

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

3

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Considerable progress has been made in expanding access to health services through strong political leadership and development of policies, guidelines and legislation. However, South Africans still face challenges and obstacles in accessing comprehensive treatment, prevention and care for sexually transmitted infections (STIs) including HIV, sexual and reproductive health (SRH), family planning and contraception, pregnancy, delivery, psychosocial support and counselling. Major challenges lie in ensuring that guidelines are implemented, that standard protocols are followed and that health-care worker performance is improved and monitored.

In order to fulfil the rights of all South Africans to equal access to health care and life-saving prevention and treatment programmes, evidence-based interventions, the provision of comprehensive and holistic care, optimal therapeutic care and SRH services need to be strengthened. The strengthening of SRH services also entails integrating reproductive health with other services and providing guidelines for implementation.

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Introduction

This chapter examines the relationship between sexual and reproductive health (SRH) and rights in South Africa and the Millennium Development Goals (MDGs). While none of the MDGs focus on setting targets for SRH, it is widely recognised that, without expanding access to SRH services and ensuring sexual and reproductive rights, many of the MDGs will not be met.

Research around the world emphasizes the crucial role gender inequality plays in undermining development of full human capacity. Gender divisions and gender inequality are nowhere more apparent than in relation to sexual freedom and reproductive expectations, as in responsibilities and experiences of men and women. Achieving *de facto* sexual and reproductive rights guaranteed in the South African Constitution will be crucial to South Africa meeting the MDGs.

South Africa stands amongst few societies in the legal protection of sexual and reproductive rights. Internationally, the recognition and naming of 'sexual and reproductive rights' is relatively recent and is borne out of a protracted struggle defying the separation between personal and political realms. The International Meeting on Women and Health in Amsterdam in 1984 expanded the concept of human rights to include reproductive rights. In 1993 at the World Conference on Human Rights, participant countries agreed to regard any violation of the specific rights of women as "human rights violations". This saw a major shift in human rights theory, with the recognition that human rights could be enjoyed in private as well as in public, and could thus be violated in both spheres, and human rights were defined as universal, interdependent and indivisible.¹ The legal framework was further consolidated and deepened in Cairo in 1994.² Despite ongoing debates over the years since then (with regard to termination of pregnancy and private sphere advocates), there has been progress in international agreements. South Africa has been at the forefront of these debates.

Outside South Africa, the United Nations (UN) Millennium Project produced a set of recommendations for ensuring universal access to SRH services and information, encompassing family planning, safe motherhood, and the prevention, treatment and care of Sexually Transmitted Infections (STIs), including HIV. Strategies identified include:

- age-appropriate education and services;
- attention to men's involvement;
- adolescent reproductive health and other life skills and education needs;
- parental education;
- ensuring contraceptive choice;

- improving counselling;
- discouraging early marriage;
- eliminating female genital mutilation and other harmful traditional practices;
- expanding access to safe abortion; and
- reviewing legislation to protect women's health.³

More specifically, for each MDG, recommendations related to SRH and rights were identified by the UN Millennium Task Force and are listed below:

Table 1: Sexual and reproductive health and the MDGs

Goal 1: Eradicate extreme poverty and hunger
Access to SRH services, especially for birth spacing, is needed to improve the nutritional status of pregnant women and children.
Supplemental feeding programmes are needed for pregnant women and nursing mothers, exclusive breastfeeding for newborns and school-based feeding programmes should be supported.
Goals 2 and 3: Achieve universal primary education and promote gender quality and empower women
Gender equality requires guaranteeing women and girls' SRH and rights.
Goals 4 and 5: Reduce child mortality and improve maternal health
Unwanted pregnancies contribute to maternal mortality.
Adolescents, particularly girls, are vulnerable to ill-health and attention to SRH is needed.
Well-functioning and equitable health systems play a key role in reducing maternal mortality.
Goal 6: Combat HIV, malaria and other diseases
The vulnerability of women and girls to HIV needs to be addressed.
Investments in health systems strengthening are needed.
Universal access to SRH and information are integral parts of the HIV response.
Goal 7: Ensure environmental sustainability
Population growth indirectly drives urban degradation and is an important driver of urbanisation.
Intra-urban health disparities exist, particularly in terms of SRH outcomes, and need to be addressed.
High prevalence of STIs, including HIV, exists in urban settings and needs to be addressed.

Source: United Nations Development Programme, 2005.³

Sexual and reproductive health policy and guidelines

Since 2000 when the MDGs were conceived, several SRH related key policies and guidelines have been implemented in South Africa.^{4,5} While South Africa has many good policies and guidelines, the main challenge lies in the effective implementation of these. An analysis of post-apartheid HIV policy in South Africa by Wouters et al. argues that a combination of the content, context, actors and process of policy can result

in a gap between the making of policies and their implementation, thus hampering their effectiveness.⁶ They argue that political actors, financial and human resources and health system factors are responsible for thwarting policy implementation in South Africa.

In 2009, the South African government created a Ministry dedicated to Women, Children and Persons with Disabilities. While the formation of this ministry indicates commitment, questions have been raised about the ability of the ministry to effectively plan and implement programmes. Moreover, there are concerns that combining these diverse vulnerable groups into one ministry does not address the individual needs of each group, let alone the specific needs of women. Furthermore, clarification is needed in terms of the role of the ministry, its relationship with other ministries such as the Department of Social Development and the Department of Health, and the overlap with the Commission for Gender Equity. Questions have been raised about the lack of appropriate indicators and outputs for measurement of progress.⁷ Activities in the current financial year have focused on commemorative days and short-term programmes rather than ongoing programmes that are likely to have greater impact.

