THE INTEGRATION OF STI/ HIV SERVICES INTO EXISTING FP AND MCH PROGRAMMES: THE PERSPECTIVE OF CLIENTS

By

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DECLARATION

This dissertation denotes original work by the author has not been submitted in any other form to another university. Where use has been made of the work of other authors and sources it has been accordingly acknowledged and referenced in the body of the dissertation.

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Signature: .....

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  1 Corinthians 2: 9

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ABSTRACT

Since the 1994 International Conference on Population and Development there has been a shift away from meeting demographic targets towards meeting the reproductive goals of individual men and women. Partially as a response to the increase in the level of HIV infection, and the associated high levels of STIs, there has been an increasing focus on integrating HIV/STI services within mainstream Maternal Child Health and Family Planning programmes. Thus clients attending clinics that provide integrated services have the opportunity to receive multiple services during a single visit to a facility.

The aim of this research was to evaluate the process of integrating FP/MCH and STI/HIV services in urban and rural areas within KwaZulu-Natal, using data gathered form semi structured interviews with clients leaving the health facilities. The research also examined the overall quality of care received within the integrated clinics.

The results show that clients rarely receive a range of services on a single visit, despite the integration of services. In most cases, clients do receive the services for which they attended the health facility. However the study found that providers are missing important opportunities to inform, educate and counsel clients on a variety of reproductive health matters. This is important if we are to avoid the negative consequences of an unwanted pregnancy and STIs (including HIV/AIDS). It was also found that the overall quality of care within integrated clinics was low amongst all clients attending the facility.

LIST OF ACRONYMS USED

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
DOH	Department of Health
FP	Family Planning
GTZ	German Technical Cooperation
HIV	Human Immune Deficiency Virus
ICPD	International Conference for Population and Development
IEC	Information, Education and Communication
IUD	Intra Uterine Device
KZN	KwaZulu- Natal Province, South Africa
MCH	Maternal Child Health
NGO	Non Governmental Organisation
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
S.A.	South Africa
SADHS	South African Demographic and Health Survey
STD	Sexually transmitted diseases
STIs	Sexually Transmitted Infections
UNAIDS	Joint United Nations Program on HIV/AIDS
VTC	Voluntary HIV Testing and Counselling
WHO	World Health Organisation

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CHAPTER ONE
INTRODUCTION

1.1. Background to the study

At the International Conference on Population and Development (ICPD) in 1994, a more encompassing definition of reproductive health developed, whereby reproductive rights was defined as

> All couples having the right to decide freely the number and spacing of their children, and to have the information and education and means to do so, the right to attain the highest standard of sexual and reproductive health and the right to make decisions concerning reproduction free from discrimination, coercion and violence.... and the right to reproductive health
> (Dwala, 2000: 45).

They have thus implicitly idealised the promotion of numerous services related to reproductive health. By adopting this rights based approach to providing reproductive health services, the ICPD has thus created a shift in terms of what services should be provided within the locus of reproductive health.

The ICPD stated, "All countries should strive to make accessible through the primary health- care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015. Reproductive health care in the context of primary health care should, inter alia, include: family-planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery, and post-natal care, especially breast-feeding, infant and women's health care... including the treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood (United Nations, 1994)."

Rather than applying the popular demographic/ populationist approach that seeks merely to reduce population growth, the ICPD endorsed an individualistic plan that

sought to give pride of place to women's rights, status & empowerment and includes the health of men and children (United Nations 1992-1994 cited in Mcintosh & Finkle). According to the policies laid out at the Cairo conference individuals have the right to STI/HIV services, and such services should be included through the primary health care system. This marked a paradigm shift in the philosophy of health in the international community.

This can be attributed by the roles played by key participants of the ICPD, one of which was the women's movement, which greatly influenced the decisions taken at the conference. Their ability to influence the decisions taken by the conference, can be attributed to the fresh ideas and research put forward by feminist NGO's as well as the political and financial support they received from women in high level policy and management positions (McIntosh and Finkle, 1995: 236-239).

Due to the political and ideological debates surrounding the outcome of the ICPD conference, the term *compromise* was a key word at the conference. This is reflected in the ICPD's choice to use the human rights / client centred approach, that also satisfies the demographic imperative i.e. to reduce excessive population growth (Walker, 1999: 1). By client centred we mean that all the sexual and reproductive health needs of the client are catered for, this includes information and education. Despite the difficulties and conflicting agendas faced, the International Conference on Population and Development managed to outline various recommendations in the form of policy statements, practice guidelines and definitions, to promote the integration of reproductive health services.

The integrated approach espoused by the ICPD, can be seen as being stimulated by an array of factors. However emerging in the early 1990's, integration was a result of the convergence of predominantly four agendas i.e. the need to improve the quality of family planning, the need to improve women health, especially in their reproductive years as well as the rapid increase in Sexually Transmitted Infections, including HIV/AIDS (Lush, 1999: 774; McIntosh & Finkle, 1995: 236).

1.2 Aims and Objectives

Since 1994 many countries have chosen to adopt an integrated approach. The term integration usually means the expansion of services such as family planning (FP), maternal and child health services (MCH) to include sexually transmitted infections (STIs) and Human immune deficiency virus services (HIV). The aim of this study is to determine the extent to which the client's reproductive health needs are being met when attending integrated health programmes. The following four research questions were explored.

- Are more clients being reached/ made aware of FP/STI/HIV services through the integration of STI/HIV services within FP/ MCH programs?
- Are FP and MCH clients provided with STI/HIV services i.e. screening including risk assessment, partner notification and counselling, during their consultation with the service providers?
- Are STI/HIV clients being provided with proper FP/STI/HIV services (i.e. screening including risk assessment partner notification and counselling, within integrated clinics/facilities?
- Are clients satisfied with the quality of care received at the clinics visited?

1.3. Defining integration

The term "integrated services" is highly contentious and there is no clear-cut definition. Despite various recommendations and the devastating threat STI/HIV & AIDS poses, an "integrated approach to reproductive health" is not explicitly defined by the Cairo conference. Also, paragraphs created in the ICPD document state that countries signing the agreement are not bound by it, declaring the " sovereign right of each country to implement recommendations in ways that are consistent with national laws and development priorities and with full respect of the various religious and ethical values and cultural background of its people" (United Nations, 1994: ch2; first numerated paragraph pg 14). The failure of the Cairo conference to *explicitly* promote, monitor and define "integrated reproductive health services" has led to countries either avoiding the integration of reproductive health services and/ or developing their own sense of what integrated reproductive health services means,

which may prove to be dangerous in certain circumstances as 'integration of reproductive health services' can be interpreted to suit a country's goal, beliefs and culture. Such goals may not necessarily be in line with the goals of the ICPD and pose a threat to the well being/ health of its people (Hardee et al, 1994: s4).

The type of services provided, the conditions under which they are provided and the extent to which they are truly integrated within the health care system ranges from country to country (Hardee, 1994: s4; Mayhew, 2000:113- 119). Lush argues that the pattern of integration offered may also depend on the type of facility, the horizontal or vertical approaches taken at the administrative level, as well as the prevalence of disease (Lush, 2002a: 72).

Integration includes STI/HIV education, information, counselling, referral, and treatment, if necessary (South African Health Review, 1999). By providing education and counselling as part of the approach, it seems that clinics that provide integrated health services, allows the client to develop an informed choice in terms of the method of treatment he or she eventually chooses to use/ receive bearing in mind his/her individual situation. This is regarded as a more client centred approach, whereby the needs of the clients are taken into consideration (Walker, 2002).

1.4.Integrating STI/HIV services into MCH/FP programs

Much has been written about the advantages and disadvantages of integrating STI/HIV services into existing MCH and FP programs. Researchers point out that by attending clinics that provide integrated services in terms of including STI/HIV services within currently available MCH and Family planning facilities, the client has the opportunity to receive multiple services during a single visit to a facility (Walker, 2002). After screening clients for a broad range of needs, providers in integrated facilities can encourage clients to receive other services. For example providers can advise FP clients to use STI services or offer contraception to women seeking postnatal care (Lush, 2002a). Bearing in mind the rapid spread of the HIV/AIDS epidemic and constringent health budgets, the integration of STI/HIV services is cost efficient as it allows reproductive health clients to receive STI/HIV testing,

counselling, education and/ or treatment within currently available facilities (Lush, 2000: 74).

STI/HIV prevention and control is a potentially key element to the strategy of reducing the spread of HIV, as these activities aim to prevent new infections in the general population, treat persons with symptoms of infection as well as improving the clients ability to self diagnose (USAID, 2001).

Research has pointed out that under certain circumstances integrated services, i.e. the inclusion of STI/ HIV services can and does overburden current health facilities and health workers to such an extent that it leads to the decline in quality of care within MCH and FP facilities. It may also lead to inefficient treatment and care of STI/HIV patients, and eventually decreasing the quality of care, not only of STI services but also of FP and/or MCH services (Hardee, 1994; Mayhew, 2000).

Obstacles/ difficulties in implementing the integrated approach range from the lack of technical support to the lack of clear policy guideline and commitment by various levels involved in health in a country including NGO's and international organisations (Hardee et al, 1994; Mayhew, 2000). This is not to say that at least some form of integration that serves to cater for the needs of the population have not occurred, but rather that a great deal of support is needed in terms of finance, coordination, training and cooperation. The constant rhetoric over the need for integrated services serves to ensure that such conditions/ concerns are addressed.

1.5.South Africa

Within South Africa too there has been a commitment by Government at policy level to promote integrated services within clinics (Lush et al, 1999). It is important that we not only understand the conditions that stimulated the need for integrated services but also the context in which this occurred, the historical and political circumstances that led to the development of such national policies within South Africa, the political/ governmental structures responsible for policy building as well as the impact that influential parties can have, both nationally and internationally, on policy development, regarding integrated services.

Plagued with the legacy of its past i.e. previous apartheid laws discriminated against black, Indians and Coloureds, vast inequalities, in health, income, education access to services such as water, light, welfare and even access to health care exist in South Africa. Such inequalities continue to exist despite the removal of the apartheid regime (Lush, 2000:157).

In line with the Alma-Ata declaration and in accordance with the new constitution the National Government sought to improve public health care to cater for the needs of its users i.e. to ensure equality & equity in terms of access to health care, achieve gender equality and reproductive rights for all (Lush et al 1999: 773). The South African Government has thus adopted the Human rights approach in guiding policy regarding the integration of reproductive health services as well as guiding the principles of the National HIV/AIDS Strategic Plan (2000-2005). "In particular it includes services for all population groups rather than being limited to child bearing women and their offspring" (Lush et al, 1999: 773).

"South Africa has thus far created one of the most progressive and farsighted policies and legislative environments in the world. However despite the existence of a well thought out plan, sufficient time, a large economy to draw on, a reasonable pool of skilled workers in the Health and Education Departments and a sophisticated media, these policies and laws have not impacted significantly on the ground (Kenyon et al, 2001: 161). "The number of infected people has more than doubled from about 2 million in 1996 to 5 million today. By 2010, adult prevalence is predicted to reach 25%. By 2015, population loss due to AIDS -related deaths is predicted to reach 4.4 million" (USAID, 2001). According to SADHS the highest prevalence of HIV in South Africa can be found in KwaZulu- Natal (32.5%) (Department of Health, 2000).

A major focus of this study is to determine the type and quality of services offered to clients under the umbrella of integrated services within clinics in KwaZulu-Natal. South Africa.

CHAPTER TWO

INTERNATIONAL LITERATURE REVIEW

2.1. Introduction

A recent overview of the research on the integration of reproductive health services shows that this research is by no means a new avenue. The following discussion will examine the research that has focused on integrated reproductive health services in terms of the expansion of Maternal & Child health and Family Planning programs to include STI/ HIV services. It will synthesize some issues from studies and will also examine some specific studies.

As pointed to in our introduction, there is a lack of uniformity in terms of what is meant by integration. For the purpose of this study however the focus is on " the incorporation of activities to prevent and /or manage STIs including HIV into programmes of FP/MCH and/ or primary health care. The incorporation of STD activities may occur at the level of the management of STD programmes and other health programmes, and/ or at the level of shared support systems (e.g. training, logistics, record keeping)" (USAID/ Washington in Dehne & Snow, 1999). In the literature however we find that there is a lack of a clear idea of what type of STI/ FP/ MCH integration is being promoted, and it is thus not surprising that "while options about the likely impact are abundant, the actual evidence is scarce" (Dehne, Snow & O' Reilly, 2000: 629).

A lack of commitment in terms of the lack of policy guidelines, the lack of consensus within government regarding the importance/need for integrated services as well as the lack of communication and coordination between the different departments/ sectors within Government, can be seen as a severe blow to ensuring integrated service provision in the country. In Peru it was found that officials believed "integrated service provision to merely be a change in name rather any real change in philosophy" (Hardee et al, 1994: s7).

2.2. Rationale for integration

Much has been written about the need for and the integration of STI/HIV services within MCH/ FP services. According to Mayhew (2000), Dehne et al (2000), Lush (1999) and Mayhew et al (1999), the integration of STI/ HIV into FP/ MCH services does hold a potential to expand the reach of even more clients in need of reproductive health services, particularly STI/HIV services.

In many countries STI/HIV/AIDS is highly stigmatised resulting in widespread reluctance to seek formal medical care. However the integration of reproductive health services, that allow STI/HIV/AIDS services to be offered within FP/MCH clinics, would allow women to gain access to STD screening, diagnosis and management without undergoing the shame of attending a "STD/HIV specific clinic"(Mayhew, 2000:119).

By integrating STI/HIV services into current MCH services in particular, we intend to see a decreases only on the level of infection but also in terms of unwanted pregnancies, as clients of Public sector maternal and child health care and family planning services are almost "exclusively women using family planning, pregnant women and women with newborn babies" (Askew & Maggwa, 2002: 77). When looking at recent statistics of infections occurring among pregnant women and women using family planning, we find that between 2% and 7% of such women have cervical gonorrhoea, chlymidia or syphilis, 4% - 34% have been diagnosed with a sexually transmitted vaginal infection and 8% - 38% are diagnosed with non sexually transmitted vaginal infections (Askew & Maggwa, 2002: 77). A disturbing reality is that 25% - 30% of pregnant women in several parts of Sub Saharan Africa are infected with HIV (Askew & Maggwa, 2002: 77). The above statistics raises an awareness of the increasing need for STI/HIV services within MCH/ FP programs, that can allow these women easy access to STI/HIV education, screening, diagnosis and treatment (Askew & Maggwa, 2002: 77). Levels of specific STIs such as syphilis are not only high among pregnant women affecting these women's health, but can have adverse effects on the health of the fetus and newborns as well.

It should also be noted that with the formal integration of STI/HIV services within MCH/ FP programs, a decrease in STI infection levels has been experienced. This is demonstrated in the study "in Nairobi as well as Kenya whereby on site syphilis screening and treatment as well as partner notification were not only feasible in detecting and managing cases of syphilis, moreover active partner notification led to 70% of partners of infected women being treated" (Askew & Maggwa, 2002: 80).

According to a study in Uganda it was found that men are twice as likely to bring an HIV infection into the marriage, thus emphasising the potential risks of HIV and other STIs among married women. Bearing in mind that these married women predominantly use FP/MCH programs, the integration of STI/ HIV services within FP/MCH programs would facilitate the reaching of these women (Askew & Maggwa, 2002: 77).

Besides the more medical advantages that integrating STI/HIV services within MCH/FP services holds, it can also facilitate the provision of *more* services at low costs. For example the sharing of personnel and facilities not only minimizes duplication in terms of administration and service delivery, it also allows us to make greater use of existing infrastructure and personnel. This would at the same time curtail the under utilization of isolated facilities (Wallace, 1982:1319).

Although in theory and basic principles, the integration of STI/HIV services into MCH/FP services is indeed positive and holds great potential for combating the spread of such infection, particularly in countries such as Africa where access to resources are limited, such integration however fails on many occasions to help those it intends to assist. The case studies of eight countries, i.e. Bangladesh, Ghana, India, Jamaica, Jordan, Nepal, Peru and Senegal, spanning a diverse range of cultural, social and economic contexts, demonstrates the various challenges and failures that countries have encountered in their efforts to integrate STI/HIV within MCH/FP programmes (Hardee et al, 1994). Although these countries have adopted the ICPD policies in their efforts to put into practice the integrated reproductive health programmes, these programmes have been hampered by either socio cultural opposition, lack of sufficient resources, lack of commitment, lack of training of

services providers, general staff and management problems, and more especially the many different interpretations/types of STI/ HIV integration.

2.3. PREVENTATIVE ACTIVITIES

2.3.1. Providing Information, Education and Communication Material

STI/HIV IEC (Information, Education and communication) activities in integrated services are considered an important component in the promotion of health care-seeking behaviour. Health care seeking is promoted by raising awareness of potential signs and symptoms of STIs/HIV and the availability of STI/HIV services, through Information, education and communication. This is done not only to prevent the spread of STI/HIV infections but also aims to promote early diagnosis and treatment of infections (Dehne & Snow, 1999)

International and national media campaigns utilising print materials, flyers and pamphlets are and have been used to inform people of STI/HIV/FP services. The provision of free samples of condoms can also be viewed as a means by which clients are educated and informed of ways to protect themselves against infections as well as pregnancy (Cisek, 1992 in Dehne & Snow, 1999). However Mayhew, in her study of upper east Ghana found that " there was a lack of appropriate educational material for northern communities as most of the material are produced in the capital in a different language and tailored to different customs" (Mayhew, 2000: 117). Dehne & Snow found that available media tends to be in English and predominantly directed to urban audiences (Dehne& Snow, 1999). It is important to bear in mind that the effectiveness of such media may be hampered by the education level/ literacy level and /or economic status of the target group (Dehne & Snow, 1999).

