

The Political Economy of Injectable Contraceptives in Post-Apartheid South Africa: A Feminist Perspective

By

Sethembiso Promise Mthembu
Student Number: 205 5190 50

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University of KwaZulu-Natal, Howard College

Supervisor: Dr Gabisile Mkhize

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DECLARATION

I hereby declare that this thesis on: *The Political Economy of Injectable Contraceptives in Post-Apartheid South Africa: A Feminist Perspective* is my own work and that it has not been submitted for a degree at any other university. All sources and quotes cited have been indicated and acknowledged as complete references.

Sethembiso Promise Mthembu
Student Number: 205 5190 50

Student Signature:  Date: March 2022

DECLARATION: SUPERVISOR

I supervised this Doctor of Philosophy Thesis to satisfaction. Title: *The Political Economy of Injectable Contraceptives in Post-Apartheid South Africa: A Feminist Perspectiv*e.

Student number: Sethembiso Promise Mthembu,
Student number: 205 5190 50

Supervisor Signature  Date: March 2022

DEDICATION

I dedicate this thesis to my daughter, Mbali Peaceful Mthembu, who gives me a reason and strength to live, grow, develop, reflect, and engage with life every day. Special dedication goes to my late father, Mfaniza Mthembu. I know you would have been proud Mvelase, Ndina yabaThembu! My brother, David Khehla Mthembu, I carry your loving memory and solidarity every day. I also dedicate this work to my brother Jabulani Mthembu, and also my late dear little Sister, Alusa Mthembu. I thank my dear sister and friend, Ms Pretty Ngcobo-Khumalo.

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ABSTRACT

In apartheid South Africa, contraception using injectable contraceptives such as Depo Provera (DP) was highly controversial and politicised. It is thus important to review the current existing contraceptive policies in post-apartheid South Africa, specifically those related to injectable contraception, to examine how these policies promote women's rights and autonomy. This research study thus examined how the policies are aligned to post-apartheid South Africa's human rights, gender transformation and development project. The objectives included understanding the framing of post-apartheid South Africa's contraceptive policy and how is aligned with the national agenda and policy and resourcing for women's health. The key research questions interrogated how international organisations responsible for health and population development such as the United Nations, human rights and philanthropist organisations, private foundations, drug companies, and international research and innovation agencies, influence the ideology and policies of contraceptives in post-apartheid South Africa. Hence, the research explored how the existing contraceptive policy enhances women's rights and autonomy in relation to reproduction and health. This research study is grounded on feminist and political theoretic frameworks. It applied qualitative research methods in its enquiry. The design of the methodology incorporated qualitative research activities such as in-depth interviews and secondary data in the form of national, regional and international policy documents focusing on contraceptives and reproduction. Participants were drawn from experts and stakeholders in policy in the Provincial and National Ministry of Health and Provincial Ministry of Social Development. Key research agencies in the field of contraceptives participated in the study, including Clinic staff and contraceptives users. In its findings, this research study identified emerging issues and discourses on injectable contraceptives in contemporary South Africa. This research recommends some policies and programmes to improve women's rights and autonomy in relation to contraceptives, reproduction and health of women who use contraceptives in South Africa.

Key words: contraceptives, political economy, policymaking, reproductive rights, women

The aims and objectives of the study are:

a) To understand the framing of post-apartheid South Africa's contraceptive policy, in relation to purpose and objectives of provision of injectable contraceptives;

b) To explore how the current contraceptives policy is aligned with the national agenda and policy and resourcing for women's health; and
c) To explore how the policy on contraceptives enhances women's rights and autonomy in relation to reproduction and health.

Research Methods

The study applied feminists' qualitative research methods in its enquiry. The design of the methodology incorporated qualitative research activities such as in-depth interviews and review of secondary data in the form of national, regional and international policy documents and reports on contraceptives.

Study Population

The total sample size of the study was 27 participants. Three different study populations were sampled for this study in order to gain insights into the positioning and politics of contraceptives in post-apartheid South Africa. Participants were drawn from experts and stakeholders in policy in the Provincial and National Ministry of Health and Provincial Ministry of Social Development. Key research agencies in the field of contraceptives participated in the study. Clinic staff and users of contraceptives from the Halley Stott Clinic in Bothas Hill and Osizweni Q Clinic in uMlazi participated in the study. The project interviewed members of Parliament serving on the Portfolio Committee on Women in the Presidency (formerly Gender Portfolio Committee) and the Portfolio Committee on Health. Representatives of Constitutional Section 9 Institutions the South African Human Rights Commission and the Commission for Gender Equality participated in the study. A representative of the United Nations Population Fund (UNFPA) participated in the study.

Outcomes of the study

The outcomes of the study are to broaden the understanding of the political economy of contraceptives in post-apartheid South Africa from a feminist perspective**.** Increase the body of knowledge on the ideology of contraceptive policy in South Africa. This includes issues of racialised targeting, women's rights to choose and autonomy, knowledge of side effects, in the context of the global neoliberal political economy. The research project presents research, law reform, and policy recommendations to improve women's rights and autonomy in relation to contraceptives, and reproductive health of women who use contraceptives in South Africa.

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
ASRHR	Adolescent Sexual and Reproductive Health Rights
AU	African Union Commission
CAPRISA	Centre for the AIDS Programme of Research in South Africa
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CGE	Commission for Gender Equality
CHAI	Clinton Health Access Initiative
CII	Center for Innovation and Impact, United States Agency for International Development
DFID	Department for International Development (United Kingdom)
DHS	Demographic and Health Surveys
DOH	Department of Health
DP	Depo Provera
FHI360	Family Health International
GRES	Gender Results Effective Scale
DSD	Department of Social Development
DHHS	Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HRP	Human Reproduction Programme
HST	Health Systems Trust
ICPD	International Conference on Population and Development

IPPF	International Planned Parenthood Federation
IPM	International Partnership on Microbicides
MRU	Maternal, Adolescent and Child Health (MatCH) Research Unit, Wits University
OHCHR	Office of the United Nations High Commissioner for Human Rights
PEP	Pro-Choice Public Education Project
PATH	Program for Appropriate Technologies for Health
RDP	Reconstruction and Development Programme
RHSC	Reproductive Health Supplies Coalition
RR	Relative Risk
RRA	Reproductive Rights Alliance
SDG	Sustainable Development Goals
SAHRC	South African Human Rights Commission
SRHR	Sexual and Reproductive Health Rights
UK	United Kingdom of Great Britain and Northern Ireland
UNFPA	United Nations Population Fund
UN	United Nation
US	United States of America
USAID	United States Agency for International Development
WRHI	Wits Reproductive Health and HIV Institute

CHAPTER ONE

1. BACKGROUND TO THE STUDY

1.1 GLOBAL AND LOCAL CONTEXT AND PERSPECTIVES ON DEPO PROVERA

Contraception, in particular Depo Provera (DP), is a highly controversial and politicised phenomenon. For decades, DP programmes have been criticised for racial and class targeting by the Western world, particularly the US and the UK (Robinson 2010; Rakusen, 1981; Kuumba, 1993). This phenomenon was mainly seen after DP was rejected in Western countries through deregistration and stringent terms of use and dispensing. Racial and class targeting, particularly of poorer Black women, have been observed in developing countries (Brown, 1987; Kaufman, 2008; Klausen, 2004; Kaler, 1997; Cooper, *et al.* 2004). The idea of targeting poor women was informed by racial eugenics and the notion that reproduction of women in lower socio-economic classes creates and sustains poverty – the much debated and contested Malthusian proposition (Frey, 2011; Robinson, 2010 Fuderi, 1997).

Other justifications for enforced use of contraceptives include environmental degradation, population explosion, famine, and over-population, in general (Robinson, 2010 Kaler 1997: 2010 1997; Frey, 2011). In recent times, the primary justifications for the application of DP have been to curb the HIV and AIDS pandemic, and to minimise the high rates of maternal mortality and urban poverty (The Rebecca Project for Justice 2014; Family Planning2020, 2012; Bill and Melinda Gates Foundation, 2018).

During the 1970s and 80s, DP was deregistered in the United States and many European countries. However, it was still registered for use in developing countries, including African countries. DP was predominantly prescribed to Black women and women from lower socio-economic strata (Hayman, 1985; Rakusen, 1981). To circumvent the US regulation that a drug that was deregistered in the US could not be exported to other countries; the pharmaceutical company that produced DP began to manufacture the drug in Belgium and Canada, where it had not been deregistered. During this period, DP remained registered as a contraceptive in the developing world, without any safety concerns or discussions on deregistration (Hayman 1985; Rakusen, 1981). This demonstrates how political economy, international relations, and trade and economic agreements impact the contraception discourse. It demonstrates how world economic orders treat women's bodies differently, based on geography, colonialism, the state of development, and where the county sits in the world economic order. This calls for unison

in women's struggles; but also acknowledges the intersection of colonial layers, regional-global and south-north differences, the political and economic history, and indeed race, class and ethnicity.

Contraceptives are part of the periodisation of politics and world orders (Frey, 2011). The Cold War (1947 to 1991) sparked fears of an undesirable population explosion in developing countries, leading to a perceived need for contraception programmes (Frey, 2011). In South Africa, White fear of communism was associated with fear of a Black population explosion, especially in urban areas (Ndengwa, 1996). Some of the contraception programmes were still linked to post-World War II decolonisation (Robinson, 2010; Ndengwa, 1996). Contraception and fertility control were part of the transition deals and became an indicator for development, and success of new governments (Thomas, 2003). Funding for aid and humanitarian deals included contraceptives. Technical support to recently decolonised countries included technical experts such as demographers, to assist with the population control programmes and contraceptives (Thomas, 2003).

The famine in India, for example, laid fertile ground for Depo Provera to be a condition for women receiving aid, mainly in the form of food parcels. Other forms of population control such as sterilisation were also used. This was a donor condition (The Rebecca Project for Justice, 2014). In South Africa, Depo Provera was a population management strategy of the apartheid government to reduce Black populations (Brown, 1987; Klausen, 2004). Klausen (2004) states that the policies and the discourse on Black population control had started; and policy positions were finalised at the time of the Union of South Africa.

The apartheid regime built a policy framework and massive implementation infrastructure for this strategy (Kaufman, 2000). Thomas (2003) states that contraceptives were used for the same purpose in Kenya and other colonial countries. In South Africa, the first contraception policy, the National Family Planning Programme, was established in 1974. This policy, having been established during the apartheid era, has been criticised for attempting to control the poor and, specifically, Black women's fertility by outlining an unjust and racialised population control contraception programme. This long-standing policy was only replaced in 2003 – almost a full decade after democracy in South Africa – even though the issue of women's sexual health and reproductive rights' justice were part of the struggle during the transition from apartheid to democracy (Moultrie, 2005).

The ideology of contraception policies in modern South Africa is rooted in the neoliberal ideology of the ruling African National Congress (ANC). This ideology is influenced by the history of the country, the global political system, and the position of the country, internationally. The country achieved its democracy through a negotiated settlement (Meer, 2007; Bond 2000). This negotiation process and settlement are referred to as *The Elite Transition* (Bond, 2000).

South Africa transformed from its apartheid past to its human rights-centred socio-democratic position of post-apartheid development, expressed through the Reconstruction and Development Programme (RDP). In 1996, South Africa had to adopt the neoliberal economic policy advocated for by international finance organisations such as the World Bank and the International Monetary Fund (Bond, 2000; Meer, 2007). The global balance of power would not have made opting out of neoliberal ideology possible for South Africa (Ndengwa, 1996). Internal concessions also left the economic structure unchanged. The structural positions and targeting of policies did not transform much, apart from ensuring inclusion of Black South Africans, creating a Black bourgeoisie class (Meer, 2007). The transition was then focused on ensuring racial inclusivity in accessing economic and political resources, with the hope that the gains would trickle down at some point (Meer, 2007).

The Reconstruction and Development Programme (RDP) was influenced by the international development agenda on the population control of the time. The provisions of the International Conference on Population and Development in 1994 (ICPD) were incorporated into the RDP policy framework (Ndengwa, 1996). The ICPD was building on the United Nations and global population control establishment that had started at the end of the Second World War. It was the beginning of formal participation and co-option of South Africa's post-apartheid government into the global population control system. Essentially, according to Ndengwa (1996), the population control movement had attached itself to the South African post-apartheid transition project. It successfully defined the trajectory of contraceptives in the country (Ndengwa, 1996).

The ICPD declaration and prior declarations on population control were instrumental in shaping the understanding of reproductive health and rights as we see it in present-day South Africa. Contraceptives, which I contend are branded as reproductive health, have claimed a definition of women's health in South Africa. In considering the objective of the study on the role of international organisations, the study found out that the field is littered with international

experts guiding South Africa on what are claimed to be good evidence-based programmes and resources without considering the price paid by women, and women's bodies.

1.2 HEALTH, SEXUAL REPRODUCTIVE RIGHTS, PRACTICAL INTERESTS AND WELFARISATION OF WOMEN'S RIGHTS

Pursuant with the objectives of the study, ideological and human rights positioning of contraceptives was interrogated. Feminist political lobbying in the development of the Constitution led to the inclusion of reproductive rights, access to health and other socio-economic rights were included the Constitution of South Africa, and to some degree, integrated into South African legislative frameworks (Hassim, 2016). In this regard, the study found that contraceptives, as part of reproductive rights, are only included from the perspective and non-discrimination from the perspective of sexual orientation. The right to choose and access to safe contraceptives, are articulated but not provided for financially and programmatically in the delivery of contraception. Furthermore, the rights violations of the apartheid past were not provided for in terms of redress and transformation. Access for all is provided, however racial targeting, which in and of itself in a human right violation is also not provided for.

The South African Constitution of 1996 refers to sexual and reproductive rights in three places: the equality clause, Section 9(3), which forbids discrimination on grounds of sex, gender, and sexual orientation; Section 27(1) (*a*), which states, Everyone has the right to health care services, including reproductive health care; and Section 12 which deals with freedom and security of the person (Constitution of the Republic of South Africa, Act 108 of 1996).

In 1994, the National Assembly adopted the Reconstruction and Development Programme (RDP), published as the White Paper on Reconstruction and Development, 15 November 1994), as South Africa's developmental framework. The RDP prioritised social services as part of progressive realisation of women's rights. The package included, amongst others, provision of free contraception, abortions, and maternal and child health care. This was a welfarist practical-needs-based approach centred on women as reproductive beings, rather than on women as females. Section 4(3) of the National Health Act provides for certain free health-care services for people who do not have medical aid. The Act provides for, amongst others, free primary health care services at government facilities, free abortion services for pregnancies up to 12 weeks, or 13 and 20 weeks, depending on the circumstances, and that pregnant and breastfeeding women and children under the age of six are eligible for free health care services at public health facilities. The study sought to understand whether contraceptives were provided within a framework of women's health. In light of the services listed above, the study

confirmed that health care services in South Africa are provided under the framework of women as mothers, which does not consider women's health beyond reproduction. Furthermore, the approach controls how women rear their infants, as for an example, it has the condition that access to free infant and mother's health is subject to women breastfeeding their infants.

Legalisation on abortion in South Africa is regarded as one of the key important gains and a victory for South African women. In the US, the 1973 legalisation of abortion was considered of paramount importance to all women and to the success of the modern women's movement (Smith, 2015). In both countries, Black women and other marginalised women were at high risk of illegal abortions for a variety of underlying structural, economic, political and cultural reasons. As such, legalisation on abortion was victory, in particular for Black women. Smith (2015) suggests that, although the legalisation was progressive, the advocacy around it was not informed by the experiences of Black women. This is partly because the advocacy was conceived by women of a different race and class (Smith, 2015). Leaving out Black women in this advocacy, for example, left out the analysis of illegal abortions industry, so that the complexities of this industry could be addressed. Black women understood the nature and cartels of the illegal abortion industry because they were exposed to it. As such, their experiences would have informed the legal framework to address barriers posed to Black women accessing safe abortion (Davis, 1983).

Black feminists contended that legalisation of abortion was not conceived from the Black women's reproductive rights, fertility control discourse. It did not consider the racist oppression of interventions that were understood by other women as liberating. The legalisation of abortion was silent on the racial, forced nature of contraceptives as a tool for racial and gender oppression. Forced sterilisations and forced injections with Depo Provera were one of these interventions (Davis, 1983). Davis (1983) argues that had the discourse considered such, it would have found solutions, gendered racial injustices, gendered human rights abuses, and critiqued the movement from race and class positions. Furthermore, the abortion law lobby did not support the anti-sterilisation campaigns and legal actions against it, in particular legal successes of Black women and women of colour (Davis, 1983). The victories came around the same time, but victories on sterilisations of Black women were not profiled (Smith, 2015).

It can be stated that the South African abortion law lobby missed the opportunity of considering the racial and abusive nature of all fertility control programmes, including Depo Provera and

sterilisations. This is because the abortion law lobby conceptualised and won the legalisation of abortion in South Africa's transitional period. This could have been achieved by understanding contraceptives and fertility control from Black women's perspectives and experience, acknowledging the racist and class nature of such targeting. The understanding of whether these are indicators of liberation of Black women would have been created at that point, including the recognition that what could be considered as reproductive liberation for some women, is, in fact, oppression for others. Furthermore, the analysis in this regard, would have kept racialised reproductive crimes and oppression in the mainstream post-apartheid reconciliatory political realm. Safer methods and choices for women would have been sought. Such would have led to direct interventions to stop the racialised violations of women's bodies under the guise of choice, and women's rights. It would have highlighted how Black women's bodies were sites of violent colonial and apartheid projects. The opportunity to analyse the human rights, choice, racial, and health implications of Depo Provera, was missed.

I argue that legalisation on abortion silenced the racialised reproductive oppression, including the use of Depo Provera and forced sterilisations. It is worth noting that the legalisation of abortion was an important milestone and victory for South African women. Abortion is in the same reproductive rights package with Depo Provera. This is arguably counterproductive in the project of post-apartheid fertility liberation. However, this victory is essentially used to silence Depo Provera (and forced sterilisations) as a tool of racial oppression expressed in women's bodies. The opportunity for deep analysis of Black women's reproduction and addressing the structural issues associated with this as a political phenomenon was missed because it perches between the liberation movement and the feminist movement.

Welfare is a deeply gendered political phenomenon, and an expression of state power in South Africa. It is morally comprehensible and essential that social services are prioritised in order to mitigate the effects of poverty on women. There are assumptions made about welfare as an intervention for liberation of women. It is, however, argued in this study, that the welfarist approach is not a good foundation for addressing issues of contraceptives when applying the political and women's oppression lens. Injustices embedded in contraception policies were silenced and depoliticised in this welfarist approach. Welfare programmes, although touted to assist women, lack feminist analysis and, as such, may place women in worse situations (Brenner, 1989). This calls for careful analysis of the welfare approach on gender transformation, positionality, and emancipation of women. This approach might have

reinforced gender relations and stereotypes that we seek to transform. Welfare services also interfere with women's privacy, as they scrutinise and keep women under surveillance – particularly in relation to their reproductive roles (Brenner, 1989). Essentially, welfare may be the extension of reproductive control over women, acting as another way of entrenching state power in the private spaces. This study found an example of this with the provision of free health services to breastfeeding women who were prescribed Depo Provera without their full informed consent in public hospitals.

Although health is considered as apolitical, oppression is also silenced in health. Health programmes are seen as for the common good and supposedly come from an apolitical field, which is medicine and demography. Women's oppression is expressed through women's bodies. Because of this, the responses have been centred on health. For example, rape is addressed predominantly from a medical perspective, rather than racialised patriarchal power and oppression of women lens. Even violence against women is considered from a health perspective. Research and data on violence against women are gathered from reproductive health research surveys. This "women as mothers" targeting in the violence against women discourse excludes women who are not of reproductive age. This limits the opportunity of feminist research and analysis of these problems, and renders these violations as apolitical, and thus not embedded in the oppression of women. The problem is blamed on individual behaviours of perpetrators; whilst leaving the societal patriarchal system intact that perpetuates these actions.

Women leaders from the National Women's Coalition and the ANC Women's League were sent to parliament, which took away skills, capacity and politicisation of women's oppression from the women's organisations (Meer, 2007). This would have compromised struggles of transformation, including Depo Provera. Meer (2007) notes that other challenges in advancing women's rights and gender equality include lack of adequate accountability mechanisms between parliamentarians and women outside parliament (Meer, 2007). Post-apartheid women's organisations were encouraged not to focus on gender politics, but rather to focus on practical needs such as development initiatives. Again, this defined women's contribution in the post-apartheid period within the ambit of welfare, and not addressing structural issues of oppression. This approach robbed women's issues of feminist analysis, and depoliticised women's struggles in the country (Meer, 2007). The Truth and Reconciliation Act did not address the issue of Depo Provera and other population control issues, such as forced and coerced sterilisations. These were reproductive crimes and hurt

women's bodies so should have been addressed at that level of the reconciliation project. This further relegated women's issues and participation to social services, which focused mainly on addressing practical needs in the social policy space. Indeed, this reinforced women's roles as carers, amplifying gender inequality and stereotypes conceived from patriarchal logic.

In recent times, Depo Provera and other contraceptives have attached themselves to policies in transitioning countries in the Middle East (The Rebecca Project for Justice, 2014). The conflict in Israel sees the immigration of poor and Black women who are coerced into taking Depo Provera without their full consent; and without having full information of the dangers of DP and other contraceptive options available to them (Dawber, 2013, Association for Civil Rights in Israel, 2013). Advocates of birth control contend that contraception is a woman's right, an attempt to liberate women from patriarchal control, and promote women's rights of choice and bodily autonomy (The Rebecca Project for Justice, 2014; Klugman, 2000; Robinson, 2010; Fuderi 1997). This position has been seen by some feminists as co-option of women's rights to their own ends by the contraception movement (Fuderi, 1997; Frey, 2011). Frey identified contradictions in these articulations and women's rights claims (Frey, 2011).

Contraception lobbyists defy the very values they advocate for, as they remove the autonomy of women by forcing and not seeking women's consent in the use of contraceptives. This is direct imposition of state power on women's bodies, amongst many other contradictions identified (Frey, 2011). Some feminists have, however, agreed that contraceptives do contribute to women exercising their choices on reproduction. Contraception, therefore, is a paradoxical phenomenon, rather than a dichotomous discourse between the population control lobbyists, maternal feminists, liberal feminists, and postcolonial feminists. The ICPD Declaration was a compromise between the population-control lobbyists and feminists (Robinson, 2010), and its outcome was a compromise between two strands of the population control movement, the neo-Malthusians and the reproductive rights strands (Wilmot and Ball, 1992).

The reproductive rights and autonomy feminists' strand advocated for individual liberal women's rights and autonomy in relation to fertility, and women's control of their reproductive rights (McIntosh and Finkle, 1995). In the compromise, the feminist strand was able to include the women's empowerment and reproductive rights language and targets in the ICPD document. Feminists also achieved, to a degree, the language of economic development for

women. Neo-Malthusians and the population establishment were able to achieve the inclusion of population and development in the language and targets (Robinson, 2010).

In the context of South Africa, the use of Depo Provera has extended from colonialism to apartheid and post-apartheid. Given the importance of South Africa's gender equality and women's empowerment programmes, this categorical paradox has important implications for women and women's human rights. The study explored the politics of public health research and policy to ascertain whether South Africa's contraceptive policies promote the rights of women or whether it advances a patriarchal, racialised, political economy agenda that is counterproductive to gender equality and the emancipation of women.

The study explored the role of other non-state actors, including international actors, in broadening the understanding of emerging issues of political economy on injectable contraceptives in post-apartheid South Africa. By including the international community, one begins to consider a web of connections and the power and influence of these in contraception policies. This approach began to locate contraceptives in the politics of oppression of women, in light of a neoliberal, neo-colonial, global economic establishment. The study sought not only to create a broader understanding of the ideology and framing of current contraception policy in South Africa, but also to locate it within the broader global and continental African colonial and post-colonial contexts. The role of international agencies and policies, research and collaborations were interrogated in trying to understand how their participation might be shaping the ideology and discourse around the policy. This research looked how the current policy accounts for the racialised historical issues of injectable contraceptives in South Africa specifically. South Africa established constitutional bodies and instruments to advance and protect human rights and gender rights. The study found that current policy on contraceptives mentions some of the human rights as provided for in the Constitution, albeit, the policies are not aligned with South African human rights, gender, and women's autonomy provisions, as they stand in the post-apartheid Constitution. The study found that current policies do not consider the historical racialised oppressive nature of contraceptives.

2. PROBLEM STATEMENT

This study addresses the gap of limited research and knowledge on ideological and women's rights positioning of injectable contraceptives and contraception from a general perspective in post-apartheid South Africa, as outlined in the objectives of the study. The South African contraceptive policy, the National Contraception and Fertility Planning and Service Delivery

Guidelines was released in 2012 (Department of Health, 2012). This was a development and review of the policy which had been codified in 2003. Further policies in the areas of contraceptives and women's health have been developed. These include the Guidelines for Maternity Care in South Africa, Fourth Edition, 2015 (Department of Health, 2015), the Ideal Health Facility Guidelines, and Adult Primary Health Care Guidelines 2019/2020 (Department of Health, 2019). These guidelines provide for provision of reproductive health and fertility planning services at primary health care system level, and at district health care level. Issues of maternal mortality, partially linked to HIV, and challenges in the health systems and teenage pregnancy, justified the need for research on how these policies and guidelines have positioned contraceptives, and the rights and what are perceived as wrongs.

Research on contraception at times uses a public health and racialised colonial population policy perspective - for example: Brown (1987), Burgard (2004), Cooper *et al.* (2004), Gready *et al.* (1997) and Moultrie (2005). These studies focused on the uptake, acceptability and usability of contraceptives, Research is also focused on product development, increasing access, and integrating commodities in other health programmes. Exploring this topic using a critical feminist lens adds value in gaining a novel insight into the current practices of contraception provision and use in South Africa. Such insight comes in light of all public health and human rights safeguards, for South African women, making this study original, and contributing to building new and current knowledge on the topic.

The research assessed how these policies have migrated from the ideological standing and policies under the apartheid regime into the democratic era of human rights. The experiences of women users of contraceptives, the providers of contraceptives, and the perspective of policy makers, are important in building this understanding. The next section of this chapter will present the objectives and key questions that guided the study.

3. KEY OBJECTIVES OF THE STUDY

In light of the gaps in research and knowledge on the ideological positioning and alignment of contraceptives to the post-apartheid period, the study sought to meet the following objectives:

a) Explore and describe the ideology and framing of contraception policies in post-apartheid South Africa.

The study seeks to understand whether the current contraception policies are aligned with the national transformation agenda and policy, including resourcing for women's health, and consideration of women's health implications.

b) Explore and describe the nature of women's involvement and participation in all spheres of the new contraception policy and practice, (including application of safeguards for participation), choice, and human rights.
c) Explore and describe whether the post-apartheid policy is informed by women's needs and priorities for health; and whether it considers, in its prescripts, women's lived experiences in the areas of health, reproductive rights and autonomy.
d) Explore and describe whether the policies are transformational and enhance women's rights and autonomy, contributing to transformation of power in structures and health systems, and addressing the past reproductive injustices of apartheid.

3.1 KEY QUESTIONS THAT GUIDED THE RESEARCH

Flowing from the rationale of the study and meeting the objectives as outlined above, the study responded to the broad questions:

1. What could influence the ideology and framing of post-apartheid South Africa's contraception policy?
2. How has the current contraception policy been aligned with the national transformation agenda, policy and resourcing for women's health; and does it consider women's health implications?
3. How was women's participation provided for in the formulation of the new policy; and how does the current contraception policy, in its prescripts, consider the lived experiences of women in health and reproductive matters?
4. How is the new policy informed by women's lived realities, needs, and priorities for health?
5. How does the current contraception policy enhance women's rights and autonomy, transformation of power and structures, and reproductive justice?

The broad questions asked helped the study achieve its objectives. The information and data obtained through the guiding questions were it in line with the objectives of the study. The study was able to define the ideology and framing of contraceptives in post-apartheid South Africa. This was achieved through interrogating the rationale and understanding of contraceptives from women users of contraceptives, researchers, policy makers, and health

workers. Specific questions on human rights and gender transformation assisted in determining the alignment of contraceptives to gender transformation programme. For this question, the study interviewed key Constitutional bodies responsible for gender and human rights.

The study found that health is removed from the broad human rights and post-apartheid women's rights discourse in South Africa. There was no indication that current contraception policies are actively designed to enhance women's rights and autonomy or to transform past racialised reproductive injustices expressed through contraceptives. The broad questions of the study assisted in understanding women's participation in the policy, community health governance structures, and how this lack of participation hinders the consideration of the lived experiences of women in contraceptives programmes, and more importantly, women's health in light of the position and oppression of women in their homes and communities.

The study identified the role of other non-state actors, including international actors, in broadening the understanding of emerging issues on injectable contraceptives in post-apartheid South Africa. The study identified a web of connections of power and influence of different international and national actors in contraceptive policy making, research and implementation. Feminist political economy analysis assisted the researcher to locate contraceptives in the politics of oppression of women, in the context of dominant global neoliberal and neo-colonial economic ideology. The application of feminist political economy assisted the study to unearth how power at a global level, dominant economic discourses in health policy and industry, global politics and power impact on women users of contraceptives in their private lives. The study observed how these global neo-liberal arrangements render the national human rights targets and principles of participation redundant.

4. RATIONALE FOR THE STUDY

Pursuant to its objectives, the study located the political and priority position of contraceptives, including injectable contraceptives, and women's reproductive rights at large in post-apartheid South Africa, with a particular focus on KwaZulu-Natal. The perspectives of policy makers and secondary influencers in research, government, and civil society on contraceptives, were included to build the understanding. Legislators, in the form of Members of Parliament, who are responsible for health and women's rights, were included in the study as well as implementers of services. This topic was chosen because of the need to increase the body of knowledge on contraception from a feminist lens in post-apartheid South Africa. It is important that the discourse on contraceptives is understood from a local perspective and nuance. The

researcher is interested in the current politics of reproduction, and how these are connected to women's autonomy, rights, and health issues in the country. The global landscapes on contraceptives and development discourse have changed over the last decade. It is therefore important to locate and examine how these shifts have impacted and influenced South African policies. The topic was chosen so that the current positioning of contraceptives could be understood in light of political choices made. Such choices are in relation to the transformation of women's rights, including health, sexual and reproductive rights.

5. THEORETICAL FRAMEWORK AND APPLICATION TO THE STUDY

The study applied a combination of feminist theoretical framework conceptualisation and analytical tools. Theories applied include intersectionality feminist theory, post-colonial feminist theory, radical feminist theory, feminist political economy, and radical feminist theories. Radical feminist theory provided a more holistic worldview of the study. This is because this theory applies women's lived experiences to create social theory of women's oppression and strategies to end that oppression (Rowland and Klein, 1996). Post-colonial feminist theory was also applied as one of the analytical theories of the study, as it allowed for the critical analysis of colonialism, history, and their effects on the past and present (Mkhize, 2012, Mohanty, 1991). The study was framed within apartheid as part of colonial history, in line with Anderson's (2003) conceptualisation of apartheid. An intersectionality feminist research paradigm (Crenshaw, 1991; Ackerly and True, 2010) was applied as an analytical tool for this study as well as the political-economy research paradigm (Riley, 2008). In contrast to classical and neoliberal economic models which analyse supply and demand of goods and services within free-market systems, political economy analyses society as an integrated whole. Political economy therefore accepts the relationship between the ruling authority and big business in capitalist economies (Armstrong and Connelly, 1989; Riley, 2008). Gender analysis frameworks and political theory were applied in the analysis of findings of the study, albeit to limited degree. Feminist policy review approaches (McPhail, 2003) were applied to analyse policy documents.

6. SUMMARY OF RESEARCH METHODOLOGY

The study applied qualitative research methods, including in-depth interviews to collect data from participants. Policy reviews and relevant reports were also used as secondary data sources. The qualitative research paradigms applied in this study are grounded on feminist research approaches. Interviews were supported by other methods, such as policy reviews.

Three different study populations were included. A multilevel sampling strategy (Onwuegbuzi and Leech, 2007) was adopted to select participants. The total sample size was twenty-seven (27) participants. The participants of the study included: a) women who are users of contraceptives in two clinics; b) health care workers responsible for contraceptives in the clinics; and c) researchers working on contraceptive research, policy, and training in the field, senior government officials, constitutional bodies, and members of parliament who are Chairpersons of the Health and Women Parliamentary Portfolio Committees. In addition, the United Nations Population Fund (UNFPA), an agency responsible for contraceptives, participated in the study. Women users of contraceptives accounted for 41 per cent. A more detailed account of research participants is presented in Chapter 3. Strategies were purposively applied to improve the credibility, transferability, dependability and confirmability of the study, the details of which are discussed in the methodology chapter of this report (Chapter 3).

6.1. ETHICAL CONSIDERATIONS

The study received full ethical clearance from the Social Sciences Ethics Committee of the University of KwaZulu-Natal. Permission to collect data in the clinic was granted by the Regional Office of the KwaZulu-Natal Department of Health. Full permission was granted upon gaining of full ethical clearance of the study. The study was registered and approved to be included by the KwaZulu-Natal's Department of Health Research Database and Health Systems Trust Research Database. Ethical principles of voluntary participation, consent, and confidentiality were adopted by this study.

7. SIGNIFICANCE OF THE STUDY

The study sought to address research gaps and increase the body of knowledge on the ideological positioning and alignment of contraceptives in post-apartheid South Africa from a feminist perspective. This research contributes valuable feminist insights, broadens understanding and knowledge on the post-apartheid ideological positioning of contraceptives and the rights of women users of contraceptives in the globalised neoliberal political economy. Researchers and scholars in the gender, feminists, public health, political economy and policy fields will benefit from this study. The study examined closely how international governance and the expanding role of business and multinational companies in health is impacting on women's lives at a micro level.

Findings and recommendations from this study will assist in informing and improving government and state policies and programmes on injectable contraceptives. Furthermore, the results will assist in informing oversight roles of Parliamentary Portfolio Committees on health and women, in this regard. The researcher committed to presenting the results and the recommendations from this study to the two committees in light of the structural changes in health policy and the introduction of the National Health Insurance Policy. The researcher hopes the research will generate knowledge that will inform the work of health care, research institutes, women's rights groups, the Commission for Gender Equality, and activists and feminists who are working on this issue. More importantly, in line with feminist values, the findings of the study will contribute to and influence discourse in the injustices and politics of reproduction, to a limited degree contributing to upsetting the status quo.

The research provided an opportunity for exploring and describing how the public exclusion from participation in health policies regarding women's reproductive rights contributed to the effective silencing of women's voices regarding their oppression, thereby, denying women of their constitutional right to bodily integrity. It was important to conduct a study to review and broaden the understanding of the current contraceptive policies that exist in South Africa and specifically policies related to injectable contraceptives. The study examines whether these policies promote the rights of women, or whether they advance a patriarchal, racialised, political economy agenda counterproductive to the advancement of gender equality and emancipation of women.

8. CHAPTER OVERVIEW AND STRUCTURE OF THESIS

This chapter details the background of the study and. discusses the gendered politics of motherhood. I argue that motherhood is, paradoxically, a key site of both empowerment and oppression of women. In addition, contraception, as a phenomenon, is embedded in patriarchal power over women's reproductive abilities. The chapter detailed the purpose, objectives, key questions, and scholarly relevance of the study and presents a summary of the methodology of this study. The next chapter will focus on theoretical positioning and on the literature review.

This research report is presented in seven (7) chapters. Chapter 1 covers the study background and introduction. Chapter 2 relates to the literature review and theoretical grounding of the study. Chapter 3 details the methodology of the study. The next three chapters present the report findings: Chapter 4 presents research findings on women's rights of choice, autonomy, and participation in policy, governance and community health structures; Chapter 5 presents

findings on human rights in provisions and application of contraceptive policies and provisions in South Africa; and Chapter 6 details findings on the global policy, and the role of international actors in contraceptive policy and practise in South Africa. Chapter 7 presents the summary of findings, conclusions, and recommendations.

CHAPTER 2:

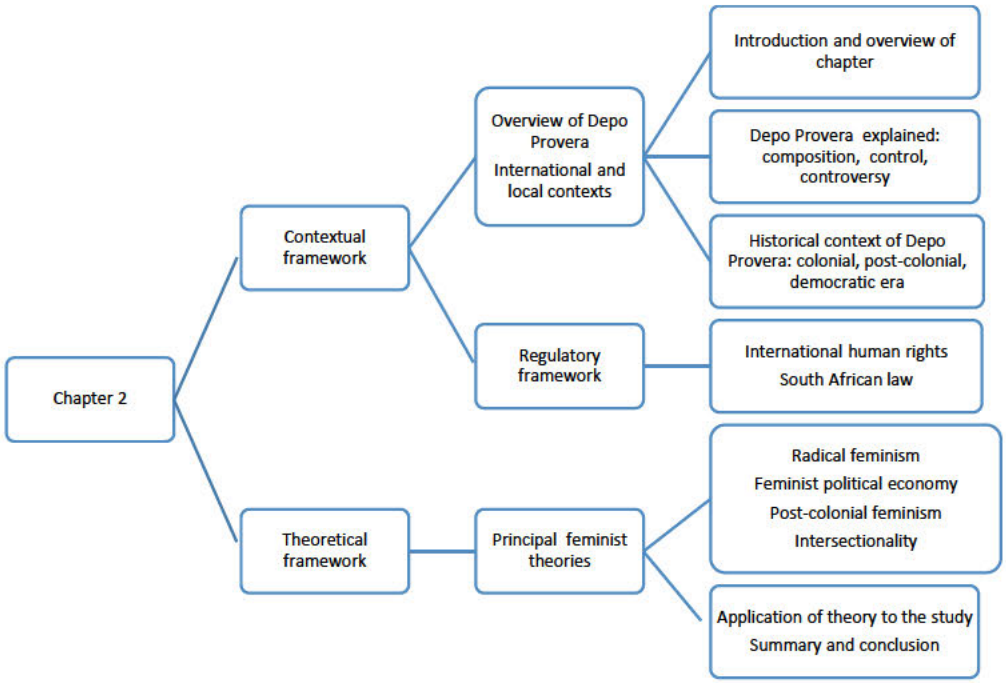
PRELIMINARY LITERATURE STUDY AND THEORETICAL FRAMEWORK

1. INTRODUCTION

This chapter presents both a contextual and theoretical framework for the study, with a focus on literature on contraceptives as a gendered political-economic phenomenon. The chapter opens with an overview of Depo Provera (DP) as an injectable contraceptive, which is the key focus of this study. A brief overview is provided of the history and the ideologies of contraceptives over time and internationally, in various societies of Africa, and in South Africa, in colonial and post-colonial times. In line with the broad objectives of the study of broadening understanding of the ideology and framing of post-apartheid South Africa's contraception policy, particularly, how the policies have migrated from the apartheid policies, have been aligned with the national transformation agenda and how the policies enhance women's rights, emancipation, participation and autonomy. I have used many of the documents discussed in this chapter as secondary data sources for the purposes of content analysis. The findings of this content analysis are presented in later chapters of this research report.

The chapter includes a discussion of the regulatory framework, with a focus on international human rights and South African law as the legal context for contraceptives policy, women's rights and the right to health, amongst other things. Furthermore, the chapter details the theoretical positioning of this study. A feminist lens is applied to assess literature on the politics of science and medicine, in relation to control and regulation of women's reproduction. I present the information in this chapter in two parts: the contextual framework, in which I provide an overview of DP in an international and local context, including the regulatory framework for contraceptives; and the theoretical framework of the study, drawing on feminist theories.

Figure 1 provides a visual overview of the chapter. This section of the chapter concludes with an application of the theoretical perspectives on the design of the research, which is the topic of Chapter 3 of this report.



2. PRELIMINARY LITERATURE STUDY

2.1 CONTROVERSY OF CONTRACEPTION AND WOMEN'S RIGHTS AND AUTONOMY

One of the objectives of the study was to broaden understanding of whether contraceptive policies are transformatory and enhance women's rights and autonomy. The study posed questions about how contraceptive policies contribute to the transformation of structural power over women and health as a system of power and oppression of women. The study looked at how the policies address the racialised reproductive injustices meted out to Black poor women in apartheid South Africa.

Contraceptives can be both a form of oppression and a form of agency to women, and their control over their reproductive rights. On the one hand, fertility regulation itself - through the use of contraceptives and fertility regulation may be considered as central means of promoting women's rights, autonomy, emancipation, and gender equality (Fuderi, 1997). On the other hand, and this is the stance taken in this study, it is argued that contraceptive policy in developing countries, including South Africa, has been underpinned by a darker objective than the 'women's rights' narratives that surfaced during the 1960s.

Advocates of birth control contend that contraception is 'a woman's right', an attempt to liberate women from patriarchal control and to promote women's rights of choice and bodily autonomy (The Rebecca Project for Justice, 2014; Kaufman, 2000; Robinson, 2010; Fuderi 1997). This position has been seen by some feminists as co-option of women's rights language to their own ends by the contraceptive movement (Fuderi, 1997; Frey, 2011). Frey (2011) identified contradictions in these articulations and women's rights claims. The contraceptives lobby defy the very values they advocate for, as they remove the autonomy of women by compulsion, and not by seeking women's consent to contraceptives.

There is evidence that, in some instances, women were coerced into taking DP in order to access social services and grants (Rakusen, 1981). For instance, in apartheid South Africa, women who were unwilling to take DP found it difficult to access health care for their children (Moultrie, 2005). The Rebecca Project for Justice (2014) provides evidence that taking DP was a condition for women to access welfare and famine aid programmes in India. Also, in stark contrast to the 'women's rights' narratives that suggest that contraception promotes female bodily autonomy, women from lower social strata have been administered DP without full informed consent (Smith, 1978). Health-care workers perceived these women as unable to make decisions regarding contraception owing to lower mental status (Smith, 1978).

The injectable hormonal contraception DP has for decades been a subject of discourses and controversies on racial, colonial, social class, and eugenics perspectives Inconsistencies in relation to how it is used, for example, the geographical spread of DP use in the developed and underdeveloped world, indicate strict limitations in developed countries, although not in developing countries. Moreover, DP is administered to women in the absence of informed consent and offering other contraceptive choices. Evidence of unethical practices in dispensing DP is evident in the literature. This study found that DP is still provided under coercive circumstances, was and is mainstreamed in essential maternal and infant care programmes, making it difficult for women to refuse taking it. The study also found that the target for DP is still Black women, and that recent policies target women who are most marginalised by society - Black women, young women and girls and women living with HIV.

2.2 INTERNATIONAL CONTEXT OF DEPO PROVERA (DP)

The understanding of the international context and position of DP is important to broaden understanding of its position and ideological underpinnings in South Africa. DP, is an injectable progesterone hormone-based contraceptive, was first registered in the United States

of America (US) by the American Food and Drug Administration (FDA), and later in the United Kingdom (UK), on questionable grounds (Rakusen, 1981). There were claims that DP had not been subjected to the rigorous process of scrutiny as in the case of other drugs. This was largely attributed to the powerful and effective lobbying for contraception undertaken by the Population Control Council and Upjohn Inc., the pharmaceutical company that produced the drug (Rakusen, 1981).

Biomedical product development research on DP was also subject to racial discrimination and human rights limitations in the US. Between 1967 and 1978, Upjohn Inc. conducted human trials of DP involuntarily on 14,000 women (Committee on Women, Population and the Environment (2007). Upjohn Inc., - now known as Pfizer - still owns and develops DP. Of 14 000 women targeted for trials without their consent, 50% were African American women of low income, and rural women (Committee on Women, Population and the Environment (2007).

The target population for injectable contraception was women from lower socio-economic strata in both the USA and the UK (Rakusen, 1981). Research indicates that, decades later, this class and racialised targeting persists - women of colour, and young women, are still targeted users (Collins, 2000; The Rebecca Project for Justice, 2014). DP is still considered a "fool-proof method" despite its effects on women's health (Committee on Women, Population and the Environment (2007).

The history and foundation of contraceptive programmes were associated with Black poverty. Margaret Sanger pioneered contraceptives to solve the problems of the poor Black women in America, from a socialist ideological persuasion (Davis, 2010). It is reported that, as the programmes took off, Margaret Sanger became part of and accountable to the eugenics movement (Davis, 2010; The Rebecca Project for Justice, 2014). The wording of the slogan of contraceptives, was advocating children from the fit and less children from the unfit (The Rebecca Project for Justice, 2014). Those who were unfit to bear children included the mentally and physically disabled, prisoners, and the non-White indigent women (Davis, 1983). According to Davis, and from feminist perspective, the very conception and history of the birth-control movement was problematic in relation to class and race power over the women it targeted for birth control. Sanger, speaking at the American Birth Control League, argued, that the mass of Negro (Black) women in the South continue to breed carelessly and that this had disastrous effects (Davis, 2010). Observing this, contraception programmes were not framed

from the autonomy of indigent Black women as such, or women in general. From this assertion, the project was set out to contain and reduce the reproduction of Negroes. According to the Rebecca Project for Justice (2014) this was hardly a reproductive liberation of Negro women, but a project to meet political ends. Margaret Sanger, the pioneer of the family planning movement, who went to set up family planning clinics in poor Black communities, was part of the eugenics movement working. In her update and reporting letter to the American Eugenics Society, Sanger defined what she considered as hyper reproduction of Negroes as being disastrous to the political establishment (The Rebecca Project for Justice, 2014). This suggested that Sanger was collaborating with eugenics and the political establishment to bring fertility and reproductive control commodities to politically manage the threat posed by the increase of the Negro population on the establishment.

Sanger was conscious that her actions were political, and she was also quite aware that the actions might have political ramifications in the form of Negros rebelling, when they understood that her actions were about extinction of Black Americans and securing the purity of the White race in America (Davis, 2010, The Rebecca Project for Justice, 2014). What this suggests, is that Sanger was aware that this was a political project, a racist project.

In South Africa contraceptives, in particular DP, were used as a racialised population and political management intervention starting from the colonial period and continuing to the Union of South Africa and apartheid South Africa. Depo Provera was a population-management strategy of the apartheid government to reduce the Black population rather than advancing the reproductive autonomy, choice and women's health (Brown, 1987; Klausen, 2004). Klausen (2004) states that the policies and the discourse of Black population control had been started by the Union of South Africa government period and policy positions were finalised in the apartheid government period. A detailed history of contraceptives in South Africa is provided in more detail later in this chapter; however, it is worth noting that South Africa followed a similar ideology and bigger goal than that of America as presented in this review. This study found out that the current policy is framed from reproductive disease management, teenage pregnancy and cost containment in public health, rather than advancing the rights and reproductive autonomy of women. The programmes target specific young women who are Black and poor, HIV positive women and poor women who use public health services mainly in urban areas as a means to address maternal mortality.

The contraceptive programmes in the United States were later institutionalised, initially through the American Birth Control League. Later, the institutionalisation led to more specific programmes targeting Black Americans, through the launching of the Negro Project in 1939 (Concerned Women for America Legislative Committee, 2001). The institutionalisation extended from this being an act of charity, becoming a lobby for legalisation, law reform, and government policies to halt the reproduction of Black and other indigent women. As early as 1932, the eugenics movement, institutionalised as the Eugenics Society, reported that twenty-six of the states had installed codified laws on compulsory sterilisation. Evidence of effective implementation of these laws had resulted in thousands of 'unfit' persons being surgically prevented from reproducing (Davis, 1983).

Furthermore, the programme introduced even more human rights and dignity concerns for women, effects of racialised slavery, and resultant poverty amongst others, in the form of racist sterilisation programmes. This history of reproductive rights, from the onset, posed contradictions. It was more complicated for Black women, other women of colour and disabled women, amongst others, who have historically been the targets of the abuse of their rights. In this violation, bodies of Black women were utilised to oppress the whole Negro and Black population. This was a way of containing and hurting the population and the dignity of the Negroes as a race. Further, the articulation of the radical Negroes suggests that there was already a political push back of the Negroes on their oppression as a race. The results of this programme began to be seen in America as early as in the 1930s and continued for decades.

A study by Solinger (2000) showed that a large proportion of Black American, Native American, and Latina women had been sterilised. Black and Latina women, in particular those who were married, had been sterilised in even greater proportions (Solinger, 2007. Many of these women were sterilised against their will or without their knowledge (Smith, 2015). In the 1960s and 70s, sterilisations, and other forms of abuse targeted at Black, Native American, and Latina women, were defined as epidemics. Solinger (2007 reports that, by the end of 1968, one-third of women of childbearing age had been permanently sterilised in Puerto Rico a US colony at the time (Solinger, 2007). In 1974, an Alabama court found that between 100,000 and 150,000 indigent Black teenagers were subjected to sterilisation each year in Alabama State (Smith, 2015).

In the USA, the 1973 legalisation of abortion was considered of paramount importance to all women: and the most important success of the modern women's movement (Smith, 2015).

Black and other marginalised women were at the high risk of illegal abortions for a variety of underlying structural, economic, political, and cultural reasons, Smith (2015) suggests that, although the legalisation was progressive, the advocacy around it was not informed by the experiences of Black women. This is partly because the advocacy was conceived based on a different race and class base (Smith, 2015). Leaving out Black women in this advocacy, for example, left out analysis and solutions for addressing the illegal abortion industry. Black women understood this industry, as they had been exposed to it.

Black feminists contended that legalisation of abortion was not conceived from the Black women's reproductive rights and racist fertility control discourse. It did not consider the racist oppression of interventions that were understood by other women as liberating. The legalisation of abortion was silent on the racial, cohesion, forced nature of contraceptives as a tool for racial and gender oppression. Forced sterilisations and forced injections with DP were part of these interventions (Davis, 1983). Had legalised abortion sought such, it would have found solutions to gendered racial injustices, gendered human rights abuses, and critiqued the movement from race and class positions (Davis, 1983). Furthermore, Davis (1983) notes that the abortion law lobby did not support the anti-sterilisation campaigns and legal actions against it, in particular legal successes of Black women and women of colour. The victories came around the same time, but victories on sterilisations of Black women were not profiled (Smith, 2015).

Legalisation on abortion is also one of the key important milestones, gains and a victory for South African women. The analysis of this study is that the South African abortion law lobby missed the opportunity to consider the racial and abusive nature of all fertility control programmes, including DP and forced sterilisations. The abortion law lobby conceptualised and won the legalisation of abortion in South Africa's transitional period. This could have been achieved by understanding contraceptives and fertility control from Black women's perspectives and intersecting experience, acknowledging the racist and class nature of targeting of such, and more importantly, the underlying ideology of such programmes. The understanding of whether these are indicators of liberation for Black women would have been created at that point. This would have included recognition that what could be considered as reproductive liberation for some women is, in fact, oppression for others. The analysis in this regard, would have kept racialised reproductive crimes and oppression in the mainstream post-apartheid reconciliatory political realm. Safer methods and choice for women would have been sought. This would have led to direct interventions to stop the racialised violations of women's bodies, under the guise of choice and women's rights. It would have highlighted how black

women's bodies were sites for violent colonial and apartheid programmes. The opportunity to analyse the human rights, choice, racism and health implications of Depo Provera was missed. I argue that legalisation of abortion silenced the racialised reproductive oppression, including DP. The gain is packaged with Depo Provera, is the opposite and arguably counterproductive in the project of fertility liberation and reproductive rights. The legalisation of abortion and its pronouncement as victory for women's rights unintentionally silenced the racialised human rights, eugenics and population controversies of Depo Provera and forced sterilisations. The approach missed the opportunity of deep analysis of reproduction of Black women as it sits in the middle of the liberation movement and the feminist movement. This missed the opportunity to address structural issues associated with reproduction of black women as a political phenomenon. This study argues in its findings that the status of Depo Provera, its continued and expanding use and targeting of Black women is a result of its depolitisation on the transition project. The study argues that forced sterilisations continue because of this depolitisation of reproductive oppression.

3. SIDE EFFECTS OF DEPO PROVERA

The study set out to explore how the current contraception policy has been aligned with the national transformation agenda; policy and resourcing for women's health; and how it considers women's health implications. The study considers side effects as one of the indicators of transformation. Side effects are also part of informed consent, and expression of the commitment of the state to the health and safety of women from the medicine regulation perspective. Controversy over DP is also based on side effects which affect women's health and quality of life, as well as that of their children. Depo Provera has a long political history owing to its regulation based on side effects, dating back to its registration in the 1970s. Owing to the limited preliminary research that DP was subjected to before being released, there have been numerous claims that injectable contraceptives are associated with various side effects. These side effects include increased vulnerability to cervical cancer, amongst many others, (Powell and Seymour, 1971).

3.1 Risk of cervical cancer and breast cancer

According to Pfizer (2010), increased risk of cervical and breast cancer is one of the long- term side effects of Depo Provera. Pfizer disclosed that some of the women who take DP have shown an increase in invasive squamous cells which are linked to cervical cancer. There has been as such, an increase in cervical cancer associated with the use of DP. The increase is more

prominent in some women who were first exposed or started to take DP before the age of 35 (Pfizer, 2010). This side effect is qualified as statistically non-significant. Li *et al*. (2012) discovered that DP increased the risk of breast cancer 2.2 fold in the population of women 20 to 44 years of age (Li *et al*., 2012).

3,2 Changes in fertility and effects of breastfeeding on children

Reduced fertility, delays in returning to fertility, increased infertility, and higher risk of ectopic pregnancy were side effects noted in the 1970s (Rosenfield A.,*et al*. 1978; and still persist in 2010 (Pfizer, 2010). Saxena, Shrimanker, and Grudzinskas (1977) suggested that children who are exposed to DP through breast milk may experience later health complications (Saxena, Shrimanker, and Grudzinskas (1977). Pfizer confirms that breast milk expressed by breastfeeding mothers who are on DP can contain detectable amounts of DP which is then passed on to babies (Pfizer, 2010).

3.3 Reduction in bone mineral density

While taking DP, women may lose significant bone mineral density that is not fully reversible and, therefore, DP should not be used as a long-term birth control method for more than two years. There have been numerous litigation and class action lawsuits on this side effect in America and Canada (Frost and Reich, 2008). In this regard, in 2004, the US Food and Drug Administration (FDA) issued a Black Box warning for DP in light of the confirmation that the contraceptive injection leads to serious side effects. The 2004 Black Box was revised in 2010. A Black-Box warning is an obligatory warning notifying patients of the significant risk of serious and life-threatening side effects or adverse effects that a drug may have. According to FDA regulations, once the drug is classified at this level, all birth control corporations, providers, agents, heath care workers and pharmacists promoting, distributing and administering DP injections to women are legally obligated to counsel women to inform them of the likelihood of harm in light of the seriousness of the side effects (Pharmacia and Upjohn Company 2004; US Food and Drug Administration Black Box Warnings: 21 Code of Federal Regulations 2004- (FDA, 2004; FDA 2010; Pfizer 2004 and 2010).

3.4 Possibility of increasing the risk of HIV/AIDS

Depo Provera also has an unintended consequence of significantly increasing a woman's susceptibility to HIV/AIDS and other sexually transmitted diseases (STDs) since the high dose of progesterone in DP induces thinning of the vaginal epithelium (Heffron, 2012). A study

indicating that there is no evidence that Depo Provera increases the risk of HIV is not higher compared to other hormonal contraceptives was released in 2019 (WHO *et. al*, 2019). The opposing scientific community argues that the questions asked in the research did not address questions created by the Heffron (2012) study, but rather did a comparison of risk between DP and other hormonal contraceptives in relation to increased risk of HIV infection. Other side effects of Depo Provera include liver tumours (Nissen, Kent and Nissen, 1976), irregular and excessive menstrual bleeding, weight gain and depression (Rakusen, 1981) were also noted. Pfizer disclosed the same side effects in 2010 (Pfizer, 2010).

Health care providers usually provide information on some of the side effects; however, long-term and more serious side effects are not communicated. This study found that some of the side effects, mainly the simple ones like weight gain and irregular and excessive bleeding were communicated to the women users. These side effects were also treated in clinics, yet the reasons and the long-term implications of these were not communicated. Clinics were providing and communicating the needs of cervical cancer screening to women, albeit, it was not communicated that DP may be linked to increased risk of cervical cancer:some of the health workers were not aware of this risk. Other long-term side effects like loss of fertility and the risk of breast cancer were not communicated as some of the health workers were also not aware of this. None of the health workers who participated in the study were aware of the possible linkage to HIV risks, nor aware of the current research and debates on the issues. Health workers reported limited training and understanding in this regard. The policies advocate women's choices but there is no evidence of financial and material provision of these at the service delivery level. Materials and written information on side effects were not made available to women. Some of the health workers were not aware of some of the side effects, although these are disclosed by the drug company producing DP. The disclosures are mandated by the court of law. Health workers register that some women do not listen to advice, for an example, improving diet when weight gain sets in. Health workers blamed the system for other challenges, mainly the shortage of stock of other methods, and lack of staff to use other methods. They expressed the sense of solidarity with the women and commitment to assist the women but are prevented by systematic issues.

The women in the study registered a culture of not asking questions, and no interest to engage beyond what they had come to the clinic for, although they could identify some of the challenges, for an example, being returned to DP after being removed from it due to side effects. Women users were aware of some of the side effects communicated by the nurses.

Women were also seeking information and having discussions on side effects on social networks and with their female peers in the communities.

Policy makers who participated in this research study articulated their awareness and concern of side effects, and expressed the need for expanding options. However, they reported that women also prefer DP, so there is a demand for it. The researchers stated that the demand for DP by created by massive marketing of these methods in apartheid times, and the ease of delivery of DP from the side of health care workers. The apartheid marketing of Depo Provera has not been undone. Some policy makers indicated that side effects not a major issue - they are to be expected in all medicines - and are better than forced sterilisation, for an example, because they are not permanent.

4. NORISTERAT INJECTABLE HORMONAL CONTRACEPTIVE

Noristerat injectable hormonal injection popularly known as a two-month injection. Noristerat is the second widely used in South Africa after Depo Provera. According to the District Health Information Systems (DHIS, 2016) 374 443, 5 002 741 and 201 045 doses of Depo Provera were administered to women in public hospitals, Primary Health Care Clinics and private health providers, respectively in 2015-2016. The same survey reported that in the same period 147 202 doses of Noristerat were administered in public hospitals, 3 387 231 in Primary Health Clinics and 142 012 in private health services. Both Depo Provera and Noristerat are injectable hormonal contraceptives, but Noristerat does not contain oestrogen like Depo Provera (Bayer, 2011).

4.1 SIDE EFFECTS OF NORISTERAT

Stacey (2022) and Bayer the manufacture of Noristerat detail the following as side effects of the contraceptive: Noristerat has been linked to some forms of liver cancer using it over a long time (Bayer, 2019). Other liver related side effects are liver enlargement or signs of intra-abdominal haemorrhage occurring in women using Noristerat *(Ibid: 4)*. Cases of development of benign liver tumours, and malignant liver tumours have been reported in users of other hormonal contraceptives.

4.2 LIVER CANCER

The patient information leaflet (Bayer, 2011) states that women should be screened for these conditions prior to initiation of the contraceptive. In this instance it states that an individual

risk/benefit analysis should be done before the contraceptive started, during the course of use and that it should be discontinued if these ailments present themselves during the course of taking the injection (Bayer, 2011). Jaundice and/or pruritus related to cholestasis; gallstone formation; systemic lupus erythematosus; haemolytic uraemic syndrome; Sydenham's chorea is one the side effects listed. According to Bayer, the manufacturer of Noristerat, cases of liver disease are very rare (2019). Some circulatory disorders with a relative risk of development of arterial thrombosis such as stroke, myocardial infarction in women with hypertension are listed as side effects of Noristerat (Stacey, 2022).

The increased risk of venous and arterial thromboembolic diseases is one of the concerns. In this regard the recommendation is stopping the injection (Bayer, 2011). Migrainous unusually severe headaches or headaches with a new pattern may develop. According to Bayer (2019), in isolated cases, these tumours have led to life-threatening intra-abdominal haemorrhages. Small increases in blood pressure have been reported in one study using injectable contraceptives, however, clinically relevant increases are rare. The recommendation in relation to these side effects is that the injection should be discontinued tumours and blood pressure increases. Chloasma may occur, especially in women with a history of chloasma gravidarum. Noristerat might cause depression at the beginning of treatment if continued during treatment the injection should be discontinued. Women could have a slight effect on peripheral insulin resistance and glucose tolerance, which might lead to diabetes (Bayer, 2019). The injection may lead to usual menstrual bleeding and menstrual cycle disturbances. Return to fertility can take a minimum of twelve weeks. In clinical studies, ovulatory patterns are restored in most women within 12 weeks after discontinuation (*Ibid: 3*).

4.3 SPECIAL PRECAUTIONS

Noristerat has a list of side effects listed as special precautions. Depo Provera on the other hand has a 'Black Box Warning', which is the highest (The Food and Drug Administration 2004). The list of special precautions includes respiratory, thoracic and mediastinal disorders: Experience has shown that the short-lasting reactions, which occur in isolated cases during or immediately after the injection. The recommendation for mitigating this risk is injecting the solution extremely slowly when it is administered for the first time. Other special precautions are reduced efficacy, reduced cycle control and amenorrhoea (Bayer, 2011).

A complete medical history should be taken, and a physical and gynaecological examination should be performed prior to the initiation or reinstitution of the use of Noristerat. The frequency and nature of these assessments should be adapted to the individual woman but should generally include special reference to blood pressure, breasts, abdomen and pelvic organs, and should also include cervical cytology. In line with contraindications and warnings issued by the manufacturer of the injection (Bayer, 2019), these screenings should be repeated at least annually.

The analysis of this study is that the side effects of Noristerat are not as severe as that of Depo Provera. The side effects of Noristerat are serious and a cost to women's health and wellbeing. The findings of this study on health workers reported that Noristerat is mainly administered to young women (Participant CS 01, Participant CS 04). This suggests that the side effects could be affecting women at a younger age, and possibly have implications for long term health care. Liver cancer and liver disease are a serious health care concern. This should concern the health policies, although the manufacture of the contraceptive suggests that this occurs in very rare cases.

Noristerate does not carry much historical controversy like Depo Provera. This study could not find reports on litigation on Noristerat. However, the contraception could not be excluded from the broader ideology of regulating certain segments of the population and control of women's fertility and reproduction. Issues of consent and choice, and provision of side effects information to the users; attaching the contraception to other healthcare services as conditionality for accessing other health care services associate were not explored in this study. The two months injection is provided within the same categorisation and system of service delivery in health clinics alluded to as part of the health systems analysis of this chapter.

5. ORAL CONTRACEPTIVES

This study did not include specific questions on oral contraceptives. However, it can be observed that all health workers interviewed (Participant CS 01, Participant CS 02 Participant CS 03, Participant CS 04, Participant CS 05) did not list, for an example, oral contraception as an alternative, or as a contraception they offer to women if women develop side effects to Depo Provera. DHIS (2016) details that in 2015-2016 the total of 89 890 doses of oral contraceptives were dispensed in public hospitals, 471 140 in Primary Health Clinics and 3 591 382 in private health care services. These contraceptives are widely used in the private sector. This suggests

issues of racial targeting and class targeting of the method of contraceptive provided. A member of parliament who is a chairperson of the portfolio Committee on health reported that the government provided hormonal contraceptives commodities to private clinics (Research Participant K11*)*. This suggests that the state is spending public funds on this commodity, which is not available in the public service.

6. LACK OF ACCESS TO INFORMATION AND INFORMATION DISCLOSURE

While the disregarding of women's choices and rights in the administration of DP is rife, various reasons for this have been identified in some studies, for example, studies by Moyle (1978), Fonn and Xaba (2001), and Dehlendorf *et al*. (2013).

Perceptions of women's ignorance: Moyle (1978) reported that health care workers seldom explained the side effects to women − they believed that the women would not understand such side effects even when these have been explained.

Health care workers' training on contraceptives: Fonn and Xaba (2001) reported, in their study in South Africa, that nurses were not always sharing information on side effects and other information with the women. Health care workers are trained to inform patients, with no expectation that the patients will have a say or a view on the matter. Their very training discourages questioning; and, as such, health care workers are very intolerant of patients who ask them questions (Fonn and Xaba, 2001).

Health care workers who participated in the Fonn and Xaba study reported that they were not trained in the social context of patients, nor on gender. They are not cognisant of including such issues in their interactions with patients.

Health care workers exercising own preferences: Dehlendorf *et al.* (2013) found that health care workers may express a specific preference or suggestion which influences the women's choice apropos of contraception (Dehlendorf *et al.*, 2013).

Power differences and trust: Women's choices, or trust in what the health care worker says, might also be influenced by power relations between health care workers and the service users (Fonn and Xaba, 2001). Power imbalances are, in part, influenced by the hierarchal nature of the health system, and the fact that health care workers did not receive any training in this regard, as indicated above. Some women in the Dehlendorf *et al.* (2013) study trusted the provider's choice. They believed that it was based on higher levels of knowledge of the health care workers (Dehlendorf *et al.*, 2013). Yet in the same study, (Dehlendorf *et al.*, 2013), women reported that they would have preferred providers only to share their knowledge of contraceptives. Health care workers could express their opinions and preferences about which

type the women should choose only if the women users solicited such assistance, or guidance (Dehlendorf *et al.*, 2013). This is direct imposition of power by the state on women's bodies, amongst many other contradictions identified (Frey, 2011). Some feminists have, however, agreed that contraceptives do contribute to women exercising their choices on reproduction. Contraceptives, therefore, are a paradoxical phenomenon, rather than a dichotomous discourse between the population control lobby, maternal feminists, liberal feminists, and post-colonial feminists.

7. THE POLITICS OF SCIENCE, MEDICINE, AND EVIDENCE-BASED INTERVENTIONS

One of the objectives of this study is to describe the ideology and framing of contraception policies in post-apartheid South Africa. The study found that contraceptive policies are framed from the public health perspective as per the findings of this study and are evidence based as they are informed by science and research. According to Salo and Moolman (2013), science is not a neutral phenomenon in terms of reproductive politics and control of women's bodies. There is a systematic relationship between sexuality, reproduction, biomedical, political, legal, and patriarchy knowledge (Salo and Moolman, 2013), and these all work in concert to control the fertility of women (Brown, 1987). Specifically, patriarchy, science and biomedical knowledge have produced a system of deciding who is allowed to exercise reproductive choice and agency (Brown, 1987). Scientific advances have been used by governments and health institutions, amongst others, to limit reproduction of certain women, at the same time encouraging and promoting reproduction of other women.

