social development

Department:
Social Development
REPUBLIC OF SOUTH AFRICA

GOVERNMENT SEXUAL AND REPRODUCTIVE JUSTICE STRATEGY FOR SOUTH AFRICA

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1. Background to the Sexual and Reproductive Justice Strategy

Whilst some individuals can decide freely and enjoy positive and safe relationships, cumulative evidence demonstrates the inequalities, discrimination, stigma, and all forms of violence experienced by many when advocating for their bodies and choices. An enabling political environment and a protective legal framework are key prerequisites for the realisation of sexual rights; however, they are not sufficient on their own. Not only is it crucial that laws and policies are implemented and enforced, which are a challenge on their own, but restrictive social, religious, and cultural values must be countered for the advancement and fulfilment of sexual rights.

Sexual and Reproductive Justice (SRJ) links reproductive rights with the social, political, and economic inequalities that affect an individual's ability to access sexual and reproductive health care services. Thus, it is with this awareness that the National Population Unit (NPU) initiated a wide-reaching effort of mainstreaming SRJ in the government and with its stakeholders.

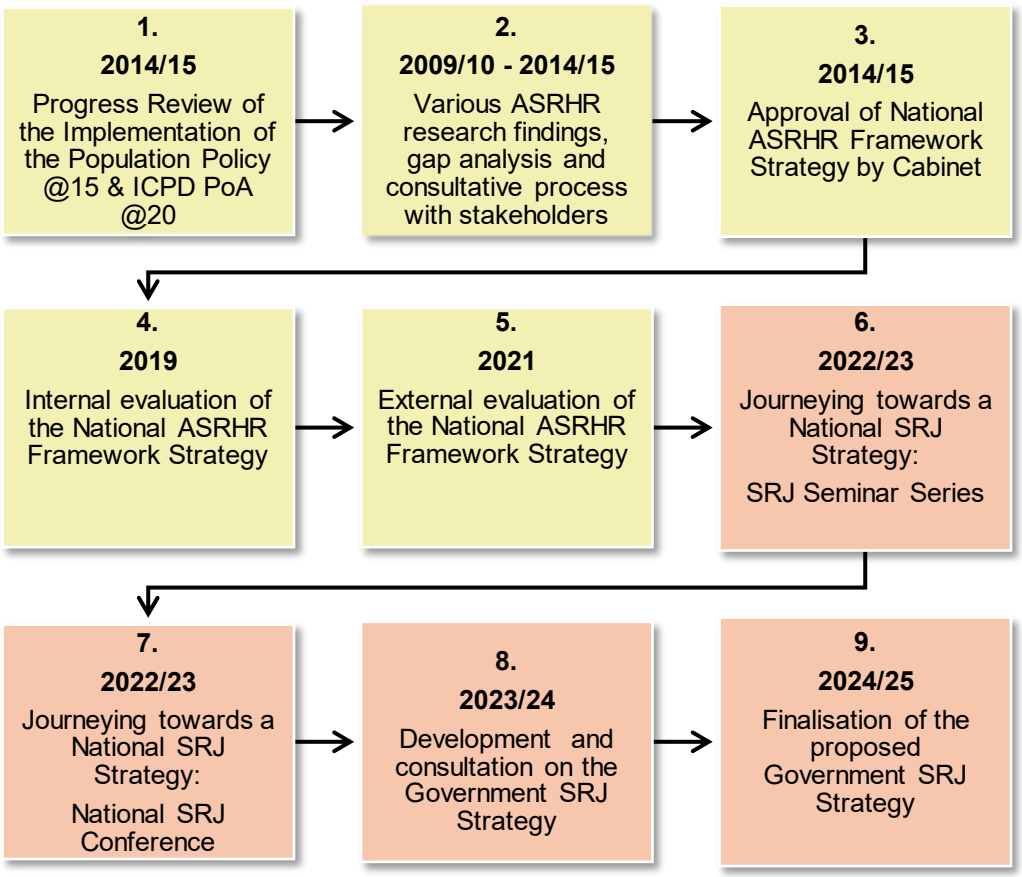
Figure 1 shows the roadmap towards the development of the SRJ Strategy by highlighting the main precursory processes (steps 1 through 5) which shaped the SRHR focus between 2014 and 2021, followed by the formulation (steps 6 through 9) of a National SRJ Strategy for South Africa. The background section briefly outlines these processes to provide contextual grounding for the strategy.

With reference to Figure 1, the Government SRJ Strategy originated from recommendations made in the 2015 Cabinet report on the Fifteen Year Progress Review of the Implementation of the Population Policy for South Africa (1998) and the International Conference on Population and Development (ICPD Programme of Action (1994) @20. The report recommended that South Africa should "approach sexual and reproductive health and rights from an SRJ perspective…" (Department of Social Development, 2015:67). This recommendation underscored the need to address structural and institutional barriers and social inequalities across the multiple ecological layers within which individuals live.

It was also during this time, that the Cabinet approved the National Adolescent Sexual and Reproductive Health and Rights (ASRHR) Framework Strategy. The development of the strategy was driven by findings of the then concluded Department of Social Development's (DSD) mixed-method investigation into 'Factors Associated with Teenage Pregnancy in South Africa". Notable research findings from other Government departments, civil society, academic

and research institutions were also taken into account. In addition, NPU consultations with young people during the early-mid 2010s at various population and development events (most notably annual commemorations of World Population Day) brought to light the current and emergent sexual and reproductive health and rights (SRHR) issues concerning adolescents and young people.

Figure 1: Roadmap to the Development of the Government Sexual and Reproductive Justice Strategy



To understand the vital importance played by the National ASRHR Framework Strategy in the development of the SRJ Strategy, it is essential to briefly dwell on its purpose and lessons learnt from its implementation.

The National ASRHR Framework Strategy (2014-2019) served as an action guide to stakeholders and was underpinned by evidence contained in reports and strategies on various aspects of ASRHR in South Africa. To address these challenges a transversal framework strategy was needed, involving focused interventions by relevant Government departments at

national, provincial and district levels as well as the civil society organisations [1]. As the strategy period drew to a close, valuable lessons and areas for improvement were already identified. These learnings were captured in the form of two evaluations.

Thus, before moving onto writing a new national strategy, gleanings from the two evaluations of the National ASRHR Framework Strategy were considered. These took place in 2019 and in 2021 as shown in **Figure 1**. [2]

Common to both evaluations were the focus on the extent of the effectiveness of the implementation model of the National ASRHR Framework Strategy in delivering on the objectives of the strategy; the overall performance of the implementation of the National ASRHR Framework Strategy; and lessons learned and good practices from the implementation of the strategy. The evaluations also proposed key actions and recommendations that could contribute to the strengthening of ASRHR in the country.[3] Key findings of both evaluations which directly influenced the crafting of the SRJ Strategy are summarised in **Box 1** and **Box 2**.

[1] The National ASRHR Framework Strategy is available online for download. Alternatively, the Population Resource Centre at the National Population Unit can be contacted at +27 12 312 7638 for hard and or electronic copies.
[2] 2019 internal evaluation conducted by NPU. 2021 external evaluation conducted by a service provider (Southern Hemisphere)
[3] The Population Resource Centre at the National Population Unit can be contacted at +27 12 312 7638 for electronic copies for both evaluations.

Box 1: Key Findings from the Internal Evaluation of the National ASRHR Framework Strategy

- The strategy fostered multisectoral collaboration through sharing of ideas, existing resources and best practices.
- Whilst existing resources and budgets from lead departments was used as a good start, specific budget allocations were required to enable full implementation of the initiatives for the strategy. Consequently, the ability of programme staff to dedicate the additional resources needed to optimize the implementation of the strategy and ensure the sustainability of such work was limited.
- Whilst there was commitment and buy-in in principle, commitment by way of actual work done was lacking. Some lead Government departments did not take on their role as envisioned resulting in other stakeholders stepping in to ensure some progress was made on the strategy's objectives.
- The coordination structures and feedback process were not adhered to, making accountability and monitoring a challenge.
- The National ASRHR Framework Strategy had the potential to contribute to better ASRHR outcomes only if the critical implementing partners were willing to take ownership and where budgets were allocated to activities.

Box 2: Key Findings from External Evaluation of the National ASRHR Framework Strategy

- The Strategy was a good tool to convene stakeholders around ASRHR. It enabled improved horizontal coordination, information sharing and collaboration.
- Limited vertical coordination resulted in poor awareness of the strategy in the provinces, and provincial departments were unclear of their roles and expectations.
- There was a monitoring and evaluation plan for the framework strategy, but indicators were not being reported on.
- Interventions were implemented within existing budgets of departments. Limited budget allocation led to poor scale up of promising interventions.
- Sustainability can be improved by having a dedicated budget, clarification of roles and responsibilities of key players, and ensuring buy-in at provincial, district and municipality levels.
- Future ASRHR strategies should be developed in a collaborative way with all stakeholders including youth.
- In order to adhere to the principle of 'leave no-one behind' (a central principle of the 2030 Agenda for Sustainable Development), the strategy should incorporate and broaden the work on gender- based violence and mental health; include a focus on LGBTQI+ and persons with disabilities; and include a focus on addressing issues related to emergency situations and pandemics and its role in preventing SRHR service access for young people, particularly in the context of restrictions and lockdowns.

