



STOP STOCKOUTS

**Access to Contraceptives in South
African Public Health Clinics
between April and June 2022**



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Executive summary

After receiving reports regarding contraceptive stockouts over the past year, the Stop Stockouts Project (SSP) conducted a survey to collect data on contraceptive availability across the country. The data was collected by Ritshidze, a community-led monitoring project, between April and June 2022. The data collected reflects the reports made to community monitors by both public healthcare users and public healthcare providers. Reports were then referred to the SSP hotline for resolution.

The impact of contraceptive stockouts falls squarely on women and girls.

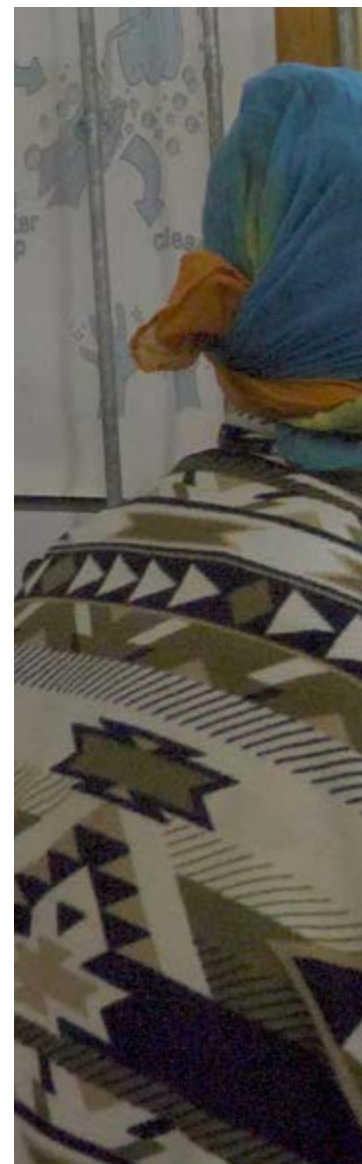
Key findings indicate that while the overall medicine stockouts situation in South Africa has broadly improved significantly since SSP began surveying this issue in 2013, of those reported, contraceptives now represent the biggest share of stockouts in the public healthcare system. While 6.9% of patients reported a stockout when at a clinic, 40% of these were stockouts of a contraceptive. Within the contraceptives category, 76.3% of stockouts reported were injectables.

Crucially, when facilities were asked about stockouts, 67.6% reported that patients had not left without medicine because they were given an alternative; and 58.3% of health facilities who answered the question stated that they recommended switching to alternative forms of contraception when stockouts occurred. While this is a reasonable response from healthcare workers trying to support patients, switching contraceptives can have a detrimental impact on women's health and lives, and is not a long-term solution to stockouts. Women and girls should be able to access their preferred contraceptive at health facilities at all times.

Marking Women's Month in South Africa this year, the SSP draws attention to the ongoing problem of contraceptive stockouts across the country and calls on government to ensure a reliable supply of preferred contraceptives.

Women are bearing the burden of the unavailability of contraceptives and continued problems in accessing safe abortion services. This is despite the clear constitutional right to access to healthcare services, including reproductive healthcare services. Interrupted or limited access to contraceptives represents a gap between the rights enshrined by the Constitution and the lived reality of many, with real and lasting impacts on women.

This report reflects the data collected before considering the global context of contraceptive supply issues, in order to determine if the situation is unique to South Africa. It concludes by laying out the legal and policy background that requires reliable access to contraceptives.





After reflecting on the data collected, the Stop Stockouts Project makes the following key recommendations to government:

1. Create a plan to address contraceptive stockouts in primary healthcare facilities, including shortening the time for resolution of stockouts where they occur;
2. Provide guidelines for how primary healthcare facilities should manage stockouts, should they occur;
3. Monitor implementation of the National Integrated Sexual and Reproductive Health Rights (SRHR) policy, including providing access to long-term removable contraceptives such as intrauterine devices (IUDs), and ensuring that stock meets need; and
4. Ensure that women and girls are able to access their preferred contraceptive.



Introduction

The Stop Stockouts Project (SSP), established in 2013, is a consortium of five civil society organisations Doctors Without Borders (MSF), Rural Doctors Association of South Africa (RuDASA), Rural Health Advocacy Project (RHAP), SECTION27, and the Treatment Action Campaign (TAC) that aims to monitor and report on medicine and vaccine shortages and stockouts at primary healthcare facilities, to enable speedy resolution of these issues and ultimately assist those whose lives are threatened by chronic supply shortages in South Africa.

In September 2017, the contract for the supply of contraceptives to the public sector in South Africa ended and contributed to disruptions in supplies to public and private sectors.¹ Since 2018, the SSP has raised concerns about ongoing shortages of contraception at public health facilities² across the country, based on individual patient and healthcare worker reports to the SSP hotline.

The SSP had conducted annual telephonic surveys of all listed public health facilities in South Africa in 2013 - 2015 and 2017 to determine the extent of stockouts, focusing on HIV and Tuberculosis (TB) medicines, as well as childhood vaccines. Responses to these earlier surveys came from health facility staff only.

In 2022, SSP explored a novel opportunity for gathering data with existing resources by using data collected by Ritshidze,³ a community-led clinic monitoring (CLM) system developed by organisations representing people living with HIV, including the Treatment Action Campaign (TAC), the National Association of People Living with HIV (NAPWA), Positive

Action Campaign, Positive Women's Network (PWN), and the South African Network of Religious Leaders Living with and affected by HIV/AIDS (SANERELA+). Using Ritshidze's CLM, SSP is able to analyse responses from health facility staff and patients making use of the service. We believe this will provide a more holistic picture of stockouts, one that notably includes patients' experiences as an alternative perspective to routine health information as reported by the Department of Health, and will strengthen engagement with government on stockouts and government efforts to respond to stockouts. SSP reached out to provincial health departments and the National Department of Health for comment about this report, but we did not receive any responses before the time of publication.

Between April and June 2022, SSP in collaboration with Ritshidze added indicators on the availability of and access to contraceptive services at clinics covered by Ritshidze monitors. In this report, we present focused findings on the state of contraception availability from this round of data collection.

1. <https://www.oatext.com/how-robust-is-contraceptive-supply-in-south-africa-a-time-series-study-of-oral-and-injectable-contraceptive-supply-following-the-end-of-the-2017-public-sector-contract.php>

2. <https://stockouts.org/Home/Media>

3. <https://ritshidze.org.za/the-model/>



Ritshidze methodology

Community-led monitoring is a systematic collection of data by community members at the site of service delivery. The data is compiled, analysed and then used by community organisations to generate solutions to problems found during data collection. In Ritshidze, people living with HIV and key populations are empowered to monitor services provided at clinics, identify challenges, generate solutions that respond to the evidence collected, and make sure the solutions are implemented by duty bearers.

Ritshidze employs 80 Community Monitors to routinely assess health service delivery on a quarterly basis at over 400 public health facilities across 29 districts, in seven out of nine provinces in South Africa. The Northern Cape and Western Cape provinces are not surveyed because monitoring focuses on high-volume PEPFAR⁴-supported clinics (which do not exist in the Northern Cape) and relies on authorisation for monitoring from each province (which the Western Cape has declined to provide).

Monitoring is carried out utilising a number of standardised survey and observation tools, including:

- Public healthcare user surveys – patients are recruited for participation while at health facilities. Quarterly patient surveys target 50 patients per facility;
- Facility Manager surveys – conducted with the Facility Manager;

- Medicines surveys – conducted with the pharmacist or person responsible for medicine stocks at the facility; and
- Observation surveys – observations of facility conditions and operations witnessed directly by Ritshidze Community Monitors.

All Ritshidze data collection tools are publicly accessible and available online,⁵ as are the data collected.⁶

Included in this analysis are all data collected during the 2022 Quarter 3 (April to June 2022) round of data collection from the Medicines survey, as well as seven indicators from the Facility Manager surveys and 14 indicators from the Patient survey relevant to available medicines stocks, contraception availability, and healthcare services available to patients.

4. The US President's Emergency Plan for AIDS Relief

5. <https://ritshidze.org.za/category/tools/>

6. http://data.ritshidze.org.za/?CC=ZA&year=2022&period=Q3&ind=cc_facility_staff&SNU1=&SNU2=&facility=



Results

During the period April to June 2022, Ritshidze clinic monitors surveyed 15 750 patients in 402 health facilities across seven provinces (Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Limpopo, Mpumalanga and North West). The patient demographic profile is shown in Table 1.

