



Country Assessment: South Africa

Family Planning Needs in the Context of the HIV/AIDS Epidemic

March 2005



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Abbreviations

AIDS	Acquired immune deficiency syndrome
ASSA	Actuarial Society of South Africa
FHI	Family Health International
HIV	Human immunodeficiency virus
IUD	Intrauterine device
MRC	Medical Research Council
PMTCT	Prevention of mother-to-child transmission
SADHS	South Africa Demographic and Health Survey
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing

Key Findings

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

Family planning services can prevent mother-to-child transmission of HIV by helping infected women avoid unwanted pregnancies. Contraceptive barrier methods, such as male and female condoms, protect against sexual transmission of the virus. But despite the potential of family planning to prevent HIV/AIDS, most HIV/AIDS prevention and care efforts are evolving as separate programs that do not include traditional reproductive health services.

Responding to concerns that HIV/AIDS programs are diverting attention and resources from comprehensive reproductive health services, the U.S. Agency for International Development (USAID) asked Family Health International (FHI) to assess how the epidemic has affected family planning needs and services in three African countries: Kenya, South Africa, and Zimbabwe.

In all three countries, FHI, in collaboration with the Commonwealth Regional Health Community Secretariat, reviewed published and unpublished literature on family planning and HIV/AIDS epidemiology, policies, and programs and assembled a team of experts to conduct a field assessment. FHI formed a local steering committee in each country to provide technical oversight and ensure that the assessment produced locally relevant information.

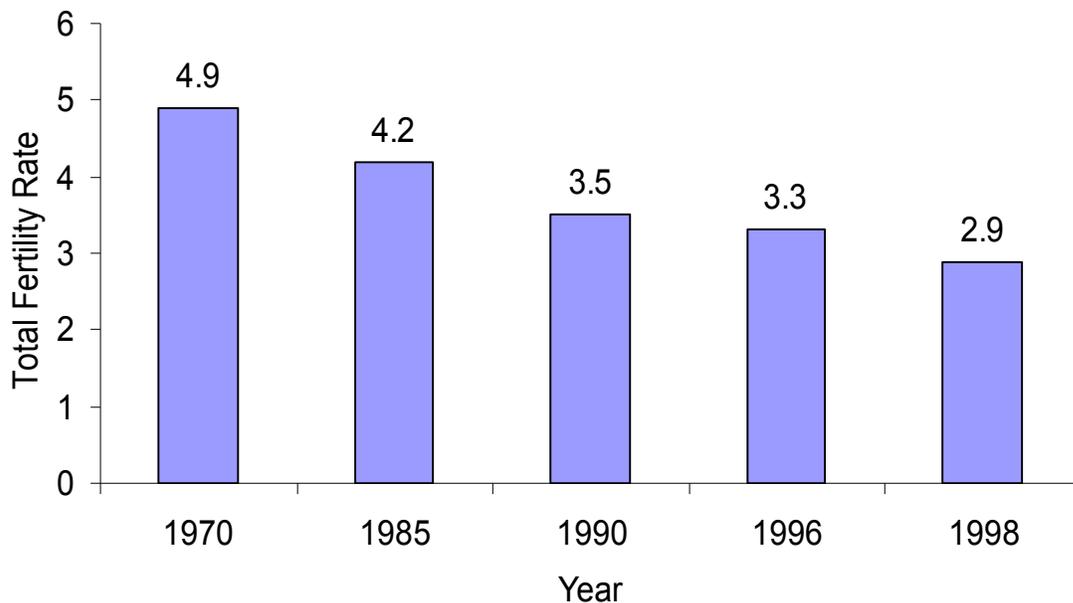
The South African Department of Health was a key collaborative partner in this assessment, with both national and provincial representatives of the department serving on the steering committee. The field assessment was conducted in 10 municipal districts from five provinces in May 2004. Assessment team members interviewed 142 program managers, service providers, policy-makers, donors, traditional healers, religious leaders, coordinators of community-based organizations, and managers of nongovernmental organizations. These key informants represented both the family planning and HIV/AIDS arenas. A summary of findings from the desk review and field assessment is presented here.

