KwaZulu-Natal Provincial
5-Point Contraceptive Strategy
2011-2016
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Foreword by the Head of Department

The leading causes of death, disease and disability, accounting for approximately 80% of the global burden of disease in women of a reproductive age, are pregnancy and childbirth. Family planning can help save women’s and children’s lives, preventing as many as one in every three maternal deaths by allowing women to delay motherhood, space births, avoid unintended pregnancies and abortions, and stop childbearing when they have reached their desired family size. The KwaZulu-Natal (KZN) MEC for Health, Dr Sibongiseni Dhlomo, has recently expressed his concerns about teenage pregnancy rates, saying: "I believe that we need to substantially reduce the rate of pregnancy among 16-19 year olds and that there are ways to achieve this goal within five to ten years." The United Nations Millennium Development (MDG) Goal 5: Improve Maternal Health directly addresses the need to improve contraceptive services, highlighting the following:

- Progress has stalled in reducing the number of teenage pregnancies, putting more young mothers at risk
- Poverty and lack of education perpetuate high adolescent birth rates
- Progress in expanding the use of contraceptives by women has slowed
- Use of contraception is lowest among the poorest women and those with no education
- Inadequate funding for family planning is a major failure in fulfilling commitments to improving women’s reproductive health

Guided by the MDGs, the National Contraceptive Policy and Guidelines currently being updated, and taking into account the high rates of unintended and teenage pregnancies in the context of high HIV prevalence, the KZN Provincial Department of Health in collaboration with UNFPA has developed this KwaZulu-Natal Provincial Contraceptive Strategy to revitalize interest in the utilization of the family planning programme and to increase contraceptive prevalence. Guiding principles key to the successful implementation of this strategy are: supportive leadership, effective communication, effective partnerships, an enabling environment, sustainable programmes and funding, a reproductive rights approach, respect, gender equality, recognizing diversity, and involving communities. This provincial contraceptive strategy sets out five priority tactics to increase contraceptive prevalence and improve contraceptive service delivery. It confirms our commitment to improving maternal health in KZN.

Dr S M Zungu
Head of Department

September 2011
Background and Situational Analysis: The Need for a Revised Provincial Contraceptive Strategy in KwaZulu-Natal

The leading causes of death, disease and disability, accounting for approximately 80% of the global burden of disease in women of a reproductive age, are pregnancy and childbirth. Poor reproductive and general health and nutritional status of the mother, coupled with inadequate antenatal care results in the death of millions of babies, less than one month of age. Family planning can help save women’s and children’s lives preventing as many as one in every three maternal deaths by allowing women to delay motherhood, space births, avoid unintended pregnancies and abortions, and stop childbearing when they have reached their desired family size. Teenage pregnancy is a major public health concern in South Africa, with more than one-third of South African women experiencing a first birth by age 19. Most first births occur to unmarried women, and contraceptive use often begins only after a first birth. A high proportion of pregnancies among teenage and young adult South African women are characterized as unplanned with the highest levels among unmarried, younger women. The huge burden placed on the South African health system by the HIV epidemic has not only overshadowed family planning services, but also requires attention to be paid to the contraceptive needs of HIV infected people and those at risk of infection. The need for integration of family planning and HIV services in South Africa is widely recognised. In particular, maximising opportunities to provide contraception services at routine HIV visits (rather than requiring a separate visit or referral) is called for, as is counselling about HIV and appropriate methods within family planning services.

In KwaZulu-Natal (KZN) access to modern contraceptive methods is relatively good, yet uptake and/or continuation remains a challenge, especially among younger women. Data on contraceptive prevalence have historically presented a positive picture with 76.8% of sexually active women aged 15-24 using some form of contraception in KZN in 2003, the highest prevalence in the country. Yet this is at odds with unplanned pregnancy rates coupled with anecdotal reports of a falling family planning population. Due to a paucity of good recent data, it has not been easy to verify or quantify the extent of the problem and there is much speculation as a result. Population level contraceptive prevalence in the province is lacking with the 2003 South African Demographic and Health Survey (SADHS) providing the last province-wide survey. The Department of Health collects contraceptive commodity distribution data and data on whether clients are new contraceptive acceptors or repeat acceptors. However these data do not allow tracking of clients, nor provide information on prevalence and user continuation rates. Further, there are limited data available on dual method (dual protection) use, emergency contraception pill (ECP) use, method switching and breaks from method use. Important indicators such as contraceptive prevalence rates and other related data require collection through population surveys.

