South African National Integrated SRHR Policy

2018

Foreword

PHOTO

This policy is yet another demonstration of our commitment as a country to providing comprehensive sexual and reproductive services in an equitable and rights based approach, in order to achieve health for all citizens of South Africa. This policy, embedded in the principles of equity and equllity further emphasises on autonomy and agency of clients seeking SRHR services. Legal guidance is taken from important statutes that govern the advancement of SRHR, such as the Sexual offences Act and the Choice of Termination of Pregnancy Act.

This important document consolidates several clinical and policy guidelines on various aspects of sexual health and reproductive rights; including the fertility and conception guidelines, termination of pregnancy guidelines, the PEP in occupational and non occupational settings guidelines, the cervical and breast cancer policy documents and the national contraception guidelines. In addition reference is made to other documents that advance adolescent health; and plans to address underserved and key populations. These documents include the National Adolescent & Youth Health Policy; the National HIV Testing Services (HTS) Policy; the National Strategic Plan for HIV, TB and STIs; the Department Basic Education National Policy on HIV, STIs and TB and the Prevention and Management of Learner Pregnancy in Schools, the South African National LGBTI HIV Plan and the South African National Sex Worker HIV plan.

This policy is also a demonstration of our commitment to international and regional policies and strategies that advancethe SRHR agenda, specifically the Sustainable Development Goals (SDGs), the SADC minimum package for SRHR services and the SADC SRHR strategy that is currently being revised; the global Family Planning 2020 framework including the International Conference on Population and Development (ICPD) of 1994, the Beijing Platform for action and the Maputo Plan of Action (2006).

This policy provides a framework through which the Department of Health manages SRHR services.

The policy goal is to promote, through informed choice, safer reproductive health practices by men, women, and youth including use of quality and accessible reproductive health services. This intergrated policy will help facilitate coordination between all stakeholders, guide decision makers, protect clients and providers, and provid a justification for allocation of resources.

Many issues have emerged since the adoption of the SDGs, and in line with our plan to further reduce maternal mortality and morbidity, this policy couldn't have come at a better time.

The SRHR policy was driven by the needs for cohesion; unification, equity, quality and integration of all activities related to SRHR service delivery, in a rights based framework. As a country we are on trck to achieve the global goals on this endeavour, and the policy equally places agency in the hands of clients seeking SRHR services.

Signature

Minister of Health

September 2018

Acknowledgements

The Department of Health urges all public and private institutions to make maximum use of this policy for proper guidance during implementation of SRHR services.

The whole exercise would have not been possible without technical support from CHAI and other technical partners, Evidence for this policy is derived from their intellectual input of many practitioners and academics, literature reviews on available evidence, and what could be practical in the South African environment.

The Department of Health would like to acknowledge the exceptional contribution of all individuals and institutions who were drafting this document. The contributors include various providers who consist of ……

The following also deserve special mention

- NDoH leads: Dr M Makua
- Clinical experts:
- Key contributors/technical experts:
- National Department of Health contributors:
- Partners and CSOs:
- Other contributors:

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

Acronyms

ACOA	Antenatal client initiated on ART
ANC	Antenatal Care
ART	Antiretroviral Therapy
ASRHR	Adolescent SRHR
BCC	Behaviour Change Communication
CFP	Contraception and Fertility Planning
CHC	Community Health Centre
CROA	Clients Remaining on ART
CSE	Comprehensive Sexuality Education
CPR	Contraceptive Prevalence Rate
CTOP	Choice on Termination of Pregnancy
CYPR	Couple Year Protection Rate
D&E	Dilation and Evacuation
DHIS	District Health Information System
DMPA	Depot Medroxyprogesterone Acetate
DOH	Department of Health
ECP	Emergency Contraceptive Pills
GBV	Gender-Based Violence
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HRT	Hormone Replacement Therapy
ICPD	International Conference on Population and Development
ICSM	Integrated Clinical Services Management Manual
IEC	Information, Education and Communication
IUD	Intrauterine Contraceptive Device
IVF	In Vitro Fertilisation
LARC	Long Acting Reversible Contraception
LGBTI+	Lesbian, Gay, Bisexual, Transgender, and Intersex

MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
iMMR	(institutional) Maternal Mortality Ratio
MVA	Manual Vacuum Aspiration
NDOH	National Department of Health
NHI	National Health Insurance
NIMART	Nurse Initiated Management of ART
NSP	National Strategic Plan for HIV, TB and STIs, 2017-2022
PAH	Post-Abortion Haemorrhage
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
PrEP	Pre-Exposure Prophylaxis
PLHIV	People (Person) Living with HIV
PMTCT	Prevention of Mother to Child Transmission
QOC	Quality of Care
SADHS	SA Demographic Health Survey
SAG	South African Government
SANAC	South African National AIDS Council
SDG	Sustainable Development Goals
SGBV	Sexual and Gender-Based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UNFPA	United Nations Population Fund
VMMC	Voluntary Male Medical Circumcision
WHO	World Health Organization

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Definition of key terms

Accessible and equitable health services	Accessible health services are services that are available to all people who need them, and are free from any form of discrimination, irrespective of where a person was born, which language they speak or their cultural or religious background, their abilities, sex or gender. Equitable health services mean that all people are treated fairly and based on their need
Adolescent	Any person between the ages of 10 and 19.
Adolescent and youth-friendly health services:	Health services that are both responsive and acceptable to the needs of adolescents and youth and which are provided in a non-judgmental, confidential and private environment, in times and locations that are convenient for adolescents and youth.1
Comprehensive	In healthcare, the term refers to services that comprise of many elements of care such as promotive, preventive, curative and rehabilitative services. Comprehensive SRH services bring together all the elements of SRH to prevent and manage conditions.
Comprehensive sexuality education (CSE)	This refers to provision of age-appropriate, culturally relevant, scientifically accurate, realistic, non-judgmental information about sex and relationships. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk-reduction skills about many aspects of sexuality.
Counselling	A confidential two-way discussion between a client and trained counsellor to help the client to cope with stress and concerns and take informed decisions about, for example, a medical sterilisation procedure
Gender equality	Means that all human beings are free to develop themselves and make their own choices and that the different behaviours and needs of individuals are valued and are equal. When genders are equal, they get the same treatment, the same access to services, and they have equal power in relationships
Gender-based violence (GBV)	All acts perpetuated against women, men, boys and girls on the basis of their sex which causes or could cause them physical, sexual, psychological, emotional or economic harm, including the threat to take such acts, or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life in peace time and during situations of armed or other forms of conflict. It covers domestic violence, sexual harassment in the workplace, human trafficking and sexual and emotional abuse, to name a few examples.
Gestational age or duration of pregnancy	The number of days or weeks since the first day of the client's last normal menstrual period in clients with regular cycles [88]. The first trimester is generally considered to consist of the first 12 weeks of pregnancy. Throughout this document, gestational age is defined in both weeks and days, reflecting its definition in the International statistical classification of diseases (ICD)

Health system	The sum total of all the organizations, institutions and resources whose primary purpose is to ensure delivery of quality services to all people, when and where they need them. The World Health Organization (WHO) identifies six core components or 'building blocks' of a health system: (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing and (vi) leadership/governance.
Informed decision making	Informed decision-making means that the client decides what is appropriate in a given situation, based on the advice received by a health professional, and taking into account the personal circumstances, belief system and priorities. It may mean that the client either accepts or declines advice and recommendation from a health professional. The client's decision is paramount and must be respected
Integration	The process of bringing together, in a holistic manner, different kinds of related sexual and reproductive health (SRH) and HIV and AIDS interventions at the levels of legislation, policy, programming and service delivery to ensure access to comprehensive services in an efficient andeffective manner
Key populations	Groups of people who are more likely to be exposed to or to transmit HIV and whose engagement is critical to a successful HIV response. These include young women, sex workers, mobile and displaced populations, injecting drug users, prisoners and sexual minorities, or as defined by the Member States in alignment with international and regional standards.
Person-centred services and care	Person-centred services and care means that individuals have control over their own health care and receive it as close as possible to where they live. This includes care focused on each client's needs, to improve the health and wellbeing. In the person-centred approach, people are seen as the experts of their lives who have the right to choose their own health professional and, together with health professionals, decide about the most appropriate course of action. This takes into account their own desires, values, social and personal circumstances and health-related behaviours as well as medical or alternative treatment and management options. This empowers people to understand their condition and how they can get better. Patient care is coordinated between different providers
Pregnancy	The period from conception to birth. After the egg is fertilised by a sperm and then implanted in the lining of the uterus, it develops into the placenta and embryo, and later into a foetus. Pregnancy usually lasts 40 weeks, beginning from the first day of the last menstrual period, and is divided into three trimesters, each lasting three months
Reproductive health	Reproductive health implies that people have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the rights of all people to be informed and to have access to safe, effective, affordable and acceptable methods of contraception of their choice, as well as to safe termination of pregnancy. People have the right to access appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant [27]
Sexual and gender-based violence (SGBV)	SGBV includes any physical, sexual or emotional harm, including threats, bullying or removals of rights in your public or private life, because of gender

Sexual and Reproductive Health (SRH)	Sexual health and reproductive health overlap and, in addition to supporting normal physiological functions such as pregnancy and childbirth, aim to reduce adverse outcomes of sexual activity and reproduction. They are also about enabling people of all ages, including adolescents and those older than the reproductive years, to have safe and satisfying sexual relationships by tackling obstacles such as gender discrimination, inequalities in access to health services, restrictive laws, sexual coercion, exploitation, and gender-based violence [89] The five core components of SRH are: 1) improvement of antenatal, perinatal, postpartum, and new-born care; 2) provision of high-quality services for contraception and infertility services; elimination of unsafe abortions; 3) prevention and treatment of STIs, including HIV, reproductive tract infections cervical cancer, and other gynaecological morbidities; and 4) promotion of healthy sexuality [90]
Sexual and Reproductive Health and Rights (SRHR)	SRHR is defined [3] as a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to: • have their bodily integrity, privacy, and personal autonomy respected • freely define their own sexuality, including sexual orientation and gender identity and expression • decide whether and when to be sexually active • choose their sexual partners • have safe and pleasurable sexual experiences • decide whether, when, and whom to marry • decide whether, when, and by what means to have a child or children, and how many children to have • have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence
Sexual consent	In South Africa, the age of consent for all sexual acts is 16 years. The law prohibits sex with a child who is between 12 and 16 years, and forbids an act of sexual violation with a child who is between 12 and 16 years. Sex between two children who are both between 12 and 16, or where one is under 16 and the other is less than two years older, is not a criminal act
Sexual health	Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled [27]
Unwanted Pregnancy	Unwanted pregnancies are pregnancies that are not desired for myriad reasons including relationship status, economic hardship, mistiming, unplanned or unintended at the time of conception. Unwanted pregnancies may result from

	lack of contraception, contraception not being effective or not being used correctly, or from non-consensual sex such as rape and sexual abuse

1. INTRODUCTION

The South African National Integrated Sexual and Reproductive Health and Rights Policy, 2018 (SRHR Policy) creates the conditions under which South Africans are able to enjoy good sexual and reproductive health (SRH) across their lifespan.

