Sexual and Reproductive Justice at the point of care: Values clarification and attitude transformation CToP guideline roll-out Contraceptive services & Infertility services

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Date: 16/09/2026

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Reproductive justice changes the question

Not only: “Is the service available?” — but also: “Can this person exercise meaningful reproductive autonomy?”

Every person should be able to decide whether, when and how to have children — and to receive respectful care without coercion, stigma or discrimination

Rights

- Information
- Privacy
- Confidentiality
- Informed choice
- Consent
- Non-discrimination

Equity

Care designed around unequal
- Geography
- Income
- Age
- Disability
- Gender
- HIV status and
- Social power

Dignity

A clinical culture that
- Listens
- Avoids judgement
- Protects agency and
- Supports the person’s goals

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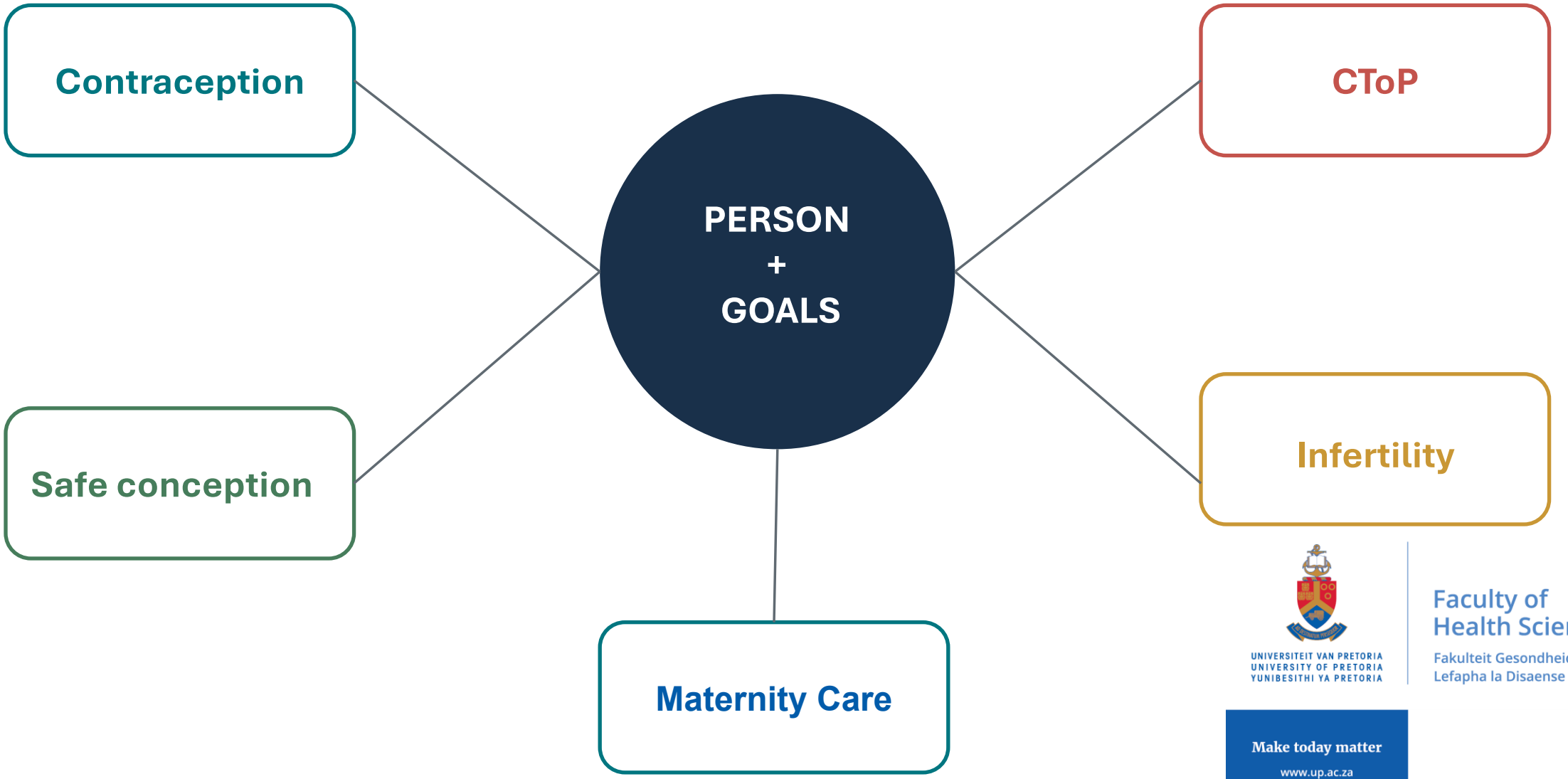
One SRHR system — different Reproductive Intentions

