

National Contraception and Fertility Planning Policy and Service Delivery Guidelines

A companion to the National Contraception Clinical Guidelines

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NATIONAL CONTRACEPTION AND FERTILITY PLANNING POLICY AND SERVICE DELIVERY GUIDELINES

A companion to the National Contraception Clinical Guidelines

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The *National Contraception and Fertility Planning Policy and Service Delivery Guidelines* is a companion to the *National Contraception Clinical Guidelines (DOH 2012)* which includes the following chapters:

Chapter 1: Introduction to clinical guidelines for contraception

Chapter 2: Clinical guidelines for method provision

Chapter 3: Contraception for special needs (adolescents, menopausal women, disabled women and women with chronic conditions)

Chapter 4: Contraception and HIV

Foreword by the Minister of Health

The National Contraception and Fertility Planning Policy and Service Delivery Guidelines and National Contraception Clinical Guidelines are extremely important documents aimed at reprioritising contraception and fertility planning in South Africa, with an emphasis on dual protection.

Contraception is one of the most powerful public health tools for any country. Providing women with access to safe and effective contraception is a critical element of women's health. Enabling women to make choices about their fertility is empowering and offers women better economic and social opportunities. Birth spacing also improves the opportunities for children to thrive physically and emotionally. Engaging men in sexual and reproductive health encourages shared responsibility in their roles as partners and parents.

The adoption of the revised Contraception Policy takes place within the context of renewed international focus - at the 2012 global Family Planning Summit held in London, the importance of contraception to human development, gender empowerment, HIV and sexual and reproductive health was once again emphasised.

Against this background I am delighted to release the revised policy on contraception and fertility planning. It is being launched during an exciting period in the history of health care in South Africa, with the re-engineering of primary health care, emphasis on health systems strengthening, implementation of the National Core Standards, and closely linked to this, the introduction of the National Health Insurance.

In addition, the policy has been developed against the background of the HIV epidemic. About one third of young South African women are HIV positive, and contraceptive provision and fertility advice must take this into account. Similarly, two thirds of South Africa's young women are HIV negative but are at risk of HIV infection, and their counseling and choices need to take issues related to risk and prevention into consideration.

Noting the above, much depends on the successful implementation of this policy. Contraception is one of the World Health Organization's four strategic prongs for the prevention of mother-to-child transmission of HIV. Contraception and planning for conception contributes to the reduction of HIV transmission, thereby supporting the National Strategic Plan on HIV, STIs and TB (2012-2016). It has enormous potential to contribute to South Africa achieving its Millennium Development Goals, particularly MDGs 4 and 5. It is also an important part of the strategy to ensure the successful implementation of the African Union's Campaign for the Accelerated Reduction of Maternal, Neonatal and Child Mortality in Africa (CARMMA), to which South Africa is a signatory.

The revision of the contraception policy was deemed necessary to ensure up to date practice in South Africa, and reflects the changes over the last decade in the fields of HIV, contraceptive technology and related research. One of the most significant changes has been the expanded scope of the policy –to embrace both the prevention of pregnancy (contraception) and the planning for a healthy pregnancy (conception). The policy also reflects the Department of Health's focus on human rights, quality and integration. Drawing on the expertise of scientists, clinicians, health workers and practitioners, the revised policy provides a framework for a broad, forward looking contraception and fertility planning programme, with an emphasis on improved access as well as expanded contraceptive choice.

Now, more than ever, the successful implementation of this policy is of critical importance. We urgently need to deal more effectively with the challenges facing our country in terms of unacceptably high rates of HIV, teenage pregnancy, unintended pregnancies, infant and maternal mortality, and the elimination of mother-to-child transmission of HIV. Improved access to and use of contraception will result in a decreased demand for termination of pregnancies. Encouraging women to plan for healthy pregnancies, including timing and spacing, will improve health outcomes for both mothers and babies.

However, the realisation of a sound, innovative policy can only be measured by its successful implementation. To ensure that this happens, I call upon all health workers to prioritise the following five key actions:

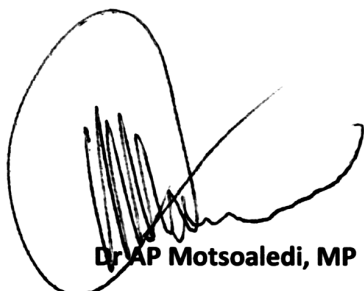
(i) The provision of quality contraceptive health services: We need to ensure that we have a robust health system so that we can provide the contraceptives and services we promise - this involves improved access, expanded choice, quality care, staff training and continuous and efficient commodity supply.

(ii) Stimulating community awareness and demand: We need to ensure that our communities understand the importance of contraception and planning for healthy pregnancies, the range of methods available and where they can be obtained - this requires advocacy and demand creation, underpinned by effective communication strategies which encourage informed decision-making and contraceptive use.

(iii) Putting integration into practice: We need to deal with the dual challenges of HIV and unwanted pregnancies, through the promotion of condom use and dual contraception as well as through the active promotion of integrated HIV and sexual and reproductive health services - we need commitment, creativity and flexibility to actively operationalise integration.

(iv) Strategic multi sectoral collaboration: We need to expand access beyond traditional clinical settings and strengthen provision. To this end, we need vibrant, responsive partnerships - with civil society, the private sector, and development and implementing partners.

(v) Evidence guided planning and provision: We need to ensure that the implementation of the policy is monitored, evaluated, and that international and local research informs decisions and planning.



Dr AP Motsoaledi, MP
Minister of Health
Date: 22/1/2013

Acknowledgments

The revision of the Contraception Policy has been a collective effort and an extensive consultative process. The Department of Health would like to acknowledge and thank all those who have contributed to this process, through attending meetings, research, writing, commenting on the many drafts and, importantly, engaging in rigorous discussion and debate.

To all the organisations and individuals who contributed to the development of the policy (listed in Appendix 1) we extend our sincerest appreciation; without their contribution we would not have developed such a forward-looking, comprehensive and responsive policy.

In particular, the Department of Health would like to thank:

- Dr Aaron Motsoaledi (Minister of Health), Dr Yogan Pillay (Deputy Director General: HIV/AIDS, TB and MCWH), Professor Eddie Mhlanga (Chief Director: Maternal and Women's Health) and Dr Nonhlanhla Diamini (Chief Director: Child, Youth and School Health) for their leadership and stewardship in ensuring that reproductive health and rights remain a national health priority;
- National and Provincial Department of Health personnel, who commented on drafts, and contributed their hands-on experience to assist in the formulation of the policy and guidelines, and especially Dr Nat Khaole (Director: Women's Health and Genetics) for the overall coordination of the revision process;
- Wits Reproductive Health and HIV Institute for project managing the revision, in particular Professor Helen Rees for chairing the respective working groups, and Melanie Pleaner for overseeing the process from its inception to publication;
- Professor Petrus Steyn and Dr Margaret Moss (University of Cape Town) for convening the HIV and Contraception, and Method Mix working groups, and for their on-going contribution to the many drafts;
- United Nations Population Fund (UNFPA) and the United States Agency for International Development (USAID) for funding the process;
- International development partners who provided technical expertise to support the development of the policy and guidelines;
- FHI 360 for their on-going technical assistance and contribution to reviewing the document.

We hope that the interest, commitment and enthusiasm that drove the revision process will extend into ensuring the successful implementation of the Contraception Policy and Guidelines.

Abbreviations

AIDS	Acquired immunodeficiency syndrome	LNG-IUS	Levonorgestrel releasing intrauterine system
ANC	Antenatal care	LARC	Long-acting reversible contraception
ART	Antiretroviral therapy or treatment	MCC	Medicines Control Council
ARV	Antiretroviral drugs/treatment	MDGs	Millennium Development Goals
BBT	Basal body temperature	NET-EN	Norethisterone enanthate
BCC	Behaviour change communication	NIMART	Nurse initiated management of antiretroviral treatment
CHC	Community health centre	NNRTI	Non-nucleoside reverse transcriptase inhibitors (only in one place)
CHC	Combined hormonal contraception	NSAID	Non-steroidal anti-inflammatory drug
CIC	Combined injectable contraception	NSP	National Strategic Plan on HIV, Sexually Transmitted Infections and Tuberculosis: 2012-2016
COCs	Combined oral contraceptive pills	PE	Pulmonary embolism
CTOP	Choice on termination of pregnancy	PHC	Primary health care
Cu IUD	Copper intrauterine device	PI	Protease inhibitor
CYP	Couple years of protection	PID	Pelvic inflammatory disease
DHIS	District Health and Information System	PMTCT	Prevention of mother-to-child transmission of HIV
DMPA	Depot medroxyprogesterone acetate	POP	Progestogen-only pill
DOH	Department of Health	POC	Progestogen-only contraceptive
DOTS	Directly observed treatment short course (for tuberculosis)	SADHS	South African Demographic and Household Survey
DVT	Deep vein thrombosis	SLE	Systemic lupus erythematosus
ECP	Emergency contraceptive pill	STI	Sexually transmitted infection
EPI	Expanded Programme on Immunisation	TB	Tuberculosis
ETG	Etonogestrel implants	TOP	Termination of pregnancy
FAB	Fertility awareness-based methods	UNFPA	United Nations Population Fund
HCT	HIV counselling and testing	USAID	United States Agency for International Development
HIV	Human immunodeficiency virus	VTE	Venous thromboembolism
HIV-RNA	HIV-ribonucleic acid (viral load)	WHO	World Health Organization
HPV	Human papillomavirus	WHO MEC	World Health Organization medical eligibility criteria for contraceptive use
IEC	Information, education and communication	WRHI	Wits Reproductive Health and HIV Institute
IUD	Intrauterine device		
IUS	Intrauterine system		
LAM	Lactational amenorrhoea method		
LGBTI	Lesbians, gay, bisexual, transgender and intersex persons		
UNITS			
µg	microgram		
mg	milligram		

Introduction

A decade after the last contraception policy was released, the National Department of Health (DOH) recognised the need to update and revise the policy documents: *National Contraception Policy Guidelines within a reproductive health framework* (2001) and the *National Contraception Service Delivery Guidelines* (2003).^{1,2} The need for the policy update was prompted by:

- changes in contraceptive technologies
- the high prevalence of HIV in South Africa
- the need to ensure linkages and alignment with other related national and international policies and frameworks.

The revision and updating process

The revision process involved the formation of an expert group and a broader consultative forum set up to make recommendations and review successive versions. There was also a wider call for submissions distributed through various electronic mailing lists. The deliberations and recommendations from these working groups, together with other submissions from individuals and organisations, form the main body of the revised policy.

Further details of the revision process, composition of the working groups and acknowledgement of contributors can be found in Appendix 1.

The purpose of the policy revision

The following aims formed the framework for the revision:

- to ensure alignment with international trends and evidence, such as the *Medical eligibility criteria for contraceptive use* (World Health Organization, 2010),³ and to bring the policy up to date in light of changes in contraceptive technologies and new research;
- to locate contraception provision in the context of high HIV prevalence in South Africa;
- to align the policy with broad overarching national priorities, including South Africa's commitment to the attainment of the Millennium Development Goals, the DOH's National Service Delivery Agreement⁴ health commitments, and the strategic framework for sexual and reproductive health and rights – *Sexual and Reproductive Health and Rights: Fulfilling our commitments*;⁵
- to develop a new expanded definition of 'family planning' within the broader context of fertility management, and in so doing, develop a more holistic framework related to contraceptive provision and fertility planning – a framework that will embrace the continuum of both pregnancy prevention and planning for conception, and address the implications thereof for people living with HIV;
- to make available and promote wider contraceptive choice and method mix in public sector facilities;
- to promote the appropriate integration of quality contraceptive services with other health services, particularly HIV services;
- to advocate for the strengthening of more specialised services and referral clinics, where necessary.

What's new in the revised policy?

This revised and updated policy replaces the previous *National Contraception Policy Guidelines within a reproductive health framework* (DOH 2001) and *National Contraception Service Delivery Guidelines* (DOH 2003).

There are now two complementary documents: The *National Contraception and Fertility Planning Policy and Service Delivery Guidelines (DOH 2012)* and its companion, the *National Contraception Clinical Guidelines (DOH 2012)*.

The revised Policy and Guidelines include the following noteworthy changes.

- ◆ **Expanding the policy's mandate.** The new policy addresses both contraception and fertility planning. This is based on the view that, particularly in the era of HIV, fertility planning must be part of the approach to counselling women of childbearing age about their fertility intentions.
- ◆ **Key revisions.** Revisions made include:
 - expansion of the scope of the policy to encompass both the prevention of pregnancy (contraception) and the planning for pregnancy (conception);
 - reformulation of principles, objectives and strategies;
 - inclusion of contraception and fertility planning within the context of HIV in South Africa – addressing the needs of women at risk of HIV, HIV-positive women either on or off antiretroviral treatment and their partners;
 - appropriate integration of contraceptive and fertility-planning services with HIV, tuberculosis, prevention of mother-to-child transmission of HIV, maternal health and adolescent services;
 - promotion of screening opportunities linked to contraceptive and fertility-planning services: HIV counselling and testing, HIV, sexually transmitted infections, tuberculosis, cervical and breast cancer;
 - special service delivery and access considerations for sex workers, lesbians, gay, bisexual, transgender and intersex persons, migrants, and men;
 - special service delivery and clinical considerations for adolescents;
 - special clinical considerations for women who are perimenopausal, have a disability or a chronic condition;
 - strengthening the role of hospital-based referral services for training doctors and nurses, and management of complex clinical cases.
- ◆ **Expanded method mix.** The methods of contraception were expanded to cover:
 - increased access to additional long-acting contraceptive methods, with specific consideration of:
 - increasing access to the copper intrauterine device (Cu IUD), with antibiotics at the time of insertion
 - introduction of single-rod progesterone implant
 - introduction of the levonorgestrel intrauterine system (LNG-IUS) as a referral method
 - introduction of combined oestrogen and progestogen injectables;
 - increased access to female condoms;
 - increased access to, and promotion of, emergency contraception pills;
 - increased access to contraception: the incremental expansion of non-clinical settings as outlets for the provision of contraception, for example ward-based primary health care teams and community health workers to issue hormonal contraceptives.

In addition, noting the changes in the World Health Organization's medical eligibility criteria, and possible increased risk of HIV acquisition with injectable progestogens, there is a shift in emphasis away from injectable progestogens towards alternative long-acting reversible contraceptives (Cu IUDs, intrauterine systems, subdermal implants); and, because of the possible increased risk of HIV acquisition, emphasis is given to the importance of condom use for women who choose to use injectable progestogens.⁶

What's new in the revised policy? *continued*

- ◆ **Alignment with DOH priorities.** The Policy is aligned with various DOH frameworks and agreements, including:
 - the National Service Delivery Agreement – taking into account re-engineering of primary health care, primary health care outreach teams, National Health Insurance, Enhanced School Health Services, National Core Standards, quality improvement and health system strengthening;^{4, 7, 8}
 - the Millennium Development Goals 4, 5, 6;^{9, 10}
 - the DOH's framework for sexual and reproductive health and rights (*Sexual and Reproductive Health and Rights: Fulfilling our commitments*);⁵
 - the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA).*

* CARMMA is an African Union Commission and UNFPA initiative to intensify the implementation of the Maputo Plan of Action for the reduction of maternal mortality in the Africa region. It was launched in South Africa on 4 May 2012. For more information see: <http://au.int/pages/carmma>; and opening address by the Minister of Health, Aaron Motsoaledi <http://www.info.gov.za/speech> (accessed 20 May 2012).

Section A

BACKGROUND AND CONTEXT

Section A consists of two chapters.

- **Chapter 1** outlines the international and national policy and legislative framework that has influenced the development of the Policy and Guidelines.
- **Chapter 2** summarises current patterns and trends in the use of contraception in South Africa.

CHAPTER 1

The bigger picture

1.1 Background to sexual and reproductive health and contraception in South Africa*

Several international events changed the landscape of sexual and reproductive health in South Africa in the 1990s. These include South Africa's participation in key world conferences and conventions from which emanated several international treaties to which South Africa is a signatory. For example: the World Conference on Human Rights (Vienna 1993); the Convention on the Elimination of all Forms of Discrimination against Women (adopted by the United Nations General Assembly in 1993); the International Conference on Population and Development (Cairo 1994); the Fourth World Conference on Women (Beijing 1995); and the World Summit for Social Development (Copenhagen 1995). These progressive and ambitious initiatives embraced social equality and human rights, and set the agenda for a strong government commitment to people-centred development as the basis for national policies and action plans for gender equity and sexual and reproductive health and rights.

Parallel to this, the first democratic elections ushered in a new era in South Africa, with the concepts of human rights and equity becoming cornerstones of its constitution. This created an enabling environment for health care transformation, including sexual and reproductive health and rights. It was within this context that South Africa's first contraception policy was written: *Contraception Policy within a reproductive health framework* and *Contraception Service Delivery Guidelines* were launched in 2001 and 2003 respectively.¹

Several important developments in South Africa form the backdrop to the revision of the contraception policy, including the strengthening of the district-based primary health care system for delivery and quality improvement, and the integration of HIV into other facets of health care. Although the total fertility rate has slowly dropped over the past 20 years, it remains above the level that would allow population replacement rather than expansion. The epidemiological context for this is that the incidence of HIV, although gradually falling, remains high. Maternal mortality is still at an unacceptably high rate, with both HIV and obstetric causes, and access to safe termination of pregnancy is becoming more difficult in many districts.

In 2010 the Minister of Health committed himself to "a long and healthy life for all South Africans." The National Service Delivery Agreement² reflects the commitment of the health sector to:

- increase life expectancy
- reduce maternal and child mortality
- combat HIV and AIDS and decrease the burden of disease from tuberculosis
- strengthen health system effectiveness.

A number of strategies to reduce maternal mortality are proposed. These include an intention to increase the availability of contraception for all individuals requiring it, and in all health facilities in order to improve access to contraception services; and a commitment to increase the percentage of health facilities that provide contraceptive services to 90% by 2013.²

As part of strengthening health system effectiveness, and in order to achieve these targets, a number of strategies are in the process of being implemented that are pertinent to the introduction of this revised Policy and Guidelines. These include: National Health Insurance,³ re-engineering of primary health care,⁴ improving client satisfaction and quality of care,⁵ the DOH's 2011 framework for sexual and reproductive health rights, as outlined in: *Sexual and Reproductive Health and Rights: Fulfilling our commitments*.^{6,7}

* The history of family planning and population policies are well described in the *National Contraception Policy Guidelines within a reproductive health framework*. Pretoria: Department of Health 2001.

1.2 Millennium Development Goals, sexual and reproductive health and contraception

In September 2000 world leaders, including those from South Africa, committed their nations to a series of time-bound targets, with a deadline of 2015, that have become known as the Millennium Development Goals (MDGs).⁸

MDG 5 includes the reduction of maternal deaths, and includes universal access to reproductive health (MDG 5b). Promoting women's reproductive rights and improving access to voluntary contraception contribute to progress towards achieving all eight MDGs. Preventing unintended pregnancies reduces neonatal and maternal morbidity and mortality (MDGs 4 and 5), including that attributable to unsafe abortions. Furthermore, improving access to voluntary contraception is a cost-effective development tool and an intervention for achieving the other six MDGs.⁹

Although South Africa has made progress toward several MDG targets, the widespread HIV epidemic and other factors have hampered potential success. The third South African progress report suggests that progress towards meeting the targets of MDG 5 has been slow.¹⁰

1.3 Legislative and policy framework

The revised policy and guidelines are aligned with the laws, principles and values enshrined in the South African legislative and policy framework. It is also guided by several international and African-based treaties and agreements to which South Africa is a signatory. All this information is detailed in the DOH publications: *Sexual and Reproductive Health and Rights: Fulfilling our commitments*⁶ and *Sexual and Reproductive Health and Rights: Reviewing the evidence*,⁷ which provided the backdrop to the revised policy.

CHAPTER 2

Contraception in South Africa: An overview

2.1 Factors influencing contraceptive use¹⁻⁹

There are a wide variety of factors that affect people's use of contraceptives, some of which are listed below. These influence patterns of contraceptive use, service utilisation, continuation and interruption rates, and other sexual and reproductive health choices.

- *Women's socioeconomic status and residence in rural versus urban areas.* Women living in poor socioeconomic conditions and women in rural areas still tend to have less knowledge of contraception and less access to contraceptive services, and these factors are associated with lower contraceptive use.¹
- *Women's education levels.* Education has a strong impact on contraceptive use among women. Improving women's levels of education is linked to increased contraceptive use. For example current contraceptive prevalence among sexually active women with post- high school qualifications is twice as high (75%) than among women with no education (38%).¹ Improving women's levels of education allows them to gain greater information and knowledge on contraception. It also allows them to seek improved employment opportunities, increasing their economic independence which can enable them to have greater control over their sexual and reproductive lives. Higher levels of education and retaining girls in school are also linked to lower levels of teenage pregnancy and HIV.⁵
- *Partner, family and community expectations around fertility.* This includes, for example, pressures on teenagers and young women to 'prove their love' through demonstrating their fertility by childbearing; negotiations concerning condom and contraceptive use between partners, and societal and familial expectations for women to have children.¹⁻⁶
- *Knowledge about how conception occurs.* Many people do not have a sufficient understanding about the fertile period and when pregnancy is most likely to occur. This influences their choices about contraceptive use and risk, and can result in unwanted, or unplanned, pregnancy. There are important missed opportunities for information provision and education on reproduction that could be provided to women in a variety of health and educational settings.¹
- *Knowledge about contraceptive choices.* Although almost all women in South Africa know about contraception, most have a limited knowledge of the range of contraceptive methods available. This hampers their ability to make informed choices about methods most suitable for them, as individuals. It may also impact negatively on their uptake of a particular contraceptive method.¹
- *Access to contraceptive services and types of contraceptive methods.* Primary health care providers play a critical part in influencing women's uptake of contraceptive services. There is evidence to show that young women in particular may be discouraged from using contraceptives by disapproving providers. Providers also influence which forms of contraceptives women may use, with evidence that method choice is frequently limited in the public sector by the opinions and practices of primary health care nurses.^{1,7,8} For some women, contraception use is linked to suitable opening times, for example, for school going youth, or working women.
- *Counselling on health-related side effects of some contraceptive methods.* Many women attending contraceptive services do not obtain sufficient information and counselling on the expected side effects of injectable contraceptive methods. Side effects are reported to be the most common reason for discontinued use of contraception. This indicates the need for better counselling of women on the expected common side effects of the methods they choose to use, especially when they first start to use a particular contraceptive method.^{1,9}

2.2 Summary of important data

This section provides an overview of selected data and research related to contraception and fertility planning in South Africa. It includes fertility, availability and use of contraceptive services. Subsequent sections outline key data relating specifically to adolescents, a summary of the number of termination of pregnancies across all nine provinces, and lastly, a summary of HIV in relation to contraception and fertility in South Africa.

2.2.1 Fertility^{10,11,12,13}

An extensive review of existing literature on the levels, trends and differentials of fertility in South Africa reveals the following trends.

