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**SRHR QUESTIONNAIRE SUBMISSIONS FOR DR TLALENG MOFOKENG, SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH**
Prepared by SECTION27
10 June 2021

**Contact Details**

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| Type of Stakeholder (please select one) | ☐ Member State<br>☐ Observer State<br>☒ Other (please specify): **Civil Society Organisation** |
| Name of State<br>Name of Survey Respondent | **South Africa**<br>**SECTION27** |
| Email | **Contributors:**<br>1. **Mbali Baduza: baduza@section27.org.za**<br>2. **Julia Chaskalson: chaskalson@section27.org.za**<br>3. **Boitumelo Masipa: masipa@section27.org.za**<br>4. **Sibusisiwe Ndlela: ndlela@section27.org.za**<br>5. **Annah Maluleke: maluleke@section27.org.za**<br>6. **Thuthu Mbatha: mbatha@section27.org.za**<br>7. **Baone Twala: twala@section27.org.za** |
| Can we attribute responses to this questionnaire to your State publicly*?<br><br>*On OHCHR website, under the section of SR health | Yes **X** No<br><br>Comments (if any): N/A |



Income Tax Exemption Reference Number: PBO 930022549. Nonprofit Organisation Registration Number: 055-382-NPO SECTION27, Non-Profit Company (2006/021659/08)
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**Question 1 and 2: Policies, laws and measures adopted in response to the COVID-19 pandemic and the impacts on the right to sexual and reproductive health rights (SRHR) in South Africa**

On 15 March 2020, after the COVID-19 pandemic hit South Africa, the State declared a National State of Disaster, as empowered by the Disaster Management Act 57 of 2002 ("the Act"). New regulations were brought into effect, which among other measures, introduced a five-level COVID-19 alert system to manage the gradual easing of the lockdown. There are several criteria that are used to guide this 'risk-adjusted approach', such as the level of infections and rate of transmission; the capacity of health facilities; the extent of the implementation of public health interventions; and the economic and social impact of continued restrictions.[1]

Alert Level 5, the most restrictive of the levels, was implemented on 25 March 2020, essentially restricted all persons to their homes and prohibited gatherings and travel. The only form of movement permitted was in relation to performing and accessing essential goods and services. Under the regulations, the definition of essential goods included menstrual hygiene products and condoms. Essential services included the broad categories of medical and health (including mental health) services. Although no express reference was made to SRHR services, it is clear that they fall within the broad category of health services. This is affirmed by the fact that section 27(1)(a) of the Constitution makes provision for the right to access healthcare services, which includes access to reproductive health care services; and section 12(2)(a) protects the right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction. Although the Constitution permits the derogation of these rights in times of crisis, the limitations must *strictly be required* for the emergency. The derogation of a person's right to access SRHR services is not strictly required by the COVID-19 pandemic, as it is not necessary to achieve the aims of the lockdown.

Despite the recognition of SRHR goods and services as essential, there have been severe constraints in relation to availability and access. Access to abortion services have been severely restricted during the lockdown with women being turned away

[1] See Government website: https://www.gov.za/covid-19/about/about-alert-system.

from health care facilities on a number of unacceptable bases. This was particularly evident in the Gauteng Province, following the release of a circular from the provincial Department of Health, which directed public healthcare facilities to only address matters related to COVID-19. A group of Civil Society Organisations, including SECTION27, urgently addressed correspondence to the Department demanding the immediate withdrawal of the circular, on grounds that it was unlawful and unconstitutional. The Department complied with the demand and issued an amended circular on 22 April 2020.