Progress in terms of MDGs

Family planning

Increased access to family planning (FP) could help South Africa to meet MDG targets by decreasing the number of maternal deaths during childbirth (Goal 5) by reducing the number of pregnancies and induced abortions. Furthermore, the number of infant and child deaths (Goal 4) could be reduced by reducing the percentage of high-risk births.

In 1994, a Reproductive Health Steering Committee was established to undertake a review of health services, including FP provision. This review identified a number of problems in the area of FP, in particular around access and quality of care.⁸ Non-governmental provision of FP has always been limited in South Africa, leaving FP provision for the majority of the population almost entirely under government structures. There was also a key women's health conference held in 1994 that dealt with important SRH issues.^{2,9}

A progressive contraceptive policy, focusing on the client's right to choose and quality of care, was launched in 2001 and includes a detailed review of the historical background of FP in South Africa.¹⁰ Service delivery guidelines for implementation of this policy were developed and providers trained. The revision of the guidelines is currently in progress. The policy guidelines for Adolescent and Youth Health introduced in 2001 also include recommendations for strategies relating to

contraception. These include improving access to emergency contraception and condoms.

The South Africa Demographic and Health Survey (SADHS) shows that FP rates increased in sexually active women between 1999 and 2003 and at 64.7% were the highest in the region.¹¹ However, more recent informal reports from the Department of Health indicate that uptake has dropped in recent years. In addition, the choice of method has become increasingly restricted in the public sector.¹²

Intrauterine devices

The uptake of the intrauterine device (IUD) has fallen and is now almost negligible.¹¹ The IUD is rarely offered as few providers are trained in insertion and on its suitability for women with STIs and/or HIV.^{12,13} Sterilisation services are difficult to access, leaving a reliance on long-acting hormonal methods. Further efforts are required to introduce IUDs, along with provider education and training regarding their use in HIV-positive women, as well as new technologies such as the SILCS diaphragm.^a These efforts will require policy advocacy in order to first ensure their availability within the health services.

Hormonal contraception

Hormonal contraception is freely available in South Africa public sector facilities, with injectables being most widespread.¹¹ Based on available research, the World Health Organization (WHO) statement of 11 October 2005 advises that HIV-positive women can generally use hormonal contraception (oral and injectable) without any restriction, as most hormonal contraceptives offer excellent pregnancy protection.¹⁴ Since current evidence is not sufficient to conclude otherwise, the WHO 2004 Medical Eligibility Criteria suggest that oral contraceptives (OCs) can generally be used by women on antiretroviral therapy (ART).¹⁵ There are, however, theoretical concerns about potential interactions between enzyme inducing drugs e.g. rifampicin (an anti-tuberculosis drug) and some classes of antiretrovirals and hormonal contraceptives that may increase or decrease the bioavailability of these drugs and alter effectiveness. Theoretically, lower concentrations could reduce the effectiveness of hormonal contraceptives (and increase risk of pregnancy), while higher concentrations could increase hormone-related side effects. Further research is required on the possible effects of hormonal contraception on infectivity of HIV-positive women and potential relationships between hormonal contraception and HIV-related disease progression. It is important, however, to balance these primarily theoretical concerns against the real risk of unintended pregnancy and its impact on maternal

a The SILCS diaphragm was developed by PATH in collaboration with SILC Inc. See <http://www.path.org/projects/silcs.php>.

and infant morbidity and mortality. Health-providers should, therefore, when possible, prescribe antiretroviral (ARV) drugs that do not interact with hormonal contraceptives. If this is not possible, women should be counselled on correct and consistent condom use. No studies have compared the effectiveness of high-dose versus low-dose combined OCs in women on ART. Consistent use of condoms as a backup method of contraception while taking low-dose combined OCs is recommended.

No clinical studies have been completed to clarify possible interactions between 'other' hormonal contraceptives, such as injectables (combined or progestin-only); vaginal rings; patches; progestin-only pills; Emergency Contraception (EC) pills, progestin implants; or the progestin intrauterine systems and ART. Until conclusive research is conducted, there is insufficient evidence to consider more restrictive changes to clinical guidelines.

Male and female condoms

Condom programmes should be comprehensive and take social, environmental and personal factors into account. They should address gender roles and expectations, men and women's familiarity and comfort with their sexual anatomy, trust issues, gender-based violence, sexual orientation, risk perception and women's rights. SRH and rights advocates must demand access to male and female condom supplies and comprehensive programming.

While a reported 400 million male condoms (MCs) are distributed in South Africa annually, this remains insufficient. Although the number of MCs distributed by the Department of Health to men aged 15 years and older has increased, it still remained low at 12 condoms per male per annum in 2007/2008.¹⁶ Five provinces report MC distribution rates below eight condoms per male per annum, while the Western Cape, with the lowest HIV prevalence rate, distributes the highest number at over 40 condoms per male per annum. The year 2009/2010 has seen male condom stock-outs, supposedly as a result of delays in awarding the national tender for condoms in late 2008.¹⁷

South Africa's female condom (FC) programme has expanded since 1999 and now over four million FCs are distributed per year, mainly through the public sector. However, FCs are not available at all sites providing family planning services and so distribution sites are still limited compared to the male condom.¹⁷ According to PlusNews only about 3.6 million FCs were distributed at public health facilities in 2008.^{18,19}

Condom use rates reported in a national survey show marked increases, with 62% of people reporting condom use at last sexual encounter in 2008. In particular, 87% of males aged

15-24 years reported condom use at last sex, while the comparative rate for females was 73%.¹⁸ Based on WHO recommendations, individuals should be given a minimum of 100 condoms per annum. The supply of condoms clearly needs to increase substantially.

