

A REPORT OF THE CSIS
GLOBAL HEALTH POLICY CENTER

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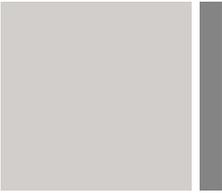
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IMPROVING WOMEN'S HEALTH IN SOUTH AFRICA OPPORTUNITIES FOR PEPFAR

*Janet Fleischman*¹

Introduction

A period of major change is unfolding in health and HIV services in South Africa, carrying opportunities and risks for delivering effective, integrated health services that improve health outcomes and save lives. South Africa is decentralizing HIV services to the primary health care level, paving the way for greater integration to address women's health and to reduce maternal mortality. The United States can find feasible, flexible ways to support this process, even though its health program through the President's Emergency Plan for AIDS Relief (PEPFAR) is scaling down. As PEPFAR transitions from an emergency to a more sustainable response, this is a crucial moment to demonstrate that it can address HIV-related goals by linking to more comprehensive services for women—notably linking HIV with family planning (FP), reproductive health (RH), and maternal child health (MCH). The stakes are high for PEPFAR and for the Global Health Initiative (GHI) to show results and, most importantly, for the women and children most at risk.

Despite much progress in fighting the HIV/AIDS epidemic and improving health services in South Africa, the country still faces unacceptably high levels of HIV-positive pregnant women, maternal mortality, and gender-based violence, all of which are correlated with the high HIV prevalence among women and girls. Accordingly, many of the key health challenges in South Africa relate directly to more effectively reaching women and girls, such as: (1) scaling up effective HIV-prevention programs that meet the needs of women and girls, including through FP/RH-MCH services; (2) promoting effective integration of health services, notably HIV (including prevention of mother-to-child transmission—PMTCT) with FP/RH/MCH, to provide services that have been proven to improve health and save women's lives; and (3) strengthening the health system to build skills, accountability, data collection, and metrics, to improve women's health services and reduce maternal mortality. The South African government's ability to adequately address these issues, and the extent to which PEPFAR and GHI will support its efforts, remain open questions and may determine the future response to the country's HIV/AIDS epidemic.

¹ Janet Fleischman is a senior associate with the CSIS Global Health Policy Center. This report was supported by a grant from the David and Lucille Packard Foundation.

The United States and South Africa are embarking on a new and potentially difficult chapter in their partnership on HIV and health, as PEPFAR hands over its HIV service delivery to the South African government. Despite looming U.S. budget cuts and an already overburdened health care system in South Africa, PEPFAR can continue to make important contributions to health outcomes by leveraging its prevention, care, and treatment platforms to strengthen other areas that are critical for the health of women and girls, strategies that are expected under GHI. To be successful, the United States should focus on: encouraging innovation and flexibility in PEPFAR programs; supporting training, capacity building, evaluation of what works, and policy development on integration of services; and sustaining U.S. global leadership on women's health and supporting the involvement of women, girls, and civil society organizations in health programs.

The statistics on the HIV/AIDS crisis in South Africa reflect both the country's successes and its many challenges, and highlight the disproportionate impact on women and girls:

- 1.4 million people are on antiretroviral (ARV) treatment, approximately half of those in need of treatment. Some 6 million people are living with HIV/AIDS and 60 percent are female;
- 1.3 million maternal orphans, underscoring the important link between HIV/AIDS and maternal mortality—an HIV-positive pregnant woman in South Africa is six times more likely to die than a non-HIV-infected woman. Rates of maternal mortality have quadrupled in South Africa in recent years;
- the high number of HIV-infected pregnant women per year in South Africa, versus other countries—300,000 in South Africa, 8,000 in the United States, 14,000 in Botswana, and 100,000 in Kenya;¹
- the rate of mother-to-child transmission has been reduced to 3.5 percent, and the rate is much lower in some parts of the country; however, HIV prevalence in antenatal clinics is still an alarming 29.3 percent (ranging from 7 percent to 40 percent);
- Unmet need for family planning is estimated to be 15 percent (as high as 24 percent in some provinces), but the rates are believed to be higher in HIV-positive women. The lack of reliable data on contraceptive prevalence rates (CPR) presents challenges to effective programming.

¹ Vivian Black, "Achieving MDGs 4, 5, & 6 through PMTCT Interventions" (presentation at Taung District Hospital, July 14, 2011).