- Fertility has been declining gradually in South Africa in the past four decades.
- The patterns of fertility differ by socioeconomic characteristics (for example, population group, province, education level of mother, language).
- Data from Statistics South Africa (Stats SA) indicate that fertility in South Africa is still on a downward trend (with an estimated total fertility rate of 2.35 in 2011, compared to 2.92 in 2001).¹¹ This places the fertility level for South Africa among the lowest in the whole of sub-Saharan Africa.

2.2.2 Provision of contraception in public sector facilities

The 2003 South African Demographic and Household Survey (SADHS)¹³ indicates that 83% of women obtain their contraceptive methods from the public sector. The District Health and Information System records the distribution of each method of contraception in public sector clinics across all provinces. An analysis for the period 2008–2010 identified the broad trends listed below.*

- Relative to other methods, provision of copper intrauterine devices (Cu IUDs) is extremely low. However, there are suggestions that provision is increasing in most provinces, with provision in the Western Cape being the highest.
- In all provinces more injectable progestogen contraceptives are used than oral contraceptives.¹⁴
- Progestogen injectable contraceptives account for 49% of current contraceptive use nationally and up to 90% in some areas. Of the two available injectable progestogens, depot medroxyprogesterone acetate (DMPA) is more commonly used than norethisterone enanthate (NET-EN). The latter is often favoured for use amongst younger women.

2.2.3 Availability of services

The National Service Delivery Agreement aims to improve access to contraceptive services with a target of 90% of all public health care facilities providing contraceptive services by 2013.¹⁵ Information on the current availability of contraceptive services is limited and out dated. The last audit of primary health care facilities was undertaken in 2003¹³ and indicated that, nationally, 88% of primary health care facilities offered contraceptive services five days a week.

The 2009 DOH annual report¹⁶ states that 1053 (30.3%) of facilities provide an acceptable contraceptive mix to clients, defined as dual protection – condom and a contraceptive method.†

* Figures extracted from the District Health and Information System, an electronic health information system that collects routine data on patient encounters from clinics and community health centres throughout the country.

† The District Health Barometer 2008/2009 reports that there are 3470 clinics and community health centres in South Africa.¹⁷ This number of facilities was used to calculate the percentage of facilities providing an acceptable mix of services. Note that mobile clinics and hospitals were excluded from this denominator.

2.2.4 Rates of contraceptive use

In terms of contraceptive use, the following data are pertinent.

- Data indicate that contraceptive use is relatively high, with an estimated 65% of sexually active women between the ages of 15–49 using a modern contraceptive method.¹³ (Modern methods of contraception include female and male sterilisation, oral hormonal pills, the Cu IUD, the male condom, injectables, the implant (including Norplant), vaginal barrier methods, the female condom and emergency contraception.)
- The District Health Information System provides data to calculate the couple year protection rate.* Data available for 2010 indicates this rate to be 31.6% nationally, but with considerable provincial variation.¹⁷

2.2.5 Knowledge and patterns of contraception use

The 2003 SADHS, together with other national studies, provide information on both knowledge and patterns of contraception use.

- *Knowledge of contraception.* Although the majority of men and women stated that they had heard of condoms and, to a lesser extent, hormonal contraceptives knowledge of other available forms of contraception, such as intrauterine devices and male sterilisation were low.¹³
- *Contraceptive use.* The 2003 SADHS reported that current contraceptive use (by any method) in sexually active women was as high as 65%. The rate varied across ethnic groups, age group and educational level. This concurs with international trends, which show that the higher the level of education, the higher the likelihood of contraceptive use. Patterns of method use show the predominance of injectable progestogen contraception.¹³
- *Continuation rates.* Both the two-month (NET-EN) and the three-month (DMPA) hormonal injections are widely offered throughout the country. Although these contraceptives make up a large percentage of the contraceptive method mix, a study has indicated that many women discontinue use, either by choice or by returning late for reinjection. Some clients are refused provision when returning late.¹⁴
- *Use of emergency contraceptive pills.* Emergency contraceptive pills are available in public sector facilities and over the counter in pharmacies. The 2003 SADHS indicates that knowledge of emergency contraception remains low (19.6% women and 3.6 % of men knew about emergency contraception).¹³ Other studies show a similar lack of awareness and low utilisation rate.¹⁹
- *Dual methods.* There is on-going recognition of the importance of the dual method (combined condom and non-barrier contraception) as an important strategy for promoting reproductive health through preventing unwanted pregnancy, HIV and STIs. Two studies, from 2006 and 2008, highlighted the very low frequency of dual method use among sexually active women (10% in one study) and suggested the need for creative ways of promoting dual contraception.^{20, 21}
- Although dual methods of contraception may not have been actively taken up, there has been a significant shift towards the acceptance of condom use in relationships. Various research studies provide data about the percentage of people who used a condom when they last had sex:
 - HIV household survey undertaken in 2008: 87% of men and 73% of women (age 15–24);²²
 - *The South African Youth Risk Behaviour Survey 2008:* 29% of male and 33% of female (learners from Grades 8 to 11);²³
 - HEAIDS 2008–2009 study: 60% students; 39% service staff and 28% administrative staff.²⁴
- *Unmet need for contraception.* There is a paucity of recent data on unmet need for contraception, the most recent is the 2003 SADHS which shows that almost 14% of women in union have an unmet need.¹³ (The SADHS defines unmet need as “women currently married, who indicated that they did not want a child or wanted to wait more than two years before having a child, and were not using any contraception”.) Provinces with a higher percentage of unmet need for contraception than the national average include the Eastern Cape, Limpopo and the Free State. Satisfaction with access to contraceptive services was lowest amongst teenage women, older women, rural women and women with lower levels of education.¹³

* The couple year protection rate is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. For more information see Appendix 3, and: http://www.usaid.gov/our_work/global_health/pop/techareas/cyp.html.

2.3 Adolescents

Contraceptive use amongst adolescents is an important issue – especially in terms of the well-documented consequences of early childbearing (with its accompanying physical and social costs) and HIV.²⁵

2.3.1 Adolescent contraceptive use

According to the second national youth risk behaviour survey in 2008 (South African Medical Research Council)²³, a survey of learners in Grades 8 to 11 in public sector schools across the nine provinces found that 37.5% of learners had already had sex, of which 17.9% indicated that they used no contraception. Overall, 45.1% of learners who had already had sex indicated that the method of contraception that they most commonly used was a condom. Only 7% used injectable contraceptives and 4.2% used oral contraceptives.

Particular challenges face adolescents when it comes to the prevention of pregnancy and accessing contraceptive services. These include:²⁶

- peer pressure to be sexually active, or to conceive and demonstrate their fertility;
- inaccurate ideas about conception, reproduction and contraception;
- negative and judgemental health care provider attitudes towards teenagers who are sexually active; clinics which are not open after school, or are not youth friendly (e.g. embarrassment to be seen at the clinic by their community);
- unanticipated sex, sexual coercion.

2.3.2 Teenage fertility and pregnancy

Reporting on teenage pregnancy rates is complicated and very little recent nationally representative data are available. Data on the number of teenagers who get pregnant come from a number of different sources and suggest that teenage fertility rates are decreasing. Teenage fertility has declined by 16% between 1996 (78 per 1000) and 2001 (65 per 1000). A further decline in teenage fertility (54 per 1000) was reported in the 2007 community survey.²⁸ Older adolescents, 17–19 year olds, account for the bulk of teenage fertility in South Africa.^{23, 25, 27, 28}

There are variations in the data on teenage pregnancy rates, and comparisons across studies are limited as denominators are invariably different. A report on teenage pregnancy in school learners indicates a steady increase in pregnant learners, as shown in Table 2.1.

Table 2.1. Learner pregnancy rates for 2004–2008

Year	Number of pregnant learners per 1000 registered	Number of learners surveyed
2004	51.42	8 058
2005	55.69	9 691
2006	56.34	9 031
2007	59.51	16 336
2008	62.81	16 320
Total	58.22	59 436

Source: *Teenage pregnancy in South Africa – with a specific focus on school-going learners, 2009*²⁵

2.4 Termination of pregnancy

Data on the availability of counselling and termination of pregnancy services are limited. Both the national and provincial Departments of Health report that service provision is suboptimal and that not all accredited facilities are actually providing termination of pregnancy services. A number of districts across the country are unable to provide such services at all. Reasons given for suboptimal service provision were inadequate numbers of trained staff, long waiting times and conscientious objection by health care workers. As a result of suboptimal service provision, the number of terminations performed decreased from 77 207 in 2009 to 68 736 in 2010.^{13, 16, 29-33}

The number of termination of pregnancies performed in South Africa over the past 10 years is summarised in Appendix 2. More recent figures for 2010 are summarised in Table 2.2 below.³⁴

Table 2.2. Number of termination of pregnancies performed in 2010

Eastern Cape	Free State	Gauteng	KwaZulu Natal	Limpopo	Mpumalanga	Northern Cape	North West	Western Cape	Total
8 738	5 595	20 930	4 332	8 342	2 670	1 226	6 395	10 508	68 736

Source: Health Systems Trust³⁴

2.5 HIV and contraception in South Africa

The overall HIV prevalence in South Africa is estimated to be 17.9%, with an estimated 5.575 million people living with HIV.³⁵ The National Antenatal Sentinel HIV and Syphilis Survey (2010) indicates that the overall HIV prevalence among pregnant women is 30.2%.³⁵ While the overall prevalence has changed little in the past three years, the persistently high HIV prevalence among young women remains a major concern, with 15–25-year-old women being the highest incidence group in the general population. While the number of girls aged 10–14 years in the antenatal survey was only 0.4% (n=121), the HIV prevalence of 9.1% in this group was significant and is of great concern. Young teenagers represent a high risk and vulnerable age group and warrant special attention.^{35, 36}

South Africa's response to HIV is shaped by the *National Strategic Plan on HIV, Sexually Transmitted Infections and Tuberculosis: 2012-2016* (NSP).³⁷ The NSP makes explicit reference to sexual and reproductive health and rights, and the necessity of including contraception and fertility planning in its HIV strategic objectives (see NSP sub-objective 2.2: "Make accessible a package of sexual and reproductive health services").³⁷

HIV and contraception intersect in several crucial ways, as discussed below.

- Many women are *simultaneously at risk for both unintended pregnancy and HIV infection*.³⁸ Ideally, women should use condoms as both a method of contraception and for protection against HIV transmission, or use condoms combined with another contraceptive method. However, it is not always possible for some women to negotiate condom use. For this reason it is important to recommend contraceptive methods that do not increase a woman's vulnerability to HIV infection; and this policy takes into account available data on this topic and makes appropriate recommendations based on the most recent research.
- The World Health Organization advocates a four-pronged approach to the *prevention of mother-to-child transmission*, and both contraception and fertility planning are essential components of this approach:³⁹
 - (i) Primary prevention of HIV infection among women of childbearing age
 - (ii) Preventing unintended pregnancies among women living with HIV
 - (iii) Preventing HIV transmission from a woman living with HIV to her infant
 - (iv) Providing appropriate treatment, care and support to mothers living with HIV and their children and families.

This Policy seeks to redress the neglected area of the prevention of unintended pregnancies among women living with HIV. In order to do this, it includes the following strategies.

- *HIV testing as part of contraceptive services.* In order to make fully informed fertility decisions all couples should be aware of their HIV status and of safe pregnancy recommendations, as well as appropriate contraception and fertility service options.⁴⁰
- *Preventing pregnancy in HIV-positive women.* Preventing unwanted pregnancy in women with HIV is a public health priority – for the health of women and the prevention of mother to child transmission of HIV. Unintended pregnancy rates are high among women with HIV in South Africa.^{41–43}
- *Provision of accessible and comprehensive contraceptive services for HIV-positive women.* The sexual and reproductive decisions faced by women with HIV involve their desire for pregnancy, their contraceptive practices, their choices about an unintended pregnancy, and their prenatal and postnatal options to reduce perinatal transmission of HIV. Therefore, for HIV-positive women and couples access to services to help them safely achieve their desired reproductive desires and reduce the risk of HIV transmission is critical.^{43–46}

NOTE:

Chapter 4 in the *National Contraception Clinical Guidelines (DOH 2012)* deals with the clinical considerations of contraceptive choice in terms of HIV acquisition, progression and transmission.

Section B

POLICY FRAMEWORK

- **Chapter 3** describes the guiding principles, goal, objectives and key recommendations of the Policy and Guidelines.

CHAPTER 3

Guiding principles, objectives and key recommendations

3.1 Guiding principles

These Policy and Guidelines for contraception and fertility planning are framed by the sexual and reproductive health and rights framework adopted by the Department of Health (DOH) in 2011 (*Sexual and Reproductive Health and Rights: Fulfilling our commitments*),¹ the guiding principles for which are:

- strong and visible stewardship for sexual and reproductive health and rights
- integrated services at the district level
- a human rights approach
- a life cycle approach
- meeting diverse needs
- care for the caregivers
- intersectoral collaboration.

In addition, a rights-based approach to contraception and fertility planning-service provision underpins the Policy and Guidelines, as outlined in Box 3.1.

Box 3.1. A rights-based approach to contraception and fertility planning

- Contraceptive services are rendered (in relation to clients' rights) according to the Constitution of South Africa and other related rights-based agreed documents, for example Batho Pele Principles, the Patient's Rights Charter, and the Sexual and Reproductive Health and Rights Framework.
- There is an enabling legislative environment for the provision of contraceptive services.
- A rights-based approach is reflected in all aspects of service delivery. This is underpinned by the principle of informed voluntary contraception and people's right to exercise their reproductive choices. This includes confidentiality and privacy, contraception choice, informed decision-making and shared responsibility. All contraceptive services are voluntary, unless the client is legally incapable of making such a decision.
- Services are rendered in an equitable and non-discriminatory manner in terms of sexual orientation, sexual preferences, sexual identity, race, gender, age and culture, with due regard for what is suitable and appropriate for individual clients' needs.
- No client requesting contraception should be sent away without a suitable method of their choice.
- Client empowerment and community participation and mobilisation are promoted as part of the overall contraceptive service package.
- Contraceptive services are free in the public sector.

3.2 Goal, objectives and key recommendations

3.2.1 Goal

Comprehensive quality contraception and fertility management services are available and accessible for all people in South Africa as part of a broader sexual and reproductive health package.

3.2.2 Objectives

The Policy objectives and key indicators are summarised in Table 3.1 and described further below.

Table 3.1. Contraception and fertility planning: objectives and indicators

Objectives	Key indicators
<p>OBJECTIVE 1: Expanded choice Contraception and fertility choices are expanded and actively promoted to enable clients to meet their reproductive intentions throughout their reproductive life.</p>	Expanded method mix: copper intrauterine device (Cu IUD) and implants – incremental expansion
<p>OBJECTIVE 2: Integration Contraceptive and fertility-planning services are integrated into other health services, as appropriate.</p>	Expanded, integrated service delivery points
<p>OBJECTIVE 3: Training and capacity-building Health care providers are provided with training and capacity-building to ensure they have the knowledge, attitude and skills to provide holistic, quality contraceptive and fertility-planning services, according to their scope of practice and level of care.</p>	All health care providers trained in each facility
<p>OBJECTIVE 4: Enabling legislative framework The delivery of contraceptive and fertility-planning services is supported by an enabling regulatory, legislative and institutional framework for all levels of care.</p>	Essential Drug List reflecting method mix
<p>OBJECTIVE 5: Communication strategies Appropriate, evidence-guided communication strategies are provided to increase the public's awareness of contraceptive and fertility-planning rights, choices and services.</p>	Knowledge of at least three contraceptive methods (DHS)
<p>OBJECTIVE 6: Monitoring and evaluation, and research The policy and service delivery guidelines are evidence guided, and an appropriate monitoring and evaluation, and research agenda is developed and funded to inform policy formulation, programme planning, future recommendations and implementation.</p>	Couple years of protection; total fertility rate; method mix; teenage pregnancy; termination of pregnancy; dual protection; unmet need for contraception services.

OBJECTIVE 1: EXPANDED CHOICE

Contraception and fertility choices are expanded and actively promoted to enable clients to meet their reproductive intentions throughout their reproductive life.

- 1.1 Methods are evaluated, recommended and provided with reference to the World Health Organization Medical Eligibility Criteria for contraceptive use (WHO MEC)² and take into account the following: mode of action; safety; efficacy; side effects; return to fertility; HIV status (prevention, acquisition, transmission, progression and drug interaction); age; fertility intentions; how the method fits into the existing service delivery system, including level of care, staff resources, training, facility requirements; and cost. Noting the above the following methods are recommended:
- provision of existing methods including hormonal oral contraceptives and progestogen-only injectables;
 - promotion of emergency contraception to prevent unintended pregnancies;
 - provision of the copper intrauterine device (Cu IUD) is strengthened (including for young women and HIV-positive women). The Cu IUD provides a long-term, rapidly reversible, very effective contraception option and is cost effective. Evidence shows that it does not increase pelvic inflammatory disease, including in HIV-positive women;
 - promotion of male and female condoms, which are made widely available for contraception and for dual protection against unwanted pregnancy, HIV and sexually transmitted infections (STIs);
 - implementation of a phased introduction of hormonal implants as a new lower dose hormonal long-acting contraceptive method, acceptable in many African settings, which offers women an alternative lower dose hormonal method;
 - referral systems for contraception are strengthened, including for tubal ligation, vasectomy and the levonorgestrel releasing intrauterine system (LNG-IUS);
 - consideration of other new contraceptive methods not currently available in South Africa but which have been found to be safe and acceptable in other low/middle-income countries, for example the combined injectable.
- 1.2 An expanded contraceptive method mix is supported by ensuring that:
- sustained supplies of methods are available at service delivery points, and systems are in place to monitor this;
 - currently under-utilised methods are promoted and are part of the method choice offered to clients;
 - new methods are costed and, where required, registered with the Medicines Control Council, listed under the Essential Drug List and introduced with a phased approach (with a concomitant training and communication strategy);
 - systems of referral are strengthened between levels of care;
 - there is improved access to postpartum sterilisation for women who choose this method.
- 1.3 Services are provided that ensure the needs of different groups are met and take into account specific considerations to improve access to contraceptive and fertility-planning services (as outlined in chapters 6. Also refer to Chapter 3 in the *National Contraception Clinical Guidelines (DOH 2012)*, the companion to this document).
- 1.4 Appropriate fertility counselling and referral mechanisms are available in all facilities offering contraception.
- 1.5 Pregnancy testing, counselling and referral services are available in all facilities offering contraceptive services.

OBJECTIVE 2: INTEGRATION

Contraceptive and fertility-planning services are integrated into other health services, as appropriate.

2.1 In order to improve access to quality contraceptive and fertility-planning services, opportunities for integration with other *policies, guidelines and programmes* are sought, as appropriate. For example:

- the inclusion of contraceptive guidance in other *policies and guidelines* (HIV, education and school health, social development, correctional services, police services, youth, defence forces);
- the integration of contraception and fertility planning with the following *programmes*:
 - sexual and reproductive health (including sexually transmitted infection (STI), breast and cervical cancer, sexual violence/sexual assault, termination of pregnancy)
 - medical male circumcision
 - HIV (including HCT, PMTCT, HIV management and ART)
 - maternal health
 - integrated management of childhood illnesses and expanded programme of immunisation
 - chronic conditions such as hypertension and diabetes
 - disability.

2.2 Contraception and fertility planning is provided and/or referrals made at the following *services*, as appropriate:

- sexual and reproductive health services (including STI, breast and cervical screening, termination of pregnancy services, rape and sexual assault, and post-exposure prophylaxis provision);
- a two-way integration of contraception and fertility planning as an integral component of the HIV care pathway (including HCT; PMTCT; HIV management; ART services);
- maternal health services (including antenatal, postnatal, postpartum (including, for example, breastfeeding advisory sessions, well-baby clinics, increased access to postpartum voluntary sterilisation) and increased access to postpartum voluntary sterilisation);
- integrated management of childhood illnesses and expanded programme on immunisation;
- other chronic services, such as diabetic and hypertension services for women in the fertile age group;
- medical male circumcision, which provides an opportunity to engage men in terms of shared responsibility, and to provide information about dual protection (contraception and condom use) and male sterilisation.

2.3 In order to increase access to contraceptive services for all those of reproductive age through channels other than public sector health facilities, partnerships are formed and strengthened with other government sectors, the private sector, development partners and non-governmental organisations. These may include, for example:

- non-clinic-based delivery systems, such as social marketing and community-based programmes;
- community health workers;
- school-based clinics;
- workplace-based clinics;
- public–private partnerships. This should include, for example, a review of the enhanced role general practitioners and retail pharmacists could play in terms of contraception provision, especially within the context of National Health Insurance.

2.4 Contraceptive services are provided at different levels of care in accordance with the service delivery guidelines; and scopes of practice are expanded to facilitate contraceptive counselling and provision at different levels of service delivery as outlined in Chapter 4.

2.5 Contraceptive and fertility-planning services are provided within a framework of quality health care and supportive health systems. Referral systems are strengthened between all levels of care. Services comply with DOH National Core Standards;³ and are monitored utilising DOH endorsed quality assurance and management tools (for example, the *Primary Health Care Supervision Manual*).⁴

OBJECTIVE 3: TRAINING AND CAPACITY-BUILDING

Health care providers are provided with training and capacity-building to ensure they have the knowledge, attitude and skills to provide holistic, quality contraceptive and fertility-planning services, according to their scope of practice and level of care.

- 3.1 An agreed national core curriculum, in line with the Policy and Guidelines, provides the basis for all institutions providing training, including universities, Further Education and Training institutions, nursing colleges, provincial training units, non-governmental organisations, and other organisations that provide sexual and reproductive health and contraception training. The curriculum should be updated every five years by a panel of experts, which is overseen and approved by the DOH.
- 3.2 A mechanism is established to ensure that any new developments are included as addendums in-between the five-year revision, in collaboration with a DOH-appointed expert panel.
- 3.3 An agreed package of in-service and post-qualification/advanced training is developed (including contraception updates for practitioners with continuing professional development points). The package is developed for the following categories of health professionals: doctors (including specialists with obstetrics/gynaecology training), medical/clinical officers, public health practitioners, midwives, nurses, and pharmacists. Collaboration and liaison with regional training centres is strengthened in this regard. In addition, where feasible, specialised contraceptive and fertility-planning services in district and tertiary hospitals are established.
- 3.4 An agreed package of in-service training is developed for the following non-medical staff: social workers, health promoters, HIV support personnel (such as HCT counsellors, ART adherence counsellors), community health and outreach workers.
- 3.5 Up-to-date provider or supervisor job aids are developed, which are adapted from local and international materials and distributed at all points of care to support the updated practices and protocols.
- 3.6 Curricula and training include the key elements contained in the Contraception Policy and Guidelines), underpinned by a rights-based approach, with emphasis placed on improved access.

OBJECTIVE 4: ENABLING LEGISLATIVE FRAMEWORK

The delivery of contraceptive and fertility-planning services is supported by an enabling regulatory, legislative and institutional framework for all levels of care.