The profile of contraceptive use in KZN, as in the rest of South Africa, is skewed heavily toward injectable hormonal methods. Despite these high levels of hormonal contraceptive use, consistency of use is poor, with high rates of discontinuation or “breaks in use”. While the injectable hormonal methods continue to dominate the method mix, other long acting reliable methods such as the intrauterine contraceptive device (IUCD) and female and male sterilization are less available. ECP is available over the counter in pharmacies and in the public sector, but its utilisation in the public sector is poor, with only 0.5% of sexually active women having ever used this method in 2003. High prevalence of HIV in South Africa has resulted in an increased need for emphasis on dual protection from unwanted pregnancy and sexually transmitted infections (STIs). However, evidence shows that in some facilities condom promotion is aimed at STI prevention, rather than a method of contraception. Although condom promotion by service providers is evident, the specifics of condom use, such as negotiation and gaining partner cooperation, and correct and consistent use are seldom touched on by providers.

Ease of access to contraception services is fundamental to uptake. Clients have indicated that they want a “one-stop shop” in accessing primary health care and family planning services within the same facility, shorter waiting times and adolescent friendly services. Long waiting times, negative attitudes among some providers and stigma experienced by young women also impact on uptake of contraception. Restricted delivery hours and lack of services at weekends mean that women with work commitments and scholars and students may find accessibility difficult. National surveys indicate that contraceptive prevalence is always higher in urban compared to rural areas. Health care
providers require training to maintain an optimal level of competence and familiarity with new developments. However, providers report that training, especially continuous training is not always feasible due to staff shortages.

The National Contraceptive Policy within a Reproductive Health Framework of 2001\textsuperscript{17} and Service Delivery Guidelines published in 2003\textsuperscript{18} are now out-dated. To address this, a National Contraception Policy Revision Expert Working Group was constituted in 2010 to update the South African National Contraception Policy and Guidelines with an intention to align these with existing policies, and in particular HIV-related policies. In line with the updated National Contraceptive Policy, and to address the challenges to contraceptive access, uptake and delivery of quality services in KZN, the KZN Provincial Department of Health, with technical support from MatCH [Maternal, Adolescent and Child Health Division] of the University of the Witwatersrand, has developed a Provincial Contraceptive Strategy to guide programmes across KZN health services and other sectors.

2 Purpose of the KwaZulu-Natal Provincial Contraceptive Strategy

The Contraceptive strategy is designed to guide the KZN Department of Health in revitalizing interest in the utilization of the contraceptive programme to increase awareness about and use of contraceptive services; to assist women to time and space their pregnancies and reduce teenage pregnancies and unplanned and unwanted pregnancies, including among HIV positive women; and to increase contraceptive prevalence and improve contraceptive service delivery.

3 KwaZulu-Natal Provincial Contraceptive Strategy Development Process

To inform the development of the KZN Contraceptive Strategy, the following activities were undertaken:
(i) A comprehensive desktop review of relevant contraceptive and related policies, guidelines, strategies, international guidelines, research findings and outcomes of key meetings was undertaken.\textsuperscript{19}
(ii) Discussions on priority areas to be addressed by the Strategy were held with key stakeholders, including: staff from KZN Provincial and District Departments of Health, hospitals and clinics, and private sector practitioners.\textsuperscript{19} (iii) A stakeholder workshop was convened on the 11\textsuperscript{th} of August 2011, with 48 participants, to discuss priority areas to be included in the KZN Provincial Contraception Strategy. At this workshop, findings from the desktop review and stakeholder discussions were also presented for feedback and interpretation. Further discussions were held with participants of the KZN Maternal, Child and Women's Health (MCWH) and Preventing Mother to Child Transmission (PMTCT) Quarterly Meeting, on the 25\textsuperscript{th} of August 2011.

4 KwaZulu-Natal Provincial Five Point Strategic Plan

Five key priority strategies have been identified to achieve the aims of the KZN Provincial Contraceptive Strategy, implementation plans to achieve the aims are structured according to these priority strategies as detailed below. Critical to the effective implementation of these strategies is supportive leadership, accountability, effective communication, effective partnerships, an enabling environment, recognition of reproductive rights, diversity, respect, gender equality, community involvement, and sustainable programmes and funding.