Policy Options

Despite budget cuts for U.S. global health programs, including for PEPFAR, and serious burdens on the South African health care system, this is not a time to retreat from ensuring essential HIV and related health services for women and girls as a key priority. Linkages between HIV (including PMTCT) and FP/RH programs constitute an important and cost-effective tool to address the health of women and girls and to reduce maternal mortality as part of prevention,

care, and treatment for HIV/AIDS. Encouraging this kind of innovation and flexibility in PEPFAR's planning and funding is also key to the success of GHI. Moving forward, U.S. policy, and especially PEPFAR, should consider an approach that addresses the following:

1. Encourage innovation and flexibility in PEPFAR programs to provide more comprehensive care for women and girls that will improve health outcomes and save lives:
 - Promote appropriate and effective linkages between HIV (including PMTCT) services and FP/RH/MCH programs within the clinic setting, where possible, and reflect such plans in the programs and funding in the new round of Country Operational Plans (COPs). These linkages should also be encouraged in country-level requests for applications (RFAs) that can bring together different U.S. government funding streams under GHI.
 - Provide all four prongs of PMTCT, as recommended by the World Health Organization (WHO), including prong 2 on preventing unintended pregnancy in HIV-positive women, and ensure that the PMTCT platforms are used to effectively link women to HIV treatment and other reproductive health services, including screening for sexually transmitted infections (STIs) and cervical cancer.
 - Ensure that PEPFAR-supported HIV and PMTCT programs provide contraceptives to those HIV-positive women who want them and that PEPFAR also provides comprehensive post-rape care kits as part of their HIV-prevention programs.
 - Develop appropriate metrics and collect data to monitor integrated services, including indicators to capture the number of facilities that provide comprehensive care to women and girls, as well as evaluation to better understand the barriers to care, such as whether there are problems in the supply of FP commodities, logistics, co-location of services, or referrals.
2. Support training, capacity building, evaluation, and policy development to enhance the delivery of appropriate and cost-effective integrated services:
 - Support training and provide technical assistance for health care providers in integrated HIV-FP/RH/MCH service delivery, especially at the primary health care level. Particular attention should be focused on protecting the human rights of HIV-positive women, including by addressing their fertility intentions and FP options.
 - Provide funding for the development of a supportive policy environment for integration and appropriate guidance for implementation, as well as for research to better understand the barriers to effective integration so that policies can be shaped accordingly.
 - Provide training and technical assistance to U.S. PEPFAR and GHI country teams to promote better implementation of the GHI principle on women, girls, and gender equality, including the role of HIV-FP/RH linkages for women and girls, and to ensure that people with gender expertise are included in their country teams.
3. Sustain U.S. global leadership on women's health through global and national-level diplomatic engagement and increase the participation of women, girls, and civil society

organizations in health programs to improve health outcomes for women, girls, and their communities:

- Involve women and girls, women's groups, networks of women living with HIV/AIDS, human rights organizations, and health advocates in educating and empowering women to create demand for effective, integrated services to address the health of women and girls across the life cycle.
- Increase harmonization with other donors to support women's health services, including FP/RH and MCH, with the goal of ensuring greater coverage and integration of services.
- Provide global leadership to focus sustained national and international support for programs addressing the health needs of women and girls and reducing maternal mortality.

U.S. Policy Context: PEPFAR, GHI, and Alignment with South African Health Priorities

The United States and South Africa have better working relations and dialogue under the new South African government. However, it will take time to reverse the parallel HIV programs largely run by nongovernmental organizations (NGOs) that were built under PEPFAR and to shift in a new direction, with PEPFAR moving away from direct HIV service delivery and toward a focus on technical support. A U.S. official in South Africa explained the challenges that this presents: "We're running and stumbling and moving away from a parallel system—the floodgates are open... It's exciting—we're doing something that no other [PEPFAR] team is trying to do."

Through FY 2010, the United States had committed some \$3.1 billion to South Africa in bilateral HIV/AIDS programs and additional sums through the Global Fund. PEPFAR funding for South Africa in 2011 was \$548 million; the funding for family planning was a mere \$1.5 million. This funding discrepancy starkly illustrates the challenges that the United States will face in trying to support health systems strengthening beyond strictly HIV programs, since health funding is almost entirely through PEPFAR. Yet given that 35 percent of child mortality and 45 percent of maternal mortality is due to HIV/AIDS in South Africa, it is clear that PEPFAR has an important role to play in addressing these key health priorities as part of HIV programs.

A central problem is the lack of a clear transition plan to transfer service delivery from PEPFAR-funded programs to the South African government's health care system. This represents a profound challenge involving how the United States will manage the next phase of PEPFAR engagement in South Africa, and how to ensure that it is done in a responsible manner in partnership with the South African government and implementing partners and that it focuses on the needs of women and girls.