Family Planning in South Africa

Family planning services in South Africa were integrated into primary health care services in the late 1980s and early 1990s. In the years since, family planning has become popular among all racial groups. According to the most recent South Africa Demographic and Health Survey (SADHS), an estimated 51% of South African adults were using contraception in 1998. Over the past five years, the contraceptive prevalence has risen to an estimated 66%, based on data from the country's 2003/2004 Health Review. This is among the highest prevalences of contraceptive use in the sub-Saharan region.

Not surprisingly, the total fertility rate in South Africa ranks lowest in the region, according to the 1998 SADHS, averaging about 2.9 children per woman. This rate continues a decline that has been noted since at least 1970, when the total fertility rate was 4.9 children per woman (Figure 1).

Figure 1: Trends in Total Fertility Rates in South Africa: 1970-1998



The types of contraceptive methods used and their rates of use in South Africa differ by the demographic characteristics of users. According to the 1998 SADHS, the prevalence of contraceptive use was highest among Western Cape residents (74 percent), urban dwellers (64 percent), white and Asian South Africans (76 and 80 percent, respectively), married women (56 percent), and those with an educational level at or above Standard 9 (79 percent). In contrast, contraceptives were used much less often in the KwaZulu Natal, Limpopo, and Mpumalanga provinces (less than 60 percent), in rural areas (45 percent), among black and African women (69 and 59 percent, respectively), and among those with no education (35 percent).

Key informants judged contraceptive use among male youths to be low, mostly because family planning services were thought to be unfriendly to men. In addition, they noted that most men viewed contraception as their partners' responsibility and indicated that the notion of "joint responsibility" for contraceptive practice was not yet popular among South African men and youths.

Overall, the 1998 SADHS indicated that the contraceptive methods used most often were injectables (30 percent of the population, and even higher among rural women), followed by oral contraceptives (13 percent) and female sterilization (12 percent). Condoms, intrauterine devices (IUDs), and male sterilization were rarely used (each by <2.5 percent).

Generally, the low rates of use for some contraceptives, such as IUDs and sterilization, reflect geographic, financial, and technical barriers to their use. The major exception is condoms, which are widely available, free, and easy to use but are being used by only 2.3 percent of the population, according to the 1998 SADHS. This may reflect their primary use for HIV/AIDS prevention rather than for contraception.