The National ASRHR Framework Strategy (2014–2019) served as an action guide to stakeholders and was underpinned by evidence from reports and strategies addressing various aspects of ASRHR in South Africa. To address these challenges, a transversal framework strategy was required, involving focused interventions by relevant Government departments at national, provincial, and district levels, as well as civil society organisations.

As the strategy period drew to a close, valuable lessons and areas for improvement were identified and captured through two evaluations conducted in 2019 and 2021.

- Common to both evaluations was an assessment of:
- The effectiveness of the implementation model,
- Overall performance of implementation, and
- Lessons learned and good practices.

These evaluations also proposed key actions to strengthen ASRHR implementation nationally.

Taking both evaluation findings into account, the design of the National SRJ Strategy places particular emphasis on:

- ensuring effective coordination mechanisms,
- securing multisectoral and political buy-in at all levels,
- strengthening cross-sector collaboration,
- adopting inclusive consultative processes,
- securing dedicated or innovative funding approaches, and
- establishing a monitoring and evaluation framework with clearly defined indicators and routine reporting.

The next section of the document concentrates on the second half of the roadmap (steps 6 through 9) shown in **Figure 1** with respect to efforts to frame and mainstream SRJ in the public sector discourse, resulting in the eventual drafting of a National SRJ Strategy.

2. Intersectionality

There are structural barriers that hinder women's and girls' access to sexual and reproductive health and rights information and services. Despite progress made, further work is required to understand how governance structures affect diverse populations and to determine who benefits from — and who is excluded from — policy priorities and resource allocation.

The Government Sexual and Reproductive Justice Strategy adopts an intersectional lens to address the multi-level social locations, forces, and power structures that shape health outcomes and well-being.

Intersectionality therefore requires a conceptual shift in how Government departments, civil society organisations, academia, development partners, and policymakers understand social categories and their interactions.

There are principles that capture the unique nature of intersectionality as a paradigm, and through these principles stakeholders could review and come up with practical possible solutions aligned to priority objectives within the Government Sexual and Reproductive Justice Strategy in response to sexual and reproductive health and rights challenges, including violence against women and girls. These are:

- *Human lives cannot be reduced to single characteristics;* For example, adolescent pregnancy cannot be understood solely as individual behaviour, but must be viewed within wider contexts such as family environments, socio-economic conditions, gender power dynamics, and exposure to violence.

- *Human experiences cannot be accurately understood by prioritising any one single factor or constellation of factors*; For example, prioritizing the use of contraceptives, such as injectables or pills, without considering consistent condom use could lead a girl child to be protected from unintended pregnancy and subsequent adolescent fertility but at risk of contracting STIs, including HIV infection. Therefore, it is critical to advocate for dual protection. Contraceptive use of both injectables or pills together with condoms, to prevent both adolescent fertility and STIs, including HIV infection.

- *Social categories or locations, such as race, ethnicity, gender, class, sexuality and ability, are socially constructed and dynamic*. For example, a white girl child staying and raised in an urban area might benefit from the privileges of access to health facilities. On the other hand, a black girl staying and raised in a rural area may be disadvantaged in terms of easy access to health facilities to access contraceptives and might need transport to reach the nearest health facility. If a black girl child is also coming from a poverty-stricken family, transport money to access contraceptives might not be a priority, instead money could be prioritized to buy food and ensure there is food on the table for the whole family. Thus, in this context, the chances of a rural black girl getting pregnant, contracting HIV infection, and ever giving birth at an early age are higher than that of an urban white girl.

- *Social locations are inseparable and shaped by interacting and mutually constituting social processes and structures, which in turn are shaped by power and influenced by both time and place*; For example, a girl child that attends school in a school where comprehensive sexuality education is provided, as per the school curriculum, and has a qualified teacher

who is passionate to teach the subject, the chances of that girl child becoming a teenage mother are less, as she would be empowered with the correct knowledge on sexuality and would make informed decisions about her life, education and future career and dreams. Therefore, Care and Support for Teaching and Learning (CSTL) would be realized in that school; and

- *The promotion of social justice and equity are paramount.* For example, a girl child who is 16 or 17 years old might be vulnerable to adult predators, who could use power over them and entice them with valuables, such as providing data and cosmetics (including make-up, nails, bonding hair, etc.). This could be worse in situations where such a girl child's self-esteem is low, and they could be blinded and believe that the adult male partner or adult predator is totally and fully in love with them, but unfortunately, could be capitalizing on such a girl child's vulnerability. This could have a negative effect, especially when the "honeymoon" period ends, and a girl child might feel trapped and scared to tell her parents that she benefited, start to blame herself, and might be pregnant because she was told a condom is no longer going to be used in this relationship and later ever given birth, and power relations in terms of intimate partner violence could prevail. Although the age of consent to sexual activity in South Africa is 16 years, children who are 12-15 years are protected by the Criminal Law (Sexual Offences Amendment Act 5 of 2015) only on consensual sex and a two-year age gap amongst them, as per Section 15 and 16 of the Act (UNFPA ESA, 2021). The Act does not provide sufficient protection for 16- and 17-year-olds who are legally able to consent to sexual activity but may still be vulnerable to sexual abuse by adult sexual partners or predators (Setlhago, 2023).

Education is a fundamental driver of social development. It equips individuals with the knowledge and skills needed to participate fully in society, contribute to the economy, and make informed decisions about their health, including their sexual and reproductive health. Education also promotes critical thinking, social awareness, and the ability to navigate societal systems, which are crucial for social mobility and reducing inequalities.

Cultural and societal norms can shape attitudes toward sexual and reproductive health. Cultural practices may marginalize certain genders, sexual orientations, or reproductive choices, hindering access to necessary care or even contributing to gender-based violence.

Health inequalities based on race, class, gender, and geography usually result in unequal access to sexual and reproductive health services. For example, low-income groups, marginalized groups such as women, persons with disabilities, LGBTIQ+ individuals, and those living in rural or impoverished areas may have limited access to essential reproductive health services. Access to safe maternal healthcare is a critical aspect of reproductive justice.

The intersection of race, class, and geography affects maternal health outcomes, with higher maternal mortality ratios among women from low-income communities. Addressing these disparities is key to achieving reproductive justice.

In conclusion, the intersectionality between health, education, and social development emphasizes that these issues are interrelated and must be addressed holistically to create equitable opportunities for individuals and communities to thrive. Efforts in one area, such as improving healthcare access, can have positive ripple effects in education and social development, and it can also address the disparities faced by vulnerable populations. Approaching these issues through an intersectional lens ensures that marginalized communities are not left behind in efforts to promote sexual and reproductive justice.

3. Framing SRJ in South Africa

Reproductive Justice (RJ) is a critical feminist framework that emerged in the United States in the mid-1990s as a response to reproductive politics that focused primarily on abortion rights. RJ was initially defined as “reproductive health integrated into social justice,” using moral, legal, and human rights language. As socio-political contexts evolved, SRHR advocates, civil society organisations, and academics broadened the concept beyond abortion to include sexual rights, gender identity, access to healthcare, and bodily autonomy.

Fundamental to SRJ is its emphasis on intersectionality. This linkage is particularly relevant in the South African context, where structural inequality, social injustice, and unequal access to opportunities continue to shape differing experiences of discrimination and privilege.

Before detailing the SRJ Strategy, it was essential to frame SRJ in a manner that reflects South Africa’s demographic, socio-economic, health, legal, and justice realities. While SRJ is familiar within some academic and advocacy circles, it remains a relatively unfamiliar concept within broader public sector discourse. Consequently, intentional efforts were undertaken to co-create a common understanding of SRJ among stakeholders.