Scientific advances in reproduction and medicine have been instrumental in improving the lives of women and societies at large. Reproductive technologies such as contraceptives have improved women's lives and enabled women in some instances to express their agency. However, in medicine, female bodies are considered reproductive bodies, and are pathologised, treated and controlled as such. Every aspect of women's medical history includes questions about her present pregnancy status and past pregnancies. Motherhood status is asked in every medical examination of women (Spar, 2013). Oakley (1984) wrote in her book, entitled *The Captured Womb*, that pregnancy and childbirth have been pathologised by medicine as a way of controlling the womb and women's reproduction (Oakley, 1984). Medical interventions to regulate women's fertility, including contraceptives, are on the one hand specific strategies that may take away women's bodily autonomy; however, paradoxically, may, on the other hand,

provide fertility control to women (Kaufman, 2000). There is a culture in society that scientific pronouncements are not subject to questioning. Science is seen as higher knowledge, which ordinary people cannot understand. Science is used to silence people and discourses. There is a fallacy that you can only critique or challenge science with science: if you are not a scientist yourself, you are not qualified to challenge science.

Public health decisions are made based on science rather than on politics. Public health is a deeply gendered political phenomenon. Society is committed to biomedical public health and disease programmes that focus on seeking solutions within individuals. This allows researchers and politicians to ignore the political context of diseases and health problems (Rogers, 2006). Making decisions based on science is silencing and sustains the oppression of those for whom the services are meant. This power of science is also sourced in power and culture of medicine. Information about control of people, the patients, control of populations, misogyny, patriarchy, bio-power, and the regulation of female bodies, is passed on by successive generations of medical scientists through intellectual genealogies in the science curricula of medical schools (Salo and Moolman, 2013).

The power of science has been used as a potent tool in describing how states should choose policies, particularly in public health, to regulate fertility and populations (Foucault, 1978). Science has been selectively utilised to provide so-called evidence-based data, evidence-based medicine, for social policy. Rogers (2006) notes that this approach is problematic from a feminist perspective. Evidence-based medicine is gender blind, lacks gender analysis, uses gender-blind language, and falsely claims neutrality in its methods (Rogers, 2006). Findings on the roles that power, implications of science, medicines and demographers play on women's rights and autonomy in relation to contraceptives are analysed and discussed in detail in Chapter five of this report.

Evidence-based medical research is mainly and increasingly being funded by private commercial enterprises. This brings on board the economic elements of this approach, by accentuating the power and interests of funders and investors in research. Understanding the issues in public health research are important for this study, in particular as the study explores the role of researchers and funders of research. It is important to understand how and who sets the research agenda, and to what end. Scientific evidence is marshalled to bolster patriarchal beliefs, and other commonly held beliefs in the field of human reproduction (Salo and

Moolman, 2013). Racial and class profiling in the design and targeting of these interventions also suggest the partiality of the science field.

Long-term contraceptives are targeted at Black women, as such carry racist undertones and political in nature. Users have limited power in terms of administration. The providers administer such, including Depo Provera injections and implants. Implants are inserted in women, providing hormonal contraceptives for a period of three years (Kuumba 1993). Implants are contraceptives over which a woman does not have control as the contraceptives are being inserted in her body. Kuumba (1993) also stated that these contraceptives were targeted at African American women (Kuumba, 1993). Research has also raised concerns over the research agenda of Depo Provera and contraceptives, more broadly. According to the Rebecca Project for Justice (2014), the safety and side effects of Depo Provera have not been responded to by the scientific community. Improving DP through the lens of safety has not been prioritised in research, while research and development on other preparations of contraceptives has been limited. Most research has focused on justifying Depo Provera in its current form and on developing various preparations of Depo Provera as a way of expanding its usage. One example of this is using the same ingredients of Depo Provera in implants, integrating Depo Provera into HIV/AIDS programmes, HIV prevention programmes and post-abortion care programmes (Curtis *et al.*, 2019; The Rebecca Project for Justice, 2014).

The study found that South Africa is one of the countries targeted for these DP expansions and advances. South Africa is also host for most of the studies for human trials of these advances and new preparations of Depo Provera. Depo Provera is also currently prepared for use as vaginal rings to prevent pregnancy and protect from HIV infection (International Partnership for Microbicides, 2019). Special preparations have been developed for Depo as easy-to-use injections. Feasibility studies of this injection have been concluded in South Africa. Such are therefore distributed to communities by community health workers, who do not require registration by health authorities, as it is the case with nurses and doctors (Cover *et al.*, 2016). PATH reported that this injection was included in the World Health Organisation essential medicine list in 2016.

8. HISTORY OF DEPO PROVERA

8.1 HISTORY OF DEPO PROVERA AND COLONIALISM

It is important to locate Depo Provera within a reproductive rights history and colonial history in order to meet the objective of the study to locate its position in the current political phase, the post-apartheid phase. Contraception, in particular DP is a highly controversial and politicised phenomenon. Depo Provera programmes have for decades been criticised for racial and class targeting by the Western world, including America and the UK (Rakusen, 1981; Kuumba, 1993; Robinson, 2010). Racial and class targeting, in particular of indigent Black women has been observed in developing countries (Brown, 1987; Kaler, 1990; Cooper *et al.*, 2004; Klausen, 2004; Kaufman, 2000). This was mainly seen when Depo was rejected by Western countries through deregistration and stringent terms of use and dispensing of Depo Provera. This position of targeting indigent women was informed by racial eugenics thinking about society, but also by the position that reproduction of women of lower socio-economic class creates and sustains poverty, the Malthusian proposition (Frey, 2011; Robinson, 2010; Fuderi, 1997). Depo Provera was introduced to African countries in 1969 (Rakusen, 1981). During the 1970s and 1980s contraceptives across the globe were promoted as a form of bodily autonomy. Control over DP administration was taken out of women's hands (Rakusen, 1981). Within three and a half years of its introduction, DP had far surpassed the pill method (Rakusen, 1981). The majority of women using DP resided in developing countries in Africa, Asia, and Latin America, with half of these women in Africa. The manufacturing pharmaceutical company Upjohn had identified the Third World as targeted consumers, given population control concerns and measures by governments in many of these countries (Rakusen, 1981).

Literature suggests that contraceptive policies have been used as a tool to further colonial population management, by restraining the growth of Black populations, whilst increasing the growth of White populations. Fertility control, by extension controlling of women's bodies, continues to be a key goal of post-colonial governments. This is determined by existing colonial ties and powers (Kuumba, 1993; Thomas, 2003). Fertility control is linked to the United States of America-led neo-colonialism of the new, post-Second World War, and end of the Cold War world order (Thomas, 2003). Other justifications for contraceptives are environmental degradation, population explosions, famine, and general over-population (Robinson, 2010; Kaler, 1997; Fuderi, 1997; Frey, 2011). In recent times, the focus of justification has been integrating contraceptives in HIV/AIDS programmes, high rates of maternal mortality, teenage

pregnancy and urban poverty, amongst many others (Department of Health, 2012and 2018, Bill and Melinda Gates Foundation, 2018, The Rebecca Project for Justice, 2014, Family Planning Partnership, 2012). This study found that recent South African policies of Depo Provera target young and women and girls in order to prevent teenage pregnancy, and HIV positive women as a way of HIV prevention interventions, as well as to reduce the maternal mortality.

8.2 COLONIAL TRANSITION AND POST-COLONIAL PERIOD

A brief detail of literature on contraceptives in the post-colonial period is important in broadening the understanding of the post-colonial political economy of contraceptives. Contraceptives are part of politics and have been a feature in the periodisation of politics and world orders (Frey 2011). Some of the fears of population explosion, and therefore a need for control, were linked to the Cold War (Frey 2011). The South African fear of Black population explosion in urban areas was linked to fears of growing communism (Ndengwa, 1996). Some of the contraceptive's programmes were linked to post-World War world order of decolonisation (Robinson; 2010, Ndengwa, 1996). Fuderi (1997) stated that the population control, eugenics, by extension, reproduction lobby, has the ability of attaching itself to all political ideologies and transitions (Fuderi, 1997).

Contraceptives and fertility control became part of the transition deals. This was the case in South Africa. As Ndengwa wrote in 2006, South Africa's policy path on reproductive health and family planning was heavily influenced by the United Nations and international population experts. The world was emerging from the ICDP Conference in 1994, and South Africa provided a fertile raw environment to implement the policies of the ICDP. In 2003, Thomas wrote that the legacy and legitimacy of post-colonial government was to be measured by how governments maintain fertility control in their countries. Furthermore, according to Thomas, fertility control became an indicator for development, and success of new governments (Thomas, 2003). Funding for aid and humanitarian deals included contraceptives. Technical support to recently decolonised countries included technical experts such as demographers, assisting with the population control programmes and contraceptives (Thomas, 2003). The famine in India, for example, provided fertile ground for Depo Provera to be made a condition for women receiving aid, mainly in the form of food parcels (The Rebecca Project for Justice, 2014). Other forms of population control such as sterilisation were also used as conditions of donors. In recent times, contraceptives are mainstreamed throughout all 17 development goals

of the 2015 Sustainable Development Goals (SDGs) (United Nations, 2015). Post-colonial governments believe that regulation of fertility is fundamental to the construction of political and moral order, proper gender, and good generational relations (Thomas, 2003). Health and prosperity of nations is linked to fertility, reproductive health, and sexuality. This can be seen as indicators of development, indicators of and threats to peace and stability, predictors of poverty, and indicators of respect for women's rights.

This may be linked to the desire of new governments to be legitimate, to prove their capability as competent leaders to the international world and other post-colonial countries. It could also be a way of addressing their own fears of population growth, the indigent providing a threat to their own power and government. Development and poverty were used to justify the need for population control interventions. This could be seen in colonial and post-colonial Africa. Since the 1960s, at the height of anti-colonial movements, and the beginning of decolonisation of African countries, population experts have been making bleak development predictions for African countries if new post-liberation governments fail to institute large-scale family-planning programmes to curb the rate of fertility (Thomas, 2003). As mentioned earlier, urban poverty was also a reason for the South African apartheid government to enact aggressive, high-impact fertility-control policies and programmes to control fertility of Blacks. Heavy dependence on foreign aid and neo-colonial economic ties of some of the post-colonial governments make these countries targets for population control programmes. Fertility and reproduction are heavily subjected to state power (Brown 1987; Klugman, 1990; Kaufman, 2008 Thomas, 2003). Politicians and officials use fertility to juggle material and moral obligations of rule. Post-colonial governments in Africa continue to oppress and control women's reproduction and fertility, through regulation and health interventions (Kaufman, 2000; Thomas 2003; Salo and Moolman, 2013).

This study found that fertility control using Depo Provera continues in South Africa. The target population is still Black women, albeit the policies target sub-population of young women and HIV-positive women. The study found out that these interventions continue to be interconnected with international, national, regional, and local level power regimes, post-colonial regimes, national, cultural, and religious regimes, science regimes, economic regimes, amongst many others societal structures of power. The study also found that philanthropists are new powerful entrants in this conglomerate of actors.

8.3 SOUTH AFRICAN HISTORY OF DEPO PROVERA

It is important to locate the current position and practise of Depo Provera use in the South African historical context in order to assess the shifts in ideology and practise. South Africa Depo Provera was a population management strategy of the apartheid government to reduce the Black population (Brown, 1987; Klausen, 2004). Klausen (2004) states that the policies and the discourse of Black population control had started, and policy positions finalised in the period of the Union of South Africa.

The apartheid government built a policy framework and massive implementation infrastructure of this strategy (Kaufman, 2000. Thomas also stated that, in Kenya and other colonial countries, contraceptives were used for the same purposes (Thomas, 2003). Colonial and apartheid governments used DP to support population control programmes in Third World countries through oppression, intrusion, and racism (Kaler, 1997). This emphasises the notion that the politics of reproduction, gender relations, population control, and eugenics are often intertwined; and cannot be divorced from politics (Kaler, 1997).

The apartheid government supported the distribution of DP as a method of reducing the growing Black population to safeguard White economic and political interests (Moultrie, 2005). During the apartheid era, fertility regulation and control through DP were introduced under the guise of women's health (Cooper *et al.,* 2004).

The Family Planning policy introduced in 1974 was the first fertility control intervention with three key aims to (1) reduce the Black birth rate, (2) increase the Black mortality rate, and (3) restrict Black movement (Furedi, 1997b). There was no mention of reproductive health in the policy document (Brown, 1987). There were no provisions for reproductive health in the policy, beyond fertility control, which Furedi (1997) is not convinced should be viewed as a health matter, or a health intervention (Furedi, 1997). The policy was a vertical policy to deal with reproduction without considering the whole reproductive health package for women (Furedi, 1997; Walker, 1995; Brown, 1987). Cooper *et al.* (2004) discovered that the 1974 South Africa policy on contraceptives was also disguised as a 'women's health' policy, without any indication or articulation to address women's health or any women's health programme attached to it (Cooper *et al.,* 2004). It can be stated that this was silencing the oppression and capturing of women's reproductive abilities and sexuality. It is observed that this phenomenon of contraceptives as 'women health' persists in South Africa today.

This policy was an effort to curb the growth of the majority Black population, whose proletariat had begun to organise and rebel against the apartheid system (Brown, 1987). The government's solution to this problem was to implement policies to reduce the Black population size (Burgard, 2004; Furedi, 1997b; Moultrie, 2005). At the time, the average birth rate among Black women was 6.5 children, compared to 3.5 among White women (Brown, 1987). White women were encouraged to reproduce copiously for national interests – to grow the White South African population (Walker, 1995). Existing studies on DP point out that gender discrimination targeting women was at the core of contraceptives policy (Moultrie, 2005; Burgard, 2004; Cooper *et al.,* 2004; Walker, 1995). Women's bodies, sexuality, and reproductive abilities of both Black and White were used to meet political ends (Moultrie, 2005; Burgard, 2004; Brown, Furedi, 1997b; Walker, 1995). The authors cited above state that the autonomy of women, in terms of their sexuality and bodies, was disregarded and their sexuality and bodies exploited to meet patriarchal and political ends. Walker's (1995) study further found that motherhood became the patriarchal political tool, which was used by men to bring women to serve their national agenda. Kaufman (1998 highlights that some Black women reported to use motherhood to meet their personal needs and socio-economic needs. For instance, women used motherhood to express their womanhood selves. They also used motherhood to secure care when elderly, amongst other reasons (Kaufman, 1998. Literature tells us that sexuality of Black women might have been perceived as irrational and reckless (Walker, 1995; Brown, 1987) and might have been seen as a problem which needed to be contained by a medical intervention, as can be seen from the goals of the policy above (Brown, 1997).

Apartheid era fertility control policies were 'justified' based on international development agendas (Furedi, 1997b). These policies were grounded on population growth concerns underlined by the Malthusian theory, and later, the neo-Malthusian theory, that populations increase at a faster rate than its means of subsistence; unless stemmed by moral restraint or disaster (e.g., famine, disease, natural disasters, or war) (Klausen, 2004). According to this school of thought, unchecked population growth inevitably results in degradation and widespread poverty (Klausen, 2004). As indicated earlier, contraceptives are still a subject of international relations and cooperation. They are based on international commitments of the United Nations, regulated at that level, and programmes which normally come from the North. South Africa for an example produces numerous reports reporting on progress made in expanding access to contraceptives.

The high uptake of DP was attributed to the possibility that Black women were not offered alternate forms of contraception (Burgard, 2004; Kaufman, 2000). Gready *et al.* (1997) found that DP was consistently offered as the first option for Black women; and that women were not given information on associated problems (Gready *et al.,* 1997). This remains the case in South Africa, as detailed earlier, the contraceptives agenda, targets and programmes are articulated through international commitments. This study found that the government relies heavily on international commitments. These commitments give international experts and bodies power to set the policy and research agenda on contraceptives. Furthermore, these agencies draw implementation targets and decide on financing mechanisms of contraceptives. The participation of the international community, international experts and scientists in contraceptive policy processes in South Africa are discussed in detail in chapter five of this report.

9. CONTRACEPTIVE POLICY IN POST-APARTHEID SOUTH AFRICA

The study looked at how the current contraception policy enhances women's rights and autonomy, transformation of power and structures, and reproductive justice in its policy prescripts from a feminist perspective. This objective of the study included establishing whether and how the post-apartheid policy framework migrates from the apartheid policies; and whether it is framed from a women's autonomy perspective.

In 2012, the South African contraceptive policy, The National Contraception and Fertility Planning and Service Delivery Guidelines, was released (Department of Health, 2012). This was a development and review of the policy which had been codified in 2003. Further policies in the areas of contraceptives and women's health area have been developed. These include the Guidelines for Maternity Care in South Africa, Fourth Edition, 2016; and The Ideal Health Facility Guidelines, and Adult Primary Health Care Guidelines 2019/2020. The Department of Health and the Department of Social Development are two key government departments responsible for population and contraceptive policies and programmes. The Department of Education, and two other departments in the social cluster the Department of Health and the Department of Social Development are more concerned with other sexual and reproductive health and has but a facilitatory role to provide contraceptives. The Department of Social Development is responsible for the population and development aspects of the policy while the Department of Health is responsible for the health policy and service delivery aspects of the policy. The policy is more about provision of actual contraceptives as commodities and

administering these. The policies and interventions of these two departments overlap in some instances. The Department of Social Development reports that, in 2016, about 59% of sexually active women of ages15-49, were using contraception. More than 90% of injectables and implants were dispensed from government clinics and community health centres. The most commonly used methods are injectables and male condoms (Department of Social Development, 2018). Depo is the second-most used method of contraception in South Africa**.** Whilst condoms may serve as contraception, they are primarily for prevention of HIV/AIDS and sexually transmitted infections.

The study finds that the Department of Health lists and defines condoms as contraceptives and used as part of integrated HIV/AIDS and sexual and reproductive health projects. This is problematic because condoms are primarily purposed and used for HIV prevention programmes. Because of their widespread distribution, condoms are listed as the most used method of contraception in South Africa (Mureithi, 2016). Including condoms as one of the methods of contraceptive commodities gives a distorted picture of the contraceptive methods that are mostly used in the country. Depo Provera is reported as the second-most used method, with a moderate use of just 26%. This is because of inclusion of condoms as a method of contraception in the country, which silences Depo Provera as the most used contraceptive in the country. It is also inconsistent that male condoms are included as part of the contraceptive statistic, all data on contraceptives usage is sourced from women because females are used as a proxy to gather statistics on contraceptive use (Mureithi, 2016).

In 2015-2016, the use of Depo Provera was recorded at 26%. This was slightly lower than what was recorded in previous years (Statistics South Africa, 2017). The decrease could be attributed to the newly introduced sub-dermal implant, Norplant, also known as Implanon which contributed 7.6% in 2014-2015, and 3.6% in 2015-2016, to contraceptives statistics (Statistics South Africa, 2017). Norplant is a subject of global race and human rights controversy. Implants, including Norplant, are also highly effective hormonal contraceptives. Norplant has the same progesterone chemical component as Depo Provera, the only difference being that Norplant is implanted under the skin, while Depo Provera is injected (The Rebecca Project for Justice, 2014). Norplant efficacy trials were conducted on African women in the Democratic Republic of Congo, Egypt, Ghana, Kenya, Madagascar, Nigeria, Rwanda, Senegal, and Zambia without their informed consent. Unethical research involving Depo without women being told that the research included Depo have been found in Ghana where 9000 poor rural women

participated, under pretext that they were provided with routine health care ([2,3]The Rebecca Project for Justice, 2014).

Norplant class and individual litigations have been seen in the United States, Canada and the United Kingdom. In the United Kingdom over 400 women lodged legal claims against Norplant manufacturers. Norplant was withdrawn from the market in the United States of America and the United Kingdom in 2002 and 1999 respectively (The Rebecca Project for Justice, 2014). The Rebecca Project for Justice (2014) is concerned that the World Health Organisation and Bill and Melinda Gates Foundation are promoting and advocating, facilitating procurement of Norplant in the developing countries, including South Africa after it was withdrawn in the United States, Canada and the United Kingdom. The next section of the chapter will be presenting human rights context of contraceptives at a global level.

10. HUMAN RIGHTS FRAMEWORK: CONTRACEPTIVES AS A HUMAN RIGHT

It is important to locate contraceptive policies in South Africa in the context of global human rights and exploring how human rights have been influenced and applied in the policies and programmes in the post-apartheid democratic dispensation. This understanding assists in meeting the study objectives of broadening the understanding and the alignment of contraceptives policies to human rights and gender transformation goals of the country. The global community under the United Nations have over decades conducted conferences on issues of fertility, reproduction and population matters. All the conferences develop declarations which are then formulated into programme for implementation by member states at a country level in collaboration with the United Nations. Member states report on these programmes to the United Nations on a regular basis. Fertility and reproduction planning has been expressed as a human right in a number of United Nations declarations. In 1968, family planning was first codified as a human right in the Teheran Declaration of the International Conference on Human Rights (United Nations, 1968). This declaration obliged every country, government, and policy maker to respect and ensure the realisation of this right - parents have a basic human right to determine freely and responsibly the number and spacing of their children (United Nations, 1968). Subsequent to that, various other international human rights, women's rights, and health rights instruments declared family planning as a human right.

Twenty-five years later, the International Conference on Population and Development (ICDP) Declaration (United Nations; 1995) defined contraceptives as women's rights in the context of population and development. These were interpreted by many United Nations entities, such as

United Nations Population Fund (UNFPA), the World Health Organisation (WHO), and other agencies, for application in their various sectors. The roles of the UNFPA and WHO overlap in the field of contraceptives (Robinson, 2010). The WHO produces regulations and policy guidelines for governments, as well as guidelines on commodities and the approval of certain drugs. UNFPA is the UN agency that is implementing the ICDP Programme of Action in South Africa. This suggests that contraceptive initiatives are located within the ambit of population, health, and reproduction in the international space.

The United Nations entity for Women (UNWOMEN) and United Nations Development Programme (UNDP) are not involved in contraceptive work. The study found a web of actors in the internationalisation of contraceptives. It also can confirm that UN Declarations internationalise the issues, and in a way, the international system assumes the role of government in this regard, albeit while all policy and protections lie within governments. The role of the international community and structures are discussed in detail in chapter seven of this report.

10.1 HUMAN RIGHTS PROVISIONS IN SOUTH AFRICA IN CONTRACEPTIVES AND REPRODUCTIVE HEALTH POLICIES

Flowing from the international human rights, the study assessed the application and participation of human rights in contraceptive policies in South Africa. Literature suggests that public health has evidently accepted incorporating human rights in its approaches. Access to health care has been defined as a human and is emphasised in health policies and programmes (Mann *et al*., 2000). This has indeed been advocated for by the International Declaration of Human Rights of 1948, and other health-related declarations. UNFPA articulates some of the principles of human rights-based approaches in sexual and reproductive health: these rights are universal, inalienable, indivisible, interdependent and interrelated (UNFPA *et al.*, 2009).

Human rights and health scholars have highlighted the need for health policies to apply all human rights applicable to health as a continuum. Mann *et al.*, 2000) stated that realisation of one right often depends wholly or in part on the right of another (Mann *et al*., 2000). The focus on the right of access to health care is conceived narrowly, which leaves out focus on other human rights issues (Mann *et al*., 2000). Gendered limitations of human rights approaches are discussed later in this report.

The South African Constitution of 1996 refers to sexual and reproductive rights in three places: the equality clause, Section 9(3), which forbids discrimination on grounds of sex, gender, and

sexual orientation; Section 27(1) (*a*), which states that, *'Everyone has the right to health care services, including reproductive health care*'. Section 12 deals with freedom and security of the person (Constitution of the Republic of South Africa, Act 108 of 1996). The Reconstruction and Development Programme (RDP), South Africa's initial post-apartheid developmental framework prioritised social services as part of progressive realisation of women's rights. The package included, amongst others, provision of free contraception, abortions, and maternal and child health care. This was a welfarist practical needs-based approach centred on women as reproductive beings, as mothers, rather than as women. This study finds this approach hindering and silencing the politicisation and location of contraceptives and women's health in the political sphere, and as issues of gender and racial oppression. Access to health care in South Africa is provided for by the National Health Act of 2003. It must be noted that the language of access to health care does not necessarily define health as a right, at least in the context of South Africa. The Act provides for a variety of structures to protect the rights and expand access, including the Health Ombudsman, Patients' Rights Charter, and drug regulation bodies, amongst others (National Health Act, Republic of South Africa, 2003). More detail on these structures is provided in chapter five which discusses human rights findings of this research.

The provision of contraceptives in South Africa is based on a human rights approach (Department of Health, 2012). Such is expressed in various Department of Health policies and structures cited above. The findings of the study are that these guidelines provide for provision of reproductive health and fertility planning services at primary health care system level, and at district health care level. Again, these focus on improving and expanding access, and ensuring that the system is adequately resourced, capacitated and managed to expand access. The rights and autonomy of women could be extrapolated in the principles of informed consent mentioned in the documents, but not provided for. The study found that, because there is no evidence that human rights structures in the country participated in the policy formulation, the policies were not subjected to human rights analysis prior to approval or implementation.

The Department of Women (Formerly Department of Women, Children and People Living with Disabilities), which has the mandate of conducting gender analysis in government policies, is not listed as one of the assessors of all these policies. This demonstrates how health and contraceptives are removed from the gender and women's rights machinery in government. A research participant who is also a senior official in the National Department of Health (Research Participant KI 09) reported that the Lancet Commission, a global scientific body, is

the only agency that assessed the policy National Department of Health 2012 policy on family planning from the human rights perspective (Research Participant KI 09). There is also no budget allocated in this regard, which may show a lack of political will to ensure this happens. As indicted earlier there is also no information on the rights of women with regards to contraceptives in the clinics. There is no direct objective of redressing the past, increasing community participation and considering or listening to the voices of lived experiences of women, the women's rights sector and structures of gender monitoring. Furthermore, the complexities of side effects are not provided for. Expanded access is advocated for by these policies with blindness to issues of race, violating and compromising the health of women through Depo Provera, although these have been on the surface for decades.

Human rights structures have received complaints and investigated some of the human rights violations, mainly around choice and lack of contraceptive commodities. The Commission for Gender Equality has investigated some of the issues of contraceptives and forced sterilisations in recent past. However, recommendations of the Commission in this regard have not yet been implemented. Detailed findings on human rights are discussed in detail later in this report. Human rights are conceived from the narrow conception of health rights which promote expanded access to health care commodities. The current contraceptive policy not been aligned to the national transformation agenda in relation to women's rights and or to specifically redress and change racialised reproductive injustices and violence.

The policies detail the international human rights framework; however, these are not integrated in the policy analysis, targets and resourcing. The current policy on contraceptives is not materially aligned with South African human rights, gender and women's autonomy provisions as they are in the post-apartheid Constitution and provided for in the role of Constitutional bodies and instruments. Accountability of the Department in Parliament is limited to coverage and service delivery, not women's rights or redress of past violations of women in the past. Parliamentary bodies responsible for gender had no participation in the entire discourse on contraceptives. Individual women in these structures mentioned that the issues had been raised as political issues in their political parties prior to the democratic dispensation. Some of the women in political parties had programmes on the issue, but these issues fell off the agenda during the transition process.

The history in the literature detailed above is necessary for this study. It gives the infusion of the incremental South African history of fertility politics, the influence of global economic

regimes and interest, reflecting different political and developmental regimes. The background studies and history locate the study and the phenomenon under investigation in the current ideology and in the South African health systems context. The role of the international community in these policies will be discussed in detail later in this report.

PART 2: PRINCIPAL THEORIES UPON WHICH THE RESEARCH IS CONSTRUCTED

1. INTRODUCTION

The study employed a combination of three theoretical approaches in its conceptualisation, application and in the analysis. A single theoretical framework could not be sufficient in constructing and debating the emerging issues of contraceptives in post-apartheid South Africa. The theoretical frameworks applied are the political economy theory, intersectionality feminist theory, radical feminist theory and post-colonial feminist theory.

2. APPLICATION OF THEORIES IN THE ANALYSIS

The combination of these theories enabled the study to explore the key diverse questions it sought to answer. The choice of theories was considered because of the inter-linkages and sync in relation to the phenomenon under investigation. Feminist political economy for an example, emphasises, among others, women's bodies, which are viewed as objects to be controlled for meeting political and economic agendas (Rich, 1995; Bokiniec, 2016). This theory is also in sync with post-colonial feminist theory, intersectional feminist theory, and radical feminist theory which deal with other aspects of women's oppression and how dominant feminist discourses have failed to address some of the issues affecting Black women's bodies, including indeed, the relationship and complexities of the feminist movement with the global economy and establishment.

The combination of theories enabled the study to describe and broaden the understanding of the ideology framing contraception policies in post-apartheid South Africa, and what influences and informs the ideological positions. In exploring this objective, the study needed to explore the role and the impact of different spheres of governance of women's bodies, reproduction and fertility, global economic power and influence, global politics, research hegemony, political, regulation, and policy framework, health systems at the country level, in contraceptives, in particular DP in the lives of women users of contraception, and women's oppression in the country. These complex myriads of issues were explored and understood by

first applying feminist political economy theory which is concerned with understanding and locating women's issues in the geo-politicalised division of power and resources and dominating arrangements in the global economics sphere. Feminist political economy is concerned with theorising social order, dominant political ideologies, the periodisation of economic history, geo-politics of power and resources in the global political systems, economic systems, relations and power between countries and their impact on women (Peterson, 2005).

The study applied intersectionality theory in order to understand how the current contraception policies are aligned with the national transformation agenda and policy, to assess the position and higher-level conception of how women's fertility was conceived in the formulation of such transformation agenda. This application was built with understanding how women's bodies and gender oppression as a whole were treated in the movement that agitated and fought for liberation, and how contraceptives were acknowledged as a tool of oppression, for Black people as a whole, but mooted and expressed in women's bodies. The broadening of understanding whether and how the policies are transformational, enhancing women's rights and autonomy, contributing to transformation of power in structures and health systems, required a robust application of post-colonial and intersectional feminist theory. The study applied a radical feminist analysis lens in order to consider deep systematic causes of women's oppression including patriarchal alliances and conceptions at all levels of governance of women's bodies in the governance system.

Intersectionality feminist theory advocates participation and creating understanding of women's oppression from the lens and base of women's lived experiences, considering that individual women's experiences are not just mere personal accounts, but, that Black women are largely the result and the consequence of gendered and class oppression (Crenshaw, 1991). In this regard the study found, for an example, that contraceptive policies and practise did not seek to understand, listen and deploy policy interventions based on women's lived experiences of DP in apartheid South Africa and in post-apartheid South Africa. The more recent policy instruments suggest that women's experiences were mediated and represented by contraceptive service providers. This fact adds a layer of class and positionality in the exclusion of Black poor women, wherein their interests will be wrongfully represented, or in this instance, suppressed by other women based on class, and the position of women who have access to power, in this case provider's access to power, policy space and financial resources of implementing government services. This fact relates directly with the feminists understanding

of participation, and the dire need for feminist 'policy analysis framework as defined by McPhail, (2003) and indeed, the limitations of seeking gender transformation and emancipation of women in policies that were not designed for that purpose as articulated in the intersectionality theory (Crenshaw, 1991).

Structural and political intersections were applied for the purposes of the intersections for themselves but also from the feminists' intersectional political lens. In this analysis, the study found out that the experience of oppressions of women users of contraception experiences are influenced by the economic policies at a macro-level (global, international, level) meso- level (provincial and national level) and micro-level (the communities they live in and their households). Crenshaw (1991) defines some of the structural and political types of intersectionalities and dilemmas and tensions these present to addressing oppression of Black women (Crenshaw, 1991). With an understanding stemming from the exclusion of Black women's experiences in White feminist movements, and the exclusion and rejection of Black women's oppression in the Black liberation movement, Black women find themselves having to fight for inclusion and acknowledgement of their issues in these groups and sometimes have to work with these two groups, which are themselves at the opposing ends. In South Africa for an example, the ANC accused feminism of undermining the national struggle of achieving political independence (Hassim, 2006).

In the same vein, Mohanty (1995) sharply criticised the Western liberal feminists for dictating that Third World feminists should not collaborate with liberation movements, (Mohanty, 1995). This analogy was applied in the analysis of political intersectionalities of women in the political transition, particularly in reproductive health and contraceptives. In the case of contraceptives in the transition of South Africa this led to the dire political consequences for Black women. ANC leaders in the pre-negotiation and negotiation processes found issues of women to be divisive to the movement, as such, successfully advocated for fighting for race first, assuming that all race oppression was the core. In light of this feminisms were rejected as a theoretical and ideological framing of women's issues in the ANC, and the ANC led Women's Caucus and in the liberation negotiations. (Hassim, 2006). One of the aspects of conflict was about feminism and nationalism, which sometimes have a difficult and antagonistic relationship. This is partly because of the often-conflicting nature of their politics and ideological positions.

At the same time, White liberal feminists were putting forward liberal solutions, which were advancing sexual and reproductive rights not conceived from the experiences of Black women, but rather what all women want, what was the international consensus and standard. Consequently, the country ended up with what was called women's victory in the form expanded access to contraception and legalisation of abortion. Racialised oppression and targeting Black women with dangerous and toxic contraception, DP fell off the agenda. This expresses the theory of intersectionality as it articulates Black women's issues being rejected in what becomes the alliances between the Black anti-racists as per political level intersectionality (Crenshaw, 1991 in the South African context with the liberation movement and White liberal feminists. The international standards had also excluded the international and global experiences of Depo Provera as per the lived experiences of Black women in the US and Canada for an example, as such the position that triumphed was the liberal international position advocated for by White liberal feminists and maternal feminists. This suggests that, because of its global nature, the manner in which White liberal feminists may fail Black women elsewhere in the world, could have, and did have, implications for Black women who are oppressed through contraceptives in South Africa.

Post-colonial feminists analyse the role of Western feminists in the oppression of Third World women (Mohanty, 1995). Considering this from the postcolonial feminists' standpoint, the White feminists' and their positions were victorious, and facilitated and benefited from their proximity to colonial governments, their financial power, and their proximity and influence in the United Nations, which will be discussed later in this report. Some United Nations agencies, the World Health organisations in particular, is used as a legitimising tool to impose policy domination in the South African governments (and other governments) in relation to research policy, population targeting resourcing, procurement of contraceptives. Both these centres of power were serving as experts empowered by global consensus and resources to sit in the policy setting agenda of post-apartheid transition project. This is the example of White liberal feminists benefitting from Colonialism and using such benefits to oppress Black women, as articulated in the post-colonial feminist theory. These oppressions are then compounded by the historical and persistent racial discriminatory in economic opportunity, access and ownership of resources, and cultural domination amongst others that Black women are often subjected to (Thomas, 2003).

3. RADICAL FEMINIST THEORY

The radical feminist theory provides a more holistic worldview to analyse the interface between the experiences of women and Depo Provera in South Africa. The theory creates an original and social theory of women's oppression and strategies to end that oppression which come from women's lived experiences (Rowland and Klein, 1996). Unlike other feminist theories, radical feminist theory comes from a premise that patriarchy as a system is the core of women's oppression. Radical feminist theory believes that women's oppression will be addressed by the eradication of patriarchy and suggests that all women are oppressed; oppression runs across all racial groups, ethnic classes, and social classes (Renzetti, 2010). The authors note that some women, but not all women, will accept this. Similarly, not all oppressed people will agree or accept that they are oppressed.

This theory was applied as a tool of analysis to show that patriarchal solutions for issues of oppression have not, and are not, conceived to address women's oppression in the area of reproduction, and particularly in the unit of study, Depo Provera. De Beauvoir (2010) asserts that an identity defined by women's reproductive role is central to the oppression of women. This study can assert that this oppression transcended from apartheid to post-apartheid, suggesting that this oppression transcends the ideological persuasions of patriarchal state power.

Applying the radical analogy, the study can confirm that oppression of women's reproductive abilities through medical interventions at different development challenges, political moments, and health crises including failure of health systems. In particular, at the moment of the study, these medical women oppressing women are deployed to address the failure of health systems, as evidenced by high rates of maternal mortality and resultant litigation costs, and high rates of HIV/AIDS in women. In this instance, patriarchy and oppression of women is expressing itself secondary oppression, failure of economic policies impacting on women and exposing women to poverty, violence against women, amongst many others, expose women to HIV infection, the targeting for Depo Provera to control their fertility is muted as a solution. The study argues that the same applies to teenage pregnancy as a justification for targeting young women and girls for Depo Provera in and out of school. Teenage pregnancy is an outcome of patriarchal commodification and violation of girls, poverty fuelled by exclusion of women in the economy and access to wealth and opportunities, amongst others. Deploying Depo Provera

to the female young bodies is secondary victimisation, and unduly placing the blame and responsibility for teenage pregnancy on young women and girls.

This study asserts to use this theory: women's experiences of injectable contraceptives are located within a patriarchal framework, which connects the personal and the political, and therefore suggests political solutions to this problem, and more importantly eradication of patriarchy as a system of oppression.

4. FEMINIST POLITICAL ECONOMY THEORY

The political economy research paradigm was also applied as an analytical framework. In contrast to classical and neoliberal economic models which analyse supply and demand of goods and services within free market systems, political economy analyses society as an integrated whole; and accepts the relationship between the ruling authority and big business in capitalist economies (Armstrong and Connelly, 1989; Riley, 2008). This theory emphasises gender, focusing specifically on women, while considering other political economy topics highlighted in the broader framework (Riley, 2008). According to this framework, society, social relations, and people's experiences may be objectified in political economies.

Feminist political economy demonstrates how bodies of women and lived experiences of women who are targeted and use Depo Provera as a method of contraceptives in the public health sector are inherently invisible in all levels of the economy and politics, and how the experiences of these women are impacted by the economic systems at all levels. Within this framework of social order, dominant political ideologies, the periodisation of economic history, geo-politics of power and resources in the global political systems, economic systems, relations and power between countries and their impact on women, are considered (Peterson, 2005). The political economy, from a feminist perspective, explores power, participation in structures of the affected in social and public life, including how their lived experiences are affected and have shaped the discourse. Political economy considers how the phenomenon is influenced and shaped by the dominant ideology and discourse at both a micro- and macro-level.

5. POST-COLONIAL FEMINIST THEORY

This study applied post-colonial feminist theories in its analysis. Post-colonial feminist theory focuses on feminists from post-colonial countries. In developing countries, resistance against their misrepresentation in the liberal and post-liberation nationalist discourses, their bodies

have been imprisoned in traditional stereotypes (Tyagi, 2014). Post-colonialist feminists are concerned with how their realities are presented by Western White feminists. Post-colonial feminists propose a theory that captures realities of women in the former colonised countries, the Third World, and Black and women of colour living in Western countries. The theory presents these women as subjects of research and interpretation by Western feminists (Mohanty, 1995). Furthermore, post-colonial feminists analyse the role of Western feminists in the oppression of Third World women. Such overlooks the intersecting oppressive layers of geography, race, sex, and class, ignoring the social, historical, and cultural contexts, and diversities, while voicing the concerns of colonised women (Mohanty, 1995). Post-colonial feminist theories seek to understand women's experiences in relation to history, culture, and society (Mkhize, 2012). Post-colonial feminism allows for the critical analysis of colonialism, history, and their effects on the past and present (Mkhize, 2012; Mohanty, 1991). By way of solution to these issues, Third World women do not intend to do away with Western feminism altogether. These women aspire to a representation that attempts to insert them back into their historical and cultural context (Tyagi, 2014).

5.1 TENSIONS BETWEEN POST-COLONIAL FEMINIST THEORY AND MAINSTREAM POST-COLONIAL THEORY

In relation to nationalist colonial liberation struggles, and post-liberal projects, post-Colonialist theorists argue that women faced a double jeopardy of control of colonial power, first as colonised subjects; secondly as women (Mohanty, 1995). With this reality in mind, feminist positions believe that focusing only on racial politics is bound to ignore the "double colonisation" (both racial and gender) situation of women under colonial imperialist conditions. This feminist theory assumes that Third World women are victims of both indigenous and alien ideologies of patriarchal imperialism (Tyagi, 2014). The conflicts over control of women between colonisers and colonised were a struggle between two opposing and intertwined forms of male centrism and domination. In this kind of struggle, women in the colonial master country and women in the colonised country became the victims and symbolic intermediaries of the struggle between the opposing men, and also the objects they used together" (Riyal, 2019). Women faced oppression of colonialism and patriarchy, both from imperial patriarchy and local patriarchy. Anderson (2003) states that the Western patriarchal system took advantage of indigenous patriarchal system, co-opting and exploiting the system to impose patriarchal ideals which assisted the colonial (and apartheid) system to flourish in South African society. Equally, indigenous systems took advantage of colonialism and

patriarchy, to find ways to oppress women and their voices. This remained the case in nationalists' liberation movements, and in post-colonial states. Mainstream anti-colonialist projects ignored the layer of gender in the oppression. The male-centred nationalist movement focused on the humiliation of the male gender, but not on the female gender. The oppressors expressed some of the oppressions of women's bodies. This led to colonised men also considering women as part of the object of colonialisation, thus controlling women even more with their patriarchal power (Tyagi, 2014). In this instance, colonised women lost solidarity of colonised men, but instead in some instances, colonised men saw colonised women as an extension of colonisation. The men and patriarchy are not accomplices of women, but oppressors themselves (Tyagi, 2014). In the nationalist movement struggle against colonisation, women were exploited, objectified, and misrepresented. Royal (2019) writes that part of the national liberation and post-liberation movement created literature and culture of returning to and reclaiming African cultural roots (Riyal, 2019).

Feminist writers of African literature have criticised this noble and altogether worthy heritage, in order to fight cultural imperialism, in that "women's issues were not only ignored, but they were also sacrificed in the service of dignifying the past and restoring African self-confidence. This cultural and literature revolution claims that the African past was orderly, dignified, and complex. The African past was made the object of a quest. The picture of woman's place and role in these societies had to support this quest and was consequently lent more dignity and described in positive terms than reality warranted" (Peterson, 2005). One of the writers criticises renowned male African writers like Achebe, who painted traditional women as happy, harmonious members of the community, even when they are repeatedly beaten and barred from any say in the communal decision-making process; and constantly reviled in sayings and proverbs (Peterson, 2005). Feminist movements developed at the backdrop of anti-colonialism liberation struggles in the colonised countries, and feminism was accused of undermining the national struggle of achieving political independence (Hassim, 2006). One of the aspects of conflict was about feminism and nationalism, which sometimes have a difficult and antagonistic relationship. This is partly because of the often-conflicting nature of their politics and ideological positions.

Post-colonial feminists contend that the mainstream anti-colonial and post-colonial theory of nationalism is characterised by gender discrimination and gender blindness in its discourse (Riyal, 2019). Gender resistance could be added to this list. The anti-colonial movement

considered and identified women as mothers (Tyagi, 2014). Nationalist discourses are largely male-centric, controlling women by capturing them in traditional stereotypes. African nationalist discourse was a predominantly male-centred tradition, in which women's political agency was conceived of in terms of motherhood (McClintock, 1995). This was the same in the South African liberation movement (Walker, 1995; Hassim, 2006). This may have further entrenched and complicated the effects of patriarchy in South Africa. In the patriarchal system, women are largely positioned in society as 'mothers' and defined by their ability to bear children. The motherhood identity is a product of patriarchy imposed on women to meet patriarchal ends (Walker, 1995). The colonial (and apartheid) system exploited this patriarchal societal state of affairs to meet its political ends. An example of this can be seen in the apartheid government's promotion of family planning measures to reduce the Black population size and increase the White population. This theory is relevant to this study because of its emphasis on women not being homogeneous, but heterogeneous. Oppression of women was one of the core strategies of colonialism. "The controlling of women's sexuality, maternity and breeding was widely perceived as the paramount means for controlling the health and wealth of the male imperial body." (McClintock 1995, Thomas, 2003).

This was the continuation of the concept of patriarchal institutionalisation and control of women's fertility and reproduction, stemming from the pre-colonial, taking new shape in colonial times, albeit having bigger goals, including control of political and economic goals This control assumed various nuances in post-colonial times (Thomas, 2003). Another nature of disagreement was geography and boundaries. Feminism's approach was to build consciousness to communities of women transcending cultural characteristics and geographic boundaries. Mainstream nationalism emphasised characteristics and boundaries in order to resist hegemonic occupation (Tyagi, 2014). In the case of the South African liberation movement, feminism was rejected in the liberation struggle, partly for the reasons stated above (Walker, 1995). National, racial and political liberation was prioritised, and gender liberation struggles placed in perpetual abeyance, with a false promise that these would be attended to once racial and political freedoms were realised (Hassim, 2006). Post-colonial feminism allows for the critical analysis of colonialism and apartheid, and their effects on the past and present (Anderson, 2003). Using this theory, the construction of race, and the oppression of women will be examined in context. The study, using this theory, claims that South African women have different realities and experiences of contraceptives.

5.2 POST-COLONIAL FEMINISM IN RELATION TO WESTERN FEMINISM

Post-colonial feminist theory was developed by Black feminists in the West and globally, as a response to Western, mostly liberal, feminists. The theory criticised the Western feminists as appropriating the Third World feminists' experiences and presenting women from the Third World as a coherent group with identical oppressions, interests, experiences, and goals prior to their entry into the socio-political and historical field (Mohanty, 1995). This universal notion of patriarchy and oppression of women does not take into account the various socio-political contexts, and as such women are robbed of their historical and political agency (Tyagi, 2014). One of the major indicators of these complexities is that the White Western feminist strategy of promoting women working together and rejecting men did not accord with the concerns of many Black feminist theorists. The latter believed that racial discrimination was a women's issue; and that they needed to collaborate with Black colleagues in resisting racial domination. Black feminists felt, for example, that sexual politics and sexual exploitation of Black women was a weapon of political oppression. Indeed, these were pervasive in Black women's lives, and are part of the politics of class and race (Tyagi, 2014). Essentially, this suggests that some Black feminists did not entirely reject the male-centred anti-colonialism project. However, Black feminists advocated that gender and women's oppression is included as a subject of analysis and solutions within the project. They advocated for acknowledgement of this oppression from both the colonisers and would-be liberators.

These feminists believed that racial struggles would probably be a means to gendered and feminised racial oppression. The critiques of Western theories include conceptual, methodological, and political problems involved in the study of Third World women, including their representation of gender, mainly by Western feminist writers. Post-colonialist feminists' critique Western representations of feminism that often do not acknowledge the oppressive nature of Western ideals over indigenous culture and contexts (Correa and Petchesky, 2010). Western feminists have not only failed to read gender issues at the cross-sections of race and class; they have also ignored the importance of socio-historical and cultural context in examining the condition of "Third World" women (Tyagi, 2014). Third World women are represented as powerless victims of dominant socio-economic systems, violence, sexual exploitation, cultural exploitation, not regarded by law as adults, but as minors, amongst many other issues. The identity of Third World women is presented as indigent, uneducated, and having no control of their bodies. Third World women are presented as a homogeneous group, in the sense that the cultural, country, religious, and social classes are not taken into account.

In this representation, Western feminists present as the opposite: the empowerment, the ones who have control and freedom. According to Mohanty (1995), Western feminists appropriate and colonise the oppression of Third World women by offering solutions without understanding the complexities, contradictions, historical, and political realities of the lives of Third World women.

Furthermore, Western feminists use power foundations of the coloniser states to appropriate women's lives and develop knowledge about and for the Third World women. In this, they become colonisers themselves. The understanding of liberation for Western women can be different from that of the Third World. One example of this, writes Mohanty (1991) is women-headed households. The phenomenon of women-headed households is considered as an indicator of women's liberation and progress; whilst in developing countries women-headed households often result from the migrant labour system. Indeed, women-headed households in South Africa are one of the drivers and indicators of deeper poverty, isolation and other social vulnerabilities, which limit women's access to resources to raise children and exposing women to poverty which could be intergenerational. The same could be the opinion about contraceptives. For instance, Western feminists who are White may consider such a sign of freedom and women's control of their bodies. In the developing world, however, it may be associated with the opposite, the control of women's bodies for some women.

There is an assumption of universality of the female experience (Mohanty, 1995). This universality is applied to contraceptives, choice, liberty, and women's rights. Post-colonial feminists have criticised Western feminists for analysing the female gender, rather than the context, in their analysis. This included using women as a category of analysis, identifying women as the same 'the oneness' homogeneous group before the process of analysis (Mohanty, 1995). The oppression of women must be theorised and interpreted within different societies to create broader understanding and improve the ability to address oppression. The analysis of women's oppression must be based on concrete, historical and political practise and analysis (Mohanty, 1995). Patriarchy is not a monolithic, ahistorical power hierarchy: there is no universal patriarchal structure; patriarchy is constructed around inherent discourses in politics, ideology, power and socio-economic conditions. As such, the Western feminist standpoint through their universalist approach, is not necessarily assisting to counter or resist patriarchy in the developing post-colonial country context (Mohanty, 1995).

6. INTERSECTIONALITY FEMINIST THEORY

The intersectionality feminist research paradigm (Crenshaw, 1991; Ackerly and True, 2010) was applied as an analytical tool for this study. In 1988, the intersectionality feminist research paradigm was first defined by feminist lawyer Kimberlé Crenshaw. The theory describes the way in which multiple layers of oppression are experienced by Black women and women of colour (Smith, 2001). Intersectional feminist analysis goes further to suggest that not all women are equal or the same, race, class and economic history, colonialism and slavery are some of the subjects of difference. Some intersectionality and post-colonial feminists question the notion of a global sisterhood: differences of advantages and disadvantages within women as a gender should be considered in the analysis (Tracy and Sorsoli, 2004). Systems of power such as the period in history, dominant political ideology, colonialism, political transitions, political ideologies, the hegemony and influence business and multinational companies, their power over international government systems, the economy and county level government is also an indicator of difference. Power structures such as government as globalisation law, and economic regimes are considered in the intersectional feminists' analysis (Tracy and Sorsoli, 2004; Manning; 2014; Marshall, 1998). The theory suggests that oppression, such as in race and gender, works together in producing injustices for Black women and women of colour (Crenshaw, 1989). The theory suggests that acknowledging one single oppression and marginalisation tends to be ineffective in Black women. Crenshaw (1991) for an example demonstrated this in her analogy of violence against women in the USA. Collins (2000) introduced the concept of matrix of dominations to the theory and formulation of intersectionality. The matrix of dominations refers to how these intersecting oppressions are actually organised, stating that, irrespective of the particular intersections at play, "structural, disciplinary, hegemonic, and interpersonal domains of power reappear across quite different forms of oppression" (Collins, 2000). The theory contends that anti-racist and sexist movements have had limited success, and in some instances, have failed to address issues of Black women. As with Mohanty (1995), in post-colonial feminist theories, intersectionality rejects the notion of oneness in women, the idea that all women are the same, and that oppression of women is the same (Mohanty, 1995). These theories reject the notion of analysing patriarchy through the lens of men against women, and vice versa.

Patriarchy has various nuances, is influenced by race and history, and as such should not be ignored. The theoretical standpoint also rejects the idea of suppressing and not taking on board racial issues in feminism. Intersectional theorists contend that Black women's experiences of sexism are shaped by racism and class inequalities. As such, the experience is vastly different

from middle class, mostly White women (Smith, 2015). Furthermore, in the intersectional theory, understanding what could be considered as liberation victory for White women could be oppression of White women. Therefore, a nuanced, racialised analysis of women's oppression should be understood from experiences of Black women.

Contraception is a contradiction in the area of feminist organising. Collins (2000) observes for example, that motherhood is a calling for women; however, Black teenage mothers are pressured to use Depo Provera and Norplant (Collins 2000). This is, in particular, in anti-racist and anti-sexist doctrines, notable in laws, and how these were applied in different cases on race and sexist exclusions in the United States of America. In this study for an example, the women who participated and policies pursued speak to the different intersections of disadvantage for the women. Some of these intersectionalities are colonialism and race. This particular disadvantage is located in the global attitudes towards the reproduction of Black women. Unlike in America, the South African case took a different nuance, that of containing the numbers of Blacks as a means of decreasing the threat to White South Africans, albeit the bigger purpose was the same, political and economic end, stemming from patriarchal beliefs of commodification of women's bodies. Women sit in the intersection of historical economic disadvantage of this. The women studied are also in the intersections of inequalities in health, in the sense that they use public health systems, which are constrained in resources, a historical phenomenon, but also a post-apartheid phenomenon. This demonstrates that the health systems have not been transformed. Poverty these women faced is also quite nuances, because for an example, within the cohort of poor women, the women targeted for Depo Provera are young women and schoolgirls and women living with HIV. These women who have a deeper exclusion created by poverty, lower economic class, race and gender continue to shape the particular ways that women experience poverty, relative to other groups (Crenshaw, 1991).

As articulated earlier, poverty of these women is the cause and consequence of their targeting and violation, and this pushes them even further into poverty and potential absence of health later in life, amongst others. Maternal mortality justifications of targeting these women, is about reducing the costs of litigation, rather than increasing safety of childbirth. Furthermore, these women have low political clout, so their voices are not heard by those in power, nor heard in their communities. This study analysed that, for an example, litigations and claims settled by the Department of Health on maternal mortality, is mainly for children and child disability rather than women themselves. Black women are discriminated against in ways and forms that do not necessarily fit in the predefined categories of oppression (Smith, 2015). The solutions

are analysed from White women's perspectives of oppression, and not from the perspective of Black women. Black women are not just women, but Black women. These solutions are equally understood from Black male and White female understanding of racial oppression, which is devoid of Black women's experiences and nuances. The centrality of White female experiences in the conceptualisation of gender discrimination disadvantages Black women. "When feminist theory attempts to describe women's experiences through analysing patriarchy, sexuality, or separate spheres ideology, it often overlooks the role of race (Crenshaw, 1989).

6.1 INTERSECTIONALITY AND THE ANTI-RACIST MOVEMENT

The theory criticises the Black anti-racist movement for not acknowledging patriarchy and intra-race oppression, which places Black women at a disadvantage, if not complicating and worsening their oppression. Intersectionality feminist theory contends that White feminists ignore how their own race and class functions to mitigate some aspects of sexism; and, moreover, how it often privileges them over and contributes to the domination of other women (Crenshaw, 1989). Writing in 2015, Smith stated that one of the profound limitations and weaknesses of the United States feminist movement, which is mostly White, has been its leaving out and not confronting racism, as a major oppression, in its analysis. This has had dire repercussions for the feminist movement, and Black women, in particular. The repercussions of this failure ultimately reproduce the racist status quo (Smith, 2015). Crenshaw (1989) states that the value of intersectionality presents a framework for mediating the tension between assertions of multiple identities and the ongoing necessity of group politics. The theory problematised the politics, in particular, the legal doctrines of race and gender (Crenshaw, 1989) and gender-based violence (Crenshaw, 1991), as limited in addressing the oppression of women of colour.

Intersectional theory rejects the essentialism in defining women found in other feminists' theories. In this approach, White women speak on behalf of women of colour, but also silence the voices and experiences of women of colour. The intersectionality theory emphasises articulation of interaction of racism and patriarchy. Furthermore, the theory suggests that women of colour are marginalised by both systems of subordination, and by feminism and anti-racism movements (Crenshaw, 1989). Crenshaw sharply problematises the tendency to treat race and gender as mutually exclusive categories of experience and analysis in law, anti-racist and feminist movements. Black women's experiences of oppression are multidimensional. As such, the single axis in feminism and race analysis distorts and theoretically erases the

experiences of Black women. Furthermore Crenshaw (1989) argues that Black women's experiences are much broader than the general categories that discrimination discourse provides. Black women face discrimination, exploitation, not as Blacks or as women, but as Black women.

Furthermore, intersectionality theory applied without intersecting margins of Black women tend to focus and benefit the most privileged group members, whilst further marginalising those who are multiple burdened (Crenshaw, 19911. The focus on otherwise privileged group members creates a distorted analysis of the whole discourse on racism and sexism (Ibid: 13). Intersectionality theory therefore seeks to broaden feminist and anti-racist analyses, as a way of addressing limitations of these theories in understanding Black women's experiences, therefore improving the efficacy of these theories (Crenshaw, 1991). Crenshaw expands to state that intersectional experience is more paramount than racism and sexism combined, as such, any analysis that does consider intersectionality into account does not have sufficient grounding and capacity to address the subordination and oppression of Black women. Intersectionality theory suggests that, for instance, the anti-racist agenda will not be furthered if it continues to marginalise and silence the reality of intra-racial violence against women of colour.

Crenshaw states that the lack of intersectional analysis creates a situation that laws created to protect White women, and sexist discrimination in employment, are thought to be sufficient for, and to work for Black women. However, in reality they do not, as they were not analysed and formulated for Black women. What this implies is that sexual and racial discrimination laws are defined respectively by White women's and Black men's experiences. In this regard, Black women are protected only when their experiences coincide with those either of White women or Black men (Crenshaw, 1989). Resistance to consider intersectionality in anti-discrimination doctrine, leading to leaving out experiences that are distinctly Black women centred in the analysis, creates interventions that do little to protect Black women. Crenshaw warns that the problem of leaving out intersecting nodes of discrimination, marginalisation, and exclusion of Black women cannot be solved simply by including Black women within an already established analytical structure. Instead, a new method of analysis, applying intersectionality is essential, if commitment to ending gendered and racial oppression for Black women is to be realised (Crenshaw, 1989).

6.2 POLITICAL AND STRUCTURAL INTERSECTIONALITY

Resistance and failure of the anti-racist movement and feminists to address the intersections of racism and patriarchy has had political implications for Black women (Crenshaw, 1991). Structural and political intersections were applied for the purposes of intersections for themselves but also from the feminist intersectional political lens.

In this analysis, the study found that women users of contraception's experiences of oppression are influenced by the economic policies at macro-level, which is the global and international, meso-level, which is national and provincial and micro level which, is the clinic, community and household levels. Crenshaw (1994) defines some of the structural and political types of intersectionalities and dilemmas and tensions these present to addressing oppression of Black women. With an understanding stemming from the exclusion of Black women's experiences in White feminist movements, and the exclusion and rejection of Black women's oppression in the Black liberation movement. Black women fight for inclusion and acknowledgement of their issues in these groups and sometimes have to work with these two groups, which are themselves at the opposing ends (Crenshaw, 1991). In South Africa for an example, the ANC accused feminism of undermining the national struggle of achieving political independence (Hassim, 2006). In the same vein, Mohanty (1995) sharply criticised the Western liberal feminists for dictating that Third World feminists should not collaborate with liberation movements (Mohanty, 1995).

This analogy was applied in the analysis of political intersectionalities of women in the political transition, particularly in reproductive health and contraceptives. In the case of contraceptives in the transition of South Africa this led to the dire political consequences for Black women. ANC leaders in the pre-negotiations and negotiations processes found issues of women to be divisive to the movement, as such, successfully advocated for fighting for race first, assuming that all race oppression was the core.

In light of this, feminism was rejected as a theoretical and ideological framing of women's issues in the ANC, and the ANC-led Women's Caucus and in the liberation negotiations (Hassim, 2006). One of the aspects of conflict was about feminism and nationalism, which sometimes have a difficult and antagonistic relationship. This is partly because of the often-conflicting nature of their politics and ideological positions. The failure of the anti-racism movement to interrogate patriarchy as a means of oppression of women has reproduced the subordination and oppression of women and, for the purposes of this study, he sustained reproductive oppression through the use of Depo Provera, with its racialised, human rights and

health implication concerns. Furthermore, this rejection has silenced Depo Provera as a political phenomenon.

7. FEMINIST POLICY REVIEWS

Feminist policy review approaches (McPhail, 2003) were applied to analyse policy documents. Feminist analysis is essential in strengthening efforts of women-centred policies, and is centred on the analysis of power, policies, and structures that resist access (Marshall, 1998). Traditional policy makers, who are insiders in the policy making process and debates, create the master narrative. Feminist analysts serve as outsiders to the policy analysis world, and identify the values, theoretical premises, interpretations, and presumptions of the insiders (Marshall, 1998). Feminist-centred questions in analysis transcend the master policy and research labels. Feminist methodologies critique the structure and power in the form of bureaucracies, leadership, communities, silent power, and how this power expressed through policy impacts women's lived experiences.

8. SUMMARY OF THE CHAPTER

The objectives of this chapter were to provide the historical, theoretical and literature overview of Depo Provera is as an injectable contraceptive, which is the key focus of this study. The overview, historical and political periodisation of contraceptives over time assisted in locating the research questions and application of the study in that context. This context assisted in the meeting the core objectives of the study, the broadening understanding of the ideology and framing of post-apartheid South Africa's contraception policy, particularly, how the policies have migrated from the apartheid policies, have been aligned with the national transformation agenda and how the policies enhance women's rights, emancipation, participation and autonomy.

This chapter has presented the literature review on contraceptives, including injectable contraceptives. In the second part of the chapter, I presented the theoretical framework of the study, drawing on feminist theories. Some of the key findings and themes of the study were infused into existing literature and similarities began to emerge. However specific nuances of the themes of the study also emerged in some instances to contradict the literature. Theories upon which this study is premised were presented and discussed in this chapter. Study findings which identified with each of the theories were highlighted. The chapter demonstrated the

application of theories in the analysis and some of the findings of the study. More detailed findings will be given in chapters 4, 5, 6, and 7 later in this report. I explored the controversy of contraception, in that contraceptives can be both a form of oppression and a form of agency for women and their control over their reproductive rights. The next chapter presents and discusses the methodology applied in this research.

CHAPTER 3

METHODOLOGY

1. INTRODUCTION

Across the globe, motherhood and contraception are gendered political phenomena. Depo Provera (DP) has been the subject of controversy on racism, colonialism, classism, and eugenics for almost half a century. Advocates of birth control frame contraception, in general, as 'a woman's right', a means to emancipation of women, and a way of fostering gender equality in the reproductive sphere of social life (Furedi, 1997a). Conversely, birth control has also been described as a patriarchal strategy to undermine, restrict, and control women's bodily autonomy, by controlling their fertility and reproduction (Kaufman, 2000). Thus, the discourse on contraception is a categorical paradox. Limited research has been conducted on injectable contraception and contraception in general in post-apartheid South Africa, particularly after South Africa's post-apartheid colonial contraception policies were enacted. The goal of the study was to broaden the understanding of political economy of contraceptives, in particular injectable contraceptives, in post-apartheid South Africa. This study explored the ideology, positioning, and political economy of injectable hormonal contraceptives, in particular Depo Provera, in post-apartheid South Africa.

2. THE OBJECTIVES OF THE STUDY

In line with the purpose and goal of the study, the objectives are detailed as follows:

a) Examining the ideology and framing of contraceptive policies in post-apartheid South Africa. The study sought to understand whether the current contraceptive policies are aligned with the national transformation agenda and policy, including resourcing for women's health; also, whether it considers women's health implications;
b) Examining the nature of women's involvement and participation in all spheres of contraceptive policy and practise of the new policy;
c) Examining whether post-apartheid policy is informed by women's needs and priorities for health; and whether it considers the lived experiences in the area of health, reproductive rights, and autonomy matters in its prescripts; and
d) Examining whether the policies are transformatory and enhance women's rights and autonomy; contribute to transformation of power in structures and health systems, including addressing the reproductive injustices of apartheid in the past.

The specific study questions posed were:

1. What could the ideology and framing of post-apartheid South Africa's contraceptive policy be?
2. How has the current contraceptive policy been aligned with the national transformation agenda and policy and resourcing for women's health, taking into consideration women's health implications?
3. How was women's participation provided for in the formulation of the new policy? How does the current contraceptive policy consider the lived experiences of women in health and reproductive matters in its prescripts?
4. How is the new policy informed by women's lived realities, needs, and priorities for health?
5. How does the current contraceptive policy enhance women's rights and autonomy, transformation of power and structures and reproductive justice?

The broader purpose of the research was to assess how these policies have migrated from the ideological standing and policies under the apartheid period into the democratic era of human rights. The experiences of women users of contraceptives, the providers of contraceptives, and the perspective of policy makers, are important in building this understanding.

3. RESEARCH DESIGN

It is important to detail the research design before the research methods. Qualitative research design is a guide or rough sketch that can be harnessed by the researcher as the study proceeds (Devers and Frankel, 2000). The methodological choices and design of this study were guided by the context and purpose of the research project (Greaves *et al*., 1995). In order to gain a robust understanding of the political economy of contraceptives in post-apartheid South Africa, a concrete study design detailing specific research participants, their positionalities and power in terms of contraceptives, the nature of their involvement, and where they are located, including their unique characteristics, was developed. Issues of accessing the participants, including gatekeeping, were considered and included in the study design.

A sampling frame detailing the criteria and approach to selecting a variety of research participants is presented. Such participants will provide their positions, insights and experiences in responding to the research question.

4. RESEARCH METHODS USED TO CONDUCT THIS RESEARCH

The study applied qualitative research methods in order to meet the objectives of the study and theoretical grounding of the study, as detailed in the previous chapter. The study applied in-depth interviews to collect data from participants. Policy reviews and relevant reports were also used as secondary data sources. Qualitative research methods were considered the most appropriate approach or methodology to answer the research questions. Constructivists' research paradigm and qualitative research were the best methods to apply in this inquiry.

Qualitative research enabled the researcher to collect rich descriptive information and context in order to developing an understanding of what is being observed (Ivankova *et al.,* 2007; Barbie and Mouton, 2001). Qualitative research not only allows for the subjective perspectives of research participants to be heard (Ivankova *et al.,* 2007), it also appropriates and provides possibilities to apply for feminist research. The qualitative research paradigms applied in this study are grounded on feminist research approaches. The goal of this study is to broaden the political economy of contraceptives in South Africa from a feminist perspective. Feminist positioning of this research applied the principles and ethics of feminist research as defined by (Ollivier and Tremblay, 2000; Ackerly and True, 2010); as such, it is from its conception bi-dimensional. The project included the construction of new knowledge, but also sought to produce social change. In line with the practice of feminists, this study applies the contraceptive lens to acknowledge and locate women's struggles against the multiple forms of their oppression in post-apartheid South Africa. Furthermore, the research sought to adhere to the value of interdisciplinary and trans-disciplinary feminist research (Ackerly and True, 2010; Ollivier and Tremblay, 2000). This research project used the lens of the experiences of women and contraceptives in an effort to address gendered social inequality and systematic oppression and exclusion of women. This research work was therefore politically motivated to influence change (Brayton, Ollivier, and Robbins, 2018).