The same person may need contraception, abortion care, safe conception or infertility care at different moments across the life course



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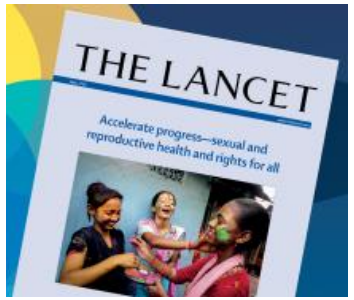
ACCELERATE PROGRESS

Sexual and Reproductive Health and Rights for All



1. information and counselling on **sexual and reproductive health and sexuality education**
2. information, counselling, and care related to **sexual function and satisfaction**
3. prevention, detection, and management of sexual and **gender-based violence** and coercion
4. a choice of safe and effective **contraceptive methods**
5. safe and effective **antenatal, childbirth,** and **postnatal care**
6. safe and effective **abortion services** and care
7. prevention, management, and treatment of **infertility**
8. prevention, detection, and treatment of **sexually transmitted infections,** including HIV
9. prevention, detection, and treatment of **reproductive cancers**

The Guttmacher–Lancet Commission on Sexual and Reproductive Health & Rights
May 2018

Maternal Mortality Objective 3.1:

By 2030 reduce global Maternal Mortality to less than 70 per 100 000 livebirths

SA: 105.4 per 100 000 livebirths

02 Women and maternal health

2.1 Maternal mortality in facility ratio (per 100 000 live births)

Definition: Maternal death is a death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause of death (obstetric and non-obstetric) per 100 000 live births in facility.

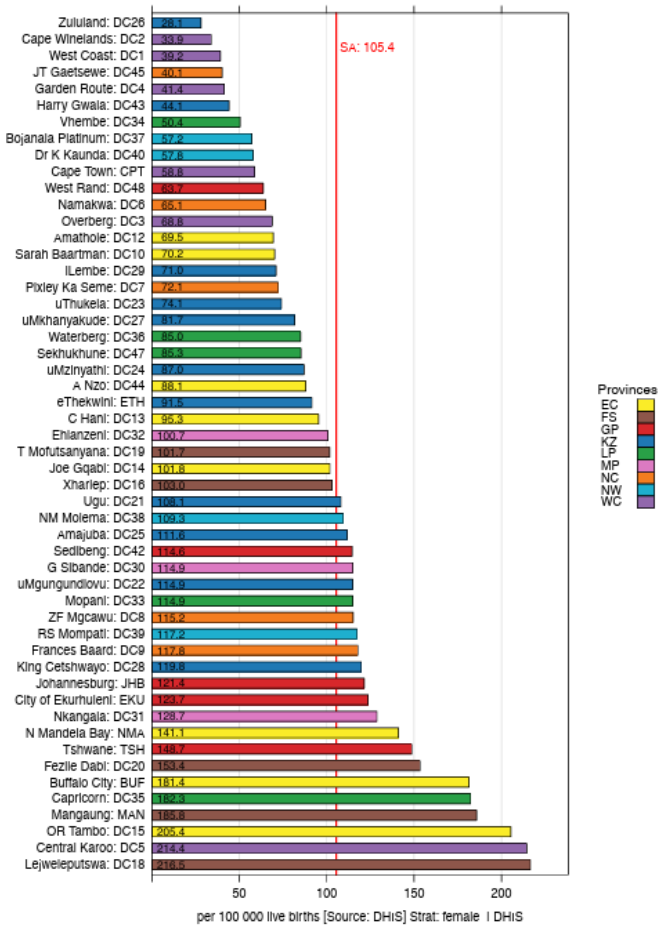


Figure 12 Maternal mortality in facility ratio by district, 2024/25

DISTRICT HEALTH BAROMETER: District Health Profiles 2024/25

To Achieve the SDG target of 70 per 100 000 by 2030

Will require:

- A concerted focus and effort by all levels of the health service to implement the recommendations of the Saving Mothers reports

- Contraception saves women's lives
  By preventing unintended and high-risk pregnancies, enabling appropriate birth spacing and reducing the need for unsafe abortion

- up to about 30% (44%) of maternal deaths could be prevented by meeting the unmet need for contraception[1,2]

1. Cleland J et al, Contraception and health. Lancet. 2012
2. Ahmed S et al, Maternal deaths averted by contraceptive use: an analysis of 172 countries. Lancet. 2012

Contraception Objective:

Attain 75% modern contraceptive prevalence rate

2.6 Couple year protection rate (%)

Definition: Women protected against pregnancy by using modern contraceptive methods, including sterilisations, as proportion of female population 15–49 year. Couple year protection is the total of (Oral pill cycles / 15) + (Medroxyprogesterone injection / 4) + (Norethisterone enanthate injection / 6) + (IUCD × 4.5) + (Sub dermal implant × 2.5) + Male condoms distributed / 120) + (Female condoms distributed / 120) + (Male sterilisation × 10) + (Female sterilisation × 10).