2.3.2. Provision of STI/HIV/FP information and education by Providers

Prevention activities, which are very much espoused as being part and parcel of the integrated approach, include promotion of condoms, the IEC approach (information, education and communication) and counselling, all of which serve to reduce risk behaviours among clients and within the general population.

While exploring the client's knowledge about STI/ HIV, the health worker/ service providers should provide information by filling in the gaps and correcting wrong information. Bearing in mind all the clients circumstances and experiences, the health worker should explain STI/HIV transmission and risk, relating it to the client's situation (Engenderhealth, 2002). The four East and Southern African programmes emphasised the prevention of infection and reinfection, by encouraging the provision of information regarding STI/HIV prevention and diagnosis by providers (Askew & Maggwa, 2002: 77-80).

However according to Askew and Maggwa's analysis of these programmes, it was found that among consultations observed and clients interviewed, the number of clients attending integrated services who received information on STI/HIV and prevention methods varied between 7% and 62% (2002). In fact it was found that in some countries such as Kenya, less than half of integrated MCH/FP clients were advised to protect themselves, use condoms or notify their partners (Mukaire et al, 1997 in Dehne & Snow, 1999). According to Ching-Bung, 1995, STI/HIV education and counselling was sometimes limited to clients assumed to be at high risk, thus negating the possibility of promoting prevention of STI/HIV to *all* clients (Dehne & Snow, 1999).

2.3.3. Counselling

Counselling plays a vital role in terms of the effectiveness of information imparted on HIV/STI protection, family planning and maternal & Child health care. Women who are unable to negotiate in matters concerning sex and reproduction also have to be counselled on matters such as sexual health, partner dynamics and empowerment (Hardee et al, 1994). Thus a more client orientated approach needs to be adopted when providing integrated services.

Empirical evidence as to whether promoted condom use and sexual behaviour change has worked is not clear, despite reported changes (Dehne et al, 2000: 633). The main constraint in educating or changing risk behaviours stems from the fact that very few female clients report behaviours associated with high STI risk. Only 2 of the 312 infected women reported having had more than one sexual partner in North Jakarta

(Dehne et al, 2000: 633). Bearing this in mind it would seem that women are indeed afraid to report possible STI/HIV infection for fear of embarrassment, violence etc.

It should also be noted that very few married female clients report behaviours associated with high STI risk, other than having sex with their husband. In a Kenyan study of Family Planning clients treated for STIs, over 2/3 of married women said that they had been infected by their spouses. In another study in a high STI prevalence area in Kenya, only 7% of all women reported having had more than one sexual partner during the previous year (Dehne et al, 2000: 633).

As pointed to earlier, the integration of STI/HIV services within MCH/FP facilities would allow women who are otherwise unable to attend FP clinic or STD clinics, to receive STI/HIV/FP services within MCH/FP clinics. Counsellors need to inform all women attending clinics about the various family planning options, and explore ways of raising women's self efficacy and sexual negotiation skills in the face of the risk of infection (Walker, 1999). An example of this would be the integration of the HIV/STI prevention program in Brazil in 1993, that prompted a women centred approach to reproductive health services that feature issues of sexuality, relationships and personnel risk (Walker, 1999). In Indonesia, counselling and screening procedures for women wanting IUD's have been extended to cover STIs (Walker, 1999). Chinge Bunge (1995) identifies the use of mixed messages i.e. referring to contraception and disease prevention during counselling as an effective means of promoting STI/HIV as well as pregnancy prevention (Dehne & Snow, 1999).

However the frequency and quality of counselling on STI risk, sexual behaviour and sexual negotiation varies within integrated services. We have to recognise that regional variation and cultural specificity plays a role in determining the sensitivity and sometimes even the content of discussions about sex and partnerships. Approaches to integrated reproductive health services have to be culturally acceptable at the same time effective in behaviour modification to facilitate the prevention of HIV/STI transmission, unwanted pregnancies and maternal and child mortality (Walker 1999; Baakile et al, 1996; Mukaire et al, 1997 cited in (Dehne & Snow, 1999).

From the few integrated programmes in Asia, little is known about the actual frequency and quality of STI prevention counselling performed during integrated FP/STI consultations (Dehne & Snow, 1999). Obtaining a STI/ RTI (Reproductive tract infection) history and present symptom of the client and partner would be very useful to health workers in identifying risks and prevention activities needed. However a study in Indonesia showed that clinical histories were taken, primarily for diagnosis purposes and not for the purpose of risk reduction education and counselling (Population council, 1997a: Djakarta, 1997 cited in Dehne & Snow, 1999). Ching Bung in his analysis of various questionnaires within numerous integrated health projects worldwide makes the important observation that health workers tended to add the HIV/STI prevention information at the end of the Family planning discussion rather than integrating it into Family planning information. Providers should impart information regarding STI/HIV protection offered by each type of contraception (Dehne et al, 2000).

2.3.4. Condom Use

Another rational for integrating STI/HIV services within both MCH and FP services, is the consequent promotion of dual protection i.e. the prevention of sexually transmitted infection and unwanted pregnancy through the use of barrier methods such as condoms (Myers et al cited in Berer, 2000: 165). The integration of Family planning and STI/HIV programmes have ended the parallel use of FP condoms and STI condoms, with different brands and prices, distributed on different occasions and in different sittings, thus allowing for the creation of a more consistent approach to contraceptive use and STI/HIV prevention (Kirsch-Woirk & Girrbach, 1998 in Dehne & Snow, 1999). Consistency in communication is imperative when educating ordinary people/ mass audiences about the ways to ensure sexual and reproductive health.

A distinction should be made between dual protection and dual method use. Clients practicing dual method use may choose to use one method for the primary purpose of pregnancy protection and condoms for STI protection. However clients may be able to achieve protection against both STIs and pregnancy using condoms alone, since condoms are effective for both disease and pregnancy prevention when used correctly

and consistently. This is referred to as dual protection (Myer et al cited in Berer, 2000: 166).

According to Myer et al, correct and consistent use of latex condoms when engaging in sexual intercourse - vaginal, anal or oral - can greatly reduce the spread of most STIs, including HIV (Myer et al cited in Berer, 2000: 166). Clients who consider themselves or their partners at high risk of HIV and other STDs are good candidates for dual protection.

Health worker and client should discuss contraceptives and STI prevention options in terms of the client's needs. They should raise awareness to the benefits of condoms and dual method use in today's dangerous sexual environment (Lush, 2002a). "Women should be made aware that some barrier methods may protect against some STDs but not others and that only male latex condoms have been proven to be highly effective for HIV prevention" (Reproline, 2002).

With the integration of STI/HIV services, condom promotion activities expanded from community based distribution schemes to free distribution in group counselling sessions at clinics (e.g. Brazil) as well the promotion of condom use for dual protection (e.g. Brazil, Kenya, Philippines) and many subtle positive changes in attitudes towards condoms by care providers and their clients, as in projects in Jamaica and Madagascar whereby nurses promoted condoms either as a primary FP method or together with other methods, and even demonstrated correct condom use (Ritstein et al, 1993 in Dehne & Snow, 1999).

Mayhew (2000) however points out that although condom promotion and dual protection are the corner stone of integration, only 5 of the 27 facilities involved in the study in Rural Ghana were actively promoting condoms to MCH or FP clients, despite 23 facilities having condoms on site. Of the places that did advocate condom promotion, it was found that "it was spontaneously mentioned, by only one provider and no sense of contraceptive choice dilemma was apparent "(Mayhew, 2000: 115). Mayhew states that although the majority of clinics in Zambia, South Africa, Kenya and Ghana stock condoms, condom promotion activities itself are limited, with the mention of condom use for protection against STIs occurring in only 12% of the 36%

consultations (Mayhew, 2000: 158). Mantell found that many providers were concerned that by promoting male or female condom use instead of hormonal methods could increase the risk of pregnancy. These providers' views on the limitations of dual protection methods may inhibit their ability to promote condoms (Mantell cited in Berer, 2000: 166).

Myers thus states that before the dual method can become a reality, popular health promotion campaigns are needed to explain the separate needs around contraception and prophylaxis and how these can be met through dual protection (Myers cited in Berer, 2000: 167).

Hardee et al point to the array of advantages that occur from promoting STI/HIV prevention activities, however the actual effectiveness, consistency and regularity of such prevention activities varies from country to country, clinic to clinic and provider to provider.

2.4. CURATIVE ACTIVITIES

2.4.1. Syndromic Management

The traditional method of diagnosing STIs through laboratory testing is often too expensive and unavailable, particularly within developing countries (UNICEF, 2002). More than 333 million STI/HIV infection (excluding HIV/AIDS) occurs each year, with the numbers increasing, having serious repercussions on women's health, child health and sexual partners. The destructive impact of STI/HIV and the fact that many of these STIs including HIV occur in places where there are often inadequate resources and infrastructures for laboratory diagnosis, WHO in 1990 recommended the use of inexpensive accessible tools such as syndromic management (UNCEF, 2002)

Syndromic management uses symptoms, signs, or risk factors that have developed, to identify and treat STIs without the need for laboratory diagnosis. The main features of syndromic management are:

- Classification of the main germs by the clinical syndromes produced
- Use of flow charts derived from this classification to manage a particular syndrome
- Treatment of all important causes of the syndrome
- Notification and treatment of sex partners

According to UNICEF, the syndromic approach using flow charts offers accessible and immediate treatment that is cost effective and efficient (UNICEF, 2002).

The syndromic management of STIs is being adopted by many countries including Bangladesh, Nepal and most pacific countries (Katonga, 1996 in Walker, 1999).

> A body of empirical evidence now indicates that syndromic management fails to identify and manage appropriately a substantial proportion of women with a cervical infection i.e. it has a low sensitivity, and it identifies many women as being infected when in fact they are not i.e. it has a low positive predictive value (Askew & Maggwa, 2002, 78).

According to Askew and Maggwa, all STI detection and management strategies based on symptoms and signs - not only the syndromic approach- is hampered because STIs in women are likely to be asymptomatic (2002: 78). Treating an uninfected woman for an STI not only incurs unnecessary expenditures in terms of medication, treatment etc but can also create a potential resistance to the drug among clients treated falsely. False diagnosis can also endanger the life of the clients as many women are at risk to violence from their partner when revealing that they have an STI (Askew & Maggwa, 2002, 78).

According to Sloan et al in their review of 32 studies, the conclusion was reached that using risk factors, symptoms and signs, simple lab test algorithms and risk scoring are not effective mechanisms for identifying or managing gonorrhoea and chlymidia, which are largely found in Sub Saharan Africa, South East Asia and Latin America, as they have generally poor sensitivity and high false positive rates (Sloan, 2000:55-68).

However because of the recognised effectiveness of Syndromic management of urethral discharge in men and of genital ulcers in men and women, as well as poor access to resources for laboratory diagnosis, the use of Syndromic management remains the recommended approach for these symptoms in resource poor settings (Askew & Maggwa, 2002, 78).

2.4.2. Screening of clients

The Syndromic approach is in many cases not effective due to poor accuracy in certain STIs but also because providers fail to perform risk assessments on the clients or fail to do it consistently (Dehne et al, 2000: 635). There are various constraints in effectively using service providers as a means to churn out integrated services. This is evident in Hardee and Yount who state, "the number one challenge in most countries is human resources, such as staff shortages and work overload and the lack of trained providers" (Hardee et al, 1994: s4).

Studies in Ghana have found that even after the introduction of the syndromic guidelines in 1996, medical staff had not been trained beyond the very basic diagnosing and treatment of STI/HIV (Sloan, 2000: 55). Bearing in mind the importance of the screening process which is in nature verbal and involving no physical examination, the training of health providers in detecting signs and symptoms or risk factors is vital if the goal of increased coverage of STI/HIV is expected, however many health providers have not been provided with such training (Mayhew, 2000:115).

In the study of the integration of STI/HIV within FP /MCH services in rural upper East Ghana, it was found that the frustration with the new integrated reproductive health protocols and the subsequent lack of dissemination by health staff, led to the failure of true integration, as many of the FP/ MCH health service providers continued to focus on FP/ MCH guidelines, without integrating Syndromic management guidelines (Mayhew, 2000:114). Family Planning services were the pre-existing infrastructure into which STI management was being integrated, hence the structure, reach and quality of the pre-existing FP services were found largely to dictate the nature and pace of STI/FP integration (Dehne, 2000: 629). For example, it was found

that in countries such as Brazil, Jamaica, the Russian federation and Zimbabwe, STI screening among FP clients is selectively associated with prescriptions for intrauterine devices (Dehne, 2000: 631).

Despite the development of policy regarding the integration of STI/HIV services with FP/MCH programmes, medical staff and health workers in Ghana felt that the guidelines had no real assessment of procedures and constraints (Mayhew, 2000:119). They considered the "reproductive health policy and standards document to be clinical protocol rather than an integrated policy" (Mayhew, 2000:114). Moreover it was felt that the policy did not tackle cultural, political and economic issues affecting reproductive health, which are of great importance when developing strategies addressing STIs, condom use and sexual behaviour (Mayhew, 2000:114).

It was found that among the 27 facilities observed in Rural Upper East Ghana, staff at only 6 six facilities were aware of Syndromic flowcharts. None of the facilities had the guidelines displayed, either because service providers said they were familiar with the procedures, or STI screening was not a priority of the clinic, or simply because there had been no follow up to remind service providers/ management (Mayhew, 2000: 116).

Studies found that the ability of clinics to offer STI detection and treatment was undercut by a lack of basic requirements such as examination equipment, supplies, staff training and drugs. A connection between policy intentions and program management processes such as training, monitoring and supervision was lacking, leading to the disintegration of integrated services. This was so even within controlled studies in Kenya and Zimbabwe, whereby providers made numerous lapses in following the standardised screening and risk assessment procedures as well as in following the algorithms for managing symptomatic clients (Askew & Maggwa, 2002, 80).

The lack of motivation and commitment of service providers to provide all services, can be partially attributed to the stigma and risks attached to STI/HIV, whereby many health providers may not be willing to treat STI/HIV clients, this can be said of doctors as well. Hardee et al also point out that even while providing a single service

such as family planning, providers may lack a "client focus" and simply deliver the services that the provider thinks the client needs, as is the case for many clients in Bangladesh (Hardee et al, 1994: s3). Other findings in the study of integrated reproductive health in Bangladesh, Ghana, India, Jamaica, Jordan, Nepal, Peru and Senegal, pointed to a lack of a curriculum that incorporated the provision of integrated services in tertiary institutions, that has eventually led to untrained staff (Hardee et al, 1994: s4).

In Nepal one ministry official stated that "workers who were trained five years ago need to undergo refresher training, as we need to change their mindset because a lot has happened since then" (Hardee et al, 1994: s4). "In the upper East of Ghana in 1995 it was found that of the 38 providers interviewed only 26 said they had received some kind of STI training in the previous two years. Even then the quality and coverage of the training varied from an in depth two day workshops on STI management, to one-hour lectures on signs and symptoms of STIs" (Mayhew, 2000: 116). By the end of 1997 there had been no follow up of these training sessions. According to regional health administration the lack of training can be attributed to the lack of time and funds (Mayhew, 2000: 116). If refresher training, which is based on the need for provision of current FP/MCH services, fails to occur, the training of service providers in providing integrated services seems unlikely.

Although STI detection and treatment are a part of the training program, they rarely seem to be carried out. When observing integrated clinics, it was found that few of the FP clients were asked key behavioural questions and within one clinic in Kenya no risk assessment questions were asked *at all.* STI diagnosis instead seemed to be based on clinical signs (Dehne et al, 2000: 631). According to Dehne et al STI screening practices such as syphilis screening and pelvic examinations for example are more likely to be carried out routinely in MCH and Antenatal care than in separate FP only programs. Bearing in mind that FP clients are sexually active and are seeking information and care related to sexual activity, it would thus seem that integration of STI/ HIV services is needed even more so in FP programmes (Dehne, 2000: 630).

In a review of anti natal syphilis screening in 22 sub-Saharan African countries it was "estimated that at best only 385 of the women attending antenatal services are

screened, and that over 1 million syphilis infected pregnant women are missed, resulting in 600000 *adverse* fetal and infant outcomes that could be averted"(Askew & Maggwa, 2002, 80). Reasons for the continued poor detection and treatment of STIs/ HIV within MCH services can be attributed to the fact that "certain STIs such as syphilis tends to be a concern of the national STI program rather than the MCH program, thus antenatal clinics and staff are not sufficiently prepared to offer screening and treatment" (Askew & Maggwa, 2002, 80). Funding, protocols and guidelines are also lacking when it comes to STI issues within MCH programmes (Askew & Maggwa, 2002, 80).

Only "2 of the 40 GTZ reproductive health projects that were reviewed provided the systematic integration of a full component *of STI care tasks i*.e. lab screening clinical diagnosis, treatment or referral, and partner notification, into FP services" (Dehne et al, 2000: 631). However even within care practices, differentiations exist with a greater focus on screening than on referrals, treatment and partner notification (Dehne et al, 2000: 631).

A key aspect that Hardee et al point to is that Governments, Department heads and management have to "move away from the vertical projects, to a more client centred package of essential services, so that all reproductive health elements are integrated with routine services provided at one service delivery site" (Hardee et al, 1994: s9)

In a recent review of 40 GTZ (German Technical Cooperation) reproductive health and PHC (Primary Health Care) project documents, mostly from Africa and to a lesser extent Asia and Latin America, 70% contained both FP and HIV/STI aspects, but only 3 of the 28 projects had taken HIV/STI into account at all levels of planning i.e. problem analysis, definition of objectives and targets, development of indicators and the listing of planned activities (Schumacher and Milowski, 1997 in Dehne & Snow 1999).