The research considered issues of racism and diversity, political and economic power, democratic decision-making at a micro- and macro-level, women's rights and empowerment, in particular, the rights of women on the margins of society. For the purposes of this research, women targeted for contraceptives, including traditionally marginalised women, are addressed (Ollivier and Tremblay, 2000). Feminist principles informed all stages of the formulation of this research project, including choice of topic, analysis of findings, and presentation of recommendations.

The researcher duly acknowledges the limitations and challenges of applying this approach throughout the process, given the patriarchal nature of the research, policy and social context, and the environment in which the research was conducted. Feminists' research has to operate within the precincts of mainstream research. The feminist research approach was the best approach to deepen the understanding of the political economy of contraceptives. This phenomenon is rooted in political and economic history, racialised, gender issues, class-based, feminised poverty and social exclusion, and the socio-economic lives of women. The study content included issues of sexuality, reproduction, motherhood, and bodily autonomy. The approach helped find women's subjective voices, as the women users of contraceptives, and the views of women's rights advocates and activists.

The study approach went beyond listening to the dominant voices of the state institutions, parliamentary structures, Chapter Nine institutions, policy makers and other structures of power in the sphere of contraceptives policy in South Africa. Mkhize (2012) reported that mainstream research disciplines are critical of feminist research because of the subjective approach that gives voice to the most historically marginalised voices, such as those of women; thus, promoting feminist epistemologies. Most women, especially those less educated, are often used and viewed as objects of research in mainstream research methods (Ollivier and Tremblay, 2000; Mkhize, 2012; Brayton, Ollivier, and Robbins, 2018). This research project has reflected and applied the feminist research principles by taking women and gender as the focus of analysis, and the importance of consciousness-raising.

The rejection of subject and object by valuing the knowledge held by the participant as being the knowledge expert; and acknowledging how research valued as objective, always reflects a specific social and historical standpoint (Brayton, Ollivier, and Robbins, 2018).

5. SAMPLING AND SAMPLE POPULATION

5.1 SAMPLING TECHNIQUE

Three different study populations were sampled for this study. The participants of the study included women who are users of contraceptives in two clinics; health care workers responsible for contraceptives in the clinics; and researchers working on research, policy, and training in the field, senior government officials, and constitutional bodies, members of parliament responsible for health and women's rights, and one of the United Nations agencies responsible

for contraceptives. The total size of the sample was twenty-seven (27) participants. Three different study populations were sampled for this study in order to gain insights into the positioning and politics of contraceptives in post-apartheid South Africa. Participants were drawn from experts and stakeholders in policy in the Provincial and National Ministry of Health and Provincial Ministry of Social Development.

This research study used both purposive and snowballing sampling methods to identify a sample that can provide adequate information on the research topic (Patton, 1990). The use of purposive sampling enhances understandings of selected individuals' or groups' experience on a particular phenomenon (Miles and Huberman, 1994; Patton, 1990). The researchers purposefully identified diverse participants with rich information and insights, in order to deepen the understanding of the political economy of contraceptives in South Africa. The researcher purposefully identified and selected women users of contraceptives from one urban and one rural clinic, health care workers from the same clinics, policy makers in the province of KwaZulu-Natal and national government, researchers, and members of parliament, in order to gather data to increase the understanding of the phenomena. Purposefulness of sampling in this regard was more in terms of locality of the clinic, and use of contraceptives, and indeed other ethical criteria considerations.

A snowballing sampling method was applied, albeit to a limited degree. In snowballing, research participants identify other potential participants who might provide more insights into the research question (Seal and Silverman, 2005). Choosing the purposive sampling approach enabled more participants to be added to the sample of the study, thus allowing the researcher to explore emerging themes and explanations further. It was observed, however, that in some instances referrals were made to institutions and participants already listed as participants in the study; some had already been interviewed. The linkages could be observed in particular between research organisations UNFPA, Department of Social Development, Clinton Health Access Initiative, USAID, and the Bill and Melinda Gates Foundation. A connection to a system of power could be identified between and amongst these participants. The snowballing technique was instrumental in identification of international institutions involved in contraceptives in the country, notably, the Clinton Health Access Initiative and the Bill and Melinda Gates Foundation. The researcher did not succeed in securing interviews for this research; however, their strategies and reports assisted in enriching the understanding of the role of international actors in contraceptives policy and practice within South Africa.

The MatCH Research Unit participant referred the researcher to other documents to consult for the purposes of this study, notably, the training manuals on the new policy and the report of the Family Planning 2020 Partnership. This allowed the study to have access to more secondary data and information to inform emerging themes in the study. An anti-snowballing approach was utilised in identifying the women. Anti-snowballing is identifying research participants by not following any system or network of power related to the research question (Ackerly and True, 2010). The women identified were not in any way connected to a network of power around contraceptives. The women were also not referred by other women, neither did they refer the researcher to other women.

5.2 SAMPLE SIZE

Mason (2010) suggests that the mean sample size for PhD studies using qualitative interviews is 31; however, the guiding principle for sample size in qualitative research is data collection to saturation. Data saturation refers to the collection of data through qualitative methods until these method no longer yield new information (Mason, 2010). For studies employing a phenomenological design, Morse (1994) suggests a minimum number of six participants be interviewed before data could reach saturation; whereas Creswell (1998) recommends a sample size between five and 25. In line with Onwuegbuzi and Collins (2007a) the researcher, for this study, ensured that the sample size was not too large for thick-data extraction. The researcher ensured that the sample was adequate, not too small, such that it is not possible to achieve data saturation as recommended by Flick (1998).

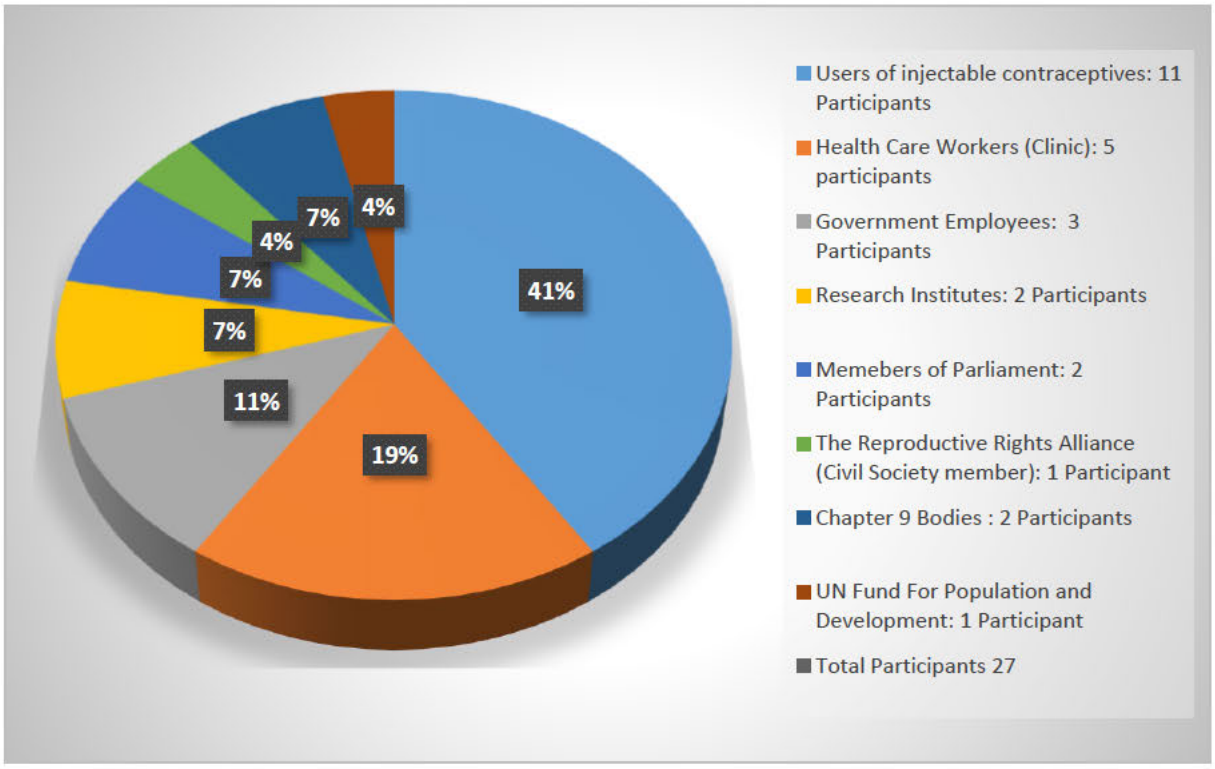
5.3 RESEARCH PARTICIPANT POPULATION

Three different study populations were sampled for this study in order to gain insights into the positioning and politics of contraceptives in post-apartheid South Africa. A multilevel sampling strategy (Onwuegbuzi and Leech, 2007) was applied to select participants. This was applied in order to enhance credible sources of data to explore the research phenomena from different perspectives. All participants sampled were over the age of 18, because of the nature of the study and legal consenting matters. There was no specific exclusion criteria stated. The total size of the sample was twenty-seven (27). The participants in the study included women who are users of contraceptives in two clinics, health care workers responsible for contraceptives in the clinics, researchers working on research, policy, and training in the field, senior government officials, and constitutional bodies, members of parliament responsible for

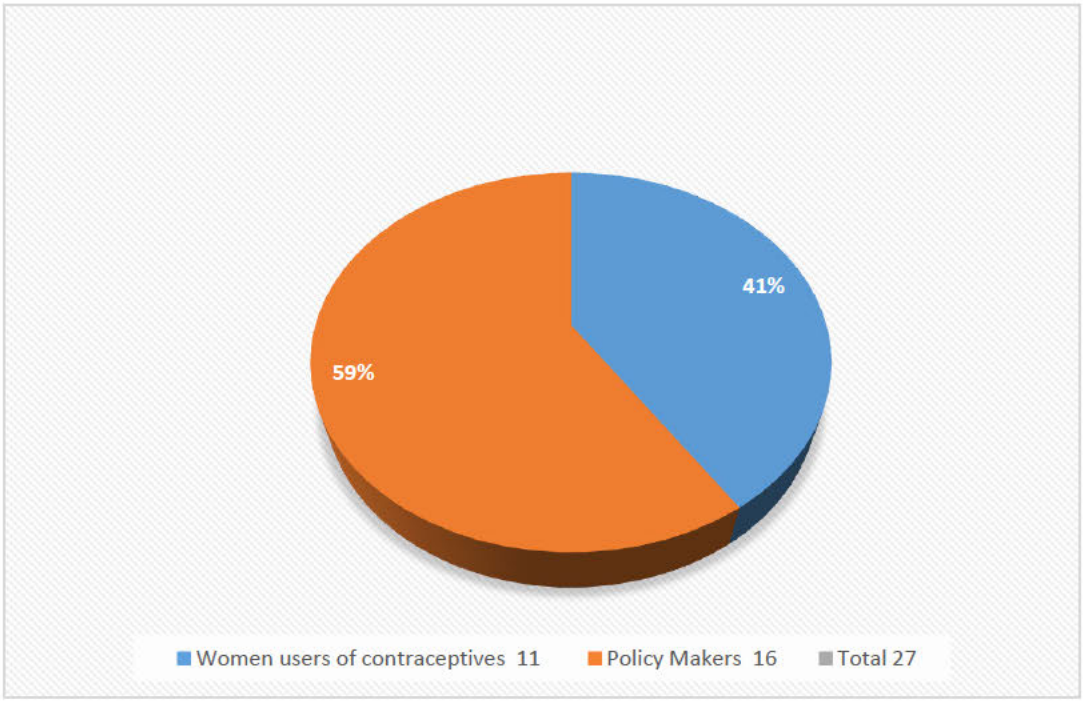
health and women 's rights, and one of the United Nations agencies responsible for contraceptives. Women users of contraceptives accounted for 41 per cent. The details of participants follow:

- Eleven (11) women – the users of injectable contraceptives
- Five (5) clinic healthcare workers
- One (1)The KwaZulu-Natal Department of Health
- One (1)The National Department of Health
- One (1) The KwaZulu-Natal Provincial Department of Social Development
- Two (2) research organisations, experts, and stakeholders in policy, MatCH Research Unit (MRU) of the University of Witwatersrand and Wits Reproductive Health and Institute (WRHI)
- Two (2) Members of Parliament, Chairperson of the Health Portfolio Committee, and the Chairperson of Portfolio Committee of Women in the Presidency
- One (1) Member of a civil society human rights organisation working on contraceptives research, policy, and human rights, The Reproductive Rights Alliance
- Two (2) Chapter Nine Consititutional Bodies, the Commission for Gender Equality (CGE) and the South African Human Rights Commission (SAHRC)
- One (1) The United Nations Fund For Population and Development.

GRAPH 1: DETAIL OF PARTICIPANTS AND PERCENTAGES



GRAPH 2: DETAIL OF POLICY MAKERS AND WOMEN USERS OF CONTRACEPTIVES



5.4 RATIONALE FOR CHOOSING THE PARTICIPANTS

The rationale for choosing participants was informed by the objectives and the theoretical positioning of the study. The political economy research paradigm was applied as an analytical framework (Riley, 2008). Political economy theoretical analysis considers society an integrated whole within the economic system (Riley, 2008). Political economy includes the relationship between the ruling authority and big business in capitalist economies, in analysing state economy. Political economy is different and developed as a critique to classical and neo-liberal economic models, which analyse supply and demand of goods and services within free-market systems, (Armstrong and Connelly, 1989; Riley, 2008). It was important that perspectives of users, providers, researchers, and policy makers, human rights bodies, and parliamentary structures which provide oversight to government departments be included in the study. The sample size and selection were based on the information the study required (De Vos *et al.*, 2011). The availability and accessibility of research participants who met the substantive and conceptual requirements and benefited the study was considered (Holloway and Wheeler, 2010). The researcher ensured that there was a balance between obtaining thick descriptions from each interview, at the same time obtaining comparative descriptions from each interview (Onwuegbuzi and Leech, 2007).

Women users of contraceptives were selected as participants in order to include women's voices in the study. The clinics selected were a rural and an urban clinic. It must be stated that within the urban clinic selected is a housing that can be classified as informal settlements. The rural community where the clinic is located also has some characteristics of a peri-urban area. Members of parliament, policy makers, government officials, and service providers at clinic level were identified as participants. The roles and positions of all levels of state, at parliamentary level, national government policy level, and government service delivery level could be interrogated and analysed for the purposes of the study. One of the objectives of this selection was to broaden the understanding of the division of power, responsibility, and accountability in relation to contraception as a women's rights issue in South Africa. International actors, the UNFPA, were identified as participants, because of the international nature of the contraceptive programmes. The role of international actors assisted in understanding the position and the evolving political economy of contraceptives.

This approach assisted in locating women's experiences of contraceptive services and their rights to international, and national power. The inquiry could examine how this power defines

and impacts the nature and quality of services women receive. More importantly, the study could demonstrate how these services impact on the rights of women, as provided for at a national constitutional level.

5.4.1 STATE ACTORS, POLICY EXPERTS AND RESEARCHERS

The researcher used purposive sampling to recruit and select state actors, policy experts, and research participants. Purposive sampling involves, amongst others, taking the population parameters into consideration, in order to ensure that the sample is based on these parameters (De Vos *et al.,* 2011). The sample size was based on the information needed and the willingness of participants to be part of the study. Considering the parameters allowed the researcher to identify and recruit the sample by her own knowledge of the participants, the research and policy sector of contraceptives, the parliamentary and state accounting bodies; this in turn ensuring that a study participant's rich information was included (Simons, 2009). The researcher, therefore, consciously selected a sample based on her knowledge of the field and the actors in the field.

The sample of experts, and the research policy was drawn from senior officials of research organisations, experts, and stakeholders in the policy MatCH Research Unit (MRU) of the University of Witwatersrand and Wits Reproductive Health and HIV Institute (University of Witwatersrand). The Reproductive Rights Alliance (RRA) participated in the study. RRA is a national feminist women's rights and advocacy organisation working on policy on contraceptives and reproductive rights in South Africa.

Chairpersons of the Parliamentary Portfolio Committees on Women in the Presidency and the Parliamentary Portfolio Committee on Health were also interviewed. Representatives of two Constitutional bodies, the Human Rights Commission and the Commission for Gender Equality were interviewed. A representative of the United Nations Population Fund (UNFPA) was interviewed.

DETAIL OF KEY INFORMANTS

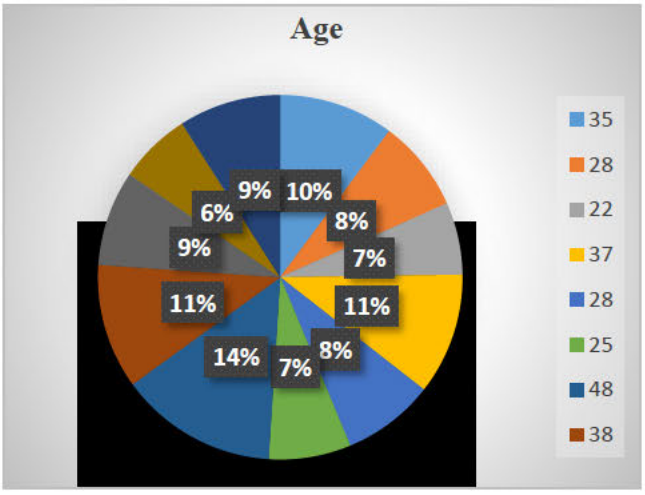
One (1) The KwaZulu-Natal Department of Health
One (1) The National Department of Health
One (1) The KwaZulu-Natal Provincial Department of Social Development
Two (2) research organisations, experts and stakeholders in policy, MatCH Research Unit of the University of Witwatersrand and Wits Reproductive and Health Institute (University of Witwaterand)
Two (2) Members of Parliament: Chairperson of the Health Portfolio Committee, and the Chairperson of the Portfolio Committee of Women in the Presidency
One (1) Member of civil society human rights organisation working on contraceptives research, policy and human rights, The Reproductive Rights Alliance
Two (2) Chapter Nine Constitutional Bodies, the Commission for Gender Equality (CGE) and the South African Human Rights Commission (SAHRC)
One (1) The United Nations Fund For Population and Development.

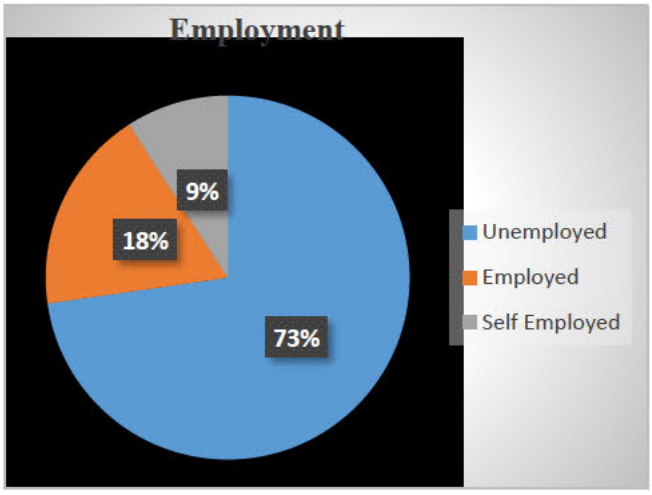
5.4.2 WOMEN WHO ARE USERS OF INJECTABLE CONTRACEPTIVES

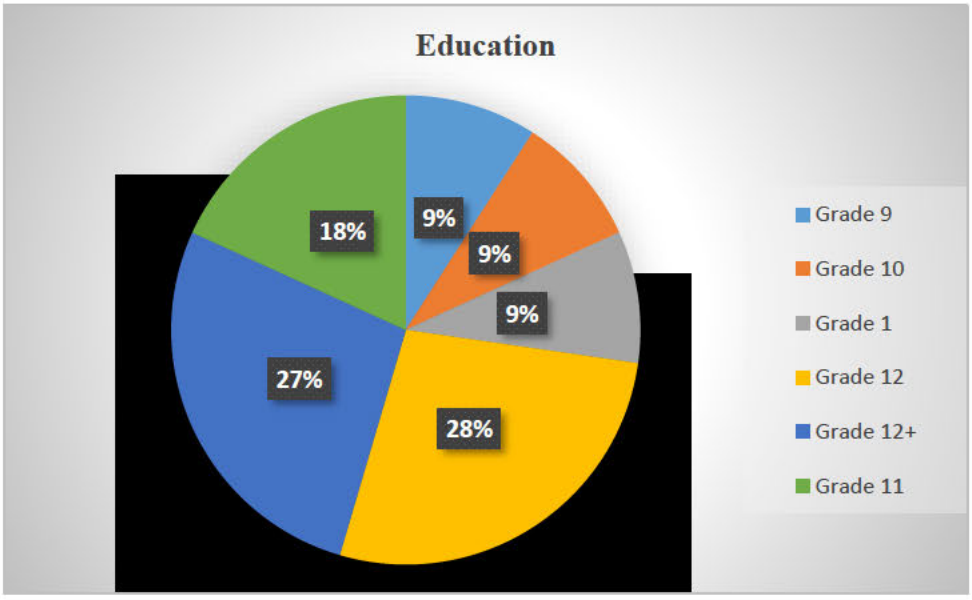
The total number of women users of contraceptives who participated in the study was eleven (11). It was important to have a higher number of his women as the study was about the use of Depo Provera. The inclusion criteria for the women users were women over the age of 18. The criteria included that women should have experience of using injectable contraception (current use/previous use), accessing injectable contraceptives in public health clinics in Durban, KwaZulu-Natal: specifically in oSizweni Q Clinic in uMlazi Township, south of Durban, and Halley Stott Clinic in KwaNyuswa, Bothas Hill, were chosen as research sites.

Women users of contraceptives were asked to share their demographic information, including age, level of education, in what context, where, when, and what contraceptives they were initiated on. This information assisted in data analysis.

GRAPH 3: DETAIL OF AGE, EDUCATION AND EMPLOYMENT







DETAIL AND PERCENTAGES OF AGE, LEVEL OF EDUCATION, AND EMPLOYMENT STATUS

Users of Contraceptives

Users#	Age	Highest Level of Education Attained	Employment Status
CU/OQC/01	35	Grade Nine (9)	Unemployed
CU/OQC/02	28	Grade Twelve (12) plus tertiary education	Unemployed
CU/OQC/03	22	Grade Twelve (12)	Unemployed
CU/OQC/04	37	Grade Ten (8)	Unemployed
CU/OQC/05	28	Grade Twelve (2) plus tertiary education	Unemployed
CU/HSC/01	25	Grade Twelve (12)	Unemployed
CU/HSC/02	48	Grade One (1)	Unemployed
CU/HSC/03	38	Grade Twelve (12)	Employed
CU/HSC/04	29	Grade Twelve (12) plus tertiary education	Employed
CU/HSC/05	22	Grade Eleven (11)	Self-employed
CU/HSC/06	31	Grade Eleven (11)	Unemployed

The clinics were chosen on the basis of their location. One of the clinics is located in a township, and the other is located in a rural area. Both clinics are managed by the KwaZulu-Natal Provincial Health Department. The study had hoped to collect data from Klaarwater Clinic in Pinetown, Durban. This clinic is managed by the municipal government, the eThekwini Municipality's City Health Department. It became difficult to gain access to the clinic because of bureaucracy, and delays in granting of full gatekeeper's access. Provisional gatekeeper's access had been granted by the Municipality Research Committee. Women were interviewed on the clinic premises. Clinic staff provided adequate space for the interviews in the clinic. Both clinics had experience of working with researchers and provided resources to the researcher. The research interview room was provided. The researcher needed to contact the clinic a day before going to the clinic so that the room could be made available.

The observation was that the researcher had some degree of power, credence and respect from health care workers. The explanation could be that the letters of authority come from offices with higher authority. The other reason could be that health care workers consider researchers as external visitors with authority. As such, they should provide the best resources to them, in order to present a good image of the clinic. All participants were informed that they could have the interview on a day, at a time and a location that was most suitable for them; however, all participants preferred to be interviewed at the clinic.

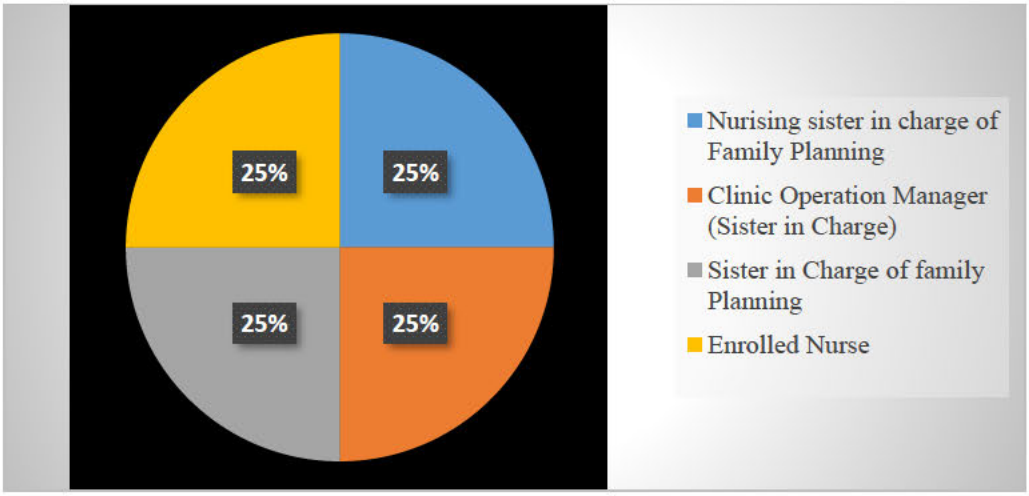
5.4.3 CLINIC STAFF/HEALTH CARE PROFESSIONALS

The study interviewed the total of four (4) participants who are clinic staff (defined as health care professionals) who are responsible for management, procurement, prescribing and dispensing contraceptives at the two clinics. The health care professionals interviewed were one (1) Clinic Operational Manager, two (2) nursing sisters in charge of contraceptives, and an enrolled nurse working in a team with the sister in charge of contraceptives.

The inclusion criteria for clinic staff included the following:

- Procurement and management experience
- Prescription/dispensing experience
- Over 18 years of age

GRAPH 4: DETAIL OF CLINIC STAFF AND PERCENTAGES



Operational managers assisted with recruitment of Clinic staff in the two clinics. The operational managers were asked questions about managerial aspects of injectable contraceptives. Questions included clinic governance matters, management, procurement and supply of injectable contraceptives, training matters in line with the policy, participation of users of contraceptives, amongst others. The nursing staff responsible for service delivery were asked questions about training in light of the policy, information provided and their interaction with the women users in line with the policy on the matter.

Clinic staff members were interviewed before the women users were interviewed. This was to assist the researcher to gain context, in terms of how the clinic operates structurally and practically.

This would allow the researcher to then locate women's experiences in this context. The researcher was able to go back to clinic staff for clarity, on some matters after interviews with women contraceptives users were completed. Clinic staff also shared documents with the researcher. These included policy documents, training manuals, and information materials developed in-house by the clinic as educational tools for the women who are initiated into contraceptive use. The researcher viewed information displayed on clinic notice boards, mainly in waiting areas, for noting the different services. The information included health information. In one clinic there was information on the Patients' Rights Charter (Department of Health, 1999). One of the clinics, Osizweni Q Clinic, displayed information and contact details of Clinic Boards on their notice board. The next section of this chapter will discuss data collection techniques applied in this study.

6. DATA COLLECTION

6.1 DATA COLLECTION INSTRUMENTS

The choice of research tools and techniques was informed and guided by the purpose and the context of the research project (Greaves *et al.,* 1995, p. 334). The study used qualitative in-depth and semi-structured oral interviews to collect data. Three semi-structured interview schedules were used to collect data from the three categories of participants, the study population. The three categories of participants in the study had triangulation applied as a rigour strategy (Eisenhardt, 1989; Barratt; Choi and Li, 2011). This approach enhanced the creditability of the data (De Vos *et al.,* 2011). Semi-structured interviews were one of the tools that provided a practical method of gathering oral information from study participants. The researcher developed a list of questions for each category of study participants based on the different areas of the objectives of the study. Semi-structured interviews focus on key themes rather than on specific questions. The questions were used as a guide; they were open-ended and were not fixed. Flexibility was one of the requirements taken into consideration when listing key questions for each category of study participants. This gave the research participant latitude in responses, and the interviewer could probe as required (Ackerly and True, 2010). Interview guides were part of the research protocol development.

On-going adaptation, alignment with study objectives and participants, and filtration was carried during this process. The purpose was to ensure that the questions were clearly presented and understood by all study participants. The project supervisor, Level One and Level Two reviewers reviewed the interview guides. The first semi-structured schedule was applied to collect data schedule from key informants, the policy makers, legislators, researchers, civil society groups and international actors **(See Appendix 3).** The open-ended interview questions focused on different aspects of contraceptives policy development, research, financing, and the role of international actors. The second schedule was for health care workers who work in management and in direct contraceptives service delivery in clinics **(See Appendix 3).** Questions focused on different aspects of contraceptives at clinic service delivery level: the health care workers' interaction with national policy developments governance, the rights of users of contraceptives, and broad women's health services related to the clinic. The third interview schedule was for women users of contraceptives. All three research data collection instruments are attached as appendices as part of this report **(See Appendix 3).** The open-ended interview questions focused on various aspects of experiences of women who use contraceptives in the two clinics sampled for this study. Questions included their experiences of initiation into contraceptives, side effects, and other women's health issues, and human rights in relation to contraceptives, amongst others.

In-depth one-on-one oral interviews were conducted to gather information. This interview method can be identified as appropriate for a feminist research perspective, as it allows often-silenced women's voices to be listened to, contributing to production of feminist subjective knowledge (Mkhize, 2012). Roberts (1981) states that feminist research methods, including interviews, are essential, and should seek to be at variance with the dictum of data collection interviews described in the research methods textbooks. Mainstream interviewing techniques detailed in textbooks are based on a masculine view of social reality (Roberts, 1981, Ollivier and Tremblay, 2000). As such, it was imperative that the alternative was created and applied, in order to ensure representation of a women's worldview in knowledge production and research (Ollivier and Tremblay, 2000). This incorporated a series of interviews with key informants who are involved in research on contraceptives in post-apartheid South Africa.

6.2 INTERVIEWS WITH USERS OF CONTRACEPTIVES

Data collection of women users of contraceptives and health care workers were conducted between September 2018 and February 2019. The study received full ethical clearance from

the Social Sciences Ethics Committee of the University of KwaZulu-Natal. Permission to collect data in the clinic was granted by the Regional Office of the KwaZulu-Natal Department of Health. Full permission was granted upon full ethical clearance of the study. The study was registered and approved to be included in the KwaZulu-Natal's Department of Health Research Database and Health Systems Trust Research Database. Ethical principles of voluntary participation, consent and confidentiality were applied in this study.

Upon granting of permission letters from the two offices of the KwaZulu-Natal Department of Health, the researcher then held initial meetings with clinic operations managers of the two clinics. The meetings introduced the study, the support and information required from the clinics, and timelines of data collection. The researcher was required to leave the document detailing the summary of the study, ethical clearance letter, and all permission letters from the regional and provincial offices of the KwaZulu-Natal Department of Health. Women who are users of contraceptives were recruited in the clinics through clinic staff. Initial meetings were held with the operational managers of the clinic. Clinic staff introduced the researcher to the women in the clinic waiting areas. For each interview, the researcher introduced the study, the purpose, and the criteria for participation. The summary of the study and the ethical clearance letter were presented and explained to the women. Copies were shared with the participants.

This was necessary information for women to make informed decisions about participating in the study. Ethical documentation detailing issues of confidentiality and the right of women to withdraw their consent at any point was presented. Women who were willing to participate in the study were then identified and interviews arranged with the women on the same day. All women who participated signed informed consent to their participation in the study. Some of the users of contraceptives did not consent to audio-recording of the interviews. The researcher stated her position as a researcher in relation to the clinic and clinic staff who introduced her to the women. It was important that this was clarified so that women do not see the researcher as the representative of the clinic. The clinics made space available for the interviews. This created a conducive interview environment that ensured privacy for interviews with women users of contraceptives.

The interviews were conducted in consultation rooms made available when the researcher was on site at the clinics. The rooms were furnished with chairs and tables. The tables were moved to the side to allow the researcher and participants to sit on the chairs. The rooms were adequately ventilated and lighted. Interviews with users of contraceptives were conducted in

isiZulu. Both the researched (contraceptive users) and the researcher spoke isiZulu. This fact enhanced trust between the researcher and the participants (Mkhize, 2012). It also allowed the participants to elaborate more in their local language; and for the researcher to pick up nuances embedded in the language. Interviews lasted between forty minutes to one hour and twenty minutes.

The interview started with asking biographical information, followed by questions about the women's experiences of starting contraceptives, the side effects, other health concerns for women, participation, and human rights. A maximum of three women per day were interviewed. This was to allow time to process the interview and the discussion with each woman. This approach was also used to examine the theme and to conduct ongoing evaluation of the interview process in order to enhance the validity of the study. The other objective was to identify women who had come for different services; some clinic services are offered on specific days. Identifying and interviewing women on different days enhanced the opportunity of identifying women from diverse clinic services. Women who participated in the study had come to the clinic for different reasons when they were interviewed.

Five (5) women had come to the clinic for contraceptive services; four (4) women had come for infant and child immunisation; and two (2) women had come to the clinic for chronic medication. The spacing of interviews allowed the researcher to take time to document and process each interview.

6.3 INTERVIEWS WITH HEALTH CARE WORKERS

Interviews with health care workers were held between September 2018 and February 2019. This was the same period as users of contraceptives. Interviews were conducted in private offices and in consultation rooms within the clinics.

The researcher provided each participant with information on all study details to enable each participant to make an informed decision whether to participate voluntarily in the study. All health care workers signed informed consent to participate in the study. Some members of the clinic staff did not consent to recording. The researcher had met with health care workers who are seniors at the clinics, the clinic operations manager, and the sister in charge, prior to the interviews. The meetings were held to make arrangements for collecting data at the clinics. The senior health care workers had seen the study information and ethical documentation prior to the researcher being granted access to the clinic.

The interviews were conducted in English, in which the researcher is fluent. English is the common language used as a formal official language. Some of the health care workers conducted the interview in a mixture of English and isiZulu. IsiZulu was mostly used by the participants to emphasise a point. The researcher asked questions about roles and positions in their clinic in relation to contraceptives and other responsibilities. This was followed by themed open-ended semi-structured research questions about their work, choices of women, side effects policies, training, human rights, and information for the users of contraceptives. Questions were followed by probes.

6.4 INTERVIEWS WITH STATE ACTORS, POLICY EXPERTS AND RESEARCHERS

Data collection with constitutional bodies, members of parliament, policy makers, and advocacy organisations were conducted between September 2018 and October 2019.
This is because it took longer to schedule interviews with a group, this not being an easily accessible group. This study population was approached to participate in the study in writing. Follow-up telephone calls were held with some participants. Some participants were approached as organisations, the organisations giving their names.

Participants in the research and policy field required time to obtain authority from the seniors within their organisations before they could participate in the study. Other participants were approached directly, whilst some were approached through their secretaries. These were members of parliament and national government officials. This group has contact details of their offices and secretaries accessible to the public. The researcher had informed some of the participants in this group about the study: interviews were requested after the study had been ethically approved. This was part of seeking gatekeeper's permission and direct contact with the organisations of the participants, mainly the research and policy participants. Details of gatekeeper's permission will be provided in the section on ethics in this chapter.

All participants were given a copy of the ethics clearance certificate and study summary when they were formally approached for the interviews. Interviews with all policy makers were conducted in English. Commitment to participating in the study was confirmed prior to the interviews. Telephone interviews were held with the chairpersons of the parliamentary portfolio committees, the researcher from Wits Reproductive Health and HIV Institute, and the Reproductive Rights Alliance. This was because of the location of the informants and

challenges in transportation to the interviews. Members of Parliament were particularly mobile and were difficult to secure interviews with them in their offices based in Cape Town. The researcher from Wits Reproductive Health and HIV Institute is based in Port Elizabeth. According to Block and Erskine (2012), telephone interviews may be appropriate for studies where purposive sampling has been applied (Block and Erskine, 2012). This is because research participants are not expected to make intricate descriptions between responses where they are reliant on their memory. The level of honesty could be greater. The research did consider the trade-off of this approach. A relationship had been developed with the participants prior to the interviews. All information had been shared with the participants. This prior relationship makes it less likely that the data would be subject to bias (Block and Erskine, 2012). All participants participated in the study voluntarily. They had the option to refuse to participate in the study. They were prepared to offer information freely. This, according to Shenton (2004), may enhance the credibility of the information shared by the participants (Shenton, 2004).

7. OBSERVATIONS AND DATA COLLECTION EXPERIENCE

The objective of the study is to explore how the policies and practices of contraceptives have shifted from apartheid South Africa to post-apartheid South Africa. The observation of the researcher in so far as the various participants, emerging issues, interviewing experiences, including power issues, are part of data analysis for this study. This is in line with the values of feminist research methods and theories applied in this study (Reinharz, 1992). The personal accounts and feelings of the researcher, the first-person voice and identification with the research subject matter is expressed in the researcher's observation (Reinharz, 1992). In line with feminist values this starts by the researcher departing from the women's standpoint. Emotional engagement of the researcher is guided by an ethic of caring: caring for the research topic, the research participants, what becomes of the research, and the eventual narrative of the research (Blakely, 2007).

Sustained visits to the clinic enabled observations in the clinic, in terms of information available, how services and waiting areas are organised and prioritised, for example, there is a separate, express queue for contraceptives. Some of the interviews were audio-recorded, while others were not. Specifically, clinic staff and some of the users of contraceptives did not consent to audio-recording of the interviews. In some instances, the researcher opted not to proceed with recording, because the users agreed, but with hesitation. A general observation was that the users of contraceptives were not comfortable with being recorded. Nordstrom

(2015) wrote in a journal on qualitative research that the researcher may decide not to use or to turn off the recorder if the interviewer is aware that the presence of the instrument makes an interviewee nervous (Nordstrom, 2015). The researchers should take detailed and accurate interview notes in the absence of audio recording (Shaver, 2005). Not using a recorder when the researcher observed discomfort in participants would be a limitation of the researcher (Shaver, 2005). Shaver (2005) states that, equally, not using a recorder, should be listed as a limitation of the study. Declining audio recording was provided for in the ethical clearance for the study.

I had also to acknowledge the power she has as a researcher in the relationship. The decision not to record interviews of women users of contraceptives who expressed hesitation and discomfort, although consenting to the recording, was informed by this acknowledgement of the power dynamics. It was important that participants feel comfortable, so that there is trust between the participants and the researcher. Considering the positionality of the women users of contraceptives and health workers, it was understandable that they would fear being recorded.

7.1 RESEARCHER POWER RELATIONS AND EXPERIENCES

Given the nature, objectives and participants in this research, it is important to consider power relationships − power relations with all research participants, and with service users in particular. The granting of interview data is a gift; as such, it is important to accept the inescapably unequal power inherent in the relationship between interviewer and participant (Rutakumwa *et al.*, 2019).

The use of an audio recorder in which the spoken word becomes indelibly recorded and taken away to be used as the researcher sees fit is key in the uneven distribution of power. Furthermore, this may diminish the answers participants may furnish, and, by extension, the questions an interviewer may ask (Rutakumwa *et al.*, 2019). Researchers have the responsibility of firmly situating themselves within contingent and imperfect power contexts, and to reflect on these throughout the phases and process of research.

The researcher faced difficulties in probing some of the policy makers. This was based on the fear that she did not want to come across as accusatory, or asking them to account for their political portfolios, albeit this function is part of feminist research. Some of the policy makers were open to giving more information off tape, in conversations that were before the formal

data collection and post interviews. Rapley (2004) suggests that allowance be made for whatever the interviewee may wish to say 'off tape' as one of the strategies for gathering rich data (Rapley, 2004). Nordstrom (2015) states that social science research tools or apparatuses and the very act of research are not mute or innocent entities that simply conduct and record interviews. (Rapley, 2004) Research and capturing of data and the capturer data are not apolitical, or acultural. Conducting and recording interviews can be linked to race, age, class, culture, and politics (Nordstrom, 2015).

Feminist research, and this study in particular, acknowledges the political nature of this research, in the sense that contraceptive policies are based on patriarchal political ideology, political power, and contestations with women's bodies and reproduction, used as weapons and proxies for such power and contestations. Qualitative research literature Shaver (2005) encourages a participant-centred approach, and guidelines for 'ethical, non-exploitative methodologies' for working with hidden populations, for example, sex workers (Shaver, 2005). The experience from this research is that in a participant-centred approach 'ethical, non-exploitative methodologies' are applicable, and should be prioritised for researching policy makers, as they are also a distinct research population with sets of vulnerabilities. The researcher successfully interviewed twenty-seven of the thirty participants aimed at for the study. The total number of participants interviewed was twenty-seven. This, however, came with multiple experiences. Some interviews were free flowing, while others were somewhat challenging.

7.2 EXPERIENCES WITH WOMEN USERS OF CONTRACEPTIVES

In line with the values and objectives of this research, the voices of women users of contraceptives in the study are important. The experience of the researcher during the research process is of central concern to the research outcome (Blakely, 2007). The study captured the research experience of women users of contraceptives in order to enrich the analysis of the results of the study. It was observed that interviewing women users of contraceptives in the clinic might have been a limitation. Women considered themselves patients rather than individual women in the interviews.

Women initially identified the researcher as a counsellor or educator or source of information on contraceptives. They asked questions about contraceptives and other women's-health-related issues, mainly side effects. The researcher did share information where she could. She also referred the women to clinic staff for information and other services, for example, pap

smears. These are some of the questions that had been asked in the interview. The researcher did not want such referrals to come across as her evaluating and interfering with the work of the clinic. This would have affected her relationship with clinic staff. The researcher therefore deemed it more appropriate to refer the inquirers to the clinic personnel. It is the researcher's concern that there is no way of following up and ascertaining whether the women were indeed assisted as per the referrals. The researcher had to probe to encourage the women to talk as women generally, rather than them being patients. Possibly, the women saw the researcher as part of the clinic establishment. Women became more open as the interview continued. In the conversations, it was observed that women have a deep sense of agency around contraceptives, and in their reproductive desires.

7.3 EXPERIENCES WITH POLICY MAKERS

Policy makers were key to meeting the objectives of understanding the policy process, the various actors, and the underlying assumptions about the policies. The policy level of government is where human rights and values of the country, in this instance, those of racial and gender transformation, are developed into programmes for implementation. Policy makers were open to participating in the study. The researcher had expected it to be difficult to persuade policy makers to participate, given the politics and their position, that of being between political principals and the public, where accountability lies. There was, however, a challenge in terms of them making time for the interviews. Appointments had to be changed from time to time to accommodate the schedules of the policy makers. There was a great deal of flexibility with some of them. One of the provincial policy makers offered to be interviewed in the community where the researcher lives. She came to the area alone and was interviewed in a restaurant.

As the data collection proceeded, the researcher revised some of the questions so that she did not ask some questions directly, but rather allowed the conversations to flow, and issues to be identified. It had been observed that officials from government for example, may have perceived some questions as criticisms, judging by how they responded to the questions. It became important that the researcher adapted the questions to accommodate the environment, in order to maintain the relationship of trust with policy makers. Morse *et al.* (2002) stated that a researcher ought to be "amenable and pliant to changing circumstances" (Morse *et. al.*, 2002).

Experience of the researcher and the research participants is of central concern to the research process (Blakely, 2007). In this study, the researcher considered all experiences encountered with all three research populations of the study. The voices and experiences of service providers of contraceptives are critical in building a complete understanding of contraceptives in the country. Their inclusion completes the picture of participation, issues of side effects, and alignment of contraceptives in the broader women's health programmes.

7.4 EXPERIENCES WITH HEALTH WORKERS AND THE CLINIC ENVIRONMENT

Participation of health workers also gave insights into understanding health care systems' challenges impacting on the rights of women and transformation of contraceptives programmes in post-apartheid South Africa. Clinic staff were very helpful and open to assist and to be interviewed. They assisted with allocating appropriate rooms for the researcher to conduct interviews. I was assisted by the most senior staff members, and the operational manager at the clinic. I was also introduced to all appropriate clinic staff so that that they could assist me when the manager was not available. I was able to interview four health care workers, three service providers and one operations manager (sister in charge). Clinic staff were receptive to questions, albeit referring some of the questions to management. There were instances when they did not know or had never heard of the issues I was raising, notably, some of the side effects and emerging issues around HIV/AIDS. Clinic staff from the rural clinic were able to share additional documents, including the policy and all training materials they had in relation to the policy. They also shared information they had produced themselves at the clinic level to educate the women about all contraceptives, including injectable contraceptives.

Assessing the information available on side effects and rights of women users of contraceptives was one of the activities in assessing women's choice, side effects and human rights provision objectives of the study. According to Bernard (2011) and Rutakumwa *et al.* (2019), observation of the participants and the research environment is a key part of the data-collection process in qualitative research. The researcher conducted an observation exercise in both clinics sampled for this study. The purpose was to look for materials displayed in the clinics in light of information gathered from the interviews. It had been observed in the interviews that written information about services was only displayed in the clinic. There was no information given to women as hand-outs to take home to read. It was therefore important to look at the materials

displayed on notice boards. The flow of the clinic set-up, in terms of where the rooms were which were allocated for contraceptives, was also part of the observation.

Working at the clinics was beginning to sway the focus of the work towards public health, focusing more on limitations in terms of resources in the clinics, rather than on the core questions of the study. I was able to pick this up as I was considering the interviews. The approach was not to reject these lessons, but to try to infuse them in the study, as per the study purpose. This is in line with flexibility prescripts of qualitative research (Morse et al., 2002). Differences between rural and urban clinics were also beginning to emerge. The study found the rural clinic to be more resourced in terms of materials, and more responsive to the study. It was also observed that there were other research organisations working in both clinics, mainly on service delivery.

7.5 SOME OF THE CHALLENGES

The purpose of the study was to examine the ideology of contraceptives in post-apartheid South Africa by examining policies, the global context, the political context, and experiences of providers and users of contraceptives. Understanding the application at a service delivery level is one of the objectives of the study. One of the challenges in data collection was control over and direction of the interviews and the research process. In some instances, there was a need for balance between open-ended and focused interviews and participants' cooperation and trust with the researcher.

The control of the interview sometimes shifted, as the participants began to discuss matters of health needs of importance to them, but that were not in the scope of the study. This was in line with the practise of flexibility in qualitative research (Morse *et al.*, 2002). In some instances, this led to exceeding the time frame for the interviews. One of the observations was that the responses were focusing more on health issues rather than contraceptives per se, as a women's rights phenomenon. As semi-structured interviews allow for open-ended questioning, in some instances it was challenging for the researcher to keep interviews focused on questions as per the data-collection tool. Additional and extra information surfaced during interviews. Not all this information was irrelevant. Some of it did give a broader context to the study.

One of the research expert interviews knew the researcher professionally. The participant did not know the position of the researcher in relation to contraceptives but was aware of the

positions the researcher has taken on other sexual and reproductive health matters and women. The interview with this expert was the longest. It was a relaxed interview. The participant took her time to detail the matters, in some instances as a way of explaining and justifying the situation she was describing. In another instance, an ethical dilemma emerged, as the participant made reference to the study the researcher had conducted with other colleagues in the past. This was in the context of informed consent. Informed consent in that study was used to demonstrate that informed consent in contraceptives is in fact a soft issue in comparison with sterilisation. The participant was not aware that the researcher was one of the authors of the study.

Policy makers were prepared for the interviews. The other observation was that policy makers seemed to be conversant with research processes, and open to participating and responding to questions. The researcher had expected the opposite. Policy makers, in particular, those in the Department of Health, started by stating that progress has been made, and that there are challenges, before responding to some of the questions. This raised the concern that the participants may have given politically correct and socially expected responses to some of the questions. The researcher observed that in some of the questions responses were not given. The respondents did not say they did not know or that they would respond to the question, instead giving responses such that we are looking forward to learning from the results of the study, so that we can understand the issue better.

8. FIELD NOTES

Field notes are written details of what the researcher has seen, heard, experienced and thought about during the interview process, from a perspective of the researcher (De Vos *et al.*, 2011). According to Holloway and Wheeler, (2010) field notes can be the researcher's personal notes and observational notes (Holloway and Wheeler 2010). The researcher wrote both personal and observational field notes. Recording and writing field notes is one of the key activities in qualitative data-collection methods. Field notes complete the data collected though recording (Bernard, 2011). This study gathered methodological, content, conversational, and observational field notes. This was to enhance the vigour of the research project and its usability (Morse *et al.*, 2002). The usability of the study is in line with feminist values of the study of usability and a study that enhances change in women's lives, has women as the point of departure, through policy and structural improvements (Reinharz, 1992). The researcher gathered detailed interview notes and field trip notes for all interviews.

The researcher recorded personal field notes detailing personal observations and experiences noticed during the interviews. Field notes assisted the researcher in reflecting on ethical dilemmas of this research (Polit and Beck, 2012. One of the dilemmas was the expectation from women users of contraception to be assisted with access to pap smears or cervical screening services. The referrals were made to the clinic; however, the researcher had no guarantee that the service would be provided. The study permissions for the clinic did not provide for follow-up on services.

In preparation for the study, the researcher had not included provision of immediate health needs that women might require as a result of awareness of need generated by the content of study interviews. Observational field notes included observations in the clinic, including where contraceptives services were provided, the fact that women did not need to go through the clinic administration and general queue if they had come for contraceptives; and special provisions for contraceptives and other reproductive health issues for young people aged 12-24.

Observations included materials and posters displayed in the clinic, where they were displayed, and whether they were professionally laid out or presented as simple computer processed and printed documents. All field notes were included in the data analysis. The researcher wrote field notes after each interview, to document the behaviour, expression, and words of the participants, as well as the researcher's thoughts and observations (Holloway and Wheeler, 2010). In this study, the field notes were handwritten. These field notes were compiled, classified, and filed as per the sequence of interviews, participant category, and date sequence of interview within that category of participants. This enables easy access and possessing of the notes for reference and data analysis. The interview notes were by date of interview, participation code, the start and finishing time of the interview.

9. SAFETY OF THE DATA

Data storage and safety is critical in ensuring rigour of the research (Billups, 2014. For the purposes of this study, data safety is particularly important for replication of the study and increasing knowledge on the feminist politics of contraceptives in South Africa. Safety of data increases credibility of the study as it provides information for data and research process audit trail (Billups, 2014. All interview recordings were protected by a code and a password. The researcher was the only person who had access to the code. The researcher enlisted services of the transcriber and translator to process some of the interviews. The services were subject

to confidentiality. The identities of the participants were not revealed in the interview recordings. Furthermore, the interviews were identified by codes. The data files were shared with the recordings, and transcripts all kept in the safe-data storage. The researcher will store the data in a safe-locked facility in the School of Social Sciences in line with conditions of ethical clearance. The recordings and notes will be discarded after five years.

10. POLICY REVIEWS

Policy analysis focusing on their effect on users of services, their origins, standpoint, and purpose and targeting has become an integral part of social disciplines (McPhail, 2003). The study conducted the analysis of contraceptives, sexual and reproductive health and rights policies from a feminist lens. The analysis focused on the women's rights, human rights, and autonomy commitments of these policies. This was in line with meeting the objectives of the study on the position of contraceptives, the ideology and how the transformatory imperatives were applied in the policies. The analysis was based in the feminist ideological frame of the research and the researcher (McPhail, 2003). The analysis of these examined the policies contrasting the experiences of women users of contraceptives.

The study utilised secondary data in the form of relevant national and international policy documentation on contraception, in particular, injectable contraceptives. Specifically, this data collection method included the review of South African government policy documents. Secondary data is data collected from documents or written official communications (Nieuwenhuis, 2007). Unlike literature reviews, secondary data serves the purpose of providing more nuanced clarity on the phenomena under research (Nieuwenhuis, 2007). This approach allowed the study to locate contraceptives and the research within an established national policy framework. The review also examined policy documents of the World Health Organisation and UNFPA. Understanding the international policy context of contraceptives assisted in understanding the position and the evolving political economy of contraceptives, and how this informs policy in South Africa.

In contrast to classical and neo-liberal economic models which analyse supply and demand of goods and services within free-market systems, political economy analyses society as an integrated whole; and accepts the relationship between the ruling authority and big business in capitalist economies (Armstrong and Connelly, 1989; Riley, 2008). This approach assisted in locating women's experiences of contraceptives services, and their rights to international and

national power, understanding how this power defines and impact the nature and quality of services women receive, and more importantly, how these impact on the rights of women, as provided for at a national constitutional level.

The policy review considered how women's autonomy, in the context of this study, on contraceptives has evolved through historical periods, dominant ideologies, colonial, and post-colonial regimes, changes in regimes, and emerging contestations at a national and global level. Post-colonial feminism allows for the critical analysis of colonialism and apartheid, and their effects on the past and present (Anderson, 2003). Interviews were supported by other methods, such as policy reviews. This mix of approaches enhanced reliability, validity, and trustworthiness of the data, and ultimately, analysis (Nieuwenhuis, 2007). The criteria used for selecting documents for review included, amongst others:

- That the documents are going to be used as secondary data
- The publication date of the document, in light of the contraceptives policy period under investigation
- The nature of the document, whether it is scientific document, or a policy document; and methodologies applied in developing the document
- The purpose and the context within which the document was formulated
- The main arguments and positions of the document in relation to this study.

For secondary data, the researcher reviewed policy documents, reports, and, where applicable, position papers, policy papers, or statements. The detail of the policies reviewed is presented below:

NATIONAL	**INTERNATIONAL**
South African National Contraception and Fertility Planning Policy and Service Delivery Guideline, RSA Department of Health, 2012	Hormonal Contraceptives Eligibility Criteria for Women at High Risk of HIV, World Health Organisation, 2017
Contraception and Fertility Planning Counselling Tool for Health care Providers, KZN Department of Health, UNFPA, Wits RHI 2016	Family Planning: A Global Handbook for Providers, World Health Organisation, United States Agency for International Development, Johns Hopkins University, 2018.

Gender Analysis of the National Development Plan Vision 2030	Programme of Action of the International Conference on Population and Development (ICDP).
The National Health Act, 2004, Government Gazette, Volume 469, July 2004	Family Planning Partnership 2020, FP2020
The Patients' Rights Charter, Department of Health, 2009	

Various reports of different organisations were consulted. These included reports of the South African Human Rights Commission, Reports of the Office of the Health Ombudsman, Report of the South African Law Reform Commission, Clinton Health Access Initiative, Bill and Melinda Gates Foundation and USAID. The next section of this chapter will present data-analysis techniques applied in this study.

11. DATA ANALYSIS

This section of the chapter focuses on data-analysis techniques applied to the study. The purpose of data analysis was to allow research findings to emerge from the frequent dominant themes in data collected from different data sources of this study. Data collection and analysis in this study were not treated as two separate processes, but rather as ongoing non-linear concurrent processes (Niewenhuis, 2007; Yin, 2014).

Data analysis in qualitative studies is a process of subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns. Data analysis serves the purpose of reducing and organising data to produce findings that require interpretation by the researcher, according to Burns and Groove (2011). Themes were reflected upon and recorded as they were emerging in the data collection and reflection process. This approach allowed for a cyclical and iterative process of collection of data, reflection on data collected, identification of gaps, and plans for future data collection (Niewenhuis, 2007). The approach facilitated focusing on the questions of the study whilst identifying sub-themes and contextual analysis issues related to the study questions. This enabled the researcher to decide on whether to explore further in terms of additional questions from participants, following up on participants identified by key informants, or on whether to

explore additional documentation. This process also assisted in identifying gaps in data and a point of data saturation.

Interviews conducted in English were recorded and transcribed. Although the researcher comfortably speaks both isiZulu and English, interviews in isiZulu were translated and transcribed into English for ethics purposes. Once all interviews were in English, they were arranged into different themes. The data was analysed using thematic analysis (McQueen, 1998). Qualitative synthesis was also applied (Elo and Kyngas, 2008). One of the key aims of the interviews was to consider the injectable contraceptives through the eyes of the participants (Nieuwenhuis, 2007). The researcher ensured that the voices of the participants and different nuances were not lost in the analysis. As such, the analysis and the researcher adhere to the values of feminists as defined by (Brandwein, 1986). This researcher details these values as including: "Elimination of false dichotomies, the conceptualisation of power, valuing process equally with product, renaming and redefining reality in consistent with women's reality and acknowledging that the personal is political" (Brandwein, 1986). Some of the feminist values, for example, social justice, respect for dignity, and worth of all people, are in line with values subscribed to by other policy frameworks and professions (McPhail, 2003). There were deliberate efforts to ensure that the context and different nuances, communicated through language and observations, are included in the analysis.

Data analysis consisted of probing, categorising, tabulating, and testing qualitative evidence to address the research questions (Hsieh and Shannon, 2005). An inductive content analysis process as described by Elo and Kyngas (2008) was applied in analysing the data collected to describe the phenomenon (Elo and Kyngas, 2008Themes and sub-themes were added as they emerged.

11.1 THEMES THAT EMERGED FROM THE STUDY ARE AS FOLLOWS:

1.	The political positioning and policy context of women's rights and health in South Africa
2.	The justification of expansions and targeting of contraceptives policies and programmes in South Africa, including maternal mortality and unwanted pregnancies

3. Poverty
4. Funding and policy formulation
5. Research collaborations
6. Autonomy choice in initiation and choosing contraceptives
7. Limitations in application of information, options requirements, and rights frameworks in consent, including time and environment of decision making
8. Side effects, other women's health issues, inclusion, provisions for these in policies in and programmes
9. Screening
10. HIV/AIDS and contraceptives policy practice and research
11. Policy formulation and participation of various stakeholders and interest groups
12. Participation of women in policy and governance of contraceptives, and in broad community health structures, as per the prescripts of the law, and human rights provisions in health care services
13. Human rights, gender and women's rights understanding and framing of contraceptive policy and provisions
14. Human rights provisions and application in contraceptives
15. The role, participation of human rights and gender structures in contraceptive policy, as prescribed by law and human rights and gender provisions
16. The interconnectedness and the role of international organisations, United Nations agencies, pharmaceutical industry, philanthropists, International Non-governmental Organisations (INGOs), bilateral institutions in policy formulation and research, funding, research collaborations, product innovation research, and procurement, and monitoring functions of contraceptives in South Africa.

The themes were then developed into a coding template. The coding template was refined throughout the coding process (McQueen, 1998). Coded excerpts were extracted, analysed, and reported on. The themes will be discussed in detail the research results chapter. The study utilised secondary data in the form of relevant national and international policy documentation on contraception, in particular, injectable contraceptives. The policy documents were analysed using a feminist policy review approach (McPhail, 2003).

Feminist analysis is essential to strengthen efforts of women-centred policies. Feminist analysis is centred at the analysis of power, policies, and structures that resist access (Marshall, 1998). Traditional policy makers who are insiders in the policy making process and debates create the master narrative. Feminist analysts serve as outsiders to the policy analysis world, who then identify the values, theoretical premises, interpretations, and presumptions of the insiders (Marshall, 1998). Feminist-centred questions in analysis transcend the master policy and research labels. Feminist methodologies critique the structure and power in the form of bureaucracies, leadership, communities, silent power, and how this power expressed through policy impacts on, or what it means in terms of women's lived experiences. Intersectional feminist analysis goes further to suggest that not all women are equal or the same. Such analysis questions the notion of global sisterhood, and that differences of advantages and disadvantages within women as a gender should be considered in the analysis (Tracy and Sorsoli, 2004). Systems of power, the period in history, dominant political ideology, colonialism, political transitions, political ideologies, the role of business and multinational companies, globalisation, and the power structures such as government law, and economic regimes are considered in the intersectional feminist analysis (Tracy and Sorsoli, 2004; Manning, 2014; Marshall, 1998).

Aspects of identity, such as race, class, ethnicity, and age are included in the analysis. Individual circumstances such as poverty, disease, ability or disability also form a core part of the analysis (Manning, 2014). Key questions posed in the analysis are detailed below.

11.2 KEY QUESTIONS ASKED IN THE ANALYSIS

Key research questions asked included understanding the rationale for the policy formulation process, for example, which agencies and structures were proponents and initiators of such policy processes. The justification of the policy formulation process was also included in the questions. The nature, the structures, and the level of government departments and spheres of

government involvement in the process were included in the analysis. The level of government involvement and their positions in the process also came under scrutiny. The nature and sources of research and knowledge and information used to inform the process and in decision-making included the nature of the studies and fields of research which contributed. The key questions posed in the analysis included the analysis of social, economic, and human costs and benefits of the policy. The nature of inclusion, acknowledgement of women, in particular, the affected women targeted by the policies. The identity and the positionality of women led to which 'women question' was posed. The capacity of women in the process included understanding whether women were involved as employees, community members, community leaders, business owners, consumers, and/or users. The role of the women was viewed through a gender lens, ascertaining whether the processes considered women as occupying traditional gender roles, as caregivers, community educators, administrators, and in non-traditional gender roles − professionals, researchers, managers, or community negotiators (Manning, 2014).

The analysis included the understanding of the community participation process. This included questions about how the community participation was conducted. The analysis established in which communities, in particular, women used the services, the target populations within the community. In this instance, young women and women living with HIV were consulted. Questions about which individuals and their position within those communities were posed.
The analysis included measures taken to make the participation more accessible to the community, in line with the feminist values of including power in the analysis (Marshall, 1998). Questions on whether power was considered as a structure in the context of the policies and practices of contraception. Specifically, questions probed whether gendered and racialised apartheid and colonial roots and the positionality of women and contraceptives emanating from these systems were recognised, and whether the policies sought to address such.

Questions of accountability and structures of accountability were also included in the analysis. The processes and structures which make final approval and institutional legitimacy of policy instruments were also posed. Lastly, the analysis included monitoring questions and reflection on questions. Feminist reflection questions are in line with feminist values of social justice and conducting research as political action, in order to challenge power as a means to ending women's oppression (McPhail, 2003). Reflective questions, as described by Manning (2014), included whether social justice was a considered in the policy or decision-making process; and whether the policy inspired transformation in its prescripts and application. Questions on

whether and how the policy intervention and the process was likely to result in transformation for the communities it is intended for, policy makers and the entire health systems were posed in the analysis. Lastly the policy analysis question explored whether the intervention challenged dominant systems of power and inspired change in institutional practices (Manning, 2014).

The goal of this policy analysis framework is to put women back where they have been left out. In line with the goals of the feminist policy analysis framework, the analysis was purposefully conducted with the goal of understanding its effect on women. This as a means to shift power in society, in the long term, working towards the empowerment of women (Manning, 2014). This approach allowed the study to locate contraceptive and the research within an established national policy framework. The review also examined policy documents of the World Health Organisation and UNFPA. Understanding the international policy context of contraceptives assisted in understanding the position and the evolving political economy of contraceptives, and how this informs policy in South Africa. Findings from the policy reviews are mainstreamed in all chapters of this report on results.

12. CREDIBILITY, TRANSFERABILITY, DEPENDABILITY, AND CONFIRMABILITY OF THE STUDY

Ensuring rigour and utility of this research is essential in order to meet its objectives (Morse *et al.,* 2002). Feminist values of conducting research to represent women's experiences, their voices and the voice of the researcher, require ensuring rigour and trustworthiness of the research process (Blakely, 2007). Qualitative methods of data analysis are often regarded as subjective or ambiguous (Atieno, 2009). To ensure that the data is analysed in a systematic manner, the process of analysis dependent on a comprehensive codebook was developed using an established theoretical framework and research objectives (McQueen, 1998). The parallel concepts of trustworthiness measures comprising credibility, transferability, dependability and confirmability were incorporated into the study design and the implementation of the study (Morse *et al.,* 2002). These strategies were applied to all aspects and stages of the study.

In order to enhance the credibility of the study, the researcher applied multiple well-established data-collection, and data-analysis methods, which had been used in other studies (Lincoln and Guba, 1985; Shenton, 2004). The researcher ensured that there was a balance between obtaining thick descriptions from each interview, at the same time obtaining comparative descriptions from each interview (Onwuegbuzi and Leech, 2007). The researcher gives a robust description of the data collection experience so as to allow other researchers and peers

to make judgements about the transferability of the study (Lincoln and Guba, 1985). The study applied triangulation in data collection (Shenton, 2004). Semi-structured interviews were used to collect data from the three populations. The three categories of study participants provided the study with triangulation as a rigour strategy) to increase the creditability of data (De Vos *et al.,* 2011). Sources of data for the study included in-depth interviews, semi-structured interviews, and secondary data in the form of documents, which were analysed (Niewenhuis, 2007; Shenton, 2004). Information from various documents and reports assisted in placing the themes in findings into context, and vice versa. Interviews were supported by other methods, such as policy reviews.

This mixture of approaches enhanced reliability, validity, and trustworthiness of the data, and ultimately, the analysis (Nieuwenhuis, 2007). Similar data was collected from clinic staff and users of contraceptives from different clinics.

Policy makers who participated in the study were from a broad spectrum of sectors, and different levels of the state, for example, policy makers in the Department of Health and Members of Parliament. Triangulation, using various methods in concert may '*compensate for their individual limitations of each data collection approach and exploit their respective benefits*' (Brewer and Hunter, 1989). To enhance dependability of the study, the processes of the study were reported in detail, so that in future, another researcher may use the exactly the same process and reach similar results (Shenton, 2004). Study design, procedures and protocols followed by the study were well detailed and applied throughout the study implementation. The research tools, data, field notes and operational details of the study are available.

The researcher incorporated evaluation throughout the process of the research (Shenton, 2004). This assisted the researcher to observe any usage or changes needed in the application of the methodology. This study incorporated reflection in the entire process of its implementeation, from collection of data, reflection on data collected, identification of gaps, to a plan for future data collection (Niewenhuis, 2007). Feminist reflection questions are in line with feminist values of social justice and conducting research as political action, in order to challenge power with a goal of ending women's oppression (McPhail, 2003). The researcher reflected on each interview as per the objectives of the study. One of the reflections, for example was on how the researcher focused on the objectives of the study whilst acknowledging issues of gendered intersections of disadvantage in the context of a failing health care system, as these were

emerging as major concerns in the data collection process. According to Shenton (2004) this process enabled the researcher to monitor the developing constructions, as a way of enhancing credibility of the study (Shenton, 2004). The study supervisor monitored progress on the study including data collection, analysis, and writing. Regular debriefing sessions were held with the study academic supervisor.

