

COVID-19 AND ACCESS TO REPRODUCTIVE HEALTH RIGHTS FOR WOMEN IN HIGHER EDUCATION INSTITUTIONS IN SOUTH AFRICA

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by Thuli Zulu*



Abstract

Reproductive health rights are rights that are internationally and domestically recognised as human rights. The right to contraception forms part of reproductive health rights. These rights have a great impact on the social, political, and economic well-being of women. This paper studies the impact that COVID-19 has had on health, specifically on access to contraceptives, as these services have not been deemed as essential during the lockdown. The lockdown has seen the closure of higher education institutions like colleges, Technical Vocational Education and Training (TVET) colleges, universities, and universities of technologies, where the majority of women who depend on public health facilities access their contraceptives, resulting in these women having to access contraceptives from their home communities. This paper further studies the challenges that these women face in accessing contraceptives from their homes, such as stigma and the lack of information that accompanies it. Lastly, this paper finds that the women that access their contraceptives in institutions of higher learning do not have any alternatives. It finds that the closure of these institutions has resulted in these women being stranded without contraceptives, resulting in a violation of their reproductive health rights.

* LLB, University of Pretoria; LLM Candidate (Multidisciplinary Human Rights Law), University of Pretoria; Candidate Attorney, Centre for Applied Legal Studies (University of Witwatersrand). ORCID iD: 0000-0001-6631-8175.

1 Introduction and background

On 31 December 2019, the World Health Organisation (WHO) was first notified by China of a pneumonia of unknown cause.¹ The severe acute respiratory syndrome coronavirus 2, SARS-CoV-2 (COVID-19), was identified as the causative virus by Chinese authorities with evidence of human-to-human transmission by 20 January 2020. On 30 January 2020, the outbreak was declared a Public Health Emergency of International Concern (PHEIC) and a pandemic on 11 March 2020.² Since its emergence in China, the pandemic has since spread with a strong hold in Europe and with multiple traces all over the world. The spread of the pandemic called for severe lockdowns worldwide with South Africa being one of the countries most severely affected by the pandemic.³

The first case of the novel coronavirus was reported in South Africa on 5 March 2020 from the province of KwaZulu Natal. The case was of a man that had travelled to Milan, Italy.⁴ On 15 March 2020, President Cyril Ramaphosa declared a State of Disaster under the auspices of the State of Disaster Management Act 57 of 2002.⁵ Following the report of the first case of COVID-19, the government imposed a strict lockdown on 23 March 2020 that would initially have lasted for three weeks, commencing on 26 March 2020.⁶ At the declaration of the State of Disaster, South Africa had recorded 554 cases with no reported deaths.⁷ The State of Disaster and the lockdown was subsequently extended to April 2020 and was praised as the most severe lockdown in the African region.⁸ On 24 April 2020, President Cyril Ramaphosa introduced five stages reopening the economy known as levels 1-5. Level 4 of the lockdown was subsequently introduced on 1 May 2020 where certain activities, such as exercising, were allowed under strict lockdown protocols.⁹ This lockdown resulted in outlets such as restaurants, taverns, and some medical outlets such as local clinics closing down. People who were capable of doing their work remotely were mandated to do so.

1 Staff Writer 'Timeline: China and World Health Organization during COVID-19 crisis' *Reuters* 13 January 2021 <https://www.reuters.com/article/us-health-coronavirus-who-china-timeline-idUSKBN2910FR> (accessed 11 May 2021).

2 K Tang et al 'Sexual and reproductive health (SRH): A key issue in the emergency response to the coronavirus disease' (2020) 17 *Reproductive Health* at 1.

3 Tang et al (n 2) 1.

4 N Stiegler et al 'South Africa: Challenges and successes of the COVID-19 lockdown' (2020) 7 *Ann Med Psychol (Paris)* at 696-697.

5 C Arndt et al 'Covid-19 lockdowns, income distribution, and food security: An analysis for South Africa' (2020) 26 *Global Food Security* at 10410.