The first step in implementing the Strategic Plan is to create a KZN Provincial Contraceptive Strategy Task Force to oversee the implementation plan. This Task Force will meet quarterly to review progress towards achieving the plan and realign activities where targets are not met. The Task Force will be guided by the underlying principles and dictates of the revised National Contraceptive Policy and Guidelines.
4.1 **Key Priority 1: Promote Healthy Timing and Spacing of Pregnancies by Improving Contraceptive Awareness and Access at Health Facilities and in the Community**

Improve awareness and access targeting: youth/adolescents, workers, men, HIV infected women and men, women in the postnatal period, including rural areas, with community mobilization, using the Sukuma Sakhe approach (ward based).

**Implementation Plan:**

(i) **Health Facility Level:**
- Re-introduce “adolescent friendly” contraceptive services with accreditation of facilities that meet criteria for adolescent services.
- Address, through training and mentoring, health care provider barriers to accessing contraception, in particular for youth.
- Ensure that a ‘fast-track’ system is in place for clients returning for contraceptive supplies.
- Strengthen referral systems for contraceptive services including for tubal ligation and vasectomy.
- Ensure availability of adequate, good quality contraceptive commodities.
- Offer contraceptive services throughout clinic opening hours and extend contraceptive service delivery hours and/or introduce flexi-hours at selected facilities to meet the needs of workers, scholars and students.
- Improve access to ECP by ensuring that ECP is available at clinics providing ‘after hours’ services to scholars, students and workers (as above).
- Strengthen contraceptive services in rural areas, including family planning mobile services, in particular ensuring an adequate contraceptive supply chain.
- Expand the scope of practice to allow enrolled nurses and nursing assistants to provide certain methods such as oral contraceptives, ECPs and injectable contraceptives (with appropriate training and within the regulatory framework), especially for clients returning for repeat visits. The methods to be provided by these cadres of workers should be in line with the new National Contraceptive Policy.
- Ensure availability of family planning counselling (including messaging about delayed initiation of sexual activity in youth and adequate birth spacing) and contraceptive methods on-site at:
  - antenatal care services
  - post delivery
  - post natal care services
  - well baby/immunization services
  - termination of pregnancy services
  - HIV services (HIV Counselling and Testing (HCT), Antiretroviral Therapy (ART))
  - STI services
  - TB services
  - medical and surgical services
  - medical male circumcision services (MMC).

(ii) **Community Level:**
- Distribute contraceptives such as male and female condoms and ECP through the revitalized community care giver programme and through non-governmental organizations, community organizations and faith-based organizations.
- Initiate discussions with regulatory authorities about community-based distribution (especially in rural areas) of ECP (see point above).
- Ensure that a priority focus in the revitalization of *School Health Programme* and in the *Health Promoting Schools Initiative*, is counselling about delayed initiation of sexual activity, contraception and contraceptive methods available; provision of contraceptive methods by the school health team; and information about other places that contraceptive methods can be accessed.
- Convene school holiday programmes for youth.
- Ensure that a priority focus is on men e.g. “men talking to boys” programmes, information about contraception at non-medical MMC services (‘camps’).
- Involve traditional leaders and healers in contraceptive awareness campaigns.
- Support community campaigns (e.g. *loveLife* campaigns).
- Use cellular telephones to send text reminders to return for follow-up appointments and for contraceptive supplies.
- Include contraceptive methods following the “please call me” messages on cellular phones.
- Establish a KZN call centre staffed by trained health care providers.
- Promote awareness of the EC hotline information service and phone number.

(iii) Community Mobilization
- Involve facility/clinic health committees in promoting awareness of and access to contraception.
- Conduct contraceptive strategy dissemination workshops at district, local municipality and ward level.
- Conduct ward-based contraception focus group discussions.
- Convene an annual provincial contraception awareness campaign at district and sub-district level.
- Address the lack of family planning information, education and communication (IEC) materials: Identify appropriate materials that are available; develop new materials consistent with the national policy and guidelines and the KZN strategy; ensure that health facilities and communities can access available materials; ensure that materials are available in local languages and are youth friendly; where possible, make materials available in braille; develop a plan for updating materials.

4.2 Key Priority 2: Improve Contraceptive Method Mix

Expand the contraceptive method mix and address the over-reliance on injectable contraceptive methods.

Implementation Plan:
- Re-introduce the IUCD, including for young women and HIV infected women. The IUCD provides long-term, rapidly reversible, very effective contraception. It is also cost-effective. Evidence shows that it does not increase pelvic inflammatory disease and that it is appropriate for virtually all women.
- Undertake acceptability studies on the hormonal implant with a view to introducing this method into the contraceptive method mix.
- Promote male and female condoms for contraception and for dual protection against unwanted pregnancy and STIs.
- Promote a wide choice of methods, including ECP, and natural family planning methods (e.g. lactational amenorrhoea).
- Increase awareness about and expand access to male vasectomy and tubal ligation; revive planned transport for these clients.

