PRB

INFORM
EMPOWER
ADVANCE

A JOURNALIST'S GUIDE to **SEXUAL** and **REPRODUCTIVE HEALTH** in EAST AFRICA

2011

POPULATION REFERENCE BUREAU

www.prb.org

TABLE OF CONTENTS

POPULATION REFERENCE BUREAU

The Population Reference Bureau **informs** people around the world about population, health, and the environment, and **empowers** them to use that information to **advance** the well-being of current and future generations.

Authors: Deborah Mesce, program director, International Media Training, PRB; Karin Ringheim, senior policy adviser, PRB; with assistance from Mia Foreman, policy analyst, PRB.

This publication was funded by the William and Flora Hewlett Foundation and is a compilation of materials provided to journalists at PRB seminars in East and West Africa.

PRB INFORM EMPOWER ADVANCE

WHY SHOULD SEXUAL AND REPRODUCTIVE HEALTH ISSUES CONCERN THE MEDIA?

Sexual and reproductive health encompasses health and well-being in matters related to sexual relations, pregnancies, and births. It deals with the most intimate and private aspects of people's lives, which can be difficult to write about and discuss publicly. As a result, the public often misunderstands many sexual and reproductive health matters. In addition, cultural sensitivities and taboos surrounding sexuality often prevent people from seeking sexual and reproductive health information and care and preclude governments from addressing the issues.

Yet, sexual and reproductive health profoundly affects the social and economic development of countries. When women die in childbirth or from AIDS, children are orphaned. When girls must take over care of their siblings, they drop out of school. Without an education, girls often marry and begin having children early, which can jeopardize their health and limit their opportunities to contribute to the development and productivity of their communities and countries.

The media play a critical role in bringing sexual and reproductive health matters to the attention of people who can influence public health policies. These people include government officials and staff; leaders of nongovernmental organizations, including women's groups and religious groups; academics and health experts; and health advocates and other opinion leaders.

Many of these influential people read news reports and listen to daily news broadcasts, and their opinions are shaped by them. Occasionally, a single news report can spur a decisionmaker to act. More often, however, a continuous flow of information is needed to educate diverse audiences about issues and inform public policy debates. Journalists who can write and speak knowledgeably about sexual and reproductive health can contribute to improved public policies.

Journalists who produce accurate and timely reports about sexual and reproductive health issues can:

continued...

- Bring taboo subjects out in the open so they can be discussed.
- Monitor their government's progress toward achieving stated goals.
- Hold government officials accountable to the public.

This guide aims to help journalists educate the public and policymakers on these issues by bringing together the latest available data on sexual and reproductive health for seven East African countries: Ethiopia, Kenya, Malawi, Rwanda, Tanzania, Uganda, and Zambia. Additional data are included for selected countries in western and southern Africa, including Ghana, Liberia, Madagascar, Mozambique, Nigeria, Sierra Leone, and Zimbabwe. Content and data sourced to websites were available as of May 31, 2011. More information is included for the countries that have had a more recent Demographic and Health Survey (DHS).

The Vision: Sexual and Reproductive Health for All

Sexual and reproductive health is internationally acknowledged as a universal human right. It was first defined in the *Programme of Action* of the United Nation's 1994 International Conference on Population and Development (ICPD):

> **Reproductive health** is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and process. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

ICPD called for a people-centered approach in which couples and individuals can freely and responsibly decide on the number and spacing of their children. The empowerment of women is central to this approach.

The ICPD agreement also recognizes the interconnection of reproductive health and other aspects of people's lives, such as their economic circumstances, level of education, employment opportunities, and family structures, as well as the political, religious, and legal environment.

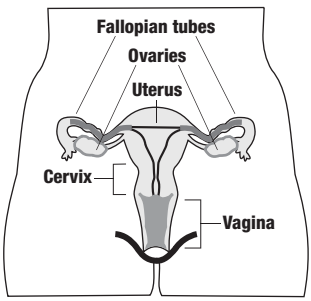
At a UN summit in 2000, nearly all the world's governments agreed upon a set of eight Millennium Development Goals (MDGs) to achieve measurable reductions in poverty and

improvements in health by 2015. The MDGs have since spurred greater attention to health and development objectives throughout the world. Reproductive health was initially omitted from the MDGs but five years later, world leaders agreed that reproductive health was essential to improve maternal health. Governments committed themselves to achieving universal access to reproductive health by 2015 as part of MDG 5, and targets, including reducing unmet need for contraception, are being carefully monitored in most countries.

THE REPRODUCTIVE SYSTEM

The Female Reproductive System

- The **ovaries** are a pair of small organs that produce female egg cells, and they release one egg each month. This process is called ovulation and occurs about 14 days after the start of a woman's menstrual cycle.
- Eggs are released into the **fallopian tubes**, where **conception**—the fertilization of an egg by a sperm—normally occurs. The egg passes through the fallopian tube that joins the ovary to the uterus.
- When a fertilized egg implants into the wall of the **uterus**, pregnancy occurs. The uterus is a hollow organ that can easily expand to hold a developing fetus. At birth, the fetus passes from the uterus through the **cervix** and then through the **vagina**, also called the **birth canal**.
- If the fertilized egg does not become implanted, **menstruation** occurs. The uterus sheds its lining in the form of menstrual blood through the cervix and vagina. The menstrual cycle occurs every 28 to 31 days for most women.



Outside the vagina are the external genitalia:

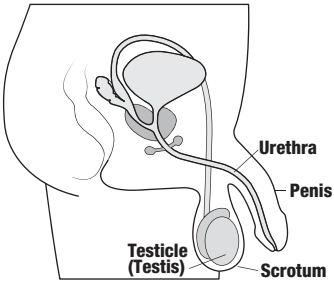
- The **labia majora** and **labia minora** surround the opening of the vagina.
- The two labia minora meet at the **clitoris**, a small protrusion that is comparable to the penis in males. Like the penis, the clitoris is very sensitive to stimulation and can become erect.
- The **hymen** is a membrane that partly covers the entrance to the vagina in most women. It is often ruptured when sexual intercourse takes place for the first time. The bleeding that usually results is often believed to be a sign of virginity, but lack of blood is not an indication that the woman has had sex before. The hymen can be

continued...

torn or stretched during exercise or insertion of a tampon, and some women are born without a hymen.

The Male Reproductive System

- The **penis** is the male organ for both urination and sexual intercourse. The head of the penis is covered with a loose layer of skin called the foreskin, which is sometimes removed in a procedure called **circumcision**.



- The penis contains a number of sensitive nerve endings. When the man is sexually aroused, the penis fills with blood and becomes rigid and erect, which allows for penetration during sexual intercourse.
- At sexual climax (orgasm), the penis expels (ejaculates) semen, a fluid which protects and transports the male reproductive cells called sperm.
- The **urethra** is a tube that transports both semen and urine through an opening at the tip of the penis. When the penis is erect, the flow of urine is blocked from the urethra, allowing only semen to be ejaculated.
- The **scrotum** is a loose pouch-like sac of skin that hangs behind the penis. It contains the testicles as well as many nerves and blood vessels that help maintain the temperature needed for normal sperm development.
- Most men have two **testicles** (also called testes), which are responsible for making testosterone, the primary male sex hormone, and for generating sperm.

Sources

WebMD, in collaboration with the Cleveland Clinic, **www.webmd.com**; MedicineNet.com, **www.medicinenet.com**; and its online dictionary, **www.medterms.com**.

PREGNANCY AND CHILDBEARING

Childbearing patterns vary greatly from one region to another, but women the world over are having fewer children than in the past. Research shows that family size is influenced by women's education and socioeconomic status, societal attitudes toward childbearing, and access to modern contraception.

Childbearing Patterns and Trends

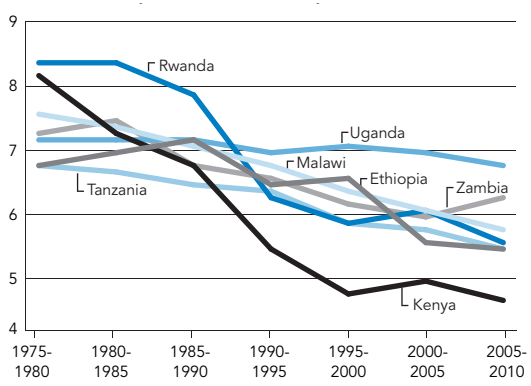
- Women in sub-Saharan Africa have more children on average than women in other parts of the world. The total fertility rate (TFR), or the average number of children a woman gives birth to in her lifetime, is 5.3 in the eastern region, more than double the rate for the world as a whole (2.5 births per woman).
- **Fertility rates** in East Africa are typical of those in sub-Saharan Africa as a whole. Uganda's total fertility rate of 6.7 lifetime births per woman is the highest in the entire sub-Saharan region outside of Niger:

Ethiopia (2005)	5.4
Kenya (2008-2009)	4.6
Malawi (2010)	5.7
Rwanda (2007-2008)	5.5
Tanzania (2010)	5.4
Uganda (2006)	6.7
Zambia (2007)	6.2

As shown in the figure on page 8, the number of births per woman has declined since 1975, but at different rates in different countries. While Kenya once had the highest fertility among this group of countries, it now has the lowest, and women in Kenya now have two fewer births on average than women in Uganda.

continued...

Lifetime Births per Woman in East Africa, 1975-2010



Sources: UN Population Division, *World Population Prospects: The 2010 Revision;* and Demographic and Health Surveys (Ethiopia, Kenya, Malawi, Rwanda, Tanzania, Uganda, and Zambia).