U.S. officials acknowledge the need to create a roadmap and, in the intervening period, the need to carefully manage the transition. Some of these transition plans might be clearer when the PEPFAR Partnership Framework Implementation Plan is published in December 2011. These

officials hope to minimize the disruption of HIV services, but some disruption seems to be inevitable. In the near term, the government is not going to be able to absorb all those who were performing services funded by PEPFAR, including PMTCT programs. One U.S. official described their concerns about how an effective transition will be accomplished: “You infuse billions of dollars into the system, and then take it out; something’s going to happen... It’s a big deal—we’ve never seen the likes of this in a bilateral development program.”

Since PEPFAR is a key part of GHI, it is important to understand how GHI could impact the PEPFAR transition in South Africa.² Two key aspects of GHI involve a focus on women, girls, and gender equality, and on integration of services. These areas align closely with the outcome areas identified by the South African government in its health priorities, articulated in the Negotiated Service Delivery Agreement (NSDA), especially regarding reducing maternal and child mortality and health system strengthening. Given the overwhelming dominance of PEPFAR funding in the U.S. health program,³ the United States does not have the flexibility to use resources from other funding streams, but many of the GHI principles that can be channeled through PEPFAR are appropriate for the situation in South Africa. This is especially the case for the women, girls, and gender equality principle, which the United States considers to be pivotal in South Africa, since the HIV/AIDS epidemic is still in large part a women’s epidemic. Nevertheless, how PEPFAR funds will be allocated to support these GHI goals will be a critical test of the viability of GHI in South Africa.

The United States’ GHI strategy for South Africa is expected to be released in the last quarter of 2011, which should provide a clearer picture of how GHI will work through existing funding streams and link with the PEPFAR platforms. The strategy is expected to focus on opportunities to create linkages between antenatal clinics (ANCs), MCH, FP, and RH at the primary health care level with HIV and tuberculosis (TB) programs, with the aim of increasing access to comprehensive care, especially for mothers and children. GHI is also expected to incorporate elements of RH programs for both males and females into HIV prevention, care, and treatment programs. In addition, there is likely to be a component to strengthen health in education programs, focusing particularly on adolescent and pre-adolescent girls, as well as targeting orphans and vulnerable children and addressing gender equity in the education system.

² GHI’s core principles are: a focus on women, girls, and gender equality; encouraging country ownership and investing in country-led plans; building sustainability through health systems strengthening; strengthening and leveraging key multilaterals and other partnerships; increasing impact through strategic coordination and integration; improving metrics, monitoring, and evaluation; and promoting research and innovation.

³ Other than PEPFAR, the U.S. health program in South Africa includes some \$13 million for TB and \$1.5 million for family planning and reproductive health. See U.S. Agency for International Development (USAID), “South Africa: Fact Sheet,” http://www.usaid.gov/locations/sub-saharan_africa/countries/southafrica/southafrica_fs.pdf. In addition, the Centers for Disease Control and Prevention (CDC) work in South Africa on global disease detection.

PEPFAR's new Country Operational Plan (COP) Guidance, issued in August 2011, acknowledges the importance of integration with other health programs, of combination prevention,⁴ and of linkages between HIV programs and FP and MCH programs. However, it focuses on these linkages largely as a way to increase PMTCT coverage, especially in areas of high HIV prevalence among women and girls: "We have shown that PMTCT works: the challenge is reaching all the women in need. In settings where access for women to HIV testing and ongoing care can be increased by heightened linkages with MCH or FP programs, this approach should be utilized."⁵

With reference to family planning, the PEPFAR COP Guidance notes the "significant unmet need for family planning and reproductive health services worldwide in both HIV-positive and HIV-negative populations," and the "strong evidence" that HIV-positive women have less access to FP and RH services, resulting in high levels of unintended pregnancies.⁶ The guidance calls on country teams: to "actively" pursue opportunities to provide counseling, referrals, and linkages to FP services for women and men in HIV prevention, care, and treatment programs; to provide FP clients with HIV-prevention services, notably HIV counseling and testing; to integrate FP services that are funded from non-PEPFAR accounts in PEPFAR PMTCT programs; and to provide HIV-prevention information and support, funded by PEPFAR, within ANC, MCH, and FP programs.

The COP Guidance then focuses on referrals or linkages between PEPFAR and FP/RH programs, but stops short of allowing PEPFAR funds to be used for contraceptives for HIV-positive women. According to the guidance, "PEPFAR programs should be used as a platform on which to incorporate and integrate other health services."⁷ This cautious approach by PEPFAR is a reaction, in part, to the strong opposition from some quarters in Congress to PEPFAR funds being used for any FP activities. In South Africa, where the United States has such a small amount of FP funding (\$1.5 million), the linkages between HIV and FP will involve linking with South African government FP-RH-MCH programs and linking PEPFAR programs with other donor-funded FP-RH-MCH projects. However, a more flexible approach that would allow PEPFAR to provide certain FP-RH services for HIV-positive women in PEPFAR-supported sites could help address the need for more comprehensive, integrated services.

