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

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Abstract

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

Introduction

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

Women's sexual and reproductive health and well-being is dependent on a complex array of socio-economic and healthcare factors.[2] Two decades after the advent of democracy, South Africa remains a highly unequal society socio-economically.[3] Black South Africans continue to be economically disadvantaged, with females most disadvantaged: on average, women are 30% poorer than men.[4] Social grants, provided to nearly 17 million people, somewhat ameliorate poverty, with more female than male-headed households (47% vs 14%) surviving on grants.[4] While gender disparity in education and adult illiteracy (<

grade 4 schooling) has decreased and generational levels of schooling completion have increased, this has not translated into increased employment.[5,6] The poor quality of basic and secondary education, and difficulties related to entry and completion of tertiary education [7,8] are contributing to cycles of poverty and inequality in South Africa. The National Development Plan, 2030 (NDP) "aims to eliminate poverty and reduce inequality by 2030"[9] by increasing economic growth, improving education and vocational skills development, with a strong emphasis on youth employment. However, labour stakeholders are ambivalent about the plan, and the misuse of state resources in the form of corruption, coupled with an inability to seal South Africa off from the effects of the global economic downturn, have undermined economic stability, job creation, and essential services delivery.[10]

Similar to other middle-income countries,[11,12] South Africa spends 8% of its gross domestic product (GDP) on health.[13] While 84% of the population relies on public healthcare, only 40% of total healthcare expenditure is in the public sector.[13] In 2016, of a total budget of USD 70 billion, the government allocated USD 109 million to health, lower than in 2014 and 2015.14 The 1996 constitution includes healthcare rights, including SRHR, and commits to free, public primary healthcare.1 The NDP refers to strengthening primary healthcare facilities, improving maternal health and child nutrition.9 In 2011, the government proposed a National Health Insurance scheme (NHI) to increase universal health coverage, with a rollout over[14] years.[15] The NHI is based on healthcare as a public good, aimed at encouraging equity, social solidarity and universal access. It aims to introduce a mandatory prepayment to the scheme through a single NHI fund that incorporates public and private health resources. In 2015, an NHI draft law was published for comment. Criticisms of the current plan include the need to first strengthen the weak public health system; disseminate pilot sites' evaluation evidence to guide planning and implementation; and improve and sustain involvement and consultation of all stakeholders. There should be public involvement of those who stand most to gain from the plan's implementation, who need to participate in developing the "basket of services" that will be offered.[16–18]

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

South African women's sexual and reproductive health status: 2004–2015
Contraception and pregnancy planning
The contraceptive prevalence rate among South African women of reproductive age, last surveyed in 2003, is 65%.[22] However, many women begin contraception late and discontinue use,[23] with 61% of first and 46% of second pregnancies reportedly unintended.[22] Satisfaction with public sector contraceptive services is low among poor

and rural women due to inadequate service availability and access.[21] Teenagers face challenges in accessing public sector contraceptive services due to judgemental attitudes from many healthcare providers for being sexually active.[20] This is despite legislation stipulating that contraception in public health care should be provided free of charge on request to any woman or girl aged 12 years and above.[24] Injectable progesterone-only contraception is the most common modern contraceptive method used (49%), followed by oral contraceptives and male condoms.[25] Female condoms are free, but infrequently promoted.[25] Condom use for pregnancy prevention is uncommon, except among women living with HIV (WLHIV).[25]

In 2012, the National Department of Health (NDoH) published a revised national Fertility Planning Policy, first introduced in 2002. The revised policy underscores the NDoH's commitment to SRHR as a principle underpinning fertility planning.[25] It pays special attention to the specific contraceptive and fertility planning service needs of people living with HIV (PLHIV), sex workers, lesbians, gay, bisexual, transgender and intersex persons (LGBTI), migrants, people with disabilities, and adolescents.[25] It promotes greater male-friendly services to encourage increased men's involvement in pregnancy prevention, traditionally considered women's responsibility.[25] The policy took into consideration the 2012 WHO technical group's guidelines26 in the light of research demonstrating possible negative consequences of hormonal contraception for HIV acquisition, progression and transmission.* It adopted the WHO's recommendation[26] that the use of hormonal contraceptive methods should remain unrestricted for women at risk of HIV or living with HIV, who wish to avoid pregnancy in high HIV prevalence settings; while at the same time strongly promoting dual protection (consistent condom use).[25] The NDoH stated that it would continually review this recommendation in the light of new evidence that may emerge in this regard.[25]

In 2014, the NDoH campaigned to encourage use of other long-acting reversible hormonal contraception, besides hormonal injectable contraception (the etonogestrel contraceptive implant and IUDs), together with condoms for dual protection. However, confusion over guidelines for implant implementation, inadequate piloting, limited human resources and training, and pre-emptive concerns about its perceived lower effectiveness in preventing pregnancy in WLHIV who are on antiretroviral therapy (ART) have contributed to removals of implants and decreased insertions.[28] While promoting client consultation, counselling and services for pregnancy planning for all women and couples wishing to conceive, the policy places specific emphasis on preconception advice and safer conception methods counselling and services for PLHIV wishing to conceive.[25]

Abortion

South Africa's Choice on Termination of Pregnancy (CTOP) Act of 1996 was ground breaking for South African women's SRHR and serves as a model for liberalisation of abortion law globally. Following this Act, abortion-related morbidity and mortality and 2002.[29] Amendments to the CTOP Act were introduced in 2004 and 2008 with the aim of broadening service access. Attempts by anti-choice groups to use the amendment process to curb the original CTOP Act and prevent amendments were unsuccessful.[30]