Emergency contraception

Emergency contraception pills, like all regular hormonal contraceptives, prevent pregnancy primarily by delaying or inhibiting ovulation and inhibiting fertilisation. EC was down-scheduled in November 2000 and is now available over the counter in pharmacies. It is also available in the public sector but its utilisation is poor and only 0.6% of women had ever used this method in 2003.¹¹ Lack of access to EC is a human rights issue. Health-care providers are key in promoting a range of methods to clients and choice of method is an essential component of a client's right to choose. Some methods that are technically available are poorly utilised due to lack of promotion. Health-care providers have concerns that EC use will be abused or that EC is an abortifacient, resulting in an unwillingness to promote or prescribe it.²⁰⁻²³ The latter is probably based on misperception, as EC is not an abortifacient but prevents pregnancy from occurring.

The right to protection from pregnancy and disease prevention can be improved by making both male and female condoms, EC and other methods available for men and women. In addition, better counselling, extended clinic hours and improving access in communities, e.g. in schools, central business districts and integration into other services, is required. With the exception of improved availability of condoms and improving counselling in the public sector, little progress has been made in respect of improving availability of other methods or in improving access to services. The only data available on the use of EC is from the SADHS (2003), published in 2007.¹¹ There is no reliable data on EC use in South Africa as much of the provision is through private sector providers and is not monitored.

Post abortion care and access to safe termination of pregnancy

The Choice on Termination of Pregnancy (CTOP) Amendment Act was passed in 2004 to ensure widespread availability of termination of pregnancy (TOP). It empowered provinces to designate abortion-providing facilities and made it illegal to perform TOP outside of a designated service.

In 2001 the Medicines Control Council (MCC) approved a medical abortion regimen for the termination of early pregnancy and this has the potential to expand access to safe abortion. Research has been conducted to show that it is feasible

to integrate medical abortion into the public sector in South Africa.²⁴ Currently, medical abortion is limited to the private sector.^{25,26}

TOP is available in both the public and private sectors. However, the service in the public sector is still restricted. The gap between the policy and accessibility of the service has consequences for women's health and reproductive rights. The number of designated facilities providing the service varies between provinces, as does the proportion of designated facilities that are actually providing a service. Private provision of TOP has made an important contribution to the availability and access to the service. In the public sector there has been considerable inequity in the number of sites offering TOP services, with some provinces providing a far more limited service than others.^{27,28}

HIV counselling and testing

Key changes in the South African counselling and testing policy in the past year include:

- the introduction of Provider-Initiated Counselling and Testing (PICT);
- the amendment to the National Health Act allowing trained health-care providers, including counsellors and retired health-care providers, to undertake withdrawal of blood for HIV testing;²⁹ and
- the launch of a national HIV Counselling and Testing (HCT) campaign.

The National Guidelines define PICT as:

HIV counselling and testing which is initiated and recommended by health-care providers to all clients attending health-care facilities as a standard component of medical care.³⁰

PICT should be offered to all adults, youth and children at any health facility, including at antenatal and postnatal clinics, tuberculosis (TB) facilities, Integrated Management of Childhood Illness (IMCI) centres, FP clinics, STI clinics and centres offering treatment for opportunistic infections (OIs) and domestic or gender based violence/trauma services, including post-exposure prophylaxis. PICT can be routinely offered and clients can 'opt out' in delivery. This will substantially increase the number of individuals receiving HCT and improve access to care and support.

Continuum of treatment, care and prevention for HIV and STIs

Comprehensive HIV treatment and care

The National Strategic Plan (NSP) 2007-2011, a multisectoral response to South Africa's AIDS epidemic, calls for treatment, care and support for 80% of HIV-positive people by 2011.³¹ South Africa currently has the largest ARV programme in the world: by November 2009, the South African Government reported nearly 920 000 individuals on treatment representing 56% of adults and children requiring ART treatment.³² However, the gap between people in need of treatment and those currently on treatment remains considerable and varies by province.³³

Given this gap and the potential barriers to its achievement, attaining near-universal coverage within a short time is an immense task. A recent review of the NSP produced a number of recommendations to ensure the 2011 and future targets are reached. These include increasing resources at provincial and district level, the need for a rolling annual implementation plan, as well as surveillance funding.³⁰ More efficient drug procurement and supply chains are also necessary for more cost-effective and efficient programmes.

South Africa has the additional burden of a TB epidemic that is being fuelled by HIV. As a result, women of reproductive age are disproportionately affected by the dual epidemics. Although some integration of TB screening, prevention and treatment services with HIV services has commenced at facility level, more targeted integration of TB and reproductive health and maternal and child health services is required.³⁴ The recent Lancet series on South Africa calls for improving TB cure rates and TB case detection rates, the integration of TB and HIV services and the identification and treatment of drug resistant TB.³⁵ Recommendations that could result in improved TB cure rates and detection include: widespread utilisation of lay counsellors and community health workers; rapid HIV tests; nurse-driven treatment and care; an electronic patient information system; and outreach support for nurses in the TB programme.³⁵

Revised South African clinical guidelines for HIV were announced on World AIDS Day 2009 that aspire towards more comprehensive care and treatment for individuals in accordance with WHO recommendations for ART.

Key changes included:

- Treatment for all HIV-positive infants under one year of age, regardless of CD4 count;
- Antiretroviral treatment to be initiated at CD4 count ≤ 350 for pregnant women and TB-HIV co-infected patients; and

- HIV-positive pregnant women with a CD4 count ≥ 350 to start ARVs at 14 weeks as part of the PMTCT programme.

Challenges to expansion, especially in light of the revised criteria, necessitate the decentralisation of care to primary care level in order to provide access closer to communities.

