidelines on different components of SRHR do not give attention to how sexual orientation may be pertinent to each issue and the specific counselling, information, and healthcare that may be required.
- There is no sustained and institutionalised effort to build healthcare providers’ awareness of and understanding about how to address the needs and rights of same-sex practising people, and how to do so in a respectful manner.
- Services do not procure safer sex technologies, such as lubricants, dental dams, finger cots, and female condoms, making these inaccessible to the public. Latex-compatible lubricants and dental dams are not part of standard safer-sex kits available to anyone who needs them.
Persons with intersex conditions

Status
There is little or no information regarding the SRHR status of people in South Africa whose biological sex cannot be classified as clearly male or female—that is, intersex people.

Persons born with genitalia or bodies deemed gender-ambiguous or gender non-conforming fall under the broad label of “persons with intersex conditions.” The causes of these developments are diverse, including a variety of genetic factors and hormonal over- and under-exposures during foetal development, many of which are discovered shortly after birth or during childhood.

Policy
The Promotion of Equality and Prevention of Unfair Discrimination Act (PEPUDA) of 2000 as amended by the Judicial Matters Amendment Act, section 16 of Act No. 22 of 2005, extends the application of PEPUDA expressly to define intersex as “congenital sexual differentiation which is atypical to whatever degree” and include intersex persons within the definition of sex. Hence, intersex persons have rights and freedoms equal to any other person in South Africa and are protected from discrimination.

The Alteration of Sex Description and Sex Status Act no 49 of 2003 allows people to change their legal sex to male or female if they are intersex. It does not, however, offer the option simply of being classified as intersex for intersex people who do not want to identify as either a man or a woman. The law requires a person to be either a man or a woman, although it does not require a person to have surgery to conform to this classification. As a result, those intersex people who do not identify as one or other find themselves in a policy vacuum, unable to get legal identification, with all of the concomitant implications for access to banking, education, healthcare and social services, etc. unless they choose one or other gender. There are cases in other parts of the world, for example in India, where there is a category of ‘third sex’ or ‘third gender’ used on official forms, which allows this group of people, as well as transgender people (see section below) to get the legal classification they need to be functional in society—such as voting or opening a bank account—without having to become a man or a woman (Sood, 2009).

Services
A number of key informants complained that, although the law does not require surgery as the basis for being classified as one or other sex, the Department of Home Affairs continues to require evidence of surgery before altering a person’s sex description.

“The intersex tends to be rendered invisible even among gender activists – blithely ignored, in effect. I doubt that it is a matter of a matter of ill will as such; it feels more like cognitive blindness at an almost subliminal level. Even when intersex is included in the sectoral “LGBT alphabet soup” acronym, often it is hardly acknowledged in practice.” Sally Gross, Personal communication 24 June 2011.

“I can remember being described as “an intersex anomaly” and actually thinking of myself in these terms when I didn’t know any better. Medical professionals often tend to pathologise intersex per se. I believe strongly that people like me are to be viewed first and foremost as human beings, and that intersex, while not typical of our species, is to be viewed as a fundamental part of human and natural diversity rather than as pathology.” (Sally Gross, Personal communication, 24 June 2011)
Although most intersex manifestations are not life-threatening, it has become common in many parts of the world to alter the infant’s or child’s body, particularly sexual organs, to conform to gendered physical norms, including through (repeated) surgeries, hormonal interventions, and other measures. The rationale for gender-reassignment or “normalizing” surgery for minors includes reducing gender confusion for the child and parents, responding to parental concerns that the child be normal and accepted, and promoting the child’s social integration and happiness. In South Africa, a team of doctors typically consult on the “best sex” to assign to an intersex baby. Corrective surgery is undertaken on this basis. In many cases, such surgery is not medically necessary.

Until recently, countries’ laws and policies generally have given minimal attention to these interventions, requiring only parental consent (assumed to be motivated by the ‘best interests of the child’) and in conformity with locally accepted general standards of medical care. Intersex advocates internationally and in South Africa have emphasized the insufficiency of these conventional standards, highlighting the lack of the child’s consent for drastic, irreversible interventions which are life-long in their consequence for physical and mental health, particularly sexual response, and the absence of medical justification for imposing these interventions in childhood, before the person has the opportunity and mature judgment to determine the advantages and disadvantages of these procedures. There is a growing movement internationally and in South Africa to protect the rights of intersex children to autonomy and self-determination by refraining from conducting any surgery before they are old enough to decide whether they want surgery and if so, to what gender they wish to be assigned. This perspective should be matched by policy. “In a society in which intersex was properly understood and accepted, few people would actually opt for any kind of genital surgery—the default should be to avoid surgery, but to be able to opt—with full understanding of all the implications and without any pressure—to seek some kind of genital surgery if one feels that one’s comfort requires this.” (Sally Gross, Personal communication, 2011) Intersex South Africa argues that the birth of an intersex baby should trigger an investigation of the aetiology, and that there should be a best guess at the optimal gender of rearing on the basis of rules of thumb. Androgen Insensitivity Syndrome (AIS) in its complete form, or high degrees of partial AIS, should lead to rearing as female, while extensive virilisation of the external genitalia in congenital adrenal hyperplasia, for example, should lead to rearing as male. This should not involve any genital surgery unless, and solely to the extent required, to preserve physical health and life. In addition, it must be a given that the best guess at the optimal gender of rearing may turn out to be wrong and should be able to be changed if the behaviour of the child, whether pre-verbal or verbal, suggests that it should be changed. In law, the gender of rearing should be viewed as provisional and open to change as required for the comfort of the person. Parents and children should be counselled that being intersexed is fine and that the gender role is not something fixed inflexibly. The norm should be no non-consensual surgery. Classification as a third sex should be an option for the intersexed person, once that person has reached an age of understanding and is relatively mature. (Sally Gross, Personal communication, 2011)

**Gaps in law, policy, and services for persons with intersex conditions**

- There is no policy recognising intersex as a third sex or as a population that can be classified within the category of ‘third sex’ to enable intersex persons to enjoy their rights under the Constitution without having to conform to one or other gender if they are uncomfortable doing so.
There is no training for healthcare providers to understand intersex conditions and enable them to provide informed and supportive guidance and counselling to parents, family, and the intersex person.

Transgender people

‘Gender identity’ refers to each person's deeply felt internal and individual experience of gender, which may or may not correspond with their sex classification at birth, including the personal sense of the body and other expressions of gender, including dress, speech and mannerisms, known as ‘gender expression’ (Yogyakarta Principles, 2006). All persons possess gender identities and seek ways to express those identities. Culturally, there is fluidity in gender identities and expression within and across cultures. Some cultures have indigenous terms for a wide and diverse range of sex/gender categories; others describe that range in relation to men or women, by talking about ‘effeminate men’ or ‘butch women,’ for example.

The term ‘transgender’ is used to refer to people whose deeply felt internal and individual experience of gender does not correspond with the sex to which they were assigned at birth. Such people may or may not modify their bodies in ways that better express their sense of their gender. Some may identify as men; some may identify as women; some may identify as a third gender or a gender conceptualisation specific to their local culture.

The UK Royal College of Psychiatrists describes this phenomenon as most constructively viewed as a rare but nonetheless valid variation in the human condition, which is considered unremarkable in some cultures (Royal College of Psychiatrists, 2006, no page numbers cited in Winter et al., 2009, p. 1999).

Some of the challenges around gender identity also are experienced by intersex people.

Status

Mainstream SRH research, prevention messaging and technologies, and care and management give little attention to people with non-conforming gender identities or expressions (Lane, 2009; Tallis, 2009; Epprecht, 2008). However, published stories illustrate extreme levels of stigmatisation, a lack of knowledge of health options among transgender people, and a lack of support in navigating their sexual and reproductive rights and healthcare needs (Morgan et al., 2009). This applies to a wide range of people who may or may not think of themselves as transgender, but whose gender expression may not conform to the expectations of those around them. South African society has little understanding of gender variance and tends to stigmatise people whose gender expression differs from their assigned biological sex. The stigmatisation of such people marginalises them, resulting in lower levels of education and access to employment and housing.

Steve still needs a pap smear

“Attening a transgender conference was not only eye opening but assisted me to better comprehend unique needs and challenges facing transgender people accessing health services. I have always prided myself on being open minded, which I attribute to long-standing experience as a health worker in the field of gender and reproductive health and rights. However I had never imagined a man, who looks everything like a man, might still need pap smears. I found it very difficult to get my head around this fact. I started imagining how hard it would be for a health provider who has not been offered information and orientation to issues of diversity, transgender, and a human rights approach to sexuality would react to the situation.” (Daphney Conco, personal communication, December 2010)
Stigma renders them vulnerable to sexual assault and punitive rape. Unresolved gender identity often results in high-risk sexual experimentation and, coupled with economic vulnerability, leads to an increased resort to sex work.

Overall, the high incidence of sexual violence and murder and vulnerability to societal ills such as substance abuse potentially can reduce the life expectancy of transgender people and exacerbate their vulnerability to HIV. There is no local research addressing HIV in transgender groups, but research in Asia, Europe, and the U.S. shows that economically and socially vulnerable transgender persons are particularly at risk for STIs linked to sex work or multiple sexual partners (Collumbien et al., 2008; Guevara, 2009; Sevelius et al., 2009; Wilson, Garofalo et al., 2009; Don Operario, 2008).

Policy
The Alteration of Sex Description and Sex Status Act no 49 of 2003 enables the legal adjustment of one’s sex description without genital surgery. This protects the rights of people who want to change their sex from female to male (FtM) or from male to female (MtF) either through surgery or medical treatment or “by evolvement through natural development” resulting in gender reassignment (Klein, 2008, p. 3). Hence, if a person has changed gender characteristics, defined as the ways in which a person expresses his or her social identity as a member of particular sex through the style of dressing, wearing of prosthesis, or other means, this law allows that person to change the sex classification at birth to match the current gender identity and expression. However, as already discussed under ‘Persons with Intersex Conditions,’ this does not provide a remedy for any person who identifies as neither male nor female.

Services
The Department of Home Affairs—which processes sex description applications—still issues documents only after completed genital surgery and demands letters from the surgeons who carried out the surgery (Klein, 2008), although this is not required by the law.

Gender identity and the health and rights of transgender persons are not part of healthcare provider training; as a result, providers are unable to provide basic information and support to people regarding the development of their gender identity and the health-related issues that arise from this. Healthcare providers are likely to be as ill-informed as other community members and are unlikely to be able to support clients in identifying to what extent their gender identity is a problem for them and to what extent their problem relates to the social violence (transphobia) visited on those who do not conform to social norms (Spanish Network, 2010). Where a transgender person’s experience does have a biomedical dimension—whether an endocrine diagnosis or gender dysphoria—there is lack of clarity on treatment pathways and standards of care, so that healthcare providers are not in a position to guide that person through the health system. (Key informant, Gender Dynamix, March 2011)

To undergo sexual reassignment surgery, a psychiatrist has to classify the gender-variant person as transsexual and fit to undergo sex reassignment surgery. This is in line with the World Professional Association for Transgender Health’s Standards of Care for Gender Identity Disorders (Klein, 2008). On the whole, Klein (2008) argues that, while the laws are progressive, long waiting lists due to budgetary constraints for trans-sex surgery effectively result in exclusions. For instance, since 1994 Steve Biko Pretoria Academic has been one of the two active hospitals in the country (out of the six designated tertiary hospitals) doing
surgery on people with variations of sex development. There is only one psychiatrist at the gender clinic responsible for assessing clients and declaring them fit for surgery. The psychiatrist is considered a hard-to-find expert, is in private practice, and offers this service only in that capacity. From this point of view, access to such surgery is influenced greatly by socioeconomic standing and the financial means to access the surgery either from the private health sector or overseas (Klein, 2008).

Even in relation to non-surgical body-altering medical services, class and race play an important role in determining access. The expensive blood screenings demanded by endocrinologists so as to be able to prescribe hormones or adjust their dosage are avoided by general practitioners due to financial considerations. In a study by Klein (2008) many male to female (MtF) transgender interviewees with low or no income stated that they had tried to gain access to birth control pills instead of (or after unsuccessfully) seeking admittance to biomedically supervised hormone treatment. However, although contraceptive pills are freely available to women, they are not freely available to transgender women. Transgender women thus depend on non-transgender women for help in accessing contraceptive pills. The contraceptive pill is popular with transwomen, as it is said to cause a greater increase in breast size than the hormones available via general practitioners and endocrinologists (Klein, 2008). This underscores the unique challenges faced by transgender individuals, especially those with a low economic status, who thus are dependent on the public health sector for body-altering interventions but without access to that system. In addition, very little is known about key health issues facing transgender people, such as possible interactions between hormones and antiretrovirals and other medicines (Tucker and Strand, 2011, p. 13). Similarly, a female to male (FtM) transgender person may never be offered a pap smear, as the quotation in this section notes, and a male to female transgender person may not be diagnosed with prostate cancer because of failure to recognise their needs (Tucker and Strand, 2011, p. 13).

Gaps in policy and services in relation to transgender sexual and reproductive health

- The right to a name change, while existing in law, is difficult to realise in practice.
- Existing sexual and reproductive health and rights policies do not provide guidance on addressing the SRHR of transgender people.
- Healthcare providers have no orientation to the reality of gender diversity and how to address the needs and rights of transgender people, and to do so in a respectful manner.

Sex workers

The terms “sex work” and “sex workers” describe the practices of, and the people engaged in, exchanging sexual services for money or goods, either regularly or occasionally. They can be male, female, or transgender (UNAIDS Guidance Note on HIV and Sex Work, 2009). Sex workers are included in this review because, although the majority are women who are subject to the same SRHR challenges as other women covered in the review, they also face some specific vulnerabilities because of the sexual nature of their work. Other sex workers, whether men or transgender people, similarly are vulnerable to sexual rights abuses and sexual health problems, but tend to be ignored in policy and service responses.

Status
The current law specifically punishes women, who predominate in the industry owing to gender inequalities in accessing jobs and opportunities for personal empowerment (Pauw and Brener, 2003). The criminalisation of sex work encourages a vicious cycle for the economic and social vulnerability of sex workers (Richter, 2010; Richter et al., 2010; Wolffers, 1999), including vulnerability to police violence (Cupido, 2011), which in turn undermines their sexual health and that of the public. These impacts also apply to the so-called “Swedish option” of decriminalising sex workers but criminalising their clients and others who benefit from the sex industry (Kilvington et al., 2001; Norwegian Ministry of Justice and the Police, 2004). International experience shows that complete decriminalisation with limited regulation offers more benefits for public health in general and for the SRHR of sex workers in particular (Brents and Hausbeck, 2005; Homaifar and Wasik, 2005; New Zealand Government, 2008; Pyett et al., 1996; Wijers, 2008). This makes it easier for sex workers to insist on condom use with clients, access appropriate health services and information about HIV, and move to alternative forms of employment (Law Assistance Centre, Namibia, 2002). It also makes it easier for sex workers to organise to protect themselves and shape policies that support their sexual health and rights and those of the public (Wotton, 2004). Further, laws and policies that encourage sex workers to go underground undermine HIV strategies that depend on communities and individuals playing an active role in curbing the spread of the disease (Wolffers, 1999).

This international experience with different regimes of criminalisation of sex workers or their clients is reflected in the status of sex workers in South Africa. The high mobility of street sex workers, a product of criminalisation, discourages follow-up on STI treatment. Policing undermines street-based sex workers’ capacity to negotiate condom use and the type of sexual services they are willing to provide because of the need not to be seen, thus increasing their vulnerability to STIs and sexual violence. In addition, criminalisation prevents sex workers from sharing information easily and keeping an eye out for each other, thus increasing their vulnerability (Gould and Fick, 2008). Additionally, they are vulnerable to sexual abuse by the police and cannot report to the police when they have been abused. Stigma and discrimination contribute towards depression, shame, and low self-esteem, all of which further discourage health-affirming sexual behaviours, such as insisting on condom use and seeking treatment for STIs (Benoit and Millar, 2001). Similarly, this explains the pervasive substance abuse by sex workers, which in turn undermines their ability to insist on safer sex practices (Wechsberg et al., 2005).