Literature reveals the various challenges and failures in attempting to fully integrate STI/HIV services within MCH/ FP programmes. A 1996 analysis of UNFPA country level support for HIV /Aids prevention elements into family planning services revealed that out of 124 countries supported, only 63 ongoing reproductive health

programmes contained an HIV/STI prevention component (Dehne & Snow, 1999). Dehne & Snow point out that according to the IPPF Western Hemisphere 1996 annual report, only 18 of the 41 Family planning associations (FPA) projects in Africa appeared to have integrated STI/HIV prevention activities into family planning (Dehne & Snow, 1999). However even then, the extent to which HIV/STI is integrated or coexists with family planning services still remains questioned and is under examination. Integration of STI/HIV services has not been effective or sustainable in terms of consistency and regularity in many countries (UNFPA, 1996 in Lush, L, 2002b).

Management and service providers are the first form of physical contact for clients and the means by which integrated services are provided. Thus the lack of commitment by management and service providers can and does greatly hinder the chances of achieving integration within a clinic.

However lack of financial and human recourses cannot be solely blamed for the lack of STI/HIV clientele within integrated services. Community context whereby access to and use of client services and Family Planning is poor, as well as attendance by men and high-risk groups are very low, such STI/HIV integration seems futile (Mayhew, 2000:114). According to background studies done in Rural Ghana it was found that in many areas such as the rural upper east region of Northern Ghana, women do not widely use FP/MCH services, thus the integration of STI/HIV services within FP/MCH, particularly in areas where STIs are low, is unlikely to result in higher usage rates of prophylaxis methods (Mayhew, 2000: 113). This points to the efficacy of integration in that training of FP/MCH staff in syndromic management is intended to improve coverage of infections, however use of these services remain low.

Also many of the success stories come from clinics that offer comprehensive integrated services at the very onset rather than clinics that integrate STI services into pre-existing FP services. The Latin American programmes that were successful in increasing STI coverage did so mainly because of the demand for such services, (high risks groups) and established clinics for men and not through the integrating *STI care* into existing FP settings (Dehne, 2000: 634). In Busoga, Uganda the increase in STI caseload was attributed to the increase in men's attendance and not female FP clients

(Dehne, 2000: 634). In Africa "STI caseloads increased in several projects following integration, however not only were the absolute numbers small, but in Mkomani (Mombassa, Kenya) only 894 out of 22551 of the FP clients were treated for STIs (Dehne, 2000: 634).

"The integration of services for HIV/STIs with those for MCH/FP, if done properly can meet the needs of a population group that has not had access to such care. However this group rarely includes the main infection transmitters- men and sexually active, unmarried women- none of whose needs can be addressed through MCH/FP services" (Lush et al, 1999: 775)

2.4.3. Referral and treatment

Even among those FP services that had recently integrated STI prevention and detection, not all offered treatment on site. "Many IPPF affiliates in Africa and the Americas have trained their staff in the detection and syndromic management of STIs, but refer clients with symptoms or signs of STIs to specialised clinics for treatment" (Dehne et al, 2000: 631). Thus even within so-called integrated services one stop services are not always available. Also only certain providers, not necessarily FP providers, may be responsible for STI patients. "In an NGO in Kenya for example STI patients were referred to the deputy manager/ nurse for treatment, since only one person was in charge of the revolving drug fund" (Dehne et al, 2000: 631).

The concern is the fact that in many clinics, FP/ MCH services are already compartmentalised and vertical with only specific nurses handling specific services. By introducing STI/HIV services into these already segregated services can result in ineffective STI/HIV screening and management. According to Mayhew "16 of the 27 clinics in 1997 treated STIs by all staff, in only four of the clinics were MCH staff allowed to treat STIs and four other clinics allowed FP to treat STIs however 4 facilities referred patients to other facilities" (Mayhew, 2000:115).

Also in many supposed integrated services women attending a clinic who needed STI diagnosis and treatment, whether they came for family planning or MCH services or only for a suspected infection, might be told they have to return on another day (the

day that either the nurse responsible for providing the service would be in or the day that STI/HIV cases are dealt with by the facility), attend a different facility (usually further from home) or go elsewhere to obtain drugs (Mayhew, 2000: 115). For example in studies in "Ghana, Kenya and Zambia, drugs are unavailable as a result of nurses being prohibited from prescribing them, regardless of whether the nurse has been able to diagnose the STI" (Mayhew, 2000: 157). Thus service providers are de-motivated due to the frustration experienced with the lack of resources needed for the integration of STI/HIV services, such as condom provision and basic STI/HIV drug provision (Mayhew, 2000: 117)

Further frustration with the administration system that tie the hands of the service providers, demotivates staff. In many instances "junior staffs were required to gain the permission of senior staff to take diagnostic and treatment decisions also lead to stagnation in STI services", particularly in the absence of their superior staff (absenteeism) (Mayhew, 2000: 117). "These barriers create obvious time and money costs for women and not surprisingly, women often ended up going for treatment to pharmacists, traditional providers or "quacks" or not getting treatment at all (Mayhew, 2000: 115).

2.4.4. Partner Notification

Partner notification is *an integral part of the syndromic approach*. Some findings from studies carried out in settings other than FP clinics, seem to suggest that women are more successful than men in referring partners despite the fact that women face potentially severe consequences, including domestic violence, verbal abuse and abandonment (Dehne et al, 2000: 632).

In the array of projects reviewed, encouraging FP clients to refer their partners was difficult and inconsistently practiced. In Uganda and in East African case studies, it was clear that women with STIs did not want anyone else to know about their STI status and did not want the clinic staff to contact their partners (Dehne et al, 2000: 632).

One has to bear in mind the cultural and social context in which STI prevention, treatment and partner notification occurs. For example in "Mombassa, Kenya where polygamy is common, women feared that they would be accused of being responsible of bringing STIs into the home if their spouses were informed" (Dehne, 2000: 632). In Mombasa, Kenya a study on the prevention of mother to child HIV transmission, screened women for HIV. On receiving their results they were provided with relevant counselling including the risks and benefits of informing their partners. Of the 331 HIV positive women interviewed, 32% of them had informed their partner, of whom 73% were understanding. In only six cases, violence or ending the relationship was reported, however 68% of those in a stable relationship did not inform their partner, for fear of their partners, family, society's reaction (Berer, 2000: 165). This is not unfounded. For example, in a survey of 52 HIV positive pregnant women in Mumbai and Sumerpur, India, a large majority reported discrimination from their spouses, families and society. Discrimination ranged from abandonment, violence, and rejection (Shah cited in Berer, 2000: 163). Similar findings in Jakarta, Indonesia suggested that provider and client referral were also difficult to achieve (Dehne et al, 2000: 632).

CHAPTER THREE

NATIONAL LITERATURE REVIEW

3.1. National Policy Developments in South Africa

Within South Africa there has been a commitment by Government at policy level to promote integrated services within clinics (Lush et al, 1999). There are a variety of conditions that have led to the National policies that South Africa has, regarding integrated service provision at present. It is important that we not only understand the conditions that stimulated the need for integrated services but also the context in which this occurred, the historical and political circumstances that led to the development of such national policies within South Africa, the political, structural and governmental structures responsible for policy building as well as the impact that influential parties can have (both national and international) on policy development, regarding integrated services.

We cannot ignore the difficulties the New Democratic Government faced in providing health care to the people as the "population policies of the past apartheid system were racist" (Lush, 2000:155). The apartheid laws discriminated against black, Indians and Coloureds resulting in vast inequalities, in health, income, education access to services such as water, light, welfare and even access to health care, which continues to exist even after the removal of the Apartheid regime (Lush, 2000:157). Bearing in mind that previously the white apartheid administration only "catered for the needs of 13 percent of the population" and that the new democratic Government had to now cater for the needs of all its people, one foresaw issues relating to finance, administration, sufficient health workers etc all becoming a concern for the new National Government. (Lush, 2000: 145). At first national policies were directed at addressing racial inequality in the provision of hospital services, however bearing in mind that "the dismantling of the apartheid health system had started well before 1994 election, the new Government of National Unity significantly shifted focus towards a principle goal of providing primary Health care (PHC) as a basic human right to all South Africans" (Lush, 2000:156).

"In line with the Alma-Ata declaration and in accordance with the new constitution, the national government also sought to achieve gender equality, to improve equity in access to care and ensure reproductive rights for all" (Lush et al 1999: 773). Bearing in mind that Whites and Asians tended to use private health care while the predominant users of public health care were blacks, the improvement of public health care to cater for the needs of its users was necessary to ensure equality in a country plagued by legacy of apartheid (Lush et al 1999: 773).

3.2. STI/HIV/AIDS

"In the midst of the change in government and political power were reports of rapid growth in the HIV epidemic, high maternal mortality, a persisting unmet need for contraception and women's poor reproductive health" (Lush, 1999: 775).

South Africa is still to recover from the past apartheid laws. For example the migrant labour system born out of the restrictive apartheid laws themselves, still continue to exist even now. It is this migrant labour system, that kept many black husbands and wives separated for long periods of time, eroding the family structure and promoting various other activities such as commercial sex, that can be seen to have facilitated the transmission and spread of STI/HIV in South Africa (Lush, 2000). The major causes and determinants of the epidemic in South Africa, according to the STI/HIV/AIDS strategic plan for South Africa (2000-2005) included various underlying socio economic factors such as poverty, migrant labour, commercial sex workers, low status of women, illiteracy, the lack of formal education, as well as stigma and discrimination that led to increased unprotected sexual intercourse, multiple sexual partners, and the consequent high prevalence of sexually transmitted disease (Department of Health, Feb, 2000:8-9).The new Government thus had to approach health care vigorously and with urgency (Lush, 2000).

Restructuring the segregated and separated system of the past was at the top of the agenda. This occurred with the creation of a single National Department of Health (DOH). In contrast to many countries studied, "management of all financial resource and logistical systems in South Africa, had been fully integrated in the provinces, assisted by the relative independence of provincial decision makers under the new

federal system adopted by South Africa, thus it is " the Provincial DOH's that are responsible for all implementation functions". The national DOH was basically responsible for strategic policy development and technical guidance (Lush, 2000:158, Lush et al, 1999).

The "provincial health departments would have to support and enable the development of district health systems which would become the main vehicles for the delivery of comprehensive Primary Health Care services"(Lush, 2000:158). Primary health care includes services for all population groups rather than being limited to childbearing women and their off spring with both HIV/ STIs and MCH/FP included in the broad package. "This clear vision of what primary care should look like and how it should be managed differs markedly from what is seen elsewhere in Sub Saharan Africa" (Lush et al, 1999:772-774).

However policies to expand PHC were not successfully implemented due to an array of disputes between state and local authority, local authorities and provincial administration etc (Lush, 2000:159). Despite integration being a central element of the primary health care approach the tension and conflict that occurred between National DOH and Provincial DOH, due to the lack of specific allocation of powers, lead to significant gaps between intended policy and actual service delivery (Lush, 1999: 773-775).

It was thus realised that the integration of health service activities is achieved more easily at local and district level than at the broader provincial and national level. "Integration is thus an expression of the PHC approach, a means of optimising the use of scarce resources, improving efficiency and effectiveness, and ultimately improving peoples lives" (Owen in S.A. Health review, 1995: 185).

However many programmes have been tempted to re-establish themselves as *separate mechanisms* due to the poor capacity of the health system management. At the service level it is found that the provision of comprehensive care, has stretched capacity at health care facilities, making it difficult for providers to prioritise activities of particular public health importance (Lush, 1999: 773-775)

The ministry of health in South Africa has designated HIV/STD control and MCH/FP as national health priorities but has however maintained separate programmes for HIV/STD control and MCH/FP. "Integration has been achieved through political and ideological commitment to the ideals of the Alma-Ata rather than through compromised attempts to [ineffectively] expand vertical programmes". (Lush, 1999: 774)

3.3. International and Academic Institutions' contribution

We should not fail to acknowledge also the contribution made by international organisations as well as academic institutions, in developing policy recommendations. NGO's (both national and international) "provided education and prevention...and have helped inject a vision of non discrimination, human rights and community participation into the National policy planning" (Schneider & Stein 1996 cited in Lush, 2000). "Non government actors also maintained strong links with international agencies and thus acted as intermediaries between global health policy developments and those taking place in South Africa" (Lush, 2000:176).

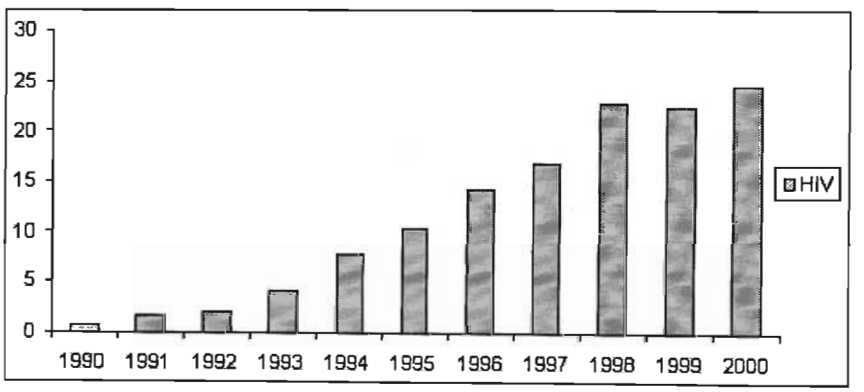
The Reproductive Health Research Unit (RHRU) had contributed to developments in policy formulation and implementation, including ensuring that new contraceptive policy took the HIV/STD into context, by providing research findings and statistics on contraception, pregnancy and STD control (Lush, 2000:174). Clearly academic input in terms of the current needs of South Africa was taken into consideration when developing policies regarding integration of services. They also served as a lobbyist for integrated service provision in South Africa.

"South Africa has thus created one of the most progressive and farsighted policies and legislative environments in the world. However despite the existence of a well thought out plan, sufficient time, a large economy to draw on, a reasonable pool of skilled health and education workers and a sophisticated media, these policies and laws have not impacted significantly on the ground" (Kenyon et al, 2001: 161).

According to the National HIV survey of women attending antenatal clinics of public services in South Africa 1990-1999, there has been a significant increase over the 10

year period from 0.7% HIV prevalence to 24,5% HIV prevalence as shown by figure 1. This translates into approximately 4.8 million South Africans and nearly 20% of all 15-49 year olds infected with the virus (Department of Health, 2000). In 2000 it was estimated that 40% of all deaths in the age category 15-49 were due to AIDS. Of great concern is the fact that the average life expectancy of individuals in South Africa has decreased from 66 years to 47 years, due largely to AIDS (Kenyon et al, 2001). National and other data have clearly indicated that HIV epidemic is severely affecting the young, black and economically poor populations in South Africa (National Department of Health, 2000).

Figure 1: National HIV prevalence trends among antenatal clinic attendees in South Africa: 1990-2000



Source: Department of Health: Facts and Statistics (2002)

It is estimated that in 1998 over 16000 people were infected with HIV daily, translating to more than 550 000 people infected each year, thus it is further estimated that by the year 2005, there will be 6 million S.A's infected with HIV. Even then we should be aware that voluntary reporting seriously underestimates the number of people who have AIDS (KwaZulu-Natal Department of Health, 2000: 8) According to UNAIDS the excess AIDS related deaths will peak in 2010-2015, particularly within the young /economically active age group i.e. 15-34, with 17 times as many deaths as there would have been in the absence of AIDS. (UNAIDS, 2001)

The various sectors of South Africa, ranging from Trade and Industry to Health and Education are all feeling the devastating impact of the HIV epidemic. By 2004 industry will have to face the fact that by 2004 up to 15% of their workforce will be

less than half productive as they were in 1999 (Business report, 29 July 1999 cited in UNAIDS, 2001) and by 2005 South Africa will have lost 11% of their workforce due to AIDS (UNAIDS, 2001). "Nationwide aids related deaths among teachers in South Africa, rose by more than 40% in 2000-2001. The loss of teachers can be especially devastating in rural communities where schools depend heavily on only one or two teachers" (UNAIDS, 2001).

Bearing in mind the relationship between STI's and HIV, as well as the devastating impact that STIs, including HIV can have on all individuals' especially pregnant women and newborns, the South African Government has also brought STD cases under the spotlight. "Approximately 11 million STD episodes are treated annually in South Africa with approximately only 5 million of these managed by private general practitioners. It is thus clear that even without the HIV epidemic, STD's pose an important public health problem in South Africa"(KwaZulu-Natal Department of Health, 2000: 8).

A study in KZN for example found that "although more than 50% had at least 1 infection of the Reproductive tract, none volunteered symptoms of an STI. The second reason is that even when symptoms occur and are recognised, treatment is often not sought after, either because treatment is inaccessible or because the infection is not regarded as serious. Thus according to Colvin (1997) "the high level of STI prevalence in South Africa is the consequence of poor education on symptoms and causes of STD's, poor access to treatment and poor quality of treatment" (Gow & Desmond, 2002: 14-15).

The South African Government has thus adopted the Human rights approach in guiding policy regarding the integration of reproductive health services as well as guiding the principles of the National HIV/AIDS and STD strategic plan (2000-2005). The HIV/AID/STI Strategic plan for 2000-2005 stressed a few general strategies that emphasized the need to, increase access and acceptability to voluntary HIV testing and counselling, promote effective and culturally appropriate information, education and communications strategy, as well as to improve STD management. The document also states the need to promote increased condom use to reduce STD and HIV

transmission and to improve the care and treatment of HIV positive person (KwaZulu-Natal Department of Health, 2000:16).