6 Stiegler et al (n 4) 697.

7 As above.

8 Stiegler et al (n 4) 697.

9 As above.

Since then, the pandemic has continued to expose the dysfunctionalities of South Africa's healthcare system.¹⁰ This is not peculiar as pandemics all over the world have proven to exacerbate ailing healthcare systems.¹¹ To illustrate, in 2015 the Zika virus in Latin America caused several complications in women's reproductive health ranging from issues surrounding abortion to those of birth.¹² One of these constraints is the delivery of socio-economic services to people, including services related to reproductive health.¹³ In the public health systems, access to reproductive health is severely limited with the Department of Health having already announced a shortage of contraceptives in 2018.¹⁴

Past pandemics have also shown that the failure to provide for services relating to sexual health rights, mental health, and gender-based services leads to sexually transmitted infections (STIs), miscarriages, unsafe abortions, depression, and inter-partner violence, amongst others.¹⁵ The COVID-19 pandemic has interrupted the manner in which these services are received.¹⁶ Access to healthcare has been affected as the numbers have continued to rise and priority has been given to providing medical care relating to COVID-19.¹⁷ In doing so, there has been a divergence from the provision of reproductive health rights services.¹⁸

This paper explores the gendered impact that the coronavirus has had in South Africa. More specifically, the paper considers the impact at the lockdown has had on women who access their contraceptives at institutions of higher learning. It is argued that women who access their contraceptives at institutions of higher learning do so out of convenience and necessity. These women are from less privileged backgrounds and have no alternative to these institutions. Most notably, their right to reproductive health through access to contraceptives is enshrined in the Constitution and the closure of these institutions hinders these women's human rights.

This paper starts by setting out the legal framework concerning reproductive health rights. Thereafter, the growing need for contraceptives for women who attend institutions of higher learning will be discussed together with the challenges that these women face

10 Arndt et al (n 5) 10413.

11 J Hussein 'COVID-19: What implications for sexual and reproductive health and rights globally?' (2020) 1 *Sexual Reproductive Health Matter* at 2.

12 As above.

13 As above.

14 M Mojela 'Injectable contraceptives shortage in Limpopo is "not a crisis"' 9 October 2018 <https://health-e.org.za/2018/10/09/injectable-contraceptives-shortage-in-limpopo-is-not-a-crisis/> (accessed 5 August 2021).

15 As above.

16 Mojela (n 14).

17 As above.

18 KS Hall et al 'Centring sexual and reproductive health and justice in the global COVID-19 response' (2020) 395 *The Lancet* at 1176.

at the closure of these institutions. These challenges will be considered alongside the subsequent challenges that many women face with their community healthcare providers. The challenges identified by the paper are those of stigmatisation and a lack of information when accessing contraceptives.

Finally, the paper investigates alternatives that can be used for women accessing contraceptives in South Africa. As we observe the decrease in numbers of infections and the gradual lifting of lockdowns, it becomes important to assess the impact that the virus has had on the provision of women's human rights services and to strategise on inclusive approaches to the unpredictable times that lie ahead.

2 Legal instruments and reproductive health rights during COVID-19.

Reproductive health rights are fundamental to the realisation of human rights.¹⁹ Reproductive health is understood to mean 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes'.²⁰ South Africa has international and continental obligations towards the realisation of reproductive health rights. South Africa is a party state to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) where Article 3 states that parties to the Convention should enact legislation and take all other appropriate measures to realise equality between men and women, both in the workplace and their personal spaces.²¹ Article 14(b) of CEDAW speaks directly to women's rights to their reproductive health. The article ascertains that women have the right 'to have access to adequate healthcare facilities, including information, counselling, and services in family planning'.²²

On a regional level, the African Union has adopted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) in 2003.²³ Article 14 of the Protocol places specific emphasis on women's reproductive rights and

19 For a discussion on reproductive and sexual reproductive rights as fundamental to human rights see United Nations 'Report of the International Conference on Population and Development' (1994) (Report on Population and Development) paras. 7.2 & 7.3. 5.; and Beijing Declaration and Plan for Action, 1996 in United Nations 'Fourth World Conference on Women' (1995) paras. 92 & 95.

20 Report on Population and Development (n 19) para 7.2.

21 Convention on the Elimination of All Forms of Discrimination against Women (18 December 1979), UN Treaty Series (1249) 13 (CEDAW).