In 2010, medical abortion with mifepristone and misoprostol was also approved for use up to 63 days gestation. The public provision of medical abortion has expanded, but remains haphazard within different healthcare settings.[31] Policy guidelines are completed in most provinces; however, service provision continues to be predominantly located in centralised facilities. Research has explored strategies to strengthen early identification of unplanned pregnancy and service access, as well as self-management of medical abortion processes.[31]

As a result of these efforts, mid-year estimates for safe abortions have increased from 26,455 for the year from June 1997-May 1998, to 87,035 from June 2004-May 2005 and to 89,126 from June 2014-May 2015.† The abortion rate (induced abortions per 1000 women aged 15–44 per year) has changed from a mid-year estimate of 2.6 for the year from June 1997-May 1998, to 7.6 for June 2004-May 2005 and 6.5 for June 2014-May 15.‡ Although data are incomplete, the figures suggest a stable, even decreasing trend in abortion in recent years. Nevertheless, a South African study of women who had been denied legal, safe abortion services found that 17% had attempted unsafe abortion by unqualified healthcare providers outside of institutional settings.[32] While abortion is legal without age restrictions or caregiver consent, girls and young women reportedly find accessing unsafe abortion outside of institutional settings easier and quicker.[21] Some of the continuing barriers to safe abortion are: abortion-related stigma; delays due to opposition among providers; poor knowledge of the law and available services; shortages of trained providers; providers' conscientious objections; and no mainstreamed nursing and medical school curricula training.[33] While the law has helped to liberalise attitudes to abortion, abortion remains contested by many and the political impetus to realize the full extent of the law has dissipated over the past decade.[33,34]

Maternal Health

Since 1997, maternal mortality is a notifiable condition with a confidential enquiry into maternal deaths every four years.[35] South Africa's Maternal and Child Health Strategic Plan for 2012–2016[36] is aligned with the African and UNFPA Campaign on Accelerated Reduction of Maternal and Child Mortality (CARMMA) which aims to generate political commitment, quality maternal health data and best practices.[37]

The most recent Report of the National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD) for 2011–2013 registered 4,452 maternal deaths in South Africa. The maternal mortality ratio (MMR) decreased from 302 per 100,000 live births in 2009 to 154 in 2013. Despite this progress, South Africa did not meet its MDG 5 target of reducing MMR to 38 per 100,000 by 2015.[38] Five causes contributed to 87% of maternal deaths, with 35% from non-pregnancy related infections, primarily among women living with HIV. Other causes were obstetric haemorrhage (16%); hypertension complications (15%); pre-existing medical and surgical conditions (11%); and pregnancy-related sepsis (9%). The remaining 13% of deaths were attributable to miscarriage, ectopic pregnancy, embolism and acute collapse.[35] The NCCEMD found that 40% of maternal deaths were preventable, with the primary causes linked to healthcare system challenges.

These included inadequate use of healthcare facilities, inadequacy of services and deficient care due to insufficient healthcare provider knowledge and skills (65%).[35]

Although the majority of South African women (88%) have professional attendance during birth, 37 only 40% attend antenatal care before 20 weeks gestation and a minority attend the recommended four antenatal visits.[39] this may impact negatively on maternal morbidity and morbidity. Maternal care disrespect and abuse is another ongoing problem.[40] Lack of privacy, confidentiality, fear of being obligated to test for HIV and difficulties meeting transport costs to healthcare facilities are reported as factors deterring women from accessing maternal healthcare. Inadequate healthcare provider training, leading to sub-optimal standards of care, is further deterring care attendance.[41] New interventions are being sought to reduce the MMR, including through the use of mobile technologies. One example is Mom connect, a mobile phone NDoH national initiative integrated into maternal and child health (MCH) services to improve MCH.

Nationally, teenage pregnancy decreased from 30% in 1984 to 23% in 2008. In addition, teenage births declined, particularly among younger teenagers (17 years or less), with 18–19 year olds comprising the majority of pregnant teenagers.[42] Nevertheless teenage childbearing remains a serious concern, with antenatal care turnout among pregnant teenagers low.[41] In addition, teenage mothers tend to have poorer educational outcomes with potentially negative consequences for their future economic opportunities. It is estimated that 13% of girls leave school due to pregnancy.[42] While unlawful, some girls face discrimination and schooling exclusion due to pregnancy. Despite legal provision for contraception and abortion provision for teenagers, service barriers continue to hamper access. Socio-economic factors underlying teenage pregnancy include differing gendered expectations of girls' and boys' sexual and social roles.[21] With school attendance compulsory until age 15, the 2012 Integrated School Health Policy,[43] if effectively implemented, could act as an important service delivery platform for school-based SRH services.[42] The 2015 National Adolescent Sexual and Reproductive Health and Rights Framework aims to increase stakeholder coordination and information. It includes fostering innovative approaches to comprehensive adolescent rights-based SRH.[44] Greater linkages between clinics and non-governmental organisation (NGO) programmes integrating healthcare and social services and stronger mechanisms for transitioning adolescents from school to adult public healthcare should be prioritised. Out-of-school youth SRHR initiatives are also vital.[45]