I kept myself abreast of developments in the field of study, for example, the researcher monitored debates in the International Contraceptives Conference. She read more on the subject and was thus exposed to varied perspectives. The researcher kept herself involved, and updated on developments of injectable contraceptives, in the sphere of HIV/AIDS. The researcher participated in various World Health Organisation consultative meetings on Depo Provera and HIV/AIDS in Geneva and in Southern Africa. In 2016 I was invited to participate and present on the issue in a regional HIV/AIDS conference in the United States of America.

The researcher's commentary and observations are detailed in the data section of this report. I followed commentaries of policy makers on contraceptives, in particular, Depo Provera during the course of the research. The issues surfaced for example, during the International Contraceptives Day, and also in topical debates on the comprehensive sexual health curriculum in schools. All participants participated in the study voluntarily. They had the option of declining to participate in the study. Those who participated were prepared to offer information freely. According to Shenton (2004) this may enhance the credibility of the information shared by the participants (Shenton, 2004). Data collection was conducted over a period of 15 months. This created sustained contact with study participants and localities.

This enhanced the relationship and also broadened the researcher's understanding of the context of study participants, including the institutional context. This was essential to increasing the credibility of the study (Shenton, 2004). The researcher contacted the participants and shared the study summary, and ethical clearance documents for the study, when approaching the participants. Some participants requested more detailed information. The researcher engaged with documentation and work of the organisations interviewed prior to conducting the interviews. Some of the information given was verified through the documentation. Certain participants offered documentation as additional information or confirmatory information during the interviews. There was a reasonable relationship of trust and cooperation between the researcher and research participants.

Steps taken to enhance credibility of the study are provided in detail in the section on credibility, transferability, dependability, and confirmability of the study. In addition, the study design has incorporated overlapping data-collection techniques to enhance the credibility of the study, enhancing the study's dependability (Shenton, 2004; Nieuwenhuis, 2007). Confirmability relates to the extent to which the results are an objective reflection of the participants' ideas and experiences, rather than the researcher's characteristics and preferences (Shenton, 2004). Triangulation approaches were applied to enhance confirmability in the research.

The feminist worldview of the researcher included being politically motivated to influence change (Brayton, Ollivier and Robbins, 2018). The researcher has worked in the field of women's rights focusing on reproductive justice, and how reproductive medicine is used as a toll to oppress women. The researcher considered contraceptive use a political issue. This research work was therefore politically motivated to influence change (Brayton, Ollivier and Robbins, 2018). The report also details on-going reflective comments.

All methods applied have the potential to provide the most useful information to meet the objectives of the study. However, it is recognised that it is possible for the findings to be interpreted differently, should another theoretical framework be imposed on the results. The next section will present ethical considerations and the application of ethics in this study.

13. ETHICAL CONSIDERATIONS

Ethical considerations of this study are important to meeting the objectives of the study and the feminist values upheld in this study, which include social justice and the perspectives of women (Brayton, Ollivier and Robbins, 2018). Application of ethics in this study adhering to feminist values of social justice, respect for dignity, and worth of all people were applied in this study (McPhail, 2003). Ethical considerations are crucial to the study for credibility purposes (Patton, 1990; Shenton, 2004; Bernard, 2011). The University of KwaZulu-Natal Social Sciences Ethics Committee granted full ethical clearance for the study. The protocol reference number is: **HSS/0550/018D** August 2018. This was to ensure that ethical considerations are provided for in the study. Permission to collect data at the clinics was granted by the Regional Office of the KwaZulu-Natal Department of Health. Full permission was granted upon full ethical clearance of the study. The study was required to be registered in the KwaZulu-Natal's Department of Health Research database before access to the clinics could be granted. Permission of the study reference number is: **NHRD REF: KZ-2018 09-032** dated October 2018. Various

organisations provided gatekeeper letters to allow for study data collection. These included The Commission for Gender Equality, Agenda Feminist Media, and the Department of Health. The Commission for Gender Equality committed to assist the study in reaching out to policy makers and members of parliament.

Participants of the study were required to sign written informed consent to participate in the study (APA, 2010) **(See Appendix 2**). All participants in the study signed the consent forms. Participants who were interviewed telephonically signed and returned an emailed consent form. Participation in the study was voluntary. Consent forms for isiZulu speaking participants were read out to them in English and translated verbally into isiZulu. Participants were given the opportunity of asking for questions to be clarified. Consent to audio record interviews was sought (APA, 2010).

It was explained that participants may opt out of recording. It was communicated that there will be no penalty involved if any of the participants do not consent to the use of audio recording (APA, 2010). Issues of recording were addressed before the interviews. As indicated earlier in this chapter, four of the eleven participants who were users of contraceptives services did not consent to recording and were therefore not recorded. This was in line with the practice of social qualitative research Rutakumwa *et al.* (2019), as detailed above.

Participants were made aware that they will not receive any direct benefits or incentives for participating in the study (APA, 2010). Identities of key informants are kept confidential. The study uses participant codes to identify participants, where it is appropriate. Participant codes are also used to identify all participants. Users of contraceptives are given the code CU. Health workers were coded as CS. Government departments, research institutes, constitutional bodies, parliamentary bodies, United Nations bodies and organisations which participated are identified by their institutions, and in some instances, also their positions in those institutions. The next section of the chapter will discuss limitations of the study.

14. LIMITATIONS OF THIS STUDY

By its very nature, qualitative inquiry and research has limitations. The aim of qualitative analysis is a complete, detailed description of phenomena. As such, social understanding, positionality, linguistic features, amongst others are limitations of qualitative research. Qualitative analysis allows for fine distinctions to be drawn because it is not necessary to compress the data into a finite number of classifications (Atieno and Mulino, 2009). In order

to enhance credibility and contribute to knowledge, this study declared the limitations and challenges in its execution, as prescribed in literature on qualitative research methods (Rutakumwa *et al.*, 2019).

This study has certain limitations. The absence of comparative data on the research topic is one of the limitations of this study. One of the broad disadvantages of qualitative research approaches, such as this study, is that their findings cannot be extended to wider populations with the same degree of certainty (Atieno and Mulino, 2009). The focus of the study was two public health clinics in KwaZulu-Natal. This study focused only on the experiences of women users of contraceptives at selected clinics in KwaZulu-Natal. In feminist and qualitative research, the experiences of these women are sufficiently valid to justify change. The transferability of findings to other women users of contraceptives in other locations may be affected.

However, the researcher provided sufficient information that could be used by other researchers to determine whether the findings apply to their situation. The focus of the policies and other participants, policy makers, researchers, and parliamentarians were national. Participation of civil society in the study was limited. The unavailability or lack of access to international funding agencies for primary data collection is also a limitation of this study.

15. SUMMARY

The chapter demonstrated how research methodology and techniques were applied to meet the objective of broadening the understanding of the political economy of contraceptives in post-apartheid South Africa. The chapter provides the details of application of the methodology to study participants in their diversities. It details how certain decisions and adaptations had to be applied in order to maintain and enhance the trust between the researcher and the participants. Power dynamics in the research process and how these were mitigated were presented in the chapter. The process of data collection, power dynamics collection methodology and the experience are discussed in the chapter. The research experience, lessons learnt, and observations of the researcher are included in the chapter as a way of increasing the body of knowledge in the application of feminist research. This chapter detailed steps and techniques applied to enhance credibility, transferability, dependability, and confirmability of the study. The application of ethical considerations and some of the challenges in the application of these

are presented in this chapter. The next chapters will present findings, as per themes detailed in this methodology chapter.

CHAPTER 4

WOMEN'S RIGHTS OF CHOICE, AUTONOMY, PARTICIPATION IN POLICY, GOVERNANCE AND COMMUNITY HEALTH STRUCTURES

1. INTRODUCTION

This chapter is divided into two sections. The first section discusses the research findings of this study on participation of women users of contraceptives in decision-making on contraceptives choices. The second section of the chapter will discuss findings on participation of women users of contraceptives and broad public policy participation in contraceptives, at a policy, governance, and community level.

The themes for this section include:

TABLE 1: CHAPTER 4 SECTION ONE THEMES AND PERCENTAGES OF RESPONDENTS

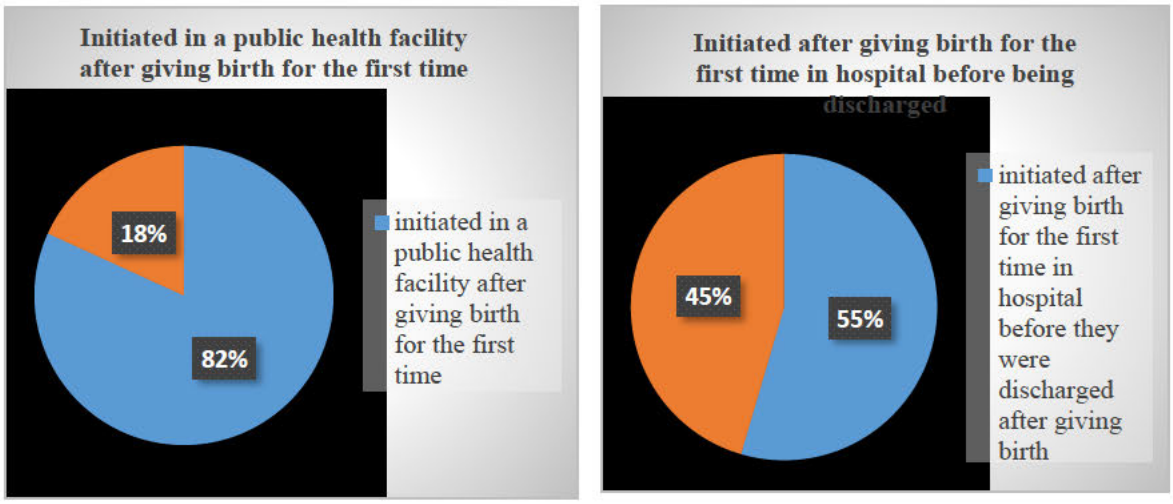
TABLE 1- THEMES FOR CHAPTER 04 (1)

RESEARCH THEMES	PERCENTAGE OF RESPONDENTS
National and international legal and policy frameworks on participation, choice, and autonomy of users of contraceptives services	30%
Women's participation and decisions and the initiation of contraceptives	67%
Side effects, information, communication, and treatment	89%
Linkages with women's health, broadly	70%
Health systems challenges	52%
International discourse and standards on side effects	15%
South Africa regulatory framework on participation in public policy processes	15%

2. WOMEN'S PARTICIPATION AND DECISIONS AND THE INITIATION OF CONTRACEPTIVES

This section presents research results on women's choices and autonomy in starting to use contraceptives, and choosing a method of contraception, in line with the objectives of the study. Nine of the eleven users of contraceptives who participated in the study reported that the public health facility had initiated their use of contraception after the participants' giving birth for the first time. This happened in their teenage years and early twenties. Five of the nine participants reported that contraception was initiated before they were discharged from a hospital after giving birth.

3. GRAPH 5: DETAIL OF INITIATION OF CONTRACEPTIVES IN HOSPITAL AFTER GIVING BIRTH

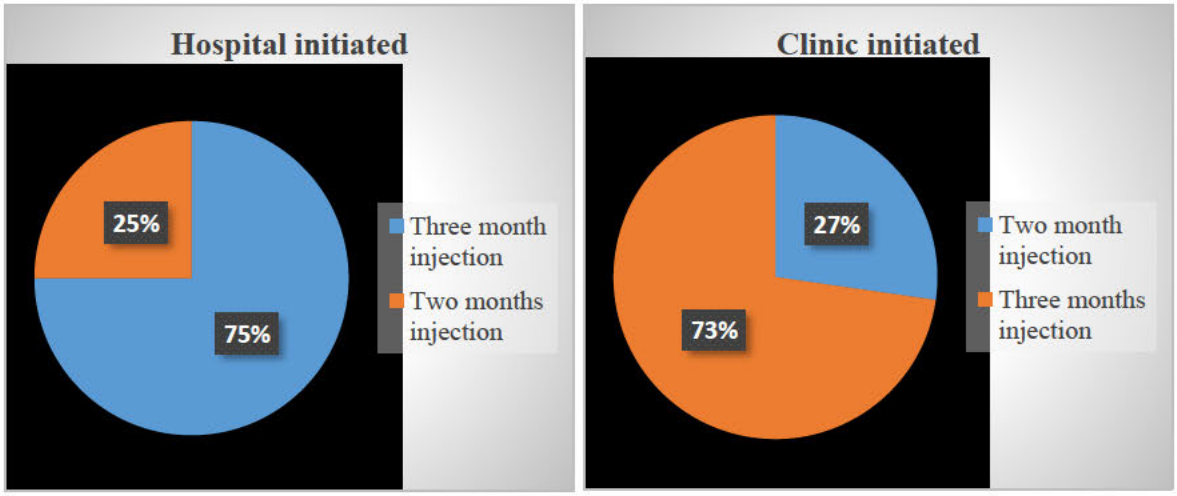


Four participants stated that contraception was initiated by the health care workers when they came back for post-delivery care, infant care, and child immunisation services (Research Participants CU OQC/01, CU HSC/04, CU HSC/05, and CU HSC/06). Two of the participants went to the clinic to request contraceptives after giving birth. The two women were participants from Halley Stott Clinic (Research Participants CU HSC/01 and CU HSC/04). *'I started to take contraception when I started to take my antiretroviral drugs'* (CU HSC/01). *'The hospital referred to the clinic to take my tablets because the clinic is closer to home. I was then given the injection and the white card. I come for my injection once in three months and my medication once in six months. I must come with my white card when I come for my medication. If I forget the white card, I must join the queue for the injection and come back to the queue for the tablets'* CU HSC/04.

The two women reported that they had been initiated into the use of contraceptives when they started to take chronic medication. The observation of this study is that initiation into the use of contraceptives is packaged and targeted at women as part of post-delivery, maternal, and infant care services. It was also observed that initiation into the use of contraceptives was linked to chronic care services. In public health care facilities, contraceptives were mainly provider-initiated, although some women in the study sought contraceptives services of their own accord.

It is clear that post-delivery women and those women who came back to the clinic for check-ups or immunisation of their infants were targeted for contraceptives services. In both clinics, women reported that they were required to bring their contraceptive record card along when they brought their infants for early post-birth follow-up monitoring and immunisation. They had to present the cards to the health care workers so that they could ensure that their contraceptive uptake records were up to date.

2.1. GRAPH 6: (TWO-MONTHLY, THREE-MONTHLY INJECTIONS, AND HOSPITAL AND CLINIC INITIATED CONTRACEPTIVE USE)



The study had the objective of understanding how and under which circumstances Depo Provera was provided to women; and whether other options were presented to the women. Three of the eleven women were given the contraceptive Noristerat, the two-monthly injection, to initiate contraception (CU OQC/05, CU HSC/04 and CU HSC/05).

Nine women received Depo Provera, the three-monthly injection. At the time of the study, however, all women were using Depo Provera because of stock shortages of Noristerat.

The three women who were taking the two-monthly injection received this at a clinic, not in the hospital. '*I was using the three months injection. I started the injection after giving birth in the hospital. I was taken off this injection because I developed severe high blood pressure. I was switched to the Noristerat injection at the clinic. I am now taking the three months injection again because the clinic does not have the two months injection. I do not want to fall pregnant again*' (CU OQC/05). The observation from the experiences of these women is that hospitals were more likely than clinics to initiate the use of Depo Provera. As it can be seen from this woman's experience shortages of the two months injection is limiting women's choices, even if health risks are acknowledged.

Women who participated in the study reported that they were not given the opportunity to choose whether or not to take the injection. Some of the women mentioned that they had trust in the health care workers. However, the women would have appreciated being given more information about what health care workers had chosen for them. Looking back, they would have liked to know more about the underlying reasons for the health care workers' choice and have been given more information about the injection. *'I would have appreciated more information on the injection … how it works, that thing … Ehhh… I was going to take the injection even if the information they told me about it was not good information, I was going to ask them to explain'* (Research Participant CU OSQ/02). The participants would have appreciated learning or being told about other options before they started using contraceptives. All women who participated reported that they did not ask health care providers about additional and alternative methods to what they had been offered when they started using contraceptives. Women reported that they had also not asked the health care workers to share more information about the contraceptive they were given. All women who were given contraceptives after birth shared that they thought taking the injection was part of routine post-delivery care. They were informed that they had to take the contraception injection before they were discharged from hospital. Some women felt forced to take the injection at one hospital. '*The sister came to the ward with a trolley and informed us, all women in the ward that it was now time to take the injection. 'We are providing family planning injection, no one is going home without taking the injection; we don't want to see you here next year to give birth'* (Research Participant, CU OSQ/02).

In this instance the women were forced into taking Depo Provera. Klugman (1990) found that women were being forced to take Depo Provera post-delivery in public hospitals (Klugman, 1990). This study makes a similar finding almost three decades later.

Experiences of women confirmed that this has been practiced over a long time. Experiences of participants in this study who were initiated into contraceptives use had the same experiences as women in the late nineties and early 2000s (Brown, 1987; Klugman, 1990; Kaufman, 2000). This study found that women who participated had similar experiences of being offered contraceptives as part of mandatory post-delivery care following pregnancies (Research Participant CUOSQ/02). Fifty-five per cent (55%) of study participants who were users of contraceptives reported that this had happened in public hospitals. These experiences of women who participated in the current study resonate with evidence of women's experiences in apartheid South Africa, where, in some instances, women were coerced into taking DP in order to access social services and grants (Rakusen, 1981), as well as health care for their children (Moultrie, 2005). In this study there was no evidence of threats of denial to access social grants should DP be refused. There was also no evidence of threats of denial of access to care for the infants and children. However, women felt obliged to comply with the staff-initiated contraceptive service.

Women perceived contraceptives as being part of the package of infant care (Research Participant CU OSQ/02, CU HSC/03, and CU HSC/04). '*I take my injection when I come for my child's immunisation or when my child is sick. I have both cards'* (Research Participant CU OSQ/02. Participant CU HSC/03 and/04) reported the same experience. The perception that DP was part of the maternal care package inevitably contributed to women thinking that refusing DP would be refusing part of their care, and that such might have implications for their continued care and the child's care. Women understood that they were given the injection to prevent numerous pregnancies. All women in the study reported that they valued contraceptives at different points of their lives. A young woman user of contraception who participated in the study reported that her contraceptive card is checked for whether it is up to date when she goes for immunisation of the child *'I was in that queue because the nurse must check that my injection card is signed. If you bring a baby at the clinic you must show your injection card before you go to weigh your baby'* (CU HSC/05). Presenting contraceptive cards when coming for children's immunisation could be interpreted as being a mandatory part of the child care package. The same may be said about women who were given contraceptives when they started chronic treatment.

The linking of contraceptives to care, without giving women a choice, and integrating these choices into other services as in this instance, can be construed as silencing women's voices

and coercion, owing to the manner in which contraception was initiated. This is also the case of women who needed chronic medication. These observations called for a closer look at how women's choices and autonomy of their reproductive health may be compromised in the integration of contraceptives services into other health care services.

3. INFORMATION PROVIDED FOR WOMEN ON DEPO PROVERA

The study assessed access to information and information given to women on Depo Provera, and other contraceptives as part of initiation. Provision of information is a criterion for informed consent and facilitating women to make informed choices. The study found that not all women were given sufficient information about Depo Provera prior to them being initiated onto the injection. The women reported that the nurses told them that there is a "two-monthly and a three-monthly" injection. Women reported that they preferred the three-monthly injection because this was perceived to be more convenient and requires less time spent on coming to the clinic. The two-monthly injection would require more frequent visits to the clinic. The women reported that they were not given information about the injection beyond the two types of injection. This reflects consistency of practices of staff-initiated use of the Depo shot, as reflected in the work of Burgard (2004) and Kaufman (2000). Both these authors attributed the high uptake of Depo Provera to the possibility that Black women were not offered alternate forms of contraception (Burgard, 2004; Kaufman, 2000). The study found that Depo Provera was mostly offered as a first contraceptive option to women, with other options being discouraged or withheld.

Health care workers used their own discretion in deciding that the three-monthly injection was the best option, based on their own assumptions about time constraints of the users. This is in line with the study by Dehlendorf *et al.* (2013) who found that health workers could express a specific preference or suggestion, which influenced the women's choice of contraception (Dehlendorf *et al*., 2013). *'To have Depo is neither here or there, it is worse to have a tubal litigation, Depo is reversible, not that it should have been done, it should have been known. ….We found it to be worse in the violation of human rights to give someone a tubal ligation without the consent or explanation of why you are having a tubal ligation, that is almost a none reversible outcome as oppose to Depo. Someone can argue that I was not aware, someone can say I told you.*

*The worse one of the two is the tubal ligation without consent (*Research Participant KI, 11). Women's choice or trust in what the health worker says might also be influenced by power relations between health care workers and the service users (Fonn and Xaba, 2011).

Power imbalances are in part influenced by the hierarchal nature of the health system, and the fact that health care workers did not receive any training in this regard. Health care workers who participated in the Fonn and Xaba, 2001 study reported that they were not trained in the social contexts of patients, nor on gender. As such, they were not prepared to be cognisant of or to include those issues in their interactions with patients. Health care workers are trained to inform and provide care to patients, with no expectation that the patients will have a say or a view on the matters. Their very training has discouraged questioning; and, as such, they are intolerant of patients who ask them questions (Fonn and Xaba, 2001).

Some women in the same study trusted the providers' choice as they felt that it was based on the higher levels of knowledge of the health care workers (Dehlendorf et al., 2010). Some of the women felt that the relative convenience of the 'three-monthly injection' was emphasized to pressurize them to choose that option. Women in the Dehlendorf *et al.* (2013) study reported that they would have preferred providers to share their knowledge of contraceptives, and only express their opinions and preferences about which one the women should choose if the women users solicited such assistance or guidance (Dehlendorf *et al.* 2013). All eleven (100%) women users who participated in the study reported that they were not given any written information on contraceptives in the form of leaflets. '*Written information? No, I have never been given. I do not know about other clinics. The nurses tell you about the injection'* (Research Participant CU HSC/03). It is usual for information on medication to be available in the form of flyers. There was, however, no information available or accessible to women patients on contraceptives on clinic walls and notice boards in either clinic. Providing women with information is part of the consenting process. The criteria for informed choice, as stipulated in the national and international policy framework detailed above (National Department of Health, 2012 was therefore not met.

4. THE USE OF DEPO PROVERA IN SOUTH AFRICA

Depo Provera is a widely used method of contraception in South Africa. Notwithstanding the limitations and concerns in giving of information and full consent, the women chose Depo Provera, the three-monthly injection, as a method of contraception.

The choices of women were informed by fact that Depo Provera is commonly used, well marketed and available. One of the study participants from a research institute stated that "*Depo Provera was well marketed in South Africa, as such most women and health care workers know it. It is widely accepted, as such it becomes a default choice for providers and users"* (Research Participant, KI 05). The participant indicated that the nurses dispensed Depo Provera because it is convenient for them to do so, and that Depo Provera is more available in clinics compared to other methods. *'Depo is just an injection, it saves them time, the nurses have to cope with large numbers of patients each day'* (Research Participant KI 01).

The study found that Depo Provera was marketed as a more convenient option over the two-monthly injection. None of the study participants had been offered any other form of contraception, such as the pill, the loop, natural contraception, patches, or morning-after pill. This suggests that the injection is a more widely available and preferred method of staff-initiated contraception. The predominant use of Depo Provera is obscured by statistics on contraceptives. For example, the Department of Social Development (2018) reported that Depo Provera is the second-most used contraceptive method in South Africa**.** The most widely used contraception method, according to the report, is the male condom. The use of Depo Provera was recorded at 26% in 2015-2016. This was slightly lower than what was recorded in previous years (Statistics South Africa, 2017). This decrease could be attributed to the newly introduced sub-dermal implants, which contributed 7.6% in 2014-2015 and 3.6% in 2015-2016 to contraceptives statistics (Statistics South Africa, 2017). Implants are accounted for as hormonal contraceptives. These are inserted into women's bodies at the clinic or hospitals. This contraceptive was introduced into South Africa in 2014-2015. It is popularly known as a sub-dermal implant (DHS, 2016). In 2016 the implants accounted for 7% of contraceptive use in South Africa (DHS, 2016). Norplant has the same progestin chemical component as Depo Provera, the only difference being that Norplant is implanted under the skin, while Depo Provera is injected (UN Population Publications, 2010). Norplant class and individual litigations have been seen in the United States, Canada, and the United Kingdom.

In the United Kingdom over 400 women lodged legal claims against Norplant manufacturers. Norplant was withdrawn from the market in the United States of America and the United Kingdom in 2002, and 1999, respectively. The drug had been used for six years only in the United Kingdom (The Rebecca Project for Justice, 2014).

The Rebecca Project for Justice (2014) is concerned that the implant is now being used in developing countries. "*Despite the fact that Norplant is no longer saleable in the United States, the World Health Organization and family-planning activists, including the Gates Foundation, openly promote a modified version of the drug in the developing world"* (The Rebecca Project for Justice, 2014). The Rebecca Project for Justice says it has been unable to find a single record of settlement to any African woman. They go further to state that African women deserve the same redress and compensation as harmed American and British women.

Male condoms account for highest numbers of contraceptives distributed. Whilst condoms may serve as a contraceptive, they are primarily for prevention of HIV/AIDS and sexually transmitted infections. The Department of Health accounts for condoms under HIV-prevention programmes. Male condoms are also included as part of the contraceptive statistics because females are used as a proxy to gather statistics on contraceptive use. *"Indicators for the use of contraceptives in years is based on female 'target population 15-49 years' where females are used as a proxy for couple"* (Mureithi, 2016). Men use male condoms. The role of women regarding the use male condoms is that of negotiating for its use. If women are proxies for data collection on use, it is therefore illogical that male condoms will be counted as being used by the women.

5. SIDE EFFECTS OF DEPO PROVERA

The political and legal history and the nature of side effects is important in broadening the understanding of the political economy of side effects. Depo Provera has a long political history owing to its regulation based on side effects, dating back to its registration in the 1970s. Owing to the limited preliminary research that DP was subjected to before being released, there have been numerous claims that injectable contraceptives are associated with various side effects. These side effects include increased vulnerability to cervical cancer (Powell and Seymour, 1971). This was one of the side effects listed by Pfizer, the company who manufactures Depo Provera, in 2010 (Pfizer, 2010). Pfizer states that: *'A statistically non-significant increase in RR estimates of invasive squamous-cell cervical cancer has been associated with the use of Depo Provera CI in women who were first exposed before the age of 35 years'* (Pfizer, 2010). Li *et al*. (2012) discovered that Depo Provera usage led to a 2.2-fold increased risk of breast cancer in the population of women 20 to 44 years of age (Li *et al*. 2012).

One of the objectives of the study was to consider how Depo Provera is mainstreamed in other women's health issues, and how side effects were provided for. Depo Provera is designed to regulate fertility, expression of sexual and reproductive rights. One of the side effects of Depo Provera might take away the very rights they are supposed to promote. Reduced fertility, and delays in returning to fertility are side effects noted in the 1970s (Rosenfield et al., 1978), and persisting in 2010 (Pfizer, 2010). Liver tumours (Nissen, Kent, and Nissen, 1976), excessive menstrual bleeding, weight gain, and depression (Rakusen, 1981) were also noted; Pfizer discloses the same side effects in 2010. Other serious side effects with mandated patient counselling and information are bleeding irregularities, weight gain, ectopic pregnancy, delayed return to fertility, and lack of return to fertility. Blood clots in arms, legs, lungs were noted, as were strokes. Saxena, Shrimanker, and Grudzinskas (1977) suggested that children who are exposed to DP through breast milk may experience later health complications (Saxena, Shrimanker, and Grudzinskas, 1977). Pfizer confirms that detectable amounts of DP have been identified in the breast milk of women receiving Depo Provera (Pfizer, 2010).

A recent study by the University of Cape Town's Centre for Lung Infection and Immunity Tomasicchio, *et al.* (2019), revealed that Depo Provera could heighten the risk of tuberculosis in women who use it. Depo Provera also has an unintended consequence of significantly increasing a woman's susceptibility to HIV/AIDS and all other sexually transmitted diseases (STDs): the high dose of progesterone in Depo Provera induces thinning of the vaginal epithelium (Heffron, 2012).

5.1 DEPO PROVERA BLACK BOX WARNING

In 2004, the Food and Drug Administration (the FDA) issued a Black Box warning for Depo Provera in light of the confirmation that the contraceptive injection leads to serious side effects. The 2004 Black Box was revised in 2010. A Black-Box warning is an obligatory warning, notifying patients of the significant risk of serious and life-threatening side effects or adverse effects that a drug may have. According to FDA regulations, once the drug is classified at this level all birth control corporations, providers, agents, health care workers and pharmacists are obligated to counsel women on the likelihood of harm (Pharmacia and Upjohn Company 2004; Pfizer 2010). This obligation extends to all agencies directly promoting and distributing and Depo Provera.

Women may lose significant bone mineral density that is not fully reversible; therefore, Depo Provera should not be used as a birth control method for more than two years. Women may

lose significant bone mineral density that is not fully reversible; therefore, Depo Provera should not be used as a birth control method for more than two years.

5.2 THE POSITION OF SIDE EFFECTS OF DEPO PROVERA, GLOBALLY

Depo Provera is registered as medicine in South Africa in the South African Medical Control Council database of approved drugs. Depo Provera is included as one of the essential medicines and in various Standard Treatment Guidelines (National Department of Health, 2018). The regulatory framework does not highlight the side effects issues stated above. The Black Box warning is not included in any South African policies. The Black Box is not one of the questions, which was posed to health care workers who participated in the study, or to women users. Clinic staff and women users of contraceptives did not report receiving any training or information on the Black Box warning. It is a reasonable expectation that the health care workers would mention this issue, given that it is a topical issue, and a recent acknowledgement in Depo Provera side effects. According to the Rebecca Project for Justice (2014), the WHO has not included these side effects in any of their guidelines, neither have they publicised them. It would have been proper to do so, given that a regulating body, the FDA in the county producing Depo Provera, had published such. Depo Provera was temporarily deregistered in the United States (US), and in many European countries during the 1970s to 1980. Although the drug was deregistered for use in the US, it was registered for use in developing countries, including African countries. In these developing countries, DP was predominantly prescribed to Black women, and women from lower socio-economic strata (Goldman, 1985; Rakusen, 1981). To avoid the US regulation that stipulated that a drug which was deregistered in the US could not be exported to other countries, the pharmaceutical company producing DP began to manufacture the drug in Belgium and Canada, where the drug had not yet been deregistered. During this period, DP remained registered as a contraceptive in the developing world, without any concerns or discussions on its deregistration status in the United States (Goldman, 1985; Rakusen, 1981). Depo Provera was later re-registered in the United States and countries in Europe, including the United Kingdom. It was registered for limited use, of no more than two years under special circumstances in both countries, including as an interim contraception used when the male partner has is recovering from a vasectomy (Goldman, 1985). The list of side effects of Depo Provera has remained the same for decades. This suggests that not much work has been done to improve the drug. It would also appear that the scientific community has had less appetite to present other, safer contraceptive options for women. Furthermore, this suggests

that the women's rights and the feminists are yet to win the struggle against Depo Provera. It is a struggle that has proceeded for decades but has not yet been resolved. It continues to affect women's bodies, in particular, indigent urban women in sub-Saharan Africa and Asia.

5.3 THE POSITION OF SIDE EFFECTS OF DEPO PROVERA IN SOUTH AFRICA

This section discusses South Africa's ideological and regulatory position of side effects in South Africa. It is important to consider how South Africa is communication side effects and how treatment of side effects is provided for in the health system and resourcing. It is important to understand the regulatory framework of Depo Provera in defining its position in South Africa. Understanding the regulatory framework enabled the study to identify some of the differences in regulation standard of developing countries like South Africa and developed countries. The South African regulatory framework treats and provides for side effects in its regulatory mandate in order to assess alignment with the transformation project. The regulations must be considered in line with human rights and gender rights advocated for by the post-apartheid South African project. Depo Provera is registered for use in South Africa and listed on The Standard Treatment Guidelines and Essential Medicines list for South Africa 2018 (National Department of Health, 2018). It is also endorsed by the International Federation of Gynaecologists and Obstetrics (FIGO). This is over and above endorsements by international bodies such as the WHO (2014) and UNFPA (2017).

Side effects of Depo Provera, however, have long been a concern for South African women. Side effects of Depo Provera were a concern of South African women pre-1994 and during the negotiations for the democratic dispensation and women's right to health. The Member of Parliament serving in the Portfolio Committee on Women in the Presidency indicated that the ANC Women's League was very concerned about Depo Provera in the early nineties. '*Our main concerns were that women were forced to take Depo Provera and that women were not informed of the side effects'* (Research Participant, KI 03). Side effects detailed above are both short-term and long-term. Most side effects impact on the bodies, lives, and rights of women in the long term. This highlights the need for a holistic approach to women's health, with contraceptives considered part of women's holistic health, keeping women safe, and considering all other health rights and needs in the lifespan of women. What is intended for one part, in this case contraceptives, has an impact in all aspects of female health. Women's bodies cannot be divided into parts. A comprehensive approach must be taken to women's

health. It can be observed that there is consensus on the dangers of Depo Provera because of extensive side effects. Pfizer, the manufacturer, acknowledges these, and communicates such.

It is a concern that DP continues to be dispensed to women, given all this knowledge about its dangers. The regulators issue warnings, but not ways to improve the drug, or completely remove it from the medical lists. Questions about who has the responsibility to protect women in this regard ought to be asked. Clarity has to be sought about whether this is the responsibility of the pharmaceutical industry, the drug regulators, international governance, or national governments. It was observed that other organisations, such as the International Planned Parenthood Federation (IPPF) communicate only a few side effects, mainly weight, excessive bleeding, and nausea (The Rebecca Project for Justice, 2014). Other side effects, such as cancers, bone density concerns, depression and diabetes, amongst others, are not communicated. The communication also does not indicate long-term effects. As indicated, this study found that clinic staff only communicated weight gain and irregular bleeding as side effects. Long-term side effects were not communicated.

5.4 DEPO PROVERA AND YOUNG WOMEN

Some of the side effects of Depo Provera detailed above have specific resonances for young women (Pfizer, 2010; Li *et al*., 2012). Young women are associated with reproduction, being the predominant group in the reproductive age bracket. Furthermore, young women are one of target populations for the contraceptives, as per the Department of Health's Contraceptives and Fertility Planning Service Delivery Policy Guidelines 2012 and 2018 policy. As alluded to earlier in this report, reports have suggested that young women are being targeted for Depo Provera (SABC News, 2018). One of the research participants confirmed this: "*They are giving Depo to school children, I thought that it should only be given to women of a certain age, not youths and children"* (Research Participant, KI 07). This study made a similar finding to that effect, that young women under the age of thirty who participated in the study were using Depo Provera (CU OQC/03 aged 22; CU OQC/05 aged 28; CU HSC/01 aged 25; CU HSC/04 aged 29; CU HSC/05 aged 22; CU OQC/05 aged 28). '*Yes, I have always known that …for the young women to receive Depo, generally speaking because of the reversibility of…it is much better, look at everything you either eat or drink or inject with has some side effects, there we are seeing more side effects of no Depo, all that combined it has never been that you have the side effects outweighing the benefits of a family planning programme like that"* (Research Participant KI 11).One of the members of Parliament who participated in this study acknowledges concerns in prescribing Depo Provera to young women. Stock-outs of other

forms of contraceptives in some health care centres have contributed to the almost exclusive use of DP.

5.5 INFORMATION AND COMMUNICATING SIDE EFFECTS TO WOMEN USERS OF CONTRACEPTIVES

Providing information on side effects ensures women's autonomy and informed choices in contraceptives. Gready *et al.* (1997) reported that women were not given information on side effects and other problems associated with Depo Provera in apartheid South Africa (Gready *et al.*, 1997). Smith (1978) wrote that health care workers perceived some women as unable to comprehend medical information and to make decisions regarding contraception, owing their 'limited' comprehension capabilities (Smith, 1978). Fonn and Xaba (2001) discovered in their research that health care workers admitted that they treated women differently according to their educational level, that they felt that providing explanations to less educated women was not a good use of time as "they just can't understand" (Fonn and Xaba, 2001). Moyle (1978) reported that in health care settings doctors and nurses seldom explained the side effects to patients considering DP, as these health care workers felt that their patients would not understand these side effects. Similarly, Savage (1978) suggested that, on occasions where consent for the administration of DP to the patient was obtained, consent was not informed, as these women were not provided with information on the drug's side effects in a comprehensible manner (Savage, 1978).

The study found that health workers communicate the side effects to some patients but not to others (Research Participants CS 01, CS 03, and CS 04). Not all side effects were communicated. For example, only bleeding was reported to have been communicated, and it was not communicated in detail. Women were told to come back to the clinic should they experience bleeding, without being told why they might experience bleeding. Some of the women who participated in the current study reported that they were not told about side effects of Depo Provera when they first started to take the injection. Some women were only told that they should come back to the clinic should they experience bleeding. This was communication of one of the side effects, albeit not presented as such. Women had also realised that changes observed in their bodies were associated with Depo Provera. Some of the women became aware of the effects of the injection when they noticed irregular and sometimes excessive bleeding (Research Participants CU OQC/01; CU OQC/02, CU HSC/04, and CU HSC/06). Weight gain was also one of the problems women noticed and reported to the clinics.

The sharing of information amongst women outside the health system and media contributed to their awareness of side effects (Research Participant CU HSC/05). The most popularly known side effect of Depo is excessive and prolonged bleeding. The women study participants and the health care workers communicated this side effect. Weight gain was also one of the side effects spoken about.

"You might bleed more or worse with Depo, but this is what we have now, it has been actually happening with that injectable, we tell them that they might experience more bleeding or more this and that, dizziness, this is what we give you but there has never been any litigation," (Research Participant, KI 11). Although bleeding and weight gain were communicated to some of the women, and women were aware of such, there was no information about why Depo induced these health problems (CU OQC/02). Health care workers had not communicated the mechanics of the side effects. This was the case even when women came back to the clinic with bleeding complaints. Women reported that they were given treatment for the side effects when they reported to the clinic (Research Participants CU OQC/01; CU OQC/02; CU HSC/04, and CU HSC/06). A conversation about this would have presented the opportunity for women to understand how Depo Provera works in the body, and how bodies may respond to it (CU OQC/01). This would have increased health literacy of women. There was no written information about these side effects presented to the women. Health care workers could also not give copies of this information to the researcher, because this information was not available. Women reported that they value contraceptives, and they would have still continued to use them when they needed them, despite the side effects and problems, but would have preferred to have been given more information and time to decide. '*I would have appreciated more information on the injection…you know, how it works, that thing…Ehhh…I was going to take the injection even if the information they told me about it was not good information, I was going to ask them to explain"* (Research Participant, CU OSQ/02).

Despite the long list of side effects, only these two concerns had been communicated. Women do not get to see the leaflet insert issued by the manufacturer in the injection pack. This is partly because the injection is opened and administered in the clinic; as such, the health care provider will be opening the box. Furthermore, the insert has to be translated into a format and language that women would understand.

Communicating such would meet the criteria for consent, assisting women to make informed choices and to weigh their health needs against the need for controlling reproduction. A health

worker in one of the clinics also did not know about the cancer risks, which may be associated with Depo Provera. This suggests that health care workers are also not given holistic information on the side effects. Lack of information material for women suggests that this is not provided for in budgets and plans of contraceptive programmes. It also suggests that there is no monitoring of how side effects are communicated at the clinic.

Further, it suggests that the participation and the rights of women to informed consent is advocated for in the policy and laws but not in practise. Health workers confirmed that they screen women for high blood pressure and diabetes when they initiate women on contraceptives. Regular screening is provided for as the need arises. These results assist them to decide whether DP is appropriate. Health care workers confirmed that they are not always able to screen the women because of time constraints, and that sometimes there will be only one or two options for contraception; therefore, they would use their discretion to provide one of these. Two of the eleven women who participated in the study had been screened for cervical cancer (pap smears). The two women had pap smears because they had other health issues; they were not screened as part of contraceptive care. One of the research participants asked the researcher to explain what the Pap smear was, and why screening was important. The woman stated she would request to be referred for a pap smear when she consulted the nurse for her injection.

5.6 TREATMENT OF SIDE EFFECTS

The study sought to understand how side effects are provided for and treated, as a way of enhancing women's health, and mitigating the effects of Depo Provera in women's bodies and lives. Health care workers stated that they treat common side effects such as bleeding in the clinic by dispensing tablets (Research Participant CS 01). If the tablet did not stop the bleeding, they changed the women to another method, as per the protocols and guidelines. Health care workers reported that some women did not come back to the facility after reporting bleeding, so they were not able to follow up. The choice and change of method were informed by the age of the woman and the availability of alternative methods (Research Participant CS 01). Clinic staff reported that they were aware of weight gain as a major concern of women: 'We have a formula to measure excessive weight gain in women who use Depo Provera. If women present with more weight they are provided with counselling. '*We counsel them on good diet and exercise, but they don't listen"* (Research Participant CS 04). Health care workers shared their challenges and what they would like to see improved. They would like to have more nurses

dedicated to contraceptives (Research Participants CS 01, CS 02 and CS 04). At one clinic, contraceptives were allocated in a dedicated room and waiting area. There are no queues in this space. It is only dedicated to family planning. Women who come for contraceptives do not have to join long clinic queues; there are nurses dedicated to dispensing contraceptives. In both clinics there are rooms dedicated to young people between twelve- and twenty-four to access contraceptives and sexual health services. In both clinics the rooms are clearly marked. In both clinics the rooms are serviced and staffed by MatCH health workers. The rural clinic family planning is integrated into child immunisation services but are provided in a dedicated room. Family planning services have also been moved to the maternity section of the clinic, in order to allow efficient multitasking roles of the nurses (Research Participant SC 02). Health workers in the rural clinic reported that there should be dedicated family planning nurses. Two of the nurses who participated in the study put this recommendation forward because family planning nurses also have to assist with child immunisation and maternity care (Research Participants CS 03 and CS 04).

The listed side effects are both short-term and long-term, and they may affect women both now and later in life. The side effects go beyond maternal and reproductive health, to the broad spectrum of women's health, hormonal health, weight, mental health, reproductive health, and cancers. The side effects may impact not only health, but also the self-esteem of women, as it may affect their body image. Bodley-Smit (2003) reported that side effects affecting women on Depo Provera in South Africa are not systematically recorded and reported on in South Africa; as such, the extent of the problem is not known (Bodley-Smit, 2003). Clinic staff reported that there is no system to monitor, prevent, or treat specific side effects related to Depo Provera (Research Participants CS 01 and CS 02).

In monitoring and mitigating side effects, Pfizer recommends, amongst other measures, that Depo Provera should not be used as a long-term birth control method (i.e., no longer than 2 years), unless other birth-control methods are considered inadequate (Pfizer, 2010). This recommendation is in line with provisions of re-registration of Depo Provera in the USA and the United Kingdom (Goldman, 1985).

One of the recommendations is that other birth-control methods should be considered in the risk/benefit analysis on the use of Depo Provera. This is not provided for in South Africa. None of the Department of Health policies consulted for this research, including the clinical

guidelines and the essential medicines list, make any mention of limiting the use of Depo Provera to a maximum of two years. Women on DP who participated in the study had used Depo Provera for more than two years, some women for more than a decade. The Pfizer guideline on monitoring recommends screening women so that those who have a history or family history of some of the listed effects may be identified. It is not clear how this screening can be provided for in the context of public health care systems with limited resources. General women's health, the very diseases DP can contribute to, are not provided for in the budgets. Pfizer recommends that a woman who is taking hormonal contraceptives should have a yearly visit with her health care provider for a blood pressure check, and for other indicated health care services. Women who participated in the study reported that they were not screened at regular intervals. *'No, we do not do pap smears here. I have never been informed or offered one. We receive treatment for bleeding and other problems when we come to the clinic with a complaint'* Research Participant CU OCQ/C5). Women users of contraceptives who participated in the study mentioned that there was no screening for risks of some of the side effects administered when they were initiated into contraceptives. This research participant requested a pap smear immediately after the interview. Clinic staff booked an appointment for her to do the Pap smear.

6. HIV/AIDS AND DEPO PROVERA

The linkages of increased vulnerability to HIV infection in women who use Depo Provera in developing countries is one of the current topical issues. The relevance of this is in the study is the progressive negative effect of Depo Provera on women, and the persistent reluctance to remove Depo Provera and explore other contraceptive alternatives for women. It has been known for decades that there could be a link between Depo Provera and increased vulnerability to HIV infection. In 2012 a retrospective data-analysis study by Heffron (2012) identified this potential increased of risk HIV vulnerability for women who use Depo Provera; and a potentially heightened risk for the women to transmit HIV to their partners (Heffron, 2011). A University of Cape Town meta-analysis of clinical observational data suggested that Depo Provera may increase women's chances of contracting HIV by up to 40%.

This is because the injection contains the synthetic hormone depo-medroxyprogesterone acetate (DMPA), which acts as an immunosuppressant (Tomasicchio *et al.*, 2019). Some of the recommendations of the Heffron study were that "women should be counselled about potentially increased risk of HIV-1 acquisition and transmission with hormonal contraception

and that nonhormonal or low-dose hormonal contraceptive methods should be considered for women with or at risk for HIV" (Heffron 2012). Brind *et al.* (2015) in collaboration with the Population Research Institute, found that the associated risk of acquiring HIV with DMPA usage was significantly higher than for women who did not use DMPA-based injectable contraceptives (Brind *et al.*, 2015).

The findings of Ralph *et al.* (2015), published in The *Lancet Infectious Diseases*, confirmed this risk and Morrison *et al.* (2015), in *PLoS Medicine*, found similar results. All three meta-analyses studies reported that in their analysis the risk of acquiring HIV for women who use Depo Provera could be between 40-50% higher than the comparison group (Ralph *et al*., 2015). This potential risk was identified to some degree in other hormonal methods of contraception. As the HIV epidemic spread, it became important to explore risk factors for HIV, including whether there was an association between use of specific contraceptives and HIV acquisition. There is evidence from observational studies that use of progestogen-only injectable methods, particularly, are associated with an increased risk of acquiring HIV infection. However, uncertainty remains on whether DMPA use actually causes increased risk.

6.1 THE EVIDENCE FOR CONTRACEPTIVE OPTIONS AND HIV OUTCOMES (ECHO)

A multi-partner, multinational study (Kenya, South Africa, Swaziland, and Zambia) was then conceptualised to confirm whether hormonal contraceptives do increase the risk of HIV acquisition in women. In total, 7829 women from these four countries participated in this study (WHO *et al.*, 2019). The study focused on three highly effective contraceptives, Depo Provera, implants, and vaginal rings (WHO, UNAIDS, UNFPA, and Human Reproduction Programme 2019).

The Human Reproduction Programme is a research partnership between UNDP, UNFPA, UNICEF (the United Nations Fund for Children), the WHO, and the World Bank. The study is called the Evidence for Contraceptive Options and HIV Outcomes (ECHO).

WRHI led this multi-country research study. The WHO responded to this potential crisis by developing guidelines on HIV/AIDS and Depo Provera. The guidelines are known as 'A technical Guidance on Contraception and HIV Technical Statement' (WHO, 2012). This guideline was updated in 2015 (the 2015 Medical Eligibility Criteria for Contraceptive Use); and in 2017, (the fifth Edition of Hormonal contraceptive eligibility for women at high risk of HIV). The guidelines acknowledge the potential risk, calling for further research. The

guidelines stated that women who use Depo Provera or who were initiated on Depo Provera should be informed of the potential risk as part of their informed consent. The guidelines state that women who use DP should be counselled to use condoms as well, for 'dual protection' (WHO, 2012). The guideline is presented in an 'Information Box' in the Department of Health's 2012 policy (Department of Health, 2012). It is copied and pasted in a box on the policy. The guideline is, however, not mainstreamed or discussed in the whole policy document. There are no clear guidelines about how information should be communicated to the women, and how compliance with the guidelines will be measured. Health workers in the clinics sampled for this study did not know about these guidelines. One of the health care workers interviewed indicated that she was not aware of the potential link between Depo Provera and potential increased vulnerability to HIV infection. *"HIV/AIDS and DMPA…Where is that information?"* (Research Participant CS 01).

Another health care worker in the same clinic stated: "*We were not trained on that, what we do know and see is that women who are on DMPA become HIV positive because they do not use condoms. We counsel them on using condoms, but they do not use condom, so they are infected" (*Research Participant CS 02*)*. Health care workers reported that they initiate recently tested and HIV-positive patients who come for ARVs for family planning. "*We provide family planning to HIV patient…. the HIV clinic refers the women to family planning after counselling them about contraceptives"* (Research Participant CS 01). Neither did women users know about this potential link. None of the women had been told about HIV in the context of contraceptives. The WHO guidelines recommend that all users of Depo Provera should be informed of the potential risks of DP in relation to HIV, being counselled to use condoms. Pfizer warns that patients with sexually transmitted diseases should be counselled that Depo Provera does not protect against HIV infection (AIDS) and other sexually transmitted diseases (Pfizer, 2010).

The results of the ECHO study were released in June 2019. The study did not find a significant difference in risk of HIV infection among women using one of the three methods. WHO *et al.* (2019) list the three methods as:

(i). DMPA-IM, a three-monthly, progestogen-only, reversible injectable contraceptive (ii). Levonorgestrel implant, a progestogen-only implant inserted under the skin in the upper arm that can be used for up to five years and (iii). A copper-releasing IUD, a device inserted into the uterus that can be used for up to 10-12 years (WHO *et al.*, 2019). The study found that the

incidence of HIV infections among the participants using different methods of hormonal contraceptives were higher (WHO *et al.*, 2019).

The incidence was the highest in the group of women using medroxyprogesterone, followed by woman using the copper IUD, and women using the implant. As can be observed, the study was measuring the risk amongst the three hormonal contraceptives, rather than whether they pose a risk (Sathyamala, 2019). The study did not respond to the question at hand, but rather made a comparison with other hormonal contraceptives (Sathyamala, 2019). The public perception and understanding are that the study was seeking to assess the risk. The scientific community in South Africa and other countries have registered their concerns with the study on different grounds. Publishing in the Biomedical Journal an article entitled '*Rapid response to: Depo contraception and HIV: an exercise in obfuscation'* the group raised these key concerns, amongst others: That the study was flawed. It should have compared highly effective hormonal to other non-hormonal contraceptives. The team registered concern at the fact that, although the study found no significant differences in proportions of HIV infections in each hormonal contraceptive researched, a higher number of infections was observed in the Depo Provera group. The ECHO study reported that women in the Depo Provera group of the study self-reported significantly lower HIV-risk behaviours, including lower frequency of having multiple sex partners and engaging in unprotected sex, compared with women in the other two groups of hormonal contraceptives users. The team of experts is concerned that the ECHO results have been widely interpreted as demonstrating safety of all three contraceptive methods. This has already led to warnings around DMPA use being eliminated as a message to women at risk of HIV acquisition. The team argues that in this study there are still grounds for concern that all contraceptive methods increased risk, and so this may prevent much-needed future research into which contraceptives might be safer, and the mechanisms by which current comparators might alter HIV risk. The team has fears that this may lead to complacency among researchers working in this field.

Overall, the team is concerned that hasty interpretation of the ECHO outcome, in the absence of its acknowledged weaknesses, will 'close the door' to finding alternatives to DMPA for safe and effective family planning in this region" (Kaull *et al.,* 2019).

The study did not tackle the question for the risk of partners of HIV-positive women on Depo Provera. The study does not seem to have considered the primary sources of vulnerability, the thinning of vaginal lining, and other vaginal and cervical physiological changes caused by

Depo Provera, hence entry points for HIV infection. What do these entry points mean in terms of other side effects: how are they related? That physiological changes that compromise women's health are supposedly safe, acceptable, and do not require action? It can be observed that the study focused on contraceptives as chemical agents, without the focus on women's bodies. Women's bodies in this regard, are vessels and objects of research.

The civil society also reacted to the release of the ECHO study results. One of the observations of this group was that some of the recommendations are in disconnect with the findings. For example, the WHO's current guidance dilutes its previous advice to *"also always use condoms while using intramuscular medroxyprogesterone" and instead recommends offering "pre-exposure prophylaxis (PrEP) in settings where the incidence of HIV is above 3%"* (Green and Pilane, 2019). In reacting to this, a consortium of civil society organisations wrote a letter to the WHO. The letter stated, amongst other matters, that *"It seems clear to us that for African women and girls, it has been decided that a pregnancy is worse than an HIV infection*" (Green and Pilane, 2019). Civil societies are concerned that preventing pregnancies is paramount, no matter the cost to women's bodies, including the heightened risk of HIV infection.

7. DEPO PROVERA IN THE HEALTH SYSTEM CONTEXT AND ENVIRONMENT

Health systems are key to ensuring that women have access to their health rights, in particular, make informed choices and have autonomy in relation to contraception. The study confirmed the findings by Burgard (2004) and Kaufman (2000). It can be observed that contraceptive utilisation is also impacted by systemic issues in the South African health care system. Clinic staff reported that they had not had stock of the two-monthly injection available for more than a year. As a result, they could only dispense Depo Provera to all women. They were not able to offer other options (Research Participants CS01 and CS02). This infringed on the women's right to information. The right to choose a method is indeed paramount. Health care workers were not informed of the reasons for stock-outs.

The health care workers reported that they are aware that the whole of eThekwini Health Region is without contraceptives other than Depo Provera (Research Participant CS 01). The Director of Maternal, Child and Women's Health in the Department of Health gave the reason for stock-outs, which occurred throughout the country: this happened as a result of supply-chain management and procurement requirements. The Department could not identify suppliers who were interested in bidding for the tender. The supplier who previously provided

the contraceptives moved their production factory to another country. This caused interruption in production and shortages of supplies. The problem persisted for over a year but had since been resolved (Research Participant KI 09). Burgard (2004) and Kaufman (2000) found that the high uptake of Depo Provera could be attributed to the possibility that Black women were not offered alternative forms of contraception. The study found that Depo Provera is mostly exclusively offered as a first contraceptive option to women. This is one of the key findings of this study. The participants indicated that the nurses dispensed Depo Provera because it was convenient and available for them to do so: "Depo is just an injection, it saves them time, and the nurses have to cope with large numbers of patients each day" (Research Participant KI 1). The participant also mentioned that Depo Provera had been heavily marketed for decades, and large amounts of resources had been committed to its marketing. Depo Provera continues to be the default contraceptive. It is difficult to change this understanding both from the providers' and the users' perspectives, without active strategies to counter the aggressive marketing of Depo Provera.

8. CONTRACEPTIVE COMMODITY STOCKS-OUTS

Non-availability of other contraceptives commodities and formulations is one of the barriers the study has identified as hindering women's choices on safe contraception. Contraceptive's choices and women's autonomy were also affected by systematic issues in the South African health care system. Issues of stock-outs pointed to the challenges of inefficiencies in procurement processes and the resourcing of the health system. The direct consequence of this is dispensing certain contraceptives, in this instance Depo Provera, even where it is not an indicated choice or medically recommended (Research Participant CS 01). In this instance, women's health rights and reproductive health choices were compromised as a result of a system failure: *"Failure of a health system is violence against women …The implementation of this policy is within the context of a failing system"* (Research Participant KI 07). Failures within the public health system led to disrupted services and insufficient resourcing. The impact of this failure adversely affected women, as the majority of the vulnerable (Rogers, 2006). This is in line with what one of the health care workers shared about limitations of available personnel to match improved policies. This also points to limited monitoring of the implementation of the policy provisions. Time constraints of nurses should be identified in monitoring exercises and be addressed. If the policy provided different options, these options should be made available; and the nurses understood the need to offer all options. The other systems issue here could be the issue of resourcing of health services. The participant shared

that there were also historical issues (Research Participant KI 01). Depo Provera had been popularised. Health care workers are most familiar with it; therefore they would blithely dispense Depo Provera. Health workers who participated in the study shared some challenges in following the new policy: "*The Department of Health developed new policies and train us on them, but they do not increase staff so that new procedures can be followed. My recommendation will be that the Department should increase staff in clinics*" (Research Participant CS 01).

The health care workers mentioned that they were also not in a position to use the expanded commodity approach. The clinics did not have stocks of vaginal rings or loops. The health care workers mentioned that, even had they had stock, they would be concerned about the time needed with each patient to insert these devices. Similar concerns were raised about implants: *"We also do not insert implants, in fact even the up-take of implants had decreased. Women take implants and come back to remove them. We are not able to remove implants, so we refer. This is because we are not trained to remove implants. If women come back to remove these, we are not able to assist them, we can only refer, this creates a problem*" (Research Participant, CS 01). Issues of stock-outs point to the challenges of inefficiency and the resourcing of the health system. The direct consequence of this is dispensing certain contraceptives, in this instance Depo Provera, even where it is not a choice or medically indicated. In this, women's rights, and possibly their health, and certainly their choices are compromised as a result of a system failure as articulated by research participant (K07) above. This is in line with what one of the health care workers shared about limitations of adequate personnel to implement improved policies. This also pointed to limited monitoring of the implementation of the policy provisions. Time constraints of nurses should be identified in monitoring exercises and be addressed.

If the policy provided different options, these options should be made available, and the nurses understood the need to offer all options. The other systems issue here could be the issue of resourcing of health services. There are no direct resources allocated to treating side effects of Depo Provera. It could, however, be observed that the cost is absorbed by the health care system, including treatment packages for diabetes, cervical and breast cancers commonly associated with the use of hormonal contraceptives. Associations between the high rates of diabetes and other diseases, which might be part of the side effects of hormonal contraceptives, is silenced, and as such, the costs of Depo Provera to the health resources and budgets are not

known. It would be difficult to cost the impact and the burden of side effects to the health systems as these connections had not been recorded. Health systems might not be bearing the costs because the system provides treatment packages for side effects associated with Depo Provera.

The major cost of side effects of Depo Provera is borne by women who use Depo Provera: *"Side effects are a huge cost on women's bodies. Women get sick and die. Women spend their time and money going to clinics to seek treatment over and over again, because of side effects. This is time they can spend productively on other things. Women always have a deep sense of worry about their health and what will happen… elderly women in Limpopo are accused and killed for witchcraft because they have bent spinal cords because of Depo Provera"* (Research Participant, KI 07*).* The research participant was associating the problem of older women in Limpopo with the side effect of permanent reduction of bone density, reflected in the Black Box Warning.

9. SIDE EFFECTS OF DEPO PROVERA AND WOMEN'S AGENCY, COPING STRATEGIES, AND ACTION

The study found that women were participating in discussions about Depo Provera on social media "*I know that the three-monthly injection is very bad. We talk about it in the injection on Facebook groups. There is so much information there. I participate in the discussions; we share and learn a lot about what it does"* (Research Participant CU HSC/05*).*

This finding is in line with the finding of Dehlendorf *et al.* (2012), that women use alternative sources of information when considering their choices of contraception (Dehlendorf *et al.,* 2013. This participant reported that she does not discuss or ask questions about what they discuss on Facebook with nurses at the clinic because '*this is never done'.* The women reported that other sources of information are mainly the radio.

Women also reported that they gained information about Depo Provera and other contraceptives from their friends and female family members (Research Participant CU HSC/04). Women discussed the problems and their concerns about Depo Provera in these contexts. They also indicated that they caution one another on Depo Provera. This suggested that, although there is no structured organisation, users of contraceptives interact, share their experiences, and find some alternative solutions. Women have agency and struggle at individual level, falling into informal groupings. Their issues might not be attractive or

deliberated on or finding expression on a formal political level, but women do find alternative spaces to express their issues. Women are also aware of the violations of their rights and their bodies and find ways to express these in safer spaces. Examples are when HIV positive women for an example, reported being forced into taking Depo Provera. Women shared these as individuals in a research project. This highlights the level of awareness, agency, and consciousness of rights and violations thereof. It also gives hope that safer spaces are needed, and that there are possibilities of educating grass-roots women on contraceptives.

Notwithstanding the challenges and limitations, women users of contraceptives were expressing their agency and needs in using contraceptives. Most of the women who participated in the study had been on and off contraceptives. Some of the women reported that they stop at one clinic, and then go to another clinic or private doctor to start again when they need contraception. Women reported that some private pharmacies provide injections at a small fee, so they go there as well. They did this to avoid being held accountable at their regular clinic. Some of the older women had been on DP for over two decades, on and off (Research Participant CU OSQ/01). Women reported that they stopped taking the injection for various reasons. Some women reported that they did not continue with the injection post-delivery. They stopped taking it because it was not their choice to take it. This is an act of women's defiance and reclaiming bodily autonomy, choice and agency. This is an expression of their choice. Other women reported that they stop taking Depo Provera because of side effects they experience, or those they hear about from their peers. Women listed weight gain, diabetes, fear of infertility, excessive and prolonged bleeding, and vaginal discharge, and reduced sex desire as side effects they suffered or heard about. Discharge gave women vaginal infections and brought fears about women losing their relationships. Women reported stopping because of other life priorities. *"There were so many things that I was focusing on solving in my family and I could not think about those things"* (Research Participant CU OSQ/05*)*.

Some reported that they stopped when they were not in relationships, or when they were in relationships and wanted to have more children. Women practised their agency and choices. Women in the study reported that they preferred Depo Provera because it is a three-monthly injection and therefore convenient. Women reported that they could only make time to come to the clinic once in three months. Mbali and Mthembu (2012) reported that many women prefer to take Depo Provera because they wanted a long-term reversible method they could readily conceal from their partners. Women reported that stopping the injection has led to pregnancy, sometimes not planned but desired, in some instances neither desired nor planned.

One of the research participants shared that *"I have four children, I do not want to have more children, so I started to use the injection again. I do not want my husband to know that I am using the injection. I also do not want my in-laws and other village women to know that I am taking contraceptives. Because of this I do not take the injection in my village clinic as my neighbours will see that I am on the contraceptives queue in the clinic. The three-monthly injection is my choice because I can only take it once in three months when I come to visit my husband in Durban"* (Research Participant CU OSQ/01). Women's choices in this instance were informed by careful examination of their circumstances. They exercised their choices, in circumstances in which their partners might refuse or interfere with their decisions.

10. RECOMMENDATIONS OF WOMEN USERS OF CONTRACEPTIVES

The research gave the opportunity for users of contraceptives to share their recommendations for change and improvement of contraceptive services. The same opportunity was offered to health care workers who participated in the study. This is in line with the values of feminist research, which advocates including the voices of the affected women (McPhail 2003, Blakely, 2007). Firstly, the women recommended that they be given more information about Depo Provera before starting on the injection. The information they needed related to how the injection works in the body, possible side effects and changes in their bodies and their health that could be expected, as well as possible interaction with chronic medication. The women recommended detailed information instead of just being initiated into the contraceptive treatment. Secondly, women recommended that they be given more time to decide on whether and when to take the injection, if they so choose. Women believed that the injection is not the same as child immunisation after birth. It was not urgent for them to take it shortly after delivery of their babies and before being discharged from hospital. They needed time to think about it and come back to act on their decision.

Thirdly, women recommended that the health care clinics where they receive antenatal care provide information and leaflets on contraception. Information should be in isiZulu, their mother tongue. They could then read the leaflet in their own time before making an informed decision on their choice of contraception. It was difficult for them to request another method of contraception at the clinic if the hospital had already given them the 'three-monthly injection' after delivery.

11. SUMMARY

This section of the chapter discussed findings of the research in relation to women's autonomy in choosing contraceptive methods, side effects and how contraceptives policy advance women's health in broad terms. The findings, in this regard participation of women users of contraceptives in the decision-making about taking contraceptives is limited. Although women need contraceptives, the choice to take them is not fully theirs. In some instances, women felt compelled: intimidation was used consent for giving women Depo Provera was not sought: women were simply told that they would be given the injection. The study found that some women consented to taking the injection and continued to take it voluntarily. However, some of the women continued to take the injection because they believed that it was part and parcel of their post-delivery care, infant care, and immunisation of their children. Women believed that refusing the injection might jeopardise their access to these services.

The historical and the current state of side effects associated with Depo Provera were presented in this chapter. Women users of contraceptives reported their experiences of side effects and how these have been addressed. Detailed information on how the injection works and potential side effects was not always provided. In instances where information was provided it was about the differences in time commitments of the two-monthly and three-monthly injections, and that women should come to the clinic if they experience abnormal bleeding. The finding is that some minor side effects were communicated to the women and were also treated, albeit women would have wanted to have more details about why they were experiencing such a side effect.

Health care workers shared their understanding on side effects and how they have addressed these within the limitations of resources. Health care workers communicated side effects of weight gain and irregular bleeding.

Long-term side effects were not communicated to the women. Health care workers reported not being aware of some of the long-term side effects, such as bone marrow issues, the cancers, and potential increased risk of HIV infection. Health care workers did report that pap smears are indicated for women who take Depo Provera, albeit the services are not always available. Broad health systems challenges and their implications for women's choices and side effects issues were discussed. All women who participated in the study were taking Depo Provera. Women who were on other methods were switched to Depo Provera because of stock-outs of the two-monthly injection. At the time of data collection for the study the stock-outs had been experienced for a year. This was a concern for the nurses, in particular, because some of the women had been moved to the two-monthly injection because of severe side effects of the other

injection. The failure of the system in this regard predetermined choice for the women. Health care workers reported challenges with uptake of implants, but also with difficulty in rolling these out in the context of limited personnel and training. They reported that they were trained to insert implants but not trained to remove them. They have to refer patients to hospitals for such removal. Health care workers reported that this compromises the trust between them and the service users, and indeed impacted on women's choices. Similar challenges were leveled against vaginal rings. Vaginal rings had also not been in stock for a period of one year. Health care workers reported not being aware that implants were made of the same ingredients as Depo Provera, that it is a different preparation of the same hormonal injection.

Women users of contraceptives reported to have agency in the situation. Women reported to need contraceptives. They reported that they had found ways of going on and off the injections by changing clinics, amongst other practices. Women reported that they access and share information through sources that are out of the clinic or health system. The study found a level of solidarity between women users of contraceptives and health care workers. Health care workers had, for example, developed materials on side effects of their own accord, and had drawn information from their own training materials to share with women users. Health workers presented concerns of stock-outs and lack of capacity from the service users' perspective.

