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Poverty, Sexual and Reproductive Health and Rights in South Africa

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Outline of the Presentation

- Introduction
  - *Background, objectives and scope*
- State of sexual and reproductive health and rights
  - *Trends, narratives and implications*
- Recommendations
  - *Future considerations and actions for Government and stakeholders*
- Conclusion
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Introduction

- Conclusions from ICPD+20 progress review (2015):
  - Considerable progress has been made in expanding access to health services through strong political leadership and development of policies, guidelines and legislation – but gaps in implementation remain.
  - South Africans still face challenges in accessing comprehensive treatment, prevention and care for STIs including HIV, family planning and contraception, pregnancy, delivery, psychosocial support and counselling.
  - The rights of all South Africans to equal access to health services and life-saving prevention and treatment programmes must be strengthened.

Demographics and SRHR

- Population 2016: 55.6 million.
- Youthful population (median age of 25 and a third under the age of 15 – Census 2011)
- 2017 mid-year population estimates: 51.0% female, increasing life expectancy (females: 66.7 years and males: 61.2 years) and a rising 65+ cohort (8.1%)
- Majority are entering or are already in reproductive ages.
- Must be mindful of the needs for those outside the 15-49 age group. Particularly, pre-adolescence and “near old” (50-59)

SRHR Legislation and Commitments

- Constitution and the country's laws and policies propagate a rights-based framework for SRH.

- Despite full legislative equality and South Africa's pledge to national, regional and global commitments; unbalanced and polarised gendered power relations undermine the advancement of SRHR, more especially for women, adolescents and those at the periphery of society.

State of SRHR in South Africa

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Fertility and Childbearing

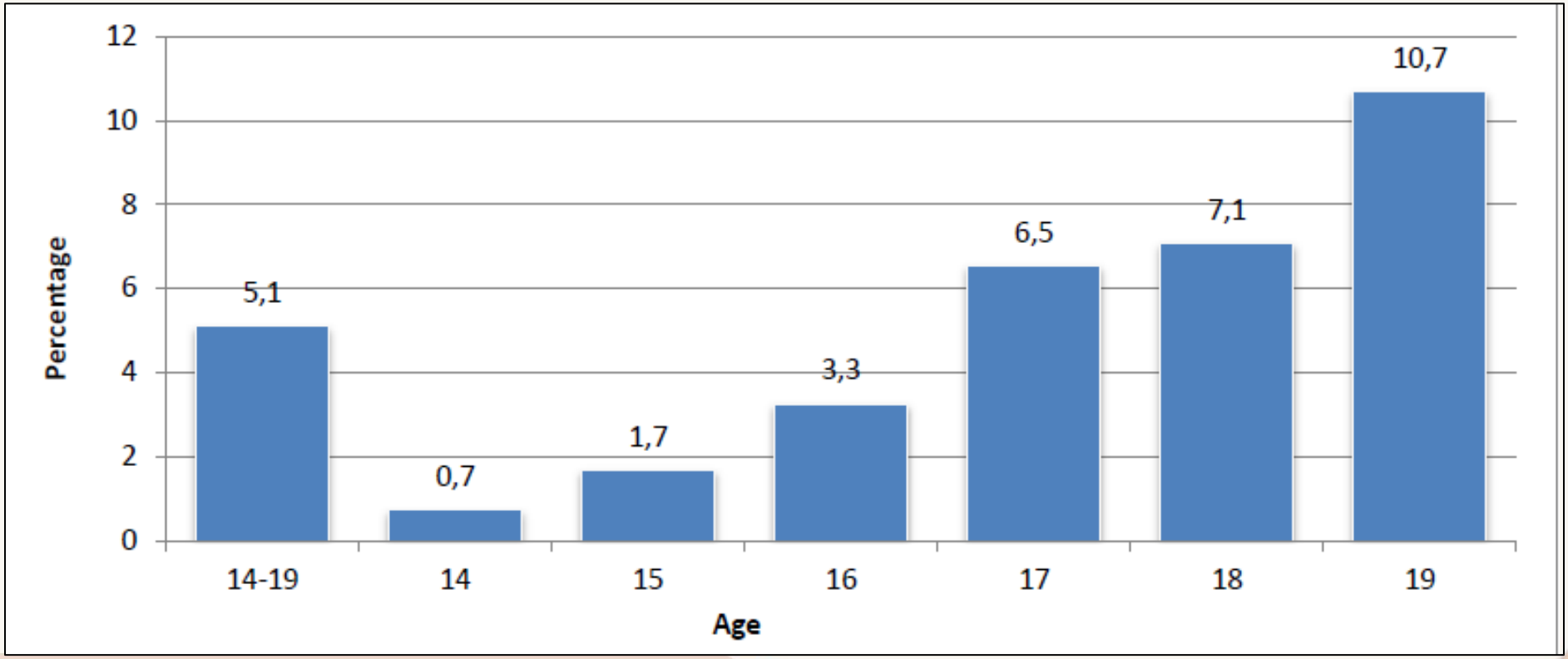
- Decline in fertility rate over time.
- Total Fertility Rate (TFR): 2.6 children in a lifetime (2016 South African Demographic and Health Survey (SADHS).
- Higher TFR was observed for women in non-urban areas (3.1 children per woman) compared to urban women (2.4 children per woman). Also higher for poor and less educated women.
- Age-specific fertility trends were higher in non-urban areas for all age cohorts.
- Increasing median ages of mothers since 2010 (27 in 2015) is indicative of women choosing to have children later in life.