- 4.1 The provision of new methods is supported by an enabling environment, which includes revised scopes of practice, Medicines Control Council approval, tendering, procurement and supply. To this end, the following activities need to be undertaken:
 - the review, revision and rescheduling of contraceptives in line with the expanded scope of practice of identified categories of primary care service providers;
 - the review and revision of the Essential Drug List according to evidence-guided recommendations to increase contraceptive choice in South Africa;
 - the review and revision of budget line items, nationally and provincially, in-line with projected needs for both method procurement, training and communication strategies;
 - consideration by the Medicines Control Council to fast track the registration of new contraceptive methods that are considered by the DOH to be appropriate for use in the public sector.

OBJECTIVE 5: COMMUNICATION STRATEGIES

Appropriate, evidence-guided communication strategies are provided to increase the public's awareness of contraceptive and fertility-planning rights, choices and services.

The implementation of a supply (health care providers) and demand (consumers; clients) driven communication strategy is developed which includes the following:

- 5.1 Active information, education and communication (IEC) outreach and social mobilisation programmes are implemented to promote:
 - the importance of planning for healthy conception, healthy spacing of pregnancies and contraception (within the context of HIV);
 - dual protection for both HIV and pregnancy;
 - available methods, including those newly introduced;
 - the relative advantages of respective methods;
 - issues such as choice, informed decision-making and shared responsibility.
- 5.2 Key messages relating to integrated sexual and reproductive health and HIV, and contraception and fertility planning are reviewed and, where necessary, adapted or developed in collaboration with non-governmental organisations, community-based organisations and other development partners and mass media.
- 5.3 Vehicles are reviewed for communication dissemination, including new technology – both traditional (for example radio campaigns) and innovative approaches (for example mobile technology).
- 5.4 Up-to-date, evidence-guided behaviour change communication (BCC) and IEC initiatives are developed and implemented. These are to be appropriate for low-literate audiences, accessible in local languages, where necessary, and available at all contraceptive services sites. Strategies are developed and implemented to promote popular, underused and new methods, with targeted interventions focusing on the latter (for example, Cu IUDs).
- 5.5 A mechanism is developed to review and disseminate existing international and locally produced material related to contraceptive choice and fertility planning, within a sexual and reproductive health and HIV context.
- 5.6 Regular research is conducted to monitor and evaluate BCC/IEC and other initiatives related to contraception in order to inform the development of future initiatives.
- 5.7 For health care providers, an integrated communication strategy which includes provider training, steps to address supplies, method availability, and supportive resources and job aids.

OBJECTIVE 6: MONITORING AND EVALUATION, AND RESEARCH

The policy and service delivery guidelines are evidence guided, and an appropriate monitoring and evaluation, and research agenda is developed and funded to inform policy formulation, programme planning, future recommendations and implementation.

- 6.1 Data is identified and collected for approved indicators for the Policy and Guidelines and regular feedback is provided on these indicators to policy-makers and service providers.
- 6.2 Based on the District Health and Information System, a monitoring and evaluation framework with targets and timelines is developed.
- 6.3 Efficient mechanisms to collate, analyse and use the routine data obtained (through the District Health Information System) are developed for responsive programming at the provincial, district and sub-district level.
- 6.4 Relevant indicators and their possible sources are listed in Table 3.2 below.

Table 3.2. Indicators and possible sources

Indicator	Possible source
i. <i>Couple years of protection (CYP)</i> : The estimated protection provided by contraceptive methods during a one-year period, based on the volume of all contraceptives sold or distributed free of charge to clients during that period, or the contraception prevalence rate.	DHIS
ii. <i>Unmet need for contraceptive services</i> : The number or percentage of women currently married or in union who are fertile and who desire to either terminate or postpone childbearing but who are not currently using a contraceptive method. The total number of women with an unmet need for contraception consists of two groups of women: (a) those with an unmet need for limiting, and (b) those with an unmet need for spacing, future pregnancies. Note: This indicator should be adapted to include women who are unmarried.	SADHS
iii. <i>Total fertility rate</i> : The average number of children that a woman gives birth to in her lifetime, assuming that the prevailing rates remain unchanged. The TFR is a useful indicator of fertility in that it provides information regarding how many children women are currently having.	SADHS
iv. <i>Method mix</i> (patterns of method provision, aim to disaggregate by age as well).	Routine collection -DHIS
v. <i>Teenage pregnancy</i> .	Planned/Special surveys
vi. <i>Termination of pregnancy</i> .	DHIS
vii. <i>Male and female condom distribution</i> .	Routine (falls under the HIV cluster)
viii. <i>Dual method use</i> .	Sentinel sites/special studies
ix. <i>HIV/contraception service integration</i> : the proportion of service delivery points that offer integrated services.	Sentinel sites/special studies

- 6.5 Research to collect data on the following is supported: contraceptive prevalence; barriers to uptake; acceptability of new methods; dual protection and dual method use; rates of unplanned and unwanted pregnancy and teen pregnancies and risk factors for unplanned and unwanted pregnancy; interventions aimed at improving contraceptive uptake and preventing unplanned and unwanted pregnancies; models for integrated service delivery and community-based service delivery; user satisfaction; commonly experienced side effects; staff competence in the provision of contraception and use of service delivery guidelines.

6.6 Surveys (for example demographic health surveys) are conducted to collect the data necessary to determine the following indicators:

- monitor the rate of termination of pregnancy service uptake, as well as incomplete abortions, as proxy indicators;
- conduct annual surveillance on contraceptive programmes;
- improve accuracy and completeness of recording and capturing data on contraception indicators (for example recording specific methods used, including emergency contraception);
- measure current human resource requirements and assess adequate human resource requirements for the effective implementation of contraceptive services;
- determine the cost of delivery of contraceptive services and their cost effectiveness.

6.7 An expert committee is established by the DOH to ensure that all aspects of the policy and guidelines are evidence guided and up to date.

6.8 The policy is revised every four years, in synchronisation with the WHO MEC revision.²

Section C

SERVICE DELIVERY GUIDELINES

Section C consists of three chapters that relate to service delivery.

- **Chapter 4** provides an overview of the different levels of care within the health system: community, primary, secondary, district and tertiary. It also links contraceptive methods with different categories of staff, and outlines the range of methods that respective health personnel are able administer.
- **Chapter 5** describes the health systems and quality dimensions that need to frame the provision of contraception and fertility-planning services.
- **Chapter 6** outlines special considerations that need to be given to groups of people with specific needs in order to ensure that everyone in South Africa has access to sexual and reproductive health services.

CHAPTER 4

Levels of service delivery

This chapter summarises the main contraceptive and fertility-planning services provided at each level within the district health system. For a full range of sexual and reproductive health services at different levels of care refer to the DOH's framework document *Sexual and Reproductive Health and Rights: Fulfilling our commitments*.¹

4.1 Service delivery guidelines for different levels of health care provision

Tables 4.1–4.6 describe contraceptive and fertility-planning services for the following levels of provision:

- community, schools, workplaces and retail (community) pharmacies
- primary health care (PHC) – PHC clinics and mobile units
- secondary health care
- district hospitals
- referral tertiary hospitals, academic and quaternary centres.

For guidelines for levels of health care providers and method-specific service provision, see Table 4.7.

NOTE:

- Whatever the level of care, it is assumed that staff should:
 - have appropriate training
 - meet regulatory requirements
 - have regular supervision.
- The levels of care need be framed by the quality dimensions described in Chapter 5, and policy principles and objectives described in Chapter 3, which provide the foundation for the delivery of contraceptive and fertility-planning services within the health system.
- The full package of screening is described in Chapter 8 Annexe Box 8.4.

Key for Tables 4.1–4.7

ART=antiretroviral therapy or treatment; BCC=behaviour change communication; CHC=community health centre;
 Cu IUD=copper intrauterine device; DOTS= Directly observed treatment short course (for tuberculosis);
 EPI=expanded programme on Immunisation; HCT= HIV counselling and testing; LNG-IUS=levonorgestrel releasing intrauterine system;
 IEC=information, education and communication; NIMART=nurse initiated management of antiretroviral treatment;
 PHC=primary health care; PMTCT=prevention of mother-to-child transmission of HIV; STI=sexually transmitted infection;
 TOP=termination of pregnancy

Table 4.1. Service delivery guidelines: Community, schools, workplaces and retail (community) pharmacies

Level	Contraceptive method	Service	Point of service delivery	Service delivery personnel
Community	<ul style="list-style-type: none"> Male condoms 	<ul style="list-style-type: none"> Package of IEC and BCC initiatives and provision of condoms 	<ul style="list-style-type: none"> Community-based outlets (e.g. non-governmental organisations, community-based organisations, faith-based organisations) Specifically targeted outlets (e.g. workplace, public toilets, shebeens, brothels, truck stops, sport stadiums) Specifically targeted groups (e.g. sex workers, youth) Retail outlets (e.g. garages, pharmacies) 	<ul style="list-style-type: none"> All – no special qualification required (e.g. community health workers, health promoters, peer educators, outreach workers) Ward-based PHC teams, community health workers
	<ul style="list-style-type: none"> Female condoms 	<ul style="list-style-type: none"> Package of IEC/BCC, provision of female condom with appropriate training 	<ul style="list-style-type: none"> Community-based outlets 	<ul style="list-style-type: none"> Trained personnel: community health workers, health promoters, peer educators, outreach workers Ward-based PHC teams: community health workers
	<ul style="list-style-type: none"> Natural family planning 	<ul style="list-style-type: none"> Information, teaching and support to people using this method 	<ul style="list-style-type: none"> Community-based health organisations, faith-based organisations, outreach programmes 	<ul style="list-style-type: none"> Personnel trained in natural family planning
	<ul style="list-style-type: none"> The three methods above, plus hormonal oral contraceptives and emergency contraceptive pills 	<ul style="list-style-type: none"> Package of IEC/BCC Provision of condoms Oral contraceptives (repeats – initiation by nurse at PHC facility) Provision of emergency contraception and counselling / referral 	<ul style="list-style-type: none"> Health organisations/NGOs providing community-based sexual and reproductive health outreach services 	<ul style="list-style-type: none"> Ward-based PHC teams: community health workers

Table 4.1. Service delivery guidelines: Community, schools, workplaces and retail (community) pharmacies continued

Level	Contraceptive method	Service	Point of service delivery	Service delivery personnel	Comments
Schools	<ul style="list-style-type: none"> Condoms and emergency contraception Combined oral contraceptives and injectables (if qualified school nurse in attendance) 	<ul style="list-style-type: none"> IEC/BCC Method provision or referral 	<ul style="list-style-type: none"> School or referral to PHC facility 	<ul style="list-style-type: none"> School health nurses for all methods listed under 'Contraceptive method' Peer educators (condom only) 	<ul style="list-style-type: none"> Because of the prevalence of teenage pregnancy, every effort needs to be placed on prevention of pregnancy and keeping school-age girls in education The interventions need to be aligned to relevant policies of the Department of Basic Education, Department of Health, local education authority and School Governing Boards (e.g. Revised Policy Guidelines for Adolescent and Youth Health; National School Health Policy and Implementation Guidelines;^a Department of Basic Education: Integrated Strategy on HIV and AIDS, 2011–2015 Full Report) Needs to be closely linked with life skills/sexuality education interventions
Further education/tertiary education institutions	<ul style="list-style-type: none"> Condoms and emergency contraception Combined oral contraceptives, injectables, Cu IUD; implants (if qualified nurse/doctor in attendance) 	<ul style="list-style-type: none"> IEC/BCC Method provision or referral 	<ul style="list-style-type: none"> Institution-based student health clinics Workplace-based occupational health services 	<ul style="list-style-type: none"> Qualified nurse Peer educators (condom only) Occupational health nurses, doctors Peer educators (condom only) 	<ul style="list-style-type: none"> Many working women have difficulty in accessing contraceptive services, workplaces should be encouraged to provide such services Where referrals are necessary, provision should be made for time off
Workplace					
Retail (community) pharmacies	<ul style="list-style-type: none"> Condoms and emergency contraception Combined oral contraceptives (injectables; implants if suitably trained pharmacist or qualified nurse in attendance) 	<ul style="list-style-type: none"> IEC/BCC Method provision and repeats 	<ul style="list-style-type: none"> Pharmacies 	<ul style="list-style-type: none"> Pharmacists, pharmacist's assistants (post-basic), pharmacy technicians (new cadre to be introduced in 2013) nurses based at pharmacy-based clinics 	<ul style="list-style-type: none"> Recommended regulatory changes: down scheduling of contraceptives to enable pharmacists to initiate hormonal contraception and amendment of legislation to enable pharmacist's assistants (post-basic) and pharmacy technicians to provide repeats
Private	<ul style="list-style-type: none"> Condoms and emergency contraception Combined oral contraceptives, injectables, Cu IUD; implants (if qualified nurse/doctor in attendance) 		<ul style="list-style-type: none"> Private practice; not for profit organisations 	<ul style="list-style-type: none"> Doctors or nurses in private practice and /or on behalf of Department of Health 	<ul style="list-style-type: none"> Legislative changes needed for nurses (CNPs, midwives, professional nurses) in private practice

^aAt the time of going to print, some of these policy documents were undergoing revision.

Table 4.2. Service delivery guidelines: Primary level of care – PHC clinics

Contraceptive method	Service	Point of service delivery	Service delivery personnel
<ul style="list-style-type: none"> Male condoms 	<ul style="list-style-type: none"> Method provision and information on correct and consistent use 	<ul style="list-style-type: none"> Accessible points within the facility and promoted at all services, including HIV, TB, STIs, contraception and antenatal services 	<ul style="list-style-type: none"> All health care providers, community health workers, peer educators, HCT counsellors, ART adherence counsellors, DOTS supporters
<ul style="list-style-type: none"> Female condoms 	<ul style="list-style-type: none"> Method provision and information on correct and consistent use 	<ul style="list-style-type: none"> All services, including HIV, TB, STI, contraception and antenatal services 	<ul style="list-style-type: none"> Health care providers trained in female condom insertion and use
<ul style="list-style-type: none"> Male and female condoms Combined hormonal contraceptives: oral and injectables Cu IUD Emergency contraception (pills and Cu IUD) Referral to CHC, district hospitals or tertiary for intrauterine system / implants 	<ul style="list-style-type: none"> IEC/BCC Screening as appropriate* Contraceptive and fertility-planning counselling and information Infertility counselling and referral Method provision or referral Medical abortion under 12 weeks TOP counselling and referral HIV/PMTCT/NIMART Other services as per PHC package for South Africa 	<ul style="list-style-type: none"> Integration with other services, including HCT, ART, TB, STI, maternal and child health (PMTCT, postnatal, antenatal and EPI) 	<ul style="list-style-type: none"> Refer to Table 4.7 for levels of health care providers and method service provision

Table 4.3. Service delivery guidelines: Primary level of care – mobile services and PHC clinics

NOTE: Mobile units have been developed in South Africa to provide PHC services to under-served and/or remote rural areas. They differ from district to district and vary according to space, staff levels and the range of services provided. In this table mobile services have been categorised as (a) limited and (b) expanded. Limited mobile services provide minimal, basic services. Expanded mobile services provide more services and have more resources, including space, equipment and staff levels.

Level	Contraceptive method	Service	Point of service delivery	Service delivery personnel
Limited mobile services	<ul style="list-style-type: none"> Condoms – male and female Combined hormonal contraceptives (injectables and pills) Emergency contraceptive pills 	<ul style="list-style-type: none"> IEC/BCC Screening (as appropriate) Contraceptive and fertility-planning counselling and information Method provision Other services as per DOH service delivery guidelines 	<ul style="list-style-type: none"> Mobile units 	<ul style="list-style-type: none"> Refer to Table 4.7 for levels of health care providers and method service provision.
Expanded mobile services	<ul style="list-style-type: none"> As above, plus Cu IUD 	<ul style="list-style-type: none"> As above, plus: <ul style="list-style-type: none"> Medical abortion under 12 weeks Other services as per DOH service delivery guidelines.^{2,3} 	<ul style="list-style-type: none"> Mobile units 	

Table 4.4. Service delivery guidelines: Secondary level of care, including community health centre (CHC)

Contraceptive method	Service	Point of service delivery	Service delivery personnel
As per PHC (Table 4.2) plus: Subdermal implants and LNG-IUS (Mirena®) <ul style="list-style-type: none"> Low risk tubal ligation and vasectomy Where not available, referral to district hospitals/tertiary level for intrauterine system /implants 	As per PHC plus: <ul style="list-style-type: none"> Maternal health: antenatal, maternity and post natal TOP and medical abortion at designated sites, or referral Limited infertility investigation and referral 	<ul style="list-style-type: none"> More specialised contraception services Maternity: PMTCT, antenatal and postnatal services HIV/ART service points TOP services 	<ul style="list-style-type: none"> Refer to Table 4.7 for levels of health care providers and method service provision

Table 4.5. Service delivery guidelines: District hospitals

Contraceptive method	Service	Point of service delivery	Service delivery personnel	Comments
As per CHC (Table 4.4) plus: <ul style="list-style-type: none"> Tubal ligation and vasectomy Infertility management 	<ul style="list-style-type: none"> Specialist service for complications, referrals and problems beyond the capacity of PHC and CHC Provision of contraceptives to any patient attending the institution Provision of method – initiative and/or appropriate down referral to PHC facility Medical abortion and surgical abortion 	Inpatients and outpatients: More specialised contraceptive services, referral methods, especially: <ul style="list-style-type: none"> Maternity: PMTCT, antenatal and postnatal services; HIV/ART service points; Obstetric and gynaecological outpatient services. 	<ul style="list-style-type: none"> Refer to Table 4.7 for levels of health care providers and method service provision As per department and area of specialisation 	<ul style="list-style-type: none"> Initiation of a method, appropriate down referral and, where indicated, on-going care at district level Medical officers, obstetric and gynaecological specialist doctors (e.g. HIV Clinician) This level should play a key role in terms of support, training and continuing professional development. Should also provide support for CHC and PHC services

Table 4.6. Service delivery guidelines: Tertiary level of care, including referral tertiary hospitals, academic and quaternary centres

Method	Service	Point of service delivery	Service delivery personnel	Comment
As for district hospitals (Table 4.5)	<ul style="list-style-type: none"> Specialist service, referrals and problems beyond the capacity of PHC/CHC/district hospital 	<ul style="list-style-type: none"> As for district hospitals (Table 4.5) 	<ul style="list-style-type: none"> As for district hospitals (Table 4.5) 	<ul style="list-style-type: none"> Recommendation: academic teaching centres of excellence should be developed, focussing on contraception and fertility planning, and for referral of difficult cases.

Table 4.7. Categories of staff and provision of contraception

KEY

Y = Yes – this category of personnel is required
Tr = requires additional clinical training

N = No – this category of personnel is not required
Rec = recommended but needs legislative change

* IEC/BCC integrated package, including contraceptive choice/rights/HIV/STI/TB

Health care provider	IEC/BCC*	Counselling	Oral contraceptive pills prescription and initiation	Oral contraceptive pills repeat	Progestogen-only injectables	Cu IUD	LNG-IUS	Subdermal implant	Voluntary sterilisation	HCT
Lay community outreach/peer educator/volunteer	Y	Y	N	N	N	N	N	N	N	N
HCT Counsellor	Y	Y	N	Y Tr Rec	N	N	N	N	N	Y Tr
Community Health Worker	Y	Y	N	Y Tr Rec	N	N	N	N	N	Y Tr
Enrolled Nursing Assistant	Y	Y	N	Y	N	N	N	N	N	Y
Enrolled Nurse	Y	Y	N	Y	Y	N	N	N	N	Y
Professional Nurse Registered Midwife/Enrolled Midwife Advanced Midwife†	Y	Y	Y	Y	Y	Y Tr	Y Tr	Y Tr	N	Y
Clinical Nurse Practitioner/Advanced PHC Nurse	Y	Y	Y	Y	Y	Y Tr	Y Tr	Y Tr	N	Y
Clinical Associate	Y	Y	Y	Y	Y	Y Tr	Y Tr	Y Tr	Y Tr	Y
Medical Officer	Y	Y	Y	Y	Y	Y Tr	Y Tr	Y Tr	Y Tr	Y
Family Physician/Doctor	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Medical Specialist Obstetrician Gynaecologist	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Pharmacist	Y	Y Tr	Y Rec	Y Rec	N	N	N	N	N	Y Tr
Pharmacist with Family Planning Permit (Sect 22A(15) of Medicines Act)	Y	Y Tr	Y Rec	Y	N	N	N	N	N	Y Tr
Pharmacist with Primary Care Drug Therapy Permit (Sect 22A(15) of Medicines Act)	Y	Y	Y Rec	Y	N	N	N	N	N	Y Tr
Authorised Pharmacist Prescriber (new cadre)			Y Rec	Y Rec	Y Rec	N	N	N	N	Y Tr
Pharmacist's Assistant (post-basic)	Y	Y	N	Y Rec	N	N	N	N	N	Y Tr
Pharmacy Technician (new cadre)	Y	Y	N	Y Rec	N	N	N	N	N	Y Tr

† Legislative changes needed for nurses (CNPs, midwives, prof nurses) in private practice (Section 56(6) of the Nursing Act).

CHAPTER 5

Quality of care

Contraceptive and fertility-planning services need to be supported by an effective health system and provided in a way that ensures quality of care.

5.1 Department of Health standards and quality improvement initiatives

Several national initiatives contribute to a clearly defined framework to ensure quality of care.

- The National Service Delivery Agreement¹ highlights the importance of health systems strengthening, with a specific focus on quality health care.
- The *National Core Standards for Health Establishments in South Africa* (DOH Office of Standards Compliance)² provides a common definition of the quality of care that should be found in all health facilities in South Africa – from primary to tertiary levels of care. The National Core Standards document can be used as a tool to identify gaps and develop quality improvement plans. In addition, it provides the benchmark for the formal certification of facilities (as mandated by the Office of Health Compliance and legislated by the National Health Act, 2011).
- As part of the national core standards, six priorities have been identified in order to fast track improvements in facilities.³ These are:
 - values and attitudes of health care providers
 - cleanliness
 - reduction of waiting times
 - safety and security of staff and security
 - infection prevention and control
 - availability of medicines and supplies.

Improvements in all these priority areas need to be shown in all health facilities, which has relevance for contraceptive and fertility-planning services.

- Other important DOH policy documents that focus specifically on quality and are relevant to the provision of quality contraceptive and fertility-planning services include:
 - the *National Infection Prevention and Control Policy and Strategy* (2007)
 - *A Policy on Quality in Health Care for South Africa* (abbreviated version, 2007)
 - *Standard Treatment Guidelines and Essential Medicines List for South Africa, Primary Health Care Level* (2008)
 - *Primary Health Care Supervision Manual: A guide to primary health care facility supervision* (2009).

5.2 Key quality areas for contraceptive and fertility-planning services

The key quality areas for the delivery of quality contraceptive and fertility-planning services are identified in Table 5.1. These are cross-cutting and apply equally to the delivery of all health services.

