NATIONAL CONTRACEPTION

POLICY GUIDELINES

WITHIN A REPRODUCTIVE HEALTH FRAMEWORK

REPUBLIC OF SOUTH AFRICA

Department of Health

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REPRODUCTIVE HEALTH RESEARCH UNIT
RHRU
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FOREWORD

Sexual and reproductive health has always been an issue close to my heart. These contraceptive policy guidelines mark a turning point in the country's understanding and approach to contraception. There is political recognition that a service that has been seen as at best routine and mundane, and at worst as coercive and oppressive, is in fact a cornerstone of development and gender equity. The epidemiological impact of contraceptive use is enormous in terms of reducing maternal and perinatal morbidity and mortality. As a technology, there is probably nothing else that contributes so significantly to gender equity.

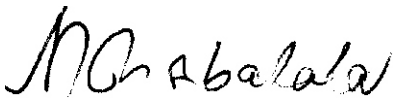
recognises the importance of involving men in this critical area. The overall approach of the policy is consistent with the political and health service reforms that are now being implemented in the country.

The process that resulted in these policy guidelines started in 1998 when the Directorate: Maternal, Child and Women's Health, together with the Reproductive Health Research Unit convened a national meeting of stakeholders. The process was truly consultative, involving national and international organizations, both governmental and non-governmental. The World Health Organization (WHO) and the United Nations Population Fund (UNFPA) provided additional technical support.

Clinical aspects of contraceptive method provision were reviewed. The WHO Medical Eligibility Criteria for contraceptive prescribing were adapted to formulate guidelines to suit local conditions. The broader issues of human rights, service provision and provider training were also addressed. A group of technical experts was then mandated to continue drafting the policy guidelines document. Subsequently, the technical group circulated draft documents to stakeholders for their inputs. These comments and inputs incorporated after due consideration and debate.

I recommend that these guideline be popularised, especially to the clients who need them, and the health workers who will be guided by them.

I leave you with this thought: *"By providing all women and men with a choice of contraceptive methods and counselling about how to use those methods safely and effectively, programmes can have a significant impact on the lives of the clients". (WHO, 1995)*. Whatever method the clients choose, the health system must be able to support that choice, including natural family planning methods.



Dr Manto Tshabalala-Msimang
Minister of Health

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AIDS:	Acquired Immune Deficiency Syndrome
CBD:	Community Based Distribution
CHW:	Community Health Worker
CIC:	Combined Injectable Contraceptive
COC:	Combined Oral Contraceptive
COPE:	Client-Oriented Provider-Efficient
DMPA:	Depo Medroxyprogesterone Acetate
DOH:	Department of Health
EC:	Emergency Contraception
ECP:	Emergency Contraceptive Pill
EDL:	Essential Drugs List
EHO:	Environmental Health Officer
HIV:	Human Immunodeficiency Virus
ICPD:	International Conference on Population and Development
IEC:	Information, Education and Communication
IPPF:	International Planned Parenthood Federation
IMR:	Infant Mortality Rate
IUD (IUCD):	Intrauterine Device (Intrauterine Contraceptive Device)
IUS:	Intrauterine System
KAPB:	Knowledge, Attitudes, Practice and Behaviour
LAM:	Lactational Amenorrhoea Method
MCWH:	Maternal Child and Women's Health
MMR:	Maternal Mortality Rate
MTCT:	Mother-to-Child-Transmission
NFP:	Natural Family Planning
NET-EN:	Norethisterone Enanthate
NGO:	Non-Governmental Organisation
OC:	Oral Contraceptive
OTC:	Over The Counter
PHC:	Primary Health Care
POP:	Progestogen-Only Pill
RH:	Reproductive Health
SADHS:	South African Demographic and Health Survey
SRH:	Sexual and Reproductive Health
STIs:	Sexually Transmitted Infections
TFR:	Total Fertility Rate
TOP:	Termination of Pregnancy
TL:	Tubal Ligation
WHO:	World Health Organisation

CHAPTER ONE

INTRODUCTION

To understand contraceptive provision in South Africa currently, and to identify gaps that need to be addressed, it is essential to know the historical background of contraceptive provision in this country, both before and during apartheid. Critical analysis of this background (as outlined in the following section) significantly contributed to the backbone of the policy guidelines. These guidelines aim to redress past neglect and violations of human rights, by prioritising the sexual and reproductive rights and choices of all individuals.

Contraceptive use is influenced by a number of factors including socio-economic development; urbanisation; women's education and status in society; cultural norms and beliefs; and the knowledge and attitudes of individuals. The current status of these factors in South Africa, the demographic characteristics of the country, and a situational analysis of contraceptive provision (as outlined in the section headed 'Current Status of Contraception') informed the development of the policy guidelines. These also should be emphasised during planning and delivery of contraceptive services.

Contraceptive, maternal, child, adolescent and women's health services, together with STI/HIV prevention and management, are integral components of sexual and reproductive health care. One of the most cost-effective ways to improve overall sexual and reproductive health is to integrate these services, or at least to develop strong links between them. The provision of comprehensive reproductive health care is one of the guiding principles of the policy framework. Contraceptive service providers are therefore challenged to look beyond the contraceptive needs of their clients to their other reproductive health needs.

Contemporary international agreements, global trends, the Constitution of South Africa, and a range of national legislation and policies uphold people-centred development and sexual and reproductive health and rights (as outlined in the section headed 'International and National Context'). The National Contraception Policy Guidelines were developed in the context of the human and health rights rationales, and are consistent with the political and health service reforms that are now being implemented in the country.

Historical Background

Traditional fertility regulation

In pre-colonial southern Africa, fertility was regulated through a range of cultural practices that ensured effective child spacing.

With the colonisation and industrialisation of South Africa, Africans largely lost the ability to exercise control over various aspects of their society, community and personal lives, which contributed to rapid population growth. Migrant labour and influx control regulations, in particular, dramatically affected Africans' control over reproduction, because of the separation of husbands from their wives and the undermining of normal social institutions. The disruption of family life and break-up of viable and stable social relations led, among other things, to the frequent discontinuation of traditional practices for fertility regulation and substantial changes in sexual mores.[1]

Family planning and population policies

Family planning services in South Africa began in the 1930s as mothers' clinics that were intended largely to provide white, poor married women with birth control methods and advice. The Government's stated support of birth control at this time was to improve the 'quality' of the white population through limiting the number of children born to poor white women.

From around the end of the 1930s onwards, the falling birth rate of the white population, together with the increase of the non-white population caused increasing fear among the white community of being swamped by large numbers of black people. During the 1960s, the Government introduced new demographic-related policies and programmes in response to the *swart gevaar* (black fear) and certain politically destabilising events, such as the growth of the Black Consciousness Movement and the 'winds of change' sweeping through the rest of the continent. In the words of Prime Minister BJ Vorster in 1972, 'We would like to reduce them, and we are doing our best to do so, but at all times we would not disrupt the South African economy.'[2] Positive incentives (eg child benefit payments) were offered to whites in the country to increase the number of children per family. A very favourable white settlement programme was also introduced. These strategies were implemented hand-in-hand with programmes aimed at reducing the number of black South Africans.

The family planning programme

In the late 1960s, the Government began preparations to launch a national family planning programme. The political rationale for family planning now became black birth control, to attempt to reduce the non-white population growth rate.

Family planning clinics throughout the country were slowly appropriated to render State-run services. The national Family Planning Programme was formally established in 1974. Free family planning services were made available to all racial groups but on a segregated basis. In municipal areas, family planning was offered as an integral part of MCH services, but elsewhere national and provincial health departments developed strong vertical family planning services. These were provided at single-purpose stationary or mobile clinics and run by specially-trained family planning nurses. In addition, well-paid, trained family planning advisers carried out family planning promotion. The family planning services operated independently of other health services which were not free and often not accessible.

During the 1970s, many other countries developed family planning programmes with underlying demographic rationales. However, in the 1980s, while international trends changed to integrating family planning into broader maternal and child health programmes, the government in South Africa continued to promote vertical family planning services as a tool for population control. Consequently, the Family Planning Programme attracted much criticism. In response, the programme's management endeavoured to break the association between family planning service provision and population control by emphasising that the goal of the Family Planning Programme was to improve women's health through birth spacing.

Despite this ideological shift, there was no real improvement in the quality of care, because the delivery of family planning services was firmly institutionalised within a demographic framework, rather than a health and human rights framework. It was not until the late 1980s and early 1990s that family planning services were integrated into primary health care services, chiefly for financial reasons, but also in response to international trends and pressure by opposition groups within the country.

The population development programme

In the early 1980s, in response to the recommendations of a Government-commissioned report,[3] an explicit Government policy decision was made to lower the national population growth rate in line with resource availability especially water. This led to the establishment of the Population Development Programme (PDP) in 1984. The major thrust of the PDP was fertility reduction through family planning, but this was to be

supported by interventions in other relevant sectors that could influence fertility levels, such as education, primary health care and economic development.