A major part of the strategic plan's prevention component was to "improve the proportion of effectively managed STD cases, using syndromic treatment in both the public and private sector, as well as to increase sexually active women's use of condoms"(KwaZulu-Natal Department of Health, 2000:17).

The South African Health review data indicates that more than 75% of all facilities do *offer* STI services, and 81% of these use Syndromic approach for diagnosis and treatment (Health Systems Trust in Mayhew, 2000: 158). Positive changes have occurred with the integration of health services to include HIV/AIDS and STI into MCH/ FP activities.

3.4. Access and use of Condoms

The provision of condoms in the public sector in S.A has increased from 6 million in 1994 to 250 million in 2000/2001. "A recent prospective review found that, five weeks after distribution of condoms, 44% had been used in sex, and only 9% had been lost or discarded" (Myer et al. 2001: 789-793). However Mayhew states that although the majority of clinics in South Africa stock condoms, condom promotion activities itself are limited, with the mention of condom use for protection against STIs occurring in only 12% of the 36% consultations (Mayhew, 2000: 158). Despite the use of condoms, as in the case study of a mining community of Carltonville, it was found that there was a lack in regular and consistent use of condoms (UNAIDS, 2001)

Also noted among the many sexually experienced youth of South Africa, was that although 80% of them knew that condom use is the best way to avoid contacting HIV, 70% said that buying or obtaining condoms was very embarrassing, thus there is a need to increase the availability and social marketing of condoms (Myer et al cited in Berer, 2000: 165)

"Due to the high prevalence of hormonal contraceptive use in South Africa, dual protection is usually promoted as dual method use i.e. the combination of barrier and hormonal contraceptive methods" (Myer et al cited in Berer, 2000: 165). Quantitative

data collected at 12 public health clinics found that participants using hormonal contraceptives were less likely to use condoms than those not using contraceptives, thus dual method is low amongst those using a single method of protection whether a barrier or hormonal method (Myer et al cited in Berer, 2000). Myers thus states that before the dual method can become a reality, popular health promotion campaigns are needed to explain the separate needs around contraception and prophylaxis and how these can be met through dual protection (Myers cited in Berer, 2000: 167)

3.5. Voluntary Counselling and Testing.

Studies in South Africa have found that at the individual level voluntary counselling and testing is a powerful tool in effecting positive behaviour change. " People who test positive are more likely to take steps to protect their partner and people who test negative are more likely to take steps to remain negative" (Kenyon et al, 2001: 169)

The National Integrated Plan (NIP) of South Africa aims to have VCT offered in all health facilities within 3 years, it also aims to promote uptake so that 12, 5% of the sexually active population has been tested by 2004. The National department of Health have developed training manuals and a set of minimum standards for counsellors, for which the provinces are responsible for implementing. Despite the positive impact that VCT can have, it was found in the 1999 evaluation of HIV/AIDS counselling, "the impact and reach of counselling is relatively narrow and limited....counselling services remain underdeveloped and under resourced , constrained by issues of competence , policy obstacles, lack of coordination" (Kenyon et al, 2001: 170). Various sites called pro test sites had been developed for the central aim of increasing access to VCT programmes as an entry point for an access to a wider set of services and health promotion activities. Success of these sites was noted in the Central district of Cape Town, which began in 1999 testing 0.4% of the adult population of the district and increased to 4% in just 2 years. Although staff encourages clients to get tested many clients of the district now self present for VCT, with self presenting clients of VCT now comprising of 71% of those tested at the central district. "This is concrete evidence of the population level benefits of an integrated package of prevention- care interventions based at the clinic level" (Kenyon et al, 2001: 170).

3.6. Maternal and Child Health services

During 2001 the provision of 'Prevention of Mother to child transmission services' became a contentious issue. Following the Durban HIV conference, 18 sites were selected for PMTCT pilot programmes. By the end of 2001, 193 health facilities (hospitals, midwife obstetric units, community health centres) were part of the national PMTCT pilot programme. It was found that 51% of all pregnant women agreed to be tested for HIV within these sites. "This translated to about 3133 pregnant women being tested per month of which 33% were HIV positive. On the basis of these VCT uptake and sero positivity rates, it is estimated that 6343 HIV positive pregnant women were identified in the National PMTCT sites from the time of its inception to the end of 2001" (Department of Health, 2000: 171). Nationally syphilis prevalence rates have dropped from 11% to 5 % in pregnant women over the past 3 years (Department of Health, 2000).

All of the above points to the important and positive effect that the integration of HIV/STI into MCH/FP services can have on the lives of many South Africans, by not only increasing coverage of clients in need of STI/HIV/AIDS services, but also in terms of reducing the rate of infection of the HIV epidemic that seeks to ruin development gains achieved thus far.

3.7. Treatment and Care

The human rights approach adopted by the National HIV/AIDS/STD strategic plan 2000-2005, that seeks not only to empower individuals and communities with the knowledge and means to avoid infection but also encourages a positive and informed willingness to undergo Voluntary HIV/AIDS testing but also ensures that the constitutional rights of South African are catered for by prescribing adequate care, support and treatment to infected persons (Kenyon et al, 2001: 162-164).

However this prescription is not met as suggested in the recent review of the management of 'HIV in Children' which found that only 20% of the clinic staff had heard of the national treatment guidelines and even then under10% of the clinics had a copy of the National treatment guidelines (Department of Health, 2000: 171).

Another recent survey in hospital found that nearly all physicians interviewed were unhappy about the lack of clinical protocols needed to deal with both the clinical and ethical aspects of care. It is thus not surprising to hear of the discrimination that HIV/AIDS patients have experienced at the hands of the health worker. Health Workers who themselves are not necessarily to blame, as the government system has not yet adequately provided its workers with the guidelines and skills to provide effective care and places tremendous stress on frontline health workers. A key focus of the National HIV strategy should therefore be the implementation of a clearly defined package of treatment and care (Kenyon et al, 2001: 173)

There are thus some very clear ideas as to why integrated services are not meeting the requirement it seeks to achieve according to the policies developed. According to Lush et al, the goals of controlling HIV/STIs or improving reproductive health are not necessarily going to be realized even where full integration has been achieved. Managers of fully integrated systems and general providers continue to need strong technical support in order to ensure a comprehensive package of care, including condom promotion for dual protection, case detection, and information on the prevention of HIV/ STIs (1999: 772-773).

3.8. Training of staff

In South Africa, nurses initial training covers basic management of sexually transmitted infections, but does not include training in syndromic management, which is currently promoted as the most effective interim method for STI management in the absence of laboratory support (Mayhew, 2000: 154). Basic STI and HIV/AIDS care remains sub-optimal with many health workers who are unwilling to offer clients voluntary counselling and testing. Health workers have also received very little training and guidance around HIV care (Kenyon et al, 2001: 179)

Also the frequency and quality of counselling on STI risk, sexual behaviour and sexual negotiation varies within integrated services. According to Penxa and Blackie (1995), based on the report on a Port Elizabeth clinic, it was found that the consistency by which clients were counselled on STI/HIV transmission varied (WHO, 2002).

Kenyon et al (2001: 179) also claim that " a high turnover of staff within the [South African] health Sector and the concomitant loss of institutional memory does hamper progress in the implementation of integrated services, which can be regarded as one of the factors that are partly responsible for the persistent growth in HIV prevalence (7.6% to 24.5%)".

3.9. Lack of commitment/ consistency

The failure to mainstream/ implement the integrated approach to include HIV/AIDS can be attributed to the sense that the "status of HIV/ AIDS in National government departments is dropping constantly" (Kenyon et al, 2001:178). HIV units in all level of Government are becoming weak in terms of budgets, staff and status (Kenyon et al, 2001:178). At the district level, the level that is directly responsible for implementation, we find that "HIV/AIDS/STD co-ordinators still feel that they get little support from the other members of the health management team" (Kenyon et al, 2001:178). This is reflected in the fact that many STI coordinator posts in public clinics have not been filled.

3.10. HIV/STI services 'the added on services"

This leads to another obstacle to progressing in the implementation of the integrated approach, as experienced by various other countries around the globe, which is aptly put in the statement by a provincial HIV Directorate, " as long as HIV is viewed as an added priority, it is susceptible to being sidelined in budgeting and management. AIDS must be built into the core business of departments instead of competing with other priorities" (Hardee et al, 1994: s2-s9).

However the provision of comprehensive care and especially free curative care in South Africa has stretched capacity at health facilities making it difficult to prioritise activities of particular public health importance such as HIV/AIDS. This has also lead to a focus on clinical services at the expense of health promotion and counselling in some clinics (Lush et al, 1999: 773). Like the various other countries mentioned in the discussion, South Africa too has encountered obstacles and difficulties in relation to

the implementation of integrated service provision, which can be highly attributed to the lack in technical support (Lush et al, 1999).

"Reviews of Studies conducted in various countries, find mixed evidence for the coverage and efficacy of integrated services for sexually transmitted infections including HIV, with MCH/FP programmes, findings that emphasise the need for country specific approaches" (Mayhew, 2000: 156).

Failure of integration in sub-Saharan Africa to reduce HIV/STIs leads us to believe that perhaps the South African model of comprehensive primary care, with the inclusion of both HIV/STI management and MCH/FP is the better response (Lush, 1999: 775)

CHAPTER FOUR

METHODOLOGY

4.1. Introduction

This dissertation attempts, as outlined in the introduction, to determine if all the clients' reproductive health needs are being met when attending integrated services. Analysis will focus on the provision of STI/ HIV services to FP/ MCH clients. The aim is to determine the extent to which STI/HIV clients are provided with family planning information/advice. The overall quality of care received within integrated clinics will also be analysed.

4.2.The choice of the study population

4.2.1. KwaZulu-Natal Study Sites

Located on the country's eastern seaboard, KwaZulu- Natal is one of the most populous of South Africa's nine provinces, with approximately 8.4 million people. 53.15% of the population are female and 46.85% male (Department of Health, 2001). An amalgamation of the former African homeland of KwaZulu and the province of Natal, the population is predominantly rural and African, with Zulu being the main language (Maharaj, 2001: 250). According to the Department of Health and Population & Development (1998) a large percentage of the population is black (76%) and the highest fertility rate exists among black females. It is also important to take note that of those that attend public antenatal clinics, over 85% of them are Africans (Department of Health, 2001).

According to the National Department of Health, KwaZulu-Natal has the highest HIV prevalence at 32,5% (Department of Health, 2001). According to the Health Economics and HIV/AIDS research division (HEARD) the high incidence of HIV/AIDS in KwaZulu-Natal is due to the consequent effect of the high-risk situation currently experienced in KwaZulu-Natal. This includes not only the effects of past wars and injustices, but also the particular aspects of KwaZulu-Natal itself, such as the extensive truck routes and the existence of 2 large ports in KZN i.e. Durban and Richards Bay (Webb, 1994b cited in Gow & Desmond, 2002). According to Wawer et

al (1997) the epidemic spreads more quickly to and is most pervasive in areas surrounding heavily travelled roads, this is partly due to roads between large towns and cities attracting sex worker interaction with truckers and travellers. The migrant labour system in South Africa has caused a steady flow of HIV infected men into and out of the rural communities in which their wives and families are situated, and the urban areas in which they work. According to Wilkinson et al (1999b) prevalence levels in Hlabisa, a rural district in KwaZulu-Natal initially lagged behind the rest of the KwaZulu-Natal population (in terms of HIV infection) but appear to have caught up more recently (Gow & Desmond, 2002:32).

Culture and tradition also play a role in the spread of the virus. Suggested evidence now points out that male circumcision is a significant bio medical determinant of HIV incidence i.e. high circumcision rates correlate with low HIV prevalence levels (Gow & Desmond, 2002). According to Williams et al (2000a) circumcision levels were found to be lower among the Zulu (12%) when compared to Xhosa, Sotho and Tswana. Bearing this in mind and that predominantly Zulu people inhabit KZN, and we can partly explain the high prevalence of HIV in KwaZulu-Natal, relative to other provinces in South Africa. The above factors, combined with high levels of unemployment, poverty, urbanisation and high levels of male absenteeism lends more to the understanding of the high HIV infection and prevalence rates in KwaZulu-Natal (Gow & Desmond, 2002).

According to Dorrington, the combination of such factors within KZN, if unchecked will have a devastating impact on the province. In the next few years, deaths from HIV/AIDS will exceed all other causes of death combined. The impact of which will be amplified due to the concentration of deaths occurring in the productive age group. According to work done in KZN by professor Alan Smith, it was found that within the age group 15-19 HIV prevalence rates among women are generally higher than among men (43.3% to 17.3 % consecutively). It was also found that HIV prevalence among females' peaks in the younger age group of 25-29, whereas male prevalence peaks in the 35-39 year old age group (Gow & Desmond, 2002).

According to the South African Demographic and Health Survey report (1998), it was found that amongst females, the most widely used method of contraception is the

injection, followed by the pill and female sterilisation. Less than 2% of all women use the IUD, condom and male sterilisation. Contraceptive use within South Africa, is highest among currently married women and women in the 20-24 age group. It was also found that women within urban areas use contraception more so than women in non-urban settings. It is important to note that provincial differences in contraceptive prevalence rates are large. KZN has one of the lowest contraceptive prevalence rates in South Africa (SADHS, 1998: 46).

4.2.2. Kwa Dumisa Ugu, Kwa- Mashu and Ntuzuma Districts

The present study was conducted in one urban and one rural site in KwaZulu-Natal. Primarily Zulu speaking people of low socio economic status inhabit both sites. The rural site was the Kwa Dumisa Ugu district, which is approximately 80 km south west of Durban. Kwa Dumisa has been described as 'typical impoverished rural hinterlands throughout South Africa' (Maharaj, 2001: 250). For example many parts of the district are not readily accessible by public transport, and a large population of the households do not have access to electricity or piped water (Maharaj, 2001: 250).
Located in the Nothern part of Durban, is the predominant black township of Kwa Mashu. This urban township has a current population of 180298 people.
Ntuzuma's population was estimated in 1998 to be 103200 people, making up 0.24% of South Africa's total population (worldatlas.brinkster.net/asp).

4.3. Data Collection

The questionnaire was developed by a member of staff at the School of Development Studies (Pranitha Maharaj). Four health facilities were selected within each area.
Firstly ethical approval for the study was obtained from the University of Natal. After ethical approval was obtained, permission was obtained from the Department of Health. Thereafter appointments were made with staff at the health facilities. Clients were interviewed as they left the health facility (exit interviews). Each interview lasted approximately 20 minutes. A total of 300 subjects was attained to provide a substantial base for the assertions and to increase the applicability of the findings. The interviews took place during the period 24 Jan 2001 – 9 October 2001.

Interviewers were conducted with 100 FP clients, 100 MCH clients and 100 STI clients. Of the 100 FP clients, 50 were new and 50 revisit clients.

To satisfy the urban/ rural differential that exists in the provinces an equal sample of 150 rural and 150 urban clients were interviewed, of which were equally split among the different types of clients i.e. FP, MCH, and STI/HIV. Clients were categorised into MCH, FP and STI/HIV clients by analysing the clients' reason for visit. Clients attending the clinic for reasons such as child/baby illness, child immunisation, antenatal care and post natal were combined to form "MCH clients". Clients visiting for reasons related to STI management & HIV/AIDS testing and counselling were combined to form the category "STI/HIV clients". Table 1 below represents the manner in which the sample was selected.

Table 1. Sample selected for analysis

Types of clients	Rural	Urban	Total
FP	50	50	100
MCH	50	50	100
STI/HIV	50	50	100
Total	**150**	**150**	**300**

4.4. Methods of Statistical Analysis

The information obtained was captured using EPI information and the data was analysed using SPSS. Crosstabs and frequencies were run to obtain results.

4.5. Limitations of the study

The data captured on quality of care within the clinic was based on the client's perceptions of quality of care. It must be noted that clients' satisfaction may not necessarily mean that quality is good; it may only indicate that expectations are low. Courtesy bias means that the respondent provides information, which he feels, will please the interviewers (Joo, 1999). Within the study it would seem that one may be concerned of the underreporting of bad quality of care as clients may only say they are

satisfied with the quality of care because they want to please the interviewer, worry that care may be withheld in the future or have some cultural or other fear of complaining (Kols and Shermen 1998 in Creel et al 2002).

The data captured was not able to ascertain reasons for the client's method of choice, sexual practices, and partner dynamics experienced. By using qualitative methods such as in-depth interviews and focus group discussions the clients' perspective could be further explored.

CHAPTER 5

ANALYSIS AND RESULTS

5.1 Description of Sample

This chapter outlines the social and demographic background of the sample. The purpose of this chapter is to provide a context for the interpretation of findings in later chapters as well give some insight into the representativeness of the sample.

The sample consists of 300 men and women. Table 2 provides a breakdown of the number of male and female clients within our population sample. According to the results there are more female clients within our sample than male clients. This is not surprising given the fact that women are more likely to visit health facilities for the FP and MCH services available. Men are more likely to visit health facilities for STI services. It is thus not surprising that more than half of the STI/HIV clients were men.