HIV

Southern Africa is the epicentre of the HIV epidemic, with an estimated 6.4 million South Africans (12%) living with HIV, more than half female.[46] HIV testing can be legally accessed without caregiver consent from age 12.[24] Preventing new HIV infections is critical to curbing the epidemic. While South Africa's National Integrated Strategy on HIV, STIs and TB, 2012–2016 aimed to reduce HIV incidence by 50%,[47] this goal has not been met and in particular, youth aged 15–24 continue to have high levels of new HIV infections. Young South African women aged 15–19 years bear the greatest burden (64%) of new infections and have an eight-fold higher HIV incidence than similarly aged young

men.[46] In South Africa, the disproportionate burden of HIV on young women, like most other SRH problems, is underpinned by biological, social, behavioural, economic and structural factors, including gender inequity in intimate partner relationships and society. The South African National AIDS Council (SANAC) launched the US government-funded DREAMS campaign to reduce HIV in girls and young women in June 2016. The campaign aims to link problems of HIV, teenage pregnancy, school "drop-outs" and gender-based violence and create economic opportunities for young people. In collaboration with NGOs and communities, it plans outreach to boys and young men and has introduced new types of male condoms to encourage greater use.[48]

Condom use in last sexual activity in the 15-24 age group declined between 2008 and 2010 from 85% to 68% among men and from 67% to 50% among women.[46] Development of female HIV prevention methods, besides female condoms, has lagged behind.[47] Recent clinical trials of a vaginal ring, Dapivirine, showed 60% effectiveness in reducing HIV incidence in women > 25 years.49 This is comparable to the protective effects of medical male circumcision against female-to-male HIV transmission in heterosexual men.[50] Insufficient detection power of Dapivirine's protective effects in women < 21 years, at greatest risk for HIV infection, was due to its inconsistent use.[49] An HIV vaccine as another biomedical strategy for primary prevention of HIV holds promise to curb HIV incidence, but it is unlikely to be realised for a further decade.[51]

Antiretroviral therapy (ART) is also important in decreasing HIV incidence, by reducing viral loads. Most importantly ART promotes healthier and longer lives for PLHIV. HIV "denialism" was an official South African government response to the epidemic from 1999–2008, obstructing access to life-saving ART.[52] As a result, only 25% of South Africans living with HIV were on ART in 2005. Expanded ART access led to 3.2 million people being on treatment by the end of 2015.53 As a result, women's life expectancy rose from 55 years in 2005 to 64 years in 2015, compared to 73 years without AIDS mortality.[53] The introduction of nurse-initiated and managed ART has contributed to the ART expansion and access.54 Fixed-dose, simplified ART regimens and adherence clubs have been shown to promote adherence.[53] In keeping with WHO guidelines, the Minister of Health announced the introduction of immediate ART initiation for those testing HIV positive ("test and treat") in the public health sector from September 2016.[55] The Health Ministry's target is to test and initiate ART treatment upon diagnosis for an additional 300,000 people per annum from this year. Current ART cost to the government is USD 250 per person per annum.[56] While earlier ART initiation for PLHIV has significant positive individual and public health effects, meeting the costs of increased numbers of people on treatment and maintaining high levels of patient adherence to life-long ART and care will be crucial.

HIV testing among women during pregnancy has increased, with more than 98% of women being HIV tested during pregnancy, and 92% of HIV-positive pregnant women receiving treatment. This has resulted in a dramatic reduction in early HIV vertical infant transmission (6 weeks), from 20% a decade ago to a current 2.4%.[39] However, higher vertical HIV transmission rates are observed among teenagers, who experience poorer

access to antenatal care, HIV testing, ART during pregnancy and post-partum infant prophylaxis.[57] Successful PMTCT programmes rely on WLHIV, particularly younger women, having access to ART early in pregnancy, and preferably before becoming pregnant.

ART programmes have emphasised women's use of contraception and PMTCT, with little attention to SRH-HIV service integration.[58] The introduction of universal "test and treat" programmes from September 2016 and the possibility of providing ART pre-exposure prophylaxis (PrEP) to those at high risk of contracting HIV, such as HIV-discordant young couples wishing to have children, hold potential for reducing HIV transmission risks. Effective safer conception methods exist for PLHIV. These include pre-and post-exposure prophylaxis treatment as prevention and "lower-tech" safer conception methods such as timed intercourse and manual self-insemination with an HIV uninfected male partner's sperm.59 Research-supported safer conception services are being successfully provided in Johannesburg, Durban and Cape Town,[60,61] and need to be scaled up.

Breast and cervical cancer

Breast cancer is the commonest cancer among women in South Africa, with an age-standardised incidence rate of 31.4 per 100 000.[62] The majority of patients present with late stage disease which is associated with limited access to healthcare. Screening mammography for the general population in middle-resource countries, such as South Africa, is not recommended as it is not considered cost effective, given other competing healthcare needs.[63] However, a national Breast Cancer Control Policy with interventions for improving awareness and early detection could lead to earlier stage diagnosis and an improved prognosis.[64,65]

Cervical cancer mortality in sub-Saharan Africa is primarily due to poor pre-cancerous cervical screening and early stage cancer diagnosis and treatment.[62] Cervical cancer is the second commonest cancer among South African women and the leading cause of female cancer deaths.[62] HIV positive women are at increased risk of Human Papillomavirus (HPV) infection, cervical precancerous lesions and cervical cancer.[66]

