REPRODUCTIVE HEALTH matters

Coming of age? Women's sexual and reproductive health after twenty-one years of democracy in South Africa

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Abstract: *This paper is a sequel to a 2004 article that reviewed South Africa's introduction of new sexual and reproductive health (SRH) and rights laws, policies and programmes, a decade into democracy. Similarly to the previous article, this paper focuses on key areas of women's SRH: contraception and fertility, abortion, maternal health, HIV, cervical and breast cancer and sexual violence. In the last decade, South Africa has retained and expanded its sexual and reproductive health and rights (SRHR) policies in the areas of abortion, contraception, youth and HIV treatment (with the largest antiretroviral treatment programme in the world). These are positive examples within the SRHR policy arena. These improvements include fewer unsafe abortions, AIDS deaths and vertical HIV transmission, as well as the public provision of a human papillomavirus vaccine to prevent cervical cancer. However, persistent socio-economic inequities and gender inequality continue to profoundly affect South African women's SRHR. The state shows mixed success over the past two decades in advancing measurable SRH social justice outcomes, and in confronting and ameliorating social norms that undermine SRHR.*

Keywords: women's sexual and reproductive health and rights, South Africa, democracy, successes, challenges

Introduction

This paper is a sequel to a 2004 article[1] that reviewed South Africa's introduction of new sexual and reproductive health (SRH) and rights laws, policies and programmes a decade after the first democratic elections. Similarly, its scope is to review key areas of South African women's sexual and reproductive health and rights (SRHR) in the context of new legislation, policies and programmes in the second decade of democracy. These areas include: contraception and fertility planning, abortion, maternal health, HIV, cervical and breast cancer, and sexual violence. We review both progress and continuing challenges in the SRHR field.

Women's sexual and reproductive health and well-being is dependent on a complex array of socio-economic and healthcare factors.[2] Two decades after the advent of democracy, South Africa remains a highly unequal society socio-economically.[3] Black South Africans continue to be economically disadvantaged, with females most disadvantaged: on average, women are 30% poorer than men.[4] Social grants, provided to nearly 17 million people, somewhat ameliorate poverty, with more female than male-headed households (47% vs 14%) surviving on grants.[4] While gender disparity in education and adult illiteracy (< grade 4 schooling) has decreased and generational levels of schooling completion have increased, this has not translated into increased employment.[5,6] The poor quality of basic and secondary education, and difficulties related to entry and completion of tertiary education[7,8] are contributing to cycles of poverty and inequality in South Africa. The National Development Plan, 2030 (NDP) "aims to eliminate poverty and reduce inequality by 2030"[9] by increasing economic growth, improving education and vocational skills development, with a strong emphasis on youth employment. However, labour stakeholders are ambivalent about the plan, and the misuse of state resources in the form of corruption, coupled with an inability to seal South Africa off from the effects of the global economic downturn, have undermined economic stability, job creation, and essential services delivery.[10]

Similar to other middle-income countries,[11,12] South Africa spends 8% of its gross domestic product (GDP) on health.[13] While 84% of the population relies on public healthcare, only 40% of total healthcare expenditure is in the public sector.[13] In 2016, of a total budget of USD 70 billion, the government allocated USD 109 million to health, lower than in 2014 and 2015.[14] The 1996 constitution includes healthcare rights, including SRHR, and commits to free, public primary healthcare.[1] The NDP refers to strengthening primary healthcare facilities, improving maternal health and child nutrition.[9] In 2011, the government proposed a National Health Insurance scheme (NHI) to increase universal health coverage, with a rollout over 14 years.[15] The NHI is based on healthcare as a public good, aimed at encouraging equity, social solidarity and universal access. It aims to introduce a mandatory prepayment to the scheme through a single NHI fund that incorporates public and private health resources. In 2015, an NHI draft law was published for comment. Criticisms of the current plan include the need to first strengthen the weak public health system; disseminate pilot sites' evaluation evidence to guide planning and implementation; and improve and sustain involvement and consultation of all stakeholders. There should be public involvement of those who stand most to gain from the plan's implementation, who need to participate in developing the "basket of services" that will be offered.[16–18]

South Africa's laws and policies support a rights-based framework for SRH, and are aligned with international conference documents and health and development frameworks: the 1994 International Conference on Population, 1995 Beijing Fourth Conference on Women,[1] the Millennium Development Goals (MDGs), Sustainable Development Goals (SDGs) and global Family Planning 2020.[19,20] South African women have full legislative equality, but unequal gender power relations continue to undermine women's SRHR, particularly among teenagers and young women.[21]

South African women's sexual and reproductive health status: 2004–2015

Contraception and pregnancy planning

The contraceptive prevalence rate among South African women of reproductive age, last surveyed in 2003, is 65%.[22] However, many women begin contraception late and discontinue use,[23] with 61% of first and 46% of second pregnancies reportedly unintended.[22] Satisfaction with public sector contraceptive services is low among poor and rural women due to inadequate service availability and access.[21] Teenagers face challenges in accessing public sector contraceptive services due to judgemental attitudes from many healthcare providers for being sexually active.[20] This is despite legislation stipulating that contraception in public health care should be provided free of charge on request to any woman or girl aged 12 years and above.[24] Injectable progesterone-only contraception is the most common modern contraceptive method used (49%), followed by oral contraceptives and male condoms.[25] Female condoms are free, but infrequently promoted.[25] Condom use for pregnancy prevention is uncommon, except among women living with HIV (WLHIV).[25]

In 2012, the National Department of Health (NDoH) published a revised national Fertility Planning Policy, first introduced in 2002. The revised policy underscores the NDoH's commitment to SRHR as a principle underpinning fertility planning.[25] It pays special attention to the specific