Although South Africa follows an integrated primary health care model, health services related to HIV are provided in a largely vertical fashion. As a result, services such as FP, PMTCT, HIV, ARV, and other STI services are poorly integrated.³⁶ Integrating SRH and HIV services can lead to improved efficiency and effectiveness of the health care system, as well as to improved reproductive health outcomes. These potential benefits include increased contraceptive prevalence or declines in unplanned pregnancies, maternal mortality, or in the incidence of HIV and other STIs.³⁷ In addition, combining reproductive health services may improve efficiency by requiring fewer client-provider contacts, reducing duplication of services, ensuring continuity of care and training staff to perform multiple tasks.³⁸ Linking services may also help to reach under-served groups such as adolescents.³⁹ At present, there is a lack of clear policies on integration within South African health services. Further, studies in South Africa have found substantial barriers to providing an integrated service, due to on-the-ground realities of vertical service provision, logistical difficulties and the need for extensive re-training of health-care providers.^{36,39}

Postnatal follow-up for HIV-positive mothers and their infants should be integrated with treatment services for HIV, as well as with treatment services for opportunistic infections such as TB. Health monitoring of children born to HIV-positive women and of the women themselves should be closely allied to programmes to prevent mother-to-child transmission. Such integration can be effective and more cost efficient than separate programmes. Prevention of HIV acquisition through unsafe injections, child sexual abuse and risky sex in older children and adolescents deserves more attention.

HIV prevention

The South African National Department of Health's HIV prevention programme includes interventions focusing on information, education and mass mobilisation; STI diagnosis and management; HIV counselling and testing; condom provision and promotion, medical male circumcision, PMTCT, safe blood transfusion and post-exposure prophylaxis.³¹

Preventing new infections and AIDS-related deaths amongst young women in South Africa is crucial. Some of the main drivers of the epidemic are early sexual debut, gender based violence and gender inequality, intergenerational sex, multiple

concurrent sexual partnerships and a lack of knowledge about HIV and HIV status.

Information, education and mass mobilisation

Several mass media campaigns implemented in South Africa in recent years include Khomanani, loveLife, Soul City, Siyanqoba Beat It!, 46664, Tsha Tsha and Scrutinize. Khomanani, the official government communication campaign, has been mired in controversy and government funding for the campaign ceased in March 2010.⁴⁰ The impact of the campaign has also been limited – the South African National HIV Survey 2008 found the Khomanani Campaign had a low coverage when compared with other campaigns, with fewer than four out of ten adults having heard of the campaign. The Soul City and Soul Buddyz interventions are well regarded, target the younger age group and are implemented in schools and through mass media. Other campaigns which target niche markets, including urban constituencies, have limited reach. Little data on the effectiveness of these interventions are available.

The National Communication Survey on HIV/AIDS, 2009 found that 90% of South Africans were reached by at least one of the eleven HIV communication programmes examined in the study, with younger audiences having a higher level of exposure to communication programmes than older audiences.⁴¹ The survey findings indicate that communication programmes are impacting significantly upon young people's knowledge levels and behaviours in relation to condom usage and HIV testing but less so in relation to numbers of partners and risk of HIV infection. Survey findings indicated that programmes need to continue to emphasize partner reduction and need to focus more on condom messaging for people in long-term and stable relationships and including condom use in family planning.

Communication campaigns need to be part of a broader comprehensive package of prevention interventions and should be carefully monitored in view of their considerable cost. Innovative ways to reach the entire population, with standardised and appropriate HIV messaging, are required as this has not been achieved through existing interventions.⁴²

STI diagnosis and management

STIs are endemic in South Africa and are SRH problems in themselves, as well as exacerbating HIV infection. Recommended treatment of symptomatic STIs is through the syndromic approach, which is based on the clinical diagnosis of symptoms and signs (syndromes). The management for each syndrome follows national flow charts.³¹ Syndromic management provides cures for most STIs and prevents clinical complications of untreated infections. Since STIs other than HIV increase the risk of acquisition and transmission of

HIV, early treatment of symptomatic STIs contributes directly to the reduction of the HIV incidence. Syndromic management of STIs is available through all public sector primary health clinics. Challenges experienced in decreasing the rate of STIs include partner notification, the fact that women are often asymptomatic and other gender issues.⁴³

While the NSP outlines South Africa's response to STIs, delays in implementing revised syndromic management guidelines and donor priorities around HIV treatment and prevention may have affected implementation of STI services. Furthermore, the quality of services requires further attention.

Cervical cancer screening

In South Africa, cervical cancer is the most commonly diagnosed form of cancer. Approximately 7 000 South African women develop cervical cancer annually. However, despite the availability of guidelines and a policy, there is poor coverage of screening and care for cervical cancer. This remains a challenge and outcomes remain poor.^{44,45} Cervical cancer is more common among older women and takes a while to progress. This is the rationale behind the national policy for cervical screening in South Africa, based on WHO recommendations for screening in limited resource countries. Screening at 10 year intervals from the age of 30 years for women who are not HIV-positive, while not optimal, would have the greatest population-based effect in reducing cervical cancer-related serious morbidity and mortality among women in the country.