HPV vaccines are highly efficacious and safe for primary prevention of cervical cancer, offering protection against major high-risk HPV types responsible for invasive cervical cancer.[67] An HPV vaccine was introduced in South Africa's public sector in 2014 via the Integrated School Health Program and is offered to all public sector schoolgirls ≥ 9 year) annually. Coverage for the first dose of the vaccine among girls was 87% in 2014.[68]

Secondary prevention through a national Pap-smear screening program that offers three free Pap-smears at 10 yearly intervals, starting at 30 years, was introduced in 2002.[69] Screening coverage increased from 18% in 2003 to 54.5% in 2014, but falls short of the goal set in 2002 of screening 70% of women aged ≥ 30 years within 10 years of the program's introduction. Poor follow-up of patients with abnormal Pap-smears is one of the main implementation challenges.[70] The revision of the policy to include a protocol for WLHIV and newer HPV-based secondary screening tests will be finalised in 2017. Unless

WLHIV are screened and treated for pre-cancerous lesions, the public health benefits of expanding ART will be offset by increased cervical cancer.

Sexual violence

There are approximately 150 rapes reported daily to the police; however, fewer than 30 cases are prosecuted and only 10 convicted.[71] In a study among men in the provinces of Kwazulu-Natal and the Eastern Cape in South Africa, 28% of men reported ever having raped a woman or girl. Most rape perpetrators are known to survivors.72 South African teenagers experience a high incidence of violence in their first sexual encounter.21 Post-apartheid, advocacy has also focused on specific forms of sexual violence, such as ukuthwala – the abduction, forced marriage and rape of young girls – a distortion of a past custom for consenting eloping young adult couples.[73] Advocacy groups highlight the targeted rape of lesbian and transgender women, who do not conform to hegemonic gender norms, as a serious problem.[74]

Policies dealing with sexual violence include the Children's Act No. 38 (2005), the National Sexual Assault Policy on HIV post-exposure prophylaxis (2005), the Sexual Offences Act No. 32 (2007) and its amendment in 2015 and the Victim Empowerment Policy.[75] Police Sexual Offences Units and Sexual Offences courts disbanded in 2011 were reintroduced in 2013. Important civil society initiatives include PREPARE and Skhokho Supporting Success, aimed at intimate partner violence prevention in teenagers; Stepping Stones and Creating Futures, aimed at youth and adults; and IMAGE, aimed at women.[76–79] PREPARE, Stepping Stones and IMAGE evaluations showed short term positive impacts in reduction of men's intimate partner violence.[76,78,79] Thuthuzela centres for rape survivors are public healthcare-based facilities that could serve as models in other contexts.

Conclusions and recommendations

South Africa's 1994 democratic transition provided unique opportunities to address racially-based political, socio-economic and health inequalities. The first five years of democracy demonstrated massive strides in progressive SRHR legislation and policy.[1] While South Africa has retained[1] and expanded its SRHR policies, haphazard implementation has frequently hindered progress.[80] Although there is greater inclusion of South African women in government, it is important to move beyond numerical progress in women occupying official roles, to changing both open and subtle structural patriarchal attitudes and practices.[21] Over the past decade government narratives have increasingly incorporated conservative gender views[21,80] and dominant patriarchal societal gender norms have been difficult to shift.[21]

South Africa shows mixed success over the past decade in advancing measurable SRH social justice outcomes and improving population-based SRHR indicator improvements.[80] Since 2004, South Africa has expanded its progressive safe abortion legislation, dramatically decreased vertical HIV transmission and established the largest ART programme in the world. Progress in curbing the HIV epidemic has increased life expectancy and reduced maternal mortality. The state has maintained and expanded legal

LGBT rights, first recognised in 1994, although social intolerance and discrimination remain. It has strengthened rights-based youth SRH legislation and policies and introduced new progressive sexual offences laws. An HPV vaccine has been introduced successfully for young girls. The state has sustained well-established data collection systems such as the Maternal Death Reviews and a strong civil registration and vital statistics system. These successes have benefited all South African women, albeit practical gains from these advances have been fewer for vulnerable groups such as poor women, teenagers and rural women.

However, twenty-two years after South Africa's first democratic elections, strong collaboration between government and civil society in comprehensive approaches to SRHR, seen immediately post 1994, has decreased.[80] Despite this, NGOs and civil society groupings have played a strong and critical democratic role including in advancing SRHR. "Shadow" civil society reports to international bodies and national advocacy have focused on retaining abortion rights, revising contraceptive guidelines, initiating safer conception services for PLHIV, and promoting youth SRH. These have played an important role in advancing and maintaining SRHR-friendly policies and holding government to account in its implementation of the country's SRHR commitments. While it was critical for the government to focus on HIV over the last decade, a broader SRHR approach has declined, with government and civil society initiatives tending to be localised and fragmented.80 International donors have contributed to fragmented SRH approaches through vertical funding of HIV care and ART programmes. Several broader SRHR NGOs have closed and other long established programmes such as Rape Crisis have faced funding crises and near closure.81 Positive NGO initiatives to address dominant masculinity have emerged and are important, but increases in vertical funding to men's engagement programmes have sometimes led to funding to women-centred approaches diminishing. Building and retaining strong grassroots organisation and mobilisation across constituencies has decreased except in the HIV arena. No similarly broad SRHR body, such as the HIV sector's South African National Aids Council (SANAC), has been established.[81]

The South African constitution commits government to SRHR but, over the past decade, this has only been reflected in practice in its 2012 Contraceptive Planning and Adolescent Sexual and Reproductive Health and Rights policies, where there has been strong civil society involvement. The government has yet to implement evidence-based, sexual violence prevention programmes and the epidemic proportions of sexual violence require redress at a broader societal level.