Quality SRH services, underpinned by a rights-based approach, are organized and delivered with respect for individual agency, ability and right to undertake SRH decisions. Sexuality, gender, and the economy are interconnected: SRHR cannot be achieved without the recognition, respect, protection and fulfilment of sexual and reproductive rights within human rights, essential for social justice, sustainable development and public health[1,2]

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

The 2030 Agenda for Sustainable Development provides an unequivocal objective for all United Nations member states to provide universal access to SRHR services, leaving no one behind.(Galati 2015) The Guttmacher–Lancet Commission also calls on countries to include all components of SRHR into national policies. Essential SRH policy and services must meet public health and human rights standards, including the "Availability, Accessibility, Acceptability, and Quality" framework of the right to health(WHO 2007).

Denial or neglect of SRHR is costly at individual, community and national levels. Poor access to or quality of SRH contributes to poverty, exclusion and inequality, not only in terms of income, but also in terms of opportunity, academic attainment, stigma, and key indicators such as maternal and infant mortality, or HIV prevalence. National implications of SRHR access and quality affect economic growth and according to Onarheim et al (2016), environmental sustainability; investment in SRHR of women in particular, benefits the individual, but also the national economy and development across generations In South Africa, this could not have been truer given the incidence of HIV among women and girls.

1.1 1.1 Purpose and Goal of the SRHR Policy

Purpose of SRHR Policy

The SRHR Policy will direct and harmonize integrated coordination and service delivery for comprehensive SRH information and services, in order to improve the health and well-being of the population, and contribute to its socio-economic development as set out in the National Development Plan and other national documents. It will further provide a coherent approach to SRHR service delivery, encompassing guidance given in key documents related to SRHR, namely the TOP guidelines; conception and fertility guidelines, the Oncology strategies for Breast and Cervical Cancer, the Post exposure Prophylaxis in occupational and Non occupational Exposures and the comprehensive

management of STIs – which includes HIV prevention, testing, therapeutic management and monitoring. Further, there are additional legislative statutes that provide legal guidance, such as the Sexual Offences Act and the Choice of Termination of Pregnancy Act.

The SRHR Policy was informed by the following needs:

- *Cohesion*: bringing together diverse efforts that share common goals
- *Unification*: linkage and alignment with related national and international policies
- *Equity*: reaffirming national commitment to reducing gender and other inequalities borne from health disparities
- *Quality*: delivering comprehensive, evidence-backed SRHR services
- *Integration*: integrating SRHR and HIV services, in light of the clear link between HIV and SRH

1.2 Goal of SRHR Policy

To integrate and improve SRH services by ensuring access, equity, efficiency, quality and appropriate services.

1.3 1.2 Guiding Principles

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

- Integration
- Universal access
- Informed, autonomous, and voluntary decision-making
- Evidence-based and evidence-informed practices
- Person-centred differentiated care in service delivery
- Rights-based approach characterised by equality, confidentiality and non-discrimination
- Life cycle approach
- Strong and visible stewardship for SRHR policy implementation
- Multisectoral collaboration

1.3.1 Focus on systems, equitable access and quality

An integrated policy presents a cohesive framework to outline clearly the priorities, structure and governance for sexual and reproductive health service delviery in South Africa. The intention is for this high level policy to impact sexual health outcomes positively at a population level.

Within the population, there are groups of people for whom this policy advocates keen attention and inclusion, including: all adolescents, women, sex workers, LGBTI+, migrants, people with disabilities, and young men and male partners of women seeking SRHR services, and surviors of sexual violence.

By calling attention to the spectrum of needs of the population, iterating the resources and guidance avialable within SRHR, prioritizing essential areas of SRHR service delviery, and illustrating comprehensive care, quality care is championed.

1.3.2 Ownership and Scope

Ultimately, the SRHR Policy exists to serve the people of South Africa through leadership of the National Department of Health (NDOH). Integrated assembly of the key elements of the nation's SRHR philosophy, strategic priorities, and practice guidance in the SRHR Policy provides conscise reference for the administrators, financiers, managers, and health workers who dedicate their professional efforts to improving health outcomes for all South Africans.

1.3.3 Consultation and Participation

The process of drafting and vetting this SRHR policy was lead by the Directorate for Women's Health and Genetics within the National Department of Health, in close consultation with key stakeholders at a national and provincial level in the health sector. Drafting was collaborative, and final input was sought through extensive consultation from various stakeholders, including frontline healthcare workers, technical partners, academic partners, non governmental organisations, civil society and private sector entities.

2 BACKGROUND

Improved and integrated SRH service forms a key pillar underpinning health, human rights, and the sustainable and equitable development of societies. The definition of SRHR suggests that people with good SRH have satisfying, safe sexual lives, and can make a choice as to whether, when, and how they would like to have children Sexual health encompasses some aspects of reproductive health, such as contraception, fertility, and abortion, even though many aspects of sexual health—including reproductive tract infections, sexual pleasure or dysfunction, and the health consequences of violence—are not directly associated with reproduction[3]

SRHR and HIV are inseparably linked. HIV is mainly sexually transmitted, or transmitted from parent to child, while STIs increase risk of HIV acquisition and progression.. Gender inequality affects many health outcomes, but is most pronounced in matters of sexuality and reproduction. Gender inequality influences the ability of individuals to exercise autonomy in their own sexuality and reproduction. Other features of gender inequality, like intimate partner, sexual and gender-based violence, increase the risk of poor SRH outcomes, including HIV.[4]).

An SRHR policy is not devoid of understanding community issues around stigma, discrinmination and acceptance of preferences for those seeking services. For example, difficulty with HIV disclosure negatively impacts indivuduals' ability to protect and fulfil their SRHR. Stigma and discrimination can take shape as coercion, to the extreme of forced abortion or sterilisation of clients living with HIV. The protection and promotion of SRHR, autonomy in deciding when, how and with whom to have sex, and whether to have children, or how many children to have, is central to ensuring health and decreasing gender inequality. This is an integral part of human development.

This agency rests on access to a full range of SRHR services in a gender equal environment, nested in a strong health system. Efficient health systems are a prerequisite for effective service integration and require strengthening of 6 key components: quality service delivery; essential medicines and supplies; human resources for health; health information systems; health care financing; and leadership and governance.[5]

2.1 The South African Context

Insufficient access to services contribute to poor SRH outcomes, including unwanted pregnancies and unsafe abortions. These issues in turn remain major causes of death and disability in South Africa, particularly among the most vulnerable, marginalised and underserved.[6, 7]

2.1.1 SRHR in the context of South Africa's modern history

The first democratic elections in 1994 ushered in a new era in South Africa, with the concepts of human rights and equity installed as cornerstones of the new constitution. South Africa's democratic transition provided unique opportunities to address racially-based political, socio-economic and health inequalities.[8]

However implementation challenges, some stemming from inadequate skills and lack of an integrated approach to SRHR programming have result in lack of access to high quality, equitable SRHR services(NDOH 2018) Dominant patriarchal societal gender norms have been difficult to shift.

Progress has been made, but challenges remainsince 2004, the expansion of progressive safe abortion legislation has been evident; there has been a dramatic decrease vertical HIV transmission, and an establishement of the largest HIV treatment programme in the world has been applauded globally.

Curbing of the HIV epidemic has increased life expectancy and helped to reduce maternal mortality. Some of the challenges stem fromthe legal and policy shift towards availability of safe abortion. Unsafe abortions remain prevalent, contributing to the 60% of maternal deaths considered preventable in South Africa. There has been a continuous reduction in potentially preventable maternal deaths since 2008 nevertheless, increased life expectancy of women from availability of life saving antiretroviral agents and a further reduction of unsafe abortion incidence through an integrated SRHR policy will undoubtedly further contribute to this beneficial trend.

Progress in legislation and policy can be best achieved when there is integration of services with due consideration to other programming and legal imperatives. Legislative progress and programming imperatives, for example in advancing safe abortion in the context of human rights, the sexual offences act, the country focus on reduction in new HIV infections among young women and girls; the need to improve the contraception coverage and mix through a policy have all led to the need to have an integrated approach to SRHR. [11]

We view this as a progressive moment in ensuring access to quality and equitable SRHR services in the country.

2.1.2 Strength of the health system

There have been major investments in the past decades to transform the health system into an integrated, comprehensive national health system. However challengs, which can be categorised into four themes, remain: [13]

- *Complex burden of disease*: resulting from four key areas: maternal, new-born and child health, HIV/AIDS and TB, non-communicable diseases, and violence and injury
- *Quality concerns*: related to health care in general
- *An ineffective and inefficient, verburdened health system*: resulting in inefficiencies in care delivery
- *Costs*: spiralling private health care costs

Amidst these challenges, notable progress has been made.

- At the higher levels of policy and law, the country has strengthened rights-based youth SRH legislation and policies as articulated above, introduced new progressive sexual offences laws and amended the Choice of Termination of pregnancy act to ensure more effective implementation.
- At systems level, the state has sustained well-established data collection systems such as the Confidential Enquiry into Maternal Deaths Reviews and a strong civil registration and vital statistics system; made progress in the ideal clinic framework and advanced the setting up of the National Health Insurance Fund (NHI). [11]

- Specific SRHR programs are commendable, for example the Human Papilloma Virus (HPV) vaccine that will reduce significantly incidence of cervical cancer has been introduced for young girls.

These successes have benefited all South Africans and need to be escalated for more vulnerable groups such as poor women, teenagers, rural women and key populations.[12, 9]

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

A policy such as this can not be complete without due consideration of the social derteminants of health. A variety of factors affects people's access to and utilisation of SRH services in South Africa, influencing patterns of use, continuation and interruption rates of services, and thereby affecting outcomes.

Key factors that point to a need for a more considered and collaborative approach when implementing this policy include:

- *Socioeconomic status and rural residence:* Women living in poor socioeconomic conditions and women in rural areas tend to have less access to SRHR services (like safe abortion), higher in-facility maternal mortality and lower delivery in facility [10]
- *Educational attatinment:* Education has a strong positive link with contraceptive and SRH service use, improved employment opportunities, and economic independence. Higher levels of education, comprehensive sexual education, and retaining learners in school are also associated with lower levels of teenage pregnancy, HIV and other STIs.
- *Gender norms and entrenched cultural practices:* interventions to empower women and engage male partners, men and boys in fostering equitable SRH in South Africa have been ongoing, but more are necessary. More work is needed to link existing initiatives to communities through multisectoral involvement to achieve sufficient scale and coverage. Changing attitudes embedded in sociocultural and political structures is important to promote contraceptive use and other proactive SRH choices
- *Gender based violence:* High levels of sexual, gender-based, and intimate partner violence beset South Africa, denying many women, including adolescents, realisation and enjoyment of full citizenship and inevitably, full enjoyment and attainement of SRHR services It undermines development efforts, and increases especially women's vulnerability to poor health and social outcomes. Various strategies have been deployed through multisectorial collaboration, but these need strategic implementation and enforcement.
- *Partner, family and community expectations around fertility:* Pressure on teenagers and young women to 'prove their love' by childbearing, troubled negotiations between partners concerning condom and contraceptive use, and societal and familial expectations for women to have children are all examples.
- *Delinking of sex, marriage, and reproduction:* Marriage does not always precede sexual activity; Increase in the age of first marriage, and changing norms and values, contribute to this, resulting in more childbearing outside of formal marriage. Many mothers raise children without spousal support; in 2016, two thirds of registered births omitted the name of the child's father.[11]

- *Knowledge about conception:* Many people do not have a sufficient understanding about the fertile period and when pregnancy is most likely to occur. This influences their choices around contraception, and can result in unwanted pregnancy. There are important missed opportunities in a variety of health and educational settings to provide information on reproduction.
- *Knowledge about contraceptive methods:* Although almost all South Africans know about contraception, most have a limited knowledge of the range of contraceptive methods available. This hampers the ability to make informed choices, and limits community experience with newer methods. Misinformation about methods may also affect uptake negatively(Massyn, Peer et al. 2015).
- *Stigma and discrimination:* Sex workers, LGBTI+ people, people living with disabilities, and young people often experience stigma from a wide range of groups, including judgemental service providers, limiting their access to SRHR services.(SANAC 2016; SANAC 2017)[12,13]

While this policy does not go into detail on how to overcome these challenges, there are legislative and implementation measures that have been put in place, in the form of guidelines, to overcome some of these challenges. Given the multifaceted nature of the issues, it is important to understand the context in which this policy is to be implemented.