However, the PDP was unable to meet its objectives, largely because it lacked both the resources with which to make real changes and the authority over other government sectors to ensure that they initiated appropriate interventions. Hence, from 1990, the PDP shifted its focus of work to the development and implementation of population information, education and communication (IEC) programmes.

Legislation that impacted on family planning services

The following legislation particularly affected the provision of family planning services:

- Abortion and Sterilisation Act, 1975 (Act No. 2 of 1975)
  This contained highly restrictive criteria that made abortion illegal or inaccessible for most women.

- Apartheid legislation
  Under apartheid, race played a major role in determining an individual's legal status. A combination of apartheid land laws, separate development laws and pass laws (eg the Group Areas Act, 1950 and 1957, and the Reservation of Separate Amenities Act, 1953) significantly affected all aspects of the lives of people of different races, including access to health services.

- Women's legal capacity
  By common law in South Africa, a woman was subjected to her husband's marital power. Regarding family planning service provision, this translated into women requiring their husbands' consent in order to be sterilised and, in some places, even to receive any family planning method. The Matrimonial Property Act, 1984 (Act 88 of 1984) abolished the common law rule.

Providers of family planning services post-1974

With the establishment of the Family Planning Programme in the Republic, coverage by public sector family planning services became extensive. By the end of 1992, the number of service delivery points had mushroomed to a total of 65 182 -- many of these in areas with no other accessible health services.

In the homelands, the provision of family planning services was left to individual authorities, and generally fell under the control of local hospital superintendents. Consequently, in most cases, peripheral clinics were given less priority than hospital facilities resulting in the sub-optimal delivery of primary health care services including family planning.

In the private sector, family planning services were provided by a number of individuals and institutions. Most private doctors (general practitioners and specialists) provided family planning services. Some occupational health services also offered family planning. In the early 1990s, as part of a Department of Health initiative to increase access to oral contraceptives, about 2 000 pharmacists were trained on a voluntary basis to dispense oral contraception. The provision of family planning services by NGOs was not very extensive. Traditional practitioners continued to promote traditional family planning practices. The Catholic Church promoted natural family planning through literature and personal instruction to interested couples.

Human rights violations of family planning clients

Human rights violations of family planning clients may be judged against

accepted international norms, as declared in major human rights treaties. These particularly highlight the basic right of individuals to decide whether or when to have children: '*All persons have the right to decide freely and responsibly the number and spacing of their children and to have access to the information, education and means to enable them to exercise this right*'.

The right to health care is explicitly broken down by the National Patients' Rights Charter.[4] This is used below as a framework to describe the extent of the violations against the rights of family planning clients under the apartheid government.

- *The right of the client to have access to healthcare, including counselling, treatment, a positive disposition by health care providers and health information*[4] was violated by the:
  - imposition of variable, restrictive rules regarding consent for family planning which limited access for certain groups of people;
  - segregation of family planning services according to race, and the provision of different contraceptive methods to the different racial groups;
  - frequent refusal to provide contraceptive services to people with disabilities;
  - limited access to family planning services for people living in certain areas of the country, such as rural areas and informal settlements;
  - inadequate provision of family planning education, information and counselling;
  - lack of provision of a range of contraceptive methods;
  - disregard of certain recommendations for safe method provision.

- *The right of the client to informed consent and decision-making*[4] was violated by the:
  - lack of good counselling on available methods;
  - use of coercive methods for contraceptive acceptance;
  - administration of family planning methods without the informed consent of clients.

- *The right of the client to confidentiality and privacy of information*[4] was violated by:
  - the public manner in which services were provided to clients at mobile and fixed clinics;
  - providers who disclosed client-related information to third parties.

  - *The right of the client to continuity of care*[4] was violated by the inflexible systems used for method supply and follow-up, as well as the infrequent and erratic mobile clinic visits made to some areas of the country.

- *The right of the client to complain about services and to have their complaints investigated and receive a full response to such an investigation*[4], was violated by the general disregard of client concerns and complaints by providers.

Further to the human rights violations in the provision of family planning services, such was the government's agenda to reduce the black population that a State-funded programme operated during the 1980s at Roodeplaat Laboratories to develop immuno-contraceptive drugs that could be used to make Africans infertile.[5]

Community response to family planning

During the 1980s, various messages about family planning were publicised by different programmes and groups. The Family Planning Programme was actively promoting family planning to improve women's health. Meanwhile the PDP was trying to popularise the view that South Africa's population was too

big for its available resources, and promoted small families. During the State of Emergency, the situation was further complicated when opposition groups and the youth politicised Government family planning services, and labelled contraception as a tool of white oppression.

Yet there was a significant demand for contraception. Despite the array of conflicting views about family planning, the widespread public concern that the Government had a sinister rationale for providing family planning services, and user dissatisfaction with respect to the quality of service provision, people held positive views about 'family planning'. Between 1987 and 1989, contraceptive use among black women of reproductive age was 50,4 percent. This is particularly high compared with the rest of sub-Saharan Africa where the contraceptive prevalence rate is mostly less than 30 percent. There remained, however, a considerable unmet need for contraception and many unplanned pregnancies occurred for a variety of reasons, such as lack of knowledge about family planning, and poor accessibility, availability and acceptability of services.

Current Status of Contraception

Background demographic characteristics

South Africa has a total population of 40,6 million. The average growth rate of the population is currently estimated at 2,02 percent a year (1991-96). The racial composition of the population is 76,7 percent African, 10,9 percent white, 8,9 percent coloured, 2,6 percent Asian and 0,9 percent unspecified. Overall, 44,2 percent of the population is under 20 years.[6]

Fertility levels

The national total fertility rate (TFR) for the period 1995 to 1998 is 2,9. This represents a gradual decline in fertility over the past two decades. There are considerable differences in TFR between the races (1,9 for white, 2,5 for coloured and 3,1 for African women). This essentially reflects differences in the level of human development, and in cultural values attached to having children. The TFR for non-urban women (3,9) is almost double that for urban women (2,3). Fertility rate declines as education increases - the TFR among women with no education is 4,5 compared with 1,9 for women with some university-level education.[6,7]

Contraceptive use and sexual behaviour

Data from the South African Demographic and Health Survey (SADHS) of 1998 indicate that three-quarters of women of reproductive age in South Africa have used contraception (see Table 1 below). Overall injectable contraceptives are by far the most commonly-used method.

The results of the SADHS also show that certain groups of women are much more likely to use contraception - those in their teens and 20s; Asian and white women; those with two or three living children; urban residents; and women with higher education. Significant differences exist in the type of method used by women of different ages and different races. The injectable was the most popular method used by women of under 40 years, while female sterilisation was the most popular for those over 40 years. African and coloured women most commonly used the injectable while Asian and white women most commonly used the pill and female sterilisation.

Table 1: Knowledge and use of contraceptive methods among all women, currently married womenandsexually active women aged 15-49

Contraceptive Method	Percent who know method			Percent who have ever used method			Percent who are currently using		
	All	CM	SA	All	CM	SA	All	CM	SA*
Any Method	96,7	98,1	98,6	75,0	84,6	87,3	50,1	56,3	62,1
Any modern method	96,5	98,0	98,5	73,9	83,2	86,1	49,3	55,1	61,2
Pill	93,2	95,4	95,8	37,6	49,3	48,2	9,3	10,6	12,3
IUD	71,3	79,5	80,2	8,5	13,1	12,2	1,2	1,8	1,9
Injections	94,4	96,7	97,3	57,0	59,1	64,5	27,3	23,2	30,1
Diaphragm/foam/jelly	16,4	21,1	19,6	0,8	1,3	1,3	0,0	0,0	0,0
Condom	88,7	89,1	91,6	17,8	19,2	23,0	1,9	1,7	2,3
Female sterilisation	67,9	77,8	75,0	8,7	15,8	12,0	8,7	15,8	12,0
Male sterilisation	35,3	44,1	40,6	1,3	2,8	2,2	0,9	2,1	1,7
Any traditional method	37,2	45,7	44,9	9,8	13,4	13,1	0,6	0,9	0,7
Periodic abstinence	25,3	30,9	31,0	4,2	5,0	5,3	0,2	0,3	0,3
Withdrawal	30,5	39,3	38,0	7,3	10,7	10,1	0,4	0,6	0,4
Herbs	12,4	14,2	13,9	0,9	1,1	0,9	0,1	0,2	0,2
Other methods	4,8	5,4	6,0	1,2	1,6	1,6	0,1	0,1	0,1
Number of women	11,735	5,077	6,062	11,735	5,077	6,062	11,735	5,077	6,062

Note: * CM = Currently married/living with a man SA = Sexually active in last 4 weeks

Research has also highlighted some common patterns of contraceptive use and sexual behaviour that are of practical relevance for contraceptive service provision. For example, studies in both urban and rural areas have shown that the onset of sexual activity ranges from around 13 to 18 years; only five percent of men and 19 percent of women use contraception during their first sexual encounter; and about half of all young people have had more than one sexual partner. [8, 9, 10]

Factors influencing contraceptive use

The most significant factors that influence contraceptive use are:

- Knowledge about contraception
  Almost all women in South Africa know of at least one contraceptive method (see Table 1). But some studies report that, among young people, knowledge of reproductive function is generally poor and there is considerable confusion and misperceptions regarding contraception. [8, 11]

- Attitudes on issues related to contraception studies [9,10,11,12] show that:
  - Smaller family sizes are preferred by urban residents and younger people.
  - Almost all men and women prefer birth spacing of two years and over.
  - While the majority of men and women think that women should be allowed to use contraception, many women believe that men generally disapprove of pregnancy prevention.
  - Women regard quality of care, including the way in which people are

treated, as the most important aspect of contraceptive service provision. Commonly requested specific changes to services are that staff should be more understanding and more available for explanation and counselling; clinics should have longer consulting hours, greater accessibility,reduced waiting timesand more privacy; and contraceptive services should be provided with other health services at one clinic. The provision of adolescent-friendly services is a need identified by young people.