The regulatory framework on the side effects of Depo Provera was discussed. The geo-politics and differences in north-south differentiation of regulation of side effects was observed. The Black Box warning, the high levels of warning, and other mandatory warnings to users of Depo Provera, and middle agents are not reflected in South Africa regulations on Depo Provera. Policy makers reported side effects to be normal; and reported that they do not see a need for Depo Provera to be treated differently. This began to highlight the different nuances and levels of oppression of women from developed and developing countries like South Africa in relation to contraceptives, body autonomy, choices, and health. The regulation in developing countries places the responsibility for disclosures squarely on drug manufacturing companies. It also began to show that manufacturers of drugs such as Depo Provera are held less accountable through litigation, and tight regulations in developed than in the developed countries.

Furthermore, the regulation in South Africa does not take into account the severe age restrictions, the fact that younger women should be excluded when dispensing Depo Provera because of side effects in the immediate term, but more importantly, in the long term, such as

the cancers, reduction of bone marrow and fertility complications, amongst many others. With absence of other methods, young women and girls, even those at school were given Depo Provera. Young women under 30 years of age, who participated in the study, were taking Depo Provera. The regulation also does not adhere to international standards of not exceeding two years in dispensing Depo Provera. Lastly, the section discussed Depo Provera and HIV/AIDS as a topical emerging side effect. Tuberculosis (TB) is also an emerging side-effect issue. The observation of this study is that Depo Provera continues to be given to women, apart from its controversial racialized political historical, but a progressively increasing list of serious and life-threatening side effects, arguably of epidemic proportions. The next section of this chapter will discuss participation in policy formulation processes.

SECTION 2

PARTICIPATION IN POLICY, GOVERNANCE, AND COMMUNITY HEALTH STRUCTURES

1. INTRODUCTION

This section of the chapter presents findings on participation of women users of contraceptives in contraceptives policy-making processes and implementation. This is one of the research questions posed in this study. The section discusses participation at policy level, governance level, community level, and participation in policy formulation and implementation. This is in line with the objectives of the study of understanding the nature and participation of women in policy processes, in particular, presenting the findings of the study on how policies and implementation are considered and informed by lived realities of women users of contraceptives. The themes of this section are grounded in different approaches and frameworks to the health policy analysis – the relationship of current contraceptives policy with gendered social exclusion, rather than inclusion and transformation. The section draws insights from both political theory and gender theory. It reflects on the transformatory potential of contraceptives policy, which is based on the rights-based approach, and the human rights principle of participation.

Key themes of this section of the chapter are:

TABLE 2: CHAPTER 4 SECTION TWO THEMES AND PERCENTAGES OF RESPONDENTS



RESEARCH THEMES	PERCENTAGES
International, national, and regional human rights frameworks codifying contraceptives and family planning as a human right	41%
Ideological and gender positioning of human rights provisions	19%
Gendered limitations of rights-based approaches	22%
South African legal frameworks and institutions of human rights protection, advancements and enforcement Human rights concerns and violations	26%
Litigation on Depo Provera, mediatory and parliamentary processes on Depo Provera	11%

2. THEORETICAL UNDERSTANDING OF PUBLIC POLICY IN PARTICIPATORY DEMOCRATIC GOVERNANCE SYSTEM

Examining the nature of women's involvement and participation in all spheres of contraceptive policy and practise of the new policy is one of the key objectives of this study. There is a plethora of definitions of public policy in scholarly literature. William Jenkins defines public policy as "a set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals and the means of achieving them" (Jenkins, 1978). Jenkins expands his statement, saying that public policy is by no means a choice, rather 'a political process consisting of several connected decisions (program, legislation)' (Jenkins, 1978). Pal (1992) defines public policy as an intellectual exercise to solve public problems, '*the disciplined application of intellect to public problems'* (Pal, 1992). Collins (2005) suggests that public policy is not a product of government as it may be commonly understood: policy is a political process (Collins, 2005). In a political process policy formulation will therefore be an enterprise of power, contestation, and trade-offs, and/or compromise. The dominant discourse at a micro problem analysis level will inform the direction of the policy proposals. Health policies normally fall under the micro-policymaking level, the lowest category of public policy. They flow from mainly long-term national development policy, the policy cluster known as macro-policy (Walt, 2008). It is important to note that second level policy is a breakdown of level one and might appear to be a softer, service-delivery level policy, but is as politically significant as level one.

Arguably, second level might also be a site of power for the governing ideology, as most opposition actors for example will contest national broad level policy rather than soft department level policies. The World Health Organisation describes the health policy as "decisions, plans, and actions that are undertaken to achieve specific health care goals within a society" (WHO, 2020). Health policy processes have elements that shape the actions of public authorities in health, in concert with the ideology of the party in government expressed in macro policy of the movement. Budget allocation mechanisms or the rules of public consultation are also facilitated and agreed upon within the dominant power and political complex. Power is a gendered phenomenon. The policy process will also be gendered, as are the solutions and/or limitations put forward. The WHO defines health goals for a society. This does not detail genders, identities, and different bodies in the society. This suggests that the health policy could therefore be addressing the problems identified by the society, rather than problems identified and nuanced from the experiences of women, considering all their intersecting advantages and disadvantages.

Public policy has been reluctant to consider health policy as political action (Bernier *et al*., 2011). This fact silences health as political action and limits the potential for a health policy to contribute to transformation, including gender transformation. It also reinforces pre-existing inequalities and injustices, which might be underlying reasons for the very health problems the policies seek to address. This approach is not conducive to transformation that is required to achieve gender equality and emancipation of women. Linkages of policy analysis and contextual factors and analyses are imperative in defining policy options (Ditto). Equally important is the consideration of epidemiological, clinical, and economic aspects of intervention in policy implemented. The options should also reflect the ethnic specificity and experience of the nation and be scientifically justified and based on international experience. Collins (2005) argues that political sciences should be applied in the analysis of health research and policy making because health is a political phenomenon.

Bernier *et al.* (2011) state that bringing the two worlds together is both a challenge for existing politics of research, and a unique opportunity for health promotion and public health research to strengthen their policy analysis capacity and influence. The inherent political nature of health policy means that conceiving politically neutral policy improvements for better public health outcomes and reduced social health inequalities is a fallacy.

Health promotional research is political by nature, and political science tools can make it more influential. In South African public policy making, public participation is defined as a process of "*consulting with the people and interested or affected individuals, organisations and government entities before making a decision. Public participation is a two-way communication and collaborative problem-solving mechanism with the goal of achieving representative and more acceptable decisions*" (Parliament of the Republic of South Africa, 2013).

Scott (2009) defined public engagement as a planned process in which people in South Africa exercise their collective and individual initiatives to promote their interests in decision-making and oversight processes of the state (Scott, 2009). Arnstein (1969) defined participation as an active process, action or strategy, in which the disadvantaged groups in society either directly or indirectly participate in the political and policy discourses to determine how and which policy goals are set, how public programmes are governed and operated, and how policy and programme information is shared (Arnstein, 1969). Public participation should include participating in decisions about how public resources, taxes, and other public goods are allocated to programmes, and how benefits such as contracts for service delivery and patronage are shared, amongst others. The transformatory strand of public participation defined by Arnstein (1969) is a classical political science influenced understanding of participation. Arnstein (1969) presented a ladder of participation detailing the three possible reasons for public policy participation in a political establishment.

2.1. FEMINISTAPPROACHES TO PUBLIC PARTICIPATION IN PUBLIC POLICY

The analysis of national and international policies on contraceptives is important in defining the ideology of contraceptives in South Africa. Participation of various stakeholders including users of contraceptives in a key unit of analysis in meeting the objectives of this study. A feminist policy analysis is one of the analytical framework approaches applied in analysing policies for this study (McPhail, 2003). The goal of this policy analysis framework is to put women back where they have been left out.

In line with the goals of feminist policy analysis framework, the analysis was purposefully conducted with the goal of understanding its effects on women. This is as a means of shifting power in society, in the long term, working towards the empowerment of women.

Feminist values of social justice, respect for dignity and worth of all people are in line with values subscribed to by other policy frameworks and professions (McPhail, 2003). This study has radical and post-colonial feminists as its theoretical framework. As such, the analysis and the researcher adhere to the values of feminists as defined by Brandwein (1986). The analysis of national and international policies on contraceptives included both process and content analysis relevant to the study. Public participation can facilitate redistribution of power and diversities of voices, because it creates opportunities for inclusion of disadvantaged groups and non-party political actors in the public political and policymaking processes. The section laid the theoretical foundation for discussing findings on participation in policy processes. The next section will discuss findings of participation of service users on the contraceptive policy processes.

3. POLICY AWARENESS AND PARTICIPATION OF WOMEN USERS OF CONTRACEPTIVES

Participation in public policy and political participation are intertwined and are not separable (Maseng, 2014). The concept of public participation has found expression in different ideological standpoints. A basic and practical needs approach is another strand of public participation (Moser, 1989). This approach is promoted mainly to achieve more efficiency of public services, for example participation of service users in health services in order to improve services (Moser, 1989). This approach does not advocate participation of users beyond the services they receive as individuals. Public participation found expression in the development era. The United Nations Development Programme (UNDP) integrated public participation as part of its development project. It developed this approach and identified participation as part of community development (Abbot, 1996). The neoliberal perspective of public participation believes that decentralisation and privatization of public goods and services is public participation (Gaventa and Barrett, 2010). In this, the ideological understanding of public participation contends that citizens are reduced to consumers of services − citizens express their preferences of services through market choices (Gaventa and Barrett, 2010; Mohamed, 2009). Neoliberals believe that citizens may be engaged in providing services at local level (Mohamed, 2009). In this approach, citizens receive funding to act as service providers at a local level. In this arrangement, providers exercise little to no material democratic power over state policies (Mohamed, 2009).

Public participation is also theorised and advocated for from a human rights perspective. Participation within this ideological positioning is rooted in human rights consensus and entitlements in society as a whole. Human rights-based approaches require public participation beyond provision of basic services. In the context of South Africa, a rights-based approach should address issues of redressing gendered, racialised, reproductive exclusions and violations of the past. This would include human rights transformation of the health system and the engendering of the entire health system, amongst others. Human rights approaches will ensure that the system does not reinforce past methods and criteria for contraceptives. For example, it will ensure that current programmes are better, and geared towards achieving the human rights ideal they advocate for.

Public participation is a gendered phenomenon. It is also embedded in other social strata such as class, ethnicity, socio-economic status, and income levels, amongst many other indicators of social difference. The blind conceptualization and definition of the public or community may exclude others. Policies assume communities to be egalitarian spaces. The gendered nature of community is not always considered. The policy positions and needs may be defined and understood from the perspective of dominant social values which may harm and/or exclude others. Contraception is subject to dominating ideology, and patriarchal consensus that women's bodies and reproduction should be regulated and controlled. Indeed, public participation has a role in negotiating power. Participation of women, for example in contraceptives, might not lead to immediate change, but might lead to change and transformation over time. This calls for participation to be critiqued, challenged, and improved over time. Public participation is an act of power. Power is subject to negotiation, contestation and shift over time.

All women users of contraceptives who participated in the study reported that they had not participated in any activities which evaluated the policies; neither had anyone shared their views on the services. This suggests that the participation provision of national and international policies of the UNFPA and the WHO stated above were not implemented in the two clinics. "*We have not seen anything about policies and changes in the clinic. We were told about new implants, some who are starting put them, but they are not good"* (Research participant CU OSQ/01). This suggests that, although policy provisions were not communicated, the commodity additions provided for by the new policies were provided.

One of the research participants mentioned that "*the policies were revised because of scientific information and new commodities that are coming to the market*" (Research Participant KI 01). The women reported that they were not aware of any reviews in which users were invited to participate.

Both clinics had 'comment boxes.' In one clinic the comment box was located in the waiting area; in another clinic it was located at the exit of the clinic building. The women stated that they had seen comments boxes in the clinic but had never shared their comments, as these had not been explained to them; neither had they been encouraged to use them. "*We don't come here for that… We come here if we are sick or get help for our needs*" (Research participant CU 0SQ/04). They also felt that this was not what they go to the clinic for. "*The toilet for public is outside, if it is raining, we get wet, but we don't say those things because it has always been like that*" (Research participant CU OSQ/04). The patients stated that they had not participated in any matters of management or running of the clinic. As can be seen from the above quote, this woman had identified a need for raising her voice about the location of the toilet but had not done so. The next section will discuss findings on participation of health care workers in policy processes.

4. POLICY AWARENESS OF HEALTH CARE WORKERS

Participation of health care workers in policy processes is because of the proximity of health care workers to women users of contraceptives. The women's rights to choices and information are delivered at the health care service level, with health care workers at the service delivery point. Fonn and Xaba (2001) state that power imbalances are inherent in the hierarchal nature of the health system. Because of this reality, health care workers are not considered essential participants in policy- and decision-making processes. The system trains health care workers to adhere to the guidelines, and to do as they crucial are told without questioning. Health care workers are trained to inform and provide services to patients with no expectation that the patients will have a say or a view on any matters. Their very training has discouraged questioning, and, as such, they are less likely to question patients, nor are they expected to do so by the superiors (Fonn and Xaba, 2001). Furthermore, health care workers are not trained in the social context of patients, the services they provide, nor on gender. Therefore, they are not prepared to be cognisant of those issues in their interactions with patients (Fonn and Xaba, 2001).

Health care workers who participated in the study did not participate or were not aware of the evaluation of the previous policies. "*We knew about the policy when it was presented in regional office meetings*" (Research Participant CS 01). "*We record and present statistics to the regional office in monthly basis, as operational managers we must make sure that stats are collected. We get called when there are new things or trainings on new developments*" (Research Participant CS 01*). …One company who supplies Noristerat was coming to the clinic for monitoring previously. They will come to look at the numbers and discuss problems of patients with us, they don't come anymore*" (Research Participant CS 01*).* Two of the senior health care workers who participated in the study at both clinics reported knowing about the new policy. Two of the senior health care workers of the three interviewed had been trained on the policy. Health care workers had also been trained in inserting implants. A senior health care worker in the rural clinic shared copies of the policy. A health care worker who works in the maternity and family planning unit of the same clinic shared presentations she received from the training on the policy. "*We were given these presentations to refer to and give to nurses who did not attend the training, I keep my copy here for me to use*" (Research Participant SC 03). Both health care workers shared these copies without being requested by the researcher to do so. Similar information had not been prepared for women users. "*Users of services do not participate in policy matters. We educate them about changes in treatment when we consult individual women*" (Research Participant CS 02). Health care workers are not able to make time for talking owing to work pressure. As such, they rely on external partners to present health education talks. "*We mainly have NGOs and research partners who come to do health education talks in the clinic. Most of them focus on TB, HIV and HIV testing*" (Research Participant CS 05). The next section of this chapter will discuss findings on tokenism and adverse incorporation of civil society actors in contraceptive policy formulation processes in South Africa.

5. PUBLIC PARTICIPATION AS A POLITICAL MANAGEMENT STRATEGY: MEANINGFUL PARTICIPATION, ADVERSE INCORPORATION AND TOKENISM

Participation in public policy is by its very nature political; is part of the political process and may be rooted in dominant political ideologies (Bernier *et al.* (2011). Furthermore, public participation in policy is impacted by class interests, and according to McPhail (2003), public participation is a gendered phenomenon.

Participation of some identity-based groups and civil society provider organisations in policy making processes can be considered adverse incorporation into Department of Health contraceptive policy processes. The Director of Maternal, Child and Women's Health in the National Department of Health mentioned that the service provider organisations represented the voices of the users in the policy formulation process (Research Participant, National Department of Health). This fact is in line with the neoliberal approach to public participation defined by Mahomed (2009), wherein public organisations' participation is understood as public providing of services at a local level with no real involvement in policymaking (Mahomed, 2009). In this approach, women's voices are silenced. This sort of inclusion is likely to manifest itself in clientelism. "Mutually beneficial association between the powerful and the weak" (Anderson, 1997, quoted in Maseng, 2014) defines clientelism association as a form of political contract, wherein the patron gives the client resources and security, amongst other benefits. In return, the client offers support and defence, legitimising the patron's position (Anderson, 1997). Clientelism is based on cultural and powerful institutional structures, which make it difficult for clients to leave, and therefore, it is even harder to address oppression, exclusion, and in the context of this research, reproductive oppression, because people are not only excluded and oppressed, but also adversely incorporated in contraceptive policy processes. Arnstein (1969) refers to a phenomenon of manipulation therapy. In this political-management approach people are placed on rubberstamp advisory committees and boards for the purpose of educating them and engineering their support (Arnstein, 1969). This approach assumes that citizens do not have capacity to make decisions, as such, subjected to patronising education exercises (Ibid: 5). This locks them into situations of deprivation, making it difficult for them to break out.

Arnstein (1969) refers to the practice of tokenism in public participation. This is when citizens gain access to power through participating on boards and programme specific government committees. Citizens in this sphere may raise issues of importance to them. However, their opinions do not go through the process, because the citizens are outnumbered, and sometimes discounted because they do not go with the dominant discourse (Arnstein, 1969). I have personally experienced this situation in HIV/AIDS and feminist organising in South Africa. Women's issues have been raised; policy makers ask for evidence; issues are researched and validated. However, issues do not make it to the policy analysis and solutions arena, because they do not meet the criteria for prioritisation, nor do other participants vote them as priority issues. In this instance, majoritarian democracy works against women.

I have also observed situations in which issues of women will be deemed 'cross-cutting' in policy spaces. Issues deemed as crosscutting get eliminated and silenced in the process of being mainstreamed on other issues. As indicated earlier in this report, feminist HIV-positive women advocated for inclusion of forced sterilisation in the 2012 policy reviewed for this study (Department of Health, 2012). The issue was taken into the policy. There is a paragraph stating the illegality of forced sterilisations of women living with HIV. The paragraph is in a box. The issue is not raised anywhere else in the policy. The tools for enforcing compliance, the targets, or any such matter, are not set. The paragraph is also not backed by any analysis. I must state that the paragraph read as though the group had submitted it. It was not edited, word for word. There was no effort to build the issue into the policy itself. These concerns in public participation raise the need for women to consider the idea of 'invited' spaces of engaging with power. Such may be consciously considered by adding the practice of setting the agenda and influence in spaces they create as a collective, and spaces they can influence. This sort of engagement may divide the voices and the urgency of the indigent, and those working to address the injustices to achieve transformation, making it almost impossible for them to organise around their issues (Mthembu, 2012). Arnstein (1969) suggests partnership, delegated power and citizen control, as more meaningful approaches to the ladder of participation (Arnstein, 1969). These policy formulation spaces have potential for healthy sharing of power, decision-making and transformation. A post-colonialist scholar, Fanon (1963), wrote that clientelism may also lead to corruption, the creating of unnecessary and unplanned government projects in order to feed clientelism, which diverts resources and hampers progress (Fanon, 1963). Lesbian, gay, transgender and intersex (LGBTI) or sexual minorities' organisations participated in the policy review process. This was to ensure that all are included in the process (Research Participant KI 01). It is my considered view informed by observations that LGTBI groups are over-represented in public spaces and discourses on women, gender-based violence, health, and many other civil society sectors. Their over-representation in these invited spaces hides and silences other bodies of women and their issues, in particular, those directly affected by contraceptives and HIV/AIDS. Non-discrimination of LGBTI is mentioned in the section of the policy on equitable and non-discrimination on the basis of sexual orientation. "*Services should be rendered in a an equitable, and non-discriminatory manner in terms of sexual orientation, sexual preference, sexual identify, race, gender, age and culture with due regard for what is suitable and appropriate for individual clients' needs*" (National Department of Health, 2012).

HIV-positive women, young women who are targeted by the policy, and other marginalised groups of women in society, for example, disabled women, do not get a specific mention. The LGBTI group at the table has also not raised issues of consent, human rights, side effects which are affecting women, issues which - if their quest for inclusion finds expression in future policies - will affect them. The policy refers to and commits to an "*equitable and non-discriminatory manner*" in relation to their groups, not transformation, safety, and respect for human rights in provision of contraceptives. This representation, identity politics, is not analysed from a feminist perspective. As such, it does not change the structural oppressive position of women as a group in contraceptives. The involvement is not broadly informed by women's politics in contraceptives.

Adverse incorporation is a phenomenon wherein a patron-client dichotomy is created between politicians, the governing elite, individuals and interest groups within the populace. The relationship is compromising power, and exploitative, to the detriment of the client, yet it is hard for the client to escape this relationship (Hickey and Du Toit, 2007). In the same vein, Woods (2003) states that the indigent are likely to be the fodder of adverse incorporation to policy and political processes (Woods, 2003). This population segment is likely to use their urgency and accept incorporation, essentially trading off their agency in return for short-term social and survival security (Woods, 2003). In this sort of relationship, women become subsidiaries of failed policies at the expense of their own rights as women (Mthembu, 2013). It was observed that women engage in processes as petit beneficiaries and/or partners, those who have a seat at the table. This incorporation prevents them from thinking about and demanding their rights as women. They become favourites and praise singers of the political elites.

I have observed with keen interest how some of these women become chairpersons of committees, playing a role of toning down critical voices of people they should be standing with. With this type of participation, the terms of inclusion are not discussed with those concerned. The agenda is already set; the invited participants participate in the prescribed agenda. Indeed, this approach could be an entry point to power and change for the marginalised groups, or a means to an end. These are known as invited spaces of power, rather than created spaces of power. In the context of this research, these might be entrenching control of women's fertility and the injustices of programmes in the areas of consent, side effects, and human rights; essentially depoliticising Depo Provera, and silencing the discourse of its oppression and political nature.

Lesbian, gay, transgender and intersex (LGBTI) organisations participated in the contraceptives policy review process. This was to ensure that all are included in the process (Research Participant KI 01). It is my considered view informed by observations that LGTBI groups are overrepresented in public spaces and discourses on women, gender-based violence, health and many other civil society sectors. Their over-representation in these invited spaces hides and silences other bodies of women and their issues, in particular those directly affected by contraceptives and HIV/AIDS. Another concern is that this group's organising is only focused on identity politics. The engagement lacks feminist analysis as such does not raise issues of oppression of all women as a gender LGBTI groups have missed the opportunity of supporting HIV-positive women, or even standing in solidarity to support HIV-positive women in HIV/AIDS structures such as the National AIDS Council, for example, where they have presence and voice. There has been no solidarity on issues affecting HIV-positive women, such as addressing gender-based violence, with a specific nuance of HIV-positivity, femicide and murder of HIV-positive women, and struggles of HIV-positive women on forced sterilisation.

It is important to note that this violence is perpetuated by the very HIV/AIDS policies and laws, such as the lobbying and inclusion of HIV-positivity as a mitigating factor in rape cases, prevention of mother-to-child transmission, and indeed, policies 'managing' reproduction of women living with HIV, such as this policy under discussion. The identity politics in this instance has not translated into feminist analysis of the issues of women with HIV/AIDS. The participation of these groups has not translated into the need for strategic interventions, which will in the long term, build consciousness and transform power. I argue that this form of engagement has not impacted positively on changing gender relations and the situation of women. If the values of feminists had been considered, the spirit of solidarity in the LGBTI groups would have problematised the fact that women who are targets of the policy were not part of the policy-making process, ensuring that this is addressed. Equally, young women are presented in HIV statistics as the most vulnerable, the most tested, the most researched, and the most controlled. Young women, women packaged in smaller bodies, are considered invisible and not mature enough to present their voices and interests. The opportunity of analysing the process from a feminist lens and problematizing the approach of the policy-making framework was missed. The next section will present findings on participation of formal community structures' participation in health care services.

6. COMMUNITY PARTICIPATION: THE ROLE OF CLINIC COMMITTEES

The National Health Act No. 61 of 2003 mandates and makes provisions for all public health clinics to have Clinic Committees, Hospital Boards and Regional Health Councils. These structures are a means to good governance, as a fundamental component of South African health care. These are formal community-based governance structures at various levels within the health care delivery system. The committees are formal "*community governance structures with the purpose to dialogue and action between health care providers and the community*" (Clayton, 2014). In line with the National Health Act of 2003 and national policy, the role of these structures is to be a link between the clinic and the communities served by the clinic, and to mediate community voices, over and above direct patient provider interaction. The structures are intended to give expression to the principle of community participation at a local and district level (Padarath, 2008). These structures are intended to act as a link between communities and the health system, and to provide a conduit for the health needs and aspirations of the communities represented at local, district, provincial, and national levels (Padarath, 2008). The two clinics that were part of this study each had clinic committees. One of the clinics, Osizweni Q, had the contact number of the chairperson of the committee displayed on the notice board. The number was typed on a plain A4 paper without the official letterhead. None of the eleven women who participated in the study knew of the existence of the clinic committees, but one participant was familiar with the ward committees*:* "*I know the Ward Committee in my section. People go to report to the Committee if neighbours are fighting and for crime. They have meetings but I have never attended… I don't know of other things them do… They report everything to the Councillor*" *(*Research Participant CU OSQ/04). Another woman reported that she partakes in a community structure and attends community meetings: "*I bake cakes and sell them, this is my business in my village, eSkotshi. I attend committee meetings and meetings called by the municipality about our businesses if someone can look after my baby… No we don't discuss health issues there*" (Research Participant CU HSC/05).

Clinic committees focus more on operational matters of the clinic, safety, and clinic staff, including the structures of the clinic, the building and fencing of the clinics. "*We report to the police and the Committee if there has been incidents of violence and theft in the Clinic*' (Research Participant CS 01).

Clayton (2014) states that *'Committee members themselves expressed confusion about their roles and reported being involved in menial tasks involved in the day-to-day running of the health facilities, such as fetching water and providing security, thereby making them in effect unpaid service providers*" (Clayton, 2014). Bunce *et al.* (2014) list a plethora of limitations of clinic committees. Such committees are not linked to either formal or informal community or civil society structures. Both clinics commented on how its committees were linked with community health care workers. However, there is confusion on roles and responsibilities of the committees, communities, facility staff, other Department of Health officials, civil society organisations, and such stakeholders. Committee members are not formally considered part of the health system. They therefore lack resources and power. MECs, provincial and regional hospitals and clinic managers are gatekeepers and decision-makers at this level. For example, as a researcher, I had to solicit gatekeeper permission to access the clinics. I applied and was granted approval by the provincial and regional Department of Health Offices. I then had to meet with operational clinic managers to present upper-level approvals and make arrangements to conduct research in the clinics.

It is highly unlikely that the committees participate in approvals of research institutes and agencies that work as researchers and service-delivery partners in the clinic. The clinic committees were not the structures I had to apply to for access to the research sites. This demonstrates the lack of power the committees and communities have in clinic governance. The research facility required no reference to clinic committees in clinics I was going to investigate. It will be difficult for such committees to negotiate power with these officials, including holding the officials accountable. Furthermore, the committees account to the provincial Ministers of Health (MECs), rather than the communities they serve (Bunce *et al.*, 2014). There is no formal training programme or formal allocation of resources in budgets for training of committee members. Lack of training and capacity results in difficulty in navigating and engaging on complex and technical policy issues of running the health care system. These structures are not funded. Members are not able to cover their transport costs to attend meetings (Clayton, 2014). The monitoring and evaluation mechanisms currently in place are inadequate for tracking the performance and functionality of these committees. Some members of these committees join, having the expectation of the appointment leading to a paid stipend or employment.

Clayton reported that members of the Committee withdraw their service when these material survival prospects do not materialise (Clayton, 2014). It is also possible that some members of

the community can participate in clinic committees in order to improve their proximity to government tenders and proximity to power. Health care workers in the rural clinic, which participated in the study, reported that the chairperson of their clinic committee was a local businessman, who is also a pastor in the community. Health care workers in both clinics reported that community health care workers are their link to the community. In the rural clinic health care workers reported that they provide a link for the community through mobile clinics. Women users of contraceptives reported that they use community mobile clinics but prefer to come to the clinic for contraceptives because the clinic is more private. The women reported that they have not had any interactions about contraceptives with mobile clinics and community health care workers beyond receiving the contraceptives.

Gender and women's health is mentioned in the National Health Act of 2003, suggesting that the Act is gender blind. This is the Act, which provides for establishment of these committees. Furthermore, the Act does not make provisions for women's health. Maternal health is considered women's health. This study has made references to challenges and limitations of the clinic committees as documented in the Black Sash review report and policy brief. This exercise was commissioned to examine the effectiveness of clinic committees through the lens of reducing maternal and child mortality (Clayton, 2014). Maternal and child health is premised on a 'women as mothers' approach to health. This approach is arguably considering women as instruments. It has not benefitted women in and for themselves, amongst many other limitations of these approaches. The women as mothers' approach have not led to structural transformation of women's rights. It has reinforced the ideas of controlling women's fertility and childbearing.

Earlier in this report we mentioned that high rates of maternal mortality are one of the justifications for intensifying contraceptives and population control of impoverished women.

7. PARTICIPATION OF EXPERTS IN THE POLICY FORMULATION PROCESS

The policy document reviewed for the purposes of this research acknowledges institutions and individuals who contributed to the policy development process. These included university-based health research institutions, two institutes of the University of Witwatersrand, Wits Reproductive Health Institute (WRHI) and University of Witwatersrand's MatCH Research Unit; the former is based in KwaZulu-Natal. The University of Cape Town's Public Health Institute also provided technical expertise for the process. The WRHI provided technical support and overall coordination of the policy formulation process and developed a training manual on the policy for health care workers.

The MatCH Research Unit (MRU) provided technical support to the policy formulation process. WRHI was the leading institute in a ground-breaking multi-country research study confirming whether hormonal contraceptives do increase the risk of HIV acquisition in women: The study is called the Evidence for Contraceptive Options and HIV Outcomes (ECHO). The WRHI details the background and defines the ECHO as follows: "*More than 150 million women worldwide use modern methods of contraception for family planning. By enabling women to avoid high-risk pregnancies, these contraceptive methods help prevent hundreds of thousands of maternal and infant deaths every year. As the HIV epidemic spread, it became important to explore risk factors for HIV, including whether there was an association between use of specific contraceptives and HIV acquisition. There is evidence from observational studies that use of progestogen-only injectable methods — particularly depo-medroxyprogesterone acetate (DMPA) — is associated with an increased risk of acquiring HIV infection, but uncertainty remains about whether DMPA use actually causes increased risk*" (Wits Reproductive Health Institute, 2019). DMPA is the medical/scientific name for Depo Provera. The MatCH Research Unit is also one of the research-implementing partners in the project. WRHI is an accredited WHO and UNAIDS collaborating centre (Wits Reproductive Health Institute, 2019).). Other individual technical experts are acknowledged. Officials from the National and Provincial Departments of Health are acknowledged for their effort.

The World Health Organisation provided technical support in the policy formulation process. FHI360 is acknowledged as providing for their on-going technical assistance and review of documents. The United Nations Population Fund (UNFPA) is also acknowledged for providing funding to the policy-development process. The United States Agency for International Development (USAID) provided funding and technical assistance to the policy-formulation process.

Family Health International (FHI360) is a United States not-for-profit organisation working in 60 countries with governments and the private sector to bring about social change, providing health care, education, and economic opportunities. One of the research participants raised a concern that the Department of Health is heavily reliant on international technical experts in policy formulation and guiding implementation of the policies (Research Participant KI 07). This is the approach of the current Minister of Health, Dr Motsoaledi. The research participant believed that there was a deliberate effort to marginalise local knowledge and views in the work

of the Department of Health in this area. "*There are more barriers in international experts to consider engaging honestly with the realities and history of the country on this matter. I participated in the 2012 policy development policy process. I am also involvement in the current policy review. I am not investing far too much time and effort in this process, knowing that the investment will not pay out because there is little that the review will achieve. 'The current review is again, full of technical experts. There is limited room for honest conversation and alternative voices. I am more watching and monitoring. This is the approach of my organisation*" (Research Participant KI 07).

I have observed that the Minister often prefaces his public address and responses to media with reference to an international multilateral body, mostly the World Health Organisation. He recently made reference to an international body when responding to a question from a community health care worker, who asked him a question about delays in processing their employment by the Department of Health, as he had committed to them. The question was asked in a live SABC current affairs television programme called '*The Big Debate'*. The Minister prefaced his response by stating that he is the only Health Minister who has raised the issue of full-time employment of community health care workers in the World Health Assembly. This did not address the question posed by community health care workers. The response came across as the Minister evoking the name of an international body to avoid responding to the question. The relevance of the World Health Assembly in this context could not be logically placed. The use of experts may marginalise and compromise internal contexts, realities and solutions. International experts come with power embedded in their stature, perceived credence and validity. They may come with credence of international obligations and at the desire of the hosting country. In this case South Africa might feel compelled to comply with international obligations, without considering the local reality, such as racial, historical, and intersecting lived realities of Black women, as well as human rights provisions and applicability of such obligations in the context of impecunious Black women. Such international or global standards are not necessarily good standards; neither do they come from an ideologically neutral place; from a political economy, post colonialism, and gendered racial oppression. This fact resonates with Crenshaw's (1989) assertion in intersectional theory that the analysis of Black women's experiences deserves a new approach to analysis; that they cannot just be added on to existing tools of analysis, as these tools will not capture or address the issues. Experiences, hidden nuances, and aspirations of women may be ignored in favour of expert opinion evidence and power. This confirms the powerlessness of women in the health

system in favour of experts. The role of international organisations, funding and resourcing is discussed in chapter six of this report. It can be observed that, in the case of the Department of Health policy processes, experts were recycled, playing different roles in the project. As indicated earlier, one of the experts was a technical adviser who coordinated the whole project and also developed a training manual for health workers on the policy.

It is of concern that only two local academic institutions participated in the contraceptive policy formulation process, and both are part of Wits University, the Maternal, Adolescent and Child Health (MatCH) Research Unit (MRU) and the Wits Reproductive Health and HIV Institute (WRHI). The MRU is an implementing partner of the youth dedicated contraceptive services in the two clinics sampled for the study, and both conducted training to health care workers on the policy. Opportunities to learn from other disciplines and universities were missed in this process. This brings to mind questions about research monopoly and suggests that, in fact, the policy is informed by one research perspective, a fact that is compromising the solutions: and also, the credibility and the value of contributions of academic institutions in the research. Furthermore, these research institutes tend to rely on external donor funding and are less accountable to the universities in which they are located.

Some of these institutions are linked to the very same international research institutions, which are essentially research wings for drugs or the pharmaceutical industry. This study interviewed two research experts who participated in the policy formulation process, both of them White women. Both MRU and WRHI's founding and current directors are White women, coming from medicine, science, pharmacy, public health and nursing backgrounds. The Department of Health mentioned that, as per the procedure, the policy was subject to review, and met the Lancet Commission. '*The Lancet'* is the world's leading independent general medical journal with international coverage and focus on all aspects of human health (The Lancet, 2019).

The policy was reviewed and approved by the South African Health Council (Research Participant KI 09). Contraceptive policymaking is based on science, and less on human rights, principles of redress, and community engagement.

Health research, mainly demography, and to some degree biomedical science, is where policy review originated. The signing off and approval of the policy was granted by the public health and science regime structures mentioned above. Public health research believes that politics is a realm that they should not enter because of its sensitivity. Scientists believe that entering into

the political arena of public health is a barrier to climbing the academic ladder (Bernier *et al.,* 2011). This is, however, an illusion, and the denial of the obvious on the part of the researchers. Research and policy making in the area of reproduction and contraceptives are far from being politically neutral. The policy making process is more often than not characterised by rational decisions made on the basis of the best information (Young and Quinn, 2002). Walt, (2008) argues that "expecting a direct connection between scientific results and policy reveals a misunderstanding about the nature of the policy environment." Bernier (2011) recommends that, because of the power that the field of demography has in policymaking and politics, it is imperative that this field include political sciences and policy-making theories in their curricula and field of practise. This will ensure that they understand and fulfil their responsibilities to the populace. This will also be a good entry point for politically conscious, responsible, policy making, which addresses underlying historical and structural issues (Bernier, 2011). The next section presents the nature of participation of constitutional bodies in contraceptive policies in South Africa.

8. PARTICIPATION OF CONSTITUTIONAL BODIES AND HUMAN RIGHTS ORGANISATIONS IN THE POLICY FORMULATION PROCESS

It is important to consider participation of constitutional bodies in broadening the understanding, the post-apartheid ideology, and the political economy of contraceptives in South Africa. According to the Department of Health, civil society organisations represented the voices of these two constitutional bodies "*the rights-based NGOs and civil society structures represented the views of Constitutional bodies such as the Human Rights Commission and the Commission for Gender Equality in the policy formulation process*" (Research Participant, National Department of Health). Sexual and Reproductive Justice is the key civil society organisation, which participated in the process (Research Participant KI 01, Research Participant KI 09 and Research Participant K1 07).

The Women's Legal Centre and Her Rights Initiative are listed as organisations, which contributed to the process (Department of Health, 2012). The Commission for Gender Equality (CGE) and the South African Human Rights Commission (SAHRC) did not participate in the policy formulation process. The two structures did not have any engagement in the implementation, oversight, and monitoring of the process and the policy itself. The

understanding of this research is that the CGE mainly monitors and responds to complaints lodged by the public on a particular matter. There are instances in which the CGE will investigate and make recommendations on particular issues on its own accord. To date, contraceptives have not been one of these issues. The role of these structures will be discussed more in detail in the chapter on human rights in this report.

The Parliamentary Committee on Women in the Presidency did not participate in the policy process reviewed for the purposes of this study. According to the participant of the study who is a Member of Parliament serving on this Portfolio Committee the Committee has not yet had any engagement with neither policies nor the issue of contraceptives in recent times. The Chairperson stated that the matter fell off the ANC Women's League agenda. "*I am not sure what happened to the ANC Women's League programme on Depo Provera in the 1990s"* (Research Participant KI 03). This participant announced that the Committee would discuss Depo Provera at the next meeting of the Committee. "*I will ensure that this issue is discussed in the meeting between my Committee and the Portfolio Committee on Health next week*" (Research Participant KI 03). The next section of this chapter peruses the participation of organised women's groups in contraceptive policy processes.

9. WOMEN'S PARTICIPATION AND GENDERED SOCIAL EXCLUSIONS

This research explored aspects of women's agency and autonomy with regard to social exclusion in contraceptive policy and choices. As service users, women who participated in the study had not been involved in the policy formulation processes on contraceptives and decision-making about service delivery on contraceptives. Furthermore, the women did not know about structures that link the clinics to the community. Women did not raise their concerns about contraceptive initiation in formal community structures or informal opportunities provided for in the clinic. Of the eleven women who participated in the study, only one woman reported to be involved in a community committee, and this was with regard to local business development.

Women were, however, able to express their concerns and fears with certain members of their families and friends. I observed that some of the women relied on family members for support, whilst others deliberately used facilities far away from their homes because they did not want some members of the family to know that they were using contraceptives. This observation makes a strong case for differentiating between public participation and decision making as

aspects of women's agency at the individual level. Non-participation, for whatever reasons, on a community level, does not necessarily imply absence of agency.

Women in this study seemed to have made well-considered decisions to secure confidentiality of their contraceptive choices and use, by carefully selecting (or considering) where and with whom they shared these decisions, both within their families and in their communities. Women were also able to share and learn from other women through informal social media channels. In this study, it was found that service providers in the policy formulation and implementation processes did not adequately represent women users. Women's gender needs and concerns had been ignored. Indeed, women had been excluded, silenced, and rendered invisible. Service providers represented women's interests only from their own perspective. The interests of the women users and providers are not the same. Women are rights holders, and providers are duty bearers. Furthermore, the policy process failed to include populations of women who are specific targets of the policy intervention, notably women with HIV and young women, despite political commitments made to this effect (Legislative Sector, 2013). A parliamentary review process on public participation stated that: "A *public participation framework for Parliament and provincial legislatures takes into account the minimal considerations in facilitating public involvement. These considerations are based on what is appropriate in light of the specific process, content, importance and urgency, as well as the response from the public. The above is dependent on the nature of the process, i.e., whether it potentially affects an identifiable section of the population, and/or whether the potentially affected section of the population is given a proper opportunity to have a say***" (**Parliament RSA, Report on the review of constitutional prescripts and constitutional court rulings pertaining public participation, 2013, Legislative Sector, 2013: 7).

The commitment in this instance was not followed through by investment in resources so that the commitments are more than paper commitments. This also suggests that contraceptives are probably not advanced for the cause of women's rights, but women are in the value chain as a means to end.

This means that women's reproduction and population is managed by the state, which has in the past manifested itself (as per the 2018 Department of Health policy review and amendment proposal on reproductive health), with high rates of maternal mortality teenage pregnancy. I argue that lack of formal participation of the users of contraceptives is linked to women's social and economic status. The demographic profile of the women who participated in this study

suggested that the women are impoverished and of low socio-economic status. I argue that their systematic exclusion is related to gendered social exclusions. These women were considered recipients of services, and their voices and views are not considered in decision-making and delivery of the services. Social exclusion is a phenomenon that is reflected in social relations, particularly in determining how economic resources are governed, distributed, and shared (Silver, 2007). Social exclusions mean socially reproduced inabilities of particular groups of people to participate in the politics and the communities in which they live owing to poverty, resulting low social status (Chen, 2000 and being in a position of disadvantage without being able to attract social solidarity in order to escape the state of disadvantage (Chen, 2000). Social exclusion creates the conditions for poverty and also sustains these conditions (Chen, 2000). Social exclusion locks people up in situations in which they are unable to access spaces of power and influence; it puts them in situations in which they are unable to explore and participate in social capital (Adato *et al.,* 2006). People can be excluded on many grounds. Relevant to the purposes of this work are the grounds of race, ethnicity, poverty, socio-economic status, education, and health, amongst others. Women who participated in this study suffered multiple intersecting layers of exclusion: They were excluded as women; as impoverished women; as young women; as unemployed women; as women of reproductive age; and as indigent women who use public health services, amongst other factors. Social exclusions hinder participation in the activities of a given society, and may prohibit access to information, resources, and social recognition (Silver, 2007). As a result of their social status, these women were denied access to information, public resources, and human rights to make informed decisions about contraceptives because of the lack of their recognition as a social group. Such marginalised women deserve political attention and solidarity, and the use of public funds to protect and enforce their rights.

The contraceptive policy and programme implementation have rendered these women invisible. Exclusion from political spaces and organisations is a major indicator of social exclusions (Gore, 1994). Exclusion may also mean denial of rights of citizenship and access to communities. Exclusions reflect inherent power relations in society (Adato *et al.,* 2006) in terms of who has power to decide on how resources are shared, who has access to such resources, and who falls in and out of the access brackets. These women were also politically excluded. Political exclusion is defined as the denial of rights, including freedom of expression and the right to equality of opportunity, as well as denial of the ability to participate and to organise for strategic positive changes or social transformation (Bhalla and Lapayre, 1997).

The impecunious generally lack the ability to represent themselves and their interests in political spaces (Woods, 2003). The Department of Health opted to use service providers and proxies for users' voices in their policy formulation, for example. This silenced these women, making them invisible. It can be argued that exclusion of these groups of women in the processes demonstrates the lack of political clout and identity of these women, and by extension their issues. This also demonstrates how the position of these women led to their inability to attract the attention of policy makers and those tasked with the responsibility of protecting their rights. Furthermore, lack of public participation on Depo Provera demonstrates that Depo Provera has been stripped of its political significance, status, and credence in the South African post-apartheid women's politics.

10. SUMMARY

This section of the chapter has presented findings and discussion on the participation of different actors in contraceptive policies. The chapter located the discussion in the broad structures of participation and power in health, including participation in policy, governance, and community-health structures. This chapter discussed the observation of a web of international actors from scientists and policymakers to donors set the agenda and led both background research and policy formulation processes. Policy changes are informed by the external factors in the global space, rather than by women's realities on the ground, and the broad needs of the country. Participation of research institutions in the country was also observed. There are two institutes involved in the policymaking, both linked to the University of Witwatersrand. These two institutes play multiple roles, from research, policy formulation, providing technical guidance, developing training manuals to training of health care workers, and in some instances, service provisions.

The chapter discussed the structures and the nature of those who participated in the process, touching on the nature of their participation. Participation of women affected and targeted by the policy was also discussed. Participation of women users of contraceptives was not part of the policy process. The interests of women were provided for by the baseline research conducted by scientists in clinics in the studies conducted after policy changes had been proposed. Service users were considered as proxies for representing women users of contraceptives in policy processes.

The chapter located the findings on participation in Constitutional and Legal (National Health Act of 2003) provisions on public participation and participation of the affected in policy processes and the broad principles of participation in democracy, particularly in health policy formulation. The observation was that these legislative arrangements, in particular, the National Health Act of 2002, is gender blind. It does not mention gender at all throughout the document. The Act does not have a provision on women's health. Women are mentioned in relation to their role as mothers, in maternal health. This suggests that no gender and women's rights advocated by the Constitution, amongst other gender transformation tools, were applied in the formulation of the Act. By extension, the provisions and policy interventions for participation, for example, the clinic committees are neither gendered nor have any specific focus on women's health issues. The study found that constitutional bodies did not participate in contraceptives policy processes.

Again, the Department of Health reported that civil society organisations who participated were proxies for participation of these structures in the processes. The politics of clientelism, tokenism, and adverse incorporation was apparent in the participation of these structures. The study found that tokenism, clientelism, and adverse incorporation and participation of LGBTI groups served as a tool to silent and block participation of the affected populations. The structures that participated did not represent the voices of women as such, but their sexual identities, thus suggesting that the policy also did not address their concerns, but only achieved inclusion. Their participation did not play any role in transforming contraceptive practises or policy, (in particular for Depo Provera) from the standpoint of human rights, side effects, women's health and rights, racial and class targeting, and shifting the ideology of contraceptives. It therefore cannot serve as a tool for transforming the South African society until these are addressed. Depo Provera Parliamentary bodies did not participate. Research participant (KI 10) reported that the Department of Health does report on the coverage of contraceptive services and distribution as this is a one the target areas the Department is mandated report on to the Portfolio Committee on Health. The Parliamentary Committee on Health had not engaged with the issue, neither had it interacted with the Department of Health on the matter. The next chapter will present findings on human rights and the role of international agencies, philanthropists, and the United Nations on contraceptive policy, in particular Depo Provera in South Africa.

CHAPTER 5

HUMAN RIGHTS IN PROVISIONS AND APPLICATION OF CONTRACEPTIVE POLICIES AND PROVISIONS IN SOUTH AFRICA

1. INTRODUCTION

This chapter discusses human rights in relation to contraceptives in South Africa. Exploring human rights is key to broadening the understanding of the current contraceptive policy and how to transform and enhance women's rights and autonomy, transform power and structures, and reproductive justice. Human rights are one of the key questions of this study, because they are key instruments of transformation from apartheid to democracy in South Africa and are therefore of paramount importance in this study.

International, regional, and national contraceptive commitments and policies reviewed in this study declare that such policies are human rights based. How these approaches are applied will help to understand the ideological positioning of contraceptives in the country. Codifying and respect for human rights are key instruments and pillars of transformation from apartheid to democracy in South Africa. The chapter will discuss the study findings on human rights. The discussion will include human rights provisions, as articulated in the national and international policy documents reviewed as part of this research. The chapter will also explore some of the topical human rights issues on contraceptives and fertility in South Africa. Lastly, the chapter will discuss some of the human rights enforcement frameworks, and how these have responded to issues of contraceptives and fertility control in the broadest sense within the country. The themes in the table below are the findings of this research and are discussed in this chapter.

TABLE 3: THEMES, AND PERCENTAGES OF RESPONDENTS

RESEARCH THEMES	PERCENTAGES
International, national, and regional human rights frameworks codifying contraceptives and family planning as a human right	41%
Ideological and gender positioning of human rights provisions	19%
Gendered limitations of rights-based approaches	22%
South African legal frameworks and institutions of human rights protection, advancements and enforcement Human rights concerns and violations	26%
Litigation on Depo Provera, mediatory and parliamentary processes on Depo Provera	11%

2. FOUNDATIONS OF CONTRACEPTIVES AS A HUMAN RIGHT AT A GLOBAL LEVEL

This section of the chapter provides the background of how international human rights instruments were incorporated into contraceptives and family planning at the international governance level, the United Nations. It is not clear whether this integration was inspired by the need to protect the women, or whether it was largely co-option of the United Nations human rights discourse by the contraceptive and population control establishment to push the contraceptive agenda. Fuderi (1997) stated that the contraceptives and population establishment had a successful strategy of co-opting and attaching itself to global problems, developments, ideologies and discourses (Fuderi, 1997). Family planning was first codified as a human right in the Teheran Declaration of the International Conference on Human Rights in 1968 (United Nations, 1968). This declaration obliged every country, government, and policy maker to respect and ensure the realisation of this right. Parents have a basic human right to determine freely and responsibly the number and spacing of their children (UNFPA, 2008). Subsequent to that, various other international human rights, women's rights and health rights instruments declared family planning as a human right. Twenty-five years later, the International Conference on Population and Development (ICDP, Cairo, 1994) defined contraceptives as women's rights in the context of population and development. These were

adopted by many United Nations entities, such as the United Nations Population Fund (UNFPA), the World Health Organisation (WHO) and other agencies for application in their various sectors. The roles of the UNFPA and WHO overlap in the field of contraceptives. The UNFPA is, however, the UN agency implementing the ICDP Programme of Action in South Africa. This suggests that contraceptive initiatives are located within the ambit of population, health, and reproduction, in the international space. The United Nations entity for women (UNWOMEN) and United Nations Development Programme (UNDP) are not involved in contraceptive work.

3. WORLD HEALTH ORGANISATION GUIDANCE ON CONTRACEPTIVES AND HUMAN RIGHTS

In 2014, the World Health Organisation and the United Nations Office of the High Commission on Human Rights revised the principles and recommendations on adherence to human rights in light of changes and development in the field of contraceptives. The rights were grouped under nine (9) headings reflecting human rights principles, and standards relating to contraceptive information and services (World Health Organisation, 2014). The principles include: non-discrimination in provision of contraceptive information and services; availability of contraceptive information and services; accessibility of contraceptive information and services; acceptability of contraceptive information and services; quality of contraceptive information and services; informed decision-making in provision of contraceptive information and services; privacy and confidentiality in provision of contraceptive information and services; participation in provision of contraceptive information and services; and accountability in provision of contraceptive information and services (World Health Organisation, 2014).

4. THE AFRICAN UNION (AU) PROTOCOL TO THE AFRICAN CHARTER ON HUMAN AND PEOPLES' RIGHTS, ON THE RIGHTS OF WOMEN IN AFRICA

Understanding of regional human rights commitments is essential in meeting the objective of understanding the human rights provisions on contraceptives. The African Union (AU) Protocol to The African Charter on Human and Peoples' Rights, on The Rights of Women in Africa was reviewed. This is one of the human rights instruments applicable in South Africa, which is a signatory of this protocol. The protocol is not mentioned or referenced in the two South African contraceptive policies reviewed for this study.

The African Union (AU) protocol was codified in 1995 and gives expression to sexual and reproductive rights, and family planning, in particular (African Union, 1981). Article Fourteen (14) of the Protocol commits to ensure that the right to health of women, including sexual and reproductive health is respected and promoted. The Protocol details the rights of women to control their fertility; decide to have children, when, how, and spacing of children; and choose any method of contraception, amongst others (African Union, 1981).

Four of the six commitments in Article 14 refer to contraceptives. The other articles refer to maternal health, HIV/AIDS and abortion. It is observed that Article 14 does not refer to any of the reproductive health diseases, for an example, cervical cancer, breast cancer, and depression. The article is conceived from the 'women as mothers' approach to women's health. This approach that improves the health of women, but does not transform gender relations, nor does it bring women closer to being entitled to state resources beyond being instruments of reproduction.

The HIV/AIDS commitment is of concern from the women's perspective, as it encourages partners to know their partners' HIV status. Women are often the first ones to be tested for HIV: this leads to feminised blame for HIV infection. This commitment potentially leads to high levels of gender-based violence and femicide of HIV-positive women. Further, this may also lead to women being stripped of their resources, for example, land, in instances of divorce, or custody of their children. HIV/AIDS programmes have hardly looked at issues of violence against HIV-positive women. Statistics on femicide in South Africa does not capture HIV status as a reason for murder. The conditions placed on the right to abortion are also of concern, and disconnect with women's rights to control their fertility, explicated in this very article. Article 14 of the Protocol, as it stands, is not informed by women's lived experiences. The Protocol is advocating for the rights of women, albeit within the ambit of population control predominant in the international population control movement. South Africa submits periodic reports on the implementation of the Protocol.

5. SOUTH AFRICAN CONSTITUTIONAL PROVISIONS FOR SEXUAL AND REPRODUCTIVE RIGHTS

The legal framework and provisions for contraceptives and family planning are derived from the Constitution. Review of the Constitutional provisions in this regard is important in meeting the objectives of locating the ideology of contraceptives in the post-apartheid dispensation. As a direct consequence of feminist political lobbying in constitutional development deliberations

and in legislatures, reproductive rights, access to health care and other socio-economic rights, are provided for in the Constitution, and integrated into South African law (Hassim, 2016). South Africa's Constitution refers to sexual and reproductive rights in three places: The equality clause (section 9.3), which forbids discrimination on grounds of gender and sexual orientation, section 27. 1. A states that '*Everyone has the right to have access to health care services, including reproductive health care''*; and Section 12 which deals with ''freedom and security of the person'' (Constitution of the Republic of South Africa, 1996).

5.1 HUMAN RIGHTS PROVISIONS IN SOUTH AFRICAN CONTRACEPTIVES AND REPRODUCTIVE HEALTH POLICIES

The provision of contraceptives in South Africa is based on a human rights approach (Department of Health, 2012). Such is expressed in various Department of Health policy instruments, notably the Department of Health National Contraceptives and Fertility Planning Guidelines and Service Delivery Guidelines of 2012, and the Policy of 2018. Some of these human rights principles are detailed in the policy as follows: Contraceptive services are provided according to the Constitution of South Africa and other related rights-based documents. Such services flow from the Health Act of 1993 and principles of good service provision in the public service, namely, the Batho Pele Principles, the Patients' Rights Charter, and the Sexual and Reproductive Health and Rights Framework (National Department of Health, 2012, and 2018). The policy claims that a rights-based approach is reflected in all aspects of service delivery.

This pronouncement is underpinned by the principle of informed voluntary contraception, and people's rights to exercise their reproductive choices. This includes confidentiality and privacy, contraception choice, informed decision-making and shared responsibility. The principles include voluntary decision-making, and guaranteed access to contraception, the principle that no women requesting contraceptives should be sent away without a suitable method of their choice (Department of Health, 2012). As alluded to in Chapter Five (5) of the findings of the study, the experiences of some women users of contraceptives suggested that this principle was not applied at the service delivery level. Not all women made informed choices about contraceptives.

Some of the women had to take contraceptives that were not of their choice, not good for their health, because of stock-outs and certain health care challenges. Both the users of

contraceptives and providers at the clinic level indicated that there are no programmes and information on human rights-based approaches to contraceptives. There was no evidence of integration of Batho Pele Principles, the Patients' Rights Charter, and the Sexual and Reproductive Health and Rights Framework, at the clinic level. Posters defining Batho Pele and the Patients Rights' Charter were displayed on the clinic walls. There was, however, no material displayed in relation to contraceptives, including the rights of women, and how these can be enforced. There were no materials dispensed; the women users and providers had not been trained, nor had they received information, entered into discussions or been provided with protocols for integration. The study did not find evidence of integration of human rights in relation to contraceptives as articulated in the policies reviewed in this study at the clinic level. Women users of contraceptives who participated in the study reported that they had not been educated, informed or given any materials in relation to human rights related to contraceptives. The provisions in the Department of Health Policy on contraceptives are neither specific human rights, nor do they have the policy provisions codified into specific legal instruments for enforcing the specific Constitutional rights. The policy specifically mentions departmental tools, which may be rights-based. However, the policy limits the matter to service delivery level, with a focus on access to contraceptives, rather than ensuring that human rights safeguards are provided for.

6. IDEOLOGICAL AND GENDER POSITIONING OF HUMAN RIGHTS PROVISIONS OF CONTRACEPTIVES

The location and broadening of understanding the ideology of contraceptives required historical grounding and underlying reasons in the evolution of global contraceptives establishment. International women's rights provisions, the Convention on Elimination of all Forms of Discrimination against Women (CEDAW), amongst others, are mentioned in the introduction to the policy, but not in the section where human rights approaches are detailed. The rights are presented in a broad, gender-silent manner.

The United Nations Development Programme has developed Gender Results Effective Scale (GRES) (UNDP, 2015). The scale is an effective tool for measuring efficacy of policies and programmes from a gender perspective. GRES rates results as gender negative, gender blind, gender targeted, gender responsive, gender transformative.

There is no indication that the GRES scales or any other gender monitoring tools were considered in policies on contraceptives. Contraceptives and family planning are not presented as a gendered phenomenon. Gendered power relationships and exclusions in relation to reproduction at a health delivery level and broad societal level are not expressed in the policy instruments. Furthermore, there is no mention of national gender equality and racial justice and other commitments that flow from the Constitution. The racial and other political economy issues embedded in contraceptives are silenced in this approach. It can be stated that, in terms of the GRES scale, the human rights-based approaches have been both gender-negative and gender-blind. The programme has a negative outcome that reinforces existing gender inequalities and norms. This suggests that the policy provision on contraceptives is not conceived from women's rights or viewed through a gender equality rights lens. It is silent on such aspects: it does not contain active goals for gender transformation; as such, it perpetuates the existing gender inequalities and norms. Specific mention of the exact clauses of the Constitution and laws applicable to these human-rights provisions would have strengthened this provision. The policy also does not list the national non-discrimination, dignity, and bodily integrity values, amongst others, as advocated for in the South African Constitution. The policy is silent on the transformation agenda.

Both the World Health Organisation's human rights and the South African ideological articulation of rights in this area emphasise the right to contraception access as commodities in and for themselves. Access to health care is viewed in isolation from other rights impacted by health, and specifically contraceptives. The bigger underlying goals of contraception are not viewed through the lens of human rights. Numerous related human-rights issues are silenced by presenting family planning and/or conception as a purely public health matter. Mann *et al.* (2000) wrote that the public-health field has rarely included human rights considerations in its approaches (Mann *et al.*, 2000). The authors indicated that there are quite pronounced epitomical chasms between health and human rights. This creates false dichotomies between the two fields, which are, in essence, about improving the quality of human life and dignity (Mann *et al.*, 2000).

Public health has evidently incorporated human rights into its approaches. Access to health care has been defined as a human right in health and is emphasised in health policies and programmes (Mann *et al*., 2000). The International Declaration of Human Rights of 1948, and other health-related declarations had indeed advocated this for.

UNFPA articulates some of the principles of human rights-based approaches in sexual and reproductive health. They are universal, inalienable, indivisible, interdependent, and interrelated (UNFPA, 2009) and notes that the realisation of one right often depends wholly or in part on the right of another.

The UNFPA, WHO, and Office of the United Nations High Commission for Human Rights (OHCHR) jointly codified human rights on contraceptives stemming from the 1949 Universal Human Rights Declaration. The OHCHR and WHO, however, do not have any role in human rights work on contraceptives in South Africa but. Produces global guidelines, set policy parameters and standards, but are not involved on implementation, monitoring, and human-rights enforcement at the country level.

In South Africa, the National Health Act of 2003 provides for access to health care. It must be noted that the language of 'access' does not necessarily define health as a right, at least in the context of South Africa. The right of access to health care is conceived from a narrow focus, which leaves out other human rights issues. The right of access to health care may not be realised if other rights are not realised and addressed by the health care system. These rights include the rights to choose, autonomy, and non-discrimination, amongst others.

Furthermore, the right of access to health care should not be conceived in isolation from health as a political phenomenon framed within the ideology of patriarchy and women's oppression. Health care should address, rather than enforce, these oppressions. Essentially, the right of access to health care should be conceived from women's lived experiences, the feminist perspective. The current approach silences the racialised gendered political, economic, and oppressive nature of contraception in public health care in South Africa. The approach is in line with the liberal view of conceiving rights bearers as consumers and clients. The right of access is promoted through the neoliberal sense of supply and creating demand, and is more focused on making sure that there are programmes and service delivery.. The demand, the consumers, are conceived as silent agents, who must enjoy the right to access without their contributions, voices, oppressions, autonomy, and aspirations, amongst many other factors being taken into consideration. Such factors are removed from women's rights to making reproductive choices and women's choices about what is inserted into their bodies. The transformation and redress agenda is not part of this approach.

7. HUMAN RIGHTS CONCERNS AND VIOLATIONS IN PROVISION OF CONTRACEPTIVES

The eleven women who participated in the study reported that they were not given the opportunity of choosing whether to take the injection (Participants CU OQC/01, /02, /03, /04, 05, CU HSC/01). Women mentioned that they had faith in the health care workers. Women who participated in the study were not provided with information to enable them to make informed choices with regard to contraceptives (CU OQC/01, OQC/02, OQC/04, HSC/04, HSC/06). Some of these concerns can be linked to human rights, in particular the right of access to information, informed consent, and the ability to choose the method of contraception, amongst others. In some instances, women's rights to bodily integrity were not adhered to. Indeed, some of the concerns, for example, stock outages, could be understood as a health systems challenge. However, this does not remove the human rights concerns, and indeed stock outages compromised women's rights to choose their preferred method of contraception, and also the right to an appropriate method of contraception (Participant OQC/03 HST/05). Health care nurses interviewed for this study expressed similar concerns (Participant HCW/01 and HCW/03). It would have been difficult to exercise choices in situations of stock outages. The stock outages of contraception material are one example that prevents women from using contraception of their own choice. The women would have appreciated being given more information about what the health care workers had chosen as the best contraception method for them (Participant OQC, /01, OQC/04, HSC/02, and HSC/05). Participants indicated that they would have preferred to know more about underlying reasons for the choice, and to be given more information about the injection as contraception. "*I would have appreciated more information on the injection…you know, how it works, that thing'… Ehhh… I was going to take the injection even if the information given to me was not good information, I was going to ask them to explain"* (Participant OQC 04). Some of the women indicated that they had not actively thought about knowing more about the contraception at the time when they received the injection. However, looking back, they felt that they should have been told more, and that they should have asked for more information (Participants OQC/01, OQC/02, OQC/03, OQC/04, OSQ/05, HSC/02 HSC/03, and HSC/05).

Women who were initiated on contraceptives after giving birth shared that they thought taking the injection was part of the routine post-delivery care. These women accounted for 82% of the contraceptives users who participated in the study. They were informed that they had to take the contraception injection before they could be discharged from hospital. Some women

participants at a particular hospital felt forced to take the injection "*The sister came to the ward with a trolley and informed us, all women in the ward that it is now time to take the injection. 'We are providing family planning, no one is going home without taking the injection, we do not want to see you here next year to give birth'*" (Participant CU OSQ/01). The study observed that this has been practiced over a period of time. Experiences of participants, who were initiated on contraceptives in the late nineties, 1997, were the same as those women initiated in the early 2000s and others who were initiated as recently as 2016. It was also observed that women had faced similar experiences of being offered contraceptives as part of mandatory post-delivery care, in subsequent pregnancies. This was mainly in hospitals: *"Clients make an informed choice after getting all the detailed information we still find that there is still a high take of contraceptives like Depo*" (Research Participant KI 10).

Two experts in the areas of research and policy who participated in the study reported that, notwithstanding health systems and compliance on the part of health care workers, women choose Depo Provera. This injection is their preferred method over other methods of because of its convenience, and because it is what they know (Research Participants KI 10 and Participant KI 01). This may be a valid point; however, the health system has a duty to inform women of the side effects, and also a responsibility to cause no harm. As per the discussion earlier in this report, the apartheid state invested multiple resources in marketing and promoting DP. The effects of such marketing have been sustained over time. Reversing the effects of such marketing has to be an active action taken by government; it will not happen by itself. Whilst time constraints and resources of health care workers are acknowledged, such cannot justify not protecting the rights of women. The UNFPA acknowledged that some women who have been on DP for a long time might choose to stay on it because of lack of information of the side effects. The women might be persuaded by the convenience it brings. UNFPA, however, suggested that there are opportunities not to prescribe DP to young women, giving young women other options. This approach will, in the long term, reduce demand for Depo Provera by users (Research Participant KI 10). *"We are talking of those that have been on it for a long time but we have a very youthful population that needs contraceptives, again it will depend on how we are promoting it, what is our messaging, things like social media, how they use those things to promote new technology and contraceptives, but at the same time we can do all that but if our facilities are not ready to deliver on it, that is a challenge*" (Research Participant K10).

A study by the Human Sciences Research Council in 2015 found that up to 37% of women living with HIV had reported being forced to take Depo Provera as a condition for receiving their HIV treatment (Cloete *et al*., 2014). The same authors found that 7.4% of women living with HIV who participated in the study reported that they had been forcibly sterilised (Ibid.). Mthembu *et al.* (2011) reported that women living with HIV were targeted and forced into sterilisations (Mthembu *et al.,* 2011). In 2019 the Commission for Gender Equality reported in a submission to the United Nation Special Rapporteur on Violence Against Women that forced sterilisations and HIV-positive women being forced to take Depo Provera was reproductive violence against women in South Africa. The picture of sterilisations in the broader population has not been documented. However, female sterilisation is reported to have increased in South Africa from 2013/2014 to 2015/2016 (Mureithi, 2016). In 2016, sterilisations accounted for 10% of contraceptives, whilst injectables accounted for 43% of contraceptives used in South Africa (DHIS 2016, Mureithi 2016. There have been reports of schools forcing learners to take Depo Provera injections in one of the provinces (SABC News, 2018). The MEC for Health in the province of KwaZulu-Natal was found to have given contraceptive implants to students who benefitted from a government bursary to study medicine and pharmacy in Cuba, the Mandela-Castro Programme (Maqhina, 2014). This was to ensure that pregnancy did not interrupt their studies and, by extension, the investment of the Department in the students.

The research participant who is a Member of Parliament indicated that there might be instances in which women might have been forced to take Depo Provera or did not receive adequate information to make informed choices. The Member of Parliament, however, felt that this was not a major issue. '*To have Depo is neither here nor there, it is worse to have a tubal litigation, Depo is reversible, not that it should have been done, it should have been known*' (Research Participant KI 11). The chairperson's major concern was forced sterilisation of women. "*We found it to be worse in the violation of human rights is to give someone a tubal ligation without consent or explanation of why you are having a tubal ligation; that is almost a non-reversible outcome as opposed to DP. Someone can argue that I was not aware, someone can say: I told you. The worse one of the two is the tubal ligation without consent*" (Research Participation KI 11).