Teenage Fertility and Pregnancy

- South Africa's teenage fertility has been declining for a number of decades.
- The SADHS 2016 reported that 16.0% of women aged 15-19 have initiated childbearing - relatively unchanged since 1998 (16.0%).
- Early childbearing noted among young women in non-urban areas, with either incomplete primary or secondary education and who are poor.
- For male high school learners,15.1% reported to have impregnated someone in the third (2011) National Youth Risk Behaviour Survey (NYRBS).
- Teenage fathers associated with poor economic backgrounds; lower educational attainment and fewer employment opportunities.

Teenage Pregnancy

Fig 1: Percentage of Females Aged 14-19 Who Were Pregnant during the Year Preceding the 2016 GHS



Teenage Pregnancy (DSD, 2017)

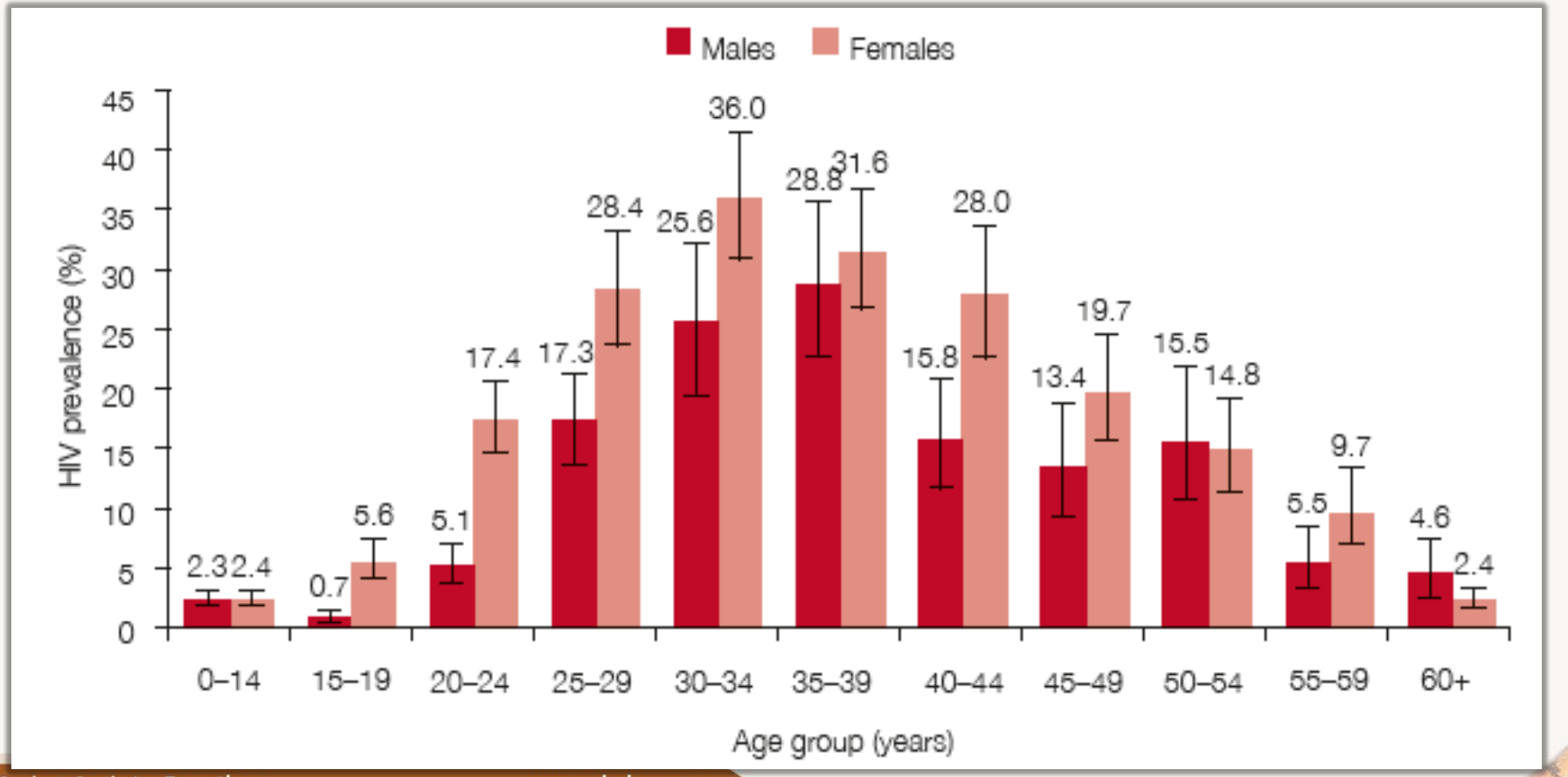
- A substantial percentage of teenage mothers reported that their sexual debut occurred below age 16 (DSD, 2017).
- First sexual partner and the impregnating partner were on average 3 years older than teenage mothers.
- The majority of first sexual partners and impregnating partners were school-going or employed.
- First pregnancies were largely unplanned and unwanted.
- Lesser proportions of teenage mothers wanted the pregnancy although the study showed in part, willful paternity.
- Other findings reveal that 95.3% of teenage mothers report having had only one pregnancy.
- Many factors associated with TP, which combine in different ways in different parts of the country.

Family Planning

- SADHS 2016 - 55.0% of currently married women are using some method of family planning, and 54% reported using a modern method. Amongst married women, the most popular contraceptive choices are injectables (24.0%), male condom (9.0%) and female sterilisation (8.0%)