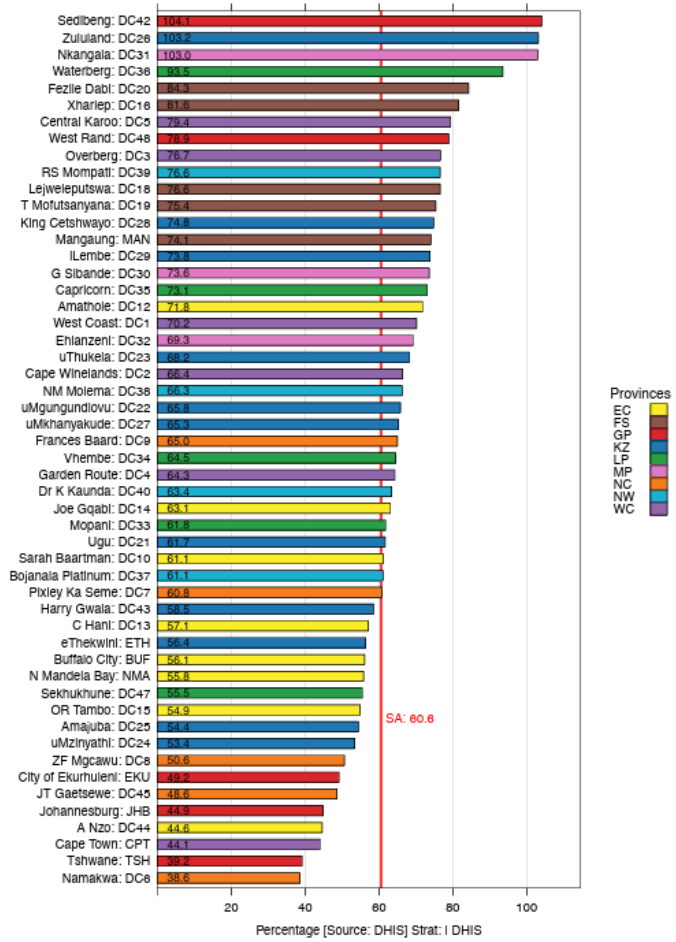


Figure 17 Couple year protection rate by district, 2024/25

DISTRICT HEALTH BAROMETER: District Health Profiles 2024/25

SECTION 1.4 · REPRODUCTIVE HEALTH

Contraceptive protection improving but target still out of reach

60.6 %
Couple year protection rate (CYPR)
↑ from 54.9% in 2023/24 · Target 75% not met

14.4 %
Deliveries to 10–19 year olds
Johannesburg 8.8% lowest · Alfred Nzo 25.1% highest

2 of 9
Provinces exceeding CYPR target
Only Mpumalanga (82.5%) and Free State (77.1%)

Three stories from the reproductive health data

The overall trend is positive

National CYPR rose 5.7 percentage points year-on-year. Male condom distribution is up. The building blocks are strengthening.

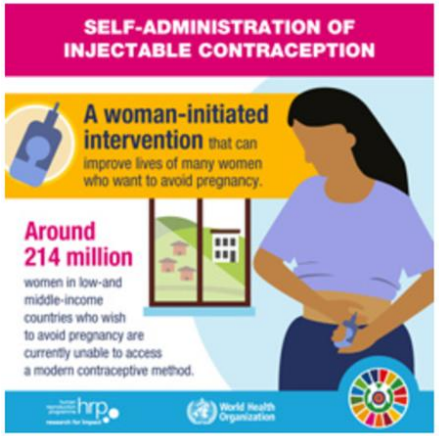
Teen deliveries falling in absolute terms

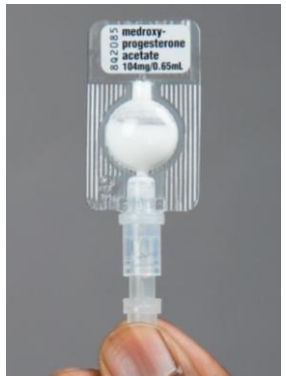
Deliveries in 10–14 year olds fell from 4 053 (2020/21) to 2 387 (2024/25). Rural-metro gap persists but narrowing.