According to the Cancer Research Institute of South Africa (CARISA), about 23% of South African women have consistent and regular access to pelvic examinations and 51-60% of women have never had a pelvic examination. Of even greater concern is the fact that screening levels are particularly low among the age cohort of women at greatest risk of developing cervical cancer (between 45 and 54 years).^{46,47} A significant barrier to the implementation and sustainability of mass cervical cancer screening in South Africa are the requirements of cytology-based screening methods. These are labour and resource intensive and require relatively complex laboratory infrastructure. Fast, innovative screening tests such as visual inspection with acetic acid (VIA) that do not require a pathologist, refrigeration of samples or a microscope require further investigation.⁴⁸

As a consequence of poor screening programmes and inadequate screening coverage, cervical cancer is often diagnosed at a late stage with associated sub-optimal outcomes. This is of particular concern to HIV-positive women who are more likely to contract the disease, generally at a younger age and with increased severity as compared with uninfected women. As cancer of the cervix is an AIDS-defining illness, the

screening policy for HIV-positive women differs and includes a pap smear on diagnosis or from age 20 and yearly or thrice-yearly thereafter, depending on whether the smear was found to be normal or not.

Human papillomavirus vaccination

Given the current limitations of South Africa's screening programme for cervical cancer, the human papillomavirus (HPV) vaccination is the only realistic strategy for prevention.^{44,49} Two vaccines that protect against HPV-related cervical, vulvar and vaginal cancers and genital warts have recently been registered in South Africa and are approved for females aged 9-26 years. HPV vaccines are not currently available through public sector health services in South Africa.

Due to the high national prevalence of HIV, HPV infection rates amongst HIV-positive women are ten times greater than those among HIV-negative women, partly due to the compromised immunity of HIV-positive women. Although 70% of cervical cancer cases in the current generation of South African girls can be prevented by HPV vaccination, the current cost of the vaccine (more than R2 000 for the three required doses) makes it inaccessible to the vast majority of South Africans who rely on public sector health care.

Public sector rollout of HPV vaccination to 80% of girls aged 9-12 years would need more than R3.6 billion for the initial vaccination effort and R1.2 billion annually thereafter. By way of comparison, the total budget for the Department of Health in 2008 exceeded R15 billion. The Global Alliance for Vaccines and Immunization (GAVI) could make the vaccine available to South Africa at a price of US\$0.30 per vaccine dose. However, South Africa does not qualify for GAVI funding that would reduce the cost of these initiatives to R18 million and R4.5 million respectively. A reduction in prices of these essential vaccines is necessary in order to protect the rights and reproductive futures of South Africa's girls and women.

In 2009 the United States (US) Food and Drug Administration (FDA) recommended the quadrivalent HPV vaccine for use in males aged 9-26 years to prevent genital warts and persistent anogenital HPV infections. Carriage in the male population of the two HPV genotypes that cause 70% of cervical cancer worldwide in women could be greatly reduced by widespread HPV vaccination. However, a cost effectiveness analysis of male HPV vaccination in the US questioned the benefits. Advocacy for male HPV vaccination is also made on ethical grounds – to promote equality and social responsibility in both sexes. Targeting girls when they are young, before they are sexually active, is important as this vaccine could prevent them from acquiring HPV. It is a priority to target girls as HPV-related cervical cancer is very common whereas HPV-related cancers in males, e.g. cancer of the penis, is uncommon.²¹ However,

consistent use of condoms can partially protect against HPV and provide cheap protection against all STIs, including HIV, as well as unwanted pregnancy.

Microbicides

Microbicides are being developed in response to the urgent need for an HIV and STI prevention method that women can control themselves. The introduction of this new technology requires careful consideration to ensure that the best possible approach is identified – one that has anticipated potential barriers such as acceptability and user issues and has been designed to maximise opportunities for introduction into existing programmes. Acceptability data collected as part of candidate clinical microbicide trials has shown in general that both women and men find the gel acceptable to use.^{50,51} In one of these studies the gel was reported to increase sexual pleasure and promote communication between partners.⁵¹ Health-care providers have also expressed enthusiasm for a product women could use to prevent infection, although policy makers had concerns relating to safety and understanding of product use.⁵² A recent randomised clinical trial in South Africa found a vaginal gel containing the antiretroviral drug, tenofovir, was 39% effective at reducing women's risk of contracting HIV.⁵³ Further research is now being undertaken to confirm the safety, effectiveness and acceptability of 1% tenofovir gel.

Prevention of mother-to-child transmission

Strengthening PMTCT including postnatal care will contribute to the health of women and children in South Africa.⁵⁴ PMTCT is widely regarded to comprise four key strategies – primary prevention of HIV infection in women; the prevention of unintended pregnancies in women living with HIV; the prevention of transmission from women living with HIV to their infants; and the provision of care, treatment and support for women living with HIV and their families.

Interventions to prevent mother-to-child transmission include: introduction of enhanced HIV testing; encouragement of sharing HIV status with partners and family; skilled supervision of labour and delivery with attention to minimising invasive procedures; and implementation of combination antiretroviral treatment, including highly active antiretroviral therapy (HAART) for mothers at particular risk and, more widely, as combined therapy increasingly replaces single-dose nevirapine regimens. Health worker support is necessary for mothers to establish optimum infant feeding and minimise any stigma related to feeding choice. In most poor populations, the hazards of transmitting HIV by breastfeeding are outweighed by the dangers of exposure to contaminated environments. ARVs given to breastfeeding infants or lactating mothers can greatly reduce breastfeeding transmission and

improve survival of infants. Re-orientation and retraining of health personnel and upgrading of antenatal, natal and post-natal services are urgently needed to address issues of HIV in mothers and infants.

Moving towards alignment with WHO recommendations, the revised South African treatment guidelines include ARVs for HIV-positive pregnant women with a CD4 count equal to or greater than 350 at 14 weeks as part of the PMTCT programme and ART for all HIV-positive children under one year.

