NATIONAL ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS FRAMEWORK STRATEGY

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FOREWORD

It gives me pleasure to present to you the National Adolescent Sexual and Reproductive Health and Rights (ASRH&R) Framework Strategy. This National ASRH&R Framework Strategy resonates with the vision of the Population Policy for South Africa (1998) which is "to contribute towards the establishment of a society that provides a high and equitable quality of life for all South Africans in which population trends are commensurate with sustainable socio-economic and environmental development." The goal of the Population Policy is "to bring about changes in the determinants of the country's population trends, so that these trends are consistent with the achievement of sustainable human development."

The Population Policy highlights "the high incidence of unplanned and unwanted teenage pregnancies, the increased risk of early child bearing and maternal mortality as major population concerns that need urgent and collaborative attention from all spheres of government, civil society and development partners. The importance to address these population concerns is also firmly stated in the *Programme of Action* of *the International Conference on Population and Development* (ICPD) in Cairo 1994; and one of the important strategies of the Population Policy is the promotion of *"responsible and healthy reproductive and sexual behaviour among adolescents and the youth to reduce the incidence of high risk teenage pregnancies, abortion and sexually transmitted diseases, including HIV/AIDS, through the provision of life skills, sexuality and gender sensitivity education, user-friendly health service and opportunities for engaging in social and community life".*

This National ASRH&R Framework Strategy was adopted by the government to address these concerns. Through its five key priority areas it commits stakeholders to a multi –stakeholder and multi-sectoral approach. This Framework Strategy also specifically targets the needs of underserved groups such as adolescents with disabilities also including groups such as lesbian, gay, bi – sexual, transgender, queer and intersex adolescents within the country.

We are convinced that the National ASRH&R Framework Strategy will serve as an action guide paving the way towards addressing the gaps and challenges that adolescents are faced with to fully realize their sexual and reproductive health and rights.

MS BATHABILE DLAMINI, MP

MINISTER OF SOCIAL DEVELOPMENT

Executive Summary

The National Adolescent Sexual and Reproductive Health and Rights (ASRH&R) Framework Strategy was developed as an explicit strategy that would serve as an action guide to stakeholders that is underpinned by evidence contained in reports and strategies that examined various aspects of ASRH&R in South Africa. The evidence indicated that there are still a number of gaps that exists in the promotion of young people's sexual and reproductive health and rights (SRHR's). SRHR is considered to be a basic human right for everyone and are fundamental to development conditions of any population. From a demographic perspective, a number of recent studies have commented on South Africa's youthful population as well as the implications to the development of the country population posed by the sheer large numbers of young people. Hence, investing in the sexual and reproductive health of adolescents and youth is of a great imperative. The need therefore arises to create and or strengthen a responsive policy and planning environment to meet the SRHR needs of adolescents especially taking into cognisance those with differing sexual orientation and those living with disability. The foundation of the National ASRH&R Framework Strategy is aligned to the South African Constitution and the Bill of Rights therefore adopting a human rights approach. It also draws considerably on guiding principles and outcomes of various prolific international treaties, guidelines, conventions and resolutions that place focus on ASRH&R. This National ASRH&R Framework Strategy is based on a holistic review of strategy documents, research reports and consultations with experts from various government departments and civil society organizations within the field of ASRH&R.

Since the Framework Strategy is adopting a multi-stakeholder and multi-sectoral approach in addressing the gaps within ASRH&R it has therefore been specifically targeted at all stakeholders within government and civil society who affirm their commitment and accountability to the implementation of the key guiding activities relevant to their areas of work. The National Youth Development Agency (NYDA) has been considered as the lead agency for coordination of the strategy since their mandate is to focus on youth issues in the country. The National Population Unit situated within the National Department of Social Development has been identified as secretariat for the coordination, monitoring and evaluation of the Framework Strategy. The National ASRH&R Framework Strategy also outlines five key priority areas that are underpinned by a set of accompanying objectives that focuses on increased co-ordination, collaboration, information and knowledge sharing for ASRH&R activities amongst stakeholders, developing innovative approaches to comprehensive SRHR information, education and counselling to adolescent, strengthening ASRH&R service delivery and support on various health concerns, creating effective community support networks for adolescents and formulating

evidence based revisions of legislation, policies, strategies and guidelines on ASRH&R.

In conclusion it is envisaged that through the National ASRH&R Framework Strategy we would achieve outcomes that are centred on addressing the current gaps that are hampering progress when it comes to ASRH&R in the country.

List of Acronyms and Abbreviations

AIDS	-	Acquired Immune Deficiency Syndrome
ART	-	Antiretroviral Treatment
ARVs	-	Antiretroviral
ASRH&R	-	Adolescent Sexual and Reproductive Health and Rights
CARMMA	-	Campaign on Accelerated Reduction of Maternal Mortality in Africa
CDC	-	Centre for Disease Control
CEDAW	-	Convention on the Elimination of All Forms of Discrimination against Women
COGTA	-	Cooperative Governance and Traditional Affairs
CPR	-	Contraceptive Prevalence Rate
CSOs	-	Civil Society Organizations
CToP	-	Choice on Termination of Pregnancy
DAC	-	Department of Arts and Culture
DHET	-	Department of Higher Education and Training
DBE	-	Department of Basic Education
DoH	-	Department of Health
DoJCD	-	Department of Justice and Constitutional Development
DSD	-	Department of Social Development
DWCPD	-	Department of Women, Children and Persons with Disabilities
GCIS	-	Government Communication and Information System
HCT	-	HIV Counseling and Testing
HIV	-	Human Immunodeficiency Virus
ICPD	-	International Conference on Population and Development
IMC	-	Inter Ministerial Committee
LGBTI	-	Lesbian, Gay, Bi-sexual, Transgender and Intersex
MDGs	-	Millennium Development Goal
MMC	-	Medical Male Circumcision
MMR	-	Maternal Mortality Ratio
MPoA	-	Maputo Plan of Action
NGOs	-	Non-Governmental Organizations
NYDA	-	National Youth Development Agency
PALAMA	-	Public Administration Leadership and Management Academy
PMTCT	-	Prevention of Mother-To-Child-Transmission
PoA	-	Programme of Action
SAPS	-	South African Police Service
SRH	-	Sexual and Reproductive Health
SRHR	-	Sexual and Reproductive Health and Rights
STI	-	Sexually Transmitted Infection
TB	-	Tuberculosis
ToP	-	Termination of Pregnancy
UNCPD	-	United Nations Commission on Population and Development
UNFPA	-	United Nations Population Fund
UNICEF	-	United Nations Children's Fund
VCT	-	Voluntary Counselling and Testing
WHO	-	World Health Organization

1. Introduction

Outlining the need for an unequivocal National ASRH&R Framework Strategy on adolescent sexual and reproductive health and rights in South Africa

Sexual and reproductive health and rights (SRHR) are usually understood as the rights of all people, regardless of their nationality, age, sex, gender, health or HIV status, to make informed and free choices with regard to their own sexuality and reproductive well-being, on condition that these decisions do not infringe on the rights of others. This includes the right to access education and information, services and healthcare on SRHR. Through the ratification of various prolific international, regional and national instruments sexual reproductive health is understood to be of vital importance to the overall well-being of all individuals. Given that the discourse around sexual and reproductive health has gained considerable momentum in the last two decades, sadly the conversation around sexual rights has in some spaces at regional and global level has become muted or has not received much deserved attention. Arguably, these two components should not be viewed at separate entities but inextricably linked; each with a purpose of influencing and impacting the other.