Nonetheless, pre-existing systemic barriers regarding access to abortion services in the public health sector remained and were exacerbated by the lockdown restrictions. These barriers manifest in women, particularly young women, who were required to present for multiple visits to multiple facilities just to get an appointment date. Women have reported to SECTION27 that they often feel discouraged by the high costs of public transport, whose services were limited during lockdown, and by the disparaging attitudes encountered at the facilities. Although data is currently unavailable, anecdotal reports imply that many young women were forced to turn to unsafe abortions to exercise their right to abortion. SECTION27 has noted the following with grave concern:

1. In the below graph, we observe a notable reduction in the availability and accessibility of Choice on Termination of Pregnancy ("CTOP") services in Gauteng which may be due to a number of factors but also correlates with the onset of the COVID-19 pandemic. Rated on a scale of severity, the graph below highlights facilities in which CTOP services have either entirely ceased or, were downscaled or were not accessible telephonically as they were in 2019.

| Facility | 2019 | 2021 |
|---|---|---|
| Ekurhuleni | | |
| Bertha Gxowa District Hospital | Up to 12 weeks | CTOP Services no longer available |
| Thelle Mogoerane Regional Hospital | Up to 12 weeks | CTOP Service no longer available |
| Tembisa hospital | Up to 12 weeks | Up to 12 weeks |
| Jabulani Dumani Community Health Centre | Up to 12 weeks | No answer |
| Johannesburg | | |
| Chris Hani Baragwanath Academic Hospital | Up to 20 weeks | No answer |
| South Rand Hospital | Up to 12 weeks | Below 20 weeks |
| Charlotte Maxeke Johannesburg Academic Hospital | Up to 12 weeks | CTOP Services no longer available |
| Chiawelo Community Healthcare Centre | Up to 12 weeks | Not willing to give information re CTOP services |
| Lenasia Community Health Centre | Up to 12 weeks | No answer |
| Zola Clinic | Up to 12 weeks | No answer |
| Sedibeng | | |
| Sebokeng Hospital | Up to 20 weeks | No answer |
| Hiedelberg Hospital | Up to 12 weeks | Up to 12 weeks |
| Kopanong Hospital | Up to 12 weeks | No answer |
| Johan Heyns | Up to 12 weeks | No answer |
| Tshwane | | |
| Jubilee Hospital | Up to 20 weeks | Up to 20 weeks |
| Odi Hospital | Up to 20 weeks | Up to 12 weeks |
| Dr George Mukhari Hospital | Up to 12 weeks | Not willing to give information re CTOP services |
| Kalafong Hospital | Up to 12 weeks | Up to 12 weeks |
| Kgabo CHC | Up to 12 weeks | No answer |
| Laudium CHC | Up to 12 weeks | Up to 12 weeks |
| Soshanguve CHC | Up to 12 weeks | Up to 12 weeks |
| Phedisong 4 CHC | Up to 12 weeks | No answer |
| West Rand | | |
| Leratong Hospital | Up to 12 weeks | Up to 12 weeks |
| Dr Yusuf Dadoo Hospital | Up to 12 weeks | No answer |
| Carletonville Hospital | Up to 12 weeks | Up to 12 weeks |

**2021 Data collected and collated by SECTION27**

2. Data from the SECTION27 pro-bono legal advice office, which receives inquiries from members of the public who need assistance with accessing services related to health and education, reveals a noticeable increase in requests from women and young girls seeking assistance in finding safe abortion services since the start of the pandemic in March 2020.

   For the period between March 2020 and March 2021, the SECTION27 advice office responded to 66 abortion cases. In the year before the COVID-19

outbreak, the advice desk dealt with 33 abortion cases. We are of the belief that this increase can be attributed to the restrictive measures implemented in response to COVID-19.

Many of our clients reported being told by healthcare workers to go back home because the hospitals were prioritising COVID-19 cases. Some were told that abortion was not an emergency and that hospitals were trying to save lives; to go to other facilities or to a private facility; or that the hospital was closed as nurses had tested positive for COVID-19.