22 CEDAW (n 21).

23 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (11 July 2003) (Maputo Protocol).

encapsulates them having control over their reproduction, choosing whether or not to have children and, if so, how many, as well as their right to any information concerning family planning.²⁴ General Comment 2 on Articles 14(1)(a), (b), (c), and (f) and Articles 14(2)(a) and (c) of the Maputo Protocol further reiterate the state's obligation to provide contraception. It states that, 'It is crucial to ensure availability, accessibility, acceptability and good-quality reproductive healthcare, including family planning, contraception and safe abortion for women'.²⁵ The right to reproduction is also domesticated in our Constitution in section 12.²⁶ The section affirms that '[e]veryone has the right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction'.²⁷

To put into effect the constitutional right to reproduction, the Department of Health adopted guidelines that are in line with providing for the right to reproductive health.²⁸ The guidelines take a human rights approach in acknowledging the need for contraception among women.²⁹ They do so by integrating the right to contraception as part of health services that women are entitled to.³⁰ The guidelines enforce the right to reproductive health through the legislative, regulatory, and institutional frameworks included therein.³¹ The implementation of the framework would grant free access to reproductive health services to women who were previously excluded from accessing these services. The framework seeks to maximise ways that women can take care of their overall health whilst upholding their human rights.³²

3 Women's need of contraception use in higher education institutions

Young people's sexual activities are reported to be on the increase, which is a communal and public concern.³³ In a study conducted

24 Maputo Protocol (n 23) Art 14.

25 General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.

26 Constitution of the Republic of South Africa, 1996 (Constitution) sec 12.

27 As above.

28 Department of Health 'Sexual and Reproductive Health and Rights: Fulfilling our commitments 2011-2021 and beyond' (2011) <http://bit.ly/1ALD1Y2> (accessed 21 May 2021) (Department of Health Guidelines).

29 Department of Health Guidelines (n 28) iv.

30 Department of Health Guidelines (n 28) 3.

31 Department of Health Guidelines (n 28) 2-3.

32 Department of Health Guidelines (n 28) 3.

33 MH Coetzee et al 'Assessing the use of contraceptives by female undergraduate students in a selected higher educational institution in Gauteng' (2015) 38 *Curationis* at 1535.

amongst 15 to 24-year-old South African women, it was estimated that only 52.2 percent of sexually experienced women are using contraceptives.³⁴ Eighty percent of undergraduate students at higher educational institutions are sexually active due to the consumption of mass media and urbanisation.³⁵ It is eventually vital that they have access to safe, accessible, and adequate contraceptive services.³⁶ The South African public health system has since provided free sexual reproductive health assistance which includes free contraceptives made accessible at institutions for higher learning.³⁷

The closure of institutions of higher learning in April 2020 saw 1 725 million students worldwide leaving their institutions to be confined to their homes to limit the spread of the coronavirus.³⁸ This movement presented risks for young people though its main aim was to protect those same people from the virus. Some of these risks include sexual abuse, exploitation, and negative outcomes from sex such as unplanned pregnancies.³⁹

The responsibility of contraception between young couples is often delegated to the woman.⁴⁰ This is because oftentimes, men would shift the pregnancy burden to women, arguing that women are the ones that carry the unborn child, hence it is their responsibility to not fall pregnant.⁴¹ Women in higher education institutions then find themselves relying solely on the services offered by these institutions to access contraceptives to avoid unwanted pregnancy.⁴² Again, we are confronted by the gendered aspect of the lockdown as it is women that must find alternative ways of accessing contraception to prevent pregnancy.

The use of contraception in institutions for higher learning is severely affected by socio-physiological factors which consequently affect their knowledge of reproductive health rights.⁴³ Women in

34 D Govender et al 'Don't Let Sexual and Reproductive Health become Collateral Damage in the Face of the COVID-19 Pandemic: A Public Health Perspective' (2020) 24 *African Journal of Reproductive Health* at 1536.

35 As above.

36 C MacPhail et al 'Contraception use and pregnancy among 15-24-year-old South African women: A nationally representative cross-sectional survey' (2007) 5 *BMC Medicine* at 8.

37 Department of Health Guidelines (n 28) 23.

38 K Odada 'Adolescent girls and women have a right to know: Accessing information on sexual and reproductive health and rights in the wake of COVID-19' 24 September 2020 <https://africlaw.com/2020/10/22/adolescent-girls-and-young-women-have-a-right-to-know-accessing-information-on-sexual-and-reproductive-health-and-rights-in-the-wake-of-covid-19/> (accessed 17 July 2021).