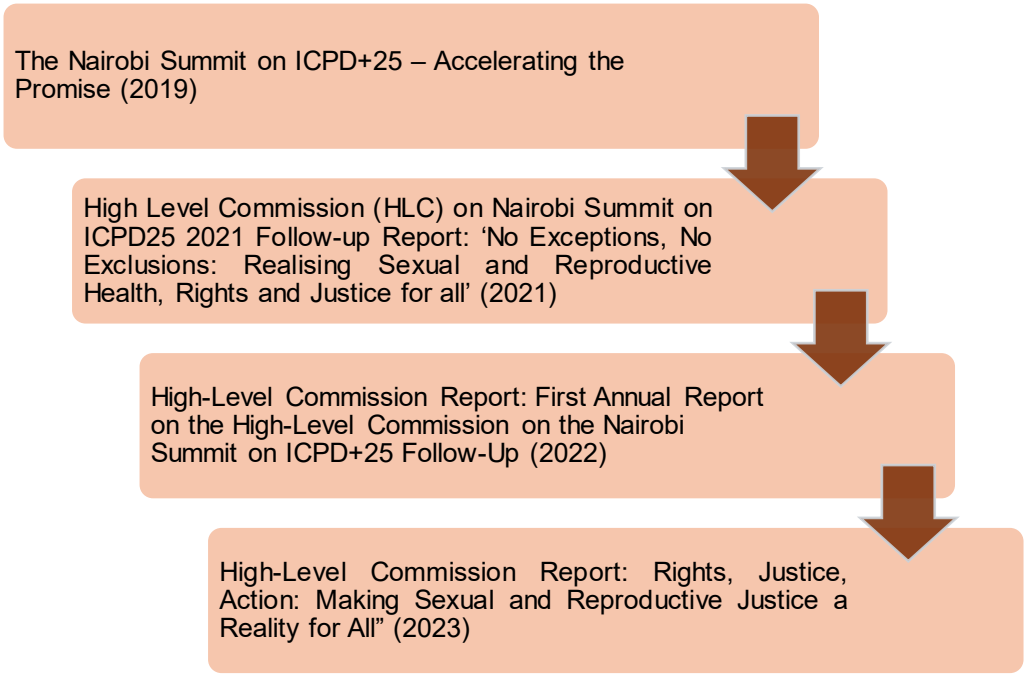
Against the backdrop of increasing global momentum around SRJ — particularly through the Nairobi Summit on ICPD+25 and publications of the High-Level Commission — government initiated nationwide engagements to contextualise SRJ within South Africa.

Thus, informed by High-Level Commission guidance, an SRJ Seminar Series was convened between October 2022 and March 2023 across eight provinces, culminating in the first National SRJ Conference.

These engagements:

- promoted shared understanding of SRJ,
- highlighted lived experiences,
- identified priority intervention areas, and
- strengthened stakeholder collaboration.

Figure 2: HLC on the Nairobi Summit on ICPD25 Follow-Up Publications



The key objectives of both processes are presented in **Box 3.**

Box 3

Objectives of the SRJ Seminar Series

- Provide a platform for stakeholders to have in-depth engagements on SRJ.
- Showcase local innovations and successes in SRJ training, education, practices, research, and policy engagements.
- Strengthen partnerships and collaboration among policy makers and practitioners in the areas of SRJ.

Objectives of the National SRJ Conference

- Provide a platform for researchers and practitioners in sexual and reproductive health and rights (SRHR), SRJ and other intersecting disciplines to disseminate research evidence, capacity building initiatives, policy, and programme engagement outcomes to a wide audience.
- Identify areas of priority within the context of SRJ in South Africa requiring intensified intervention by all role players.
- Showcase innovations and proven methodologies to inform multi-disciplinary approaches to expand SRJ research, capacity building, advocacy, programme, legal reform, and policy development in South Africa.
- Create new networks and build on existing connections between stakeholders leading to more collaborative ventures with a shared vision.
- Make recommendations on how to facilitate and strengthen SRJ across all spheres of Government in collaboration, with civil society, academia, and other relevant stakeholders.

Attended by multisectoral stakeholders across the country, both the SRJ Seminar Series and the National SRJ Conference served as fora to discuss the local application (also referred to as the 'domestication') of SRJ in the South African context. Discussions also drew attention on why pre-understandings of SRHR required a further conceptual leap of integrating SRJ in addition to the SRHR framework. In sum, the basic premise for the seminar series and conference was the acknowledgement that despite different understandings of SRJ by stakeholders, there remains a unified vision and common goal of the realisation of SRJ for all.

This collaborative approach and hearing a multiplicity of voices resulted in rich content by way of shared learning, exploration of ideas, outlining the focus of SRJ for South Africa and creating a culture of knowledge management and generation of accessible evidence bases.[4]

The framing of SRJ for the strategy comes largely from two sets of cumulative knowledge bases. Firstly, through the SRJ consultative process and by documenting on-the-ground, lived experiences of individuals who had their sexual rights and justice compromised. These provided a sobering worldview that SRJ requires better socio-economic development where fairness, inclusivity and justice must be central to the attainment and transformation of rights to empower all individuals irrespective of their multiple, intersecting identities. In addition, education, fair and equal pay, universal social protection, the elimination of gender-based violence and a healthy and socially cohesive environment are among the factors determining whether people experience SRJ, rights and choices or not.

Secondly, existing, and nascent bodies of knowledge of SRJ as shared by academics, civil society organisations, development partners and other experts, has contributed to the way in which SRJ has been conceptualised for the strategy. This combination of drawing on lived experiences and learnings from the scientific sphere created a more relatable understanding and framing of SRJ, especially in the South African context (characterised by inequality, poverty, the scourge of sexual and gender-based violence, high unemployment, gaps in access and quality in healthcare, amongst other issues) and more so for the intention of a strategy which is aimed at addressing and promulgating an otherwise complicated concept.

Bearing this discussion, the next section of the strategy presents how SRJ is defined for the purpose of the implementation of the strategy.

4. Defining the Concept of SRJ for the Strategy

. A commonly used definition states that SRJ exists when all people have the power and resources to make healthy and autonomous decisions about their bodies, sexuality, and reproduction. While useful, this definition does not adequately capture the structural barriers, power relations, and inequalities that shape lived realities.

[4] The Population Resource Centre at the National Population Unit can be contacted at +27 12 312 7638 for electronic copies for the SRJ Seminar Series Report and the National SRJ Conference Report. The reports provide greater detail into these consultative processes leading up to the development of the National SRJ Strategy.

Despite South Africa's progressive legislative environment and global commitments, structural inequalities persist and continue to undermine the advancement of SRHR, particularly among marginalised groups.

For this reason, the strategy adopts a broader, domesticated conceptual understanding of SRJ rather than a single prescriptive definition.

The Sexual and Reproductive Justice Coalition of South Africa (SRJC SA) provides this understanding of SRJ in their statement of intent where SRJ is:

- "Locating sexualities and reproduction intersectionality within social, economic, cultural, gendered, geographical, political, racialized, age-based, and ability-based and other power relations.
- Overcoming inequalities and oppressions, including silencing, stigma, judgement, and other barriers to accessing information, resources, and services.
- Affirming diversity of identities.
- Recognizing different vulnerabilities and abilities.
- Addressing violations, particularly gender-based coercion and violence that occur in a number of settings.
- Advocating comprehensive care, including mental, physical, emotional, and spiritual health.
- Acknowledging and overcoming cross-cutting pervasive social challenges such as transport, safety, water, sanitation, violence, crime, alcohol, drugs, migration, labour exploitation; and
- Affirming sex positive, sexualities positive and positive reproductive decision-making approaches "(SRJC, 2016)

Another way of thinking of SRJ is that it is a movement-building framework that identifies how reproductive oppression is the result of the intersections of multiple oppressions and is inherently connected to the struggle for social justice and human rights. An individual's societal institutions, environment, economics, and culture affect their reproductive life.

SRJ is a positive approach that links sexuality, health, and human rights to social justice movements by placing sexual and reproductive health issues in the larger context of the well-being and health of individuals, families, and communities.

Most importantly, SRJ can be achieved by examining power structures and intersectionality, joining across identities and issues, and putting groups who have been most marginalised at the centre of advocacy.

SRJ:

- locates sexual and reproductive experiences within intersecting social, economic, gendered, geographical, racial, and political power relations;
- addresses inequalities, stigma, and barriers to accessing services;
- recognises diversity of identities and vulnerabilities;
- promotes comprehensive care inclusive of mental, physical, emotional, and social well-being;
- addresses cross-cutting social challenges that influence reproductive choices.

SRJ is therefore both a rights-based and systems-based approach that seeks to transform structural inequalities impacting sexual and reproductive outcomes.

The next section positions the SRJ Strategy within existing global, regional, and national frameworks and policies. This congruence between what the strategy is trying to achieve in relation to the larger body of frameworks, legislation and policies is important for the continued focus and commitment in upholding human and sexual rights and justice.

5. Goal and Focus Areas of the SRJ Strategy

The overall goal of the SRJ Strategy is to contribute towards improving socio-economic, health, structural, institutional, and political conditions that enable individuals — especially women — to make informed and autonomous decisions regarding their sexual and reproductive health and rights through coordinated multisectoral interventions at all levels.