- In Kenya, fertility declined steeply in earlier decades but remained at a nearly constant level between 1995 and 2008. The government has now made a new commitment to meet demand for contraception.
- In Zambia as well as in Uganda, women still average more than six births each, among the highest rates in the world. In Zambia, fertility was higher in the 2007 DHS than in the previous survey.
- Because of continuing high fertility in most of sub-Saharan Africa, projections show that the region's 2010 population of 863 million will increase to 1.75 billion by 2050—assuming that fertility declines to about 2.5 children by then. If fertility drops only to 3.0 children by 2050, the region's population will surpass 2 billion.
- In East African countries today, 44 percent of the population is younger than 15 years old. As these youth enter their reproductive years in the next two decades, they will fuel population growth and increase demand for reproductive, maternal, and child health services.
- Population growth in East Africa will begin to level off only after countries reach replacement level fertility, the number of children needed to replace their parents (usually defined as 2.1).
- Throughout Africa, and, in fact, throughout the world, more-educated and better-off women marry later, start childbearing later, and are more likely than poor, uneducated women to use family planning.

Unintended Pregnancies

- Men and women in East Africa typically want smaller families than those in West Africa. Because they want

fewer children, women in East Africa are more likely to have unintended (mistimed or unwanted) pregnancies and births (in the last five years, including current pregnancy):

Ethiopia (2005)	35%
Kenya (2008-2009)	43%
Malawi (2004)	41%
Rwanda (2007-2008)	34%
Tanzania (2010)	26%
Uganda (2006)	46%
Zambia (2007)	41%

- Men typically want to have more children than women do, but in East Africa, the number of children that men and women want is becoming more similar. For example, in Kenya, the ideal number of children for women is 3.8 while for men it is 4.2. In Malawi, women's ideal family size is about the same as men's (4.1 versus 4.0).
- The vast majority of unintended pregnancies occur because contraception is not used, or because couples are relying on a traditional method such as withdrawal, which has a high failure rate. Less often, pregnancy occurs because a modern method is used incorrectly or fails.
- Unintended pregnancies can pose more serious health risks than planned pregnancies. Women who are under age 18 or over age 35, who have babies too close together (especially less than two years apart), or who have had many births, face greater health risks for themselves and their babies.
- Unintended pregnancy may also lead a woman to seek an abortion, which is highly restricted in most African countries and, therefore, often carried out in an unsafe manner or in unsafe circumstances.

Infertility

Infertility is the biological inability to conceive children.

- **Primary infertility** refers to the inability of women or couples to ever have conceived a pregnancy (usually after one year of regular sexual intercourse without use of contraception). **Secondary infertility** refers to an inability to conceive another child among those who have had at least one child. This is often the result of a sexually transmitted disease that was not treated.
- Globally, about 10 percent of couples have problems conceiving children. About one-third of these couples

continued...

are affected by primary infertility and two-thirds by secondary infertility.

- In East Africa, infertility is estimated to be generally higher than 10 percent. For example, it is 16 percent in Kenya, Uganda, and Zambia; and 18 percent in Malawi and Tanzania. However, in Rwanda, the rate is much lower: 7 percent.
- Most infertility in the East Africa region is secondary and most commonly caused, in both men and women, by untreated gonorrhea or chlamydia.
- Women are often blamed for infertility. However, men are equally likely to be infertile, and men contribute to about half of infertility among couples in the region. Age contributes to infertility for both men and women.

Sources

Demographic and Health Surveys: Ethiopia 2005, Kenya 2008-2009, Malawi 2004 and Malawi 2010 Preliminary Report, Rwanda 2007-2008, Tanzania 2010, Uganda 2006, and Zambia 2007 (Calverton, MD: ORC Macro, various years). **www.measuredhs.com**

Carl Haub and Mary Mederios Kent, *2010 World Population Data Sheet* (Washington, DC: Population Reference Bureau, 2010). **www.prb.org/Publications/Datasheets/2010/2010wpds.aspx**

Ulla Larsen, "Primary and Secondary Infertility in Sub-Saharan Africa," *International Journal of Epidemiology* 29 (2000): 285-91.

Rhonda Smith et al., *Family Planning Saves Lives*, 4th ed. (Washington, DC: Population Reference Bureau, 2009). **www.prb.org/Reports/2009/fpsl.aspx**

UN Population Division, *World Population Prospects: The 2010 Revision* (New York: UN Department of Social and Economic Affairs, Population Division, 2011). **http://esa.un.org/unpd/wpp/index.htm**

Notes and Tips for Journalists

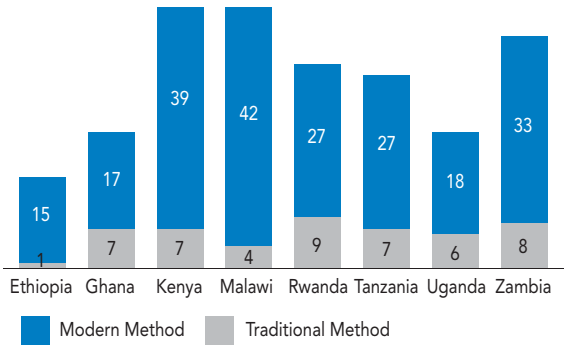
- It is usually sufficient to use the term "fertility rate" in place of the formal term "total fertility rate" when referring to the number of children the average woman has in her lifetime.
- When reporting on fertility rates, it is usually sufficient to use a whole number rather than the precise number with a decimal point. For example, a fertility rate of 5.4 can be expressed as "more than five children" or a rate of 4.9 can be "nearly five children."
- Do not express fertility rates as percentages.
- To find population projections for specific countries and years, go to the website of the UN Population Division, *World Population Prospects: The 2010 Revision*. **http://esa.un.org/unpd/wpp/index.htm**
- Obstetricians and gynecologists are the medical specialists to consult on questions of reproductive health and family planning.

FAMILY PLANNING

Globally, organized family planning programs began in the 1960s to make modern contraception available to women and couples who wanted to limit childbearing. Today, 62 percent of married women worldwide use some form of contraception and 55 percent use a modern method. In sub-Saharan Africa as a whole, 23 percent of women use some form of contraception while 18 percent use a modern method.

- In East Africa, the proportion of married women using any method of contraception (modern or traditional) is generally higher than in the sub-Saharan region as a whole, but ranges in these countries from 16 percent in Ethiopia to 46 percent in Kenya and Malawi.

Percent of Married Women Using a Modern or Traditional Contraceptive Method



Source: Demographic and Health Surveys (Ethiopia 2005, Ghana 2008, Kenya 2008-2009, Malawi 2010 Preliminary Report, Rwanda 2007-2008, Tanzania 2010, Uganda 2006, and Zambia 2007).

- Use of modern methods has increased; however, more than half of married women in all of these countries are neither using a modern nor a traditional method of family planning.

Contraceptive Methods

- **Modern methods** include hormonal methods such as injectables like Depo-Provera, birth control pills, and hormonal implants; female sterilization (tubal ligation); male sterilization (vasectomy); intrauterine devices (IUD);

continued...

barrier methods such as the male or female condom, diaphragm, and cervical cap; and chemical spermicides in the form of jelly or foam.

- **Lactational amenorrhea (LAM)** is a modern, temporary method of family planning based on the natural contraceptive effect of breastfeeding. It is highly effective when three conditions are met: the mother's monthly bleeding has not returned; the baby is breastfed throughout the day and night and receives little or no additional food or drink; and the baby is less than 6 months old.
- In East Africa, use of injectables has risen rapidly and they are now the most popular modern method. In Malawi, modern method use rose from 33 percent to 42 percent between 2004 and 2010, largely due to increased use of injectables.
- Female sterilization is also becoming more common, but use of vasectomy in these countries is negligible.
- **Traditional methods** include periodic abstinence (also known as the calendar or rhythm method) and withdrawal.

Percent of Married Women Using Various Modern Contraceptive Methods

	ET	KE	MW	RW	TZ	UG	ZM
Pills	3	7	3	6	7	3	11
Injectables	10	22	26	15	11	10	9
IUD	<1	2	<1	<1	<1	<1	<1
Implants	<1	2	1	2	2	<1	<1
LAM	<1	<1	na	1	1	na	6
Female sterilization	<1	5	10	1	4	2	2
Not using	85	55	54	64	66	76	59

Note: na=data not available. ET=Ethiopia; KE=Kenya; MW=Malawi; RW=Rwanda; TZ=Tanzania; UG=Uganda; ZM=Zambia.

Source: Demographic and Health Surveys (Ethiopia, 2005, Kenya 2008-2009, Malawi 2010 Preliminary Report, Rwanda 2007-2008, Tanzania 2010, Uganda 2006, and Zambia 2007).

Contraceptive Effectiveness

- If used correctly, modern contraception is highly effective. However, no contraceptive method is 100 percent effective at preventing pregnancy. The most effective methods are those that are long-acting (IUDs and implants) or permanent (sterilization), because they do not rely on users' behavior. Lactational amenorrhea is highly effective for the first six months after birth if used correctly.

- Male and female condoms are less effective at preventing pregnancy than hormonal methods, but they are the only methods capable of preventing both pregnancy and sexually transmitted infections (STIs). Condoms can be used in combination with highly effective hormonal methods for "dual protection" against pregnancy and STIs.
- Traditional methods often fail to prevent pregnancy. More than one in four women who rely on withdrawal, for example, will become pregnant within one year.