HIV/AIDS in South Africa

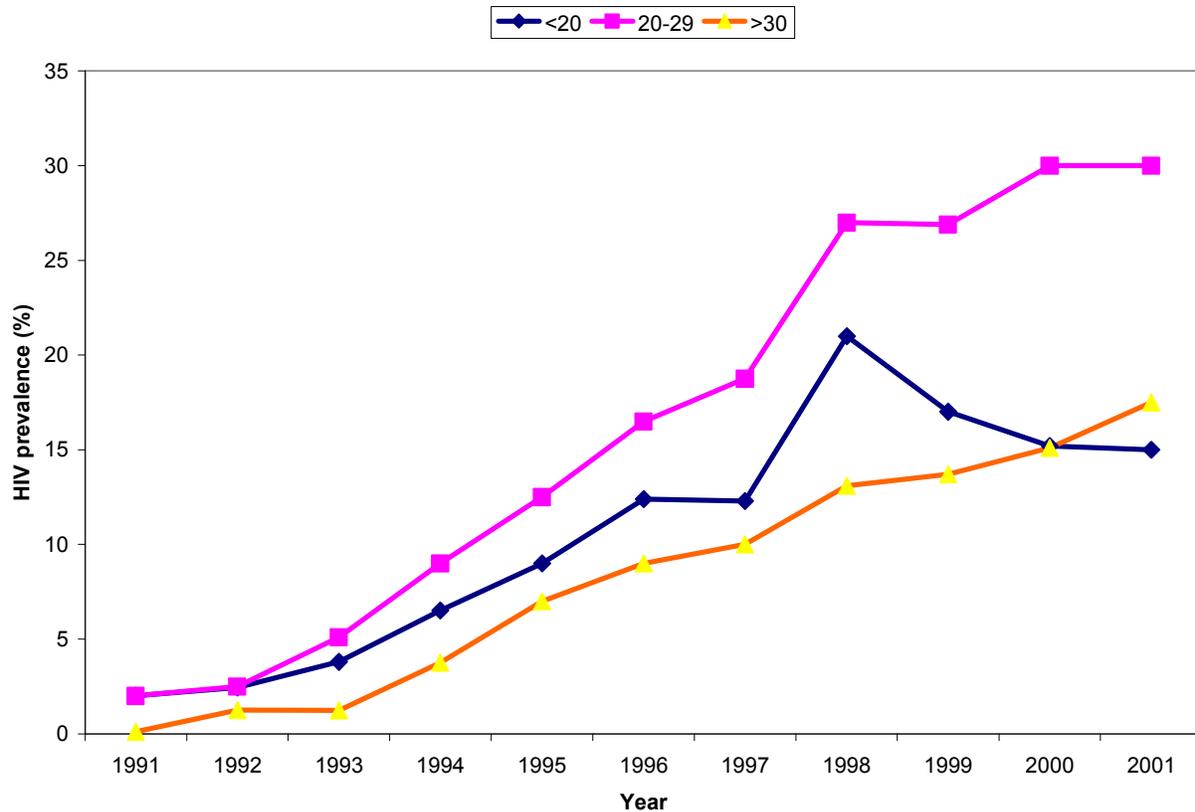
Estimates of the extent of the HIV/AIDS epidemic in South Africa vary, but all attest to a "mature and generalized epidemic." Department of Health data indicate that about 5 million South Africans were living with HIV at the end of 2002, with about 1 in 10 residents being HIV-positive. Prevalence varied by sex, however; women had higher prevalences for almost every age when compared with men. Further, the prevalence of HIV/AIDS among pregnant women visiting prenatal clinics rose from less than 1 percent in 1990 to 26.5 percent in 2002. An encouraging note is that HIV infections among persons younger than 20 years appear to be decreasing (Figure 2).

The prevalence of HIV/AIDS also varied by race. Prevalence was highest among Africans (12.9 percent) and lowest among Indians (1.6 percent), while prevalences among whites (6.2 percent) and blacks (6.1 percent) were similar.

A 1999 Department of Health report indicates that transmission through homosexual or heterosexual intercourse accounts for an estimated 95 percent of infections. Perinatal transmission and infection through breast milk together account for an additional 3.8 percent of infections. The remaining cases can be attributed to needle-stick injuries, intravenous drug abuse, and blood transfusions.

In a 2004 projection by the Medical Research Council (MRC) and the Actuarial Society of South Africa (ASSA), AIDS accounted for about half of maternal orphans younger than 15 years in all but three provinces. In all, more than half a million children younger than 15 years are orphaned by AIDS in South Africa.

Figure 2: HIV Prevalence among Pregnant Women at Antenatal Clinics in South Africa, by Age Group: 1991- 2001



Policies, Strategies, and Guidelines

In addition to creating key pieces of legislation related to family planning and HIV/AIDS, the government has developed many guidelines and strategic plans, including the National Contraceptive Policy guidelines and the HIV/AIDS/STD 2000-2005 Strategic Plan.

Both family planning and HIV/AIDS policies are disseminated similarly, mainly through workshops, in-service trainings, and meetings. Some nongovernmental service providers mentioned discovering policy documents accidentally or downloading them from the Internet, implying that the private sector (which serves 15 percent of family planning users and 25 percent of health service users in South Africa) often is excluded from policy training programs. Indeed, one nongovernmental key informant commented that policies and guidelines “*are never officially distributed to us.*” This statement should not be generalized, however. In fact, the National Contraceptive Policy Guidelines and the Adolescent Reproductive Health Policy Guidelines were formally launched by the Minister of Health at Prince Mushyeni Hospital in Umlazi in October 2002. This initiative was supported by the United Nations Children’s Fund (UNICEF) and the United Nations Population Fund (UNFPA), which assisted with the distribution of both policies to nongovernmental organizations, community-based organizations, the Youth Commission, government departments, and international development agencies.