6. Alignment with Global Strategies, Statutes, National Legislation, Strategies and Policies

, South Africa’s legislative and policy environment strongly supports a rights-based SRHR framework aligned with global and regional commitments, the 1993 Convention on the Elimination of all forms of Discrimination Against Women (CEDAW). 1994 ICPD PoA, the 1995 Beijing Platform for Action (BPfA) that was adopted at the Fourth Conference on Women, The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol, 2003) the 2015 Sustainable Development Goals (SDGs) and the

2018 Regional Strategy for Sexual and Reproductive Health and Rights (SRHR). The SRJ Strategy supports calls for SRHR improvement, prevention, diagnosis, treatment, and care that should be evidence-based and in line with global and national policies, protocols, and clinical guidelines. Below is a list of the prominent global statutes, national legislation, and policies that the National SRJ Strategy is aligned with. The SRJ Strategy strengthens implementation of these commitments by promoting evidence-based services, rights protection, and equitable access.

Global Frameworks

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Beijing Declaration and Platform for Action, and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) affirm that women have the right to sexual and reproductive health and rights including autonomy over their bodies, access to comprehensive health services, freedom from discrimination, coercion and violence, and the ability to make informed decisions about sexuality and reproduction as a matter of justice and equality.

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) clearly establishes reproductive rights, health rights, and autonomy in deciding on children, which form the legal basis of SRHR.

Although the SDGs Framework excludes the explicit 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, Comprehensive Sexuality Education (CSE), and the ability to make decisions about one’s health.

- SDG Framework
    - Goal 3: Ensure healthy lives and promote well-being for all at all ages.
    - Goal 5: Achieve gender equality and empower all women and girls.
    - 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.

International and Regional Guidance

The National SRJ Strategy is also aligned with the following global and regional clinical and service delivery guidance.

- Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), 1993.
- International Conference on Population and Development (ICPD) Programme of Action (PoA), 1994.
- Beijing Platform for Action (BPfA) that was adopted at the Fourth Conference on Women, 1995.
- The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), 2003.
- The Sustainable Development Goals (SDGs), 2015.
- SADC Regional Strategy for Sexual and Reproductive Health and Rights 2019 – 2030 (SRHR), 2018.
- Nairobi Statement: 12 Global Commitments (ICPD+25), 2019.
- WHO Clinical practise 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
- Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region
- SADC Protocol on Health, Article 16
- Sexual and Reproductive Health Strategy for the SADC Region 2006 – 2015

National Legislation, Strategies and Policies

- The Constitution of the Republic of South Africa, 1996
- White Paper on Population Policy for South Africa, 1998
- South Africa's Commitments to the Nairobi Summit on ICPD+25 for the continued implementation of the ICDP Programme of Action, 2019.
- National Department of Social Development Strategic Plan, 2020 – 2025
- National Department of Health Strategic Plan 2015– 2016 to 2019 -2020
- National Integrated Sexual and Reproductive Health and Rights Policy, 2019
- National Strategic Plan for HIV, TB and STI's 2023-2028
- Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011–2022
- National Health Insurance Act, 2024
- National Adolescent and Youth Health Policy 2016-2020
- National HIV Testing Services (HTS) Policy 2016
- Department Basic Education National Policy on HIV, STIs and TB 2017 - 2022

- National Policy on the Prevention and Management of Learner Pregnancy in Schools 2023
- The South African National LGBTI HIV Plan, 2017-2022
- The South African National Sex Worker HIV Plan, 2016-2019
- National Breast Cancer Prevention and Control Policy, 2017
- National Cervical Cancer Prevention and Control Policy, 2017
- Health Sector HIV Prevention Strategy 2016
- Choice on Termination of Pregnancy Act and CTOP Amendment Bill 2004
- National Clinical Guideline for Contraception, 2019
- National Guideline for Implementation of Choice on Termination of Pregnancy Act, 2019
- National Clinical Guideline for Safe Conception and Infertility, 2019
- Sexually Transmitted Infections Management Guidelines, 2015
- Population Policy for South Africa, 1998
- Older Persons Act 13 of 2006
- Children's Act 41 of 2007
- Traditional Health Practitioners Act, 22 of 2007
- White Paper on the Rights of Persons with Disabilities, 2016
- Integrated School Health Policy, 2012
- National Youth Policy, 2020 – 2030

7. Situational Analysis of SRHR and SRJ in South Africa

Whilst a detailed analysis of SRHR and SRJ is beyond the scope of the strategy, general remarks on the current state of SRHR and SRJ are made as a forerunner to the later presented goal, focus areas, priorities, and objectives of the strategy. The narrative analysis presented below were derived from presentations from SRHR and SRJ experts and conversations with stakeholders during the SRJ Seminar Series and National SRJ Conference. These included points that illustrate:

- South Africa is a country of two realities that are yet to be reconciled. On the one hand, there are progressive laws, committed activists, scholars, academics, and law makers who are advancing the sexual and reproductive rights agenda.
- On the other hand, South Africa is also highly patriarchal, religiously conservative and an unequal society, where much of the population (especially poor rural, marginalised, and mainly women) have become tolerant of dehumanising treatment.
- Service providers for termination of pregnancy are experiencing burn out, as there are not enough service providers who perform this service.

- Acknowledging South Africa's non-homogenous composition of young people, significant structural and systematic barriers including race, gender, class, abilities, education, socio-economic background continue to affect South Africa's young people and their outlook on realising SRJ.
- Identifying the opportunities and barriers of promoting the sexual health and rights of migrants remains a challenge that requires multidisciplinary consideration.
- Strengthening investment in prevention and early intervention on sexual and reproductive health care services, including access to information, education, and communication on contraceptives/ family planning to limit the impact of risks associated with reproductive injustices; and facilitate empowerment on an individual to make informed decisions and change in the individual, environment and societal factors that could impact on the health and wellbeing of an individual.

Critical Areas for Guided Action to Stakeholders

- More frequent updates of relevant information on guidelines and this should be communicated to all service providers and communities.
- Awareness on SRHR/ SRJ must be raised to all people including persons with disabilities.
- Engage traditional leaders and Faith Based Organisations and educate them on SRH.
- More health data for mobile populations to guide policy and programming is needed due to the increasing levels of circular migration in South Africa.
- While South Africa's constitution is progressive and inclusive, policies need to acknowledge that Sexual and Reproductive Justice is borderless sexual and reproductive citizenship.

Knowledge Management, Programmes, Advocacy and Capacity Building

- Mainstream SRJ within government along with its partners. Synergizing efforts at the onset is vital.
- Generate an SRJ evidence base that cuts across the pillars of research, programmes, advocacy, capacity building, and policy.
- Highlight the importance of SRJ capacity, aspects of interventions, guideline development, provider training, service delivery platforms, community engagement will be profiled, particularly in limited resourced settings and amongst communities who find themselves on the periphery.
- Prioritize funding and support research and innovations so that local evidence can be built.
- Constant and regularly updated training and capacity-building initiatives consistent with state obligations.

Accountability and Governance

- Hold all office bearers accountable – “no talk-shops.”
- There must be sufficient human resource allocations in healthcare and justice systems.
- Strong call for economic, budgetary, and infrastructural reform.
- Centring and driven by participants, with responsive and transformative justice systems for avenues of recourse.
- Factors contributing to risky sexual behaviour are complex and multi-faceted, therefore a participatory approach to policy making and a deeper understanding of Sexual and Reproductive Justice is required.

Service Provision: Health and Legal Services

- In recent decades, owing to its progressive Constitution and Bill of Rights, a strong culture of human rights and protection of freedoms has been inculcated in South Africa.
- Persons residing in South Africa have an increased awareness of their rights and constitutional democracy. Whilst this is a positive development and point of departure from the pre-1994 era, there has been a surge in human rights violations documented by various institutions.
- There is an ever-growing concern of individual breach of human rights being committed in spaces which are dedicated to persevering life, dignity, protection, safety, and well-being by all who access such spaces.
- The state of medico-legal service provision in the South African context of SRJ must be further explored.
- Provision of medico-legal services in cases of sexual and gender-based violence must be inclusive of psychosocial support, counselling, and psychological and psychiatric care and treatment for mental health responses.
- Services and interventions must be disability responsive.
- Decommodification of health care, ideally access to universal health care.
- Sensitization of health care practitioners
- Strengthening of police services, the legal system, and correctional services
- Mandatory debriefing sessions for health workers, educators, and social workers.
- Safety measures must be in place for health workers and patients.
- Lack of legal documents affects access to SRHR services, particularly to undocumented migrants.
- Sexual and reproductive justice requires interventions to make a full range of sexual and reproductive services available to migrant women.

Children and SRJ

- Access to SRHR in its entirety is particularly crucial for children. It provides medical care and age-appropriate comprehensive sexuality education (CSE), which gives them vital information about their sexualities, gender identities and expression as well as access to age appropriate SRHR/SRJ services.
- It also allows them bodily autonomy and power over their lives, as well as raise awareness by linking it to the rights of the child.
- Emphasise the critical role that children and adolescents in their diversity play in the attainment of SRJ by reflecting on their lived experiences and how the persisting social and structural barriers negatively impact children's access to services.
- Examine the alignment of policies and practices affecting the children in relation to their SRHR and benefits of SRJ.
- Promote meaningful child-adolescent engagement and participation in decision-making spaces towards a sustained health and well-being, inclusive of SRJ.