Contraceptive Efficacy Rates With Typical Use

METHOD	% OF WOMEN WHO BECOME PREGNANT WITHIN THE 1ST YEAR OF USE (U.S.)*
No method	85
Female sterilization	<1
Male sterilization	<1
Implants	<1
IUD	<1
Lactational amenorrhea	2 (within first six months)
Injectables	3
Pill	8
Male condom	15
Female condom	21
Diaphragm	16
Periodic abstinence	25
Withdrawal	27
Spermicides	29

*Most contraceptive effectiveness data come from studies conducted in developed countries.

Source: *Contraceptive Technology: Nineteenth Revised Edition* (2007).

continued…

Emergency contraceptives (EC) are backup methods of preventing pregnancy after unprotected sexual intercourse. They do not terminate existing pregnancies, and they do not protect against STIs.

- EC—also called the "morning-after pill"—uses the same hormones as birth control pills but in higher doses and can reduce the risk of pregnancy by 60 percent to 90 percent if taken within five days of unprotected sex. The earlier EC is taken after unprotected sex, the more effective it is at preventing pregnancy.
- If a woman is pregnant (a fertilized egg is implanted in her uterus), EC pills will not cause an abortion and the pregnancy will continue.
- EC is intended for use in exceptional circumstances, such as when a contraceptive method was not used or failed, or when sex was forced. It is not intended to be used in place of regular, ongoing contraception.

Unmet Need for Family Planning

- A woman has an unmet need for family planning if she says she prefers to avoid a pregnancy—wanting to either wait at least two years (spacing) before having another child or stop childbearing altogether (limiting)—but is not using an effective contraceptive method.
- Women who rely on a traditional method may still be considered to have an unmet need because of the high probability of becoming pregnant while using a traditional method.
- Women may have an unmet need for family planning for a variety of reasons: lack of knowledge about the risks of becoming pregnant; fear of side effects of contraceptives; perceived opposition to family planning on the part of their husbands, other family members, or their religion; or lack of access to family planning services.
- Unmet need is higher in sub-Saharan Africa than in other world regions. According to recent surveys in East Africa, as desire for smaller families has risen, unmet need for family planning has increased. Overall, nearly a third of currently married women have an unmet need for family planning:

Ethiopia	34%
Kenya	26%
Malawi	28%
Rwanda	38%
Tanzania	25%
Uganda	41%
Zambia	27%

- Unmet need is often highest among women with a primary school education. This is because women with more education are more likely to use contraception, and women with no education generally want more children.

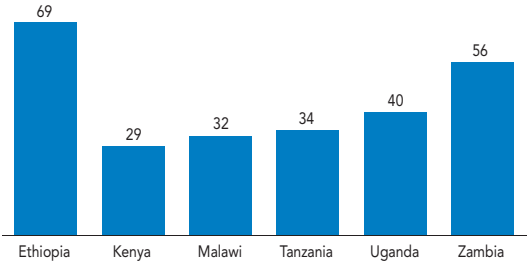
The Media's Role in Family Planning

Nearly all women in these East African countries know of at least one modern method of family planning. However, in Ethiopia 12 percent of women do not know of either a modern nor traditional method. In Kenya, Malawi, Rwanda, Uganda, and Zambia, half or more of married women have tried a method at least once, but many are no longer using contraception.

- The media has an important role to play in raising awareness about family planning and its importance to women's and children's health and national development. Media exposure to family planning messages is generally higher in East than in West Africa. More than half of women in East Africa have heard a message about family planning on the radio, on TV, or in a newspaper or magazine in the past several months.
- Beginning in 1993, the national radio station of Tanzania began to air two radio soap operas with family planning messages incorporated into the story lines. These broadcasts have continued, although listeners have declined substantially since 2004. In 2010, one out of four women and one out of three men reported having heard one of these dramas in the past six months.
- Live drama is also a popular medium for incorporating family planning messages, especially as a way to engage men and to get information to illiterate women who do not read newspapers and journals. Twenty percent of women in Tanzania have recently seen such a drama.

continued…

Percent of Women Who Have Not Heard About Family Planning in Any Media (TV, Radio, Newspapers, or Magazines) in the Recent Past



Source: Demographic and Health Surveys (Ethiopia 2005, Kenya 2008-2009, Malawi 2004, Tanzania 2004-2005, Uganda 2006, and Zambia 2007).

Sources

Emergency Contraceptive Services in Africa. **www.ecafrique.org/eng_index.php**

John Cleland, Robert Ndugwa, and Eliya M. Zulu, "Family Planning in Sub-Saharan Africa: Progress or Stagnation?" *Bulletin of the World Health Organization* 89, no. 2 (2011): 137-43. doi:10.2471/BLT.10.077925

Donna Clifton, Toshiko Kaneda, and Lori Ashford, *Family Planning Worldwide 2008 Data Sheet* (Washington, DC: Population Reference Bureau, 2008). **www.prb.org/Publications/Datasheets/2008/familyplanningworldwide.aspx**

Carl Haub and Mary Kent, *2010 World Population Data Sheet* (Washington, DC: Population Reference Bureau, 2010). **www.prb.org/Publications/Datasheets/ 2010/2010wpds.aspx**

International Consortium for Emergency Contraception. **www.cecinfo.org**

Scott Moreland and Sandra Talbird, *Achieving the Millennium Development Goals: The Contribution of Fulfilling the Unmet Need for Family Planning* (Washington, DC: Constella Futures, 2007).

Population Reference Bureau (PRB) and African Population and Health Research Center, *2008 Africa Population and Health Data Sheet* (Washington DC: PRB, 2008). **www.prb.org/Publications/Datasheets/2008/apds2008.aspx**

Rhonda Smith et al., *Family Planning Saves Lives*, 4th ed. (Washington, DC: PRB, 2008). **www.prb.org/Reports/2009/fpsl.aspx**

Notes and Tips for Journalists

- Do not confuse emergency contraception with abortion. The "morning-after pill" can prevent pregnancy (page 14). The "abortion pill" is a medication that terminates pregnancy.

MATERNAL HEALTH

Worldwide more than 358,000 girls and women die of pregnancy-related causes each year—nearly 1,000 every day—and 99 percent of these deaths occur in developing countries.

- Complications of pregnancy and childbirth are a leading cause of death and disability among women of reproductive age in sub-Saharan Africa.
- The probability that a 15-year-old girl will die from a complication related to pregnancy or childbirth during her lifetime is one in 31 in sub-Saharan Africa, more than 100 times the risk in more developed countries.

Maternal Deaths and Maternal Mortality Ratios, 1990 and 2008

COUNTRY	MATERNAL MORTALITY RATIO (DEATHS PER 100,000 LIVE BIRTHS)		NUMBER OF DEATHS	LIFETIME RISK OF DYING OF MATERNAL CAUSES
	1990	2008	2008	2008
Ethiopia	990	470	14,000	1 in 40
Kenya	380	530	7,900	1 in 38
Malawi	910	510	3,000	1 in 36
Nigeria	1,100	840	50,000	1 in 23
Rwanda	1,100	540	2,200	1 in 35
Tanzania	880	790	14,000	1 in 23
Uganda	670	430	6,300	1 in 35
Zambia	390	470	2,600	1 in 38
More Developed Countries	26	17	2,400	1 in 3,600

Source: World Health Organization, *Trends in Maternal Mortality: 1990-2008* (Geneva: WHO, 2010).

- One out of seven maternal deaths globally occurs in Nigeria, which has the second highest number of maternal deaths outside of India.
- Most of the countries shown above have made some progress in reducing maternal deaths. Although none are on track to reach the Millennium Development Goal of a three-fourth's reduction in the 1990 maternal mortality

continued…

ratio by 2015, maternal deaths have declined by 53 percent in Ethiopia and 51 percent in Rwanda since 1990.

- **Direct causes** of maternal deaths related to pregnancy and delivery worldwide are:

Severe bleeding	25%
Infection	15%
Unsafely performed abortion	13%
Hypertensive disorders	12%
Obstructed labor	8%
Other	8%

- About 20 percent of maternal deaths are due to **indirect causes**, including underlying diseases such as malaria, anemia, HIV/AIDS, and heart disease, which are aggravated by pregnancy.
- For every woman who dies, at least 30 others suffer serious illness or debilitating injuries, such as severe anemia, incontinence, damage to the reproductive organs or nervous system, chronic pain, and infertility.
- **Obstetric fistula** is one of the most physically and socially devastating complications of pregnancy. An obstetric fistula is a hole between the vagina and bladder and/or rectum most often caused by prolonged, obstructed labor without medical attention. In most cases, the baby dies and the woman is left with chronic incontinence and continuously leaking urine and/or feces, and she is often ostracized by her community. As many as 100,000 cases occur each year, mostly in sub-Saharan Africa and South Asia. Surgical repair is possible but not available to most poor women.

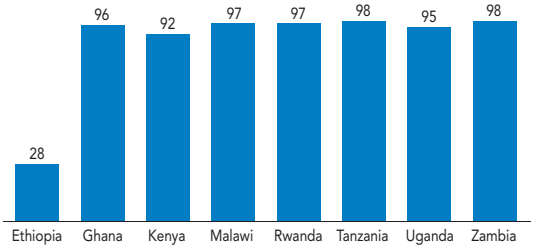
Reducing Deaths and Disabilities

- Most deaths and disabilities that result from pregnancy and childbirth can be avoided if women plan pregnancies, prevent complications through antenatal care, and use safe delivery services, including having a skilled attendant at birth.
- Family planning reduces the risk of maternal death and disability by reducing a woman's exposure to pregnancy, particularly unintended pregnancy. While every pregnancy poses some health risk, the risks are higher for women who are under age 18 or over age 35, have babies too close together, and have had many births.
- Many pregnant women do not get the care they need before, during, and after childbirth because there are no services where they live, they cannot afford the services or transportation to reach them, or they do not recognize complications or symptoms in need of attention. Some

women do not use maternal health services because the quality is poor or they dislike how care is provided.