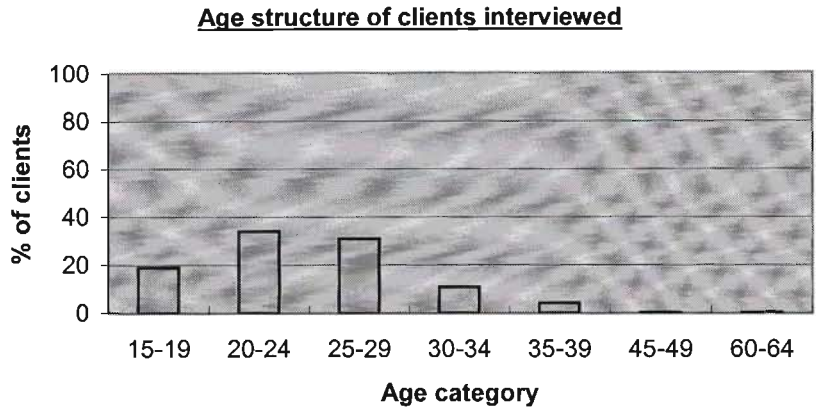
Table 2: Sex of clients

Sex	Total Number	Total %
Male	56	19
Female	244	81
Total	300	100

5.1.1. Age of clients

For analytical purposes a simple division of the sample into 5-year age categories was created. Figure 3 illustrates the age structure of the sample population. By region, the mean age in the rural area was 23.42 years, with a median age of 23. The mean age for the urban area was 26.03 and the median age was 25. Information obtained from men and women showed that most clients tended to be in the 20-24 age group. The age of the clients within the sample ranged from to 15 to 62 years. Bearing in mind that the qualifier for being interviewed is the fact that these clients are sexually active, the age of the clients is an important fact. Thus most of the sample consists of a very young sexually active population.

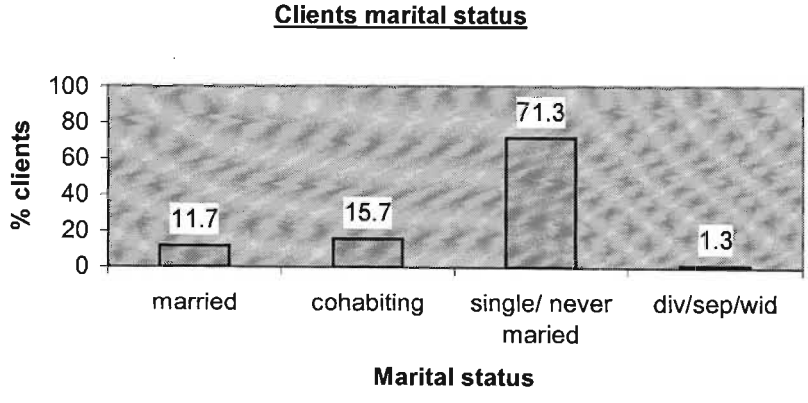
Figure 3: Age structure of clients within sample



5.1.2. Marital Status

At the time of the interview, 27% of respondents were either currently married or living with their partner, as shown in Figure 4. As might be expected, older men and women were more likely to be married or living with their partner. The overwhelming majority (71%) of the sample were not married. One specific effect of the cultural, social and political developments that occurred within the black population in South Africa is the relaxation of norms governing non-marital and extramarital sexual relations (Chimere-Dan, 1996).

Figure 4: Marital status of clients



5.1.3 Contraceptive use

Contraceptive use is high in the sample. Of the 300 clients interviewed, 212 said that they were using at least some method of contraception. However the choice of contraception is an important factor that requires attention. The most popular methods

were the injection, the pill and condoms. This is consistent with other studies, which found that hormonal contraceptives such as injectables and the pill were most commonly used (Myer et al cited in Berer, 2000: 165).

All clients within the sample are more than likely sexually active, or considering becoming sexually active as they are FP, MCH, or STI/ HIV clients. However 30% of all clients are not using any form of contraception. This may be partially explained by the fact that nearly 11% of the clients are currently pregnant and 4 % planning to have a child within 12 months. However the choice of not using any barrier method of contraception leaves them exposed to STIs including HIV. It is important to note that female sterilisation is relied upon as a contraceptive yet male sterilisation is not.

Table 3 provides a breakdown of the first method of contraception chosen by FP, MCH and STI/ HIV clients. Table 4 provides a breakdown of the second method of contraception mentioned by FP, MCH and STI/HIV clients. Tables 3 and 4 reveal that condom use is lowest among MCH clients and highest among FP clients. Overall only 18% of the STI/ HIV clientele reported using condoms as a first or second method of choice. Nearly 80% of all FP clients report using hormonal methods as their first choice of contraception, however their reliance on hormonal contraceptives leaves them exposed to possible STIs including HIV. Even after taking into account of the fact that condoms have been mentioned as a second method of contraception we find that this only brings condom use among all FP clients up to 28%. Only 51% of all STI/ HIV clients have reported using condoms as a first or second method of choice. Thus counselling on condom use especially within the South African context (i.e. high HIV and STI prevalence rates) is imperative. A few clients have reported using traditional methods. Traditional methods of contraception may leave clients vulnerable to the risks of STIs (including HIV).

Table 3: Method of choice by FP, MCH and STI/HIV clients

Method choice	FP (100)	MCH (100)	STI/HIV (100)	Total (300)
Pill	17	5	14	**36**
IUD	2			**2**
Injections	61	38	47	**146**
Implants				
Diaphragm/foam/jelly	1			**1**
Condom	8	3	6	**17**
Fem sterilisation		4	3	**7**
Male sterilisation				
Rhythm				
Withdrawal		3		**3**
Sporadic abstinence				
Other				

Table 4: Second Method of choice by FP, MCH and STI/HIV clients

Method choice	FP (100)	MCH (100)	STI/HIV (100)	Total (300)
Injections	3			**3**
Condom	20	2	12	**34**
Sporadic abstinence		1		**1**

* It was not specified if the second method of choice was used in conjunction with the first method of choice or not.

Table 5 provides a breakdown of the method of contraception chosen by male and female clients. Among men and women, the most popular method of contraception is the injection. The injection, pill as well as female sterilisation are female oriented and as a result, women may be able to use these methods without their partner's knowledge. According to Chimere Dan (1996) women may sometimes use a method without their partner's knowledge, especially if they perceive their partner as disapproving. It is indeed disturbing that very few men reported condom use. Men were more likely than women to report condom use.

When probing for contraceptive use, clients were offered the option of naming more than one method of contraception used, it was found that condoms were commonly mentioned as another method of contraception used. When analysing condom use amongst all clients it was found that even when condoms were mentioned as a second option, condom use among clients was only prevalent among 17% of all clients, most of which were urban, male clients. It should be noted that sometimes clients perceive the condom as a means of protection against disease rather than pregnancy. Sometimes women do not report their partner's method, and this may partially explain the reason for low condom use amongst females (Solo et al, 1999)

Table 5: Contraceptive Method choice by Sex

Method choice	Male %	Female %
Pill	18	16.8
IUD	0	1.2
Injection	66.7	69.4
Diaphragm/foam/jelly	0	0.6
Condom	12.8	6.9
Fem sterilisation	2.6	3.5
Withdrawal	0	1.7

Table 6: Second choice of Contraceptive method by sex

Method choice	Male (56)	Female (244)
Injection	0	3
Condom	6	28
Sporadic abstinence	0	1
Total	6	32

Table 7 illustrates the difference in contraceptive choice amongst all rural and urban clients. Within our sample we find that the hormonal contraceptives are popular amongst rural and urban clients. Within our sample it was found that rural female clients were more likely than their urban counterparts to use the withdrawal method. This may be a reflection of the partner dynamics within sexual intercourse and the level of information regarding safe sex among such clients.

Table 7: Urban vs. rural contraceptive first method choice

Method choice	Urban	Rural
Pill	9	27
IUD	1	1
Injection	83	63
Diaphragm/foam/jelly	1	0
Condom	11	6
Fem sterilisation	0	7
Withdrawal	0	3
None	45	43

5.2. Reaching clients through integration of STI/HIV services.

5.2.1 Integration of STI/ HIV/ FP IEC material

An important aim of integrating STI/HIV services into MCH/FP facilities is to inform and educate clients about STIs, including HIV. Thus most clinics provide IEC (Information, Education and Communication) materials, such as posters /pamphlets/ brochures etc that aim to warn clients of the risks associated with STI/HIV, promote self screening/ risk assessment and promote the use of preventative and curative practices (Walker, 2000).

Table 8 below provides a breakdown of the percentage of clients who have viewed specific FP, STI and HIV IEC material within the clinics analysed. We find that clients were more likely to report having seen IEC material on HIV and the sample of condoms while fewer clients reported having seen IEC material on FP and STIs.

Table 8: Clients who have seen FP/STI/HIV IEC material

IEC material	Percentage of Clients
FP pamphlets/brochures/posters or info	53
STI pamphlets/brochures/posters or info	47.6
HIV pamphlets/brochures/posters or info	68.7
Sample of condoms	63.7

Table 9 provides a breakdown of the type of clients i.e. FP, MCH & STI/HIV clients that had viewed the different IEC material available within the clinics. The table reveals that FP clients are more likely to report having seen IEC material on FP than on STI or HIV. Similarly STI/HIV clients are more likely to report having seen IEC material on STI and HIV material than on FP. Clients are also more likely to remember reading posters/ pamphlets related to condom use, safe sex practices etc, when their reason for visiting the clinic is related to STIs whereas FP clients are more concerned with methods of contraception (hormonal and barrier). It is important to take note that many FP and MCH clients visiting the clinic do report seeing both the STI material & HIV material.

Table 9: Number of MCH, FP and STI clients that viewed FP, STI & HIV IEC material including a sample of condoms

IEC Material (Pamphlets/poster/brochure/info)	Number of clients		
	FP (100)	MCH (100)	STI/HIV (100)
FP Material	70	51	38
STI Material	41	37	65
HIV Material	65	67	75
Sample of condoms	59	46	86

Table 10 below provides a breakdown of rural clients and urban clients who viewed FP, STI and HIV material including the sample of condoms. The level of exposure to IEC material varies between urban and rural clients. Urban clients are more likely

than rural clients to have been exposed to all types of IEC materials on FP, STIs and HIV. It is encouraging to observe that almost half of all clients reported having seen a sample of condoms.

Table 10: Rural vs. urban clients who viewed FP/STI/HIV IEC material

IEC Material (Pamphlets/poster/brochure/info)	RURAL (150)	URBAN (150)
FP Material	43 29%	106 71%
STI Material	42 28%	101 67%
HIV Material	87 58%	106 71%
Sample of condoms	85 57%	106 71%

Table 11 provides a breakdown of the percentage of all male clients and the percentage of all female clients that have viewed the various IEC materials available within the clinic. Women were more likely than men to report having seen IEC material on FP. It is important to bear in mind that all the males visiting the clinic are STI/HIV clients; this explains their greater exposure to IEC material of STIs and HIV/AIDS. Over half of all male clients were exposed to some IEC material on STIs and HIV/AIDS during their visit.

Table 11: Percent of Males and Females who viewed FP/STI/HIV IEC material

IEC Material (pamphlet/poster/brochure/info)	Male %	Female %
FP Material	20 %	61 %
STI Material	59 %	45 %
HIV Material	63 %	70 %
Sample of Condoms	88 %	58 %

Table 12 below represents the type of information (written material) given to clients attending the integrated clinic. Clients are rarely given written material to take home. Providers are not taking advantage of opportunity to use written material to counsel clients attending health facilities.

Table 12: No of clients receiving Written Material to take home

Subject of Written Material	Number of clients (300)
STIs	11
HIV/Aids	11
Child Nutrition	3
Other	1

Also, few clients were exposed to a group talk during their visit to the health facility. When clients were asked if they had attended a group talk it was found that only 54 of the 300 clients had had attended the group talk, of which only 13 clients had been informed of STI/HIV/AIDS.

5.2.2 Awareness and use of FP, MCH & STI/HIV services.

By integrating STI/HIV services within MCH/FP clinics we aim to reach more clients by making the larger community more aware of the STI/HIV services that are available at the clinic i.e. diagnosis, treatment, testing and counselling.

Table 13 represents the percent of clients that are aware of the various services available at the clinic. Clients are relatively well informed about the range of services at health facilities. However, clients are better informed about STI treatment than STI diagnostic services. Use of services is more limited. Although almost all clients were aware of FP services, only 64% of all clients have ever made use of FP services.

Also, nearly 64% of all clients are aware of STI diagnosis, however less than half of all clients have ever made use STI diagnosis services. Clients were more likely to have used STI treatment services.

Despite the availability of HIV services within these clinics we find that only 62,6% of all clients are aware of the availability of any of the HIV services, even then less than 10% of all clients have ever made use of any of the HIV services available. Table 14 represents the total percent of all clients that ever used the various services available. Despite many clients being aware of HIV testing very few clients reported having ever been tested for HIV. We thus find that only 15% of those clients that were aware of HIV testing had ever made use of the HIV testing services.

Table 13: Percent of clients who are aware of services available at facility

Aware of Services available	Percent of clients Aware of services
FP services	99
MCH services	98.4*
STI services	88.3*
STI diagnosis	63.7
STI treatment	90.4
HIV services	62.6*
HIV testing	59.7
HIV counselling	61.3

*Represents the percentage of all clients who were aware of at least one of the services available within each category of service in table 13.

Table 14: Percent of clients who make use of services available at facility

Services used	Percent clients that made use of service
FP services	64
MCH services	58.7*
STI services	45.7*
STI diagnosis	29
STI treatment	45.3
HIV services	9.7*
HIV testing	8.7
HIV counselling	9

* Represents the percentage of all clients who were aware of at least one of the services available within each category of service in table 14

Table 15 provides a breakdown of the FP, MCH, STI and HIV clients' knowledge and use of the various services available within integrated facilities. Table 15 reveals that knowledge of HIV services is generally low, even amongst STI/HIV clients (66%).

FP clients are more likely to have used FP services than MCH and STI/HIV clients. Similarly MCH services had been used by MCH clients more so than by FP and STI/HIV clients. STI/HIV services (though very low in use), were used more so by STI/HIV clients than all other types of clients.

Table 15: Awareness and Ever use of services available within facility by type of client i.e. FP, MCH & STI/HIV Client

Aware of services available	**FP (100)**	**MCH (100)**	**STI/HIV (100)**
FP services	100	100	97
MCH services	99	99	97
STI services	85	81	99
HIV service	60	62	66
Use of services available			
FP services	97	65	30
MCH services	51	98	27
STI services	26	18	93
HIV service	6	8	15

Table 16 illustrates the discrepancies that exist between rural and urban clients' knowledge of health services available within integrated facilities. We find that of those clients that are unaware of the provision of STI/HIV services, around 60- 63% seem to be found largely within rural clinics. Almost twice as many clients are unaware of HIV services in rural clinics than in urban clinics. It was found that within our sample of urban clinics HIV services don't seem to be as popular as STI services.

According to table 16 we find that within our sample few clients have ever made use of STI/HIV services. Among clients who did use STI services, it was found that most of these clients were found in urban clinics. STI *diagnosis* in particular, is used far more by clients in urban clinics than clients in rural clinics. However discrepancies of STI treatment among urban and rural clients are not as greatly significant. Within rural clinics, the use of STI treatment by clients is far greater than the use of STI diagnosis. Such discrepancies may be due to the fact that STIs may be more prevalent within urban areas than within rural areas, or as pointed to in table 16, clients in rural clinics are less aware of STI services.

Table 16: Rural vs. urban clients Awareness and Ever use of services within integrated facilities

Aware of services available	Rural (150)	Urban (150)
FP services	150 100%	147 98%
MCH services	149 99%	146 97%
STI services	128 85%	137 91%
HIV service	78 52%	110 73%
Use of services available		
FP services	95 63%	97 65%
MCH services	93 62%	83 55%
STI services	62 41%	75 50%
HIV service	16 11%	13 9%

5.3. Provision of STI/ HIV services to FP and MCH Clients

This section of analysis aims to explore the extent to which current FP and MCH clients are being, educated, screened and counselled about STI and HIV by providers during consultation.

Table 17 provides a breakdown of the STI/HIV services provided during consultation with FP and MCH clients within integrated programs. Overall few FP and MCH clients received STI/HIV services. STI screening activities are rarely undertaken at health facilities. However, MCH clients are more likely to be screened for STIs than FP clients. Risk assessment, though extremely low, occurred more often among MCH clients than among FP clients.

Providers do not actively promote condoms among FP and MCH clients. However, providers were more likely to mention condoms to FP clients than to MCH clients. This is probably because condoms may be used as a method of dual protection against pregnancy and STIs (including HIV/AIDS). Only one third of FP clients reported having been told by providers that condoms can be used in combination with other

methods. This meant that providers are missing important opportunities for promoting condom use as a method of dual protection against unwanted pregnancy and STIs. The condom is a highly effective method of protection against both risks, if used correctly and consistently (Myer et al cited in Berer, 2000: 166).

Less than 5% of FP clients and MCH clients were asked if they had any concerns about contracting an STI. Few clients reported receiving counselling on STI/HIV. This suggests that providers are missing opportunities to manage/ detect STI among FP and MCH clients. Providers also failed to ask many MCH and FP clients if they had discussed STIs with their partner. Moreover, few FP clients were asked about their sexual partners. MCH clients were more likely than FP clients to have received counselling.

Table 17: STI/HIV service provision among FP and MCH clients during consultation.

Did the service provider:	**FP (100)**	**MCH (100)**
Clinical		
Ask about vaginal discharge	6	12
Perform pelvic exam	0	5
Risk Assessment		
Discuss multiple partners	1	4
Ask whether your partner is likely to have more than one partner	1	1
Ask you if you had any concerns about getting an STI	5	5
Ask if you discussed STIs with your partner/ husband	5	2
Partner Notification		
Ask if your Partner is willing to receive treatment	2	1
Counselling		
Advise you to have lab test done	1	5
Mention anything about STIs	8	15
Mention anything about HIV	8	15
Mention condoms as method of contraception	28	1

Respondents were asked if they would have welcomed more information and counselling on STIs/HIV. As shown in Table 18, the majority of FP and MCH clients felt that they would have welcomed more information and counselling on STIs/HIV. Providers are missing opportunities for counselling FP and MCH clients on STIs/HIV.