⁴ PEPFAR announced a new, \$45-million initiative to study combination prevention, including in South Africa. See Department of State, "PEPFAR Announces Largest Study of Combination HIV Prevention," September 14, 2011, <http://www.state.gov/r/pa/prs/ps/2011/09/172389.htm>.

⁵ PEPFAR, "Country Operational Plan (COP) Guidance," August 2, 2011, <http://www.pepfar.gov/documents/organization/169694.pdf>.

⁶ *Ibid.*, p. 34.

⁷ *Ibid.*, p. 35.

New Opportunities and Missed Opportunities for HIV-FP/RH Integration in South Africa

The government of President Jacob Zuma, especially the leadership of Minister of Health Aaron Motsoaledi, represents a new approach to health and to HIV/AIDS in South Africa, and the government is recognizing the importance of integration between HIV (including PMTCT) programs and FP-RH services.

The rise of the HIV/AIDS epidemic in South Africa led to a diminution in attention and resources to FP and RH services. As the treatment, prevention, and care programs rolled out, FP services were not integrated, which meant that HIV-positive women in ART clinics were not routinely being given information on FP or having discussions about their fertility intentions with the health care provider. All too often, this has resulted in women having unsafe sex and returning to the HIV clinic when they are pregnant, many being unintended pregnancies, some of which result in termination of pregnancy (TOP).⁸ In fact, a CDC study on the impact of PMTCT in South Africa presented at the International AIDS Society (IAS) Conference in July 2011 found that almost two-thirds of pregnancies in HIV-positive women were unplanned.⁹

Currently, the major change in South Africa's health policy is known as "reengineering," which involves decentralizing health services to the primary health care system, with important roles for nurses and community health workers and new opportunities for service integration. A key element of the reengineering is known as NIMART—nurse initiated management of ART (antiretroviral therapy). Although it is still early days of the primary health care (PHC) roll out, the government is attempting to restructure health care services that have usually been run as vertical programs and to allow greater interaction between/integration of basic services. These services often target women, including forging better links between and among ANC, RH, PMTCT, and MCH services.

The government's new health priorities were articulated in the Department of Health's Negotiated Service Delivery Agreement (NSDA), which seeks to improve aid effectiveness and focuses on four outcomes areas: increased life expectancy; reduced maternal and child mortality; HIV/TB integration; and health systems strengthening. The new policy calls on South Africa's development partners to realign their programs to fit with the new strategic priorities and plans.

On World AIDS Day 2009, President Zuma announced several important changes in the country's HIV/AIDS treatment policy, including changes in the way treatment is provided: decentralization to PHC; all patients with TB/HIV coinfection with a CD4 count of 350 or below and all pregnant women at 14 weeks (instead of 28 weeks) would receive treatment with dual

⁸ Abortion is legal in South Africa, according to the Choice of Termination of Pregnancy Act of 1996.

⁹ Thu-Ha Dinh, "Impact of the National PMTCT Program Measured at Six Weeks Postpartum in South Africa, 2010" (presentation at 6th International AIDS Society, Rome, July 2011), <http://pag.ias2011.org/flash.aspx?pid=202>.

therapy; and all pregnant women with CD4 of 350 or less would be immediately initiated on ARV treatment. This new attention to treatment for pregnant women, for their own health and not only to prevent HIV transmission to their infants, represented an important shift in policy and complies with the 2010 WHO PMTCT Guidelines.¹⁰

In April 2010, President Zuma launched a national HIV Counseling and Testing (HCT) campaign to test 50 million South Africans for HIV and to screen for TB and other chronic diseases (e.g., hypertension, diabetes, and anemia). This was the biggest testing campaign ever launched in South Africa, and included ambitious targets for all districts. The HCT campaign was quite successful, reaching some 80 percent of its targets. In addition, the campaign led to a growth from 490 health facilities that could initiate ART to 1,700 PHC facilities, and from 290 to more than 2,000 nurses trained to provide ART. The number of South Africans on treatment also increased, from 1 million to 1.4 million during that period.