Youth as a Priority Group

- Prioritise youth (including adolescent girls, young women, adolescent boys, young men, the LGBTIQ+ and youth with disabilities)
- Dynamic youth centred health care services
- Empowerment and development of the youth holistically.
- Empower youth to be SRH advocates and volunteers.
- Involve young men and boys in gender-sensitive programmes that advance sexual and reproductive health and rights and have the potential to transform unequal power relations.
- Advocate that information on contraceptives as well as access to requisite services is widely available to help avoid unintended pregnancies.

Self-Expression, Bodily Autonomy and Bodily Integrity

- This theme recognises the principle that a person's body is for them, and their body is theirs. Every human being, including children, have the right to autonomy and self-determination over their own body. Any unconsented physical acts are an explicit violation of these principles and rights.

- An emphasis must be made on the narratives around power, agency, choice, and dignity in the context of bodies and sexuality. In so doing, coercions, violations, and reproductive injustices experienced by all, but especially so for young girls and women when advocating for autonomy and self-expression are discussed in the theme.

Mental Health and SRJ

- Inherent to one's well-being is the ability to make informed decisions about our bodies and healthcare we wish to access and receive (including quality and ethics of care). Not only are physical health and well-being at the forefront of such decisions, short and long-term mental health is also at stake.
- Existing evidence shows that people who are minorities are at a higher risk of experiencing mental health conditions due to having different life experiences from the general population.
- This becomes particularly compounded when social and political identities and layered inequalities are considered. Reproductive rights provide the choice and the right to freely choose which has a positive impact on mental health and well-being. The converse is a reality too.
- People's rights and abilities to choose are often restricted, denied or when the right is realised through access, the experience is not always positive. Mental health may be affected by the institutions, structures and thought processes that currently shape the world we live in.
- Mental Health challenges may arise when people are denied access or experience negative and stigmatising services in relation to contraception, infertility, antenatal care, safe termination of pregnancy, prenatal care (including choice on birthing options), birthing experiences, postpartum care, and importantly socially based stress.
- Mental health challenges may also be experienced by persons on the grounds of sexual orientation, gender identity, gender expression, and sex characteristics.

Climate Change, Crisis Preparedness and Management

- SRHR is essential to individuals at all stages of life and is crucial to human development. This is especially important when faced with crisis and emergency situations. An individual's (especially for girls and women) need for services does not stop or diminish during such circumstances – in fact, they may become greater.
- Like most other countries, South Africa could not escape the COVID-19 pandemic. It suffered the loss of lives and livelihoods. COVID-19 underscored the multiple gaps in health care, social protection, and overall welfare of all but especially so for children, youth, and older persons. The redirection of human and especially financial resources

impacted critical SRHR services including HIV services where long-term gains have been jeopardised.

- Numerous studies have pointed out the disproportionate impacts that global warming and climate-related disasters have on certain populations, most notably for children, youth, and older persons. Parts of South Africa are still dealing with the aftermath of heavy rains and catastrophic floods experienced in some provinces. Events like this underscore the deep connections between climate change, social and health inequality.
- Given the importance to keep track of global events shaping our world and understanding their impact on people and communities, it's important to cover crises such as the COVID-19 pandemic and climate change affected SRHR outcomes and what the immediate and long-term implications for SRJ are.
- Use lessons learned from the recent health and environmental crises to take meaningful action and strategize on future crisis preparedness to support SRHR needs and interventions for all with the goal of realizing SRJ.

People on the Move and SRJ

- The complex social, political, and economic hardships which mobile populations such as internal migrants, immigrants, asylum seekers, and refugees are exposed to are well documented.
- Whilst the South African Constitution and existing legal frameworks and policies guarantees the right of access to health care and essential services to all including migrants and those in humanitarian and or emergency situations, the implementation thereof is widely described as inadequate.
- In addition, South Africa is urbanising rapidly. Living conditions are marked by overcrowding, social and economic marginalisation, poor environmental conditions with little to no basic services which are linked to deteriorating health and well-being.
- The link between migration, urbanisation and SRJ must be strengthened as it is critical to the development of healthy productive urban (including mobile) populations. By placing emphasis on SRJ being borderless and instilling the idea of SRJ citizenship, the People on the Move and SRJ theme focuses on the experiences of mobile populations and spaces (both urban and rural) they settle in from a socio-economic, health, legal and gender perspective. It highlights their challenges, coping mechanisms and opportunities (if any) present and how this relates to the realisation of SRJ.

Families, Maternities and SRJ

- The SRJ framework clearly states that individuals may choose to have or not have children; choose the conditions under which to give birth or create a family; care for their children with the necessary social support in a safe and healthy environment and control their own body and self-expression, free from any form of sexual or reproductive oppression.
- As individual rights (especially women's) are undermined by the inability to receive safe care and act on their preferences, the Families, Maternities and SRJ theme underscores that SRJ includes the right to accept or refuse any type of maternity care and to access this care from respectful and culturally appropriate providers.
- Growing evidence from South Africa's maternities shows that medically managed childbirth, women's oppression, racism in health care is pervasive, where too many women experience discrimination, punishment, or mistreatment in maternity care.
- Advocate towards a world where people everywhere have control over their own bodies, and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they will have and when; free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections, including HIV. A world where gender or sexuality are no longer a source of inequality or stigma.

Crucial Factors Extracted for the Purpose of Drafting the SRJ Strategy

- There are various health disparities amongst LGBTQIA+ people.
- There is also worrying levels of suicide, substance abuse, obesity, and anxiety.
- Health care stigma against LGBTQIA+ people emanate from lack of training on understanding issues facing LGBTQIA+ persons and misinformed personal beliefs.
- Social stigma attached to abortion is a serious matter that leads people to choose unsafe and illegal abortions.
- Funding for combatting unsafe abortions in South Africa remains scarce.
- Though many have contested the system, patriarchal structures and practices anchored in some rural areas have historically made it difficult for African women to move from place to place on their own.
- Any approximation to SRJ – in the sense of women's independent power to make healthy decisions about their bodies, gender, sexuality, and reproduction – is doubtful until and unless the woman migrant can navigate through the maximum-risk entry phase of urbanisation.

In support of the many of the above points, the Population Policy @25 Progress Review Report (forthcoming) produced by the National Population Unit concludes that attaining SRJ will ensure that all individuals have full autonomy over their own bodies. This is however the ideal we strive for and not the norm in South Africa where inequality, marginalisation and discrimination abound for too many citizens – hence the great need for a strategy of this kind.

Consultations with stakeholders towards the development of the strategy

The aim of the consultative meetings was to promote and strengthen the interconnectedness of research, training, policy making, practice and advocacy evidence to expand universal access to Sexual and Reproductive Justice in South Africa. To that end, they provided a platform for participants to discuss and disseminate evidence on what works and what doesn't work and how successful programmes can be expanded to reach diverse groups in society.

Specifically, the consultative meetings aimed to:

- Provide a platform for the specialists in Sexual and Reproductive Health and Sexual Reproductive Justice as well as other researchers to share and discuss the impact and role of their training, research, policy and practice engagement approaches and outcomes.
- Strengthen partnerships and collaboration among policy makers and practitioners in the areas of SRJ.
- Identify priority SRJ areas to inform policy and practice to improve universal SRJ services.
- Create new networks and build on existing connections between stakeholders leading to more collaborative ventures with a shared vision and
- Make recommendations on how to facilitate and strengthen SRJ across all spheres of government in collaboration, with civil society, academia, and other relevant stakeholders.
- Stakeholders were invited based on their experience, expertise, and current areas of work, related to SRJ. A concerted effort to invite participants from all sectors (National, Provincial and Local Government, Science Councils, Civil Society, Academia, Development Partners etc.) was made, to ensure a representative audience and meaningful deliberations.

Process towards the development of the Sexual and Reproductive Justice Strategy

- The NPU has consulted with key sector departments and organized sector specific priority core working groups in line with their functions. The purpose of the meetings was to share the SRJ seminar series and conference report and recommendations per sector, as a means towards developing sector specific priority areas, with attainable objectives and interventions.

- Sector specific priority areas are as follows:
- Department of Health-related matters formed part of priority area on health.
- Department of Education related matters formed part of priority area on education.
- Department of Social Development related matters formed part of priority area on social development, including psychosocial support.
- Department of Women, Youth and Persons with Disabilities related matters formed part of priority area addressing SRJ issues affecting women, youth, and persons with disabilities.
- A reference group was established to ensure rigour and guidance towards the development of a quality and comprehensive strategy. The reference group members are representatives from academia, development partners and civil society and they were selected based on their specialist knowledge and experience as well as their ability to represent stakeholders and capacity to identify and resolve issues.

