

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

Patients' Rights

Everyone has the right to:

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

Providers' Needs

All providers should have:

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

Guiding Principles

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

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

Goal

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

Purpose

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

Objectives

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

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

Objective 3: To provide high quality contraceptive services.

To remove barriers that restrict access to contraceptive services.

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

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

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

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

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

3. Review and revise the scheduling of contraceptives in line with the expanded scope of practice of identified categories of primary care service providers.**4. Collaborate with other government departments and agencies, as well as the private/NGO sector to develop or strengthen policies and guidelines that affect contraceptive use and service provision.****5. Collaborate with other government departments and agencies to expand and strengthen contraceptive services.**

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

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

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

Objective 2

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

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

Strategies

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

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

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

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

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

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

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

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

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

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

To provide high quality contraceptive services

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

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

Strategies

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

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

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

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

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

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

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

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

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

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

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

Effective counselling requires that providers:

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

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

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

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

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

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

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

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

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

without being unnecessarily denied the method of their choice.

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

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

- **Informed choice**
All women, men and young people should be provided with the contraceptive method(s) that they request, subject to meeting the relevant medical eligibility criteria, and without the influence of service provider biases.
- **Client assessment**
Comprehensive medical history and blood pressure measurement are essential before clients begin hormonal contraception. Pelvic and breast examination are not mandatory. It is recommended that these examinations are performed at a mutually convenient time during the first year of contraceptive use. This opportunity should be used also to instruct clients on breast self-examination. Cervical (PAP) smears should be performed in line with the DOH's national guideline for the Cervical Cancer Screening Programme.
- **Follow-up visits**
These should be scheduled according to sound medical reasoning. Unnecessary frequent follow-up visits should be discontinued. (Recommendations for the timing of follow-up visits for each contraceptive method are given under the respective method-specific chapters in the National Contraception Service Delivery Guidelines.)
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- **Barrier methods**
More extensive use of barrier methods should be urgently promoted in view of the STI/HIV epidemic. At least one female-initiated barrier method should be made available.
- **High dose COCs**
Routine use of high dose COCs should be phased out. Unless specifically medically indicated, clients using high dose preparations should be changed to formulations of less than 35 micrograms oestrogen, as soon as possible.
- **Injectable contraceptives**
These have few contraindications. Young clients should not be prevented from using **either** DMPA or Net En because of their age.
- **Timing of initiation of hormonal contraceptives**
This should not be restricted to menstruation only, because it is largely

unnecessary and serves as a barrier to access.

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

Note:

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

- **Postpartum**

On discharge from a health facility after childbirth and at the six-week postnatal check-up, all women should be counselled about contraception and supplied with a suitable method(s) of their choice.

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

- **Lactational Amenorrhoea Method (LAM)**

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

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

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

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

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

- **Core methods that should be always available and in stock at all health facilities:**
 - *Male condoms*: Should be widely promoted for dual protection.
 - *Oral contraceptives*: Low-dose combined and progestogen-only pills.
 - *Progestogen-only injectables*.
 - *Emergency contraception*: ECPs should be extensively promoted and made available. They are safe, effective, have few contraindications and, although not recommended for regular contraception, they can be used repeatedly for emergency contraception.
- **Referral methods that may require client referral to another facility:**
 - *Intrauterine Device (IUD)*: Should be promoted for carefully selected women who are at low risk of exposure to STIs/HIV.
 - *Female sterilisation services*: including the minilaparotomy procedure under local anaesthetic, should be strengthened and expanded. Services should be made accessible to and promoted for women who are certain that they do not wish to have more children.
 - *Male sterilisation services*: Effective, safe, permanent male sterilisation procedures should be made accessible to and promoted for men who are certain that they do not wish to have more children. There is a need to raise public awareness and understanding about vasectomy.
 - *Female condom*: Is available at selected facilities throughout the country and strict monitoring of user patterns is continuing.
 - *Natural family planning*: Clients who are interested in NFP methods (excluding LAM) should be counselled and instructed by specially-trained NFP teachers who specialise in providing the methods.

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

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

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

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

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

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

- Abstinence, including non-penetrative alternative sexual practices. Abstinence (and mutual monogamy between uninfected partners) offer the best protection against STIs/HIV.
- Barrier methods: The use of male or female condoms (alone or with spermicides) prevents both pregnancy and STIs/HIV. Motivated and well-counselled individuals who use condoms correctly and consistently can achieve effective dual protection. In the event of condom failure, access to emergency contraception should be promoted more extensively. Women who are at risk of STI/HIV infection but have difficulty negotiating male condom use, should be counselled about using the female condom, if these are available.
- Dual method use: Clients who are at risk of STI/HIV infection but wish to use a contraceptive method that does not offer STI/HIV protection, should be counselled to use condoms as well for dual protection.

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

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

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

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

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

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

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

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

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

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

14. Improve referral systems between contraceptive service delivery points

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

15. Improve routine data recording, collection and reporting

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

various contraceptive records that should be kept include:

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

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

- Collection of good-quality data on the number and type of clients served, quantity of contraceptives received and dispensed and the anticipated demand for the next quarter.
- Timely reporting (monthly and quarterly) from all service delivery points.
- Rationalisation to the essential minimum of the various items of data that providers are required to collect, in order to improve the quality of data collected and to cut out the wasted time and effort spent by providers collecting data that is of little or no programmatic use.

16. Strengthen monitoring and evaluation of contraceptive services

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

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A

Abortion

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

Adolescents, youth and young people

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

Amenorrhoea

is the absence of menstrual periods.

B

Back-up method

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

C

Clients

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

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

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

Contraception

is the prevention of pregnancy through temporary or permanent means.

Contraceptive prevalence

is the percentage of couples using a contraceptive method.

D

Disadvantaged communities

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

Discrimination-free

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

Dry sex

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

Dual method use

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

Dual protection

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

E

Equity of services

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

Essential Drugs List (EDL)

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

F

Family planning

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

Fertility regulation

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

Fully breastfeeding

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

G

Gender

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

H

Health

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

Homelands

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

I

IEC (Information Education and Communication)

are the identified elements for health promotion.

Infertility (male or female)

is the inability to conceive or to cause conception spontaneously after one to two years of regular unprotected coitus.

L

Lactational Amenorrhoea Method (LAM)

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

N

Natural family planning (NFP)

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

P

People with disabilities

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

Population growth

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

Population growth rate

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

Preferred family size

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

Q

Quality of care

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

R

Racial classifications

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

Reproductive health and rights

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

Reproductive health services

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

S

Safer sex

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

Service provider (contraceptive)

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

Sex

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

Sexual behaviour

encompasses the physical practices (eg penetrative, non-penetrative, vaginal, anal, oral), and patterns (eg a stable sexual relationship with one partner; the tendency to have casual sex and multiple partners; use of dual protection strategies) associated with the act of sexual intercourse.

High risk behaviour encompasses activities and features that are associated with a high risk of contracting STIs/HIV infection, ie unsafe sexual practices. Sharing needles for intravenous drug use, though obviously not sexual, is a high risk behaviour for HIV infection.

Low risk behaviour encompasses activities and features that are associated with a low risk of contracting STIs/HIV infection, such as safe sexual practices.

Sexual health

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

Sexual health care

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

Sexuality

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

Sexually transmitted infections (STIs)

are infections affecting men and women that generally are transmitted during

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

Supportive/facilitative supervision

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

Sustainable human development

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

T

Teenage birth rate

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

U

Urban

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

Unsafe sex

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