- Socio-economic development
  Poor socio-economic development is associated with low contraceptive use. As a legacy of apartheid and the inequitable development of the people of South Africa, the extent of socio-economic development is markedly dissimilar for the different ethnic groups, among provinces, and between urban and rural populations.[13]

- Urban-rural residence
  Urbanisation is associated with greater contraceptive use. Overall, 53,6 percent of the population of South Africa is urbanised but there are marked provincial differences. Following the end of apartheid influx control measures, it is predicted that Africans will continue to urbanise rapidly over the next decade. Of those living in non-urban areas, three-quarters reside in the former homelands, where more than 73 percent of the population live in poverty and health services are not always accessible.[7]

- Women's education and status
  In South Africa, seven percent of women aged 15 to 49 years have had no formal education at all, but almost a quarter have completed matriculation or more.[6] Improving women's educational and economic opportunities can have an important impact on their use of contraception, and their control over sexual and reproductive matters. Likewise, contraceptive use can help women to improve their status, level of empowerment and quality of life by enabling them to choose to have smaller and healthier families, and thereby freeing them more to participate in educational, economic and social activities.

- Cultural values, beliefs and norms
  These significantly influence decision-making regarding sexual and reproductive matters, such as the ideal number of children, when to have children, and contraceptive use. In South Africa today, traditional values regarding children remain to varying extents. Together with the need for women to prove their fertility, these values continue to influence the sexual and reproductive choices of many people.

  The gradual decline of the taboo against pregnancy before marriage, and the breakdown of social mechanisms to ensure that unmarried young men take responsibility for procreation, have influenced adolescent decision-making regarding the timing of full sexual debut and contraceptive use. Cultural beliefs regarding reproduction can cause unfounded concerns about the effects of certain contraceptives, and lead to the unnecessary rejection of effective methods. In South Africa, the increasing preference for dry sex may result in the rejection of some highly effective contraceptives that are associated also with greater vaginal wetness.

Providers of contraceptive services

The State is the main provider of contraceptive services in South Africa. Contraceptive services, including methods, are provided free of charge in the public sector. Public health services, including contraceptive services, are still going through the process of transformation in an attempt to redress past inequities and improve the quality of care. At national level, the Maternal,

Child and Women's Health (MCWH) and Nutrition Cluster is responsible for contraceptive service policy-making and the production of training and education materials.In the provinces, provincial MCWH and Nutrition Directorates manage contraceptive services - in line with national policies - through the district health system. Contraceptive service delivery points range from those at community level, mobile units, clinics and community health centres to district hospitals, referral/tertiary hospitals and academic centres.

- The private sector contributes significantly to the provision of contraceptive services through the following main providers:
  - Private general practitioners of whom there are about 10 067 in the country.
  - Private specialists, ie gynaecologists (a total of around 700 practising nationally) all of whom provide contraceptive services in some way, and some urologists who perform male sterilisation.
  - Occupational health services in some workplaces.
  - Pharmacies selling condoms and spermicides over-the-counter. Pharmacists with special permits also provide oral contraceptives without prescription but in accordance with strict criteria.
  - Some commercial outlets sell condoms.
  - Traditional practitioners who continue to provide advice and supplies for various traditional family planning practices to those seeking their services.
  - Some national NGOs provide contraceptive services directly through their own clinics (eg the Planned Parenthood Association of South Africa and Marie Stopes International); community-based distribution programmes (the Planned Parenthood Association of South Africa); and social marketing of condoms (the Society for Family Health). Many national NGOs including the Planned Parenthood Association of South Africa, the Reproductive Health Research Unit, Reproductive Rights Alliance and the Women's Health Project work closely with Government on contraceptive policy-making, advocacy, information, education and communication initiatives, service management, quality of care and research. There are also a number of NGOs working at a local level on contraceptive service provision specifically, and within a comprehensive primary health care framework.
  - The Fertility Mastery Association of South Africa (FERMASA), the Couple to Couple League (CCL) and the Catholic Church promote and teach the use of methods based on fertility awareness.
  - Various international organisations, agencies and bodies support work in reproductive health and contraception through financial and/or technical assistance.

Quality of care

Quality of care with respect to contraceptive service provision may be considered under its essential components.

- Choice of methods
  The range of methods offered by public sector health facilities remains limited and racially-biased. Only two methods are commonly promoted at most clinics -injectables and the pill, with the majority of African women using injectables.

  Other shortfalls regarding method provision include:
  - Inadequate range of methods for adolescents. In many areas, adolescents are not offered an adequate method mix that includes methods for dual protection, and/or emergency contraception.
  - Restricted IUD provision. IUDs are generally only offered at urban centres and referral facilities in rural areas. This is largely because of a lack of suitable facilities and staff trained in IUD insertion.

- Female sterilisation services generally are not readily available. They are often logistically difficult to access and most provinces have long waiting lists. Male sterilisation is unheard of or unacceptable by many communities. Vasectomy is currently performed mostly in the private sector a nd predominantly for white clients.
- Restricted condom supply. Nationally the male condom is available at most public sector health facilities, but only a limited number of facilities supply the female condom. Both types are sold by social marketing outlets in some areas. Although male condom distribution has increased considerably, there are concerns that the data on distribution do not necessarily reflect condom usage.
- Limited promotion of and access to emergency contraception (EC) throughout the country. Provider knowledge of EC is generally inadequate and in some cases incorrect.

- Technical competence of providers
  Currently, some providers do offer good quality of care. However, the workperformance of many contraceptive service providers is inadequate. Reasons for this include a lack of addressing provider needs throughout the country, particularly for comprehensive reproductive health-care training, standardising guidelines for contraceptive service delivery and regular in-service updating.Inadequate facilitative supervision systems and lack of infrastructure, equipment and supplies are also common constraints.

- Interpersonal relations
  There are frequent reports from contraceptive clients about the negative attitudes and rudeness of service providers towards them. Service providers in general are not youth-friendly.[11]

- Client information
  High provider workloads, staff shortages and inadequate specific training in health promotion significantly constrain the provision of effective client counselling and public health education. The specific IEC needs of disadvantaged groups (e.g. adolescents, the blind and deaf) are particularly neglected. In addition, national and provincial budgetary constraints restrict adequate development and supply of IEC materials, as well as the expansion of innovative public health education methods (such as community theatre).

- Mechanisms to encourage continuous contraceptive use
  These include:
  - Easy access to services: Inequalities in access to health services still exist in the country. This applies particularly to disadvantaged communities such as people living in rural areas and peri-urban informal settlements.
  - Adequate availability of services: Rigid and relatively short clinic opening times for client consultation (generally Monday to Friday from 8 am until around 1pm) reduce service availability and contribute to long waiting times when the clinic is open. The availability of contraception is further reduced at clinics where contraceptive services are not integrated into primary health care services.
  - Acceptable services: Privacy during client consultations is inadequate at many health facilities. Inconvenient times of services, long waiting times, and providers of the opposite sex also reduce service acceptability for clients.
  - Adequate and consistent supplies: Contraceptive methods and materials are on the Essential Drug List (EDL) for primary health care. On the whole, the system of supply is fairly reliable, though stock-outs of methods do occur occasionally.
  - Responsive services: Providers spend a significant amount of time completing records, collecting data and writing monthly reports in duplicate. Most providers do not use the data that they collect to help identify problems and respond to service shortfalls. Generally, the

feedback on monthly reports is poor.

- Appropriate constellation of services

  The integration of vertical family planning services into primary health care (PHC) has been continuing since 1991. Integrated PHC services are now widespread, especially in rural areas, but many single-purpose family planning clinics remain in urban centres. There is no single model for integration. In some clinics there is complete integration of health care, with the same provider delivering all services at all times. In other clinics there are special days for different services, or else all services are offered every day but by different providers.

  Comprehensive reproductive health care: Contraceptive, maternal, child, adolescent and women's health services, together with STI/HIV prevention and management, are integral components of sexual and reproductive health care. One of the most cost-effective ways to improve overall sexual and reproductive health is to integrate these services or, at least, to develop strong links between them. This comprehensive approach to reproductive health care challenges contraceptive service providers to look beyond the contraceptive needs of their clients to their other reproductive health needs.