SRHR is considered to be a basic human right for everyone and are fundamental to development conditions of any population. From a demographic perspective, a number of recent studies have commented on South Africa's youthful population as well as the implications to the development of the country posed by the sheer large numbers of young people. Hence, investing in the sexual and reproductive health of adolescents and youth is of a great imperative. Through the advancement of sexual and reproductive health and rights for adolescents acknowledging and including those underserved groups such as lesbians, gay, bisexual, transgender and intersex(LGBTI), sex workers, HIV positive youth and those living with a disability calls for the development of an inclusive agenda that intends to promote the quality of life and the right to choose whether and when to have children; the right to exercise sexuality free of violence and coercion; the right to seek pleasure with respect for other people's rights; the right to protect fertility; and the right to access modern techniques for the prevention, diagnosis and treatment of sexually transmitted infections. Whilst the provision and the right to accessing SRHR are assured at various levels; at local and community level, people are not always aware of these services and do not know how to access them. Given that these challenges are experienced for many within the adult population, more especially for those living in areas where services are not so easily available; one can only imagine the difficulties experienced and the reality faced by adolescents in accessing their constitutional right in realizing their SRHR.

The lack of comprehensive material around SRHR for all target groups and which ideally is informative, age, language and content appropriate, accessible and accurate to the needs of adolescents both within and out of school are of great concern. Therefore various methodologies should be explored through which comprehensive sexuality education can reach adolescent and youth. Involving both young men and women within gender-sensitive programmes on SRHR can possibly transform unequal power relations. Encouraging intergenerational dialogues amongst adolescent, parents and faith based organisations can bridge the gap on empowering these groups on how deal with discussions around issues of sexuality. Campaigning should be increased around the need to improve standards within the provision of health care services to ensure that the rights of adolescent are respected, protected and fulfilled within an environment free of discrimination based on sex, HIV-status, sexuality, sexual orientation or gender identity. This can be achieved through increasing service delivery on SRHR to all adolescent and youth in both urban and rural areas.

The need therefore arises to create and or strengthen a responsive policy and planning environment to meet the SRHR needs of adolescents contributing to their health security. These efforts will ultimately benefit and transform this youthful population into an asset for the country resulting in desired outcomes achieved such as reduced teenage pregnancy, declined levels of maternal mortality amongst young mothers; increased levels of educational attainment , decreased HIV levels amongst young people etc. If we can attain this and more we will most certainly reap the anticipated demographic benefits associated with having a youthful population. The National ASRH&R Framework Strategy has been developed through the consultation with stakeholders from government departments, civil society and development partners. The following dates indicated below were when the consultations took place.

The following Stakeholder Consultative Workshops was held on the National ASRH&R Framework Strategy.

- 26-27 July 2012 - Burgerspark Hotel Pretoria
- 05-06 December 2012 - Burgerspark Hotel Pretoria
- 09-10 July 2014 – Protea Capital Hotel Pretoria

A World Population Day Workshop was held with young people on sexual and reproductive health and rights dialogues in South Africa

- 10 July 2014

The Commemoration of 2014 World Population Day event with the theme *Investing in young people*

- 11 July 2014

2. Background to the Framework Strategy

What led to the development of the National ASRH&R Framework Strategy?

The impetus to draft an explicit National ASRH&R Framework Strategy that would serve as an action guide to stakeholders is underpinned by evidence contained in reports and strategies that examined various aspects of ASRH&R in South Africa that indicates that there are still a number of gaps that exists in the promotion of young people's sexual and reproductive health and rights (SRHR's).

Since the 1990s various United Nations conference agendas advocated for the advancement and promotion of sexual and reproductive rights. These conferences reiterated that countries should adopt an inclusive view of human rights to health that goes beyond the right to health services. These conferences included the Vienna Conference in 1993 on human rights; the Cairo Conference in 1994 on population and development; and the Beijing Conference in 1995 on women. These conferences transformed the traditional understanding of the right to health by directing attention to girls and women's rights to bodily autonomy, integrity and choice in relation to sexual and reproduction. These conferences thus affirmed a more inclusive meaning for the right to health: for women and girls, in particular, the right to health is not only about obtaining health services or providing nutrition, clean water and sanitation but also the right includes the right to decision – making, control, autonomy, choice, bodily integrity and freedom from violence and fear of violence.

The Millennium Development Goals (MDGs) speaks clearly on issues that are pertaining to the development and well-being of a population. Certain targets have been developed and it will be measured according to progress within the year 2015. If SRHR interventions are not properly implemented for advancement of services, etc. the following targets will show negative progress such as the attainment of targets Goal 3 (promote gender equality), Goal 5 (reduce maternal mortality), and Goal 6 (combat HIV/AIDS, malaria and other diseases).

The National ASRH&R Framework Strategy was informed by 23 reports and strategy documents produced by government departments, the HSRC and MRC, since 2005 that deal with matters related to ASRH&R.

Listed below are some of the strategy documents research reports that has been consulted.