Most respondents were at least somewhat satisfied with existing family planning policies, but no respondent indicated satisfaction with the level of implementation of the policies.

Implementation appears to be hindered by a lack of trained and knowledgeable staff, high turnover of existing staff, and inadequate dissemination of policies.

Most respondents were aware of existing HIV/AIDS policies and considered them appropriate in addressing the epidemic. Besides knowing about the Department of Health's Strategic Plan, respondents were aware of the guidelines for voluntary counseling and testing (VCT), feeding of infants of HIV-positive mothers, prevention of mother-to-child transmission (PMTCT), post-exposure prophylaxis, and antiretroviral rollouts.

Several policies and strategies—particularly those addressing HIV/AIDS—acknowledge linkages between family planning and HIV/AIDS. The comprehensive national policy on HIV/AIDS in South Africa mentions family planning in the context of PMTCT in that it advocates *“improving family planning services to known HIV-positive women.”* South Africa's VCT guidelines also mention family planning as part of providing comprehensive care for people with HIV/AIDS and as part of pretest counseling on *“safer sex strategies to reduce risk.”* Family planning services are mentioned in the guidelines for feeding infants of HIV-positive mothers as part of the comprehensive care these mothers may need. The National Contraceptive Policy Guidelines highlight the dual role of barrier methods in protecting against pregnancy and sexually transmitted infections (STIs) including HIV/AIDS, and acknowledge HIV/AIDS as a specific reproductive health concern.

Policy Gaps

Despite the availability of several policies in South Africa on family planning and HIV/AIDS, the key informants identified several gaps in the policies:

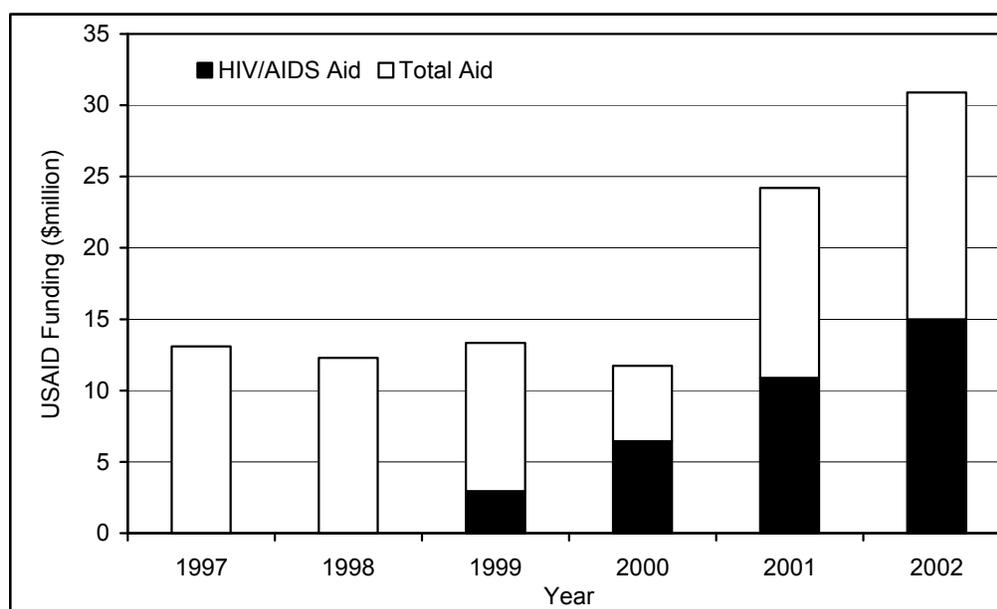
- **Monitoring and implementation.** Although some national strategy documents have sections on monitoring and evaluation (e.g., the HIV/AIDS Strategic Plan), respondents highlighted that monitoring and evaluation of policies was poor, not standardized, and often unfunded.
- **Fragmentation in execution.** Another gap in the policies was the poorly defined guidelines for interdepartmental collaboration in policy execution. A program manager remarked that, *“There is a lack of integrated interdepartmental policies at the national level. For instance, schools refuse promotion and distribution of condoms based on Department of Education Policies.”*
- **Gender-related issues.** Some respondents believed policies were “gender blind,” but others felt that women were overemphasized in relation to men or couples.
- **Sociocultural sensitivities.** Key informants commented that policies do not address critical cultural practices affecting HIV/AIDS prevention and care and family planning use. These practices, which include circumcision, virginity testing, and tattooing, among others, have been associated with high levels of morbidity and mortality in several ethnic groups in South Africa.