- The World Health Organization (WHO) recommends that pregnant women have a least four **antenatal care** visits, starting in the first three months of pregnancy. In East Africa, the great majority of women receive such care at least once, except in Ethiopia, where nearly three out of four women receive no antenatal care.

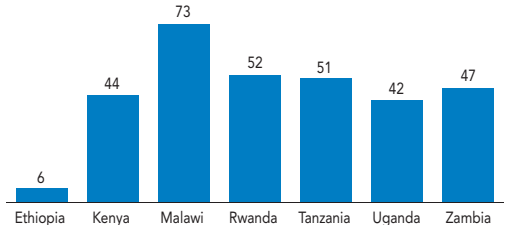
Percent of Pregnant Women Who Received at Least One Antenatal Care Visit



Source: Demographic and Health Surveys (Ethiopia 2005, Ghana 2008, Kenya 2008-2009, Malawi 2010 Preliminary Report, Rwanda 2007-2008, Tanzania 2010, Uganda 2006, and Zambia 2007).

- Because many pregnancy complications cannot be predicted, safe deliveries rely on **skilled birth attendants**. These include physicians, nurses, and midwives, but do not include traditional birth attendants.
- Throughout Africa, rural women have less access to skilled attendants than do urban women. In Ethiopia, where 85 percent of women live in rural areas, only 6 percent of women had a skilled health attendant assisting them at birth.

Percent of Women Receiving Skilled Attendance at Birth



Source: Demographic and Health Surveys (Ethiopia 2005, Kenya 2008-2009, Malawi 2010 Preliminary Report, Rwanda 2007-2008, Tanzania 2010, Uganda 2006, and Zambia 2007).

- To address complications, skilled attendants need access to medical equipment and a facility for

continued...

emergency care. **Emergency obstetric care** includes: the ability to perform surgery (for Caesarean deliveries), anesthesia, and blood transfusions; management of problems such as anemia and high blood pressure; and special care for at-risk newborns.

- Most infant deaths occur on the first day and in the first week of life, but rates of **postnatal care** are even lower than the rates of antenatal care. Health services often fail to follow up women during the postnatal period (up to 42 days after birth), even though this period is important for identifying and treating childbirth-related injuries and illness and counseling women on breastfeeding and family planning methods.

Sources

Wendy J. Graham et al., "Maternal and Perinatal Conditions," in *Disease Control Priorities in Developing Countries*, 2d ed., ed. Dean T. Jamison et al. (New York: Oxford University Press, 2006): chapter 26.

World Health Organization (WHO), *Trends in Maternal Mortality: 1990-2008* (Geneva: WHO, 2010).

WHO, *World Health Report 2005: Make Every Mother and Child Count* (Geneva: WHO, 2005). **www.who.int**

UN Population Fund (UNFPA), *Campaign to End Fistula*. **www.endfistula.org**

Notes and Tips for Journalists

- In your stories, avoid using technical terms that readers and listeners may not understand. For example, instead of mortality you can say death, and instead of morbidity you can say disability or disease.
- If you do use technical terms, use them correctly. For example, a maternal mortality ratio—a demographic measure of pregnancy-related deaths—is expressed as the number of maternal deaths per 100,000 live births. This can be a difficult concept for many people to comprehend. The number of deaths or the lifetime risk of dying may be easier to understand and useful in comparing countries or regions.
- Accurately measuring deaths due to pregnancy and childbirth is very difficult in countries that have no registration system for recording such deaths. Even where deaths are recorded, a woman's pregnancy status may not be known and her death might not be reported as a maternal death. Many developing countries have no reporting systems, so the number of maternal deaths is estimated using a variety of methods, all of which have limitations. As a result, estimates can vary.

HIV/AIDS AND OTHER SEXUALLY TRANSMITTED INFECTIONS

Two-thirds of all people infected with HIV live in sub-Saharan Africa. An estimated 22.5 million people in the region are living with the virus, and each day nearly 5,000 adults and children become infected. Nearly three-quarters of the 1.8 million global AIDS-related deaths in 2009 occurred in sub-Saharan Africa.

Basic Facts About HIV and AIDS

- HIV (human immunodeficiency virus) causes AIDS (acquired immune deficiency syndrome) by destroying certain white blood cells (called CD4 or T cells) that the human immune system needs to fight disease.
- HIV is present in blood, semen, and vaginal fluids of an infected person. People who are infected are referred to as HIV positive or as people living with HIV/AIDS (PLHA). The virus can be transmitted by:
  - —Having unprotected sexual intercourse with an infected person.
  - —Sharing needles or other drug-injecting equipment with an infected person.
  - —Receiving a blood transfusion that contains HIV-infected blood or receiving a medical injection using equipment that has not been properly cleaned.
  - —Being exposed to the virus while still in an infected mother's uterus, during birth, or through breastfeeding.
- HIV cannot be transmitted through casual contact like shaking hands or hugging, and it is not transmitted by mosquitoes.
- Using a male or female condom during sexual intercourse is the only effective means of protection from sexual transmission of HIV.
- New research has shown that antiretroviral treatment for people with HIV reduces the risk that they will transmit the virus to HIV-negative partners by 96 percent.

continued...

WOMEN AND HIV

Women are most commonly infected through heterosexual intercourse. During vaginal or anal intercourse, tiny cuts and scrapes can open up on the skin of the penis, vagina, or anus, allowing HIV from an infected partner to enter the body of an uninfected partner. Because the vagina and anus have larger surface areas than the penis, they expose more tissue to the virus. In addition, they are more susceptible than the penis to small tears that can make transmission easier. While any sexual intercourse with an infected person is risky, transmission is more likely:

— During violent or coerced sex.

— During anal sex.

— In young women who are not fully developed and are more prone to tearing.

— If either partner has a sexually transmitted infection that causes open sores or lesions.

MALE CIRCUMCISION

- In many countries, boys have part of the foreskin of the penis removed as a cultural or religious practice called **circumcision**. This is most often done right after birth or during infancy, but may be done later.
- Studies have demonstrated that men who are circumcised have a lower risk of becoming infected with HIV than men who are not. Circumcision by itself lowers the risk but does not protect men from HIV infection. Men are still strongly advised to use a condom.

TRENDS IN SUB-SAHARAN AFRICA

- In sub-Saharan Africa, HIV is mainly transmitted through **heterosexual contact**. More women are infected because they are biologically more susceptible to HIV than men are and often lack the power to negotiate condom use.
- Among HIV-infected adults in the region, 60 percent are women. The rising percentage of HIV-infected adults who are women is referred to as the "feminization" of the HIV epidemic.
- **Young women** ages 15 to 24 in the region are nearly three times more likely than young men to be infected with HIV. Not only do young women have greater biological susceptibility, but many resort to "transactional" sex—in exchange for money. Older men more often have disposable money and are more likely than younger men to be infected with HIV.

- 2.3 million children are living with HIV/AIDS in sub-Saharan Africa, and more than 90 percent of them became infected through mother-to-child transmission of HIV during pregnancy, birth, or breastfeeding. Antiretroviral therapy during and following delivery can significantly reduce this risk. However, many pregnant women do not receive services to prevent their infants from becoming infected and stigma still prevents many women from actively seeking services.

TRENDS IN EAST AFRICA

In most East African countries, the percentage of adults living with HIV (prevalence) is either stable or has declined in recent years. However, due to rapid population growth in the region, a *stable percentage over time* means an *increase in the number* of people living with HIV. In all of the countries shown below, more people were living with HIV in 2009 than in 2001, despite a decline in prevalence. Expanded access to antiretroviral therapy has also enabled more people to survive longer with HIV, contributing to the increasing number of those living with the disease.

HIV Infections and Trends as of 2009, East Africa

	TOTAL ADULTS AND CHILDREN INFECTED, 2009	% OF ADULTS INFECTED, 2001	% OF ADULTS INFECTED, 2009	% OF INFECTED ADULTS WHO ARE WOMEN, 2009
Ethiopia	1,100,000	na	1.4-2.9	59
Kenya	1,500,000	8.4	6.3	58
Malawi	920,000	13.9	11.0	59
Rwanda	170,000	3.7	2.9	63
Tanzania	1,400,000	7.1	5.6	61
Uganda	1,200,000	7.0	6.5	61
Zambia	980,000	14.3	13.5	57

Note: na=data not available.

Sources: UNAIDS, *2010 Report on the Global AIDS Epidemic;* and Federal Democratic Republic of Ethiopia, *Report on Progress Toward Implementation of the UN Declaration of Commitment on HIV/AIDS* (UNGASS, 2010).

PROFILES OF EAST AFRICAN HIV EPIDEMICS

HIV prevalence is generally higher in eastern and southern Africa than in West Africa.

continued...

While some knowledge of HIV is nearly universal in these countries, comprehensive knowledge about how HIV is transmitted and how people can reduce their risk is not.

- A person is considered to have comprehensive knowledge of HIV if he or she knows that a healthy-looking person can have HIV; HIV cannot be transmitted by mosquitoes or by sharing food with a person who has AIDS; and people can reduce their chances of getting HIV by only having sex with an uninfected partner who is also faithful or by consistently using condoms.

ETHIOPIA

- Ethiopia has a relatively small and stable epidemic, with an estimated 1.4 percent to 2.8 percent of adults infected. Because of Ethiopia's large population, however, it has one of the largest numbers of HIV-infected people in the world—an estimated 1.1 million people.
- Only about 7 percent of HIV-positive pregnant women receive antiretroviral drugs to reduce risk of mother-to-child transmission.
- According to the 2005 Demographic and Health Survey, about 6 percent of young women and 37 percent of young men ages 15 to 24 said they had engaged in high-risk sex during the past 12 months, but less than half of them said they had used a condom during their last high-risk encounter.