Findings and recommendations from Consultative Session with youth on SRJ

Group 1: Service Delivery and SRJ Priority recommendations

- Provision of medical legal services in cases of sexual and gender-based violence-prioritize queer persons and statistics have revealed that they too are victims of sexual and gender-based violence and set legal representative youth-led organizations in place that will fight for the rights of all GBV victims specifically AGYW and queer persons.

- Young people see the need to draft their own charter based on youth health conditions that focus on SRJ.

- Allow youth-led organizations to participate in the implementation of the SRJ in all its priorities for example, prioritize youth-led organizations that focus on GBV cases to offer counseling services to victims and to assist police officers with taking statements of victims to avoid insensitivity and to assist with sensitization trainings for police officers on how to work and assist GBV victims and sexual offences cases, to allow youth-led organizations to operate in police stations and offer technical assistance to all GBV related cases that require personnel who are experienced and equipped to work with victims.

- There is a dire need to train more healthcare workers on different contraceptive methods and how they should equip young people with the knowledge on family planning. These trainings should be conducted by youth-led organisations that are equipped to offer the trainings, and the Department of Social Development should assist the selected youth-led organizations with any technical assistance they may require to ensure that the trainings are implemented successfully.

- To address the issue of safety measures for healthcare workers and patients, healthcare facilities should regularly open available vacancies to avoid short staffed and overwhelmed workers and again young people feel the need to include youth led organizations that have the required technical assistance for example in cases where a young person is tested positive, a young person from a youth led organization who is stationed at a healthcare facility may offer counseling services instead of the nurse to ensure that all patients receive healthcare services without any delays.
- With the aspect of mandatory debriefing sessions for healthcare workers, young people request that's healthcare workers are informed on all the policies and laws set in place to address sexual and reproductive health rights inequalities.
- Young people want to be prioritized and be made part of the monitoring and evaluation reference group processes for the SRJ strategy.
- Services and interventions must be disability responsive; this entails allowing young people with disabilities the right to access to choose without discrimination and equipping them with knowledge on all their sexual and reproductive health rights.
- Language barriers in policies should be addressed, allow young people to lead the process.
- Implement outreach programs in communities such as mobile pop-up clinics even in rural areas and asylums to ensure a full range of sexual and reproductive services to migrant women, young people with disabilities, young people with HIV, sex workers, and queer persons.
- TVET College students to have wider access on health facilities for example have on campus nurses. This would also allow room for collaboration and partnerships between youth-led organisations, healthcare facilities and the Department of Social Development, Department of Education, and the Department of Health to ensure this service is implemented.
- Stock taking on contraceptives should be prioritized regularly to ensure that there is no shortage.
- Ensure that we have necessary documentations and policies that protect our healthcare workers and patients from any health injustices and advocate for awareness on such policies.

Group 2: Poverty, Inequality, and SRJ

- There is a need to address the lack of access to basic needs.
- People living in poverty are not correctly represented and most do not have access to SRJ services.
- There is a need to address inequality in education and how poverty influences this.
- There is a challenge of not having the right infrastructure, in terms of housing and government facilities for young people.
- Traditionally, and or it has been normalized within certain communities that women depend on men.
- Persons with disabilities must be involved in government policy processes and should not be left behind.

Group 3: GBV and SRJ

- Address social and cultural norms that perpetuate GBV e.g. issues of consent, conjugal rights, intimate partner violence, behaviour change with service providers such as health service providers, social workers and police and encourage them to report cases of GBV.
- Awareness programmes targeting potential perpetrators of GBV on consequences of perpetrating GBV.
- Address issues of GBV by family members.
- Advocate for tougher laws regarding GBV.
- Advocate for victim-friendly courts
- Review of the justice system e.g. secondary victimisation of victims
- Reinforcement of Comprehensive Sexuality Education
- Address society's stigmas e.g. abortion.
- Address the issue of referrals so that GBV services are comprehensive, and service providers do not work in silos.
- An emphasis must be made on bodily autonomy.

Group 4: SRJ Issues facing the LGBTIQ+ Community.

- Countering homophobia and transphobia, religious and cultural stigma and addressing violence and hate crimes through civic engagement.

- Harmful perceptions of the public towards members of the LGBTIQ+ community i.e., bisexual people seen and “promiscuous”.
- Lack of access to contraceptives and access to information on contraceptives i.e. dental dem.
- Secondary victimisation at the hands of police officers and healthcare providers
- Lack of representation of LGBTIQ+ persons in positions of influence in society
- Lack of sensitisation of healthcare providers, police officials and other key professionals
- Insufficient consideration for inequality and intersectionality within the community
- Lack of specialised services and service providers
- Conversion therapy still being the preferred “treatment” for members of the community.
- High STI infection rate
- General neglect at the hands of broader community and society
- Insufficient geographical reach of government initiatives and information
- Inadequate longevity of government projects targeted at the community.
- Legal barriers and discrimination
- Solutions to issues faced by LGBTIQ+ Persons.
- Medical research centres must be established and resourced.
- Intergenerational sensitisation is required, especially amongst parents of LGBTIQ+ children.
- Allow for non-binary identifying persons to identify as such in legal documents and broader society.
- Legal reforms required, specifically anti-discrimination laws and policies.
- Sensitisation programmes must be enrolled throughout society and across various professions.
- Safe spaces and information centres must be established.
- Access to contraceptives must be ensured.
- Specialised healthcare providers for LGBTIQ+ community must be provided.

- Culturally competent healthcare and key service providers must be provided.
- Sexual education must be made more inclusive
- Consultative workshops must be more meaningful and representative.
- Mental health support must be prioritised.
- HIV/AIDS prevention and care must take centre stage.
- Anti-violence initiatives must be established throughout society to curb homophobia and hate crimes.
- Approaches to LGBTIQ+ matters must take a more intersectional nature.
- Advocacy and community engagement must be intensified.
- Data Collection on LGBTQ+ health disparities and access to healthcare services must be optimised to better understand and address the specific needs of the community.

8. Priorities and Objectives of the SRJ Strategy

This objectives of the strategy are organised under 6 priorities

Priority 1: Information and Knowledge Management	**Interventions and Recommendations**
1.1 Promote Information and Knowledge Management and sharing on SRHR and SRJ in the South African legislative framework amongst all stakeholders.	• To share information and capacitate stakeholders on South African legislative framework in relation to SRHR and SRJ. • To prioritize funding and support research and innovations and build on local evidence-based data for programming through various avenues. • To establish an information and knowledge management hub/ repository on SRHR and SRJ. • To document and share knowledge and information on best practices on SRHR and SRJ interventions and programmes.

Priority 2: Promote Governance and Human Resource Management and Development in the Social Sector	Interventions and Recommendations
2.1 To create an enabling environment that will lead to the retention of qualified and motivated staff. 2.2 To strengthen the capacity of community health workers in providing quality health care services. 2.3 To allocate qualified and motivated health care providers in health facilities according to the patient-provider ratio. 2.4 To prioritise and resource an essential package of SRH services/interventions with the goal of progressively expanding access under the NHI. 2.5 To strengthen public-private partnerships to improve the efficiency of existing SRH expenditure with the purpose of aggressively reducing fiscal inefficiencies and wastage.	• Clinical mentoring/support • Peer support programmes (District Clinical Specialist Teams) • Regular updates on new evidence-based developments. • Compulsory Values Clarification and Attitude Transformation (VCAT) training for health care workers (Mode: Online and or physical compulsory course).