- 2016 SADHS - 64.0% of currently unmarried sexually active women reported using a contraceptive method; with most using a modern method. Preference for method is varied with the most popular being injectables (26%); male condom (24.0%), the contraceptive pill (5.0%) and implants (5.0%).
- Contraceptive Prevalence Rate (CPR) amongst married women has remained relatively unchanged (1998 vs 2016)

HIV Prevalence

Fig 4: HIV Prevalence by Age and Sex (Shisana et al, 2014)



Abortion

- Since the CToP Act (1995) there has been a decline in abortion related morbidity and mortality in South Africa.
- DHIS reported that 52 172 abortions were performed in 2000. Ten years later this increased to 71 548 and in 2015 this figure was 84 220 (Day and Gray, 2017).
- Possible increased uptake of abortion services but also improved reporting of cases by service providers through the DHIS system.
- Nevertheless, these statistics are only reflective of abortions in public health facilities.

Access to Safe Abortion

- Needless unsafe abortion and related injuries and mortalities occurring outside public health facilities (not referring to designated private facilities) have not been eradicated.
- Major barriers still exist for women, especially younger women to access the service.
- Some of these barriers include provider opposition or sometimes referred to “conscientious objection”, stigma associated with abortion, poor knowledge of the CToPA, lack of providers trained to perform the procedure as well as well-equipped facilities designated to provide abortion services especially in outlying, rural areas.