Table 5.1. Key areas for quality improvement in contraceptive and fertility-planning services

	Key quality area	Examples include:
Management systems	Training	<ul style="list-style-type: none"> Knowledge, attitudes and skills to implement contraception and fertility planning, as outlined within the Policy and Guidelines, is included in training
	Supportive supervision	<ul style="list-style-type: none"> Encouragement and support are provided in order to implement the full package of contraceptive services Clinical mentorship is given
	Community profile	<ul style="list-style-type: none"> Profile includes: sexual and reproductive health; HIV and TB indicators; unmet needs; teenage pregnancy; TOP; referral resources
	Record keeping and data collection	<ul style="list-style-type: none"> Compliance with the District Health and Information System (DHIS) Data collection tools to reflect integration are used Data are used to improve services and promote method mix
	Quality improvement	<ul style="list-style-type: none"> A quality improvement structure and process is in place whereby gaps in services are identified and continuously improved
	Client feedback and participation	<ul style="list-style-type: none"> Accessible mechanisms are used to get client feedback concerning contraceptive, and other, services (e.g. suggestion boxes, exit interviews) and a process to improve services based on these Facility health committees are established and supported
Accessible and acceptable services	Infrastructure and operational issues	<ul style="list-style-type: none"> Access routes and facilities for people with disabilities are provided (e.g. ramps and specially-designed toilets) The location is accessible and there is public transport to facility The opening times accommodate the needs of working people and school-going youth
	Waiting times (one of the six DOH priority quality areas)	<ul style="list-style-type: none"> Systems are followed that help to keep waiting times to a minimum (e.g. systems to triage, appointment/fast queue systems especially for re-supply of contraceptive method)
	Staff attitude (one of the six DOH priority quality areas)	<ul style="list-style-type: none"> All personnel (including security guards, clerical staff and health care providers) provide services in a non-judgemental, respectful manner – regardless of race, class, sexual orientation, age, gender, subculture, or HIV status of client. It is important to note that negative attitudes, on the part of health personnel, can discourage clients from returning for follow-up services, which could result in method discontinuation
	Integration	<ul style="list-style-type: none"> Contraceptive services are integrated with other services to reduce referrals, improve access and to prevent missed opportunities. For example: <ul style="list-style-type: none"> integration of contraceptive services into HIV services, and HIV services into contraceptive services opportunities are considered for integration with chronic models of care, and family-based models; also post rape/sexual assault services
	Information, education and communication (IEC); behaviour change communication (BCC)	<ul style="list-style-type: none"> IEC and BCC initiatives are implemented that are age-appropriate, in local languages, with custom-designed messages for specific target groups, wall displays and posters up to date and in good condition Supply and demand driven communication strategies are implemented
	Accessible and acceptable services	<ul style="list-style-type: none"> Effort is made to accommodate clients who may not feel comfortable using contraceptive services (e.g. men, adolescents, HIV-positive people) Population groups with special needs are targeted (e.g. sex workers; lesbians, gay, bisexual, transgender and intersex persons (LGBTI); migrants) and make them feel welcome with services that are adapted to their needs Adolescent-friendly services are provided (see Chapters 6. Also refer to Chapter 3 in the companion to this document - the <i>National Contraception Clinical Guidelines (DOH 2012)</i>). Specific consideration is given for people living with HIV: <ul style="list-style-type: none"> respect for confidentiality and privacy, and for contraceptive and fertility choices services provided by health care providers with knowledge about HIV, PMTCT and ART, contraceptive choices and safer conception for people living with HIV

Table 5.1. continued

Key quality area	Key quality area	Examples include
Rights	Respect and dignity	<ul style="list-style-type: none"> Privacy is maximised (e.g. doors closed during consultations; minimal interruptions, only those involved in the delivery of health care are allowed in the consultation room; client's clothing is removed only if necessary for examination; and during examination only the areas of the body that are being examined are exposed) Dignity of client frames the consultation – guided by respect, confidentiality and privacy
	Confidentiality	<ul style="list-style-type: none"> Rights are respected with regard to confidentiality All staff know and respect client's rights, including non-professional staff Client's records are only accessible to health care providers working with clients Information is shared on a need to know basis
	Informed decision-making	<ul style="list-style-type: none"> Services (and training) are underpinned by a rights-based approach – contraceptive and reproductive choices, and informed decision-making
	Clients informed of their rights	<ul style="list-style-type: none"> Patient's rights (Batho Pele principles and Patient's Rights Charter) and channels for complaints are visibly displayed
Continuity of care	Referrals	<ul style="list-style-type: none"> Referrals are minimised, with systems to integrate provision of other services where possible Systems are in place to ensure client-centred referrals – for services within the same facility as well as referrals to other facilities and levels of care. The referral system needs to: <ul style="list-style-type: none"> follow mutually agreed processes between the services/facilities to which the client is being referred provide key information about the client: name, age, reason for referral, results of tests and investigations, and current medication/treatment (to avoid duplication) and ensure continuity of care confirm that clients have reached their destination and are receiving treatment as per referral
	Return and rescheduled appointments	<ul style="list-style-type: none"> Clients are provided with services during the same visit, and return visits are only scheduled if clinically necessary, and having taken into account the fact that return visits are costly in terms of time and money (for both the client and the facility) Dates and times for reappointments are made in consultation with the client, and contact information is exchanged in case the appointment needs to be rescheduled (due to unforeseen circumstances on the side of either the client or the facility), no client should be denied a contraceptive method due to a late return for an appointment
Drug management and equipment	Drug management (one of the six DOH priorities)	<ul style="list-style-type: none"> Supplies of drugs are managed according to provincial drug management protocols, which include protocols for storage, inventory and reordering Stock is maintained according to the Essential Drug List Full supplies of contraceptives are maintained and, where appropriate, dispensed at points of care
	Effective procurement and supply	<ul style="list-style-type: none"> All contraceptive methods are available at appropriate levels of service delivery Drugs and equipment are available to facilitate integration (e.g. contraceptives are available at HIV service delivery points, and HCT and HIV medication is available at contraceptive service points)
Environment of care and infection control	Environment of care	<ul style="list-style-type: none"> Consideration is given to issues such as: <ul style="list-style-type: none"> the provision of adequate seating, an infrastructure that allows for privacy (where people cannot see or over-hear others) cleanliness, including clean consultation rooms, toilets, waiting rooms and other public areas
	Infection control: TB	<ul style="list-style-type: none"> Measures are taken to prevent cross-infection of TB, including N95 masks, ultraviolet lights, ventilation, posters and education on cough etiquette, outdoor areas for cough sputum sample, separate seating for TB clients
	Infection control: universal precautions	<ul style="list-style-type: none"> The most recent DOH infection control guidelines are adhered to, including measures for contact precautions, such as elbow taps, disposable towels and liquid soap dispensers, correct hand-washing procedures, and correct waste and needle disposal Supplies and equipment for sterilisation and/or disinfectant are available Procedures are followed for needle-stick injuries and post-exposure prophylaxis

CHAPTER 6

Special considerations for service delivery adolescents, migrants, sex workers, LGBTI, men

South Africa has a statutory commitment to ensure that all people have access to health care, and in this case, reproductive health as embodied by the Constitution of South Africa, the National Health Act, the Batho Pele Principles and the Patients' Rights Charter.

In term of access to sexual and reproductive health services there are certain groups of people that warrant special considerations. Barriers to contraceptive and fertility services may result in poor service and/or poor method utilisation, which in turn results in unintended and unwanted pregnancies, teenage pregnancies, unhealthy pregnancies (for either mother or baby), termination of pregnancy; increased vulnerability to STIs and HIV (acquisition and transmission); and contribute to an array of potential socioeconomic challenges, including low-levels of education and a perpetuation of the cycle of poverty.

Barriers to contraceptive and fertility services may arise from ambiguous legislation, discrimination and prejudice, and the attitudes of health care providers. Such barriers may result in staff being rude, judgemental and prejudiced, with a disregard for their clients' rights and dignity; and assumptions being made about lifestyle and health needs – all of which impact on the quality of care delivered to clients, particularly those from 'key populations'. In this context the term 'key populations' refers to vulnerable, at risk clients, who may have special needs that require careful consideration when rendering HIV and sexual and reproductive health services (see below).

- **Vulnerable.** Some people are more vulnerable than others to situations that result in unwanted or unplanned pregnancy and/or acquiring HIV. Such vulnerability is related to unequal opportunities, social exclusion and other social, cultural, political and economic factors. For example, social status, age, negotiating skills, poor service delivery, level of empowerment, exposure to discrimination, violence, abuse and exploitation.¹
- **At risk.** Certain factors, such as lifestyle and sexual behaviour, significantly increase the possibility of a person acquiring or transmitting HIV, and/or having an unwanted or unplanned pregnancy. Certain behaviours create, increase, or perpetuate risk. The focus is on behaviour, rather than membership of a group, that increases the likelihood of exposure to HIV or unwanted/unplanned pregnancy.¹
- **Special considerations.** The term 'special considerations' implies that certain groups of clients require a more finely tuned service in order to accommodate specific needs as determined by their physical or mental ability, societal factors, age, sexual orientation or specific medical condition. For these groups, considering special needs is about making services accessible, and dismantling barriers that would prevent service utilisation.

In terms of contraception and fertility planning, this chapter discusses the specific needs of: adolescents; lesbian, gay, bisexual, transgender and intersex persons (LGBTI); men; sex workers, migrants and disabled persons. It focuses particularly on improving access to services and the provision of services that accommodate their respective needs.

NOTE: There are certain medical conditions and circumstances that require special consideration when determining the most appropriate contraceptive method. These include people living with HIV, adolescents, perimenopausal women, women with disabilities, and women with chronic medical conditions. These are discussed in Chapter 3 in the companion to this document, the *National Contraception Clinical Guidelines (DOH 2012)*.

6.1 Adolescents

The World Health Organization (WHO) defines adolescents as young people between the ages of 12 and 19 years. Adolescents are not a homogeneous group and their needs vary in terms of age, physical and emotional development, culture and maturity as well as life circumstances. Such factors influence the sexual and reproductive health needs of adolescents, which implies that services need to be more finely attuned to these variables. For example, the needs of a 12 year old are different to those of a 19 year old. In addition, there is a more recent dynamic with a cohort of HIV-positive young people transitioning from childhood into adolescence. South Africa has the additional complexity of AIDS-related orphans and vulnerable young people. All these factors have specific implications in terms of pregnancy prevention, fertility planning, and HIV prevention and management.

6.1.1 Adolescence and the law in South Africa^{2,3}

Key legislation that affects the provision of contraceptive services to young people is outlined below.

The Children's Act

The Children's Act, No. 38 of 2005 (as amended by the Children's Amendment Act, No. 41 of 2007) came into effect, with regulations, on 1 April 2010. Section 134 of the Act facilitates children's access to contraception. The objective is to prevent sexually active children from contracting STIs (including HIV) or falling pregnant.

Section 134 ('Access to contraceptives') states that no person may refuse to sell condoms to a child over the age of 12 years; or refuse to provide a child over the age of 12 years with condoms on request, where such condoms are provided or distributed free of charge. A person who disregards these provisions is guilty of an offence and can be fined or imprisoned for 10 years or be given both a fine and a term of imprisonment.

Contraception other than condoms (such as the pill or injection) may be provided to a child on request from the child and without the consent of the parent or caregiver of the child if:

- the child is at least 12 years of age and
- proper medical advice is given to the child and
- a medical history is taken and an appropriate examination is carried out to determine whether there are any medical reasons why a specific contraceptive option should not be provided to the child.

Finally, a child who obtains condoms, other contraception or contraceptive advice is, in terms of this Act, entitled to confidentiality. However, this is subject to Section 110(1) of the Act, which obliges health professionals to report cases of physical or sexual abuse, or deliberate neglect of a child to the Department of Social Development or a designated child protection organisation or the police.

The health professional must always consider the child's best interests before making a decision to breach the minor's confidentiality by reporting the case. This is particularly important in the case of sexually active teenagers who are at risk of becoming pregnant or acquiring an STI or HIV if they cannot access contraception and sexual health services because they fear being reported.⁴

HCT and adolescence

According to the *National HIV Counselling and Testing Policy Guidelines* (DOH 2010)⁵ and Section 130 of the Children's Act, a child may consent independently to HIV testing if he or she is:

- 12 years old or older or
- under the age of 12 years and of sufficient maturity (as outlined below) to understand the benefits, risks and social implications of such a test.

A child is considered to be sufficiently mature if they can demonstrate that they understand information on HIV testing and can act in accordance with that knowledge. In deciding whether a child is sufficiently mature, factors that should be taken into account include:

- age – the older the child the more likely it is that they will be sufficiently mature;
- knowledge – a child with knowledge of HIV and its implications is more likely to understand its consequences;
- views – a child who is able to articulate their views on HIV testing and whether or not it is in their best interest is likely to meet the maturity requirements;
- personal circumstances – an assessment of the child’s personal situation and their motivations for HIV testing may help in assessing their maturity.

Choice on termination of pregnancy and adolescence

According to the Choice on Termination of Pregnancy (CTOP) Act (No. 92 of 1996) minors may consent to termination of pregnancy, without parental consent. An adolescent mother may consent to surgical treatment of her own child.

Criminal law

The Sexual Offences and Related Matters Amendment Act (No. 32 of 2007) provides overarching protection for adolescents against rape and sexual abuse. Section 15 criminalises acts of sexual penetration by adults with children between the ages of 12 and 16 years, despite their consent; and Section 16 criminalises sexual penetration between consenting young people between the ages of 12–16 years.

The Act obliges anyone with knowledge of a sexual offence against a child to report the case to the police. Because the Act makes consensual sex between adolescents a sexual offence, this means that health professionals providing contraception to adolescents or treating them for STIs or HIV have a legal obligation to report the case. This poses a major ethical dilemma for health care providers because reporting the child may do the child more harm than good. This is because reporting sexually active teenagers is not necessarily in their best interests as it is likely to result in preventing them from accessing contraceptive and sexual health services. This in turn makes them more vulnerable to pregnancy, STIs and HIV, all of which can have dire consequences for their life, health and future.⁴

The overarching public health imperative to prevent teenage pregnancy and prevent HIV and STIs needs to guide the provision of quality health services for young people. Every effort should therefore be made to provide accessible sexual and reproductive health services that take into account young people’s vulnerability, psychosocial needs and their right to confidentiality. All initiatives should focus on prevention and, where this fails, to provide safe, quality youth-friendly services. This needs to be the overriding ethos, and should be counter-balanced with the rigid implementation of the reporting obligations.*

* In recognition of this ethical dilemma the Teddy Bear Clinic and RAPCAN have approached the High Court to challenge the constitutionality of the section of the Sexual Offences Act that criminalising consensual sex between teenagers. The case was heard in April 2012 and judgement had not been delivered at the time of going to print. If the case is successful, it will no longer be a sexual offence for teenagers to have sex, which will also mean that health professionals will not have a legal obligation to report teenagers who have consensual sex.⁴

6.1.2 Youth-friendly services⁶⁻⁸

An understanding of the main drivers of the spread of HIV amongst young people can assist in formulating messages tailored to young people's needs and understanding. Research conducted by the Human Sciences Research Council in South Africa has shown that the main drivers of the HIV epidemic in young people between 15 and 24 years of age can primarily be attributed to sexual behaviour risk factors, such as early sexual debut, intergenerational sex and multiple concurrent partners.⁹ In addition, other factors include peer pressure, transactional sex, lack of hope and pessimism for the future, low self-esteem, sexual coercion (particularly for females), biomedical factors, gender-based violence, poverty, lack of education, and leaving school at an early age. Retention in education has proven to be an important factor for reducing risk of HIV infection and teenage pregnancy. Earlier studies show that in many countries (including the world's poorest countries) the more educated and skilled young people are, the more likely they are to protect themselves and the less likely they are to engage in risky sexual behaviour.¹⁰

Every effort must be made to find ways to prevent both HIV and pregnancy. While abstinence is the ideal, many young people are sexually active. Pregnancy and HIV can have dire consequences on the life and future of a young person.

If a young person requests contraceptives or advice about contraception, it means they are most likely sexually active. Counselling about safer sex and prevention of STIs and HIV needs to be an integral part of the consultation. Contraceptive services are very often the only entry point for a young person into the health care system. It is a useful opportunity to discuss other health issues and concerns. An informal discussion about any problems at school or home can uncover other health risks such as sexual abuse or exploitation.

There are many barriers for young people in terms of using contraceptive services, and wherever possible, services should be structured in such a way to mitigate these barriers. The provision of youth-friendly services can contribute significantly to the health outcomes of young people, including the prevention of teenage pregnancies and associated risks, HIV infection, STIs, and terminations of pregnancy. Therefore, youth-friendly services need to be prioritised. For more details see the *Policy Guidelines for Adolescent and Youth Health*.¹¹

NOTE:

Method-specific guidelines for adolescents can be found in Chapter 3 of the Contraception Clinical Guidelines (DOH 2012), the companion to this document.

6.2 Migrants (refugees, asylum seekers and migrant workers)

Migration includes the movement of people within a country (internal migration) and the movement of people across international borders (cross-border migration). Migrants include refugees, asylum seekers and migrant workers. In South Africa, the majority of migrants are internal migrants and most migrants, both internal and cross-border, move in order to seek improved livelihood opportunities. Some cross-border migrants are undocumented.

6.2.1 Challenges related to health care

In terms of health, some migrant groups face challenges, some examples of which are given below.

- *Access to health care.* At health facilities, migrants may face prejudice and/or refusal of health care. Migrants without relevant documents may be fearful of seeking health care.
- *Sexual and reproductive health challenges.* Some migrant women are susceptible to rape and sexual exploitation. They are even more vulnerable in terms of securing police protection and recourse to justice. This is exacerbated by the prevalence of overt or covert xenophobia in certain communities. In some instances, migrants are refused treatment at health services.
- *Mobility.* Many migrants, both internal and cross-border migrants, remain connected to their place of origin and may return home regularly. They may need to travel or relocate in search

of employment. This makes accessing regular health care difficult and requires support from health care providers. Such support can include, for example, the provision of referral letters and sufficient supplies of medication to ensure that treatment is not interrupted.

- *Treatment unavailable or the need for treatment change.* For some migrants, the treatment they use is unavailable in the host country (i.e. South Africa). This may include, for example, different forms of contraception, or ART regimens. This may warrant referral (for example for implant removal) or a change in regimen.

6.2.2 Contraception and fertility planning

In terms of contraception and fertility planning in relation to migrants, this Policy is guided by South Africa's constitutional and legal framework, with its emphasis on human rights, the key elements of which are given below.

- Different categories of cross-border migrants are granted differential rights to access free public health care services. Asylum seekers and refugees are governed by the Refugee Act (1998); other cross-border migrants are governed by the Immigration Act (2002).
- Clause 27 in the Bill of Rights (in the South African Constitution, 1996) states that everyone has the right to have access to health care services.
- The National Health Act (2003) and the Constitution assures everyone in the country, regardless of immigration status, access to care in life-threatening circumstances.
- The Refugees Act 130 (1998) states that refugees should have access to the same basic health services that are available to all South Africans (there is ambiguity in relation to asylum seekers).
- The 2007 Financial Directive¹ from the DOH confirms that refugees and asylum seekers, with or without a permit, have the same right as South Africans to access free basic health care and ART in the public sector.
- Other documented cross-border migrants (such as those with visitor, work or study permits) should be charged a 'foreign fee' at the point of use. However, in terms of undocumented migrants the legislation is unclear and they are only covered if they are refugees or asylum seekers, as per the 2007 directive.

A public health perspective²

It is particularly important to provide comprehensive sexual and reproductive health, and HIV services to all populations – the burden of unwanted/unintended pregnancies and communicable diseases have no borders and affect all communities. Sexual networks also go beyond nationality, and so do prevention, HIV testing, HIV management, ART, TB and STI management. Therefore, contraceptive and fertility-planning services need to be available to all, regardless of people's nationality, citizenship and migration status.

Key considerations for contraceptive and fertility-planning services for migrants

In light of the above, the points listed below should guide the provision of services to migrants who request contraceptive and fertility-planning services.

- All migrants should receive contraceptive and fertility-planning services, with full respect for the clients' rights. Information should be provided on contraceptive options, termination of pregnancy, emergency contraception, PMTCT, and antenatal and postnatal services in South Africa. Information should be available in a range of languages, including South African languages.
- Where necessary a translator should be engaged for non-English speakers. Translators need to be trained in correct translation and in confidentiality. In the context of sexual and reproductive health, translators should be the same gender as the client.
- Specialist referral services need to be available where clinic staff do not have the required skills (for example to provide services for women who have a subdermal implant from their home country). A referral system or training programme for staff needs to be implemented.

- In terms of HIV, all services need to be provided. This includes HIV testing, re-testing, CD4 monitoring, initiation onto ART; PMTCT; and post-exposure prophylaxis, where indicated. For some cross-border migrants this may require the switching of ART regimens. In such cases, guidelines provided by the Southern African HIV Clinicians Society² should be followed.
- Pregnant women on PMTCT should be encouraged to delay moving away from the area so they can complete PMTCT treatment – in case there is no PMTCT programme in the area to which they plan to move. Thereafter, clear referral letters should be provided.
- Provide clients with ‘health passports’ where information about all contraceptive methods being used, treatment and testing (including CD4 monitoring if appropriate) are recorded. Encourage clients to keep these health passports with them.
- Encourage clients to make a note and memorise all contraceptive methods, medication and the doses thereof, in case they need to move to another location and/or lose their health passport (or other records). Encourage clients to come to the clinic before they relocate and provide sufficient treatment and a referral letter for their next health facility.
- In terms of contraception, as with all clients, health care providers should encourage informed decision-making and provide choice. Methods provided should take into account the women’s risk, mobility, and fertility plans for the future. Packs of emergency contraceptives need to be provided.
- Information and access to counselling and termination of pregnancy must be provided – migrants have the same rights to safe termination of pregnancy as ‘non-migrants’.
- Some migrant groups are more vulnerable to violence, sexual assault and exploitation. The provision of additional counselling may be necessary, given the trauma experienced by some migrant women and men. Such trauma may relate to circumstances and experiences in their home country and during their journey to South Africa, as well as the particular vulnerabilities to which they may be exposed, such as rape, bribes, sexual exploitation and abuse. In addition, information about post-exposure prophylaxis and emergency contraception, and the provision thereof is important.
- As with all clients, post-rape management should include antiretroviral post-exposure prophylaxis, STI management and emergency contraception.

“It is the role of health workers to act, within a legal framework, as advocates for access to health care, and not to restrict or ration care. The ethical duty of a health worker is to treat patients in a manner that serves the patient’s best interest. Medical assistance should ensure the ‘right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ and must be offered without discrimination. People in need of health care should not be denied HIV care because of their nationality.”

