

2005-6 Baseline Assessment for the CRTU Program: Reproductive Health and Family Planning in South Africa

June 2006



Source: USAID



Source: CIA World Fact Book, 2005



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for the CRTU Program:
Reproductive Health and
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Executive Summary

Introduction

Family Health International (FHI) was awarded the Contraceptive and Reproductive Health Technologies Research and Utilization Program (CRTU) by USAID in 2005. The CRTU's goal is to expand the range and increase the use of safe, effective, acceptable, and affordable contraceptive methods and reproductive technologies, delivered through high-quality family planning and reproductive health services in developing countries. By concentrating its resources in a few carefully selected countries, the CRTU strives to maximize the public health impact of its work. FHI will identify and prioritize local research and program needs within these selected focus countries, develop and implement country work plans that address those needs, foster collaborative partnerships with local groups, and facilitate the translation of research into practice. For many reasons, including FHI's successful program and strong Mission support there, South Africa was quickly identified as one of the CRTU's focus countries.

This report provides a baseline assessment of the current state of the family planning and HIV program in South Africa. It is intended to serve two primary purposes: 1) as a resource for CRTU staff and colleagues who are working together on research, research utilization, and other reproductive health activities in South Africa under the CRTU; and 2) as a tool to assess and document changes in South Africa over the course of the five-year CRTU program.

The assessment compiles information from key resource documents and synthesizes the most recent qualitative and quantitative data on family planning and reproductive health in South Africa, with special attention paid to the integration of HIV and family planning services.

In addition, this report summarizes ongoing work under the CRTU, as well as results of the first CRTU stakeholders' meeting, in which the National Department of Health (DOH), partner cooperating agencies (CAs), and health providers identified areas for the CRTU to address. The USAID/South Africa Mission has articulated its desire for the CRTU to focus exclusively on strengthening the integration of HIV and family planning. FHI's new PEPFAR-supported programs center HIV/FP integration around strengthening PMTCT programs, integrating family planning with palliative care for people living with HIV/AIDS (PLHA), and making improvements to FP/antiretroviral treatment (ART) delivery through home-based care. These priority areas, coupled with the CRTU's own goals and outcomes and shaped by partnerships and funding realities, will inform and influence the future course of work in South Africa under the CRTU.

Highlights of Current Family Planning and HIV/AIDS Trends and Issues in South Africa

- Contraceptive use has been increasing in South Africa. According to the [South African Health Review](#) conducted in 2003-2004, the contraceptive prevalence rate rose from 61 percent in 2001 to 65 percent in 2003.¹
- South Africa has a relatively young population, with its largest cohort aged 15-19 and its second and third largest cohorts aged 10-14 and 20-24, respectively. Thus, there is

currently tremendous pressure on health systems to meet the needs of young people with HIV prevention messages before they become sexually active, as well as pressure for a range of reproductive health services among the sexually active in these large cohorts.

- Knowledge of family planning is high in South Africa. As evidenced in the 1998 DHS, nearly 97 percent of all women have knowledge of at least one modern method.
- At 23.2 percent use, injectables are the most popular family planning method among married contraceptive users in South Africa. Unlike most of the African continent, sterilization is also a relatively popular method in South Africa, with 15.8 percent of married women relying on female sterilization and 2.1 relying on their partner's sterilization.
- South Africa's contraceptive guidelines correspond for the most part with international standards; however, there are several differences which could pose potential medical barriers to contraceptive use.
- Stakeholders are mixed in their opinions about how the HIV/AIDS epidemic has affected family planning funding. Some speculate that family planning funding has remained stable, while others argue that family planning funds have been diverted to fight the HIV/AIDS epidemic.
- As of January 2006, there were seven ongoing subprojects in South Africa affiliated with the CRTU and one ending under the CTR. Of these, four were supported with USAID core funds, one with USAID field-support funds and three with PEPFAR funds. Information about these and other Institute for Family Health subprojects is contained in Table 5 of this report.

Integration of HIV/AIDS and Family Planning Services

- Women are disproportionately affected by South Africa's HIV epidemic. Of the 5.3 million adults currently living with HIV in South Africa, the group facing the highest prevalence is women aged 25–34 years – more than one in three women is estimated to be living with HIV.
- Integration policies are progressive in South Africa, and attempts to integrate HIV/AIDS and family planning are relatively advanced compared to other African countries; however, the family planning component of current VCT, ARV, and PMTCT programs still needs to be strengthened, and integrated HIV/FP training programs for health care providers are yet to be established.
- Active integration efforts are encouraged by numerous individuals and organizations. Particularly noteworthy is the USAID/South Africa Mission's focus on the intersection of HIV/AIDS and family planning services. Given the high prevalence of HIV/AIDS in South Africa and the progress the country has made in increasing contraceptive prevalence, the focus of the CRTU Program in South Africa is the integration of family planning and HIV/AIDS services, particularly antiretroviral treatment services. With PEPFAR support, FHI works nearly exclusively in this area, centering efforts around PMTCT and new integration initiatives that involve home-based and palliative care for people living with HIV/AIDS (PLHA).

Adolescent Reproductive Health

- Given that adolescents are such a significant proportion of South Africa's population, research and reproductive programs need to continue to include special consideration for this group. National policies pertaining to youth are in place, including the 2001 [Policy Guidelines for Adolescent and Youth Health](#).²
- The concept and establishment of youth-friendly health facilities appears to be well-developed in South Africa, with the vast majority of providers holding progressive attitudes regarding young people's access to RH information and services. Youth-friendly services are mandated by national policies, including the Policy Guidelines for Adolescent and Youth Health.

USAID and Other Key Organizations in South Africa

- USAID/South Africa Mission funds for HIV/AIDS, population, and health dropped dramatically from US\$31 million in 2004 to US\$5.2 million in 2006. The current goals of its population and health activities relate to improving child survival, health and nutrition; reducing transmission and impact of HIV/AIDS; and preventing and controlling diseases of major importance. Its activities are focused in the Limpopo, Mpumalanga, and Northern Cape provinces. Links to several key USAID planning documents are contained in this report.
- Over the past five years, FHI's Institute for Family Health has worked with several other CAs and local reproductive health organizations in South Africa, including Baragwanath Hospital in Soweto, South Africa; Centre for Epidemiological Research in South Africa (CERSA); Reproductive Health Research Unit (RHRU) at the University of Witwatersrand; Centre for AIDS Development, Research and Evaluation (CADRE) in Johannesburg, South Africa; Research International, Ltd.; the Medical Research Council (MRC), and others. In addition, FHI has collaborated with a number of nontraditional partners on YouthNet and CRTU projects.
- Numerous government entities play a role in the conduct of reproductive health work in South Africa. These include, but are not limited to, the National Department of Health and Department of Education. Coordinating travel and CRTU activities with the South Africa office is not only essential but also beneficial to projects given the experience and expertise of the in-country staff.

Priority Setting

Priorities, as identified among stakeholders in South Africa, are listed at the end of this report. Recurring themes include addressing staffing shortages; improving provider training; updating guidelines and training curricula; and strengthening the support and infrastructure for integrated FP/HIV services.

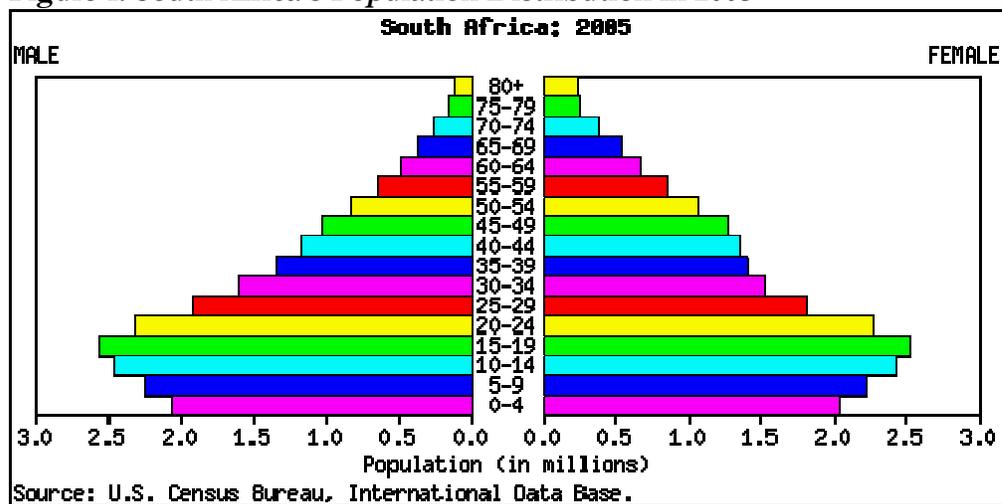
Ultimately, it is necessary to marry the realities of limited resources – human and financial – with the priorities identified by all stakeholders, and with the outcomes which the CRTU is striving to achieve. It is intended that this document will serve as resource to those developing and implementing CRTU activities in South Africa, in addition to providing a baseline against which to measure changes over time. To the extent it is used to inform the difficult task of prioritizing future activities, then it will have served an even further purpose.

Land and Population

South Africa is situated at the southernmost tip of the continent of Africa occupying a total land area of 1,219,912 sq km. Its population totals 44,344,136.³ South Africa has a considerably higher population density (36 people per sq km) than that of its adjacent neighbors, Namibia (2), Botswana (3) and Mozambique (25), a similar population density to that of Zimbabwe (33), but a much lower population density than its closest neighbors Lesotho (61) and Swaziland (68).

South Africa has a relatively young population, with the largest age stratum belonging to people aged 15-19 years. (See Figure 1.)

Figure 1: South Africa's Population Distribution in 2005



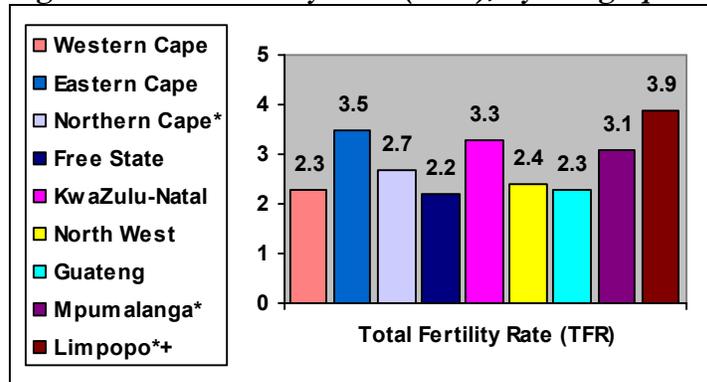
South Africa has 11 official languages (including English, Afrikaans, Sesotho, Setswana, Xhosa, and Zulu) and is well known for its ethnic diversity. According to the 2001 census, South Africa's population is 79 percent black African, 9.6 percent white, 8.9 percent colored, and 2.5 percent Indian/Asian.⁴

South Africa is a middle-income country, ranking 119 out of 177 countries on UNDP's Human Development Index.⁵ The country's largest industries are tourism and the export of minerals. While it is one of the richest countries on the African continent, its development is threatened by extreme socioeconomic disparities, high unemployment, and the AIDS epidemic. South Africa is currently taking measures to make up for decades of social disruption and lost education under the apartheid system. The [World Bank South Africa Country Profile](#) reports that the country's per capita income was US\$3,630 in 2004;⁶ however, aggregates such as these hide persistent inequalities in income and wealth between white and non-white populations in South Africa.

Reproductive Health Demographics

Women of reproductive age (15-49 years) make up 54 percent of the total female population in South Africa.⁷ The total fertility rate (TFR) in urban areas, such as the Free State and Western Cape provinces, averages 2.3, a much lower rate than the average 3.9 in rural areas such as the Eastern Cape and Limpopo provinces. (See Figure 2.) The country's overall TFR is 2.9.

Figure 2: Total Fertility Rate (TFR), by Geographical Region. South Africa, 1998.



* Indicates provinces where USAID/South Africa Mission concentrates its efforts

+ Formerly known as "Northern" province

Source: South Africa Demographic and Health Survey, 1998

Of young women aged 15-17 years, 17.9 percent are currently mothers and nearly one-quarter (24.5 percent) have ever been pregnant.⁸ The median age at first birth is 20.8 years.⁹

Over 53 percent of second or third births among South Africans are spaced more than two years apart, indicating that while the women tend to have their first child at a young age, they postpone the birth of the next child for a substantial length of time.¹⁰ Indeed, 67 percent of all the births among those surveyed in the last five years of the South Africa DHS were spaced at least three years apart. Compared to that of other sub-Saharan African countries, South Africa's median birth interval (47 months) is very high.

For more information about reproductive health demographics in South Africa, refer to Chapters 3 and 4 of the [1998 South Africa Demographic and Health Survey \(DHS\)](#).*

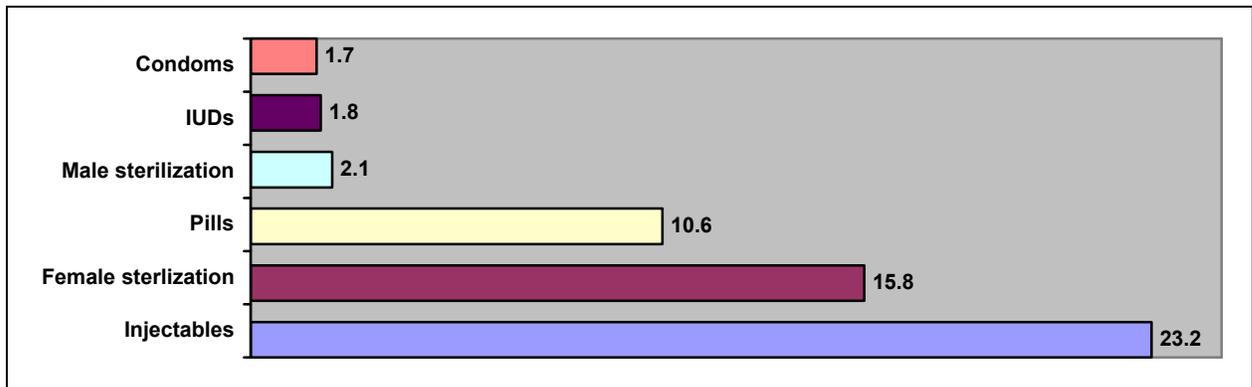
Family Planning Use

Knowledge of family planning is high in South Africa. As evidenced in the 1998 DHS, nearly 97 percent of all women have knowledge of at least one modern method. Injectables (93 percent) and the pill (94 percent) are the two most well-known methods among all women.

* Publication of the most recent DHS has been delayed. The [Measure DHS Web site](#) states that data collection and analysis for the 2003 South Africa DHS will end in December 2006. Note that preliminary data from the 2003 DHS are available in the Documents section of the [South Africa Department of Health Web site](#). For information about obtaining data, contact Macro International, Inc. at (301) 572-0851.

Of currently married South African women, 55.1 percent used a modern family planning method at the time of the 1998 DHS.¹¹ According to the [South African Health Review](#) conducted in 2003-2004, the contraceptive prevalence rate rose from 61 percent in 2001 to 65 percent in 2003.¹² Injectables (23.2 percent), female sterilization (15.8 percent), and the pill (10.6 percent) are the most commonly used methods among currently married women.¹³ (See Figure 3.)

Figure 3: Percent Distribution of Current Use of Modern Family Planning Methods among Currently Married South African Women, by Type of Family Planning Method



Source: South Africa DHS, 1998.

A reported 75 percent of all South African women have ever used a modern family planning method.¹⁴ Injectables are the most common first-used method (57.5 percent), followed by the pill (28.8 percent).

Breaks in contraceptive use

Rather than measuring method discontinuation rates within the first 12 months of use, the [1998 South Africa DHS](#) reports on *breaks in contraceptive use*. In total, 22 percent of all women in South Africa had taken a break from their contraceptive use at some point in the last 12 months preceding the survey. These numbers were highest among women aged 25-29 years, of whom 25 percent had taken a break from contraceptive use. Becoming pregnant was the most common reason for taking a break. Other reasons included health reasons, sexual inactivity, and wanting to menstruate. Of the latter, 84 percent were injectable users.

If only 22 percent of women took a break in their contraceptive use and becoming pregnant was the most common reason, then relative to many other countries in Africa, there would seem to be less reason to focus on reducing discontinuation or breaks in contraceptive use among South African women. However, recent FHI research indicates that among those using DMPA, nearly 50 percent of DMPA and norethisterone enanthate (NET-EN) users were late for their re-injections,¹⁵ according to World Health Organization (WHO) guidelines.

Sources of contraceptives

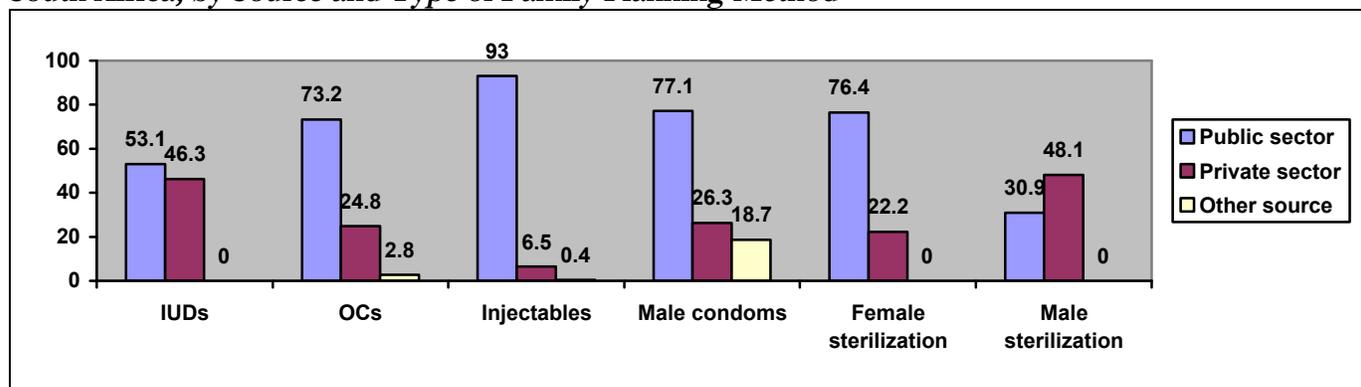
The [1998 South Africa DHS](#) results show that the majority of users (84 percent) obtain their contraceptives from the public sector. (See Figure 4.) Government hospitals are the most common public source (38 percent), followed by day hospital/clinics (20 percent), and

family planning clinics (20 percent). Mobile clinics are used by six percent of modern method users. A very small proportion of women reported obtaining their method from a community health worker, which might refer to the community-based distribution program that was available as a pilot project at limited sites in six provinces at the time of the survey.

Fourteen percent of women use the private medical sector to get their contraceptives. Half of the private sector users (7 percent) go to a private doctor or gynecologist, while five percent use a private hospital and two percent a pharmacy. Although the private sector is used by a smaller proportion of women, it is the source of supply for almost half (46 percent) of IUD users and a quarter of pill users (25 percent). Half of male sterilizations (48 percent) are also performed in the private sector. Public sector sources supplied almost all (93 percent) of injectable users and over three-quarters (77 percent) of condom users.

Because nearly half of the IUD and more than 20 percent of female sterilizations are obtained from the private sector, efforts to expand long-term and permanent method (LAPM) use in South Africa should consider including those in private practice in targeted LAPM training or information dissemination activities.

Figure 4: Percent Distribution of Source of Modern Family Planning Methods in South Africa, by Source and Type of Family Planning Method



Source: South Africa DHS, 1998.

Family Planning Program and Guidelines

Policies and guidelines

South Africa's progressive National Contraceptive Policy Guidelines ([Part 1](#) and [Part 2](#)),¹⁶ launched in 2002, focus on the client's right to choose and quality of care. The 2003 [Primary Health Care Service Delivery Guidelines](#)[†] include a short chapter (Chapter 8) on family planning provision, which contains a limited set of procedures for delivery of hormonal methods to women.¹⁷ See Table 1 for a summary of facts about contraceptives in South Africa, as excerpted from these guidelines.

A comparison of these national policies and the [WHO's Medical Eligibility Criteria for Contraceptive Use \(MEC\)](#) shows that while South Africa's contraceptive guidelines

[†] Allow ample time to download this 1.8 MB document.

correspond for the most part with international standards, there are several discrepancies. These differences, which could pose potential medical barriers to contraceptive use, include the restriction of initiation of IUD use for women who have had a second or third trimester abortion, requiring blood pressure measurement for all hormonal methods, and requiring women who initiate DMPA late in their cycle to return for a pregnancy test after four weeks. In other cases, South Africa's guidelines are vague and do not provide eligibility information for Category 3 and 4 conditions as outlined in the WHO MEC. See Table 1 for details.

Table 1: Summary of Key Facts in South Africa National Family Planning Guidelines and Comparison with WHO Guidelines

Methods	South Africa age guidelines	Other limitations in South Africa	Comparison with WHO guidelines
Intrauterine Devices (IUDs)	No age limits specified.	<p>“Should be promoted for carefully selected women who are at low risk of exposure to STIs/HIV.”</p> <p>In the case of second or third trimester abortion, IUD insertion should be delayed until four to six months after the abortion and another family planning method used in the interim.</p>	<p>The following are Category 2 conditions in the MEC: following 2nd trimester abortion; increased risk for STIs/HIV; partner at increased risk for STIs/HIV; and HIV infection or AIDS <i>and</i> is not doing well on ARVs. Providers may initiate IUD method among women with Category 2 conditions, though follow-up is recommended.</p>
Combined Oral Contraceptives (COCs)	No age limits specified.	<p>“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... 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 six months postpartum, or when the infant is weaned (whichever occurs soonest).”</p> <p>“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.”</p>	<p>“Clarification: It is desirable to have blood pressure measurements taken before initiation of COC use. However, in some settings blood pressure measurements are unavailable. In many of these settings pregnancy morbidity and mortality risks are high, and COCs are one of the few methods widely available. In such settings, women should not be denied use of COCs simply because their blood pressure cannot be measured.”</p> <p>Category 3 and 4 conditions from the WHO MEC which contradict COC use are not outlined in the South Africa national guidelines.</p>
Progestin-Only Pills (POPs)	No age limits specified.	<p>“It is recommended that initiation of progestogen-only methods (pills or injectables) is delayed until six weeks postpartum.”</p> <p>“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</p>	<p>The WHO MEC recommends that use of POPs be delayed until after six weeks postpartum only for women who are breastfeeding.</p> <p>“Clarification: There is concern that the neonate may be at risk of exposure to steroid hormones during the first 6 weeks postpartum. However, in many settings pregnancy morbidity and mortality risks are high, and access to services is</p>

		<p>convenient time during the first year of contraceptive use.”</p>	<p>limited. In such settings, POCs may be one of the few types of methods widely available and accessible to breastfeeding women immediately postpartum. Evidence: Studies have shown that among breastfeeding women less than 6 weeks postpartum, progestogen-only contraceptives did not affect breastfeeding performance and infant health and growth. However, there are no data evaluating the effects of progestogen exposure via breast milk on brain and liver development.”</p> <p>“Clarification: It is desirable to have blood pressure measurements taken before initiation of POC use. However, in some settings blood pressure measurements are unavailable. In many of these settings, pregnancy morbidity and mortality risks are high, and POCs are one of the few types of methods widely available. In such settings, women should not be denied use of POCs simply because their blood pressure cannot be measured.”</p> <p>Other Category 3 and 4 conditions from the WHO MEC which contradict POP use are not outlined in the South Africa national guidelines.</p>
<p>Injectables</p>	<p>No age limits specified. “Young clients should not be prevented from using either DMPA or Net En because of their age.”</p>	<p>“These have few contraindications.”</p> <p>“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.”</p> <p>“Comprehensive medical history and blood pressure measurement are essential before clients begin</p>	<p>The WHO MEC does not recommend that the woman returns after four weeks to confirm that she is not pregnant. “There is no known harm to the woman, the course of her pregnancy, or the fetus if CICs, P, or R are accidentally used during pregnancy.”</p> <p>“Clarification: It is desirable to have blood pressure measurements taken before initiation of combined injectable contraceptives (CIC), patches (P), or ring (R) use. However, in some settings blood pressure measurements are unavailable. In many of these settings, pregnancy morbidity and mortality risks are</p>

		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.”	high, and CICs, P, or R may be one of the few methods available. In such settings, women should not be denied use of CICs, P, or R simply because their blood pressure cannot be measured.”
Male Condoms	No age limits specified.	No limitations specified.	Other Category 3 and 4 conditions from the WHO MEC which contradict use of injectable hormonal contraceptives are not outlined in the South Africa national guidelines. Allergy to latex is a Category 3 condition.
Female Condoms	No age limits specified.	No limitations specified.	Allergy to latex is a Category 3 condition.
Emergency Contraceptive Pills (ECPs)	No age limits specified.	“CAUTION! Tablets must be taken within 72 hours of unprotected intercourse... 2 tablets within 72 hours of unprotected intercourse and 2 tablets 12 hours later.”	ECPs may be used up to 120 hours after unprotected intercourse.
Male Sterilization	No age limits specified.	No limitations specified.	No discrepancies.
Female Sterilization	No age limits specified.	“Female sterilization may be performed immediately postpartum by a trained and experienced operator, or after an interval at a time that suits the client.”	The WHO MEC cautions that female surgical sterilization should be delayed in the case of post-abortion sepsis or fever; severe post-abortion hemorrhage; acute haematometra or severe trauma to the genital tract. If the woman has experienced uterine perforation has multiple risk factors for cardiovascular disease or has vascular disease; complicated valvular disease; endometriosis; AIDS; pelvic TB; nephropathy, retinopathy or neuropathy related to diabetes; other vascular disease of diabetes of >20 years’ duration; severe cirrhosis; hyperthyroid disorder; coagulation disorders; chronic asthma, bronchitis, emphysema or lung infection; fixed uterus due to previous surgery for infection, or abdominal wall or umbilical hernia, the sterilization procedure should be undertaken in a setting with an experienced surgeon and staff, equipment needed to provide general anaesthesia, and other back-up medical support. For these

conditions, the capacity to decide on the most appropriate procedure and anaesthesia regimen is also needed. Alternative temporary methods of contraception should be provided, if referral is required or there is otherwise any delay.

Sterilization should also be delayed until when the woman has any of the following conditions: pregnancy; 7-42 days postpartum; severe pre-eclampsia or eclampsia; prolonged rupture of the membranes postpartum; puerperal sepsis, intrapartum or puerperal fever; severe antepartum or postpartum hemorrhage; current DVT, major surgery with prolonged immobilization; current ischaemic heart disease; unexplained vaginal bleeding; malignant gestational trophoblastic disease; cervical cancer awaiting treatment, endometrial or cervical cancer; current PID; current purulent cervicitis, chlamydial infection or gonorrhoea; current gall-bladder disease; active viral hepatitis; anemia (Hb < 7 g/dl); abdominal skin infections; acute bronchitis or pneumonia; systemic infection or gastroenteritis; emergency abdominal surgery; or any other infectious condition.

Source: [2002 National Contraceptive Policy Guidelines](#) and [2003 Primary Health Care Service Delivery Guidelines](#). Comparison provided by Roberto Rivera, Director of the Protection of Human Subjects Committee at FHI, 2006.

Though South Africa has published its national guidelines, knowledge about whether they are effectively distributed and carried out is much less certain. As excerpted from FHI's March 2005 South Africa assessment, [Family Planning Needs in the Context of the HIV/AIDS Epidemic](#):

. . . the government has developed many guidelines and strategic plans, including the National Contraceptive Policy Guidelines. . . Both family planning and HIV/AIDS policies are disseminated similarly, mainly through workshops, in-service trainings, and meetings. Some non-governmental service providers mentioned discovering policy documents accidentally or downloading them from the Internet, implying that the private sector (which serves 15 percent of family planning users and 25 percent of health service users in South Africa) often is excluded from policy training programs. Indeed, one nongovernmental key informant commented that policies and guidelines “*are never officially distributed to us.*” This statement should not be generalized, however. In fact, the National Contraceptive Policy Guidelines and the Adolescent Reproductive Health Policy Guidelines were formally launched by the Minister of Health at Prince Mshyeni Hospital in Umlazi in October 2002. . . Most respondents were at least somewhat satisfied with existing family planning policies, but no respondent indicated satisfaction with the level of implementation of the policies. Implementation appears to be hindered by a lack of trained and knowledgeable staff, high turnover of existing staff, and inadequate dissemination of policies.¹⁸

Quality of Care

While information about the Department of Health's quality of care assessment system is limited, FHI's South Africa staff report that a set of indicators related to reproductive health and family planning services are routinely collected by hospitals, clinics, and mobile units as part of the District Health Information System (DHIS). The information is then used by provincial- and national-level Department of Health officials to assess utilization of services and to make management and planning decisions.

The types of data collected include terminations of pregnancy rates, male sterilization rates, female sterilization rates, and woman-year protection rate. Woman-year protection is calculated using the following data elements: IUDs inserted, oral pill cycle, Medroxyprogesterone injections, Norethisterone enanthate injections, male condoms distributed, and female condoms distributed. Stock-outs of male condoms and injectables form part of the drug management indicators, which are also routinely collected¹⁹.

Facilities and services

Most of South Africa's public health care facilities provide family planning services. According to the [2003 National Primary Health Care Facilities Survey](#), 3182 public sector clinics and community health centers exist in South Africa.²⁰ Of the randomly selected 437 facilities included in the survey, an average of 88 percent offered contraception and 80 percent offered emergency contraception at least five days a week.

Table 2 provides a list of the types and costs of contraception available in public health facilities, as well as the brands and costs of condoms sold in pharmacies.

Table 2: Cost of Contraceptives in the Public Sector, and Cost of Condoms in the Private Sector, South Africa

Contraceptives available in public sector	Cost to client, in South African rands
Intrauterine devices (IUDs)	(No data available)
Triphasil (levonorgestrel and ethinyl oestradiol)	R3.49 per month (US\$.58)
Other oral contraceptives (Microval)	R4.45 per month (US\$.74)
Male condoms	Free in most facilities
Female condoms	(No data available)
Emergency contraceptive pills (ECPs)	Free
Medroxyprogesterone acetate injectable (DMPA)	R4.87/vial (US\$.81)
Noresthisterone enanthate injectable (NET-EN)	R7.62/vial (US\$ 1.27)
Female sterilization	(No data available)
Male sterilization	(No data available)
Condoms available in pharmacies	Price for pack of 3
Durex	R25 (US\$ 4.20)
Contempo	R15 (US\$ 2.50)
Lovers Plus	R8 (US\$ 1.30)
Trust	R5 (US\$.80)
Female condoms	R60 (US\$ 10.00)

Source: Department of Health, Limpopo Province Medical Depot, Kalapeng Private Pharmacies in Pretoria and Midrand. Data provided by FHI/South Africa staff, May 2006.

EC is generally available free of charge at public sector health facilities in South Africa in the form of cut-up combined oral contraceptives and are approved for over-the counter sale in pharmacies.²¹ Condoms are usually offered free to youth at South Africa's public sector clinics and through many other non-clinical venues around the country.²²

Sonja Martin, Project Director FHI/South Africa, points out that provinces in South Africa function autonomously in terms of health care provision and that health services differ nationwide depending on each province's priorities and budgets. Thus it is important to note that national statistics on service delivery, such as those found in the [National Department of Health's 2004-5 Annual Report](#), fall short of providing an accurate picture of the disparities in health care service provision across South Africa. For province-specific information, refer to the annual reports submitted by each province, which are also available through the Department of Health.

For information on family planning service standards, refer to the in-depth program review chapter of the [Clinic Supervisor's Manual \(2003\)](#)²³ published by the [National Department of Health](#).

Method mix

According to the [2002 National Contraceptive Guidelines](#), the following methods "should always be available and in stock at all health facilities:"²⁴

- *Male condoms*: Should be widely promoted for dual protection.
- *Oral contraceptives*: Low-dose combined and progestin-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.

[Research by the Population Council](#) in the KwaZulu-Natal province found that of the 12 rural public clinics surveyed in 2002 :

All clinics provide progesterone-only pills, combined oral pills, 3 and 2 monthly injectables, and male condoms to their clients. Only one intervention clinic reported offering counseling on natural family planning. Two intervention clinics and one comparison clinic reported providing emergency contraception, while female condoms, spermicides, diaphragm, IUCD, and Norplant® implants were not provided in any clinics.²⁵

The 2002 National Contraceptive Policy Guidelines ([Part 1](#) and [Part 2](#)) outline the country's goals to increase accessibility to family planning by improving the range of methods and services available in health facilities. See Table 3 for a summary of these plans.

Table 3: The Range of Family Planning Methods and Services the Public Sector Must Provide to Increase Accessibility, by Level of Service Delivery

Level	Method	Service	Provider
Community	Male and female condoms, COCs, POPs, ECPs, NFP and LAM.	Method provision and information on correct and consistent use. Education and counseling for all available methods. Provision of limited selection of methods. Pregnancy testing. Management of other sexual and reproductive health needs in line with national guidelines.	Condoms: easily accessible outlets (schools, workplace, shops, petrol stations). All other methods: a wide range of service providers and access points, including trained CBDs, Environmental Health Officers (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 of the above, plus injectables.	IEC and provision of wider range of methods. Breast and pelvic examination. Management of other sexual and reproductive health needs in line with national guidelines.	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 of the above, plus IUCDs.	IEC and provision of wider range of methods. Management of other sexual and reproductive health needs in line with national guidelines.	All of the above, plus general practitioner.
Community health centers and district hospitals	All of the above, plus vasectomy and tubal ligation.	All of the above but for the range of all methods. Management of other sexual and reproductive health needs in line with national guidelines.	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 and academic centers	All of the above.	Routinely all of the above for inpatients and exceptionally for outpatients. Primary service for referrals and problems beyond the capability of community health centers and district hospitals.	Hospital medical staff with specialized training.

Source: 2002 National Contraception Policy Guidelines, [Part 2](#).

Changes to the method mix

National efforts are underway to increase the access to and use of emergency contraception and female condoms. In 2000, the South African Medicines Control Council reclassified emergency contraceptive pills (ECPs) to permit pharmacists to sell them without a doctor's prescription.²⁶ However, according to 2002 research, knowledge and use of ECPs are still low in South Africa,²⁷ and a national effort continues to encourage access to and use of ECPs in the country. As reported in [research from the African Journal of Reproductive Health](#), emergency contraception (EC) is most commonly available in the form of Ovral-

28® oral contraceptive pills cut into sections, while dedicated products are more costly and used less.²⁸

For more information about emergency contraceptive pills, refer to the report from the June 2005 [Emergency Contraception Strategy Meeting](#), organized by the Reproductive Health and HIV Research Unit (RHRU) of the University of Witwatersrand, Johannesburg.²⁹

In partnership with RHRU, FHI and the Society for Family Health (SFH), the National Department of Health launched the National Introduction of the Female Condom Program in eight provinces in 1998.³⁰ The National Department of Health wanted to expand female condom distribution beyond family planning service delivery points. In the context of dual protection promotion, female condoms were initially distributed in approximately 120 sites that included services targeting individuals at elevated risk for STI transmission, such as men in the workplace, adolescents, sex workers, and persons living with HIV/AIDS.³¹

Since the start of the program, the numbers of female condoms distributed at these sites have increased annually. Currently, the Department of Health is also distributing female condoms in non-clinical sites, including truck stops, brothels, universities, and workplaces. In 2005, 2.4 million female condoms were procured for use in South Africa, up from 1.2 to 1.3 million in previous years. By the end of 2005, an additional 90 master trainers and 902 health care providers were trained through the program. Greater expansion is planned for 2006, with an eventual 250 female condom distribution sites. According to FHI's South Africa staff, statistics about the distribution of female condoms are now routinely collected as part of the Department of Health's District Health Information System (DHIS).

Female condoms are also available and sold in private pharmacies. However, private pharmacists who were informally interviewed admitted that the sales for these are very low. Even among people with access to financial medical assistance and those who can afford the female condoms, they remain unpopular. Many South African women complain about the difficulty in using and inserting the female condom and the added interruptions during intercourse as well as the fact that they are expensive. The female condom is heavily subsidized in South Africa; even so, the cost to those that purchase female condoms is roughly three times that of the male condom.³² Cost remained the greatest barrier to further use, as reported at the time of the [2003-4 South African Health Review](#).

The HIV Center for Clinical and Behavioral Studies at Columbia University, in partnership with the Reproductive Health Research Unit Wits Health Consortium of South Africa, is conducting [a five-year project \(2004-2009\) to promote female condom use](#) among South African university students.

For more information and updated results related to the National Introduction of the Female Condom Program in South Africa, refer to the PowerPoint presentation [Country Experiences in South Africa](#) developed by FHI's Theresa Hatzell-Hoke in September 2005.

Trends in the family planning program

As excerpted from FHI's 2005 assessment [Family Planning Needs in the Context of the HIV/AIDS Epidemic](#),³³

. . . key informants were mixed in their opinions of how the HIV/AIDS epidemic has affected family planning funding. Some speculated that family planning funding has remained stable, while others argued that family planning funds have been diverted to fight the HIV/AIDS epidemic.

One representative of a top donor agency supported the view that family planning may be receiving little attention, highlighting the focus of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) fund: "Due to the focus on the PEPFAR key areas of 2-7-10, reproductive health and family planning is becoming less relevant . . . only projects that address the 2-7-10 agenda are being given attention at all levels." Others expressed concern that high contraceptive prevalence could be in danger because of inadequate attention to and funding for delivery of family planning services.

Contraceptive supply

Contraceptive supply in South Africa is generally sufficient. The [2003 National Primary Health Care Facilities Survey](#)³⁴ shows that both injectable and oral contraceptives are almost universally available across the country.

The [2003-4 South African Health Review](#) states that the [National Department of Health](#) "is responsible for procurement and distribution of male condoms to primary sites in all provinces. The system of distribution has been improved by the introduction and maintenance of the Logistic Management Information System (LMIS). The system facilitates continuous supply of condoms on the basis of consumption."

Results of the [National Baseline Assessment of STI and HIV Services in South African Public Sector Health Facilities 2002/2003](#), conducted by the [National Department of Health](#), show that of 962 randomly selected facilities across the country, only 3.9 percent were out of stock of male condoms at the time of the survey.³⁵

[Research by the Population Council](#) showed that 11 of the 12 rural public clinics in their study had stockouts of emergency contraceptives, while 2 out of 12 had stock-outs of male condoms.³⁶

FHI's South Africa staff report that the Minister of Health and senior NDOH officials have made it clear that, for the sake of sustainability, South Africa should not accept donor support for commodities. They plan instead to use donor funds to strengthen supply systems which will then help to ensure availability of these commodities.

Community-based distribution (CBD)

There is limited literature available about CBD programs in South Africa. It is known, however, that six percent of the facilities surveyed in the [2003 National Primary Health Care Facilities Survey](#) offered contraceptive and family planning outreach services.³⁷

The [1998 CBD report](#) funded by the [Planned Parenthood Association of South Africa \(PPASA\)](#), reported that a PPASA-led CBD pilot program project was conducted in Khayelitsha, Cape Town from 1996-1998.³⁸ The program was a door-to-door service in which oral contraceptive pills, condoms and reproductive health education were offered to the community. The project was implemented in collaboration with two other

nongovernmental health organizations, South African Christian Leadership Assembly (SACLA) and Zibonele, a project that provides health care and education information in Cape Town via radio and community-based distribution programs.

For more information about the PPASA-led CBD program, refer to the results of a study entitled [An Evaluation of the Community-Based Distribution \(CBD\) of Contraceptives Program in Khayelitsha, Cape Town: A Follow-Up Survey](#),³⁹ which assessed the impact of the CBD pilot program by determining changes in reproductive health behavior and attitudes among women and men. The study found that that the CBD pilot program “served a substantial part of the market for the oral contraceptive pill.” While overall contraceptive prevalence did not increase over the two years of the pilot program, oral contraceptive use increased among young South African women, as well as among women who had previously been users of injectable contraceptives.

Research conducted by FHI has pointed out that CBD approaches can improve access, method mix, and cost in South Africa. As excerpted from a [1999 issue of Network](#):⁴⁰

. . . the [Planned Parenthood Association of South Africa](#) included the costs clients pay (travel and time lost from work) to evaluate clinic and community-based distribution costs. Clinics provided only injectables, oral contraceptives and condoms, not methods that result in a high number of CYPs -- such as sterilization and intrauterine devices -- which would skew calculations in favor of clinics. CBD workers provided pills and condoms. When client costs were included, CBD was cheaper (than clinics), about U.S. \$42 per CYP compared to U.S. \$44 per CYP at clinics. Also, the CBD cost declined to U.S. \$25 per CYP in the second year, since community agents often provide only information during initial visits . . . “CBD is comparable in cost to clinic provision, and may, in fact, provide significant money savings,” concluded Edina Sinanovic, a health economist at the University of Cape Town Medical School, who conducted the study. The study found that CBD services may also save money by allowing professional clinic staff to devote more time to services that require more expertise.

According to the [2002 National Contraceptive Policy Guidelines](#), all CBD agents are required to be supervised by a nurse.

Provider knowledge of family planning methods

Health providers in South Africa learn about family planning methods during medical, pharmacy, or nursing training while at the university. Previously, nurses participated in a two-day family planning training while in clinical practice, but this has since been phased out of the standard curriculum. Currently, family planning topics are covered in nursing schools only superficially as part of an HIV/AIDS course. There is a general consensus among health care providers that a separate, in-depth training course on family planning is needed in the standard medical curriculum.

Most private providers are offered some training by pharmaceutical companies that manufacture oral or injectable contraceptives. The leading manufacturer of contraceptives in South Africa, Schering-Plough, provides technical contraceptive training through their medical representatives.

Provider knowledge about emergency contraception has considerable room for improvement. Results of a [2003 study of 28 pharmacies](#) sampled from Soweto and the Johannesburg Central Business Districts showed that a substantial number of pharmacists in these areas believe that emergency contraceptive pills (ECPs) are not appropriate for women under the age of 18 and that repeated use of ECPs is related to health risks. The pharmacists admitted denying access to minors and said they are reluctant to provide the method to women on repeated occasions.⁴¹

The [2003 situational analysis on emergency contraception](#) (EC) found that among the 197 providers interviewed in three provinces, “knowledge of EC was relatively good . . . Although most providers had a reasonable knowledge of EC mode of action, 12 providers believed that EC pills were abortifacients.”⁴²

Family Planning in the Context of HIV

HIV statistics

According to the [2005 UNAIDS AIDS Epidemic Update](#), approximately 21.5 percent of adult South Africans (aged 15-49 years) are infected with HIV. Currently, 5.3 million South Africans are estimated to be living with HIV/AIDS.⁴³

Women are disproportionately affected by the epidemic. According to the Department of Health, HIV prevalence is highest among women aged 25–34 years, with more than one in three in this cohort estimated to be HIV-infected. Prevalence in women aged 20–24 years is nearly as high, with almost one in three infected. The [2005 South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey](#) reports a 19 percent prevalence rate among women aged 15-49 years, compared to 13.7 percent among men of the same age range.⁴⁴ In 2004 nearly 30 percent of the pregnant women attending antenatal care clinics were HIV-positive.⁴⁵

The dominant mode of transmission for HIV is heterosexual intercourse, and the disease is spreading fastest in provinces which contain highways and other major transport links to neighboring countries.⁴⁶ The UNAIDS update states that South Africa’s epidemic “shows no sign of relenting.”

AIDS-related deaths in South Africa are commonly attributed to tuberculosis or other AIDS-related conditions, without any reference to the underlying HIV disease on the death certificate.⁴⁷ As a result, cause-of-death statistics in South Africa cannot be taken at face value. [UNAIDS South Africa page](#) estimates the 2003 AIDS-related death count at 370,000 [range: 270,000 – 520,000], including adults and children.⁴⁸

The [2004 UNAIDS Report of the Global AIDS Epidemic](#) estimated the number of orphans and vulnerable children (OVC) living in South Africa in 2003 to be 1.1 million.⁴⁹ For more information about OVC in South Africa, refer to a [2004 Research Update by the Population Council’s HORIZONS program](#)⁵⁰ as well as the Joint Working Paper of the Children’s Institute and the Centre for Social Science Research, University of Cape Town entitled “[But](#)

[Where Are Our Moral Heros?": An Analysis of South African Press Reporting on Children Affected by HIV/AIDS.](#)⁵¹

For additional statistics related to HIV in South Africa, refer to the [2005 South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey](#) and the [2004 UNAIDS/WHO Epidemiological Fact Sheet](#) for South Africa.

National integration strategies

FHI's 2005 assessment [Family Planning Needs in the Context of the HIV/AIDS Epidemic](#) reports five key findings:⁵²

- The incidence of HIV/AIDS in South Africa appears to be stabilizing, and is actually decreasing among young people. Women remain disproportionately affected by the disease.
- The level of contraceptive use is generally high in South Africa, but so is the prevalence of HIV/AIDS. Lack of promotion of contraceptive methods that offer dual protection against both pregnancy and HIV/AIDS is a gap in reproductive health services.
- Although sexual activity often begins during adolescence, the reproductive health needs of youth are not being addressed adequately.
- Almost no attention has been paid to the specific reproductive health needs of South African men. This has largely negated the use of couples counseling, a cornerstone of family planning and HIV/AIDS services.
- Key stakeholders agree that integrating family planning and HIV/AIDS services is both necessary and feasible, although they disagree as to the level of integration that should be pursued.

As excerpted from this assessment,

Several policies and strategies—particularly those addressing HIV/AIDS—acknowledge linkages between family planning and HIV/AIDS. The comprehensive [HIV/AIDS Strategic Plan for South Africa](#) mentions family planning in the context of PMTCT in that it advocates to *“improve family planning services to known HIV-positive women.”*⁵³

To accomplish this goal, the country's stated strategy is “to train reproductive health providers on HIV/AIDS counseling and improve access to comprehensive reproductive health services for HIV positive women.” Lead agencies in this effort are the [Department of Health](#), the Women's Sector, NGOs, and the [National Progressive Primary Health Care Network \(NPPHCN\)](#).

The [2003 Operational Plan for Comprehensive HIV/AIDS Care, Management and Treatment for South Africa](#) mentions family planning only once: “In addition to assessing the efficacy of the interventions, research is needed to understand and improve the organization, management, access, delivery, cost-effectiveness, and cost utility of health care, family planning, social services, drug treatment services, and alcoholism treatment that reduce HIV risk behaviors and transmission.”⁵⁴

The Population Council conducted a [2004-2005 study of reproductive intentions and choices among HIV-infected individuals](#) in Cape Town and found major integration policy gaps. One of the key recommendations was the “need for specific and overt policy that can

help to ensure reproductive choice and improved access to contraception and other reproductive health services for HIV-positive individuals.”⁵⁵

For more information about national integration strategies in South Africa, refer to the POLICY Project’s 2004 report, [An Analysis of Family Planning Content in HIV/AIDS, VCT and PMTCT Policies in 16 Countries](#).⁵⁶ The report is extremely thorough and discusses important references to family planning within the country’s HIV/AIDS, VCT, and PMTCT policies.

The analysis also points out that the South African Development Community (SADC) developed a set of model VCT guidelines in 2002, which are meant to serve as a resource for other countries establishing their own national guidelines and programs. These model guidelines identify family planning as one of the six essential components of a comprehensive VCT program. South Africa’s HIV and PMTCT policies are similarly as comprehensive. Indeed, South Africa is the only country among the 16 in the analysis in which family planning is mentioned all three of the documents reviewed (national HIV/AIDS, PMTCT, VCT guidelines).

Target areas for improvement

FHI’s 2005 South Africa assessment, [Family Planning Needs in the Context of the HIV/AIDS Epidemic](#), offered its recommendations about where program- and policy-level improvements to family planning and HIV integration could be made.⁵⁷

These include:

- Reproductive health outreach programs for youth should be established through schools and youth groups.
- Family planning, VCT, and PMTCT services should address gender issues and increase male involvement through a renewed focus on couples counseling.
- Incentives such as increased salaries and allowances should be explored to halt the “brain drain” among health professionals.
- Integrated professional training should be established for family planning and HIV/AIDS staff. This training should emphasize dual-protection counseling and update trainees on the medical eligibility criteria for contraceptive use among HIV-infected women.
- The disbursement of social and HIV/AIDS grants should be strictly monitored and evaluated to minimize abuse.

It is important to note that under the CRTU, FHI’s activities address outreach for youth. The “ABC Approach for Youth on University Campuses in South Africa” (FCO 153101) informs university students about specific risks for HIV/STIs and unintended pregnancy and educates them in specific life skills to help them adopt ABC behaviors. This subproject, originally funded under the CTR, now continues under the CRTU.

Dual protection

The 2002 [National Contraception Policy Guidelines](#) mandate that health care providers counseling clients about family planning and HIV should promote dual protection.

From 2001-2005, FHI worked with RHRU and the National Department of Health on a project entitled [Expanding Dual Protection Strategies \(FCO 9481\)](#) to 1) design a training and

monitoring system on dual protection strategies for health care workers in South Africa; 2) expand female condom distribution; and 3) provide technical assistance to the RHRU on an assessment of whether use of barrier method protection is greater among FP clients who have access to male and female condom or to male condoms only. The results of the project's 2003 survey among 3,700 clients in 24 primary health care facilities showed the following:

While 70% perceived themselves to be at risk of STI/HIV transmission, only 38% reported using a condom for their last sex act. While nearly all respondents had heard of condom use for dual protection, just under half had ever used a condom alone for dual protection against pregnancy and infection. Condom use alone for dual protection was significantly higher (55%) among younger women in the age group 15-24 years and decreased drastically in older women (>35 years) with only 6% reporting condom use for dual protection ($p=0.02$). Concerning use of condoms with another form of contraception, 61% of respondents had heard of dual method use while 25% had ever used a condom with another method for dual protection. Main reasons for non-use of condoms were partner preferences (46%) and relationship factors 17%. Least mentioned were access and lack of knowledge.

The [Situational Analysis Focusing on HIV/AIDS Services](#) conducted by the Population Council examined services provided to 89 new family planning clients in 58 clinics in the KwaZulu-Natal province. The results showed that 73 percent of family planning clients were encouraged to use condoms for STI/HIV protection and 55 percent for pregnancy protection. Forty-five percent received encouragement to use condoms for both STI/HIV and pregnancy prevention.⁵⁸

In a [2001 study](#) of sexually active men and women aged 15–24 in KwaZulu-Natal, 59 percent of young people surveyed said that they used condoms during their last sexual intercourse, including six percent who used them along with another method. The most commonly cited reason for using condoms (64 percent of users) was protection against both pregnancy and HIV infection. Overall, young people who considered pregnancy as “highly problematic” were nearly twice as likely (OR 1.4 – 2.3) to use condoms as young people who viewed pregnancy as “no problem.”⁵⁹

For more information on the dual protection method in South Africa, refer to the results of a study on [Dual Method Use in South Africa](#), published in a 2002 issue of the *International Family Planning Perspectives*. This study interviewed 554 individuals obtaining condoms at 12 public primary care sector facilities throughout the country and found that 16 percent of them reported using both a condom and another form of contraception at their most recent sexual encounter.⁶⁰ The authors of this research concluded that, “the implementation of STI and pregnancy risk assessment and counseling and the promotion of dual protection in primary health care settings have the potential to increase dual method use in South Africa.” Despite such comments, however, there remains some skepticism as to the ability of dual method promotion to make a significant difference in the fight against AIDS, as voiced by Helen Rees at FHI's Contraceptive Technology Research Program's Technical Advisory Committee meeting in 2005.

Integration of Family Planning through Other Services

Table 4 provides a list of known family planning and HIV service integration activities currently underway in South Africa.

Table 4: Known Integration Research Projects in South Africa, as of December 2005[‡]

Objective	Public health rationale	Study design	Geography, target group, dates	Project contact info
To determine the feasibility, effectiveness, and cost of implementing a nurse-driven, integrated post-rape care program including HIV PEP and emergency contraception, within the rural, public sector health services.	In settings with HIV prevalence, rape survivors need care for the possibility of both pregnancy and HIV infection.	Diagnostic phase will involve an assessment of existing attitudes, practices, and services related to post-rape care. In addition, it will be used to refine the intervention “package” to be tested. Intervention phase will assess and document the feasibility, impact, and costs of the intervention, which include training of health care workers and establishing a Rape Care Network.	Limpopo Province, South Africa Providers Rape survivors	FRONTIERS in Reproductive Health project Ian Askew iaskew@pcnairobi.org
To examine the feasibility of alternative strategies for serving the family planning needs of PMTCT clients, and to test the effectiveness of an identified strategy in increasing FP uptake.	Even though South Africa’s national service delivery guidelines advocate for FP provision in the PMTCT package, few efforts have been made to integrate the two services. The purpose of this study is to gather evidence on the potential synergies of family planning and PMTCT services, and to provide guidance on possible integration strategies.	The study will be conducted in two phases. Phase 1 will consist of formative research to assess clients’, providers’, and managers’ perspectives on potential integration mechanisms between FP and other MCH services. Results will be fed back to program managers, who will select a strategy for testing. Phase 2 will consist of operations research to test the selected strategy’s impact on FP uptake among post-partum women.	South Africa PMTCT clients October 2005 – March 2007	Family Health International (FHI) Theresa Hatzell Hoke thatzell@fhi.org

[‡] This does not include newly proposed activities in FHI’s 2006-07 Workplan.

Visit the [Electronic Information System \(EIS\)](#) for more information about Year 2 CRTU activities.

<p>To test the acceptability, feasibility, and cost of two different models of integration of counseling and testing for HIV into family planning services in South Africa and to evaluate the effectiveness of the best model against standard practice.</p>	<p>Providing VCT to family planning clients in a high FP prevalence setting will increase access to and use of VCT services among a population at risk.</p>	<p>To determine whether educating FP clients about VCT and offering counseling and testing for HIV within a routine FP visit by a FP provider is more or less acceptable and feasible than educating FP clients about VCT and referring interested clients for testing and post-test counseling to a specialized VCT service.</p> <p>To compare the two models of VCT integration into FP services with the standard FP service in terms of the quality of family planning services, the intention to use VCT, and the cost per FP client.</p> <p>To evaluate the effectiveness of the more feasible model with respect to:</p> <ol style="list-style-type: none"> a. Uptake of VCT by FP clients b. Uptake and use of dual protection by FP clients. 	<p>North West Province, South Africa</p> <p>Providers</p> <p>FP clients</p> <p>2004 - 2006</p>	<p>Saiqa Mullick smullick@pcjoburg.org.za</p>
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Source: FHI's [Electronic Information System \(EIS\)](#), December 2005.

Family planning through voluntary counseling and testing (VCT)

The [2004 Health Services Coverage report](#) calculates that at the end of 2003, there were 1,625 sites providing VCT services and that 212,289 VCT clients had been served that year.⁶¹

While South Africa's VCT guidelines refer to family planning provision, formal integration of the two services in South Africa is limited. FHI's 2005 [Family Planning Needs in the Context of the HIV/AIDS Epidemic](#) assessment points out that,

South Africa's VCT guidelines mention family planning as part of providing comprehensive care for people with HIV/AIDS and as part of pretest counseling on "safer sex strategies to reduce risk." Family planning services are mentioned in the guidelines for feeding infants of HIV-positive mothers as part of the comprehensive care these mothers may need. The National Contraceptive Policy Guidelines ([Part 1](#) and [Part 2](#)) highlight the dual role of barrier methods in protecting against pregnancy and sexually transmitted infections (STIs) including HIV/AIDS, and acknowledge HIV/AIDS as a specific reproductive health concern.⁶²

Results from the [National Baseline Assessment of STI and HIV Services in South African Public Sector Health Facilities 2002/2003](#), conducted by the National Department of Health, show that of 962 randomly selected primary health care facilities across the country, 53 percent consider themselves designated VCT sites.⁶³

A [Situational Analysis Study Focusing on HIV/AIDS Services](#), conducted in 2003 in the KwaZulu-Natal province in South Africa, looked at reproductive health services and reported that voluntary counseling and testing (VCT) was offered in only 52 percent of the 98 service delivery points involved in the study.⁶⁴ Of the 67 VCT clients observed in this study, 78 percent were women and 22 percent were men. Staff turnover and exodus were noted as problems that need to be addressed along with the need to expand access to VCT and STI services.

The Population Council is conducting a study called [Feasibility, Effectiveness, and Cost of Models of Integrating Counseling and Testing for HIV within Family Planning Services in South Africa](#) which will end in July 2006. As excerpted from their Web site:

FRONTIERS is working in collaboration with the Maternal Child and Women's Health cluster of the National Department of Health to provide programmatic guidance on how to make counseling and testing for HIV more widely available through family planning services and on the most feasible and effective ways of doing this. The study will determine whether educating family planning clients about voluntary counseling and testing (VCT) for HIV within routine family planning visits is more acceptable than referring clients for specialized VCT services. Researchers will compare the two models of VCT integration in terms of the quality of family planning services, the intention to use VCT, and the cost per family planning client. The study will also evaluate the effectiveness of the more feasible model with respect to the uptake of VCT and use of dual protection by family planning clients.⁶⁵

For more information about family planning and VCT service integration in South Africa, refer to the article [Integration of Sexual and Reproductive Health Services in KwaZulu-Natal, South Africa](#)⁶⁶ and an [ID21 Research Brief](#).⁶⁷

Family planning through prevention of mother-to-child transmission (PMTCT) services

Literature regarding PMTCT service integration with family planning services in South Africa is limited. However, some of the country's national HIV policies make reference to family planning in the context of PMTCT:

- The National Department of Health's [2002 Circular Minute on PMTCT](#)⁶⁸ recommends that pre-test counseling include individual sessions on contraception.
- As one of the objectives in its goal to reduce MTCT, [South Africa's national HIV policy](#) states, "Improve family planning services to known HIV-positive women."

Results from the [National Baseline Assessment of STI and HIV Services in South African Public Sector Health Facilities 2002/2003](#), conducted by the National Department of Health, show that of 962 randomly selected primary health care facilities across the country, 29 percent consider themselves designated PMTCT sites.⁶⁹ The [2004 WHO Health Services Coverage report](#) shows that by the end of 2003, 12,000 facilities in South Africa were providing PMTCT services.⁷⁰

Results from the 2003 [National Primary Health Care, Facilities Survey](#), however, showed that throughout the country there is poor availability of PMTCT services. Facilities in the Western Cape and North West provinces showed higher availability of PMTCT, although these still topped out at less than 50 percent.⁷¹

The survey also showed considerable disparities in the degree to which PMTCT services are provided, depending on the province. Fewer than 25 percent of pregnant women who visited facilities offering a PMTCT service were tested for HIV in the Northern Cape, Eastern Cape, and Limpopo, while more than 80 percent were tested in the North West, Free State, and Gauteng. Six of the 10 regions surveyed provided nevirapine to 70-80 percent of women who tested positive for HIV, while facilities in the Northern Cape provided it to 100 percent of pregnant women who tested positive. The Limpopo and Free State regions' facilities provided to only one and five percent, respectively. No facilities provided PMTCT in Mpumalanga.

The [2005 UNAIDS' AIDS Epidemic Update](#) stated that, "Inadequate access to antiretroviral prophylaxis remains a major concern. In South Africa, for example, of some 33,000 pregnant women testing HIV-positive only 18,857 received antiretroviral prophylaxis."⁷²

An important finding from a 2005 study entitled [Integration of sexual and reproductive health services in KwaZulu-Natal, South Africa](#) was that "about 30 percent of both FP and MCH clients felt that they were at medium or high risk of HIV infection, yet received no information or advice on the topic of STIs/HIV."⁷³

For more information on integrated services, refer to the Population Council's 2005 assessment entitled, [Feasibility of Introducing a Comprehensive Integrated Package of Antenatal Care Services in Rural Public Clinics in South Africa](#).⁷⁴

Family planning through antiretroviral treatment (ART) services

The extent to which South Africa has integrated ARV and family planning service provision is not well documented, though it seems there have been some attempts to link the two with policy. The [2004 National ART guidelines](#), for example, state that “it is important to ensure reliable contraception in women of child-bearing age. This should preferably be an injectable contraceptive as well as using a barrier method. If unable to guarantee reliable contraception, nevirapine will be substituted for efavirenz.”⁷⁵

While the [IRIN PlusNews Treatment Map](#) reports a total of 178 sites currently providing ARV treatment in South Africa, the [Kaiser Family Foundation South Africa Profile](#) points out that South Africa still has the highest estimated unmet need for ART in the world. As of June 2005, an estimated 97,000–138,000 people were receiving ART, amounting to only 10–14 percent of those in need.

For more information about ARV treatment in South Africa, refer to the 2005 [WHO Treatment Scale-Up Profile for South Africa](#)⁷⁶ and the Department of Health’s 2003 [Operational Plan for Comprehensive HIV and AIDS Care and Treatment for South Africa](#).⁷⁷

Family planning through post-abortion care (PAC) services

The *Choice on Termination of Pregnancy Act* was passed on February 1, 1997, making South Africa the first country in sub-Saharan Africa where women can legally have an abortion.⁷⁸

According to the 2002 [National Contraception Policy Guidelines](#), “after spontaneous or induced abortion, all women should be offered counseling 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 is IUD insertion after second or third trimester abortion, in which case insertion should be delayed until **four to six** months and another method used in the interim.” FHI’s South Africa staff affirm that family planning is available through post-abortion care services, however, uptake data are unavailable.

Adolescent Reproductive Health

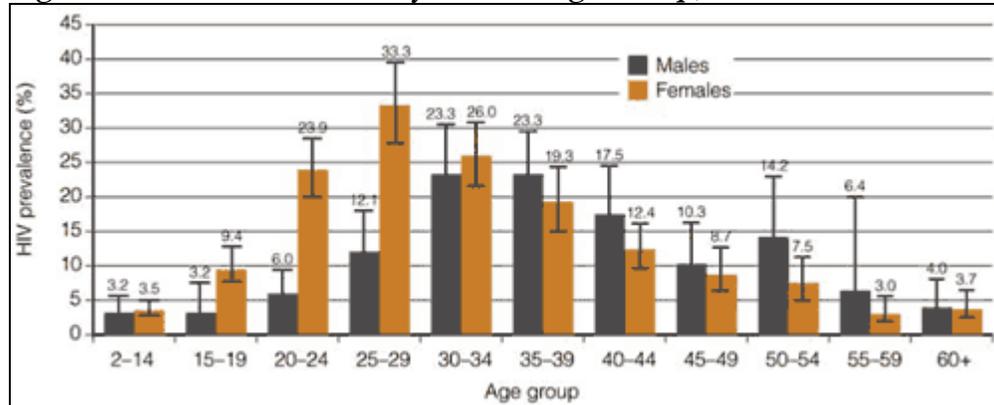
Reproductive health statistics

A 2003 survey entitled, [HIV and Sexual Behaviour among Young South Africans: A national survey of 15-24 year olds](#), reports that the mean age of sexual debut among youths having reported sexual experience was 16.4 years for males (median 16 years) and 17 years for females (median 17 years).⁷⁹ These are considerably younger ages at first sex than those reported during the 1998 DHS, where the median age at sexual debut was reported as 18.4 for males and 18.2 for females.⁸⁰

In 1998, the overall median age at which South African women aged 25-49 years had first given birth was 20.8 years.⁸¹ Stratified, the median age varied widely by level of education [range: 18.8 – 25.6] and by geographical region [range: 19.5 – 23.8]. Specifically, higher levels of education and residence in certain provinces were demographic characteristics associated with a higher median age at first birth.

Among 15-24 year olds in South Africa, 16.7 percent of females and 4.6 percent of males are currently HIV-positive.⁸² (See Figure 5.)

Figure 5: Prevalence of HIV by Sex and Age Group, South Africa 2005



Source: [South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005](#)

Contraceptive use

Contraceptive use among young people in South Africa is relatively high.⁸³ An impressive 28.5 percent of all 15-19-year-old females were using a modern family planning method at the time of the 1998 DHS. Results of the survey [HIV and Sexual Behaviour among Young South Africans: A national survey of 15-24 year olds](#)⁸⁴ show that,

Of the 59 percent of women who reported having had sex in the past 12 months, 57 percent reported that they were currently using a method of pregnancy prevention. Of these women, 58 percent reported that they were using injectable contraceptives, 34 percent reported using the male condom and 13 percent reported that they were using oral contraceptive pills.

Among sexually active youth, 57 percent of males reported using condoms at last sex, as compared to 48 percent of females.⁸⁵

The need for South African youth to further protect themselves from STIs was also documented in the 2004 survey. Among sexually active youth 19 percent of young women and nine percent of young men self-reported experiencing an unusual vaginal or penile discharge in the 12 months prior to the survey. Overall six percent of youth reported having had a genital ulcer during the same time period.

Knowledge and behavior

Based on the results of a [HORIZONS project survey](#)⁸⁶ of approximately 5,000 South African youths, awareness of HIV/AIDS is nearly universal (97 percent). Knowledge about prevention, however, is disproportionately skewed toward condom use, at 89 percent. Relatively few youths (32 percent and 23 percent, respectively) mentioned abstinence or fidelity as HIV prevention methods.

Knowledge disparities were evident between the sexes. The survey reports that,

Females were more likely to report being aware of the existence of an HIV test (82

percent) and dual protection methods (87 percent) than were males (76 percent and 85 percent, respectively). Overall, females were more aware of how to become infected with HIV (mean knowledge score = 1.95) or how to avoid HIV infection (mean knowledge score = 1.87), compared to males (mean knowledge scores = 1.77 and 1.67, respectively).

Females were also more likely than males to know about mother-to-child transmission.

While the youths were quite knowledgeable about condoms and HIV prevention, knowledge about STIs in general or family planning methods other than condoms, was much more limited. For example, only 63 percent of youths had ever heard of sexually transmitted infections. As for family planning methods,

Contraceptive awareness among youth was higher for the male condom (94 percent) than for the injection methods (74 percent), the pill (66 percent), and the female condom (58 percent). Other contraceptive methods, such as the intrauterine contraceptive device (IUD), female sterilization, male sterilization, diaphragm, foam/jelly, emergency contraceptives, lactation amenorrhea, rhythm, and withdrawal were known by less than a quarter of youth each. The menstrual cycle was not well understood by respondents, as indicated by the fact that only seven percent knew the correct time in the cycle when a woman is most likely to get pregnant.

For additional information, refer to:

- [Socioeconomic Disadvantage and Unsafe Sexual Behaviors among Young Women and Men in South Africa](#),⁸⁷ a 2004 Population Council study.
- [Vulnerabilities and Intervention Opportunities: Research Findings on Youth and HIV/AIDS in South Africa](#),⁸⁸ a 2004 Population Council Research Update.
- [Young People in South Africa in 2005: Where We're at and Where We're Going](#).⁸⁹
- [National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005](#).⁹⁰

Youth-centered policies in South Africa

The [Policy Guidelines for Adolescent and Youth Health](#), developed in 2001 by the [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 counseling; integrating sexual and reproductive health services.”⁹¹

Youth-friendly health services

The concept and establishment of youth-friendly health facilities appears to be well-developed in South Africa. During is 2001 [Assessment of Youth Centres in South Africa](#), the [Population Council](#) found that “the vast majority of providers held liberal attitudes regarding young people’s access to RH information and service.”⁹²

The National Adolescent Friendly Clinic Initiative (NAFCI) was a five-year project implemented from 1999-2004, led by the [Reproductive Health Research Unit \(RHRU\) of the University of the Witwatersrand](#). Its main objective was to contribute to making health care facilities more accessible and acceptable to adolescents. Its goals were to:

- expand access to youth-friendly health services including HIV and STD prevention, reproductive health information to young people
- provide HIV/AIDS testing and counseling
- provide care and support services
- promote a holistic approach to the management of adolescent health needs by health care providers
- set national norms and standards for adolescent health care in clinics throughout the country
- promote an appropriate clinic environment for the provision of adolescent health services.

For more information about the NAFCI, refer to the [South African Regional Poverty Network](#) and FHI's article [Programs for Adolescents: Encouraging Youth-Friendly Clinics](#)⁹³ in a 2000 issue of Network.

During the NAFCI project, some of South Africa's first youth policies were developed. Youth-friendly service provision, for example, is mandated in Chapter 4 of the 2001 [Policy Guidelines for Adolescent and Youth Health](#), where strategies include allocating certain days or sessions to youth and adolescents and involving youth in the development of new clinics for young people.⁹⁴

Sexuality education

The government of South Africa's [2000-2005 HIV/AIDS and STD Strategic Plan](#) included provisions to allocate 50 percent of its total national HIV budget toward ensuring that "Life Skills Education" would be implemented in all primary and secondary schools in the country. South Africa's Life Skills Education initiative, according to an [assessment of school-based HIV prevention programs](#) conducted by the Population Council in 2005, aims to reduce the HIV prevalence among students and includes peer education, teacher training, and motivational workshops.⁹⁵ The [WHO's 2004 Health Services Coverage Report](#) shows that 80 percent of primary school children and 72 percent of secondary school children are currently covered by national HIV education.⁹⁶ For more information about Life Skills Education in South Africa, refer to a [2003 evaluation](#) of the program conducted by the Population Council's HORIZONS project.⁹⁷

The [Department of Education](#) is currently working to revise the health education curriculum, especially the sex education program, in public schools. The DoE has endorsed the "School Health and Wellness Plan," which includes closer collaboration with the Department of Health in improving the health of students in South Africa. Part of this plan is to strengthen family planning education and support in schools. The plan also provides a checklist for the basic package of services that improves health and development among students.

The [LoveLife](#) program, with its National Adolescent Friendly Clinic Initiative (NAFCI) component, was launched in 1999. *LoveLife* is a “comprehensive reproductive health program for youth that works to establish national standards for adolescent health care clinics, increase access and acceptability of health services for adolescents and provide public education about reproductive health.” The program is primarily a multimedia social marketing campaign, which organizes TV shows, newsletters, festivals and more, all aimed at raising HIV awareness and knowledge about sexuality among young people. According to *LoveLife*’s [2004 annual report](#), 798 schools in South Africa are now implementing *LoveLife*’s programs. Meanwhile, *LoveLife* also has an outreach program in non-school settings and rural areas to reach youth who fall outside the educational system. For more information about *LoveLife*, view [LoveLife’s 2004 annual report](#)⁹⁸ and [a 2003 study](#) conducted by the Guttmacher Institute to evaluate the *LoveLife* program.⁹⁹

Youth-focused reproductive health programs

In addition to the *LoveLife* program, other reproductive health initiatives for young people in South Africa include UNFPA-DfID Youth Adolescent Reproductive Health Programme (YARHP) and the KwaZulu-Natal’s Provincial Department of Health (DOH) program, both of which are reviewed in this [2003 Population Council report](#).¹⁰⁰ Another KwaZulu-Natal sports program for youth, [Playing for Peace](#), has trained 25,000 children in HIV awareness and basketball since 2000.

Youth-focused social marketing programs

As excerpted from the [Kaiser Family Foundation Web page](#), [LoveLife](#), South Africa’s national HIV prevention programme for youth, was launched in September 1999 . . . *LoveLife* combines a highly visible sustained national multi-media HIV education and awareness campaign with countrywide adolescent-friendly service development in government clinics, and a national network of outreach and support programmes for youth.

For more information about social marketing programs geared toward South African youth, refer to the Population Services International (PSI) report from 2000 called [Social Marketing for Adolescent Sexual Health](#).¹⁰¹ The report evaluates the Social Marketing for Adolescent Sexual Health (SMASH) project, which started in South Africa in 1994 “to increase awareness among policymakers and program managers of the potential effectiveness of social marketing programs for reducing the vulnerability of adolescents to HIV/AIDS.”

PEPFAR and USAID funding restrictions on reproductive health activities

The Mexico City Policy – re-imposed in 2001 – “restricts foreign non-governmental organizations (NGOs) that receive USAID family planning funds from using their own, non-U.S. funds to provide legal abortion services, lobby their own governments for abortion law reform, or even provide accurate medical counseling or referrals regarding abortion.”¹⁰²

A [2003 article by the Guttmacher Institute](#)¹⁰³ described the repercussions of this abortion policy on family planning in South Africa:

White House staff contemplated a situation, for example, in which a South African NGO that provided counseling about abortion, which is legal in South Africa, could receive U.S. HIV/AIDS funds even though it was ineligible for U.S. family planning funds under the pre-existing gag rule. There would be one condition, however: The U.S-

funded HIV program and the non-U.S.-funded family planning programs would have to be entirely “separate.” Under this scenario, if a woman in the NGO’s HIV program wanted family planning, the NGO could not refer her to its own family planning service. It would have to refer her to another “gagged” provider (presuming one exists)—all so the U.S. government could be assured she would receive no information about abortion.

The USAID’s anti-prostitution policy from the [Acquisition and Assistance Policy Directive](#)¹⁰⁴ of 2005 prohibits USAID funds to be used “to promote the legalization or practice of prostitution or sex trafficking,” and requires that recipients adopt a policy “explicitly opposing prostitution and sex trafficking.” Further provisions advise recipients “to not endorse or utilize a multisectoral approach to combatting HIV/AIDS, or to not endorse, utilize or participate in a prevention method or treatment program to which the organization has a religious or moral objection.”

The President’s Emergency Plan for AIDS Relief (PEPFAR) emphasizes the provision of treatment and care for people with AIDS and mandates that 55 percent of its funds will be allocated toward those activities. PEPFAR does not fund condom education or distribution for the general public; instead, it funds such interventions only for certain designated high-risk groups.¹⁰⁵ Twenty percent of PEPFAR funds can go toward HIV prevention activities; however, one-third of these prevention funds must support abstinence-only-until-marriage programs targeting young people.

Ongoing and Planned Reproductive Health Activities

Table 5: FHI/IFH's Subprojects in South Africa, as of January 2006

Subproject Title	Project/Award	FCO	Tech Monitor	Div	Total Approved Budget	Start Date	Projected End Date	Subproject Objective
HPTN 035: Safety and Effectiveness Study of the Vaginal Microbicides BufferGel and PRO2000/5 Gel (P) for the Prevention of HIV Infection in Women	NIH/NIAID /DIADS: HIV Prevention Trials Network Leadership Group	735	KHinson	HPT	US\$ 285,201	11/28/01	1/30/2008	To provide expertise in site assessment and preparedness, study design, protocol development, and site staff training and community development for HPTN 035: Phase II/IIb Safety and Effectiveness Study of the Vaginal Microbicides BufferGel and 0.5% PRO2000/5 Gel (P) for the Prevention of HIV Infection in Women.
HPTN 046: Phase III Trial to Determine the Efficacy and Safety of an Extended Regimen of Nevirapine in Infants Born to HIV Infected Women to Prevent Vertical HIV Transmission during Breastfeeding	NIH/NIAID /DIADS: HIV Prevention Trials Network Leadership Group	746	KHinson	HPT	US\$ 177,971	11/28/01	8/31/2008	To provide expertise in site assessment and preparedness, study design, protocol development, and site staff training and community development for HPTN 046: Phase III Trial to Determine the Efficacy and Safety of an Extended Regimen of Nevirapine in Infants Born to HIV Infected Women to Prevent Vertical HIV Transmission during Breastfeeding.

Documenting PMTCT Best Practices in South Africa	CTR	9403	HReynolds	HSR	US\$ 236,000	01/21/04	8/31/2006	To document the essential components of high-performing PMTCT services and to estimate the cost of replicating these services in other sites in South Africa. In September 2005, this subproject was expanded to Kenya with the following objectives: To determine what elements appear to increase the proportion of HIV+ pregnant women obtaining ARV prophylaxis, delivering in facilities, participating in infant feeding counseling, and getting postpartum family planning methods, and to assist 60 “typical” PMTCT sites to implement these elements identified during activities related to the first objective.
ABC Approach for Youth on University Campuses in South Africa	CRTU	153101	CJagemann	FITS	US\$ 200,000	08/03/05	3/31/2006	To inform university students about specific risks for HIV/STIs and unintended pregnancy and to educate them in specific life skills to help them adopt ABC behaviors.
Enhanced Country Program Implementation	CRTU	113117	TNutley	FITS	US\$ 8,706,661 (for 5 countries, 5 years)	09/08/05	4/28/2010	To identify and prioritize local reproductive health research and program needs in five focus countries; and 2) to facilitate efficient, effective implementation and utilization of reproductive health research and programs in the focus countries.
Improving Continuation Rates for Injectable Contraceptives	CRTU	114102	JBaumgartner	HSR	US\$ 496,386	09/06/05	1/1/2008	The overall study goal is to improve continuation rates for injectable contraceptives. More specifically, it is to develop and test an intervention tool for family planning providers that will: 1) reduce the proportion of DMPA/NET-EN clients who discontinue (i.e., do not come back at all); 2) reduce the proportion of DMPA/NET-EN clients who are late for their re-injections; and 3) increase the proportion of late DMPA/NET-EN clients who leave the clinic with a re-injection or another temporary contraceptive method until their next scheduled re-injection.
Enhancing PMTCT Performance in South Africa	CRTU	153104	WCastro	FITS	US\$ 175,000	9/8/2005	9/30/2006	1) To provide technical assistance to 30 sites in South Africa to design, develop, and implement high quality, comprehensive and cost-effective PMTCT programs, with an emphasis on strengthening family planning counseling and referral; 2) To expand upon lessons learned from previous FHI projects in PMTCT and FP/HIV integration (FCOs 3449, 9403, and 3447).

Strengthening Linkages between FP, HBC, and ARV Services	CRTU	153105	ECanoutas	FITS	US\$ 365,000	09/09/05	9/30/2006	1) To build communication and referral skills of HBC volunteers regarding pregnancy prevention as effective PMTCT approach; 2) To build clinical counseling skills of family planning providers and ARV providers regarding pregnancy prevention as an effective PMTCT approach, and contraceptive methods that are safe for HIV-infected women and HIV-infected women on ARVs; 3) To build the skills of HBC volunteers to provide basic information about VCT, the availability of and access to ARV services, and to assist HBC clients to adhere to the treatment regimen; and 4) To conduct a process evaluation of the subproject.
South Africa: Enhanced Country Program Implementation	CRTU	113123	ECanoutas	FITS	Approved annually	10/27/05	4/28/2010	To identify and prioritize local reproductive health research and program needs in South Africa as a focus country under the CRTU; and 2) To facilitate efficient, effective implementation and utilization of reproductive health research and programs in South Africa.
Acidform Behavioral Data Analysis	CRTU	116101	GGuest	BASS	\$ 198,852	08/26/05	7/31/2006	The overall objective of this subproject is to analyze and synthesize qualitative and quantitative data to understand acceptability of the diaphragm with Acidform gel. Specifically, the behavioral analysis plan aims to: 1) Determine if subjective experience is related to reported use of the product; 2) Identify predictors of positive experiences with, and/or use of, the method; 3) Map experience with, and use of, the product over the course of the trial; 4) Identify co-variables of product experience and use over the course of the trial; and 5) Identify problems associated with correct product usage.

Source: Electronic Information System (EIS), Family Health International. Accessed January 2006.

USAID's Family Planning, Reproductive Health, and HIV Programs

USAID financial assistance to South Africa in the areas of health, population, and nutrition increased substantially from 1999 – 2004; however, funding has plunged dramatically in the past two years. [USAID's budget summary](#)¹⁰⁶ for South Africa shows \$5.2 million obligated toward HIV/AIDS and primary health care for FY 2006, slightly less than the \$5.3 million in FY 2005, but significantly reduced from the \$31 million budget dedicated in FY 2004. For a look at how field support funds were allocated in 2004, refer to [USAID's Mission Field Support budget for FY 2004](#).¹⁰⁷

The 2005 PEPFAR budget for South Africa totals \$148 million, of which FHI received US \$740,000 in 2005. Refer to FCOs 153101, 153104, and 153105 in Table 5, above, for PEPFAR-supported subprojects in South Africa. For additional information, visit the [PEPFAR South Africa page](#).

USAID strategies in South Africa

The overall strategies for FY2006, as excerpted from [USAID's FY2006 South Africa Budget](#), include:

Improving Child Survival, Health and Nutrition (\$3,328,000 CSH). USAID's efforts to strengthen the primary health care delivery system will continue to focus on integrating all services at the clinic level and on delivering a comprehensive PMTCT package at the district level. USAID also will support at least five mentoring initiatives where stronger districts/facilities will provide technical support to weaker districts. USAID plans to support training of health care and community level workers, and will support 10 district-level facilities that promote integration of youth and adolescent reproductive health services into primary health care. All family planning agreements will incorporate clauses that implement the President's directive reinstating the Mexico City policy. Principal contractors and grantees: Management Sciences for Health (prime), and University Research Corporation and Health Systems Trust (subs).

Reducing Transmission and Impact of HIV/AIDS. See the [State Department Congressional Budget Justification](#), Global HIV/AIDS initiative section, for a discussion of this program. (Note: also refer to pages 319-321 in the [State Department's Africa regional budget justification document](#), which gives FY2006 and FY2007 budget estimates.)

Preventing and Controlling Infectious Diseases of Major Importance (\$1,850,000 CSH). USAID will continue to support initiatives to improve the diagnosis and treatment of TB in high prevalence areas, and to increase the capacity of the South African government to manage TB programs. USAID technical assistance activities will expand to a total of 20 districts. In addition, USAID will work closely with universities and research institutions to develop and test innovative models for involving the private sector, including traditional providers and employers, to expand access to TB prevention and control services. USAID also will fund at least five local NGOs in high prevalence areas to promote early detection and treatment of TB.

To reduce treatment interruption rates and improve treatment adherence, USAID will continue to strengthen linkages between health centers and community-based directly observed treatment short course (DOTS) supporters. Principal contractors and grantees include: Management Sciences for Health (prime) and University Research Corporation, Health Systems Trust, and Tuberculosis Coalition for Technical Assistance (subs). All family planning assistance agreements will incorporate clauses that implement the President's directive restoring the Mexico City policy.

The USAID Mission's field support includes several reproductive health activities implemented by partners. As excerpted from [USAID's South Africa Strategy 1997-2007](#),¹⁰⁸ these include:

- Helping South Africa's Education Department conduct studies to determine the impact of AIDS and respond with appropriate policies and activities
- Developing information that school teachers use for HIV/AIDS education
- Providing technical assistance to improve quality and supply management of condoms nationwide
- Improving STI recording/reporting mechanisms and treatment protocol
- Improving access to family planning services and STI treatment
- Developing improved models of healthy behavior change in reproductive health
- De-stigmatizing HIV infection
- Increasing the quality of adolescent health care.

For additional information about USAID's program priorities in South Africa, refer to the [Country Strategic Plan 1996-2005](#)¹⁰⁹ and the [USAID South Africa Mission Web site](#).

Other Country Information

Donors

According to the [USAID's South Africa budget page](#),

Donor coordination remains strong. The United States is the largest bilateral donor and second largest overall donor in South Africa. The European Union (EU) is the largest donor in health, education, criminal justice reform, and community water projects. Other major bilateral donors and their principal areas of focus, in rank order of resources, include the United Kingdom (health, private sector development, democracy and governance, labor and criminal justice); Germany (democracy and governance, education, health and economic policy); and Sweden (democracy, governance, labor, and poverty alleviation). The USG is working closely with several bilateral governments, as well as the EU and the United Nations (UN), on HIV/AIDS research and poverty alleviation. The 13 UN agencies in South Africa focus on HIV/AIDS, rural development, and regional integration. The European Commission will soon launch a major local government initiative in South Africa.

FHI/South Africa staff confirms that the following donor organizations support work in South Africa:

- United Nations Population Fund supports work in RH .Other key UN agencies relating to FHI's work include UNFPA, UNAIDS and UNICEF.
- Australian Overseas Aid Program (AUSAID)
- OXFAM UK
- UK's Department for International Development (DFID)
- Norwegian Aid
- Swedish International Development Agency (SIDA)
- US Centers for Disease Control and Prevention (CDC)
- Japan International Cooperation Agency (JICA)

A donor coordination forum, led by the DOH and the [International Health Liaison Directorate](#), brings together international development agencies working in South Africa to share information. (See “Government entities relevant to FHI’s work”, below, for contact information.)

For additional information about donor-funded reproductive health projects in South Africa, refer to the [Global Fund’s South Africa funding portfolio](#).

For updated information about major donors in South Africa, refer to the [ReliefWeb’s Financial Tracking Service](#), which produces instant reports by year and by donor.

Other donor priorities relevant to the scope of the CRTU

Most private pharmacies and clinics in South Africa serve high numbers of family planning clients and provide the same services as public facilities. Thus, they provide opportunities for collaboration with FHI, including provider training and provision of FHI-developed material for clients. Potential partners include the Community Pharmacists Network, other private doctor associations, and Planned Parenthood Association of South Africa (PPASA), all of which have a presence in most South African provinces.

Government entities relevant to FHI’s work

Several directorates at the National Department of Health are relevant to FHI’s reproductive health and family planning programs. The people that FHI would most likely work with are:

- Dr. Anna Amos, Chief Director, Maternal, Child and Women’s Health
- Dr. Nomonde Xundu, Chief Director, HIV/AIDS & STIs
- Dr. Lillian Makubalo, Chief Director Health Information, Research and Evaluation
- Mr. Bennet Asia, Primary Health, District and Development
- Ms. Mandisa Hela, Pharmaceutical Policy and Planning
- Ms. Catherine Makwakwa, International Health Liaison Directorate

Other potential FHI partners include the following departments and organizations:

- The [Department of Education \(DoE\)](#)
- The [Department of Social Development](#)
- The [South Africa Medical Research Council \(MRC\)](#), which works on a WHO Evidence-based Reproductive Health Care Training Initiative consisting of a four-day workshop targeting policy-makers, medical and nursing staff, and midwives.

Future collaboration in initiatives such as this could expand FHI's work. The South African Cochrane Centre is also part of the MRC.

Refer to [IRIN PlusNews South Africa Country Profile](#) for a complete list of national HIV/AIDS organizations and government entities.

National reproductive health strategies

In terms of addressing reproductive and human rights, South Africa has some of the most progressive reproductive health policies and strategies in the world. For an overview, refer to the 2004 *Reproductive Health Matters* article [Ten Years of Democracy in South Africa: Documenting Transformation in Reproductive Health Policy and Status](#).¹¹⁰

South Africa's National Contraceptive Policy Guidelines ([Part 1](#) and [Part 2](#)), launched in 2002, focus on the client's right to choose and quality of care and reflect the country's priorities in reproductive health. The guidelines' three main objectives are to:

- Remove barriers that restrict access to contraceptive services
- Increase public knowledge of clients' rights, contraceptive methods, and services
- Provide high quality contraceptive services.

Research ethics requirements in South Africa

According to a 2005 article from *Applied Clinical Trials*,¹¹¹

South African has a well-established regulatory process based on International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH) and Good Clinical Practice (GCP) guidelines for clinical studies. However, the review and approval process is relatively lengthy—currently averaging 12 to 14 weeks from the time an application is submitted to the Medicines Control Council (MCC) until a decision is rendered. From the submission deadline, there is also a one-week validation process when the MCC can request information omitted from the original submission. Four to five weeks after the original submission deadline, the clinical trials committee (CTC) meets to discuss the application and may provide feedback to the applicant. Another five weeks after this, the MCC meets to discuss the application and responses. The results of the assessment are delivered to the applicant after the MCC meeting.

In addition to MCC approval, all clinical trials must be approved by an accredited ethics committee (EC). In South Africa, an EC is typically associated with the particular hospital, clinic, or academic center where a study is to be conducted, but there is also an alternative, centralized EC process. The application requirements are similar to those required by the MCC, and a small application fee is typical. The average turnaround time for ethics committee reviews is about two weeks. The MCC and EC application processes can take place in parallel.

Given the complexities and timeframe of the clinical trial application process in South Africa, it is essential for sponsors to work with a local partner experienced in preparing applications for the MCC and local ECs. An organization that is familiar with the many complex requirements can help draft the regulatory submission to expedite the process and avoid undue delays.

FHI staff should coordinate all local IRB requests with the FHI country office.

Evidence of the impact of FHI/CTR research

As excerpted from the CTR (1995-2005) program's [Final Results Briefs](#),[§]

In 1998, FHI provided technical assistance to the South African Reproductive Health Research Unit at the University of Witwatersrand to establish a system for monitoring female condom uptake. Most clinic visitors who used the female condoms supplied in the study were also using injectables for contraception; the most frequently reported reason for using male and female condoms was STI prevention. In a subsequent South Africa study, 198 women who had accepted the female condom at least once and agreed to be contacted again were interviewed to examine correlates of one-time and continued use. Among 177 respondents who had ever used the device, about one-third (32 percent) had used it three or fewer times, and about one-third (35 percent) had used it 10 or more times. Women who reported sustained use said they were able to talk with their partners freely about sexual matters. (Note: The expansion of female condom distribution by the Government of South Africa was in part inspired by the results of this technical assistance. For more information, see the subproject report for FCO 9481 in the EIS.)

In collaboration with the East, Central and Southern Africa Health Community (formerly the Commonwealth Regional Health Community Secretariat) and local partners, FHI assessed opportunities for strengthening family planning services in the context of the HIV/AIDS epidemic in South Africa, Kenya, and Zimbabwe. The assessments, completed in 2004-2005, identified gaps in the family planning services offered and showed that family planning programs in some countries were being threatened as priorities and resources shifted toward HIV/AIDS programs. Key informants in all three countries agreed that integrating family planning and HIV/AIDS services would allow maximum use of limited resources and provision of more comprehensive services.

A recently completed FHI study in South Africa showed that nearly 50 percent of DMPA and norethisterone enanthate (NET-EN) users were late for their re-injections, according to World Health Organization (WHO) guidelines. The South Africa study also found that about one-third of all DMPA and NET-EN clients coming for a re-injection left the family planning clinic without one.

Contraceptive briefs developed under the CTR Program by FHI staff and local and international partners were instrumental in introducing new and revitalized contraceptive methods in the developing world. Female condom briefs were used in the national introduction of the female condom in South Africa.

A randomized controlled trial in four countries (Jamaica, Kenya, Ghana, and South Africa) evaluated the impact of providing a choice of condoms on acceptability, self-reported use, and incident STI. Participants at all four sites were offered a choice of condoms; they reported a strong preference for the Rough Rider condom. However,

[§] Currently available only through FHI's Intranet.

this preference did not translate into a higher proportion of protected acts. The clear message for programs is that resources need not be further stretched to provide a choice of different condoms.

Ongoing microbicide research

The Population Council has been working with South African institutions to test its leading microbicide candidate, **Carraguard®**. As excerpted from [University of Cape Town – School of Public Health](#) Web site:¹¹²

A Phase III trial that is testing the effectiveness of Carraguard® in preventing the transmission of HIV and other STIs, is currently underway. This is a randomised, controlled, double blind trial among 6,000 women at 3 sites in South Africa. Two thousand women will be enrolled from the Nyanga District. A clinical trial site has been developed at a community centre in Gugulethu to accommodate the study. Each woman will be followed for 2 years with follow-up visits every 3 months.

Additional microbicide trials in South Africa include:

- Phase 2/2B safety and effectiveness study of the vaginal microbicides **BufferGel** and 0.5% PRO 2000/5 Gel (P) for the prevention of HIV infection in women (HPTN 035). This study is being conducted through the R.K. Khan Hospital in Durban and the Medical Research Council in Hlabisa. Sponsors are NIAID, Indevus and ReProtect.
- Phase III international multi-center, randomized, double-blind, placebo-controlled trial to evaluate the efficacy and safety of 0.5% and 2% **PRO 2000/5 gels** for the prevention of vaginally acquired HIV infection. The DfID-funded study is being conducted by the UK Microbicide Development Program (MDP) through the RHRU of the University of Witwatersrand in Johannesburg, the South African Medical Research Council in Durban, and the Africa Centre for Health and Population Studies in Mtubatuba. The study is sponsored by Indevus, MRC and DfID.

An FHI-led **Tenofovir Gel** study is also being conducted in collaboration with CONRAD and the Center for the AIDS Programme of Research in South Africa (CAPRISA). For more information, refer to FCO 132108 in FHI's [Electronic Information System \(EIS\)](#).

[The International Partnership for Microbicides](#) is planning to conduct additional microbicide studies in Johannesburg and possibly other locations in South Africa. For an updated list of microbicide research in South Africa, refer to the clinical trial registry at the [Alliance for Microbicide Development](#).¹¹³

For more information about microbicides in South Africa, refer to the 2004 report from a qualitative study by EngenderHealth called [Paving the Path: Preparing for Microbicide Introduction](#).¹¹⁴

Research and Administrative Capacity

FHI's South Africa field office includes staff from the Institute for HIV/AIDS, as well as one project director, Sonja Martin, from FHI's Institute for Family Health (IFH). IFH shares

an accountant and administrative assistant with the Institute for HIV/AIDS. Eva Canoutas serves as the Country Monitor for IFH's South Africa field program and provides administrative backstopping from FHI's North Carolina headquarters.

Table 6 provides a list of the research organizations FHI/IFH has partnered with in the past five years.

Table 6: Research Organizations FHI Has Worked with in South Africa in the Past Five Years

Research organization and point person	Project title	FHI technical monitor
Baragwanath Hospital	IMC: CHB-South Africa Subcontract SFP2AB	V. McLaurin
Centre for Epidemiological Research in Southern Africa (CERSA) and Medical Research Council (MRC) of Durban, South Africa (PI: Salim Abdool Karim)	IMC: CERSA: South Africa Subcontract SFP2AB	V. McLaurin
CERSA/MRC; Stanford University, School of Medicine	HIVNET/HPTN 023 Phase I/II Study to Assess the Safety and Plasma Concentrations of Nevirapine Given Daily, Twice A Week or Weekly as Prophylaxis in Breastfeeding Infants from Birth to 6 Months	V. McLaurin
Baragwanath Hospital; University of Alabama at Birmingham	HIVNET 025: Ph III Study of Tolerance and Safety of Differing Concentrations of Chlorhexidine, for Peripartum Vaginal and Infant Washes, to Prevent Mother to Infant HIV-1 Transmission	V. McLaurin
Baragwanath Hospital (PHRU); CERSA/MRC; Johns Hopkins University, School of Public Health; Stanford University, School of Medicine; University of Alabama at Birmingham	HIVNET 028-HIV Virology/Immunization in Southern Africa	V. McLaurin
Reproductive Health Research Unit (RHRU) at the University of Witwatersrand	Female Condom Monitoring and Evaluation, Phase II Special Studies	T. Hatzell-Hoke
Centre for AIDS Development, Research and Evaluation (CADRE, Johannesburg, South Africa); Research International, Ltd. (Accra, Ghana)	Impact of Choice of Condoms on Increased Condom Use	(Information not available.)
Medical Research Council (Durban)	South Africa: Support to the Medical Research Council	J. Wesson
Progressus Research and Development Consultancy	Integrating Reproductive Health (RH) into an HIV/AIDS Home-based Care (HBC) Program: A Post-Intervention Assessment	D. McCarraher
Women's Health Research Unit, University of Cape Town (UCT)	Assessing and Improving the Management of Late DMPA Clients	J. Baumgartner
Women's Health Research Unit, University of Cape Town (UCT)	Improving Continuation Rates for Injectable Contraceptives	J. Baumgartner
Centre Hospitalier; Centre Muraz; Medical Research Council; Public Health at Makerere University; St. Johns Medical College; YRD Care	Behavioral Support for CONRAD Phase III Trial of Cellulose Sulfate (CS)	L. Severy

Source: FHI [Electronic Information System \(EIS\)](#), April 2006

Dissemination

Of its 349,936 total online visitors between January 1 and March 31, 2005, the FHI Web site received 6,751 visits from South Africa during that time period.¹¹⁵

The major South African communication initiatives related to health are:

- [Soul City](#), an NGO that broadcasts television and radio series and publishes booklets about health topics. It is funded by the National Department of Health, several bilateral and two commercial donors.
- [LoveLife](#).
- South African government's [Khomani](#) program.

Women's magazines and private newspapers also cover reproductive health and HIV health topics, and most are affordable and accessible to the general public.

Stakeholder Perspectives

Primary challenges in providing family planning services

Based on a 2006 programmatic assessment conducted by FHI in the Northern Cape province, the following challenges were identified:

- Lack of trained and skilled staff to provide FP services in some facilities
- Shortage of staff to provide proper counseling which affects FP services
- The child grant seen as an “incentive” to becoming pregnant especially among youth/teenagers
- Female sterilization is not acceptable in most cultures as a form of long-term contraception
- Lack of knowledge about post-coital contraception in the community
- Inaccessibility of health care in some areas.

On March 15, 2006, 19 representatives of the Department of Health and other organizations such as Right to Care, Health Systems Trust, and the Reproductive Health Research Unit (RHRU) at the University of Witwatersrand convened for a CRTU Stakeholders' Meeting in Pretoria.¹¹⁶ Collectively, they identified the major challenges and needs in reproductive health and HIV programming by magnitude, impact, and potential for change. The list of challenges they produced included, in no particular order:

- Out-of-date guidelines and training manuals which do not reflect new evidence on integration issues
- Lack of support and understanding among management staff regarding integration of services
- Lack of information on innovative models for integration and monitoring of impact
- Lack of a multi-sectorial, holistic approach to provision of integrated RH/HIV services
- Poor service provider skills.

Stakeholders then worked in small groups to generate strategies to address the challenges, such as:

- Advocating for better understanding of and support for integrated services
- Packaging and making accessible existing information and research regarding integration
- Developing integrated training curricula
- Developing a standardized and centralized mechanism and approach for the review, revision, and development of guidelines and training curricula
- Identifying an NDOH champion for integration and facilitating the creation of an integration coordination structure within the NDOH.

How HIV programs affect family planning programs in South Africa**

While some provinces attempt to integrate the programs and activities of the HIV/AIDS unit with the Maternal, Child and Women's services unit, most of them do not. Fortunately, the HIV/AIDS training curriculum for health workers also incorporates some aspects of PMTCT and family planning.

Due to the high prevalence of HIV among young people in the 15-25 year age range, many prevention programs such as *LoveLife* now try to emphasize dual protection: condom use as a form of contraception and also as a way to reduce HIV infection.

Misinformation among providers

Many family planning providers in South Africa are not fully informed about the benefits and risks of different methods of family planning. Most health workers, particularly nurses, acknowledge their need for in-depth training and skills in family planning methods.

Long-term safety of hormonal contraceptives

Health care providers and clients have concerns about the long-term use of contraceptives, particularly the presentation of thrombotic diseases, which stakeholders would like FHI and its partners to address. Specifically, there is a general perception among women that they should take oral contraceptive "holidays" when they are not sexually active in order to minimize the risks of long-term use. These types of misinformation should be addressed by FHI and its partners.

Sterilization

Sterilization for both male and females is still much lower than it should be. The main reason for the slow uptake is that, from a cultural standpoint, sterilization is not well accepted in South Africa, particularly among the country's black community. Stakeholders point out that FHI and its partners might try to bring about improvements in this area by training health workers about all contraceptive methods and ensuring that at the facility level, the health workers are able to provide adequate counseling and emphasize sterilization as a family planning option. These stakeholders' perspectives, combined with the other data and resources referenced in this report, will serve to provide further guidance to the CRTU Program in South Africa.

** Information in the following four Stakeholder Perspective sections provided by FHI/South Africa staff, May 2006.

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