KENYA

- Kenya has one of the highest number of HIV-infected people in the world. In 2009, an estimated 92,000 people were newly infected and 80,000 people died, while 1.2 million children have lost one or both parents to AIDS.
- Three out of five of those infected are women. Nearly half of infected women say they do not want to become pregnant for at least two years or want to stop childbearing, but are not using family planning.
- Between 2009 and 2010, more than 90,000 adult men chose to be circumcised to reduce their risk of HIV, and evidence shows that HIV among circumcised men in Kenya is lower than among men who are not circumcised.
- Less than half of youth have a comprehensive knowledge of AIDS, but knowledge improved between the 2003 and the 2008-2009 DHS surveys. Condom use during last high-risk sex increased to 52 percent among men and 35 percent among women.

MALAWI

- More than one in 10 adults ages 15 to 49 in Malawi are infected with HIV, but new infections peaked in the early 1990s and the percentage of adults with HIV has been declining since 2001.
- One percent of women and 9 percent of men reported having more than one sexual partner in the past 12 months. About one-quarter of these women and men reported using a condom during the last high-risk sexual encounter.
- Older men and married men were more likely to have more than one sexual partner.
- More than half of HIV-positive women receive antiretroviral therapy to prevent mother-to-child transmission.

RWANDA

- Less than 3 percent of adults are infected, significantly less than during the aftermath of the 1994 genocide.
- Nearly everyone with a critical need for antiretroviral treatment receives it. However, just over half of pregnant women with HIV receive services to prevent mother-to-child transmission.
- Fifteen percent of younger men have been circumcised, largely for health reasons. About one in five were circumcised after age 20, presumably to reduce risk of HIV infection.

TANZANIA

- About 1.4 million people, or 3.4 percent of the total population, are living with HIV.
- About 1.3 million children have lost one or both parents to AIDS. About 60 percent of these children attend school.
- Many young people still lack correct information about HIV. Among youth ages 15 to 24, only about 40 percent of them have comprehensive correct knowledge. Youth in urban areas are better informed than those in rural areas, where most of the population lives.
- Less than one in four men who had high-risk sex with two or more partners in the past year used a condom during the last high-risk sexual encounter.

UGANDA

- Uganda has 1.2 million adults and children living with HIV, or about 3.7 percent of the total population. The

continued…

number of people newly infected with HIV peaked in the early 1990s. The decline in new infections over the following decade was attributed to fewer sexual partners, increased use of condoms, and young people beginning sexual activity at older ages.

- Declines slowed after 2000 and currently about 43 percent of new infections are occurring among people who are married or in long-term, stable relationships, implying that the relationships are not monogamous.
- More than half of HIV-infected pregnant women receive antiretroviral treatment to prevent mother-to-child transmission of HIV, while around 40 percent of infected adults in critical need of treatment are receiving it.

ZAMBIA

- Zambia has the highest HIV prevalence among these East African countries, nearly 14 percent among adults and 8 percent of the total population. Annual new infections declined only by 6 percent between 2001 and 2009.
- HIV prevalence is highest—about one in four—among women ages 30 to 34 and men ages 40 to 44.
- HIV prevalence is highest among those in the upper income levels.
- Thirty percent of women who had two or more partners in the past 12 months are HIV-positive compared with 10 percent among women who had one partner only.

Other Sexually Transmitted Infections

Sexually transmitted infections (STIs) are a common source of ill-health in the region and increase the likelihood of HIV transmission. Unprotected intercourse with different partners places people at high risk for STIs and HIV.

Data on the prevalence of STIs are scarce because the vast majority of cases are not diagnosed or treated. Nevertheless, the consequences of untreated STIs are serious and include infertility and death.

The following STIs are known to be common worldwide:

- **Chlamydia** is the most common bacterial STI. If left untreated, it causes pelvic inflammatory disease (PID), which can lead to infertility and ectopic pregnancy (when a fertilized egg starts to develop outside the uterus, usually in a fallopian tube).

- **Genital herpes** is a highly contagious infection that is easily transmitted between sexual partners and can also be passed from a mother to her baby.
- **Gonorrhea** often does not have symptoms in women but, if left untreated, can lead to PID and infertility. In men, gonorrhea can cause epididymitis, a painful condition of the testicles that can lead to infertility if left untreated.
- **Human papillomavirus (HPV)** is one of the most common STIs in the world and has dozens of subtypes. If left untreated, specific types of this virus lead to cervical cancer.
- **Syphilis** is a genital ulcer disease, which untreated can cause damage to the nervous system, heart, or brain, and ultimately death. In pregnant women, the infection greatly increases the risk of stillbirth and birth defects, making it critical to test for syphilis early in pregnancy.
- **Trichomoniasis** is caused by a parasite that affects both women and men, but symptoms are more common in women, who are also more easily cured. Failure to treat it can increase the risk of HIV transmission and low birth weight in babies.

Sources

Sevgi O. Aral and Mead Over, "Sexually Transmitted Infections," in *Disease Control Priorities in Developing Countries*, 2d ed., ed. Dean. T. Jamison et al. (New York: Oxford University Press, 2006): chapter 17. **www.dcp2.org**

Farzaneh Roudi-Fahimi and Lori Ashford, *Sexual and Reproductive Health in the Middle East and North Africa: A Guide for Reporters* (Washington, DC: PRB, 2008). **www.prb.org/Reports/2008/mediaguide.aspx**

National Institute of Allergy and Infectious Diseases, "Treating HIV-Infected People With Antiretrovirals Protects Partners From Infection," May 12, 2011. **www.niaid.nih.gov/news/newsreleases/2011/Pages/HPTN052.aspx**

Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and Macro International Inc., *Tanzania HIV/AIDS and Malaria Indicator Survey 2007-2008* (Dar es Salaam, Tanzania: TACAIDS, ZAC, NBS, OCGS, and Macro International Inc., 2008).

UNAIDS, *2010 Report on the Global AIDS Epidemic* (Geneva: UNAIDS, 2010). **www.unaids.org**

UNAIDS and WHO, *Sub-Saharan Africa AIDS Epidemic Update Regional Summary* (Geneva: UNAIDS, 2008). **www.unaids.org**

U.S. Global Health Policy. **http://globalhealth.kff.org/**

WebMD. **www.webmd.com**

Notes and Tips for Journalists

- Respect requests for anonymity from people living with HIV and AIDS, and take care in reporting people's HIV status and when interviewing children.
- Risk reduction is not the same as protection. For instance, being circumcised reduces the risk that a man will become infected with HIV but does not mean that a circumcised man cannot become infected.

continued…

- Prevalence and incidence are not the same thing. Prevalence refers to the percentage of a population living with HIV/AIDS at a given time. For example, if you describe a country as having an adult prevalence rate of 10 percent, it means that 10 percent, or one in 10 adults (ages 15 to 49) in that country has HIV. Incidence refers to new infections at a particular time and measures the frequency at which infection is occurring.

ABORTION

Many women who become pregnant unintentionally resort to abortion. When performed by a trained provider under sanitary conditions, abortion is a very safe procedure. But abortion is a very serious health issue in countries where women's access to safe abortion is limited and they resort to unsafely performed abortions. Each year, unsafe abortions lead to the deaths of 47,000 women, about 13 percent of the 358,000 maternal deaths that occur worldwide each year. Ninety-nine percent of maternal deaths occur in developing countries. The World Health Organization estimates that unsafely performed abortions account for one in seven maternal deaths in the sub-Saharan region.

- Data on abortion are not easily available. Few organizations can collect such sensitive data because when laws are restrictive, health providers and women often do not report abortions. Estimates are therefore often based on indirect information, such as what is known about contraceptive use, birth rates, and admissions to hospitals for abortion complications.

Understanding the Terms

- The term *abortion* generally refers to **induced abortion**—a procedure intended to end a pregnancy, although technically it can also refer to a **spontaneous abortion (miscarriage)**.
- The term "induced abortion" has been synonymous with **surgical abortion**, a procedure carried out in clinics or hospitals. Recently, **medication abortion** has also become available. This method relies on medications that a doctor prescribes for a woman to take at home.
- In countries where abortion is illegal or highly restricted, women sometimes try to abort the pregnancy themselves or they go to unskilled practitioners. This is an **unsafely performed abortion**, defined by WHO as "a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both."

Incidence of Abortion

- WHO estimates that about one in five pregnancies (42 million out of 210 million) each year are voluntarily aborted. Nearly half of abortions, about 20 million, are performed unsafely.

continued…

- In sub-Saharan Africa as a whole and in East Africa, most abortions are performed unsafely. Among women who have unsafely performed abortions, about one in four require medical care for severe complications.
- In sub-Saharan Africa, about 1.2 million women are hospitalized for complications of unsafe abortion each year. About half of these hospitalizations occur in East Africa.