Source: Clinical guidelines for antiretroviral management for displaced populations, Southern Africa. South African HIV Clinicians Society²

6.3 Sex workers

Sex workers are a key population in terms of HIV prevention. Sex workers are particularly vulnerable to HIV and STIs. In the absence of effective, focussed HIV and STI prevention and management strategies, sex workers may transmit HIV to both their clients and their regular sexual partners, thereby extending transmission into the general population. Data analysed from 50 countries shows that female sex workers have a 14-fold higher risk of infection than women of a similar age in the general population.^{1–6} In addition, the prevention of pregnancy and access to effective contraception is a priority. Factors such as socioeconomic status, race, gender, and fear of the law impede the ability of sex workers to insist on safer sex practices.

Given the above, it is particularly important for sex workers to benefit from accessible and acceptable sexual and reproductive health and HIV services. However, sex workers face several barriers to health care. These include issues related to the opening hours of health care facilities; the negative, judgemental attitudes of some health care providers and some members of the community; and fear of stigma and judgement if they are open about their work, as well as fear of criminal prosecution.^{7–9}

There are certain groups of sex workers who are particularly vulnerable, including those listed below.

- Street sex workers face a range of risks in addition to the risks associated with sex work. They are more exposed to crime, police harassment, and exploitation and abuse from their clients.
- Young sex workers who lack relevant life-skills are also particularly vulnerable. They are an easy target for ‘middle men’, who promise security, a place to stay and money in exchange for them working for them. Lured by a false sense of security, they often fall prey to drug addiction, sexual exploitation and sexual violence.
- Brothel-based sex workers are often subject to labour practices and working conditions that endanger their health because brothels are not subject to labour law.
- Refugees, illegal immigrants or displaced persons who cannot seek any protection from the law, have few rights and are often protected by illegal ‘under-world’ syndicates.

Key considerations for contraception and fertility planning for sex workers

The points below provide guidance for the provision of contraceptive and fertility-planning services for sex workers.

- As with all clients, HIV testing is important. In addition, because of increased risk and exposure to HIV, repeat tests should be encouraged at regular intervals. Post-exposure prophylaxis may also need to be considered.
- The choice of contraceptive methods needs to be as a result of informed decision-making, with the relative advantages assessed in relation to the client’s lifestyle and circumstances. For example, if regular trips to the clinic are difficult for the client, then methods of long-acting reversible contraception (LARC) may be more suitable.
- The risks of pregnancy as well as STIs and HIV infection need to be considered. Condom use needs to be reinforced. Information concerning emergency contraception and termination of pregnancy must be provided.
- Many sex workers use condoms with their clients, but not with their regular sexual partner. This needs to be discussed in the context of HIV and pregnancy risk.
- In terms of planning for a pregnancy, the following need to be explored with the client, in a non-judgemental way: their HIV status; their partner’s HIV status; safe conception and ways to prevent mother-to-child transmission of HIV; lifestyle and health related issues, such as breastfeeding and child care.

A comprehensive package for sex workers includes access to the following:

- male and female condoms and water-based lubrication
- pap smears as per policy
- contraceptive choice
- emergency contraceptive pills
- fertility planning services
- STI management
- post-exposure prophylaxis, HCT, and TB screening
- promotion and support of peer educators.

6.4 Lesbian, gay, bisexual, transgender and intersex persons

LGBTI persons remain marginalised from mainstream health care. It is important that services work towards clarifying and meeting the needs of these groups of people, especially in the area of sexual and reproductive health.

Clarification of terms. ‘Lesbian’ refers to women who have sex with women. ‘Gay’ refers to men who have sex with men. ‘Bisexual’ refers to people who have sex with both men and women. ‘Transgender’ refers to people who identify with a different gender than the one they were assigned at birth. ‘Intersex’ refers to people born with a mix of male and female sexual and/or reproductive anatomical characteristics.

Although there are many differences between these groups, and further variation within subgroups, LGBTI persons share common challenges. Their sexual orientation, gender identity, gender expressions and sexual preferences deviate from mainstream norms relating to sexuality and gender expression in society.* As such, these groups are often marginalised and, in spite of being protected by the Constitution of South Africa, face prejudice, discrimination and stigma.

In terms of health care, there are several barriers that limit access to services. Barriers include staff attitudes, together with embarrassment and stereotypical assumptions about the needs of LGBTI persons. These prevent an honest, open exchange about clients’ sexual orientation, gender identity and the needs related to these. Even well-intentioned health care providers seldom have the required knowledge and skills to provide quality sexual and reproductive health care appropriate to the needs of respective groups.

While it is not within the scope of this policy to provide expanded guidelines on health care for LGBTI clients, the following provides some basic considerations related to contraceptive and fertility counselling within a sexual and reproductive health and rights-based framework.

- Many LGBTI clients will not feel comfortable about disclosing their sexual orientation or gender identity for fear of judgement and prejudice. Health care providers need to be sensitive to this, and ask questions in a way that does not automatically assume that every client is heterosexual. For example, by asking ‘What form of contraception does your partner use?’ (rather than using the terms wife/girlfriend or husband/boyfriend). In this way questions can be asked in a gender-neutral manner and openings can be created to indicate that people can have sexual partners of either gender. Furthermore, asking which pronoun a person prefers (he or she or gender neutral replacement) can create an environment that is friendly to different gender identities and expressions.
- If a client discloses their sexual orientation or gender identity, then health care providers need to have a non-judgemental and accepting attitude. It is important to discuss issues relating to lifestyle, sexual health, risk, safe sex, HIV testing, fertility planning and, where appropriate, need for contraception.
- A starting point is to ensure that all clients, including LGBTIs, have access to services that foster informed decision-making and encourage healthy relationships based on shared responsibility and mutual respect, without sexual or physical abuse and violence.
- LGBTI persons are at equal risk of acquiring or transmitting HIV as their heterosexual and cisgender counterparts. Discussion about risk and risk reduction, HIV prevention, and HIV testing needs to be part of every consultation. There are certain practices, such as anal sex, which increases the risk of HIV transmission, but these safer sex messages apply as much to LGBTI persons as they do to heterosexual persons. Furthermore, no assumptions should be made as to the sexual practices a person engages in or the type of body a person has (as this may be different from how they present themselves in terms of gender).

* For further definitions relating to sex, gender, gender identity and sexual orientation see *Sexual and Reproductive Health and Rights: Fulfilling our commitments*, DOH, 2011.¹

† Cisgender (also known as gender normative) refers to a person whose gender identity is aligned with the gender assigned at birth, i.e. a person who is not transgender.

- The rights of LGBTI persons need to be safeguarded and promoted. This includes protection from violence and rape, including, notably, the worrying trend of ‘corrective’ rape. Health care providers can assist in reducing stigma and working together with the community, law enforcement and human rights organisations to ensure that the rights of LGBTI persons are upheld.

Key considerations for contraception and fertility planning for LGBTI persons

Some factors to consider when providing contraceptive and fertility-planning services for LGBTI persons are given below.

- Throughout the public health system there needs to be a commitment to understanding the needs of transgender persons and developing strategies to meet those needs.*
- Oral contraceptives should not be used by transwomen and health workers should discourage this practice.
- As recommended in the report *Sexual and Reproductive Health and Rights: Fulfilling our commitments*,¹ specialised transgender clinics should be established, to which transwomen should be referred for assessment and hormonal therapy as indicated. The existing clinics (for example at Steve Biko and Groote Schuur hospitals) need to be replicated elsewhere.
- Training of health care personnel should include sensitisation to the challenges and health needs of LGBTI persons, including the fact that they have similar desires to heterosexual couples, and may have similar aspirations in terms of marrying and having a family.

6.5 Men[†]

Contraception is traditionally seen as a woman’s responsibility, and women predominantly use contraceptive services. However, male involvement is important for several reasons: a man has a vested interest and partnership in a woman’s decision to prevent or plan pregnancies; men are critical partners in terms of STI and HIV prevention – with regard to both condom use and reduction of sexual partners and faithfulness; and there are methods of contraception specifically for men, namely, condoms and vasectomy. In addition, it is important for couples to know their partners’ HIV status in terms of: planning for or preventing pregnancy; safer sex; HIV and STI prevention; living with HIV for either or both partners; and support.

The following are ideas for how men can be encouraged to share responsibility and participate as partners in sexual and reproductive health more broadly and in contraceptive and fertility services more specifically.

- Encourage women to bring their male partners with them to the clinic, and conduct a joint consultation that solicits a mutual commitment to both HIV and pregnancy planning or prevention.
- Provide women with the confidence and skills to discuss with their partners fertility planning, sex, HIV and STI prevention.
- Encourage both partners to be tested and offer couple counselling and testing, where appropriate.
- Encourage HIV-positive, seroconcordant and serodiscordant couples to attend sessions for joint counselling, sessions related to pregnancy prevention and/or planning, PMTCT and HIV prevention, according to their needs.
- Explore options for making women-dominated clinics more men friendly, for example hold sessions for men at specified times, promote the idea that men are welcome to attend the clinic, adapt opening hours to accommodate working men, and promote male-specific services.
- Actively promote health services for men, which can include provision or referral of the following: condoms, vasectomy and counselling about other contraceptive methods; counselling and help for sexual problems; TB prevention and treatment; STI/HIV counselling, testing and treatment; infertility counselling; screening for penile, testicular and prostate cancer; and medical male circumcision.

* For more information see the Intersex Society of South Africa www.intersex.org.za.

† Section 6.5 is adapted from: *Family Planning: A global handbook for providers*, 2011 update. Knowledge for Health Project. World Health Organization Department of Reproductive Health and Research; and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs.¹

- Develop outreach strategies and promote men’s sexual and reproductive health, which includes issues such as: mutual respect; shared responsibility; contraception; STI prevention, treatment and partner notification; HIV prevention, HIV testing, ART; discussion of gender issues that fuel violence against women, rape, the importance of reducing sexual partners, pregnancy prevention, pregnancy planning, pregnancy spacing, pregnancy care and safe delivery; and infertility.
- Appropriate integration: use opportunities such as male circumcision (medical and traditional) and services that men use, such as STI services, to promote the issues mentioned above.

Contraceptives specifically for men

Two contraceptives designed specifically for men are outlined below. Men can be encouraged to use these methods through integrating them with other services.

- *Condoms.* Condoms provide protection against HIV, STI and prevention of pregnancy, if used correctly and consistently with all sexual partners during each and every event of sexual intercourse. Therefore, men need to know, in detail, how to use condoms correctly and consistently for each sexual act. Men who use condoms need to understand the importance of emergency contraception in the case of breakage, slippage or incorrect use of the condom. They will also need to have an HIV test, and post-exposure prophylaxis may be necessary if either partner is HIV-positive.
- *Vasectomy.* Vasectomy is a permanent choice of contraception and, as such, requires serious consideration. It has fewer side effects and complications than most contraceptive choices for women. It is therefore suitable for men who definitely do not want to have any more (biological) children. See Chapter 2 in the *National Contraception Clinical Guidelines (DOH 2012)*.
- *Integration.* In order to encourage men to utilise contraceptive and fertility-planning services it is useful to integrate them with other aspects of male sexual and reproductive health and other health issues. For example, HIV testing, medical male circumcision, TB, STIs, sexual health, prostate health, blood pressure, diabetes screening.

Section D

THE CLIENT'S CONSULTATION

Contraception or conception?

SECTION D consists of three chapters relating to a health care provider's consultation with a client.

- **Chapter 7** presents some general issues to consider before doing any consultation related to contraception and fertility planning.
- **Chapter 8** provides guidelines for consultations about contraception and includes the process of initiating a contraceptive method, follow-up visits and counselling.
- **Chapter 8 Annexe** has all the boxes referred to in Chapter 8.
- **Chapter 9** provides guidelines for consultations about fertility planning and conception, with a focus on healthy conception for HIV-positive individuals and couples. It concludes with a section on infertility.
- **Chapter 9 Annexe** has all the boxes referred to in Chapter 9.

CHAPTER 7

Client's consultation: Fertility choices and planning

This chapter highlights key issues to consider when providing contraceptive and fertility counselling services. It provides the background for the guidelines presented in Chapter 8 (contraceptive provision) and Chapter 9 (planning for healthy conception and infertility care).

7.1: Key issues to consider

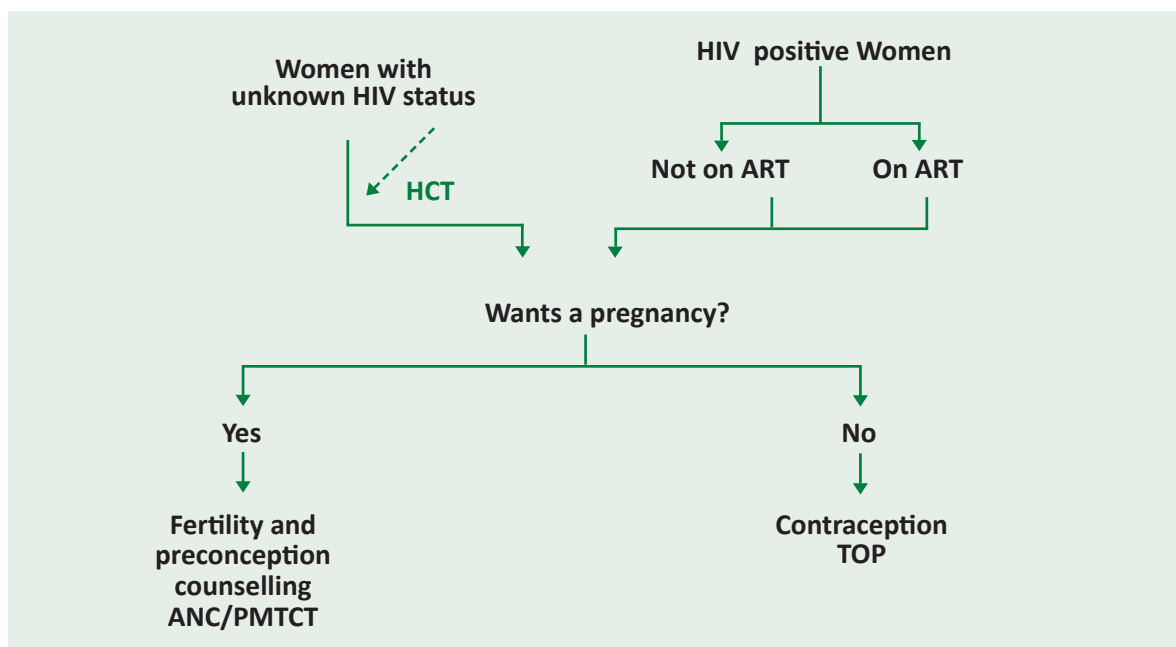
Consideration of the issues outlined below can help clients to explore their needs, issues or concerns. This process will assist decision-making about contraception and fertility planning.

- *Fertility planning and counselling.* Issues related to fertility intentions and pre-conception planning need to complement contraceptive services, and become an integral part of routine sexual and reproductive health care for all women and couples, including those living with HIV. In particular, health care providers need to assist individuals and couples to consider and express their fertility desires and concerns and, on the basis of this, provide support, information and explore options. In this way, the health care provider can assist in ensuring that conception, pregnancy and delivery take place with the least possible risk to the mother, her partner, and the resulting child.¹
- *An on-going process.* The desire either to prevent pregnancy or to have a child should be discussed at every opportunity over time. Fertility decision-making is a dynamic and changing process. Women using contraceptives may change their minds over time, from wanting to prevent pregnancy to the desire to conceive.
- *Male and female involvement.* There has been a tendency to 'feminise' contraception and contraceptive services – based on the perception that it is a women's issue and women's responsibility. Wherever possible, both partners should be involved in any consultation and clients encouraged to bring their partner so they can discuss and consider the options together. Condom use needs to be part of such discussion, even when the woman chooses a non-barrier method. Vasectomy should be explored as an option, where appropriate. Shared responsibility needs to be encouraged. The decision to plan for a pregnancy should ideally involve both partners, as is the case for infertility investigations. In terms of couples and HIV, sensitivity needs to be exercised when asking if there has been disclosure of HIV status, and this needs to be discussed separately with the client, prior to the consultation with the client's partner.
- *Diversity.* Possible diversity within relationships needs to be taken into account. Not all men and women who would like to have children are part of a heterosexual couple – single people, as well as non-heterosexual individuals and couples (e.g. gay, lesbian, bisexual, transgender and intersex persons) may wish to have children.
- *Contraception or conception? Explore the issues.* Issues relating to the desire to get pregnant or prevent pregnancy need to be discussed with the client at the initial assessment and revisited during subsequent consultations. Not only do life circumstances change over time, but also time allows rapport and trust to develop between the health care provider and the client, which may help a client to disclose more information and, perhaps, be more honest.

See Box 8.1. (Chapter 8 Annexe) for some questions to assist with the client's decision-making process in terms of planning or preventing pregnancy.

- *Healthy timing and spacing.* The healthy timing and spacing of pregnancy needs to be discussed. The time intervals recommended by the World Health Organization (WHO) are given below.²
 - **Spacing after a live birth:** The recommended interval before attempting the next pregnancy is at least 24 months in order to reduce the risk of adverse maternal, perinatal and infant outcomes.
 - **Spacing after a miscarriage or induced abortion:** The recommended minimum interval to the next pregnancy should be at least six months in order to reduce the risk of adverse maternal and perinatal outcomes.
- *Living with HIV.* In terms of HIV-positive clients, discussions concerning sex and the desire to get pregnant may cause embarrassment and fear of judgement. For example, for a client it means admitting that even though they are HIV-positive, sexual activity and the desire for pregnancy is part of their life. This may require reassurance from the health care provider that these anxieties are common, and being HIV-positive does not mean that one cannot still enjoy a healthy sex life, nor does it preclude having children.
- *Women in high HIV prevalence settings.* There are certain overarching considerations in terms of HIV, contraception and conception. These are summarised in figure 7.1 below.

Figure 7.1. What to consider when counselling a woman who lives in a setting with high HIV prevalence



Key

ANC=Antenatal care; ART = Antiretroviral treatment; HCT = HIV counselling and testing;
 PMTCT = Prevention of mother-to-child transmission of HIV ; TOP = Termination of pregnancy

CHAPTER 8

Client's consultation: contraception

This chapter provides guidelines for a health care provider's consultations with a client as they go through a process of selecting and providing an appropriate contraceptive method, follow-up visits and counselling.¹⁻⁵

8.1 The initial consultation

In the initial session, the issues listed below need to be discussed with the client. This discussion will assist the health care provider to provide information and advice on the choice of appropriate contraceptive methods.

- *Previous contraceptive methods used by the client.* Discuss the client's experience with previous methods, including whether or not they were acceptable, their reasons for stopping, or for switching to another method, any side effects, etc.
- *The client's future reproductive intentions.* This discussion will include her desire to prevent pregnancy, or to get pregnant and how to plan for it (see Box 8.1).
- *HIV related issues.*
 - What is the HIV status of the client and that of her sexual partner/s? Discuss the advantages of knowing their status and having an HIV test. Use this as an opportunity to discuss safe sex, sexually transmitted infections (STIs) and HIV prevention.
 - If the client is HIV positive:
 - Has the client had a CD4 count test? If not, ensure that this is done and provide information concerning the importance of monitoring one's CD4 count.
 - Counsel the client about living positively with HIV and, if eligible, initiation onto antiretroviral treatment (ART). This involves a discussion about the appropriate contraceptive method to use – in the interim and in the long term.
- *Issues related to lifestyle and risk.* These include, for example: sexual partners, smoking, alcohol, substance abuse; and socioeconomic issues, such as whether the client is employed, cost to come to the clinic (in terms of both travel and time). (See Box 8.2.)
- *Available contraceptive options.* Discuss the options with the client and help them to make an informed choice.
- *History taking and screening.* Explain the need for appropriate history taking, eligibility screening and clinical assessment, as required for the method, and ensure that the appropriate procedures are carried out (see Boxes 8.3–8.5).

8.1.1 Relevant history taking and assessment¹

The main issues to cover when doing a history taking and assessment for contraception are given below.

General history taking

Find out relevant details about the client's personal circumstances, contraceptive, obstetric, menstrual, gynaecological and basic medical history (including any medications that the client is currently taking, as well as HIV-related issues). All of these may influence contraceptive use. Explain that this information is needed to help choose the best method. (See Boxes 8.1, 8.3, 8.5.)

Risk discussion

A risk discussion, or assessment, explores issues related to sexual behaviour, including number of sexual partners, alcohol and substance abuse and lifestyle. It enables the health care provider to address issues related to risk and vulnerability. It provides an entry point for more holistic care, not only care related to sexual and reproductive health but also to the client's well-being in general.

Risk discussions assist with determining appropriate approaches to risk reduction, including preventing exposure to STI and HIV, and the feasibility of consistent and correct condom use. A risk discussion is also a potential vehicle to educate and empower clients. Through being more aware of their own risks and challenges, clients can be encouraged to develop strategies to overcome them. See Box 8.2 for more details about doing a risk assessment and examples of questions to ask the client.

Information and choice about available contraceptive methods and method choice

Clients need to know about available contraceptive methods in order to make an informed choice. The level of detail provided about different methods will depend on the clients' interest in particular methods and their existing knowledge. Key elements of the process are outlined below.

- Ask the client which methods are of specific interest to them.
- Check the client's knowledge – they may not know that certain methods exist, and/or have incorrect information about others.
- Briefly describe each available method of contraception that is of interest to the client, and any other available methods that may be suitable. Discuss:
 - how the method works
 - the effectiveness and benefits of the method
 - the common side effects of the method
 - any special considerations relating to the client's circumstances.
- Use appropriate educational aids (such as flip charts, models, diagrams) to assist understanding.
- Inform the client about the availability of emergency contraception in cases of method failure.
- Explain the importance of dual protection (barrier method plus other contraceptive method).
- On the basis of this discussion, help the client to make a choice.

Determine the client's medical eligibility for the method of choice

Some methods are not medically safe for some clients. Recommended screening procedures (history taking and examination) for each available method are given within the relevant method-specific sections in the *National Contraception Clinical Guidelines (DOH 2012)*, the companion to this document.

For guidelines about comprehensive history taking and examination checklists and guidelines refer to Boxes 8.3, 8.5, 8.6.

Explain to the client the screening that is necessary to enable her/him to use the method of choice safely (see Box 8.4 for information about routine screening).

If, as a result of screening, a method is not deemed safe, clearly explain the reason/s to the client. Then help the client to choose another method. Abnormal conditions that are identified during client screening (for example abnormal vaginal bleeding, STIs and suspicious cervical lesions) should be appropriately managed or referred.

Establish that the client is not already pregnant. For the purpose of initiating certain contraceptive methods a history-based checklist to rule out pregnancy (Box 8.6) may be sufficiently accurate, with the knowledge that, in any case, hormonal contraceptives will not abort an established pregnancy. Early urine pregnancy testing should be used for those clients for whom the checklist is unsuitable (for example women who have discontinued progestogen-only injectables and have not yet resumed regular menstruation).

8.1.2 Selected procedures for contraception initiation

For many women, contraceptive services are the entry point to other aspects of health care. Of specific importance is the necessity of HIV, STI and tuberculosis (TB) screening (see Box 8.4).