Table 1: List of Strategy documents and Research Reports Consulted

Dept./ Organization and Year of Publication	Title of Publication
	Strategy document and brief summary
Department of Women, Children and People with Disabilities (2011)	**National Plan of Action on Children** The aim of this National Plan of Action was to ensure that appropriate social and welfare services are provided for vulnerable children living in poverty including those with special needs. The provision of adequate services including preventative and protection facilities such as social relief and social security programmes.
Department of Health (2011)	**SRHR Strategy: Fulfilling our Commitments: 2011 -2021 and Beyond** The aim of the report defines comprehensive sexual and reproductive health and rights as including all aspects of promoting a culture of sexual and reproductive rights and all aspects of promotion, prevention, diagnosis, treatment and care and management in relation to sexual and reproductive health.
Dept./ Organization and Year of Publication	**Research Publication and brief summary**
Department of Health (2009)	**Review of the South African Research and Interventions in the Development of Policy Strategy on Teen-aged Pregnancy** The report is based on two broad principles. The first is the adoption of a nuanced and critical approach to understand adolescent pregnancy and the second principle is the adoption of a human based approach that underlines much of the South African legislation and policies with respect to youth sexuality and reproductive health.
Department of Basic Education (2009)	**Teenage Pregnancy in South Africa – With a Specific Focus on School-Going Learners** The aim of the report was to establish the prevalence and determinants of teenage pregnancy. The study focused on pregnancy although more detailed trends on teenage fertility have been documented. It was concluded that as prevention strategy there should be universal implementation of sexuality education, a targeted intervention for high risk adolescent

	groups and also interventions should be strengthened to retain learners at school.
Human Sciences Research Council (2009)	**Teenage Tata** Through qualitative research the report provides an in depth portrayal of men who become fathers while teenagers, offering insight into young father's personal, emotional, financial and cultural dilemmas as they grasp and grapple with the circumstance of becoming or being a father.
Medical Research Council (2003, 2010, 2013)	**National Youth Risk Behaviour Survey (2002, 2008 and 2011/12).** The National Youth Risk Behaviour Survey reports are based on primary data collected amongst school-going learners. The aim of the surveys was to provide nationally and provincially representative data on the prevalence of the above behaviours that place school-going learners at risk. The prevalence of key risk behaviours, namely behaviours related to infectious disease, sexual behaviour, hygiene, chronic disease, nutrition physical activity, injury and Trauma, violence and traffic safety, Mental health, substance use (tobacco, alcohol and other drugs) are reported on. All three rounds of the survey sampled 23 schools per province. In 2002 the survey sampled 14 766 learners of which 10 699 participated. In 2008, the survey sampled 13 379 learners and 10 270 participated. For 2011/12, 14 387 were sampled and 10 997 participated.
Statistics South Africa (2005, 2010, 2013)	**Millennium Development Goals – South African Country Reports(2005, 2010, 2013 – Updates in 2007 and 2008)** The country reports detail South Africa's report on the eight MDG targets as agreed upon during the United Nations Millennium Summit in the year 2000. The country reports seek to provide an account of progress or otherwise made on the targets set out in the goals. The 2013 report also includes the domesticated indicators which are applicable to the South African context. The key feature and contributor in the 2013 MDG report has been the availability of data emerging out of the Population Census of 2011.
Department of Health (2011)	**Health Data Advisory and Co-Ordination Committee Report (HDACC), 2011** The Health Data Advisory and coordination Committee (HDACC) was established by the Director-General of the Department of Health with the aim of i) improving the quality and integrity of data on health outcomes, ii) establishing consensus among research experts from various academic institutions, research institutions and government departments on indicators and

	indicator values, identification of reliable empirical data sources to be used to monitor these indicators as well as mechanisms to improve data systems, and iii) advising on baseline values and targets for the negotiated service delivery agreement (NSDA) for the 2010–2014 period. In the report, HDACC presents its recommendations from the completion of the first phase of its mandate in this report. The report discusses indicators such as maternal mortality, risk factors for HIV and AIDS and child and infant mortality. The committee has agreed on high-level indicators to be used to monitor the NSDA and recommended targets and the data to be used through the process of consultation across the sectors and experts.
National Youth Development Agency (2012)	**The South African Youth Context: The Young Generation** The report examined the youth integrated strategy and plan of Action to advance youth development within the country. A point of interest of this report is the significance which is worth nothing about South Africa's youthful population. The priority areas of focus are on such as on youth economic participation within South Africa, education and skills development and also important challenges facing South Africa youth such as their health and well-being.
National Youth Development Agency	**National Youth Policy 2015 -2020 (Draft)** A review of the implementation of the National Youth Policy (NYP) 2009 – 2014 was done and the review and other research informed the priorities contained in this current draft policy 2014 -2019. This means that the NYP is a progression from the first NYP 2009 – 2014. The current draft improves upon and updates the previous policy by speaking to new and continuing challenges faced by South Africa's youth. The policy proposals focuses on the following Economic participation, Education, Skills and Second Chances, Health Care and Combating Substance Abuse, Nation building and social cohesion and optimising the youth machinery for effective delivery and responsiveness.
Department of Social Development (2012)	**The South African Child Support Grant Impact Assessment** The report examined access to the CSG and its impact on key aspects of child and adolescent well-being. The study concluded that the CSG generates positive development impact relating to reducing poverty; vulnerability and promoting nutritional, educational and health outcomes. It was also found

	that access to the CSG by adolescents is linked to a reduction of risky sexual behaviours.
Department of Social Development – National Population Unit (2012)	**Background Resource Document on the State of ASRH&R in South Africa** The report provided a snapshot of the current state of adolescent SRHR in South Africa. The current challenges and constraints that hamper progress in the field of adolescent SRHR. It provided recommendations such as to strengthen and provide greater compliance to existing initiatives policies and legislation, catering for the SRHR needs of neglected and underserved groups such as adolescents with disabilities and ensuring that adolescents are well informed of their rights.
Department of Social Development – National Population Unit	**Fifteen year progress review of the implementation of the Population Policy for South Africa (1998) and the International Conference on Population and Development (ICPD) Programme of Action (1994)@20** The current report strives to update that report to 2014, particularly on the basis of Census 2011 results. It also covers a broader set of themes including Poverty and Inequality; Population Distribution, Migration and Urbanisation; Gender Equality, Equity and the Empowerment of Women; Sexual and Reproductive Health and Rights; HIV and AIDS and Health Concerns with Demographic Implications; The Changing Structure and Composition of Families in South Africa; Older Persons; Youth; Children and Persons with Disabilities. This report provides a comprehensive assessment of population trends and dynamics since the adoption of the Population Policy in 1998, identifying challenges and population priorities for the current term of government. These priorities are supportive of those identified in the National Development Plan.
Department of Health (2012)	**Saving Mothers 2008-2010: Fifth Report on the Confidential Enquiries into Maternal Deaths in South Africa (and preceding years)** The Confidential Enquiries system of recording and analysing maternal deaths has been in operation since 1 October 1997. In total five reports have been compiled (i.e. 1997, 1999-2001, 2002-2004, 2005-2007 and 2008-2010). These reports all described the magnitude of the problem of maternal deaths, the pattern of disease causing maternal deaths, the avoidable factors, missed opportunities and substandard care related to these deaths and made recommendations concerning ways of decreasing the number of maternal deaths. The latest report describes the pattern of disease causing maternal deaths and the health system failures related to these deaths during 2008-