8. PROVISION OF INFORMATION ON HUMAN RIGHTS IN CONTRACEPTIVES PROVISION

Information on human rights-based approaches to contraceptives advocated by the policies and various human rights instruments are not made available to women users of contraceptives, in the form of materials and verbal information to the women. The policies reviewed for the purposes of this study, for example, mention rights but do not provide for measures to protect

the rights, including the basic practise of ensuring that rights bearers are educated and informed about their rights and provisions for their participation, in order to listen to their voices and experiences. The Department of Health states in the policy "*Client empowerment and community participation and mobilisation are promoted as part of the overall contraceptive service package*" (Department of Health, 2012).

The Patients' Rights Charter was visibly displayed on the walls of both clinics sampled for the study. The Department of Health developed this charter as an acknowledgement that the majority of the South African population experience either a denial or violation of fundamental human rights, including rights to health care services (Department of Health, 1999). The purpose of the charter is to ensure the realisation of the right of access to health care services as guaranteed in the Constitution of the Republic of South Africa (Act No 108 of 1996). The charter serves as the Department of Health's commitment to upholding, promoting, and protecting this right. The charter is provided for by the National Health Act, 61, of 2003, and was written in English and isiZulu. One of the clinics, the Osizweni Q clinic, also had ten *Batho Pele* principles pasted on the wall. These were in isiZulu. In the dedicated room for young people, there was a one-page typed document detailing contraceptives, and other sexual and reproductive health services offered to young people The youth services are provided by an external partner, the MRU. This suggests that there is commitment to human rights, albeit at a superficial level in health-delivery services. It is observed that the rights commitments are on broad health services, but not specifically available for contraceptives, in particular Depo Provera, which is a duly acknowledged tool of controlling women's bodies, therefore deserving of political and redress attention in the post-apartheid social justice project.

Women users of contraceptives who participated in the study made no mention of any knowledge of the history of contraceptives. Admittedly, this was not one of the research questions. The women also did not mention knowledge of issues of trust, racialized systematic cohesion, and targeting associated with Depo Provera either in the past or in the present. This is in contrast with the findings of Dehlendorf *et al.* (2013) that in the United States women of colour expressed lack of trust, resistance, and race-sensitivity issues if White workers were dispensing contraceptives to them, because of the history of racial differentiation and targeting of Black women for certain forms of contraceptives (Dehlendorf *et al*., 2013). This indicated the lack of awareness and openness, and profiling of reproductive injustices against women in apartheid South Africa as political issues.

The historical perspective of women's reproductive oppression, such as the goals and the provision of Depo Provera in a coercive and forced manner, is not publicised. Women are acknowledged for their contributions to the struggle for liberation, duly so. However, the acknowledgement is mainly on the mainstream part of the struggle, such as the arms struggle, torture, labour rights, resisting their removal from urban areas in South Africa, amongst others. The focus of the contributions to the struggle is male-centred traditional roles. Reproductive violations and the cost of the struggle on women's reproductive autonomy are not counted. Women are also praised for the reproductive and care roles they played in the struggle, including supporting men, being carers, and raising children. The gendered nuance of the oppression of women's bodies has been depoliticised in the post-apartheid South African project.

9. TRAINING AND INFORMATION FOR HEALTH CARE WORKERS

Training health workers, providing guidance and monitoring systems for human rights is key in expressing commitment on adherence to human rights at the facility level. This builds the foundation of respect for human rights of women. Education on human rights with regard to contraceptives is focused on health care workers. Evidence of this is seen in the training manual on the 2012 policy, which is mentioned earlier in this report. Users of contraceptives have not been provided for in programmes, for example, training or development of material for them. "*We are not directly in contact with patients but our contact is the health care worker and we work with the health care worker and the focus being capacity building, the example of the counselling tool that has been developed emphasises that the client must be provided with all methods so the client can make an informed choice, you should not give a client a method because that is what you can do in the time you have*" (Research Participant KI 10).

The UNFPA contracted an agency to develop the training tool on behalf of the Department of Health. "*Yes, she was contracted by us*" (Research Participant KI 10). The UNFPA provides financial and technical assistance to policy formulation and capacity building on contraceptives. However, the capacity building for women users of contraceptives is not provided for in their funding packages and programmes. This would have been in line with their mandate as an agency responsible for contraceptives, family planning, and other services in the UN system. UNFPA does not invest in ensuring that the users know what they rights are through provision of information and capacity. UNFPA also does not invest in enforcing or ensuring that women can enforce the rights they codify. As indicated earlier, UNFPA does

monitor uptake of contraceptives, and provides different support for uptake at the health care delivery level. It can be concluded that the UNFPA is not committed to ensuring that the rights of the users are respected. It can also be stated that articulation of rights in UNFPA policy statements is a tool to silence human rights violations and advocacy for human rights in contraceptives. The focus on health care workers could be reinforcing the power imbalances between health care workers and women users of contraceptives, essentially reducing the women to passive consumers of services. Indeed, the approach of capacitating the 'supply' side of the value chain and leaving out the 'demand' side of the chain is compromising the demand − the women users. This approach further compromises the power imbalances between health care workers and women users of health services. It entrenches the idea that women should be passive users of services and that providers should be information givers. This also suggests that there is limited commitment to the rights of users, although such is committed to and articulated at a higher level. Implicit in UNFPA's articulations, there is an acknowledgement that the training has had limitations: there is still a lack of application of training to practice. "*Unfortunately as much as they train and advocate, what happens at a facility, there is a notion that the health care worker will do the right thing, the human rights is that all the information is given so the client can make an informed choice, not you imposing a method on the client, that is human rights, in all our training we advocate for that, to bring that on board, like I am saying is what we have found is that some health care workers are doing it but some based on the workload and the client waiting in the waiting room etc. and on issues of stock, they go with what they can do, which should not be the case*" (Research Participant KI 10). In UNFPA registered training, there are still concerns on the level of information transmitted to women users in order for them to make informed decisions on methods of contraception. By its' own admission, the training interventions on rights-based approaches do not always produce the desired results. "*Our training is carrying that element of human rights-based approach, but we have no means of ensuring that it happens*" (Research Participant KI 10).

The UNFPA acknowledges that Depo Provera has some potential dangers, and there is a need for women to be discouraged from using it: "*If I just give you an example, we know that in South Africa Depo is most widely used, despite training and efforts to change that women still prefer Depo… Where UNFPA comes in is we provide training for health care workers, the training is to inform clients of all the methods that are available, to provide information to counsel them so they can choose the appropriate method that is most suited to them, although*

our experience has shown that as much as we try and promote that way, clients make an informed choice after getting all the detailed information we still find that there is still a high take of contraceptives like Depo" (Research Participant KI 10). There are also suggestions and calls for Depo Provera to be removed as a contraceptive in South Africa.

One of the research participants noted that the state is missing the opportunity of removing DP as a main contraception: "*There is an opportunity to change to safer methods of contraception, young women can be introduced to other safer methods*" (Research Participant KI 10). The Chairperson of the Portfolio Committee suggested that there is an expectation that Depo Provera should not be used: "*We will not go into specifics, we have not been aware of the side effects outweighing the benefits thereof, of the general family planning. It has to be the department that dissects, I think Depo is still in the market or has it been removed*?" (Research Participant K11*).* This research participant was the member of the executive responsible for health in KwaZulu-Natal prior to joining National Parliament.

Some human rights, feminist, and public health structures have called for Depo Provera to be banned completely as a method of contraception in South Africa and other African countries. This is because of its racialised, colonial, political economy association with the eugenics movement, side effects, including recent fears of association with increased exposure to HIV, amongst many other reasons (Watts, 2017). These arguments have been countered with public health concerns that removing DP will increase maternal mortality: women will not have other options of contraceptives. This argument does not hold, because there are other safer options that can be made available to women who need contraceptives. The assertion also does not consider women's personal, socio-economic desire and agency to plan for their children. Furthermore, this standpoint places the responsibility and blame on women for high rates of maternal mortality, subjecting women to reproductive punishment through interfering with their bodily integrity and autonomy. Of even more concern is that this assertion silences and diverts attention from key drivers of maternal mortality.

Thaddeus and Maine (1994) provided a groundbreaking formula for understanding the drivers of maternal mortality from a developmental perspective. They list the drivers of maternal mortality as three delays: The first is delay in decision to seek care. This delay is impacted by the low status of women, poor understanding of complications and risk factors in pregnancy, and when to seek help, poor experiences of health care, acceptance of maternal death, and financial implications; the second delay is in reaching care due. This delay is influenced by

distance to health care centres, availability and cost of transport, geographical location, for example, mountainous locations; The third delay is in receiving adequate health care owing to poor facilities and lack of medical supplies, inadequately trained and poorly motivated medical staff, and inadequate referral systems (Thaddeus and Maine, 1994). The delays, as detailed above, identify maternal mortality as a result of a complex of disadvantages. Such are gendered, expressed in the low status of women, women as a group, and women from different social classes. Other indicators of disadvantage, poverty, age, race, ethnic, marriage, and so forth impact levels of female status. The other factors are developmental, or the lack thereof. The second delays are related to failing health systems, which is partially linked to development. Lack of development is a result of organisation of global political and economic power. This shapes local political economies and determine the level or lack of development impacting on maternal mortality. The biomedical health and scientific solution to this complex gender and developmental problem is controlling the reproduction of the poor. A more logical solution would be to improve the status of women by eradicating patriarchy, addressing poverty, and underdevelopment by ensuring fair and equitable political and economic arrangements in the global and national economic regimes. Focus on reducing fertility of indigent women is therefore allocating an unfair dividend of the burden of system failures on women's bodies.

10. INSTITUTIONS OF HUMAN RIGHTS PROTECTION, ADVANCEMENTS, AND ENFORCEMENT

The UNFPA framework on human rights-based approaches to sexual and reproductive health state the accountability principle between and amongst the rights holders and duty bearers. The state has a duty to respect, promote, and fulfil these rights. "*Ill-health constitutes a human rights violation when it arises, in whole or in part, from the failure of a duty bearer, typically the state to protect or full fill a human rights obligation*" (UNFPA, 2009). South Africa has a number of constitutional bodies and other structures, which are mandated, to promote, protect and fulfil human rights, including women's rights, as provided for in Chapter 9 of the Constitution of the Republic of South Africa. In addition, the National Health Act of 2003 provides mechanisms to ensure compliance with health procedures and protocols, in order to protect, enforce, and advance the rights of people who use health services.

10.1 PATIENTS' RIGHTS CHARTER

The Patients' Rights Charter referred to earlier in this chapter provides patients with the right to report complaints about health care services, whether public or private health care services.

However, the Charter does not detail where and how the complaints should be launched. It also does not provide contact numbers or addresses of where women could go to lodge their complaints. In 2013, the National Department of Health: Office of Health Standards Compliance developed a National Complaints Management Protocol for the Public Health Sector of South Africa (National Department of Health, 2012). The details of this protocol and the protocol itself were not displayed in the two clinics sampled for this study. The next section of the chapter discusses the role of the Office of the Ombudsman on contraceptives policy and enforcement of the rights of users of contraceptives.

10.2 OFFICE OF THE HEALTH OMBUDSMAN

The Office of the Health Ombudsman was established in 2016 under the National Health Act, 2003. The mandate of the Office is "*to protect and promote the health and safety of users of health services by considering, investigating and disposing of complaints in the national health system (private and public health establishments) relating to non-compliance with prescribed norms and standards and 'contribute towards a development of public service culture characterized by fairness, dedication, commitment, openness, accountability and the promotion of the right to good public administration*" (Office of the Health Ombudsman, 2018).

According to the 2017-2018 Annual Report of the Office of the Health Ombudsman the office investigated fifty (55) formal complaints from the public (Office of the Health Ombudsman, 2018). The report does not list any complaints apropos to contraceptives received in this period. Reports of medical students on a bursary scheme who were forced and coerced to take Depo Provera and implants as a condition of their scholarships had surfaced (Maqhina, 2014). Reports of learners who were routinely injected with Depo Provera in schools without being told what the injection was for, nor with the consent of their parents, was reported in the same period (SABC News, 2018). In the same reporting period HSCR has revealed in the study that 37% of women living with HIV who participated in the study were forced and coerced into taking Depo Provera (Cloete A., Simbayi L., K Zuma K., *et al*., 2014). During this period the scientific debate and concerns about the association of Depo Provera with increased biological vulnerability of HIV infection in women was in its heights (Heffron, 2011; Brind *et al.*, 2015). Issues of stock outages of other forms of contraceptives in clinics and hospitals in KwaZulu-Natal were reported at the same time were also not reported during this period either; only women's health issues were reported. This illustrates that the issue of Depo Provera did not attract the health policy and compliance responses it deserves both from the public and the

Office of the Health Ombudsman. The office of the Health Ombudsman missed the opportunity to fulfill its' mandate in this regard. The investigative mandate of the Office extends beyond cases reported by the public.

The Office investigated two complaints related to maternal health, specifically, the death of infants. One of the two complaints was in Gauteng, and the other was in KwaZulu-Natal. One complaint was about the mother not being informed in good time of the death of her infant (Office of the Health Ombudsman, 2018). It is observed that none of the cases reported were about the mothers themselves. There was only one women's health-related complaint, that of unreasonable delay in diagnosing cervical cancer. This particular complaint was not investigated to final resolution, because the complainant died, and the family was not keen to pursue the complaint further. The overwhelming number of complaints investigated during this period was concentrated in Gauteng. Twenty-six (26) cases from Gauteng province were investigated, whilst four (4) and eight (8) cases from KwaZulu-Natal, and the Eastern Cape, respectively, were investigated. The details and the contact details of the Office of the Health Ombud were not publicised in either clinic, which participated in the study. This picture suggests that there is limited awareness and knowledge of the Office of Health Ombud in the communities. Furthermore, the Office has had limited reports of women's health, suggesting in part, that the Health Ombud has not targeted nor has a specific focus on contraceptives and on broad issues of women's health. In the 2017-2018 Annual Report, the Office of the Health Ombud detailed the engagement it has had with various structures of the state. The Office met with different medical associations, investigative bodies, and health department officials in the provinces, and also visited certain hospitals. The Office also had engagements with key Chapter Nine institutions, including the South African Human Rights Commission and the Office of the Public Protector. The report does not mention engagement with the Commission for Gender Equality or with any of the public structures responsible for women, for example, the Parliamentary Committee on Women in the Presidency, nor the Department of Women (Office of the Health Ombudsman, 2018).

10.3 THE COMMISSION FOR GENDER EQUALITY (CGE)

Constitutional bodies such as the Commission for Gender Equality and the South African Human Rights Commission have been involved in contraceptives. The analysis of these structures is in line with the objectives of understanding the ideology and the position of

contraceptives in the post-apartheid reconciliation and transformation project. Human rights are a backbone of South Africa's transformation.

The Commission for Gender Equality (CGE) reported that it has not worked directly with issues of contraceptives or injectable contraceptives. This Chapter Nine institution is in the process of formulating a strategy on women and health. The plan will be presented and will form part of the CGE's work in the next strategic plan. "*We have reviewed the National Development Plan (NDP) from gender and found that health for women was not broadly provided for. Our review is to start to proactively ensure compliance with gender*" (Research Participant KI 04). The CGE reported that they had received complaints and investigated issues of forced sterilisations of women living with HIV/AIDS. "*The CGE is in the process of finalising an investigation based on complaints and a wider sampling relating to coerced sterilisation. The investigation is however not finalised and information in this regard cannot be shared*" (Research Participant KI 04). The CGE reported that they had also received and investigated a complaint on high rates of maternal mortality (Research Participant KI 04). "*There are other investigations on-going, e.g., the issue of women in labour lying on the floor in a Germiston Hospital, but that matter is also still on-going, and I can therefore not divulge any further information*" (Research Participant KI 04). The officer stated that when the CGE received a complaint that relates to women's health, the matter would be taken up and investigated.

10.4 SOUTH AFRICAN HUMAN RIGHTS COMMISSION (SAHRC)

The South African Human Rights Commission (SAHRC) was interviewed for the study. The Commission indicated that they do not work with the National Department of Health to monitor policy to ensure that the human rights provisions are adhered to. They confirmed what the Department of Health had indicated, which was that they did not participate in the formulation of contraceptive policies of the Department of Health National Contraceptives and Fertility Planning Guidelines and Service Delivery Guidelines of 2012 and 2018. However, they do work with the Department of Health on various issues at a high level. The Commission confirmed that they had not received any complaints in relation to contraceptives, including Depo Provera. The Commission investigates issues of individual members of the public as well as group complaints. In some instances, the Commission will investigate strategic issues that are in the public interests (Research Participant, KI 08). Contraceptives have not been one of the issues the Human Rights Commission has investigated.

The Commission works mainly in the space of social rights. In the area of health, the Commission has worked on investigating Esidimeni, regarding the state of cancer services in KwaZulu-Natal and the state of hospitals in the Eastern Cape. The Commission has worked with government on these issues, and also hosted seminars and dialogues with the communities on such (Research Participant, KI 08). The Commission reported that they are also working with the Department of Health in addressing the concerns of the litigation bill of the Department of Health. The nature of the engagement is to find alternative ways of resolving complaints. SARHC has missed the opportunity to address this issue from the perspective of affected women, thereby making systematic and structural recommendations, which will benefit more women in the long term. This would have assisted in defining maternal mortality as a human rights issue, in essence, increasing the pool of interventions on this issue, and deploying more measures of respect for human rights in health care services.

The Human Rights Commission indicated that their interventions were broad and focused on more general issues. For example, the cancer investigation was focusing on all cancer services: there was no specific focus on provision for women's or reproductive cancers, for example. The SAHRC Research Brief on Gender and Equality in South Africa states that only two (2) per cent of the complaints investigated between 2013 and 2016 were gender-related (SAHRC, 2018). This is because they refer gender-related matters to the Commission for Gender Equality. Both the CGE and SAHRC alluded to this fact of referral arrangements between these two organisations. Neither the SAHRC nor the CGE could provide the nature, numbers, and state of cases referred. "*In relation to complaints referred from SAHRC, I would suggest you contact SAHRC to provide you with this information. It does not automatically follow that the matter will be gender related even if it is referred to us. SAHRC is therefore best placed to assist you in that regard*" (Research Participant KI 04).

The Research Brief focuses on women in employment, education, land, and alternative streams. Cultural practices, in particular, *uKuthwala* and virginity testing, and gender-based violence are addressed in the brief. Inequalities in health were not part of this research brief (SAHRC, 2018). HIV/AIDS is part of the brief; however, the focus is on HIV/AIDS discrimination in the workplace. The HIV/AIDS workplace programmes have focused on mainstream issues. Men have lodged most of the Court cases. SAHRC has missed the opportunity of addressing issues of forced contraception in post-apartheid South Africa, including forced sterilisations of HIV-positive women. These are systematic human rights violations. Furthermore, the SAHRC could have identified these issues as strategic issues, because of their racialised discrimination of

women in apartheid South Africa. The referral of gender issues to the CGE is also a challenge. This may be marginalising the issues of human rights of women. The CGE will focus on the gender discrimination nuances of the issues. There is justification for joint investigations of the issues from the two perspectives, for example, forced sterilisations of HIV-positive women. The CGE will present gender-specific findings and redress: joint investigation will have been stronger. The political position of the CGE and the level of resources referenced earlier in this report are areas of concern that indicate the political clout of gender and women's rights in the South African state, which would obviously impact on the quality of investigation and the political clout attached to the recommendations of the CGE.

The UNFPA indicated they are not working with the Human Rights Commission or the Gender Commission. The UNFPA is also not involved in any work that ensures accountability for human rights issues and adherence to agreed procedures on contraceptives. "*We can do training and all of this but we depend on government to put structures of accountability, you must remember these are core aspects that should be done in anyway, we are so called outsiders, we can give you guidance, we can support you to strengthen systems and capacity but its governments prerogative to monitor*" (Research Participant KI 10). The UNFPA indicated that it is difficult for them to conduct monitoring of the compliance of human rights in service provision.

The current situation is that the UNFPA does not have capacity to monitor the contraceptive policies and service delivery from the perspective of human rights. The UNFPA is not conducting any community- or user-based evaluation studies or programmes to monitor adherence to human rights provisions they codify to safeguard women's rights in contraceptive policies and programmes in South Africa. The community can report to the UNFPA on whether they were offered Depo Provera without their informed consent or whether they were offered other alternatives, or whether they were even made aware of other alternatives (Research Participant KI 10). The UNFPA had recommended a service user and community monitoring study "*We need to hear from clients themselves, it will be a major study, it has been recommended if they want to improve systems, we have the information, we know what is*" (Research Participant KI 10).

The South African Constitutional Court has not dealt with cases of reproductive injustices, including contraceptives and forced sterilisations in the country. This fact was listed as one of the limitations of the courts in an interview with the outgoing Deputy Chief Justice of the

Constitutional Court in 2015/16 (Power987 FM Radio interview with outgoing Deputy Chief Justice Dikgang Moseneke, November 2016). This suggests that, although contraception, and Depo Provera in particular, is a human rights matter, and its provision in policies are based on human rights, there has been no enforcement of human rights in the Courts, Constitutional Courts, Chapter Nine Constitutional Bodies, and internal DOH structures provided for by the National Health Act of 2003, the Office of the Ombudsman.

11. LITIGATION ON DEPO PROVERA

In understanding the political economy of contraceptives, it is important to consider how the laws protecting the women have been applied. Litigation on Depo Provera is particularly important for this research as it begins to show the global structural inequalities, in entitlements to legal rights, and human rights. Analysis of litigation demonstrates how pharmaceutical companies benefit from the power imbalances; neo-colonisation embedded in foreign aid extended to developing countries. The chapter makes an observation of the far-reaching effects on the involvement of the external developed world in policy formulation in the developing world, such as South Africa.

South Africa does not have documented medico-legal litigation on forced use of Depo Provera or any other related matter. The research participant who serves on the Parliamentary Portfolio Committee on Health confirmed that there has not been any litigation in the country on Depo Provera. "*You might bleed more or worse with Depo, but this is what we have now, it has been actually happening with that injectable, we tell them that they might experience more bleeding or more this and that, dizziness, this is what we give you but there has never been any litigation*" (Research Participant KI 11).

Legal reports from the United States of America suggest that Pfizer, the drug company that manufactures Depo Provera, has been subjected to litigation for decades. The litigations included class as well as individual cases, and in most instances, women launched both. In all cases the drug company has either lost or settled cases out of court. *Tens of thousands of women initially sued Wyeth Pharmaceuticals and Upjohn Pharmaceuticals amongst others, (these companies are part of Pfizer group) for allegedly failing to warn them of the side effects"* (The Rebecca Project for Justice, 2014; Frost and Reich, 2008). In 2011, Pfizer settled the Norplant contraceptive lawsuits, for its subsidiary Wyeth, for approximately $30 million in the United States of America (Frost and Reich, 2011). Similar lawsuits were seen in Canada. These have

been present for at least three decades. The most prominent was a class action amounting to about $700 million (Superior Court of Quebec, 2010). In 2021 a Superior Court in Quebec Canada ordered compensation in the form of payment of $1.9 million class action settlement. Canadian women who took Depo Provera injections for at least four consecutive times every three months as contraception were later diagnosed with osteopenia or osteoporosis before May 31, 2010, and within 30 months of their last Depo Provera shot (Ministry of Justice, Superior Court of Québec, Canada, 2021).

Mediatory means have been used to redress Depo Provera in other countries. In 2013, the government of Israel instituted a ban on all new Depo Provera prescriptions. The Israeli health officials maintain that administrators coerced the immigrant poor and Black women of African origin, mainly from Ethiopia to use Depo Provera without consent and full understanding of harm (Dawber, 2013, Association for Civil Rights in Israel, 2013). The government of Israel set up a committee to probe Depo Provera further after the moratorium was ordered (Nesher, 2013).

Litigation has been on the grounds of side effects, including cancer of the cervix, breast cancer, excessive bleeding, fertility complications, depression and hair loss, amongst many others. Litigation has also been on grounds of coercion and forced administration of the injection. Litigation and ethical questioning of Depo Provera was also associated with its prescription to sexual offenders, to decrease their sexual hormones, as a condition of their parole and part of sentencing in the United States.

More recent litigation has been on reduction of bone density, medically known as osteoporosis, leading to many bone and spinal-related diseases. The loss of bone density associated with Depo Provera is permanent and irreversible. One of the research participants who is a medical doctor, and a former Chairperson of the Reproductive Rights Alliance in South Africa raised her concerns about this bone-density issue in South Africa, and how it is silenced. She raised some of the cost of this to women in Limpopo: "*Elderly women in Limpopo are accused and killed for witchcraft because they have bent spinal cords because of Depo Provera*" (Research Participant KI 07). Decreased bone density is one of the side effects, which are not listed, in the hand-written posters demonstrated in the rural clinic, which was sampled for this study.

In most of the side effects claims, the main issue is failure to inform the women of possible side effects. In some instances, Pfizer would have withheld information even to medical practitioners. In the case of bone density, the manufacturer of Depo Provera was ordered to

have the risks highlighted in a 'Black Box' in the insert, detailing the drug, its use, and any further pertinent details. The Black Box is the highest risk warning issued by United States Food and Drug Administration (FDA). The FDA is an agency within the U.S. Department of Health and Human Services (HHS) that oversees the manufacturing and distribution of food, pharmaceuticals, medical devices, tobacco, and other consumer products, and veterinary medicine (FDA, 2019). The Black Box warning is silent in South Africa. It has not been mentioned nor discussed either from the side of government or the providers. South Africa has not focused on holding the manufacturers of drugs companies accountable. The drug companies have not been sued as in America and Canada, for example. The country has a culture of holding political power accountable, but not much holding of economic power, in this instance, the pharmaceutical industry, accountable.

In 2012 the US-based agency the Program for Appropriate Technologies in Health (PATH) and USAID (2012) proclaimed that they were working to expand Depo Provera as a contraceptive method of choice, so that is it accessible to more than 200 million in the poorest countries of the world (Cover *et al*., 2016). These two agencies seem to have double standards. Women in the developed counties rarely use Depo Provera. If they do, it is very short-term and with strict conditions. The Rebecca Project for Justice (2014) observed that mainly White women have sued Pfizer for harm. However, Depo Provera is still promoted for Black women, and women of colour in third-world countries (The Rebecca Project for Justice, 2014).

12. MEDIATORY ADVOCACY AND PARLIAMENTARY PROCESSES ON DEPO PROVERA

Mediatory means have been used to redress Depo Provera in other countries. As detailed in the discussion of Constitutional bodies and Ombudsman above, this has not been the case in South Africa. In 2013, the government of Israel instituted a ban on all new Depo Provera prescriptions. The Israeli health officials maintain that administrators coerced African women to use Depo Provera without consent and full understanding of harm (Dawber, 2013, Association for Civil Rights in Israel, 2013). The ban was inspired by internal human rights groups and women's rights organisations; and external condemnation at the targeting of African women for the contraceptive (Association of Civil Rights in Israel, 2013). The government of Israel set up a committee to probe Depo Provera further after the moratorium was ordered (Nesher, 2013). The Israeli scenario demonstrates that litigation is not the only

way to address violations related to Depo Provera. Political and moral pressure can persuade governments to take decisive action on the matter.

Civil society and human rights structures have not taken up this issue in South Africa. State constitutional structures have missed opportunities to act in the interests of women in this regard. I argue that South Africa has missed the opportunity of using a political solution to Depo Provera. This is a missed opportunity. The country failed to call for a moratorium on Depo Provera even during the HIV/AIDS crisis.

In 2013 a Senator, Senator William Lacy Clay, led the Congressional Black Caucus Legislative Conference to discuss "Black Box Warnings to Protect Black Women" (The Rebecca Project for Justice, 2014). The hearings called some of the agencies involved in Depo Provera, for example, the Bill and Melinda Gates Foundation, to respond to some of the questions about side effects and targeting of Black women. This suggests that parliamentary structures may also call for accountability on the matters of Depo Provera. There are routes other than courts that can be pursued in seeking justice and change for women in this regard. There is room for political action and solutions on these matters. India officially banned Depo Provera from its welfare programmes in the year 2012. The banning was mainly on the grounds of lack of informed consent (Population Council and Engender Health, 2003). The decision was also political. It was political action to undo the Ghandi political legacy of humiliating, violating, inhumane sterilisations and deaths of Indian women in return for Western food aid (Connelly, 2008). India was able to achieve this ban despite the country being one of the world's most targeted countries for population control.

13. NORPLANT LITIGATION

Norplant is included as a subject of analysis of this study, as it is the extension of the political economy of Depo Provera. In 2014/2015, this contraceptive was introduced into South Africa. Norplant is popularly known as a sub-dermal implant (DHS 2016). In 2016, the implants accounted for 7% of contraceptive use in South Africa (Mureithi, 2016.) Norplant has the same progestin chemical component as Depo Provera, the only difference being that Norplant is implanted under the skin, while Depo Provera is injected (UN Population Publications, 2010). Norplant class and individual litigations have been seen in the United States, Canada, and the United Kingdom. In the United Kingdom over 400 women lodged legal claims against Norplant manufacturers. Norplant was withdrawn from the market in the United States and the United Kingdom in 2002, and 1999, respectively. The drug had been used for six years only in

the United Kingdom (The Rebecca Project for Justice, 2014). There has also been no litigation on Norplant in South Africa. The public discourse about Norplant as another formulation of Depo Provera has been limited. The new formulation of the Depo Provera is being marketed as another form of contraception to expand choices for women. The invention and expansion is benefitting from the silencing of Depo Provera as a racialised political phenomenon and violation of Black women's bodies to meet economic and political ends.

The sale of Norplant is prohibited in the United States of America, however the World Health Organisation and global actors in the family planning establishment including the Gates Foundation, systematically promote the use of modified version of the drug in the developing countries, and African countries in particular (The Rebecca Project for Justice, 2014). Some of the efficacy human trials research on Norplant in African countries has been a subject violation of women's human rights and non-compliant to research ethical standards. Similar controversies characterised some of the Depo Provera research projects in the Africa region. Research According to the Rebecca Project for Justice (2014), Norplant efficacy trials were conducted on African women in the Democratic Republic of Congo, Egypt, Ghana, Kenya, Madagascar, Nigeria, Rwanda, Senegal, and Zambia, without the informed consent of the women.

Similarly, unethical research involving DP, in which women were not told that the research included DP, has been found in Ghana, where 9000 impoverished rural women participated, under the pretext that they were being provided with routine health care ([2,3]The Rebecca Project for Justice, 2014). The research project was funded by the Gates Foundation, USAID, the Rockefeller Foundation, and the Population Council ([3] Ibid). There is no evidence that there has been any litigation, or legal claims, nor have settlements been given to the women from the countries listed above.

There have also been ethical issues raised about the ECHO trials. The purpose of the ECHO research was to confirm the heightened risk of HIV infection in women using hormonal contraceptives, chief amongst them Depo Provera. The ECHO study purposefully administered Depo Provera; a drug suspected to increase vulnerability to HIV infection to women. The human trial targeting for the ECHO study is in line with the racialised targeting of developing countries, in this instance, women from ten countries in Southern and Eastern Africa with high rates of HIV infection were targeted. Numerous retrospective studies had identified this association. Retrospective confirmatory studies and other research not exposing women to

further harm could have been explored. Furthermore, questions should be asked about the rationale to conduct studies to confirm harm, rather than exploring safer methods for the women. Researchers in the biomedical field have also shared their concerns about this study. Sathyamala (2019) discussed some of ethical issues around randomising women to a drug that is hypothesised to cause harm (Sathyamala, 2019). The sentiment is that it was not necessary to conduct such a study. Furthermore, the research targeted indigent women who are already vulnerable to HIV infection. There was also no moratorium on Depo Provera whilst confirmatory studies were conducted. Furthermore, the conflict of interests for the researchers and funders was of huge concern. The main funder of the study was the Bill and Melinda Gates Foundation, the key promoters of Depo Provera.

14. MEDICO-LEGAL CLAIMS AGAINST THE DEPARTMENT OF HEALTH

Examining the enforcement and women's claims of human rights is important in assessing the human rights commitments afforded to contraceptives and broad reproductive health in South Africa. The Department of Health has seen an increase in medical negligence litigation. The Department of Health is employing various measures to address the escalation in claims for damages based on medical negligence and the increasing financial implications thereof for the public-health sector (South African Law Reform Commission, 2017. One of these measures is to strengthen access and delivery of contraceptives, as articulated in the rationale for Department of Health Contraceptive Policy Guidelines (2012 and 2018). The other measure is to explore legal reforms to address this concern, amongst many others. The former measure is to specifically reduce medico-legal claims in maternal health services (South African Law Reform Commission, 2017). The Office of the State Attorney reported that the office had paid the total of ZAR 49. 9 billion between 2010 and 2014 − four years. Of this amount, the total of ZAR 205.3 billion was paid on behalf of KwaZulu-Natal Department of Health (Phahlane, 2015). According to Algorithm Consultants and Actuaries (2017), the South African Department of Health had a contingency liability of ZAR40.9 billion for medico-legal claims in the public sector at the end of the 2015-2016 financial year. Of this amount, ZAR 9.9 billion was a contingency liability in the province of KwaZulu-Natal. In the same year, South Africa had allocated a total of R527.9 billion to health (Algorithm Consultants and Actuaries, 2017). The National Department of Health was not able to share the detailed list of the nature of the claims. In its report on the medico-legal claims, the South African Law Reform Commission reported some of the judgements for 2011 and 2015 as case law (South African Law Reform Commission, 2017). The Commission stated that not all claims go to court because some of

them are settled out of court (Ibid). Eleven (11) out of (20) cases were about maternal health issues, in particular issues of childbirth. Two (2) cases were of still births, one (1) case was that of the mother dying after birth, one (1) was for another disability; whilst six (6) of the eleven (11) claims were for children who developed cerebral palsy as a result of neglect and non-compliance with procedures at birth (South African Law Reform Commission, 2017). This confirms the fact that, indeed, the majority of medico-legal claims on the Department of Health are for maternal health and birthing services. What can be observed with these claims, however, is that most of them are about children, with only one case for a mother, not mothers, as such. This suggests that, even in the maternal mortality litigation sphere, the focus is on saving babies rather than the mothers. Further, looking at these numbers, this phenomenon could be better understood as maternal infant disability.

These claims are not related to unplanned pregnancies. Claims rather speak to the three delay drivers of maternal mortality, as defined by (Thaddeus and Maine, 1994). They speak to a lack of following procedure and respect for human rights, and in most instances sheer negligence is the problem. Given the circumstances, up-scaling contraceptives and targeting certain population groups is not a logical conclusion for addressing maternal mortality and the levels of legal claims. The logical solution will be to address the problems in the health system, enforcing compliance and respect for women's reproductive rights. Funding for medico-legal litigation claims is not budgeted for separately. Such funding is therefore provided for in the same budget for health care services. "*Claims are instituted against the Member of the Executive Council (MEC) for Health in the province, but the money to pay the claim, which could run into several million rand in each case, is in most instances derived from the budget of the hospital concerned. The more damages to be paid, the less money is available for service delivery, the poorer the quality of the service rendered by the hospital, the more room for negligence and error, the more the claims*" (South African Law Reform Commission, 2017:16). This suggests that the exact number of claims cannot be predicted. Such, inevitably, has a direct impact on the provision, the quality, and the availability of health care services.

The impact of spending resources of this nature has not been scientifically measured from a gender and women's health rights perspective in South Africa. At a health care delivery level, it could be difficult to count the cost to women's health, even harder to do so in the context of non-availability of resources allocated to women's health. It can, however, be hypothesised that these costs create a spiral, in which the more funds are spent on litigation, the less resources

are available, therefore the increase in maternal mortality, morbidity, disability, and death. The real cost of these failures is borne by women as individuals, and as a group. The litigation narrative has been presented as an outcome of an antagonistic relationship between human rights lawyers, health care workers, and professionals.

This was the popular view propagated by the former Minister of Health. This view places the real issues for women in the power struggles of two potent patriarchal establishments, the legal and the medical fields. The effect of this is that litigants may not achieve social solidarity because they may be seen to be working with greedy lawyers to divert resources from essential services, therefore compromising access to good quality health care. It is also observed that there could be a role for community health structures, such as Clinic Committees, in reducing the errors through monitoring services, and ensuring that the women are provided with the best possible care. There is also no record of these structures holding the Department of Health accountable for the high rates of litigation, and consequent diversion of resources.

Women bear the cost of the disability of their children. I argue that the cost is there whether women are compensated or not. Women could lose the opportunity to pursue education to improve their lives. This is in the context of high rates of teenage pregnancy and understanding that mothers who bear disabled children are more likely to be young or teenage mothers. Disability adds another complex layer on intersecting vulnerabilities and exclusion of women at a family and societal level. The care burdens, costs, and emotional costs of child-to-adult disability are borne by women. It must be noted that disabled children are less likely to grow up to be independent adults. As such, care and provision for mothers is a lifetime burden. Furthermore, it is observed that child disability, in particular cerebral palsy, is missing from the discourse. It has to be noted that litigation brings justice; however, litigation focuses on one individual woman. The legal fraternity has failed to use litigation for social transformation, to improve the situation of women in reproduction. The country is yet to see lawyers, who successfully litigate these cases, using the success of cases to advocate for broader change on a societal level. This is a missed opportunity.

Disability is part of the continuum of failed maternal health services. In the continuum there is maternal death, infant death, maternal morbidity, and infant disability. Where mothers, and/or infants do not die as a failure of maternal health care, babies are born with a disability. Improving maternal mortality will therefore decrease infant disability. Infant disability is silenced as one of the outcomes of failed maternal mortality services. Infant disability in the

country has not been viewed from a feminist lens. Disability programmes are focused on the disabled individual, leaving out the women, who are at the center of providing care, carrying the burdens of disabilities. There is a need for the system to address the added exclusions and disadvantages faced by women, mainly young women, who are parenting disability. The implications of child disabilities on women's health, emotional health, and exposure to violence are of great concern. The contribution of cultural and religious regimes to this is also a matter of concern.

15. LIMITATIONS OF RIGHTS-BASED APPROACHES

It is important to consider the broad limitations of human rights approaches, based on the findings of the study. This contributes to the study objectives of exploring how the human rights frameworks enhance the rights of women users of contraceptives. According to Doyal (1995), being female is a risk for increased experiences of inequality. Women are mostly an economically excluded group, facing many other forms of oppression and poverty which lead to ill health. These include, amongst others, female infanticide, inadequate food, medical and health care, violence against women, rape, teenage pregnancy, amongst many others, (Doyal, 1995). Improving public health has the potential to decrease inequalities between men and women. Because of women's over-representation in public health, is it assumed that women will benefit more than men from health services. Human rights-based approaches are therefore adopted in health programmes, with the assumption that protecting everyone's rights will lead to women benefitting more (Rogers, 2006). This is, however, not possible in the current situation in which women's rights are not protected and gender is not considered in the conception of the programmes. Programmes are conceived from the prevailing patriarchal understanding of women's roles and position in society, in this instance, reproduction. Such programmes will not contribute to gender equality nor improve the situation of women, but will rather reinforce and sustain the status quo. Rights-based approaches should not be removed from the pre-existing and underlying gendered population and reproduction management agenda. Rogers (2006) states that equal rights commitments' approaches which are not gendered nor conceived from a gender perspective may not be competent to deliver the expected benefit for women (Rogers, 2006). I agree with this assertion. Generalised rights-based approaches may not lead to equity, which is an essential condition for achieving human rights. Without direct focus on women's rights in health and in society, women will not benefit. Furthermore, there is a need for social transformation as well as transformation of health care as a sector.

There is a need for categorical commitment to eliminate gender inequalities in health. Rights-based approaches do not include gender or socio-economic status as relevant variables. The interventions of these approaches could lead to various outcomes if gender and socio-economic status are included. Meaningful recognition of women's agency and allowing women to identify their own needs based on their lived experiences, is one of the more likely routes to gender equality (Bangser, 2002). Failure to address specific inequalities, such as gender-blind or gender negative interventions, tends to enable people to tolerate deprivation, without changing the material and non-material injustices that lead to such deprivation (Rogers, 2006).

Human rights-based approach commitments are limited as they make assumptions about the abstract characteristics of rights bearers, including independence, rationality, impartiality, and autonomy (Lloyd, 1984). Human rights approaches may silence the voices of the most vulnerable (Ferraz, 2009). Certain groups, in the context of this study women users of contraceptives, are invisible as rights bearers. This invisibility stems from their intersecting layers of vulnerability and exclusion, including, amongst other aspects, gender, socio-economic status, their level of entitlement to societal goods, and position in society. As stated earlier, Depo Provera, and major population control programmes are targeted at the majority of impecunious women in low- and middle-income countries. In the USA, for example, Black women accounted for 84% of users of Depo Provera, whilst in South Africa and Zimbabwe; only Black women were given Depo Provera (Scully, 2015). In South Africa it is impoverished Black women, and women who use public services who are given Depo Provera. Black African Jewish women were targeted for Depo Provera in Israel (Dawber, 2013; Association for Civil Rights in Israel, 2013). Over and above race and socio-economic status, the policies for DP target HIV-positive women, women at risk of HIV/AIDS, and young women. This is evident in the main populations targeted by the policies.

In India, Depo Provera targeted women beneficiaries of welfare services. Beyond poverty, women who were targeted were of lower caste. The Chairperson of the Parliamentary Portfolio Committee on Health, who is a former MEC for Health in KwaZulu-Natal, South Africa, stated that the Department had provided oral contraceptives to private clinics and providers in the past. "*I am aware of private health facilities like private hospitals who do not necessarily want to spend money on procuring family planning devices, especially oral contraceptives coming into the Provincial Department of Health to request that they stock some medicines, why they do not buy is another story*" (Research Participant KI 11). The sharing with the private sector

could have been part of the importance of the programme. Contraceptives are part of the national strategy, which will reach all classes of women. One possible reason for doctors in private facilities being reluctant to prescribe Depo Provera is the high likelihood of the middle-class patients they service suing them.

It is, however, of concern that women who use private medical services, have medical insurance, and can be classified as middle class, are subsidised for oral contraceptives, a safer method which women have more control over. This may explain the politics of class in provision of contraceptives; or that there is a lower demand for injectables in the private sector. It is of concern that the Department would spend public resources on subsidising private providers, given the status of resources for public health. "*Provincial departments have not been refusing to send boxes and boxes to private health facilities to stock, we do not sell it, family planning is not sold, it has been reaching there, not for sale but to be dispensed to those that need it, that is the orals, not the injectables, we have the procurement which has never been a problem, it is not one of those sort of commodities that are difficult to find*" (Research Participant KI 11).

According to the research participant, there was a surplus of oral contraceptives, which could be shared between and amongst provinces and regional health authorities (Research Participant KI 11). According to this research participant, this could be as a result of excessive procurement, or lower prescription of oral contraceptives in the public sector. Indigent women are more likely to prioritise other basic needs, for example, sustenance for their families, or safety for their families. As discussed earlier, such women might be receiving social support from the state, and/or the community, and as such, they would feel indebted to them, avoiding challenging the system through fear of losing such support. This hinders the women from exploring legal redress for their health violations. Furthermore, the organisation and activism of feminists on women's health rights is limited. Local women are mostly organised as part of the general public focusing on practical issues, such as, housing, water, and sanitation. Social exclusions are a result of lack of action in enforcing rights, rather than being associated with discriminatory practices (Adato *et al.,* 2006). Judicialisation of health requires access to financial and other resources to litigate. Cases of human-rights violations are located within the civil rights claims in the judicial system. Civil rights claims are not promoted nor funded as much as criminal rights and defence in the South African legal system. Rights violations in health care may be defined as criminal, but it is unlikely or very rare that women will report matters of consent to the police, for example. It also has to be acknowledged that the judiciary

and criminal systems are not a panacea for enforcing human rights. Social transformation on gender and targeted gendered human rights interventions in health, with the intention of transforming the health system may address some of these problems. The society and the community do not acknowledge rights violations in contraceptives.

At deeper patriarchal, economic, cultural, religious, and broad societal levels, it is acceptable to control women's fertility and reproduction; as such, the violations are silenced. Rights approaches do not always work, owing to lack of structured monitoring and enforcement of rights. The status of women and societal ideology on contraceptives may be a contributing factor. Contraceptives are silenced as part of public health programmes designed to address maternal mortality, and to address the challenge of teenage pregnancy. Contraceptives are also located in poverty alleviation programmes, for example, the Department of Social Development in South Africa. These are issues that carry certain prevailing moral values in society. This creates an environment for uncritical societal support and approval of contraceptives. The integration of contraceptives into HIV programmes silences the issues of control and potential harm of women's bodies even further. Society will support interventions that are HIV-related because of the devastation of HIV/AIDS.

Critical feminist thinking on these issues in the country is therefore essential to change the status quo, and for the country to live up to its goals of the emancipation of women, and gender equality. In this instance, the violation of rights of women is legislated against, but not prohibited. Women may be aware of their rights but choose to forego or bargain away some of their rights to access others, such as fear that refusing a method of contraceptives offered to them may affect their post-delivery care. The medical profession is one of the most powerful patriarchal establishments. It is therefore more difficult for individual women than women as a group to challenge this power. The pharmaceutical industry is another global capitalist power which is difficult to challenge, because of its power entrenched in governments and the international governance system. Accessing and enforcing human rights may be difficult for impoverished women because of costs associated with legal services.

Other barriers are rooted in international trade and the hegemony of multinational corporations. Companies producing the drugs are registered in the United States or other developed countries, not in the countries where they are distributed and the companies may only sue in the countries where they are registered this creates a major barrier and is a disadvantage for plaintiffs or those who wish to sue; for the purposes of this study, women from developing

countries targeted for Depo Provera. Women in other countries, like South Africa, will have more hurdles to access the US legal system in the event that they decided to sue the drug company manufacturing Depo Provera. "*USAID, Pfizer, and Gates' legal teams also recognize that the multiple legal options available to women in the U.S. and Europe are not available to millions of harmed women of colour globally, who have to depend on the Alien Tort Statute 28 U.S.C. § 1350 (ATS) to seek redress*" (The Rebecca Project for Justice, 2014:13). Other gendered barriers, such as time, familial and community support, cultural issues, time spent in care, and other intersecting violations, may prohibit women from seeking legal redress for their health violations. This study found that, for example, women did not use the comments boxes provided or complaint about the location of toilets at the clinic. The women reported that they did not use comment boxes because they did not trust that complaining would change their situation. Indeed, women expressed their agency after weighing up their situation and chose not to litigate or challenge the system. This does not, however, suggest that the violations cease to be violations. Notwithstanding the need for litigation redressing such matters, this points to the need for a multi-pronged strategy for gendered social transformation. Such would substantially transform the health sector from a human rights perspective, creating the cultural web of responsibility and accountability between health workers, the medical field, individual women, and society; amongst other aspects, redressing interventions to protect and advance the rights of women in this regard.

16. SUMMARY

This chapter has discussed human rights-based approaches to contraceptive policies and programmes. The chapter examined how these are provided for and presented as programmes, and detailed findings on how approaches were applied in the programmes of the two clinics sampled for this study. The chapter concludes that the policy framework is progressive, in terms of articulating human rights-based approaches; however, these are not provided for at the programme level. This demonstrates that the articulation of rights is not matched with the environment within which the rights are to be realised. The rights articulation misses the analysis of women's lives, as indigent Black women in a post-colonial society. Such analysis is conceived from a mainstream human rights perspective, as such, missing the women. This is notwithstanding that the rights are not provided for in programmes and budgets. Furthermore, the chapter concludes that human-rights approaches are not viewed from a women's rights lens. Assumptions are made about equality of rights bearers. The chapter explored the possibilities

and the limitations of enforcing human rights through formal legal remedies and other reconciliatory channels, including political action. Human rights are universal. It is, however, observed that, broadly speaking, women's oppression, the location and status of their country in the global economic complex, is one of the indicators of whether they can access their rights, as well as the politico-economic history of their country, colour of their skins, the age, and socio-economic status. Protection and enforcement of human rights is barely provided for, even by the international bodies that codify human rights, such as the United Nations. A plethora of barriers exist in terms of these structures monitoring human rights at the ground level. Such structures participate in setting the agenda, undertaking research and dictating policy processes for contraceptives. These structures monitor distribution, coverage and uptake processes; however, they present with challenges in monitoring human rights implementation.

Furthermore, it can be observed that the legal liability for drugs lies in the drug companies in countries such as the United Nations and Canada, amongst others. Although we have not had litigation in South Africa, all litigation, the faults and the liability, lies with the state. This points to the gendered political economy of laws of a post-colonial state. In this regard, for example, the laws have protected the multinational drug companies from being sued. This speaks to negative effects neoliberalism, that of the external world setting the policy agenda in the country, in this instance, the policy agenda has protected the external world, and placed the responsibility on the state. This suggests that women in the country are disadvantaged twice, in being issued with toxic contraceptives, their rights to choose and health removed; also, their access to resources as citizens are diminished, because resources for litigation are taken from the health resources (budgets) of the country, so every litigation claim aid reduces the resources available. The observation on this human rights enforcement and litigation suggests that the struggles for women in contraceptives do not end. They appear progressively in various political regimes, transitions, and ideologies.

Litigation on Depo Provera has been around for more than four decades, and court cases will continue to surface if Depo Provera – or its ingredients- re-surfaces in other contexts. There has not been any recorded litigation of Depo Provera in developing countries. The global legal systems and drug regulatory framework have ensured that economic power is excluded from litigation. This suggests that the problem is more deeply embedded than simply in Depo Provera. The problem is patriarchy using political, economic, and pharmaceutical power to control the reproduction of women. The lasting solution to this is liberation of women and

ending patriarchy. This suggests that women's struggles do not end; that they should be embedded in all transitions.

This study observes that there have not been international human rights and diplomatic relations outcries on these issues, considering that some of the Depo Provera crimes are fairly recent. This international solidarity has been missing even in the feminist spaces: contraceptives, and Depo Provera in particular, have not been seen as international human rights violations. This suggests that contraceptives and Depo Provera are considered apolitical in the global political economy system.

CHAPTER 6

THE ROLE OF INTERNATIONAL ORGANISATIONS IN POLICY, FUNDING, RESEARCH, AND PROCUREMENT OF CONTRACEPTIVES IN SOUTH AFRICA

1. INTRODUCTION

This chapter discusses the international political economy of contraceptives. This is in line with the objectives of the study to explore how contraceptives, Depo Provera in particular, are at the centre of the international political economy, neoliberal agenda, and the emerging power in the international governance system. The chapter explores the roles of the global contraceptive's movement, especially those leading the economic and political aspects of the movement. They do this in shaping the ideology, policy, and delivery of contraceptives in South Africa, by applying the feminist political economy theoretical framework. The theory emphasises considering women's bodies, control and subordination of women, particularly in relation to reproduction in the global political economy system and regimes (Riley, 2008).

The themes that emerged from the policy reviews and participants are as follows:

TABLE 4: THEMES PERCENTAGES OF RESPONDENTS

RESEARCH THEMES	PERCENTAGES
Global policy, regulation, and governance of family planning programmes.	26
Historical perspectives of contraceptives, including the population explosion concerns, eugenics, and the Malthusian theory	33
Global policy framework, including the international conference on population and development (ICDP) programme of action and family planning 2020(FP2020)	44
The role of international unilateral United Nations and bilateral organisations in policy agenda setting and development, funding, research, and procurement of contraceptives globally, and in South Africa	26

The power and influence of private foundations and philanthropists in contraceptives policy, financing, and procurement in South Africa Continuous research, geo-politics of research and innovation on Depo Provera.	7
The power and role of philanthropical organisations and bilateral agencies in high-level strategic South African health policy, treasury health budgeting and allocations**.**	22

2. GLOBAL INTERGOVERNMENTAL GOVERNANCE OF CONTRCAEPTIVES: INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT (ICPD)

The South African contraceptive policies must be located in the global intergovernmental relations and unilateral governance frameworks. This section of the chapter discusses how the unilateral structures serve as vehicles and engines of neoliberal internalisation of contraceptives, Depo Provera in particular. Discussion centres on how this international political economy of contraceptives then produces the ideology of contraceptives in South Africa**.**

The ICPD conference is said to be the first international conference, which secured international commitment to reproductive rights, including contraceptives (ICPD, Programme of Action, Action 7:10 1994:77). This conference was considered a breakthrough in terms of women's rights and reproductive rights. The ICPD mandated developed countries to provide technical assistance, training, and contraceptives supply in the developing countries, transitioning countries, and post-Cold War countries. "*Without jeopardizing international support for programmes in developing countries, the international community should, upon request, give consideration to the training, technical assistance, short-term contraceptive supply needs and the needs of the countries in transition from centrally managed to market economies, where reproductive health is poor and, in some cases, deteriorating*" (ICPD Plan of Action, 1994:77*).*

This assertion makes it clear that contraceptive support should be built on the existing support aid programmes. These resources should not be removed from existing programmes. This is a

classic case of neo-colonialism and neoliberalism in contraceptives. An international declaration, which is supposed to advance women's rights, is used to legitimise this act of neo-colonialism. This support is offered to assist. The declaration states that the focus is on countries in transition from centrally managed to market economies, suggesting that this interference in contraception is also part of the agenda for liberalisation of the economy. The Plan of Action recommended that countries prioritise reproductive health, albeit emphasising contraceptives, and discouraging abortion. "*Those countries, at the same time, must themselves give higher priority to reproductive health services, including a comprehensive range of contraceptive means, and must address their current reliance on abortion for fertility regulation by meeting the need of women in those countries for better information and more choices on an urgent basis*" (ICPD Plan of Action, 1994:77). This can amount to international ideological bullying on priorities, as well as on abortion.

Discouraging abortion by labelling it as being used as a form of contraceptive is not in line with the spirit of women's rights and choices. The language of abortion as a form of contraceptive is also of concern. The language used suggests that abortion happens because of lack of contraception. However, by extension, if this is the case, contraceptives are therefore to be deployed as a solution to abortion. Complex and mounting reasons for women to opt for abortion are ignored, and women's rights to choose are also ignored in this instance. Furthermore, the argument may be that women die in backstreet abortions. However, the reason for those deaths is partly because of failure of health services for women, including post-abortion care. The other major driver of backstreet abortions is patriarchal cultural and religious values, which drive the perceptions of women on abortion and the choices they make. The permeation of these two institutions of oppression of women, culture and religion into the health care service, is also a driver. Women who need abortion services and post-abortion care might be refused such care, directly, or insidiously, as a way of punishment for 'not listening when told to take contraceptives. Furthermore, this is driven by class and other marginalisation that destitute women face. Abortion for women of higher social and economic status is not seen, nor is it subjected to public debate. The logical solution will therefore be to ensure that the services are available for all women. This articulation on abortion also suggests a lack of understanding of abortion from the perspective of a Black woman of low social class - the position of women in this articulation is not considered. What this suggests, also, is that the ICPD is committed to supporting contraceptives, and not abortion; although abortion is part of the reproductive rights package the declaration is committing to. Furthermore, this articulation

might give the donors power to insist on discouraging abortion as one of the conditions of funding.

USAID funds a programme called post-abortion family planning. The programme extends post-abortion care patients access to contraceptive methods, including long-acting reversible contraceptives, permanent methods, and lifesaving care (Baynes *et al.,* 2019). The argument in this regard is that it will be highly unlikely for women to make informed choices in light of the vulnerable position they will be in post-abortion. The offering of permanent contraceptives in this vulnerable period is also an issue, particularly in light of well-documented forced and coerced sterilisations of some marginalised groups of women in South Africa. In this instance, we again see contraceptives and ending of women's fertility being mainstreamed into post-abortion services.

The programme does not provide for safe abortion, nor does it address the health system drivers that contribute to increasing abortion and the subsequent need for post-abortion care. One of the outcomes of the ICPD conference was a compromise between two strands of the population movement, the neo-Malthusians, and the liberal feminist strands (Robinson, 2010). The reproductive rights and autonomy strand is feminist, advocating for individual women's rights and autonomy in relation to contraceptives (McIntosh and Finkle, 1995). This strand of feminists was holding a different view. They did not believe that ending poverty means eliminating people who are poor. In the compromise, the feminist strand was able to include the women empowerment and reproductive rights language and targets; and neo-Malthusians were able to achieve inclusion of social-economic development in the language and targets (Robinson, 2010). Population observation at the time had proved that access to education, economic resources, and eradication of poverty, amongst other factors decreases birth rates in individual women (Frey, 2011). The feminists were calling for the transformation of the fairer rules of international trade and development assistant as a solution to poverty (Frey, 2011).

The women's rights and autonomy achieved by feminists were framed from an economic development perspective, with decreased emphasis on population control (Frey, 2011). Although contraceptives and family planning programmes do bring women closer to realising their reproductive autonomy, the paradox is that human rights framing of contraceptives are not necessarily about advancing the rights of women.

This study did not find evidence of women's economic empowerment in policies, the programmes, and experiences of women users of contraceptives who participated in the study. Furthermore, women users were not provided for in resources or by way of information, and training in sexual and reproductive rights. This is presented in the findings detailed in Chapter five (5) of this study. The study found no programme or investments in the rights of women users, both by national actors or international actors such as the UNFPA, USAID, Gates Foundation, and Clinton Health Access Initiative. Some scholars have suggested that the contraceptives lobby might have co-opted the human rights language to advance population control. Robinson (2010) refers to the neo-Malthusian movement as the macro, and the feminist population movement as the micro (Robinson, 2010). Fuderi (1997), for example, cautioned that the population control establishment has co-opted the women's rights discourse and language to advance its goals through contraceptives (Fuderi, 1997).

3. MALTHUSIAN THEORY, EUGENICS, POPULATION EXPLOSION AND POPULATION CONTROL ESTABLISHMENTS

This section examines the theoretical ideological understandings that led and influenced the contraceptives movement, its institutionalisation and globalisation, as solutions to global problems of the time and the future, both real and imagined. Locating such understanding and debates in this research is important. The overarching visions and assumptions for contraceptives establishment are positioned at the global level. Malthus hypothesised, reacting to a growing population in England that the population increased at a faster rate than its means of subsistence. Klausen argues that family planning policies are grounded on population growth concerns propagated by Malthusianism. Malthusianism argues that this phenomenon will have catastrophic effects such as famine, disease, natural disasters, or war unless there is either contained moral restraint or disaster (Klausen, 2004). This theory became known as the Malthusian theory (Ndengwa, 1996). According to this school of thought, unchecked population growth inevitably results in widespread poverty, environmental degradation, loss of food security, and general threat to development (Robinson, 2010; Thomas, 1993; Klausen, 2004). The theory was developed further to include contraception as means to control population. This theory was referred to as Neo-Malthusian (Ndengwa, 1996). Neo-Malthusianism found expression in post-colonial Africa. "*Social scientists, politicians and the press have located the roots of many problems of Africa's post-colonial problems in reproductive practises- paraded as new issues of development they are not*" (Thomas, 1993). Furthermore, these theories suggest that population is not a concern in the developing world.

This is not the case, in Africa, which has a vast landmass per capita compared with other continents. Without justifying population control in India, India's population of 1.2 billion is greater than the whole of Africa; however, India's landmass is eleven times smaller (The Rebecca Project for Justice, 2014).

The concern in Africa is that of colonialism, global inequalities, global division of labour and power in the global economic, underdevelopment, internal wars, and resultant poverty and disease, amongst others (Fuderi, 1997). Indeed, women who have access to education and other development services have fewer children. This contributes to the improvement of their lives and those of their children. This suggests that development reduces the rates of childbearing rather than the other way round. Poverty is the driver of high population rates, rather than population rates driving poverty. Anti-natalist feminist Marie Stopes from England, Margaret Sanger from the USA, Elise Ottesen-Jensen from Sweden and Rama Rau from India brought a feminist perspective to the discourse. These feminists contended that having fewer children would emancipate women and engender common good for all societies. The justification was that indigent women give birth to too many children, thus prolonging vicious generational circles of dependence, deprivation and poverty (Frey, 2011).

Other advocates of family planning emerged in social sciences. Social scientists theorised economic justifications for controlling fertility and reducing populations. One of the claims put forward is that children are costly in terms of their health and education, amongst other aspects. In contrast to this position, Ansley (1958) theorised that children provided an economic asset at micro- and meso-levels of the economy. The researcher proposed classification of costs for education and health for children as an investment, rather than as a consumption (Ansley, 1958). The two social scientists suggested that more non-economically active dependants (including children) in a society lead to reduced savings and investments. They concluded that family planning was thus a crucial instrument of economic development (Ansley, 1958). In the 1970s demography, a relatively new field of study defined as the study of population in social sciences, took prominence, and occupied the family planning academic space from the 1970s (Frey, 2011).

Margaret Sanger pioneered and founded family planning programmes in the United States of America. Sanger was using family planning to reduce the rate of poverty in local Black American communities as she understood that high rates of fertility was the cause of poverty, amongst her other motivations (Zubrin, 2012). The family planning programmes increased over

time and was later institutionalised, and later globalised. Some of the institutions formed were Planned Parenthood Federation of America, later known as International Planned Parenthood Federation (IPPF) and Marie Stopes. The family planning movement had assumed a global population control movement character at the time, rather than family planning at a micro level.

According to Zubrin (2012), Margaret Sanger and many other pioneers of the family planning movement establishment were driven by the eugenics philosophy rather than reducing fertility to out-root poverty or promote women's reproductive autonomy (Frey, 2011, Zubrin, 2012). According to Zubrin, (2012), Smith (2015) and Davis (1983), Sanger was institutionally attached, working for and accounting to the Eugenics movement, through the American Society of Eugenics. Sanger was acting on the mandate of the Eugenics establishment to fulfil its vision to contain the reproduction of the Black population in the United States of America (Davis, 1983).

Population control is able to attach itself to most discourses and topical global problems of the time (Fuderi, 1997). Development, famine and poverty are issues co-opted by this population control lobby. The recent South African 2012 contraceptive policy lists integration of contraceptives into other health services, in particular, HIV/AIDS, as one of the objectives of the policy (Department of Health, 2012). This suggests that contraceptive measures were attached in the global crisis and programmes of HIV/AIDS. The IPPF partnered with local political elites in India to launch a massive population control programme in India. This included large-scale sterilisations of Indian women (Paige 2004, Zubrin, 2012), which were funded by the United States government, USAID; later organisations, such as the Ford Foundation funded the UNFPA, and IPPF to expand the programme. At this stage sterilisation camps had been established (Paige, 2004, Connelly, 2008).

The United States of America, under President Johnson, included sterilizations of Indian women and other population control measures as conditionality for aid (Paige, 2004). The World Bank also made population control and sterilisations of women in India a condition for their funding and aid to assist with famine, which had resulted in food shortages (Paige, 2004). The population lobby's argument was not holding in the 1990s. There was lack of solid evidence on the negative effects of population growth as they had hypothesised. Funding for population control programmes decreased, partly because of the end of Cold War and recession of the 1990s. Furthermore, population rates were decreasing across many continents, as such; their argument was no longer as plausible (Hodgson and Watkins, 1997; Frey, 2011). This state

of affairs necessitated a movement to find other ways to justify and resource its course. Contraception in South Africa is located as a health issue, therefore silenced of its political nature. Contraceptives are also located in poverty-alleviation programmes in the Department of Social Development in South Africa (Department of Social Development 2018). Contraceptives are mainstreamed in the Sustainable Development Goals, the Global Development Agenda (SDGs, 2015). South Africa reports on these goals on contraceptives on a regular basis (Department of Social Development, 2018). The study observed that the reporting is focused on numbers and types of contraceptives dispensed, rather than any analysis on development or women's rights or how these are aligned and progressing in South Africa's transition.

The population policy and management of the country is located in the DSD, and teenage pregnancy and population dynamics are part of the mandate of this department. The Department of Social Development researcher, who participated as a respondent in this study, is working on population research and policy, not a social-assistance programme (Research Participant KI 02). UNFPA is at the centre of the work of this department. The UNFPA technical adviser who participated in this study is housed in the Department of Social Development in KwaZulu-Natal (Research Participant KI 10). The official advises and coordinates work with DSD, the Department of Health, research institutes and international partners (Research Participant KI 10). What this suggests is the link between contraceptives, poverty alleviation, social assistance, and population policy or management. This also demonstrates how close the international agency is in government. '*A UNPFA officer who is responsible for comprehensive sexuality education in schools is located in the National Department of Health offices on a secondment basis'* (Research Participant KI 09). Viewing this programme more closely, the main focus is on contraceptives, according to the report of the Department of Social Development 2018 (Department of Social Development, 2018). It can be extrapolated that, in the main, contraceptives might be linked to social assistance programmes provided by the developed countries, in particular, the United States of America. In India, for example, sterilisation was a condition of aid from USAID (Paige, 2004; Connelly, 2008). At the meso-level of this condition was that sterilisation was formulated as part of the welfare policy. At a micro-level, women who did not agree to be sterilised, for example, received reduced food-aid rations, and the cutting of welfare benefits.

Thomas (1993) observed that, in line with this practice, the contraceptives and population lobby had attached itself to the HIV/AIDS crisis in Africa. "The emergence of HIV/AIDS was a

fertile ground for population control" (Thomas, 1993). Epidemiologists, donors and international agencies have found fresh ground in targeting women's wombs to advance population control, as a way of preventing and mitigating HIV/AIDS. This project is known as integrating sexual and reproductive health in HIV/AIDS: "*what we are moving towards when a client comes to you for family planning, you don't only provide family planning, you use that opportunity to do an HIV test and any other health services that the client may need, we are encouraging that health care workers should promote*" (Research Participant KI 10).

According to the 2017-2018 annual report of the Department of Health, South Africa is receiving HIV/AIDS treatment funding and support from USAID. It is highly likely that the HIV/AIDS funding facilitates South Africa's openness to the international community on the contraception agenda, if this is not one of the conditions of the funding. South Africa would be a viable target for the contraceptives' movement. The country has an established history of targeting indigent Black women for contraceptives, and established apartheid-era structural inequalities and division.