2.6 To scale up school social work for the provision of psychosocial services, including speciality on sexual and reproductive health and rights through the sexual and reproductive justice approach.	• To support the DSD Human Resource Development unit through additional information, highlighting sexual and reproductive justice to strengthen the business case for National Treasury's consideration and budget approval for the recruitment of social workers.
2.7 To promote and strengthen budgets for NPOs supported by DSD implementing sexual and reproductive health and rights contributing to decreasing unintended pregnancy.	• To identify all DSD funded NPOs that implement sexual and reproductive health and rights and introduce sexual and reproductive justice. • To mobilise resources for DSD funded NPOs implementing sexual and reproductive health and rights through the sexual and reproductive justice approach.
Priority 3: Increased coordination and collaboration on SRHR and SRJ	**Interventions and Recommendations**
Education related issues	
3.1 Utilize the Integrated School Health Programme as an anchor to promote/enhance a national conversation on sexuality and reproduction in healthy growing to adulthood.	• DSD; DOH; DBE collaborate in Integrated School Health Programme to give all learners digital wellness profiles. • Social workers/Psychological Services at schools (to offer integrated support to CSE teachers & learners)
Health Related Issues	
3.2 **Abortion:** To implement the National Choice on Termination of Pregnancy (CToP) guidelines	• To cascade guidelines to provinces • Support providers in the roll-out of the guidelines. • Create community awareness. • Conduct Values Clarification for Action Transformation (VCAT) workshops at facilities and at Faith Based

	Organisations (FBOs) and House of Traditional Leaders and Khoi San leaders. • Compulsory values clarification training for providers. • Create provincial toll-free line/ (Whatsapp line) for termination of pregnancy services (geo-location of where services can be accessed).
Social Development Related Issues	
3.3 To strengthen collaboration amongst key sector departments in delivering a service on sexual and reproductive health and rights through the sexual and reproductive justice approach.	• To scale up integrated service delivery programmes, such as the Integrated School Health Programme, highlighting sexual and reproductive health and rights through the sexual and reproductive justice approach.
3.4 To de-stigmatise sexuality in society for young people.	• To raise awareness on sexuality education, especially amongst older generations to address intergenerational gaps. • To identify all the existing training manuals targeting adults, such as Intergenerational Communication on Adolescent Sexual and Reproductive Health and Rights; Families Matter Programme; Comprehensive Sexuality Education (CSE) Online Training; Sexual and Reproductive Health and Rights and scale them. • Strengthen collaboration with other programmes addressing children, for example the 365 days child protection programme of action.
Priority 4: **Strengthen service delivery by integrating SRJ in the South African SRHR agenda.**	**Interventions and Recommendations**
Education related issues	
4.1 Instil in every child in South Africa an understanding of what SRHR/SRJ means	• LSA (Learner Support Agents) in every school to encourage peer to peer education and to assist in

practically in their everyday lives, on how to achieve this and the agency to act on both.	implementing co-curriculum programmes inclusive to SRJ Strategy • Support groups for all in the school network (SAPS, Traditional Leaders, community leaders, pastors etc). • Emphasis on mental health • Digital profiling of learners (with strict access controls) • Strengthen Access to SRH Services and CSE for all a schooling environment. • Strengthen access to Sexual and Reproductive Health interventions by civil society organisations, in the fields of CSE, mental health, GBV, pregnancy and contraceptives, HIV and AIDS prevention and LGBTIQ+, such as the Ibis Reproductive Health Mmoho Advocacy Campaign. • Schools should do annual wellness audits and refer learners for better services and health. • Parents, grandparents and caregivers should form part of the CSE stakeholders. • CSE curriculum be offered in all language (including mother tongue) more information/advocacy sessions on SRH (including male contraceptive methods)
Health Related Issues	
Vulnerable and Marginalised Populations: 4.2 To sensitise health care workers and people in the health system to the needs of vulnerable and marginalised groups in accessing quality health services.	• Compulsory VCAT training for health care workers, including traditional health practitioners (Mode: Online and or physical compulsory course). • Collaboration with the traditional health sector and traditional health practitioners to promote healthy initiation practices, including the Sexual and Reproductive Health of initiates.
Social Development related issues	
4.3 To advocate on moral regeneration for adolescents in line with the	• To educate children on their rights, responsibility, and the consequences of engaging in unprotected sex.

South African age of consent, which is 16 years and related legislation stated above.	• To educate children on relevant legislation, such as, Children's Act, Choice on Termination of pregnancy, Sexual Offences Act (Amendment Act) – especially the 2015 court judgement on consensual sex. • To raise awareness on statutory rape contributing to prevention of teenage pregnancy. • To focus on behaviour, change programmes. • Understanding the root causes and challenges that communities experience, for example infrastructure and resource challenges.
4.4 To develop a basket of DSD services, including sexual and reproductive justice.	• To implement a basket of DSD services, including sexual and reproductive justice within the drop-in centres. • Promote SRJ interventions as per sector mandates and synergise response. • Establish clear indicators to measure impact of services for SRJ. • Strengthen youth zones, prevention programmes example, Risiha programme, Chommy, YOLO
4.5 To capacitate parents, caregivers, guardians, traditional leaders, and faith leaders on sexual and reproductive and rights through the sexual and reproductive justice approach.	• To establish concerted targeting of parents, caregivers, guardians, traditional leaders, and faith leaders, to capacitate them on sexual and reproductive health and rights through the sexual and reproductive justice approach.
Priority 5: **Youth related issues**	**Interventions and Recommendations**
5.1 To provide meaningful participation and inclusion of youth in all processes.	• Strengthening and promoting inclusive critical youth participation processes i.e., inclusion and support of youth advisory councils & youth led organisations in youth related work.

5.2 To create ASRHR & SRJ central points that will deliver youth friendly ASRHR/SRJ services rendered by youth.	• Uniformly implementing, and monitoring youth friendly ASRHR/SRJ services at health care services nationally.
5.3 To develop youth personally, socially and professionally integrating ASRHR/SRJ.	• Integrated multisectoral collaboration advancing ASRHR/SRJ activities i.e., youth policy trainings on ASRHR/SRJ and how these intersect with other policies i.e., DSD National Development Policy.
5.4 To elevate contraceptive uptake, intensifying access to emergency contraceptives, and reduce gate keepers in relation to youth ASRHR/SRJ Services.	• Use ASRHR/SRJ national campaigns and training programmes to raise awareness of contraceptive use and emergency contraceptives i.e., reproductive helpline, and providing CSE training to health care workers dealing with/servicing children.
5.5 To develop integrated health programmes targeted at young men and boys.	• Developing collaborative multisectoral advocacy campaigns/trainings with youth civil society organisations working with young men and boys.
5.6 Review and strengthen CSE curriculum in schools & programmes to provide inclusive, integrated, and comprehensive ASRHR/SRJ information.	• Reviewing policies to identify for existing gaps specifically relating to CSE, and ASRHR/SRJ. The review will ascertain policy revisions are not silent on these topical issues. Moreover, enhancing CSE teacher trainings and programmes for out-of-school youth.
Priority 6: Persons with disabilities related issues	**Interventions and Recommendations**
6.1 Review and strengthen framework of service delivery for persons with disabilities.	• Physical infrastructure and transport services to health care facilities must be a priority. • Mobile clinics in townships and rural areas to cater to the needs of women and persons with disabilities. • Provide support to medical staff and educational institutions through the provision of sign language interpreters. • Provide adequate services to women and persons with disabilities, including preventative and protection

	facilities such as social relief and social security programmes. • Provide sanitary dignity to women in places of health and safety, including psychiatric wards. • Health care facilities to provide material in brail and voice prompts. • Messaging and language should be integrated in the school curriculum for young people with disabilities, this includes brail. • To capacitate parents and care givers of persons with disabilities on dealing with reproductive health functions and rights. • Access to mental health care and supportive sexual and reproductive health and rights services. • Prioritise the security and wellbeing of adults with intellectual disabilities regarding their sexual and reproductive health and rights. • Uphold the inherent dignity of persons with intellectual and physical disabilities, their fundamental freedoms, and their right to enjoy equal access to sexual and reproductive rights and importantly their self-determination in whether and when to exercise these rights, must be supported. • Human rights should be at the forefront when providing sexual and reproductive health and rights services to persons with disabilities, particularly women and girls.

9. Institutional Arrangements for the SRJ Strategy

The NPU within DSD will oversee the institutional arrangements for the National SRJ Strategy. This function will be done in liaison and partnership with the Department of Planning, Monitoring and Evaluation (DPME). The NPU will serve as the secretariat for the coordination process between stakeholders, and implementation oversight.

A Core Group comprising of the Departments of Health, Social Development, Basic Education and Women, Youth and Persons with Disabilities will communicate and coordinate the implementation of the National Sexual and Reproductive Justice (SRJ) Strategy through:

- A Reference Group made up of experts in Sexual and Reproductive Justice, Sexual and Reproductive Health and Rights, as well as Gender.
- A Technical Committee, which is open to all government departments who deliver services related to Sexual and Reproductive Justice, Civil Society Organisations, UN Agencies and Development partners who support the goal and objectives of the strategy.

Representatives from various stakeholders, including sector departments, civil society organisations, Chapter Nine Institutions, development partners, and donors will form part of the Reference Group. Through this Reference Group, development partners will be engaged to provide expert advice on budgeting, resource mobilization, and other advice on the implementation of the SRJ Strategy. Progress on the SRJ strategy will be a standing agenda item on the National Coordination Forum (NCF) of the United Nations Population Fund (UNFPA) Country Support Programme. Reporting should be aligned to the South African commitments to the Nairobi Summit ICPD+25.[5] Some of the commitments made by the South African Government fall under:

- Achieving universal access to sexual and reproductive health as part of universal health coverage (UHC).
- Address gender-based violence and the harmful practices of child, early and forced marriages and female genital mutilation.
- Mobilise the required financing to finish the ICDP Programme of Action and sustain the gains already made.
- Draw on demographic diversity to drive economic growth and achieve sustainable development.
- Uphold the right to sexual and reproductive health care even in humanitarian and fragile contexts.