While SANAC's inclusion of monogamy, condom use and discouraging age-disparate relationships in its campaign[48] could theoretically decrease girls' and young women's HIV risks, similar prior campaigns have not been effective in the absence of active changes in gender power relations and poverty. Promotive and preventive youth SRHR programmes such as Stepping Stones [78] need to be institutionalised.[81] There is a disconnect in youth sexual education through school-based Life Orientation curricula with young people's life experience and a predominantly heteronormative approach that needs to be addressed.

[Editor's note: please see Ngabaza et al in this issue on Life Orientation curricula in South Africa].

A significant proportion of maternal mortality is non-HIV related and health service preventable. While the NHI White Paper mentions maternal health, it needs to clarify specific initiatives and services that will improve women's SRHR.[15,18] Given our progressive abortion legislation, it is of deep concern that some girls and young women report a preference for accessing unsafe abortion outside of institutional settings.[21] This needs further remedial investigation. More updated data is needed on age-disaggregated contraceptive prevalence and on maternal health and abortion outside institutional settings. The 2012 Ministerial Advisory Committee on Cancer Control should accelerate finalising cervical cancer screening policy for WLHIV and introducing improved cervical screening methods.

Alongside its international commitments to SRHR, South Africa's commitments to national statutory institutions such as the Gender Commission and the South African Human Rights Commission need to be upheld and strengthened. Promoting SRHR requires multi-dimensional comprehensive strategies that cut across individual, interpersonal, systems-based, and socio-economic and other structural levels. We need to actively rekindle progressive government, NGO and civil society collaboration[80,81] to meet tangible improvements in all areas of South African women's sexual and reproductive health and rights over the coming decade.

References

1. Cooper D, Morroni C, Orner P, et al. Ten years of democracy in South Africa: documenting transformation in reproductive health policy and status. Reproductive Health Matters, 2004; 24(12):70–85.
2. Channon A, Falkingham J, Matthews Z. Sexual and reproductive health and poverty. In: Malarcher, editor. Social determinants of sexual and reproductive health: informing future research and programme implementation. Geneva: World Health Organisation, 2010. P.75–91.
3. Coovadia H, Jewkes R, Barron P, et al. The health and health system of South Africa: historical roots of current public health challenges. Lancet, 2009; 374: 817–834.
4. Reinhard S, Leibbrandt M, Lam D. Assessing the impact of social grants on inequality: a South African case study. In: Besley, editor. Contemporary Issues in Development Economics. London: Palgrave Macmillan, 2015. p.112.
5. Lustig N. The Redistributive Impact of Government Spending on Education and Health: Evidence from Thirteen Developing Countries in the Commitment to Equity Project. March 2015:1–35.
6. Graham L, Mlatsheni C. Youth unemployment in South Africa: Understanding the challenge and working on solutions. In: De Lannoy, Swartz, Lake, et al, editors. South African Child Gauge 2015. Cape Town: Children's Institute, University of Cape Town, 2015. p.51–59. ISBN: 978-0-7992-2525-9.
7. De Lannoy, Swartz, Lake, et al, editors. South African Child Gauge 2015. Cape Town: Children's Institute, University of Cape Town, 2015. p.60–68. ISBN: 978-0-7992-2525-9.
8. Branson B, Clare Hofmeyr C, Papier J, et al. In: De Lannoy, Swartz, Lake, et al, editor. South African Child Gauge 2015. Cape Town: Children's Institute, University of Cape Town, 2015. p.42–50. ISBN: 978-0-7992-2525-9.
9. Republic of South Africa. Our Future Make it Work. The National Development Plan, 2011. (At http://www.gov.za/ issues/national-development-plan-2030).
10. Seekings J, Nattrass N. Policy, Politics and Poverty in South Africa. London: Palgrave Macmillan, 2015.
11. World Bank. Health expenditure. 2014. At. http://www. tradingeconomics.com/botswana/health-expenditure-public-percent-of-government-expenditure-wb-data.html.
12. World Bank. Health expenditure. 2013. At. http://www. tradingeconomics.com/brazil/health-expenditure-public-percent-of-government-expenditure-wb-data. html.
13. Ataguba JE, Akazili J, McIntyre D. Socioeconomic-related health inequality in South Africa: evidence from general household surveys. International Journal for Equity in Health, 2011;10:48.
14. Republic of South Africa. Ministry of Finance. Budget Speech. 2015. At. http://www.treasury.gov.za/documents/ national%20budget/2015/speech/speech.pdf.
15. Republic of South Africa. National Health Insurance in South Africa. Department of Health, 2015. (Policy Paper. At http://www.gov.za/sites/www.gov.za/files/ nationalhealthinsurance.pdf).