Despite the success of the HCT campaign, there were also missed opportunities; notably that the link with FP and RH was not included in the package of services provided. Indeed, the government's push on testing also missed important opportunities with those who tested negative, but who could have been provided information and services on FP as part of the HIV-prevention package.¹¹

Recent research conducted in Johannesburg found high unmet need for FP and a high incidence of unplanned pregnancies among HIV-positive women in four ART clinics, supported by PEPFAR.¹² The vast majority of the women in the study—93 percent—reported having had a discussion with their HIV provider about condoms, but only 48 percent reported discussions about non-barrier methods of contraception, including hormonal contraception. Dual method use was very low, at 15 percent. The authors believe that the main reason HIV providers are not providing information on FP methods other than condoms involves health care worker concern that women will substitute other FP methods for condoms. The study did not find evidence of

¹⁰ WHO, "Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: Recommendations for a public health approach (2010 version)," <http://www.who.int/hiv/pub/mtct/antiretroviral2010/en/index.html>.

¹¹ This situation also has implications for the ART regimens available in South Africa, since efavirenz is not recommended for pregnant women in their first trimester, and some medical professionals believe that it should not be used at all for pregnant women. The alternative, nevirapine, also raises concerns with some clinicians, given its known side effects. Ethical issues prevent conducting studies on the effects of efavirenz in pregnancy, but cohorts are being observed. In any event, clinicians in South Africa find that it is relatively rare to see a pregnant HIV-positive woman in her first trimester; they usually come later, at around five months, which should be safer for efavirenz. Yet while medical doctors can make these decisions about ART regimens for pregnant women, nurses have to follow the protocol.

¹² Sheree Schwartz et al., "High unmet need for family planning amongst HIV positive women on antiretroviral therapy in Johannesburg" (presentation at the Meeting on Integration of FP/HIV/MNCH Programs, Washington, D.C., March 29, 2011).

this practice, however. The study did find evidence that negotiating condom use is an empowerment issue, indicating how difficult it is for many women. The study concluded that “[i]ntegration of service provision within ART clinics would provide an opportunity to decrease unplanned pregnancies and eliminate barriers to FP amongst HIV-positive women.” Indeed, the study found that ART initiation over the past year is “the strongest predictor of an unmet need for family planning” and therefore that efforts must be undertaken to address training and education for HIV providers about FP methods.

Maternal Mortality and HIV

Despite being a middle-income country, South Africa continues to face extremely high rates of maternal mortality—from 2005 to 2007, there was a 20.1 percent increase in the number of deaths reported compared to the previous three-year period¹³—indicating how far the country is lagging behind its commitments under the Millennium Development Goals (MDGs); specifically MDG 5 on maternal health, which calls for a 75 percent reduction in maternal deaths by 2015.¹⁴

According to the South African National Commission on Confidential Enquiries into Maternal Deaths, 46.2 percent of those deaths were HIV-positive women, and 41.3 percent had unknown HIV status,¹⁵ although many of those women were likely to be HIV infected. South Africa’s strengthened laws and policies on sexual and reproductive health have not been accompanied by an expansion of the necessary training and accountability in the health care system to address these issues.

Studies conducted in Johannesburg found similar trends relating to facility-based maternal mortality—HIV-positive pregnant women were 6.2 times more likely to die than HIV-negative mothers, and 44 percent of maternal deaths were attributable to HIV.¹⁶ These disturbing data about increasing maternal mortality in South Africa and its relation to the HIV/AIDS epidemic also underscore the importance of discussing FP as part of PMTCT and other HIV programs, so women can plan and space their pregnancies as safely as possible. This important opportunity to discuss FP illustrates why preventing unintended pregnancy among HIV-positive women is the second pillar of WHO’s guidance on PMTCT.¹⁷

¹³ National Committee on Confidential Enquiries into Maternal Deaths, “Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa: Expanded Executive Summary,” p. 3, <http://www.doh.gov.za/docs/reports/2007/savingmothers.pdf>.

¹⁴ There are varying estimates for the maternal mortality rate (MMR) in South Africa, ranging from 230 to 702 per 100,000 live births. See Duane Blaauw and Loveday Penn-Kekana, “Maternal Death,” *South African Health Review* (2010), http://www.hst.org.za/sites/default/files/sahr10_1.pdf.

¹⁵ *Ibid.*, p. 10.

¹⁶ Black, “Achieving MDGs 4, 5, and 6 through PMTCT Interventions.”

¹⁷ WHO et al., *Guidance on Global Scale-Up of the Prevention of Mother-to-Child Transmission of HIV* (Geneva: WHO, 2007), p. 2, http://whqlibdoc.who.int/publications/2007/9789241596015_eng.pdf.