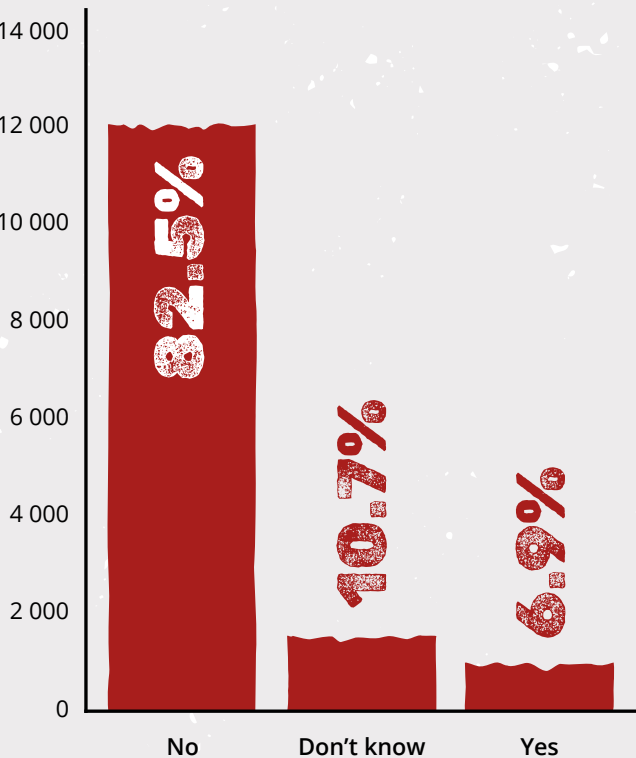
Table 1: Patient Survey Demographics⁷

Age	<18 years old	375 (2.4%)
	18 – 25 years old	2,691 (17.1%)
	>25 years old	12,592 (80.0%)
	Don't know	36 (0.2%)
Gender	Female	10,475 (66.5%)
	Male	5,216 (33.1%)
	Transgender	27 (0.2%)
	Don't know	6 (0.04%)
People living with HIV		9,873 (62.7%)

7. Some participants did not answer all the questions.

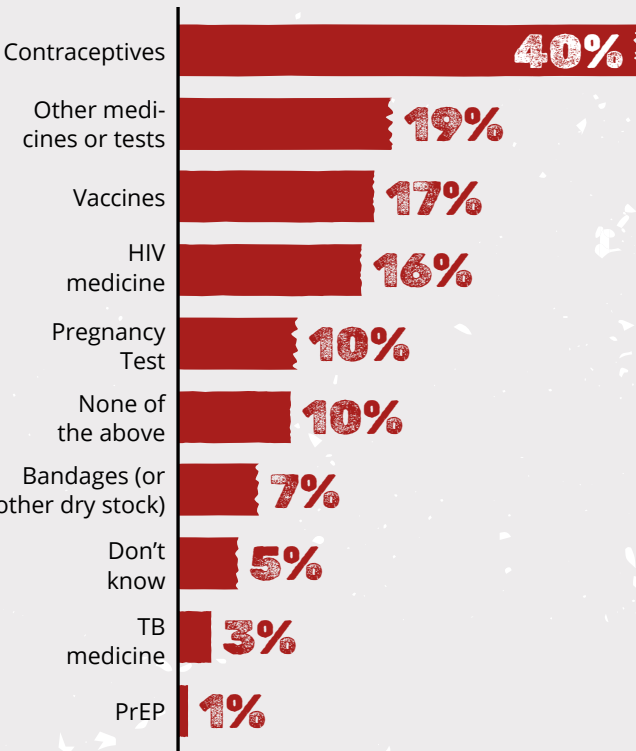
Patient surveys

Graph 1: Number of patients who left without medicine due to a shortage. (n = 14 815 patients)



Nationally, 6.9% (1 018/14 815) of patients surveyed at 380 health facilities across seven provinces reported that in the past three months, they or someone they knew had left the facility without the medicines, contraceptives, vaccines, dry stock or tests they needed due to stockouts or a short supply, as shown in Graph 1. 10.7% of people reported that they don't know if they left without medicine due to a shortage in the past three months. Province-specific responses are shown in Table 1 of the Annex.

Graph 2: Patient reports on medicine shortages.* (n = 978 patients)

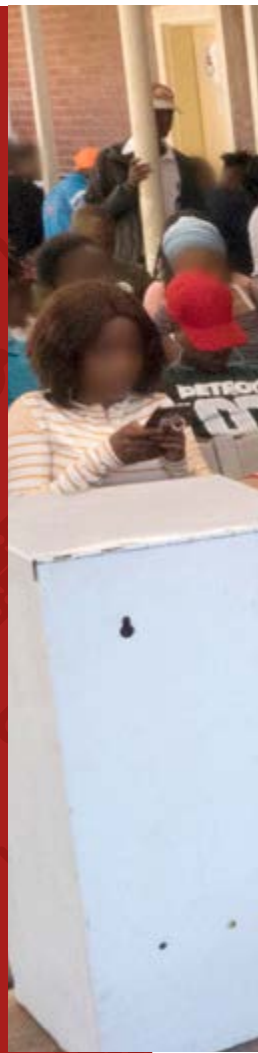


Graph 2 shows the types of medicines that patients have reported shortages of in the past three months. Of those who reported leaving the facility without medicine in the past three months, 387 (40%) reported contraceptives, 181 (19%) 'Other medicines or tests', 165 (17%) vaccines and 155 (16%) HIV medicine as being in short supply or out of stock on the day of the survey. More than one medicine could be selected by patients. 40 of 1 018 patients chose not to respond to this question. Specific results are shown in the provincial breakdown table in the Annex. *Some patients selected more than one option



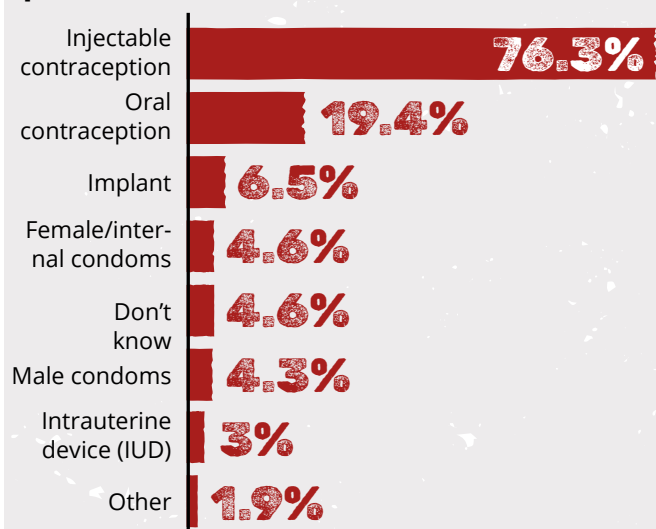
"As a young woman, having access to a variety of contraceptive methods allows me space to be independent and equal in society, with choice and control over my body. Not having the option I prefer for months at a time has not been ideal."

Xabisa Qwabe – TAC Communications Officer and TAC branch member



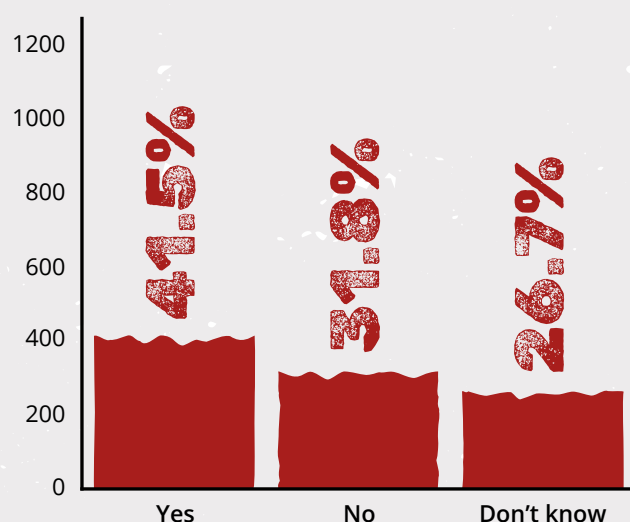


Graph 3: Type of contraception shortage or stockout.* (n = 372 patients from 126 health facilities)



Graph 3 shows that 372 (96.1%) of 387 patients reporting contraceptives as out of stock or in short supply responded to the question on the type of contraception that was unavailable. 284 (76.3%) reported injectable contraception as unavailable, followed by 72 (19.4%) for oral contraception and 24 (6.5%) for implants. *Some patients selected more than one option

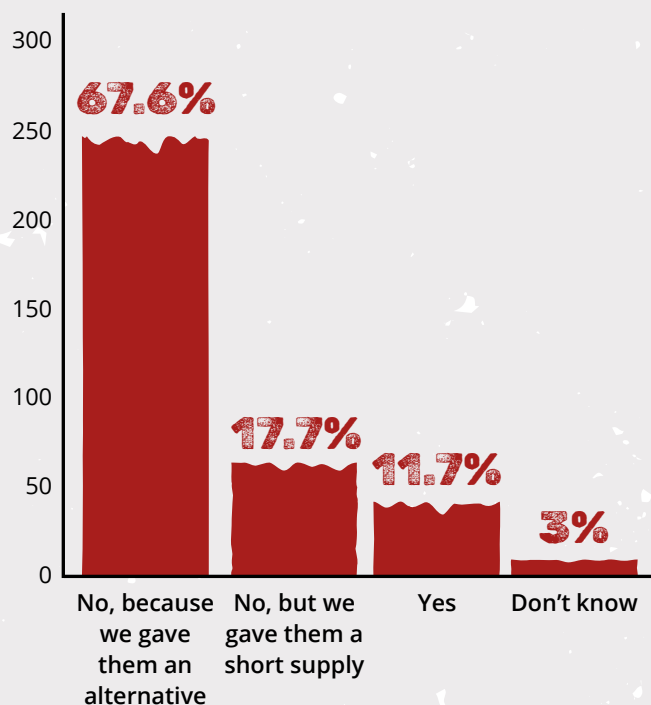
Graph 4: Stockout or shortage occurring on the day of survey. (n = 1 004 patients)



Graph 4 shows the patient responses to the question about whether the stockout or shortage of medicine, contraception, vaccine or test was occurring on the day of the survey. Of the 1 004 responses (98.6% of 1 018 patients who reported leaving the facility without their medicine), 417 (41.5%) said yes; 319 (31.8%) said no; and 268 (26.7%) did not know.