2.2 South African SRHR context by the numbers

Indicators related to SRHR suggest both wide access to primary healthcare and substantial scope for improving quality of care. Statistics illustrate some progress made, and challenges to be overcome.

- The strategies to reduce maternal mortality are working, with more facility based deliveries. , a positive finding is that 84% of women with a live birth in the past 2 years received a postnatal check during the first 2 days after birth.[17]
- There is also a fertility decline, with the number of children ever born per woman being 2.4 in 2016, compared to 2.9 in 1996-98. [17] A challenge however has been on missing fathers, where women aged 20-29 years registered the most births and the most reported without paternal details. Overall, more than two-thirds of births do not contain information on fathers.[14]
- Contraceptive use has risen at a much slower pace with a high unmet need for contraception.. The district health information system (DHIS) reported the 2016/17 couple year protection rate (CYPR) at 70.2%. When comparing 1998 data with the 2016 data, modern contraception protection rate (CPR) among married women in South Africa remained almost unchanged (55% and 54%, respectively). From 1998 to 2016, the modern CPR among sexually active unmarried women has actually declined (68% versus 64%). [22] Shift in methods used is notable:
    - Use of oral and injectable contraceptives has *decreased*
    - Use of condoms for contraception has *increased*
    - *Modest uptake* of contraceptive implants (5-6% in 2016) was observed *but*
    - Unmet need for contraception has *increased*.
- The national average for *unmet need for contraception* among married and sexually active women 15-49 years is 18% while about 30% of married or sexually active women 15-24 years report an unmet need for contraception. Unmet need for contraception varies between 11% and 24% across provinces, as shown in Figure 1.

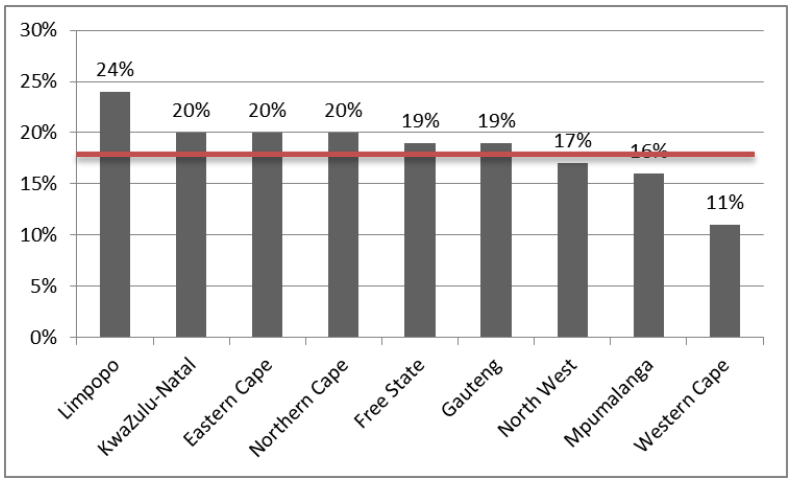


Figure 1 Unmet need for contraception across provinces [17]

2.2.1 Selected SRHR indicators against national targets

Observing change in indicator measurement over time and in relation to national targets highlights areas of achievement and those in need of extra support. Table 1 below summarizes:

Table 1 Selected SRH indicators against national targets [22]

Category	Indicator	2011	2012	2013	2014	2015	2016	Target
Delivery	Delivery in facility under 18 years rate (%)	8.1	7.7	7.8	7.4	7.1	6.8	N/A
	Maternal mortality in facility ratio (iMMR) (per 100,000 live births)	144.9	132.9	133.3	132.5	119.1	116.9	120
PMTCT	ANC 1st visit before 20 weeks rate	40.2	44.0	50.0	53.9	61.2	65.2	62
	ANC client initiated on ART rate	80.4	81.6	76.3	91.2	93.0	95.1	95
Sexual Health	Cervical cancer screening coverage	50.2	50.3	54.1	54.5	56.6	61.5	62
	Couple year protection rate (CYPR)	-	-	-	63.4	66.7	70.2	50
HIV	HIV testing coverage (including ANC)	-	-	26.1	32.1	34.5	35.9	90
	Male condom distribution	15.7	21.8	27.9	38.4	44.4	47.5	1 billion

Delivery in facility under 18 years rate: The proportion of in-facility deliveries to women under 18 years old can be used as a proxy for the adolescent birth rate. Despite the mandate for availability of modern contraception and safe abortion services for women of all ages, these services remain unequally available and/or accessible, especially in rural areas. There was a downward trend from 7.7 in 2012/13 to 6.8 in 2016/17, but preventing unwanted teen pregnancies is a complex issue requiring inter-Departmental effort between Health and Department of Basic Education and Social Development for multisectoral solutions.[22]

Institutional Maternal Mortality Ratio (iMMR): South Africa has shown a decreasing trend in the iMMR over the past five years. The national iMMR in 2016/17 met the target of 120 per 100 000 live births with 116.9 per 100 000 live births, down from 132.9 in 2012/13.[22] The target for 2019 is less than 100/100 000 live births and is on track for the SDG targets on maternal mortality reduction

Antenatal 1st visit before 20 weeks rate: The DOH aims to have 66.0% of 1st antenatal visits before 20 weeks gestation by 2018/19. In 2016/17, the rate in South Africa was 65.2%, 3.2 percentage points above the current target of 62%.[22] Focused interventions by the Department to improve early ANC booking rates contributed to this improvement through:

- Implementation of the 90-90-90 strategies[15]
- The announcement of the Last Mile Plan[15]
- The launch of ward-based community outreach teams[16]
- Implementation of the 2015 National Consolidated Guidelines[17]
- Annual PMTCT stock-take workshops

ANC client initiated on antiretroviral treatment (ACOA) rate: The 2014/15 move to option B+ and the introduction of 90-90-90 [57] in 2016 have ensured a high coverage of ART to pregnant women accessing ANC services. In 2016/17, the ACOA rate in South Africa was 95.1% and 0.1 percentage points above the national target of 95% for this year.[22]

Cervical cancer screening coverage: Data collection prescribed by the National Policy on Cervical Cancer policy was implemented in April 2017. Prior to April 2017, cervical cancer screening was monitored only once within the 10-year interval. The national cervical cancer screening coverage has increased over the past three years (to 61.5%), nearly reaching the national target of 62% in 2016/17.

Couple year protection rate (CYPR): The CYPR measures the proportion of women protected against pregnancy by using modern contraceptive methods, including sterilisation. The average CYPR for the country has increased from 63.4% in 2015/16 to 70.2% in 2016/17, which was considerably higher than the national target of 50% for the country.[22]

HIV testing coverage: The average HIV testing coverage rate (including ANC) for the country has been increasing steadily, from 26.1% in 2013/14 to 35.9% in 2016/17 translating to more than 10 million HIV tests annually. HIV testing coverage reports on testing done within public health facilities and those in non-medical sites that report data to the DHIS. This includes ANC clients. The target is to ensure that 90% of all persons and 95% of ANC clients living with HIV know their HIV status.[18]. In terms of the national effort to increase HIV testing to 90% of people living with HIV, 59% of women and 45% of men age 15-49 reported that they were tested for HIV and received their result in the past 12 months.[15, 17]

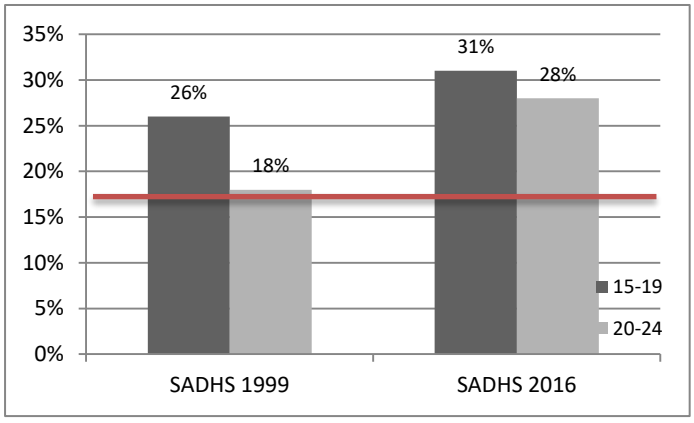
Male condom distribution: This indicator monitors the distribution of male condoms for prevention of HIV and other STIs, and contraception. The target for 2016/17 was that 750 million male condoms be distributed, 917 253 117 were distributed in the period. Among adults age 15-49 years, 17% of men and 5% of women reported having two or more sexual partners in the past 12 months, but only 58% of women and 65% of men who had multiple partners in the past year reported that they used a condom during their last sexual intercourse.

2.2.2 Access to safe abortion: Data on the availability of abortion services is still limited. However the CTOP amendment Act indicate an increase in the rates of safe abortion, a proxy for access, even though more needs to be done. Some facilities are not providing abortion - even though they have the capacity to, with some districts not providing any abortion services at all. With an estimated background abortion rate of 31 per 1,000 women aged 15-44, it is further estimated that the public sector provides 20% of all abortions, and the illegal sector provides 26% unsafely, which burdens the public sector when morbidity from unsafe abortion has to be managed.[19] The reasons are multifaceted including mere lack of knowledge, skills paucity among frontline health care workers, conscientious objections and stigma that is often associated with seeking such services.

2.2.2 Adolescent girls and young women

2.2.2.1 Unmet need for contraception among youth

Specific mention on adolescents and young girls when it comes to SRHR is key. As they exhibit high incidence of HIV and high levels of *unmet need for contraception* around 30%. This is illustrated in Figure 2, below.