As the strategy was developed through multiple engagements, the ownership, active participation and meaningful contributions towards meeting the objectives of the SRJ Strategy rests with all stakeholders, including sector departments at all levels, civil society organisations, Chapter Nine Institutions, development partners, academia, religious and traditional structures, donors and all who affirm their commitment and accountability to the implementation of the key guiding activities/interventions with particular alignment to the South African Commitments made at the Nairobi Summit, ICPD+25.

[5] The full list of South African Commitments made to the Nairobi Summit can be accessed at https://www.soulcity.org.za/news-events/news/south-african-government2019s-commitments-for-the-nairobi-summit-on-icpd25

10. Implementation, Monitoring and Evaluation of the SRJ Strategy

The main implementation modality for the SRJ Strategy will be through the Technical Committee. Sector departments, civil society organisations, and other stakeholders will participate in the Technical Committee to better coordinate and align their programmes that support the priorities, objectives, interventions, and recommendations of the SRJ Strategy, including the indicators of the South African Commitments at the Nairobi Summit, ICPD+25.

The Implementation Plan (2026-2029) is attached as Annexure D.

Monitoring and evaluation will be done through several mechanisms, including annual reports on priorities, objectives, interventions, recommendations, and indicators aligned to the South African Commitments at the Nairobi Summit (2019). Output and outcome indicators will be formulated to monitor and evaluate the progress on the implementation of the National SRJ Strategy.

Each stakeholder will be responsible for reporting on priorities, objectives, interventions, and indicators that are in their line functions. Indicators will be developed (with government and stakeholders) based on the objectives of the priority areas and aligned to the Global and South African Commitments of the Nairobi Summit (2019).

The evaluation of the SRJ Strategy will be done at the end of each term of government. Results of the evaluation will provide direction on priorities, interventions, and recommendations for the next term's implementation plan.

11. Budget and Resource Mobilisation

Implementation of the relevant South African Commitments made at the Nairobi Summit ICPD+25 with the SRJ Strategy being the main conduit, requires investment from government departments and support from development partners and donors, to direct more human and financial resources to SRHR services and enablers. It is well-known that healthcare investment has a "multiplier effect" across the economy, meaning it triggers a wave of other investments and developments across society, particularly when universal health coverage is guaranteed. Investments in sexual and reproductive healthcare are amongst the most cost-effective health care investments.

At this stage, the implementation of the Government SRJ Strategy will be done using existing resources with the reliance on improved coordination, synergy, and alignment of the programmes of government departments, civil society organisations and development partners that actively work in SRHR and SRJ. Additionally, as the SRJ strategy is implemented and rolled out at all levels, regular reports from stakeholders with meaningful contributions to improve SRJ will serve as a platform for investment cases for further resource mobilisation.

12. Conclusion

The Sexual and Reproductive Justice approach is necessary because the structural barriers (political, economic, and social) and social inequalities that shape people's (particularly women's and girls') lived experience of their sexual and reproductive health and rights must be addressed on an individual basis, within households and communities. This conclusion was supported throughout the discussions during the seminar series, conference and consultations that led to the development of the National SRJ Strategy, It is envisioned that through increased stakeholder buy-in, active commitment and participation, multi-sectoral collaboration, resource and budget mobilisation, the priorities and objectives of this SRJ strategy will be achieved, where the overall goal of creating the conditions that allow people to make decisions about their own sexual and reproductive health is realised.

13. Glossary of terms

Abortion (Safe Termination of Pregnancy)

A medical procedure to end a pregnancy conducted in accordance with national laws, clinical guidelines, and human rights standards. In South Africa, abortion is legal under the Choice on Termination of Pregnancy Act and associated national clinical guidelines.

Adolescent Fertility

The occurrence of pregnancy among girls aged 10–19. Often used as an indicator of access to contraception, education, and social support.

Adolescent Sexual and Reproductive Health and Rights (ASRHR)

A focused area of SRHR addressing the specific health, legal, and social needs of adolescents, including access to services, CSE, and protection from exploitation.

Age of Consent

The legally defined age at which a person can consent to sexual activity. In South Africa, this is 16 years, subject to provisions in the Criminal Law (Sexual Offences and Related Matters) Amendment Act.

Antenatal Care

Healthcare provided during pregnancy to monitor and improve maternal and foetal health outcomes.

Behaviour Change Programmes

Structured interventions aimed at transforming harmful norms and risky behaviours related to sexuality, GBV, and health-seeking practices.

Bodily Autonomy

The right of individuals to make decisions about their own bodies without coercion, discrimination, or violence.

Bodily Integrity

The inviolable right to physical self-determination and protection from unwanted physical interference.

Care and Support for Teaching and Learning (CSTL)

A framework that integrates social support services into schools to improve learner well-being and educational outcomes.

Choice on Termination of Pregnancy (CTOP)

Legal access to abortion services in accordance with national legislation and guidelines.

Comprehensive Sexuality Education (CSE)

Age-appropriate, culturally relevant education about sexuality, relationships, consent, contraception, gender identity, and sexual health.

Contraception

Methods used to prevent pregnancy, including hormonal, barrier, long-acting reversible contraceptives (LARCs), and male methods.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

An international treaty adopted by the United Nations promoting women's rights. Convention on the Elimination of All Forms of Discrimination Against Women

Dual Protection

Simultaneous use of condoms and another contraceptive method to prevent both unintended pregnancy and STIs, including HIV.

Equity

Fair distribution of resources and opportunities according to need, acknowledging structural disadvantages.

Evidence-Based Programming

Interventions grounded in research, data, and evaluated best practices.

Faith-Based Organisations (FBOs)

Religious organisations engaged in community development and service delivery.

Gender-Based Violence (GBV)

Violence directed at an individual based on gender, including physical, sexual, psychological, and economic abuse.

Gender Equality

Equal rights, responsibilities, and opportunities for all genders.

Governance (SRJ Context)

Institutional arrangements, coordination, and oversight mechanisms guiding SRJ implementation.

Harmful Cultural Practices

Traditions or norms that negatively affect health and rights, such as forced marriage or unsafe initiation practices.

High-Level Commission (HLC) on ICPD25

A global body promoting SRHR and SRJ commitments following the Nairobi Summit on ICPD+25.
High-Level Commission on the Nairobi Summit on ICPD25 Follow-up

Human Rights-Based Approach

A framework aligning policies and programmes with international human rights standards.

Inclusive Service Delivery

Provision of services without discrimination based on race, gender, sexuality, disability, nationality, or socio-economic status.

Intersectionality

A framework recognizing how overlapping identities (race, gender, class, disability, etc.) shape experiences of privilege and oppression.

International Conference on Population and Development (ICPD)

A landmark 1994 conference establishing global commitments on reproductive rights.
International Conference on Population and Development

Maternal Mortality Ratio

The number of maternal deaths per 100,000 live births.

Medico-Legal Services

Integrated medical and legal services for survivors of sexual and gender-based violence.

Multisectoral Collaboration

Coordinated action across health, education, social development, justice, and civil society sectors.

National Health Insurance (NHI)

South Africa's universal health coverage framework.
National Health Insurance Act

Non-Profit Organisation (NPO)

Civil society entity delivering social or health services.

Peer Support Programmes

Community-based support mechanisms involving trained peers.

Postpartum Care

Care provided after childbirth, including mental health support.

Reproductive Justice (RJ)

A framework linking reproductive rights with social justice and structural inequalities.

Reproductive Oppression

Systemic control or denial of reproductive autonomy.

Sexual and Reproductive Health and Rights (SRHR)

A comprehensive framework encompassing sexual health, reproductive health, and rights protections.

Sexual and Reproductive Justice (SRJ)

A broader framework integrating SRHR with social justice, equity, intersectionality, and structural transformation.

Sexual Citizenship

Recognition of individuals' rights to bodily autonomy, identity expression, and access to services irrespective of nationality or migration status.

Sex-Positive Approach

Affirming sexuality as a natural, healthy part of life.

Social Cohesion

Strengthening inclusive communities that support dignity and equality.

Structural Barriers

Systemic obstacles (poverty, discrimination, lack of transport, stigma) limiting access to services.

Sustainable Development Goals (SDGs)

Global goals adopted in 2015 promoting health, gender equality, and reduced inequality. Sustainable Development Goals

Traditional Leaders

Recognized community leaders playing governance and cultural roles.

Underserved Populations

Groups facing systemic exclusion from services (e.g., rural women, migrants, LGBTQIA+, persons with disabilities).

Universal Health Coverage (UHC)

Access to quality health services without financial hardship.

Values Clarification and Attitude Transformation (VCAT)

Training methodology aimed at addressing stigma and bias among service providers.

World Health Organization (WHO)

UN agency providing global health guidance.
World Health Organization

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