The sex industry is characterised by high levels of violence, which discourages sex workers from insisting on condom use as a safer sex practice (Stadler and Delaney, 2006). The prevalence of violence and sexual coercion predisposes women to genital cutting and bleeding, which exacerbates vulnerability to HIV infection. Douching and other vaginal practices used by sex workers for dry sex result in this vaginal cutting and bleeding, making them more susceptible to HIV infection (Wojcicki and Malala, 2001). Hence, sex workers are regarded as a high-risk group that plays a key role in the transmission of STIs and HIV (Pettifor et al., 2000; Rees et al., 2000; Ramjee et al., 1998), yet epidemiological research on sex workers in South Africa is sparse. An epidemiological study conducted between 1996 and 1997 with sex workers who work along the trucking routes of KwaZulu-Natal showed an HIV prevalence rate of 50.3 percent (Ramjee et al., 1998). Another in Hillbrow in 1997
showed an HIV prevalence of 45 percent in a sample of 247 sex workers. In both studies, the study sample also exhibited a high prevalence of other STIs (Rees et al., 2000). It also showed that the prevalence of HIV is similar between new entrants into the industry and those who have been in it for a longer period (Rees et al., 2000).

Migrant women often are engaged in sex work because, as illegal work, their lack of documentation does not prevent them from doing it and it provides a livelihood for them and their families. Nevertheless, according to a qualitative ethnographic study conducted in a hotel-turned-brothel in Hillbrow, Johannesburg, women sometimes embrace the shame and stigma society accords to sex work and self-degrade. The study highlights how Zimbabwean migrant sex workers in South Africa have been forced to create their own social networks outside of the accepted networks to deal with the every-day challenges of sex work, including, but not limited to, social and health-related services. The study highlights systemic gender inequalities at the root of women’s entry into sex work. It reveals that these migrant women are propelled into sex work, not by traffickers or pimps, but structural gender inequalities embedded in marriage, the general disregard for feminised work and sexual inequalities in society, and their lack of legal status and the right to work (Nyangairi, 2010). At the same time, working in a criminalised industry—sex work—further exacerbates the vulnerability of immigrants. Decriminalisation is more in line with the ethos of human rights (Law Assistance Centre, Namibia, 2002; Wojcicki, 2003) espoused by the Constitution of South Africa (Boudin and Richter, 2009) and would enable sex workers to protect and promote their health more effectively and report sexual and gender-based violence and cases of people trafficked into sex work and children being involved in sex work.

Policy

Sex work is criminalised in South Africa under the Sexual Offences Act 23 of 1957.

The South African Law and Rights Commission was tasked to “provide workable legal solutions for the problems surrounding adult prostitution” (SALRC, 2002, p. 3). It did not come up with a clear position on sex work regulation. Rather, it put forward the following three options:

- Criminalise all aspects of adult prostitution, thus maintaining the status quo;
- Legalise adult prostitution within certain narrowly circumscribed conditions; and
- Decriminalise adult prostitution, which would involve the removal of laws that criminalise sex work and giving sex work a professional status that would include extension of labour law and occupational health rights.

The momentum of this process was lost, but it revived during the period of the World Cup in 2010. However, at the time of writing, the law remains in place (Richter, 2010).

A recent judgement by the Labour Appeal Court of South Africa (Kylie vs. van Zyl, Case No. CA10/08) found that, even though sex work is illegal, “... where a sex worker forms part of a vulnerable class by the nature of the work that she performs and the position that she holds and she is subject to potential exploitation, abuse and assaults on her dignity, there is ... no principled reason by which she should not be entitled to some constitutional protection designed to protect her dignity ...” (Para 44). The implication of this judgement is that sex workers’ human rights, including the right to health, must be respected and protected as much as those of any other person in South Africa.
Services
The criminalisation of sex work and related activities in South Africa essentially means that the government, while aware of the existence of this industry, cannot offer services targeted at sex workers or ensure that existing health services welcome sex workers. Where this does happen, as noted in the study (Ramjee, 1998) cited below, the intervention may be seen as necessary but runs contrary to the legal stance of the government on prostitution. Sex workers in South Africa experience prejudice and discrimination at the hands of healthcare workers, who deny them services and subject them to public humiliation (Stadler and Delaney, 2006; Wojcici and Malala, 2001). Sex workers thus are discouraged from disclosing their profession and do not get needed services, such as advice on appropriate hygiene and safer sex practices between clients. They tend to stay away from public health SRH services because they fear ill-treatment at the hands of service providers (Stadler and Delaney, 2006; Wojcicki and Malala, 2001).

Efforts to provide quality services to sex workers
There are two schools of thought on the question of how to structure SRHR services for sex workers, although they are not mutually exclusive. One maintains that establishing specific sexually transmitted infection clinics for sex workers is both unethical and counterproductive. It is unethical in that it reduces sex workers to sexual organs, and thus further stigmatises those involved in the profession by segregating them from the rest of society. Since most services for sex workers are set up only to address HIV, they also fail to meet sex workers’ broader health needs, both in relation to reproductive health and broader services, including for their children. Establishing specific STI clinics for sex workers would leave out those who do not identify as sex workers but may engage in transactional sexual relations or have multiple sexual partners, and would encourage increased surveillance from the authorities. This school of thought advocates that primary healthcare be made more accessible to sex workers, thus honouring the right of sex workers to healthcare (Alexander, 1999; Wolffers, 1999).

The other school of thought argues that the status of sex work would increase rather than diminish targeted programmes that are sensitive and responsive to the unique challenges that sex workers face. Based on experience running a brothel-based clinic for sex workers in Hillbrow, in inner city Johannesburg, Pettifor and colleagues (2000) argue that targeted interventions allow sex workers to mobilise themselves and have a voice in such interventions. Such services would be located where they are most needed, such as on outlying trucking routes, and the staff would treat clients with respect and empathy. In particular, the hours of operation of conventional public healthcare services are at odds with the hours of operation of sex workers. Sex workers mainly operate at night, when they may have an emergency need for condoms, post-exposure prophylaxis, and psychological support. Stadler and Delaney’s (2006) assessment of the brothel-based STI treatment clinic run by the RHRU in Hillbrow describes the “head mama” model—a peer education programme in which older sex workers teach younger sex workers about safety, condoms, and other negotiation skills and hygiene practices. The experience of the NGO SWEAT in offering mobile services on trucking routes also could provide key lessons. Vickerman and colleagues (2006) argue, based on evidence from the Hillbrow intervention, that targeted interventions for sex workers are still cost-effective in a generalised epidemic, such as in South Africa.

In a similar vein, SHAKTI (Stopping HIV/AIDS through Knowledge and Training Initiatives) is a sex workers’ project run by CARE International in Bangladesh. The idea behind it is to decrease the vulnerability of sex workers by empowerment, education, and the
provision of services. One of the pillars of the programme is peer education to promote condom use. The other important component is to provide appropriate reproductive health facilities. The project has four contact points or drop-in centres at different locations in Dhaka City. Once a week, staff from the NGO Marie Stopes Clinic Society come to the drop-in centres to provide STI treatment (Alexander, 1999).

A drop-in centre is usually in an area where sex workers work, to ensure easy access, and open at times when sex workers are active, offering a place to talk to project staff and each other, pick up condoms, use the toilet, and relax. Drop-in centres provide a welcoming environment.

The range of services that can be provided is outlined below (what is feasible for any one project will depend on staff, buildings, and resources):

- Meeting room with coffee and tea (food if possible), where sex workers can relax and talk to each other or staff;
- Counselling room for private discussions between sex workers and staff;
- Emergency phone numbers, especially for emergency accommodation and rape counselling;
- Drugs support, advice, and sterile syringes. If drug-dependant sex workers predominate among the drop-in users, it would be a good idea to arrange these services on site;
- Toilets, if possible, including a shower; and
- Condoms and lubricants, a dedicated STI and contraception service, and general health services, if space and resources are available.

A drop-in centre should be a safe place for sex workers. It should be a place where sex workers can come and talk about their concerns without encountering hostility from other users (or staff). Sometimes it may be preferable to run separate services for different target groups (such as women, men, transgender sex workers, young people, or drug users). Sex workers may prefer a building used by other people, as this gives a degree of anonymity because a person entering the building is not immediately presumed to be a sex worker.

A drop-in centre may be the only place where sex workers can meet and talk about their work openly, which is critically important, given that the work stigmatises and isolates. It provides the opportunity to meet and develop or express a sense of solidarity and mutual self-respect, as well as a basis from which to organise for sex workers’ rights and services.

Stadler and Delaney (2006) argue that a sex worker-friendly clinic has the potential both to service the needs of sex workers and change public attitudes about sex work as “dirty and contaminating”. They further argue that such a clinic can encourage clients to use condoms.

**Gaps in law, policy, and services**

- Criminalisation of sex workers increases their vulnerability to rights abuses and poor sexual and reproductive health.
- Aside from HIV services, there is no effort to reach sex workers with SRHR services or ensure that existing health services are welcoming of and knowledgeable about the needs of sex workers.
- Healthcare providers are not trained in the specific health challenges facing sex workers, particularly in the current context of criminalisation, notably sexual violence; difficulties in insisting on condom use; and vulnerability to STIs, HIV, and
unwanted pregnancies, nor are they supported in developing a professional and respectful attitude towards sex workers, regardless of their personal views of sex work.

- Sex workers do not feel confident that healthcare providers will not report them to the police as being sex workers or illegal migrants, when that is the case.
- There is no institutionalised and sustained process of targeting appropriate information, educational materials, and programmes to sex workers, let alone with their participation.
- Criminalisation of sex work makes it impossible to establish a system to identify and assist those who are forced into sex work for whatever reason.

Migrants
Since migrants may arrive in countries in poor health and/or with immediate, short-term, and long-term health needs, and since the process of migration itself may make people vulnerable, the SRHR services for migrants are briefly reviewed.

Status
The Forced Migration Studies Program’s extrapolations from census data suggest that the overall foreign population is likely to be between 1.6 and 2 million, or 3 percent to 4 percent of the total national population. The figure is also lower than many receiving countries within Africa and elsewhere in the world (Department of Home Affairs, 2008/9; Forced Migration Studies Program, June, 2010).

Migrant and refugee women are at increased risk of gender-based violence, particularly violence within relationships. This is primarily a result of the fact that migration introduces new dynamics to gender power relations. Violence against migrant women is pervasive while they are in transit. It has been reported that migrant women often experience violence as they attempt to enter South Africa from neighbouring countries, and are vulnerable to being raped and beaten—and forced to “pay” to be assisted to enter South Africa (Human Rights Watch, 2009b; MSF, 2009).

With regard to internal migrants, there are linkages between migration and the spread of HIV (Lurie, 2000; Anarfi, 2005; Banati, 2007, cited in Vearay, 2011b). Migration increases the vulnerability to HIV for both migrants and their partners who remain behind, and different migratory processes are associated with different vulnerabilities to HIV acquisition (Vearay, 2011b). Furthermore, it is the conditions associated with the migration process that affect the vulnerability of individuals to HIV. Data from a longitudinal HIV surveillance study in rural South Africa show that migrants are twice as likely to acquire HIV, compared to non-migrants, when controlling for sex, age, education, wealth, household expenditures, and place of residence (Barnighausen et al., 2007). A prospective study conducted with internal migrants in rural South Africa, cited by Vearay (2011b), found that in almost one-third of discordant couples, it was the female partner who ‘remained at home’ who was infected with HIV (Lurie et al., 2003, Lurie, 2006, cited by Vearay, 2011b).

Policy
The South African Constitution grants all South African citizens, as well as documented and undocumented migrants, the rights to life, dignity, equality before the law, administrative
justice, basic education, basic healthcare, and labour rights. Furthermore, South Africa has ratified World Health Assembly Resolution 61.17 on the ‘Health of Migrants.’ This places a number of obligations on South Africa to implement migrant-sensitive health provisions, such as the following:

- Promote migrant-sensitive health policies;
- Promote equitable access to health promotion, disease prevention, and care for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality, or race;
- Establish health information systems to assess and analyse trends in migrants’ health, disaggregating health information by relevant categories;
- Devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery;
- Gather, document, and share information and best practices for meeting migrants’ health needs in countries of origin or return, transit, and destination;
- Raise health service providers’ and professionals’ cultural and gender sensitivity to migrants’ health issues;
- Train health professionals to deal with the health issues associated with population movements; and
- Promote bilateral and multilateral cooperation on migrants’ health among countries involved throughout the entire migratory process.

However, South Africa has not ratified the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.

In early 2006, the NDoH issued a statement highlighting that any treatment-eligible HIV patient does not need to be in possession of a South African identity booklet to access antiretroviral treatment (ART) (NDoH, 2006). Additional guidelines have been developed in collaboration between the Southern African HIV Clinicians Society and the United Nations High Commissioner for Refugees (UNHCR), supplementing the National Department of Health Antiretroviral Treatment guidelines, to guide antiretroviral provision for international migrants, asylum seekers, and refugees (Southern African HIV Clinicians Society and UNHCR, 2007). As a result of the lobbying of civil society groups and the UNHCR, a more recent (September 2007) Financial Directive from the NDoH confirmed that refugees and asylum seekers, with or without a permit, have the same right as South Africans to access free basic healthcare and ART in the public sector (NDOH, 2007b). The latest HIV and AIDS National Strategic Plan (2007–2011) specifically includes non-citizen groups (NDoH, 2007). A key guiding principle to the successful implementation of the 2007–2011 plan is towards ‘ensuring equality and non-discrimination against marginalised groups’; refugees, asylum seekers, and foreign migrants are mentioned specifically as having ‘a right to equal access to interventions for HIV prevention, treatment and support’ (NDoH, 2007, p. 56).

**Services**

Despite the policy guidelines and frameworks, many challenges continue to be experienced by international migrants, including those with documentation, when they attempt to access public health services in South Africa, as protective policy has not been transformed effectively into protective practices (Crush and Tawodzera, 2011; Pursell, 2004; CoRMSA, 2009; Human Rights Watch, 2009a, 2009b; Vearsey et al., 2011; Pedersen, 2010). Given high levels of xenophobia and violence towards African immigrants in South African society (Sigsworth et al., 2008), it is not surprising that stigmatisation and discrimination have
“Everything went well at the time of my arrival at the clinic. Maybe it was because I was pregnant…most people generally respect you when you are pregnant. But when they realized that I was a foreigner everything changed. The nurses started being rude, asking me rude questions like whether I knew who the father of the child was. One even asked me to go back to my country because I was wasting their tax money. They did not check my blood pressure or check to see if the baby was lying in the right posture…all they did was to ask some few questions about how I was feeling and they said everything is fine. That was the last time that I visited that clinic, now I go to a private doctor even though it is expensive.” (Zimbabwean woman in Cape Town, cited in Crush and Tawodzera, 2011, p. 18)

NGOs and churches have been pivotal in providing trauma services, HIV/AIDS counselling, and shelter to women migrants who have fallen victim to violence at the borders, as well as assisting victims to access medical services (Human Rights Watch, 2009b). However, despite the work of churches and NGOs, many migrant women who are victims of gender-based violence do not report their perpetrators, and women find themselves facing insurmountable obstacles with respect to accessing health services and the judiciary system or claiming their rights (Human Rights Watch, 2009b).