Data-quality flags need action

Districts reporting CYPR > 100% (Sedibeng, Zululand, Nkangala) warrant verification. Female condom distribution remains low.

District Health Barometer 2024/25 | Launch, 23 April 2026
https://knowledgehub.health.gov.za





Reproductive justice changes to improve access

Reproductive empowerment, Expands Choice, Improve Access, Autonomy

Self-administration of injectable contraception	
Recommendation 14	Self-administered injectable contraception should be made available as an additional approach to deliver injectable contraception for individuals of reproductive age. *(Strong recommendation; moderate certainty evidence)*

Interventions	Recommendations and key considerations[a]
Self-management of contraceptive use with over-the-counter oral contraceptive pills	
Recommendation 15	Over-the-counter oral contraceptive pills (OCPs) should be made available without a prescription for individuals using OCPs. *(Strong recommendation; very low certainty evidence)*
Over-the-counter availability of emergency contraception	
Recommendation 16 (new)	WHO recommends making over-the-counter emergency contraceptive pills available without a prescription to individuals who wish to use emergency contraception. *(Strong recommendation; moderate certainty evidence)*

Contraception should be available where reproductive decisions happen

Integrate rather than refer away - whenever it is clinically safe and operationally feasible

- Postpartum & post-abortion
- HIV / STI services
- Adolescent & youth services
- Primary care & chronic care
- Emergency care after sexual violence
- Gynaecology & fertility pathways

Measure: method availability • stock-outs • same-day initiation • removals on request • discontinuation support • informed choice • patient experience

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TOP Objective:

Expanded access to safe TOP services

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NATIONAL CONSULTATIVE WORKSHOP ON CHOICE ON TERMINATION OF PREGNANCY MEETING REPORT

CLINTON HEALTH ACCESS INITIATIVE

Ipas Partners for Reproductive Justice

World Health Organization

26 – 28 AUGUST 2026

- The workshop convened multidisciplinary stakeholders
- To review and update national clinical guidelines, so they are aligned with WHO and actionable within the country

Facility lists versus operational reality

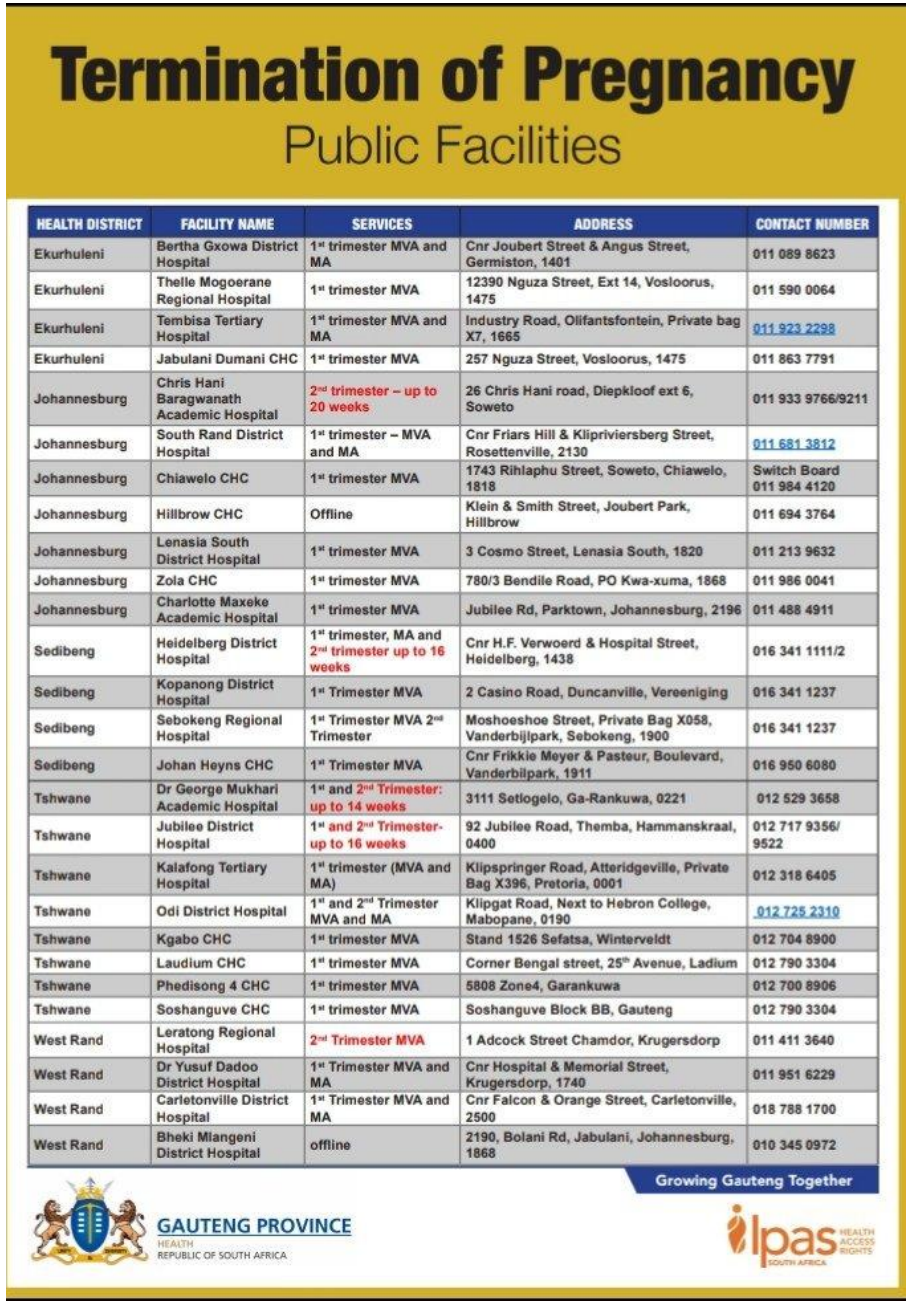
- Multiple provinces reported discrepancies between designated sites on paper and facilities that are operational.
- Audit visits regularly find fewer functional sites than provincial records claim
- publish an audited list of operational TOP and cancer service facilities, with contact details and basic readiness information such as ultrasound availability, on the provincial website