Resources for Family Planning and HIV/AIDS Programs

The South African government provides most of the health care funds for the country, allocating about 8.5 percent of its gross domestic product to “*supporting hospitals, curative services, primary health care and HIV and AIDS related services.*” International and local donors also contribute major funding—up to U.S. \$50 million in 2003.

Although government allocations for health generally have stagnated over the years, the allocation for HIV/AIDS has almost quadrupled in the last three years, from \$0.21 R billion (0.8 percent of the annual national budget) for 2000-2001 to \$1.95 R billion (2.9 percent) for 2002-2003. A breakdown of USAID assistance to South Africa for health, population, and nutrition shows that financial assistance has increased substantially over the years, especially for HIV/AIDS (Figure 3).

Figure 3. USAID Funding for South Africa, by Year and Indication



It is unknown whether specific allocations for family planning have increased or decreased because the government budget for family planning falls under the ambit of reproductive health within the primary health care package of the South African health system. However, key informants were mixed in their opinions of how the HIV/AIDS epidemic has affected family planning funding. Some speculated that family planning funding has remained stable, while others argued that family planning funds have been diverted to fight the HIV/AIDS epidemic.

One representative of a top donor agency supported the view that family planning may be receiving little attention, highlighting the focus of the U.S. President’s Emergency Plan for AIDS

Relief (PEPFAR) fund: “Due to the focus on the PEPFAR key areas of 2-7-10,* reproductive health and family planning is becoming less relevant...only projects that address the 2-7-10 agenda are being given attention at all levels.”

Others expressed concern that high contraceptive prevalence could be in danger because of inadequate attention to and funding for delivery of family planning services.

Current Status of Family Planning and HIV/AIDS Services

Family planning and HIV/AIDS services and programs are provided by the government and by nongovernmental agencies such as universities and academic departments, research institutes and organizations, religious bodies, professional associations, health support networks, and local and multinational family planning and HIV/AIDS organizations and resource centers. Specific contributions of partner agencies include funding, government and community capacity building, awareness campaigns, social mobilization, advocacy, and provision of health services.

Challenges Facing the Provision of Family Planning Services

While contraceptive prevalence remains high in South Africa, key informants cited a number of emerging challenges facing family planning service provision. These challenges pertained to unmet service delivery needs, deficiencies in sustaining family planning services in the face of the HIV/AIDS epidemic, coping with dwindling donor support, and sociocultural factors among service users, as follows:

- ***Sustainability of family planning at all levels.*** In the face of the monetary and service delivery demands of the HIV/AIDS epidemic, many respondents fear that family planning will receive less priority than it has and that gains in family planning made over recent decades will erode.
- ***Limited number and high turnover of competent staff.*** Health care workers who offer family planning services seldom have appropriate training for HIV/AIDS care, which precludes the opportunity to holistically address clients’ reproductive health needs. Quality family planning services are also hampered by “brain drain,” or high turnover among trained staff. The high rate of staff turnover may reflect poor incentives, poor infrastructure, and low remuneration.
- ***Increased staff workload.*** Some respondents suggested that HIV/AIDS heightens the reproductive health care needs of family planning users, thus increasing the already heavy workload of staff. The added workload is mostly due to time spent on VCT.