The links between HIV infection in women and maternal mortality in South Africa have been raised with growing urgency in recent years. In an article in *The Lancet* in 2010, Quarraisha Abdool Karim and colleagues identified the increased risks of avoidable maternal death faced by HIV-positive women, including poor access, inadequate quality of health care, and substantial stigma and discrimination from health care providers, and noted that these concerns are especially acute for adolescents with HIV. The article concludes: “A comprehensive approach to the prevention of mother-to-child transmission of HIV could lead to improved services for HIV-infected women, including family planning and early initiation of lifelong antiretroviral treatment for women in need.”¹⁸

The situation for HIV-positive women in South Africa is exacerbated by the abuses they are subjected to in the health care system. In August 2011, Human Rights Watch issued a report outlining the physical, verbal, and other abuses of maternity patients, especially HIV-positive women, by health care workers in South Africa, which contribute to the increasing maternal mortality rate in the country.¹⁹ This situation raises serious concerns about how the new South African policy of devolving HIV care to the primary health care level will be monitored for quality of care and how abuses will be addressed.

New South African Government Policies: Contraception Policy Review and School Health Policy

An important new development with potential impact on PEPFAR and the HIV-prevention agenda for women and girls involves the South African government’s current efforts to revise the policy on contraception, which dates from 2001. The former contraception policy was only superficial on the integration of HIV and FP, since the South African government at the time was still in a state of denial about the epidemic. PEPFAR has provided support for this policy review.

In the years since the last contraception policy, FP has taken a back burner in South Africa, overtaken by the HIV/AIDS epidemic. The need to update the policy stems from the realities of the HIV/AIDS epidemic, as well as changes in contraceptive technologies, new research, and updated WHO guidelines. Many women’s health practitioners in South Africa see the policy revision as an important way to revitalize discussion and services to improve women’s

¹⁸ Quarraisha Abdool Karim et al., “HIV and maternal mortality: turning the tide,” *The Lancet* 375, issue 9730 (June 5, 2010): 1948–1949, [http://www.thelancet.com/journals/lancet/article/PIIS0140-736\(10\)60747-7/fulltext?_eventId=login#](http://www.thelancet.com/journals/lancet/article/PIIS0140-736(10)60747-7/fulltext?_eventId=login#).

¹⁹ Human Rights Watch, “South Africa: Failing Maternity Care: Abuse, Poor Accountability Cause Needless Death and Suffering,” August 8, 2011, <http://www.hrw.org/news/2011/08/08/south-africa-failing-maternity-care>.

information on and access to contraceptive choice and rights, dual protection,²⁰ method mix, and safety, while also contributing to HIV prevention and integrating HIV into other aspects of health care.²¹

The new contraceptive policy will aim to expand the mix of contraceptive methods beyond just injectables (Depo-Provera) and to better integrate information and training on contraception and fertility planning into the health system. In particular, this means promoting opportunities to integrate contraception provision and fertility planning with HIV and related services. This integration is intended to improve access, reduce unmet need for FP, and prevent missed opportunities. The policy will be grounded in a rights-based approach, respecting human rights and sexual and reproductive rights, which are recognized in the South African constitution. The new policy is meant to align with the South African government's new framework on sexual and reproductive health, presented in "Sexual and Reproductive Health and Rights: Fulfilling our Commitments," which emphasizes that services should be comprehensive and integrated.

Another area of policy development involves the school health program, linked to the challenge of reaching adolescents with HIV and RH information and services. PEPFAR has supported some work for the Department of Basic Education relating to school health and the HIV curriculum. This is an area of particular concern for adolescent girls, who are infected with HIV at much higher rates than boys their age—some five times higher—a reflection of the risks girls face related to intergenerational sex. As the minister of health explained in Washington in March 2011: "I like saying HIV/AIDS in my country...is a disease brought on by males but suffered by females. Unfortunately, because...[of] intergenerational sex, that is quite older people who are having sex with these young girls and infecting them. That's why there is that difference."²²

The Department of Basic Education (DBE) has released a Draft Integrated Strategy on HIV & AIDS, 2012–2016, which seeks to: decrease HIV incidence among 15- to 19-year olds and among

²⁰ Dual protection refers to the combined use of a condom and a non-barrier contraceptive, which constitutes an important strategy to promote reproductive health and prevent both unintended pregnancy and sexually transmitted infections (STIs), including HIV.