CD4 count is a key indicator for ensuring that women access appropriate treatment and care during pregnancy. However, the data are missing for many districts. The percentage of women accessing CD4 counts varies markedly between and within provinces with districts reporting from 10% to over 90% of women receiving CD4 counts. Polymerase Chain Reaction (PCR) rates for babies born to HIV-positive women remain low, with large differences reported by district and province.¹⁶

Key challenges in implementation of PMTCT are largely related to health systems issues and include delayed initiation of ANC and poor follow-up of HIV-exposed infants. Poor record keeping and inadequate District Health Information System data on PMTCT limit the ability of the South African government to measure the impact of PMTCT services and programme outcomes. The PMTCT Accelerated Plan aims to address many of these concerns, including improving the quality of PMTCT services and improving the integration of PMTCT with maternal and child health services. Without improved tracking of programme impact and quality improvement in implementation, however, reaching the NSP target of less than 5% mother-to-child transmission rates by 2011 will prove difficult.⁵⁵

Post Exposure Prophylaxis

Post-Exposure Prophylaxis (PEP) is short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. PEP provision has been policy for sexual assault survivors since 2002. However, challenges in service delivery still remain in 2010. The challenges include poor uptake among rape survivors, limited accessibility of services, lack of trained service providers and problems with adherence to a complete course of ART.^{56,57}

Information and services for under-served and diverse populations

Adolescents

The NSP includes a defined package of youth-friendly SRH services calling for sensitisation of health workers, STI management, HCT, contraception, TOP referral, mental health interventions, reducing substance abuse, Information Education and Communication (IEC), peer education, provision of male and female condoms and appropriate service hours. The NSP outlines two interventions to address the health related needs of young people through the education system:

- Identify and prioritise interventions in schools reporting high annual rates of teenage pregnancies through a gender-sensitive package that addresses SRH and rights, HIV, alcohol and substance abuse; and
- Introduce, strengthen and evaluate life skills, SRH education and HIV prevention programmes in all primary and secondary schools.

The National Adolescent-Friendly Clinic Initiative offered health services to young people through peer education and support for a limited period in the early 2000s.⁵⁸

Currently, dedicated facilities or identifiable health professionals for SRH needs of adolescents are largely absent in South Africa. Adolescent years differ from the early childhood period and are characterised by the dominance of risk-taking behaviours and psychosocial disorders.⁵⁹ Multi-disciplinary teams to manage these problems and social services are often not available, more especially in the public sector.

There has, however, been considerable progress since 1994 in the provision of health services at schools. Approximately half of all provincial departments of health and education have developed policy documents regarding school health. In most provinces there is collaboration between Departments of Health and Education in developing programmes for school-aged young people. In almost all provinces, school health programmes are currently being implemented in secondary schools. Such programmes include counselling, mental health interventions, feeding programmes, education regarding the environment and sexuality and life skills.⁶⁰⁻⁶²

Consideration should be given to the expansion of dedicated SRH services for young South Africans, including young men. Targeted services for the latter could include medical male circumcision as well as counselling on sexual health and substance abuse.

Men

Involving South African men in SRH is important in their own right and also to protect women's SRH rights. Currently there is a disproportionate distribution of SRH responsibilities between South African men and women, including decisions about contraception.⁴³ Although there is much literature calling for the need for male programmes to be put in place in South Africa, there is little in the way of policies or programmes that have specific guidelines for male SRH services.

SRH needs and rights of men are generally not addressed in public sector health services. Male reproductive health services are largely absent in public sector health services and men do not use health facilities as often as women. There are a number of IEC materials produced around male SRH, e.g. counselling around sexual relations, staying healthy, means of contraception and substance abuse. Local initiatives targeting men have been shown to alter social practices that affect the health of both men and women, especially in the context of HIV, and should be taken to scale.^{63,64}

Medical male circumcision

The WHO recommended medical male circumcision (MMC) as an HIV prevention measure in 2007 following evidence that it reduced the risk of HIV infection through heterosexual transmission by around 60%.⁶⁵ Furthermore, findings from Male Circumcision (MC) trials conducted in South Africa⁶⁶ and Uganda⁶⁷ showed that MMC offers men partial protection against HPV and herpes simplex virus type 2. MMC has also been found to be partially protective against HIV in heterosexual men. It is not protective against the acquisition of infection directly in women and in men who have sex with men.

South Africa combines high HIV prevalence with relatively low prevalence of MC which is not widely practiced except among sub-populations such as the Xhosa and Sotho ethnic groups and Jewish and Islamic religious groups. Efforts to ensure that traditional circumcision is undertaken under safe and hygienic conditions are required and interventions to make traditional MC safer is essential to implementing a national MC programme. Potential issues affecting implementation of MMC in communities that practice traditional MC include reluctance to involve female health providers in the procedure; suspicion around disposal of the foreskin through medical waste disposal; and possible stigma and discrimination for males who opt for circumcision in clinical settings and before the age of traditional initiation. Deeply rooted cultural beliefs may mean communities may be reluctant to embrace medical circumcision.

There is recent strong political commitment and leadership for introduction of MMC as an HIV prevention strategy in South Africa. The South African National Department of

Health is adopting implementation of MMC as part of a package of HIV prevention interventions, after extensive consultations with the South African National AIDS Council (SANAC), civil society and traditional leaders. MMC guidelines are currently being drafted. A policy on MMC was drafted in 2009 and has yet to be finalised.

Prior to June 2010, very few MMCs were performed in government facilities. The majority are conducted by private doctors and non-government agencies. Availability of trained service providers and other constraints facing the public sector impact on the implementation of the MMC programme. Significant expansion of MMC in South Africa will necessitate the participation of private and non-government health institutions in scaling up of the services. Services must be delivered as part of a recommended minimum package which includes HIV counselling and testing, counselling on MMC risks and benefits, counselling around risk reduction, couple counselling, condom promotion and provision and STI management.