The mix of methods of contraception used by young women is uneven; the popularity of progestin only injectable contraception in South Africa specifically among adolescent girls and younger women, is attributed to its convenience and high acceptability among clients and health providers, amd cost effectiveness.[20]

Figure 2 Unmet need for contraception among youth under 25 years old [17]

It is an emphasis in this policy, that primary healthcare providers play a critical part in influencing uptake of SRHR services. Evidence shows that contraceptive uptake and method choice in the public sector is limited by the opinions, conveniences, and habitual practice of primary healthcare nurses.

Figure 3 demonstrates the impact of this influence on mix of contraceptive methods used by young women.

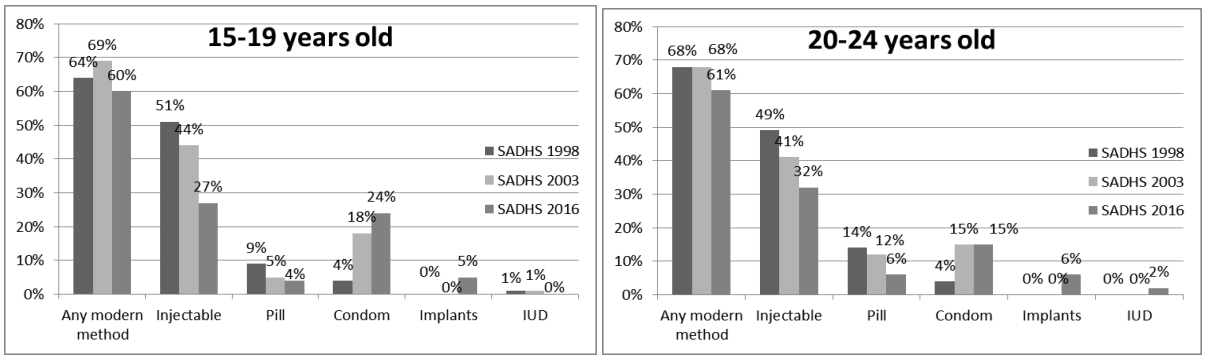


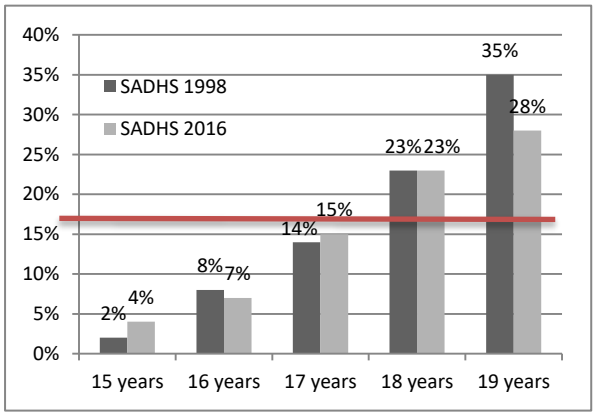
Figure 3 Type of contraception used 15-19 year olds and 20-24 year olds [17]

2.2.2.2 Youth and HIV acquisition risk

Many South African youth are sexually active and practice risky sexual behaviour. There is need to accelerate the implementation of startegies that specifically address HIV among young people, where the incidence of unwanted pregnancies and HIV dispolays worrying trends. When asked about sexual behaviour in the past 12 months, youth aged 15-24 years reported:[17]

- 5% of young women reported 2 or more sexual partners
- 52% of young women reported sex with a partner who is not their spouse or living with them
- 62% of young, unmarried women not living with a partner used a condom at last sex
- Only 38% of young women 15-19 and 67% aged 20-24 years reported that they tested for HIV
- Only 29% of young men 15-19 and 49% of men 20-24 years reported that they tested for HIV

2.2.2.3 Teen pregnancy and motherhood



Nationally, 16% of women 15-19 years have begun childbearing, ranging from 8% in Western Cape to 20% in Northern Cape and North West. Figure 4, illustrates the modest shifts in teen motherhood from 1998 to 2016; most notable is the increase in motherhood among the youngest age group, and the decline among 19 year olds:

Figure 4 Percentage of women 15-19 years who have begun childbearing [17]

The teenage pregnancy rate of 71 per 1000 women shows little change since 1998. Overall, 16% of teens between the ages of 15 and 19 years have begun childbearing, indicated by the red box in Table 2.[17]

Table 2 Number and percentage of births by age of mother [25]

Age of mother	Number birth occurrences	Percentage

10-14	1 444	0.0
15-19	107 730	12.3
20-24	225 847	25.8
25-29	226 996	25.9
30-34	184 962	21.1
35-40	97 218	11.1
40-44	29 298	3.3
45-49	1932	0.2
50-54	110	0.0
Unspecified	898	0.1
Total	**876 435**	**100.0**

Teens between the ages of 10 and 19 contributed 13.9% to registered childbirths in 2016. In an attempt to stem learner pregnancy in South African schools, the Department of Basic Education included the reduction of unwanted teen pregnancy as a separate objective in its HIV, STI and TB Policy.[21]

3 POLICY COMPONENTS AND ALIGNMENT

South Africa's laws and policies support a rights-based framework for SRH, and are aligned with international frameworks: the 1994 International Conference on Population and Programme of Action, 1995 Beijing Fourth Conference on Women, the SDGs, and the Guttmacher–Lancet Commission report on SRHR, and the SADC SRHR strategy[22, 23, 4, 3]

SRHR includes basing services on the best available evidence. Prevention, diagnosis, treatment and care should be evidence-based and in line with national policies, protocols and clinical guidelines. Building upon document: Sexual and reproductive health and rights: Fulfilling our commitments 2011-2022, components of SRH services will focus on:[24]

1.1 Key focus areas

3.1.1 Sexual heath – sexual desire, pleasure and function

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

3.1.2 Confronting sexual and gender based violence

- Promote indvidual and cultural values that decrease sexual and gender based violence
- Provide comprehensive clinical management of sexual based violence

3.1.3 Pregnancy testing

- Provision of pregnancy testing and screening in public health facilities
- Provision of pregnancy testing and screening outside public health facilities

3.1.4 Fertility management

- Provision of comprehensive contraception services
- Addressing safe conception and infertility
- Provision of safe abortion services

3.1.5 Maternal Health

- Provide comprehensive antenatal care services
- Elimination of mother-to-child transmission of HIV
- Provide safe delivery care
- Provide postpartum care including post partum contraception counseling and service

3.1.6 HIV and other STIs

- Prevention, detection and treatment of HIV and other STIs

3.1.7 Cancers of the reproductive system

- Prevention and management of cervical cancer
- Detection and management of breast cancer

3.1.8 Menopause

- Management of SRHR beyond child-bearing

3.1.9 Occupational and non-occupation exposure risk

- Prevention and management of HIV, STI, pregnancy, hepatitis, and tetanus risk

1.2 SRHR Policy alignment to DOH strategy

The SRHR Policy supports the Department of Health's five year strategic goals for 2014-2019:[13]

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

This SRHR policy also supports crosscutting goals of the National Strategic Plan for HIV, TB and STI's 2017-2022. Fostering an enabling policy environment to accelerate prevention of new HIV and sexually transmitted infections, reducing associated morbidity and mortality, reaching key populations, and grounding policy in human rights are all key alignments between the SRHR Policy and HIV, TB and STI strategic plan.

The Sexual and reproductive health and rights: Fulfilling our commitments 2011-2022 document and literature review created the platform for a multisectoral framework, further informed by the CTOP Act, in which SRHR are recognised and valued for delivery of equitable and accessible SRH services in South Africa.[35, 30]

3.1.10 National Health Insurance (NHI)

The NHI, as one of the mechanisms to facilitate universal health coverage, will offer all South Africans and legal residents access to a defined package of comprehensive health services, including comprehensive SRHR services. The NHI will create a single payer financing system that will make sure that all citizens of South Africa, and legal long-term residents, are provided with essential healthcare, regardless of their employment status and ability to make a direct monetary contribution to the NHI Fund. Implementation of the NHI is planned for financial year 2025/26.[25]

3.1.11 National Policies and Guidelines

The SRHR policy is aligned with the current body of South African health policies. Table 3, below, lists the relevant South African policies, plans and laws:

Table 3 Alignment with national health policies, laws and plans

South African Policies and laws informing the SRHR Policy
Sexual and reproductive health and rights: Fulfilling our Commitments [35]
Sexual and reproductive health and rights: Literature review to inform: Sexual and reproductive health: Fulfilling our Commitments [30]
National adolescent SRHR framework strategy (ASRH&R), 2014-2019 [26]
National adolescent & youth health policy 2016-2020 [21]
Sexual offences policy
National HIV testing services (HTS) policy [29]
National strategic plan for HIV, TB and STIs, 2017-2022 [15]
Department Basic Education national policy on HIV, STIs and TB and the prevention and management of learner pregnancy in schools [32]
The South African national LGBTI HIV plan, 2017-2022 [24]
The South African national sex worker HIV plan, 2016-2019 [23]
Management of TB
The breast cancer prevention and control policy [27]
The cervical cancer and control policy [28]
Health sector HIV prevention [29]
Choice on termination of pregnancy Act and CTOP Amendment bill 2003 [42, 43]

Front line implementation of the SRHR Policy will be directed by South Africanclinical practice and service delivery guidelines relevant to SRH. Table four below lists them.

Table 4 Clinical practice and service delivery guidelines supporting the SRHR Policy

South African clinical practice guidelines informing the SRHR Policy
Clinical guidelines on contraceptive services [30]
Clinical guideline on abortion services [31, 32]
Clinical guidelines on safe conception and fertility services
Clinical guidelines on comprehensive STI management [33]
Clinical guidelines on PEP for occupational and non-occupational exposure
National guidelines on pre-exposure prophylaxis (PrEP) and test and treat [34]
National consolidated guidelines for PMTCT and management of HIV in children, adolescents, & adults [28]
Maternal and neonatal care guidelines
The ideal clinic manual [35]
The integrated clinical services management manual (ICSM) [36]

1.3 Other global strategies and statutes

3.1.12 Sustainable Development Goals

Following global consultations, the United Nations Summit held in 2015 formally adopted 17 Sustainable Development Goals (SDG) of the 2030 Agenda, replacing the eight Millennium Development Goals (MDG).[4] While considerable progress towards the MDG has been made, continued high rates of HIV prevalence and acquisition, especially among adolescent girls, young women, and key populations, reflects the on-going challenges to these populations' ability to exercise and realise SRHR.[37] Although they exclude mention of sexual rights, several SDGs are inclusive of SRHR goals for health, education and gender equality, incorporating certain key SRHR aspects into the

targets, such as access to SRHR services, CSE and the ability to make decisions about one's own health. [38, 4, 3]

Table 5 SDGs related to SRHR Policy

Goal 3: Ensure healthy lives and promote well-being for all at all ages	
Target 3.1	By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
Target 3.3	By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
Target 3.7	By 2030, ensure universal access to sexual and reproductive health-care services, including for contraception, information and education, and the integration of reproductive health into national strategies and programmes
Goal 5: Achieve gender equality and empower all women and girls	
Target 5.1	End all forms of discrimination against all women and girls everywhere
Target 5.2	Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation
Target 5.3	Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation
Target 5.6	Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences
Goal 10: Reduce inequality within and among countries, relates to achieving SRHR for priority populations most affected by HIV, discrimination, and fulfilling the right to development	

3.1.13 Guttmacjher – Lancet Commission

The 2018 Guttmacher-Lancet Commission report proposes a comprehensive and integrated definition of SRHR, recommending an essential package of SRHR services and a positive, progressive, evidence-based agenda for progress on SRHR to 2030 and beyond.[3] The package is consistent with but more prescriptive than the SRH targets of the 2030 Agenda for Sustainable Development.