Challenges with access

- **2nd trimester TOP** Challenge
- Designated facilities - ? Functioning
- Need “Walkabout”
- Barriers to access
  - ✓ Adequate staff
  - ✓ Debriefing of staff

Implementation and Operational Considerations

- Ultrasound – for dating
- Workforce Retention
- Mandatory Reporting and legal concerns - reluctant to complete Form 22 (legal reporting requirement)
- Strategies to reduce stigma and improve patient compliance
- Respectful and patient-centred care
- Conscientious Objection
- Referral pathways



Termination of Pregnancy

Public Facilities

HEALTH DISTRICT	FACILITY NAME	SERVICES	ADDRESS	CONTACT NUMBER
Ekurhuleni	Bertha Gxowa District Hospital	1st trimester MVA and MA	Cnr Joubert Street & Angus Street, Germiston, 1401	011 089 8623
Ekurhuleni	Thelle Mogoerane Regional Hospital	1st trimester MVA	12390 Nguza Street, Ext 14, Vosloorus, 1475	011 590 0064
Ekurhuleni	Tembisa Tertiary Hospital	1st trimester MVA and MA	Industry Road, Olifantsfontein, Private bag X7, 1665	011 923 2298
Ekurhuleni	Jabulani Dumani CHC	1st trimester MVA	257 Nguza Street, Vosloorus, 1475	011 863 7791
Johannesburg	Chris Hani Baragwanath Academic Hospital	2nd trimester – up to 20 weeks	26 Chris Hani road, Diepkloof ext 6, Soweto	011 933 9766/9211
Johannesburg	South Rand District Hospital	1st trimester – MVA and MA	Cnr Friars Hill & Klipriviersberg Street, Rosettenville, 2130	011 681 3812
Johannesburg	Chiawelo CHC	1st trimester MVA	1743 Rihlaphu Street, Soweto, Chiawelo, 1818	Switch Board 011 984 4120
Johannesburg	Hillbrow CHC	Offline	Klein & Smith Street, Joubert Park, Hillbrow	011 694 3764
Johannesburg	Lenasia South District Hospital	1st trimester MVA	3 Cosmo Street, Lenasia South, 1820	011 213 9632
Johannesburg	Zola CHC	1st trimester MVA	780/3 Bendile Road, PO Kwa-xuma, 1868	011 986 0041
Johannesburg	Charlotte Maxeke Academic Hospital	1st trimester MVA	Jubilee Rd, Parktown, Johannesburg, 2196	011 488 4911
Sedibeng	Heidelberg District Hospital	1st trimester, MA and 2nd trimester up to 16 weeks	Cnr H.F. Verwoerd & Hospital Street, Heidelberg, 1438	016 341 1111/2
Sedibeng	Kopanong District Hospital	1st Trimester MVA	2 Casino Road, Duncanville, Vereeniging	016 341 1237
Sedibeng	Sebokeng Regional Hospital	1st Trimester MVA 2nd Trimester	Moshoeshoe Street, Private Bag X058, Vanderbijlpark, Sebokeng, 1900	016 341 1237
Sedibeng	Johan Heyns CHC	1st Trimester MVA	Cnr Frikkie Meyer & Pasteur, Boulevard, Vanderbilpark, 1911	016 950 6080
Tshwane	Dr George Mukhari Academic Hospital	1st and 2nd Trimester: up to 14 weeks	3111 Setlogelo, Ga-Rankuwa, 0221	012 529 3658
Tshwane	Jubilee District Hospital	1st and 2nd Trimester- up to 16 weeks	92 Jubilee Road, Themba, Hammanskraal, 0400	012 717 9356/ 9522
Tshwane	Kalafong Tertiary Hospital	1st trimester (MVA and MA)	Klipspringer Road, Atteridgeville, Private Bag X396, Pretoria, 0001	012 318 6405
Tshwane	Odi District Hospital	1st and 2nd Trimester MVA and MA	Klipgat Road, Next to Hebron College, Mabopane, 0190	012 725 2310
Tshwane	Kgabo CHC	1st trimester MVA	Stand 1526 Sefatsa, Winterveldt	012 704 8900
Tshwane	Laudium CHC	1st trimester MVA	Corner Bengal street, 25th Avenue, Ladium	012 790 3304
Tshwane	Phedisong 4 CHC	1st trimester MVA	5808 Zone4, Garankuwa	012 700 8906
Tshwane	Soshanguve CHC	1st trimester MVA	Soshanguve Block BB, Gauteng	012 790 3304
West Rand	Leratong Regional Hospital	2nd Trimester MVA	1 Adcock Street Chamdor, Krugersdorp	011 411 3640
West Rand	Dr Yusuf Dadoo District Hospital	1st Trimester MVA and MA	Cnr Hospital & Memorial Street, Krugersdorp, 1740	011 951 6229
West Rand	Carletonville District Hospital	1st Trimester MVA and MA	Cnr Falcon & Orange Street, Carletonville, 2500	018 788 1700
West Rand	Bheki Mlangeni District Hospital	offline	2190, Bolani Rd, Jabulani, Johannesburg, 1868	010 345 0972