NOTE:

In resource-limited settings, or in settings where there is a high demand for contraception, pre-contraceptive general examination and screening should not be a barrier to contraception initiation. While physical examination and laboratory tests may be part of good preventive medicine in general, very few contraceptive methods require specific tests or examinations prior to initiation. The method-specific assessment and pre-existing medical conditions that may exclude use of certain methods are noted in Chapter 2 in the *National Contraception Clinical Guidelines (DOH 2012)*, the companion to this document.

8.1.3 Counselling, method provision and follow-up visits

Method-specific counselling

Counselling for should include the following:

- how to use the method
- common side effects and their management – this is essential in order to reduce method dissatisfaction and subsequent early discontinuation of method use
- follow-up requirements
- return to fertility
- what to do if method is used incorrectly (for example missed pill/s or coming late for re-injection) or appointments are missed
- information about emergency contraception and TOP, should the method fail.

For further detail of method-specific counselling, see Chapter 2 in the *National Contraception Clinical Guidelines (DOH 2012)*, the companion to this document)

HIV, STI and safer sex counselling

When providing counselling on HIV, STIs and safer-sex, include the following:

- a review of previous discussions about risk, and a discussion of risk behaviours and strategies to change
- a discussion about correct and consistent condom use
- if the client is HIV-negative, discuss the need to repeat HIV testing
- if the client is HIV-positive, discuss the need for condom protection to prevent reinfection. Also discuss HIV management, CD4 monitoring, and eligibility for ART initiation, as appropriate.
- encourage the client to seek prompt treatment at the first sign of an STI, the importance of condom use and of treating sexual partners as well.

Method provision

After the appropriate method of contraception has been chosen:

- provide the method or make arrangements for its provision
- supply condoms to all clients who at risk of exposure to STI and HIV
- provide appropriate IEC (information, education and communication) materials for the client to take away.

Make arrangements for a follow-up visit

Follow-up visits should be scheduled for each contraceptive method as medically indicated. In addition, ensure that:

- there is a mutually agreed plan in case the client cannot make the next appointment, and encourage the client to return, even if late, rather than not at all
- all relevant findings are briefly recorded on the client's card – these may be of particular clinical use when reviewing the client at future clinic visits.

8.2 Follow-up visits

Appropriate arrangements for follow-up visits should be scheduled with each client according to sound medical reasoning. (Recommendations for the timing of follow-up visits for each contraceptive method are given under the respective method-specific sections in Chapter 2 in the *National Contraception Clinical Guidelines (DOH 2012)*, the companion to this document).

Clients should be encouraged to come back at any time if they have any health concerns. Clients who are dissatisfied with a method and wish to change methods should be free to do so and be given the necessary information and counselling.

Guidelines for particular types of follow-up visits are given below.

Client feedback and counselling

- Ask the client if they have any questions. Find out whether they are happy with the method or have any concerns. Also ask if they have had any health problems since their last visit.
- Check method compliance and correct use as appropriate.
- Remind clients about the availability of emergency contraception as a backup.
- Check HIV related issues. For example: whether an HIV test has been done, or CD4 monitoring/ART initiation is indicated; whether the client is on ART and its compatibility with the chosen method; assess STI and HIV risk by asking a few key questions about sexual behaviour; discuss STI and HIV prevention as appropriate.
- Check that the client is happy preventing pregnancy, and provide an opportunity to discuss any intentions to get pregnant.

Examination checks

- For clients on hormonal contraception, measure blood pressure at each visit and check weight and perform breast examinations at least annually or whenever indicated (**Note:** this need only be done where possible, it is not essential, and should not be a barrier to contraception provision.)
- Conduct other examinations as indicated by the client's history.

Provision of contraceptive method

- Provide adequate supplies of the method/s and condoms.
- Provide appropriate IEC materials for the client to take away.

Make arrangements for the next follow-up visit

- This should be done as medically indicated.
- All relevant findings should be briefly recorded on the client's card. These may be of particular clinical use when reviewing the client at future clinic visits.

8.3 Counselling

Counselling is an essential component of contraceptive services. It can be divided into three phases.

1. *Initial counselling on arrival.* During a discussion with the client explore: risk; state of health/ medical history; intentions in terms of pregnancy planning and prevention; and HIV related issues, including HIV and CD4 testing as appropriate. In terms of contraceptive choice, describe all methods and help the client to make an informed choice.
2. *Method-specific counselling.* Give the client information about the specific method, including common side effects and how to use the method, and when and why to return for a follow-up visit. The need for dual protection should be discussed as appropriate, including issues related to consistent and correct condom use and condom negotiation with sexual partner/s.
3. *Follow-up counselling during the return visit.* Discuss with the client the use of the method, their satisfaction with the method, and any problems that they may have experienced. If the client is (or should be) using condoms, discuss the success of correct and consistent condom use. Explore the necessity of HIV testing and/or a CD4 count test. Discuss any intention the client has to get pregnant in the future, and how to plan for this.

For effective contraceptive counselling that facilitates informed choice and decision-making, health care providers should:

- listen to the client's needs and establish open, interactive communication;
- explore what has motivated the client to request a method;
- provide impartial information on the available contraceptive method mix without the interference of personal opinions or biases;
- assist clients to choose an appropriate contraceptive method that is appropriate to their personal circumstances and is medically safe, and takes into account the risk of exposure to STI and HIV, drug interactions with ART, TB and other medication, and their fertility desires;
- 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, follow-up arrangements and return to fertility;
- emphasise the importance of correct and consistent condom use and dual protection;
- provide information about emergency contraception and TOP;
- encourage the client to keep to appointments, and to return even if scheduled appointment dates are missed;
- if a client wishes to discontinue with contraception to plan for a pregnancy, provide pre-conception information and counselling, such as PMTCT, HIV prevention, risk of transmission and acquisition, the importance of a healthy lifestyle and, where indicated and feasible, screening of common genetic disorders.

After being counselled, the client should:

- feel satisfied with their method of choice
- know how to use the method
- have an understanding of how to prevent STI and HIV and the importance of dual protection (correct and consistent condom use)
- know when to return for follow-up appointments.

A summary of key generic counselling skills are provided in Box 8.7.

Chapter 8 annexe: Boxes 8.1–8.7

Box 8.1. Contraception or conception? Exploring the options¹⁻⁵

The health care provider should encourage the client to think through and be honest about their fertility desires and options. Some issues to explore and examples of questions to ask to help guide the discussion are given below.

- The number of living children, the age of the client's youngest child, and/or the number of other children for whom the client is responsible and the resources available to meet the needs of these children.
- HIV status of both partners, if known, and the implications thereof in terms of risk of HIV transmission to other partners and to the baby.
- The health of their existing children, including whether the children's HIV status is known.
- How committed is your partner to your relationship? Does your partner desire to have children?
- The implications of pregnancy and having a child at this point in one's life: How would having a child affect your education/work? Do you have access to health care?
- Age and health risks associated with age – with being too young or old, as well as the natural decline in fertility associated with older age.
- Why do you want a child? Why do you want to prevent pregnancy?
- The type of support that is available for the client – financial, material (e.g. housing) emotional.
- If the client has had a baby within the past year, discuss the value of pregnancy spacing for the health of both mother and child.
- If the client is HIV-positive, some additional issues to focus on include the need to assess both partners' current health status, the risk of HIV transmission to an HIV-negative partner, reinfection of an HIV-positive partner, and PMTCT.
- Discuss ways to ensure a healthy pregnancy, including healthy conception for people living with HIV.

Box 8.2. Doing a risk assessment

A risk assessment is a focussed discussion with clients concerning aspects of their lives that may make them more vulnerable and susceptible to unwanted pregnancy, HIV, STI, sexual abuse and other medical or psychosocial problems. The questions below provide a loose framework for the kind of issues to explore. The questions are given in no particular order and may be asked whenever the opportunity arises during the consultation. The aim is to discuss and explore the issues, rather than follow a formal questionnaire.

NOTE

- Explain why you would like to discuss some personal issues, and ask permission to do so.
- Ensure that you use sexual terms that the client understands. Get to know the terms that are used by clients in your area.
- Ask questions relevant to the person's health requirements and circumstances.
- Being non-judgemental and empathetic is pivotal to a successful discussion.

Issues to explore*General health concerns*

- Do you have any worries about your health?
- Have you ever been diagnosed with TB? If yes: Were you treated? Did you complete your treatment? If not: Why not?
- If TB is suspected, ask questions to find out whether the client has had: a persistent cough for more than two weeks, night fever, weight loss.

Lifestyle factors that may influence health

- Do you smoke? If yes: How many cigarettes per day?
- Do you take any drugs? If yes: ask about the frequency and type of drugs
- Do you drink alcohol? If yes: ask about the frequency and amount.
- Does your partner drink? Is this a problem?
- Explore whether the client is interested in stopping any of the above and suggest options for getting further support for doing so.

Emotional health

- Do you have a happy relationship? Any violence? Any problems?

Sexual partners

- Explore the following: Are you married? Are you in a stable relationship? Do you have a regular, committed sexual relationship?
- Do you have other sexual partners? As far as you know, does your partner have other sexual partners?

HIV/STIs

- Are you worried about HIV?
- Do you know your HIV status?
- If HIV-positive: Do you know your CD4 count? Are you on ART?
- If HIV-negative: When were you last tested? Any possible exposure since your last HIV test? Would you consider a re-test?
- Do you know the HIV status of your sexual partner? Also ask about the HIV status of the client's child/children.
- Have you or your partner had an STI in the past six months? The past year?
- Were you treated?
- Was your partner treated?

Contraception and fertility plans

- Do you use a condom? Regularly? Occasionally?
- Do you plan to have a child? Now or in the future?

Box 8.3. Comprehensive history-taking checklist for contraceptive services

Adapt the questions in this checklist appropriately for male and female clients and according to each client's needs.

Personal details

How old are you?
Are you sexually active?
Are you married/in a stable relationship?

Reproductive goals

Are you planning to get pregnant?
If yes: When?
If no: Are you using a contraceptive method?

Contraceptive history

Have you used contraception before?
If yes: Which method(s) have you used? Did you have any side effects? How long did you use it/them for? Why did you stop using it/them?

HIV

Have you been tested for HIV?
If yes, and HIV-negative: When were you last tested? Would you consider re-testing?
If yes, and HIV-positive: Have you had your CD4 monitored/do you know your CD4 count?
If on ART: What is your ART regimen? How long have you been on ART? What is your CD4 count/viral load?
If not on ART: ask questions to find out about staging, CD4 count, initiation/referral for ART (if indicated).
Explore: partner's HIV-status and children's HIV-status.

Obstetric history

How many pregnancies have you had?
How many births have you had?
When was your last pregnancy?
Are you currently breastfeeding?
How many living children do you have?
Did you have any health problems during pregnancy, labour or after childbirth?
Have you had any miscarriages?
If yes: How many? At what stage of pregnancy did you miscarry? Were there known causes?
Have you had a termination of pregnancy?
If yes: Why? At what stage of pregnancy?

Reproductive goals

Are you planning further pregnancies?
If yes: When?

Menstrual history

Are your periods regular?
On average, how many days are there between the first day of one period and the first day of the next one?
Are your periods heavy?
Are your periods painful?
How many days of bleeding do you have?

Gynaecological history

Have you experienced any abnormal vaginal bleeding (i.e. bleeding between periods and/or after sexual intercourse)?
Have you had/do you have an abnormal vaginal discharge/pelvic infection?
Have you ever had a pregnancy outside of the womb (ectopic pregnancy)?
Have you had/do you have pain during sexual intercourse (i.e. dyspareunia)?
Have you had a pap smear in the last five years?
If yes: What was the result?

Basic medical history

Have you ever had any serious illnesses or operations?
Do you suffer from any diseases (such as diabetes, heart disease, serious liver disease, cancer, blood clots in your legs, anaemia, hypertension, tuberculosis or epilepsy)?

Drugs and allergy history

Are you taking any medicines at the moment?
If yes: Which ones?
Are you allergic to any medicines or anything else that you know of?
If yes: Which ones?

Family history/relationships

Does anyone in the family suffer from any serious illnesses? Ask specifically about early heart attack, stroke, hypertension, diabetes, and breast cancer.

Box 8.4 (a). Routine screening**(a) What examinations or tests should be done routinely before providing contraception?**

While various types of examination, tests and screening procedures may be desirable for optimal sexual and reproductive health care, time and resources do not always allow for them. Their contribution to ensuring safe and effective use of contraceptives is also sometimes limited.

Various examination and screening procedures for different contraceptive methods are shown in the table below, classified according to three criteria.

Class A = essential and mandatory in all circumstances for safe and effective use of the contraceptive method.

Class B = contributes substantially to safe and effective use, but implementation may be considered within the public health and/or service context. The risk of not performing an examination or test should be balanced against the benefits of making the contraceptive method available.

Class C = does not contribute substantially to safe and effective use of the contraceptive method.

This classification system applies only to the safe initiation of a contraceptive method. It is not meant to address the appropriateness of these examinations or tests in other circumstances, such as in the provision of preventive health care services or integrated sexual and reproductive health services, or for diagnosing and assessing suspected medical conditions.

These classifications restrict their focus to the relationship of the examinations or tests for safe initiation of a contraceptive method. They do not address the appropriateness of these examinations or tests in other circumstances, which may be appropriate for good preventive health care; for integrated sexual and reproductive health care or for diagnosing or assessing suspected medical conditions.

A classification system for examinations and screening procedures to assist in decision-making

Specific situation	Combined oral contraceptive	Combined injectable contraceptive	Progestogen-only injectables	Implants	Cu IUDs (copper intra-uterine devices)	Condoms	Female sterilisation	Vasectomy
Breast examination	C	C	C	C	C	C	C	Not applicable
Pelvic/genital examination	C	C	C	C	A	C	A	A
Cervical cancer screening	C	C	C	C	C	C	C	Not applicable
Routine laboratory test	C	C	C	C	C	C	C	C
Haemoglobin test	C	C	C	C	B	C	B	C
STI risk assessment; medical history and physical examination	C	C	C	C	A*	C	C	C
STI and HIV laboratory tests	C	C	C	C	B*	C	C	C
Blood pressure screening	‡	‡	‡	‡	C	C	A	C [§]

* The *Medical eligibility criteria for contraceptive use* (WHO, 2011) states that if a woman has a very high individual likelihood of exposure to gonorrhoea or chlamydial infection, she should generally not have a Cu IUD inserted unless other methods are not available or not acceptable. If she has current purulent cervicitis or gonorrhoea or chlamydial infection, then she should not have a Cu IUD inserted until these conditions are resolved and she is otherwise medically eligible.

Women who request IUD insertion and are at risk of exposure to STI/HIV infection should be counselled about the need for additional correct and consistent use of condoms. These guidelines also recommend the use of prophylactic antibiotics to cover women who may already have asymptomatic infections (See Chapter 2.2 in the *National Contraception Clinical Guidelines (DOH 2012)*, the companion to this document)

‡ It is desirable to have blood pressure measurements taken before initiation of combined oral contraceptive pills, combined injectable contraceptives, progestogen-only pills, progestogen-only injectables, and implants. However, in some settings, blood pressure measurements are unavailable. In many of these settings, pregnancy morbidity and mortality risks are high, and hormonal methods are among the few methods widely available. In such settings, women should not be denied use of hormonal methods simply because their blood pressure cannot be measured.

§ For procedures performed using local anaesthesia.

Source: *Selected practice recommendations for contraceptive use*, WHO⁵

Box 8.4. *continued***Box 8.4(b). Integrated routine screening**

For many women, contraceptive services are the entry point to other aspects of health care. Contraceptive services provide an opportunity for HIV, STI, TB and gender-based violence screening.

A comprehensive screening package should include the following (as appropriate for the level of care and the qualifications of the health care provider, and according to the guidelines recommended by their respective policies: pregnancy test or pregnancy screening (see Box 8.6);

- measurement of blood pressure and weight;
- in terms of HIV – all clients requesting contraceptive services should be encouraged to be tested for HIV, or re-tested depending on the likelihood of exposure after the last test, and assess their CD4 count and eligibility for ART, depending on the results of the HIV test;
- TB screening should be done according to national guidelines and managed or referred, according to levels of care and provincial/local protocols;
- specific tests, such as urine, blood and STI screening tests, should be done as indicated (for example if diabetes mellitus, anaemia and/or genital infection is suspected clinically);
- cervical smear tests to detect pre-malignant lesions and early cancer of the cervix, should be performed in line with local protocols for screening or if specifically indicated. For example, if the client has post-coital bleeding, genital warts, previous atypia and/or a suspicious lesion is seen on the cervix;
- breast examination to detect breast masses should be done, combined with the encouragement of breast self-examination.

Box 8.5. Comprehensive physical examination checklist for contraceptive services

Adapt this checklist according to each client's gender, needs and method of choice, as well as to the facilities and time available.

NOTE

- There should be privacy, a good light source and the necessary equipment for the examination (for example, gloves and speculum for a pelvic examination).
- Explain the reasons for the examination and the procedure to the client before starting.
- Respect the client's right to privacy by, at any one time, only exposing the parts of the body being examined. If possible, clients should be chaperoned.
- Avoid being rough. A careful and gentle examination will minimise the client's discomfort and ensure that important signs are not overlooked.
- Report on any normal findings while performing the examination as this will help to relax the client.
- The client has the right to refuse an examination.

General examination

- ✓ General appearance: Is the client too thin? Does she/he look malnourished/sick?
- ✓ Emotional state: Does she/he seem overly anxious or depressed?
- ✓ Record the client's weight, height, and arm circumference.
- ✓ Record the client's blood pressure and pulse rate.

Head and neck examination

- ✓ Hair: check for alopecia and excessive hair distribution.
- ✓ Eyes: check for jaundice and anaemia.
- ✓ Face: check for acne, chloasma and hirsutes.
- ✓ Tongue: check for anaemia.
- ✓ Ears: check for allergy to metallic earrings.
- ✓ Check for skin lesions, such as acanthosis nigricans.

Hands, feet, lower limbs and groins

- ✓ Hands and feet: check for rashes and pitting oedema.
- ✓ Lower limbs: check for pitting oedema and varicosities.
- ✓ Groins: check for inguinal lymphadenopathy and lumps.

Chest examination

- ✓ Heart: check for abnormal heart sounds/murmurs.
- ✓ Lungs: check for abnormal sounds.

Abdominal examination

- ✓ Check for abdominal masses and/or tenderness.

Breast examination

- ✓ Inspect and palpate for breast masses and nipple discharge.
- ✓ Check axillae for lumps and enlarged nodes.

Pelvic examination (only where indicated)

- ✓ Check for signs of infection and masses of the external and internal genitalia in female clients (put on gloves before touching the client); or external genitalia in male clients.
- ✓ Check for signs of infection and testicular masses in male clients (put on gloves before touching the client).

Box 8.6. Pregnancy checklist**How do I know if a client is pregnant?**

Ask the following questions to determine whether or not a client is pregnant. Have you given birth in the last four weeks?

- Are you less than six months postpartum and fully breastfeeding and free from menstrual bleeding since you had your child?
- Did your last menstrual period start within the last seven days?
- Have you had a miscarriage or abortion in the last seven days?
- Have you abstained from sexual intercourse since your last menstrual period (menses)?
- Have you been using a reliable contraceptive method consistently and correctly

If the client answers 'No' to all questions, pregnancy cannot be ruled out. The client should be advised to abstain or use condoms until her next menses or do a pregnancy test to exclude pregnancy.

If the client answers 'Yes' to any one of these question and is free of signs or symptoms of pregnancy, provide her with her desired method of contraception.

Box 8.7. Summary of generic counselling skills

A positive relationship with health care providers encourages the client to utilise and trust the health service and to discuss issues more openly, ask questions, adhere to advice and return for follow-up visits when required.

A positive health encounter includes the following elements.

- *Rapport.* To establish rapport with your client: be welcoming; greet the client politely and respectfully; give your full attention; give positive feedback in terms of the client coming to the health service to seek a method.
- *Awareness of one's own attitude.* Be aware of how your own personal views influence your interaction with the client. Be empathetic, respectful and non-judgemental towards all clients – regardless of their age, sex, race, religion, culture, disability, social status, sexual orientation, sexual preferences and number of sexual partners.
- *Effective communication.* Communicate in a manner that encourages trust and openness, and fosters education and understanding. This includes:
 - being aware of body language: focussing on the client, maintaining eye contact;
 - listening to the client and providing opportunities throughout the consultation for the client to ask questions, raise issues and voice concerns without embarrassment or fear of ridicule;
 - using simple, non-technical language.
- *Personalise the consultation and develop empathy with the client.* Take an interest in the client as an individual and seek to understand their needs, concerns and barriers by stepping into their shoes.
- *Respect the rights of the client:*
 - accept the client's right to make their own informed choice of contraceptive method. Clients should be given adequate information and counselling, without the influence of health-care provider biases, in order to assist them to make an informed and voluntary decision about contraception and method use;
 - discuss confidentiality, and the people who may be told about the consultation on a 'need to know' basis. This is especially important for adolescents who are often concerned that information will be disclosed to their parents or guardians;
 - counselling should be provided in a private and comfortable environment.

CHAPTER 9

Client's consultation: Towards healthy conception

9.1 Pre-conception planning and counselling*

Pre-conception planning and counselling can go a long way towards contributing to a healthy pregnancy and birth. Fertility/pre-conception planning can greatly assist in reducing both maternal morbidity and mortality from complications of unplanned and/or high-risk pregnancies. Box 8.1 (Chapter 8 Annexe) outlines issues to explore when discussing a client's needs in terms of planning for or preventing pregnancy.

The key aspects of pre-conception screening and counselling are summarised in the checklist in Box 9.1.

9.2 Special considerations for HIV-positive individuals and couples wanting to conceive

When considering planning for pregnancy for HIV-positive individuals and couples, the aim is to minimise the risks of HIV transmission, acquisition and mother-to-child transmission. HIV positive people should be encouraged to plan for conception in order to improve health outcomes. Issues to think about are discussed in more detail in this section, and include:

- consideration of the decision to get pregnant and its implications on a person/couples' life;
- maximising the health of an HIV-positive person so they can enjoy a healthy pregnancy and birth, with minimal risk of HIV transmission to sexual partners and the baby;
- exploration of the mode of conception and strategies to minimise HIV transmission during conception.

9.2.1 Conception and risk of HIV transmission

The risk of HIV transmission depends on HIV plasma viral load, the presence of STIs, and the length and frequency of exposure to HIV.¹

Recent research has shown that the probability of transmission is markedly reduced in people with lower viral loads.^{2,3} This can occur naturally through improved health status and/or with taking ART. ART substantially reduces transmission to the HIV-negative sexual partner in serodiscordant couples, in some instances by as much as 96%.³⁻⁶ However, an undetectable plasma viral load does not mean that HIV cannot be transmitted, as traces can still be found in the genital tract and semen. Although the risk is substantially reduced, there is still a small risk and this has implications for natural conception and unprotected intercourse.