	2010.
Department of Social Development – National Population Unit (2012)	***Report on Consultative Workshop with Stakeholders on ASRH&R*** The aim of the report was to share information amongst stakeholders from government departments, NGO and UN agencies within the field of Adolescent Sexual and Reproductive Health and Rights. The gaps and challenges in addressing the needs of Adolescent Sexual and Reproductive Health and Rights were documented. The report concluded with an outcome focusing on the development of an explicit Framework Strategy on Adolescent Sexual and Reproductive Health and Rights.
Department of Health (Various Years)	***The 2012 National Antenatal Sentinel HIV and Herpes Simplex Type-2 Prevalence Survey (2013 and preceding years).*** The report details the 23rd National Antenatal Sentinel HIV Prevalence Survey in South Africa. It was conducted across the nine provinces and 52 health districts using the cross-sectional standard unlinked and anonymous design (WHO/UNAIDS Reference Group). The survey is used as a proxy to assess the HIV sero-prevalence among pregnant first bookers aged 15 - 49 years served in public health facilities. The survey was conduct during the month of October in 2012 among pregnant first time antenatal care bookers recruited from 1 497 public health clinics.
Department of Social Development – National Population Unit (2014)	***National Report on Factors Associated with Teenage Pregnancy in South Africa*** Through the use of detailed survey questionnaires with teenage mothers (aged between 13-18) and service providers (e.g. teachers, nurses etc.), focus group discussions with young-school going boys and girls as well as family and community members the research is aimed at finding answers to the 'why' questions on the factors associated with teenage pregnancy and its implications for the individual, family and society.
Department of Health	***National Contraception and Fertility Planning Policy and Service Delivery Guidelines 2012*** The need for the policy update was prompted by: • Changes in contraceptive technologies • The high prevalence of HIV in South Africa • The need to ensure linkages and alignment with other related national and international policies and frameworks. The following aims formed the framework for the revision: • to ensure alignment with international trends and evidence, such as the Medical eligibility criteria for contraceptive use (World Health Organization, 2010),

	and to bring the policy up to date in light of changes in contraceptive technologies and new research; • to locate contraception provision in the context of HIV prevalence in South Africa; • to align the policy with broad overarching national priorities, including South Africa's commitment to the attainment of the Millennium Development Goals, the DOH's Negotiated Service Delivery Agreement, health commitments, and the strategic framework for sexual and reproductive health and rights – *Sexual and Reproductive Health and Rights:* *Fulfilling our commitments;* • to develop a new expanded definition of 'family planning' within the broader context of fertility management, and in so doing, develop a more holistic framework related to contraceptive provision and fertility planning - a framework that will embrace the continuum of both pregnancy prevention and planning for conception, and address the implications thereof for people living with HIV; • to make available and promote wider contraceptive choice and method mix in public sector facilities; • to promote the appropriate integration of quality contraceptive services with other health services, particularly HIV services; • to advocate for the strengthening of more specialised services and referral clinics, where necessary.
Department of Health and Department of Basic Education	***Integrated School Health Policy 2012*** The policy focuses on addressing both the immediate health problems of learners (including those that constitute barriers to learning) as well as implementing interventions that can promote their health and well – being during both childhood and adulthood. **School health package of services:** Health education and promotion; Learner Assessment and Screening; Provision of onsite services; Follow – up and referral; Coordination and Partnership; Community Participation; and Learner Participation

Human Sciences Research Council (2009, 2014)	*South African National HIV Prevalence, Incidence, Behaviour and Communication Survey (2008 and 2012)* The reports covers the epidemiology of HIV from both social and biomedical points of view, providing us not only with statistical data on HIV prevalence, HIV incidence and antiretroviral treatment (ART) exposure, but also socio-behavioural and structural aspects that contribute to the spread of HIV infections in the population. During the 2012 round of the survey information that was collected the report founded that the country has indeed succeeded in the roll –out of treatment to people living with HIV / AIDS. Although there is still a high rate of new HIV infections especially amongst young women aged 15 -24 is troubling and can be associated with social factors such as age - disparate relationships that should be addressed with urgency. The research findings also revealed that the knowledge levels have declined and is accompanied by an increase in risky sexual behaviours. It also indicated that there are still high rates of new HIV infections The researchers also show us that people in informal areas of the country continue to be most-at-risk of HIV, with the highest HIV incidence compared to those living in other areas. This suggests that a strong multi-sectoral approach is necessary to address socio-economic challenges that continue to fuel the epidemic.
Department of Basic Education	*Review of Teenage Pregnancy in South Africa* Experiences of Schooling and Knowledge and Access to Sexual and Reproductive Health Services. This report explores the drivers of teenage pregnancy, in particular gendered norms, knowledge, access and use of contraceptives and the barriers and facilitations to returning to school. The literature review included academic and policy literature over the past 12 years, primarily focused on South Africa. This study was commissioned to provide strong evidence based from which to develop advocacy strategies around reducing unplanned teenage pregnancy and ensuring teenage mothers realized their right to schooling. **Situational Analysis** Key findings of reports: • Of all teenage girls who fall pregnant only around a third stay in school during their pregnancy and return following the childbirth with the highest return rate amongst those in Grade 12

	- Even so for the majority of teenage girls, falling pregnant has have devastating effect on their secondary schooling with consequent negative impacts on their lives - When exploring knowledge, access and use of contraceptives we found that many teenagers have a basic knowledge about contraceptives and protection from unplanned pregnancies, STIs and HIV. However many report insufficient contraception knowledge and not using contraceptives correctly and consistently as well as limited reproductive knowledge about fertility and conception. In these words if one of our respondents. - Most teenage mothers reported limited contraceptive use prior to falling pregnant and following pregnancy a large number of girls began using hormonal injection.
Department of Basic Education	***Integrated Strategy on HIV, STI and TB 2012 – 2014*** - The strategy articulates government's intention to provide school environments that are caring safe and conductive for learning, and aligned to the education sector's duty of care in schooling, thus responding to the new National Strategic Plan HIV, STI and TB 2012 – 2016 (NSP 2012 – 2016) - The DBE Integrated Strategy on HIV, STI and TB 2012 – 2016 was developed to advance ASRH&R of learners in schools through the HIV and AIDS Life Skills programme and Life Orientation curriculum.