39 Odada (n 38).

40 F Ngozi 'Ugoji an Examination of University Students' Attitude to Contraceptive Use' (2013) 2 *American International Journal of Social Science* at 19.

41 As above.

42 Ngozi (n 40) 20.

43 M Makhaza et al 'Knowledge and Use of Contraceptives among Tertiary Education Students in South Africa' (2014) 5 *Mediterranean Journal for Social Sciences* at 503.

institutions of higher learning understand that the use of contraception allows them to make better economic decisions as it lessens the financial burden especially for those in larger families.⁴⁴

The unplanned pregnancy of women within institutions of higher learning leads to many undesired consequences. Unplanned pregnancies usually require women to drop out of these institutions to rear the child, making the cycle of poverty ongoing.⁴⁵ The women's use of contraceptives obtained at higher institutions of learning allows them to complete their qualifications, to freely look for employment without the hindrance of having to care for children, and to make independent marital decisions.⁴⁶ This speaks to these women having agency over, and being able to plan for their future. Providing for contraceptives in institutions for higher learning means that in doing so, these institutions are advancing the students' autonomy over what happens to their lives. This is to ensure that the students' academic welfare is catered for and to protect their overall well-being.

4 Stigmatisation and the lack of information in accessing contraceptives in communities

Access to contraception is the ability to attain services through an acceptable effort and at an acceptable cost by the majority of the population in need of these services.⁴⁷ Access is the cornerstone of the quality of family planning programmes. A successful family planning programme is unachievable without access. At entry-level, access to contraceptives is a function of the availability of contraceptive commodities at service delivery points. Contraceptive supply systems in the public health system are the responsibility of the government, as they must purchase and distribute commodities that allow potential users to access them.⁴⁸ Women are faced with many challenges in accessing contraceptives. Stigma due to political, religious, or social convictions plays a huge role in women not accessing contraception, and a lack of information leads to women not being able to use contraceptives effectively. These two challenges will be considered more thoroughly below.⁴⁹

44 As above.

45 Makhaza et al (n 43) 502.

46 As above.

47 MJ Welsh et al 'Access to modern contraception' (2006) 20 *Best Practice & Research Clinical Obstetrics & Gynaecology* at 325.

48 As above.

49 As above.

4.1 Stigmatisation in accessing contraceptives

Stigma is used as a primary power role in social control. This power is saturated in people of authority, in this instance being nurses that bear the primary duty of supplying contraceptives to young women that need them.⁵⁰ This power shapes the manner that we understand healthcare services, specifically free healthcare services.⁵¹ Women who receive free medical health services are often under much more scrutiny than their counterparts who receive paid medical services.⁵² These women are forced to take more precautions during sexual activities because they do not want to be considered a burden to the system.⁵³ Stigma has dire consequences for women who are in need of these services as it affects those less advantaged socially, economically, and politically in accessing healthcare services.⁵⁴ It results in discrimination against young women accessing their reproductive healthcare rights.

Stigmatisation is a barrier that many African women face in accessing contraceptives.⁵⁵ To provide for reproductive services free of stigma, these services should include, amongst other things, reproductive rights and confidential, stigma-free, and unbiased contraception; counselling options and services; treatment and prevention of sexually transmitted infections (STIs), including HIV; and information and counselling services on sexuality.⁵⁶ In understanding how stigma affects different categories of women, we must consider the micro-aggressions that human immunodeficiency virus (HIV) positive women face in accessing contraceptives, as these women are stigmatised further because of a general stereotype that HIV-positive women are hypersexual.⁵⁷ HIV-positive women are amongst the thousands of women who have had to leave their institutions of higher learning which had made it easier for them to access their contraceptives.⁵⁸ The need for free contraception in

50 AO Savage-Oyekunle & A Nienaber 'Adolescent girls' access to contraceptive information and services: An analysis of legislation and policies, and their realisation, in Nigeria and South Africa' (2015) 15 *African Human Rights Law Journal* at 442.

51 Welsh (n 47) 325.

52 As above.

53 Welsh (n 47) 325.

54 As above.

55 L Nyblade et al 'Perceived, anticipated and experienced stigma: exploring manifestations and implications for young people's sexual and reproductive health and access to care in North-Western Tanzania' (2017) 10 *Culture, Health & Sexuality an International Journal for Research, Intervention and Care* at 1092.