Abortion Procedures

- Abortion is safest when performed early in pregnancy. (The length of a pregnancy is measured from the first day of a woman's last menstrual period.)
- Safe methods that can be used during the first trimester (the first 12 weeks of pregnancy) include:
  - — **Vacuum aspiration**, usually performed on an outpatient basis, uses a tube inserted into the uterus to suction out the contents of the uterus; an electric pump or manual aspirator can be used in this procedure.
  - — **Medication abortion** uses one or more drugs, most commonly mifepristone (known as RU486) and misoprostol (also known as Cytotec), to expel the contents of the uterus. The procedure usually requires at least two outpatient visits and the abortion is almost always complete within a week. In the 2 percent to 5 percent of cases where abortion is incomplete, vacuum aspiration or dilation and curettage is required.
  - — **Dilation and curettage (D&C)** uses mechanical dilators to open the cervix and metal instruments (curettes) to scrape the uterine walls. The procedure is usually performed under heavy sedation or general anesthesia and has a higher risk of complications. WHO advises that D&C be used only when vacuum aspiration or medication abortion is unavailable.
- When induced abortion is performed by qualified practitioners using correct techniques and in sanitary conditions, the procedure is safe. In the United States, for example, where abortion is legal, the death rate from induced abortion is 0.6 per 100,000 procedures, making it as safe as an injection of penicillin. In developing countries, however, the risk of death following unsafely performed abortion may be several hundred times higher.

Legal Status of Abortion

Abortion laws around the world span a wide range from very restricted (prohibited in all cases or allowed only to save a woman's life) to unrestricted. Within that range, countries may specify a number of conditions under which

a woman may have an abortion, for example, for health or socioeconomic reasons.

LEGAL STATUS OF ABORTION AND EXCEPTIONS TO PROHIBITION

ETHIOPIA

Permitted to save a woman's life, preserve her physical health, and in cases of rape, incest, or fetal impairment; or when a woman is a minor, or is physically or mentally injured or disabled.

KENYA

Permitted only to save a woman's life. Passage of a new constitution in 2010 may enable lifting some of the current restrictions.

MALAWI

Permitted only to save a woman's life. Spousal authorization required.

RWANDA

Permitted to save a woman's life or preserve her physical health.

TANZANIA

Permitted only to save a woman's life.

UGANDA

Permitted only to save a woman's life.

ZAMBIA

Permitted to save a woman's life, preserve her physical and mental health, and in cases of rape, incest, or fetal impairment; as well as on socioeconomic grounds, such as a woman's economic resources, age, marital status, and number of children.

Source: Center for Reproductive Rights, *The World's Abortion Laws* (2009).

continued…

- Written laws or policies on abortion do not necessarily reflect the reality of what is actually practiced. Women, families, and health providers may lack knowledge of the laws or interpret them differently. Enforcement of laws also can vary.
- Even where abortion is legally permitted on some grounds, women may not be able to get a safe abortion due to:
  - — Lack of trained providers.
  - — Lack of adequately equipped medical facilities.
  - — Providers unwilling to perform abortions because of complicated procedural requirements, religious beliefs, social stigma, or unclear laws.
  - — Lack of resources to pay for safe abortions.
  - — Social stigma or family disapproval.

Post-Abortion Care

Post-abortion care services are of very poor quality in sub-Saharan Africa. These factors, as well as judgmental attitudes of providers, deter some women—particularly women who are young, poor, or unmarried—from seeking medical care for complications. In East Africa, an estimated 612,000 women are hospitalized annually for complications of induced abortion. In developing countries globally, an estimated 15 percent to 25 percent of women who need treatment for complications do not receive it.

- Women who seek medical treatment after an unsafely performed abortion may require extended hospital stays, ranging from several days to several weeks. Treatment of abortion complications consumes scarce hospital resources, including personnel time, bed space, medications, and blood supply. Hospitals in some developing countries spend as much as half of their budgets to treat complications of unsafely performed abortions.
- International health organizations generally recommend that post-abortion care include:
  - — Emergency treatment for any complications of induced abortion or miscarriage.
  - — Counseling to meet women's emotional and physical health needs and other concerns.
  - — Family planning services to help women prevent an unintended pregnancy or to space pregnancies.
  - — Management of sexually transmitted infections.
  - — Reproductive or other health services that are provided on site or through referrals to other facilities.

- The Programme of Action for the 1994 International Conference on Population and Development (ICPD) called for all women to have access to treatment for abortion-related complications and post-abortion counseling, education, and family planning services, regardless of the legal status of abortion.

Sources

David Grimes et al., "Unsafe Abortion: The Preventable Pandemic," *The Lancet* 368, no. 9550 (2006): 1908-19.

Deborah Mesce and Donna Clifton, *Abortion Facts and Figures, 2011* (Washington, DC: Population Reference Bureau, 2011).

Guttmacher Institute, *Facts on Abortion and Unintended Pregnancy in Africa, In Brief* (New York: Guttmacher, 2009).

Susheela Singh, "Hospital Admissions Resulting From Unsafe Abortion: Estimates From 13 Developing Countries," *The Lancet* 368, no. 9550 (2006): 1887-92.

WHO, *Safe Abortion, Technical and Policy Guidance for Health Systems* (Geneva: WHO, 2003). **www.who.int**

WHO, *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008*, 6th ed. (Geneva: WHO, 2011). **www.who.int**

Notes and Tips for Journalists

- Avoid contributing to stereotypes about women who have abortions.
- When writing about abortion—whether safely or unsafely performed—respect a woman's request for anonymity.

FEMALE GENITAL MUTILATION/CUTTING

Female genital mutilation/cutting (FGM/C) is a harmful traditional practice in which part or all of the external female genitalia is removed. More than 100 million women and girls in the world today have undergone some form of genital cutting, usually between ages 4 and 12.

FGM/C is now widely recognized as a violation of human rights. The procedure has no medical benefits, it is not mandated by any religion, and it can pose serious health risks.

Generally, three types of cutting are practiced. In the first, Type 1, the clitoris is partly or completely removed. In Type 2, excision, the clitoris along with small skin folds of the outer genitals are removed. In Type 3, infibulation, the outside genitals are cut away and the vagina is sewn shut, leaving only a small hole through which urine and blood can pass.

Where FGM/C Is Practiced

- The vast majority of girls who undergo FGM/C live in 28 countries on the African continent, including many countries in East Africa.
- Of the 3 million African girls and women who are cut each year, nearly half of them live in just two countries: Egypt and Ethiopia.
- National FGM/C prevalence rates often hide large regional variations within countries. In Kenya for example, prevalence varies by region from less than 1 percent to almost 98 percent.

Health Consequences

- FGM/C has immediate and long-term mental and physical health effects, including severe pain, extensive bleeding, tetanus, infection, cysts and abscesses, and sexual dysfunction.
- Type 3 infibulation is widely practiced in some parts of East Africa, such as Somalia, where 79 percent of women have been infibulated. Among the countries in the figure on page 37, infibulations are highest in Ethiopia, where 6 percent of women have undergone this procedure. According to a recent WHO study, the most

continued...

extensive forms of cutting can increase complications during childbirth for both mother and baby.

Human Rights and Laws

- The United Nations Children Fund (UNICEF) calls FGM/C "one of the most persistent, pervasive, and silently endured human rights violations."
- The UN Commission on Human Rights condemned FGM/C as a violation of human rights as early as 1952. The 1989 Convention on the Rights of the Child identified the cutting as both a violent and harmful traditional practice.
- Ethiopia, Kenya, Ghana, Tanzania, and Uganda have enacted laws to prohibit FGM/C. Liberia, Nigeria, and Sierra Leone have no such laws.
- Despite legal sanctions against health providers performing FGM/C, medical practitioners are increasingly performing the procedure as parents seek safer ways to continue the practice.

Tradition Perpetuates the Practice

- FGM/C is deeply rooted in the social, economic, and political structures of communities.
- In communities where it is practiced, the procedure is perceived as a way to curtail premarital sex and preserve virginity of girls, and parents believe their daughters will not be marriageable if they are not cut.
- Girls who undergo the cutting are thought to bring honor and respect to themselves and their families, while those who do not bring shame and exclusion.

Is it Cutting, Circumcision, or Mutilation?

Women's rights and health advocates have more often labeled the procedure *female genital mutilation* to emphasize the damage caused by the procedure. Some experts refer to it as *female genital cutting* and insist that this is a less judgmental term. The once-heated debate appears to have been resolved by many organizations and programs that now refer to *female genital mutilation/cutting*, recognizing that the extent of the procedure ranges from a ritual pricking of the clitoris with a needle (classified as Type IV), a practice in parts of Indonesia, to the most severe form of infibulation.

The term *female circumcision* is sometimes used, but health experts say that it mistakenly implies an analogy

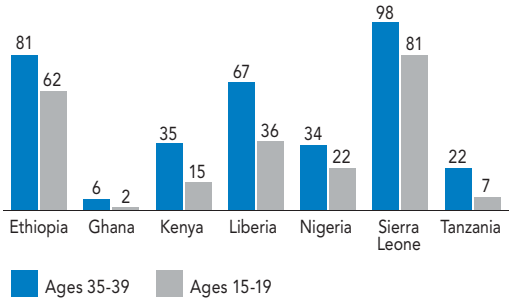
to male circumcision, in which the foreskin of the penis is removed. In contrast to FGM/C, male circumcision does not harm the organ itself, and it confers some health benefits.

Trends

A decline in the percentage of women who have been cut among older age groups as compared with younger age groups can signal that the practice is slowly being discontinued.

- In Kenya, where FGM/C usually takes place during childhood or early adolescence, communities have been mobilizing to abandon the practice for two decades. Overall prevalence of FGM/C is 27 percent, but among girls ages 15 to 19, 14 percent have been cut as compared to 35 percent of women ages 35 to 39.
- Virtually no change has occurred in Somalia, where 98 percent of women still undergo FGM/C. In Uganda, prevalence is less than 1 percent countrywide but it is practiced at high rates in some communities.