* treating 2 million people with AIDS, averting 7 million new HIV infections, and providing palliative care to 10 million people.

- ***Inadequate dual-protection promotion.*** Many key informants believed that family planning service providers failed to actively promote dual protection, especially in rural areas. Instead, there is too much reliance on injectable contraceptives and limited discussion of the need for barrier method use to protect against both pregnancy and HIV infection.
- ***Misuse of child-support grants.*** The desire to have children in order to access child-support grants was mentioned as a barrier to contraceptive use among some South African women. In the words of one participant, “*Young women are not using family planning services because they want to secure child support grants—sometimes for their own use.*” Another informant commented, “*The reason why people are falling pregnant is because they need the child support grant.*”
- ***Inadequate male involvement in family planning.*** Key informants reported that men were usually more concerned about privacy and confidentiality than were women and were likely to feel intimidated by the large numbers of women attending regular family planning clinics. Developing special “men-friendly” programs was suggested as a useful approach to increasing male participation in family planning. Consensus of partners on their reproductive choices, although ideal, has not been the target of most family planning sites.

Challenges Facing the Provision of HIV/AIDS Services

Key informants also noted several challenges facing the provision of HIV/AIDS services:

- ***Lack of regular in-service professional training.*** Respondents called for more comprehensive in-service training for providers of HIV/AIDS services. They expressed concern about the proliferation of workshops and conferences that focused principally on granting certificates of attendance (to claim continued professional development points) rather than developing relevant professional skills.
- ***Low acceptance of HIV/AIDS interventions.*** Respondents said that men and young people were most likely of all persons to decline the use of HIV/AIDS prevention and care interventions, especially HIV testing, and called for stronger efforts to reach these groups.
- ***Lack of access to HIV/AIDS services in rural areas.*** Even when HIV/AIDS services are available, not all testing and treatment options are available in remote areas.

Family Planning in the Era of HIV/AIDS

Most respondents felt that HIV/AIDS has not affected the sexual and reproductive health behavior and choices of family planning users, particularly the younger users, as judged by the continued high rates of teen pregnancy despite educational campaigns and ready availability of condoms. They further agreed that individual family planning needs did not differ depending on one’s HIV status. As one key informant explained, “*HIV-positive people are provided condoms to protect themselves, while HIV-negative people should continue to use condoms as well...there is no difference between them.*” Another respondent remarked that “*family planning needs and practices of the HIV-positive do not differ from those who are HIV-negative.*”

Respondents were mixed, however, in their opinions of how the HIV/AIDS epidemic has affected fertility desires. Some respondents believed that the desire to have children because of the availability of child-support grants might be overriding any concerns about contracting HIV/AIDS. As one key informant said, *“Sexual behavior has not changed. The poorer they are the more sex they have. Married couples desire to have children regardless of their HIV status ... they do it because they want the child grant.”* Other respondents stated that the fear of HIV infection and leaving a trail of orphans might be diminishing the desire to have children. As one participant explained, *“Parents do not want to have children because they are scared to leave babies behind as orphans when they die.”* Another observed, *“We are seeing a lower birth rate because of HIV and AIDS.”*

A few service providers expressed concern about the appropriateness of certain contraceptive methods for HIV-infected women. In particular, they said they would not administer an IUD to an infected woman because they thought it increased the risk of HIV/STI transmission. But all available evidence shows that IUD use is safe for HIV-infected women. The World Health Organization now recommends IUDs as an option for women living with HIV unless they have developed AIDS and do not have access to or are not responding to antiretroviral treatment. These concerns among providers may reflect a need for refresher trainings on contraception for HIV-infected women.