Growing Gauteng Together

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Infertility Objective 3.7:

Ensure Access to sexual & Reproductive Health Services

Infertility Objective 5.6

Ensure Universal Health Access to SRHR

Infertility services are part of SRHR — not an optional luxury

Reproductive justice includes both the right to avoid pregnancy and the right to pursue parenthood with appropriate support

Prevent

- STI prevention treatment
- Reproductive health education
- Fertility awareness
- Iatrogenic risk reduction

Evaluate

- Both partners where relevant
- Female and male factors
- Avoid gendered blame
- Evidence-based work-up

Treat / Refer

- Care at the appropriate level
- clear referral criteria
- continuity while awaiting specialist services

Support

Psychological wellbeing

- stigma
- grief
- relationship strain

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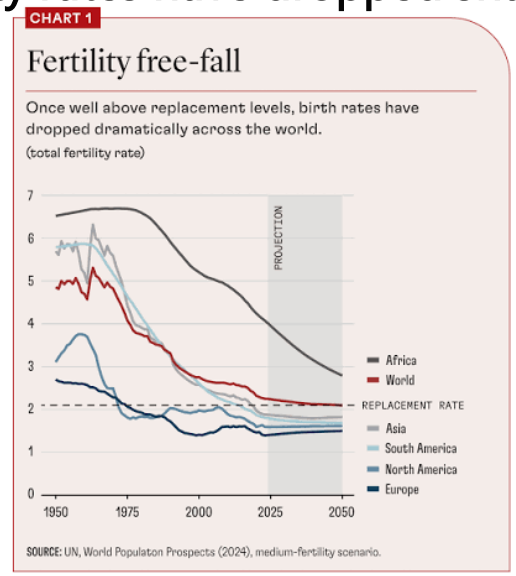
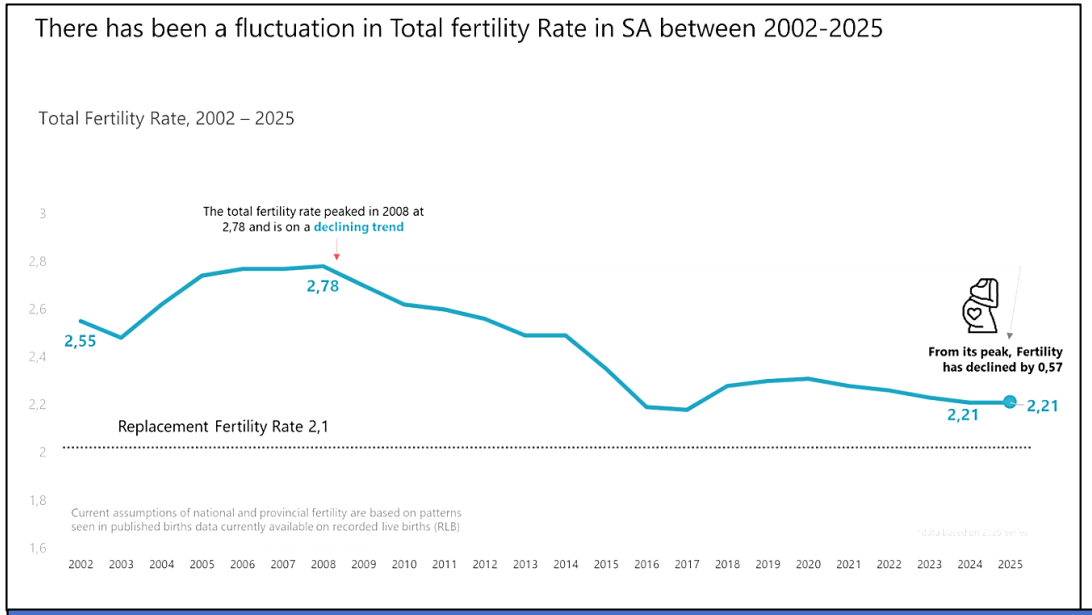
Global fertility rates have dropped sharply across all regions