While much of the focus of policy in relation to migrants has been on HIV, other SRHR services also appear to be out of reach. A baseline study to determine levels of knowledge, attitudes, and practices in relation to reproductive health among male and female refugees ages 10–24 years living in Gauteng Province, South Africa determined that

- There is a discrepancy between known contraceptive methods and actual usage, with the best known method of contraception being male condoms (55–75%), while usage of male condoms for 15–19 year olds was 37 percent and 20–24 year olds was 44 percent.
- Forty percent of male and female respondents (15–19 year olds) stated that it is not acceptable for a woman to ask her partner to use a condom.
- Women reported feeling uncomfortable at requesting that their partners use a condom because this was seen as a challenge to male authority or highlighted infidelity in the relationship.
- One in three women relied on natural or traditional methods to prevent pregnancy.
- Usage of emergency contraception to prevent pregnancy after unprotected sex was very low (16%).
- Knowledge about existing family planning services was low, with more than half of the respondents not knowing the location of the nearest family planning clinic (Abrahams and Hajiyiannis, 2001, p. 32).

The literature identifies that appropriate responses are required from the entities responsible for providing health services, social support, food security, and development in both urban and rural areas. This includes addressing urban and peri-urban informal settlements, identified as home to many recent internal and cross-border migrants (Vearey et al., 2011). Access to basic health rights also is undermined in areas of high internal migration, such as urban informal settlements. According to Veary (2011), the reality of migration needs to be accounted for. “This includes providing greater support and resources for rural hospitals,
Abuse of human rights during childbirth and labour

“Veronica* did not realize she had been sterilized while giving birth to her daughter until four years later when, after failing to conceive, she and her boyfriend consulted a doctor.

“I was like 'Okay, fine,' because there was nothing I could do by then, but I was angry. I hate [those nurses].” Veronica tested HIV-positive during a routine antenatal visit and was given a form to sign by nurses at the hospital where she went to deliver.

“I didn't know what it was all about, but I did sign,” said Veronica, who was 18 at the time and had been scolded by the nurses for being unmarried.” (PlusNews, 2010; *name has been changed)

Gaps in services

- Access to basic healthcare and sexual and reproductive healthcare remains problematic for immigrants and refugees, including those with documentation, despite the presence of protective legislation.
- There is no institutionalised process for ensuring that health service managers and healthcare providers understand the rights of immigrants and refugees to healthcare and provide it in a non-discriminatory manner.
- There are no sustained and institutionalised interventions to challenge xenophobia and promote the human rights of immigrants and refugees, including their sexual and reproductive rights.

Health Services: Respecting and Protecting Health Providers’ and Clients’ Human Rights

Status

As this review has shown thus far, one of the biggest factors undermining the quality of current health services is the lack of an environment that respects and protects human rights, including the rights to information and education, autonomy and security, equality and non-discrimination, privacy, and the rights of people to decide on the number and spacing of their children. These rights are essential if people, in all of their diversity, are to realise their sexual and reproductive rights and health.

Many vulnerable populations suffer stigmatisation from healthcare providers, as discussed in this chapter. In addition, women, who are the primary target of public health services, also suffer stigma and discrimination. Gender norms in relation to men and women are fundamental barriers to sexual and reproductive rights, as discussed in Chapter 1. “As reproductive health is such a central piece of people’s lives and sexual identities, the nexus of HIV/AIDS prevention, maternal health and family planning is intrinsically intertwined with gender and sexuality” (Kambou, 2006, p. 10). Over the past decade, the NDoH increasingly has recognised the need to mainstream attention to gender equity into SRHR services.

Despite the “collective stock of knowledge about the gender-related determinates of risk and vulnerability… putting knowledge to good practice which are providing care for large numbers of the most critically ill patients who return home when too sick to work; an effective referral system to support ART adherence for patients who move between urban and rural areas; improved prevention and treatment programmes in urban informal settlements; ensuring drug efficacy by initiating programmes to improve nutrition security, for example, by establishing food markets within informal settlements; and by keeping transport systems effective to facilitate safer and cheaper movement of people between South African cities and rural areas” (Vearay et al., 2011, p. 17).
has proved to be a formidable challenge” (WHO, 2003, p. 5). The WHO Review, *Integrating Gender into HIV/AIDS Programmes*, suggests that, although there is a continuum of approaches shown to be useful, at a minimum, health services should not do any harm or reinforce damaging gender and sexual stereotypes. Rather, the review highlights that integrated services optimally should have programmes that seek to transform gender roles and create more gender-equitable relationships as they attempt to challenge the underlying conditions responsible for gender inequalities (WHO, 2003, pp. 27–43).

While clients suffer most from rights violations, healthcare providers also suffer from a mix of violations, as noted thus far in this review. Those offering contentious services are subject to stigmatisation; those offering services in resource-poor settings, or where the demand outstrips the numbers of staff available, may lose their sense of autonomy; those working in unsafe spaces fear for their security; and those whose task is to support people in major psychological crises, whether as a result of the findings of an HIV test or from sexual violence, may come under intolerable pressure without recognition of their need for support. In addition, lack of security and protection puts health workers in 24-hour services at risk (Sedibe, 2011).

**Policy**

South Africa is a signatory to a range of international treaties upholding the right to health, which “contains the freedom to make decisions about one’s own health; the entitlement to a system of health protection; available, accessible, acceptable health facilities, goods and services that are appropriate and of good quality; non-discrimination; government obligations to respect, protect and fulfil the right to health; monitoring; accountability mechanisms and remedies; and finally, participation” (Potts, 2009, p. 4).

Many South African policies recognise that economic factors increase vulnerability to SRH problems and, as a result, cannot be addressed only within the health services. For example, this is spelled out explicitly in the HIV/AIDS and STI Strategic Plan for South Africa 2007–2011, which includes in its prevention strategies, “Accelerate poverty reduction strategies and strengthen safety nets to mitigate the impact of poverty.”

As a result, many of the interventions needed to promote SRHR fall outside of the ambit of health services. It nevertheless is essential to recognise that the levels of disempowerment that result from poverty undermine people’s capacity to protect and promote their own health, use health services effectively, and make demands on health services for high-quality care. From this perspective, empowering people to know their rights and their health status is part of the mandate of the DOH.

A range of policies beyond the DOH promote human rights; for example, the Local Government Municipal Systems Act No 32 of 2000 notes the role of local government in encouraging the participation of the local community and promotes gender equity. Similarly, general health policies have an explicit rights orientation. For example, the National Health Act no 61, 2003 has objectives setting out the rights and duties of healthcare providers, health establishments, and users; and the objectives of protecting, respecting, promoting, and fulfilling the rights of

- The people of South Africa to the progressive realisation of the constitutional right of access to healthcare services, including reproductive healthcare;
- The people of South Africa to an environment that is not harmful to their health or well-being.
Children to basic nutrition and basic healthcare services as contemplated in Section 28(l)(c) of the Constitution; and
Vulnerable groups, such as women, children, older persons, and persons with disabilities.

Specific rights include the right to
- Emergency medical treatment;
- Full knowledge of his or her health status, diagnostic and treatment options, the implications associated with each option, and refusal of health services;
- Consent to all medical procedures;
- Participate in all decisions affecting his or her personal health or treatment;
- Confidentiality and protection of health records; and
- Lay a complaint against a health establishment or healthcare provider.

Strategic Priorities for the National Health System, 2004–2009 notes that health services should “Contribute to human dignity by improving quality of care” and A policy on quality in healthcare for South Africa (NDoH, April 2007) notes that “Not only individuals need to be encouraged to participate in healthcare, but also whole communities.” It elaborates: “Enabling patients to care for themselves—empowering individuals with the skills and tools to care for themselves is especially important. Informing patients and involving them in decisionmaking—the active participation of patients in their care—can improve the effectiveness of care as well as their satisfaction with their care. Patients who are treated with dignity and are well informed and able to participate in treatment decisions are more likely to comply with their treatment plans.”

Objective: to create an effective enabling framework to guide the process of developing, implementing, and monitoring laws, policies, programmes, procedures, and practices to ensure equitable attention to the needs of women, men, girls, and boys and equal access to quality of care at all levels of the health system; and equal rights and opportunities for both women and men within the DOH. The guidelines do not address gender identity and expression, issues taken up earlier in this chapter.

The guidelines argue for the need to address gender inequity, among the many forms of inequities in the country, by pointing out that “…whereas the issues of poverty and race discrimination have and continue to receive substantial theoretical and practical attention by the health services, identifying and addressing the causes and consequences of norms and practices which devalue and discriminate against women is a new and more difficult task” (NDoH, 2002, p. 26).

Its specific strategies are to
- Gain senior management’s commitment and build its confidence and capacity to promote, implement, and monitor gender mainstreaming;
- Facilitate senior managers’ integrating of gender analysis into the strategic planning and business planning processes of their own directorates or institutions;
- Build an understanding of and commitment throughout the health system to address the impact of gender-based discrimination in health and health services;
- Ensure input from civil society, and particularly from beneficiaries of health services; and
• Integrate gender concerns into the department’s overall plans and monitor them accordingly (ibid, p. viii).

It notes that “All programmes of the department, from communicable diseases to mental health to nutrition to women’s health, have to address the causes and consequences of gender inequality as they pertain to their specific programmes” (ibid, p. 17).

In motivating the need for the Gender Policy Guidelines in relation to SRHR, the document notes that “provision of reproductive health services, even if these are to both women and men, does not necessarily mean addressing the gender dimensions of reproductive health. For example, programmes aiming to get women to deliver at health centres often fail to recognise that gender issues—such as men’s control over access to transport or women’s inability to leave children behind—may be hindering women’s ability to access emergency obstetric care on time. Interventions to build men’s support and understanding of the need for health centre deliveries may be a critical reproductive health intervention. The same applies in the field of sexual health. Programmes for AIDS prevention frequently avoid dealing with gender-related issues such as promoting communication about sex, and equality and mutual respect in sexual decision-making between men and women, despite the fact that this is the central problem in vulnerability to HIV. People are called upon to use condoms or to be faithful without challenging women’s lesser power to negotiate sexual behaviour, that is, without addressing the gender dimensions of vulnerability to HIV.”

“For all of these reasons, the Public Health Sector needs to understand how gender roles, norms and values impact on women’s and men’s health and health-seeking behaviour, as well as on the operation of the health system itself and its priorities. This understanding will allow all units within the Department of Health to frame both their internal practices and their policies and programmes in such a way as to further social justice and improve both the efficiency and quality of health care.”

This human rights approach is also emphasised within SRHR policies. For example, the National Policy on Rape, Sexual Assault and Other Related Sexual Crimes (2010 pending) says that “Services must recognise the rights and autonomy of patients and respect confidentiality and patient’s dignity within the legal framework”; the HIV/AIDS and STI Strategic Plan for South Africa 2007–2011 includes the strategy to “Accelerate programmes to empower women and educate men and women, (including the boy and girl child), on human rights in general and women’s rights in particular.”

Most SRHR-related policies spell this out more specifically; for example, the preamble to the Choice on Termination of Pregnancy Act of 1996 lays out the following bases for the law:

• “Recognising the values of human dignity, the achievement of equality, security of the person, non-racialism and non-sexism, and the advancement of human rights and freedoms which underlie a democratic South Africa;
• Recognising that the Constitution protects the right of persons to make decisions concerning reproduction and to security in and control over their bodies;
• Recognising that both women and men have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and that women have the right of access to appropriate health care services to ensure safe pregnancy and childbirth;
• Recognising that the decision to have children is fundamental to women’s physical, psychological and social health and that universal access to reproductive health care
services includes family planning and contraception, termination of pregnancy, as well as sexuality education and counselling programmes and services; and

- Recognising that the State has the responsibility to provide reproductive health to all, and also to provide safe conditions under which the right of choice can be exercised without fear or harm.”

This is reinforced in the National Strategic Plan for the Implementation of the Choice of Termination of Pregnancy Act 92, 1996, which aims to “provide acceptable, accessible, affordable, cost effective, safe and user-friendly TOP services” and “promote reproductive choice as a fundamental human right.”

The Guidelines for Maternity Care in South Africa 2007: A manual for community health centres and district hospitals argue that successful implementation of programmes to reduce MTCT of HIV requires a climate of social support and community involvement—“a package of care tailored to the needs of the mother must include ongoing support for the mother, her infant and the family. Human rights, including reproductive rights and the right to informed choices and confidentiality, should be respected. This means that the social environment must enable women and families to make informed choices and cope with the choices they make.”

The ‘Principles’ section of the Policy Guidelines for Youth and Adolescent Health include the following:

- Adolescents and youth should have the right to participate in all decisions relating to their health status, treatment, care, and rehabilitation;
- Every young person has the right to holistic and sustainable care; and
- Every person should have the right to access available healthcare services.

The level of attention to human rights in SRHR policies is exemplary and may well be unsurpassed internationally. The challenge is their implementation.

Services
There was a strong sense among those interviewed that the issue of rights is largely ignored in the planning, organisation, implementation, and monitoring of SRH services. Even HIV programmes, which are relatively newer than other services and have had substantial civil society input, show a very limited understanding of sexual and reproductive rights.

“On the other hand, I think what HIV lacks is the kind of sexuality and reproductive rights basis of the sexuality and reproductive health sphere. I think they’ve got their own rights basis in terms of pushing for rights of HIV-positive people and issues of stigma, discrimination, and the right to treatment and so on, but I don’t think they integrate that so well, with the sort of broader rights...I think the fact that you’re looking at the rights aspect is important, because I think that often, although it’s acknowledged at the level of the policy and even at the level of providers, you know, they know that they must say that people have rights, but I don’t think it runs very deep.” (Key informant, Researcher, 2010)

Central to the promotion of the right to participation is the establishment of mechanisms for community decisionmaking and monitoring of health services, with particular attention to the meaningful involvement of those who are socially or economically marginalized. This is a subject of concern to the health system as a whole and is not particular to SRHR, hence we do not cover it here, except to note that, whereas the HIV and AIDS civil society movement
has been relatively effective in achieving the participation of people living with HIV, the involvement of communities in general health system governance remains a challenge, as discussed in Chapter 2. The absence of the involvement of poor, young, and disabled people and other marginalised groups is problematic if services are to be responsive to their needs.

Similarly, most SRHR policies describe ways in which social and cultural norms need to be challenged in favour of human rights and gender equality to achieve SRH. Models for doing so are discussed in the next section of this chapter, but this aspect of policy also lacks an institutional basis.

This section of the review focuses on interventions to address how to support the health system in identifying and addressing human rights issues, particularly gender inequity and other sources of prejudice, and how to support healthcare providers in promoting clients’ rights to dignity and freedom from stigma, discrimination, and violence.

**Addressing inequitable gender norms in health service priorities**
While gender focal points were designated and have an essential role for implementation of this policy, these roles were allocated to officials who already had full-time responsibilities and were at low levels within the provincial hierarchy, making it impossible for them to participate in the decisionmaking spaces envisioned in the policy.

Despite the Gender Guidelines, and indeed the commitment to human rights in most sexual and reproductive health and rights policies, there is little systematic gender analysis and action within the DOH. Implementation of the guidelines would require the gender focal points at all levels of the department to increase the knowledge base and capacity of senior management to understand and shape their programming so as to address the ways in which gender and other inequities influence social determinants of health, health-seeking behaviour, and the ability to access services, prevention, and treatment options (Klugman and Ravindran, 2003, p. 12).

**Healthcare provider curricula: A human rights approach to sexuality and reproduction**
As noted in Chapter 1, the first domain of the World Health Organisation’s Core Competencies in Sexual and Reproductive Health is “...the overarching attitude, which builds on SRH workers’ knowledge of ethics and principles, and thus becomes the “sine qua non” (essential item) for the fulfilment of the individual client’s human rights” (WHO, 2011, p. 13). Providers need knowledge of ethics and principles that will enable them to provide services driven by human rights, and the social values of equity, solidarity, and social participation. Although this domain forms the fundamental basis, it does not come with core competencies; rather, it underlies all other SRH competencies. For example, competency 4 states that: “…driven by human rights values; this competency emphasizes the importance of educating individuals and the community about their sexual and reproductive health and rights” (WHO, 2011, p. 15).