What these anecdotes illustrate is that the already unequal access to SRHR services, and barriers to accessing them, have worsened by the COVID-19 lockdown. The lack of access to SRHR services and violations of corresponding rights were intersectional and experienced acutely by young women and queer people of colour from lower socio-economic class backgrounds.[2]

**Question 3(1): Regarding sexual and reproductive health care, any changes compared to pre-COVID-19? Has any service, good or information been deprioritized or defunded? Who is this affecting in particular?**

In the face of the urgent need for increased resource allocation for economic relief to mitigate the impact of the pandemic, the government tabled a Supplementary Budget on 24 June 2020. Following years of underfunding and pre-existing austerity trends in social spending, this supplementary budget further reduced pre-existing programmes to finance the COVID-19 response. Programmes that are essential to protect the availability and accessibility of SRHR services saw spending cuts and/or a lack of additional resource allocation. This is despite the regulations of the Disaster Management Act, which provide that any measures taken to respond to COVID-19 ought to be implemented "as far as possible, without affecting service delivery in

[2] Ingrid Lynch and Andrea Teagle (2020) "The COVID-19 impact on sexual- and reproductive-health rights and gender based violence". *HSRC Review* 18(2):36-37, accessed at http://www.hsrc.ac.za/en/review/hsrc-review-covid19-april-2020/covid19-impact-on-gender-violence

relation to the realisation of the rights contemplated in sections 26 to 29 of the Constitution".[3]

In spite of the express provision affirming the need to protect the right to health, which is entrenched in section 27 of the Constitution, it is clear that the measures that were put in place resulted in regression in the funding of SRHR programmes. The amount of R21.5 billion was allocated to the health sector through the Supplementary Budget to fight COVID-19, but only R2.9 billion of this was new additional funding from the National Treasury. Provincial health departments had to find the remaining R18.6 billion for the pandemic from their existing 2020 budget baselines.[4] Funded in large part by reprioritisations within pre-existing programmes, a new COVID-19 component worth R3.4 billion was added to HIV, TB, Malaria and community outreach grant. Funds from the HIV/AIDS component of this grant were cut by R600 million due to the reportedly slow uptake in the antiretroviral therapy ("ART") programme, supply constraints for condoms and lower demand for medical male circumcision. Anecdotal evidence from SECTION27's field researchers supports the hypothesis that these budget cuts had impacts on SRHR, and that far fewer condoms were distributed at clinics and schools.

In 2021, to compensate for COVID-19 spending over the past year, the baseline of the HIV/AIDS grant – the largest conditional grant in the healthcare sector which is responsible for funding many of South Africa's primary SRHR services – was further reduced by a total of R5.8 billion over the medium term. These cuts reduce the real value of the grant considerably this year and for the next three years, jeopardizing the future realisation of SRHR. While the substantial expenditure on COVID-19 is essential, it has come at the cost of reducing critical investments in other areas of the health budget in South Africa, including the realisation of SRHR.

The budgetary measures also made substantial revisions to the HIV/AIDS Life Skills conditional grant, which funds compulsory comprehensive sexuality education ("CSE")

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[3] Regulation 2(4) of the regulations made under section 27(2) of the Disaster Management Act 57 of 2002.

[4] See: Budget Justice Coalition South Africa (30 April 2021) "Detailed analysis of the Supplementary Budget proposals on spending and raising more revenue" accessed at: https://budgetjusticesa.org/media/detailed-analysis-of-the-supplementary-budget-proposals-on-spending-debt-and-raising-more-revenue/.

programmes in South African schools. This grant was cut by R60 million, and a further R40 million of the conditional grant was reprioritised within its remaining funds to pay for the printing and distribution of support material about COVID-19. Previously planned teacher training sessions for CSE for 20 000 educators were cancelled. Funding for CSE was reprioritised to COVID-19 health messaging, which – while important – should not come at the expense of SRHR education in the context of a society in which HIV and other STI transmission rates, gender-based violence ("GBV") and unplanned teenage pregnancies are unacceptably high among young people. Cuts to the HIV/AIDS Life Skills conditional grant meant that teachers were not trained to deliver CSE in 2020, and those funds were not recovered in 2021. This means there is a high chance of critically important SRHR messaging not reaching adolescents.