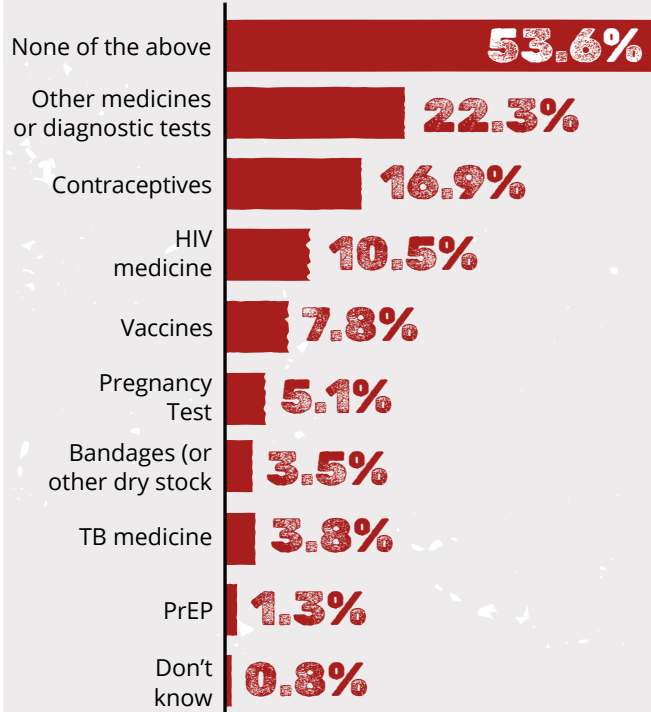
Facility staff surveys

Graph 5: Facility report on response to stockout or shortage (n = 367 health facilities)



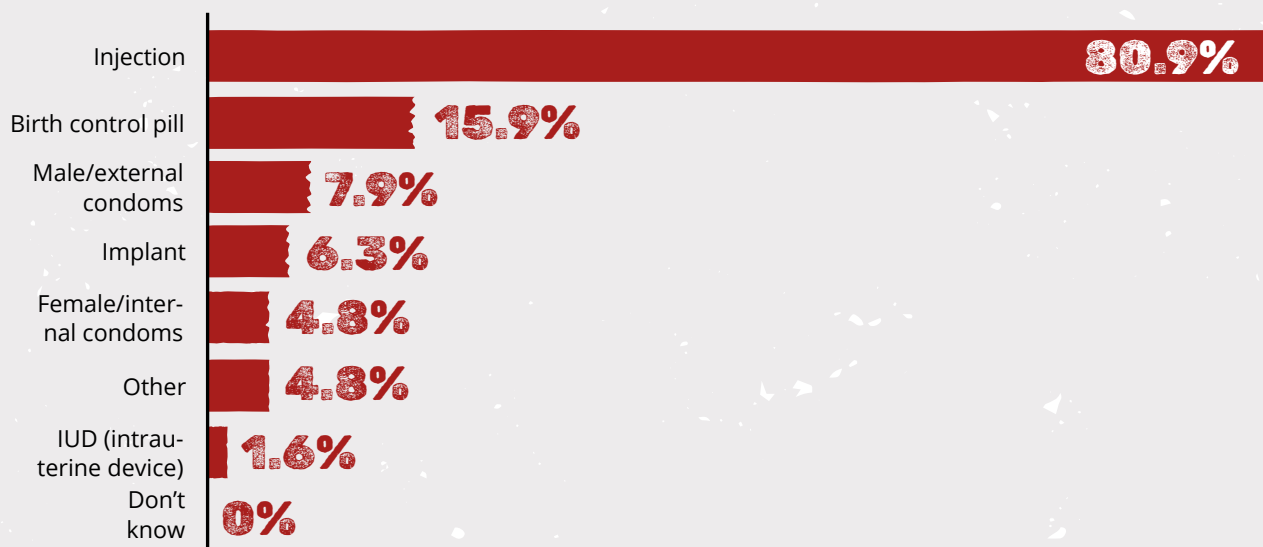
Graph 5 shows the responses from health facility staff at 367 health facilities across seven provinces to the question asking if in the past three months, any patient had left the facility without the medicine they needed due to a stockout or shortage. 248 (67.6%) responded 'No, because we gave them an alternative'; 65 (17.7%) 'No, but we gave them a short supply'; 43 (11.7%) 'Yes'; and 11 (3%) did not know.

Graph 6: Facility responses to types of medicine shortages (n = 373 health facilities)



Graph 6 shows the responses from 373 health facilities to a multiple-choice question on the types of medicine shortage each facility had experienced in the past three months. Of the 173 reports on shortages, 83 (22.3%) facilities reported 'Other medicines or diagnostic tests'; 63 (16.9%) contraceptives and 39 (10.5%) HIV medicine. Notably, more than half of the staff who completed the survey said that none of the medicines listed were out of stock.

Graph 7: Facility report on type of contraceptive shortage (n = 63 health facilities)



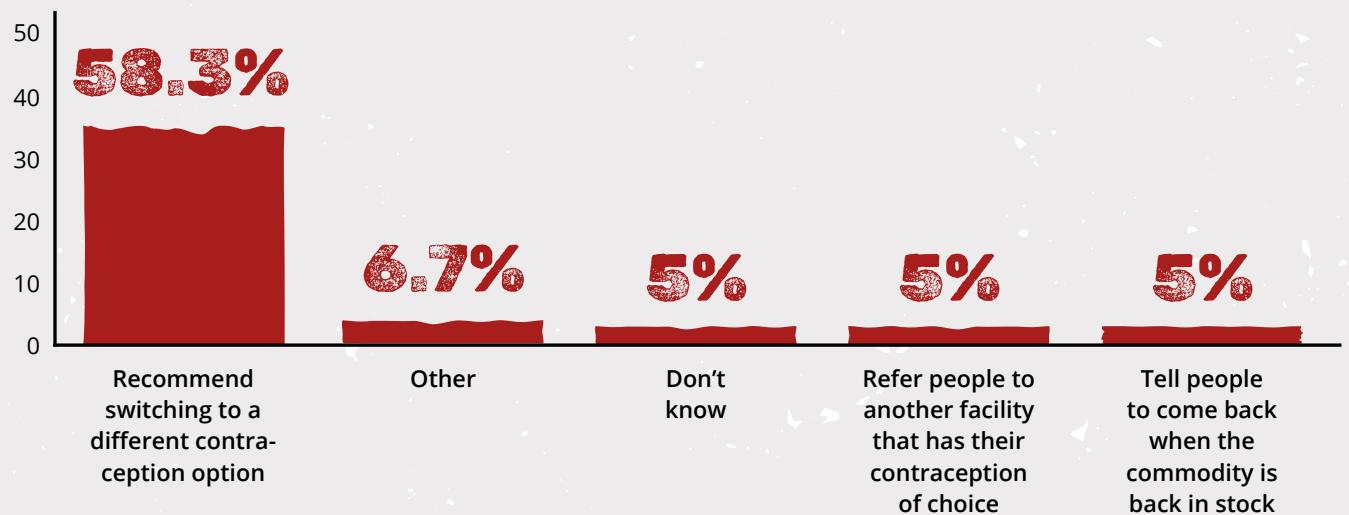
Graph 7 shows that of the 63 facilities reporting a contraceptive shortage in the past 3 months, the most commonly reported shortages were injectable contraception, at 81% (51/63), and oral contraception, at 15.9% (10/63).

“Clients need longer counselling on alternate methods, which takes time and increases waiting times.

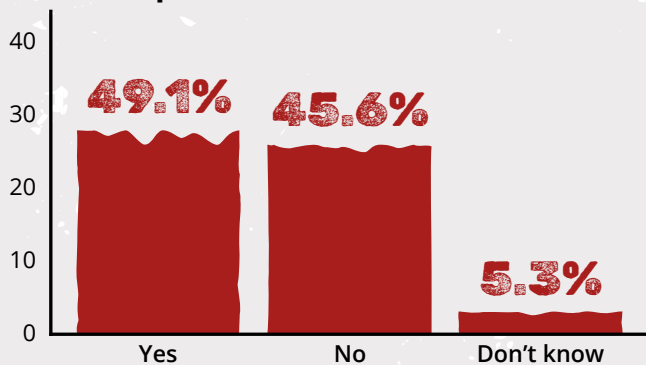
If patients are not switched carefully, we may increase their risk of pregnancy. Some patients are using particular methods without their partners knowing, and changing methods may create interpersonal problems. Alternatives such as condoms and abstinence may be difficult to negotiate with partners, and are less effective methods. The first year on a contraceptive method carries the highest risk, therefore switching methods subjects patients to exposure to risks just as a new user would be. We already have an unmet need for contraception for various reasons, and stockouts worsen the situation. During the COVID-19 pandemic there were barriers to accessing contraception, and stockouts worsened the situation, especially when we tried extending prescriptions so patients didn't need to come in very often. If the already high rates of unintended pregnancy increase, it has a direct effect on worsening abortion rates, maternal morbidity and death. Facilities also have a role to play in the supply chain, and ordering enough stock timeously helps.”