The National ASRH&R Framework Strategy draws considerably on the research and consultative evidence produced by the above reports and strategies. Key elements from the research findings and stakeholder consultations have been extracted and have been outlined as major objectives and key areas of focus for the Framework Strategy. A brief synopsis of the findings of each of the three reports is presented in **section 5.**

3. Key definitions adopted by the National ASRH&R Framework Strategy

Perhaps the most crucial definition of the National ASRH&R Framework Strategy rests on what is meant by 'adolescence/adolescent'. Within South Africa the period between adolescence and early adulthood overlaps hence consideration must also be given to defining what is meant by 'youth'. Highlighting these important concepts at the onset will outline appropriate forms of stakeholder engagement, programme design and intervention with clear parameters as set by national legislation, policies, strategies and guidelines.

- **Adolescence:**

United Nations Population Fund (UNFPA) along with the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) defines adolescence between the ages of 10-19. The UNFPA breaks this age category down further by classifying early adolescence for the ages 10-14 years and late adolescence for the ages 15-19). Hence, the Framework Strategy aligns itself with the above defined age category of 10-19 as well as embracing the breakdown of this category for age-appropriate SRHR interventions and education.

- **Youth:**

According to the South African National Youth Policy (2009-2014) crafted by the National Youth Development Agency (NYDA); youth is defined as individuals between the ages of 14-35. The Framework Strategy supports this definition of youth for the applicable ages that fall within the period of adolescence described above.

The core of the Framework Strategy rests upon the fundamental SRHR definitions that have been identified and agreed upon both internationally and nationally. Below are some of these key definitions as well as the inclusion of other terms that also form a key part of the proposed Framework Strategy.

- **Sex:**

The biological and physiological characterises that define people.

- **Gender:**

"Gender is a social construct as it is determined by the socio-cultural attitudes, stereotypes and norms in any given society. These constructs are learned and reinforced by the family structure, the educational system, the community and the media" (PALAMA, 2008:11).

- ***Reproductive Health:***

"Within the Framework Strategy the WHO's definition of health is defined as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, 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 to this are the right of both men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant"(ICPD PoA, 1994: 40, Para 7.2)

- ***Reproductive Rights:***

"Reproductive rights embrace certain human rights documents and other consensus documents. These 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 sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community" (ICPD PoA, 1994: 40, Para 7.3)

- ***Sexual Health:***

"Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence" (WHO, www.who.int)

- ***Sexuality:***

Sexual health cannot be defined, understood or made operational without a broad consideration of sexuality, which underlies important behaviours and outcomes related to sexual health. The working definition of sexuality is: a central aspect of being human throughout life 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. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is

influenced by the interaction of biological, psycho-logical, social, economic, political, cultural, legal, historical, religious and spiritual factors (DoH, 2011: 2).

- **Sexual Orientation:**

"Sexual orientation refers to an enduring pattern of emotional, romantic, and/or sexual attractions to men and women, or both sexes. Sexual orientation also refers to a person's sense of identity based on those attractions, related behaviours, and membership in a community of others who share those attractions" (American Psychological Association, www.apa.org).

- **Gender Equality:**

Gender equality occurs when "women, men, girls and boys need to be afforded equal opportunities to enjoy their full human rights and to reach their full potential" (PALAMA, 2008:8).

- **Gender Equity :**

Gender equity focuses on the "difference between women and men, girls and boys to ensure that they benefit equitably from all interventions. It is about equality of outcome or results" (PALAMA, 2008:8).

- **Sexual and Gender Based Violence:**

Gender-based violence is defined at that which is directed against a person on the basis of gender. The inclusion of sexual violence as defined by WHO includes "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work" (Population Council, 2008: 9). The scope of the definition is also expanded to include forced sexual relations, sexual coercion and the rape of adult and adolescent boys and girls also including the sexual abuse of children.

- **Disability/ Disabilities:**

"Disabilities are an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while participation restriction is a problem experienced by an individual involvement in life situations. Thus disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives"(WHO, www.who.int). This Framework Strategy cites disabilities relating to limitations due to physical, visual, hearing, intellectual, mental impairments.

- ***Teenage Pregnancy:***

Teenage pregnancy is teenage girls (15 – 19 years) who have ever been pregnant (HIV & AIDS and STI, National Strategic Plan 2007 -2011).

- ***Contraception:***

Contraception is people's conscious efforts and capabilities to control their fertility. It does not capture all actions taken to control fertility, since induced abortion is common in many countries. www.un.org

- ***Fertility:***

Live birth is the complete expulsion or extraction of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered live-born (WHO, 1950 and UN, 1991).

- ***Abortion:***

Abortion is induced expulsion of the foetus during the first part of a pregnancy. (European Commission, 2003. Demographic Statistics: Definitions and Methods of Collection in 31 European Countries. Working Papers and Studies).

4. Alignment of the National Adolescent Sexual and Reproductive Health Framework Strategy to International and National Instruments

What forms the basis for the guiding principles of the National ASRH&R Framework Strategy?

The foundation of the National ASRH&R Framework Strategy and its proposed guiding activities is grounded within a human rights approach. Apart from the South African Constitution and the Bill of Rights, the Framework Strategy aligns itself to the guiding principles and outcomes of various prolific international treaties, conventions and resolutions that place focus on ASRH&R especially with a focus on adolescents. These are listed below:

International Treaties, Conventions and Resolutions
- Convention on the Elimination of All Forms of Discrimination Against Women (1979);
- United Nations Convention on the Rights of the Child (1989);
- International Conference on Population and Development Programme of Action (1994);
- Platform for Action of the Fourth World Conference on Women (United Nations, 1995);
- Millennium Development Goals (2000);
- Maputo Plan of Action (MPOA) on the Continental Policy Framework strategy on Sexual and Reproductive Health and Rights (2006);
- Convention on the Rights of Persons with Disabilities (2006);
- Resolution 2012/1 on 'Adolescents and Youth' adopted at the 45th UN Commission on Population and Development (2012);
- Colombo Declaration on Post 2015 Youth Agenda; and
- Addis Ababa Declaration on Population and Development in Africa beyond 2014.

National Legislation
- National Development Plan (NDP) Vision 2030 for the country;
- Choice on Termination of Pregnancy Act 92 (1996); Amendment Acts (2004, 2008);
- Domestic Violence Act 116 (1998);
- Sterilisation Act 44 (1988); Sterilisation Amendment Act 3 (2005);
- Promotion of Equality and Prevention of Unfair Discrimination Act 4 (2000), as amended by section 16 of the Judicial Matters Amendment Act 22 (2005);
- National Health Act 61 (2003);

- Alteration of Sex Description and Sex Status Act 49 (2003);
- Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 (2007);and
- National Directives and Instructions on conducting a Forensic Examination on survivors of Sexual Offence cases in terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007; Government Notice 223, 6 March 2009.