**Question 3(2): Have there been any impacts on the availability, accessibility, acceptability or quality of sexual reproductive services during COVID-19?**

### a. Limited access to sexual and reproductive health medicines

In the nationally representative National Income Dynamics COVID Rapid Mobile (NIDS-CRAM) Survey conducted in May/June 2020, 23% of respondents reported being unable to access medication, condoms or contraceptives in the month before when South Africa was in Level 5 lockdown. This rate was much higher (39%) in the subset of respondents who had a chronic condition (like HIV, TB, a lung condition, a heart condition or diabetes). In the Maternal and Child Health (MATCH) Study conducted by the National Department of Health, 11% of respondents – pregnant or new mothers – who needed ART ran out in May and June.

In May 2020, the Gauteng Department of Health reported that 11,000 persons living with HIV ("PLHIV") in the province had failed to collect their ART since the start of the lockdown period in March 2020. Other estimates went so far as to say that HIV treatment had decreased between 30% and 70% during the Level 5 lockdown. Because movement was restricted during this period, many respondents stated that the reason why they did not seek care for acute or chronic health needs was the lack of access to transport.

Although there was a recovery in the uptake of primary health care services in the latter months of 2020 as restrictions eased, it is unclear what catch-up plans have been put in place to address interruptions in access to ART, or pre and postnatal care. Budget cuts will likely impact the ability of the State to reverse these losses.

Researchers showed that there was a significant decrease in the dispensing of contraceptives in the public health sector in Gauteng for the two months before and during the Level 5 lockdown, with a 45% reduction in numbers of people receiving injectable hormone contraceptives in the province. Anecdotal evidence from SECTION27's field researchers in other provinces depicted similar issues, with limited access to injectable contraceptives due to stock outs. Staff duties were also reportedly redirected towards COVID-19 healthcare services, at the expense of SRHR, with fewer healthcare workers available to address adolescent SRHR needs.

### b. Maternal Health

The widely representative NIDS-CRAM survey conducted in May and June 2020 and the Maternal and Child Health (MATCH) survey from the Department of Health surveyed in June 2020 revealed worrying evidence about maternal healthcare, with the numbers of ante- and post-natal care visits dropping. In South Africa, pregnant women are advised to visit the clinic every six weeks. But in the early period of lockdown, 1 out of every 6 pregnant women reported a two-month gap since their last clinic visit, and 37% of these indicated that fear of catching COVID-19 deterred them from seeking the ante- and post-natal care that they needed. Further, 9% of respondents reported a three-month gap in care. Approximately a quarter of respondents whose babies needed immunisations had not visited a clinic in two months, implying missed or delayed vaccination.

While there has been some recovery to pre-COVID-19 levels of access of primary healthcare services like maternal care, we do not yet know the full impact of the attrition in mothers and infants who accessed these services, and whether losses will be reversed.

## c. Comprehensive sexuality education

South Africa adheres to several international benchmarks by having a compulsory stand-alone subject that includes CSE, which is taught through the subject of Life Orientation (LO). At the end of 2019 and the beginning of 2020, new scripted lesson plans ("SLPs") for CSE – developed in line with UNESCO's latest edition of the International Technical Guidance on Sexuality Education – were piloted in schools. But when the COVID-19 pandemic struck, schools were closed before SLPs could be rolled out nationally.

It is estimated that learners lost a minimum of 55 days due to the COVID-19 lockdown school closure between 2020 and 2021 but many learners sustained longer losses to learning time. In order to compensate for the lost learning time, all grades had to "trim" learning curricula and time tables. In this process of revision, some important CSE topics were removed from the curriculum.

For example, the adjusted teaching plan for Life Orientation for grade 10 (for 16 year old learners) cut all information about "Physical changes: hormonal, increased growth rates, bodily proportions, secondary sex/gender characteristics, primary changes in the body (menstruation, ovulation and seed formation) and skin problems" and "violence, HIV and AIDS, safety, security, unequal access to basic resources".