The curricula for healthcare providers in South Africa, specifically those for nurses and doctors, include compulsory modules on ethics. This suggests that they are trained on fundamentals of human rights that should guide their conduct in dealing with clients. The South African Nursing Council (SANC) Regulations: Government notice No. 425 of 22 February 1985 includes a programme objective stating that “curriculum shall provide for personal and professional development of the student so that, on completion of the course of study, he- (sic) … shows respect for the dignity and uniqueness of man (sic) in his social-
Abortion Doctor Speaks Out

―The week starts not too bad. I perform eight second trimester terminations. No problems, apart from the electricity not working, but I have enough light coming through the windows. The only problem is that I can't do a scan and the fan is not working. I don't normally perform abortions in this hospital, but since my colleague's accident, I have to do her list since no one else is prepared to. Performing terminations of pregnancy, and especially second trimesters, is a lonely struggle. The nurses usually don't understand our problems very well. They consider it ‘my problem’ and curse me for doing abortions‖ (Alblas, 2009).

In-service interventions enabling healthcare providers to promote human rights

“I went to [hospital] for a termination of pregnancy but had a bad experience . . . I was told it was fully booked for the whole month and they [the nurses] kept asking me why I want to kill, I am a murderer. I went back to the traditional healer who gave me medicine to induce” (21-year-old, cited in Jewkes et al., 2005a, p. 1240).

According to national policy, healthcare settings need to provide an environment that is welcoming and helpful to all people who need information, treatment, or care. SRHR services suffer particularly because of lack of professionalism and the inability of healthcare providers to distinguish between their personal views and their responsibilities as providers. Clients complain of rudeness and abuse. In addition, services for aspects of SRHR that are socially stigmatised get inadequate attention. One of the most notable human rights challenges in relation to SRHR is the failure to build systematically a culture of human rights that challenges discrimination and stigma on the basis of sexuality—whether sexual orientation, adolescent sexuality, gender expression, or the denial of sexuality of disabled people; indeed, even in relation to the women and men who are the primary targets of current services.

Services are supposed to be provided in line with the Batho Pele Principles and the Patients’ Rights Charter (Appendix 1). The implications for health staff are especially relevant for the delivery of SRHR services. Health personnel will provide the following:

- Services with a high standard of professional ethics;
- A mission statement for service delivery;
- Services measured with performance indicators displayed, so the community can understand the level of achievement;
- Services in partnership with or complementing other sectors, e.g., the private sector, NGOs and CBOs;
- Services that are customer friendly and confidential;
- Opportunities for community consultation;
- Types of outreach that can reach all communities and the families in greatest need;
- Easily accessible and effective ways of dealing with complaints or suggestions for improvement; and
Current information on services available and hours of service, staff changes, and extra activities, such as health days.

By implication, health service management and healthcare providers should provide an environment that is welcoming to all people who need SRHR information, counselling, or services. They should be equipped with the skills and knowledge they need to address the diversity of SRHR issues facing people at different stages of the lifecycle with different types of sexual practices and gender expressions.

Key informants saw resistance to certain policies as resulting mainly from poor consultation. Reference in this regard was made to the introduction of the Choice on Termination of Pregnancy Act and the provision of contraception for HIV-positive women. Most of the time, only programme managers are introduced to the new policy and then left with the responsibility to cascade it down. Key informants argued that, in most cases, this has not worked. The policy needs to be introduced to managers at different levels, including municipal, local authority, and provincial managers.

“...most of our policies are failing because we do not care about the service providers. We only care about who gets the service. I mean the patients’ rights, human rights, everything is about the consumer of the service. Who is the provider, how is the provider going to take care of others when no one is looking into the provider? All the policies, we are busy with statistics, we are running after statistics, statistics are quantity but not quality. You can test 20 people and they still go back to re-infect each other.” (Facility supervisor, 2010)

“Providers need to understand why this is necessary and be given a space to engage with it so that they understand and relate to it, you know.” (Researcher, 2010)

“People have different cultural beliefs and the policies did not consider this and were pushed through regardless. ... need to consider the impact of policies on people that they are to help.” (District Manager, 2010)

As the Gender Guidelines recognise, this is an area that a number of civil society groups have investigated and developed interventions to address. While they often focus explicitly on gender issues, they aim to build respectful relationships between healthcare providers and clients, reinforcing the dignity of all.

There are a number of studies of interventions to improve healthcare provider understanding of, comfort with, and ability to incorporate a human rights approach in their engagement with clients. (See Table 12: Initiatives and outcomes to improve healthcare provider values and responses to clients.) Most notable in relation to SRHR are the Values Clarification and Health Workers for Change / Health Workers for Choice studies, which both deal most explicitly with the devaluation of women in social norms, including by healthcare providers, who often are women themselves; coupled with discrimination against women for wanting to make autonomous decisions about their sexual or reproductive lives.

The key challenge with these interventions is that they have been run by nongovernmental organisations or university staff, even when undertaken within public health services. They have not been built into the ongoing operations of the system. Currently DENOSA, a leading nurses’ organisation, has started running Health Workers for Change workshops. Training of shop stewards in seven out of eight provinces has incorporated this methodology, reaching
approximately 280 nurses. Furthermore the organisation has committed to ensure that the methodology becomes part of all future shop stewards’ training. DENOSA has coordinators who have been trained as HWFC facilitators and would be able to run the program in all nine provinces, given the opportunity and funding. (Key informant, 2011)

**Values clarification**
To address the attitudes of healthcare workers, Ipas, an international NGO, in collaboration with local health departments, began implementing values clarification (VC) workshops in South Africa shortly after the implementation of the new CTOP Act. The aim of these workshops was to enable healthcare providers and key stakeholders to clarify their values and attitudes and engender changes in attitude and behaviour towards women seeking an abortion.

An evaluation of the VC workshops was conducted in Limpopo Province. The evaluation was a retrospective multi-method design developed to measure the impact of the workshops at the individual, community, and facility levels. Both qualitative and quantitative assessments of personal transformation were collected from 193 workshop attendees. Knowledge, attitudinal, and behavioural indicators were measured. In addition, site visits were conducted in 20 hospitals and clinics before and after the intervention. Findings from the evaluation indicated that VC workshops “have an important role to play in expanding TOP access. These workshops are effective in addressing issues such as: misunderstandings of the facts, deleterious underlying societal assumptions about women, and the lack of peer support for TOP advocates. Through strategic consideration of real cases, these workshops humanize the issues by tying them to lived experiences. VC workshops also make it easier for stakeholders across the spectrum to appreciate the importance of safe abortion services. While the workshops did not change all negative opinions overnight, they did inform participants and favour a shift toward tolerance. Moreover, the workshops inspired a proportion of attendees to take ownership of the issue of reproductive freedom and to assume personal responsibility for resolving service barriers. The VC workshops are not a quick fix for ingrained opposition to TOP, nor are they likely to stimulate a sea change in entrenched bureaucracies with structural problems, such as the Limpopo DOH. However, this study shows that VC promotes incremental progress on multiple levels. The authors suggest that the effectiveness of the VC design can be enhanced by instituting some small changes in recruitment for and the content and implementation of the workshops. VC workshops are most effective when provided as part of a comprehensive package that also addresses equipment, training and policy obstacles” (Mitchell et al., 2004, p. 38).

**Inner Spaces Outer Faces**
The *Inner Spaces, Outer Faces Initiative (ISOFI)* (Care, 2007), designed and implemented by CARE International, focuses on gender and sexuality as influencing factors of reproductive health outcomes in multiple dimensions. ISOFI uses multiple methodologies to mainstream gender and sexuality into SRH work, including HIV. ISOFI is modelled around a rights-based approach to community empowerment and its goal is to provide a strong foundation for integrating gender and sexuality into programmatic approaches to achieving reproductive health. ISOFI initially focused on personal learning and change, followed by organisational learning and change. ISOFI as a methodology features structured iterative loops of reflection/learning, action/experimentation, and analysis/assimilation. Its systemic nature means that a safe space for reflection and dialogue can and should be carved out at all levels of an organisation.
A participatory evaluation model was applied as a mid-term process review and an end-of-project evaluation in the two pilot project sites in India and Vietnam. Baseline and endline surveys were implemented. The survey instruments consisted of qualitative and quantitative questions aimed at capturing CARE staff’s knowledge and attitudes toward the integration of gender and sexuality into CARE reproductive health and HIV programmes. In the endline survey, respondents overwhelmingly reported that ISOFI’s implementation had resulted in a change in CARE’s incorporation of gender equity in its reproductive health and HIV programmes. ‘Respondents reported that staff was better equipped, more knowledgeable and more aware of issues of gender equity following ISOFI. Two respondents pointed out that for those staff who participated in ISOFI, change had occurred, but that among staff who had not participated and within the larger organisational levels, change had not been as forthcoming” (Kambou et al., 2006, p. 47).

**Health Workers for Change**

*Health Workers for Change (HWFC)* (UNDP et al., 2005) is an intervention developed in South Africa and tested there, as well as in six other countries (five in Africa and Argentina) by WHO. The HWFC initiative was based on the idea that increasing healthcare providers’ understanding of social (gender, health, illness, and health-seeking behaviour), cultural, and economic determinants would increase their understanding of how these determinants interplay within their communities and affect clients’ use of services (Hartigan, 2001). HWFC elicited information from participating healthcare workers on awareness of gender issues and enabled them to take these issues into account in their interactions with clients. The premise behind HWFC is ultimately to improve quality of care by providing insight into the determinants of health. ‘There were several indications that, as a result of the HWFC workshop series, health care providers were able to integrate their heightened understanding of gender issues into their daily practices. For example, in the sites of the HWFC acceptability studies, health care providers described many situations in which they had blamed women for coming late to their facilities for treatment, although they recognized that gendered power relations often prevented women from coming earlier” (Fonn and Xaba, 2001). This increased understanding led, in most cases, to measurable, positive changes in healthcare providers’ relationships with their clients and improved the delivery of services in a number of ways (Vlassoff and Fonn, 2001, p. 48).

An evaluation of HWFC in the seven intervention countries was conducted in 2001. The purpose of the evaluation was to determine how HWFC affected health service delivery, the extent to which the workshops encouraged healthcare providers to find solutions to their work problems, and the degree to which they were motivated to seek assistance from the health system with problems they were unable to address. The impact of HWFC thus was assessed at the facility level, at the local health system level in which the facility operated, and at the client level as to how the quality of services was perceived by clients. Overall, the aggregated findings indicated that “HWFC has a positive impact on the relationship between providers and clients, creating teamwork within a facility, creating a supportive environment for facility staff to take more initiative and to some extent, to demand more responsiveness from the system level” (Onyango-Ouma et al., 2001, p. 30). In addition, clients’ experience of healthcare providers and health services is improved, hence associating interventions like HFWC with improved quality of care and human rights of clients (Vlassoff and Fonn, 2001).
These initiatives all aim to create a more professional and respectful workplace environment that promotes the human rights of both healthcare providers and clients. Implicit is the need for health information to be imparted in a way that considers clients as whole people rather than only as recipients of information. From this perspective, it is about enabling healthcare providers to see their role as supporting clients in making appropriate decisions and improving their health and well-being. For example, rather than seeing their role simply as providing HIV testing or providing contraceptives, healthcare providers need to see their role as supporting clients in understanding their current HIV status and fertility desires and, on that basis, making decisions that best suit their needs.

All of these initiatives also have community-based applications—to promote a human rights approach within community cultures and strengthen engagement between communities and health services. The issue of shifting community cultures is discussed in the next section.

**Gaps in addressing human rights in healthcare facilities**

- The **Gender Guidelines for Public Health** have not been implemented.
- The guidelines do not make clear their pertinence to gender identity and expression.
- There is no systematic institutionalisation of tested interventions (such as *Health Workers for Change/Choice; Inner Faces/Outer Spaces; or Values Clarification*) to improve health worker professionalism, help them promote the human rights of their clients, and address gender inequity and sexual and reproductive health and rights within the health service and in relation to clients.
### Table 12. Initiatives and outcomes to improve healthcare provider values and responses to clients

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<tr>
<th>Title</th>
<th>Objectives</th>
<th>Methods</th>
<th>Outcome/ Impact</th>
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<tr>
<td>CARE: Inner Spaces, Outer Faces Initiative (ISOFI) (Kambou et al., 2007)</td>
<td>• To learn how to integrate gender and sexuality more effectively into CARE’s sexual and reproductive health programmes; and • To dig deeper into the realm of gender and sexuality to achieve lasting impact on global health issues, such as maternal mortality and HIV/AIDS.</td>
<td>• An iterative, reflective set of approaches to unlock the powerful cultural and personal meanings of gender, sexuality, and power.</td>
<td>• More work needs to be done—sharing ‘how-to’ modules on facilitating dialogue around gender, power dynamics, and sexuality is not sufficient to learn how to manage the subtleties and complexities of helping development workers turn the mirror first onto themselves.</td>
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<td>Abortion values clarification and attitude transformation (IPAS, no date)</td>
<td>• Identify the values that inform their current beliefs and attitudes about abortion; • Describe alternative values and their consequences; • Choose and affirm values that inform their attitudes and beliefs towards abortion services and the women who seek them; • State their abortion-related behavioural intentions consistent with their affirmed values; and • Demonstrate a separation of their personal beliefs from their professional roles and responsibilities in the provision of abortion services (for service providers).</td>
<td>• Large- and small-group discussion; • Individual and group work; • Hypothetical and real dilemmas and case studies; • Rank ordering and forced choices; • Empathy-evoking experiences; • Active listening techniques; • Expressive activities, such as songs, skits, and artwork; • Games; • Simulations, such as role plays and visualizations; • Journaling and interviewing; and • Self-analysis.</td>
<td>• Secure key stakeholders’ buy-in to the abortion programme; • Preparation for developing abortion clinical standards and guidelines that allow broad access; • Screening, selection, and preparation of clinicians and healthcare providers for abortion training and service provision (first and/or second trimester); • Preparation for abortion advocacy training; and • Community stakeholders’ buy-in to create enabling environment for women’s use of abortion services.</td>
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<td>Values Clarification (Mitchell et al., 2005)</td>
<td>• To foster support for reproductive rights among stakeholders who may influence availability of and access to reproductive healthcare; and • To decrease opposition to termination of pregnancy.</td>
<td>• Health Workers for Choice: Working to Improve Quality of Abortion Services</td>
<td>• Effective, but does not resolve all of the problems with the lack of access to abortion services. • Play an important role in creating a climate supportive of TOP services</td>
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<td>NAFCI: National Adolescent Friendly Clinic Initiative (Ashton and Slimperi, no date)</td>
<td>• To make healthcare services more accessible to adolescents; • To establish national standards and criteria for adolescent healthcare in clinics throughout the country; and • To build the capacity of healthcare providers to improve service performance for the delivery of adolescent-friendly services.</td>
<td>• Values clarification • Self-assessment • Quality improvement</td>
<td>• Change in staff responsiveness to youth. • Increased participation of youth at clinics. • Increased participation of community in clinic activities.</td>
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<td>HWFC—Health Workers for Change: a manual to improve Quality of Care (Onyango-Ouma, 2001; Fonn and Xaba, 2001; Vlassoff and Fonn, 2001)</td>
<td>• Identify the factors that motivated individual healthcare providers to choose their occupation and how these may influence the client-provider relationship; • Describe their perceptions of how their clients see them; • Describe and explain their perceptions about women, female clients and women’s health problems; • Describe their understanding of the structure and lines of authority in the health service in which they work; • Identify and rank the factors that affect them either negatively or positively;</td>
<td>• HWFC is participatory, rather than prescribing how the workshop series should be conducted. • HWFC is a methodology to assist facilitators to encourage participation, break down hierarchical structures, and explore health and health services within the local social and organisational context. • Within the six workshop sessions, the content is</td>
<td>• In general, the HWFC workshops had an impact that led to an improvement in the provision of services by changing health providers’ interpersonal communication skills and making them more committed to their work. • HWFC is useful in eliciting gender issues in the context of health services but should not be used as a gender sensitization tool alone. • As a separate initiative outside of a broader commitment to health systems development, improved attitudes or actions are unlikely to be sustained.</td>
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<td><strong>positively in carrying out their work; and</strong></td>
<td><strong>generated both by facilitators, creating locally appropriate scenarios and, more important, by the participants themselves, who bring to each activity and discussion their own reality.</strong></td>
<td><strong>HWFC should be applied as a quality-of-care intervention only in the context of commitment to health sector reform based on communication and participatory management.</strong></td>
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<td><strong>Identify practical interventions to ameliorate those factors that negatively influence their work.</strong></td>
<td><strong>Require that higher-level personnel change the way they do things. It thus is essential that their commitment to HWFC is obtained, recognizing its broader implications for health sector transformation.</strong></td>
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**Stepping Stones—an HIV prevention behavioural intervention (Jewkes et al., 2007)**

| **To improve sexual health through building stronger, more gender-equitable relationships with better communications between partners; and** | **Uses participatory learning approaches to build knowledge of sexual health and awareness of risks and the consequences of risk taking.** | **Reduce sexually transmitted infections in women.** |
| **To provide opportunities for facilitated self-reflection on sexual behaviour.** | **The manual is a resource for those undergoing training in provision of sexual assault care.** | **Change men’s sexual risk-taking behaviour and reduce their use of violence.** |