Table 18: Satisfaction with STI/ HIV counselling among FP/ MCH clients

Do you feel you:	Rural (100)	Urban (100)
Do you need any more info on STI'/HIV/AIDS	81	82
Would you Welcome more info/advise on STI/HIV/AIDS	78	76

The service offered to urban and rural clients does vary somewhat. Table 19 illustrates the discrepancy in the treatment of rural and urban FP and MCH clients. Urban clients are more likely to be screened for STIs than rural clients. However, it is worth noting that only 4 of the rural clients were asked about symptoms of STIs. Urban clients are more likely to be counselled on STIs than rural clients. However, providers are more likely to mention condoms to clients visiting rural health facilities than clients visiting urban health facility.

Table 19: STI/HIV service provision within rural and urban clinics amongst FP and MCH clients during consultation with service provider.

Did the service provider:	Rural (100)	Urban (100)
Clinical		
Ask about vaginal discharge	4	14
Perform pelvic exam	0	5
Risk Assessment		
Discuss multiple partners	0	5
Ask whether your partner is likely to have more than one partner	0	2
Ask you if you had any concerns about getting an STI	0	10
Ask if you discussed STIs with your partner/ husband	1	6
Partner Notification		
Ask if your Partner is willing to receive treatment	1	2
Counselling		
Advise you to have lab test done	1	5
Mention anything about STIs	1	22
Mention anything about HIV	4	19
Mention condoms as method of contraception	19	10

Table 20 provides a breakdown of the satisfaction experienced with STI/HIV counselling among urban and rural clients attending integrated programmes. Urban clients were more likely to report that they needed more information on STIs/HIV. However, fewer urban than rural clients felt that they would have welcomed more information on STIs/HIV.

Table 20: Satisfaction with STI/ HIV counselling

Do you feel you:	Rural (100)	Urban (100)
Need any more info on STI/HIV/AIDS	65	98
Would have welcomed more info/advise on STI/HIV/AIDS	78	76

5.4 Provision of integrated services to STI/ HIV clients

5.4.1. Provision of STI/ HIV services to STI/HIV clients within integrated facilities.

Table 21 illustrates the provision of STI/HIV services to STI/HIV clients during consultation with provider. We find that the level of STI screening including risk assessment and counselling done by providers within the clinics analysed are low (table 21). Within our sample of STI/ HIV clients we found that only 2 of the 100 STI/HIV clients had a pelvic examination performed. We also find that only 16 STI/HIV clients were advised to have a laboratory test done. In most cases, STI clients were asked if they had a discharge. This is a less expensive and less time consuming way to screen clients, however less than 100% coverage is disappointing. It is also disappointing to know that within our sample many STI/ HIV clients were not told to refrain from sexual intercourse nor were all of them informed that condoms protect against STI/HIV infection.

Providers also failed to ensure that clients knew when they should return for a follow up visit. Over half of all of the STI/HIV clients, did not know when they should return (table 21). Although we find that more than half of all STI/HIV clients have not been told when to return, we have to bear in mind that perhaps, they don't require a follow up visit.

Table 21: Provision of STI/HIV services to STI/HIV clients

Did the service provider:	Rural (50)	Urban (50)	Total clients (100)
Screening			
Perform pelvic exam	1	1	2
Explain exam	1	1	2
Explain results	1	1	2
Advise to have lab test	2	14	16
Take specimen for test	12	0	12
Probe for discharge	37	40	77
Discuss multiple partners	17	28	45
Partner notification			
Advise you to bring partner for treatment	36	42	78
Partner is willing to receive treatment for an STI at this clinic	18	32	50
Counselling			
Tell you to refrain from sexual intercourse	2	36	38
Discuss condoms	46	35	81
Mention that condoms protects against STI/HIV	41	32	73
Told when to return for follow up	18	24	42

Table 22 provides a breakdown of the percentage of male and female STI/HIV clients who were provided with the various STI/HIV services. According to the analysis we find many more male clients were advised to have a lab test than females clients. However providers had taken more specimens for testing from female clients than from male clients. Probing for discharge and discussion for multiple partners were similar for male and females STI/HIV clients.

It is interesting to observe that providers were more likely to inform female clients to refrain from sexual intercourse than the male clients. This is probably because most of the providers are female and they may not feel comfortable discussing sexual matters with men. However providers are more likely to discuss condoms with male rather than female clients. This is hardly surprising since the condom is seen as a male method.

According to table 22, female STI/ HIV clients were more likely to be advised to bring in partner for treatment than male clients. Partner notification and treatment is an important part of the syndromic approach. However, not all clients were advised to bring their partner in for treatment. Males were more likely than females to report that

their partner would be willing to receive treatment for STIs. Almost 61% of males felt confident that their partner would attend the clinic to receive treatment, compared with 36% of women.

Table 22: Percent of male vs. female STI/HIV clients provided with STI/HIV services

Did the provider:	Percent of clients who answered yes	
	Males %	Females %
Screening		
Perform pelvic exam	0	4.5
Explain exam	0	100
Explain results	0	100
Advise to have lab test	21.4	9.1
Take specimen for test	8.9	15.9
Probe for discharge	82.1	70.5
Discuss multiple partners	44.6	45.5
Partner Notification		
Advise you to bring partner for treatment	75	81.8
Partner is willing to receive treatment for a STI at this clinic	60.7	36.4
Counselling		
Tell you to refrain from sexual intercourse	33.9	43.2
Discuss condoms	85.7	75
Mention that condoms protects against STI/HIV	76.8	68.2
Told when to return for follow up	33.9	52.3

Fewer clients were told when to return for a follow up visit. Table 23 shows that FP and MCH clients were more likely to be told when to return for a follow up visit than STI clients.

Table 23: Follow up visits among FP clients and STI/ HVI clients

Type of clients	Yes	No
FP clients (100)	95	5
STI/HIV clients (100)	42	58

5.4.2. Provision of FP services to STI/ HIV clients within integrated facilities

The aim of integration is to provide clients with a comprehensive range of services. It is therefore necessary to determine the extent to which STI/HIV clients are being provided with FP advice and information. Table 24 illustrates the number of STI/ HIV clients that were provided with FP services during consultation with a provider. According to table 24 we find that despite the integration of STI/HIV services within FP/MCH programs, providers did not provide STI/HIV clients with FP services. It is disappointing to note that only 4 STI/HIV clients had been asked if they had any concerns about using any method, and only 2 STI/HIV clients were asked if they had discussed FP methods with their partner.

Table 24: Provision of FP services to STI/HIV clients

Did the service provider:	STI/HIV clients (100)
Mention anything about Family planning	2
Ask if you wanted another child	2
Whether you wanted to rest/ space before having a/ another child	0
Ask whether you were interested in using Family planning	3
Ever used any method	9
Ask you if you had any concerns about using any method	4
Ask if you discussed FP methods with your partner/ husband	2
Mention any specific method of contraception	26
Mention condoms as a method of contraception	25

Not only do STI/HIV clients need to protect themselves against STIs but also against unwanted pregnancies. Table 25 represents STI/ HIV clients' satisfaction with FP services within integrated service provision. Over half of all STI/HIV clients reported that they needed and would have welcomed information on FP. Providers are missing important opportunities for providing STI clients with FP information and counselling.

Table 25: Satisfaction with FP counselling

Do you feel you:	STI/HIV clients (100)
Need any more info/ advice on FP	63
Would have welcomed more info/advise on FP	63

5.5 Overall quality of care.

Table 26 provides a breakdown of FP, MCH and STI/ HIV client's perception of the quality of care they received at health facilities. Table 26 reveals that FP clients expressed higher levels of satisfaction with the quality of services than MCH and STI clients.

The majority of clients rated the staff as friendly and helpful. Bearing in mind the high staff load and the difficult environment in which providers work, the above results seem fairly good. From table 26 we find that clients rated the quality of information relayed by services providers as being adequate and good. However, clients expressed less favourable attitudes towards interpersonal relations with providers.

Overall, almost three-fifths of clients felt that they received good quality of care. However, it is worth noting that almost one-fourth of clients felt that they did not.
Privacy and time are key factors in getting clients to open up and be truthful of their sexual experiences. Table 26 shows that more than two-fifths of clients felt that there was not sufficient time to ask question. Moreover, almost 22 percent felt that there was insufficient privacy during their consultation. In addition, one third of clients felt that it was difficult to talk about their sexual life. It is therefore not surprising that a substantial proportion of clients felt that they would see a traditional healer if they had a STI.

Table 26: Perceived quality of care among clients attending integrated facilities

Quality of care aspects	Agree with the statement			
	FP (100)	MCH (100)	STI (100)	Total (%)
Staff courtesy				
Staff are friendly	92	79	61	77.3
Staff are helpful	86	83	68	79
Staff treat clients with respect	86	74	60	73.3
Staff provision of information				
Staff difficult to understand	*9*	*22*	*26*	*19*
Staff provided information	77	71	65	71
Provided with all info wanted during consult	60	62	44	55.3
Staff answered all Q to my Satisfaction	48	52	38	46
Staff gave me opportunity to ask questions	31	42	35	36
Staff usually too busy to answer questions	*39*	*43*	*46*	*42.7*
Quality of facility/service				
Insufficient time for client to ask questions	*42*	*38*	*56*	*45.3*
Insufficient privacy during consultation	*20*	*22*	*25*	*22.3*
Waiting time for consultation was reasonable	51	40	39	43.3
I find it difficult talking to staff about sexual life	*25*	*33*	*43*	*33.7*
Overall quality of care				
Came away from clinic receiving good quality of care	69	65	48	60.7
If I thought I had an STI I would first go to the traditional healer	*2*	*8*	*16*	*8.7*

Table 27 below represents the quality of care experienced by male and female STI/ HIV clients only According to Agarwal et al male clients may in fact feel "intimidated in the presence a large number of women attending regular family planning clinics", this is supported by the findings within our study whereby when compared to women, more males felt they did not have sufficient privacy and confidentiality.

Table 27: Quality of care amongst male and female STI/ HIV clients

Quality of care	Male %	Female %
Insufficient privacy during consultation	35.7	11.4

Find it difficult talking to staff about sexual life	53.6	29.5

CHAPTER SIX

DISCUSSION

6.1 IEC Material within integrated facilities

The integration of STI/HIV services within MCH/FP programs entails the inclusion of STI/HIV Information/ education and communication material within MCH/FP clinics. Viewing of FP/STI/HIV material including condoms is an important component to preventing the transmission of STIs including HIV, as well as pregnancy prevention. Provision of FP/STI/HIV IEC material in terms of pamphlets, brochures, posters and the sample of condoms are also an important component in the promotion of health care seeking behaviour. Health care seeking behaviour is promoted by raising awareness of potential signs and symptoms of STIs/ HIV, and the availability of STI/HIV services (Dehne & Snow, 1999).

Condom promotion, through the provision of free condom samples is a key STI/HIV prevention strategy. Within the study it was found that urban clients were more likely to report having seen a sample of condoms than rural clients. Moreover, clients attending urban clinics were more likely to have been exposed to IEC material on FP, STIs and HIV/AIDS than clients in rural clinics. The low viewing of STI and HIV posters / pamphlets and brochures, and specifically within the rural clinics can be a result of numerous factors such as literacy level of clients, the language in which the material was printed in and the location of the material etc (Dehne & Snow, 1999) It is important that programmes take these factors into consideration when trying to improve the IEC material. The results also show that clients have a great tendency to report having seen material that is directly related to their reason for the visit to the health facility. As a result, STI clients were more likely to report exposure to STI material.

6.2. Awareness and ever use of services available within integrated facilities

Clients are aware of the range of services that are offered at health facilities. Most clients seemed to be aware of the availability of FP and MCH services. However, fewer FP and MCH clients were aware of STI services. Early diagnosis and treatment of STIs is important in order to curb the further spread of HIV/AIDS. Also, awareness

of HIV testing services is relatively low within the study. This is particularly disturbing given the fact that more than three-quarters of clients perceive themselves at risk of HIV infection.

We also found that many FP and MCH clients had not ever made use of any of the STI diagnosis and HIV testing services available within the clinic, despite being aware of their availability. Thus the importance of testing and diagnosing of STIs including HIV, among FP and MCH clients in particular have not been sufficiently stressed upon.

6.3. Provision of STI/HIV services to FP and MCH clients

Integration of STI/HIV services into FP/MCH programmes can and in many instances does increase the number of FP and MCH clients that use STI/HIV services. After screening clients for a broad range of needs, providers within integrated facilities can encourage FP/MCH clients to receive other services for e.g. advising FP clients about STI services or offering contraception to women seeking postnatal care (Lush, 1997). Risk assessment can potentially address the problem of missing women who are asyptomatic i.e. women who have neither signs nor symptoms of an STI (Solo et al, 1999).

However within the clinics analysed it was found that the integration of STI/HIV services within MCH/FP programmes did not lead to greater provision of STI/HIV services, i.e. counselling, screening including risk assessment and partner notification, by providers to FP and MCH clients.

There existed a clear lack of commitment and consistency among providers in providing MCH and FP clients with STI/HIV activities. In South Africa, nurses initial training covers basic management of STIs but does not include training in syndromic management, which is currently promoted as the most effective interim method for STI management in the absence of laboratory support (Mayhew et al, 2000: 154).

The present study found that providers rarely screen clients for STIs, a finding similar to that observed in Ghana, Kenya and Zambia (Mayhew et al, 2000: 158). According to Askew and Maggwa (2000), such lack of commitment to screen and educate FP and MCH clients for and about STIs including HIV can result in missing the opportunity to prevent FP and MCH clients from contracting an STI or detecting if the

client already has an STI. It may thus result in missing pregnant clients who are at risk to contracting an STI or already have an STI. STI infections among pregnant women can result in adverse fetal outcomes, including death, if not treated early (Askew and Maggwa, 2000: 630).

By neglecting to inform MCH clients of the benefits of condom use, as found within the sample, and failing to mention that it is the most effective form of protection against STIs including HIV, leaves many FP, MCH and STI /HIV clients unaware of the importance of dual method use and/ or dual protection.

According to Hardee et al the lack of commitment and consistency in the provision of STI/HIV services amongst FP and MCH clients can be attributed to the lack of training, work overload and the fact that the process is time consuming (2000). However a study in Zimbabwe that included a time motion study of providers showed that risk assessment took very little time, and so was not a significant burden on providers (Marangwanda et al, 1999 in Solo et al, 1999). According to Mayhew (2000) many FP and MCH providers continue to focus on FP and MCH guidelines without integrating STI/HIV activities. According to studies undertaken in Kenya and Zimbabwe it was found that providers made numerous lapses in following the standardised screening and risk assessment procedures (despite the presence of a checklist) (Askew et al, 2000: 80).

From the analysis, we find that providers seem to be lacking a client focus and merely provide clients with the services that they feel the client needs. Clients in urban area have a greater likelihood of being counselled and screened for STIs than clients in the rural area. This may be attributed to the provider's inability to communicate with rural clients on issues relating to STIs. It may also be that social and cultural barriers that are heavily indented within the rural community prevent providers from communicating STI/HIV messages. Within the study it was found that providers have a tendency to screen MCH clients more often than FP clients. Studies in Ghana found that standardised protocols for integration are frequently adapted to suit the way in which individual providers feel most comfortable offering these services (Askew et al, 2000, 80).

Findings within the study were similar to that of Dehne et al whereby syphilis screening and pelvic examinations were more commonly done on MCH clients than with FP clients (Dehne, 2000: 630). Mayhew et al (2000) acknowledges that particularly poor levels of STI/HIV integration activity are apparent within FP services, which have, thus far, been considered the most appropriate services to target clients. A multi-country study found that antenatal services, in contrast with FP services, reach more than 80% of women at some point during each pregnancy. Relatively high rates of screening during antenatal care (albeit performed for syphilis) indicate a major window of opportunity for improving STI management if it is linked with antenatal services (DeGraft Johnson, 1995 & S.A. Health dept 1997 &1998 in Mayhew, 2000: 160).

Despite FP clients being sexually active or contemplating becoming sexually active, within a dangerous sexual environment (highest HIV prevalence rate found in KZN), only 28 of the 100 FP clients had received or been told of condoms as a method of contraception. The inability of providers to at least mention condom use means that many clients remain unaware of the advantages of dual protection and /or dual method use.

The overall quality of counselling cannot be regarded as being as efficient as many of the FP and MCH clients claimed they needed and would have welcomed more information on STI/ HIV. This tells us there is a need for more information on STI/ HIV. When analysing clients need for more information and advise regarding STIs including HIV, it was found that more clients within the rural clinics did not feel a need for more information as compared to urban clients, despite not being informed of STIs. This is an indication that perhaps clients' satisfaction may not necessarily mean that quality is good, it may only indicate that expectations are low.

6.4. Provision of STI/HIV services to STI/HIV clients

Within the study, STI/HIV clients are rarely provided with a comprehensive range of services during their visit to the health facility. Providers often do not undertake many of the STI management activities that are recommended to treat STIs more effectively. Providers often do not advise clients to have a laboratory test performed.

Of course, it should be borne in mind that laboratory tests are expensive, and most clinics are not equipped nor do they have the funds to pay for a laboratory test, this is not unusual (Hardee et al, 1994). The syndromic management approach is an important component of integrated services and has an important role to play in the management of STIs in resource poor settings such as South Africa, particularly rural clinics.

However within our sample it was found that service providers failed to follow syndromic management guideline, i.e. screening including risk assessment, partner notification and counselling. In their study in Kenya, Solo et al (1999) found that providers were often unable to conduct routine counselling and screening of STIs because they are not given written guidelines and checklists to assist them in carrying out risk assessment. Moreover providers often do not have enough time to screen clients because of the large caseloads (Solo et al, 1999).