The teaching of CSE has been limited and jeopardised in the context of curriculum revision and constrained time allocations for the LO subject. Although a close investigation into the impact of COVID-19 on the delivery of CSE messaging in schools has not yet been undertaken, it is likely that many thousands of learners were not given crucial age-appropriate, scientifically accurate and judgmental information about their SRHR.

**Question 3(3): Information on other practical obstacles or challenges to access sexual reproductive services during the pandemic, and who were most affected**

During the lockdown, access to public transport was severely limited and more expensive, which discouraged many people from seeking healthcare. Over and above these practical concerns, the COVID-19 lockdown in South Africa saw a nationwide rise in GBV, particularly against women and children, and a rise in femicide. The United Nations acknowledges a correlation between increased reports of domestic violence and emergencies such as epidemics.

GBV in South Africa was already prevalent before COVID-19 – a crisis that was exacerbated by the pandemic. South Africa is said to have one of the highest rates of violence against women and children in the world. Femicide rates are also among the highest in the world. In an address to the nation, President Cyril Ramaphosa spoke about the severity of the situation in the country, noting that a woman is killed every three hours – making South Africa the most dangerous place in the world to be a woman. During the height of national lockdown restrictions, President Cyril Ramaphosa spoke about the scourge of GBV as "a war against women and children." Despite President Ramaphosa declaring gender-based violence and femicide ("GBV-F") its own "pandemic", no additional funding was allocated to support survivors of GBV and important prosecutorial and investigative institutions to support the fight against GBV-F saw significant funding cuts in 2020.

Global Risks Insights describes a situation during the South African lockdown in which many women were trapped inside their homes with perpetrators of GBV. The closure of schools as a measure to combat the spread of the virus, also lead to a rise of abuse against children who were confined at home with GBV perpetrators. Health-e wrote about COVID-19 providing the perfect storm for GBV in South Africa, acknowledging that many women and children were targets for the release of frustrations bought about by the impact of the COVID-19 on household incomes.

The move to postpone school reopening several times in 2020 was also criticised, as school closures cut off valuable social services that are ordinarily available in schools to respond to children suspected of experiencing domestic abuse.

The Call to Action Collective, a civil society group including SECTION27 and led by organisations working on GBV-F have made demands for the government to intervene in the crisis and commit to the national strategic plan on GBV. Last year, the collective undertook a series of workshops to popularise the National Strategic Plan for GBV-F and strengthen the development of the GBV-F council. The South African parliament has now adopted three bills relating to GBV.

**Question 3(4): Identified good practices and opportunities in the provision of sexual and reproductive health care during the pandemic**

Although the COVID-19 pandemic has highlighted inequalities and inefficiencies with the South African healthcare system, it has also ignited widespread interest in public health measures and we have seen unusual examples of solidarity for such an unequal society. With the same level of political will, public buy-in and economic support, South Africa could overcome its SRHR challenges and curb HIV transmission.

**a. Telemedicine**

In response to the access difficulties during the lockdown, the Health Professions Council of South Africa, the statutory body responsible for regulating the healthcare profession, released an advisory that permitted health care professionals to diagnose, treat and dispense medical advice and treatment using virtual or telephonic platforms. This presented an opportunity to explore the use of telemedicines to facilitate access to self-managed abortion, which allows the self-administration of abortion drugs without the direct supervision of the health care professional in a manner that affirms a person's right to health care services and to bodily autonomy.

The success of telemedical consultation is notable in the private sector, however we are not aware of similar provision being made in the public sector. In some ways, self-managed abortion is captured in the recently finalised National Clinical Guideline for Implementation of the Choice on Termination of Pregnancy Act (2021) that provides that medical abortion (up to 10 weeks) can be conducted with mifepristone being administered in the health care facility and misoprostol being self-administered at home. Unfortunately, these guidelines do not go far enough in allowing broader access to abortion as women are still required to present to health care facilities in order to receive the services.