**Caring for survivors of sexual assault and rape: A training programme for healthcare providers in South Africa (Jina et al., 2008)**

| **Designed to equip doctors and nurses with the knowledge, attitudes, and skills to meet comprehensively the healthcare needs of the survivors of sexual assault and rape and mitigate its impact.** |  |  |
Society: Primary Prevention—Changing Communities’ Sexual and Reproductive Cultures

As this review has shown, most of the sexual and reproductive health problems that require health service interventions have underlying social, economic, and cultural determinants. While there is not an enormous amount of literature on tested interventions to shift SRH behaviours, what we do know is that interventions to build individuals’ knowledge are not enough. Improved knowledge does not necessarily lead to changes in behaviour. This is because people’s sexual and reproductive behaviour is rooted in cultural patterns and social structures of power (Weeks, 1998). Notions of masculinity and femininity are deeply rooted, and within them are power relations that privilege men in relation to sexual and reproductive decisionmaking. Jewkes and Morrell describe how men and women’s sexual behaviour is best understood not in individual terms, but by understanding “the overarching gender order that provide(s) a context within which these practices were and are encouraged” (2010, p. 5). These gendered relationships also can be found in homosexual and lesbian couples (Kheswa with Wieringa, 2005).

“Existing evidence suggests that in order for programmatic efforts to achieve desired outcomes, it is essential to acknowledge and address gender and sexuality as fundamental components of reproductive health and rights. At a minimum, this requires understanding that both gender and sexuality are socially defined and constructed, that institutional arrangements for sexual behaviour (such as marriage systems) define gender-based power relations, and that social norms and ideologies manifest idealised views of male and female sexuality. It also requires understanding how in a given social setting, existing institutions and norms define knowledge, behaviour, partners, motivations and power dynamics within sexual relationships and behaviour, and how these factors directly affect reproductive health outcomes” (Kambou et al., 2006, pp. 9–10).

In relation to community values, culture, and behaviour, national-level policies include some that focus predominantly on community engagement and some on the broader public, which assumes mass media approaches.

Policy
The Delivery Agreement for Outcome 2: A Long and Healthy Life for All South Africans (October 2010) commits the Minister of Health, and therefore the DOH, to community outreach.

- Health education and social mobilisation will be conducted regularly in conjunction with various partners within government, NGOs/CBOs, the academic sector, and development partners; ‘basic public health education’ will be the major activity.
- A model for the delivery of PHC services that incentivises effective health promotion and disease prevention at the household and community levels.
- On HIV
  - An integrated prevention strategy based on behavioural change, among other interventions; and
  - Working closely with social partners to promote and facilitate open dialogue among communities, civil society, and social partners to address the social,
cultural, and political barriers to reduce stigma and proactively address gender issues that put women at risk.

Most SRHR policies refer to the need to change social and cultural values, as noted in Chapter 3. Some are the responsibility of other government departments, while others are a shared responsibility with the DOH. The policies are summarised broadly here, having been described and discussed in detail above.

The SHR policies described in Chapter 3 include the following issues requiring local community and broader public and media interventions:

- Support national efforts to strengthen social cohesion in communities and support the institution of the family;
- Ensure public knowledge of and adherence to the existing legal and policy framework; accelerate programmes to empower women and educate men and women, (including the boy and girl child) on human rights in general and women’s rights in particular;
- Focus on the human rights of women and girls, including people with disabilities, and mobilise society and develop and implement strategies to promote gender and sexual equality to address gender-based violence;
- Ensure equality and non-discrimination against marginalised groups, including refugees, asylum seekers, and foreign migrants;
- Promote reproductive choice as a fundamental human right; implement an effective community information strategy to increase the understanding of and support for women’s and minors’ sexual and reproductive rights;
- Develop appropriate IEC messages, materials, and programmes about contraception for multimedia dissemination;
- Efforts need to go into building public awareness about the availability of male sterilisation;
- Harness the mass media as a critical pro-choice ally;
- Increase public knowledge of clients’ rights, contraceptive methods and services; implement contraceptive IEC initiatives, in collaboration with suitable partners, to reach priority groups in the community;
- Strengthen behaviour change programmes, interventions, and curricula for the prevention of the sexual transmission of HIV, customised for different groups, with a focus on those more vulnerable to and at higher risk of HIV infection, including interventions for young people, and focusing on young women, the workplace, and HIV-positive people;
- Increase open discussion of HIV and sexuality between parents and children;
- Mobilise society and build leadership of people living with HIV to mitigate stigma and discrimination;
- Identify and remove legal, policy, religious, and cultural barriers to effective HIV prevention, treatment, and support;
- Increase minors’ awareness of their rights and sexuality;
- Strengthen and mainstream existing life skills programmes for youth on unwanted pregnancy and the Choice on Termination of Pregnancy Act;
- Promote safer sex practices that include delaying primary sexual debut, secondary abstinence, and non-penetrative sex;
- Develop and integrate interventions for reducing recreational drug use in young people with HIV prevention efforts; and
Stop smoking or never start.

**Interventions**

Community-level cultural change interventions

The policies identify a mix of types of intervention. There are those which build a direct relationship between communities and local health services, some serving as a basis for strengthening the quality of care and support provided within services and in communities. These have been expanded dramatically to address the treatment and care of people living with HIV. There are, similarly, community-based rehabilitation programmes for disabled people, which could operate in synergy with HIV programmes to be mutually reinforcing.

Other health service-community linked initiatives aim to hold health services accountable and ensure that both services and communities provide the necessary support, as envisaged in the Sexual Assault Policy described above. For want of adequate evidence at this stage, these are not explored further in this review.

**Interventions to promote gender equity and sexual and reproductive rights**

This review explores another type of intervention—the wide range of community-based interventions for men, women, adolescents, and more specific groups, which have been developed to try to shift cultures towards promoting gender equity and human rights for women and other marginalised groups. Few have been tested rigorously. Moreover, most have been initiated and run by nongovernmental organisations, a situation which raises challenges about how the DOH might implement them. This review highlights those which have been evaluated that the Departments of Health, Social Development, Education, and other departments concerned with building a culture of human rights, could consider for ‘mainstreaming’ and that private sector and civil society groups could implement more widely.

The key informants all agreed that community outreach as part of primary prevention was critical to SRHR. They noted that primary prevention seems to have taken a back seat, as healthcare providers feel overwhelmed by the number of clients that they must deal with daily. The respondents also were aware that failure in promotive and preventive care is partly responsible for complex conditions, such as multi-drug resistant TB, and for the high numbers of unwanted pregnancies and STIs that they confront every day.

Awareness campaigns are the most common form of community outreach that health services initiate. The key issue is the nature of their messages. Key informants felt that communities are overloaded with knowledge, but that it does not appear that this knowledge is protecting them from new infections or unwanted pregnancies. There are outreach campaigns in which community members are invited to the clinic for awareness days. However, informants recognised that people are not given space to engage, query, or debate, and that there is no system to establish how useful the information has been to them. There is a need to engage community members in a more focused way, like focus group discussions, dialogues, and other qualitative methods of communication, rather than relying on the passive transmission of information.

In addition to healthcare provider roles in outreach, the department does support wide-ranging efforts by nongovernmental organisations to reach young people in particular, predominantly in relation to HIV. DOH policies, as described above, commit it to do more. But there is no standard against which projects must comply, unless they draw on training.
accredited by SETA (Sector Education and Training Authority). While SETA does have an accredited course on gender equity, it is seldom used, with the focus rather on the provision of information on SRH or, more narrowly, on HIV prevention (Klugman and Mokoetle, 2010).

To the extent that community-based prevention and promotion are the responsibility of the DOH, there currently are no standards for the values embraced by interventions or the pedagogical approach. As discussed in relation to sexuality education above, best practice in efforts to shift people’s values and practices requires more than provision of information. It requires methods of engagement with groups and individuals that allow them to explore ideas and values.

The following examples provide ideas about how this has been done successfully with diverse target groups. Some programmes operate only in communities, some in both—bringing together the health service interventions already mentioned above with community interventions, such as values clarification, Communities for Choice (Varkey et al., 2001; Marais, 1996) and Inner Faces/Outer Spaces (Care, 2007). Others are described below.

<table>
<thead>
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<th>Jijenge</th>
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<td>In Tanzania, the Jijenge intervention aims to enhance reproductive health, human rights, and gender equity in relation to women of child-bearing age as a means of improving reproductive health outcomes. The intervention is focused at both the family and community levels as well as the health clinic level. At the community level, women and girls are empowered in sexual and health decisionmaking and participation in health systems development. At the service outlets level, service providers are encouraged to improve the delivery of health services and to ensure that services are responsive to the reproductive health needs of women and their families. Jijenge specifically aims to improve primary healthcare services, mainstream gender and basic human rights, and sponsor local networks for the promotion of women’s SRHR within existing government structures and frameworks.</td>
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Multiple participatory approaches and strategies were used in implementing Jijenge, including the following:

- The promotion of enabling environments by building the capacity of 24 CBOs and 16 domestic violence watch groups;
- Community engagement through the mobilisation and skills enhancement of community leaders;
- Capacity building and community empowerment through the identification and addressing of capacity gaps by leaders in the area of reproductive health, gender, and rights;
- Referral and house to house networking by community mobilisers and counsellors to facilitate the identification of community members facing GBV and referring them appropriately;
- Establishing local multisectoral networks to address issues of gender, children, and health;
- Participatory community planning meetings to involve community leaders in planning educational activities, thus ensuring ownership of the intervention; and
- Data collection and use through the reporting of incidences of GVB in all streets, villages, and sub-villages on daily basis.
The intervention has shown significant success at the community level. The involved communities have formulated community bylaws against GBV and have created an enabling and supportive environment for women’s rights and gender equality. The practices have been copied by other communities beyond the project areas, where GBV is discussed in the open and justice is sought without discrimination. Successes at the district level include the implementation of gender-sensitive health plans by health management teams and more resources for reproductive health (Matasha et al., no date).

**IMAGE**

The Intervention with Microfinance for AIDS and Gender Equity (IMAGE) Study (Pronyk et al., 2006) was an intervention implemented and evaluated between 2001 and 2005 in Limpopo Province. IMAGE aimed to reduce GBV and HIV through the implementation of microfinance initiatives, health education, and community development. IMAGE combined a poverty-focused microfinance initiative that targeted the poorest women in communities with a participatory curriculum of gender and HIV education.

Key features of the IMAGE intervention included the provision of microfinance services by the Small Enterprise Foundation. Loans were administered to women from the poorest households in the catchment area. The loans were administered for the development of income-generating activities, using a group lending model. Each business was managed by individual women, but groups of five women guaranteed each other’s loans. To receive additional loans, group members repaid their loans together. Groups of women met fortnightly. Another key component of the IMAGE study was training. This component included the implementation of a 12 to 15 month training curriculum called Sisters-for-Life (SFL), which was implemented during the fortnightly meetings.

Sisters-for-Life was made up of the following two phases:

- **Phase One** consisted of ten one-hour training sessions. Topics covered included gender roles, cultural beliefs, relationships, communication, intimate partner violence (IPV) and HIV. The training also focused on strengthening communication skills, critical thinking, and leadership.

- **Phase Two** selected women for additional leadership training and supported them to work with their loan centres to mobilise and engage the wider community around priority issues, including HIV and IPV.

The evaluation component pair-matched and randomly allocated villages to receive the intervention at study onset (intervention group), or three years later (comparison group). Both arms of the trial were divided into three groups: direct programme participants or matched controls (cohort one), randomly selected 14–35-year-old household co-residents (cohort two), and randomly selected community members (cohort three). Primary outcomes for evaluation were experience of intimate-partner violence—either physical or sexual—in the past 12 months by a spouse or other sexual intimate (cohort one), unprotected sexual intercourse at last occurrence with a non-spousal partner in the past 12 months (cohorts two and three), and HIV incidence (cohort three). Findings from the evaluation indicated that in cohort one, experience of intimate-partner violence was reduced by 55 percent. The intervention did not affect the rate of unprotected sexual intercourse with a non-spousal partner in cohort two; and there was no effect on the rate of unprotected sexual intercourse at last occurrence with a non-spousal partner or HIV incidence in cohort three. Based on the findings, it is evident that a combined microfinance and health education intervention can positively impact levels of intimate partner violence in programme participants (Pronyk et al., 2006), but not direct HIV prevention.
Stepping Stones

The Stepping Stones methodology (Welbourn, 1995) is a workshop series designed to promote SRH. It currently is being implemented in the Eastern Cape. It uses transformative methods of building life skills to addresses questions of gender, sexual health, HIV, gender violence, and relationship communication within the broader community context. In doing so, it recognises that sexual relationships are always situated within a broader context of relationships with sexual partners, families, and the community or society in which people live. Stepping Stones is a participatory methodology that enables participants to gain insight into why individuals behave the way they do, understand HIV and safer sex, and ways in which individuals can change. It can be used in health service settings and communities.

The key features of Stepping Stones include the following:

- The use of participatory learning approaches, including critical reflection, role play, and drama;
- Facilitated by project staff of the same sex and slightly older than the participants;
- Delivered to groups over several weeks;
- Sessions mainly held in schools; and
- The inclusion of a final meeting with the whole community.

The Stepping Stones evaluation was a cluster randomised controlled trial, in which Stepping Stones was compared with a three-hour session on safer sex and HIV. It was designed as an effectiveness trial, with the intervention delivered as far as possible according to the operating norms of the Planned Parenthood Association of South Africa. The study was conducted in 70 clusters (mostly villages) in the area around Mthatha. Findings from the evaluation indicated that “two years after the baseline assessment, the women in Stepping Stones had 15% fewer new HIV infections than those in the control arm [incidence rate ratio = 0.85 (95% CI 0.60, 1.20) p=0.35] and 31% fewer HSV 2 infections [incidence rate ratio = 0.69 (95% CI 0.47, 1.03) p=0.07]. This provided some evidence that Stepping Stones had had a beneficial impact on sexual behaviour, although neither result was statistically significant at the 5% level” (Jewkes et al., 2007, p. 2). Furthermore, “Stepping Stones is an important intervention and, although not unequivocal, findings provide evidence of success in bringing about changes that reduced sexually transmitted infections in study participants. We have also shown it to be effective in reducing sexual risk taking and violence perpetration among young, rural African men. The cluster of male behaviours transformed by the intervention are associated with ideas of masculinity that entail risk taking and anti-social behaviour, one that we have also shown be linked to perpetration of IPV, rape and participation in transactional sex. Our findings confirm conclusions of smaller scale evaluations of Stepping Stones in many other countries that have shown a reduction in male perpetration of intimate partner violence” (Shaw 2002; Wallace 2006, cited in Jewkes et al., 2007, p. 3).