**Dr Mala Panday, Obstetrician
Gynaecologist, Family Planning Services
Department, King Dinizulu Hospital
Complex, Durban, KwaZulu-Natal**

Graph 8: Facility survey on alternative options for contraception stockouts (n = 60 health facilities)



Graph 9: Official guidance to facilities on how to manage contraceptive stockouts (n = 57 health facilities)

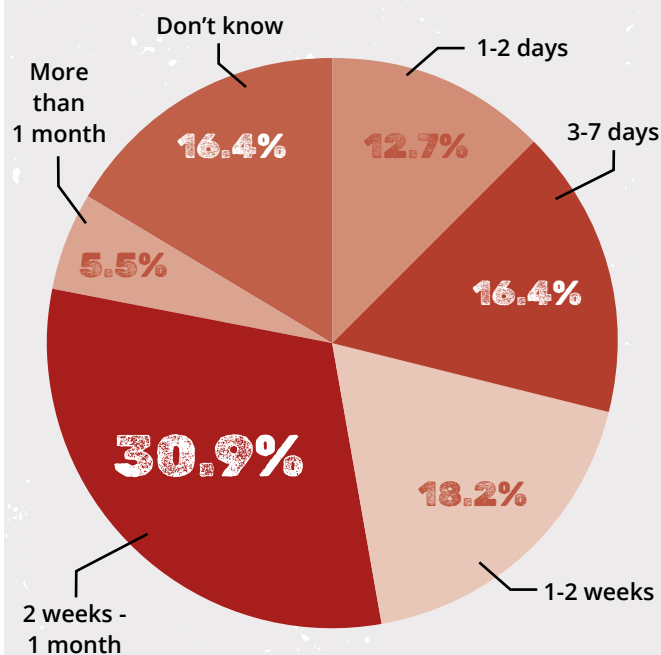


Graph 8 shows responses (from 60 out of 63 health facilities reporting contraceptive shortages in the past three months) to the question about alternative options for users during periods of hormonal contraceptive stockouts. 58.3% (35/60) reported recommending patients switch to a different contraception option. However, Graph 9 indicates that half of these facilities with contraceptive shortages have not been provided with official guidance on how to manage the contraceptive shortages.



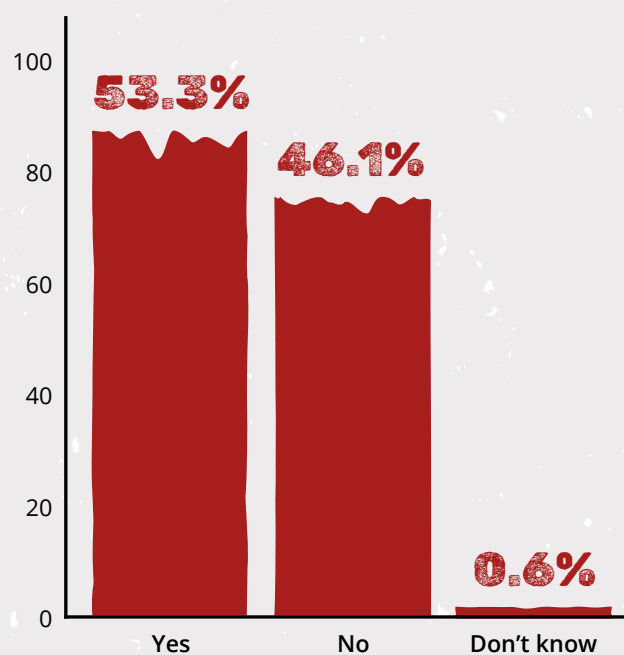


Graph 10: Facility expectations for more contraceptive stock (n = 55 health facilities)



Graph 10: 55 of 63 health facilities reporting contraceptive stockouts in the past 3 months responded to the question on when they anticipated receiving more stock. Although 30.9% (17/55) answered 'from two weeks to a month', responses varied from 'a few days' to 'more than a month'.

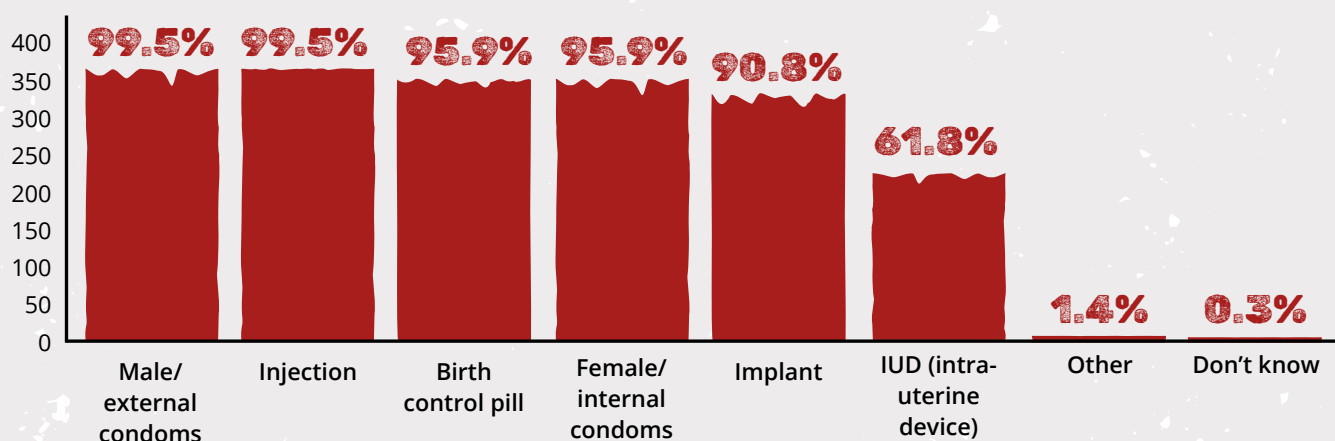
Graph 11: Facility report on stockout or shortage resolution (n = 167 health facilities)



Graph 11: Of 173 facilities reporting a stockout or shortage in the past three months, 167 (96%) responded to the question about whether the stockout or shortage had been resolved. 89 (53.3%) said yes, 77 (46.1%) said no, and 1 (0.6%) did not know.

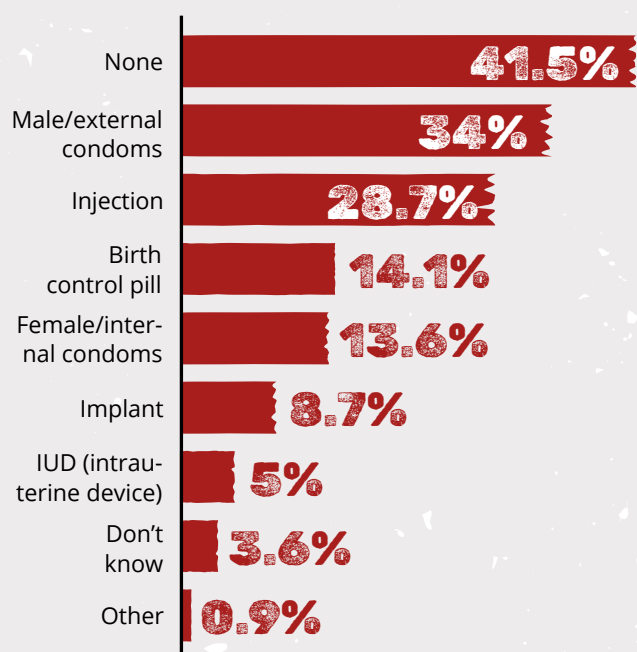
Service delivery compared to patient needs

Graph 13: Contraception options available at facilities (n = 369 health facilities)



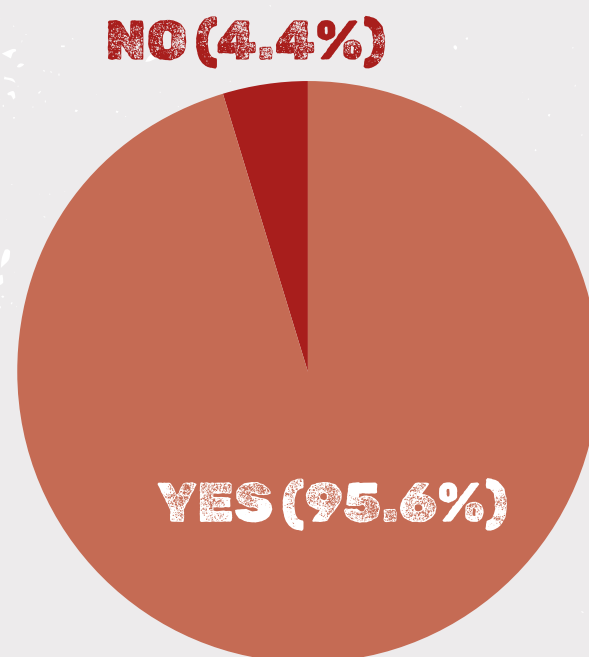
Graph 13 shows the responses from 369 facilities across seven provinces. 90% of facilities reported availability of condoms, oral (birth control pills) and injectable contraception, and the hormonal implant. The intrauterine device (IUD) was less commonly available (61.8%). The reported availability of these services must be considered in light of patient and staff reports on stockouts, which suggest that the 'available options' are in fact not always on offer.