Elective MMC is currently available on demand through private sector providers and a few non-governmental organisations. Some medical schemes, such as Discovery Health, do not cover the cost of voluntary MMC despite evidence that MC is one of the most effective HIV prevention strategies currently available.⁶⁸

The National Children's Act of 2005 prohibits circumcision of children under 16 without their consent, except for medical or religious reasons.⁶⁹ Based on scientific evidence that MMC substantially reduces the risk of contracting HIV and other sexually transmitted diseases and that neonatal MMC carries a lower risk of complications than child or adult MMC, a medical practitioner is well within the law to recommend elective neonatal male circumcision to parents of new born boys.⁷⁰ A plan for the introduction of voluntary neonatal MMC services within the provisions of the Children's Act of 2005, and for the integration of neonatal MMC into existing maternal, women, neonatal and child health programmes, is needed.

MMC can act as a gateway to providing men with increased access to other prevention services and an entry point to getting men into the health care system. In South Africa MMC has to be placed within the context of male SRH. Men attending health facilities can be provided with combined circumcision/behaviour change messages, as well as a comprehensive package of HIV prevention services and interventions that includes consistent, correct condom use; delaying sexual debut; promoting sexual and gender equality; access to HCT, reduction of sexual partners and of multiple concurrent partnerships, and STI treatment. Only when combined with preventative measures, such as the above, can MMC become effective in reducing the rate of HIV infection in South Africa.

People in emergency situations

The South African Constitution guarantees the right of access to health care and essential services, including to migrants and people in emergency situations such as refugees and migrants. However, in practice, access to HIV treatment and care for these people is limited. Access to public sector health care for individuals without a South African identity document is often challenging. Despite a circular from the Department of Health in 2007 expressly stating that no individual was to be denied treatment for not possessing an identity document, people continue to be turned away from public sector health facilities on this basis.⁷¹ In addition, xenophobic attacks in 2008 and 2009 may also have affected the ability of illegal and legal immigrants to access treatment, care and support. In April and May 2009, the Department of Home Affairs announced a moratorium on deportations and special dispensation allowing Zimbabweans with travel documents to get a 90-day visa. There is also no evidence that migrants are less adherent to treatment.⁷² Médecins Sans Frontières (MSF) has documented some of the challenges faced by Zimbabweans in accessing health care and the related implications in terms of SRH rights in South Africa.⁷³ Additional efforts to mobilise these populations and to educate health-care providers on the rights and obligations to provide care and treatment to these vulnerable populations, are needed. Further research, including situational analyses at district level documenting mobile populations and their needs, would provide data on programmes required. Ongoing monitoring and evaluation of implementation is important for tracking outcomes and the reach of programmes.

Conclusions

Whilst significant progress has been made towards developing a framework in support of SRH service delivery (including indicators for monitoring and evaluation, policies, guidelines and legislation), gaps remain in service delivery. With only five years left until the 2015 deadline to achieve the MDGs, there is an urgent need for stronger links between reproductive health and HIV policies, programmes and services. For the majority of South African men and women, despite having good access to therapeutic services, decision-making around pregnancy and childbirth is currently characterised by a number of negative factors, including obstacles to pregnancy prevention such as lack of information on contraception; interactions between contraceptives and drugs for treatment of opportunistic infections; inability to use condoms and contraception consistently; lack of knowledge about HIV status when pregnant; lack of knowledge about fertility options; and inadequate access to prevention of unwanted pregnancies. There is also a paucity of programmes to make information, counselling and services for reproductive health accessible to adolescent males and

adult men. Future such programmes must both educate and enable men to share more equally in FP, domestic and child-rearing responsibilities and to accept major responsibility for the prevention of STIs.⁴³

Whilst the South African NSP⁷⁴ supports the need for a comprehensive package of services for SRH in the context of the HIV epidemic, HIV-positive men and women continue to face challenges and obstacles in accessing comprehensive services for sexual health, STIs, FP and contraception, pregnancy, delivery, psychosocial support, counselling and treatment. Provision of comprehensive and holistic care will entail enhancing integration of HIV and reproductive health services and providing guidelines for its implementation.

Other pertinent considerations include improving antenatal, obstetric and postnatal care; strengthening linkages with community-based support structures; supporting HIV-positive people in their choice of having children or not; building capacity of health providers in non-judgmental SRH service delivery; expanding access to provider-initiated counselling and testing; empowering women through increasing male involvement in SRH and through improvement of the socio-economic environment.

South Africa has made significant progress in rapidly expanding access to HIV counselling and testing, PMTCT and ART, and has produced policies and guidelines supportive of high quality treatment and care. There are, however, challenges and gaps in translating these policies into action. Although the Department of Health has made considerable strides in the procurement of cheap, life-saving AIDS treatment, these strides are often negated by poor management and distribution of the drugs. Health-care facilities are experiencing frequent stock-outs of ARVs and other essential medicines due to inadequate pharmaceutical systems and unqualified managers at facility, district and provincial levels.⁴³

The value of increasing early access to PMTCT, and ARVs for pregnant women, cannot be underestimated. There is evidence of greater mortality among HIV-positive women who are very ill and who give birth (as opposed to those who are relatively well).⁷⁵ Voluntary use of contraception has been an undervalued and little-used intervention in the fight against HIV. Contraception is important because preventing unintended pregnancies in women with HIV can prevent mother-to-child transmission of HIV and reduce the number of children needing HIV treatment. Moreover, women with HIV need access to reproductive health services to ensure their needs are addressed and their reproductive rights are protected. There is a strong need for the integration of HIV and SRH services for the effectiveness of HAART. In addition, access to HAART for HIV-positive women is in vain if cervical cancer screening services are not provided, as these women

will eventually die of cancer of the cervix.