Condom promotion is a key strategy of integrated services but clients are rarely counselled on condoms. Bearing in mind the low use of condoms amongst STI clients and the fact that they are visiting the clinic for STI/ HIV services it seems imperative that part of the counselling should include condom use. STI/HIV clients are the primary target group for condom awareness and education as it is a means by which providers can curb the infection rate, as condoms can prevent STI/HIV clients from passing on the infection. It is important that these clients' protect themselves by ensuring they stay healthy and are not reinfected. By neglecting to inform STI clients of the benefits of condom use, provides are also failing to inform STI clients of ways to protect their partners.

Within the study it was found that not only did providers fail to inform all STI clients of the importance of condoms but many providers also neglected to inform STI clients to refrain from sexual intercourse. Given the high level of HIV infection it is imperative that providers inform clients of the importance of the condom and the need for STI clients to refrain from sex (Flemming & Wasserheit, 1999: 3-17).

It is also imperative that providers undertake partner notification in order to curb the further spread of HIV infection. However, many clients do not inform their partners

because they are afraid of their partner's reaction. Other studies have also found that women do not tell their partner that they have a STI because they are afraid of being accused of infidelity or subject to physical violence (Dehne et al, 2000: 630). Bearing in mind that female clients are uncertain about the willingness of their partners to come to the clinic for STI treatment it would seem that providing STI clients with ways to protect themselves against STIs (counselling) is of vital importance.

Notable disparities were observed between urban and rural clients. Clients in urban areas are more likely to be screened for STIs than clients in rural areas. This may be due to the social and cultural barriers that are heavily indented within the rural community that prevent providers from communicating STI/HIV messages. It is also possible that providers do not have clear guidelines to assist them in managing STIs. In Ghana, Mayhew (2000) found that health workers in rural areas have a certain status relative to their patients, which resulted in them treating women, especially rural uneducated women, disparagingly (Mayhew, 2000: 118). Also, some health professionals may not be able to communicate in the local language and as a result, important STI/ HIV education messages are not communicated to clients (Mayhew, 2000: 118).

6.5. Provision of FP services to STI/HIV clients

Clients of integrated services have the right to make an informed choice by being given information in order to protect themselves against the risks of unwanted pregnancy and STIs including HIV/ AIDS. Thus the provision of specific FP services, such as counselling to STI clients is essential. However within our sample of clients it was found that providers failed to provide STI clients with information about family planning. Despite these clients being sexually active and already coming to the clinic for reasons related to STIs we find that providers have failed to address any concerns STI/HIV clients may be having in terms of their choice of contraception or their ability to negotiate contraceptive use with partners. Thus most STI clients within our sample felt they needed more information on family planning.

6.6. Quality of care within integrated facilities

As pointed out by Hardee (1994) and Mayhew (2000), the inclusion of STI/HIV services within MCH/FP programmes can overburden the health facility and health workers to such an extent that it leads to a decline in the quality of care among all clients. Among the clinics analysed within this study we find that there exists inefficient care and treatment of clients.

Privacy and time are key factors in helping providers develop a rapport with clients, to make the client trust the provider, feel that he/ she is receiving good treatment and that the provider cares about the health of the client. However within the sample analysed it was found that many clients particularly STI/ HIV clients felt that there was a general lack of time and privacy, which would thus mean providers are unable to gauge client's knowledge, fears and needs regarding STI/ HIV information (Walker 1999; Baakile et al, 1996; Mukaire et al, 1997 in Dehne & Snow, 1999).

Despite having already had a consultation visit with providers (these were exit interviews), many clients were willing to first see a traditional healer if they had an STI (almost 20%). This reveals that many clients were not convinced that services providers/clinics were the first and most appropriate choice to seek health care. Bearing in mind that STIs are curable infections, if diagnosed early enough, it is imperative that clients are educated about the risks and dangers of STIs as well as what can be done medically to treat it. This also requires an understanding of the social and cultural context within South Africa that affects clients' knowledge and perceptions/ attitudes towards medical care as well as clients' belief in traditional healing. Counselling using the clients centred approach ensures that clients are informed of the risks associated with STIs as well as the various preventative and curative services available within the clinic. However government and various NGO's and institutions within South Africa have pointed to the potential advantages of creating partnerships/ collaborations with traditional healers. Rather than being in competition with traditional healers for clients, traditional healers can be educated and trained in various health service provision activity to ensure that people's health will not deteriorate by seeking help from a traditional healer, but rather seen as a means to reach more clients.

Within the study it would seem that one may be concerned of the underreporting of bad quality of care as clients may only say they are satisfied with the quality of care because they want to please the interviewer, worry that care may be withheld in the future or have some cultural or other fear of complaining thus the results above that indicate a low quality of care may in fact be lower (Kols and Shermen 1998 in Creel et al 2002).

It is imperative to address clients perspective on quality of care, since it leads to improved client satisfaction, continued and sustained use of services and improved health outcome (Bertrand et al 1995 cited in Creel et al 2002).

CHAPTER SEVEN

CONCLUSIONS AND RECOMENDATIONS

The aim of this dissertation was to draw attention to the importance of and challenges in offering integrated services, particularly within KwaZulu-Natal. The following 4 questions were used as a basis to obtaining responses that culminated in the data grouped into 4 themes that were analysed in detail in chapter 5.

The 4 themes posed were:

i. Are more clients being reached/ made aware of FP/STI/HIV services through the integration of STI/HIV services within FP/ MCH programs?

ii. Are FP and MCH clients provided with STI/HIV services during their consultation with the service providers?

iii. Are STI/HIV clients being provided with proper FP/STI/HIV services within integrated facilities?

iv. Are clients satisfied with the quality of care received at the facilities visited?

7.1. Conclusions

According to the results gained from the analysis we find that services are not fully integrated. Health facilities are missing important opportunities for reaching clients.

It was found within the study, that most clients have a tendency to view material that is directly related to their reason of visit, thus STI and HIV material, including the sample of condoms, is most seen by STI/HIV clients. This is not to say that the provision and existence of STI/HIV material including the sample of condoms was unnoticed by FP and MCH clients, however it was predominantly low. However the purpose of integrating STI/HIV IEC material into FP/MCH is not only to reach possible STI/HIV clients by promoting health care seeking behaviour but also to inform the general clientele of the signs, symptoms and risks associated with STI's including HIV and to promote preventative behaviour. Bearing in mind the minimal effort and cost associated with incorporating STI/HIV material within facilities and the fact that STI/HIV infection levels within South Africa are high it seems reasonable that facilities should continue to integrate STI/ HIV IEC material, including the sample of condoms within FP/MCH facilities.

According the study it was found that many FP and MCH clients are unaware of all STI services available within the clinics and even more are unaware of availability of HIV services. Even fewer have ever made use of the STI/ HIV services that are available. This is not to say that FP and MCH clients have never used STI/ HIV services, which they have, but rather that activities where all clients are made aware of the availability of the STI/HIV services and the importance of using such services should be carried out. STIs are curable, provided they are diagnosed and treated early it. Bearing this in mind early diagnosis and treatment through early use of STI/ HIV testing and diagnosing services is of vital importance to bringing down STI/ HIV infection and prevalence levels in South Africa (Lush et al, 2000).

Despite South Africa's policies and recommendations in terms of integrated service provision i.e. the formal integration of STI/HIV activities within MCH/FP programmes, providers failed to consistently provide STI/HIV screening including risk assessment, partner notification and counselling to MCH and FP clients. According to the results within the study we found that rather than adopting a client centred approach to providing clients with integrated services i.e. providing the clients with all necessary reproductive health services, providers tended to provide FP/ MCH clients with the services they believed the client needed. Thus many FP and MCH clients had not been provided with the various STI/ HIV services available.

Overall it was found that not only was the goal of counselling and screening FP and MCH clients not being met, but that the added burden of attempting to integrate such screening and counselling may overburden providers in their responsibilities and resulting in the low overall quality of care among FP/ MCH clients within integrated clinics. It was found that STI/ HIV clients also experienced less than satisfactory service provision within integrated clinics. Perhaps quantity of services is being traded for quality of service provision. According Dehne et al (2000) the integration of more services i.e., STI/HIV services in an already burdened facility, whereby service providers already have a high case load, may lead to the overall quality of care within the clinics analysed being less than satisfactory. Thus as suggested by Agarwal et al (2002), rather than integrating all STI/HIV services within FP/ MCH programmes, integration should be confined to condom provision & promotion and

counselling. However even as so far as condom provision and STI/ HIV counselling among FP and MCH clients is concerned, it was found that within the study providers failed to consistently provide even these services to FP and MCH clients.

Service providers are expected to be screens for patients, thus the effectiveness of screening greatly depends on the provider- client interaction. Bearing in mind that the screening is entirely verbal and no physical examination occurs, it is imperative that the provider follows the guidelines provided by the health department, to ensure that the client is provided with the necessary treatment, counselling and care (Mayhew, 2000: 115). However within the study it was found that the level of service provision in terms of screening including risk assessment, partner notification and counselling, received by STI/ HIV clients attending integrated services was low. Despite attending integrated facilities we find that STI/ HIV clients had also not been provided with the necessary FP counselling that should be made available during consultation with service providers.

According to the results of this study it was found that the viewing of STI/HIV/FP IEC material including condoms by men within integrated facilities is limited to men already coming in for STI/HIV services. Thus according to Askew et al (2002), the integration of STI/HIV services within MCH/ FP programs is merely the easier option taken by National government and NGOs and donors in an effort to bring down STI/HIV levels, as they are wary of delving into a new arena of reaching new clientele, which are the high transmitter groups of males, single women and sex workers. According to Agarwal et al (2002) it is suggested that FP clients may not be at a disproportionately high risk for HIV and other STIs and that high risks groups such as males and young people may not be disposed to seek services at family planning sites. Thus the integration of STI/HIV services within FP/ MCH facilities are not likely to increase clientele for STI/ HIV service provision, and therefore not likely to make a significant impact in reducing infection and prevalence levels within the country.

Overall it was found that generally the frequency of STI/ HIV screening including risk assessment, partner notification and counselling was higher within urban clinics than in rural clinics, despite the need to follow syndromic management guidelines,

particularly within resource poor rural settings. According to Mayhew et al (2000) such discrepancies in the treatment of rural and urban clients may be a reflection of the differences that exist between providers and clients, in terms of status, knowledge and language. The deeply embedded traditional/cultural/ social norms may also inhibit the providers' ability to discuss sexual issues more frequently with rural clients.

7.2. Recommendations

Integrated service provision has the potential to meet all the clients reproductive health needs, however the application of such service provision has thus far not been successfully achieved. Thus the following recommendations have been made:

- Improve Information Education and Communication material for STIs including HIV by ensuring that such material is available in the indigenous language of the clients; also make use of diagrams to assist the reader in understanding the message conveyed. IEC materials must be explicit about new and existing project services so that clients are fully aware of the services offered.

- Promote a Primary Prevention strategy that involves promoting safe and responsible sexual behaviour in couples, ensuring that they have the knowledge to protect themselves from STIs including HIV as well as personal skills and access to condoms so that they can act on their knowledge.

- According to studies in Kenya, Zimbabwe and Latin America it was found that the use of a structured checklist to guide providers through an integrated consultation, seems to improve their ability to convey integrated messages. Clients not only received FP information, but also were educated on a range of STI related issues and had their risk assessed (Skew et al, 2002; 8). Thus we should encourage the use of integrated and standardised checklists in the provision of FP, MCH and STI/ HIV services.

- For the provision of STI/ HIV services to STI/ HIV services in terms of syndromic management, clear service protocols and guidelines are necessary

for successful diagnosis and treatment of STIs including HIV. However such guidelines are not always disseminated amongst all providers. Thus a comprehensive monitoring and evaluation plan, that will ensure checklists are followed, needs to be developed.

- Concrete guidelines in terms of National and Local policy for the promotion of dual protection as a part of primary care services, should be put in place to address the high STI/ HIV prevalence rates in South Africa.

- There is a need to improve financial resources, strengthening human resources and addressing socio cultural issues (gender biases) that may impede service delivery and the achievement of good reproductive health.

- The kind of information needed for an integrated approach should be built in the requirement of record keeping and reporting (Shierhout & Fonn, 1999: 35).

- Ensure that the curriculum for service providers includes training in Syndromic management and ongoing training of all health care workers in existing programs and for the implementation of integrated services.

- Ensure that effective monitoring and evaluation tools are put in place to ensure that providers integrate STI/HIV screening and risk assessment within MCH/FP programmes.

- The promotion of current and new reproductive health choices, such as the female condom, vaginal microbicides and male hormonal contraception, have the potential to rearrange the gender specific obstacles to use of contraceptives and barriers methods by giving partners of both sexes a range of options through which to achieve dual protection (Myer et al, 2002: 120).

- Put in place effective Monitoring, accreditation systems and Supervision systems, which enable managers and inspectors to determine which providers, and facilities meet minimum standards of care, and assesses the performance of staff members and identify areas that need attention. Monitoring visits

should be seen as mutually beneficial for the implementing agencies to assess their performance and seek corrective measures and for government to formulate appropriate policy.

- Encourage discussions of sexual health and reproductive decision making within communities in a way that helps to empower women, and reaches high risk groups within the community.

REFERENCES

Askew, I. & Maggwa, N.B. (2002). "Integration of STI Prevention and Management with Family Planning and Antenatal Care in Sub Saharan Africa- What more do we need to know?" *International Family Planning Perspectives.* 28 (2), 77- 85.

Barnett, T. & Whiteside, A. (2002) "AIDS in the Twenty First Century: Disease and Globalisation". New York: Palgrave Macmillan Ltd.

Berer, M. (2000). "HIV/Aids: Sexual and Reproductive health at AIDS 2000, Durban" *Reproductive Health Matters: Reproductive Rights, Advocacy and changing the law.* 8(16), 160-180.

Caldwell, J.C. & Caldwell, P. (2002). "Is integration the answer for Africa?" *International Family Planning Perspectives.* 28 (2) 108- 110.

Chetty, E. (2002). " Combating AIDS/HIV spread in the workplace: A case study of the Durban Clothing Industry". Unpublished Masters Dissertation. Durban: University of Natal Press.

Creel, L.C., Sass, J.V. & Yinger, N.V. (2002). " Client-centred Quality: clients perspectives and Barriers to receiving Care" Population Council and Population Reference Bureau Brief no2. Washington: Population Council.

Creel, L.C., Sass, J.V. & Yinger, N.V. (2002). " Overview of quality of care in Reproductive Health: Definitions and Measurements of Quality" Population Council and Population Reference Bureau Brief No 1. Washington: Population Council.

Chimere-Dan, O. (1996). "Contraceptive Prevalence in Rural South Africa" *International Family Planning Perspectives,* 22 (1).

Dehne, K and Snow, R. (1999). "Integrating STI management into FP Services: What are the benefits" WHO/ RHR/ 99.10, Geneva: World Health Organisation. www.who.int/reproductive-health/ publications/RHR

Dehne, K.L., Snow, P. & O' Reilly, K.R. (2000). "Integration of prevention and care of sexually transmitted infections with family planning services: What is the evidence for public health benefits?" *Bulletin of World Health Organisation.* 78 (5), 628- 639.

Department of Health (2002). "National HIV and Syphilis Sero-Prevalence Survey of women attending Public Antenatal Clinics in South Africa". Pretoria: Government.

Department of Health (2000). "HIV/ AIDS/ STD Strategic plan for South Africa 2000-2005". Pretoria: Government Printers.

Dwala, S.E. (2000). "Reproductive rights of Egyptian Women: Issues for debate" in *Reproductive Health matters: Reproductive Rights, Advocacy and changing the Law.* 8 (16), 45-53.

Engender Health Organisation (undated). "Preventing STIs/ RTI's: Key elements of Integrated Family Planning, STI/ HIV prevention Counselling" Engenderhealth www.Engenderhealth.org/res/onc/sti/preventing/sti6p10.html. downloaded 25/08/2002.

Flemming, D.T. & Wasserheit, J. (1999) From Epidemiology synergy to public health policy and practice: the contribution of other sexually transmitted diseases to sexual transmission of HIV infection" *Sexually Transmitted Infection* (75) 3-17.

Fleischman Foreit, KG., Hardee, K. & Agarwal, K. (2002). " When Does it Make Sense to Consider Integrating STI And HIV Services with Family Planning Services?" *International Family Planning Perspectives* (28) 2, 105-107.

Garnett, G.P., Grassly, N. & Gregson, S. (2001). "Aids: The Making of a Development Disaster?" *Journal of International development* (13) 391-409.

Gow, J. & Desmond, C. (2002). "Impacts and Interventions: The HIV/AIDS Epidemic and the children of South Africa" Durban: University of Natal Press.

Hardee, K., Agarwal, K., Luke, N., Wilson, E., Pendzich, M., Farrell, M. & Cross, H., (1994). "Reproductive Health Policies and Programs in Eight Countries: Progress Since Cairo" *International Family Planning Perspectives*, 25, S2-S9.

Joo, D.J. (1999). "Doing Social Research in Developing Countries" A Book Review on Martin Bulmer and Donald P. Warwick (eds.) *Social Research in Developing Countries: Surveys and Censuses in the Third World*, London: UCL Press.

Kenyon, C., Heywood, M. & Conway, S. (2001). "Mainstreaming HIV/AIDS: Progress and Challenges" in South African Health Review. Eds Ntuli, A., Suleman, F., Barron, P. & McCoy, D. The Press Gang, Durban.

KwaZulu- Natal Department of Health (2000). " An AIDS free KZN by 2020- Strategic Framework". Pretoria: Government Printers.