Graph 14: Type of contraception patients tried to access at facilities (n = 14 430 patients)



Graph 14: 7 963 (55.2%) of 14 430 patients reported the types of contraception they tried to access at the health facility. Condoms were the most requested (34%), followed by injectable (28.7%) and oral contraception (14.1%).

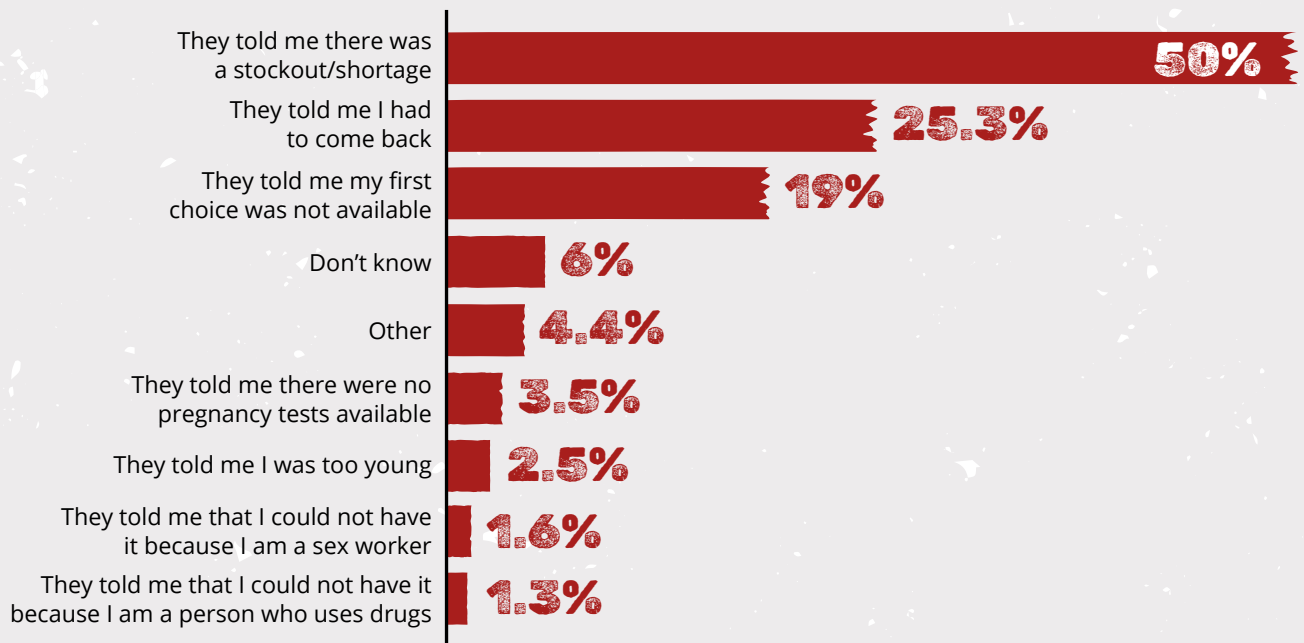
Graph 15: Patient response to accessing preferred contraception (n = 7 874 patients)



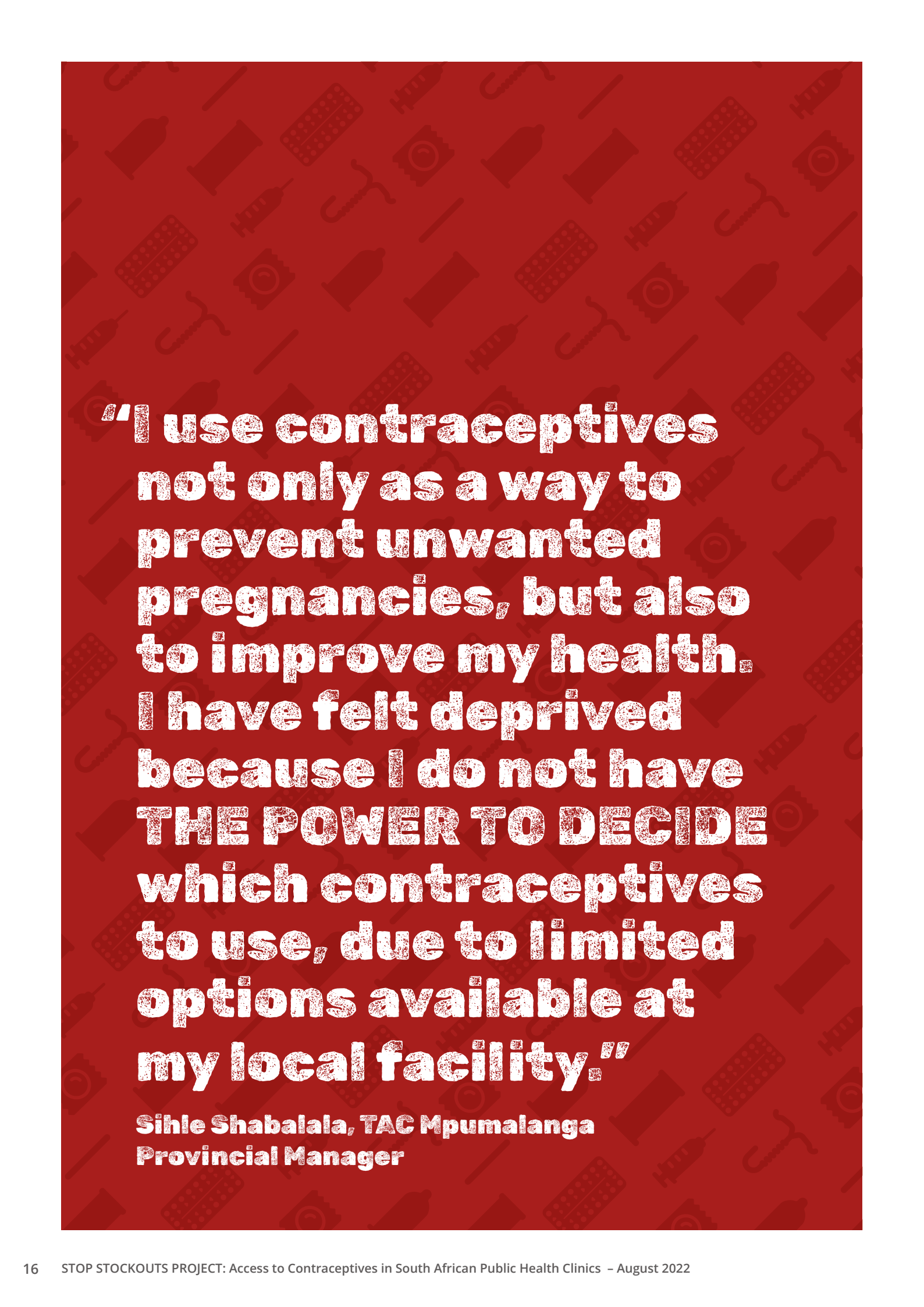
Graph 15 shows that 7 524 (95.6%) of 7 874 patients who reported the type of contraception they tried to access were able to get the contraception they wanted.



Graph 16: Reasons for not getting contraception of choice (n = 316 patients)



However, Graph 16 below highlights that the most common reasons given for not getting the contraception of choice were being told it was due to a shortage or stockout (50.0%), followed by being told to come back (25.3%) and being told the patient's first choice wasn't available (19.0%).



“I use contraceptives not only as a way to prevent unwanted pregnancies, but also to improve my health. I have felt deprived because I do not have THE POWER TO DECIDE which contraceptives to use, due to limited options available at my local facility.”

**Sihle Shabalala, TAC Mpumalanga
Provincial Manager**

Discussion: what these findings mean for women's sexual and reproductive health

While this report reflects a survey using different methodology and a different focus compared with previous [SSP annual reports](#),⁸ it demonstrates a significantly improved overall picture of medicine availability in South Africa, with only 7% of patients reporting leaving the health facility without their medicine in the past three months due to a stated stockout.

In addition, Ritshidze's community-led clinic monitoring data reflects the experience of public health service users, and is an important alternative perspective to the routine health information reported by the Department of Health.

According to the 2020 edition of the Standard Treatment Guidelines and Essential Medicines List for South Africa, there are three types of hormonal contraception accessible at public health facilities: a subdermal implant; depot injectables; and combined oral contraceptive pills. Research from [Contraception coverage and methods used among women in South Africa: A national household survey](#)⁹ suggests injectable and oral contraception are more commonly used by sexually active women compared to other forms of contraception. Data from this survey indicate that these most commonly used methods are not reliably available.