Percent of Women in Two Age Groups Subjected to Female Genital Cutting in Selected East and West African Countries



Sources: Charlotte Feldman-Jacobs and Donna Clifton, *Female Genital Mutilation/Cutting: Data and Trends, Update 2010* (Washington, DC: Population Reference Bureau, 2010), **www.prb.org/Publications/Datasheets/2010/fgm2010.aspx**; and Tanzania DHS, 2010.

Sources

National Research Council and Institute of Medicine, *Growing Up Global: The Changing Transitions to Adulthood in Developing Countries*, ed. Cynthia B. Lloyd (Washington, DC: The National Academies Press, 2005).

UNICEF, "Changing a Harmful Social Convention: Female Genital Mutilation/Cutting," *Innocenti Digest* (Florence, Italy: UNICEF, 2007).

UNFPA, *A Holistic Approach to the Abandonment of Female Genital Mutilation/Cutting* (New York: UNFPA, 2007). **www.unfpa.org/publications**

United Nations Special Session on Children, "A World Fit for Children," May 2002. **www.unicef.org/specialsession/wffc/**

continued…

Notes and Tips for Journalists

- Be sensitive to the stigma surrounding FGM/C, as it affects both girls and women who have been cut as well as those who have not.
- "Medicalization" of FGM/C refers to the involvement of health professionals in performing FGM/C at the request of parents. This is against the law in most countries.

ADOLESCENTS AND YOUNG ADULTS

In sub-Saharan Africa, 175 million people, one in every five, are between the ages of 15 and 24. Most people become sexually active during this age range, which makes it a critical time for them to learn about sexual and reproductive health risks, including HIV and other sexually transmitted infections, unintended pregnancy, early childbearing, and unsafely performed abortion.

The youth population of sub-Saharan Africa has increased by 70 million in one decade (2001 to 2011), fueling a greatly increased demand for "youth-friendly" reproductive health services that offer comprehensive information and services to young people in a respectful and confidential manner.

Sexual Health Risks

In East Africa, young women ages 14 to 24 are two-and-one-half times as likely as young men to be infected with HIV because:

- Females are biologically more susceptible than heterosexual men to becoming infected.
- Their husbands or sexual partners tend to be older, more likely to have had previous sexual relationships, and to already be infected with HIV.
- Young women often are unable to negotiate safer sex and condom use with their sexual partners.
- Young women often lack access to sexual and reproductive health information and services.

Unintended Pregnancy

- Nearly half of sexually active never-married adolescent females say they do not want to become pregnant in the next two years but are not using contraception.
- More than one-third of adolescent pregnancies in sub-Saharan Africa are unintended.
- One in three unintended pregnancies among adolescents is aborted.

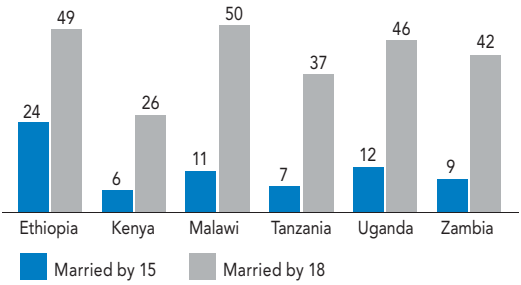
continued…

- Nearly 60 percent of women in sub-Saharan Africa who have unsafely performed abortions are younger than 25 and one-quarter are still in their teens.

Early Marriage and Childbearing

- Marriage before age 18 is considered child marriage and violates international law as well as the laws of many countries where it continues to be practiced. Laws against early marriage often go unenforced because of poverty and the realities of prevailing social and cultural norms.
- Child marriage is especially common among poor and rural families who marry their daughters for economic benefit, or out of fear that premarital sex will lead to an out of wedlock pregnancy. Girls are often married to much older men, increasing the girl's risk of a sexually transmitted infection, including HIV.
- Marriage and childbearing take place at young ages in the East Africa region as a whole. In Ethiopia, one in four girls is married by age 15. In Ethiopia, Malawi, and Uganda, nearly half of women marry before they turned 18.
- Child marriage is less common but still prevalent in Kenya, where 26 percent of girls are married by age 18.

Percent of Young Women Married by Age 15 and by Age 18

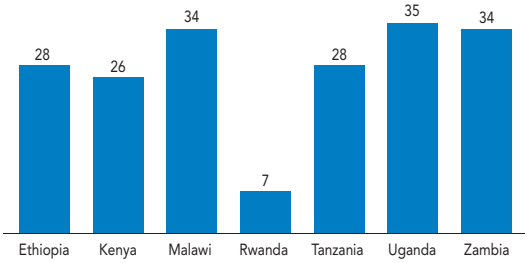


Source: Demographic and Health Surveys (Ethiopia 2005, Kenya 2008-2009, Malawi 2004, Tanzania 2010, Uganda 2006, and Zambia 2007).

- Early marriage is related to education—girls who drop out of school may marry early and girls who marry at a young age usually drop out of school. A low level of education has lifelong economic and social consequences for girls, and many programs to delay marriage first aim to keep girls in school.
- Early marriage is typically followed by early childbearing, as young wives are often expected to demonstrate their fertility as soon as possible.

- The proportion of adolescents who have given birth by the age of 18 ranges from 7 percent in Rwanda to 35 percent in Uganda.

Percent of Young Women Giving Birth by Age 18



Source: Demographic and Health Surveys (Ethiopia 2005, Kenya 2008-2009, Malawi 2004, Rwanda 2007-2008, Tanzania 2010, Uganda 2006, and Zambia 2007).

- Teenage mothers face a greater risk of dying of pregnancy-related causes than women who give birth in their 20s and 30s. Because their bodies are often not fully developed, those who give birth before age 16 are at an especially high risk of obstructed labor, fistula, and permanent damage to their reproductive organs.
- Infants born to young mothers are more likely to have a low birth weight (less than 2,500 grams), which is associated with a range of health problems, including breathing difficulties due to immature lungs. Infants born to girls under age 18 face a 60 percent greater risk of dying in the first year of life than infants born to mothers over age 18.
- Women who give birth as teenagers are more often poorer than those who delay childbearing. These young mothers are more likely to be poorly educated, to have fewer income-producing opportunities, and to be socially isolated.

Sources

Ann E. Biddlecom et al., *Protecting the Next Generation in Sub-Saharan Africa: Learning From Adolescents to Prevent HIV and Unintended Pregnancies* (New York: Guttmacher Institute, 2007).

Alexandra Hervish and Charlotte Feldman-Jacobs, *Who Speaks for Me? Ending Child Marriage* (Washington, DC: PRB, 2011).

National Research Council and Institute of Medicine, *Growing Up Global: The Changing Transitions to Adulthood in Developing Countries*, ed. Cynthia B. Lloyd (Washington, DC: The National Academies Press, 2005). **www.nap.edu**

Population Reference Bureau, *2009 and 2010 World Population Data Sheets* (Washington, DC: PRB, 2009 and 2010).

UN, *World Youth Report 2007: Young Peoples' Transition to Adulthood: Progress and Challenges* (New York: UN Department of Economic and Social Affairs, 2007).

U.S. Bureau of the Census, International Data Base, accessed at **www.census.gov/ipc/www/idb/informationGateway.php**, on April 22, 2011.

continued…

Notes and Tips for Journalists

- When talking to young people for a story, be sure they understand you are a journalist. Recognize that adolescents can be endangered if they are revealed to have engaged in socially unacceptable behavior such as sex before marriage. Respect the adolescent's right to privacy and do not ask personal questions in the presence of family members or other adults.

GLOSSARY OF SEXUAL AND REPRODUCTIVE HEALTH TERMS

Adolescence: The transitional period between puberty and adulthood, generally including ages 10 to 19. Data on adolescent health, education, employment, and behaviors are usually provided for ages 15 to 19. The youth population is generally defined as ages 15 to 24. (page 39)

Antenatal period: The period from conception until the onset of labor, approximately 40 weeks. (page 19)

Acquired immune deficiency syndrome (AIDS): A progressive, usually fatal condition that reduces the body's ability to fight certain infections. It is caused by infection with human immunodeficiency virus (HIV). There is no cure for AIDS, but antiretroviral therapy (ART) can control symptoms and extend life, often for many years. (page 21)

Childbearing years: The reproductive age span of women, assumed for statistical purposes to be ages 15 to 44 or 15 to 49. (page 7)

Chlamydia: A sexually transmitted infection that often causes irregular bleeding and pain during intercourse in women, burning during urination in men, and discharge in both men and women. If left untreated, chlamydia can lead to pelvic inflammatory disease. (page 26)

Circumcision (male): Surgical removal of the foreskin or prepuce of the penis, commonly done for religious or cultural reasons during infancy, but increasingly for health reasons during adulthood. Men who have had the procedure have been shown to have reduced risk of becoming infected with HIV or other sexually transmitted diseases. (page 22)

Contraceptive prevalence rate: The proportion of women of reproductive age (usually ages 15 to 49) who use a contraceptive method at a particular time. Generally shown for women who are married or "in union," but may also be given for unmarried women. (page 11)

Dual protection: Using two types of contraceptive methods at the same time: a barrier method such as a condom, and another modern method such as the oral pill

continued...

or intrauterine device, to simultaneously safeguard against pregnancy and sexually transmitted infections (STIs), particularly HIV. (page 13)

Eclampsia and pre-eclampsia: Complications of pregnancy. Pre-eclampsia generally appears in the second half of pregnancy and is marked by high blood pressure, swelling in the hands, legs, and feet, and high protein levels in the urine. It can progress to eclampsia, which can cause convulsions and coma and can be fatal.