16. University of the Western Cape. Comments on White Paper: National Health Insurance of South Africa. Submission. School of Public Health of the University of the Western Cape. May 2016.
17. University of Cape Town. Comments on the White Paper: National Health Insurance for South Africa: towards Universal Health Coverage, Thursday 10 December 2015 (Version 40) Submission made by the School of Public Health and Family Medicine (SOPH& FM). Faculty of Health Sciences: University of Cape Town, May 2016.
18. Medical Research Council of South Africa. Comments on and Contributions to the White Paper on National Health Insurance (NHI), 11 December 2015. South African Medical Research Council: Health Systems Research Unit, May 2016.
19. United Nations. Millennium Development Goals. At. http://www.un.org/millenniumgoals/. September 2000.
20. United Nations Foundation. Family planning 2020. At. http://www.unfoundation.org/what-we-do/campaigns-and-initiatives/family-planning-2020/?referrer=https:// www.google.co.za/. 2015.
21. Mkhwanazi N. Twenty years of democracy and the politics of reproduction in South Africa. African Identities, 2014; 12(3-4):326–341.
22. Department of Health, Republic Of South Africa. South African Demographic and Health Survey. 2003 Pretoria: Department of Health. At. http://www.mrc.ac.za/bod/sadhs.htm. 2007.
23. Beksinska ME, Rees HV, Smit J. Temporary discontinuation: a compliance issue in injectable users. Contraception November, 2001;64(5):309–313.
24. Republic of South Africa. The Children's Amendment Act, No, 41 of 2007. At. http://www.gov.za/sites/www.gov.za/files/a41-07.pdf. 2007.
25. Republic of South Africa, Department of Health. National contraception and fertility planning policy and service delivery guidelines. A companion to the National Contraception Clinical Guidelines. Pretoria. 2012:1–106.
26. WHO. Hormonal contraception and HIV. Technical Statement. Geneva: World Health Organization, 2012. (At http://www.who.int/reproductivehealth/topics/family_planning/Hormonal_contraception_and_HIV.pdf).
27. Polis CB, Phillips SJ, Hillier SL, et al. Levonorgestrel in contraceptives and multipurpose prevention technologies: does this progestin increase HIV risk or interact with antiretrovirals? Lancet, http://dx.doi.org/10.1097/QAD. 0000000000001229. 2016.
28. Lince-Deroche N, Harries J, Mullick S, et al. Achieving universal access to sexual and reproductive health services: the potential and pitfalls for contraceptive services in South Africa. South African Health Review. Health Systems Trust, 2016:95–105. (At http://www.hst. org.za/publications/south-african-health-review-2016).
29. Dickson KE, Jewkes RK, Brown H, et al. Abortion service provision in South Africa three years after liberalisation of the law. Studies in Family Planning, 2003;34(4):277–284.
30. Trueman K, Magwentshu M. Abortion in a progressive legal environment: the need for vigilance in protecting and promoting access to safe abortion services in South Africa. American Journal of Public Health, 2013;103:397–399.

31. Constant D, de Tolly K, Harries J, et al. Assessment of completion of early medical abortion using a text questionnaire on mobile phones compared to a self-administered paper questionnaire among women attending four clinics, Cape Town, South Africa. Reproductive Health Matters, 2015;22(44 Supplement):83–93.
32. Harries J, Momberg M, Gerdts C, et al. An exploratory study of what happens to women who are denied abortions in a legal setting in South Africa. BMC Reproductive Health, 2015:12:21.
33. Harries J, Cooper D, Strebel A, et al. Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study. BMC Reproductive Health, 16 February 2014;11(1):16.
34. Hodes R. The Culture of Illegal Abortion in South Africa. Journal of Southern African Studies, 2016;42(1):79–93.
35. Republic of South Africa, Department of Health. Saving mothers 2011-2013: sixth report on confidential enquiries into maternal deaths in South Africa. Short Report. At http://www.kznhealth.gov.za/mcwh/Maternal/Saving-Mothers-2011-2013-short-report.pdf. 2014.
36. Republic of South Africa. Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH and Nutrition in South Africa. Department of Health. At https://extranet. who.int/nutrition/gina/en/node/11521At. 2012.
37. Republic of South Africa, Department of Health. Campaign on Accelerated Reduction of Maternal and Child Mortality (CARMMA) to reduce maternal mortality in Africa. 2010: 1–48.
38. Republic of South Africa. Millennium Development Goals Country Report 2015. Statistics South Africa. Pretoria: Statistics South Africa, 2015. (http://www.statssa.gov.za/ MDG/MDG_Country%20Report_Final30Sep2015.pdf).
39. Massyn N, Day C, Dombo M, et al. District health barometer 2012/13. Health Systems Trust: Durban, 2013. (http://www. hst.org.za/publications/district-health-barometer-201213).
40. Chadwick RJ, Cooper D, Harries J. Narratives of distress about birth in South African Public Maternity settings. Midwifery, 2014;30:862–868. (http://dx.doi.org/10.1016/ j.midw.2013.12.014).
41. Amnesty International. Struggle for Maternal Health. Barriers to antenatal care in South Africa. London. 2014. (Index: AFR 53/007/2014).
42. Branson N, Ardington C, Leibbrandt M. Trends in teenage childbearing and schooling outcomes for children born to teens in South Africa. SALDRU: University of Cape Town, 2013. (At http://www.opensaldru.uct.ac.za/bitstream/ handle/11090/614/2013_98.pdf?sequence=1).
43. Republic of South Africa, Department of Education. Integrated school health policy. 2012. At http://www. education.gov.za/Portals/0/Documents/Publications/ INTEGRATED%20SCHOOL%20HEALTH%20POLICYB-W_1.pdf?ver=2015-02-24-152647-000.
44. Republic of South Africa. National Adolescent Sexual and Reproductive Health and Rights Framework Strategy 2014-2019. Department of Social Development. At http:// www.dsd.gov.za/index2.php?option=com_docman&task=doc_view&gid=578&Itemid=39. 2015.