The evaluation also highlights that for implementation to be effective, this methodology requires time, good training, skilled facilitators, negotiation, and prolonged follow-up. In addition, regular attendance, reducing barriers to attendance, bringing peer groups together, meeting special requests, challenging gender and age norms, working with issues of difference within the community, and ongoing participatory monitoring also are necessary for programmatic success.
RAISING VOICES (currently being evaluated—results were unavailable at time of publication)

Raising Voices is a results-oriented organisation based in Kampala. Violence against women (VAW) programming has been underway at Raising Voices since its inception in 1999. It works to prevent VAW by addressing the root causes, such as traditional gender roles and the imbalance of power between women and men. The focus is on primary prevention and changing the attitudes and behaviours that perpetuate VAW. Primary prevention approaches to violence against women are relatively new in the region. Many organisations are reorienting traditional service delivery programmes to include prevention activities, while many others are seeking to strengthen community education, campaigns, and training activities into a more holistic and systematic social change programme. Raising Voices, in collaboration with the Center for Domestic Violence Prevention, established and runs a Learning Center for other organisations and individuals interested in building skills and learning at first-hand how community mobilization for violence prevention can be done. Learning Center visits are tailor-made to the interests and needs of visiting colleagues and can range from two or three days to several weeks. Various topics covered include

- Conceptual framework for violence prevention;
- Facilitating individual and social change;
- How to use the Resource Guide and Training Process program tools;
- Working with the police, healthcare, and educational institutions;
- Community mobilization, including drama, impromptu discussions;
- Working with community volunteers and counsellors;
- Training skills;
- Development of effective communication skills;
- Media campaigns and strategies;
- Working with religious institutions; and
- Internal capacity building for NGO staff.

In addition, Raising Voices includes a Staff Skill Building Library, consisting of training modules designed to build the capacity of staff implementing or supporting community-based VAW prevention programmes. The Staff Skill Building Library is designed particularly for organisations using the SASA! Activist Kit for Preventing Violence against Women and HIV, but can be used by anyone working to mobilize their community to prevent VAW. The SASA! intervention is about rethinking power—your power, my power, the power we can have together. Individuals have the power to learn and inform, support others, and create change for safer, healthier relationships and communities. Individuals have the power to prevent VAW and HIV. Sasa is a Kiswahili word that means now. The intervention stresses that the time to prevent VAW and its connection to HIV is now. SASA! consists of tools, guidance and encouragement for individual activists and activist organisations. SASA! is a methodology for addressing the link between VAW and HIV. Documented in a user-friendly Activist Kit, it is meant to inspire, enable, and structure effective community mobilization to prevent VAW and HIV. SASA! is an exploration of power—what it is, who has it, how it is used, how it is abused, and how power dynamics between women and men can change for the better. SASA! demonstrates how understanding power and its effects can help us prevent VAW and HIV. Until now, community norms have portrayed men as more valuable and powerful than women. SASA! focuses on mobilizing communities to change the perceptions and norms that lead to violence and HIV. The principle behind SASA! is that that all people are equal in worth and value. SASA! shows how a balance of power between women and men means healthier lives for everyone.
Interventions to shift adolescent sexual and reproductive cultures

In addition to in-school sexuality and relationships education, discussed under ‘Adolescents’ above, there are a large number of groups implementing life skills programmes for adolescents out of school. loveLife is the largest intervention; it focuses on development of peer leaders who work in more than 700 communities and 4,000 schools. Research shows a significant impact of this programme on the leaders themselves in terms of increased educational and employment opportunities, and leadership roles in communities (Panday et al., 2009).

Many of the youth outreach programmes are being implemented by nongovernmental organisations (NGOs) and faith-based organisations (FBOs). Most have not been evaluated. The content and messaging of the programmes is not standardised and, as a result, the SRHR messages that youth receive are different and depend on the particular group responsible for implementing the specific programme.

The focus of many FBO programmes is on abstinence and delaying sexual debut (Ward et al., 2007). Reviews of abstinence-only education programmes in the peer-reviewed literature focus on the United States but are worth mentioning here in light of the extent to which current youth outreach programmes rely on FBOs—although they do not all take an abstinence-only stance. The reviews note that these programmes are largely ineffectual. Moreover, they promote scientifically inaccurate information and gender stereotypes (Santelli et al., 2006; Ott and Santelli, 2007; Underhill et al., 2007). Unfortunately, there are few rigorous evaluations of abstinence-only programmes. The majority of evaluations and reviews are found in gray literature and tend to vary depending on who funded the review. Three studies show no change in behaviours between abstinence-only and control groups (Barnett and Hurst, 2003; Kohler et al., 2008; Kirby et al., 1997). Two studies showed increase in knowledge and intentions to remain abstinent, but had significant methodological weaknesses, since they measured only intentions and not behaviours (Sather and Zinn, 2002). Two studies showed a short-term reduction in sexual initiation or sexual activity, but these results were only after three months and were not sustained for longer follow-up periods (Jemmot and Fong, 2010; Denny and Young, 2006). Abstinence-only programmes are particularly problematic in the South African context when engaging adolescents who are already sexually active, since these youth often cannot identify with the content.

On the other hand, systematic reviews of the literature describe a positive association between certain kinds of health education programmes and improved health. The most
effective programmes did not focus on knowledge alone but combined education with skills building or other health promotion activities (Harrison et al., 2010; Oringanje et al., 2009; Peters et al., 2009; Portnoy et al., 2008; Robin et al., 2004; Shepherd et al., 2000).

**Collaborative HIV Prevention and Adolescent Mental Health Programme (CHAMP)**

This is an example of a family-focused, developmentally timed programme, targeting pre- and early adolescents (9–13 years). It provides a model for primary and secondary HIV prevention programme development and has been tested in numerous studies in the United States, sub-Saharan Africa, the Caribbean, and South America (Bhana et al., 2000). “Initially, CHAMP embraced the developmental model with two basic views: (1) for HIV prevention to be successful, programmes need to intervene with youth prior to the initiation of sexual and drug risk-taking behaviour, specifically in pre- and early adolescence; and (2) adolescent sexual decisionmaking occurs within social relationships and reflects a combination of social and psychological factors that need to be addressed. More specifically, family and peer relationships significantly predict high-risk sexual and drug use behaviours in adolescents. For example, family availability and monitoring are critical protective factors for reducing high-risk behaviours, while family conflict and low levels of communication are associated with increased sexual and drug use behaviour. Also, research with youth has indicated that peers are a strong influence on sexual activity and the use of condoms, and friendships with peers who are not involved in problem behaviours are also protective factors for reduced sexual risk behaviour” (Bhana et al., 2010, p. 1). Implementation of the CHAMPS model sought out community representatives as advice and consent givers, influential community representatives as endorsers of the programme, community members as advisors, and community members as participants in the direction and focus of the research.

The South African implementation of the CHAMPS model adopted similar strategies to the original U.S.-based model, namely the establishment of strong community and institutional partnerships ensuring that prevention efforts are supported by communities and institutions, and the use of empirical evidence reflecting the relevant experiences of youth and families in the local setting to form the basis of the intervention. Key issues emerging from focused ethnographic studies for uninfected and infected South African youth were used to inform the adaptation of the programme for the South African context. In keeping with other CHAMP interventions, the South African adaptation developed and wrote manuals for family group interventions, focusing on family and interpersonal influences and community influences to strengthen family processes. However, the South African programme introduced the use of open-ended participatory cartoon narratives to address low literacy rates and facilitate small group participatory experiential learning. In comparison with control groups, the intervention showed improved knowledge of HIV transmission for intervention families; less stigmatising attitudes towards people with HIV; and more dialogue and greater comfort in discussing sensitive issues with their children, as well as increased monitoring of their children. In addition, families utilised social networks more effectively and community protective influences also were strengthened (Bhana et al., 2010, p. 1).

**MEMA kwa Vijana (MkV)—Good things for young people**

An example of integrated youth friendly services, bringing together health, education, and community-based interventions, can be found in Tanzania. MEMA kwa Vijana (MkV)—Good things for young people—is a multi-component adolescent sexual and reproductive health intervention that was developed and evaluated in four districts in Mwanza, Tanzania. MkV is one of the few interventions in sub-Saharan Africa to have been evaluated through the rigour of a community randomised trial.

This intervention was implemented between 1998 and 2001 in 62 schools and 18 health facilities. The three primary components of the intervention included teacher-led peer-
There are very few programmes focusing on pre-adolescents, despite pre-adolescents being an important target group for SRHR services. However, the Soul Buddyz initiative, implemented by Soul City, is an example of a successful pre-adolescent programme.

**Soul Buddyz** is a multimedia programme implemented throughout South Africa targeting pre-adolescents ages 8 to 14. The Soul Buddyz series was designed to address multiple issues related to gender, masculinity, HIV, nutrition, and financial management. Soul Buddyz and the complementary programme Buddyz on the Move specifically target HIV issues, including care and support for people living with HIV, knowledge of HIV prevention, and delay of sexual debut. The intervention focuses on the promotion of well-being through the provision of health information and skills for healthy lives and sexuality. The intervention includes a television drama, a radio intervention consisting of drama and interactive talk between children and adults, and a life skills booklet for Grade 7. In addition, Soul Buddyz clubs are implemented in primary schools in collaboration with the Department of Education. A reality television programme, Buddyz on the Move, showcases Soul Buddyz club activities. Complementary materials and messaging for parents and the caregivers of children are also part of the intervention.

A 2008 evaluation report (Soul City, 2008) of the 2006 Soul Buddyz programmes found that 82 percent of children surveyed (sample size 1,500) in the 8–15 age group reported being exposed to Soul Buddyz television, of which 63 percent reported having seen Buddyz on the Move. Soul Buddyz radio achieved lower reach, with 32 percent of survey respondents indicating that they had listened to the radio programme. Around 45 percent of children had heard of Soul Buddyz clubs, while only 6 percent reported ever being members. The evaluation also found no significant difference in reach between girls and boys. In terms of impact, the findings showed Soul Buddyz to be highly successful in achieving increased positive attitudes towards people living with HIV; increased knowledge of HIV prevention and transmission; and increased knowledge of ARV, care, treatment, and support. More specifically, across all of the knowledge items, exposure to the Grade 7 booklet was consistently more strongly associated with improvements in knowledge than the other Soul Buddyz interventions. Exposure to Soul Buddyz media series was strongly associated with an increased awareness about the importance of condoms for HIV prevention. The greatest impact was made by the Grade 7 booklet. Of the children who had read the booklet, 93 percent agreed with the statement “it is true that HIV can be prevented by using condoms,” compared to 76 percent of survey respondents who had no exposure to the booklet—the 16 percent difference is attributable to this intervention. Belonging to a Soul Buddyz club and listening to Soul Buddyz radio was also associated with positive perceptions about the importance of condoms as barriers to HIV transmission, with observed attributable differences of 6 percent and 3 percent, respectively. Exposure to Soul Buddyz television was not shown to have made an impact.
Engaging men and boys

In the Platform for Action of the International Conference on Population and Development, countries agreed that “Special efforts should be made to emphasise men’s shared responsibility and promote their active involvement in responsible parenthood; sexual and reproductive behaviour, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution of family income; children’s education, health and nutrition; and recognition and promotion of the equal value of children of both sexes. Male responsibilities in family life must be included in education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children” (United Nations, 1994, para 4.27).

Traditionally, family planning and family planning services were perceived as in the domain of women, particularly since the introduction of “female-oriented” modern methods of contraception, such as the oral pill, IUD, and injectable methods. As a result, the design and delivery of family planning services focused largely on women. However, more recently, and probably as a result of the HIV epidemic, the focus of family planning programmes has become more inclusive of men. The inclusion of men in reproductive health provision has the direct benefit of improving the reproductive and sexual health of men themselves, and the indirect benefit of improving that of their female partners. Since men are often the decisionmakers, they are instrumental in promoting or hindering the sexual and reproductive health of their partners. This is seen even in circumstances when women are educated and motivated to practice contraception. “It is essential to empower boys and young men with negotiation skills, supportive role models and networks, positive notions about sexuality and gender relations in schools and through community-based approaches, and to ensure adequate access to youth-friendly services. Similarly, enabling men to explore new family roles, to express their needs and seek help, to discuss such sensitive subjects as contraception, risk reduction and STD and HIV prevention and reproductive intentions with their partners, and inviting them to make joint decisions on such matters require concerted efforts” (Cohen and Burger, 2000).

As a result of the HIV epidemic, there has been a growing interest in identifying strategies that are effective in reaching out to men and empowering them to change their attitudes and behaviours that affect their own and their partners’ SRHR. Moreover, research suggests that “for men, the experience of having HIV can be part of the process of gender transformation” (Jewkes and Morrell, 2010, p. 8).

Meg Greene of the Center for Global Health at George Washington University School of Health noted the variety of activities that are included under the rubric of male involvement in sexual and reproductive health. These activities fall into three broad categories, corresponding to three successive phases through which the conceptualisation of male involvement has passed, namely

- Phase 1: Men and family planning – focus on getting men into family planning services in order to improve women’s sexual and reproductive health, with emphasis on accessibility of services.
- Phase 2: Male equality in sexual and reproductive health – focus on addressing men’s sexual and reproductive health needs, with emphasis on relevance and quality of services.
- Phase 3: Gender equity – focus on involving men in achieving improved sexual and reproductive health for all by working to transform gender roles and norms and
promoting gender equity, with emphasis on diversity of strategies for personal and social change.” (International HIV/AIDS Alliance, 2003).

WHO (2007) conducted a review of 58 programmes to assess their effectiveness in engaging men and boys in achieving gender equality and equality in health. The review found that programmes that were well designed showed compelling evidence of behaviour change for both men and boys. The review highlighted that, as a result of relatively short-term programmes, men and boys can change their attitudes and behaviours related to SRH, maternal, newborn, and child health; their interactions with their children; their use of violence against women; questioning violence with other men; and their health-seeking behaviour. Overall, 29 percent of the 58 programmes were classified as effective in changing attitudes or behaviours, and 65.5 percent (38/58) of the programmes were classified as being promising.

Gender-transformative programmes—that is, programmes that seek to transform gender roles and promote more gender-equitable relationships between men and women—were seen to be more effective than gender-sensitising programmes—that is, programmes that recognise the specific needs and realities of men based on the social construction of gender roles but do not seek to transform them. The review also found that programmes that were integrated or targeted through community outreach mechanisms and mass media campaigns had a greater impact on behaviour change. The review highlighted that one of the challenges facing programmes targeting men and boys is that the vast majority of the programmes do not go beyond the pilot phase, and limited scale-up, if any, is ever achieved (WHO, 2009, pp. 1–27). The review provides a table identifying the strengths and weaknesses of diverse programmes targeting men (WHO, 2009, pp. 52–59).

**Men as Partners (MAP): South African men respond to HIV/AIDS and gender-based violence**

MAP was established in 1998 by Engender Health, and is currently being implemented independently by a number of NGOs. The initial focus of MAP activities was community-based approaches, which included workshops, community education events, peer education, theatre, and so on. However, over the years the focus has shifted to the inclusion of men in the healthcare system by training service providers and working with community groups to increase the demand for quality services among men in the communities.

The Men as Partners workshops usually run over 4–5 days and use participatory, experiential learning to create opportunities to explore, challenge, and discuss alternatives to attitudes and behaviours that compromise both men and women’s health. These encourage men to take action to end violence and promote gender equity in their personal and public lives. Some of the key lessons learnt by MAP for programme implementation that can be applied to other programmes targeting men and boys include approaching men as part of the solution, creating a “safe” space for workshop participants to discuss pressing issues, offering options to support community-based activities, recognising and addressing personal challenges and processes of change among MAP programme staff, and realising that change can put men at risk of stigmatisation and rejection within their families and communities (http://www.engenderhealth.org/our-work/gender/men-as-partners.php; 2010).