Policies and Strategic Plans
- 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 strategy (2001) (currently being revised);
- A Policy on Quality in Health Care for South Africa (2007);
- National Youth Policy (2009-2014);
- National Youth Policy (2015 – 2020) Draft;
- National Service Delivery Agreement for Outcome 2: A Long and Healthy Life for All South Africans (October 2010);
- National Strategic Plan for HIV, STIs and TB for South Africa (2012–2016);
- Campaign for the Accelerated Reduction of Maternal and Child Mortality in Africa (2012); (CARMMA)
- National Policy on Rape, Sexual Assault and Other Related Sexual Crimes (2010 draft, drawing on the National Sexual Assault Policy 2005);
- National Sexual Assault Policy (Department of Health 2005 revised 2011) but still a draft; and
- National Contraception and Fertility Planning Policy and Service Delivery Guidelines (2014).

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);
- The School Health Policy and Implementation Guidelines (2003);
- National Strategic Plan for the Implementation of the Choice on Termination of Pregnancy Act (2004);
- Draft National Policy for Conscientious Objection in the Implementation of the Choice on Termination of Pregnancy Act of 1996 (2007);
- Guidelines for Maternity Care in South Africa: A Manual for Community Health Centres and District Hospitals (2007);

- Saving Mothers: Essential Steps in the Management of Common Conditions Associated with Maternal Mortality (2007);
- National Contraceptive and Fertility Planning Policy and Service Delivery Guidelines 2012;
- First Line Comprehensive Management and Control of Sexually Transmitted Infections: Protocol for the Management of a Person with a Sexually Transmitted Infection according to the Essential Drug List (2008);
- Policy Guidelines: Child and Adolescent Mental Health (2008);
- Primary Health Care Supervision Manual: A Guide to Primary Health Care Facility Supervision (2009);
- Clinical Guidelines: Prevention of Mother-to-Child Transmission (2010);
- Clinical Guidelines for the Management of HIV/AIDS in Adults and Adolescents (2010);
- Guidelines for the Management of HIV in Children (2010);
- National HIV Counselling and Testing Policy Guidelines (2010);
- Guidelines for Tuberculosis Preventive Therapy among HIV infected individuals in South Africa (2010);
- Policy Guidelines: Integrated School Health Policy (Department of Health 2012); and
- National Contraception Clinical Guidelines (2014).

5. Situation analysis of Adolescent Sexual and Reproductive Health and Rights in South Africa

What are the major trends and concerns on ASRH&R in South Africa?

Research reports mentioned in **section 2** highlighted several trends on ASRH&R in the country. Much of the findings of the reports echo findings of other myriad research initiatives also listed in the table that have taken place at the national, provincial and some instances at local level on the subject of ASRH&R. The following points are a brief summation of the key findings of these reports.

- Higher levels of sexual activity amongst young male adolescents;
- Significant percentages of sexually active adolescents below the age of 16;
- Increasing trends of multiple concurrent sexual relations;
- Increasing trends of inter-generational sexual relations;
- High level of substance use and abuse (i.e. alcohol and drugs) especially amongst males especially prior to sexual activity;
- Increased uptake of condom usage but low levels of consistent condom usage during sex;
- High levels of maternal mortality amongst young mothers;
- Compromised quality of antenatal care to young mothers compared to older mothers;
- High levels of HIV and AIDS among young people;
- Increased levels of STI treatment amongst female adolescents;
- Increased medical male circumcision in adolescent years conducted largely within a hospital settings; and
- Vulnerability and sexual violence arising from contextual factors such as poverty and the disruption of the family.

The reports also discussed the current challenges and constraints that hamper progress in the field of ASRH&R. These include:

- Gaps in the knowledge of legal rights and information regarding sexual health and risks, especially around termination of pregnancy and access to emergency contraception;
- Unsafe motherhood and the quality of antenatal care received;
- Reluctance of some male adolescents to be involved in ASRH&R programmes and the implications of their non-involvement for themselves, partners, family etc.;

- Inadequate attention being paid to the SRHR needs (i.e. provision of appropriate mediums of information, communication and service delivery) of adolescents with disabilities;
- Research has shown a deep reluctance to acknowledge adolescents sexual curiosity, request for services among communities and health care providers;
- Reluctance to accept (either by community and health care workers or society [religious, traditional leaders, parents and caregivers) and cater to the ASRH&R needs (SRH services, information, contraception, VCT etc.) of adolescents with differing sexual orientation (e.g. lesbian, gay, bisexual, transgender and intersex [LGBTI]) within integrated sexual and reproductive health services; and
- Worrying trends of sexual and gender-based violence amongst adolescents.

The reports generally concluded with critical areas for guided action to stakeholders. These include:

- Strengthening, greater compliance, enforcement and accountability of existing initiatives, policies and legislation by relevant stakeholders;
- Ensuring adolescents are well informed of their rights and accompanying responsibilities;
- Equip health care providers and community members with adequate information on adolescent rights;
- Involving young men appropriately in SRHR programmes and services;
- Encouraging active involvement and buy-in of the community in contributing to an improved state of ASRH&R through the use of best practice, evidence-based programming whilst still acknowledging the context specific make-up of communities; and
- Health care providers should be equipped with the necessary skills on how to cater for the SRHR needs of neglected and underserved groups such as adolescents with disabilities and adolescents with differing sexual orientation (LGBTI community).

To further deepen the argument for an explicit Framework Strategy on ASRH&R, the synopsis presented below captures the most salient findings that have emerged from primary research on teenage pregnancy as reflected in the ***National Report on Factors Associated with Teenage Pregnancy in South Africa (2014)***.

The most crucial factors that have been extracted for the purpose of the drafting of the Framework Strategy include:
- The mean age for sexual debut occurs often below the legal age of consent or at times at the age of consent;

- Whilst most teenage pregnancies tend to occur above the age of 16, the majority of these pregnancies are unintended/ unplanned;

- There is a very short duration from sexual debut to first pregnancy. This period is estimated to be usually just over a year;

- High proportion of forced or coerced sex amongst adolescents 16 or younger;

- The research has found that the majority of teenage mothers do not know that it is a crime to have sex less than age 16 even if the encounter was consensual;

- Teenage mothers have little or inadequate knowledge about contraceptive methods beyond pills and injections. Other methods such as the IUDs are completely unknown;

- Teenage mothers believe that having multiple and intergenerational partners are helpful economically however this misperception on their part predisposes them to further health and social risks;

- Psycho-social factors such as low self-esteem and seeking love were identified by the majority of respondent groups as a key factor causing the incidence of teenage pregnancy;

- Poverty and unemployment and having access to alcohol also contributed to the high incidence of teenage pregnancy;

- Dual orphans were more than twice as likely to experience an unwanted pregnancy before the age of 16 compared to paternal orphans and those with both parents alive;

- Paternal orphan-hood or departure is linked with increased likelihood (at times a 2 to 3 times greater risk) of having an early unplanned pregnancy;

- The majority of teenage mothers viewed that the lack of parental supervision contributed to teenage pregnancy;

- The inability of parents and caregivers to communicate with children on aspects of sexuality is a contributing factor; and

- The study reported that the larger the household size, the increased likelihood of a teenage pregnancy. This could be a possible effect of less supervision and care.