Linkage of HIV/AIDS and Family Planning Services

Most respondents saw integrating family planning and HIV/AIDS services as the logical way forward for providing high-quality, comprehensive reproductive health care. Key informants identified the following benefits of an integrated approach:

- Expanded access to and coverage of family planning, STI/HIV, and AIDS services
- Improved efficiency and cost-effectiveness
- Delivery of more services during each client contact
- Improved client satisfaction
- Increased acceptance of family planning services
- Changes in HIV/STI risk behaviors
- Increased condom use by family planning clients
- Reduced duplication of service-delivery functions

In addition, key informants noted that the policy environment was supportive of these service-delivery linkages, and that the skills providers need for family planning and HIV/AIDS service delivery are similar. However, they also acknowledged that additional training on integrated service delivery would be needed. One key informant said, *“Integration is critical in changing the course of the epidemic, but this is not as yet commonplace. In fact there is a core of well-trained family planning staff, which could be provided additional training on HIV/AIDS issues and could make a very significant contribution towards integrating different services at the level of primary health care.”*

When discussing the opportunities for integrating family planning and HIV/AIDS services in South Africa, key informants described two different approaches. The first is a holistic approach (i.e., rendering comprehensive reproductive health services, to include all aspects of HIV/AIDS and family planning services) in centers nationwide. Proponents of the holistic approach also recommend recruiting and training comprehensive reproductive health counselors and not just HIV/AIDS counselors.

The second mode of integration proposed was a phased-in approach whereby only certain services are integrated and referrals are made as needed to appropriate services. Key informants made two main arguments for this approach. First, the clientele targeted by HIV/AIDS services may be unlikely to use family planning services, and family planning clients may not be at disproportionately high risk for HIV/AIDS. Second, operations may be incompatible between some family planning and HIV/AIDS programs. For example, certain technical HIV/AIDS procedures may not be easily performed in family planning settings, and vice versa.

In South Africa, efforts to formally integrate family planning and HIV/AIDS services, or to ensure that persons using only one service receive equal attention with respect to the other, are currently limited. However, key informants reported that the integration of family planning services with PMTCT and VCT programs should be pursued. They argued that family planning counseling and services in PMTCT programs would help prevent unintended pregnancies among HIV-infected women, thereby reducing vertical transmission of HIV. With respect to family planning and VCT, respondents felt that, at a minimum, the possibility of pregnancy should be discussed with VCT clients during pretest counseling and referral for additional services should be provided as needed. Likewise, they felt that family planning clinics should offer HIV counseling and then refer clients to testing services. Achieving integration of these services, however, will likely involve a number of operational challenges including modifications of worker roles, allocations of time, and development of referral systems.

Recommendations

Given the backdrop of support in the country, efforts to begin implementing and evaluating the integration of HIV/AIDS and family planning services in South Africa are recommended.

Policy

- Policies should be developed to improve access to and functioning of referral systems between family planning and HIV/AIDS services.
- Guidelines on the delivery of integrated services should be developed to support programmatic efforts to integrate.
- Cultural perspectives should be considered in policy formulation.

Programs

- Reproductive health outreach programs for youth should be established through schools and youth groups.
- Family planning, VCT, and PMTCT services should address gender issues and increase male involvement through a renewed focus on couples counseling.

- Incentives such as increased salaries and allowances should be explored to halt the “brain drain” among health professionals.
- Integrated professional training should be established for family planning and HIV/AIDS staff. This training should emphasize dual-protection counseling and update trainees on the medical eligibility criteria for contraceptive use among HIV-infected women.
- The disbursement of social and HIV/AIDS grants should be strictly monitored and evaluated to minimize abuse.

Research

- A situational analysis should be performed in all provinces in South Africa to assess the readiness of clinics to provide integrated HIV/AIDS and family planning services. In addition, operations research should be conducted to determine effective models of integration.
- Given the conflicting opinions among key informants, rigorous behavioral research should be conducted with both HIV-infected and non-infected individuals to determine how the HIV/AIDS epidemic is affecting fertility desires and contraceptive practices.
- The factors contributing to the use and nonuse of different contraceptive methods should be studied, especially for condoms.
- The relationship between social grants and the spread of HIV/AIDS in South Africa should be examined.
- The economic and sociocultural issues surrounding dual-protection practice in South Africa should be elucidated.