²¹ This new contraceptive policy review is particularly timely, given the concerns that have been raised in South Africa—especially by Wits Reproductive Health and HIV Institute (WRHI)—and internationally about possible effects on HIV progression and acquisition related to hormonal contraceptives. These concerns were recently raised in a paper at the IAS meeting in Rome in July 2011 by Renee Heffron et al., from the University of Washington, who then published an article in *The Lancet* on October 4, 2011, which found increased risk for women living with HIV who were taking hormonal contraception. A USAID communication to the field, dated August 5, 2011, stated that without full information, the agency does not believe that a change in contraceptive policy is necessary, but that it will update any guidance changes after more thorough review. In October, USAID stated that there is nothing in the new *Lancet* article that changes this guidance.

²² Kaiser/CSIS Forum with South African Minister of Health, Kaiser Family Foundation, Washington, D.C., March 29, 2011, http://globalhealth.kff.org/~media/Files/KGH/Support%20Files/2011/032911KFFCSIS_transcript.pdf.

educators; increase sexual and reproductive health among students and educators; and increase students' physical and psychological safety, including reduced gender-based violence and stigma/discrimination. There was some controversy associated with the HCT campaign in schools, involving how best to provide services to students who might test positive for HIV, which has slowed down implementation.

Linkages between HIV and Family Planning: Examples from the Field

Despite the challenges, health care providers interviewed in a number of the primary health care clinics, as well as district hospitals, believe that providing integrated services at the primary health care level is helpful for female clients. Many of these sites receive technical assistance from PEPFAR-supported NGOs. In particular, the providers noted the benefits for clients of not having to spend the money or the time to travel to different sites for services and the reduction in stigma since, in an integrated setting, no one knows which services you have come to receive. They recognized the particular value for HIV-positive women, who could get all their services in one place, as well as for women who don't know their HIV status but should be tested, and who come to clinics for antenatal care, child welfare (well baby) visits, and FP services.

A primary health care clinic in the Yeoville section of Johannesburg illustrates some of the challenges in providing an integrated package of services, especially related to increased workload without increased workforce. The clinic began initiating ART in February 2011, and as of July 2011, 158 patients clients had been initiated on ART, and 356 were down referred. Although the clinic routinely offers HIV tests and condoms and refers from all other on-site primary health care services—including FP, ANC, TB, child welfare, and chronic care—the workload and limited staff have impeded their ability to provide effective services. The clinic treats some 8,300 patients per month with nine nurses and has not received any new staff to address the new demands of the ART program, as the government had promised. In FP alone, the clinic sees some 1,000 clients per month, the vast majority choosing injectables. Nevertheless, the staff says that their ART services are “long overdue,” since many of their patients need to be on ARVs and can now receive all their services under one roof.²³

A rural district hospital in Taung, in Northwest Province, provides a concrete view of the importance of integrating HIV and FP/RH services for the health of the patient and especially for addressing the needs of women at risk of HIV or those that are already infected. The staff explained that, for practical purposes, they began integrating services in July 2010. “We treat the patient, not the ailment,” according to one doctor. Since it is mostly a farming area, and many of the men leave for long periods to work as migrant mine workers in other parts of the country, the HIV risks for women often increase when the men return. “The women, the wives, they're helpless—it's a gender issue. The husband comes back [from the mines] and doesn't want to use a

²³ Interviews at Yeoville Primary Health Care Clinic, Johannesburg, July 13, 2011.

condom, and the poor wife can't do anything, that's it," a program manager explained. This raises important issues for FP and HIV prevention.

Yet the difficulties and sensitivities of discussing women's risks related to HIV and FP/RH remain considerable. A nurse in a primary health care clinic in Taung district explained that after she talks to her clients about FP, especially the women left at home when the men leave to work in the mines, she is sometimes confronted by their husbands or partners: "The men say, you nurses, what are you doing in our bedrooms? Our women say the sister [nurse] says we must use condoms. Who are you to tell my wife what to do!"²⁴ The clinic staff described the importance of reaching the men and changing attitudes on HIV prevention and FP/RH by working with traditional schools and traditional leaders in the area. However, as one doctor from the district hospital noted, "to tap into this, you have to be credible to the traditional leaders, and not many health workers have that credibility. That's the crux of the problem."

Not surprisingly, integrated service delivery is more successful with trained and motivated staff. For example, a primary health care clinic in the rural town of Christiana was run by a nurse who clearly understood the imperative to discuss FP with her clients. "I discuss with them," she said. "If they are HIV positive, they must let us know if they want to have children... We are trying by all means to integrate our services."²⁵ She described how women may come to the clinic for FP, but the nurse then finds that the woman has another problem, such as STIs or HIV. "So I always ask... They are a sexually active group, so it is very important to do C & T [counseling and testing] to see if we cannot help before they fall pregnant." In March 2011, out of 112 FP clients, 37 accepted an HIV test, and 5 were positive. In April, out of 16 new ANC clients, all were tested (14 for the first time), and 3 were positive. For those who test negative, she discusses condoms, FP, and encourages them to come for re-testing. A particular concern, however, is adolescent and teenage girls. "Teenagers are afraid to come. I only see them when they're pregnant."