4.3 Key Priority 3: Promote Integration of Contraceptive Services with other Services

Ensure that opportunities to provide contraception are maximized by facilitating access to contraception through other appropriate services.

Implementation Plan:
- Include contraception guidance in other policies and guidelines (HIV, fertility, sexual & reproductive health and rights, condom, school health, education, social welfare, protection services, correctional services, youth).
- Develop service delivery guidelines for the integration of contraception services with:
  - Other reproductive health services (termination of pregnancy (CTOP), cervical cancer, pre-conception counselling)
  - HIV services (HCT, ART, wellness, Preventing Mother to Child Transmission)
  - primary health care services (antenatal, post natal, immunization, well baby, STI)
  - MMC services
  - TB services
  - Other state sectors (education, social welfare, protection and correctional services).
- Strengthen referral systems for contraception including for tubal ligation and vasectomy.
- Develop integrated training curricula that include counselling about contraception.
- Promote male and female condoms for contraception and for dual protection against unwanted pregnancy and STIs.
4.4 **Key Priority 4: Improve Health Care Provider Training and Mentoring on Contraception**

Improve competency and skills and familiarise providers with new developments, revitalize contraception and fertility training for health care providers at all service delivery levels (primary to tertiary) and for all cadres of health care providers, including supervisors, and for other sectors.

**Implementation Plan:**

- Develop contraception training curricula (for in-service and university/college), based on the latest evidence.
- Integrate contraception training curricula with other health worker training curricula.
- Develop integrated training curricula that include counselling about contraception for other sectors, including education, protection services, correctional services and social welfare services.
- Develop a plan for regular updates of training curricula.
- Collaborate with Department of Social Development (Population Unit) on contraception skills development and mentorship.
- Re-introduce an annual contraception update for health service providers.
- Capacitate primary health care providers to provide comprehensive sexual and reproductive health services.
- Focus specifically on training health care providers in the provision of contraception:
  - to youth
  - to HIV infected women and men
  - to physically challenged, blind and hearing impaired
  - on the IUCD
  - on new methods introduced e.g. hormonal implants.
- Include contraception in comprehensive, integrated outcomes-based mentoring programmes at facility level.
- Include practicals with mentorship in the training programmes.
- Review available job aids with recommendations for updates or need for the development of new aids.
- Determine the feasibility of appointing a dedicated training team for contraception.

4.5 **Key Priority 5: Improve Record Keeping and Monitoring and Evaluation**

Improve record keeping and monitoring and evaluation of contraceptive uptake and delivery, in order to determine if indicators are improving and to identify and develop appropriate interventions.