56 As above.

57 For a discussion on the importance of contraceptive accessibility for HIV-positive women, see Dugg et al 'Contraceptive Use and Unmet Need for Family Planning among HIV Positive Women: A Hospital Based Study' (2020) 64(1) *Indian Journal of Public Health* at 32.

58 Dugg et al (n 57) 32.

higher education institutions is linked to the socio-economic standing of HIV-positive women, which further exposes their vulnerability.

There are many perceived biases faced by young women who go to public health institutions to access contraceptives. These biases are on account of these women being young and unmarried with the notion being that they should, therefore, have no business asking for contraceptives.⁵⁹ Political taboos, religion, and traditional values also play a huge role in young women being afraid to collect contraceptives at public clinics.⁶⁰ These women constantly find themselves trapped in the intertwined socio-belief spectre that seeks to control their lives, silencing any reproductive choices that they are entitled to, and violating their rights to freely choose their preferred modes of contraception.⁶¹

This group of women, stigmatised when accessing contraceptives, are thus subject to unplanned pregnancies despite access to contraceptives being free.⁶² They are usually scolded by nurses and are then deterred from enquiring into or requesting these services. In an empirical study by Woods, one nurse was asked why she scolds young female patients when they come to access contraceptives. She responded that 'it is important that they let women know of the dangers of having sex when they are still young and all the diseases that come with it'.⁶³ One young woman, when asked if this scolding contributes to them (her and other young women) not having sex, replied that 'sex is nice and they will not stop going to public clinics to access contraceptives'.⁶⁴ The response by this young woman shows the agency that young women have in having sex and in turn accessing contraceptives. It is then in the government's hands to deliver on the right to reproductive health as per its obligations.

4.2 Lack of information in accessing contraceptives

The right to information is codified in our Constitution. This right states that everyone 'has the right to freedom of expression which includes freedom to receive and impart information or ideas'.⁶⁵ Section 32 (1) of the Constitution further states that:⁶⁶

Everyone has the right of access to—

(a) any information held by the state; and

59 Nyblade et al (n 55) 1092.

60 As above.

61 As above.

62 K Wood et al 'Blood Blockages and Scolding Nurses: Barriers to Adolescent Contraceptive Use in South Africa' (2006) 14 *An international journal on sexual and reproductive health and rights* at 110.

63 Wood (n 62) 113.

64 As above.

65 Constitution (n 26) sec 32.

66 Constitution (n 26) sec 32(1).

- (b) any information that is held by another person and that is required for the exercise or protection of any rights.

The right to information in accessing contraception was enforced by the Cairo International Conference on Population and Development (ICPD). South Africa is part of the international community that has adopted guidelines to provide for voluntary family planning programmes.⁶⁷ These programs entail women receiving accurate information on the modes of contraception available to them in a manner free of coercion and in line with international standards.⁶⁸ This information must be distributed, taking into account the socio-economic backgrounds of women this information is directed to.

Information should be provided on large scales to reach the large number of women in need of it, specifically women in destitute areas.⁶⁹ This information must be clear and must enable women to make informed and final decisions regarding contraception. In order to affect the reach of information circulated, social markets and a variety of communication channels should be utilised. These channels can include magazines, newspapers, radio stations, television, and social media.⁷⁰ This is in line with the resolutions that were taken at the Cairo conference,⁷¹ and the Contraception Guidelines enacted by the Department of Health.⁷²

In accessing reproductive healthcare services, women should be adequately informed of what these services entail. Research has shown that the reason women do not use contraceptives is often because they do not have sufficient information about modes of contraceptives, their side effects, and the ability to reverse the effects of these contraceptives.⁷³ Women who do not use contraceptives also tend to show little knowledge of their reproductive systems.⁷⁴ However, these women cannot be solely blamed for this ignorance. The reproductive health programmes have

67 Welsh (n 47) 324.

68 As above.

69 E Durojaye 'Access to contraception for adolescents in Africa: a human rights challenge' (2011) 44 *The Comparative and International Law Journal of Southern Africa* at 28.

70 Welsh (n 48) 324.

71 United Nations 'Report of the International Conference on Population and Development Cairo, 5-13 September 1994' 1994 at 1-156.