Lush, L. (2000). "Integrating HIV/STD and Primary Health Care Services: International Policy Developments and National responses with special reference to South Africa" 144-177, University of London.

Lush, L. (2002a). "Service integration: An overview of Policy developments" *International Family Planning Perspectives,* 28 (2). http://www.guttmacher.org/pubs/journals/2807102.html Downloaded 13/01/2003

Lush, L. (1997). "Barriers and opportunities to Integrated Reproductive Health Services" *Paper prepared for the General Conference of the International Union for the scientific study of Population, Beijing*. www.lshtm.ac.uk/eph/dfid/80.htm. Downloaded 20/04/2002.

Lush, L. & Mayhew, S. (1999)."Triumph of Politics over Science" Insights Issue (32). www.id21.org/insights32/insights-iss32-art02.html Downloaded 08/08/2002.

Lush, L., Mayhew, S., Cleland, J., & Walt, G. (1999). Integrated reproductive health: Myth And Ideology, *Bulletin of World Health Organisation,* 77 (9), 771-777.

Maharaj, P. (2001). Male Attitudes to Family Planning in the Era of HIV/AIDS: Evidence from KwaZulu- Natal, South Africa. *Journal of Southern African Studies*. 27 (2), 245-257.

Mayhew, S. H., Lush, L., Cleland, J., & Walt, G. (2000). "Implementing the Integration of Component Services for Reproductive Health" in *Studies in Family Planning*, 31 (2), 151-162.

Mayhew, S.H. (1996). "Integrating STD/ HIV and MCH/ HIV services: Current Debates and Future Direction" Health Policy and Planning 11 (4) 339-353.

Mayhew, S.H. (2000). "Integration of STI services into FP/MCH services: Health services and Social contexts in Rural Ghana" in *Reproductive Health matters: reproductive rights, Advocacy and changing the law,* 8 (16) 112-122.

Mcintosh, C.A. & Finkle, J.L. (1995). " The Cairo Conference on Population and Development: A New Paradigm" *Population and Development Review,* 21 (2) 223-260.

Myer, L., Mathews.C, Little, F. & Abdool Karim S. (2001). "The Fate of Male Condoms Distributed to the Public in South Africa, AIDS 2001" 15, 789-793 in Mainstreaming HIV/ AIDS in S.A. Durban: Lippincott Williams & Wilkin.

Myer, L., Morronni, C., Matthews, C. & Little, F. (2002). "Dual Method use in South Africa" *International Family Planning Perspectives,* 28(2) 119-121.

NGO Networks (2001)."Delivering Integrated FP/ HIV/ STI Services: Achieving more together" NGO Netowoks: Zambia www.ngonetworks.org/pubs/technical.html

Owen, P. (1995). "District Health Systems Development" South African Health Review. Durban: Health Systems Trust.

Population Council (1998). " Integration of STD/HIV and MCH/ FP services: Analysis of situation analysis survey data". New York: Population Council.

Reproductive Health Outlook "Family Planning Programme issues", Reproductive Health Organisation, http://www.rho.org/html/fp_program_issues.html. Downloaded 27/09/2002.

Reproline (2002). "Recommendations for Contracetive Use", http://www.reproline.jhu.edu/english/6read/6multi/tgwg/tgrh07e-01.htm. Downloaded 09/12/2002.

Schierhout, G. & Fonn, S. (1999). " The Integration of Primary Health Services: A Systematic Literature Review". Durban: The Press Gang. www.hst.org.za Downloaded 16/11/2002.

Shelton, J.D. (1999). "Prevention first: a three-pronged strategy to integrate family planning program efforts against HIV and sexually transmitted infections" *International Family Planning Perspectives*, 25(3) 147-153.

Sloan, N. L., Winikoff, B., Haberland, N., Coggins, C., & Elias, C. (2000). "Screening and Syndromic Approaches to Identify Gonorrhea and Chlamydial Infection among Women" in *Studies in Family Planning*, 31 (1), 55-67.

Solo. J., Maggwa, N., Naburu, J., Karuiki, D. & Maitha, G. (1999). "Improving the management of STIs among MCH and FP clients at the Nakuru Municipal Council Health Clinics" New York: Population Council.

South African Demographic Health Survey. (1998). "South African Demographic Health Survey". Pretoria: Department of Health.

South African Health Review (1999). Durban: Health Systems Trust www.hst.org.za .Downloaded 12/11/2002.

UNFPA (1997) "Reproductive Health: Including Family Planning and Sexual health" http://www.unfpa.org/about/ report/ report98/ppreproduc.html

UNICEF (1990). "Facts for Life- HIV/AIDS". www.unicef.org/ffl/11/9.htm downloaded 15/08/2002

United Nations (1994) "Report of the ICPD". www.un.org/popin/icpd/conference/offeng/poa/html.

UNAIDS (2001) Fact sheet, 2 July. www.unaids.org

USAID (2001). "Integrating STI/HIV/ AIDS Services into other Service delivery programmes" USAID Africa Bureau: Office of Sustainable development. Reproductive health brief August 2001 www.afr-sd.org/ReproductiveHealth/IntegratingStiHivAids.pdf.

Walker, G. (1999). "Implementation Challenges of Reproductive Health". www.unescape.org/pop/icpd/walker.htm updated 27 Sept 1999 downloaded 1/09/2002

Wallace (1982). "Maternal and Child Health Practices, Problems, Resources and Methods of delivery". Ch 7 & Ch 36 Eds Wallace,H.M., Gold E.M. & Lis,E.F. Springfield Illinois.

World Statistics and Atlases worldatlas.brinkster.net/asp

Appendix

Appendix : Guide for Exit Interviews

1. SDP visited (Name): _____
2. District (Name): _____
3. Date of Interview: _____
4. Name of Interviewer: _____
5. Type of SDP
   - Hospital 1
   - Health Centre 2
   - Clinic 3
   - Other (Specify) 4
6. Locality of Facility
   - Rural 1
   - Urban 2
7. Time of Interview
   - Beginning of the Interview: _____
   - End of the Interview: _____

Section 1: Background Questions

8. Sex
   - Male 1
   - Female 2
9. What was your age at your last birthday?
   - Age in completed Years [| |]
10. What is your current marital status?
    - Married 1
    - Cohabiting 2
    - Single, never married 3
    - Divorced/separated/widowed 4
    - Refused to answer 5
11. How many living children of your own do you have?
    - Number of Children [| |]
    - If none enter 00 → Go to Q13
12. What is the age of your youngest child?
    - Age in completed years [| |]
13. Are you currently pregnant?
    - Yes 1
    - No 2
    - Don't Know 3
14. Would you like to have a/another child in the future?
    - Yes 1
    - No 2 → Go to Q16
    - DNK/undecided 3 → Go to Q16
15. Would you like the (next) child within the next 12 months?
    - Yes 1
    - No 2
    - Don't Know 3
16. Are you or your partner currently using any method of contraception?
    - Yes 1
    - No 2 → Go to Q18
17. Which method are you using? (Probe: What else?)
    - Pill 1
    - IUD 2
    - Injections 3
    - Implants 4
    - Diaphragm\Foam\Jelly 5
    - Condom 6
    - Female Sterilisation 7
    - Male Sterilisation 8
    - Rhythm 9
    - Withdrawal 10
    - Sporadic Abstinence 11
    - Other (specify) 12

Section 2: Information, Education and Counselling

18. Did you see any of the following today? (**Read through 1-7**)

	Yes	No	DK
1.FP Poster	1	2	3
2.STI Poster	1	2	3
3.HIV/AIDS Poster	1	2	3
4. FP Pamphlet/ Brochure/ Information Sheet	1	2	3
5. STI Pamphlet/ Brochure/ Information Sheet	1	2	3
6. HIV/AIDS Pamphlet/ Brochure/ Information Sheet	1	2	3
7. Sample of Condoms	1	2	3

19. Did you receive any written material to take home during this visit?

Yes 1
No 2 → Go to Q21

20. If yes, what was the subject of the written information? Circle all that apply (**Probe: What else**)

Family Planning 1
Antenatal Care 2
Post-Natal Care 3
STIs 4
HIV/AIDS 5
Child Nutrition 6
Other (Specify) 7

21. Did you attend a group health talk at the facility today?

Yes 1
No 2 → Go to Q23

22. What was the subject of the group talk? Circle all that apply (**Probe: What else?**)

Family Planning 1
Antenatal Care 2
Post-Natal Care 3
STIs 4
HIV/AIDS 5
Child Nutrition 6
Other (Specify) 7

Section 3: Quality of Care

I am going to read some statements with regard to your visit to the clinic today. I would like you to say whether you agree, disagree or have no opinion about the following statements.

	Statements	Agree	Disagree	Mixed / No opinion
23.	Staff were friendly	1	2	3
24.	Staff were difficult to understand	1	2	3
25.	Staff were helpful in providing information.	1	2	3
26.	I was provided with all the information I wanted during today's consultation	1	2	3
27.	I felt that there was insufficient time to ask questions	1	2	3
28.	Staff answered all my questions to my satisfaction	1	2	3
29.	Staff gave me the opportunity to ask questions about health issues that I thought were important	1	2	3
30.	There was insufficient privacy during the consultation	1	2	3
31.	The waiting time for the consultation was reasonable	1	2	3
32.	I came away from the clinic feeling that I had received good quality care	1	2	3

Section 3: Quality of Care (continued)

I am going to ask you about your general experiences at this health centre. I would like you to say whether you agree, disagree or have no opinion about the following statements.

	Statement	Agree	Disagree	Mixed/No Opinion
33.	The Staff are helpful	1	2	3
34.	The staff treat me with respect	1	2	3
35.	I find it difficult talking to staff about my sexual life	1	2	3
36.	Staff are usually too busy to answer my questions	1	2	3
37.	If I thought I had an STI, I would first go to the traditional healer	1	2	3

Section 4: Knowledge and Ever Use of Services Available at Facility

Services	38. I am going to read out a list, tell me whether this type of service is provided at the clinic?			39. (If yes to Q38) Have you ever used this service?	
	Yes	No	DK	Yes	No
1. Family planning	1	2	3	1	2
2. Antenatal care	1	2	3	1	2
3. Postnatal care	1	2	3	1	2
4. Delivery	1	2	3	1	2
5. Child health	1	2	3	1	2
6. Child growth monitoring	1	2	3	1	2
7. STI diagnosis	1	2	3	1	2
8. STI treatment	1	2	3	1	2
9. HIV/AIDS testing	1	2	3	1	2
10. HIV/AIDS counseling	1	2	3	1	2
11. Other (specify	1	2	3	1	2

Section 5: Main Reason for Visit

40. What was the main reason for visiting the clinic today?

Family Planning	1	→ Go to Q47
Personal Illness	2	
Child/Baby Illness	3	
Child Immunisation	4	
Antenatal Care	5	
Postnatal Care	6	
STI management	7	
HIV/AIDS testing	8	
HIV/AIDS counselling	9	
Other (Specify)	10	

Section 6: Non-Family Planning Clients

41. During your visit to the clinic today, did the service provider mention anything about family planning?

Yes	1
No	2
Don't Know	3

42. Were the following issues mentioned to you during your consultation today? (Read 1 through 7).

	Yes	No	DK
1. Whether you wanted a/another child	1	2	3
2. Whether you wanted to rest or space before having a/another child.	1	2	3
3. Whether you are interested in using family planning	1	2	3
4. If you have ever used any method	1	2	3
5. If you have any concerns about using any method	1	2	3
6. If you had discussed family planning with your husband/partner.	1	2	3

43. Did the provider mention any specific methods of contraception during your visit today?

Yes	1	
No	2	→ Go to Q45
Don't Know	3	→ Go to Q45

44. Which methods did the provider mention? (**Probe by asking: "Anything else?"**) Circle all that apply

Pill	1
IUD	2
Injections	3
Implants	4
Diaphragm\Foam\Jelly	5
Condom	6
Female Sterilisation	7
Male Sterilisation	8

45. Do you need any (more) information or advice about family planning?

Yes	1
No	2
Don't Know	3

46. Would you have welcomed (more) information/advice on family planning on today's visit?

Yes	1
No	2
Don't Know	3

Section 7: Non-STI/HIV/AIDS clients [NB: Answer only if response to Q40 was 1-6]

47. During your visit to the clinic today, did the service provider mention anything about: (Read 1-2)

	Yes	No	DK
1. STIs	1	2	3
2. HIV/AIDS	1	2	3

48. During your visit to the clinic today, did the service provider: (Read out 1-8)

	Yes	No	DK
1. Ask about vaginal discharge	1	2	3
2. Perform a pelvic examination	1	2	3
3. Ask whether you have more than one partners	1	2	3
4. Ask whether your partner is likely to have more than one partner	1	2	3
5. Ask if you have any concerns about getting an STI	1	2	3
6. Ask if you had discussed STIs with your husband/partner.	1	2	3
7. Ask if your partner would be willing to receive treatment.	1	2	3
8. Advise you to have a laboratory test/ has test done	1	2	3

49. Do you need any (more) information or advice about STIs/HIV/AIDS?

Yes	1
No	2
Don't Know	3

50. Would you have welcomed (more) information or advice on STIs/HIV/AIDS on today's visit?

Yes	1
No	2
Don't Know	3

Section 8: Family Planning Clients [NB: Answer only if response to Q40 was 1]

51. I understand that your main purpose for coming to this health facility today was family planning. What was the reason for visiting the family planning provider?

Adoption of a new method	1
Re-supply	2
Method Change	3
Problem with Method	4
Other (Specify)	5

52. Did you receive any contraceptive supplies during this visit?

Yes	1	
No	2	→ Go to Q54

53. Which method(s) did you accept today? (**Probe: What else?**)

Pill	1
IUD	2
Injections	3
Implants	4
Diaphragm\Foam\Jelly	5
Condom	6
Female Sterilisation	7
Male Sterilisation	8

54. During your visit did the provider mention any other methods?

Yes	1	
No	2	→ Go to Q56
Don't Know	3	

Section 8: Family Planning Clients [continued]

55. Which other methods did the provider mention? (**Probe by asking: "Anything else?"**) Circle all that apply.

Pill	1
IUD	2
Injections	3
Implants	4
Diaphragm\Foam\Jelly	5
Condom	6
Female Sterilisation	7
Male Sterilisation	8

56. Did the provider discuss condoms with you?

Yes	1
No	2
Don't Know	3

57. Did the provider mention that condoms can be used in combination with other methods?

Yes	1
No	2
Don't Know	3

58. Did you have a pelvic examination during your visit today?

Yes	1	
No	2	→ Go to Q61
Don't Know	3	

59. Did the provider explain the purpose of the examination?

Yes	1
No	2
Don't Know	3

60. Did the provider explain the results of this examination?

Yes	1
No	2
Don't Know	3

61. Were you told when to return for a follow up visit?

Yes	1
No	2
Don't Know	3

Section 9: STI/HIV clients [NB: Answer only if response to Q40 was between 7-9]

62. I understand that your main purpose for coming to this health facility today was STI/HIV. What was the main reason for visiting the provider? (Read out list) Circle only one answer

Confirmed HIV Positive	1
Possibly HIV Positive	2
Awaiting HIV test	3
Confirmed STI	4
Possible STI	5
Awaiting Diagnosis	6
Cured STI	7
Other (Specify)	8

63. Did you have a pelvic examination during your visit today?

Yes	1	
No	2	→ Go to Q66
Don't Know	3	

64. Did the provider explain the purpose of the examination?

Yes	1
No	2
Don't Know	3

65. Did the provider explain the results of this examination?

Yes	1
No	2
Don't Know	3

66. Did the provider advise you to have a laboratory test?

Yes	1
No	2
Don't Know	3

Section 9: STI/HIV clients [continued]

67. Did the provider take any specimen (such as blood, urine or swab) for testing in a laboratory?

Yes	1
No	2
Don't Know	3

68. Did the provider ask about vaginal discharge?

Yes	1
No	2
Don't Know	3

69. Did the provider talk to you about multiple sexual partners?

Yes	1
No	2
Don't Know	3

70. Did the provider advise you to bring your partner for treatment?

Yes	1
No	2
Don't Know	3

71. Would your partner be willing to receive treatment for a STI at this clinic?

Yes	1
No	2
Don't Know	3

72. Did the provider tell you to refrain from sexual intercourse?

Yes	1
No	2
Don't Know	3

73. Did the provider discuss condoms with you?

Yes	1
No	2
Don't Know	3

74. Did the provider mention that condoms protect against STIs/HIV?

Yes	1
No	2
Don't Know	3

75. Were you told when to return for a follow up visit?

Yes	1
No	2
Don't Know	3

Section 10: Perceived Risk of HIV/AIDS

To end up with I would like to ask you some questions about yourself. I would like to remind you that the information that you provide will remain strictly confidential.

76. How many sexual partners have you had in the past 12 months?
    - Number of Partners ☐☐
    - Don't Remember.....99

77. Did you have sex with any new partner(s) in the past 12 months?
    - Yes 1
    - No 2
    - DNK/ can't remember 3

78. Did you use a condom the first time you had sex with your most recent new partner?
    - Yes 1
    - No 2
    - DNK/ Can't remember 3

79. Before today, have you ever thought about your own chance of contracting HIV/AIDS?
    - Yes 1
    - No 2

80. Considering all things, do you consider your chance of getting HIV to be high, medium, low or no chance at all?
    - High 1
    - Medium 2
    - Low 3
    - No chance 4

81. If a doctor or nurse advised you to use a condom, would it be possible for you to do so with your spouse or main partner?
    - Yes 1
    - No 2
    - Don't Know 3

Thank you very much for answering these questions