Integrating reproductive health and HIV programmes has proved difficult for a variety of reasons, but new opportunities are emerging to strengthen these essential linkages. The integration of HIV care with SRH (including FP and STI services) and the availability of social support must be improved. Integration of services would increase opportunities for screening and prevention, reduce duplication of services, provide continuity of care and make maximum use of finite resources.

Approximately 40 million South Africans do not have access to private health care and are completely dependent on public sector health facilities. Whilst primary health care services are free of cost at the point of service, financial barriers to accessing health care include transport costs and loss of income due to long waiting times at clinics because lengthy queues necessitate taking significant time off work.

Current public health programmes in South Africa do not address the sexual health of women, including HIV-positive women and despite widespread global recognition of the importance of sexual health to well-being, there is minimal coverage of this area in undergraduate health provider training in South Africa. In several South African studies, HIV-positive women report limited receptiveness of health providers to discussing sexuality and childbearing.⁷⁶ This causes many HIV-positive women to avoid discussing sexual activity with providers for fear of reprisals for engaging in sub-optimal safe sex practices. Supportive services that promote non-judgmental open discussions of the SRH of HIV-positive women are urgently needed in South Africa. To facilitate this, ongoing training in sexual health and counselling for health providers is required, as is values clarification training.⁷⁷

Recommendations

In order to accelerate progress towards achieving MDGs focusing on SRH rights for men and women in South Africa, it is recommended that the following be urgently implemented:⁴³

Health system recommendations

- Restructuring vertical programming for SRHs and STIs, including HCT and HIV prevention and treatment, by integrating some services, adding and strengthening others, expanding outreach to new population groups and creating efficient referral links, e.g. between antenatal and ARV services and between HCT and FP clinics.
- Rapid scale-up of implementing strategies to increase male involvement in SRH issues, including couple counselling and safe male-oriented MMC services, packaged with HIV

prevention and SRH programmes (such as home-based testing) with a focus on special needs of adolescent boys. This could be expanded through both schools and health facilities and could include counselling on sexual health, substance abuse and gender issues.

- Minimising missed opportunities for HIV testing by ensuring provider-initiated HIV testing and by expanding access to counselling and testing to women at STI and TB services, postnatal care, abortion-related care, emergency contraception and rape crisis services, whilst maintaining the rights of women.
- Strengthening and formalising linkages between health facilities and community-based support groups and systems.
- Innovative programming to maximise the use of existing personnel and to develop new cadres of health-care workers, while retaining those already in the system.
- Increasing awareness and availability of TOP services, EC and female condoms, especially in rural areas.
- Broadening and fast-tracking of public sector TOP services to include the option of medical abortion for termination of early pregnancy.

Targeted recommendations

- Exploring alternative and cheaper cost-effective screening methodologies for cervical cancer.
- Exploring alternative sources of funding and/or reduced pricing structures to allow for HPV vaccination for girls aged 9-12 years.
- Increasing coverage of PEP services and building capacity of health providers in provision of PEP.
- Addressing gender inequality by scaling up counselling of women on negotiating condom use.
- Promoting and providing of condoms during pregnancy and family planning/dual protection counselling in post-natal care.
- Providing FP and contraception services and counselling about appropriate contraceptives as part of post-TOP care.
- Values clarification training, including gender issues and reproductive health rights, for health providers to facilitate non-judgmental support, information and services.

HIV-positive client-specific recommendations

- Disseminating information about the impact of HIV on the course and outcome of pregnancy and the impact of pregnancy on HIV-related disease progression.
- Scaling up counselling on the risk of pregnancy to mother and child and commencing PMTCT early in the course of HIV care.
- Providing FP and contraception services and counselling about appropriate contraceptives as part of integrated HIV services.
- Scaling up counselling for women diagnosed with HIV during pregnancy to facilitate their ability to make informed choices about future fertility and about opportunities to terminate pregnancy safely if desired.
- Addressing infertility in HIV-positive women by increasing awareness, support and access to assisted reproduction techniques and about possibilities of fostering and adopting.
- Developing contraception guidelines for HIV-positive people.
- Integrating family planning into HIV services (PMTCT, ARV), ie: provider-initiated family planning.
- Increasing support for breastfeeding and improving counselling for mothers on infant feeding to promote exclusive and continued breastfeeding; expanding support to mothers; avoiding provision of infant formula as a routine part of programmes to prevent mother-to-child transmission of HIV; strengthening education about complementary feeding; and promoting local, nutrient-rich complementary foods.
- Prioritising ARV therapy and prophylaxis among pregnant and lactating women. Implementing programmes to provide CD4 count testing to identify pregnant and lactating women in need of ARV therapy. Making extended infant prophylaxis regimens available for women who do not meet criteria for ARV therapy, for their own health.
- Improving co-ordination between maternal care services and HIV treatment services to provide mothers with a full package of nutrition and health interventions.

Recommendations for further research

More research is required on:

- Patterns of contraception use and on the role of providers in counselling about contraception options among young women (<25 years) using hormonal contraceptives.
- How best to use existing resources to improve programme outcomes.

- Implementation of integration of TB and HIV services, including rapid diagnosis of TB.
- Implementation and evaluation of models of integration of SRH into HIV.
- Introducing safer conception methods for HIV-positive individuals wishing to have children.
- Increasing male involvement in SRH issues and services, e.g. antenatal care and medical male circumcision.
- The safety, effectiveness and acceptability of 1% tenofovir gel.

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