Patients who responded to this survey were mostly women (66.5%) and people living with HIV (62.7%), and male condoms were the most frequently requested form of contraception, followed by injectable and oral ('birth control pill') contraception. While it is reassuring to see that 95.6% of patients requesting contraception in this survey were able to get what they wanted, it is concerning that contraception, specifically injectable contraception, stands out as the most reported medicine shortage across the country. The number of reports of contraception shortages by those who left health facilities without their medicines was more than twice that of HIV medicines (16%) and vaccines (17%), both of which are also categories of essential primary healthcare medicines. Also relevant to sexual and reproductive health

services in this survey is that 10% of stockouts were of pregnancy tests.

Persistent stockouts of the hormonal contraceptive impacts women and girls directly, both socio-economically and clinically. The availability of male condoms does not mitigate the impact on women of hormonal contraceptive and pregnancy test stockouts. Not being able to access one's contraception of choice or getting a short supply implies one must choose from accepting an option that is not preferred, going without contraception, or trying to find it elsewhere at additional cost and inconvenience. Moving between different types of hormonal contraception can result in increased side-effects and/or gaps between contraception use, increasing the chances of an unplanned pregnancy, and cause physical discomfort as well as the psycho-social stress of managing these effects.

Overall, most facilities responding to this survey reported offering a range of contraceptive options; however, service is probably severely compromised when there is a shortage of contraception stock. The reported lack of clinical guidance on how to manage hormonal contraceptive stockouts puts staff and (particularly) patients in a difficult position. Further, the varied time frame for expected resolution of contraceptive shortages suggests that the system is not responsive to the needs of those it is serving. Together, these findings indicate shortcomings in planning and poor communication within and by the Department of Health. This is especially concerning considering that contraceptive stockouts have been ongoing since at least 2017, as SSP data has consistently shown.

8. Previously, the SSP collected data through telephonic surveys only with facility managers that we could contact. For the findings from these surveys, visit <https://stockouts.org/Survey/SurveysAndResearch> This year, we partnered with Ritshidze to survey both facilities and health users.

9. Chersich, M F, Wabiri, N, Risher, K, Shisana, O, Celentano, D, Rehle, T, Evans, M, & Rees, H. (2017). Contraception coverage and methods used among women in South Africa: A national household survey. SAMJ: South African Medical Journal, 107(4), 307-314. <http://www.samj.org.za/index.php/samj/article/view/11856>.



In the South African context, where misogyny and gender-based violence are widespread, we cannot afford a de-prioritisation of women's sexual reproductive health issues.

We therefore recommend that government urgently:

1. Create a plan to address contraceptive stockouts in primary healthcare facilities, including shortening the time for resolution of stockouts where they occur;
2. Provide guidelines for how primary healthcare facilities should manage stockouts should they occur;
3. Monitor implementation of the National Integrated SRHR policy, including promoting long-term removable contraception such as IUDs, and ensure that stock meets need; and
4. Ensure that women and girls are able to access their preferred contraceptive.



“The reality is this [also] has implications for students in training,

because they miss opportunities to learn best practices with the disruptions that stockouts pose. Students have limited clinical observation time for the various skills that are in their scope of practice, and they should be assessed in all areas of their nursing practice. When they miss out, this has implications for their knowledge, skills and assessment outcomes. The class could finish their rotation and move from the family planning clinic to another clinic without having observed the administration/dispensing of particular commodities.”

Dr Mzikazi Nduna, Dean of Health Sciences, University of Fort Hare

The negative impacts of contraceptive stockouts are more deeply felt by women and girls in resource-constrained settings such as the rural provinces of South Africa, where the per-province data in the Annex shows the problem of contraceptive stockouts to be most acute.

Resolving hormonal stockout issues would decrease the burden on women and girls' sexual reproductive health and rights. Findings from this survey and their impact on patients are in keeping with a [2020 study by Govender et al.](#), in which

the authors highlight “the judgemental attitude of nurses and limited stocks of injectable contraceptives at clinics” as one of the main findings from their interviews with adolescent mothers aged 16-19 years old.¹⁰ The authors conclude that healthcare services “may be a barrier to rather than an enabler of sexual and reproductive health support”, and that the perceptions of participants in their study illustrate that sexual and reproductive health is provided in a demeaning rather than an empowering manner.

10. Govender, D., Naidoo, S. & Taylor, M. “My partner was not fond of using condoms and I was not on contraception”: understanding adolescent mothers' perspectives of sexual risk behaviour in KwaZulu-Natal, South Africa. *BMC Public Health* 20, 366 (2020). <https://doi.org/10.1186/s12889-020-08474-2>

The bigger picture: global access to contraceptives

Thanks in large part to increased education and awareness, demand for contraceptives has been rising steadily over the last decade, particularly in low- and middle-income countries. This was seen up to and including 2020, despite supply chain difficulties and uncertainties caused by the COVID-19 pandemic.

In fact, in 2020, the public sector contraceptive market reached a five-year high of USD261 million across 69 countries monitored by the [Reproductive Health Supplies Coalition \(RHSC\)](#).¹¹ The biggest increases in market share were seen in oral contraceptives (29%), injectables (26%) and implants (20%).¹² In terms of regional market share, sub-Saharan Africa took the largest proportion from 2016 to 2020 at an average of 68%, with Asia and the Pacific following at an average of 18% in the same time period.¹³

What this shows us is that the need for contraceptives of all kinds is increasingly important to women and girls across the globe. It is therefore critical that all who want to access

these health products are able to do so. Where access to contraceptives is limited or difficult, impacts are immediately seen in the lives of women, ranging from unwanted pregnancies, sexually transmitted diseases and other health issues to social issues such as reductions in likelihood of higher education, maintaining employment and financial independence. This is explored further in other chapters of this report.

Despite these increases in the market, it is [estimated](#) that around 214 million women and girls globally are not using contraception, despite not wanting to become pregnant;¹⁴ it can be assumed that a significant proportion of these would



11. The 69 FP2020 focus countries (defined as countries with a 2010 gross national income per capita less than or equal to \$2,500) emerged from the 2012 London Summit on Family Planning. The countries are listed here: <https://www.familyplanning2020.org/countries>. CHAI RHSC Family Planning Market Report Dec 2021 <https://3cdmh310dov3470e6x160esb-wpengine.netdna-ssl.com/wp-content/uploads/2021/12/2021-CHAI-RHSC-Family-Planning-Market-Report.pdf> at 4.

12. Ibid

13. Ibid at 12

14. <https://www.ippf.org/blogs/contraception-and-covid-19-disrupted-supply-and-access>



like to access contraceptives but cannot. While it is difficult to quantify how many cannot address their contraceptive needs due to stockouts, it is certain that part of this unmet need is because of stockouts at health facility or country level.

Reasons for stockouts vary greatly by country and geographic area, and clear evidence for the root causes of stockouts is limited. However, most experts agree that “supply chain bottlenecks contribute significantly to persistent high stockout rates”,¹⁵ particularly in low- and middle-income countries. Supply chain issues are often caused by suboptimal planning and requisition processes at facility level, inaccurate demand forecasting, or budgetary issues. These need to be addressed urgently by governments and donors for any intervention to succeed.

The impact of the COVID-19 pandemic has probably only worsened these problems, according to the International Federation of Planned Parenthood, with factors such as lockdowns, border closures and manufacturing restrictions all disrupting supply chains.¹⁶ Delays and disruption in the production and supply of contraceptives at global and national levels can lead to immediate stockouts, which in turn create access issues for these critical products.

For example, there is currently a global shortage in the supply of condoms, resulting in patients facing difficulties in accessing them at facility level. This is due to some of the world's largest manufacturers being forced to restrict manufacturing in early 2020 due to COVID-19 lockdowns.¹⁷ While factories have resumed normal capacity, the knock-on effects of this supply disruption are being felt now, with many countries struggling to procure their needed volumes.

Additionally, stakeholders in reproductive health are increasingly concerned about the resilience of funding for Sexual and Reproductive Health commodities, as well as the global political climate impacting access to contraceptives. This is largely due to an increasingly conservative approach to sexual and reproductive health in the USA, from which significant donor funding originates, as well as economic uncertainty in a post-COVID-19 world. Additionally, in early 2021, large cuts to United Nations Population Fund (UNFPA) Sexual and Reproductive Health funding from government donors were announced¹⁸, for example by the UK (85% cut),¹⁹ putting further pressure on contraceptive commodity funding. For the many countries dependent on donor funding or aid partnerships to supply contraceptives for their populations, these kinds of cuts can be catastrophic, with severe impacts for women and girls across the globe.

This pressure is unlikely to ease any time soon: analysis suggests that the number of contraceptive users in low- and middle-income countries will increase by up to 75 million people by 2030, probably outpacing government and donor funding to meet these needs.²⁰ It is therefore critical that along with increasing funding, there must be continued work to decrease costs and increase accessibility of effective, quality-assured contraceptive products. Until the sector is diversified in both funding and manufacturers, particularly in a post-COVID-19 world with weakened supply chains, stockouts will continue to occur at all levels and will continue to impact the lives of women and girls negatively and directly.