Throughout the country, a distinct challenge involves the attitude of health care workers, many of whom are uncomfortable discussing FP and fertility intentions with HIV-positive women or don't believe that HIV-positive women should be sexually active. The overall lack of adequate and effective communication often results in HIV-positive women clients coming back pregnant. As one nurse put it: "Most HIV-positive women refuse to use contraceptives until they start feeling better. They want to give us the impression that they don't have sex...when they are pregnant, sometimes they are shy and stop treatment. They must be taught about family planning."²⁶ This combination of health care workers attitudes toward HIV-positive women, and clients' fears of discussing their fertility desires with the providers, leads to significant missed opportunities for effective and appropriate service delivery.

²⁴ Interviews at Cokanyane Primary Health Care Clinic, Northwest Province, July 14, 2011.

²⁵ Interview at Town Clinic, Christiana, Northwest Province, July 15, 2011.

²⁶ Interviews at Pudumong health center, Northwest Province, July 14, 2011.

Problems of stigma also continue to prevent women living with HIV from accessing services. One HIV coordinator in a rural district noted that most pregnant women still don't disclose their HIV status at home, fearing the reaction of their partners or mothers-in-law. In one recent case, an HIV-positive pregnant woman came to the clinic to deliver her baby, but purposefully left behind the nevirapine syrup for the infant to prevent mother-to-child transmission, since bringing it home might expose her HIV status. The nurse at the clinic followed up with her, and after the baby's father died a few days later (apparently related to HIV/AIDS), the baby was given the syrup and has remained HIV negative.²⁷

An example of how a PEPFAR implementing partner can work on HIV-FP integration is the Wits Reproductive Health and HIV Research Institute (WRHI).²⁸ The evolution of WRHI's program reflects many of the changes underway in PEPFAR and in South African policy on HIV and RH.

WRHI—headquartered in Hillbrow, an inner city neighborhood of Johannesburg, but with sites in other parts of Gauteng and in Northwest Province—used to provide some direct HIV/AIDS services along with quality improvement methodologies, but it is now shifting to providing technical assistance for the Ministry of Health, especially focusing on nurses who are now being trained to initiate ARVs. WRHI staff have also been key players in the revision of government guidelines on HIV/AIDS treatment, PMTCT, and the forthcoming policy on contraceptives.

At the Esselen Street Clinic, WRHI continues to run a number of integrated programs that are supported in part by PEPFAR, including a youth friendly clinic and a sex worker program (which is supported by donors other than PEPFAR). The youth clinic is staffed by a nurse and 10 peer educators (6 girls, 4 boys) and provides HIV testing and a wellness program, FP information and services, and treatment for STIs. The nurse is waiting for the department of health training to be able to initiate ARVs there. The clinic sees about 600 young people per month and a total of some 5,000 girls and 3,000 boys per year. According to the clinic's nurse, "it's a comprehensive service—no one can tell what you're coming for, so the young people are more comfortable here." In May 2011, for example, 82 females were tested in the clinic, and 15 were positive; 13 males were tested, and 9 were positive. In June 2011, 224 females came for FP services, and 10 of them agreed to be tested for HIV. The sex worker project includes a clinic at Esselen Street, as well as a mobile clinic that goes directly to the brothels in Hillbrow—23 of them every month—and to the street-based sex workers. The services provided include STI treatment, FP information and commodities, HIV testing and counseling, and referral for ARVs, but they will soon be able to initiate ARVs through the clinic. The program has seen a total of some 22,000 sex workers, about 400 per month.

In Northwest Province, WRHI provides technical assistance to a number of hospitals and clinics related to HIV/AIDS care, PMTCT, and reproductive health. WRHI is using PEPFAR funding to

²⁷ Interviews at Cokanyane Primary Health Care Clinic, Northwest Province, July 14, 2011.

²⁸ WRHI was formerly known as RHRU, and is a leading South African academic research institution focusing on reproductive health and HIV.

strengthen the district health system by providing technical support, shifting away from direct service delivery.

These examples from sites in South Africa, many of which receive some PEPFAR support, show that linkages between HIV and FP/RH constitute a viable, valuable, and vital strategy to address the health of women and girls. For GHI and PEPFAR to meet their goals, PEPFAR should expand these linkages to comprehensive services for women, thus improving women's health and saving lives.



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