The contraceptives movement has solid resources and infrastructure, and it still bears the fruit of investment in the marketing of contraceptives in South Africa. The effects of this marketing, I argue, have not been interrupted. In addition, South Africa is one the countries with high rates of HIV infection in women of reproductive age, as well as in young women. The same is applicable to maternal mortality and teenage pregnancy. All of this contributes to strengthening the contraceptives lobby. The lobby has also attached itself to teenage pregnancy: contraceptives are provided as a solution to teenage pregnancy. Indeed, some degree of contraceptives and better planning is required for teenagers, however, these must be coupled with interventions addressing the real drivers of teenage pregnancy, which are intergenerational poverty, the position and the situation of young women, especially commodification of young women's bodies (Luker, 1997; Buske, 2002). The South African Department of Health's 2012, and draft 2018 reproductive fertility planning policies concur with this global priority. Teenage pregnancy has expression in both these policies. There are other supporting youth-specific policies that are speaking to the same − contraceptives, teenage pregnancy, and sexuality education. Some of these policies are the National Adolescent Sexual and Reproductive Health Rights (ASRHR) Strategy 2014-2019 (Department of Social Development, 2018).

This strategy provides for comprehensive sexuality education curriculum, family planning messages, access to contraceptives and access to condoms. These policies are formulated by

the Department of Health and the Department of Education. All these policies have contraceptives, and specifically injectables, as their core solution. These are now provided for in schools; and clinics have spaces created for young people to access these with ease. The Department of Social Development and Department of Health in KwaZulu-Natal are collaborating with UNFPA to roll out a contraceptives programme to address teenage pregnancy. Such will mitigate the impact of *ukuthwala* (Research Participant KI 02, Research Participant KI 10). The Department of Justice and Constitutional Development defines *ukuthwala* as a form of abduction and kidnapping a girl child or a young woman by a man, his male friends or male family elders with the intention of compelling the girl child or young woman's family to endorse marriage negotiations (Department of Justice and Constitutional Development, 2015).

The population control movement has attached itself to maternal mortality in Africa and South Africa. UNFPA, USAID, the Gates Foundation, amongst others, are now listing maternal mortality as one of the justifications for increasing contraceptives support (Family Planning, 2020). The recent proposed and draft South Africa 2018 policy lists maternal mortality as one of the justifications for scaling up of targeted contraceptives programmes. As detailed in the previous chapter, these interventions do not seek to address the drivers of maternal mortality. The FP2020 programme (2012) lists maternal mortality as a justification for family planning programmes. Looking more closely at the programme goals and investments, there is nothing that point to interventions to address maternal mortality and morbidity apart from contraceptives. Again, this is a contraceptives programme branded as maternal mortality. "*Funding comes from the Bill Gates of this world, they find DOH, they are not interested in women's health, but in good contraceptives outcomes*" (Research Participant KI 04).

The international community, through the ICPD reporting frameworks, is closely monitoring South Africa's progress on population control. As mentioned in the previous chapter, the African Union is also monitoring the country in this regard. This indeed suggests that population control is embedded in South African international relations and obligations. As such, interventions of international and regional community on this and surrounding issues are regarded by some as legitimate and justified. Apartheid-era fertility control policies were "justified" based on international development priorities and commitments (Furedi, 1997b).

There have been numerous international conferences and debates on population growth and a need for fertility control in the post-World War II period, and after the formation of the United

Nations (Ndengwa, 1996). The justifications for this came from an array of motivations, including political and economic stances. A key international policy, which institutionalised population control and development, is the Declaration of the International Conference on Population and Development. The Declaration seems to be sound on issues of reproductive health and rights. It is, however, observed that the priority issue is family planning and provision of contraceptives. "*Since 1994, achievement of reproductive health for all has been a primary principle for UNFPA and has also focused the population movement's activities more generally*" (Robinson, 2010). Eager (2004) and Lane (1994) state that the UNFPA contributed to the institutionalisation of the concept of reproductive rights in the population movement (Eager, 2004; and Lane, 1994).

The current ideology of contraceptives policies in South Africa is also rooted in the neoliberal ideology of the ruling African National Congress (Bond, 2000 Meer 2007). This ideology is influenced by the history of the country, the global political system, and the position of the country in the global system. The country achieved its democracy through a negotiated settlement (Meer, 2007; Bond 2000). Bond (2000) refers to this negotiation process and settlement as '*The Elite Transition'* South Africa diverted from its human rights centred socio-democratic positions of post-apartheid development, expressed through the Reconstruction and Development Programme, the RDP. In 1996, South Africa had to adopt the neoliberal economic policy advocated for by neoliberal international finance organisations such as the World Bank and the International Monetary Fund (Bond 2000; Meer, 2007). South Africa achieved its independence at the end of the Cold War, when such neoliberal agendas dominated global economic ideology (Ndengwa, 1996). The global balance of power and forces would not have made opting out possible for South Africa. It can be observed that international family planning has targeted political transition as entry points, such as the end of the Second World War, decolonisation of African states, and the end of the Cold War (Thomas 2003; Frey, 2011). The ICPD Plan of Action categorically mentions the prioritisation of countries in transition (ICPD, 1994). The targeting of countries in transition was mainly driven by fear of the spread of colonialism. The vulnerability of incoming political elites, and their reliance on aid and skills to govern, and more importantly the quest for international legitimacy, opened the doors for entrenchment of these interventions in their governments (Thomas, 2003).

The Rebecca Project for Justice (2014) has identified the targeting of the Middle East political transitions and the instability, as one of the opportunities used by the population control community (The Rebecca Project for Justice, 2014). The internal South African transition

concessions left the economic structure unchanged. The structural positions and targeting of policies did not transform much, apart from ensuring inclusion of Black South Africans, and thereby creating a Black bourgeoisie class (Meer, 2007). The transition was then focused on race, the Black and White, ensuring that individuals of a certain class of Black people had access to economic and political resources, with the hope that the gains would trickle down at some point (Meer, 2007). The Reconstruction and Development Programme were influenced at the time by the international development agenda on population control. The provisions of the declarations of the international conference on population and development 1994 (ICPD) were incorporated into the RDP document (Ndengwa, 1996).

This conference was building onto the United Nations and global population control establishment, which had started to globalise after the end of the Second World War. It was the beginning of formal participation and co-option of South Africa's post-apartheid government into the global population control system. The ICPD is advocating sexual and reproductive health; however, there is a pronounced focus on contraceptives, mainly referred to as family planning.

4. THE INVOLVEMENT AND INFLUENCE OF THE UNITED NATIONS POPULATION AND DEVELOPMENT FUND (UNFPA) AND THE WORLD HEALTH ORGANISATION (WHO)

The two United Nations multilateral organisations, UNFPA and the WHO helped to shape the ideology, the policies, regulation, programme and financing of contraceptives and provision of contraceptives in South Africa. In this, they met the objectives of understanding the role of intergovernmental and international actors. The two bodies became involved and influenced the ideology and policies around contraception programmes.

The United Nations Population Fund (UNFPA) is acknowledged for providing funding to the policy development process of the Department of Health, which has been reviewed as part of this study. UNFPA does not provide funding for commodities in South Africa. "*In terms of securing we do not secure commodities, not at all, what we do is strengthen the capacity of health care workers, that they can provide family planning services, one that is the right based*" (Research Participant KI 10). UNFPA funding of contraceptives is dependent on the economic grading and status of the country. UNFPA only provides commodities in low-income countries. South Africa is a medium-income country, as such; it is excluded from this programme.

"*UNFPA does not secure any form of commodities for the South African Government, only countries like…because South Africa is categorised as an upper middle-income country, UNFPA has never purchased or secured any commodities, low income countries they do*" (Research Participant KI 10). This means that South Africa does not qualify for grants or aid to procure contraceptives, and therefore must procure, contraceptives. According to USAID (2020), the UNFPA AND USAID provide technical support so that national governments are able to fund contraceptives. "*USAID and UNFPA support national governments in their efforts to step up ownership and financing for their family planning programs and on their journeys to self-reliance*" (USAID, 2020). UNFPA is also involved in training of health care workers in contraceptives. For example, UNFPA contracted a consultant to develop a training manual to train health care workers on the Department of Health 2012 policy. UNFPA provides the training to health care workers as needed "*In terms of family planning itself, what we have done is we have assisted in KZN, we found a need for the intensive counselling that health care workers were lacking, in how they should counsel clients in providing them with the contraceptive that would best suit them, so we've trained them, we have given them counselling tools and through that we are hoping that things will change*" (Research Participant KI 10).

The study found that UNFPA set the policy agenda, set priorities, and led policy formulation for the two Department of Health policies reviewed for this study. The role of UNFPA includes internationalising the policy. "*In terms of the policies, these family planning strategies and the name are now the revised Contraceptive and Fertility Strategy and it also includes elements of conception, we focus on contraception, and we also need to emphasis the point of healthy conception*" (Research Participant KI 10). UNFPA conducts and pilots policies to inform the national policy agenda in South Africa. "*The thinking behind UNFPA is that we pilot in a particular district'… to see results and then its replicated in 2012 we supported the development of a 5 Point Family Planning Strategy, basically giving all the information that one would need, the strategy was found to be so good that it was adopted by National, obviously with some modifications, then last year we re-visited that strategy and because South Africa, they don't want to call it family planning because young people say we are not planning any family*" (Research Participant KI 10). UNFPA has been providing support in promoting integrated services, which they call 'family planning plus': "*We are currently piloting in uThukela District, there are a few facilities we are piloting. We are integrating teenage pregnancy*" (Research Participant KI 10).

The Head of Research in the KwaZulu-Natal Department of Social Development reported that they collaborate with UNFPA to address issues of *ukuthwala* and high levels of teenage pregnancy in the uThukela region of KwaZulu-Natal. *Ukuthwala* is the practice of abduction and rape of young women and girls for marriage (Research Participant KI 02). The interview with UNFPA acknowledged UNFPA's involvement in this programme. The programme focuses on working with *Amakhosi* (traditional leaders) and young women. The focus on young women is to provide them with contraceptives in order to prevent pregnancies and second pregnancies in pre-, post- and during *ukuthwala* period. The project has recently started to screen for gender-based violence in teenagers (Research Participant KI 02). The concern here is that contraceptives are provided to assist girls to 'cope' with the violation of *ukuthwala,* (i.e., pre-consenting age sex) by preventing pregnancy, rather than addressing their violation and violation of the laws; and applying other interventions to ensure the safety of girls. The patriarchal system perpetuating the commodification and trading of women's bodies is not interrupted or challenged by these interventions. The exploitative system is made to be safe by deploying a business solution to this violation of young women. In this approach contraceptives have found a way of integrating with socio-cultural problems, they are being presented as a solution.

The Department of Health is always part of the technical support and work that the UNFPA does on the ground. In some instances, the Department of Health requests technical support from UNFPA. "*They are part and parcel from the onset, we do not do anything without the involvement of the Provincial Department of Health, they also give guidance in identifying where they need support, they are on board from the onset, there is a consultation, what we do is what they want and what is within our mandate, if it works, they replicate it*" (Research Participant KI 10). UNFPA has been involved in promoting newly innovated contraceptives commodities in the market "*We were very instrumental in advocating for Implanon (Norplant), the long-lasting contraceptive method"* (Research Participant KI 10). UNFPA is now part of the process to prepare for the introduction of the DP injection that women can self-inject at home. The agency has also been involved in community mobilisation work "*What we do is strengthen systems and strengthen capacity and community mobilisation to use the contraceptives, even doing that we do it on a very small scale and we depend on the Department of Health and the Department of Social Development, our funding is very little, we call it free funding*" (Research Participant KI 10). UNFPA has been receiving the average of 50% of its

funding from USAID since its inception (Robinson, 2010; The Rebecca Project for Justice, 2014).

The World Health Organisation (WHO) is responsible for global health governance. It also has a mandate to respond to global health emergencies. The agency is responsible for developing regulations for health practitioners, systems, and medicines. It issues guidelines on issues related to health and practice, including policy guidelines on key and emerging health issues. The WHO sets standards for health care practitioners (WHO, 2019) and has a mandate to respond to health emergencies and epidemics, such as Ebola (Reddy, 2018). The WHO has responded to HIV/AIDS, malaria and diseases emerging as post-natural disasters. The WHO is one of the United Nations agencies, which is part of the family-planning global establishment and is more focused on ensuring that interventions are scientific and evidence-based. Needless to say, some degree of prudent pragmatism should be applied. The WHO stamp of approval brings legitimacy and credibility to interventions (Frenk *et al.,* 2013) and this has been observed in South Africa. My observation, however, has been that the sector which benefits from WHO credibility is the medical field. I have observed over many years that the former Minister of Health in South Africa, Minister Motsoaledi, would invoke the World Health Organisation to legitimise his articulations. It has been very rare to hear structures of civil society or communities referring to the World Health Organisation.

South African policies on contraceptives flow from the policy guidelines of the WHO (Research Participant, KI 01). The World Health Organisation is acknowledged in the two recent contraceptives policies in South Africa and for providing technical support to the policies (Department of Health, 2012). The 2012 WHO Technical Guidance on Hormonal Contraceptives and HIV Infection is included as an '*Information Box'* in the policy document.

South African policymaking is guided by the WHO's continued revolving of Depo Provera and other hormonal contraceptives. Some of the global-health researchers, scholars, political economists, and human-rights organisations have argued that the WHO's reliance on programme targeted private donations opens the WHO to external donors dictating the priorities of the organisation (Gostin, 2015). Frey (2011) shares similar sentiments about the power of private foundations to set the agenda and priorities in WHO affairs. The Bill and Melinda Gates Foundation donations to the WHO are earmarked for programmes and priorities defined by the foundation rather than by the WHO as an organisation (Ooms *et al.,* 2014; Ruger, 2014; Yamey, 2002). Public-private partnerships (PPPs) such as the Global Fund, the

GAVI, and the UNITAID, and non-state actors such as the Bill and Melinda Gates Foundation partnership have led to new non-state actors playing a key role in global health (Reddy *et al.*, 2018). Correnti (2015) states that currently all World Health Organisation's major high-level policy decisions are subjected to Gates Foundation vetting before they are implemented (Correnti, 2015).

In 2013, Senator William Lacy Clay led the US Congressional Black Caucus Legislative Conference to discuss Black Box Warnings to protect Black women (The Rebecca Project for Justice for Justice, 2014). The hearings called some of the agencies involved in Depo Provera, for example, the Bill Gates Foundation, to respond to some of the questions about side effects and targeting of Black women (The Rebecca Project for Justice for Social Justice, 2014). According to Correnti (2015), the Gates Foundation gave the following response to one of the questions posed by the Caucus: "*The Gates Foundation collaborates with partners and governments to give women and couples access to a broad range of voluntary family planning services and information. The foundation doesn't procure Depo Provera. Our investments are to in-country service organizations that provide family planning services according to national guidelines, as well as WHO guidelines. These guidelines take into account the manufacturer's safety labelling and other clinical recommendations*" (Correnti, 2015). What can be seen from this statement is that the Gates Foundation uses the power it is given by the guidelines of the WHO and the countries to remove itself from the responsibility. Gates and USAID and their grantees have power to influence, draft these policies, as in the case of South Africa, and to initiate these policies. So, the establishment dictates policies, which will protect their interest. It is clear that the Foundation is also using WHO credibility in this instance. I could not find a record of any instance of the WHO being summoned to answer questions posed by a national parliamentary body.

USAID is one of the largest donors to the WHO. The Bill and Melinda Gates Foundation is a new actor in the field and contributes substantially to the WHO including setting aside a $40 billion endowment for the WHO which disburses $3 billion annually - this totals 10% of the WHO's annual budget (Correnti, 2015). The donated funds contribute greatly to WHO operations in human resources, primarily in Africa and in specific programmes (Reddy *et al*., 2018). The power of private foundations contributes to skewing global health priorities to suit wealthy foundations and foreign policy priorities of nations who are wealthy enough to contribute substantially to the WHO, for example, the US, and the United Kingdom. What this

also means is that it takes away the decision-making and the credibility of the WHO as a multinational institution accountable to member states and the global community.

Some human rights organisations have credited this influence on certain policy positions the WHO has taken on matters relating to contraceptives to power wielded by overlords; in particular, with regard to Depo Provera and HIV infection (The Rebecca Project for Justice, 2014). Another example of this is the Family Planning 2020 Summit 2011, and the resultant partnership, a global programme initiated and driven by private foundations. By all accounts, the partnership is driving the global contraceptives agenda post ICPD, rather than the agenda being driven by the United Nations structure such as the WHO. In a way, the funding by private foundations does not only interfere with WHO priorities, taking advantage of its legitimacy and credibility, it is also taking over the very work of the WHO.

5. THE UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

USAID is the dominator and key player involved in contraceptive policies and programmes in South Africa. As can be seen above, the role of USAID is integrated into the role of the United Nations bodies on contraceptives. It is important to understand the extent of the position and the role USAID plays in contraceptives policies, and how these can be understood in the context of the position of women who access contraceptives in public health institutions. USAID has numerous programmes on contraceptives and family planning in South Africa and in other countries in Africa. Located within the broad partnership strategy, USAID defines the goal of its contraceptives programmes as promoting access to voluntary family planning information and services, thereby improving the lives of women and girls around the world (USAID Strategy 2019). USAID is one of the founding partners of Family Planning 2020 (FP2020) is a global collective strategy to invest in family planning. The agency is one of the key agencies supporting the goal of the partnerships to reach an additional 120 million more women and girls in the world's poorest countries with access to voluntary family planning information and services by 2020 (USAID 2012, Family Planning 2020, 2019).

5.1 USAID INVOLVEMENT IN GOVERNMENT POLICY AND PROCUREMENT

Contraceptives are medical commodities; as such, they are part of business, subject to global economic rules, markets, competition, and neoliberal projects. Economically dominant countries such as the United States, will dominate the space to safeguard their interests. As can

be seen in this section of this chapter, there is a relationship between US companies producing and distributing Depo Provera, and the foreign policy of the US government.

According to USAID, the FP2020 partnership has generated unprecedented political will and financial support to reduce unmet needs for contraception. USAID has a dedicated programme on policy and advocacy. Under this programme, the agency works with national and local governments, civil society organisations, development networks, and other local institutions to build capacity to design and implement effective population and family-planning strategies (Family Planning 2020, 2012, USAID). USAID provided funding and technical assistance to the policy formulation processes of the two recent South Africa family planning policies, the 2012 and the draft 2018 policies (Department of Health, 2012; Department of Health, 2018). USAID support extends beyond policy to include sustainable leadership, management, and governance capacity at all levels of the health system. *'USAID has its offices and technical staff located in the National Department of Health. The office of USAID is located next to the office of the Director General'* (Research Participant KI 07). USAID provides support by deploying interventions for health care providers, programme managers, and policy makers, to achieve improved health-system performance and better health outcomes through USAIDs Global Health Initiative (USAID, 2019).

USAID works in collaboration with other public, private, and non-governmental organisations to ensure that people living in low- and middle-income countries have access to high-quality reproductive health supplies. This work is part of the Reproductive Health Supplies Coalition (RHSC), of which USAID is a member (USAID 2019). The Clinton Health Access Initiative is also one of the collaborators in this Coalition (CHAI, 2019).

"*The purpose of the RHS Coalition is to assist governments in meeting their reproductive health goals as expressed in different international declarations and commitments, to improve the market for contraceptive supplies in order to minimise supply stock-outs of contraceptives* (Reproductive Health Supplies Coalition, 2018). The Reproductive Health Supplies Coalition (RHSC) works in close collaboration with USAID and US pharmaceutical companies such as Merck, Bayer, and Pfizer. According to the RHSC (2018) the collaboration includes regulation of prices for several high-demand contraceptives (Reproductive Health Supplies Coalition, 2018).

The agency is also part of the Central Contraceptive Procurement partnership instituted to ensure steady and reliable mechanisms for the supply of contraceptives. Partnership functions include procurement, warehousing, and freight services of contraceptives to USAID missions (Reproductive Health Supplies Coalition, 2018). CHAI is also a partner on this project, with USAID being involved in the Global Health Supply Chain and Procurement and Supply Management. This initiative is to ensure uninterrupted supplies of broad health commodities and to strengthen supply chain systems in low- and middle-income countries (Reproductive Health Supplies Coalition, 2015). CHAI, Bill Gates Foundation, Centre for Diseases Control, USAID, PEFPAR, UNFPA, and other agencies are part the same initiative. "*By harmonizing supplier communication, data structure and tools for FP commodities, GHSC-PSM and UNFPA are improving the quality of registration data and reducing the unnecessary burden for suppliers of providing the same data to multiple parties*" (USAID Global Health Supply Chain Program Procurement and Supply Management Report, 2019).

5.2 USAID INVOLVEMENT IN NEW RESEARCH AND INNOVATION ON DEPO PROVERA

As has been demonstrated in previous chapters, Depo Provera is marred with controversies of side effects, racial targeting, and litigation. DP is not registered for use in some Western countries, including the country of its origin and manufacture, the United States. The controversies have been on the surface for decades. The science-biomedical innovation field, with support from Department for Foreign Development of the United Kingdom (DFID) and USAID, are innovating and developing new preparations of Depo Provera in order to expand the use of Depo Provera to address contemporary global challenges −HIV/AIDS, maternal mortality, and teenage pregnancy.

USAID, in partnership with DFID, the Bill and Melinda Gates Foundation, Pfizer and Programme for Appropriate Technologies in Health (PATH) is collaborating on the introduction of a new Depo Provera packaged in a pre-filled single-use syringe (Cover et al., 2016; Bill Gates Foundation, 2012). The syringe will expand access to use of the injection. Health care workers can take this to women at home and in other accessible areas (Cover et al., 2016; Bill and Melinda Gates Foundation, 2012). As indicated in a previous chapter, this injection will eliminate the need for health care workers to administer the injection. The World Health Organisation approved for use of (depo-medroxyprogesterone acetate -DMPA-SC) Sayana Press WHO EML Application (WHO, 2016). The UNFPA participant in this study

indicated that the feasibility studies and regulatory framework of this injection have been completed in South Africa; and that the injection will soon be rolled out to communities (Research Participant KI 10).

The HIV/AIDS and Sexual and Reproductive Health Rights (SRHR) integration project has developed prescribed combinations of HIV/AIDS medication and contraceptives. USAID is supporting the International Partnership on Microbicides (IPM) in the development of a combination of contraceptive and anti-HIV vaginal ring. The ring will be effective for 90 days. The ring will combine the recently proven HIV prevention drug, Tenofovir, with the hormonal contraceptive. Another combination of contraceptive and "*anti-HIV vaginal Ring Project', is being explored by USAID and IPM. This will be a sixty-day vaginal ring that combines the potential HIV-prevention drug, Dapivirine, with a hormonal contraceptive'* (International Partnership on Microbicides, 2019:1, USAID's USAID Center for Accelerating Innovation and Impact (CII), 2019). The agency is involved in development of two other vaginal rings for contraceptives (IPM, USAID). South Africa is one of the countries conducting human trials on women on these new innovations. WRHI, MATCH, and the Centre for the AIDS Programme of Research in South Africa (CAPRISA) are collaborating partners in trials of these interventions. Studies conducted in South Africa include acceptability studies on young women (USAID Center for Accelerating Innovation and Impact (CII) 2017).

These innovations and repackaging of Depo Provera follow the novel implant, Implanon, recently introduced into South Africa. As indicated in the previous chapters, Norplant is essentially Depo Provera prepared as an implant; and is released to the body over the period of three years.

As indicated, this preparation of DP has similar side effects as straight DP and has been subjected to litigation in different countries − the US, Canada, and the United Kingdom.

USAID is involved in key public-health research in South Africa. One such research programme is the Demographic and Health Surveys (DHS). The purpose of the DHS is to improve the collection, analysis, and presentation of population, health and nutritional data. The data informs and facilitates planning, policymaking, resourcing, budgeting, and health programme management (Demographic and Health Survey, South Africa 2016, USAID Annual Report, 2018). The South Africa DHS is conceptualised and supported under the remit of the USAID Global Health Programme.

5.3 USAID INVOLVEMENT AT COMMUNITY LEVEL

USAID is also involved in community level work, focusing on education on new and old methods of contraception. Community programmes introduce and expand the understanding of contraceptive technologies and approaches within communities. The programme advances and supports community-based programmes seeking to improve community health, especially in relation to family planning, by providing global leadership, small- and medium-sized sub-grants and building technical capacity. The next section of this chapter will present the role and power of philanthropy in defining and leading global policies on contraceptives.

6. INVOLVEMENT AND INFLUENCE OF PRIVATE FOUNDATIONS AND PHILANTHROPISTS IN CONTRACEPTIVE POLICY, FINANCING, AND PROCUREMENT IN SOUTH AFRICA

This section of the chapter explores the role of private philanthropic foundations operating in South Africa including the Bill and Melinda Gates Foundation and the Clinton Health Access Initiative. Exploring the influence of these structures at the country level is important in meeting the objectives of the study of considering how international actors influence contraceptive policies in South Africa. Robinson (2010) categorises international actors in the population movement as bilateral donors, through inter-country foreign aid arrangements, the multilateral donors, the United Nations, economic regional blocks, and private foundations (Robinson, 2010).

This study identified a web of interconnectedness in interests of private foundations and pharmaceutical industry actors operating in South Africa. Research institutes, sector-specific experts, international organisations, and public health experts are part of the movement at a meso-level. At the local micro level, you find governments and NGO providers of services. University-based private institutes were also identified as playing the provider role in South Africa. The movement forms a web of operations, which makes it difficult to categorise their functions. The actors operate at the level of international policy, advocacy, and research and resources mobilisation. At a national level, actors are operating on policy, procurement, funding and service delivery, which includes demand creation. This demonstrates that the international governance, economic, political and government hegemonies collaboration is a political economy to regulate women's bodies. In the meantime, they achieve economic and political gains; more importantly, reducing the reproduction of the impoverished. Such actors create economic and market demands and nodes of power to regulate women's bodies.

Furthermore, they use women's bodies to negotiate and wrestle their regional block power struggles.

The two Department of Health polices reviewed for the purposes of this study acknowledge the contributions of international actors. The WHO provides technical support in the policy formulation process. FHI360 is acknowledged as providing their on-going technical assistance and review of documents. The United Nations Population Fund (UNFPA) is also acknowledged for providing funding to the policy-development process. USAID provided funding and technical assistance to the policy formulation process. The Bill and Melinda Gates Foundation and the Clinton Health Access Initiative (CHAI) are international private foundations having a prominent role in contraceptives and population control movement globally, also in South Africa. Other key actors are the IPPF and the Population Council (Frey, 2011).

6.1 INVOLVEMENT OF THE BILL AND MELINDA GATES FOUNDATION

The Bill and Melinda Gates Foundation is a philanthropist organisation that has influence on global contraceptives policy. Family planning is the flagship programme of the Bill and Melinda Gates Foundation. The programme is part of the Global Health and Development strategy of the Foundation. Melinda Gates is a dedicated philanthropic ambassador of family planning. The work of the Foundation in South Africa includes HIV/AIDS, new drugs, research, and innovation of drugs, water, sanitation, and family health. The Foundation collaborates with the government of South Africa to achieve shared goals for global health and development (Bill and Melinda Gates Foundation, 2015). Flowing from the FP2020, the Bill and Melinda Gates Foundation developed a family planning strategy with the goal of increasing the use of contraceptives in urban areas amongst the impecunious and vulnerable (Bill and Melinda Gates Foundation Family Planning Strategy Overview, 2019, FP2020, 2012). This prioritisation of urban poor was because the Foundation believes that births are concentrated among the poorest populations in urban areas of sub-Saharan Africa and Asia. Some of these births are not intended. Therefore, maternal and infant mortality including poor reproductive health status is higher in rural areas than in urban areas. The strategy is rolled out through the Urban Reproductive Health Initiative, an investment which aims to provide high-quality, cost-effective, and voluntary family planning services to the urban poor of Asia and sub-Saharan Africa (Bill and Melinda Gates Foundation, 2012). This articulation demonstrates intersections of gender, poverty, geographical location, and urban and rural divide, as indicators of vulnerability and targeting. This is in line with intersectional feminist theories (Crenshaw,

1989). The radical feminist analysis of this indicator of prioritisation is that the patriarchal solution to a problem of poverty lies in controlling and potentially violating women's bodies. There is no indication in the assertion that indigent women in urban areas have suggested that they recommend family planning as the solution to poverty. The programme does not state how it will address poverty, poverty being the main issue in this understanding. The programme does not suggest how it will provide for sexual and reproductive rights of these women, beyond limiting their reproduction. This demonstrates the paternalistic nature of the global economic system and patriarchy. Furthermore, urban poverty can be seen, and is therefore easily targeted, not only by politicians, but also by the population movement and business interests. The observation also suggests that rural women are probably not the more oppressed women than urban women, as the popular discourse suggests. All indigent women from urban or rural are oppressed, albeit the nuances will change from time to time. Gender and poverty oppression is intersected across urban and rural divides. It can also be observed that the apartheid population control and forced contraception was targeted at poor women.

6.2 THE BILL AND MELINDA GATES FAMILY PLANNING SUMMIT 2011 (FP2020)

Bill and Melinda Gates conceptualised, founded, and funded one of the biggest global gatherings of contraceptives interest groups, The London Family Planning Summit, since the ICDP Conference in 1994 (Correnti, 2015). USAID and DFID funded the summit. The Summit set the new agenda for global contraceptives policies, funding, and programming post ICDP period. The outcome of the Summit was a multi-stakeholder international partnership to ensure increased uptake and utilisation of contraceptives. The partnership committed all partners to mobilise funding for contraceptives at all levels of national governments, bilateral and multilateral donors. The commitment increased the capacity of civil society to promote family planning, integration of family planning in the national HIV strategies, including the Global Fund to Fight HIV/AIDS, TB and Malaria, conducting an economic analysis of the return on investments of family planning expenditures on policy, such as the MDGs (Bill and Melinda Gates Foundation, 2012).

South Africa is a member of this partnership. South Africa is a middle-income country and, as such, does not qualify for contraceptives funding (Research participant KI 10). South Africa procures contraceptives. Other African countries meeting the criteria for low-income country category are funded by USAID and DFID amongst others, in procuring contraceptives (Bill and Melinda Gates Foundation 2019; Robinson, 2010). Robinson (2010) stated that Sweden

was one of the countries financing contraceptives in low-income countries but has since changed the approach to support women's development in broader terms, rather than focusing specifically on contraceptives. The partnership has a concentrated focus on procurement of contraceptives from the USA-based pharmaceuticals (Clinton Health Access Initiative, 2018). US foundations negotiate for prices and volumes, and so forth. Furthermore, it can be observed that the partnership forges the utilising of other funding mechanisms in HIV/AIDS and broader development to finance contraceptives for impoverished countries. As indicated earlier, South Africa finances its contraceptives procurement, as such, the partnership will therefore be negotiating procurement deals for South Africa.

The Department of Health Policy 2012 has specific objectives of expanding choices of contraceptives, integrating contraceptives into other health services, training of health care workers, enabling regulatory frameworks, communication strategies, monitoring, and evaluation and research (Department of Health, 2012). A research organisation, which participated in the study, understood that the policy seeks to increase uptake of contraceptives and to expand method mix of contraceptives *(*Research Participant KI 01). The same participant indicated that the Clinton Health Access Initiative was the international partner working on commodity procurement and financing.

6.3 THE POSITION OF DEPO PROVERA IN THE FP 2020 PARTNERSHIP

Correnti (2015) and the Rebecca Project for Justice (2014) wrote that the production of Depo Provera increased significantly post the FP2020 Summit (Correnti, 2015; The Rebecca Project for Justice, 2014). Pfizer announced at the Summit that it would double the production of Depo Provera. Such would naturally generate considerable returns in sales and profit margins to Pfizer (Correnti, 2015). "*Depo Provera is also one of Pfizer's fastest growing products by total sales, with an almost 30% increase in revenue from financial year 2012-2013*" (Abbamonte, 2016*)*. The chief beneficiary of the Summit was therefore business, the big pharmaceuticals industry, and intermediaries, in the form of private foundations, amongst others. As Correnti 2015 states, the Summit was an investment summit on the part of Melinda Gates (Correnti, 2015).

The Summit was to generate handsome returns. It was also to make Melinda Gates and her businesses key players in contraceptives provision (Farrell, 2012). The Foundation promotes development of new contraceptives technologies. In this regard, the Foundation has repackaged Depo Provera in other forms. The Foundation stated that their strategy is to address barriers to

contraceptives measures. They have a set goal to accelerate the uptake of contraceptives in sub-Saharan Africa and South Asia through the discovery and development of new technologies (Bill and Melinda Gates Foundation, 2012). The Foundation has invested in implants and Sino-implants, which are long-acting effective and low-cost implants. The investment included securing registration, standards for quality assurance, and regulatory approval in selected developing countries. Determining prices and generating markets are also part of the investment "*Efforts are now underway to finalize the prequalification of this product, negotiate public sector price ceiling agreements, work with distributors to secure regulatory approvals, and provide technical assistance for its introduction in various countries*" (Bill and Melinda Gates Foundation, 2012). The implants became available in South Africa in 2014-2015. They are the same composition as Depo Provera. The difference is that they are inserted under the skin and remain effective for longer, up to three years, although the WHO says up to seven years (The Rebecca Project for Justice, 2014). The implants are banned and cannot be used in the United States. They are manufactured in China on behalf of a US pharmaceutical company (Bill and Melinda Gates Foundation, 2012). This is the political economy of neo-colonialism and neoliberalism.

In this instance, international business is the innovator, creates the product, the market, draws quality measures, and facilitates registration and regulation of the drug. The role of the state in this instance is eroded: the international business is in fact drawing up government policy and essentially how the policy should be monitored. It can also be observed that which is defined, as a foundation for social assistance is in fact simply a business. In this instance is difficult to differentiate between the state and business actors.

The Foundation is also involved in developing a version of Depo Provera self-injection, the Uniject injection system (DMPA-subQ in Uniject). This is a new subcutaneous presentation of the popular injectable contraceptive depo-medroxyprogesterone acetate (DMPA) Depo Provera (Bill and Melinda Gates Foundation, 2012). DP currently requires a health worker to provide the method in most countries because it is injected into a muscle. "*The new DMPA-subQ in Uniject, which is manufactured by Pfizer, has the potential to be delivered by nonmedical providers, such as trained community health workers, and possibly by women themselves*" (Bill and Melinda Gates Foundation, 2012). Again, in this regard, the Foundation is also putting in place the necessary framework for the introduction of this new formulation of Depo Provera. According to UNFPA, South Africa is on course with regulatory frameworks and a service-level preparatory foundation for this injection.

6.4 CLINTON HEALTH ACCESS INITIATIVE (CHAI)

CHAI is the initiative of Bill Clinton, the former President of the United States of America. The Initiative defines itself as using a business-minded approach to shape health care markets, thereby reducing costs of medications, diagnostics, and other health products in developing countries. CHAI works with governments to reform health systems. "*We work with governments to reform their health systems, targeting areas where current approaches are failing, moving too slowly, or at a scale that leaves too many dying or suffering needlessly*" ([1]Clinton Health Access Initiative, 2018). CHAI is working within the ambit of the FP 2020 partnership to support what it considers the integrated approach to reproductive health. This is the approach, which seeks to address unwanted pregnancies, infant and maternal mortality, early pregnancy, and other reproductive-health concerns. This approach has found expression in South African policy, through the formulation of the 2018 policy, and to some degree, the 2012 policy. As alluded to earlier, this policy approach is advocated by UNFPA, who provided technical support and funding for this policy. USAID provided funding for the policies. FHI360, the contracting agency, provided technical support to the same policy. In this regard, CHAI is working with governments to improve options for effective contraception and family-planning services, to help women safely plan pregnancies, improve economic outcomes, and save lives (Clinton Health Access Initiative, 2018).

6.4.1 INVOLVEMENT OF CLINTON HEALTH ACCESS INITIATIVE IN FAMILY PLANNING

Starting from 2012, CHAI has been working with a consortium of donors to negotiate a price reduction of more than 50 per cent for implants, to make them more accessible to low- and middle-income countries. Such would make the implants the most cost-effective hormonal method on the market. This partnership culminated in the launch of the Implant Access Program, which improved the global implant market, and built systems across low- and middle-income countries, to deliver the contraceptive methods to women. The success of the programme is the doubling of the volume of contraceptives implants procured between 2012 and 2018. Because of increased demand for the product, manufacturers have committed to maintaining the reduced price for contraceptive implants beyond 2018 (Clinton Health Access Initiative, 2018 CHAI is now recruiting for a third supplier to enter the quality-assured implant market (Clinton Health Access Initiative, 2018). In the area of contraceptives CHAI is leading a well-coordinated commodity procurement programme. It is using the FP2020 partnership to source knowledge, creating procurement and market opportunities for contraceptives. CHAI and

the Reproductive Health Supplies Coalition produce an annual Family Planning Market Report. The report is published by the Global Markets Visibility Project and is part of the FP2020 partnership. Market and procurement data is sourced from manufacturers and suppliers of contraceptives. The purpose of the report is to provide the most comprehensive and reliable view on the public and social sectors of the family planning procurement market across 69 FP2020-focus countries. "*The report provides insightful and strategic outputs for donors, ministries of health, implementing organizations, and suppliers to develop and implement more effective strategies aimed at ensuring that an additional 120 million women in the world's 69 poorest countries have access to family planning products and services by 2020*" ([3] CHAI, Family Planning Market Report, 2019).

6.4.2 SOUTH AFRICAN HEALTH POLICY AND DEPARTMENT OF HEALTH BUDGET ALLOCATIONS

The Clinton Health Access Initiative is also involved in the budget allocations of the Department in the National Treasury. CHAI reports that, in 2019, it worked in collaboration with the University of California San Francisco to successfully advocate that the National Treasury allocate the additional US$ 24 million over three years to the National Department of Health. An additional US$4.4 million was allocated to cost-reduction activities in health care procurement functions ([2]Clinton Health Access Initiative Annual Report, 2018). National Treasury is the highest level of government. This suggests that CHAI has access to and can influence power at a high level in South Africa. This is over and above the ostensible power over the National Department of Health. Local advocacy groups in the civil society space have had difficulty in reaching Treasury for their advocacy demands. Most of them have listed Treasury as one of their targets for advocacy. In recent years, for example, the feminists and women's rights organisations have been self-critiquing for not targeting National Treasury for funding for what they demand of other government departments, in particular the Department of Health. In 2019, CHAI had a strategic high-level role in procurement of health services in the Department of Health in the province of Northwest.

The Initiative reported that they worked with the Department of Health to review private sector contracts in the health sector, identifying the potential for around US$20 million in annual savings. Developing from this work, the Initiative is now in collaboration with the National Treasury, engaging with Department of Health to secure additional savings across the health sector (Clinton Health Access Initiative Annual Report, 2018). CHAI is providing technical

and business support on procurement of ARV drugs to the National Department of Health. According to the CHAI annual report (2019) CHAI assisted in drafting and negotiating the national three-year ARV tender as a component by which to shape the market and lower the cost of the medication through encouraging competition, engaging with the manufacturers of drugs, amongst others (Clinton Health Access Initiative Annual Report, 2018).

CHAI is involved in high-level South African health care reform negotiations and planning. CHAI wrote in its 2018 Annual Report that it has successfully worked with the National Department of Health, and the National Treasury, to design and prepare for National Health Insurance (NHI). In this regard, CHAI developed institutional capacity for insurance reform. CHAI has developed and conducted standardisation of benefits packages and services to be provided in the National Health Insurance (Clinton Health Access Initiative, 2018). CHAI's technical and programming work in South Africa has done so far is informing National Health Insurance (NHI) resources allocation and upgrading of service, including alignment of public and private sector services (Clinton Health Access Initiative, 2018).

7. DISCUSSION

The international community, in particular private foundations, biomedical research institutions, and some government-aid agencies such as USAID, are entrenched in contraceptives policy formulation, procurement, financing, and budgeting in South Africa. The foundations work collaboratively in the country. In some instances, they work on similar initiatives. The most prominent of these are US foundations. These foundations also work collaboratively with USAID in their programmes with the South African government. Although the UN agencies are independent, they are linked to the foundations through funding and the concomitant influencing power. USAID is also one of the major funders of the two UN agencies involved in contraceptive work. There are many entry points for their influence in the country; this includes HIV/AIDS and family planning. I hypothesise that the challenges and possible collapse of the health system is one of the entry points for the international contraceptives hegemony. Their entrenchment is also seen in the strategic South African health system transformation and engineering project. The National Health Insurance. As detailed above, the entrenchment of the establishment extends to the National Treasury on how budgets are allocated.

The establishment has, for example, decided on the packages that citizens should have access to in the NHI. South African citizens should be setting the agenda and dictating what the NHI package should comprise. It is also highly likely that in these circumstances, the allocations for women remains as they are, in a 'women as mothers' approach, wherein women's health is understood as maternal health. This has led to lack of resourcing of women's health in the country. South Africa does not have a women's health policy. The National Health Act provides free health care services to women, as a vulnerable group, and also as mothers. The Act does not provide a comprehensive package and resources for women's health. There has never been an effort to review the Act through a women's or gender lens so that this glaring injustice of the Act is addressed.

The amendment of the Act will be one way of addressing this issue. South Africa should have had a women's health policy. Such reviews would have then informed the NHI process, so that the NHI would have provided for women.

USAID is also funding the District Health Information Service periodic surveys. These are strategic surveys, which detail the status of health and the entire health system of the country. Competence for this strategic information and knowledge generation should lie with the state, the Department of Health. Instead, we have a case of neo-colonialism or 'capturing' of the public health system policy making in South Africa. It can be observed that the establishment negotiates with National Treasury on behalf of the National Department of Health. In this arrangement, citizen participation and transparency is limited. The process will not be subject to public scrutiny and evaluation against our national ideals of gender equality, inclusion, and human rights. Lack of transparency in this process will limit possibilities of contestation, creating another situation of a missed opportunity for influencing the policy in its development phase. Private foundations hold entrenched power in the international health governance. Both the WHO and UNFPA are beneficiaries of these foundations. As is the case with national government of South Africa, the foundations have access to high levels of decision-making in the global governance, the United Nations. UNFPA is involved in policy, research, programme implementation, setting of policy priorities, and drawing up policy experiments in the country. Programme implementation is located at national as well as provincial levels of government. The provincial government provides a direct link to the regional and district health structures, including clinics and communities where policy experiments, research, and programme piloting take place.

Private foundations have philanthropic ideals; however, these are not informed by the priorities of the people concerned. The solutions formulated are conceived from an outsider perspective, which is a world away from the realities of women. The solutions proposed do not seek to address the root of the problem, but provide a short-term simplistic solution, which puts the very women it seeks to advance in a compromising position. The actors employ Western liberal ideology to sustain the transnational bio-political discourse sold by its forebears in the 1950s. In 2012, Frey argues, "*A Western, educated, influenced, elite-centred, transnational bio-political discourse, persuaded by divergent interests, crystallized in the early 1950s to produce a powerful 'epistemic community'. This transnational epistemic community, dominated largely by North Americans and held together by a shared set of values and norms as well as policy recommendations, convinced international agencies and national governments to take action on the 'problem' of national and global population*" (Frey, 2012). The pronounced characteristics and differences of the current international establishment are its economic interests embedded in its actions. The main theme of involvement of private foundations in contraceptives is centred on negotiating deals, procurement, coordinating with drug companies to understand and create the market, control of supply, leading innovation research, in order to expand reach of the product. These are all classical economic activities. More pronounced is how the establishment has taken over the strategic policy making functions in government.

There is no indication of how women's rights, human rights, and gender transformation ideals are provided for in this state of affairs. Economic interests and the reliance of the establishment on existing colonial organisations, the patriarchal establishment, and their very competing interests creates a paradoxical situation. "*Ideologically committed to liberalism, the community operated, until the 1970s, with paradoxes that it could hardly reconcile and disguise: it called for an amelioration of inequality while reserving for itself privileges that prolonged and cemented inequalities; it stood for individualism while admiring the determination of authoritarian population programmes; it emphasized emancipation and voluntarism while implicitly favouring coercion; and it called for a 'reproductive Westernization' of individuals and the comprehensive modernization of societies while in fact being more focused on reducing the number of poor instead of reducing poverty*" (Frey, 2012). The paradoxes have been part of the movement and provision of contraceptives through the decades. Women are in need of contraceptives; such are a means to realise their sexual and reproductive rights.

However, the politics and discourse of women's rights have been taken over by other interests, mainly economic opportunism and racism. As indicated earlier (Robinson, 2010 for an example), the current family planning movement has in a way shifted from population concerns. The establishment is now focusing on poverty, mainly urban poverty. It justifies its course of action by pointing to the effects of poverty and failing health systems, resulting in high rates of maternal mortality. The failing of the post transition development project is also a reason given, because maternal mortality is not only driven by health systems (Thaddeus and Maine, 1994).

Other developmental issues include lack of transport and roads, family and societal values about who should have children, and therefore who should be prioritised for health. The diseased, for example, HIV-positive women, are part of this category.

Teenage pregnancy, which is a result of intergenerational poverty and commodification and oppression of young Black women, is another justification. As Frey (2011) states, the movement is reducing the numbers of disaffected people rather than addressing poverty (Frey 2011). Poverty in South Africa and other developing countries cannot only be credited to failing states, corruption, and poor governance. The international political economy of power in the global economy is also part of this problem. Capturing of governments in the South to adhere to the global economy, and in this instance, the policy agenda driven by multinationals and foreign governments, also contributes to the poverty. These policies tend to serve the interests of the externals more than the interests of the citizens of the South.

Furthermore, is has recently been established that corruption, lack of transparency and accountability of governments of the South involve external governments and multinational companies. All these lead to waste of resources, which should otherwise be utilised for development. Contraceptives do present a good entry point to women's health. They have highlighted many women's health concerns and diseases, which manifest as side effects of contraceptives, but are also diseases in their own right. Contraceptives present the opportunity to highlight such, and advocate for them to become resources in the health care system; however, that opportunity has been missed. Indeed, contraceptive provision presents an opportunity to analyse health from a feminist perspective, by intersectionality and post-colonial feminists. Such analysis highlights the cost of these systems to women's bodies in the physical and economic sense. Contraception has the potential to elicit the underlying patriarchal oppressions, which impact on women's health, addressing such. It has the opportunity to reach

out to women and gather their life experiences. Again contraceptives, defined differently, provide the opportunity to infuse feminist analysis in government policies. However, the contraceptive interventions have been attached, and have taken advantage of the status quo. There is evidence that the transition periods, de-colonialisation, and the end of the Cold War (Thomas, 1993), apartheid transition (Ndengwa 1996), and the transition in the middle East (The Rebecca Project for Justice for Justice, 2014), have not necessarily improved the situation of women regarding contraceptives; instead, these have given the opportunity for the establishment to entrench itself, taking advantage of the problems of the day.

8. DEPARTMENT OF HEALTH DIRECTORATE ON MATERNAL, CHILD, AND WOMEN'S HEALTH IN POLICY FORMULATION

The National Department of Health has a directorate dedicated to maternal, child, and women's health, and its work is policy formulation. Not many of the policies developed focus on women's health. South Africa does not have a women's health policy, neither is women's health provided for in the National Health Act of 2003. As such, the policies developed have been on family planning, reproductive health, commitment to screening for cervical cancer, inter alia, all programmes within the primary health care approach. The directorate is presented in a 'women as mothers' framework. It understands women's health as maternal health. It is also debatable whether maternal health programmes in South Africa are for mothers or infants. According to Fonn and Xaba (2001), women make up most people using primary health care services in South Africa. This is because of their biological reproductive role and gender division of labour in child-care and rearing, particularly as these relate to health care services (Fonn and Xaba, 2001). Vlassoff (1994) states that health care services have more focus, and concentrate more on women's reproductive functions, women as mothers, mainly to pregnancy and contraception, including their children as infants, rather than on the health of the woman in a more holistic sense. Gendered understanding of women and women's health is important in making services appropriate to women's needs. There is a need for health policy to focus on women as clients in their own right, outside of their gender role as mothers or caregivers (Fonn and Xaba, 2001). The unit gives the opportunity for women's specific health issues, including a women's health policy, to be explored. The unit should also be considering the amendment of the National Health Act, 2003 so that it provides for women's health. The Act currently provides only for maternal and child health. The programmes that have made considerable progress in this unit and in the country are contraceptives programmes. The National Department of Health recorded a total expenditure of ZAR 14.5 million and ZAR 14.2 million

on Women Maternal and Reproductive Health in 2016/17, and 2017/18, respectively (National Department of Health, 2018). This amount of budget is inadequate for what the directorate should be providing, especially in light of the country's commitment to women and gender rights. Considering the role and the level of engagement of international players in policy formulation in the National Department of Health defined earlier in this report, it can be concluded that the main role of the directorate is to coordinate policy interventions of international external players. Indeed, all policies reviewed for this study acknowledge the role of international actors at all levels of policy formulation. This may justify the low level of investment in this Directorate.

The research participant serving on the Parliamentary Portfolio Committee on Health clarified that the international partners and donors do not determine the policies of the country. "*Ok, what I have always noticed and observed is that they respect policies of any country, even if they come in and want to try and influence, they ask what is your baseline, what is your point of departure, they are funding and assistance has never been to say take this policy or not take this policy, it has always been a complementary role, …acutely create your own base of policies which are going to be influenced by the direction politically and not influenced by the monies that come in there and like say we want to sterilise women, whatever you want to do, there is still the groundwork which has to be done by the country itself, this support that comes from external donors and funders is an add on not a starting point of your own policy*" (Research Participant KI 11). The participant clarified the role of the funder and the responsibility of the state in relation to engaging with external partners and funders. "*What they are supposed to do, …always be mindful, each country must guard against an influence of its policy by an external partner, the funder must come in to support your already existing programs that are probably not adequately funded but not to put in a new policy or influence you to say the policy that we must adopt must be this, the funding must be an enabler for your own policy to move on*" (Research Participant KI 11).

9. OTHER ACTORS INVOLVED IN CONTRACEPTIVE POLICY IN SOUTH AFRICA

9.1 THE FAMILY HEALTH INTERNATIONAL 360 (FHI 360)

Family Health International 360 (FHI36) is one of the agencies that have a role in the contraceptives policy and programmes in South Africa. The Family Health International (FHI360) is a United States not-for-profit organisation working in 60 countries with

governments and private sector to bring about social change, provide health care, education, and economic opportunities. FHI360 is a contractor of USAID and is acknowledged as providing for their on-going technical assistance and review of South African policy (2012 and 2018 review of contraceptives policy document). FHI 360 is also leading HIV/AIDS integration initiatives at district health level and in clinics.

9.2 THE LANCET COMMISSION

The Department of Health mentioned that, as per the procedure, their contraceptives policies are subject to review, and have met the Lancet Commission standards. This was the case for 2012, and for the policy revision process of 2018. *The Lancet* is one of the most prestigious medical journals. The journal's coverage is international in focus and extends to all aspects of human health. Over and above being a journal, the Lancet has commissions studying many different issues. There is a commission dedicated to contraceptives and reproductive health (The Lancet, 2019). The policy was also reviewed and approved by the South African Health Council (Research Participant KI 09). It is observed that the structures improving and validating the policy are medical, scientific, public health and demographical professional bodies. Human rights, women's rights, feminists, and developmental organisations are not part of structures providing approval for the policies of contraceptives. This is a concern, given that contraceptives are said to be human rights-based, and are about emancipation of women.

9.3 LOCAL ACTORS

Local expert organisations are involved in contraceptive research, policy and service delivery. Some of these agencies are acknowledged as collaborators in the development of policies reviewed for this study. Two of these organisations participated in this study. The agencies are all attached to one university. As mentioned earlier in this report, WRHI, the main actor, is accredited as a collaborating centre for the WHO and United Nations Programme on HIV/AIDS, UNAIDS, (WHRI, 2019). The agency led the HIV/AIDS and contraceptives ECHO study mentioned in this report.

9.4 LOCAL BUSINESS ACTORS

It can be extrapolated that local businesses are also involved in procurement of contraceptives. Their role could be that of collaborating with the partnerships with manufacturers facilitated by the CHAI, the Bill and Melinda Gates Foundation and USAID as secondary middle level procurers or distributors. CHAI, for example, reported that they work to negotiate and attain

favourable tenders on behalf of the government of South Africa (Clinton Health Access Initiative, 2018). The Department of Health in KwaZulu-Natal and the National Department of Health stated that the companies tender for the supply of contraceptives. Furthermore, the national Department of Health mentioned that local companies were suddenly reluctant to tender for distribution of Depo Provera. This suggests that the commodities may be coming from the US and tendered locally for distribution. The study found no mention of local businesses in the formulation of contraceptives policies in South Africa. The Director of Maternal, Child and Women's Health Directorate in the National Department of Health reported that procurement of contraceptives is funded by provincial conditional grants, which they receive from the National Treasury (Research Participant KI 09). The Chairperson of the Portfolio Committee confirmed that procurement was provided for by provinces in their provincial budgets "T*hey procure based on their needs, they do what we call a transversal procurement, it is cheaper than buying one time and disperse, at each given time each province buys, I don't remember details, whether contraceptives are on the transversal tender or on the provincial tender, transversal is buying in bulk*" (Research Participant KI 11). The Chairperson further stated that provinces distribute contraceptives to clinics. Even those clinics run by local municipalities receive contraceptive stock from the provincial departments.

10. SUMMARY

This chapter presented findings on the role of the global political economy in relation to contraceptives in South Africa. It sought to highlight the how contraceptives are influenced by the global political economy of development, research, multinational companies, and philanthropy. The chapter discussed and announced findings on how the policies and choices made in contraceptives are influenced by bilateral relationships South Africa has with other countries, in particular, the power structures in those relationships. The chapter outlines that policies in South Africa are influenced by what is happening at the global health governance level. The chapter discussed the troubling relationship between the WHO, UNFPA, and USAID. The funding role of USAID creates a situation in which USAID is hegemony for global contraceptives governance and policy making. The influence of the new wave of power and structural positioning in the global space, the emergence of private foundations, philanthropic organisations, and multinational companies, in determining the global priorities of contraceptives in the world, was reflected. The private foundations have taken over the role of the UNFPA and the WHO, and all governments in the international governance system. They are leading the contraceptives policy at all levels.

The FP2020 was the first official public move of the takeover. It was observed that the private foundations could be safe proxies for the multinational corporations. The hegemony translates into neo-colonialism at the country level, wherein UN agencies are working with USAID and private foundations to drive the policy formulation agenda and processes in the country, influencing budgeting at the highest level. Such bodies have insinuated themselves into procurement involvement in service delivery and the re-engineering of the whole health system and driving innovative research on contraceptives. Indeed, the economic history of South Africa explains such conditions. Persisting feminised poverty continues to be used to justify entry points to control reproduction of indigent women. A combined failure – of the health system, of development and of society in general - is responsible for high rates of maternal mortality, teenage pregnancy, HIV infection and urban immigration, amongst others. The direct impact is that these outcomes are used to justify the control of reproduction of women.

South Africa is going through a transition in which it is recovering, and reconsidering the state capacity to govern, considering the challenges of the past twenty-five years, and notably, challenges of the past decade, characterised by poor governance, state capture, and corruption. This state of affairs has potentially opened the country to the contraceptives hegemony and the capturing of the entire health system. The hegemony has replaced the voices of citizens in all strategic national policy discourses on contraceptives and the entire health system.

The contraceptives movement has migrated from overpopulation as a justification for population control to justification of poverty, urban poverty, HIV/AIDS, women who are at higher risk of HIV infection, HIV-positive women and teenage pregnancy. All these are gendered, and all are targeting women's bodies and lives. I argue that, although the involvement has some benefits for South African women, the main driver of the hegemony is profits. There is a deliberate strategy to increase and create more demand. Big business desires to innovate, so that the hormonal contraceptives, in particular Depo Provera can have its reach extended.

The innovation, it seems, is also rebranding Depo Provera. The innovation is taking the integration of sexual and reproductive health and HIV services to a bio-medical level, wherein ARV drugs are now going to be combined with contraceptives, and vice versa. What are missing in all these developments are the decades of old concerns apropos of Depo Provera. There is no discourse about possibly removing DP and investing in safer methods. The global

marriage and commitment to Depo Provera is frightening. The other missing piece in research and innovation, at the very least, is improvement of the safety of Depo Provera.

CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS

1. INTRODUCTION

Motherhood and contraception are gendered political phenomena. Depo Provera (DP), an injectable hormonal contraceptive, is a subject of deep controversy around the world. Depo Provera has been a subject of racism, colonialism, classism and eugenics controversies for decades. The discourse on contraception is a categorical paradox. Advocates of birth control frame contraception, in general, as a woman's right, as a means of fostering gender equality in the reproductive sphere of women's lives. Conversely, birth control has also been described as a political and socio-economic patriarchal strategy to undermine, restrict, and control women's bodily autonomy, by controlling their fertility and reproduction. The use of Depo Provera has extended from colonialism to apartheid and post-apartheid South Africa. Depo Provera, as an economic and political phenomenon, is part of the neo-colonial, neoliberal political and economics in the global neoliberal capitalists' economic model. The study sought to build understanding on how the racialised, gendered, political nature of Depo Provera has been transformed in South Africa, considering post-apartheid transitions to the culture of human rights, and advancement of women's rights from a feminist perspective.

Depo Provera was one of the racialised, political, reproductive, oppression tools used by the apartheid government for Black population management. The goal of population management was to limit and contain the Black population for political reasons. The use of Depo Provera for this purpose had started in the US and UK, amongst other countries. The apartheid state relied on the validation and codification of fertility control as a right codified in various United Nations Declarations, and the strong lobby of the international eugenics and population-control establishment.

2. RESEARCH QUESTIONS AND OBJECTIVES

Limited research has been conducted on how the ideology, the rationale, racial targeting, and the practice of contraceptive use, and Depo Provera have shifted in post-apartheid South Africa. Most of the current research on Depo Provera has a limited public health focus on expanding access and uptake of contraceptives.

Studies focus on behavioural interventions, acceptability studies to inform and improve public education and demand for contraceptives. The new biomedical research agenda on Depo Provera focuses on product development of new formulations of Depo Provera. This has seen the emergence of supporting social science research focusing on increasing access and integrating of commodities in other health systems, examining integration and population targeting, and behavioural studies, expanding accessibility, and informing communications and marketing programmes of the new formulations.

The study broadens the understanding of the political economy of contraceptives in post-apartheid South Africa from a feminist perspective. The study explored how post-apartheid policies on contraceptives have migrated from the ideological standing and policies under the apartheid period into the democratic era of human rights, emancipation of women, and gender equality. The study examined the factors influencing the ideology, framing, the transformatory participation of human rights' provisions and enhancement, resourcing of women's health, and consideration of lived experiences of women in contraceptive policies and programmes in post-apartheid South Africa. This chapter discusses key findings and conclusions of the study. The chapter also presents a set of recommendations considering the findings of this study.

3. OVERVIEW OF METHODOLOGY

The study applied qualitative research methods. In-depth interviews were used to collect data from study participants. Policy reviews and relevant reports were also used as secondary data sources (Nieuwenhuis, 2007)**.** A multilevel sampling strategy (Onwuegbuzi and Leech, 2007) was applied to select participants. The various study participants included women users of contraceptives in two clinics, health care workers responsible for contraceptives in the clinics, researchers, and policy makers. Policymakers included researchers, senior government officials, civil society members, the Commission for Gender Equality, the South African Human Rights Commission, and Members of Parliament serving as Chairpersons of the Portfolio Committees for Health and on Women, and the United Nations Population Fund (UNFPA). The total sample size of the sample was twenty-seven (27). Data analysis was conducted concurrently with data collection **(**Nieuwenhuis, 2007; Yin, 2014). Feminists, and other qualitative data-analysis techniques; including probing, categorising, tabulating and testing qualitative evidence were applied to address the research questions. (Ollivier and Tremblay, 2000; Ackerly and True, 2010**)**. After all data processing, content and inductive

content analysis were applied to analyse the data collected from all three categories of study participants. Themes and sub-themes of the findings were added as they emerged.

4. OVERVIEW OF FINDINGS

4.1 THE POLITICAL POSITIONING AND POLICY CONTEXT OF WOMEN'S RIGHTS AND HEALTH IN SOUTH AFRICA

The findings in this section relate to study objective of broadening the ideology and framing of contraception policies in post-apartheid South Africa. Contraceptives in post-apartheid South Africa are understood as a public-health phenomenon. Contraceptives are presented as part of women's health in South African policies, although they are stand-alone programme, with no link to other women's health programmes. South Africa does not have a women's health policy. The National Health Act considers women solely as mothers. It only provides for family planning services and maternal health. The Act does not make provisions for women's health. Contraceptives' policies and programmes in South Africa are considered apolitical. They are not considered within the historical apartheid ideological context of race, gender, and class oppression, and violence of the past and the present. The ideological foundation of contraceptives and fertility control regarding Black women, globally, and in colonial and post-colonial South Africa, does not form part of the framework of current policies. The current ideological positioning of contraceptives in South Africa is a consequence of programmes not subject to apartheid transitioning, and redress processes of reconciliation projects, critical post-colonial, intersectional feminists' and Black women's lived experiences in the democratic South Africa.

Racialised violations and targeting of users of contraceptives were silenced in the transition project. As such, the injustices remained unaddressed and continued to flourish in post-apartheid South Africa. Liberal feminist views were influenced by participation of international bodies in the definition of reproductive rights. This led to the silencing of contraceptives use as a deep political phenomenon. I argue that the legalisation of abortion, perpetuated as a universal women's victory, and conceived from the liberal feminist perspective, void of experiences of indigent Black South African women, silenced the injustices of Depo Provera. Other reproductive rights violations including forced and coerced sterilisations of impoverished Black South African women were injustices experienced.

The rejection of feminism as an ideology and theoretical framework by the African National Congress is one of the reasons for depoliticization of Depo Provera in transitional processes and in post-apartheid South Africa. Depo Provera was a matter of political organising of the ANC Women's League prior to rejection of feminism. Consequently, Depo Provera did not make it to the transition negotiations and reconciliation project South Africa adopted. Depo Provera, amongst many other issues, lost its political and justice status in the transition period.

The current position of the women's rights lobby is the product of the rejection of feminism and how women's organisations were reduced to deliver care services, low-level community development and focus on access to public services. Depo Provera is one of the issues that lost political identity and nature. This came in the context of depoliticization of health, given that health was one of the key weapons of the South African colonial and apartheid projects. Access to health care became the main issue of organising, without questioning the ideology, the politics, the packages, targeting and quality of services, which the health access comprised for indigent Black people. Women's rights organisations hardly work on health as a women's right, and none is working on Depo Provera as a tool of oppression in post-apartheid South Africa. The feminist agenda and organising in health and contraceptives is missing in South Africa. I argue that this is partly sustaining the status quo of Depo Provera. The popular liberal mainstream discourse on contraceptives flourishes in this environment.

4.2 ALIGNMENT OF POLICIES WITH WOMEN'S RIGHTS NATIONAL TRANSFORMATION AGENDA

The study sought to interrogate whether the current contraception policies are aligned with the national transformation agenda and policy, including resourcing for women's health, and consideration of women's health implications. Population targeting of Depo Provera remains focused on impecunious Black women in post-apartheid South Africa. The targeting has nuances and intersecting positions and marginalisation of women, women who sit further out on the margins of society. The targeting of policies includes women living with AIDS, who use public health services, indigent young Black women exposed to intergenerational poverty and economic exclusion to teenage pregnancy; and impoverished urban women who use public health services − women of colour, mainly young women. The goals of this targeting are to address social problems of decreasing HIV infections, reducing teenage pregnancy, and reducing maternal mortality, in particular, the litigation costs of the Department of Health for damages from failing maternal and delivery services.

This targeting is in line with global targets and justifications for increasing Depo Provera, albeit reduction of urban indigence being one of the justifications in South Africa. Failure of health systems and lack of development drive these problems. It can be concluded that women's bodies are therefore used to address or reduce the impact of these policy-failure issues. Indeed, women have agency, and some women do benefit from these programmes; however, they are not conceived or designed to empower or enhance reproductive rights or autonomy of women, contrary to the popular discourse. The targeting of women for Depo Provera remains racial and political around the world. In America, where the use of Depo Provera is limited to short-term use in exceptions, the targeting is the same. In recent times, Black women of African (Ethiopian) origin have been targeted in Israel. In some instances, the targeting has been disguised as developmental, but race is always found in the background.

Margaret Sanger, who pioneered contraceptives in the 1960s-1970s, did so to address poverty of Black African women. It was later discovered that she was an agent of the eugenics movement. In India, impoverished Indians of lower caste with darker skin tones were targeted. In Zimbabwe and South Africa, only Black women were targeted. The justification for targeting of women for Depo Provera are racial, gendered, and rooted in historical and present gender oppressions. Such oppression stems from patriarchy, gendered race oppression, marginalisation of females, and gender inequality. Medical interventions are deployed to oppress women and violate women's bodies.

These contraceptives programmes lead to shifting of focus onto the socio-political sources of women's position and problems, for example, teenage pregnancy. There is also poverty, failure of health systems, and exposure to HIV infection. Post-apartheid South African ideology on and policy provision of contraceptives are not conceived from women's rights or as gender equality rights. The programmes and policies mention women's rights and gender equality, and refer to international commitments on gender and women's rights; however, policies do not contain active goals for gender transformation. There is no mention of national gender equality policy frameworks, racial justice, and other commitments flowing from the Constitution in the policies and programmes. The human-rights-based approaches have been both gender-negative and gender-blind.

The programme has a negative outcome that reinforces perpetuation of gender oppression. It sustains the racialised past and existing gender inequalities and norms, with indigent Black women at the receiving end of such futility.

The deeply racialised political economy nature of contraceptives is silenced in this approach. In this approach, health care is conceived as isolated from health. Health care is presented as a political phenomenon framed within the global ideology of neoliberalism, capitalism embedded in patriarchy, and women's oppression. Health care should be transformed from the perspectives of intersecting post-colonial indigent Black women's lived experiences and rights. Health care should address rather than enforce these oppressions. Essentially, the right of access to health care should be conceived from women's lived experiences, the feminist perspective. The current approach silences the racialised, gendered, political, economic, and oppressive nature of contraception in public health care in South Africa. This approach is in line with the international neoliberal conception of conceiving rights bearers as consumers and clients, wherein the rights are co-opted in the neoliberal project of creating supply and demand.