45. Beksinska M, Pillay L, Millford C, et al. Editorials. The sexual and reproductive health needs of youth in South Africa – history in context. South African Medical Journal, 2014;104(10):675–678.
46. Shisana O, Rehle T, Simbayi LC, et al. South African national HIV prevalence, incidence and behaviour survey, 2012. Cape Town: HSRC Press, 2014.
47. Republic of South Africa, Pretoria. National Strategic Plan on HIV, STIs and TB 2012-2016. 2011. 2011:1–86. (At http://sanac.org.za/2013/07/01/the-national-strategic-plan-nsp-2012-2016-in-a-nutshell/?option = com_ docman&task = doc_download&gid = 7&Itemid =).
48. SANAC. Launch of national campaign for young women and girls. At http://sanac.org.za/2016/06/27/launch-of-national-campaign-for-young-women-and-girls/. 27 June 2016.
49. International Partnership for Microbicides. Two large studies show IPM's monthly vaginal ring helps protect women against HIV. 2016. At http://www.ipmglobal.org/publications/two-large-studies-show-ipm%E2%80%99s-monthly-vaginal-ring-helps-protect-women-against-hiv.
50. Auvert B, Taljaard D, Lagarde E, et al. Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 trial. PLoS Medicine, 2005;2(11): 1112–1122.
51. Child K. SA testing HIV vaccine. At http://www.timeslive.co.za/thetimes/2016/03/17/SA-testing-anti-HIV-vaccine.
52. Simelela N, Venter WDF. A brief history of South Africa's response to AIDS. South African Medical Journal, 2014; 104(3)Supplement 1:249–251. http://dx.doi.org/10.7196/SAMJ.7700.
53. Fatti G, Mothibi E, Shaikh N, et al. Improved long-term antiretroviral treatment outcomes amongst patients receiving community-based adherence support in South Africa. AIDS Care, 2016;28(11):1365–1372.
54. Nyasulu JCY, Muchiri E, Mazwi S, et al. NIMART rollout to primary healthcare facilities increases access to antiretrovirals in Johannesburg: An interrupted time series analysis. South African Medical Journal, 2013;103(4):232–236.
55. Health-e news [Internet]. South Africa moves to 'test and treat'. South Africa: Health-e news. Available from:. https://www.health-e.org.za/2016/05/10/south-africa-moves-test-treat/. 2016.
56. Republic of South Africa, Department of National Health. HIV and AIDS 2014/15 data fact sheet. 7th South African AIDS conference. Durban: Kwazulu-Natal, 2015. (At http://www.health-e.org.za/wp-content/uploads/2015/06/2014-15-HIV-Data-Fact-Sheet-01-June-2015.pdf).
57. Fatti G, Shaikh N, Eley B, et al. Adolescent and young pregnant women at increased risk of mother-to-child transmission of HIV and poorer maternal and infant health outcomes: a cohort study at public facilities in the Nelson Mandela Bay Metropolitan district, Eastern Cape South Africa. South African Medical Journal, 2014; 104(12):874–880.
58. Cooper D, Moodley J, Zweigenthal G, et al. Fertility intentions and reproductive health care needs of people living with HIV in Cape Town, South Africa: implications for

integrating reproductive health and HIV care services. AIDS and Behavior, 2009 Jun;13(Suppl 1):38–46.
59. Bekker L-G, Black V, Myer L, et al. Guideline on safer conception in fertile HIV-infected individuals and couples. Southern African Journal of HIV Medicine, 2011;12(2):31–44.
60. Schwartz S, Bassett J, Sanne I, et al. Implementation of a safer conception service for HIV-affected couples in South Africa. AIDS, 2014;28(S277-S85).
61. Matthews LT, Milford C, Kaida A, et al. Lost opportunities to reduce periconception HIV transmission: safer conception counseling by South African providers addresses perinatal but not sexual HIV transmission. Journal of Acquired Immune Deficiency Syndromes, 2014; 67(Suppl 4):S210–S217.
62. National Cancer Registry. Cancer in South Africa. 2011. At http://www.nioh.ac.za/assets/files/NCR 2011_cancer tables(1).pdf.
63. Anderson BO, Cazap E, El Saghir NS, et al. Optimisation of breast cancer management in low-resource and middle-resource countries: executive summary of theBreast Health Global Initiative consensus. The Lancet Oncology, 2010;12(4):387–398.
64. Dickens C, Joffe M, Jacobson J, et al. Stage at breast cancer diagnosis and distance from diagnostic hospital in a periurban setting: A South African public hospital case series of over 1,000 women. International Journal of Cancer, 2014. http://dx.doi.org/10.1002/ijc.28861.
65. Kingham TP, Alatise OI, Vanderpuye V, et al. Treatment of cancer in sub-Saharan Africa. The Lancet Oncology, 2013; 14(4):e158–e167.
66. Moodley JR, Hoffman M, Carrara H, et al. HIV and pre-neoplastic and neoplastic lesions of the cervix in South Africa: a case-control study. BMC Cancer, 2006; 6:135.
67. Lu B, Kumar A, Castellsague X, et al. Efficacy and safety of prophylactic vaccines against cervical HPV infection and diseases among women: a systematic review & meta-analysis. BMC Infectious Diseases, 2011;11(13).
68. World Health Organization. Human papilloma virus (HPV) and cervical cancer. Fact sheet no. 380. Geneva. At http://www.who.int/mediacentre/factsheets/fs380/ en/. 2015.
69. Republic of South Africa, Department of Health. National Guideline for Cervical Cancer Screening Programme. Pretoria: Department of Health, 2002:1–12.
70. Day C, Gray A. Challenges in implementing the policy. Chapter 17 Health and related indicators. South African Health Review, 2014:38–41.
71. Smythe D. Rape Unresolved: Policing Sexual Offences in South Africa Claremont. Cape Town: UCT Press and Juta and Company (Pty) Ltd, 2015.
72. Jewkes R, Sikweyiya Y, Morrell R, et al. Why, when and how men rape? Understanding rape perpetration in South Africa. South African Crime Quarterly, 2010;34.
73. Monyane C. Is Ukuthwala another form of 'Forced Marriage'? South African Review of Sociology, 2013;44: 64–82.J.
74. Anguita l. Tackling corrective rape in South Africa: the engagement between the LGBT CSOs and the NHRIs (CGE and SAHRC) and its role. The International Journal of Human Rights, 2012;16(3):489–516.