72 Department: Health Guidelines (n 28) 11-12.

73 See J Harries et al 'A multidimensional approach to inform family planning needs, preferences and behaviours amongst women in South Africa through body mapping' (2019) 16 *Reproductive Health* at 159; L Myer & Others 'Knowledge and use of emergency contraception among women in the Western Cape province of South Africa: A cross-sectional study' (2007) 7 *BMC Women's Health* at 14; and J Smit et al 'Emergency contraception in South Africa: Knowledge, attitudes, and use among public sector primary healthcare clients, Contraception' (2004) 64 *PubMed* at 337.

74 Harries et al (n 73) 6.

failed to be of assistance in supplying women with enough information regarding contraception consequences.

It is notable that misconceptions due to a lack of information surrounding contraception are also caused by misunderstandings concerning the different modes of conception. These misconceptions include that the progesterone-only injectable contraceptive, Depo-Provera, causes cancer and that contraceptives cause infertility.⁷⁵ Women have pointed out that it is hard for them to seek information from places of mistrust, and that familiarity plays a vital role in accessing information about contraception.⁷⁶ Part of creating this trust between them and the people providing these services is by means of counselling.⁷⁷

Students in the higher education sector are not susceptible to the lack of information that comes with contraception misinformation. In their study, Kabir et al write that some sexually active students lament that they would like to have more information on how contraceptives work.⁷⁸ This is despite them having knowledge on the use of the different modes of contraception. Universities are the engines of knowledge production but despite this, they rarely have programs that educate on the different aspects of sexual reproduction as much attention is still directed to HIV and AIDS programmes by the state.⁷⁹ Due to this lack of knowledge, some students show disdain for the use of contraception out of fear of infertility, cancer, and weight gain.⁸⁰ The pandemic has aided to this lack of information where contraception is concerned. Women who find themselves going back to their primary residences are not only confronted with the shortage of contraception but also with the lack of information on where and when to go about accessing these services.

5 A way forward: Access to contraceptives during the COVID-19 pandemic

This paper has shown that there is an unmet demand for contraception during societal disruptions. This demand leads to unplanned pregnancies and the consequences that come therewith. It is vital that during national disasters, crucial information regarding

⁷⁵ Harries et al (n 73) 7.

⁷⁶ Harries et al (n73) 6.

⁷⁷ As above.

⁷⁸ M Kabir 'Sexual behaviour among students in tertiary institutions in Kano, Northern Nigeria' (2004) 16 *Journal of Community Medicine & Primary Health Care* at 22.

⁷⁹ As above.

⁸⁰ JC Oonyu 'Contraceptive Knowledge and Practices of Undergraduate Female Students at Makerere University Uganda' (2020) 7 *Women's Reproductive Health* at 66.

the different modes of contraception is continuously communicated. This is because unplanned pregnancies may also result in a spike of domestic violence, as women are often solely blamed for unplanned pregnancies that they are not solely responsible for.

Reproductive health is a concern, especially in the public health system. There is no definitive research of when we would be able to be rid of the virus given the way that it is evolving. It is then important for the scientific community to generate epidemiological, and psycho-social behavioural links between the pandemic and reproductive health rights.⁸¹ In particular, there is a strong need for timely planning and actions for epidemiological research and surveillance of the key vulnerable groups of women and adolescents. There is also a need to assess the immediate, medium, and long-term effects on their sexual and reproductive health rights. Perhaps more importantly, we need to solidify operational strategies and actions to protect sexual reproductive health rights together with the rights of women, young people, and vulnerable populations during the epidemic.⁸²

A way forward for providing contraceptives to women during the surge of the COVID-19 virus is through adopting an intersectional approach that prioritises the needs of women. This approach also includes adequate communication between the state and the women in need of the contraceptives.