3.1.14 Regional guidance, including SADC

The SRHR Policy also is aligned with global clincial and service delivery guidance: WHO Clinical practice handbook for safe abortion, Family planning: A global handbook for providers, Selected practice recommendations for contraceptive use, Global health sector strategy on STIs, the global Family Planning 2020 framework, and Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region, the SADC Protocol on Health Article 16 , and the SADC SRHR strategy .[39, 40, 41, 42, 8]

4 THE NATIONAL INTEGRATED SRHR POLICY OBJECTIVES

There are five SRHR Policy objectives, with accompanying policy statements to direct their implementation.

The following table summarizes the five SRHR Policy objectives, and sub-components:

Table 6 SRHR Policy Objectives, sub-objectives, and intended results

SRHR Policy Objectives		***Intended Result***
Objective 1: Equip all people to make informed decisions about their SRH and ensure that their SRH rights are respected, protected, and fulfilled		
1.1	Disseminate the SRHR Policy to all levels in Department of Health and collaborating implementing partners	*Informed and autonomous decision-making*
1.2	Create awareness and improve SRHR knowledge to stimulate demand for SRHR services in the general population	
1.3	Offer person-centred counselling to all clients who access SRHR services	
Objective 2: Increase the access to and uptake of SRHR care and treatment services across all life stages		
2.1	Make pregnancy testing is available to all clients	*Person-centred differentiated care across all life stages*
2.2	Offer a range of modern contraception methods, together with counselling and information to encourage informed choice	
2.3	Provide safer conception and infertility services to all clients who experience difficulty with conception	
2.4	Provide safe abortion-related and post abortion services at all facilities	
2.5	Provide HIV, TB and STIs services, including prevention, detection and management	
2.6	Provide programmes for the prevention, detection and management of cervical cancer and breast cancer	
2.7	Ensure well-being of clients beyond child-bearing, during and after menopause	
2.8	Provide occupational and non-occupational PEP to clients at risk of HIV, STIs, pregnancy, hepatitis B and C, and tetanus	
Objective 3: Ensure access to respectful and non-judgmental SRHR services for priority groups		
3.1	Adolescents and young people (10-24 years)	*Rights-based approach characterise*
3.2	LGBTI+ people	
3.3	Female Sex workers	

3.4	People living with disabilities	*d by non-discrimin-ation, confiden-tiality, and privacy*
3.5	Migrants and asylum seekers	
3.6	Male partner and male involvement	
Objective 4: Strengthen the health system to deliver integrated SRHR services at the lowest feasible level in the healthcare system		
4.1	Provide quality SRH services at primary health care level or lowest level possible	*Enabling environment for high quality services delivered by trained providers*
4.2	Ensure uninterrupted supply of commodities and drugs	
4.3	Ensure healthcare providers have the skills and knowledge to deliver integrated SRH services	
4.4	Maximise the use of programmatic data and research to improve service provision and increase impact	
4.5	Mobilise financial resources and maximise efficiencies to support implementation	
4.6	Promote strong leadership and management to enforce the SRHR Policy	
Objective 5: Promote multisectoral engagement and shared accountability		
5.1	Strengthen partnerships to implement the SRHR Policy	*Coordinated implementa-tion for a sustainable response*
5.2	Improve collaboration and co-operation between government, civil society, development partners and the private sector	
5.3	Strengthen collaboration between and co-ordination of accountable government departments	

4.1 Objective 1: Enable all people to make informed decisions about their SRH and ensure that their human rights are respected, protected, and fulfilled

4.1.1 O1.1 Disseminate the SRHR Policy to all levels of DOH and collaborating implementation partners

- Host provincial workshops to introduce the SRHR Policy and get buy-in
- Use existing and create new channels to distribute policy documents to all districts in the country
- Conduct value clarification workshops with provide groups and other implementers to ensure equitable comprehensive SRHR service delivery to all clients, specifically priority populations. A workshop should result in planning and the policy should be reflected in provincial and district planning

4.1.2 O1.2 Create awareness and improve SRHR knowledge to stimulate demand for SRHR services in the general population

O1.2.1 Inform the general population about available SRHR services through national campaigns

- Use a variety of communication channels, including technology based, to inform the public of available SRHR services
- Reduce stigma and discrimination through community dialogues and mass media
- Provide comprehensive sexuality education in all schools

O1.2.2 Provide knowledge and information to clients accessing SRHR services

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

4.1.3 O1.3 Offer person-centred counselling to all clients who access SRH services

O1.3.1 Offer person-centred counselling

- To provide accurate, evidence-informed information to all clients accessing SRHR services
- To learn about the lived experience of the client through non-judgemental, open-ended questions to inform SRHR service choices
- To avoid coercion, emphasizing non-directive communication
- To provide clients with information to make healthy choices about their bodies and sexuality, and services that could mitigate social, political and economic challenges
- To avoid stigmatisation, underming autonomy, or compounding inequalities[43]

O1.3.2 HIV counselling and testing

All clients accessing SRHR services who are not known to be HIV+ and have not tested for HIV recently should be offered HTS, in line with national HTS Policy: [29]

- All forms of HIV Counselling and Testing are voluntary and adhere to the five C's: consent, confidentiality counselling, correct test results and connections to care, treatment and prevention services
- People found to be living with HIV should be commenced on treatement without delay.[45, 28]
- It is the responsibility of healthcare providers to identify and refer clients to appropriate services, and clearly outline pathways of linkage and support to clients, especially adolescents and priority populations

O1.3.3 Adherence counselling

All interventions which require adherence, for example clients initiated on a contraceptive method, ART, STI treatment, or PrEP, must be supported to follow their treatment plans:

- Encourage clients to return to the clinic if they have concerns or need additional information ('Come back anytime' policy)

- Prompt clients to identify and discuss factors that impede compliance with treatment

O1.3.4 Uptake of contraceptive services counselling

Contraceptive counselling, including male and female sterilisation, introduces clients to the contraceptive options available and the benefits of each method. The goal of method choice counselling is to help the client find a method they can use successfully with satisfaction.:

- It is not expected or necessary to provide complete information about every method during counselling. Clients need key information, especially about the methods that they show interest in and choose

O1.3.6 Safer conception and fertility counselling

As stipulated in the safe conception and fertility guidelines, clients should not only be counselled about prevention of pregnancy, but also the planning of a healthy pregnancy, and optimising the chances of getting pregnant when pregnancy is desired:

- Preconception counselling is important to all clients seeking fertility treatment to optimise pregnancy outcomes; offer comprehensive preconception counselling in accordance with the WHO preconception care package of interventions[44]
- Include reduction of risk factors of infertility such as over- and under weight, smoking, alcohol, caffeine and illicit drug use
- Train community health workers to dispel myths and misperceptions in fertility counselling, and to refer affected couples to the appropriate services at district or regional hospital level
- Follow clincial gudiance for conception in HIV serodiscorandant couples
- Counsel both partners together, if possible and welcome

O1.3.7 Safe abortion counselling

Safe abortion counselling promotes informed choice and better outcomes:

- As outlines in the TOP guidelines, counselling should include decision making counselling , pre abportion, procedural counselling and post abortion counselling. Such counselling should offer informational, non-mandatory counselling to all women seeking abortion services about where to obtain a safe abortion, and what to expect in an abortion procedure and follow up

O1.3.8 Counselling for clients exposed to violence

Many clients who seek SRHR services experienced incest, domestic violence, intimate partner violence, or other physical and emotional trauma. Healthcare providers are in a good position to identify clients who experience violence and to attend to their physical health needs while providing psychosocial support:

- Clients who experience violence often seek health services, without mentioning the violence.
- Violence can lead to a range of health problems, including injuries, unwanted pregnancy, HIV and other STIs, decreased sexual desire, pain during sex, endometriosis, and chronic pelvic pain.

Both the Prevention of Family Violence Act (Act No. 133 of 1993), and the Child Care Act of 1983 impose an obligation to report the suspected ill treatment and abuse of children

- Violence may start or become worse during a pregnancy, placing the foetus at risk as well.
- A violence or the threat of violence can deprive clients of their rights to make choices about whether to use contraception or what method to use.
- Provide clients exposed to violence with first line support and counselling, and enable them access to other complementary services, such as legal recourse.[51]

O1.3.9 Sexual offence counselling

With the legal guidance of the Sexual offences Actr, the National Management Guidelines for Sexual Assault provides a structured and integrated approach to the management of sexual offences, focusing on the emotional and physical needs of the client.[45]

People experiencing sexual violence or rape have specific, urgent and ongoing health needs:

- These clients may present at facilities later in gestation, seeking termination of the pregnancy that resulted from the traumatic sexual violence to which they were subjected
- Provide prompt comprehensive support and immediate referral options if services are not available in the facility, including for mental health support, proper medico-legal examination and documentation.[46]
- Directly after the sexual offence, restrict counselling to an explanation of the examination, specimens needed, the risks of pregnancy or STIs, and treatment/prophylaxis needed
- After this acute phase, ongoing detailed psychological support and counselling may be needed. This can be delayed for at least three days and should integrate various aspects of care, which may be provided at different times, for example trauma counselling and HTS
- Note that during the immediate post trauma period when emotion is either blunted or very intense, clients without immediate psychological support may become depressed, aggressive, or even suicidal.[56]

O1.3.10 Informed consent counselling

- Any client undergoing a procedure that requires informed consent must understand fully what the procedure entails:[47]
- Provide sufficient information on the diagnosis, proposed treatment, expected benefits, risks, alternative treatment, probable results, what will be done during the procedure, what to expect in terms of pain or discomfort, how to deal with it, how to act in the case of an emergency and most importantly, the consequences of undergoing the procedure
- Ensure that the client understands everything and make arrangements to assist the process of understanding, i.e. use an interpreter to explain the details to the client if necessary
- Informed consent must always be voluntary and without constraint or coercion, obtained from a client capable of consenting
- The client must give the consent personally, unless proxy consent is applicable
- Consent must not conflict with national guidelines, Acts, or the Constitution.[48]
- In the case of an HIV test, consent should preferably be written, although consent may be implied.[29]

4.1.4 Objective One Policy Statements: Ensure a collaborative approach, generate demand, provide user information and enhance communication

Policy statement 1.1: This policy requires cooperation and collaboration of provinces, the district health system and other collaborating partners for full implementationPolicy statement 1.2: Through innovative use of media and communication startegies , populations , especially the underserved, must have information related to services that they need , to ensure increased demand.Policy statement 1.3: All clients must receive integrated and person-centred service packages appropriate to their needs

Policy statement 1.4: Clients must have equitable access to information that is comprehensive in content

Policy statement 1.5: Contraceptive services must focus on attracting new users, improving continuation rates, and encouraging past users who still want to avoid pregnancy to resume use, using effective, non-coercive counselling as a primary tool.