75. Ward CL, Arz L, Berg J, et al. Violence, violence prevention, and safety: A research agenda for South Africa. South African Medical Journal, 2012;102:218–224.
76. Mathews C, Eggers M, Townsend L, et al. Effects of PREPARE, a Multi-component, School-Based HIV and Intimate Partner Violence (IPV) Prevention Programme on Adolescent Sexual Risk Behaviour and IPV: ClusterRandomised Controlled Trial. AIDS and Behavior, 2016. http://dx.doi.org/10.1007/s10461-016-1410-1.
77. Jama Shai N, Sikweyiya Y. Programmes for change: Addressing sexual and intimate partner violence in South Africa, SACQ 51: 31. Institute for Security Studies, 2015. (At http://dx.doi.org/10.4314/sacq.v51i1.4).
78. Jewkes R, Nduna M, Levin J, et al. Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial. British Medical Journal, August 7 2008; 337:a506.
79. Kim JC, Watts CH, Hargreaves JR, et al. Understanding the impact of a microfinance based intervention on women's empowerment and the reduction of intimate partner violence in South Africa. American Journal of Public Health, 2007;97(10):1794–1802.
80. Gouws A, Hassim S. Who's afraid of feminism? South African democracy at 20: an introduction: empowering women for gender equity. Agenda, 2014;28(2):4–6.
81. Klugman B. Effective social justice advocacy: a theory-of-change framework for assessing progress. Reproductive Health Matters, 2011;19(38):146–162.

Résumé
Cet article fait suite à une publication de 2004 qui examinait l'introduction de nouvelles lois, politiques et programmes de santé et droits sexuels et génésiques en Afrique du sud, dix ans après l'avènement de la démocratie. Comment 2004, l'article est axé sur les principaux domaines de la santé sexuelle et génésique des femmes: contraception et fécondité, avortement, santé maternelle, VIH, cancer du sein et du col de l'utérus, et violence sexuelle. Au cours de la dernière décennie, l'Afrique du sud a conservé et élargi ses politiques de santé et de droits sexuels et génésiques dans les domaines de l'avortement, de la contraception, des jeunes et du traitement du VIH (avec le plus grand programme de traitement antirétroviral au monde). Il s'agit là d'exemples positifs dans le domaine des politiques de santé et droits sexuels et génésiques. Ces ameliorations incluent un recul des avortements à risque, des décès dus au sida et de la transmission verticale du VIH, de même que l'administration dans le secteur public d'un vaccin contre le papillomavirus humain afin de prévenir le cancer du col de l'utérus. Néanmoins, la persistance des inégalités socio-économiques et de genre continued'influencer profondément la santé et les droits sexuels et génésiques des femmes sud-africaines. L'État affiche des succès nuancés ces vingt dernières années pour relever les résultats mesurables de justice sociale dans le domaine de la santé et des droits sexuels et génésiques, et pour confronter et améliorer les normes sociales qui minent ce secteur.

Resumen
Este artículo es la continuación de un artículo redactado en el año 2004, que revisó la introducción en Sudáfrica de nuevos programas, leyes y políticas de salud y derechos sexuales y reproductivos (SSR y DD. SS. RR.), tras una décadade democracia. De manera similar al artículo de 2004, este artículo se enfoca en las áreas clave de la SSR de las mujeres: anticoncepción y fertilidad, aborto, salud materna, VIH, cáncer del cérvix y de mama, y violencia sexual. En la última década, Sudáfrica ha conservado y ampliado sus políticas referentes a la salud y los derechos sexuales y reproductivos en las áreas de aborto, anticoncepción, juventud y tratamiento del VIH (con el mayor programa de tratamiento antirretroviral del mundo). Estos son ejemplos positivos en el campo de las políticas sobre SSR/DD. SS. RR. Estas mejoras incluyen un menor número de abortos inseguros, muertes por SIDA y transmisión del VIH, así como la provisión pública de una vacuna contra el virus del papiloma humano para prevenir el cáncer cervical. Sin embargo, persistentes inequidades socioeconómicas y desigualdad de género continúan afectando profundamente la SSR/DD. SS. RR. de las mujeres sudafricanas. El estado mues-tra un éxito desigual en las últimas dos décadas en promover resultados mensurables de justicia social en SSR y en confrontar y mejorar las normas sociales
que debilitan la SSR/DD. SS. RR.