Following on from the research findings described the above the following recommendations are made to stakeholders:

- A multi-stakeholder, multi-sectoral approach is needed in preventing and managing teenage pregnancy.
- This should include key partners in schools, hospitals and clinics, traditional leaders, community based organizations, family, caregivers, the community and government.

- There is a clear need to make aware and enforce the SRHR of all individuals especially adolescents and youth so that they are empowered and are able to exercise their rights with responsibility.
- There is a need for targeted awareness campaigns to promote teenage sexual rights and to change those traditional, religious and modern norms that violate their rights.
- Multiple and innovative methods need to be used to educate, inform and empower communities on issues that relate to teenage pregnancy.
- Health workers need to conduct forums where they capacitate other services providers so that they may assist in cascading the relevant information to the teenagers and communities.
- Teenage mothers could play a role in campaigns whereby they can mentor and provide motivation and inspire fellow teenage mothers and young girls and share their experiences.
- Further programmatic intervention where parents and caregivers need support and training on how to communicate on matters of sexuality.
- Parents and caregivers need resource materials in English and local languages on how to communicate sexuality education to their children.
- Greater attention is needed to provide adequate psychological and social support to restore self-confidence, self and mutual respect with the aim of contributing to a positive state of mind amongst teenage boys and girls.

To add to these findings, the following key aspects were highlighted from consultations with stakeholders at the workshop, held in July 2012.

- There should be an increase towards resources allocated for SRHR programmes.
- There should be more focus placed on the translation ICPD commitments into national legislation.
- There should be better integration of health service for adolescents especially young women when it comes to their sexual and reproductive health.
- Reduce maternal mortality especially among young mothers.
- There should be greater importance placed on young people's SRHR.
- Campaigning should be increased to combat HIV and AIDS among young people.
- There should be an expansion of contraceptive use especially to underserved groupings.
- Reducing levels of unsafe abortion through increasing access to safe abortion services.
- The need arises to address gender inequality and sexual and gender based violence with urgency.

As illustrated, these summative points on the research findings and consultative interaction with stakeholders describe the extent and indeed the necessity for a dedicated National ASRH&R Framework Strategy that seeks to address the many concerns of ASRH&R. Hence these findings have led to the development of the objectives for the National ASRH&R Framework Strategy. These are discussed in **section 6.**

6. Outline of the National ASRH&R Framework Strategy

The National ASRH&R Framework Strategy on ASRH&R is based on a holistic review of the three lead documents **(National Report on Factors Associated with Teenage Pregnancy in South Africa (2014), Background Resource Document on the State of ASRH&R in South Africa (2012), Report on Consultative Workshop with Stakeholders on ASRH&R (2012) discussed in section 5)** which identified gaps and issues of ASRH&R that deserved further attention.

These have been singled out as five key priority areas and are underpinned by a set of accompanying objectives. These priorities that are outlined below aims to generate the revitalization of sexual reproductive health care for adolescents.

On the basis of the analysis in **section 5** the following cross-cutting priorities have been identified to be addressed through the Framework Strategy are below:

- Priority 1 – Increased coordination, collaboration, information and knowledge sharing on ASRH&R activities amongst stakeholders;
- Priority 2 – Developing innovative approaches to comprehensive SRHR information, education and counselling for adolescents;
- Priority 3 - Strengthening ASRH&R service delivery and support on various health concerns;
- Priority 4 – Creating effective community supportive networks for adolescents; and
- Priority 5 – Formulating evidence based revisions of legislation, policies, strategies and guidelines on ASRH&R.

For each priority, objectives have been identified to be pursued by government departments, civil society and development partners.

Table 2: Priorities and objectives for the National ASRH&R Framework Strategy

PRIORITY 1	**INCREASED COORDINATION, COLLABORATION, INFORMATION AND KNOWLEDGE SHARING ON ASRH&R ACTIVITIES AMONGST STAKEHOLDERS**
	• To strengthen coordination and collaboration between all stakeholders (incl.all spheres of Government, NGOs, civil society partners, etc.) to improve the state of ASRH&R in South Africa. • To share knowledge and information on best practices on ASRH&R interventions and programmes. • To improve resources mobilisation amongst stakeholders. • To strengthen on usage of resources to increase the better use of knowledge and resources. • To capacitate existing organisations and structures to make more appropriate use of resources on SRHR amongst themselves.
PRIORITY 2	**DEVELOPING INNOVATIVE APPROACHES TO COMPREHENSIVE SRHR INFORMATION, EDUCATION AND COUNSELLING FOR ADOLESCENTS**
	• To develop a comprehensive sexuality education curriculum and implementation framework for the country. Including learning from international best practices. • To increase awareness and provide non-conflicting, gender sensitive, culturally appropriate and positive SRHR messaging to adolescents (including adolescents with disabilities). • To educate adolescents of their SRHR responsibilities and rights (as covered in national legislation, policies and guidelines). • To devise effective and appropriate communication mediums on ASRH&R to adolescents with disabilities (especially in rural areas). • To develop novel approaches that are age-appropriate, gender and culturally sensitive to complement existing SRHR advocacy

	material to adolescents.
PRIORITY 3	**STRENGTHENING ASRH&R SERVICE DELIVERY AND SUPPORT ON VARIOUS HEALTH CONCERNS** • To strengthen ASRH&R service delivery and support on comprehensive health concerns. • To increase access to ASRH&R services and information. • To reduce incidents of STIs, HIV and AIDS and TB. • To reduce incidents of unplanned, unintended pregnancy. • To promote maternal health to reduce maternal mortality amongst adolescents. • To integrate gender based violence programming amongst ASRH&R services.
PRIORITY 4	**CREATING EFFECTIVE COMMUNITY SUPPORTIVE NETWORKS FOR ADOLESCENTS** • To strengthen and scale up community networks aimed at supporting adolescents. • To secure active buy-in and participation by relevant stakeholders. • To capacitate parents, caregivers, religious and traditional leaders, municipal councillors, School governing bodies, youth forums, parents of youth living with disability. • To capacitate parents and caregivers, etc. of adolescents with disabilities on dealing with reproductive health functions and rights (especially men). • To generate interest and involvement of young male adolescents (especially out of school) in SRHR programming.