Stats SA: Mid-year population Estimates, 2025

- Fertility has been declining gradually in South Africa in the past four decades
- Dropping from a Total Fertility Rate of:

  6,7 children/woman in 1960s to

  3,2 children/woman in 1996

  2,8 children/woman in 2001

  2,6 children/woman in 2011

  2.4 children/woman in 2020

  2.3 children/woman in 2022

  2.2 births/ woman in 2025

- The level of fertility in South Africa is among the lowest in the whole of Sub-Saharan Africa

Estimation of fertility from the 2007 Community Survey of South Africa

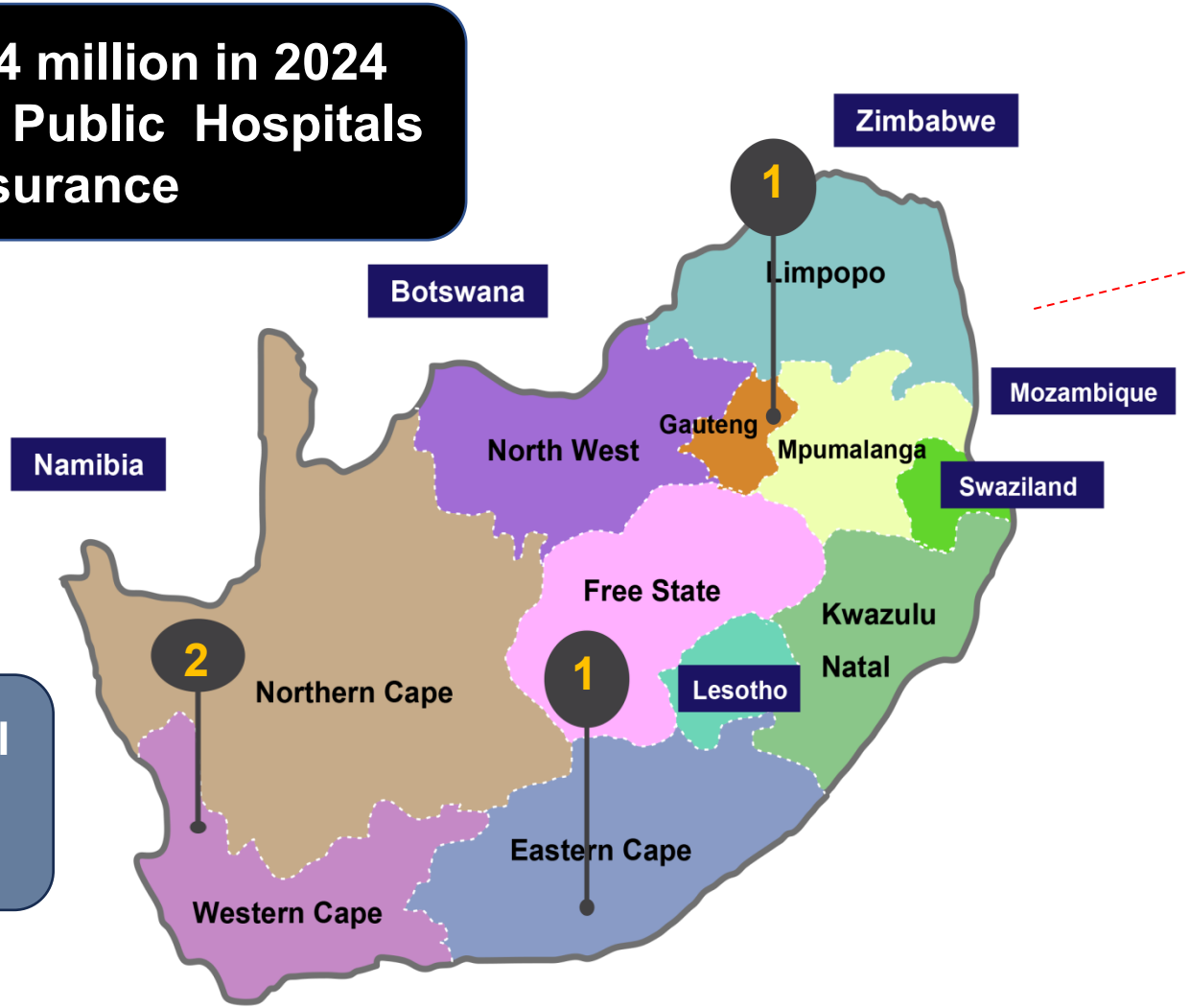
Statistics South Africa
Preferred supplier of quality statistics