The effective use of CEDAW in conjunction with the Maputo Protocol and the South African laws and policies on the right to reproductive health would aid in guaranteeing women's reproductive rights during the pandemic. CEDAW brings women's rights at the forefront of prioritising their human rights.⁸³ In its Preamble, the CEDAW notes that despite the various international laws put in place to protect women's rights, discrimination against them on the basis of gender persists.⁸⁴

The Maputo Protocol is also important in prioritising African women in delivering reproductive health rights. In Article 14, the Protocol reiterates that states ought to ascertain women's reproductive health rights such as the right to contraception.⁸⁵ These international and regional obligations are reiterated in South African legislation and policies to complement the right to reproductive health as enshrined in the Constitution.⁸⁶ In Objective 4 of the

81 Tang (n 2) 2.

82 As above.

83 CEDAW (n 21) Preamble.

84 As above.

85 Maputo Protocol (n 23) Art 14.

86 Constitution (n 26) sec 27.

National Integrated Sexual & Reproductive Health and Rights Policy,⁸⁷ the policy's strategy is outlined to 'strengthen the health system to deliver integrated sexual and reproductive health rights services at the lowest feasible level in the healthcare system'.⁸⁸

To fully ascertain human rights for Black and poor women, these women must be at the helm of policy-making in rolling out contraception during the pandemic. The representation of these women should be equal in that it must encompass the diverse groups of women affected by the shortage of contraceptives during the pandemic.⁸⁹ The women who received their contraceptives from institutions of higher learning form an integral part of this inclusion. It is vital that the stigmatisation experienced by these women is properly addressed to realise this full inclusion.

The inaccessibility of contraceptives during the pandemic is driven by the need for people to socially distance themselves with the health system severely being under pressure. In solving the predicament caused by social distancing weighed up against the need to collect contraceptives, public health officials can use one or more of these methods to ensure that contraceptives are readily available to women that need them during this time. For example, they can ensure that hotlines are made accessible for women to confidentially request for contraceptives to be delivered at their places of residence.⁹⁰ The public health system can also ensure an online system where women who are not able to go to public health facilities can log on to request contraceptives. These online services should be made free of charge, given that most of the women in need of these services are from disadvantaged backgrounds.

Alternatively, the existing modes of contraception can be utilised to their full capacity to realise women's rights to reproduction. Uses of long-term contraception such as intrauterine contraception (IUC), progestin implants, and contraception patches may be extended in their use given that it is safe to do so.⁹¹

The declaration of different levels of the lockdown in South Africa means that during the lockdown, essential services are usually prioritised. Sexual and reproductive health rights have since taken

87 National Department of Health 'National Integrated Sexual & Reproductive Health and Rights Policy' (2019) at 15.

88 As above.

89 UNAIDS 'Six concrete measures to support women and girls in their diversity in the context of the COVID-19 pandemic' 2020 https://www.unaids.org/sites/default/files/media_asset/women-girls-covid19_en.pdf (accessed 11 May 2021) at 2.

90 UNAIDS (n 89) 7.

91 A Black et al 'Contraception consensus: Updated guidance during pandemics and periods of social disruption' 2020 <https://sogc.org/common/Uploaded%20files/2020-04%20Contraception%20Consensus%20-%20Final%20Submitted.pdf> (accessed 10 September 2021).

backstage in the deliverance of essential services. An alternative to the suggestion of the virtual methods of providing contraceptives is for the government to declare reproductive healthcare rights as essential.⁹² These include the providence of condoms, pre-and post-exposure prophylaxis, antiretroviral therapy, diagnosis and treatment of sexually transmitted infections, safe abortion, contraception, and maternal and newborn care. The declaration of Sexual and Reproductive Health Rights as essential reprioritises them as human rights and affords women protection against unwanted pregnancy during this pandemic.

6 Conclusion

This paper set out the legal framework on the advancement of sexual and reproductive health rights as human rights. It argued that South Africa is party to international and regional instruments that guarantee this right as a human right. Despite this categorisation, the paper has argued that failure to classify reproductive healthcare as an essential service at the scourge of the pandemic means that these rights are denied to millions of women that depend on public health facilities.

The paper has further discussed the need for contraceptives during the COVID-19 pandemic. It illustrated that with the lockdown, there would be a rise in unplanned pregnancies due to the scarcity of contraceptives. It further showed that women in higher learning institutions use contraceptives to further plan their lives. The closure of higher education institutions has thus presented these women with further challenges, such as stigmatisation and the lack of information, which they face regarding accessing contraceptives. Lastly, the paper has proposed alternative means to accessing contraceptives whilst the world continues to combat the spread of the virus.

92 T Mbatha 'The dreadful effects of lockdown on access to sexual and reproductive health services' 31 July 2020 <https://www.spotlightnsp.co.za/2020/07/31/the-dreadful-effects-of-lockdown-on-access-to-sexual-and-reproductive-health-services/> (accessed 17 July 2021).