Policy statement 1.6: Health providers should ensure that informed consent fits the package of services and age of the client, because age restrictions exist for some SRHR services, though most SRH services do not require informed consent

4.2 Objective 2: Increase the quality and uptake of SRHR care and treatment services across all life stages

This Objective should be read with the National Contraception Clinical Guidelines, the National Abortion Guidelines, the Conception and Fertility Guidelines, National consolidated guidelines for PMTCT and the management of HIV in children, adolescents, and adults[28], and the National PEP Guidelines for occupational and non-occupational risk

A dramatic increase in the uptake of, demand for, and access to SRHR services is only possible if service delivery meets the demand and the needs of individual clients. The SRHR Policy provides for a comprehensive package of services that is available and accessible to anyone who needs the services at primary healthcare level.

The essential package of comprehensive SRH services available to all clients in public health facilities in South Africa, includes:

- accurate information and counselling on SRHR, including evidence-based, comprehensive sexuality education in schools [32]
- information, counselling, and care related to sexual function and satisfaction
- prevention, detection, and management of SGBV and sexual coercion
- Pregnancy testing
- A mix of modern contraceptive methods including liberal access to condoms and water-based lubrication
- Safe conception and fertility planning services
- Safe abortion services
- HIV, TB, and STI prevention, screening, and management, including PrEP for high risk populations
- Prevention, screening, and management of breast cancer and cervical cancer
- SRHR services for clients beyond child-bearing age
- PEP for occupational and non-occupational risk

4.2.1 O2.1 Ensure pregnancy testing is available to all clients

To increase access to pregnancy testing:

- Provide free pregnancy testing services at all public health facilities
- Provide pregnancy tests outside facilities
- Inform clients that pregnancy test kits are also for sale at retail pharmacies

4.2.2 O2.2 Offer a range of modern contraceptive methods, together with counselling and information to encourage informed choice

This Section should be read with the National Contraception Clinical Guidelines (under development)

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

- Subdermal hormonal implants
- Female sterilisation
- Male sterilisation
- Levonorgestrel IUD (LNG-IUD)
- Copper-bearing intra-uterine devices (Cu-IUD)
- Progestin-only injectables

- Combined oral contraceptives
- Progestin-only pills
- Male and female condoms and lubrication
- Emergency contraception

4.2.3 O2.3 Fertility: Provide fertility support to all clients who experience difficulty with conception and safe conception support to HIV serodiscordant couples

This Section should be read with the National Conception and Fertility Guidelines and National consolidated guidelines for PMTCT and the management of HIV in children, adolescents, and adults[28]

O2.3.1 Planning pregnancy

All clients who want to have a child can use advice about preparing for safe conception, pregnancy, delivery, having a healthy child, and contraception.

- Take a holistic reproductive life-span approach during contraception and conception planning, rather than focusing only on prevention of pregnancy.
- Provide information, education and communication (IEC) to promote:
  - the importance of planning for healthy conception, healthy spacing of pregnancies and contraception (within the context of HIV)
  - dual protection for both HIV and pregnancy
  - available methods and the relative advantages of respective methods
  - issues such as choice, informed decision-making and shared responsibility
  - HIV testing at ANC visits
- Include future fertility plans as part of the history taking for all clients.
- Provide timely access to safe delivery; post partum contraceptive; and prevention, detection, and treatment of infections to reduce secondary infertility
- Motivate pregnant clients to attend ANC early in pregnancy, ideally before week 12.

O2.3.2 Fertility treatment

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

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

Preconception counselling is important to all clients seeking fertility treatment in an effort to optimise the pregnancy outcomes. Communication should support clients emotionally to manage the psychological effects of infertility, and otherwise be in accordance with the WHO preconception care package of preconception care interventions.[55]

O2.3.3 Safe conception for HIV serodiscordant couples

This Section should be read with the National consolidated guidelines for PMTCT and the management of HIV in children, adolescents, and adults[28]

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

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

4.2.4 O2.4 Safe abortion services: Provide safe abortion-related services at all health facilities

This Section should be read with the Termination of Pregnancy guidelines, practice guidelines underpinned by the Act.[42, 43, 49]

O2.4.1 Access to safe abortion

- All clients presenting for abortions, must be welcomed, supported and given care
- If the facility is unable to provide medical or surgical abortion, the client should be provided with a clear list of facilties that will be able to accommodate her

O2.4.2 Conscientious objection

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

- All health professionals are under legal and ethical obligation to provide care for patients presenting with complications arising from an abortion, regardless of whether the abortion was induced or spontaneous, or how or by whom it was performed
- In non-emergency cases, health providers who believe that their religious or moral beliefs may affect the treatment or the advice that they provide may refuse to participate in an abortion but must fulfil the requirements stipulated in the National Abortion Guidelines *(under development)*.
- Conscientious objection should not be invoked by persons not directly conducting abortion procedures such as support personnel
- Management of public sector facilities are obliged to ensure that clients have access to the services to which they are legally entitled; Conscientious objection may not be the basis for a facility staff to limit or deny access to safe abortion at that facility
- Refusal only applies to trained health professionals and not to groups, an institution, support personnel, or complementary services
- The clients' right to information and access to health care services must always be respected [50]
- At minimum, information and facilitation of referral about where to obtain a safe abortion must be provided respectfully to the client seeking an abortion[51]
- Health professionals not willing to conduct abortions must document the unwillingness in writing, addressed to the facility manager, when applying for a position
- Facility managers need to confirm whether a staff member is fit for purpose in terms of providing abortion services when appointing staff

- Each objecting staff member must be dealt with individually; never in a group, or through group action at facilites

O2.4.3 Pre-abortion care

- Provide information in a way that the client can understand, enabling her to make informed decisions about her pregnancy, and what method of abortion to choose, if appropriate.
- Give an opportunity to discuss contraception choices for the future, and affirm that consent to contraception is not a prerequisite to accessing an abortion[14]
- All clients who need abortion services should enter the health system at the primary health care level irrespective of whether the facility provides abortion services
- In most cases, abortion care can and should be offered in an outpatient setting.
- Facilities providing abortion services, which currently are all facilities that are able to perfom a delivery, should have trained staff, appropriate equipment, and communication available, so that emergency care is available 24 hours

O2.4.4 Pain management

- Clients undergoing an abortion have the right to pain relief, which should be provided proactively [52, 53]
- Following the pricincipal that experience of pain varies by individual, by gestational age, and maternal age and parity, estimate the client's pain perception and evaluate pain treatment given to achieve optimal pain relief

O2.4.5 Medical abortion

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

O2.4.6 Surgical abortion

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

O2.4.7 Post abortion care

- Women receiving abortions should be clear on signs and symptoms of excessive bleeding post procedure and how to get help, at what times of day, should that occur
- Provide access to comprehensive SRHR services including for HIV and other STIs, cervical cancer screening, and contraception

O2.4.8 Obligations in emergency settings

No provider has the right to conscientious objection in an emergency situation. When continuation of a pregnancy poses a serious danger to the life or health of a client or the foetus, regardless of gestational age, health workers cannot recuse themselves from duties:

- A health care worker cannot legally or ethically object to the rendering of care in cases of life-or health-endangering emergencies, including suicidality, where abortion or post abortion service provision is part of addressing the emergency

- If a health care worker denies access to abortion services under such circumstances, she or he may be charged with negligence where disciplinary steps may need to be taken
- Where a health professional refuses to assist in performing the abortion in emergency circumstanes, she or he will be disciplined for misconduct or failure to carry out instructions as per the CTOP Act and may be vulnerable to legal action taken by the client or her family.

4.2.5 O2.5 HIV and other STIs: Prevent, diagnose, and treat HIV and other STIs

This Section should be read with the National Consolidated Guidelines for the Prevention of Mother-To-Child Transmission of HIV (PMTCT) and the Management of HIV in Children, Adolescents and Adults[28], the National strategic Plan for HIV, TB and STIs[15], the Sexually Transmitted Management Guidelines[44], the DBE HIV, STI, and TB Policy[32], and the National Guidelines on PrEP and Test and Treat[45]

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

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

O2.5.1 Contraceptives for clients living with HIV and other STIs

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

O2.5.2 PMTCT for pregnant HIV positive clients

- Prevention of mother to child transmission of HIV (PMTCT) has been accelerated in South Africa through various elimination startegies. This policy emphasises the need toOffer HTS to all pregnant clients reporting for ANC, where those who are infectecd with HIV need to be started on treatment and continue HIV prevention services for those who are not infected
- Offer and start clients on ART immediately after a positive HIV diagnosis to reduce the chances that she will become ill, or that baby will be infected with HIV in utero, during delivery, or postpartum
- Offer and start clients at high risk if HIV infection on oral PrEP containing TDF immediately after a negative HIV diagnosis
- Newborns of mothers living with HIV should receive newborn PEP to further reduce the chances of HIV transmission in the period around birth in accordance with PMTCT clinical guidance [28]

4.2.6 O2.6 Breast and cervical cancer: Provide programmes for the prevention and management of cervical cancer and breast cancer

O2.6.1 Cervical cancer

This Section should be read with the Cervical Cancer Prevention and Control Policy[39]

- Comprehensive cervical cancer prevention and control requires equitable and affordable access to care:
- Provide access to the 4 key interventions, along with information, education, and counselling:
    1. Primary prevention with HPV vaccination for girls aged 9–13 years

2. Secondary prevention with cervical screening, diagnosis, and treatment of precancerous lesions
3. Treatment for invasive cervical cancer
4. Palliative care[39, 54]

- Screen all clients 30-50 years for cervical cancer as prescribed in the Cervical Cancer Prevention and Control Policy[39]
- Screen all clients with HIV at time of diagnosis and repeat as per HIV treatment guidelines
- Offer all clients found with HG-SIL or CIN 2/3 appropriate pre-cancer treatment using ablative or excisional methods
- All clients with histologically diagnosed cervical cancer must undergo staging before any treatment is initiated

O2.6.2 Breast cancer

This Section should be read with the Breast Cancer Prevention and Control Policy[38]

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

- Perform a clinical breast examination on all clients with breast symptoms, and refer immediately to a designated specialised breast unit as per protocol[38]
- Diagnose all eligible patients using triple assessment (clinical examination, imaging and histological confirmation), followed by staging and referral to appropriate services
- All clients with early breast cancer should undergo breast cancer surgery, mastectomy (with or without reconstruction), or treatment to obtain cancer clearance from the breast at an appropriate facility including access to life saving treatment such as Herceptin for those who qulify for such treatment.
- Palliative care services should be available to every eligible patient (Stage 4 disease) and involved early in their care
- All clients should receive an appropriate cost-effective strategy for follow-up

4.2.7 O2.7 Ensure SRH well-being of clients after child-bearing age, during and after menopause

This section references the Primary Care 101: Symptom-based integrated approach to the adult in primary care[55]

For clients older than 35 years:

- If younger than 50 years continue contraception for 2 years after last period
- Take a medical history at every visit and perform general breast and gynaecological examinations at first visit and when due according to guidelines[38, 39, 66]
- Order special investigations, if indicated, for example bleeding between periods or after sex
- Initiate hormone replacement therapy (HRT) for proven indications, provided there are no contraindications, and individualise according to each client's needs
- Inform clients of all risks and benefits regarding HRT[56]
- Advise on lifestyle modifications such as cessation of smoking, adjustment of diet, maintenance of a healthy weight, adequate exercise and stress control
- Provide psychosocial support if necessary

4.2.8 O2.8 Provide occupational and non-occupational PEP to clients at risk of HIV, STIs, pregnancy, Hepatitis B and C, and Tetanus

This Section should be read with the Guideline on Management of PEP in Occupational and Non-occupational Exposures

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

- Provide information, advocacy, and social mobilisation on PEP
- Provide appropriate counselling and psychosocial support
- Supply comprehensive PEP services including referral at all health facilities
- Recognise the additional needs of children and people with disabilities
- Identify possible abuse and protection from ongoing abuse
- Adhere to medico-legal responsibilities, if indicated
- Record, monitor, and evaluate all incidents of potential exposure

O2.8.1 Occupational exposure

- Provide comprehensive PEP services to all healthcare providers exposed to body fluids, semen and vaginal secretions through percutaneous injury, or contact of mucous membranes or non-intact skin
- All employers to enforce and all employees to practice Universal Precautions to prevent exposure

O2.82 Non-Occupational exposure

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

4.2.9 Objective Two Policy Statements: Provision of Quality, Comprehensive SRH services

Policy statement 2.1: The package of services must be aligned to the level of care and must include access to elements of services that are available through inter-facility transfers or referral

Policy statement 2.2: Provision of contraception services must be guided by the principle of informed choice, non-coersion, and availability of a varied method mix

Policy statement 2.3: Pregnancy testing should be available in all facilities, and is not limited to dipstick testing but also includes clinical examination, laboratory testing, and sonography as required

Policy statement 2.4: Multiple contraceptive methods, including sterilisation, must be offered to meet the individual needs of clients

Policy statement 2.5: Encourage all sexually active clients to practice dual protection—contraception plus HIV and STI prevention.

Policy statement 2.6: Emergency contraception shall be made available to all women needing or requesting it

Policy statement 2.7: Childbearing decisions are the right of the client, irrespective of HIV status, and service providers must not interfere with those decisions

Policy statement 2.8: Health care providers must provide appropriate guidance about safe conception to clients in HIV serodiscordant relationships planning pregnancy

Policy statement 2.9: Services for infertility management are provided at the tertiary level and are not included in the free service for maternal and child care package

Policy statement 2.10: No health care worker has the right to refuse a client access to abortion services, directly or indirectly, by not providing information about the facilities or providers where abortions services are available or by providing erroneous information

Policy statement 2.11: No health worker can deny abortion or post-abortion services to any client in an emergency situation

Policy statement 2.12: Lifelong ART is recommended for all adults and children from the time their HIV-positive status is known

Policy statement 2.13: The HPV vaccine must be offered to all girls aged nine to 12 years, as primary prevention of cervical cancer

Policy statement 2.14: Secondary cervical cancer prevention, screening and treatment of cervical lesions, is a national priority and must be offered by the public healthcare system free of charge to all eligible clients

Policy statement 2.15: All clients attending PHC clinics will be taught breast self-examination and given printed educational material, while female clients over 40 years attending a PHC clinic will have clinical breast examination as well

Policy statement 2.16: The menopausal transition must be utilised as a window of opportunity to assess and manage specific SRH and general health matters

Policy statement 2.17: The comprehensive Post Exposure Prophylaxis for HIV, PEP, and package should be available at all levels of care

4.3 Objective 3: Ensure access to respectful and non-judgemental SRHR services for priority groups

People who do not fit gender stereotypes, people living with HIV, adolescent girls, sex workers, and LGBTI+ people (priority groups) experience unique barriers to accessing services and may require additional services tailored to their needs (See Table 8).

4.3.1 O3.1 Adolescents and young people

This Section should be read with the National Adolescent Sexual and Reproductive Health and Rights Framework Strategy,[37] the National Adolescent and Youth Health Policy,[21] and the Department Basic Education HIV, STIs and TB Policy[32]

Adolescents, especially girls, are a key population for nearly all SRH services, including prevetnion, detection and treatment of HIV and other STIs.[15] Adolescents and young people must have access to youth-friendly services and school-based services, including comprehensive sexuality education, the prevention of unwanted pregnancies and risks associated with teen pregnancy, prevention of HIV and other STIs, and access to safe abortion.[15, 32]

Facilities should remove barriers to accessing SRH services by:

- Refraining from moral judgement and discrimination by health workers
- Welcoming adolescents to access SRHR services and information
- Promoting personal choice in decisions guided by friendly, non-judgemental and empathetic health-, social- and community workers with the support of family

Priority groups:

- *Adolescents and young people (10-24 years)*
- *LGBTI people*
- *Sex workers*
- *People with disabilities*
- *Migrants*
- *Male partners of women*

- Challenging taboos, myths, misperceptions, stereotyping and discrimination on sexuality, cultural and traditional practices as well as against certain groupings in a positive manner and with fact and openness
- Informing adolescents on risky sexual behaviours, such as early sexual debut, intergenerational sex and multiple concurrent partners, often driven by patriarchal gender norms and poverty

4.3.2 O3.2 LGBTI+ people

This Section should be read with the South African National LGBTI HIV Plan, 2017-2022[24]

Although there are many differences between the groups, and further variation within subgroups, LGBTI+ persons share common challenges.

Facilities should remove barriers to accessing SRH services by:

- Addressing negative staff attitudes
- Sensitising staff on stereotypical assumptions about the needs of LGBTI persons
- Training staff on required knowledge and skills to provide quality SRHR care appropriate to the needs of respective groups
- Providing psychosocial support for mental health problems, alcohol, and substance abuse

4.3.3 O3.3 Female Sex workers

This Section should be read with the South African National Sex Worker HIV Plan, 2016-2019[23]

Female sex workers are particularly vulnerable to HIV and other STIs. They are exposed to many human rights violations that limit their access to good SRHR interventions, including criminalisation.[57, 58]

Facilities should remove barriers to accessing SRH services by:

- Ensuring access and referral to support services for mental health problems, social grants, substance and alcohol use, and legal support
- Providing support for sexual-, verbal-, and gender-based violence
- Adapting facility opening hours and modes of delivery to suit sex workers
- Sensitising staff to the needs of sex workers
- Providing the comprehensive package of services described in South African national sex worker HIV plan[23]

4.3.4 O3.4 People living with disabilities

People living with disabilities are anunderserved population subjected to harmful stereotypes and myths. They have similar SRH needs as able-bodied people; however, they are much more likely to be victims of physical and sexual abuse and rape, even by their caretakers in some situations. They are also more likely to be subjected to forced or coerced procedures, such as sterilisation, abortion, and contraception.[1, 59]

Facilities should remove barriers to accessing SRH services by:[60]

- Informational access, for example the availability of information in a range of formats including sign language and braille
- Physical access comprising the distance between the facility and users' homes, transport, the structure of entrances/exits, passages, and structures within the facility buildings
- Financial access comprising the cost of the health service to an individual, including the hidden cost of transportation and loss of income when going to the health facility

To ensure people living with disabilities have access to comprehensive SRHR, all facilities:[46]

- Are accessible for people in wheelchairs
- Provide a toilet with wheelchair access indicated by a pictogram
- Fast track people living with disabilities

4.3.5 O3.5 Migrants and asylum seekers

SRHR needs are heightened for displaced people and refugees.[1] All migrants and asylum seekers should receive SRH services, with full respect for the client rights:

- Provide information on contraceptive options, HIV and STI prevention, detection and treatment, abortion, emergency contraception, PMTCT, and antenatal and postnatal services in South Africa. Information is available in a range of languages, including South African languages. Where necessary a translator (trained in correct translation and in confidentiality) is engaged for non-

English speakers. In the context of SRHR, translators should preferably be the same gender as the client.

- Provide specialist referral services where clinic staff do not have the required skills (for example to provide services for women who have a subdermal implant from their home country). Implement a referral system and training programme for staff.
- Provide all HIV services, including HTS, initiation onto ART; PMTCT; and PEP, where indicated. For some cross-border migrants this may require the switching of ART regimens. In such cases, national ART guidelines should be followed.[28] Pregnant women on PMTCT should be encouraged to delay moving away from the area so they can complete PMTCT treatment with continuity of care and in the case there is no PMTCT programme where they plan to move.[28] Thereafter, clear referral direction, documentation and letters should be provided.
- Issue clients with 'health passports' where information about all contraceptive methods being used, treatment and testing are recorded. Encourage clients to keep these health passports with them and to make a note and memorise all contraceptive methods, medication and the doses thereof, in case they need to move to another location and/or lose their health passport (or other records). Encourage clients to come to the clinic before they relocate and provide sufficient treatment and a referral letter for their next health facility.
- Encourage informed decision-making and provide choice in contraception methods. Methods provided should take into account the client's risk, mobility, and fertility plans for the future.
- Some migrant groups are more vulnerable to violence, sexual assault and exploitation. The provision of additional counselling may be necessary, given the trauma experienced by some migrants. Such trauma may relate to circumstances and experiences in their home country and during their journey to South Africa, as well as the particular vulnerabilities to which they may be exposed, such as rape, bribes, sexual exploitation and abuse. As with all clients, post-rape management should include PEP, STI management and emergency contraception. Provide.

4.3.6 O3.6 Partner and male involvement

Partners of clients and men account for half of the reproductive-age population but are often reluctant to seek care at health facilities that cater primarily to pregnant clients and their infants, leaving them underserved and inhibiting them from playing a greater role in supporting sexual and reproductive health.[1] Men play a key role in bringing about gender equality since, in most societies, men exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of families to the policy and programme decisions taken at all levels of government.[33] Despite, most awareness and implementation efforts related to SRHR and HIV prevention disregard the cultural and gender norms that may affect a client's decision-making regarding SRHR issues. Partners often lack information to support their spouses' SRHR decisions and the roles they might play in promoting overall family health. Increased knowledge will also increase partner access to and utilisation of HIV and other SRHR services.

O3.6.1 Promoting SRHR services to males and male partners

Male and male partner involvement provides an opportunity to offer SRHR services to men.[51, 68] Facilities must promote partner and male involvement by:

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

4.3.7 Objective Three Policy Statements: Equity, non-discrimination and inclusivity

Policy statement 3.1: All clients must be treated equally and in a prompt fashion regardless of age, ethnicity, socioeconomic, marital status or similar characteristic,

Policy Statement 3.2: Adolescents, including disabled, male and rural clients should be provided with comprehensive sexuality education and SRHR services including gender based and sexual violence prevention and treatment, in non-judgemental, accessible environments

Policy statement 3.2: Five interlinked peer-led service packages shall be implemented to serve the needs of LGBTI groups in the areas of health; empowerment; psychosocial services; human rights, and strategic information as outlined in the National LGBTI HIV Plan

Policy statement 3.3: Six interlinked peer-led packages related to health, social, legal, human rights, social capital, and economic empowerment services addressing the needs of sex workers, shall be implemented as outlined in The National Sex Worker HIV Plan

Policy statement 3.4: In implementing partner involvement, a client centred approach must be adopted that does not limit engagement to legally defined groups such husband and wife

Policy statement 3.5: Individuals and couples should be empowered to decide freely and responsibly the number, spacing and timing of children and be provided the means to do so without coercion

Policy statement 3.6: Health workers are entitled to their own opinions on abortion, but as providers in the public sector, those personal beliefs should never be used to obstruct access to safe abortion for those requesting and needing it.