15. Contraception supply chain challenges: a review of evidence from low- and middle-income countries 2017 <https://www.tandfonline.com/doi/pdf/10.1080/13625187.2017.1394453?cookieSet=1>

16. Ibid

17. <https://www.insider.com/looming-global-shortage-of-condoms-could-be-devastating-un-says-2020-4>

18. <https://news.un.org/en/story/2021/04/1090892>

19. <https://www.unfpa.org/press/statement-uk-government-funding-cuts>

20. RHSC LEAP analysis <https://leap.rhsupplies.org/#/contraception>

The legal and policy background to contraceptive stockouts

The Constitution places a duty on government to fulfil and promote the right to access reproductive health services. Stockouts of hormonal contraception and pregnancy tests directly affect women and their ability to enjoy their constitutional right to access health services. Thus, it is disheartening that public healthcare facilities are experiencing stockouts of this nature and to this extent. There is a long chain of actors responsible for translating these rights into tangible, effective and experienced impact on and benefit to the lives of women and girls. Although laws and policies may be progressive, ineffective administration and implementation of these policies on the ground can stunt their intended impact. Thus, realising and protecting Sexual and Reproductive Health Rights includes ensuring the efficiency of this chain at every point.

This section:

1. provides a guide to laws and policies that apply to Sexual and Reproductive Health Rights in South Africa, with an emphasis on access to contraceptives;
 2. highlights the relationship between Sexual and Reproductive Health Rights and women's and health rights;
 3. discusses how stockouts are a barrier to women's right to access medical services such as contraception, and defeat government's efforts to fulfil their obligation to enable the enjoyment of that right; and
 4. discusses law and policy on access to abortion.
- Medicines and Related Substances Control Act, Act No. 101 of 1965, which provides for the provision of contraceptives and medicines used during termination of pregnancy;
 - Children's Act No. 38 of 2005, which empowers adolescents to consent to access to reproductive services and to test for HIV (though this ability to consent excludes sterilisation); and
 - Choice on Termination of Pregnancy Act No. 92 of 1996, which provides for access to termination of pregnancy services and lays out the rules that apply.

Sexual and Reproductive Health Rights laws in South Africa

Sexual and Reproductive Health Rights are protected in section 27 of the Constitution, which provides that "everyone has the right to have access to healthcare services, including reproductive healthcare... [and]... the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights".

Since 1994, South Africa has legislated and/or amended the enabling legislation to achieve the realisation of the right to reproductive health care. These laws include laws such as:

South African Sexual and Reproductive Health law enabling access to contraception is in line with international laws and standards, which establish everyone's right to the highest attainable standard of health,²¹ and recognise reproductive healthcare as an essential component of the right to health, including maternal and post-partum health as well as access to contraception.²² Article 16 of the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) guarantees women equal rights in deciding "freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights".²³ Further, at the International Conference on Population and Development (ICPD), Cairo 1994, 179 states recognised that "reproductive

21. International Covenant on Economic, Social and Cultural Rights (ICESCR) <https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights>

22. <https://www.gfmer.ch/SRH-Course-2012/Geneva-Workshop/pdf/Sexual-reproductive-rights-Campo-2013.pdf>

23. <https://www.ohchr.org/sites/default/files/Documents/ProfessionalInterest/cedaw.pdf>



health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so".²⁴

Sexual and Reproductive Health and women's rights

Sexual and Reproductive Health Rights are intrinsically linked to the fulfilment of other rights. These rights include the right to life, the right to health, the right to privacy, the right to education, equality rights and the right to freedom and security of the person.

In order to exercise the right to freedom and security of the person, a woman must be able to decide for herself whether and when she wishes to become pregnant and/or when to give birth. This decision is impaired when she cannot access contraceptives due to stockouts in public facilities. This decision is also impaired if she is denied access to education about contraceptives due to discriminatory beliefs held by healthcare providers in public facilities.

A woman's right to equality is impaired when she cannot access contraceptives because she is unable to go to a private healthcare facility to access contraceptives, especially when they are unavailable in a public healthcare facility.

A girl's right to education is hampered when she falls pregnant earlier than planned and is not able to continue with her schooling.²⁵

Stockouts are a barrier to women's Sexual and Reproductive Health Rights

Government seeks to facilitate the fulfilment of women's Sexual and Reproductive Health Rights, including access to contraception and abortion, through various policies including the [National Development Plan](#)²⁶ and the [National Integrated SRHR Policy](#)²⁷ ('integrated policy') which was finalised in 2019. Until the integrated policy, various policies informed access to contraceptives in public facilities. The integrated policy consolidates several clinical and policy guidelines on various aspects of Sexual and Reproductive Health Rights, including the National Contraception Clinical Guidelines, the National Clinical Guidelines for Safe Conception and Infertility, and the National Guidelines for Implementation of Choice on Termination of Pregnancy.

The integrated policy aims to "provide an opportunity to define a package of service benefits for women throughout their reproductive lifecycle... The policy will respond to women's needs on agency and choice in a rights-based approach". The integrated policy recognises the unmet need for contraception and aims to improve access to modern methods of contraception and improve the method mix for contraception.

The disparities between the [National Contraceptive Clinical Guidelines](#),²⁸ the Integrated SRHR Policy and the results of this annual survey illustrate government's failure to make real progressive law and policy. The gaps between policy and lived reality, demonstrated by the central role that stockouts play as barriers to women's access to medical services such as contraceptives, must be addressed.

24. https://www.unfpa.org/sites/default/files/pub-pdf/programme_of_action_Web%20ENGLISH.pdf

25. The Minister of Basic Education stated that 90 037 schoolgirls aged 10 to 19 gave birth in South Africa in 2021; see Phumla Mkhize (4 July 2022) <https://sundayworld.co.za/news/motshhekgga-admits-that-90-037-school-girls-gave-birth-in-past-year/>.

26. <https://www.gov.za/issues/national-development-plan-2030>

27. https://www.knowledgehub.org.za/system/files/elibdownloads/2021-03/National%20Integrated%20SRHR%20Policy_Final_2021.pdf

28. https://www.knowledgehub.org.za/system/files/elibdownloads/2021-03/National%20Contraception%20Clinical%20Guidelines_Final_2021.pdf



One of the goals of the integrated policy is to meet women's need for contraceptives and provide women with their preferred choice of contraception. Health facilities report that they offer a selection of contraceptives, but the most preferred contraceptives experience the highest stockouts.

The Clinical Guidelines indicate that public health facilities should now encourage the use of long-acting reversible contraceptives such as the IUD. These guidelines were published in 2019; and although the survey shows that staff have been trained in the insertion of the IUD, IUDs are not uniformly available. The Clinical Guidelines provide that women must be counselled and provided a contraceptive which meets their need. However, clinics are unable to do that if they experience stockouts, and they recommend alternatives on the basis of the stockouts rather than to match a woman's health and lifestyle.

Therefore, if what is provided for in policy is not provided in reality, Government has failed to fulfil its obligation. It is imperative that the weaknesses in implementation that inhibit the realisation of these policies are strengthened in order for government to fully fulfil women's Sexual and Reproductive Health Rights. A failure to do so is to continue to interfere with women's Sexual and Reproductive Health Rights, which government has a negative obligation not to violate and a positive obligation to protect and fulfil. While the policy meets the positive obligation, in practice government fails to meet both aspects of these Constitutional imperatives.

Abortion

Lack of access to contraception means that many more women may seek out abortions, should they wish to discontinue or be unable to continue with their pregnancy. In South Africa, the Choice on Termination of Pregnancy Act 92 of 1996 provides for termination of pregnancy. Women have a right to legal and safe termination of pregnancy. They are also entitled to access legal and safe termination of pregnancy at different gestational stages up to 20 weeks in public health facilities. Although the law provides for safe abortions, women still undergo illegal and unsafe abortion due to [lack of real access to safe and legal abortions](#) at facilities where they are entitled to receive them.²⁹

Termination of pregnancy is not available at all public health facilities, [only at designated facilities](#).³⁰ In 2017, the Bhekisisa Centre for Health Journalism reported that the National Department of Health had provided them with a list of 450 designated facilities.³¹ Bhekisisa called all the facilities to enquire about the termination of pregnancy services that they offer. Of the 236 facilities that were reached by phone, 156 offered first-trimester (during the first 12 weeks of pregnancy) abortions, three conducted second-trimester (during weeks 13 to 20 of pregnancy) abortions only, and 38 facilities offered both first- and second-trimester abortions.

It is clear that there is a disconnect between the official designation of facilities and the reality of service provision. Sometimes, termination of pregnancy is not available due to the trained healthcare provider leaving the healthcare facility for alternative employment. Often, women are turned away from an abortion facility due to long queues and the inability of the facility to meet the demand for termination of pregnancy. Where women are able to find designated termination of pregnancy facilities, they often face stigma or shame in their community, or discrimination and judgment from healthcare providers in the designated facility. Women seeking legal abortions at public health facilities are often discriminated against due to healthcare providers' personal religious convictions, which they allow to infiltrate their termination of pregnancy counselling. Women also report being denied pain management or post-termination care due to healthcare-provider discrimination and biased belief.