  The adoption of the approach has been slow despite the benefits to clients of holistic care, greater cost-effectiveness, and the need to address the STI/HIV/AIDS epidemic and other reproductive health priorities (such as teenage pregnancy, breast and cervical cancers, and violence against women). Risk assessment for exposure to STIs/HIV infection and reproductive health screening of contraceptive clients are not carried out routinely; and the wider sexual and reproductive health needs of young people are often neglected. Reasons for this include a heavy workload, as well as a lack of up-to-date information on policy changes, suitable skills, clear guidance by supervisors and adequate infrastructure and supplies.

International agreements and charters

A series of global government conferences, organised by the United Nations in the 1990s, produced an action agenda for socially equitable, sustainable development for the 21st century. These conferences - including the World Conference on Human Rights (Vienna, 1993), the International Conference on Population and Development, ICPD (Cairo, 1994), the Fourth World Conference on Women (Beijing, 1995) Convention on the Elimination of all forms of Discrimination against Women, CEDAW (1993) and the World Summit for Social Development (Copenhagen, 1995) - culminated in a progressive, ambitious agenda for social equality, justice, development and peace. The conference documents reflect strong government commitment to people-centred development as the basis for national policies and action plans. The ICPD and Beijing particularly were also landmarks for the reproductive health agenda in that they embraced the concepts of sexual and reproductive health and rights, and reinforced gender equity.

The Constitution, national legislation and policies

National commitment to upholding sexual and reproductive rights and access to reproductive health care is seen in the Constitution and relevant legislation and policies.

- The Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996): enshrines reproductive rights and the right of access to reproductive health care:

  - 'Everyone has the right to bodily and psychological integrity, which includes the right: to make decisions concerning reproduction; to

security in and control over the body; and not to be subjected to medical and scientific experiments without their informed consent.' (*Freedom and security of the person)*

- 'Everyone has the right to have access to health care services, including reproductive health care; sufficient food and water; and social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.' *(Health care, food, water and social security)*

Medicines and Related Substances Control Act, 1965 (Act No. 101 of 1965): allows for the sale of oral contraceptives in accordance with the Act's Schedules.

- Child Care Act 1983 (Act No. 74 of 1983): states that:
  - Minors of 14 years and older may consent to their own medical treatment without the assistance of parents/guardians.
  - Any person of 18 years and older may consent to surgical procedures (operations) being performed on themselves without the assistance of parents/guardians. (An exception to this general rule is that girls under the age of 18 can have an abortion without their parents'/guardians' permission.)

    In practical terms, this means that children of any age can approach a clinic for sexual and reproductive health information and condoms. The clinic may not inform the child's parents/guardians of the visit. Girls of 14 years and older can be prescribed any form of medical contraceptive without the assistance or knowledge of their parents/guardians. Girls under the age of 14 years need the consent of their parents/guardians before being supplied with the pill or other prescription forms of contraceptive.[14] However, adolescents who may be sexually active and/or request contraception, but are unwilling or unable to obtain their parents'/guardians' consent, should have their health and social needs met.

- Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996): '...repeals the restrictive and inaccessible provisions of the Abortion and Sterilisation Act, 1975 (Act No. 2 of 1975), and promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs'. Contraception is regarded as an integral part of TOP care. The approved short TOP training course for registered midwives contains a module on contraception.

- Population Policy, 1998*:* towards achieving the goal of human development, the strategies of the policy include:
  - 'Improving the quality, accessibility, availability and affordability of primary health care services, including reproductive health and health promotion services (such as family planning), to the entire population in order to reduce mortality and unwanted pregnancies, with a special focus on disadvantaged groups, currently underserved areas and adolescents; and eliminating disparities in the provision of such services.'
  - 'Promoting responsible and healthy reproductive and sexual behaviour among adolescents and the youth to reduce the incidence of high-risk teenage pregnancies, abortion and sexually transmitted diseases, including HIV/AIDS, through the provision of life skills, sexuality and gender-sensitivity education, user-friendly health services and opportunities for engaging in social and community life.'
  - 'Promoting the equal participation of men and women in all areas of family and household responsibilities, including responsible parenthood, reproductive health, child-rearing and household work.'

- Sterilisation Act, 1998 (Act No. 44 of 1998):
  - Provides for the right to sterilisation of any person over the age of 18

years if he/she is capable of consenting.
- Prohibits sterilisation on any person capable of consenting without his/her consent and on any person under the age of 18 years except on medical grounds.

The Domestic Violence Act, 1998 (Act No. 116 of 1998): aims to afford victims of domestic violence the maximum protection from domestic abuse that the law can provide; and to introduce measures which seek to ensure that the relevant organs of the State give full effect to the provisions of the Act, and thereby to convey that the State is committed to the elimination of domestic violence. Under the law, abusers may be arrested without a warrant and dangerous weapons seized. An abuser may be convicted of marital rape even if the parties are married according to civil, customary or religious law.

The National Health Bill, 2000: prioritises maternal, child and women's health (MCWH) and includes the following policy intentions that:
- MCWH services should be accessible to mothers, children, adolescents and women of all ages, with a focus on the rural and urban poor.
- MCWH services should be comprehensive and integrated.
- Women and men should be provided with services that will enable them to achieve optimal reproductive and sexual health.
- Individuals, households and communities should have adequate knowledge and skills to promote positive behaviour related to maternal, child and reproductive health.

- Health Sector Strategic Framework 1999-2004, National Department of Health: contains the following health priorities within its ten-point plan to strengthen implementation of efficient, effective and high-quality health services: improving quality of care (through, for instance, the launching of the Patients' Rights Charter); and decreasing morbidity and mortality rates through strategic interventions that relate directly to sexual and reproductive health such as reducing teenage pregnancy, decreasing the incidence of HIV/AIDS, improving women's health, reducing maternal mortality and tackling violence against women and children.

- The Patients' Rights Charter, National Department of Health: directly upholds and promotes the right of access to health care. Other rights of particular relevance to contraceptive services that are contained in the Charter are: confidentiality and privacy of information concerning patients' health and treatment; choice of health services (such as a particular health care provider or facility) in line with normal ethical standards and prescribed service delivery guidelines; treatment by a named health care provider; and informed consent and decision-making on matters regarding their illness, diagnostic procedures, proposed treatment and costs involved.

Batho Pele ('People First'), 1999, National Department of Public Service and Administration: is the White Paper on transforming public service delivery. The main thrust of the document is the establishment of a culture in which all State employees put the public or customer first and are accountable for the service they give. The framework consists of the following seven simple principles of public service delivery: consultation; service standards; courtesy; information; openness/transparency; responsiveness; and value for money.

Policy Guidelines for Adolescent and Youth Health, 2001, national Department of Health: include sexual and reproductive health among its six top health priorities for adolescents and youth. Key intervention strategies that relate to contraception include promoting delayed childbearing; promoting marriage preparedness; facilitating easy, cheap and private access to all forms of contraception (including emergency contraception and condoms); using multimedia methods to provide information to adolescents, youth and their families about all sexual health matters; building skills specifically relevant for sexual health such

as negotiating contraceptive use; providing sexuality counselling; integrating sexual and reproductive health services.

Guidelines for Maternity Care in South Africa, 2000, national Department of Health: guide those health workers providing obstetric services in clinics, community health centres and district hospitals. The document covers the management of conditions which commonly arise in maternal deaths. The guidelines also address the need to counsel pregnant women on their future contraceptive needs.

National Guideline for Cervical Cancer Screening Programme, 2001, national Department of Health: focuses on secondary prevention of cervical cancer by the detection and treatment of the pre-invasive stage of the disease. It proposes three smears per lifetime, with a 10-year interval between each smear, commencing at not earlier than 30 years. The Programme also promotes primary prevention strategies, some of which relate to contraception - the promotion of barrier methods of contraception to prevent the spread of the human papillomavirus (HPV) and other STIs; the postponement of sexual debut; and the decrease in parity.

The Essential Drugs List (EDL) for Primary Health Care (1998): specifies under the Family Planning section those contraceptive methods that should be available at each service level in the public sector, together with their recommended doses and method of availability.

POLICY FRAMEWORK FOR THE PROVISION AND USE OF CONTRACEPTION

The policy framework for the provision and use of contraception was developed to address the identified current major reproductive health challenges. All sections of the policy framework are in line with international agreements and national legislation and policies. They embrace the new definitions of sexual and reproductive health, and the comprehensive reproductive health care paradigm. They focus on the rights of patients and the needs of providers.

Patients' Rights

Everyone has the right to:

- *A healthy and safe environment* that will ensure their physical and mental health or well-being.
- *Participation in decision-making,* in terms of both the development of health policies and on matters affecting their own health.
- *Access to healthcare,* including timely emergency care, treatment and rehabilitation, provision for special needs, counselling, palliative care, a positive disposition by health care providers and health information.
- *Knowledge of one's health insurance/medical aid scheme* and to challenge, where necessary, the decisions of such providers relating to the member.
- *Choice of health services, in terms of a particular health care provider or facility* in line with normal ethical standards and prescribed service delivery guidelines.
- *Be treated by a named health care provider*, ie one who can be clearly identified.
- *Confidentiality and privacy of information* concerning their health and treatment, except if they give informed consent for disclosure, or it is required by law/court order.
- *Informed consent and decision-making,* on matters regarding their illness, diagnostic procedures, proposed treatment and costs involved.
- *Refusal of treatment,* provided that such refusal does not endanger the health of others.
- *Referral for second opinion* on request and to a health provider of their choice.
- *Continuity of care* by a health care worker or facility that initially took responsibility for their health care.
- *Complain about health care services* and to have such complaints investigated and receive a full response to such investigation.