4.4 Objective 4: Strengthen the health system to deliver integrated SRHR services at the lowest feasible level in the health care system

This section should be read with the Ideal Clinic Manual,[46] the Integrated Clinical Services Management Manual,[47] and the Primary Healthcare Laboratory Handbook[61]

The success of South Africa's NHI will depend on a well functioning primary health care system. Community based services must be complimented by primary health care facilities that provide equitable access to South Africans, prioritising health services to those most in need. To achieve optimal primary healthcare delivery, the National Department of Health initiated the Ideal Clinic Programme, which outlines systematic preparation of optimal conditions to provide quality, integrated services.[46]

4.4.1 O4.1 Integrated service delivery: Provide quality integrated SRHR services at PHC level, or lowest level possible

This section should be read with the Ideal Clinic Manual,[46] National Guideline to Manage Complaints, Compliments and Suggestions in the Public Health Sector of South Africa[62] and the National Policy of Patient Waiting Time in Outpatient Departments[63]

O4.1.1 Service integration

4.4.1.1 Deliver integrated services within the district health system:

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

4.4.1.2 Provide integrated SRH services within a single facility:

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

- Organise all planned streams of care efficiently
- Use a functional patient appointment system
- Ensure each client has only 1 file across their lifespan
- Ensure that linkages between facilities provide all elements of the SRH service package
- Establish referral paths for services not available

O4.1.2 Quality of care

Ensure Quality of care (QOC) in delivering SRH services:

- Regular clinical audits are conducted (See Clinical Audit Guideline).[46]
- Respectful treatment by technically competent providers
- Improved informed choice and empowered individuals and couples make choices in line with their SRH needs
- Client are satisfied with SRHR services
- Clients can complain about the services they receive, to have complaints investigated and receive a full response on investigations.[76]

4.4.2 O4.2 Supply chain: Ensure uninterrupted supply of SRH commodities and drugs

"A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use." [9]

Looking at the value chain for commodities, this objective would be fulfinned through a clear coordination framework between the suppliers, the reguilatory pathwatys withion SAHPRA and the distribution systems to a facility and eventually to a client level. Building upon existing ysstems syuch as the CMMDD program, commodities could equally be distributed through the same mechanism. The following activities need to be accelerated:

Build capacity of responsible health workers to ensure efficient forecasting and procurement of essential SRHR commodities

- Develop and implement systems to ensure joint planning, procurement and supply chains for essential SRH commodities
- Develop an efficient procurement, distribution and supply chain management system to enable consistent and regular provision of essential SRHR commodities
- Prevent stock outs and ensure that SRH drugs and commodities are always in stock
- Pre-pack chronic prescriptions and keep buffer stock of medicines and supplies to pre-empt stock outs
- Include surgical equipment in SRH commodity supply chains to ensure that adequate equipment is available and that updated clinical techniques are used

4.4.3 O4.3 Skilled workforce: Ensure healthcare providers have the skills and knowledge to deliver integrated SRHR services

Health workers benefit from continuing education and competency improvement; training and capacity building to ensure adequate knowledge, attitude and skills to provide holistic, quality SRHR services, must be offered according to the staff category's scope of practice, current skills, and the level of care permitted at their home facility:

> *"A well-performing health workforce is one which works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances, i.e. there are sufficient numbers and mix of staff, fairly distributed; they are competent, responsive and productive."* [8]

- Develop a national core curriculum, in line with the SRHR Policy, to provide the basis for all institutions providing training, including universities, Further Education and Training institutions, nursing colleges, provincial training units, non-governmental organisations, and other organisations that provide SRHR training.
- Update the curriculum every five years and include new research findings as addendums to the curriculum in-between the revisions
- Develop a package of in-service- and post-qualification/advanced training for the following categories of health professionals: doctors (including specialists with obstetrics/gynaecology training), medical officers, public health practitioners, midwives, nurses, and pharmacists
- Strengthen collaboration and liaison with regional training centres

- Develop an agreed package of in-service training for the following non-medical staff: social workers, health promoters, HIV support personnel (such as HTS counsellors, ART adherence counsellors), community health and outreach workers
- Develop provider or supervisor job aids and distribute at all points of care to standardise policy implementation
- Include a rights-based approach into curricula and training with emphasis on improved access and integrated care

4.4.4 O4.4 Strategic information generation and usage: Maximise the use of programmatic data and research to increase impact

South Africa has a range of information, review, and monitoring systems in place, including routinised public health monitoring and evaluation activities; a variety of robust surveillance activities and rigorous epidemiologic, laboratory and programmatic research.[15] To improve the ability to fully leverage this capability for progress against targets, improve programmes over time, maximise efficiencies, and close research gaps, the following are necessary:

> *"A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status."* [8]

O4.4.1 Optimise routinely collected data to improve planning and management

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

- Review indicators and reporting tools to ensure the correct aspects of implementation are measured
- Disaggregate data collection by age, gender and priority populations
- Identify service access gaps and outcomes and report on these indicators
- Revise, adapt or develop tools and standard operating procedures for quality assurance in the provision of comprehensive integrated SRHR services
- Revise or develop single or linked registers and tools for integrated SRHR services to facilitate recording, monitoring and reporting of integration indicators

O4.4.2 Monitor and evaluate implementation and outcomes of the SRHR Policy

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

- Develop an M&E framework to track progress against targets
- Establish efficient mechanisms to collate, analyse and use the routine data collected (through the District Health Information System) for responsive programming at the provincial, district and sub-district level
- Disseminate data to policy-makers and service providers

O4.4.3 Strengthen surveillance and research activities for improved efficiency and impact

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

- Include SRHR Policy indicators in routine surveys
- Identify research questions aimed at improving SRHR outcomes
- Integrate SRHR research questions into the national research agenda
- Develop systems for the documentation and sharing of best practices on SRH and HIV integration

4.4.5 O4.5 Financing of SRHR services: Mobilise resources and maximise efficiencies to support the achievement of the SRHR Policy Goal

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

> *"A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them."* [8]

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

4.4.6 O4.6 Leadership and governance for commodity security: Promote strong leadership and management to enforce and implement the SRHR Policy

O4.6.1 National and provincial levels:

- At a national and provincial level, implementation of integrated services is supported by an enabling environment, which includes strong political support as this policy espouses the principles of the National Development Plan. Leadership is needed to ensure scopes of practice are aligned with the goals of this policy, that the regulatory pathways that anchor a successful program such as the South African Health Products Regulatory Authority (SAHPRA) are efficient and that eeffective

> *"Leadership and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, the provision of appropriate regulations and incentives, attention to system-design, and accountability."*[8]

tendering, procurement and supply systems are established through visionary leadership. Leadersip is also necessary at various other levels

O4.6.2 Facility level:

Implementation of the SRHR policy requires leadership, management, and accountability at all facilities, including: [64]

- Facility managers monitor current caseload frequently and remain alert to developments that could affect waiting times
- Clients presenting for emergency procedures receive care or are referred for services
- Facility managers train staff members on clients' rights to access to SRHR, ensuring availability of sufficient staff for rendering comprehensive SRHR services
- Facility managers match the skills and capacity of the team to implement comprehensive and integrated SRHR and primary healthcare services
- Facility managers create an enabling environment for staff to perform their work responsibilities
- Staff have access to confidential counselling and debriefing, if needed
- Facilities implement the SRHR policy in the context of the health needs of the community and populations served
- Facilities cooperate with schools and school health teams to assist with the removal of health related barriers to learning
- The facility maintains functional home- and community-based services where coordination takes place at district and provincial levels

4.4.7 Objective Four Policy Statements: Strengthening systems and decentralising SRH services

Policy statement 4.1: Ensure all clients, including priority populations, receive integrated services tailored to their needs, and that all clients who need additional support are referred and followed up

Policy statement 4.2: All facilities must adhere to Ideal Clinic standards to ensure all SRHR services are offered, effective referral networks and practices are in place, adequate transport between levels of care are available, and co-ordination between the units within hospitals and other larger referral facilities are functional

Policy statement 4.4: Every effort shall be made to implement effective infection control systems throughout facilities

Policy statement 4.5: The facility manager and /or person in charge of ordering drugs and supplies must deal with the logistics of obtaining necessary equipment and supplies, and supervise its maintenance.

Policy statement 4.6: Staff must receive adequate training in SRHR service delivery and linked to refresher training, debriefing and continuing professional development

Policy statement 4.7: Client data: Facilities must record and report accurate client data in the national health information system. All client data are treated as confidential.

Policy statement 4.8: The SRHR Policy is underpinned by research evidence to guide best practices, policies, and the legal framework for improving SRHR outcomes for all

Policy statement 4.9: Facility managers must ensure that clients have access to all the health services prescribed by South African laws and policies

Policy statement 4.10: Facility managers must plan for comprehensive SRHR services, including effective systems for managing the flow of clients through a facility despite fluctuations in caseload

4.5 Objective 5: Promote multisectoral engagement and shared accountability for a sustainable response

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

4.5.1 O5.1 Strengthen partnerships to enforce and implement the SRHR Policy

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

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

4.5.2 O5.2 Improve collaboration and co-operation between government, civil society, development partners and the private sector

- Establish and strengthen multi-sectoral coordination mechanisms, such as SRH social pacts and structures at all levels, which have clear terms of reference
- Establish, strengthen and coordinate effective and seamless referral systems between government facilities and non-governmental organisations
- Engage the private sector in hybrid service delivery models, for example private general practitioners, clinics, retail and courier pharmacies
- Engage civil society groups and others committed to advancing SRHR to hold governments accountable to their commitments to improve health and to uphold human rights
- Develop strategies, including supportive supervision and mentorship for health workers and other service providers, to ensure quality assurance in the provision of integrated services

4.5.3 O5.3 Strengthen collaboration between and co-ordination of accountable government departments

- Collaborate with the Department of Basic Education for the provision of SRHR services in schools and provision of comprehensive sexuality education
- Collaborate with SASSA and Department of Housing to align policy implementation
- Collaborate with the Department of Justice and police service, such as is the case with Thuthuzela centres for one stop shop for survivors of violence seeking legal and medical attention
- Put in place systems to ensure availability of information and commodities in other government departments, for example condoms and IEC materials
- In collaboration with other stakeholders, develop innovative specific interventions to address economic-related structural factors among priority groups that hinder access to SRHR
- Develop strategies to ensure the involvement of adolescents and youth in the design, implementation, monitoring and evaluation interventions

- Develop strategies that support SRHR programmes in national youth movements and in government departments and units
- Develop strategies and interventions for integration of SRHR and other communicable and non-communicable diseases.

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