Many women turn to illegal abortion services as a result of lack of knowledge about abortion services, lack of knowledge about designated facilities, poor access due to designated facilities being far away, or because they are turned away from designated facilities due to issues such as the unavailability of someone to conduct the termination of pregnancy.

Stockouts of contraceptives affect women's ability to plan their pregnancies. These women may choose to terminate unplanned pregnancies, and may struggle to access pregnancy termination from public healthcare facilities. Often it is poor women who are most affected by the impact of stockouts on access to contraceptives and abortion. When women who cannot afford to have more children are denied services that enable them to plan or prevent their pregnancies or exercise their choice to terminate, they are forced to increase the number of children in their care. This forced child rearing increases the burden not only on individuals but also on government programmes including social security and the education and health programmes. Adolescents who are unable to access contraceptives or are unable to terminate pregnancy will experience obstacles to completing school; this has life-long, generational impacts on the girl-child's ability to provide for herself and her children and to improve her socio-economic circumstances.

South Africa has progressive laws and policies that provide for the fulfilment of women's Sexual and Reproductive Health Rights, including women's right to access contraceptives and abortions from public health facilities. The State has an obligation to ensure that public health facilities are able to meet women's need for contraceptives and abortions. The survey results show that patients' experience is that government is failing to actualise their policies. Government's failure to do so has gendered and classist impacts that affect the most vulnerable women in our society, as well as having broader impacts on public health and the public purse.

29. For extensive reporting on the problems in accessing abortion, see: <https://www.spotlightnsp.co.za/tag/abortion/>

30. Harries J, Constant D. (2020) "Providing safe abortion services: experiences and perspectives of providers in South Africa." *Best Pract Res Clin Obstet Gynaecol*, Volume 62, pages 79–89 <https://doi.org/10.1016/j.bpobgyn.2019.05.005>

31. <https://bhekisisa.org/article/2017-11-10-00-mind-the-gap-only-5-of-health-facilities-offer-abortions-heres-how-to-find-them/>

Conclusion

This survey collected data on contraceptive stockouts in primary healthcare facilities. The results highlight the prevalence of hormonal contraceptive stockouts. These stockouts affect women and girls and are more prevalent in rural areas. The socio-economic and clinical impact of these stockouts falls on women and girls.

At a global level, contraceptives are prone to stockouts, and COVID-19 interruptions of supply chains exacerbated this issue. Although there are challenges to ensuring an adequate supply of contraceptives, government has an obligation to provide access to reproductive healthcare services. Progressive laws and policies that recognise women and girls' right to reproductive health care are not enough. Government must address the shortcomings that prevent contraceptives from reaching women's hands.

Annex: Stockout data by province

Table 1: Number of patients per province who left without medicines due to a shortage (N = 1 018)

Province	Districts	Facilities	Surveys completed	Number of patients who left without medicine due to a shortage
Eastern Cape	5	36	1 420	119
Free State	3	18	785	200
Gauteng	4	66	2 596	208
KwaZulu-Natal	4	45	1 789	136
Limpopo	2	8	304	64
Mpumalanga	3	32	1 435	135
North West	3	9	450	156
Total	24	214	8 779	1 018

Table 2: Patient reports of type of medicine shortages by province (N = 978)

Province	No. of facilities surveyed	No. of surveys completed	HIV medicine	PrEP	TB medicine	Contraceptives	Pregnancy tests	Vaccines	Bandages (or other dry stock)	Other medicines	None of the above	Don't know
Eastern Cape	36	117	22	2	0	50	20	11	4	18	6	7
Free State	17	192	16	1	13	88	35	77	53	9	42	1
Gauteng	66	203	25	3	5	72	9	4	4	50	24	23
KwaZulu-Natal	43	132	13	1	1	79	3	7	0	15	7	10
Limpopo	8	58	9	1	2	7	4	32	1	6	1	1
Mpumalanga	31	121	28	1	0	36	8	7	2	22	14	9
North West	9	155	42	0	7	55	22	27	4	61	1	0
Total	210	978	155	9	28	387	101	165	68	181	95	51

Table 3: Patient reports of type of contraceptive stockout by province (N = 372 patients from 126 facilities)

Province	No. of surveys completed	Condoms (male/external)	Female/internal condoms	Birth control pill	Injection	Implant	IUD (intra-uterine device)	Other	Don't know
Eastern Cape	50	5	6	7	42	3	1	0	3
Free State	80	4	2	7	73	17	7	0	6
Gauteng	71	1	5	10	55	3	1	3	4
KwaZulu-Natal	78	2	0	1	76	0	0	1	0
Limpopo	6	0	0	0	2	1	2	0	1
Mpumalanga	32	2	1	0	27	0	0	0	3
North West	55	2	3	47	9	0	0	3	0
Total	372	16	17	72	284	24	11	7	17

Table 4: Patient reports by province of whether the stockout or shortage occurred on the day of the survey (N = 1 004 patients)

Province	No. of surveys Completed	Yes	No	Don't know
Eastern Cape	119	46	43	30
Free State	198	119	50	29
Gauteng	207	54	66	87
KwaZulu-Natal	134	19	87	28
Limpopo	64	25	23	16
Mpumalanga	126	50	34	42
North West	156	104	16	36
Total	1004	417	319	268

Table 5: Facility report by province on response to stockout of shortage (N = 367 health facilities)

Province	No. of facilities responding	Yes	No, but we gave them a short supply	No, because we gave them an alternative	Don't know
Eastern Cape	46	10	5	30	1
Free State	20	3	4	13	0
Gauteng	114	10	19	77	8
KwaZulu-Natal	120	9	21	88	2
Limpopo	12	4	0	8	0
Mpumalanga	42	6	10	26	0
North West	13	1	6	6	0
Total	367	43	65	248	11

Table 6: Facility response to type of medicine shortages by province (N = 373 facilities)

Province	No. of surveys completed	HIV medicine	PrEP	TB medicine	Contraceptives	Pregnancy Tests	Vaccines	Bandages (or other dry stock)	Other medicines or diagnostic tests	None of the above	Don't know
Eastern Cape	46	6	0	4	10	6	5	3	17	20	0
Free State	20	1	0	1	1	1	1	3	8	9	0
Gauteng	116	12	3	3	12	1	4	3	24	68	0
KwaZulu-Natal	124	6	2	4	27	0	7	1	6	84	2
Limpopo	12	4	0	0	1	0	2	1	3	5	0
Mpumalanga	42	5	0	2	8	7	7	2	21	11	0
North West	13	5	0	0	4	4	3	0	4	3	1
Total	373	39	5	14	63	19	29	13	83	200	3

Table 7: Health facility reports by province on the type of contraceptive shortages (N = 63 facilities)

Province	No. of facilities	Condoms (male/external)	Female/internal condoms	Birth control pill (oral)	Injection	Implant	IUD (intrauterine device)	Other	Don't know
Eastern Cape	10	0	0	0	9	1	1	1	0
Free State	1	0	0	0	1	0	0	0	0
Gauteng	12	1	0	2	10	0	0	0	0
KwaZulu-Natal	27	3	2	0	25	1	0	0	0
Limpopo	1	1	1	0	0	0	0	0	0
Mpumalanga	8	0	0	4	5	0	0	1	0
North West	4	0	0	4	1	2	0	1	0
Total	63	5	3	10	51	4	1	3	0

Table 8: Facility reports by province on whether the stockout or shortage was resolved (N = 167 facilities)

Province	Surveys	Yes	No	Don't know
Eastern Cape	26	16	10	0
Free State	11	4	7	0
Gauteng	47	20	26	1
KwaZulu-Natal	36	30	6	0
Limpopo	7	2	5	0
Mpumalanga	31	14	17	0
North West	9	3	6	0
Total	167	89	77	1

Table 9: Contraceptives that patients tried to access at health facilities, by province (N = 14 430 patients, multiple-choice selection)

Province	No. of patient surveys completed	Condoms (male/external)	Injection	Female/internal condoms	Birth control pill	Implant	IUD	None	Other	Don't know
Eastern Cape	1 773	710	525	176	249	20	3	806	5	50
Free State	933	166	333	40	47	99	5	428	6	7
Gauteng	4 284	1 410	1 054	499	533	243	27	1 839	14	183
KwaZulu-Natal	4 620	1 895	1 456	1 045	966	745	670	1 638	38	204
Limpopo	482	182	189	140	78	9	8	173	1	18
Mpumalanga	1 735	496	498	59	108	123	1	753	9	18
North West	603	41	85	3	60	12	4	346	55	4
Total	14 430	4 900	4 140	1 962	2 041	1 251	718	5 983	128	484

Table 10: Patient reports on accessing contraception of choice (N = 7 874)

Province	No. of patient surveys completed	Yes	No
Eastern Cape	916	883	33
Free State	494	451	43
Gauteng	2 256	2 159	97
KwaZulu-Natal	2 752	2 712	40
Limpopo	293	276	17
Mpumalanga	962	885	77
North West	201	158	43
Total	7 874	7 524	350