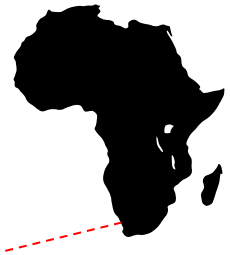
TFR = Average number of children a woman would have by the end of her childbearing years

"Replacement level" threshold where a population replaces itself and sustains its current size

Unmet Need for Infertility Treatment in South Africa

SA population is 64 million in 2024
- **80% population = Public Hospitals**
- **20% = Medical Insurance**





Fertility Clinics Total
- **4 Public**
- **25 (private)**

- Estimated need for ART = **1500 couples/million population/year** [1]
- Cycles in SA 2020 = **7,991** ART Procedures[2]
- Ideal ART cycles = **85 500** cycles/year

1 ESHRE Capri workshop Group, 2001

2 African Network and Registry for ART, 2020 (Reproductive BioMedicine Online, 2024)

Addressing falling fertility rates in Europe

Policy area	Policy	Fertility rate impact*	Economic impact (return on investment)*	Societal or individual impact (wellbeing)
Childcare policies	Increasing childcare availability	★★★★	★★★★	★★★★
	Subsidising childcare costs	★★★		
	Introducing a home care subsidy	★★		
	Implementing longer hours for childcare	★★		
	Improving the quality of childcare	★★		
Workplace policies	Introducing longer maternity leave	★★★★	★★★	★★★★
	Introducing higher-paid maternity leave	★★★★		
	Mandating paternity leave	★★		
	Allowing flexible working arrangements	★★		
	Ensuring job protection and no discrimination	★★		
Financial policies	Proving a one-time baby bonus	★★★	★★	★★★★
	Providing tax credits for families	★★★		
	Providing universal child allowance	★★★		
	Providing housing benefits for families	★★		
Assisted reproduction policies	Introducing public funding of ART	★★★	★★★	★★★★
	Increasing availability of ART	★★★		
	Providing egg-freezing subsidies	★★		
	Allowing more inclusive ART for same-sex couples and single women	★★		
	Introducing programmes to improve fertility education and awareness	★★		

https://www.fertilitycounts.com/wp-content/uploads/2024/10/Fertility-policy-and-practice-a-Toolkit-for-Europe.pdf

A toolbox to address and manage demographic change

Demographic change requires comprehensive and integrated solutions. Reforms and investments are needed, using a combination of EU and national-level instruments, to maintain the EU's competitive edge. The demography toolbox draws on experiences from across the EU and sets out a comprehensive approach to demographic change structured around 4 pillars.

- **Europe is an ageing continent,** raising the dependency ratio from 33% to 60% by 2100.

https://commission.europa.eu/publications/communication-demographic-change-europe-toolbox-action_en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The minimum facility bundle for reproductive justice

Sexual and Reproductive Justice at the point of care means ensuring that every person who enters a healthcare facility can exercise their sexual and reproductive health and rights in practice

People

VCAT + clinical competencies + mentorship + respectful-care standards

Pathways

Clear SOPs, eligibility, referral criteria

Products

Reliable medicines, contraceptive method mix, equipment and diagnostics

Place

Privacy, confidentiality, disability access, adolescent-friendly and non-stigmatising flow

Data

Access, waiting time, stock-outs, referrals, complications, equity and experience

Governance

Named accountable leads, review meetings, incident learning and patient feedback

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