	• To create safe platforms that promote gender equality and encourage socialisation amongst adolescents in an effort to reduce stigma, discrimination and other prejudices gender based violence held in the context of SRHR (especially in rural areas).
PRIORITY 5	***FORMULATING EVIDENCE BASED REVISIONS OF LEGISLATION, POLICIES, STRATEGIES AND GUIDELINES ON ASRH&R***
	• To generate research, monitoring and evaluation as a basis for reviewing existing legislation, policies, strategies and guidelines • To advocate for the amendment and harmonisation of SRHR legislation, policies, strategies and guidelines (taking cognisance of Research, Monitoring and Evaluation evidence).

7. Intended Outcomes of the National Adolescent Sexual and Reproductive Health and Rights Framework Strategy

What is the intended change that the National ASRH&R Framework Strategy seeks to attain?

The National ASRH&R Framework Strategy has envisioned the following intended outcomes for the identified groups listed below. It is hoped that the implementation of this Framework Strategy will seek to achieve the following:

For the Adolescent:
- Inculcating a core value system that does not ascribe to gender stereotyping or other prejudices but instead promotes and emphasizes non-discriminatory attitudes, respect for human dignity, gender equality, gender equity, receipt of rights with responsibility, accountability, empathy and tolerance;
- Equipping adolescents with a sense of inner-belief ,self and mutual respect where an understanding towards their own sexuality and that of others regardless of gender, gender identity, gender expression, sexual orientation, disability, race, ethnicity, nationality etc. is deepened and respected;
- Building the skill and capacity of the adolescent to be assertive and exercise self-agency and choice in order to negotiate, take informed decisions about their SRHR and to report cases when their sexual rights are infringed or violated;
- Where adolescents feel free to access SRHR services and information; and exercise personal choice in decisions guided by friendly, non-judgemental and empathetic health, social and community workers with the support of family on their SRHR;
- Breaking down self-imposed and contextual (societal, cultural, familial etc.) barriers with the aim of establishing a philosophy of positive knowledge and health seeking behaviour amongst adolescents; and
- Such an ethos is envisioned with the hope of protecting adolescents from coerced sexual experiences, exploitative sexual and reproductive relationships, sexual and gender-based violence, STIs (including HIV), substance abuse, unwanted and unplanned pregnancies etc.

For the Family and Community:
- Building a supportive network to adolescents through the active involvement of the family and members of the community (especially religious and traditional leaders);

- Where taboos, myths, misperceptions, stereotyping and discrimination on sexuality, cultural and traditional practices as well as against certain groupings are challenged in a positive manner and with fact and openness;
- Building the skill and capacity of the family and community to communicate to adolescents on their SRHR with freedom and with confidence especially in local language; and
- Where the family and community are considered a key stakeholder in the conception, design, advocacy, implementation, monitoring and evaluation of SRHR programmes and interventions in their communities.

For Stakeholders and Service Providers of SRHR Programmes and Initiatives:

- Increased collaboration amongst stakeholders in order to improve ASRH&R in the country; and
- Increased inter-departmental collaboration by government and greater cooperation between government and civil society.

8. Implementation, Monitoring and Evaluation of the National ASRH&R Framework Strategy

The Inter - Ministerial Committee (IMC) for the Population Policy will oversee the implementation, monitoring and evaluation of the National ASRH&R Framework Strategy. Ownership of the National ASRH&R Framework Strategy rests with all stakeholders who affirm their commitment and accountability to the implementation of the key guiding activities relevant to their areas of work.

The National Population Unit located at the Department of Social Development will serve as the secretariat for the implementation, coordination and evaluation of the National ASRH&R Framework Strategy. The IMC member departments and civil society organizations will form a Technical Committee to support the IMC. The Technical Committee will meet twice a year and will report to cabinet through the IMC on an annual basis regarding progress of the implementation of the National ASRH&R Framework Strategy.

- **Implementation**

The main implementation modality for the National ASRH&R Framework Strategy will be through implementation coordination, synergy and alignment of existing work log line function departments and other stakeholders in the area of ASRH&R.

- **Monitoring and Evaluation**

Monitoring and Evaluation activities will be conducted through a number of mechanisms and the reporting will be done periodically. Monitoring activities will measure progress and evaluation activities will measure the impact of the strategy on the adolescent population. The M&E of the National ASRH&R Framework Strategy will be done by all the relevant stakeholders. Each stakeholder will be responsible for reporting on indicators that are in their line functions.

The status of ASRH&R in South Africa will be evaluated through the following high level indicators:
- Incidence of STIs, HIV and AIDS and other SRH illnesses such as cervical and breast cancer;
- Incidence of under-18 years childbirths;
- Maternal mortality ratio amongst adolescents;
- Termination of Pregnancy among adolescents;
- Gender based violence amongst adolescents;
- Adolescent Age at sexual debut;
- The uptake of condom usage and levels of consistent condom usage during

sex; and

- Level of medical male circumcision in adolescent.

Output indicators will be developed on the basis of the objectives of the priority areas. This National ASRH&R Framework Strategy will be renewed and updated after the current term of government and recommendations thereon will be made in the new term of government second half of 2019.

9. Budgetary and Resource mobilisation in support of the National ASRH&RFramework Strategy

How will resources be mobilised to implement the National ASRH&R Framework Strategy?

The impact of the National ASRH&R Framework Strategy will first and foremost be through improved coordination, synergy and alignment with the programme of government, civil society and development partners that already work in the area of adolescent SRH.

This will ensure the more effective and efficient use of resources that are already allocated to ASRH&R health related services. Additionally the Framework Strategy will serve as a platform for further resources mobilisation.

The monitoring activities in **section 7** of the Framework Strategy will include the monitoring of resource allocations and the IMC annual reports to cabinet will contain recommendations on the sufficiency and need of funding for ASRH&R related activities.

The secretariat function of the National Population Unit will be funded through the Population Policy Promotion sub-programme of DSD.

10.   Conclusion

This National ASRH&R Framework Strategy serves as an important call to action by all stakeholders at the national, provincial and local level to improve the lives of adolescents in South Africa. Critical to responding to the objectives and desired outcomes of the Framework Strategy is joint ownership, accountability, transparency and confidence in the capabilities and strengths of fellow ASRH&R campaigners as well as garnered political and institutional support at various levels.

Through the promotion and advancement of the SRH needs of adolescents in-roads can be made to improve the health prospects and well-being of the current and future adolescent generation of South Africa.

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