COVID-19 provides an opportunity for South Africa to expand the use of alternative care for obstetrics and post-natal care through increasing reliance on midwifery and birthing units and centres. Research shows that this has proven beneficial in relieving pressure on hospital resources during COVID-19. The change in environment might also alleviate some of the stress and anxiety of birthing during a pandemic.

### b. HIV and TB

"This situation presents an opportunity for positive, long-term, systematic change to transform inefficient, paternalistic policies and practices" authors argue in The Lancet. Their research suggests that health systems and interventions that were developed during COVID-19 could be adapted to support HIV and TB programmes in future. COVID-19 has highlighted inefficiencies and systemic challenges with South Africa's health system, but has prompted that use of innovative ways of reaching vulnerable patients. Community healthcare workers have been central to this effort, and could be better integrated into the health system in future – a long time call of activists. Healthcare systems which result in long waiting times at clinics and long queues to fetch repeat medication could be transformed systematically after COVID-19 through telemedicine, home-based care and community health networks. These networks could be strengthened to support access to screening and self-testing for HIV. Anti-stigma campaigns during Covid-19 could be expanded to provide positive messaging about HIV and other SRHR concerns.

HIV treatment activists suggest the integration of HIV and COVID-19 testing programmes. They advocate for an increased focus on HIV self-testing and for people to be able to start ART in community and home settings. The integration of the programmes could include the incorporation of repeat collection strategies of ART, and thereby mitigate pre-existing issues highlighted by COVID-19. These issues often relate to PLHIV's dissatisfaction with the quality of services at clinics; PLHIV missing treatment; and the number of patients being sent home without medication. The proposed integrated programme would therefore balance adequate preparation with the availability of medicine.

**Question 5: Please indicate if your country, institution or organization has decreased financial support or aid to other State, donor or institution or programme in the area of sexual and reproductive health, including through international cooperation, compared to pre-COVID time**

SECTION27 does not sub-grant to other organisations. SECTION27 is a donor-funded organisation, relying on donations from cooperatives and foundations and, to a lesser extent, from individuals. Our work on SRHR is supported through core funding and through dedicated project funding. Our main source of SRHR project funding grant cycle comes to an end this year (unrelated to the COVID-19 pandemic) and we are fundraising to continue to support this work.

We note that while there seem to be plenty of opportunities to apply for SRHR funding, many of these grants are for regional work. These type of grants generally benefit international organisations and largely exclude locally based organisations like SECTION27, and bear the risk of diluting impact.

SECTION27's SRHR work has a number of components. As a legal advocacy organisation, we use the law in a number of ways to ensure the realisation of SRHR. We use litigation, research, rights awareness and mobilisation in this advocacy.

Our work in schools started as a response to a growing number of sexual violence cases that were reported to us, where learners were being sexually abused or entered into intimate sexual relationships with teachers. As a response to the alarming rates

of sexual abuse of learners in schools, a guide on managing sexual abuse was developed to assist learners and communities on how to identify and report sexual violence. An additional component to this programme is the sex positive SRHR element involving workshops to empower learners on their SRHR, using our adolescent guide on SRHR. From July 2017 to March 2021, we have conducted a total of 90 workshops, reaching 4030 learners.

Our work on SRHR also targets local and provincial AIDS councils, School Governing Bodies and Clinic committees. We have also been collaborating with organisations in the East and Southern Africa region, mainly conducting workshops in Kenya, Zambia, Lesotho and speaking to the barriers to realising SRHR for women and girls in Africa.

The funding of SRHR programmes, particularly amidst the current health and economic crisis, is critical to respond to the persistence of barriers in the realisation of SRHR. Adolescent SRHR must remain a priority to deal with South Africa's challenges with HIV/AIDS, high teenage pregnancy rates and the prevalence of sexual abuse inflicted upon children and women. With more funders shifting their donor priorities towards the COVID-19 response, there are fewer funding opportunities for this fundamental work.