In addition, when trying to conceive there is a small risk of reinfection or super-infection with another strain of HIV that may or may not be drug sensitive, and this needs to be considered.⁷ The implications may include increased viral load in someone not on ART, or infection with a drug-resistant virus in someone who is already using ART.

* This section has been adapted from Bekker L-G et al. Guideline on safer conception in fertile HIV-infected individuals and couples. *Southern African Journal of HIV Medicine*, 2011, 12(2):31 Full acknowledgement is extended to the journal and authors. ¹

9.2.2 Optimising the health of an HIV-positive individual or couple

As with any chronic condition, attention should be paid to minimising potential risk before and during pregnancy. There are certain steps that can be taken prior to conception in order to reduce transmission and ensure a safe pregnancy, for both mother and baby. These include those listed below.

- *Identifying the serostatus of both partners.* This is an important starting point, as the status of one or both partners may be unknown, and have implications for both seroconcordant and serodiscordant couples wishing to conceive.
- *Managing the health of the woman.* This includes identifying and managing HIV-related co-morbidities, including opportunistic infections, such as TB. In addition, the usual screening for other medical conditions that may negatively influence pregnancy apply, for example, hypertension, epilepsy or diabetes. It is recommended that conception is delayed until treatment is completed for conditions that require short-term management, such as TB or acute infections. For chronic conditions that require on-going treatment, it is recommended that treatment regimens are adjusted to exclude medications that are potentially teratogenic, and that the condition is actively managed before and during pregnancy.
- *HIV assessment.* The health status of both the woman and her partner need to be assessed in terms of HIV related factors. This involves a clinical assessment, a CD4 count to assess eligibility for ART, plus a viral load measure if available. As previously noted, an undetectable viral load does not guarantee that HIV will not be transmitted. A detectable viral load in a person on ART is an indication to delay conception.
- *ART initiation as appropriate.* Given the benefits of ART in reducing the viral load and the risk of HIV transmission (in addition to all its other health benefits), the initiation of ART in eligible individuals is recommended before proceeding with conception.

Recommendations for optimal outcomes

- Given current evidence, HIV-positive persons wishing to conceive (or reproduce in the case of men) should have an undetectable viral load before doing so. Initiation onto ART for at least 3–4 months prior to unprotected sexual intercourse, and the assessment of viral load 3–4 months after ART initiation is recommended where possible. For an optimal outcome, there should be high levels of adherence and immune recovery, and preferably documented virological suppression for at least 4–6 months.
- South African national guidelines provide for ART initiation in adults with CD4 cell counts <350 cells/ μ l.
- South African PMTCT guidelines make the following provisions: ART for all pregnant women; continuing ART for maternal health in women with CD4 <350 cells/ μ l; and cessation of ART after pregnancy or breastfeeding in women in whom initial CD4 counts are >350 cells/ μ l. (Refer to DOH's PMTCT guidelines.)
- Care is needed in the selection of regimens prior to conception and in pregnancy, and ART with potential teratogenicity should be avoided at least in the first trimester.⁸ Recommendations for antiretroviral drug regimens for use in the first trimester pregnancy are revised and updated in DOH's PMTCT and ART guidelines.
- It is recommended that the CD4 count is >200 to improve both maternal and fetal outcomes.

9.3 Pre-conception counselling for HIV-positive individuals and couples*

There are several ways in which the health care provider can assist an HIV-positive client/couple in preparing for conception, these include counselling and promoting safer conception strategies.

At a minimum, all women should receive HIV-related investigations as well as syphilis screening, haemoglobin measurement, and a physical examination with visual inspection of the cervix for abnormalities and for signs of STIs. Where resources are available, a cervical smear (pap smear) may be considered. This may be extended to include a full screen for TORCH infections (toxoplasmosis, rubella, cytomegalovirus, herpes simplex) and some other infections that carry the risk of being transmitted from mother to child during pregnancy, as well as viral hepatitis, and a full blood count.

9.3.1 Pre-conception counselling for people living with HIV

Pre-conception counselling should ensure informed choice about reproductive options, including the inherent risks and costs of each treatment and the likely chances of success. See Box 9.1 for a checklist for pre-conception counselling.

Particular elements to cover in pre-conception counselling for people living with HIV are outlined below.

- Pre-conception screening, see Box 9.3.
- The availability of different methods for safer conception in the locality needs to be established – within both the public and private sector (where appropriate).
- Information provided concerning different options should include:
 - up-to-date information on the safety for each method of conception together with advice on additional ways of reducing risk, such as limiting intercourse to the fertile window (Box 9.2 and 9.4);
 - appropriate use of ART, including early initiation in ART for HIV-positive individuals, and/or use of pre-exposure prophylaxis for HIV-negative individuals in discordant couples (see Appendix 6);
 - artificial insemination with partner's sperm (if he is HIV-negative) or donor's sperm (if partner is HIV-positive);
 - regular screening for STI and HIV;
 - the fact that each option still poses a relative risk.

In addition, the following should be discussed:

- the possibility of treatment failure and how the couple would cope if (a) they successfully had a child but the HIV-positive parent's health deteriorates; and (b) if HIV is transmitted to the previously HIV-negative partner while trying to conceive;
- if it is the female partner who is HIV-positive, the couple needs to understand the risks of mother-to-child transmission and the approaches used to reduce the risk;
- the importance of attending an antenatal clinic when pregnant to ensure that support and advice is provided to minimise the risk of mother-to-child transmission.

9.3.2 Safer conception strategies for people living with HIV

There are several ways to make conception safer in HIV-positive couples – both seroconcordant and serodiscordant couples. Some of the methods are evidence based, others are experimental. They can be used alone or in combination, depending on relevance and feasibility, and include:

- ART and viral load suppression in the HIV-positive partner/s
- limiting unprotected sex to peri-ovulatory window
- intrauterine or intra-vaginal insemination with partner's sperm (if female partner is HIV-positive) or donor's sperm (if male partner is HIV-positive)
- male circumcision (if male partner is HIV-negative).

* This Policy has limited recommendations for conception to options currently available in the public health sector (resource-limited settings). Options available in resource intensive settings can be found in: Bekker L-G et al. Guideline on safer conception in fertile HIV-infected individuals and couples. *Southern African Journal of HIV Medicine*, 2011¹

Other options include:*

- sperm washing (if male partner is HIV-positive)
- surrogate sperm donation
- post-exposure prophylaxis in the HIV-negative partner (see Appendix 6)
- pre-exposure prophylaxis in the HIV-negative partner (see Appendix 6).

It is important to note that in deciding which strategies to use for safer conception for HIV-positive couples, either seroconcordant or serodiscordant couples, there are factors that may influence the choices. These include issues such as resources, availability of treatment strategies, risk of HIV transmission and the clients' and health care providers' preference.

The recommended conception strategies for serodiscordant and HIV-positive seroconcordant couples, applicable to resource-limited settings are outlined in Box 9.4. In all cases where unprotected sex with an HIV-positive partner or vaginal insemination with potentially infected semen is considered, both partners should be counselled about the risk of transmission and strategies to reduce it, depending on which partner is infected. Such strategies include ART, pre/post-exposure prophylaxis, male circumcision,⁹ sperm washing and insemination with either partner's sperm (if uninfected), or uninfected donor's sperm, according to availability.

The couple should be assessed for reasonable expectations of fertility, for example no evidence of reduced ovarian reserve or tubal damage. Referral for infertility investigation should be considered when pregnancy is not achieved after 12 months of peri-ovulatory sex.

Vaginal or uterine insemination

An important strategy to minimise HIV transmission to the HIV-negative partner is vaginal or uterine insemination. The semen of the HIV-negative male partner is collected. (In cases when the male partner is HIV-positive and the woman is infection-free, sperm from a known or anonymous uninfected donor from a sperm bank can be used). Vaginal self-insemination with uninfected sperm is done around the time of ovulation, thus maximising the chance of fertilisation. This procedure can easily be learnt and can be performed with ease at home. In addition, if a freshly collected semen fluid specimen is brought to a clinic, vaginal insemination could be performed as a service. Intrauterine insemination may be more effective, but needs to be done by a trained health care provider. This is further explained in Box 9.5.

9.3.3 Summary of options for seroconcordant and serodiscordant couples

(Also see summary in Box 9.4)

Seroconcordant positive couples (both couples are HIV-positive)

In resource-limited settings, vaginal self-insemination may be considered (See Box 9.5), but the benefit of this procedure will be limited for seroconcordant couples because while the male partner will be protected from theoretical super-infection, the female partner will still be exposed to HIV-infected sperm. Limiting unprotected sex to the peri-ovulatory window of each menstrual cycle is a sensible approach to achieving pregnancy, although both partners must acknowledge the potential risks associated with the small possibility of super-infection,⁴ and have a good understanding of how to calculate the time of ovulation so they can time intercourse to the peri-ovulatory window (Box 9.2). Ideally, even in resource-limited settings this risk can be further reduced in seroconcordant couples by ensuring viral load suppression in both partners during the time they are trying to conceive. As discussed above, in all settings ART-eligible individuals should be stabilised on optimal therapy prior to conception.

Serodiscordant couples

Research shows that in discordant couples who want to conceive, where the HIV-positive individual was using ART and adherent, there was a 96% reduction in the risk of HIV transmission to the HIV-negative partner.^{2, 3, 5, 6} For couples in this situation, therefore, timed peri-ovulatory sex is recommended.

* This Policy has limited recommendations for conception to options currently available in the public health sector (resource-limited settings). Options available in resource intensive settings can be found in Bekker L-G et al. 2011¹

If the male partner is HIV-positive

When the male partner is HIV-positive in a serodiscordant relationship, he requires optimal medical therapy, including ART when indicated, to minimise the risk of transmission. Therefore, optimally, this together with timed peri-ovulatory intercourse is advised. Both partners should be counselled on the risks of transmission and advised to limit unprotected sex strictly to the peri-ovulatory window of each menstrual cycle. This will maximise the chance of fertilisation and minimise occasions on which the HIV-negative female partner will be exposed to infected sperm.

Intrauterine insemination may also be considered. This affords the possibility of conception with minimal risk of male-to-female HIV transmission. Pre/post-exposure prophylaxis may also be considered in this setting as protection for the HIV-negative female partner (see Appendix 6). The HIV-negative female partner requires regular HIV antibody testing throughout pregnancy in order to detect and manage seroconversion, starting with an HIV test at least six weeks post-conception. The use of condoms is advised throughout pregnancy.

If the female partner is HIV-positive

When the female partner is positive in a serodiscordant relationship, there is a wider range of options. It is beneficial for the HIV-negative male to have been circumcised.⁹ If he undergoes a male circumcision procedure, this should be at least two months before considering unprotected sex. In addition, vaginal self-insemination (or uterine insemination performed by a trained provider) around the time of ovulation maximises the chances of fertilisation while protecting the male partner from HIV exposure (see Box 9.5). Couples may attempt unprotected sex limited to the peri-ovulatory window of each menstrual cycle (see Box 9.2).

The woman's HIV management should be optimised (viral load undetectable on ART) prior to the couple attempting pregnancy. The couple should also receive thorough counselling on the existing risks of HIV transmission even when viral load is low and the number of unprotected sexual acts is minimised. The HIV-negative male partner may benefit from pre/post-exposure prophylaxis (see Appendix 6); he will also require on-going HIV testing to identify possible seroconversion. No unprotected sex post-conception is advised.

9.3.4 Contraindications for pregnancy

Ultimately, the decision to have a child rests with the client. However, there are several instances when a health care provider may reasonably decide to discourage or defer attempts to conceive.

Factors indicating that pregnancy should be discouraged or deferred include:

- either couple has a high viral load, where viral load suppression has not as yet been adequately achieved
- non-disclosure of HIV status to a partner
- documented infertility in either partner
- conditions affecting fertility (although specialist fertility clinics may be able to intervene in such cases)
- other obstetric/medical contraindications.

9.3.5 Alternative ways to conceive/have a child

Individuals and couples may wish to consider alternative ways of having a child, i.e. other than via sexual intercourse or pregnancy. Examples of such alternatives are listed below.

- *Artificial insemination.* Women who want to get pregnant but do not have a partner can consider a sperm donor. Lesbian partners can do the same. Where the male partner is HIV-positive, sperm from an HIV-negative sperm donor can also be considered. The sperm can be from a known donor or an anonymous donor from a sperm bank accredited by the Health Professions Council of South Africa. The sperm from a known donor can be self-inseminated, whereas sperm from a sperm bank requires the assistance of a designated health facility. Refer to Box 9.5 for further information on self-insemination. (Remember: An HIV-positive pregnant woman must ensure that she benefits from ART to prevent mother-to-child transmission.)

- *Adoption.* Adoption may be possible through an approved facility, or through a social worker. Note that chronic illnesses (including HIV) and sexual orientation are not precluding factors. In terms of chronic illness, there needs to be evidence that the illness is well controlled and that the adoptive parent is able to care for the child.
- *Surrogacy.* Surrogacy may be an option (i.e. another woman carries the pregnancy for the couple). Surrogacy is not widely practised in South Africa.
- *Developing relationships with other children.* A further alternative is to develop close relationships with children of others, for example friends and family; or taking specific responsibility and building a relationship with a child in need of care.

9.4 Subfertility and infertility

A couple is considered to be infertile when pregnancy has not occurred after at least 12 months of regular sexual intercourse without contraceptives. There are gradations of infertility, a sterile partner will render a couple infertile and some couples have reduced fertility or subfertility. It may take such couples much longer to achieve pregnancy, or they may not be able to conceive without specific medical interventions.^{5,6}

The causes for infertility vary from person to person. HIV infection can result in reduced fertility. In both HIV-positive and HIV-negative women, infertility may be due to the following reasons: genetic or endocrinological factors; infectious diseases; complications associated with STIs (particularly chlamydial infection and gonorrhoea) which could affect both partners; complications from postpartum and post-abortion infection; problems with sperm (such as low mobility and/or low sperm count).

The myth that contraception causes infertility needs to be dispelled. Women who use injectable contraceptives may experience a delay in returning to fertility but their fertility is not affected permanently. Other contraceptive methods cause no delay. The average time-to-pregnancy in women who discontinued contraception in order to become pregnant is very similar to time-to-pregnancy in women who never used contraception.

It is important to involve both partners. All too often infertility is seen as the woman's problem, however male infertility is almost as common as female infertility. It is important to counsel and treat the problem with both partners. Not only is it important for both partners to be tested in order to establish possible causes of infertility, but also they need to provide mutual support to one another. For many people infertility is a lonely, painful journey. It can also put a lot of stress on a couple's sexual relationship, as intercourse becomes a means to procreate and loses spontaneity as it has to be timed to a peri-ovulatory window, and the pleasure of sex can be diminished by the anxiety about getting pregnant.

Assisted reproduction technologies are increasingly improving but still have a limited success rate in terms of pregnancy results. In South Africa, hormonal treatments and assisted technologies, such as in vitro fertilisation, are predominantly available in the private sector. This Policy advocates for making fertility services (including infertility services) more accessible and available through the public sector.

Infertility counselling needs to include:

- ways to increase the chances of conception, including an explanation of how to identify the fertile (or peri-ovulatory) window (see Box 9.2);
- emotional support, dealing with family pressure, coping with one's feelings as a woman, living with uncertainty and other pressure or stress on the couple's relationship, etc.;
- an explanation of subfertility and its possible causes;
- an exploration of other options:
 - where possible, patients who are struggling to conceive may be referred to specialist fertility services for further support, including assessment of luteinising hormone levels in women and sperm assessment in men
 - assisted reproductive technologies for couples that are found to be infertile (where available and affordable)
 - adoption, or involvement with other people's children, family or community.

Chapter 9 annexe: Boxes 9.1–9.6

Box 9.1. Pre-conception screening and counselling checklist

A general health screen

- ✓ Past medical history.
- ✓ Past obstetric history.
- ✓ Family history of inherited disorders or congenital abnormalities.
- ✓ Ensure that all immunisations are up to date. If appropriate, immunisations may be offered. After receiving rubella and hepatitis immunisations, a woman should delay conception for three months.
- ✓ Conduct general examination including height, weight and blood pressure measurement.
- ✓ HIV screening, preferably of both partners. If HIV-positive, it is essential for both partners' health to be optimised prior to conception. This may include initiating appropriate ART.
- ✓ Evidence of reduced fertility or sterility in either partner.
- ✓ TB screening.
- ✓ STI screening and pap smear.
- ✓ Dental check.

Optimal control of chronic medical conditions

- ✓ This includes evaluating any current medication that may be potentially teratogenic. These should be revised before conception is attempted.

Counselling for a healthy lifestyle

- ✓ Advise to avoid alcohol, smoking, use of recreational drugs and traditional medicines and other 'over-the-counter' supplements.
- ✓ Encourage relaxation and avoidance of stress.
- ✓ Recommend exercise, best exercises are low-impact aerobics, swimming, brisk walking and jogging. Avoid contact sports, high-impact sports and vigorous racquet sports.
- ✓ Encourage a healthy body weight. Ideal body mass index (BMI) between 20 and 25. BMI = mass (kg) ÷ height (m²)
- ✓ Recommend folic acid supplements for women planning a pregnancy, 400 µg daily starting 3 months prior to conception and continued through the first trimester.
- ✓ Folic acid supplements for protection for women at risk (for example history of neural tube defect), 5 mg daily starting 3 months prior to conception and continued through the first trimester.¹⁰
- ✓ Advise about stopping contraception.
- ✓ There is no delay in the return to fertility after stopping oral contraceptives or removing a copper intrauterine device (Cu IUD), levonorgestrel releasing intrauterine system (LNG-IUS) or implant.
- ✓ Women using the contraceptive injection may experience a delay of several months before returning to fertility. During this time the couple may consider using a non-hormonal method of contraception to allow the woman's body to resume regular menstrual ovulatory cycles. This is recommended if more accurate prediction of ovulation is needed, especially if more targeted peri-ovulatory intercourse is desired. However, generally, it is not necessary.
- ✓ Avoid exposures to potentially infectious or toxic substances at home and work.

Pre-conception counselling

- ✓ The importance of each partner knowing their own, and their partner's, HIV status, HIV counselling and testing if necessary, information about PMTCT.
- ✓ Health checks – keeping healthy before and during pregnancy; understanding conception, ovulation, fertility and ways to increase the chances of conception (see Boxes 9.2 and 9.5).
- ✓ Options to reduce the risk of HIV transmission while attempting to conceive (if one of the partners is HIV-positive) (see Boxes 9.3, 9.5).
- ✓ Contraceptive options post-pregnancy, and the importance of waiting a minimum of two years between pregnancies
- ✓ Alternatives to pregnancy in order to have a child.

Box 9.2. How to determine a woman’s fertile time

Understanding how to determine a woman’s fertile time is useful for several reasons. When a women wants to plan either intercourse or self-insemination to coincide with her fertile time in order to increase the chances of pregnancy, it is important to know her fertile time as accurately as possible. In addition, when HIV-positive individuals or couples are attempting conception, limiting unprotected intercourse to fertile (or peri-ovulatory) time allows couples to minimise their exposure to HIV.

There are various ways in which a woman’s fertile time can be determined. The methods described here presume normal fertility and require minimal resources. In situations where a woman’s fertility may be impaired, more resource-intensive methods may be used by a reproductive specialist (for example, progesterone measurements on day 21, or serial ultrasound monitoring with or without ovulation stimulation – clomiphene administration is usually performed in consultation with specialist services). These more intensive methods may also be used for women living with HIV (who have presumed normal fertility) in order to increase their chances of determining fertile time accurately.

Ovulation prediction kits – for testing urine and saliva

A number of over-the-counter products are available that enable ovulation prediction. These methods may utilise sampling and analysis of either urine or saliva, and detect the surge of luteinising hormone that occurs immediately before ovulation.

Basal body temperature (BBT) charting

A woman’s body temperature increases by 0.25–0.5 °C during ovulation. Charting a woman’s BBT daily will therefore result in a pattern that may assist her in predicting ovulation. For this method of ovulation prediction to be accurate, it is essential that the woman plots her BBT at the same time every day (preferably between 6 and 8 a.m.) and before getting out of bed or drinking or eating anything. She should attempt conception after the first rise in BBT has been detected. After the third day of raised BBT the chances of conceiving are greatly reduced.

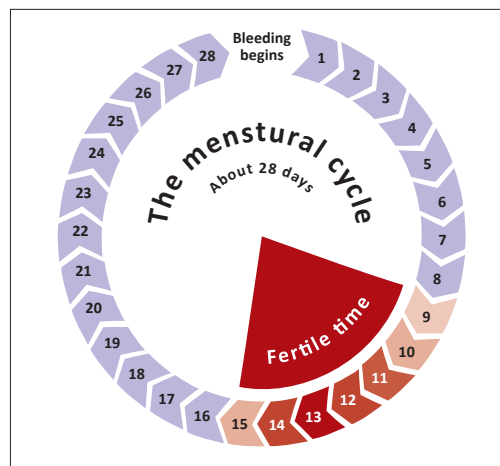
Cervical mucus monitoring

In addition to BBT, a number of other physiological changes occur around the time of ovulation that may be used to help time intercourse. Cervical mucous changes are used most commonly. During non-fertile days, the cervical mucus is thick and acidic. In contrast, during fertile days, the mucus undergoes a change to become thin, profuse, transparent and ‘stretchy’ like the white of an egg. A woman’s awareness of these changes in her cervical mucus may help her to predict her fertile time.