Providers' Needs

All providers should have:

- *Training:* on knowledge and skills necessary to do their work.
- *Information:* on issues related to their duties.
- *Appropriate facilities:* to be able to provide good quality services.
- *Adequate and reliable supplies*: of contraceptive methods and materials.
- *Guidance*: that is clear, relevant and objective.
- *Back-up*: in terms of technical support and good referral systems.
- *Respect:* and recognition of their competence and human needs.
- *Encouragement:* in the development of their potential and creativity.
- *Feedback:* concerning competence and attitudes.
- *Self-expression:* regarding the quality and efficiency of services.

Guiding Principles

The guiding principles for the provision of high-quality contraceptive services are:

- There should be respect for and promotion of human and reproductive rights for each client seeking contraceptive services.
- An enabling legislative environment for the provision of contraceptive services should be created.
- Contraceptive services should be free in the public sector.
- Contraceptive services should be equitably distributed throughout the country.
- Contraceptive services should be made available to all who need them, including adolescents, men, and people with disabilities and special needs.
- Service provision should include information and counselling on contraception, sexuality and reproductive health.
- Contraceptive services should be provided as part of comprehensive reproductive health care.
- Contraceptive methods should be prescribed on the basis of informed choice.
- No client requesting contraception should be sent away without a suitable method of her/his choice.
- Services should offer a method mix appropriate to the level of service delivery.
- Services should be provided through a well-managed system with clear referral pathways.
- Service providers should have all their technical and professional needs appropriately met.

Goal

The goal is to improve the sexual and reproductive health of all people in South Africa.

Purpose

The purpose is to enable all people to exercise their contraceptive choice safely and freely.

Objectives

Objective 1: To remove barriers that restrict access to contraceptive services.

Objective 2: To increase public knowledge of clients' rights, contraceptive methods and services.

Objective 3: To provide high quality contraceptive services.

Objective 1

To remove barriers that restrict access to contraceptive services.

The right of all individuals to freely access contraceptive services can be hindered through existing legislation, policies and guidelines which are outdated or no longer useful. Removal of these barriers is essential for the unrestricted provision of contraceptive services today. It is also essential for relevant guidelines and programmes in health and related fields to support and complement one another so that they act synergistically to improve reproductive health.

Strategies

1. **Review and revise existing legislation to allow full implementation of the National Contraception Policy Guidelines.**

   This may include amending legislation (Child Care Act, 1983) pertaining to the age at which minors can receive medical treatment in order to meet their health and social needs, without being required to be assisted by their parents/guardian.

2. **Review and revise the scope of practice of identified categories of primary care service providers to allow them, after appropriate training, to provide certain contraceptive services.**

   This may include expanding the scope of practice of enrolled nurses and nurse assistants to enable them, after training, to provide a broader range of contraceptive methods.

3. **Review and revise the scheduling of contraceptives in line with the expanded scope of practice of identified categories of primary care service providers.**

4. **Collaborate with other government departments and agencies, as well as the private/NGO sector to develop or strengthen policies and guidelines that affect contraceptive use and service provision.**

5. **Collaborate with other government departments and agencies to expand and strengthen contraceptive services.**

   This may include working more closely with the Department of Education to provide contraceptive services in schools.

6. **Use research findings to inform policy development and programme planning.**

   Relevant research findings could usefully inform the process of policy/legislation revision regarding, for instance, the minimum age for minors to give consent for contraception without parental assistance. They also could be used for responsive programme planning, such as to address identified gaps in service provision for adolescents and male clients.

Objective 2

To increase public knowledge of clients' contraceptive rights, methods and services.

Information education and communication (IEC) and counselling on contraceptive rights and available services are crucial to enable people to make informed choices.

Strategies

1. **Develop appropriate IEC messages, materials and programmes about contraception for multimedia dissemination.**

Aspects that require specific consideration with respect to this IEC strategy include:

- *Identification of the specific audience(s) for whom the IEC material/programme is (are) intended:* The audiences will vary in different areas and over time. They may include influential local leaders; current users; potential users, such as adolescents, parents with children of less than two years, individuals/couples with satisfied parity, people living with HIV infection or sex workers.
- *Identification of the appropriate content of the IEC messages and materials*: The content will depend on the knowledge gaps of the specific audience. It may include information on:
  - The rights of all individuals to freely regulate their own fertility
  - The range of benefits of contraception
  - The fundamentals of the National Contraception Policy Guidelines, such as the paradigm shift in the approach of service delivery
  - The availability of contraceptive services
  - Basic information on the currently available contraceptive method mix
  - Safer sexual behaviour practices for the prevention of STIs/HIV infection
- *Use of appropriate multisectoral IEC approaches and media* according to the specific audience. These should be determined and developed through participatory methodologies.
- *Development of alternative forms of IEC materials* that are appropriate for people with special needs, in terms of the language and media used.

2. **Trainservice providers and educators to increase public knowledge on contraception using a variety of innovative methodologies and appropriate IEC materials.**

   Effective ways of reaching the public include community radio slots, and short items (eg songs or plays) performed at popular recreational events such as music concerts and football games.

3. **Utilise all opportunities to provide IEC about contraception and reproductive health.**

   All points of contact with clients, including in the waiting room and any consultation, should be used to provide IEC about contraception and reproductive health matters.

4. **Implement contraceptive IEC initiatives, in collaboration with suitable partners, to reach priority groups in the community.**

   The need exists for greater collaboration between relevant stakeholders in the public and private/NGO sectors to develop innovative and complimentary IEC initiatives.

5. **Conduct research to monitor and evaluate IEC initiatives related to contraception so that the findings can inform the development of future initiatives.**

To provide high quality contraceptive services

Improved service delivery and the provision of high-quality care are sometimes considered unattainable for programmes with limited financial resources. However, increased efficiency and improved planning go hand in hand with increasing the benefits of health care interventions. Central to the concept of high-quality care is the need for service providers to be sensitive and responsive to clients' needs, and to respect the right of each client to make an informed choice of contraceptive method. To enable service providers to deliver high-quality care, their needs must be met for training, continuous updating, facilitative supervision and back-up, and they should enjoy adequate infrastructure, equipment and supplies.

The contraceptive service delivery strategies discussed below are intended to standardise contraceptive method provision, remove unnecessary restrictive practices of method provision, and safely increase the accessibility of client-acceptable methods. Implicit in the strategies is that contraceptive method provision includes appropriate counselling, and is offered as part of comprehensive reproductive health care in particular the prevention and management of STIs/HIV and infertility; total abortion care; pregnancy care; management of the menopause; and breast and cervical screening. In light of the current STI/HIV epidemic, the promotion of dual protection is essential for the prevention of STIs/HIV as well as pregnancy.

Strategies

1. **Continue programmes and implement new initiatives to improve the accessibility of contraceptive services for underserved groups and communities.**

   Partnerships should be formed or strengthened with other government sectors, the private sector and NGOs to increase access to contraceptive services for all those of reproductive age through channels other than public sector health facilities. These may include:

- Non-clinic-based delivery systems, such as social marketing and community-based programmes.
- Private/NGO sector clinics, school-based clinics and employment-based clinics.

   In forming public-private partnerships, all services provided through the private/NGO sector would be required to comply with the latest national contraceptive service delivery guidelines.

2. **Introduce measures to improve the acceptability of contraceptive services.**

   Measures should address areas that are known to be important in making services more acceptable for clients, such as convenient clinic opening times, reasonable waiting times and a clean, safe clinic environment.

3. **Explore and implement the most suitable measures to make contraceptive services more acceptable to people with special needs.**

   Measures may include the provision of special IEC materials for the deaf and blind; and putting in a ramp or a wider door to assist wheelchair-bound clients to physically access the facility more easily.

4. **Provide contraceptive services during other primary health care consultations, as appropriate.**

5. **Provide effective counselling in a private and comfortable environment and ensure confidentiality.**

   Counselling is an essential element of reproductive health services that should be part of all consultations. It should be provided in a private, comfortable environment and client confidentiality should be ensured. Following counselling for contraception, the client should feel satisfied with his/her choice of method, know how to use the method correctly and what follow-up is necessary. They also should know how to prevent STI/HIV infection.

Effective counselling requires that providers:

- Are empathetic, respectful and non-judgemental towards all clients, regardless of their age, sex, race, religion, culture, disability or social status.
- Listen to the client's needs and establish open interactive communication.
- Use appropriate language and IEC materials.
- Provide impartial information on the available contraceptive method mix.
- Assist the client to choose an appropriate contraceptive method(s) that suits his/her personal circumstances, is medically safe and takes into account the risk of exposure to STIs/HIV.
- Provide complete information on the chosen method, including how to use it; re-supply or removal requirements; common side effects and how to deal with them; warning signs of complications and what to do if they occur.
- Provide preconception information to clients who wish to discontinue contraception in order to plan for a pregnancy. For example, information on the prevention of congenital infections (e.g. syphilis) and neural tube defects; and the effects of drugs, smoking, toxins and alcohol on the unborn child.

6. **Safely increase the accessibility of client-acceptable contraceptive methods.**

   The table on the next page (Table 2) contains guidelines on the range of contraceptive methods that different levels of service delivery should provide in order to safely increase the accessibility of client-acceptable methods.

Table 2: Methods and services by level of service delivery point

LEVEL	METHOD	SERVICE	PROVIDER
Community	Male and female condoms	Method provision and information on correct and consistent use	Easily accessible outlets - schools, workplace, shops, petrol stations
.	Both the above *Plus* COCs, POPs, ECPs, NFP and LAM	Education and counselling for all available methods Provision of limited selection of methods Pregnancy testing Management of other SRH needs in line with national guidelines Referral	A wide range of service providers and access points, including trained CBDs, EHOs, CHWs, NGOs, lay NFP teachers and pharmacists Type of method provided is dependant on regulatory requirements, training, indirect supervision and back-up referral systems
Mobile units	All the above *Plus* Injectables	IEC and provision of a wider range of methods Breast and pelvic examination Management of other SRH needs in line with national guidelines Referral	Professional nurse/midwife Nursing Assistant with appropriate training who meets regulatory requirements, uses suitable checklists, and has indirect supervision and back-up referral systems
Clinics	All the above and IUCDs	IEC and provision of a wider range of methods Management of other SRH needs in line with national guidelines Referral	All the above *plus* General practitioner
Community health centres & District hospitals	All the above *Plus* Vasectomy and tubal ligation	All the above but for the full range of methods.* Management of other SRH needs in line with national guidelines Referral	General practitioner Professional nurse/midwife with appropriate training who meets regulatory requirements, uses suitable checklists and has indirect supervision and back-up referral systems
Referral/ tertiary hospitals & Academic centres	All the above	Routinely all the above for inpatients, and exceptionally for outpatients Primary service for referrals and problems beyond the capability of community health centres and district hospitals	Hospital medical staff with specialised training

Note: *There should be at least one accessible service point in each district providing this method by referral.

7. Provide contraceptive methods safely and correctly in accordance with standardised contraceptive clinical practice guidelines and infection prevention protocols

In South Africa, as in many other countries, clinical practice for contraceptive method provision is not nationally uniform – in some cases it is unnecessarily restrictive and/or incorrect. In an attempt to update and standardise the provision of contraceptive methods and eliminate unnecessary restrictive practices and medical barriers, the WHO developed a set of medical eligibility criteria for the provision of contraceptives. This is based on the results of careful collaborative inter-agency review of all clinical, epidemiological and programmatic research on new and old contraceptive methods over the last ten years.

The suitability of each contraceptive method in the presence of specific medical conditions was categorised by weighing the health risks against the benefits. The criteria allow service providers to prescribe contraceptives according to the clients' personal preferences while maintaining an adequate margin of safety. They represent an advance towards ensuring that women and men (and their offspring) are adequately

protected from possible health risks associated with contraceptive use, without being unnecessarily denied the method of their choice.

National experts met at a workshop in February 1998, to consider the WHO contraceptive medical eligibility criteria in the South African context. Based on the representation of the latest scientific evidence on contraceptive methods, national clinical practice guidelines were developed in order to update and standardise common existing problem areas in method provision. The clinical practice guidelines take into account the STI/HIV epidemic in the context of prescribing. All aspects of contraceptive service provision should be carried out in line with current infection prevention protocols.

Clinical practice guidelines on aspects of method provision for which existing practice commonly differs from current recommendations

- Informed choice
  All women, men and young people should be provided with the contraceptive method(s) that they request, subject to meeting the relevant medical eligibility criteria, and without the influence of service provider biases.

- Client assessment
  Comprehensive medical history and blood pressure measurement are essential before clients begin hormonal contraception. Pelvic and breast examination are not mandatory. It is recommended that these examinations are performed at a mutually convenient time during the first year of contraceptive use. This opportunity should be used also to instruct clients on breast self-examination. Cervical (PAP) smears should be performed in line with the DOH's national guideline for the Cervical Cancer Screening Programme.

- Follow-up visits
  Theseshould bescheduled according tosound medical reasoning. Unnecessary frequent follow-up visits should be discontinued. (Recommendations for the timing of follow-up visits for each contraceptive method are given under the respective method-specific chapters in the National Contraception Service Delivery Guidelines.)
  These should be scheduled according to sound medical reasoning. Unnecessary frequent follow-up visits should be discontinued. (Recommendations for the timing of follow-up visits for each contraceptive method are given under the respective method-specific chapters in the National Contraception Service Delivery Guidelines.)

- Barrier methods
  More extensive use of barrier methods should be urgently promoted in view of the STI/HIV epidemic. At least one female-initiated barrier method should be made available.

- High dose COCs
  Routine use of high dose COCs should be phased out. Unless specifically medically indicated, clients using high dose preparations should be changed to formulations of less than 35 micrograms oestrogen, as soon as possible.

- Injectable contraceptives
  These have few contraindications. Young clients should not be prevented from using **either** DMPA or Net En because of their age.

- Timing of initiation of hormonal contraceptives

This should not be restricted to menstruation only, because it is largely unnecessary and serves as a barrier to access.

- If the first pill or injection is taken within five days of the onset of menstruation there is immediate protection.
- A woman can start a hormonal method of her choice at any time during her cycle providing that she is reasonably sure she is not pregnant*. Protection is provided after seven active pills have been taken, or seven days after injection. The use of a back-up method or abstinence is recommended in the interim.
- After pregnancy has been reasonably excluded, a woman who initiates an injectable late in the cycle (or receives an injection more than two weeks later than scheduled) should return after four weeks to confirm that she is not pregnant. If pregnancy is confirmed at this stage, the client should be counselled about the options for the pregnancy, including termination of pregnancy.

Note:
Until reliable early pregnancy testing is routinely available, a client's history must be taken as sufficiently accurate to ascertain the possibility of pregnancy – with the knowledge that, in any case, hormonal contraceptives will not abort an established pregnancy.

- Postpartum

  On discharge from a health facility after childbirth and at the six-week postnatal check-up, all women should be counselled about contraception and supplied with a suitable method(s) of their choice.
  - Each client's/couple's needs for contraception should be discussed and assessed individually. For instance, couples intending to abstain from sexual activity for a period of time after childbirth may not require immediate postpartum contraceptive cover.
  - Women who are not intending to breastfeed may start progestogen-only-methods immediately. Combined oral contraceptives should be started only after three weeks postpartum when the risk of venous thromboembolism is reduced.
  - Women who are breastfeeding should not use oestrogen-containing methods until after 6 months postpartum, or when the infant is weaned (whichever occurs soonest). It is recommended that initiation of progestogen-only methods (pills or injectables) is delayed until six weeks postpartum. This is not based on clinical evidence but is in line with international opinion that a theoretical risk exists for exogenous hormones transmitted within breast milk to affect newborn infants of under six weeks. If, after discussing this information with the client, she is unwilling to accept the very small risk of pregnancy associated with delaying initiation or to use a back-up method, she can be provided with her progestogen-containing method of choice immediately.
  - Female sterilisation may be performed immediately postpartum by a trained and experienced operator, or after an interval at a time that suits the client.
  - Natural family planning can be used postpartum, but additional training and support may be needed to help women to use the method effectively.

- Lactational Amenorrhoea Method (LAM)

  This method is not being actively promoted in view of the local practice of early weaning in some parts of the country; and the high incidence of HIV infection with the risk of transmitting the virus from mother-to-child (MTCT) through breast milk. However, providers should be well informed about LAM to be able to effectively counsel women who wish to use the method. Women who are known to be HIV-positive should be counselled about all infant feeding methods and the risks involved, make an informed choice, and be supported in their choice.

- Post-abortion
  After spontaneous or induced abortion, all women should be offered counselling and a choice of contraception from the range of available methods. Any method of the client's choice may be initiated immediately following uncomplicated abortion at any stage, provided that the medical eligibility criteria are met. The *only* exception being IUD insertion after second or third trimester abortion, which should be delayed until **four to six** and another method used in the interim.

8. Expand and strengthen the current method mix to meet the varying needs and preferences of clients throughout their reproductive lives

The available public sector contraceptive method mix should be strengthened and expanded to meet the varying needs and preferences of clients throughout their reproductive lives. This requires that sustained supplies of core methods are available at all service delivery points; that currently under-utilised methods are promoted and made more accessible; and that new methods are introduced in a phased process.

The promotion of under-utilised methods and introduction of new methods should be carefully evaluated, particularly with respect to the characteristics of the method, in terms of its mode of action, safety, efficacy, side-effects, return to fertility; and how it fits into the existing service delivery system, including staff resources, training, facility requirements, and cost. User issues should also be evaluated, particularly user preferences, satisfaction, needs and socio-cultural factors.

- Core methods that should be always available and in stock at all health facilities:
  - *Male condoms:* Should be widely promoted for dual protection.
  - *Oral contraceptives:* Low-dose combined and progestogen-only pills.
  - *Progestogen-only injectables.*
  - *Emergency contraception:* ECPs should be extensively promoted and made available. They are safe, effective, have few contraindications and, although not recommended for regular contraception, they can be used repeatedly for emergency contraception.

- Referral methods that may require client referral to another facility:
- - *Intrauterine Device (IUD):* Should be promoted for carefully selected women who are at low risk of exposure to STIs/HIV.
  - *Female sterilisation services:* including the minilaparotomy procedure under local anaesthetic, should be strengthened and expanded. Services should be made accessible to and promoted for women who are certain that they do not wish to have more children.
  - *Male sterilisation services:* Effective, safe, permanent male sterilisation procedures should be made accessible to and promoted for men who are certain that they do not wish to have more children. There is a need to raise public awareness and understanding about vasectomy.
  - *Female condom:* Is available at selected facilities throughout the country and strict monitoring of user patterns is continuing.
  - *Natural family planning:* Clients who are interested in NFP methods (excluding LAM) should be counselled and instructed by specially-trained NFP teachers who specialise in providing the methods.

Current situation regarding methods that may be considered for future introduction:

- *Diaphragm:* May be piloted at selected sites to assess acceptability as a female-initiated method providing partial protection against some STIs.
- *Combined injectable:* Containing both oestrogen and progestogen,

may be introduced at selected pilot sites to assess acceptability.

- *Spermicides:* High cost and low contraceptive efficacy mean that for now spermicides are not a cost-effective method for inclusion within the public sector method mix. Currently, there are concerns also that high concentrations and/or frequent use of spermicides containing nonoxynol-9 may predispose women to HIV infection. The WHO and UNAIDS are reviewing research work on nonoxynol-9 and will release a more definitive statement about its use during 2001.
- *Levonorgestrel-releasing intrauterine system:* Is highly effective, and has fewer side-effects than copper-IUDs. Routine availability of the method through the public sector, however, is unlikely in the near future because of the high cost of the device.
- *Long-acting progestogen subdermal implants:* Are acknowledged to have potential benefits. However, introduction into the public sector method mix is not being considered at this time because of the complex operational issues associated with method provision.

9. Promote dual protection approaches for protection against pregnancy and STIs/HIV infection

The HIV/AIDS pandemic has graphically brought to light that women in all societies carry the greatest burden of both unwanted pregnancies and STI/HIV infection. Hence it is imperative that, during contraceptive counselling, providers assist all clients to carry out their risk assessment for STI/HIV infection and promote dual protection strategies, as appropriate.

Dual protection is any strategy that prevents both unwanted pregnancy and STI/HIV infection, ie:

- Abstinence, including non-penetrative alternative sexual practices. Abstinence (and mutual monogamy between uninfected partners) offer the best protection against STIs/HIV.
- Barrier methods: The use of male or female condoms (alone or with spermicides) prevents both pregnancy and STIs/HIV. Motivated and well-counselled individuals who use condoms correctly and consistently can achieve effective dual protection. In the event of condom failure, access to emergency contraception should be promoted more extensively. Women who are at risk of STI/HIV infection but have difficulty negotiating male condom use, should be counselled about using the female condom, if these are available.

  Dual method use: Clients who are at risk of STI/HIV infection but wish to use a contraceptive method that does not offer STI/HIV protection, should be counselled to use condoms as well for dual protection.

10. Revise or develop contraceptive training curricula for the different categories of service providers and students

Revised or newly developed reproductive health curricula, in line with the latest national contraception policy guidelines and service delivery guidelines, should be used by all training institutions, including universities, nursing colleges, technikons and provincial training units as well as for on-site training. The content of training should be based on an assessment of service needs. Training should focus on the skills and information that providers need to do their work effectively. Service providers requiring training or retraining on reproductive health care include doctors, clinical officers, public health practitioners, health assistants, midwives, nurses, pharmacists, community-based workers and social marketing suppliers of contraceptives. Providers should be selected for training according to their ability. After training, providers should be supervised and supported to ensure that they are able to deliver the services for which they have been trained. Training received should be taken into consideration during senior management decision-making regarding staff placements and transfers.

Curricula for service provider training and retraining should include the following:

- Values clarification, anti-bias training and the development of client-centred approaches of care, to help ensure that providers uphold clients' rights, and provide services to all people, irrespective of age, race, sex, social status and disability, in a respectful, understanding, and non-judgemental manner.
- The provision of IEC and counselling to the public and clients.
- Technical knowledge and skills on contraceptive technologies; method provision and follow-up; infection prevention; special sexual and reproductive health care needs of priority groups; and prevention and management of interrelated sexual and reproductive health priority areas (eg STI/HIV infection, infertility, cervical cancer, breast cancer, violence against women, teenage pregnancy).
- Management skills, including quality improvement methods, recording of client information, and the collection, collation and use of clinic data.

11. Establish supportive supervisory systems at all levels of care to ensure that service providers' needs are met

- At all levels, supportive supervisory systems should be established or strengthened to ensure that clients' rights and providers' needs are met.
- Managers/supervisors should be trained and regularly updated to enable them to supervise and give support on all aspects of contraceptive service delivery.
- Supervision should be supportive, ongoing and frequent in order to monitor and update the knowledge and skills of providers.
- Providers should be given constructive feedback to help them perform their duties effectively.
- On-site training and periodic retraining/updating should be conducted to fill identified gaps in provider knowledge, skills, values and attitudes.

12. Improve the logistics system to support contraceptive service provision in the public sector

All service delivery points should have adequate, sustained and good quality contraceptive supplies and equipment available, as well as the necessary supplies and equipment for infection prevention. This requires an efficient logistics system that includes:

- National standards for the equipment and supplies necessary to deliver high-quality contraceptive services at each level of care.
- Appropriate storage procedures and quality standards for equipment and supplies.
- Regular monitoring to ensure good product quality.
- Efficient systems for inventory control, projection of supply needs, procurement and distribution.

13. Make available adequate, sustained supplies of contraceptive methods and materials, as well as appropriate, properly functioning equipment at all service delivery points in accordance with national norms and standards

14. Improve referral systems between contraceptive service delivery points

At each service delivery point, referral systems should be established, strengthened and/or expanded to include facilities in the private/NGO sector.

15. Improve routine data recording, collection and reporting

To be able to provide adequate client follow-up care, service providers should keep adequate and accurate records of clients and supplies. The

various contraceptive records that should be kept include:

- Clinic-held or client-held (Women's Health Card) records containing basic client details, contraceptive history, other relevant history, and health indicators.
- Daily activity register on the number of client visits, quantity of each type of contraceptive method supplied, type of service provided for other sexual and reproductive health problems, and reasons for referral to another facility.
- Stock records with information on the type and quantity of supplies available.

Routine data collection and reporting is also an important part of service provision because it allows for monitoring and evaluation of services together with responsive management and planning. To strengthen the routine health information system, the following is required:

Collection of good-quality data on the number and type of clients served, quantity of contraceptives received and dispensed and the anticipated demand for the next quarter.

Timeous reporting (monthly and quarterly) from all service delivery points.

Rationalisation to the essential minimum of the various items of data that providers are required to collect, in order to improve the quality of data collected and to cut out the wasted time and effort spent by providers collecting data that is of little or no programmatic use.

16. Strengthen monitoring and evaluation of contraceptive services

- Key national, provincial and local indicators should be identified and appropriate data collected through the most suitable method (eg periodic surveys, via sentinel sites, and the routine health information system).
- There should be efficient mechanisms to collate, analyse and use the data obtained through the routine health information system for responsive programming at the national, provincial and local level. Mechanisms should include regular feedback of the results to service delivery points, and support of providers to use the data that they collect.
- Service providers should use appropriate tools to assess the quality of care provided and to initiate appropriate improvement strategies such as a local audit of method continuation rates, and self-assessment exercises on client acceptability of the services provided.
- Operational research should be conducted, using measurable indicators of achievement for various aspects of contraceptive service delivery. Such indicators include user satisfaction, commonly experienced side effects, staff competence in the provision of contraception and use of service delivery guidelines.
- Periodic Knowledge, Attitude, Practice and Behaviour (KAPB) studies should be conducted to evaluate the impact of services.

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A

Abortion

is the spontaneous or induced termination of pregnancy (TOP) before the foetus has attained viability, ie become capable of independent extrauterine life. Viability is usually defined in terms of duration of pregnancy and/or weight of foetus or, occasionally, length of foetus.

Adolescents, youth and young people

'Adolescents' are defined as those aged between 10 and 19, and 'youth' as those between 15 and 24. However, true adolescence (ie the period of physical, psychological and social maturing from childhood to adulthood) may fall within either age range. The term 'young people' covers both adolescents and youth, ie those between 10 and 24.

Amenorrhoea

is the absence of menstrual periods.

B

Back-up method

is a contraceptive method, such as condoms or spermicide, that can be used temporarily for protection against pregnancy in certain situations, for example while waiting for a new method to become effective or when supplies of a regular method run out.

C

Clients

are those individuals who approach the health care system for services and also those in the community who are in need of services (sometimes referred to as potential clients).

Community-based distribution (CBD) or community-based reproductive health services (CBRHS)

is a cost-effective approach for increasing access to contraceptives and reproductive health education through the use of trained non-medical personnel. In South Africa, CBD or CBRHS agents are required to be supervised by a nurse.

Contraception

is the prevention of pregnancy through temporary or permanent means.

Contraceptive prevalence

is the percentage of couples using a contraceptive method.

D

Disadvantaged communities

are groups of individuals who are recognised as generally having less than average in some aspect(s) of life eg the poor; isolated rural communities and people with special needs.

Discrimination-free
means that all people are treated in the same way and are shown the same respect for their human rights and other entitlements, regardless of race, gender, marital status, age, ethnic or social origin, colour, sexual orientation, disability, religion, conscience, belief, culture, language and any other characteristic which may place individuals in certain groups.

Dry sex
is a sexual practice whereby the woman dries her vagina prior to sexual intercourse. It is thought to be popular among some African couples because of a male preference for the practice. Common substances used to dry the vagina are methylated spirits, vinegar, iced water, zam-buk cream, snuff, alum powder or *muthi* prepared by traditional healers.

Dual method use
is the use of two contraceptive methods at the same time: one with particularly high efficacy to prevent pregnancy (eg combined oral pill), and the other to prevent the transmission of STIs/HIV infection during sexual intercourse (eg condoms).

Dual protection
is the use of any means to prevent both unwanted pregnancy and STIs/HIV infection. Abstinence, the use of condoms alone, and dual method use are all dual protection strategies. Mutual monogamy of uninfected partners, together with the use of a contraceptive method, is also a dual protection approach.

E

Equity of services
implies that access to and the standard of care offered by services in the country are the same. It implies that services that were unable to provide adequate care under the previous government are brought up to an acceptable level, given the current limited financial and human resources, even at the expense of services which were previously inequitably well-resourced.

Essential Drugs List (EDL)
is a list of the drugs that are available for different levels of health care. The EDL for Primary Health Care Services contains the drugs available for primary health care services.

F

Family planning
is the ability of individuals and couples to decide on and attain their desired number of children and the spacing between births. It is achieved through contraception and the treatment of involuntary infertility.

Fertility regulation
is the process by which individuals and couples regulate their fertility through, for example, use of contraception, treatment of infertility and termination of an unwanted pregnancy.

Fully breastfeeding
means giving the baby no other food or liquid other than breast milk.

G

Gender
refers to the characteristics of male or female that are socially created and conditioned. It pertains to culturally perceived masculine and feminine roles. While sex is given and for the most part unalterable, gender roles are constructed within particular societies and, theoretically at least, can be changed.

H

Health
is the state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity.

Homelands
is the term used to describe the areas of land (ie the four independent countries and ten self-governing states) that were designated by the apartheid government for the residence of black people.

I

IEC (Information Education and Communication)
are the identified elements for health promotion.

Infertility (male or female)
is the inability to conceive or to cause conception spontaneously after one to two years of regular unprotected coitus.

L

Lactational Amenorrhoea Method (LAM)
is an effective (98%) natural family planning method that can be used to avoid pregnancy by women if they are fully or nearly fully breastfeeding; amenorrhoeic; and less than six months postpartum.

N

Natural family planning (NFP)
is the observation and interpretation of the natural occurring signs and symptoms of the fertile and infertile phases of the menstrual cycle with the use of complete abstinence of sexual intercourse during the fertile time if pregnancy is not intended. The modern NFP methods (Billing's ovulation method and the sympto-thermal method) that are based on the signs and symptoms of ovulation, have replaced methods such as the rhythm or calendar method that were based on menses as the marker point for use of the method. NFP methods are sometimes referred to as fertility awareness-based methods.

P

People with disabilities
are individuals whose prospects of securing and retaining suitable employment are substantially reduced as a result of physical or mental impairment.

Population growth
is the overall increase in population in a geographic area, due to fertility, mortality and migration factors.

Population growth rate
is the rate at which the population increases over a given time period, expressed as a percentage of the base population. It takes into account all the components of population growth, namely births, deaths and migration.

Preferred family size
is an individual's or couple's desired number of children.

Q

Quality of care
is the term used for the standard of service provided to contraceptive clients. The concept which really gained ground in the late 1980s shifts away from the traditional focus of family planning programmes on number of couples reached, to analysing the quality of services offered to couples. Pivotal work in this area was done by Judith Bruce. She identified the following framework of six fundamental elements for measuring the quality of care offered by contraceptive services: choice of methods; information given to clients; technical competence (of providers); interpersonal relations; mechanisms to encourage continuity; and appropriate constellation of services. On the basis of performance against these key elements, services commonly are described as offering poor, adequate or high/good quality of care.

R

Racial classifications
the terminology used in this document reflects the apartheid system of racial classification according to which data was collected. The continued use of these classifications is warranted in order to monitor the process of trying to achieve equality for all people in South Africa. The terms 'African', 'Asian', 'coloured' and 'white' are used in the main, except when collectively referring to Africans, Asians and coloureds, in which case the term 'black' is used.

Reproductive health and rights
addresses the reproductive processes, functions and system at all stages of life within the framework of WHO's definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. Reproductive health implies that people are able to have a responsible, satisfying and safe sex life; and have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this is the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go through pregnancy and childbirth safely and provide couples with the best chance of having a healthy infant.

Reproductive health services
refer to the constellation of services aimed at fostering sexual and reproductive health. They include preventive and promotive services (such as information, education, communication and counselling); management of STIs/HIV/AIDS, infertility, abortion, and cancers of the reproductive system; contraceptive services; antenatal care, safe delivery and postnatal care.

S

Safer sex
is sex with no or minimal risks or negative consequences. Different people see different consequences as negative. The two main negative consequences of sexual intercourse for most contraceptive clients are pregnancy and STI/HIV infection. Dual protection strategies are safer sex practices to avoid both pregnancy and STIs/HIV.

Service provider (contraceptive)
is a person trained to provide some or all contraceptive services. The term encompasses community health workers and environmental health officers who may provide contraceptive information and a limited range of contraceptive methods, to nurses and doctors who are trained to provide counselling and a fuller range of contraceptive methods.

Sex
sex refers to the biological status of male or female. It is also used to mean sexual activity or intercourse.

Sexual behaviour
encompasses the physical practices (eg penetrative, non-penetrative, vaginal, anal, oral), and patterns (eg a stable sexual relationship with one partner; the tendency to have casual sex and multiple partners; use of dual protection strategies) associated with the act of sexual intercourse.
High risk behaviour encompasses activities and features that are associated with a high risk of contracting STIs/HIV infection, ie unsafe sexual practices. Sharing needles for intravenous drug use, though obviously not sexual, is a high risk behaviour for HIV infection.
Low risk behaviour encompasses activities and features that are associated with a low risk of contracting STIs/HIV infection, such as safe sexual practices.

Sexual health
is the integration of the somatic, emotional, intellectual, and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love. It implies a positive approach to human sexuality.

Sexual health care
aims to enhance life and personal relationships and not merely provide counselling and care related to procreation and sexually transmitted infections.

Sexuality
is a complex part of our personality that encompasses lifestyle and choices, intimate feelings, sexual preferences and behaviour from birth to death. It is not just about genitals and reproduction but involves physical, psychological and social components. Sexuality is always changing, shaped by what we learn, choose and do. It is influenced, among other things, by being male or female; as well as social, cultural, religious and sexual norms.

Sexually transmitted infections (STIs)
are infections affecting men and women that generally are transmitted during

sexual activity. The infections usually cause discomfort. Some may lead to infertility, and some may be life-threatening. The term 'sexually transmitted infections' (STIs) has replaced the term 'sexually transmitted diseases' (STDs).

Supportive/facilitative supervision
is an approach to supervision that focuses on mentoring, joint problem-solving and two-way communication between the supervisor and those being supervised.

Sustainable human development
is the increase of people's choices and capabilities through the formation of social capital to meet the needs of future generations as equitably as possible.

T

Teenage birth rate
is the percentage of total live births per annum to women of under 20 years.

U

Urban
the term 'urban' includes areas with a local authority of some form, and areas of an urban nature but without any local management. All other areas are classified as non-urban.

Unsafe sex
Is the practice of sexual activities that carry a higher risk of negative consequences. Activities that involve exchange of, or contact with, semen, vaginal fluids, penile or vaginal discharges, or blood are high risk. Sexual practices that are particularly associated with an increased probability of STI/HIV infection and/or pregnancy include: (a) unprotected vaginal, anal or oro-genital sex between two people, one or both of whose risk status for STI/HIV infection is unknown; (b) unprotected sexual intercourse in the presence of an STI; (c) having multiple partners; (d) frequently changing sexual partners; and (e) having casual sex or sex with strangers.