4.3 ADVANCEMENT OF WOMEN'S REPRODUCTIVE RIGHTS AND HEALTH

In line with the study objective on advancing women's reproductive rights and women's health, the study concludes that human rights conception is therefore removed from women's rights to make reproductive choices, and choices about what goes into their bodies. This is counterproductive to the women's rights course, violating women's rights. The contraceptive programmes and women's rights are a falsely constructed paradox. The paradox suggests that it is not possible to provide safe contraceptives which are driven by women's needs and urgency, removed from racialised population control and the eugenics project. The paradox suggests that drug companies and unsafe contraceptives are the only solution; such creates the essentialism of Depo Provera. This study concludes that the oppression of women in this matter is continuous over time and historical periods. The study observes that human rights-based instruments; integration of women's rights and liberation does not change the status quo. The observation is also that these oppressions do not end, even with the passing of laws and litigation. A case in point is America, where there have been laws and litigation; nevertheless, the establishment continues to target women at lower strata of society.

4.4 SIDE EFFECTS, INFORMED CHOICES AND CONSENT

This section gives an overview of findings relating to study objective on assessing informed consent, choice and side effects. Although women need contraceptives, the choice to take them is not fully theirs. In some instances, women were compelled to use contraceptives through intimidation. Consent by women to take Depo Provera was not sought − women were simply told that they were to have the injection. The study found that some women consented to taking

the injection and continue to take it voluntarily. Women reported that health workers encouraged them to choose Depo Provera because of the advantage that they need only come to the clinic once in three months. The marketing of Depo Provera as a time saving method is still one of the reasons women opt for it; and equally, for health care workers promoting it. The choices presented by the policies do not consider the historical context of the women targeted. There has not been investment on undoing the historical marketing and provision of Depo Provera on both the side of the providers and the users. However, some of the women continued to take the injection because they believed it to be part and parcel of their post-delivery care, infant care, and immunisation of their children. Women believed that refusing the injection might jeopardise their access to these services.

Outright coercion into taking Depo Provera is also still the practice, the case in point being the 37% women in the HSRC study, the schoolgirls forced to take the injection. Also, students on Department of Health bursaries to study medicine in Cuba were given Depo Provera hormonal contraceptive implants as part of their bursary conditions. This suggests that the programmes have limitations and failures in application of information, options requirements, and rights frameworks in consent, including time and environment of decision-making. The study found that information is provided only on two side effects− weight gain, and irregular bleeding.

Long-term and more life-threatening side effects are not communicated. Information on emerging side effects and topical debates on these were not provided. Detailed information on how Depo Provera works in the body, and potential side effects was not always provided. Health care workers reported not being aware of some of the long-term, more serious side effects, such as bone density loss, the cancers, and potential increased risk of HIV infection. There are also broad health systems challenges and their implications on women's choices and side effects. Because of stock outages of the two-monthly injection, all women who were taking the Depo Provera two-monthly injection had been switched to the Depo Provera three-monthly injection.

4.4.1 HEALTH SYSTEMS CHALLENGES

The study found that health system challenges have a direct impact on women's choices of contraceptives. At the time of data collection for the study, the stock outages had been experienced for a year. Health workers cited challenges of staff capacity and training as a barrier to using other methods when these are available, notably, vaginal rings, and implants.

Vaginal rings had also not been in stock for a period of one year. Health care workers reported that they were trained to insert implants but not trained to remove them. This is a challenge, as many women return to request removal of implants. According to the health workers, failure to remove implants compromises the trust between them and the service users, and indeed impacts on women's choices. At the time of data collection, implants were not available at the clinics. Health workers presented concerns of stock outages and lack of capacity from the service users' perspective. Women users of contraceptives reported to have agency in the situation, stating that they need contraceptives. Women reported to have knowledge that Depo Provera was not a good contraceptive. The women reported have their own strategies of dealing with side effects. These include going on and off the injections, changing clinics to avoid being reprimanded, and accessing and sharing information through sources that are out of the clinic or health system. The study found a level of solidarity between women users of contraceptives and health care workers. Health care workers in one of the clinics developed materials on side effects of their own accord. They had taken information from their own training materials to share with the women users.

Depo Provera is registered and included in the essential list of medications in South Africa. Scientists and the medical field populated regulatory framework on the side effects of Depo Provera differ in developed countries from developing countries. The scientific knowledge on the dangers of Depo Provera applied in regulations in developed countries is not applied in South Africa. In this regard, science, biomedical, and medical expertise responsible for regulation are not protecting women who use Depo Provera in South Africa. This suggests that science has double standards in terms of the women's bodies benefitting from scientific advances. South African women who use Depo Provera and groups of women targeted for use and research of Depo Provera are excluded from the scientific advances.

The accountability of the scientific and medical field is removed from the public sphere. This is in sharp contrast with the experience in the United States where Courts of Law have made rulings on how Depo Provera side effects should be communicated by drug regulatory bodies and the pharmaceutical industry. South African women who use Depo Provera are not benefitting from these court rulings, although the drug in question and side effects and other dangers to women's bodies are the same. The study found that scientists responsible for regulation and policy making are responsible to other scientists and medical bodies, rather than to human-rights and Constitutional structures in protecting the rights of women. The

manufacturers of Depo Provera, Pfizer and promoters, are also not held directly accountable for side effects, as is the case in the Western countries. Contraceptives' policies, in particular provision of Depo Provera, are not conceived from women's rights, autonomy, and women's health agendas at a broader level. The cost of side effects on women's lives is not reckoned and accounted for.

4.4.2 CURRENT SCIENTIFIC INNOVATIONS OF DEPO PROVERA

The study found that there is no research agenda for increasing safety of Depo Provera. On the contrary, the study found that there is significant investment in new innovations and formulations of Depo Provera. There has been an upsurge of Depo Provera scientific and bio-medical innovations of recent times. The innovations are on various preparations of Depo Provera. According to the agencies the innovations research is to expand access to and use of Depo Provera. The research includes behavioural studies to inform marketing strategies of the new inventions. There is no record of innovations to improve the safety of Depo Provera, nor to minimise side effects. The recent innovations are led by the Bill and Melinda Gates Foundation, USAID, FHI360, IPM, under the auspices of the FP2020.

South Africa is one of the countries where the trials and feasibility studies of the new innovations are carried out. Research bodies, such as local research institutes WRHI, and MatCH Research are collaborating partners in these studies. The two afore-mentioned agencies also have strong involvement in policy and other research on contraceptives. New innovations include a Depo Provera injection, the Sayana Press (DMPA-SC) in the Uniject injection system, which can be administered by women in the communities and by women users themselves. This contraceptive is injected under the skin. As such, it does not require a trained and certified health worker to administer it. The goal for this is to expand community access. The other hidden goal could be to remove legal liability from health workers. In the US drug manufacturing companies have a legal liability to communicate all side effects and to make counselling provision as per the regulatory law. This injection was approved by the WHO. It has been registered for use in South Africa and will be introduced into the South African public health facilities in the near future. This invention follows approval and introduction of implants, the Implanon formulation of Depo Provera in South African public health systems. The implant is Depo Provera in implant format. It is released into the body over three years.

The other intervention is the Dapivirine Ring. This intervention will combine Depo Provera with an HIV drug. It will be used to prevent HIV infection in women while also preventing pregnancy. This intervention is still under development. South Africa is one of the countries where human trials are developed. It is worth noting that human trials on HIV are only conducted in countries and in localities with high rates of HIV infection. Over and above all other burdens of indigent women in these communities, the women must now submit to research trials on their bodies. South Africa is one of the sub-Saharan African countries where human trials of a study to confirm the increased risk of HIV vulnerability for women who use Depo Provera, the ECHO study, were conducted. Science, medicine and biomedical science are, however, not neutral in terms of racial politics, racial oppression, reproductive politics, and control of women's bodies, colonialism, and other dominant political ideologies.

Clinical trials are conducted on women who are Black, indigent, vulnerable, and who use public health care services. Researchers, science, scientific inventions and product developments authorities, multinational drug companies, funders and bilateral agencies work in collaboration. There is a clear division of labour between Northern and South African researchers. Local researchers in the main provide women's bodies for trials. The racial division of labour in the South African research institutions is worth noting. Furthermore, medical and scientific fields and associations are not neutral bodies. Most of these bodies were operating in apartheid South Africa, promoting Depo Provera as a contraceptive of choice for disaffected Black women. Furthermore, the South African drug regulation bodies, societies of clinicians, and pharmaceutical regulation bodies, are institutes of the National Department of Health. This suggests challenges in terms of checks and balances. The scientific and health fields are self-regulating. It is observed that, although health is and was a political actor in apartheid South Africa, it was not subjected to human rights transformation during the transition and during post-apartheid South Africa.

5. PARTICIPATION IN CONTRACEPTIVES POLICY FORMULATION AND PROGRAMMES

One of the objectives of this study was to explore the nature of women's and public involvement and participation in all spheres of contraception policy and practice. The post-apartheid contraceptive project is said to promote women's rights. Looking more closely at these, however, there is no evidence of promotion of rights of women. Rather, there is addressing of specific social problems that impact women, and in some instances, contradict

the very principles of women's rights and autonomy. The level and nature of participation of women, women's organisations, and women's rights lobbies safeguarding the interests of women, would be one of the indicators of women's rights commitments of the programmes. Public participation is duly legislated in the National Health Act of 2003. Legislation includes participation of communities in the policy processes and the governance of clinics and hospitals where these are located. This study found that scientists, researchers, and international experts from various agencies have a pivotal role and are overrepresented in policy formulation on contraceptives in South Africa. Participation of human rights and gender structures in contraceptives policy formulation is limited. The study found that there was only one representative who participated in the 2012 policy process. The same participant participated in the 2018 policy process, albeit did not invest much time therein.

This was because of what the participant perceived as the tokenistic nature of the engagement. The Department of Health reported that the voices of women users of contraceptives were represented in pre-policy review baseline studies conducted by experts. This suggests that the Department does not believe in the role and participation of the women users, although this is a provision in its own policy on a human rights framework. According to the Department, the voices of women are better mediated through the experts. The Department reported that service provider organisations represent the women users of contraceptives. This is not in line with the policy values of public participation and human rights provisions. Gay and lesbian groups participated in the policy.

The policy in question is not targeting this group: the women who are targeted by policy were not participants. Furthermore, the participation of this group did not translate to the mainstreaming of women's rights in the policy process. It did not call for the inclusion of the targeted women nor for advancement of the targets of the policy. It also did not touch on the risks of Depo Provera, which might endanger the health of members of this very group who are using Depo Provera for various reasons. This demonstrates the culture of adverse incorporation, and how this has impact on women's rights. The co-option of this group silenced women living with HIV, young women, and indigent women who are targets of the policy.

5.1 COMMUNITY LEVEL PARTICIPATION

The two clinics sampled for this study had Community Clinic Committees, in line with the legislative provision. The Committees do not represent the interests of the women users of contraceptives in clinics. Women were not aware of the existence of such structures, therefore

did not participate in these structures, nor in community health structures. Clinic Committees would not have access to contraceptives policy nor participate in the interests of women. These committees are not involved in clinical matters, nor governance of the clinic, although the legislation empowers them to be part of governance. There is no indication of how these structures will incorporate women's health and gender into contraceptives in their mandate. Gender, and women's health is not provided for in the legislation apropos of their formulation and operations, the National Act of 2003. The Committees do not have much decision-making power in running the clinics: this lies with the province. The Committees are not budgeted for, as they should be, and do not have formal training on health policies or carrying out oversight functions. Because of high rates of unemployment in the Committee, members may work as volunteers in the clinic, with the hope of being employed by the clinic. Some Committee members participate in order to have close proximity and business opportunities in the clinics. This fact compromises the power of the members within the clinics. Lack of connection with the committee and accountability to the community was one of the limitations identified. The study found that community health care workers and community nurses were playing more of a role in connecting the clinic with the communities than were the clinic committees. While not having a role in management or oversight, committees are there to extend services, including monitoring contraceptive use in the communities. The community had not raised any issues in relation to women's health or contraceptives. It would have been expected, for example, that the community would register the concerns about stock outages. In the popular South Africa culture of protest, the community could have protested on the issue of stock outages of contraceptives; and on media reports of targeting schoolgirls without the consent of parents, and HIV-positive women. The women users reported that they had not used the complaints boxes placed in the clinic for their feedback, nor complained about the location of the toilets, although they had issues with such. This demonstrates that there is limited community activism on health issues. Without consciousness building and women-centred community engagement in the broadest terms, learning how the power in health services is understood and practised, it will be even harder for the community to act on women's health issues. There is a need for transformation of health services from the women's-rights and human rights perspectives conceived from women's lived experiences. Women's intersecting disadvantages must be acknowledged and embedded in the goals of eradicating patriarchy and state and societal power over women's bodies.

5.2 PARTICIPATION OF CONSTITUTIONAL AND PARLIAMENTARY BODIES

The Commission for Gender Equality (CGE), and the South African Human Rights Commission (SAHRC) do not participate in the contraceptive policy formulation or monitoring processes. Both these institutions receive and investigate formal complaints they receive on violations from the public and other interested parties. The two institutions have the prerogative to investigate topical matters of public interest, even if there is no formal complaint lodged. In 2019, the Commission for Gender Equality reported in a submission to the United Nations Special Rapporteur on Violence Against Women that forced sterilisations and forced administering of Depo Provera to HIV-positive women was reproductive violence against women in South Africa. The two institutions have not investigated Depo Provera, although there have been recent reports of forced administering of Depo Provera to young women, HIV positive women, and students on state medical training bursaries in Cuba. The Human-Rights Commission has investigated hospitals in response to public outcries about lack of commodities, including contraceptives, and high Department of Health litigation bills. There is no indication of how the gendered nature of failures of lack of commodities and failures of the health systems were brought to the surface. This speaks to the limitations of the separation of gender and human rights expressed through the mandates of the CGE and the SAHRC. SAHRC investigations and recommendations will not impact on gender and address women's specific issues if the SAHRC is leaving out gender analysis. Depo Provera was not singled out in these investigations, despite being part of the equation. The SAHRC delegating gender issues to the CGE suggests that gender may not have been a focus of their investigation. The Parliamentary Committee on Health plays the role of monitoring implementation of all health programmes from a targets and budget-expenditure point of view, monitoring overall plans of the Department. The Committee does not focus on specific programmes, despite special circumstances. The Committee had not dealt with issues of contraceptives and Depo Provera in light of the historical and current controversies. The Portfolio Committee on Women in the Presidency did not have any role in the contraceptive policy nor implementation. They have not had any engagement with the policy nor the issue of contraceptives in South Africa. The Portfolio Committee had not yet deliberated on Depo Provera. According to the chairperson of the Portfolio Committee, the matter might have fallen off the agenda of the ANC Women's League. Depo Provera was one of the key programme issues of the Women's League in the 1990s. This suggests that Depo Provera is not part of the women's rights agenda in Parliament. The Department of Women in the Presidency is not acknowledged in any of the Department of Health Policy documents reviewed for this study. This suggests that these policies were not

subjected to gender analysis, and by extension, will not be subjected to such, this being the function of this ministry. These two committees seemed not to have worked together on any matter. The matter had also not been raised in the Multiparty Gender Committee. The absence of Depo Provera in parliamentary discussions suggests that there is no civil society grouping advocating on this matter. Issues of public interests reach parliamentary structures through advocacy and lobbying of parliament and members of parliament.

6. HUMAN RIGHTS PROVISIONS OF CONTRACEPTIVE PROGRAMMES

The study considered the role and participation of human rights bodies in order to meet the study objective of assessing whether policies are centred in women's rights and are transformatory from the perspective of racialised reproductive injustices of apartheid South Africa. In this regard, the study explored the enforcement of human rights pursuant with the objectives of the study and the fact that enforcement of human rights is embedded in the mandate of these structures in contraceptives policies. The study concludes that the policy framework is progressive in terms of articulating human-rights-based approaches; however, these are not provided for at the programmatic level. The articulation of rights is therefore not matched with the environment within which the rights are to be realised. The rights articulation misses the analysis of women's lives, as indigent Black women in post-colonial society. The rights of Black indigent women are conceived from a mainstream human rights analysis and framework. This leads to specific gendered patriarchal nuances of the violations and women's oppression is missed in the analysis and remains unaddressed if not compromised even further. This is not withstanding that the rights are not provided for in programmes and budgets. Furthermore, the chapter concludes that human rights approaches are not conceived from a women's-rights perspective therefore assumptions are made about equality of rights' bearers.

Human rights are universal; however, it is observed that in women's oppression, broadly speaking, the location and status of their country in the global economic complex is an indicator of whether they can access their rights. The politico-economic history of their country, colour of their skins, their age, and socio-economic status are all indictors. Protection and enforcement of human rights is barely provided for, even by the international bodies that codify human rights, such as the United Nations. Furthermore, it can be observed that the legal liability for drugs lies in the drug companies in countries such as the United States and Canada, amongst others. Although we have not had litigation in South Africa, all litigation, the faults and the liability lie with the state. This is because of the legal and regulatory framework of

contraceptives, in particular, Depo Provera. This study argues that this is because the international agencies of the developing countries insulate and safeguard the interests of drug companies of the developed countries in their involvement on regulations and policy processes. This points to the gendered political economy of laws of a post-colonial state. For example, the laws have protected the multinational drug companies from being sued. This observation links to the negative effects of having the external world setting the policy agenda in another country, such as South Africa. In this instance, the policy agenda has protected the external world, and placed the responsibility on the state. Therefore, women in the country are disadvantaged twice. Firstly, they are given toxic contraceptives, denying rights of choice and health. Secondly, their resources as citizens for litigation are taken from the health resources of the country.

Human rights enforcement and litigation suggests that the struggles for women on Depo Provera do not end. They appear progressively in different political regimes, transitions and ideologies. Litigation on Depo Provera has been noted over many years. However, litigation continues in developed countries. Depo Provera continues to appear in different forms. Dispensing practises remove DP from health care workers at higher levels dispensing it to health workers on lower strata of public health. Litigation on Depo Provera has not been recorded in South Africa and other developing countries. Ghana is the only country that has successfully litigated on the use of Depo Provera for research purposes without informing the women. The concentrated involvement of external organisations with proximity to drug companies and foreign governments has ensured that legal and regulatory matters insulate the drug companies. Whatever responsibility lies in countries like South Africa for an example lies with the government. Regulations, the bans, restrictions and compulsory disclosures by health workers in the US, Canada, and the UK, are not applied in South Africa. This even extends to the results of court actions on Depo Provera, the impact of these have not benefitted women in developing countries including South Africa. Legal and human rights public interests' organisation have not litigated on Depo Provera on public interests' grounds. It is a reasonable expectation that they will be aware of litigation on these matters in the US, Canada, or the UK, because of the globalisation of the sector. Ethical research in medicine and science are defined, applied, reviewed, and enforced by scientists. In this debate, scientific research ethics prevailed. The matter was not reported to a human rights body for testing of ethical arguments, or to a Court of Law for legal testing of ethical arguments. Other countries in the West have successfully litigated on studies involving Depo Provera. In South Africa, scientific studies and clinical trials have also been accused of subjecting large numbers of research participants.

Black women using public health services to Depo Provera, whilst knowing the harms and potential dangers.

The targeting for the studies is communities with high rates of HIV infection in poor urban centres and in rural areas. This begins to demonstrate the intersection of research fodder and historical poverty and economic marginalisation created by the apartheid and colonial political systems. Such is unfortunately sustained by the current neo-liberal economic project. This was particularly a concern in the large ECHO study involving thousands of women referred to earlier in this report. The UNFPA is the leading UN agency on contraceptives in South Africa. The UNFPA, WHO, and the Office of the United Nations High Commission for Human Rights (OHCHR) jointly codified human rights on contraceptives stemming from the 1949 Universal Human Rights Declaration. The OHCHR and WHO, however, do not have any role in human rights work or contraceptives in any individual country. The role of the WHO is limited to producing global guidelines, setting policy parameters and standards, but it is not involved in implementation, monitoring, and human rights enforcement. The study observes that the United Nations Agency for Women (UNWOMEN) is an agency for advancement of women's rights and gender transformation if contraceptives are the means for advancement of women's rights. The UNDP is an agency responsible for international socio-economic development and poverty alleviation programmes, which is also not involved in contraceptives in South Africa. This suggests that the development goals and justification of contraceptives as developmental interventions are a fallacy.

It is an observation that the involvement of the OHCRH in codifying human rights guidelines is more about increasing the credibility of contraceptives programmes with human rights language. It is also a concern that OHCRH would know about human rights abuses and a plethora of litigation on human rights and side effects of Depo Provera in the USA and Canada, for an example, but has not shown interest in using such lessons from other countries to investigate or to protect the South African women in this regard. The global human rights structures of the United Nations therefore do not safeguard the rights of women users of contraceptives, such as Depo Provera, most of these women being poor Black women. These United Nations human rights bodies create a favourable environment for the abuse of the very rights they pronounce and advocate for. Furthermore, the OHCHR would be aware of recent human-rights breaches in relation to Depo Provera in South Africa, but not have acted on them. UNAIDS was a leading partner on the HSRC study that found that 37% of women living with

HIV were forced into taking Depo Provera but has not acted on those findings. The same study revealed that 7.4% of women living with HIV in the study were forced into sterilisation, but UNAIDS has not acted on these gross human rights violations. The study found no evidence on the UHCR and other UN agencies, such as the WHO intervening to protect the rights of South African women (oppressed and colonised bodies) through Depo Provera.

There is also no evidence of how these UN structures were held accountable for their part in the apartheid racial contraceptive programmes. The UNFPA representative who participated in the study reported to be aware of human rights, safety, and side effects of Depo Provera. The UNFPA has, however, not monitored application of human rights and human rights guidelines, which they codified on contraceptives and Depo Provera. The UNFPA cited a plethora of legal, institutional, and international relations barriers constraining their ability to monitor human rights at the country level. These structures participate in setting the agenda and research, and dictating policy processes on contraceptives, facilitating and monitoring distribution, coverage uptake processes, and participating in implementation.

However, their mandate is limited on enforcing and monitoring the rights of women users of contraceptives. UNFPA believe that human rights monitoring is the duty of the national state human rights agencies. UNFPA confirmed that they do not work with or support any of the local human rights bodies in this regard. The agency reported that proposals for monitoring research on contraceptives at a community level have been made. This suggests that, although the UNFPA codified and put together human rights commitments and guidelines on contraceptives, the body is not committed to human rights for women users of contraceptives.

7. THE ROLE OF INTERNATIONAL AGENCIES

The study explored the role and influence of international agencies in order to fully broaden the political economy of contraceptives in post-apartheid South Africa. The ability of the policies to transform power, redress violations of apartheid policies in order to enhance women's rights and autonomy is dependent on the dominant global economic ideology and neoliberal power system, and the position of South Africa in this system. In this regard the study found that international actors overly influence the South African contraceptive policy and practice. These actors form a conglomerate of neoliberal forces of multinational companies, United Nations, bilateral agencies, and liberal biomedical and health sciences researchers. Such actors dictate the high-level regulations, policies, resourcing, innovation and

expansion, and population targeting of Depo Provera. Key to these actors, are the United Nations Fund for Population and Development (UNFPA) and the World Health Organisation (WHO). Private philanthropical foundations involved in contraceptives policy and practice are the Bill and Melinda Gates Foundation, the Clinton Health Access Initiative, and FHI360. The University of Witwatersrand's Reproductive and Health Institute (WRHI) and the University of Witwatersrand's Institute and Maternal Adolescent and Child Health (MatCH) Research Unit (MRU) are the only two South African research institutes participating in contraceptives policy processes. USAID is a common denominator in this interconnected conglomerate. The agency has direct links with individual actors, and also with actors as a collective in various areas of the policy process. Research institutes, sector-specific experts, international organisations, and public health experts are part of the network at a meso-level. A clear division of labour and power between global- and country-level actors could be seen. In the case of Department of Health policy processes, experts were recycled and played various roles in the project.

The Bill and Melinda Gates Foundation have deeper influence in contraceptives policy at a global level because of its funding and power within the WHO. This foundation has close proximity to Pfizer, the company who manufactures Depo Provera. The current global policy framework, FP2020 is initiated and led by the Bill and Melinda Gates Foundation, not by the WHO, as part of its mandate. This is evident in the Family Planning 2020, wherein the global contraceptives policy of the United Nations, is dictated by a non-State actor. The WHO is not accountable to the members of the United Nations. Member states therefore are not playing their oversight role of monitoring the WHO and ensuring that the organisations operate within the mandate of the member states. Contraceptives are impacted by the limitations of the global health governance systems.

The global contraceptives agenda is focused on the increase of uptake of Depo Provera. Such comes about via intensified programmes of innovation of Depo Provera in different formats, intensifying the roll out to targeted populations in developing countries. The agenda is not on research into safe contraceptives, or making Depo Provera any safer, nor is it on the impact of Depo Provera on women's health. The target is developing countries; there is no evidence of how developing countries are pushing back on this. Depo Provera, at a global level, is rooted in neo-liberalism, the emergence of new powers in philanthropists. Depo Provera is attached

to the HIV/AIDS crisis, to HIV funding and assistance. DP is also linked to maternal health assistance services, which are part of development assistance.

The United Nations have power over the South African contraceptives policies through ICDP's and SDG's declarations, amongst others. These declarations give the UN access to South African policy making processes and programmes. This power is taken over or co-opted by donor countries, notably the US, who brings on board financial and technical resources for the UN to do its work. The very commitment, for ICDP in particular, does call for developed countries to finance and provide technical guidance to the developing countries in this regard. The donor countries, in this instance, mainly the US, bring on board their country research institutes, and drug companies through their philanthropy arms, and public health experts and agencies, co-opting the minority of local research institutes.

The study found interconnectedness in the involvement of international unilateral organisations and bilateral agencies, including USAID. The interconnectedness expands to pharmaceutical industry, philanthropists and INGOs. The external parties form an agglomerate of power in South Africa's contraceptive policy formulation. The web extends and is legitimised by the power and control the conglomerate has on defining the research agenda and funding research processes. The conglomerate uses its power to use bodies of women to conduct innovative research on Depo Provera in South Africa and other developing countries. Furthermore, the conglomerate has power and high-level access to budget allocations and restructuring, procurement, and even monitoring uptake functions of contraceptives. The South African contraceptive agenda is not driven by internal need or aspirations, nor is it informed by the country's realities, priorities, nor history. International agencies set the agenda for contraceptives policy and changes in South Africa. The agencies recommend policy changes, changes in guidelines and standards, conducting local baseline research to feed into the research they would have conducted elsewhere. The external agencies finance, provide technical guidance, facilitate the processes, develop training, and train health workers on the practice provisions of the new policies, conducting commodity-expansion-monitoring work. Looking closer at the budget and human resources allocated to the directorate responsible for contraceptives policy, it is clear that the role of the unit is limited to coordinating actions of international actors in the contraceptive policy space. International actors prepare and dictate the policy environment for rolling out contraceptives, which are provided by drug companies in their countries. This suggests a crisis in health policy formulation processes in South Africa. This begins to validate that public policy is a political action. In this instance, neoliberal policy

has a direct impact on women's lives. Women users of contraceptives and women who are targeted are impacted directly by political, economic, and geo-political decisions made at a global level. The colonial economic and political history of their countries has led to their countries being on the receiving end of neo-colonialism and neoliberalism. This form of oppression plays itself out on women's bodies at a micro level. Depo Provera was the tool for colonial, and in South Africa the apartheid suppression of reproduction of Black women. The current state of affairs is that indigent Black women in South Africa are still not liberated. Population control colonialism still continues. The burden of poverty and disease, the direct impact of colonialisation and exclusion, is impacting on women. Such brings another layer of women's oppression, suppression of their reproduction, using Depo Provera with negative impacts and cost on their health.

WRHI and MRU are two local agencies credited for providing research and technical guidance to policies reviewed for this study. WRHI provided overall coordination of one of the policy processes, developing training manuals and training for health workers in the policy. MRU is one of the implementing partners of contraceptives in the two clinics sampled for this study. Participation in these processes is not open to other universities. As such, the policy formulations are informed by one research perspective, therefore comprising information bias.

The international community is heavily involved in the budget allocations on procurement in South Africa. International actors such as CHAI, the Bill and Melinda Gates Foundation, with support from USAID, are the leading global procurement arms of the global contraceptives' agenda. Procurement is facilitated through the Contraceptives Procurement Network. CHAI, Pfizer, and other drug companies manufacturing contraceptives lead this network. The core mandate of the network is to provide technical support to developing countries on procurement, through policy instruments, efficient enabling, bulk procurement, favourable pricing, regulations and structuring of budgets. The network also facilitates expansion and shipping of the contraceptives to various counties. As a middle-income county South Africa does not qualify for grants for contraceptives, as such, the country must procure contraceptives. CHAI also plays the same role structuring government tenders in this regard. CHAI plays a similar role in procurement of HIV drugs and in the structuring of government budgets.

International actors have access to and power in high-level decision-making processes of health policy and financing. CHAI has a pivotal role in the National Health Insurance. The agency, in collaboration with USAID through the USAID Global Health programme, plays a key role in

the development of the National Health Insurance (NHI) system. CHAI stated in its annual report that it worked with the Treasury and the Department of Health to determine packages for the NHI. CHAI assisted the Department of Health on budgeting, shifting and moving budgets in the North West Province.

8. RECOMMENDATIONS

8.1 RECOMMENDATIONS FOR RESEARCH

It is recommended that researchers consider conducting more monitoring research on experiences of women who use contraceptives, viewing such through a feminist lens so that issues of women and their voices are brought to the surface. The research will inform policy on improving compliance and improving the experiences of women on consent matters, and other matters of concern to women. The research could explore opportunities, which begin to define contraceptives as women's rights and gender oppression matter, by extension, a subject of gender equality and justice.

This approach could present opportunities for more understanding, solidarity, and collaboration on women's rights and emancipation of women between health workers and women users of contraceptives. The research could provide the opportunity for building consciousness and planting a seed of community engagement and activism on contraceptives from women's perspectives.

It is recommended that developmental health economics researchers conduct studies on the impact of Depo Provera on women's health. Such studies could document the incidence of side effects in targeted localities in order to extrapolate the national picture. The study should focus on long-term side effects, like cervical cancer, and decreasing of bone density, for example.

Research on the costs and burden of Depo Provera side effects on public health, including financing, is a necessity. The cost to wellbeing of women should also be monetarily quantified. Some of the side effects will not be provided for nor treated in the health system. For example, cervical cancer is one of the marginalised diseases in terms of treatment and budget allocation. This is because it affects mainly older and indigent Black women, and recently HIV-positive women. The exact costs to the system will not be documented. The research should extrapolate the health systems costs, infrastructure of replacing Depo Provera with safer methods of contraceptives, including investing in research on new methods, and expansion of safer methods.

It is recommended that researchers conduct feminist analysis on how the multilateral agencies and bilateral donors practising in health and reproductive health in South Africa impact the course of women's rights, as codified in the Constitution and international human rights frameworks. This targeted research will assist in building a feminist case to critique and transform these structures. Lessons from this research should be used to inform feminist international and bilateral relations, wherein South African women's intersecting realities of race, colonialism, systematic exclusion, and poverty is at the centre.

8.2 RECOMMENDATIONS FOR HUMAN RIGHTS AND CONSTITUTIONAL BODIES

It is recommended that the South African human rights and Constitutional bodies set up a process to engage the Office of the United Nations Commission on Human Rights, the WHO, and UNFPA on the provisions for and adherence to the human rights guidelines and regulations they have codified apropos of contraceptives. The institutions should facilitate public accountability.

The study recommends that human rights and Constitutional bodies initiate a process of transforming health from a human rights perspective. This is with acknowledgement that increasing and expanding access to health does not address gendered racial and human rights violations of the past. It is recommended that the Commission for Gender Equality and the Human Rights Commission conduct investigations into the structural and systematic human rights violations committed in the continued provision of Depo Provera in South Africa.

The Chapter Nine Institutions should investigate violations of women's choices, consent, and bodily integrity, specifically probing unavailability of safer forms of contraceptives, lack of consent, uninformed consent, concealment of side effects, and incidents of forced provision of Depo Provera. Chapter Nine Institutions should have a role to closely monitor and measure compliance of regulatory bodies with human rights provisions.

8.3 RECOMMENDATIONS TO PARLIAMENTARY PORTFOLIO COMMITTES ON HEALTH AND ON WOMEN, YOUTH, AND PERSONS WITH DISABILITIES

South Africa should ensure the accountability of the WHO and United Nations Population Fund in use of Depo Provera and any relevant regulation of contraceptives. Accountability of these structures insofar as double standards vis-à-vis the developed and developing countries, to the detriment of developing countries, should be interrogated and addressed.

South Africa has a duty to redefine the roles of these organisations in the South African public health sphere, as a way of including them in the transition project, given their role in health regulation and approval of Depo Provera, in particular, in South Africa.

The nature and sources of scientific evidence used by the WHO to make regulations and recommendations should be subjected to interrogation and review. South Africa should advocate for equitable utilisation of all scientific research, liberal and progressive science, public health and human rights in health-rights positions in developing of WHO regulations, approval of medicines and guidelines. It is recommended that Parliament institute a process to consider deregistration of Depo Provera as a contraceptive in South Africa. The process should include the racialised global, regional, and national political history of Depo Provera. The process should include listening to the voices of women who use Depo Provera and experiences of women who used Depo Provera in the past.

South African scientists and regulatory bodies should be subjected to public accountability through a parliamentary process. The process should deliberately consider national and international literature and science, from different perspectives, specifically, progressive scientists, racial justice and human rights communities who have successfully built a case for Depo Provera as a toxic medical intervention to violate bodies of Black women and the Black race as a whole. Parliament should commission preparatory exercises to increase and expand all safe methods of contraception, in preparation for the removal of Depo Provera. The exercise should include review of all long-term contracts and other agreements binding the country to long-term procurement and use of Depo Provera.

Parliament should prohibit all research that promotes expansion, innovation, and promotion of Depo Provera in South Africa. Parliament should evaluate and assess implications of all collaborations, agreements, and partnerships on contraceptives on women's rights and racial justice.

8.4 TRANSFORMATORY RECONCEPTUALISATION REGULATION OF HEALTH AND DRUGS REGULATORY BODIES

Regulatory bodies responsible for contraceptives should be reviewed. Transformatory imperatives of these groups should be considered, specifically, how they are aligned with the racial, gendered, and human rights transformatory agenda of the country. Expanding participation of regulatory bodies to include researchers from different perspectives should also

be considered − feminist researchers and human rights monitoring bodies. Expansion of participation should be applied to international agencies advising and aligning with the regulatory bodies.

All Depo Provera provision should be aligned with international regulations on the drug, including high levels of warnings, limit of ages, and length of taking of Depo Provera. Litigation should be initiated, and court orders issued against drug manufacturers for application in the South African law. Regulations should emphasise legal liabilities of drug manufacturing companies and promoters of Depo Provera. Stronger regulation and laws holding drug industries accountable should be introduced.

It is recommended that South Africa enact stronger regulations on public health research on women. The regulation should be transformatory, be based on the rights of women, racial justice, and human rights. All professional ethical provisions should be reviewed and aligned with human rights, South African law, and the Constitution. Participation in research ethical boards should be expanded to include statutory legal and human-rights organisations. This will address the self-regulatory nature of the research sector and opening up the sector to public accountability on women's rights.

8.5 RECOMMENDATIONS TO PORTFOLIO COMMITTEE ON INTERNATIONAL RELATIONS

It is recommended that the Parliamentary Portfolio Committee on Department of International Relations and Cooperation consider setting up a framework to ensure accountability of all United Nations and other bilateral agencies involved in contraceptives, in particular, Depo Provera, in relationship with South Africa. The accountability should be premised on the racial history of contraceptives, the effects on Black women and human rights violations of the past and present. Monitoring should include that all external funding for Depo Provera and other health external funding for women is aligned with and reviewed from the Constitutional imperatives and lived realities of reproductive oppression of impoverished Black South African women.

The Parliamentary Committee should consider reviewing, regulating, and limiting the role of international United Nations, bilateral agencies, and philanthropists in government health funding decisions. This includes in National Treasury and the Department of Health policy

making and implementation. These impact on gender, women's rights transformation agenda of the country and sovereignty of the South African as a State.

The South African government should interrogate the impact of power and over-influence of non-state actors in the governance of the WHO, UNFPA, and other contraceptive regulatory bodies in the international governance systems. South African has a duty to protect the rights and interests of South African women in international relations, and the United Nations.

8.6 RECOMMENDATIONS ON LAW REFORM

The Amendment of the National Health Act of 2003 is essential to the implementation of the recommendations of this research. It is recommended that the legislative arm of Parliament conduct the evaluation of the Act from a feminist perspective, considering women's lived experiences of racial discrimination, patriarchal oppression, systematic economic marginalisation and poverty. The review of the Act should be a transformatory process seeking to end oppression of women in recognition of a racialised history of health as an instrument of oppression.

It is recommended that the Act be amended to make provisions for women's health. The definition of women's health should be beyond the 'women as mothers' approach; it should be focussed on all progressive aspects of women's health needs and rights from puberty to death. The legislation for children's health should be separate, and be defined in line with children's rights, separate from women's health.

Fertility and reproductive health care - including provision of a variety of safe contraceptive methods, fertility treatment, pre- and post-menopausal hormonal treatments, treatment for reproductive diseases and for reproductive cancers - should be provided as a full continuum of care package. Other diseases such as diabetes, diseases of soft organs and other secondary diseases should be part of the broader package. Women's health should be provided in a holistic continuum of prevention, cure, and care. The legislative provisions of women's health in the National Health Act should be provided for in the National Health Insurance (NHI) resourcing. It is recommended that the Act and NHI make specific resources provisions and budget allocations for women's health.

The Act should provide for feminist and gender transformatory models of participation of women in health policy decision-making, politics, and governance of health. The amendment

of the Act should make provisions for more integration and resourcing of community health structures in a gender conscious and feminist understanding of community participation, wherein safe spaces for women's participation are provided. Community participation should have goals of gender transformation and liberty of women in its conception.

8.7 RECOMMENDATIONS ON DRUG REGULATION AND REGISTRATION

The persistence of use of racially biased Depo Provera and non-application of health warnings and restrictions applied in Western countries and in the country of its origin, including litigation, calls for transforming regulatory bodies. The South African Medicines Control Council and other relevant bodies must be held more accountable to the South African post-apartheid transformation process. It is recommended that Parliament enact new laws or amend the Medicines and Related Substances Act 101 of 1965. Applicable clauses of the National Health Act of 2003 can be used to address such. South African Medicines Control Council and statutory drug regulation bodies should be aligned with women on human rights and gender imperatives of transformation in South Africa. Legislative transformation of regulatory bodies should be premised on women's lived experiences of racialised targeting of Depo Provera and controlling reproduction of indigent Black women in post-apartheid South Africa.

LIST OF PARTICIPANTS

Users of Contraceptives in two clinics sampled for the study

Participant CU/OQC/01
Participant CU/OQC/02
Participant CU/OQC/03
Participant CU/OQC/04
Participant CU/OQC/05
Participant CU/HSC/01
Participant CU/HSC/02
Participant CU/HSC/03
Participant CU/HSC/04
Participant CU/HSC/05
Participant CU/HSC/06

Clinic Staff Responsible for Contraceptives in two clinics sampled for the study

Participant CS 01
Participant CS 02
Participant CS 03
Participant CS 04
Participant CS 05

Key Informants (Members of Parliament, Constitutional bodies (Chapter Nine Institutions Researchers, Policy Makers)

Participant KI 01
Participant KI 02
Participant KI 03
Participant KI 04
Participant KI 05
Participant K1 06
Participant KI 07
Participant KI 08

Participant KI 09

Participant KI 10

Participant KI 11

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Appendix 1

UNIVERSITY OF
WAZULU-NATAL

INYUVESI
YAKWAZULU-NATALI

03 August 2018

Ms Sethembiso Promise Mthembu (205519050)
School of Social Sciences
Howard College Campus

Dear Ms Mthembu,

Protocol reference number: HSS/0550/018D
Project Title: The Political Economy of Injectable Contraceptives in Post-Apartheid South Africa: A feminist perspective

Approval Notification – Expedited Application

In response to your application received 25 May 2018, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

[redacted]

/ms

....
Professor Shenuka Singh (Chair)

Cc Supervisor: Dr G Mkhize
Cc Academic Leader Research: Professor Maheshvari Naidu
Cc School Administrator: Mr N Memela



Appendix 2

Informed Consent Document

Dear Participant,

My name is **Sethembiso Promise Mthembu,** 205519050 (*Student Number*). I am a PhD candidate at the University of KwaZulu-Natal' School of Social Sciences, (Gender Studies) Howard College in Durban.

The title of my research is: **The Political Economy of Injectable Contraceptives in Post-A**partheid South Africa: A Feminist Perspective**

The objectives of the study are to:

a) Examine the ideology and framing of post-apartheid South Africa's contraceptive policy,
b) To explore how the current contraceptives policy is aligned with the national agenda and policy and resourcing for women's health and how it considers women's health implications
c) Explore how women's participation is provided for in the formulation of the new policy?
d) Examine how post-apartheid policy is informed by women's needs and priorities for health.
e) Explore how the policy enhances women's rights and autonomy; and how it considers the lived experiences of women in health, reproductive matters in its prescripts.

I am interested in interviewing you so as to share your experiences and observations on the subject matter.

Please note that:

- The information that you provide will be used for scholarly research only.
- Your participation is entirely voluntary. You have a choice to participate, not to participate or stop participating in the research. You will not be penalized for taking such an action.
- Your views in this interview will be presented anonymously. Neither your name nor identity will be disclosed in any form in the study.
- The interview will take about one hour.
- Interviews will be recorded ONLY if you agree to the recording. There will be no penalty for not agreeing to recording.
- The record as well as other items associated with the interview will be held in a password-protected file accessible only to my supervisors and myself. After a period of 5 years, in line with the rules of the university, shredding and burning will dispose it.

- You will be provided with a full report at the end of the study
- If you agree to participate please sign the declaration attached to this statement (a separate sheet will be provided for signatures)

My supervisor is Dr. G. Mkhize who is located at the Discipline of Gender Studies in the School Social Sciences, College of Humanities at the Howard College Campus of the University of KwaZulu-Natal. Contact details: email: Mkhizeg2@ukzn.ac.za Phone number: +27 (0) 31 260 7614. The Humanities and Social Sciences Research Ethics Committee contact details are as follows: Ms Phumelele Ximba, University of KwaZulu-Natal, Research Office, Email| ximbap@ukzn.ac.za Phone number +27(0) 31 260 3587. I can be contacted on telephone number +27(0) 31 260 4199, Mobile number + 27([redacted] or 27(0) 76 [redacted] Email: mthembus11@ukzn.ac.za or sethembisomthembu24@gmail.com

Thank you for your contribution to this research.

DECLARATION

I…… *(full names of participant*) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire. I understand the intention of the research. I hereby agree to participate.

I consent / do not consent to have this interview recorded (if applicable)

SIGNATURE OF PARTICIPANT DATE

…….

Appendix 3

Semi-structured interview schedule (Key informant)

Participant Identification Number	
Interviewer	Sethembiso Promise Mthembu
Date of interview (dd/mmm/yyyy)	
Interview start time	
Interview stop time	

Thank you for agreeing to talk with us today. My name is _____. I am from _____.

We are interested in talking with you today about issues relating to injectable contraceptives in South Africa. There are no right or wrong answers; I am interested injectable in hearing your opinions about injectable contraception. Our talk will take maximum forty minutes.

I will be recording our talk using an audio recorded so that I will be able to play it back later to remember and understand what we talked about today. I may contact you again at a later stage to clarify issues that need more discussion.

PART 01: About Your Organisation

1. Could you tell me about your organisation? When was your organisation formed?

- What is your position in this organisation?
- Where does your organisation work (National Province & town/city)?
  How big is your organisation? How many people work in your organisation?

  a. =Staff members?
  b. = Board Female

c. = Board Male

d. = Positions-Women staff members

e. = Positions- Male Staff Members

2. Could you share what your organizations' involvement and interest on current issues relating contraceptives in South Africa?

Probe

a. What is the nature of your organisation's involvement and interest?

b. Strategic Position

c. Specific programmes

3. What could be your comment of how issues of contraceptives were treated in South Africa's transition and reconciliation initiatives and beyond?
4. Could you describe some of the measures employed to address these in the reconciliation efforts in the transition period and now?
5. Looking into South Africa today, what would you consider as attitudes and expectations of towards reproduction of different groups?

Part 02: The Current South African Policy on2013

1. What was the nature of your organisation's participation in the formulation of the new contraceptives policy of 2013?

   a. If not, are you aware of such are policy?

2. Are you aware of other organisations, women's groups or human rights organisations; which were participating?
3. What could you describe as your organisations overall view on the current policy and practice on injectable contraceptives in South Africa?
4. What would consider as the bigger goals that drive or inspire the current contraceptives policy?

(i) Population concerns?

(ii) Public health concerns? (iii) Development?

(iv) Women's rights concerns?

5. According to your knowledge how does the new policy communicate known side effects and other known possible health complications to the women who

(i) How are side effects provided for in the new policy? More specifically:

(*Cervical Cancer, Depression, possibly infertility amongst others)*

(ii) *Possibly enhanced vulnerability to HIV infection, (ii) How is your organisation involved in these debates?*

(i) Treatment

(ii) Monitoring

(iii)How does this policy provide for infertility treatment and other related diseases?

(iv) How does the new policy incorporate other women's health more broadly?

Kindly share the examples of these diseased or concerns?

(i) Budgets?

Power, Women's Participation and Agency

1. How does the current contraceptive policy consider lived experiences of women in health, reproductive matters in its prescripts?
2. How does the policy consider and address power relations between women and health-care providers?
3. How does the new policy consider issues of coercion, force and sometimes violence in provision of injectable contraceptives for certain groups of women?
4. How would you say the current contraceptives policy enhances women's rights and autonomy?
5. What was the level of participation of women who are potential and or users of contraceptives in the formulation of the new policy?
6. Participation of other women and groups? Which ones? Representing which interests?
7. What are the monitoring mechanisms dispensed at implementation level to ensure that the provision of contraceptives respect the rights of women in relation to choose and bodily integrity?
8. How are these measures implemented and monitored?
9. In your knowledge how are these women participating in the policy monitoring process of this policy?

Human Rights, Women's Rights and Gender

10. How are groups of women or organisations of women participating in the monitoring the new policy?
11. In your knowledge, how was the formulation of this particular policy advocated for by women, based on their health and their need for contraceptives?

(i) Please elaborate?

(ii) How was the current policy aligned with South Africa's codified commitments to gender equity, autonomy in term of reproductive choices, bodily autonomy and transformative/racial justice?

(iii) Which gender or human rights institutions or public bodies assessed and contributed in aligning this policy with gender and human rights commitments?

(iv) Which specific instruments was it aligned to?

(v) Is your organisation aware of human rights/women's rights monitoring instruments and or processes designed to monitor this policy?

 If yes, which ones?

(vi) Is your organisation involved in the monitoring of this policy?

 If yes, how?

(vii) Are you aware of any other organisation involved or working in monitoring this policy?

(viii) What was the level of participation of parliament and parliamentary structures in the formulation of this policy?

In particular the health or the gender portfolio committee

- What were the comments and concerns raised by parliamentary bodies/committees? Please share both positive and negative concerns.
- What were the recommendations if any were put forward?
- Was it ever subjected to review or revision by these bodies?
    - Please elaborate.

Economic and International Relations Considerations

1. How are injectable contraceptives financed?

2. What is the size of budget and funding commitments of injectable contraceptives in comparison to other forms of contraceptives?
   (i) In relation to women's health programmes or commodities?

3. How are procurement processes of contraceptives managed?
4. What is the nature of involvement of international governmental organisations (United Nations) concerned with contraceptives in the policy formulation and contraceptives programme in the country, in particular in relation to this policy?
5. How is funding for contraceptives linked or integrated to funding for other programmes,

(i) for an example, HIV/AIDS and
(ii) Maternal mortality among others?
(iii) Teenage pregnancy?

6. What is the nature of involvement of international non-governmental organisations concerned with contraceptives in the policy formulation and contraceptives programme in the country?
7. In your knowledge how did this policy take advantage of any bi-lateral trade agreements we have with any countries?
8. What is the nature of involvement of pharmaceutical industry in the policy formulation and implementation process? Injectable contraceptives in general?
9. How long have South Africa been using the injectable contraceptives methods (types and brands), for an example, Depo Provera for?
10. Could you comment on the length/duration of these contracts?
11. Does South Africa source these methods from one company or from different companies?
12. Has South Africa introduced new types/brands/preparations of injectable contraceptives in recent past?

Recommendation

What could you recommend as what should be considered, improved in contraceptives policymaking and service delivery in the country?

Is there anything you would like to add?

This is the end of our interview, thank-you very much for your time.

Semi-structured interview schedule (Clinic staff)

Participant Identification Number	
Interviewer	
Date of interview (dd/mmm/yy)	
Interview start time	
Interview stop time	

Thank you for agreeing to talk with us today. My name is _____. I am from _____.

We are interested in talking with you today about issues relating to contraceptives in post-apartheid South Africa. There are no right or wrong answers; I am interested in hearing your opinions about contraceptives. Our talk will take maximum one hour.

I will be recording our talk using an audio recorded so that I will be able to play it back later to remember and understand what we talked about today. After our talk today I may contact you again at a later stage to clarify issues that need more discussion.

About The Participant

1. Could you tell us about yourself in relation to this clinic?

- What is your position in this clinic?
- When did you join this clinic?
- Do you have any training on contraceptives?
- How long have you worked in the field of contraceptives?

Contraceptives Programme in the Clinic

1. Could you describe the contraceptives programme of this clinic? Are these staff members specifically trained for contraceptives?
2. Are these staff members trained on different types of contraceptives? Which ones? Could you describe other specific women's health or reproductive health training?
3. Are there special contraceptives days or contraceptives are dispensed at each clinic days?
    - If there are special days, which day? How many days a week?
4. Which of the different options you could say is mostly available or dispensed at the clinic?
    - Injectables? Which ones?
    - Tablets
    - Others?
5. How are decisions about which contraceptives should be mostly and dispensed in this clinic made?
6. Could you describe how are contraceptives integrated to other health programmes in this clinic? Which programmes are these? What would to say is the rationale behind integrating contraceptives to these programmes?
7. In your experience, would you say more women come to the clinic to ask for contraceptives or more women are offered contraceptives whilst they are at the clinic for other health care services?
8. In the case where women come in to request contraceptives, do they normally communicate the choice of contraceptives they prefer, or this decision is made after counselling?
9. In the instances where clinic staff offer contraceptives to women? What are the criteria they will use to recruit women?
10. At which point of health care does this clinic normally recruit women for contraceptives?
    - After delivery?
    - During child immunisation clinics?
    - After an abortion?
    - After an HIV test?

- During or after receiving any care? What sort of care?
- Voluntarily?

11. Could you describe the criteria you use to decide on which mode or type of contraceptive (injectable or tablets) to dispense or recommend to women in this clinic?

Side Effects of Injectable (Depo Provera) Contraceptives

1. Could you kindly share your understanding of side effects related to injectable contraceptives, in particular, Depo Provera?
    - Could you list the side effects you are familiar with based on your experience of working with injectable contraceptives? Depo Provera?
    - Cervical cancer,
    - Breast cancer,
    - Weight gain
    - Diabetes,
    - Depression and
    - Infertility
    - Possible exposure to HIV infection
    - Other women's diseases?
2. As per your knowledge, are side- effects included in the training on injectable contraceptives? Are all members of staff providing contraceptives in this clinic trained on these? If not, how many are trained?
    - Who normally provides the training?
    - Are there regular updates or refresher training on the side effects?
3. Would you kindly share the details of how the side effects are documented, reported, and monitored?
    - Do you document side effects? Is there a form or a system of documentation?
    - Where does this information go?
4. What is the role of the clinic in the treatment of side effects?
    - Does the clinic provide this treatment?
    - Do you refer? Which centers do you normally refer to?

- Do you follow-up and monitor referrals? Is there a system to monitor these referrals?
- Is there a system to document end results of referrals?
- Does this clinic participate in any structures/fora to discuss side effects and ways of addressing the problems?
- If yes, what are those structures? What has been the main issued discussed? The outcomes of discussions?
- If not, do you know of any such structures?

5. Does the clinic continue to dispense injectable contraceptives to the women who would have suffered side effects from the injection?
6. What has been the involvement of your clinic on issues on WHO guidelines on Depo Provera and other contraceptives in relation to increased risk of HIV?
    - Have you received and trained on guidelines on contraceptives?
    - Does this clinic have a copy of these guidelines?
        - Is the clinic communicating the content/the risks contained in the guidelines to women who are using, considering or being offered Depo Provera, an injectable contraceptive?

Other Women's Health Programmes in the Clinic

1. What are other women's health services provided in this clinic?
    - What are they?
    - Reproductive?
    - Fertility services?
    - Pap Smears
    - Mental Health
    - Diabetes
    - Other Cancers- screening
    - Others?

2. How are these provided? Daily?
3. Would you say that this clinic has enough resources to provide for these services?
    - Equipment
    - Staff
        - Other resources?

Women's Agency Information and Choice

1. Could you describe on how the women participate in the decision making around choosing the contraceptive?
2. What normally happens if a woman does not choose the option, which is recommended by clinic staff?
3. What normally happens if the contraceptive the woman chooses is not available at the clinic?
4. Are there instances where women refused or decline to take contraceptives? What normally happens, the next course of action if the woman refuses to take contraceptives?
5. How are side effects communicated to the women?
    - Which side effects are communicated to the women?
    - How is the information given? Is it written information, flyers, and information packs?
    - Counselling?
    - At which point are these communicated?
6. Could you talk about the information given to women about what to do- steps to take- when they identify or suspect that they might be having side effects?
7. Could you share an experience where a woman/women refused or changed their minds about taking injectable contraceptives after learning about side effects?
8. Based on your experience of working in this clinic, would you say women make choices on contraceptives from an informed perspective?
9. Would you say the women autonomously chose contraceptives and methods of contraceptives based on information and choices available to them?
    a. Please elaborate.

10. How have staff members in the clinic, in particular staff working with contraceptives trained or updated on the rights of women in relation to contraceptives?
    - Does this information form part of the training on contraceptives?
11. How does this clinic train or inform the women of their rights in relation to contraceptives?
    - How is this training or information distributed?
    - Patients Charter?
    - Mission Statement of the Clinic?
    - Are these provided say for an example in clinic health education seminars?
12. What would you consider as a reason behind or the goal of providing injectable contraceptives?
    - Is it about population control?
    - Reducing poverty/monies spent on grants
    - Reducing orphans
    - Giving power to the women so that they exercise their rights to reproduction?

Participation and Engagement of Community, Human Rights and Women's Rights structures and organisations

1. Could you tell us how issues of injectable are discussed in the clinic's interaction with the community structures?
    - For an example, the clinic committee or The Clinic Board? Community Health Committees
    - CBO's and local NGO's?
2. What are some of the issues discussed in these structures, in relation to injectable contraceptives?
3. Could you tell us about some of the issues/concerns that have been raised by these structures in terms of injectable contraceptives?
4. How were those concerns addressed?
5. What would you consider as the role women play in the Clinic Committee or Clinic Board?

6. How does this clinic interact with any local or national women's or human's rights organisations on issues of contraceptives and other women's health and rights matters?
    - Which structures has the clinic interacted with?
    - What was the nature of interaction? When was this?
    - What were the outcomes of such interaction?
    - Any other community structures?
7. Does this clinic inform women about these organisations and structures?
8. Does this clinic refer women to these organisations and structures?
    - Please elaborate.

Procurement Matters

1. How are the injectable contraceptives commodities procured?

Does the clinic procure directly?

Do they come from a centre or are procured at a central- region or provincial level?

2. Do NGO's local or international) or non-state health institution or entity provide injectable contraceptives to this clinic?
    - Please elaborate.

3. How are decisions about procurement made? Does the clinic participate in the making of these decisions?

4. As far as you are aware, where do the budgets for contraceptives come from?
    - Clinic
    - The region
    - Province or
    - National

5. What could you describe as a role of companies manufacturing and providing these involved with the clinic at all?
    - Do they provide training to the clinic staff?
    - Support community education on contraceptives?

- Give incentives to the members of clinic staff who tend do well in their work on administering injectable contraceptives?
- Presentations to the clinic staff?

6. Are contraceptives (funding, training and provision) linked to other programmes? For an example, HIV/AIDS or programmes to reduce maternal mortality*? Please elaborate on how these linkages are organised.*

7. What is the role and involvement of NGO's, national and international NGO's in the contraceptives matters in the clinic?

- Training
- Provision of services Community awareness Other?

New Contraceptives Policy 2013

1. Could you kindly share your understanding of the new Contraceptives Policy of 2013?
2. How did you or this clinic participate in the formulation of this policy?
3. Would you say that the policy addressed some of challenges in providing you were facing taken on board in the formulation of such a policy?

   Which ones?

   How were they taken on board?
4. Are you perhaps aware of other health workers or structures of health workers who participated in this policy formulation?
5. How has this clinic taken this policy on board?
   - Has the clinic staff responsible for contraceptives trained on this policy?
   - Clinic management trained on the new policy?
6. Has the clinic been provided with written guidelines on the new policy?
7. What is the content of the guidelines? Could you share a copy of the guidelines?
8. What are the measures provided in terms of monitoring that the new policy and or guideless in implemented?
9. Could you perhaps list the things that have changed in the delivery of contraceptives since the enactment of the new policy?

   a. Please elaborate?

Recommendations

1. Is there anything you would like to say or add?
2. What do you think should be done to improve injectable contraceptive services so that they take into account and respect and respond better to women's needs and rights?

Semi-structured interview schedule (Contraceptive users)

Participant Identification Number	
Interviewer	
Date of interview (dd/mmm/yy)	
Interview start time	
Interview stop time	

Thank you for agreeing to talk with us today. My name is _____. I am from _____.

We are interested in talking with you today about issues relating to contraceptives in post-apartheid South Africa. There are no right or wrong answers; I am interested in hearing your opinions about contraception. Our talk will take maximum one hour.

I will be recording our talk using an audio recorded so that I will be able to play it back later to remember and understand what we talked about today. After our talk today I may contact you again at a later stage to clarify issues that need more discussion.

Are you taking injectable contraceptives, the one known as Depo Provera?

About the Participant

1. Could you tell us about yourself please? How old are you? Are you in a relationship?
    - What is the highest level of education?
    - Are you employed?
    - If yes what work do you do?

Experience of Taking Injectable Contraceptives

1. Could you tell us about you experience of starting or being initiated to injectable contraceptives?
    - When did you start to use contraceptives?
    - How old are you when you started?
    - Have you ever stopped using contraceptives? What were the reasons for you to stop?
2. When you first started using the current contraceptive, were you offered, or did you go to the health facility to request that you be put on contraceptives?
3. If you were offered, what had you gone to the health facility for when you were offered contraceptives?
    - After delivery?
    - During child immunisation clinics?
    - After termination of pregnancy?
    - After an HIV test?
    - During receiving HIV/AIDS care?
    - During or after receiving any care? What sort of care?
    - Other? Please specify
4. If you were offered contraceptives, what were you told are the reasons for you to be on injectable contraceptives?
5. What was your understanding of these reasons?
6. Could you share what information were you given on fertility health, fertility and infertility health services?

7. Were you offered other health services at the time?
    - Sexual health services at the time?
    - Pap Smears, Breast examination, Diet, Others? Please elaborate.

Side Effects of Injectable (Depo Provera) Contraceptives

1. What is your understanding of side effects of injectable contraceptives?
2. Were you told about the side effects in the clinic?
3. Which side effects were communicated you?
    - Cervical cancer
    - Breast cancer
    - Weight gain
    - Diabetes
    - Depression and
    - Infertility
    - Possible exposure to HIV infection
    - Other women's diseases
4. How were the side effects communicated to you? At which point are these communicated?
5. How was the information given to you?
    - Was it written information, flyers, and information packs?
    - Counselling?
    - Talks?
6. Were you given the option of going home to think about the injectable contraceptives in light of side effects discussed and come back if you chose to take the contraceptive regardless of side effects?
    - If yes, how did you feel about it?
    - If no, how did you feel about it?
    - How did you feel about it?

7. Were you offered the option of discussing injectable contraceptives with anyone before taking a decision to take them with a partner, family member of friend?
    - If yes, how did you feel about it?
    - If no, how did you feel about it?
    - How did you feel about it?
8. Could you share whether you considered changing your mind about taking injectable contraceptives after learning about side effects?

 If yes, what did you do?

9. Could you talk about the information you were given about what to do- steps to take-when you identify or suspect that you might be having or developing side effects?

10.What level of assurance were you given that side effects will be monitored and be treated?

11. What are other alternatives or options were you given to this particular injectable contraceptive?

Women's Agency, Information and Choice

1. Could you describe on how you think you participated in the decision making around choosing the contraceptive?
2. Could you say that feel that you were able to say 'no' to the injectable contraceptive or contraceptive method given to you?

 Can you explain why or why not?

3. Can you describe the circumstances at the time when you agreed to take contraceptives
4. Did you or consider choosing another option other the one recommended by clinic staff?

If yes, what did you do about that?

Why did you do that?

5. Would you say you felt as if you had a right to refuse or decline to take injectable contraceptives?

If yes, why?

If no, why?

6. Would you say that you chose injectable contraceptives based on informed choices? Did you feel you were given enough information to make a decision to choose an injectable contraceptive?
    a. Please elaborate.
7. How does the clinic inform you of your rights in relation to injectable contraceptives?
    - How is this training or information distributed?
    - Is there a Patients Charter, which details your rights? Have you been told or encourage to read this?
    - Have you asked any questions of clarity on the Charter? Have you or know of any woman who has questioned the practice of the clinic based on the Charter?
    - Is there a Mission Statement of the Clinic?
    - Are your rights discussed and mentioned say for an example in clinic health education seminars or health talks?
8. What would you consider as a reason behind or the goal of providing injectable contraceptives to women?
    - Giving power to the women so that they exercise their rights to reproduction?
    - Is it about population control?
    - Reducing the numbers of children women have
    - Reducing poverty/monies spent on grants Reducing orphans? Others?

Participation and Engagement of Community, Human Rights and Women's Rights structures and organisations

1. How are you connected to other women who are taking contraceptives in your community?
    Are you connected or talk to other women?
2. Do you talk about the challenges you have in taking contraceptives with other women? What sort of challenges do you discuss with other women?
    Other issues? Positives of using injectable contraceptives?
3. How have you interacted with Community organisations working on contraceptives or other women's health issues in your community? If yes, what was the nature of your interaction?
    - If no, why?

- Do you know of community organisations; which are working on contraceptives in your community?

4. Could you tell us how issues of injectable are discussed in your community?
    - For an example, the clinic committee or The Clinic Board?
    - Community Health Committees?
    - Ward Health Committees?
    - CBOs and local NGOs in the community?
5. What are some of the issues discussed in these structures, in relation to injectable contraceptives?
6. Could you tell us about some of the issues/concerns that you or other women have raised in these structures in terms of injectable contraceptives?
7. How were those concerns addressed?
8. What would you consider as the role women play in the Clinic Committee or Clinic Board?
9. Have you or any of the women you know been invited to participate in the Clinic Committee to share your experiences (positive and negative) on injectable contraceptives services or other women's health services?
10. How have you interacted with any local or national human rights or women's organisations and structures on issues of contraceptives and other women's health and rights matters?
    - Which structures have you interacted with?
    - What was the nature of interaction? When was this?
    - Have you interacted with any other community structures on human rights?
11. Have you received any information or training with regards to your rights in relation to issues of reproduction and in particular, contraceptives and fertility matters?

- What sort of information did you receive?
- How did you receive this information?
- From which source?
- Organisations? Media? Community Meetings?
- Other?

12. Have you ever been told by the clinic about these organisations?
13. Have you ever been referred to the organisations?
14. Have you heard or participated in any public discussion (media or community) about contraceptives?

20. Please elaborate.

Impacts of Contraceptives

1. How has taking contraceptives impacted your life?
    - Positively?
    - Negatively?
    - Other?
2. How do you feel about taking contraceptives?
3. How do you feel about your body and fertility now?
4. What has been your experience of using the healthcare services after taking injectable contraceptives?
5. Have you experienced any medical problems as a result of using contraceptives? If yes, please describe.
6. Could you describe the medical help you receive after experiencing the health problem?
7. Did you receive medical care at the clinic where you take contraceptives?

   Or you were you referred by the clinic to another facility?
8. On the overall how would you say taking injectable contraceptives have affected your health?
9. How has using injectable contraceptives affected your financial and economic opportunities or life?

   Please elaborate.
10. Would you say using injectable contraceptives has affected your sexual relationships?
    - Positively or negatively?
    - If yes, how?

11. Have you considered and or enquired about stopping or changing contraceptives? Did you stop or change?
12. Is there anything else you would like to share about how injectable contraceptives have impacted your life?

Other Women's Health Programm*es in the Clinic*

1. What are other women's health services have you received from this clinic?
    - What are they?
    - Reproductive?
    - Fertility services?
    - Pap Smears
    - Mental Health
    - Diabetes
    - Other Cancers- screening Others?
2. How are these provided? Daily?
3. Would you say that you have received all the services you required from this clinic when you needed the services?
    - Please explain.

New Contraceptives Policy 2013

1. Are you aware of the New Department of Health 2013 Policy on Contraceptives?
2. Did you participate and or asked questions about your experiences when this policy was being developed?
   If yes, how did you participate?
3. How did you know or hear about this policy?
4. Did the clinic inform you about this new policy?

- How were you told?
- Were you told what this policy means to you?
- Were you given copies of this policy?
- Were you given any materials relating to this policy? Which materials?

- Has the clinic talked about this policy during the health education talks at the clinic?
- Are there materials and communications about this policy readily available and accessible at the clinic?

5. Have you observed any changes to the manner in which service is provided since the inception the new policy? What are those changes? Please elaborate.
6. Do you get information about contraceptives somewhere else rather than the clinic? Who will be providing this information?
7. Have you heard about this policy from other places? Media or any other places? Please elaborate?

Recommendation

3. Is there anything you would like to say or add?
4. What do you think should be done to improve injectable contraceptive services so that they take into account and respect and respond better to women's needs and rights?