Engender Health conducted two evaluation studies of MAP, which assessed the attitudes, knowledge, and practices of workshop participants. They interviewed 200 male participants and a group of male controls about knowledge, attitudes, and practices pre- and post-workshops, and three and six months after, as well as 50 female partners.
See also the box below on Puntos de Encuentro—a mass media intervention to engage men in the section below.

The examples above illustrate that evaluated interventions exist to change gender norms and shift gender dynamics in different cultural settings. These shifts will have positive human rights and health outcomes for both men and women and will positively affect sexual and reproductive health behaviours. To maximize impact, these interventions will need to be scaled up in an attempt to reach as many people as possible.

**Mass outreach programmes to change cultural norms, knowledge, and behaviour**

There is growing interest in the use of mass communications for shifting sexual and reproductive cultures and behaviour. People living in South Africa have been exposed to wide-ranging HIV communication and mass media outreach initiatives—loveLife, Soul City, Soul Buddyz (described above), Scrutinise (JHU), Khomanani, and Mindset, to name a few. The primary aim of all these campaigns is to create greater awareness of HIV issues, including the social determinants of the epidemic, and to shift behaviour. However, since measuring behaviour change is extremely complex, and linking behaviour change to specific mass outreach programmes is challenging, it is often difficult to determine the effectiveness of these interventions.

In 2006 and 2009, national communication surveys were conducted to examine the effectiveness of the major South African communication programmes. In 2006, 14 programmes where evaluated, and in 2009, the evaluation focused on 11 programmes (www.info.gov.za/issues/hiv/survey.html, 2010). Findings from the 2009 survey showed that 90 percent of South Africans surveyed were reached by at least 1 of the 11 HIV communication programmes; and that younger audiences had a high level of exposure (5 or more) to communication programmes (42%) than older audiences (20%). The survey highlighted that the majority of South Africans listened to the radio and watched television (86.4% and 86.5%, respectively); 63 percent of people read newspapers; and 18.4 percent used the Internet.

In terms of knowledge acquisition, knowledge of condoms as an HIV prevention method was high across age groups, but knowledge of other HIV prevention methods—such as faithfulness, partner reduction, and abstinence—was significantly lower, despite improvements made since the 2006 survey. The survey also found that there was a low level of knowledge of medical male circumcision as a method of lowering the risk of HIV transmission (7.5%)—and of those that were aware of male circumcision’s protective factor, 12–22 percent of men and 12–17 percent of women across age groups (15% in total) also believe that circumcised men do not need to use condoms. Exposure to communication programmes also resulted in a higher number of people reporting that they had undergone HIV testing in the past 12 months. Of those that reported being tested, 63 percent of men and 59 percent of women reported being tested in the past 12 months. A high number of youths...
(16–19 years) reported that they had been tested for HIV in the last 12 months (75% of young men and 78% of young women). Being tested increased with exposure to the number of communication programmes; discussing HIV testing with one’s sexual partner also increased with exposure to more of these programmes. Last, in terms of testing, the survey found that respondents who discussed testing with their partners were almost four times more likely to actually test for HIV.

Some other behaviour change indicators from the survey, although based on self-report and more difficult to measure as to whether actual behaviour change was occurring, included increases in condom usage among respondents exposed to more communication programmes: of those not exposed to communication programmes, only 33 percent used condoms, while 50 percent of those who were exposed to all 11 programmes used condoms. (This was after adjusting for 15 socioeconomic variables—clearly demonstrating the effect of communication.) Decreases in multiple sexual partners by women can be more clearly correlated to exposure to communication programmes than such decreases in men: 1.9 percent of women with no exposure to communication programmes, compared to 7.2 percent of women exposed to all 11 programmes (a more than threefold difference); with men, there is no statistical difference. The survey report noted that communication programmes about multiple and concurrent partners were less than a year old at the time the study was conducted, while communication programmes promoting condoms had been around for more than 12 years (www.info.gov.za/issues/hiv/survey.html, 2010).

The implications of the findings highlight that, although the survey shows the success of communication programmes in promoting condom use, these messages have been around for a long time. Other programme messages that have been disseminated for only 12 months have limited impact. In addition, communication programmes need to ensure that their messages go beyond the prevention of HIV and are more inclusive of general sexual and reproductive health and rights—and certainly where government supports these initiatives, it could require this standard. In addition, measuring actual behaviour change as a result of these interventions is difficult, as most data are self-reported. Government also needs to be aware of the limitations around large-scale mass media and community outreach programmes.

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**Puntos de Encuentro**

In the mid-1990s, a Nicaraguan project, Puntos de Encuentro, carried out Swimming against the Tide, a pioneering piece of research on men, masculinities, and violence. This study formed the basis of a national multimedia campaign, “Violence against women, a disaster that men CAN avoid” that was aimed at men living in areas most heavily affected by Hurricane Mitch. (Hurricane Mitch affected large areas of Nicaragua at the end of 1998.) The cornerstone of the campaign was that gender-based violence, especially within families, rises in the aftermath of natural disasters. The campaign ran for several months and included prime time television and radio spots; the distribution of posters, leaflets, calendars, and baseball caps; and the organisation of workshops and seminars for men on the prevention of GBV.

A participatory evaluation was conducted and found that three out of five men knew about the campaign and almost all of them had seen the television spots or heard the radio jingles. The men who were aware of the campaign were more likely to report that they avoided violence against women and that violence affects the development of their community. The campaign showed that it was possible to disseminate the idea that men can be different and create a critical mass of men consciously questioning machismo and seeking alternative ways of being men in society. In addition, the campaign’s use of mass media focused on the need to challenge and change power structures and power relations. In addition to the successes shown in the evaluation, as a result of the intervention, a large number of NGOs in Nicaragua also began to incorporate masculinities into their work on gender (Welsh, 2007, pp. 4–5).
**Soul City** currently is promoting its OneLove initiative. Research mid-way into the initiative indicates that 61 percent of adults in South Africa are aware of the OneLove message. Of those exposed to OneLove, single women were 66 percent less likely to have multiple sexual partners than in the previous year. Men exposed to the campaign were 42 percent less likely to become involved in transactional sex. According to a statement issued by the Soul City Institute, OneLove is the first regional campaign of its kind and challenges the common practice of multiple concurrent partnerships and the issues that drive this practice, given that this practice has been identified as a key driver of new HIV infections in many southern African countries. The campaign included edutainment mass media (TV, radio, and print material) and community action, with messages uniquely conveyed in each country.

**Eyi Medh Eyi Roudro**
The Bangladeshi television series Eyi Medh Eyi Roudro (Now Cloud, Now Sunshine) is a good example of the use of mass media for public education. Its primary aim was to encourage both women and men to attend health services. The key message behind the television series was “Come with your family for healthcare.” The television drama featured many popular performers and revolved around stories in both urban and rural areas. It highlighted healthcare facilities and centred on the people of various villages, focusing on their health and happiness. Although the drama centred on the personal lives of the characters, each with a distinct philosophy of life that affected his or her attitude toward health and health services, the series also included a call for action from local healthcare centres. The 30-minute drama was followed by Health Talk, a segment focusing on health topics, including breastfeeding, diarrhoea, pregnant women’s health, antenatal and postnatal care, child vaccination, and nutrition. These topics also were addressed in the drama. In addition, Health Talk had quizzes, with the added bonus of performers awarding prizes to winners (The Communication Initiative, Programme Experiences, Eyi Megh Eyi Roudra).

An impact assessment of the series was conducted in 2002 via a telephone survey. The survey targeted married men and women ages 15–49 from urban and rural areas. Findings revealed that 27 percent of the respondents had watched the drama, 56 percent women and 43 percent men, although the majority (70%) were from urban areas. Significant knowledge shifts resulted after viewing the series. These included that 43 percent of viewers stated that they had learned something from the quiz sessions (i.e., how to take care of pregnant women (28%); health-related information (26%); child immunisation and proper care of children (42%); and family planning (15%)). Considerable impact also was seen in healthcare workers who had viewed the series, of which 71 percent stated that, as a result of the series, they were committed to providing “sincere services” to patients, 26 percent committed to being patient when providing services, and 12 percent committed to providing quality services to pregnant women. Intentions to change behaviour also were demonstrated when male viewers said the show had inspired them to give up “bad habits,” such as untidiness (34%), smoking (20%), rude behaviour towards their wives (13%), and going to brothels (7%). Seventy percent of female viewers had received antenatal care (ANC) services during their last pregnancy, compared to 48 percent of non-viewers. More non-viewers (58%) had taken “no preparations” for their pregnancy compared to 41 percent of viewers (The Communication Initiative, Impact data, Eyi Megh Eyi Roudra).
Gaps in implementation of public outreach in line with existing policies

- The absence of standards for community outreach interventions—for both content, values and skills-building methodologies—and the absence of mechanisms for monitoring the quality of such outreach, undermines the effectiveness of existing policies in promoting a human rights approach.
- The absence of a sustained funding stream for high-quality community outreach targeting diverse groups and addressing the full spectrum of SRHR issues and groups affected similarly undermines policy, with this work remaining predominantly an unfunded mandate.

Research conducted in four other countries in the region (Botswana, Lesotho, Malawi, and Swaziland) indicated that people exposed to the campaign are altering their behaviour and rethinking issues related to multiple concurrent sexual partnerships, such as gender and culture, HIV testing, and alcohol abuse and condom use. “The crucial role played by edutainment media as a health communication strategy in bringing about social and behaviour change is also evident. An end of programme impact evaluation will be conducted in 2011,” says Goldstein, Programme Director of Health Communication and Promotion at Soul City (Matshediso, 2011).
CHAPTER 5: CONCLUSIONS

“I am sure you are aware that we have, should I say, some beautiful policies already, and that the key issue is implementation.”
(Researcher, 2010)

“This policy, how do we make it user friendly for us, as South Africans, so as to be able to address this whole thing of sexuality and reproductive health challenges that we have, including culture?”
(District manager, 2010)

The gaps identified in this review create a litany of repetition from section to section. There are a number of themes that consistently emerge. Many relate to general weaknesses of the health system which are not addressed further in this conclusion. Some relate to policy and others to implementation.

Policy

In general, South Africa’s policies in relation to sexual and reproductive health and rights are in compliance with international human rights treaties and with South Africa’s constitution. Three broad weaknesses were identified.

The first relates to emerging issues regarding sexuality and gender identity. Increased knowledge about how sexuality and sexual development affect people’s sexual health and human rights has resulted in recognition of the need for greater attention to these issues in health services. Current policies tread very lightly on these issues and address them mostly instrumentally—for example, mentioning the need to promote safer sexual practices. But there is little recognition at the policy or service level of the need to be explicit about sexuality and sexual development and to build the capacity of the health services to address a diversity of sexual health and rights needs. Some specific gaps include recognising problems in sexual function across the life-cycle, including during menopause, and in relation to the impact of various drug regimens on sexual function. Another is the need to engage with the reality of sexual coercion beyond addressing the negative consequences of sexual assault, so that healthcare providers can have the competence and confidence to talk about sexuality with all their clients. There is a policy lacuna in relation to gender identity and addressing the needs of transgender or gender variant people, and intersex people. There is also a policy vacuum in relation to sexual orientation, both in terms of the ability of the health services to provide a supportive environment for young people exploring their sexual identities and in terms of healthcare providers’ ability to provide appropriate information and outreach to people with diverse sexual practices and identities.

The second area of policy weakness relates to the ability of existing policies to address emerging evidence and new challenges, particularly in relation to HIV and AIDS. This challenges the DOH to find ways of ensuring that current policies and practices are in line with the most contemporary available information and that different policies are in accord with each other, perhaps establishing a regular review, in line with the World Health
Organisation’s four-year review of its Medical Eligibility Criteria. The question of the appropriate and cost-effective protocols for cervical cancer screening is one such example; another is the need to assess the interactions of antiretrovirals with hormonal contraceptives taken by women and transgender persons, and with other drug regimens.

The third area of policy weakness may be resolved by the implementation of the new ‘Reengineering Primary Healthcare’ approach, but is nevertheless worth noting: the lack of provision for integrated care. Current policies promote the integration of care but in many instances there are still missed opportunities for care and support. These will continue as long as policies do not note opportunities for integration; for example, so that those working on HIV recognise the place for abortion alongside the place for PMTCT, or the need to engage people about their reproductive intentions when discussing safer sex options.

**Implementation**

The review makes clear the enormous space between the intentions of DOH policies and actual delivery—gaps that result both from overall health system failures and from specific challenges that pertain to delivering sexual and reproductive services; many pertaining to the reality that issues of sexuality are a source of personal and social discomfort among both healthcare providers, and society more broadly.

Women of reproductive age are the primary target of SRH services, yet they experience service failures in terms of both content and quality of services, frequently not being provided with the information and support that they need to protect their own health; in addition, they suffer loss of dignity and humiliation in the health system. This has been exacerbated by the inability of the services to keep up with changing needs in the context of high HIV prevalence. Many people tend to be neglected or are made to feel unwelcome by the current services. Among women, this includes older and younger women, transgender women, disabled women, lesbians, women who have sex with women, women sex workers, and migrant women. It also includes men and boys, including transgender men, disabled men, men who have sex with men, gay men, male sex workers, and migrant men, as well as intersex people and people with non-conforming gender identities.

The World Health Organisation (2007) proposes six building blocks of a well-functioning healthcare system. Each of these is critical to the effective implementation of the sexual and reproductive health and rights services reviewed in this document. In conclusion, this review considers what needs to be done in relation to each of these areas to meet the demands of existing policies and address the policy gaps already mentioned.

<table>
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<tr>
<th>The World Health Organisation’s six building blocks of a well-functioning healthcare system:</th>
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<tr>
<td>- Leadership and governance;</td>
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<td>- Financing;</td>
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<tr>
<td>- Medical technologies and products;</td>
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<td>- Service delivery;</td>
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<td>- Human resources; and</td>
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<td>- Information, monitoring, and evaluation for improving service quality.</td>
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Leadership and governance

Political leadership
Strong and visible leadership and political will are critical for building a culture of human rights and providing effective health services. While this review has noted recent commitment from the President and Minister of Health, political leaders and health service leaders at all levels in South Africa seldom articulate a commitment to sexual and reproductive health and rights as a whole, let alone building it into all public platforms, including international forums. At best, the focus is on HIV or maternal mortality. There is little articulation of a sexual rights perspective, or a reproductive rights perspective, however. Standard, clear, and unambiguous messages need to be communicated to promote a culture of human rights in relation to sexuality and reproduction, and a common vision and approach to sexual and reproductive rights in health services.

Intersectoral collaboration
A tremendous challenge is that addressing the social and economic determinants of poor sexual and reproductive health requires intersectoral collaboration, with a wide range of government departments and civil society groups working together. A limitation of this review is that it has focused on the DOH and has not addressed the “how” of intersectoral collaboration.

Engagement with development partners and civil society
Much of the service provision and community outreach on SRHR is undertaken by stakeholders other than government—the private sector, bilateral and multilateral agencies, development agencies, nongovernmental organisations, community and faith-based organisations, and other civil society groups. What is clear is that within areas of the DOH’s purview, it has failed to hold its partners to account for implementation of its policies. As a result, development agencies are able to support services that fail to offer or provide information on abortion; or outreach interventions that promote abstaining from sexual relations and fail to provide other options for preventing STIs or unwanted pregnancy. Partnerships for implementation need to be set up on the basis of non-negotiable standards that match existing policies.

Accountability and meaningful participation
Meaningful participation is a fundamental dimension of human rights and essential in achieving the right to health (Potts, 2009). This is important for both effectiveness and accountability. There is increased awareness that one of the reasons for the failure of interventions is that they do not consult the target population while shaping the interventions (Johnson, 2007). A theme that emerged in key informant interviews was a sense that policies would fail if community members, and in particular community leaders, were not involved at the development stage. Communities have structures that facilitate consultation, and these should be used. At the same time, key informants noted the need to engage a mix of community members, including young people, traditional leaders, and people who often are marginalised because of sexuality. This needs to be done in people’s own languages.