**Implementation Plan:**

- Identify appropriate indicators for contraception and collect appropriate data for these indicators (see Table below for reproductive health indicators/data elements, relevant to family planning, currently collected by the KZN Department of Health, and those proposed).
- Develop and implement a monitoring and evaluation framework for contraception indicators.
- Once indicators are identified and measured, develop targets and timelines to measure progress.
- Develop efficient mechanisms to collate, analyse and use the data obtained through the routine health information system for responsive programming at the provincial, district and sub-district level. This system should be standardised across the province, district and sub-district. In particular, the following indicators should be calculated from routine data:
  - **Couple years of protection (CYP):** 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.\(^{20}\)
  - **Method mix:** The % distribution of contraceptive users (or acceptors) by method.\(^{20}\)
  - **Number of acceptors new to modern contraception:** The number of persons who accept for the first time in their lives any contraceptive method; to be reported for a defined reference period (e.g., one year).\(^{20}\)
• Provide regular feedback on the indicators to providers on progress in improving contraceptive services.
• Develop an assessment/screening tool for contraception to be used in all facilities.
• Support research to collect data on 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. In particular, surveys/studies (e.g. demographic health surveys) should be conducted to collect data necessary to determine the following indicators:
  - **Contraceptive prevalence rate (CPR):** The percentage of women of reproductive age who are using (or whose partner is using) a contraceptive method at a particular point in time. Generally, the measure includes all contraceptive methods (modern and traditional), but it may include modern methods only. The indicator is calculated as follows: 
    \[
    \text{CPR} = \left( \frac{\text{# of women 15-49 using a contraceptive method}}{\text{total # of women 15-49}} \right) \times 100.20
    \]
  - **Contraceptive continuation rate:** The cumulative probability that acceptors of a contraceptive method will still be using any contraceptive method offered by the programme after a specified period of time (e.g., one year).20
  - **Family planning programme effort index:** A score measuring the strength of the national family planning programme of a given country on four dimensions (policies, services, evaluation, and method access).20
  - **Percentage of births reported as unintended:** Percentage of births that resulted from pregnancies that were reported to be either unwanted (i.e., they occurred when no children, or no more children, were desired) or mistimed (i.e., they occurred earlier than desired). Intentions are only measured for pregnancies ending in a live birth. This indicator is calculated as
    \[
    \text{Percentage of births reported as unintended} = \left( \frac{\text{# of births reported as unintended}}{\text{total # of births reported}} \right) \times 100.20
    \]
  - **Unmet need for family planning:** The number or % of women currently married or in union who are fecund 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 family planning consists of two groups of women: (a) those with an unmet need for limiting, and (b) those with an unmet need for spacing.20 Note: This indicator should be adapted to including women who are unmarried.
    - **Teenage pregnancy rate.** Percentage of women aged 15-19 who are mothers or who have ever been pregnant.21
• Monitor the rate of CTOP 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 (e.g. recording specific methods used, including ECP).
• Measure current human resource requirements and assess adequate human resource requirements for the effective implementation of contraception services.
• Determine the cost of delivery of contraception services and their cost effectiveness.
## Current and Proposed Indicators

<table>
<thead>
<tr>
<th>Reproductive Health Indicators/Data Elements Currently Collected by DHIS, Relevant to Family Planning $^{22}$</th>
</tr>
</thead>
<tbody>
<tr>
<td>FP Acceptor under 18 years</td>
</tr>
<tr>
<td>FP Acceptor 18 years and older</td>
</tr>
<tr>
<td>IUCD inserted</td>
</tr>
<tr>
<td>Oral pill cycle</td>
</tr>
<tr>
<td>Medroxyprogesterone acetate injection</td>
</tr>
<tr>
<td>Norethisterone enanthate injection</td>
</tr>
<tr>
<td>Male condoms distributed</td>
</tr>
<tr>
<td>Female condoms distributed</td>
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<tr>
<td>Sterilization – female</td>
</tr>
<tr>
<td>Sterilization – male</td>
</tr>
<tr>
<td>Termination of Pregnancy performed</td>
</tr>
<tr>
<td>Termination of Pregnancy performed 18 years and older</td>
</tr>
<tr>
<td>Termination of Pregnancy performed under 18 years</td>
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<tr>
<td>Abortion incomplete expulsion</td>
</tr>
</tbody>
</table>

### Proposed Contraception Indicators/Data Elements to be Collected (in addition to the current indicators)

- Number of women attending antenatal care services reporting a live birth that resulted from pregnancies that were reported to be either unwanted, unintended or mistimed
- Number of women attending post natal services receiving contraception
- Number of women aged 15-19, attending primary health care services, who are mothers or who have ever been pregnant
- Number of new clients receiving HCT at family planning service delivery points
- Number of new clients referred for HCT from family planning service deliver points
- Number of clients referred for contraceptive methods (from TB, HIV, CTOP or other services)

## Concluding Comments

This **KZN Provincial 5-Point Contraceptive Strategy** confirms the Provincial Department of Health’s commitment to improving maternal health in KZN. This strategy serves as a call to action to KZN health care providers to assist women to time and space their pregnancies and reduce teenage pregnancies and unplanned and unwanted pregnancies, including among HIV positive women; to increase contraceptive prevalence and improve contraceptive service delivery; thus ultimately assisting in the attainment of the MDGs. This plan should be viewed as a dynamic document that will be subject to regular critical review.

## Acknowledgements

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MatCH for facilitating and developing this strategy and all key stakeholders for their valuable contributions.

## Acronyms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
</tr>
<tr>
<td>CTOP</td>
<td>Choice on Termination of Pregnancy</td>
</tr>
<tr>
<td>CYP</td>
<td>Couple Years of Protection</td>
</tr>
<tr>
<td>ECP</td>
<td>Emergency Contraception Pill</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>HCT</td>
<td>HIV Counselling and Testing</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>IUCD</td>
<td>Intrauterine Contraceptive Device</td>
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</tbody>
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