Access to Safe Abortion

- Amnesty International's 2017 report on barriers to safe and legal abortion in South Africa (based on data from Department of Health) revealed that only 264 out of 505 designated health facilities were providing first and second trimester abortion services
- Access to safe abortion (both medical and surgical) in rural areas is severely compromised due to disparities in access to medicines for safe abortions provincially, large distances to facilities and the high cost of transport borne by patients to reach them (Amnesty International, 2017).
- No referral of patient in cases of "conscientious objection". Inconsistent application, no formalisation of protocol.

SRHR and Persons with Disabilities

- The Census 2011 estimated South Africa's disability prevalence at 7.5% (aligned to the domains used to measure disability)
- Prevalent assumption that people with disabilities are 'asexual'.
- Disability predisposes them to increased vulnerability and exploitation where their well-being and safely is greatly compromised.
- Several sources of mainstream research exclude persons with disabilities as a respondent group – great void and a policy and planning 'blind spot'.

Maternal Health Care

- Maternal mortality remains one of South Africa's major population concerns.
- At the culmination of South Africa's MDG reporting process, the country achieved its target for antenatal coverage as early as 2011.
- By 2010, South Africa noted that 94.2% of births was attended by a skilled professional and almost universal in 2016.
- Recent data from the 2016 SADHS show that 76% of women attended an antenatal clinic four or more times
- 84% of women with a live birth in the past 2 years received a postnatal check during the first 2 days after birth.

Maternal Mortality

- Findings from the latest enquiry into maternal deaths for the period 2011-2013 reveal that there were 4452 maternal deaths in 2014.
- The Institutional Maternal Mortality Ratio (iMMR) decreased from 176.22 per 100 000 live births in 2008-2010 to an iMMR of 154.06 per 100 000 live births in 2011-2013 (a 12.6% decrease).
- The top three causes of maternal death (non-pregnancy related infections, obstetric haemorrhage and hypertension) accounted for just more than two thirds of all (avoidable) maternal deaths.

Migrants and Emergency Situations

- The South African Constitution guarantees the right of access to health care and essential services for migrants and people in emergency situations such as refugees.
- Access to public sector health care for individuals without a South African identity document is often challenging.
- Existing legal frameworks and policies that ensure the right to HIV prevention, treatment, care and support services for all migrant groups need to be effectively implemented.
- There is a great need to include migration health on to the public health agenda.

Sexual Orientation

- Often persons with different sexual orientation and gender identity are lumped together and treated as a homogenous group when in fact there are multiple diversities present.
- Despite variances, experiences of social isolation and stigma are a common denominator and unifying factor.
- Sexual violence and rape are key issues facing transgender people.
- LGBTQI families - either through adoption, IVF, donor and surrogacy.
- Emphasis is taken away from defining what a family should look like and rather focusing on how people create their own.
- Services should ideally be tailored service to each client, based around their very specific needs.

Recommendations

- Sexual and reproductive justice – core principle.
- Reproductive justice is achieved when “when all people have the social, political and economic power and resources to make healthy decisions about their gender, bodies and sexualities” (DSD, 2015:68).
- Advancing SRHR for people with disabilities.
- Making motherhood safe for all but especially for young mothers; Greater Involvement of family in SRHR of adolescents; Positive Focus on Teenage Fatherhood
- Lifting Societal Barriers around Sexual Orientation.
- Increasing access to safe abortion.

Conclusion

- Mixed success in advancing SRHR
- Whilst some areas are progressive (e.g. access to contraception, safe and legal abortion, stabilising HIV prevalence, increased life expectancy, improved maternal health care); glaring gaps remain.
- These include maternal deaths which were avoidable or prevented by early presentation or detection, HIV incidence especially amongst young females, continued sexual violence against sex workers and LGBTQI community and fragmented efforts or initiatives.
- Overall, gains in SRHR made have not fully filtered to the vulnerable, marginalised, poor women, men, children and youth of the country.