Fertile dates

The average normal duration of a menstrual cycle is 28 days (see Diagram 9.1). The first day of a woman’s menstrual period is considered to be day 1 of her menstrual cycle. Ovulation is assumed to occur half way through her cycle (day 14). Her fertile time would include five days before predicted ovulation, the day of ovulation itself, plus one day after ovulation. For example, in a woman whose cycle is 28 days long, ovulation would be assumed on day 14. The woman’s fertile time would therefore start on day 9 (five days before ovulation) and continue through day 15 of her menstrual cycle (a total of seven days). However, menstrual cycle length may differ considerably between women and may even differ from month to month for an individual woman. Therefore, in order to determine an average menstrual cycle length, it is essential that a woman keep a record of her menstrual cycle (typically taking into account the first day of her menstrual period) for at least four months. It is important to explain to patients that regular menstrual cycles may not necessarily indicate that ovulation has occurred.*

Diagram 9.1. The menstrual cycle



Source: Adapted from Bekker L-G et al. 2011¹

* The Standard Days Method is usually promoted as a way to prevent pregnancy by identifying the fertile window and using condoms during that time, but it is just as useful as a pregnancy planning tool for the same reasons, except that the conception efforts would be focused around the fertile period instead of condom use. <http://www.plannedparenthood.org/health-topics/birth-control/fam-standard-days-method-22141.htm>

Box 9.3. Pre-conception work-up for HIV-positive individuals desiring pregnancy*

	Female partner	Male partner
Resource-limited strategy	<ul style="list-style-type: none"> • CD4, syphilis serology, clinical assessment for other STIs; haemoglobin; visual inspection of the cervix • ART (with the exclusion of teratogenic drugs) and undetectable HIV viral load also strongly advised 	<ul style="list-style-type: none"> • CD4, syphilis serology; clinical assessment for other STIs • ART and undetectable HIV viral load also strongly advised
<p>* This Policy has limited recommendations for conception to options currently available in the public health sector (resource-limited settings). Options available in resource intensive settings can be found in Bekker L-G et al. 2011¹</p>		

Box 9.4. Optimal support strategies for resource-limited settings, according to the HIV status of the couple

	Seroconcordant couple (both partners HIV-positive)	Serodiscordant couple (male HIV-positive)	Serodiscordant couple (female HIV-positive)
On ART/ eligible for ART according to national guidelines	<ul style="list-style-type: none"> • If not yet on ART, initiate as soon as possible • Ensure client is well and has an undetectable HIV viral load before attempting to conceive • Adjust female's ART regimen as needed to exclude possible teratogens (as per national ART and PMTCT guidelines) prior to conception and during the first trimester if pregnancy is achieved • <u>Conception</u>: timed peri-ovulatory unprotected intercourse 	<ul style="list-style-type: none"> • If not yet on ART, initiate as soon as possible • Male partner on ART with undetectable viral load • <u>Conception</u>: timed peri-ovulatory unprotected intercourse • Female partner to have repeated HIV antibody tests during pregnancy with appropriate management if she becomes HIV-positive • During non-fertile periods, couple to practice protected intercourse 	<ul style="list-style-type: none"> • If female partner not on ART, initiate ART as soon as possible • Adjust the regimen as needed to exclude possible teratogens (as per national ART and PMTCT guidelines) prior to conception and during the first trimester if pregnancy is achieved • Ensure female partner has undetectable HIV viral load in blood before trying to conceive • <u>Conception</u>: timed peri-ovulatory unprotected intercourse • Sperm collection with vaginal self-insemination • Male partner to consider medical male circumcision (circumcision should be done at least two months prior to attempts to conceive) • During non-fertile periods, couple to practice protected intercourse
HIV-positive but not yet eligible for ART	<ul style="list-style-type: none"> • <u>Conception</u>: peri-ovulatory unprotected intercourse • Female partner to book at antenatal clinic as soon as possible once pregnancy is achieved so that the appropriate PMTCT regimen can be initiated promptly • At non-fertile times, couple to practice protected intercourse 	<ul style="list-style-type: none"> • Female partner to have repeated HIV antibody testing before pregnancy • <u>Conception</u>: timed peri-ovulatory unprotected intercourse • Female to have repeated HIV antibody testing during pregnancy with appropriate management if female partner becomes infected • At non-fertile times, couple to practice protected intercourse 	<ul style="list-style-type: none"> • <u>Conception</u>: timed peri-ovulatory unprotected intercourse • Alternatively sperm collection with vaginal self-insemination • Female partner to make an appointment at antenatal clinic as soon as possible once pregnancy is achieved so that the appropriate PMTCT regimen can be initiated • Male partner to consider medical male circumcision (circumcision should be done at least two months prior to attempts to conceive) • At non-fertile times, couple to practice protected intercourse
In all of the above, no unprotected intercourse during pregnancy is advised			

Box 9.5. Low-technology sperm collection and self-insemination techniques

Artificial insemination is the process whereby semen is introduced into the female reproductive tract other than by sexual intercourse. It may be intrauterine or vaginal. Intrauterine artificial insemination is a specialist procedure, which needs to be done by a trained professional. Vaginal artificial insemination is a low-risk procedure that can be carried out by a health care provider or by the client herself. It is advisable that vaginal artificial insemination be attempted at the most fertile time in the menstrual cycle (see Box 9.2).

Semen needs to be provided in a clean receptacle, either by male ejaculation into a condom during intercourse or by male ejaculation into a clean specimen jar provided for the purpose. The semen (most men ejaculate 3–5 ml) should be used for insemination as soon as possible. Useful equipment to insert the semen includes a 5 ml plastic syringe or plastic disposable pipette. These items should be supplied to prospective female clients along with the instructions below.

How to perform vaginal artificial self-insemination

Vaginal artificial self-insemination is the process of placing semen into your vagina without having unprotected sex and your partner ejaculating inside you. If you are HIV-positive, it gives you the chance to get pregnant without the risk of passing HIV on to your partner.

Two important things will give you the best opportunity to get pregnant:

1. Do the artificial vaginal insemination at the time of the month when you are most fertile; and
2. Place the semen inside your vagina as soon as possible after the semen has been collected.

How do you know when it is your most fertile time?

The most fertile time in your menstrual cycle is 2 weeks before you get your period, or around day 14 if your cycle is 28 days (see Box 9.2). Other signs to look out for are an increase in your body temperature (if you have a thermometer) or changes in your vaginal mucus. During fertile days, the mucus will become more clear and sticky – you can pull it into strings if you rub it between your fingers.

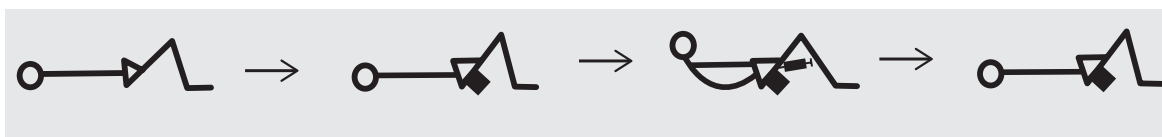
What do you need to do when the time is right?

The first thing to do is to get a sample of sperm from your partner. You can do this in two ways. You can have sex with a condom (do not use one with spermicide) and use the semen that is captured inside the end of the condom after your partner ejaculates. The other way is to get your partner to ejaculate into a clean container that you can get from the clinic for this purpose. He can do this with your help or on his own.

Once you have the semen sample, do not wait too long. As soon as possible you need to draw the semen either into a 5 ml clean plastic syringe (without the needle), or into a bulb pipette (your local clinic can provide you with one).

The next thing to do is to get yourself in the right position. Lie on your back with your knees bent. Place a cushion under your hips to get your back flat and your pelvis tipped up. Make sure you have got all the extra air out of the pipette or syringe and place it into your vagina, a bit like you would a tampon. Do not push it up too far. (This should NOT be painful. If it is, stop what you are doing and report to your clinic.) Then slowly push the semen out of the syringe or pipette into your vagina.

If possible try to stay in this position for an hour. You can try this technique 2–4 times during your fertile time. The more often you try, the greater your chance of success. If you have any questions ask your counsellor or health care provider



Lie on back with knees bent

Place a cushion under hips

Slowly push semen from syringe into vagina

Stay on your back for 1 hour

APPENDICES

- **Appendix 1:** Acknowledgements
- **Appendix 2:** Termination of pregnancy in South Africa: 1997–2010.
- **Appendix 3:** Couple year protection rate
- **Appendix 4:** Opportunities provided through integrating contraception and fertility planning with HIV and sexual and reproductive health services
- **Appendix 5:** WHO Statement: HIV and hormonal contraception
- **Appendix 6:** Pre-exposure and post-exposure prophylaxis

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Appendix 2: Termination of pregnancy

Terminations of Pregnancy in South Africa: 1997-2010

Definition:	The number of terminations of pregnancy.									
	EC	FS	GP	KZN	LP	MP	NC	NW	WC	ZA
1997	2 670	2 527	13 497	1 259	570	1 489	429	218	3 796	26 455
1998	2 938	4 107	19 005	5 167	823	1 857	552	455	5 008	39 912
1999	3 109	4 062	19 195	5 766	1 288	2 269	642	2 166	5 741	44 238
2000	3 264	6 919	15 172	11 592	1 962	3 697	583	2 286	6 697	52 172
2001	4 652	4 824	19 970	4 688	4 254	3 520	738	3 021	8 300	53 967
2002	5 814	3 949	18 227	9 592	4 706	3 218	910	3 070	10 065	59 551
2003	6 819	4 952	29 021	11 015	4 236	2 206	779	2 011	10 513	71 552
2004	6 210	8 343	37 806	10 602	4 587	3 757	1 408	3 165	11 157	87 035
2005	10 034	8 890	33 727	12 706	4 357	1 346	1 305	2 336	15 149	89 850
2006	10 015	7 834	32 464	9 679	4 241	-	1 418	4 948	13 314	83 913
2007	-	7 142	23 268	3 883	6 506	-	1 734	1 377	14 131	58 041
2007 DHIS	11 522	8 666	9 639	5 511	10 862	1 870	2 006	4 900	14 451	69 427
2008	-	9 275	28 995	-	5 773	-	1 227	-	18 390	63 660
2008 DHIS	11 596	7 710	13 379	5 642	9 522	2 970	1 242	5 978	14 903	72 942
2009	-	6 641	32 814	-	5 024	-	1 266	-	-	45 745
2009 DHIS	10 460	6 262	23 810	5 540	8 630	2 456	975	5 886	13 188	77 207
2010 DHIS	8 738	5 595	20 930	4 332	8 342	2 670	1 226	6 395	10 508	68 736

Key

EC, Eastern Cape; FS, Free State; GP, Gauteng Province; KZN, KwaZulu-Natal; LP, Limpopo; MP, Mpumalanga; NC, Northern Cape; NW, North West; WC, Western Cape; ZA, South Africa

Source: <http://indicators.hst.org.za/healthstats/47/data> Accessed 3 Dec 2012

Appendix 3: Couple year protection rate

Couple Years of Protection (CYP)

What is it?

CYP is the estimated protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period.

How is CYP calculated?

The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, to yield an estimate of the duration of contraceptive protection provided per unit of that method. The CYP for each method is then summed for all methods to obtain a total CYP figure. CYP conversion factors are based on how a method is used, failure rates, wastage, and how many units of the method are typically needed to provide one year of contraceptive protection for a couple. The calculation takes into account that some methods, like condoms and oral contraceptives, for example, may be used incorrectly and then discarded, or that IUDs and implants may be removed before their life span is realized.

Why does USAID use CYP as an indicator to measure program performance?

CYP is easy to calculate from data that programs routinely collect; these data can come from a variety of sources and are relatively easy to track. The term "CYP" reflects distribution and is a way to estimate coverage and not actual use or impact. The CYP calculation provides an immediate indication of the volume of program activity. CYP can also allow programs to compare the contraceptive coverage provided by different family planning methods.

Source: http://www.usaid.gov/our_work/global_health/pop/techareas/cyp.html

Couple year protection rate

Definition:	The rate at which couples (specifically women) are protected against pregnancy using modern contraceptive methods INCLUDING sterilisations. (previously Women year protection rate). Numerator: Contraceptive years equivalent Denominator: Target population 15-44 years (couples using females as proxy)									
	EC	FS	GP	KZN	LP	MP	NC	NW	WC	ZA
2001 DHIS	28.5	27.6	17.2	19.6	29.9	23.5	25.0	28.3	29.4	24.0
2002 DHIS	26.8	27.3	17.1	20.5	32.9	20.6	26.5	26.0	30.4	24.0
2003 DHIS	27.0	27.9	16.8	20.6	31.4	20.5	28.8	24.8	31.1	23.8
2004 DHIS	58.7	25.6	19.7	19.7	30.7	20.7	28.8	24.6	34.5	28.4
2005 DHIS	26.4	26.4	18.9	19.8	31.2	18.4	29.1	24.6	33.0	23.9
2006 DHIS	25.1	26.9	26.3	21.8	32.4	23.2	30.9	25.0	47.5	27.8
2007 DHIS	25.6	28.2	23.2	21.0	33.5	24.6	29.4	23.7	52.3	27.9
2008 DHIS	27.5	29.2	25.2	21.3	33.9	27.3	30.5	23.5	49.9	28.7
2009 DHIS	29.7	31.9	27.3	24.2	35.5	31.6	33.7	26.0	59.5	32.0
2010 DHIS	30.6	32.3	26.4	24.1	32.8	32.9	35.8	26.3	58.5	31.6

Key

EC, Eastern Cape; FS, Free State; GP, Gauteng Province; KZN, KwaZulu-Natal; LP, Limpopo; MP, Mpumalanga; NC, Northern Cape; NW, North West; WC, Western Cape; ZA, South Africa

Source: <http://indicators.hst.org.za/healthstats/231/data>, accessed 5 Jan 2012.

Appendix 4: Opportunities for integration

<i>Opportunities provided through integrating contraception and fertility planning with HIV and sexual and reproductive health services</i>	
Type of integration	Provides an opportunity to:
HIV integrated with contraception and fertility-planning services	<ul style="list-style-type: none"> • Test for HIV, and re-test if previously tested negative; CD 4 count and provision or referral for PMTCT and/or ART • Establish HIV status, and any treatment, including opportunistic infections, TB and ART • Discuss prevention of pregnancy, STIs and HIV • Provide contraception and fertility-planning information and counselling; pre-conception counselling; risk assessment, and behaviour change communications (BCC) for informed decision making • Health checks can also pick up signs of HIV and TB
Contraceptive and fertility planning integrated with HIV services	<ul style="list-style-type: none"> • Provide assessment of fertility intentions and information about contraception and fertility management as an integral part of comprehensive, client-centred HIV services – during HCT (depending on the client’s receptivity), wellness management, PMTCT, ART initiation and follow up visits • Provide pre-conception counselling, to optimise positive health outcomes for both HIV-positive mothers and their babies • Reach a range of people not reached in traditional contraception services, e.g. youth, men, commercial sex workers, men who have sex with men but who also have female partners, and injecting drug users
Combining contraception and fertility planning with HIV services	<ul style="list-style-type: none"> • Expand providers’ skills set to improve their performance of required tasks • Discuss broader sexual and reproductive health issues such as STIs, CTOP, PMTCT, gender issues related to rights (such as safer sex negotiation), condom use, sexual violence, pregnancy and HIV prevention • Encourage and strengthen integrated supportive health systems • Support women’s access to a wider variety of treatment options without the fear of pregnancy and potential fetal damage • Reinforce the dual HIV- pregnancy prevention messages, thereby encouraging condom use • Ensure that the risk of HIV is considered as part of making informed fertility decisions; and contraception and fertility management is considered at various points in the client’s HIV care pathway • Encourage new provider partnerships (e.g. contraception and fertility-planning service providers will need to consult with HIV service providers, and case management will demand consultation between nurses, physicians, and people living with HIV) • Integrate training (and re-training): Contraception and fertility-planning service providers need training in HIV; and HIV health care providers need training in contraception and fertility management – depending on their level of care and scope of work
Sexual and reproductive health combined with HIV and contraception and fertility planning	<p>A combined discussion about HIV and contraception at the following, and to include in HIV and contraceptive services, as appropriate:</p> <ul style="list-style-type: none"> • STI • TOP • rape sexual assault counselling • emergency contraception • TB • cervical screening

Source: Adapted from Farrell B. *Family Planning-Integrated HIV Services: A framework for integrating family planning and antiretroviral services*. New York: Acquire Project/Engender Health, June 2007, page 11.

Appendix 5: WHO statement: HIV and hormonal contraception

The following is an extract from the statement issued in response to recent research which indicated a possible link between hormonal contraceptives (especially progestogen-only injectable methods) and HIV transmission and or acquisition. (Source: WHO. *Hormonal contraception and HIV*. Technical Statement. Geneva: World Health Organization, 2012.)

Hormonal contraception and HIV: Technical statement (WHO 2012)

Following new findings from recently published epidemiological studies, the World Health Organization (WHO) convened a technical consultation regarding hormonal contraception and HIV acquisition, progression and transmission. It was recognized that this issue was likely to be of particular concern in countries where women have a high lifetime risk of acquiring HIV, where hormonal contraceptives (especially progestogen-only injectable methods) constitute a large proportion of all modern methods used and where maternal mortality rates remain high. The meeting was held in Geneva between 31 January and 1 February 2012, and involved 75 individuals representing a wide range of stakeholders. Specifically, the group considered whether the guideline Medical eligibility criteria for contraceptive use, Fourth edition 2009 (MEC) should be changed in light of the accumulating evidence. After detailed, prolonged deliberation, informed by systematic reviews of the available evidence and presentations on biological and animal data, GRADE profile summaries on the strength of the epidemiological evidence, and analysis of risks and benefits to country programmes, the group concluded that the World Health Organization should continue to recommend that there are no restrictions (MEC Category 1) on the use of any hormonal contraceptive method for women living with HIV or at high risk of HIV. However, the group recommended that a new clarification (under Category 1) be added to the MEC for women using progestogen-only injectable contraception at high risk of HIV as follows:

Some studies suggest that women using progestogen-only injectable contraception may be at increased risk of HIV acquisition, other studies do not show this association. A WHO expert group reviewed all the available evidence and agreed that the data were not sufficiently conclusive to change current guidance. However, because of the inconclusive nature of the body of evidence on possible increased risk of HIV acquisition, women using progestogen-only injectable contraception should be strongly advised to also always use condoms, male or female, and other HIV preventive measures. Expansion of contraceptive method mix and further research on the relationship between hormonal contraception and HIV infection is essential. These recommendations will be continually reviewed in light of new evidence.

Recommendations

All evidence was reviewed carefully, and there was extensive discussion of the interpretation and implications of the results. The group considered the strength of the epidemiological and biological data, possible implications for country programmes, taking into account the need for HIV prevention, and the risk of unintended pregnancy on maternal mortality and pregnancy related morbidity. Most concern focused on the relationship between progestogen-only injectable contraception and risk of HIV acquisition in women. In considering the totality of available evidence, the group determined that currently available data neither establish a clear causal association with injectables and HIV acquisition, nor definitively rule out the possibility of an effect. The group agreed that use of hormonal contraceptives should remain unrestricted if a strong clarification was added to the MEC, which reflected the difficulties the group had with the data, the need for an enhanced message about condom use, for both male and female condoms, and other HIV prevention measures, and the need for couples to have access to as wide a range of contraceptive methods as possible. A clear recommendation was also made on the need for further research on this issue and an undertaking to keep emerging evidence under close review. Thus, the expert group determined that women at high risk of HIV or living with HIV, can continue to use all existing hormonal contraceptive methods (Category 1) (oral contraceptive pills, contraceptive injectables, patches, rings, and implants),

but that a strong clarification (as detailed above) relating to the use of progestogen only injectables be added for women at high risk of HIV. Overall, women should receive correct and full information from their health-care providers so that they are in a position to make informed choices.

Recommendations for women at high risk of HIV infection

- Women at high risk of HIV can continue to use all existing hormonal contraceptive methods without restriction.
- It is critically important that women at risk of HIV infection have access to and use condoms, male or female, and where appropriate, other measures to prevent and reduce their risk of HIV infection and sexually transmitted infections (STIs).
- Because of the inconclusive nature of the body of evidence on progestogen-only injectable contraception and risk of HIV acquisition, women using progestogen-only injectable contraception should be strongly advised to also always use condoms, male or female, and other preventive measures.
- Condoms must be used consistently and correctly to prevent infection.

Recommendations for women living with HIV infection

Women living with HIV can continue to use all existing hormonal contraceptive methods without restriction.

Consistent and correct use of condoms, male or female, is critical for prevention of HIV transmission to non-infected sexual partners.

Voluntary use of contraception by HIV-positive women who wish to prevent pregnancy continues to be an important strategy for the reduction of mother-to-child HIV transmission.

For more information: http://www.who.int/reproductivehealth/topics/family_planning/hc_hiv/en/index.html

Appendix 6: Pre-exposure and post-exposure prophylaxis

The role of pre-exposure and post-exposure prophylaxis (PrEP and PEP) in minimising HIV transmission in serodiscordant partners trying to conceive

In South Africa, PEP for sexual assault survivors and occupational exposure has been available for some time.^{a,b}

There is growing interest in PEP and PrEP to prevent transmission of HIV in serodiscordant partnerships. However, it is important to note that PrEP and/or PEP for discordant couples, initiated before or after sexual intercourse in situations where sperm washing/insemination is not available, have not been validated and does not guarantee prevention of HIV transmission, with significant implications for the health of the man, woman or a subsequent child.

While PEP efficacy has not yet been established in a randomised clinical trial, significant data have been collected from cohort studies that suggest that it is an effective intervention for preventing transmission. PEP has been recommended for accidental exposure to HIV, either occupational or non-occupational, where the benefits of the medication clearly outweigh the risks.

In the case of a serodiscordant couple wanting to conceive, PEP in the negative partner may be considered. PEP protocols generally state that antiretrovirals have to be given for 28 days after exposure. This implies that after every episode of unprotected intercourse, the HIV negative partner would have to take antiretrovirals for 28 days (meaning that after every additional act of intercourse which happens when a person is already on PEP regimen, the count of days begins anew). Therefore, the practicality of this approach is not clear. Conception may take several months and if couple has sex around ovulation time (as advised) and then negative partner takes PEP for 28 days, it would lead straight to the next month's ovulation time/unprotected sex and another 28 days of PEP, meaning that uninterrupted PEP will have to continue for months until pregnancy is achieved.

The evidence for PrEP is also still not well established. The most promising candidate drugs are tenofovir or emtricitabine/tenofovir disoproxil fumarate (FTC/TDF, Truvada).

The results of research for men who have sex with men (MSM) are promising, and it is likely that PrEP may offer some protection from HIV acquisition in men exposed to HIV rectally.

While there are still on-going studies in relation to PrEP research on heterosexual transmission being undertaken in Africa in a variety of population groups, as yet there are not definitive conclusions about effectiveness and cost-effectiveness. It is important to note that unprotected intercourse with an HIV infected person is never 'no-risk' of transmission, even if PrEP is found to be partially effective.

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Recent research on pre-exposure prophylaxis

Three studies highlight successes and challenges of PrEP strategy (Source: 60percent-bounces@lists.hst.org.za)

The results of three clinical trials (published in the *New England Journal of Medicine*, July 11, 2012) show that the antiretroviral drug, Truvada (a combination of tenofovir and emtricitabine) can be “highly effective at preventing infection in HIV-free individuals – as long as those individuals take the drug every day as prescribed.” The strategy of using antiretrovirals to prevent HIV among healthy people at risk of contracting the virus is known as pre-exposure prophylaxis, or PrEP.

Two studies from Africa in heterosexual patients found that the drugs reduced the rate of HIV infection by 62 percent to 75 percent, a success rate that is comparable to results from studies of gay men.

“A third study in African women at high risk of infection, however, was ended early after researchers saw the drugs had no effect on HIV rates, largely because fewer than 40 percent of study participants took their pills as instructed.”

Antiretroviral Pre-exposure Prophylaxis for Heterosexual HIV Transmission in Botswana

http://www.nejm.org/doi/full/10.1056/NEJMoa1110711?query=featured_home

Antiretroviral Prophylaxis for HIV Prevention in Heterosexual Men and Women

http://www.nejm.org/doi/full/10.1056/NEJMoa1108524?query=featured_home

Pre-exposure Prophylaxis for HIV Infection among African Women

http://www.nejm.org/doi/full/10.1056/NEJMoa1202614?query=featured_home

Also see: www.prepwatch.org and www.avac.org/prep

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Section A: Background and Context

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