“Now the message I’m hearing is that no matter how good your policy is, it needs to be taken to the community; communities need to know and be informed, otherwise it will not begin, okay?” (Researcher, 2010)
One key reason to engage communities is the importance of considering cultural and religious beliefs that influence issues such as sexuality. Considerable differences in perspectives and practices between those interviewed in the health services were noted.

"... as Africans we have got our own, you know, cultural beliefs and cultural rituals and so forth. How does it influence those? For example we have got this virginity test in the KZN province. We also have got these initiation schools in most provinces, in Limpopo, Mpumalanga, inclusive of the boys and the girls’ initiation schools. Those are the lessons that are being given to the inmates or the initiates to understand what sexuality and reproductive health is.” (District manager)

Civil society can play a key role in promoting SRHR ‘literacy’ as it has done regarding HIV/AIDS literacy, not only to strengthen people’s ability to protect and promote their own health, but to enable monitoring of health services to hold them accountable for implementing policy.

This assumes they have the knowledge and confidence to play this role. Mechanisms to educate clients about their rights and ensure recourse in instances when these rights are not upheld are critical. This includes ensuring that health service governance structures that involve community representatives are functioning effectively, and that members have the necessary orientation to understand the DOH’s policy commitments. Members of these governance structures need to be offered standardised training programmes that include SRHR, to ensure that they are able to monitor the performance of health system facilities in delivering services in line with existing policies.

**Financing**

Most of the health services covered in the policies reviewed are core to primary healthcare and should be included in district health services budgets and, in the future, will remain part of the core package of services to be funded by National Health Insurance. However, some products, for example female condoms, remain expensive, and the DOH needs to undertake advocacy and negotiation to lower the prices, as has been done in relation to antiretrovirals. In some cases, further policy decisions need to be made regarding what the public health services can and cannot cover—for example, in relation to sex reassignment surgery.

On the other hand, while most clinical services are funded, much of the policy content on public and community outreach remains an unfunded mandate, with no sustained resources going to implementation of that aspect of existing policies by DOH. Strategies for funding such outreach against agreed upon and monitored standards of content and methodologies need to be developed. This also is an area for potential collaboration with other departments—the Department of Education in relation to sexuality education, the Department of Social Development in relation to community outreach, and with development agencies, as long as they are willing to support DOH policies in full, including their commitment to choice in relation to termination of pregnancy, and adolescents’ right to sexuality and relationships information and education, rather than an abstinence-only approach.

**Medical technologies and products**

All drugs and supplies required to deliver the current package of essential SRHR services should be incorporated in the Essential Primary Care and Hospital Drugs lists and made available at the appropriate level of care. For example, Mifepristone (approved for use in
medical abortion) needs to be made available to all designated facilities, as should essentials for safer sex practices, such as lubricants.

**Service delivery**
National, provincial and district levels of the health system need to be organised and run to facilitate the delivery of comprehensive and integrated SRHR services, as follows:

Sexual and reproductive health and rights services need to be provided in a way that ensures
- Continuity of care for an individual across health conditions, across levels of care, and over a lifetime
- Effective, safe, quality services
- Accessible and equitable services, available to all who need them.

SRHR policies and clinical and supervision guidelines need to be updated regularly in line with emerging evidence and good practice.

Priority should be given to the following:
- Raising public concern for human rights, including sexual and reproductive rights, and mobilising communities to protect these rights for all people, including more vulnerable populations;
- Raising the demand for services by informing and educating individuals and communities;
- Supporting clients in knowing their HIV status and reflecting on their fertility intentions to inform further sexual and reproductive service provision;
- Reducing the financial, cultural, and social barriers to access;
- Providing all services in an integrated way;
- Building the managerial, technical, and conceptual capacity of district and clinic managers to foster the integrated delivery of SRHR services as an essential part of primary healthcare and undertake supportive supervision; and
- Ensuring regular and scheduled supportive supervisory visits by primary healthcare managers to monitor the quality of service delivery, community perceptions of services, and whether services meet community needs, and key aspects of service delivery that will have the most impact on SRHR. The new supervision guidelines will monitor the extent to which policies are implemented as intended.

Health system managers need to receive ongoing training in facilitation skills and primary healthcare management with a human rights perspective. Regular and supportive supervision and training could ensure that managers foster a working environment that enables and requires healthcare providers to work in a professional manner.

**Human resources**
The effective provision of SRHR services requires skilled managers and providers possessing the appropriate attitude and competencies. The lack of provider capacity and supportiveness is a recurrent theme across this review, raising issues of attitude, competencies, training, and care for the carers.
Attitude
District and facility managers and healthcare providers need to do the following:

- Respect each other and their clients and work in accordance with personal and professional ethics;
- Approach all clients, especially vulnerable and marginalised people, in a non-judgmental and non-discriminatory way;
- Respect their clients’ choices and show empathy and reassurance;
- Ensure that services are confidential and private; and
- Maintain the values and the communications skills to engage respectfully with clients about SRHR across the life cycle and to meet the specific SRH challenges of diverse groups.

The review has identified a range of tested interventions that would foster a respectful and effective working environment and could be ‘mainstreamed’ within the health services.

Competencies
Health system managers will have the management, leadership skills and resources to foster

- Team work;
- The provision of quality services;
- An environment that enables and requires healthcare providers to work in a professional manner that respects and promotes the human rights of all clients; and
- An environment that supports the needs of healthcare providers, including their mental health and their safety.

Healthcare providers will

- Have the clinical competencies to provide the services outlined this review, including counselling services;
- Be able to share information;
- Be able to work with communities as well as individuals; and
- Be able to recognise the health concerns and needs of all people, including marginalised, vulnerable, and stigmatised populations.

Training
The Health Professions Council of South Africa and the South African Nursing Council need to ensure that the curriculum for healthcare providers incorporates all aspects of existing laws, policies, and guidelines pertaining to SRHR and that all curricula are regularly updated in line with new evidence and experience.

Pre-service training institutions need to ensure that all cadres of healthcare providers have the attitudes and competencies outlined above. This includes community health workers, nurses, and doctors. The training agencies for different health professionals, including counsellors, have a responsibility to produce competent healthcare providers capable of promoting human rights in line with all national health policies. The Global Consensus for Social Accountability of Medical Schools highlights the importance of producing graduates who can best meet societal needs.

District and clinic managers need to receive ongoing training in facilitation skills and primary healthcare management with a human rights approach.
In-service education and training conducted by different units in the DOH needs to incorporate training that supports existing healthcare providers in offering integrated SRHR services in a client-centred and respectful manner, as mentioned under ‘attitude’ above.

Care for the Caregivers
The review identified stress faced by healthcare providers on multiple grounds, including working in contexts with high demand and inadequate facilities and resources, working with fears for personal security, and victimisation by other healthcare providers and the community in cases where providers are offering stigmatised services (such as abortion) or services to stigmatised populations. In some cases, experience of treating people who are under great stress can damage healthcare providers’ mental health. For this reason, it is essential that managers establish systems for ongoing debriefing and support for their staff.

Monitoring and evaluation for improving service quality
Information on the social and cultural determinants of sexual and reproductive health and changes in social norms and practices
To shift public values and cultural norms in favour of gender equity and end the sexuality- and gender-related stigmatisation of a wide range of people requires a deep understanding of changing cultural norms in many different communities in South Africa. This review was unable to find current information on the cultural understandings of diverse communities and populations across class, geography, ethnicity, sexual orientation, and age, among other areas. Without this information, public and community outreach interventions cannot be targeted effectively. There is a need for the DOH to work with tertiary educational and applied research institutions to undertake research that contributes to social and cultural understandings of sexual and reproductive health and rights; assesses the effectiveness of mass media and community-based interventions to promote sexual and reproductive rights; and assesses changes in public values and practices over time.

Information on clinical guidelines
While there is substantial international research informing clinical protocols, some of the conditions in South Africa require very current information and, in some cases, new research. For example, there is very sparse information available to inform services regarding mental health sequelae of SRH problems and abuses of sexual and reproductive rights in South Africa; there also is little information on the relationships between anxiety, depression, and addiction in vulnerable populations, such as sex workers.

Information on health system performance
Existing health information systems collect extensive data on health system performance. The current system of confidential inquiries into material death provides an outstanding example. District quarterly reviews and monthly supervisory visits that are intended to provide information on the delivery of SRHR services. Selected indicators are used to monitor the delivery and use of sexual and reproductive health and rights services, communities’ perceptions of these services (annually) and healthcare provider satisfaction (annually). Client satisfaction surveys include assessments of the quality of care and the human rights focus of services. These do not function well at the moment but assuming that these processes work effectively as part of the efforts to Reengineer Primary Healthcare, a key dimension will be to pay attention to developing and sharing lessons learnt, particularly about the most effective ways of strengthening the SRHR approach. These lessons need to be shared within and across districts by district managers during district quarterly reviews. In addition, they need to be collated to fill current gaps—for example, to be able to assess trends in relation to
use of different contraceptives, or uptake of termination of pregnancy. There is also a need to collect information regarding the health status and use of health services of particularly vulnerable groups—for example, UNAIDS requires countries to report to it using core indicators on the ‘most at-risk populations’—men who have sex with men (MSM), female and male sex workers, and injecting drug users. To these should be added data on lesbians, women who have sex with women, and gay, transgender, intersex (Tucker and Strand, 2011), and disabled people, so that it would be possible to assess specific health challenges and whether the needs of these groups are being met.

The DOH needs to work with tertiary and applied research institutions to undertake research that informs service delivery and monitors its effectiveness. This is particularly important in relation to new services that are not well understood, such as male medical circumcision, which has clinical safety challenges and implications for people’s understanding of the sexuality, manhood, and sexual safety of circumcised men and their sexual partners.

Collaboration also is needed to undertake ongoing research and monitoring of outreach programmes that aim to shift local cultures and public values so as to work out what components are essential for effective implementation and whether interventions developed in one context will work effectively in another; also to assess to what extent partners of the DOH are keeping to agreed minimum standards in terms of content and methodologies.

Information on health status and health outcomes
Changes in health status and health outcomes, as well as in the prevalence of cultural practices, such as the levels of sexual and gender-based violence, currently are monitored through a few key indicators at the national level.

Moving Ahead

The current reorganisation of the health services and the development of a cadre of community healthcare providers create windows of opportunity for strengthening SRHR services. The Minister's and Department’s concern with dignity and quality create an opportunity to implement well-tested interventions to build a human rights culture in the health system and involve both managers and service providers in the process. Their commitment to social mobilisation around both maternal health and HIV creates an opportunity to draw upon existing evidence to shape effective public outreach and community interventions that address the underlying SRHR issues, including gender inequities, that are prerequisites for effective prevention of sexual and reproductive health and rights problems.

In relation to each of these findings, the review has identified effective interventions. It is clear what needs to be done and how it needs to be done. Now the challenge is to do it.
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APPENDIX 1: BATHO PELE PRINCIPLES & THE PATIENTS’ RIGHTS CHARTER

BATHO PELE PRINCIPLES FOR THE DELIVERY OF HEALTH CARE SERVICES


<table>
<thead>
<tr>
<th>CONSULTATION</th>
<th>Communities will be consulted about the level and quality of public services they receive and where possible will be given a choice about the services offered.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SERVICE STANDARDS</td>
<td>Citizens would know the level and quality of public service they are to receive and know what to expect</td>
</tr>
<tr>
<td>ACCESS</td>
<td>All citizens have equal access to the services to which they are entitled</td>
</tr>
<tr>
<td>COURTESY</td>
<td>Citizens should be treated with courtesy and consideration.</td>
</tr>
<tr>
<td>INFORMATION</td>
<td>Citizens should be given full accurate information about the public service they are entitled to receive.</td>
</tr>
<tr>
<td>OPENNESS and TRANSPARENCY</td>
<td>Citizens should be told how national and provisional departments are run, how much they cost and who is in charge.</td>
</tr>
<tr>
<td>REDRESS</td>
<td>If the promised standard of service is not delivered they should be offered an apology, an explanation and an effective remedy, when complaints are made, citizens should receive a sympathetic positive response.</td>
</tr>
<tr>
<td>VALUE FOR MONEY</td>
<td>Public services should be provided economically and efficiently in order to give citizens and communities the best possible value for money.</td>
</tr>
</tbody>
</table>

THE PATIENTS’ RIGHTS CHARTER


For many decades the vast majority of the South African population has experienced either a denial or violation of fundamental human rights, including rights to healthcare services. To ensure the realisation of the right of access to healthcare services as guaranteed in the Constitution of the Republic of South Africa (Act No 108 of 1996), the Department of Health is committed to upholding, promoting and protecting this right and therefore proclaims this PATIENTS’ RIGHTS CHARTER as a common standard for achieving the realisation of this right. This Charter is subject to the provisions of any law operating within the Republic of South Africa and to the financial means of the country.

A healthy and safe environment
Everyone has the right to a healthy and safe environment that will ensure their physical and mental health or well-being, including adequate water supply, sanitation and waste disposal as well as protection from all forms of environmental danger, such as pollution, ecological degradation or infection.

Participation in decisionmaking
Every citizen has the right to participate in the development of health policies and everyone has the right to participate in decisionmaking on matters affecting one’s health
Access to healthcare
Everyone has the right of access to healthcare services that include:
1) receiving timely emergency care at any healthcare facility that is open regardless of one's ability to pay;
2) treatment and rehabilitation that must be made known to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof;
3) provision for special needs in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain, person living with HIV or AIDS patients;
4) counselling without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV/AIDS;
5) palliative care that is affordable and effective in cases of incurable or terminal illness;
6) a positive disposition displayed by healthcare providers that demonstrate courtesy, human dignity, patience, empathy and tolerance; and
7) health information that includes the availability of health services and how best to use such services and such information shall be in the language understood by the patient.

Knowledge of one’s health insurance/medical aid scheme
A member of a health insurance or medical aid scheme is entitled to information about that insurance or medical aid scheme and to challenge, where necessary, the decisions of such health insurance or medical aid scheme relating to the member.

Choice of health services
Everyone has the right to choose a particular healthcare provider for services or a particular health facility for treatment provided that such choice shall not be contrary to the ethical standards applicable to such healthcare providers or facilities, and the choice of facilities in line with prescribed service delivery guide lines.

Be treated by a named healthcare provider
Everyone has the right to know the person that is providing healthcare and therefore must be attended to by clearly identified healthcare providers.

Confidentiality and privacy
Information concerning one’s health, including information concerning treatment may only be disclosed with informed consent, except when required in terms of any law or an order of the court.

Informed consent
Everyone has the right to be given full and accurate information about the nature of one’s illnesses, diagnostic procedures, the proposed treatment and the costs involved, for one to make a decision that affects anyone of these elements.

Refusal of treatment
A person may refuse treatment and such refusal shall be verbal or in writing provided that such refusal does not endanger the health of others.

Be referred for a second opinion
Everyone has the right to be referred for a second opinion on request to a health provider of one’s choice.

Continuity of care
No one shall be abandoned by a healthcare professional worker or a health facility which initially took responsibility for one’s health.

Complain about health services
Everyone has the right to complain about healthcare services and to have such complaints investigated and to receive a full response on such investigation.
RESPONSIBILITIES OF THE PATIENT

Every patient or client has the following responsibilities:

1) to advise the healthcare providers on his or her wishes with regard to his or her death.
2) to comply with the prescribed treatment or rehabilitation procedures.
3) to enquire about the related costs of treatment and/or rehabilitation and to arrange for payment.
4) to take care of health records in his or her possession.
5) to take care of his or her health.
6) to care for and protect the environment.
7) to respect the rights of other patients and health providers.
8) to utilise the healthcare system properly and not abuse it.
9) to know his or her local health services and what they offer.
10) to provide healthcare providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes.