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2. Review and revise the scope of practice of identified categories of primary care service providers to allow them, after appropriate training, to provide certain contraceptive services.	
3. Review and revise the scheduling of contraceptives in line with the expanded scope of practice of identified categories of primary care service providers.	
4. Collaborate with other government departments and agencies, as well as the private/NGO sector to develop or strengthen policies and guidelines that affect contraceptive use and service provision.	
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1. Develop appropriate IEC messages, materials and programmes about contraception for multimedia dissemination.
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3. Utilise all opportunities to provide IEC about contraception and reproductive health.
4. Implement contraceptive IEC initiatives, in collaboration with suitable partners, to reach priority groups in the community.
5. Conduct research to monitor and evaluate IEC initiatives related to contraception so that the findings can inform the development of future initiatives.

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To provide high quality contraceptive services

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1. Continue programmes and implement new initiatives to improve the accessibility of contraceptive services for underserved groups and communities.
2. Introduce measures to improve the acceptability of contraceptive services.
3. Explore and implement the most suitable measures to make contraceptive services more acceptable to people with special needs.
4. Provide contraceptive services during other primary health care consultations, as appropriate.
5. Provide effective counselling in a private and comfortable environment and ensure confidentiality.
6. Safely increase the accessibility of client-acceptable contraceptive methods.
7. Provide contraceptive methods safely and correctly in accordance with standardised contraceptive clinical practice guidelines and infection prevention protocols. Clinical practice guidelines on aspects of method provision for which existing practice commonly differs from current recommendations
8. Expand and strengthen the current method mix to meet the varying needs and preferences of clients throughout their reproductive lives.
9. Promote dual protection approaches for protection against pregnancy and STIs/HIV infection.
10. Revise or develop contraceptive training curricula for the different categories of service providers and students.
11. Establish supportive supervisory systems at all levels of care to ensure that service providers' needs are met.
12. Improve the logistics system to support contraceptive service provision in the public sector.
13. Make available adequate, sustained supplies of contraceptive methods and materials, as well as appropriate, properly functioning equipment at all service delivery points in accordance with national norms and standards.
14. Improve referral systems between contraceptive service delivery points.
15. Improve routine data recording, collection and reporting.
16. Strengthen monitoring and evaluation of contraceptive services.

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

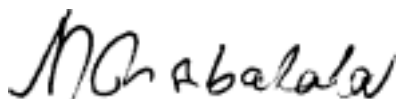
Investing in women's health is one of the most cost effective development strategies. Investing in women's reproductive health allows women to make reproductive choices they could not otherwise make, and helps them to be more effective in all the roles that they play in daily life. In the past, the family planning programme has traditionally neglected men's needs and responsibilities. For the first time this policy recognises the importance of involving men in this critical area. The overall approach of the policy is consistent with the political and health service reforms that are now being implemented in the country.

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

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

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

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



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Minister of Health

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

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

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

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

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

## Historical Background

### Traditional fertility regulation

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

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

### Family planning and population policies

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

From around the end of the 1930s onwards, the falling birth rate of the white population, together with the increase of the non-white population caused

increasing fear among the white community of being swamped by large numbers of black people. During the 1960s, the Government introduced new demographic-related policies and programmes in response to the *swart gevaar* (black fear) and certain politically destabilising events, such as the growth of the Black Consciousness Movement and the 'winds of change' sweeping through the rest of the continent. In the words of Prime Minister BJ Vorster in 1972, 'We would like to reduce them, and we are doing our best to do so, but at all times we would not disrupt the South African economy.'<sup>12</sup> Positive incentives (eg child benefit payments) were offered to whites in the country to increase the number of children per family. A very favourable white settlement programme was also introduced. These strategies were implemented hand-in-hand with programmes aimed at reducing the number of black South Africans.

### **The family planning programme**

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

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

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

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

### **The population development programme**

In the early 1980s, in response to the recommendations of a Government-commissioned report,<sup>3</sup> an explicit Government policy decision was made to lower the national population growth rate in line with resource availability especially water. This led to the establishment of the Population Development Programme (PDP) in 1984. The major thrust of the PDP was fertility reduction through family planning, but this was to be supported by interventions in other relevant sectors that could influence fertility levels, such as education, primary health care and economic

development.

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

### **Legislation that impacted on family planning services**

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

- **Abortion and Sterilisation Act, 1975 (Act No. 2 of 1975)**  
This contained highly restrictive criteria that made abortion illegal or inaccessible for most women.
- **Apartheid legislation**  
Under apartheid, race played a major role in determining an individual's legal status. A combination of apartheid land laws, separate development laws and pass laws (eg the Group Areas Act, 1950 and 1957, and the Reservation of Separate Amenities Act, 1953) significantly affected all aspects of the lives of people of different races, including access to health services.
- **Women's legal capacity**  
By common law in South Africa, a woman was subjected to her husband's marital power. Regarding family planning service provision, this translated into women requiring their husbands' consent in order to be sterilised and, in some places, even to receive any family planning method. The Matrimonial Property Act, 1984 (Act 88 of 1984) abolished the common law rule.

### **Providers of family planning services post-1974**

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

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

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

### **Human rights violations of family planning clients**

Human rights violations of family planning clients may be judged against accepted international norms, as declared in major human rights treaties. These particularly highlight the basic right of individuals to decide whether or

when to have children: 'All persons have the right to decide freely and responsibly the number and spacing of their children and to have access to the information, education and means to enable them to exercise this right'.

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

- *The right of the client to have access to healthcare, including counselling, treatment, a positive disposition by health care providers and health information<sup>4</sup>* was violated by the:
  - imposition of variable, restrictive rules regarding consent for family planning which limited access for certain groups of people;
  - segregation of family planning services according to race, and the provision of different contraceptive methods to the different racial groups;
  - frequent refusal to provide contraceptive services to people with disabilities;
  - limited access to family planning services for people living in certain areas of the country, such as rural areas and informal settlements;
  - inadequate provision of family planning education, information and counselling;
  - lack of provision of a range of contraceptive methods;
  - disregard of certain recommendations for safe method provision.
- *The right of the client to informed consent and decision-making<sup>4</sup>* was violated by the:
  - lack of good counselling on available methods;
  - use of coercive methods for contraceptive acceptance;
  - administration of family planning methods without the informed consent of clients.
- *The right of the client to confidentiality and privacy of information<sup>4</sup>* was violated by:
  - the public manner in which services were provided to clients at mobile and fixed clinics;
  - providers who disclosed client-related information to third parties.
- *The right of the client to continuity of care<sup>4</sup>* was violated by the inflexible systems used for method supply and follow-up, as well as the infrequent and erratic mobile clinic visits made to some areas of the country.
- *The right of the client to complain about services and to have their complaints investigated and receive a full response to such an investigation<sup>4</sup>*, was violated by the general disregard of client concerns and complaints by providers.

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

### **Community response to family planning**

During the 1980s, various messages about family planning were publicised by different programmes and groups. The Family Planning Programme was actively promoting family planning to improve women's health. Meanwhile the PDP was trying to popularise the view that South Africa's population was too big for its available resources, and promoted small families. During the State of Emergency, the situation was further complicated when opposition groups

and the youth politicised Government family planning services, and labelled contraception as a tool of white oppression.

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

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## Current Status of Contraception

### Background demographic characteristics

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

### Fertility levels

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

### Contraceptive use and sexual behaviour

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

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

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

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

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

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

### Factors influencing contraceptive use

The most significant factors that influence contraceptive use are:

- Knowledge about contraception  
Almost all women in South Africa know of at least one contraceptive method (see Table 1). But some studies report that, among young people, knowledge of reproductive function is generally poor and there is considerable confusion and misperceptions regarding contraception.<sup>8,11</sup>
- Attitudes on issues related to contraception studies<sup>9,10,11,12</sup> show that:
  - Smaller family sizes are preferred by urban residents and younger people.
  - Almost all men and women prefer birth spacing of two years and over.
  - While the majority of men and women think that women should be allowed to use contraception, many women believe that men generally disapprove of pregnancy prevention.
  - Women regard quality of care, including the way in which people are treated, as the most important aspect of contraceptive service provision. Commonly requested specific changes to services are that staff should

be more understanding and more available for explanation and counselling; clinics should have longer consulting hours, greater accessibility, reduced waiting times and more privacy; and contraceptive services should be provided with other health services at one clinic. The provision of adolescent-friendly services is a need identified by young people.

- **Socio-economic development**  
Poor socio-economic development is associated with low contraceptive use. As a legacy of apartheid and the inequitable development of the people of South Africa, the extent of socio-economic development is markedly dissimilar for the different ethnic groups, among provinces, and between urban and rural populations.<sup>13</sup>
- **Urban-rural residence**  
Urbanisation is associated with greater contraceptive use. Overall, 53,6 percent of the population of South Africa is urbanised but there are marked provincial differences. Following the end of apartheid influx control measures, it is predicted that Africans will continue to urbanise rapidly over the next decade. Of those living in non-urban areas, three-quarters reside in the former homelands, where more than 73 percent of the population live in poverty and health services are not always accessible.<sup>7</sup>
- **Women's education and status**  
In South Africa, seven percent of women aged 15 to 49 years have had no formal education at all, but almost a quarter have completed matriculation or more.<sup>6</sup> Improving women's educational and economic opportunities can have an important impact on their use of contraception, and their control over sexual and reproductive matters. Likewise, contraceptive use can help women to improve their status, level of empowerment and quality of life by enabling them to choose to have smaller and healthier families, and thereby freeing them more to participate in educational, economic and social activities.
- **Cultural values, beliefs and norms**  
These significantly influence decision-making regarding sexual and reproductive matters, such as the ideal number of children, when to have children, and contraceptive use. In South Africa today, traditional values regarding children remain to varying extents. Together with the need for women to prove their fertility, these values continue to influence the sexual and reproductive choices of many people.

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

### **Providers of contraceptive services**

The State is the main provider of contraceptive services in South Africa. Contraceptive services, including methods, are provided free of charge in the public sector. Public health services, including contraceptive services, are still going through the process of transformation in an attempt to redress past inequities and improve the quality of care. At national level, the Maternal, Child and Women's Health (MCWH) and Nutrition Cluster is responsible for contraceptive service policy-making and the production of training and education materials. In the provinces, provincial MCWH and Nutrition

Directorates manage contraceptive services - in line with national policies - through the district health system. Contraceptive service delivery points range from those at community level, mobile units, clinics and community health centres to district hospitals, referral/tertiary hospitals and academic centres.

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

## Quality of care

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

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

Other shortfalls regarding method provision include:

- Inadequate range of methods for adolescents. In many areas, adolescents are not offered an adequate method mix that includes methods for dual protection, and/or emergency contraception.
- Restricted IUD provision. IUDs are generally only offered at urban centres and referral facilities in rural areas. This is largely because of a lack of suitable facilities and staff trained in IUD insertion.
- Female sterilisation services generally are not readily available. They are often logistically difficult to access and most provinces have long waiting lists. Male sterilisation is unheard of or unacceptable by many

communities. Vasectomy is currently performed mostly in the private sector and predominantly for white clients.

- Restricted condom supply. Nationally the male condom is available at most public sector health facilities, but only a limited number of facilities supply the female condom. Both types are sold by social marketing outlets in some areas. Although male condom distribution has increased considerably, there are concerns that the data on distribution do not necessarily reflect condom usage.
- Limited promotion of and access to emergency contraception (EC) throughout the country. Provider knowledge of EC is generally inadequate and in some cases incorrect.

- Technical competence of providers

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

- Interpersonal relations

There are frequent reports from contraceptive clients about the negative attitudes and rudeness of service providers towards them. Service providers in general are not youth-friendly.<sup>11</sup>

- Client information

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

- Mechanisms to encourage continuous contraceptive use

These include:

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

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

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

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

## International agreements and charters

## International and National Context

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

## The Constitution, national legislation and policies

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

- The Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996): enshrines reproductive rights and the right of access to reproductive health care:
  - 'Everyone has the right to bodily and psychological integrity, which includes the right: to make decisions concerning reproduction; to security in and control over the body; and not to be subjected to medical and scientific experiments without their informed consent.'  
(*Freedom and security of the person*)

- 'Everyone has the right to have access to health care services, including reproductive health care; sufficient food and water; and social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.' (*Health care, food, water and social security*)
- Medicines and Related Substances Control Act, 1965 (Act No. 101 of 1965): allows for the sale of oral contraceptives in accordance with the Act's Schedules.
- Child Care Act 1983 (Act No. 74 of 1983): states that:
  - Minors of 14 years and older may consent to their own medical treatment without the assistance of parents/guardians.
  - Any person of 18 years and older may consent to surgical procedures (operations) being performed on themselves without the assistance of parents/guardians. (An exception to this general rule is that girls under the age of 18 can have an abortion without their parents'/guardians' permission.)

In practical terms, this means that children of any age can approach a clinic for sexual and reproductive health information and condoms. The clinic may not inform the child's parents/guardians of the visit. Girls of 14 years and older can be prescribed any form of medical contraceptive without the assistance or knowledge of their parents/guardians. Girls under the age of 14 years need the consent of their parents/guardians before being supplied with the pill or other prescription forms of contraceptive.<sup>14</sup> However, adolescents who may be sexually active and/or request contraception, but are unwilling or unable to obtain their parents'/guardians' consent, should have their health and social needs met.
- Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996): '...repeals the restrictive and inaccessible provisions of the Abortion and Sterilisation Act, 1975 (Act No. 2 of 1975), and promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs'. Contraception is regarded as an integral part of TOP care. The approved short TOP training course for registered midwives contains a module on contraception.
- Population Policy, 1998: towards achieving the goal of human development, the strategies of the policy include:
  - 'Improving the quality, accessibility, availability and affordability of primary health care services, including reproductive health and health promotion services (such as family planning), to the entire population in order to reduce mortality and unwanted pregnancies, with a special focus on disadvantaged groups, currently underserved areas and adolescents; and eliminating disparities in the provision of such services.'
  - 'Promoting responsible and healthy reproductive and sexual behaviour among adolescents and the youth to reduce the incidence of high-risk teenage pregnancies, abortion and sexually transmitted diseases, including HIV/AIDS, through the provision of life skills, sexuality and gender-sensitivity education, user-friendly health services and opportunities for engaging in social and community life.'
  - 'Promoting the equal participation of men and women in all areas of family and household responsibilities, including responsible parenthood, reproductive health, child-rearing and household work.'
- Sterilisation Act, 1998 (Act No. 44 of 1998):
  - Provides for the right to sterilisation of any person over the age of 18 years if he/she is capable of consenting.
  - Prohibits sterilisation on any person capable of consenting without his/her consent and on any person under the age of 18 years except on medical

grounds.

- The Domestic Violence Act, 1998 (Act No. 116 of 1998): aims to afford victims of domestic violence the maximum protection from domestic abuse that the law can provide; and to introduce measures which seek to ensure that the relevant organs of the State give full effect to the provisions of the Act, and thereby to convey that the State is committed to the elimination of domestic violence. Under the law, abusers may be arrested without a warrant and dangerous weapons seized. An abuser may be convicted of marital rape even if the parties are married according to civil, customary or religious law.  
The National Health Bill, 2000: prioritises maternal, child and women's health (MCWH) and includes the following policy intentions that:
  - MCWH services should be accessible to mothers, children, adolescents and women of all ages, with a focus on the rural and urban poor.
  - MCWH services should be comprehensive and integrated.
  - Women and men should be provided with services that will enable them to achieve optimal reproductive and sexual health.
  - Individuals, households and communities should have adequate knowledge and skills to promote positive behaviour related to maternal, child and reproductive health.
- Health Sector Strategic Framework 1999-2004, National Department of Health: contains the following health priorities within its ten-point plan to strengthen implementation of efficient, effective and high-quality health services: improving quality of care (through, for instance, the launching of the Patients' Rights Charter); and decreasing morbidity and mortality rates through strategic interventions that relate directly to sexual and reproductive health such as reducing teenage pregnancy, decreasing the incidence of HIV/AIDS, improving women's health, reducing maternal mortality and tackling violence against women and children.
- The Patients' Rights Charter, National Department of Health: directly upholds and promotes the right of access to health care. Other rights of particular relevance to contraceptive services that are contained in the Charter are: confidentiality and privacy of information concerning patients' health and treatment; choice of health services (such as a particular health care provider or facility) in line with normal ethical standards and prescribed service delivery guidelines; treatment by a named health care provider; and informed consent and decision-making on matters regarding their illness, diagnostic procedures, proposed treatment and costs involved.
- Batho Pele ('People First'), 1999, National Department of Public Service and Administration: is the White Paper on transforming public service delivery. The main thrust of the document is the establishment of a culture in which all State employees put the public or customer first and are accountable for the service they give. The framework consists of the following seven simple principles of public service delivery: consultation; service standards; courtesy; information; openness/transparency; responsiveness; and value for money.
- Policy Guidelines for Adolescent and Youth Health, 2001, National Department of Health: include sexual and reproductive health among its six top health priorities for adolescents and youth. Key intervention strategies that relate to contraception include promoting delayed childbearing; promoting marriage preparedness; facilitating easy, cheap and private access to all forms of contraception (including emergency contraception and condoms); using multimedia methods to provide information to adolescents, youth and their families about all sexual health matters; building skills specifically relevant for sexual health such as negotiating contraceptive use; providing sexuality counselling; integrating sexual and reproductive health services.

- Guidelines for Maternity Care in South Africa, 2000, National Department of Health: guide those health workers providing obstetric services in clinics, community health centres and district hospitals. The document covers the management of conditions which commonly arise in maternal deaths. The guidelines also address the need to counsel pregnant women on their future contraceptive needs.
- National Guideline for Cervical Cancer Screening Programme, 2001, national Department of Health: focuses on secondary prevention of cervical cancer by the detection and treatment of the pre-invasive stage of the disease. It proposes three smears per lifetime, with a 10-year interval between each smear, commencing at not earlier than 30 years. The Programme also promotes primary prevention strategies, some of which relate to contraception - the promotion of barrier methods of contraception to prevent the spread of the human papilloma virus (HPV) and other STIs; the postponement of sexual debut; and the decrease in parity.
- The Essential Drugs List (EDL) for Primary Health Care (1998): specifies under the Family Planning section those contraceptive methods that should be available at each service level in the public sector, together with their recommended doses and method of availability.