Ectopic pregnancy: A life-threatening condition in which pregnancy forms outside of the uterus. The pregnancy can cause massive internal bleeding or spontaneous abortion and must be surgically terminated. (page 26)

Emergency contraceptive (EC): Also known as the "morning-after pill," EC is used to prevent pregnancy after unprotected intercourse, such as when a contraceptive fails or when sex occurs without contraception. (page 14)

Female genital mutilation/cutting (FGM/C): All procedures involving cutting or removing all or part of the external female genitalia or other injury to the female genital organs. Also referred to as female genital mutilation (FGM) and female circumcision. (page 35)

Fistula or obstetric fistula: An abnormal opening between the vagina and bladder, or between the vagina and rectum that can lead to incontinence—the inability to retain urine and/or feces. Obstetric fistulae are typically caused by obstructed labor when the baby cannot pass through the birth canal. (page 18)

Gonorrhea: A sexually transmitted infection that, if left untreated, can lead to pelvic inflammatory disease in women and infertility in men and women. (page 27)

Hemorrhage: Heavy bleeding, the leading cause of maternal death worldwide. (page 18)

Human immunodeficiency virus (HIV): A virus that attacks the body's immune system, making the body unable to fight infection. It can lead to AIDS, which is the last stage of HIV infection. Because there is no cure, HIV is the most dangerous sexually transmitted infection. (page 21)

Human papillomavirus (HPV): A group of related viruses, more than 40 of which are common sexually transmitted infections. Most show no symptoms, but genital HPV can cause several different diseases in women and men, especially genital warts. Certain types of HPV can lead to cancers of the cervix, vagina, penis,

oral cavity, head and neck, or anal canal if not detected and treated early. (page 27)

Hypertension: High blood pressure as measured by a systolic pressure above 140 with a diastolic pressure above 90. (page 20)

Incidence rate: A measure of the frequency with which a disease occurs in a particular time frame; for example, the number of people who are newly infected with HIV within one year per 1,000 people at risk.

Incomplete abortion: An abortion that leaves products of conception in the uterus.

Induced abortion: The intentional ending of a pregnancy. (page 29)

Lactational amenorrhea method (LAM): A family planning method that relies on nearly exclusive breastfeeding without supplemental feeding to provide natural protection against pregnancy for up to six months after childbirth. (page 12)

Lifetime risk of maternal death: The probability that a woman will die during her lifetime of causes related to pregnancy and delivery. It combines the probability of becoming pregnant with the risk of death from each pregnancy, across a woman's reproductive years. (page 18)

Live birth: Birth of an infant who shows some sign of life, such as breathing or a heartbeat, regardless of the length of the pregnancy. (page 20)

Low birth weight: A weight at birth of less than 2,500 grams, which increases the infant's risk of death and disability. (page 41)

Manual vacuum aspiration: A method of removing tissue from the uterus by suction for diagnostic purposes or to remove the elements of conception. (page 30)

Maternal morbidity: Illness or disability occurring in relation to pregnancy, childbirth, or in the postpartum period. (page 20)

Maternal mortality: The death of a woman while pregnant, during delivery, or within 42 days (six weeks) of delivery or termination of the pregnancy. The cause of death is always related to or aggravated by the pregnancy or its management; it does not include accidental or incidental causes. (page 20)

continued...

Maternal mortality ratio: The number of women who die during pregnancy, or during the first 42 days after delivery, per 100,000 live births in a given year from any cause related to or aggravated by pregnancy, but not from accidental or incidental causes. The ratio reflects the risk women face of dying once pregnant. (page 20)

Millennium Development Goals (MDGs): A set of eight measurable goals agreed upon by world leaders following the United Nations Millennium Summit in 2000, to combat poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women. MDG 5, for example, aims to reduce maternal deaths by three-fourths of their 1990 level and to provide universal access to reproductive health by the target date of 2015. Progress toward these goals is being carefully monitored in most countries and by the UN. **www.mdg.org** (page 2)

Pelvic inflammatory disease (PID): A progressive infection that harms a woman's reproductive system. It can occur throughout the pelvic area, fallopian tubes, uterus, uterine lining, and ovaries. PID can lead to infertility (sterility), ectopic pregnancy, chronic pain, and death. (page 27)

Post-abortion care: Includes emergency treatment of incomplete abortion and potentially life-threatening complications as well as post-abortion family planning counseling and services. (page 32)

Postpartum period: After childbirth; the period from the delivery of the placenta through the first 42 days after delivery. The "extended postpartum period" refers to the first 12 months after birth.

Prenatal period: The period between conception and birth; now more commonly called the antenatal period. (page 19)

Prevalence rate: A measure of how prevalent a particular condition or circumstance is in a given population at a given time. For example, the HIV prevalence rate is the proportion of the total population living with HIV at a given time. (page 23)

Reproductive age: The ages during which women are able to bear children, generally considered to be 15 to 44 or 15 to 49.

Sexually transmitted infection (STI): Any infection acquired mainly through sexual contact; also referred to as sexually transmitted disease (STD). (page 21)

Skilled birth attendant: Refers exclusively to people who have the training and skills necessary to proficiently manage normal deliveries and diagnose, manage, or refer complications of pregnancy and delivery, such as doctors,

nurses, and midwives, but not traditional birth attendants (TBAs). (page 20)

Spontaneous abortion: Miscarriage, or loss of a pregnancy due to natural causes. (page 29)

Stillbirth: Definition of this term varies by country; however, for the purposes of international comparison, the World Health Organization defines stillbirth as a baby born with no signs of life at or after 28 weeks' gestation. (page 27)

Syphilis: A sexually transmitted infection that, if left untreated, can damage the nervous system, heart, or brain, and ultimately cause death. In pregnant women, the infection greatly increases the risk of stillbirth and birth defects. (page 27)

Total fertility rate: The average number of children that a woman would have assuming that the current age-specific fertility rates remain constant throughout her childbearing years. (page 7)

Trichomoniasis: A sexually transmitted infection; one of the causes of vaginal discharge. (page 27)

Tubal ligation: Female sterilization. A procedure to "tie the tubes" (fallopian tubes) of a woman, which prevents transport of an egg to the uterus and blocks the passage of sperm up the tube where fertilization normally occurs. (page 11)

Unmet need for family planning: The percentage of married women who prefer to wait at least two years before another birth or to stop giving birth but are not using contraception. Women who rely on a less effective traditional method may be considered to have an unmet need for effective contraception. (page 14)

Unsafely performed abortion: Termination of a pregnancy either by someone lacking the necessary skills, or in an environment lacking minimal medical standards, or both. (page 29)

Vasectomy: Male sterilization. A permanent form of contraception in which the vas deferens, the channel through which sperm travel from the testicles, is permanently shut off either by cutting, cauterizing, or otherwise blocking the vas. The sperm are reabsorbed into the body. Semen is still produced, but without sperm, the egg is not fertilized to begin a pregnancy. (page 11)

continued...

Sources

Arthur Haupt and Thomas Kane, *PRB's Population Handbook*, 5th ed. (Washington, DC: Population Reference Bureau, 2004). **www.prb.org**

Reproductive Health Outlook. **www.rho.org**

White Ribbon Alliance. **www.whiteribbonalliance.org**

WebMD. **www.webmd.com**

World Health Organization. **www.who.org**

SOURCES OF INFORMATION

The following are evidence-based sources of information on sexual and reproductive health and related topics. Many were consulted in preparing this guide.

African Population and Health Research Center (APHRC) is a nonprofit, nongovernmental organization that conducts policy-relevant research on population, health, and education issues in sub-Saharan Africa. Based in Nairobi, APHRC promotes the use of research in policy and practice, and strengthens the research capacity of African scholars and institutions. **www.aphrc.org**

The Centre for African Family Studies (CAFS) is a nongovernmental African institution dedicated to strengthening the capacities of organizations and individuals working in the field of reproductive health, population, and development to contribute to improving the quality of life of families in sub-Saharan Africa. With a main office in Nairobi and country offices in Addis Ababa, Ethiopia; Abuja, Nigeria; and Lomé, Togo, CAFS conducts courses and provides research and consultancy services. **www.cafs.org**

Centers for Disease Control and Prevention (CDC) is a U.S. government agency whose mission is to promote health and quality of life by preventing and controlling disease, injury, and disability. It works throughout the United States and the world monitoring health, investigating health problems, conducting research, and implementing prevention strategies. **www.cdc.gov**

Center for Reproductive Rights is a nonprofit legal advocacy organization based in the United States dedicated to promoting and defending women's reproductive rights worldwide. **http://reproductiverights.org**

Demographic and Health Surveys (DHS) are a global data collection effort funded by the U.S. Agency for International Development (USAID) and in-country governments, donors, and other organizations. These nationally representative household surveys collect data on demographic patterns, fertility, health, and nutrition for policy and program planning. **www.measuredhs.com**. *The Journalist's Guide to the Demographic and Health Surveys*

continued...

provides demographic terms and web addresses for tools to use the DHS. **www.measuredhs.com/pdfs/guide%20FINAL.pdf**

Global Health Gateway operated by the Kaiser Family Foundation provides journalists and others with the latest data and information on the U.S. role in global health, and on HIV, tuberculosis, malaria, child health, and other topics. **www.globalhealth.kff.org**

Guttmacher Institute is a U.S.-based, nonprofit organization focused on sexual and reproductive health research, policy analysis, and public education. **www.guttmacher.org**

International Consortium for Emergency Contraception unites numerous international organizations working in the field of family planning in a mission to expand access to emergency contraception worldwide, especially in developing countries. **www.cecinfo.org**

Ipas is an international nonprofit organization that has worked for three decades to increase women's ability to exercise their sexual and reproductive rights and to reduce deaths and injuries of women from unsafely performed abortion. **www.ipas.org**

Population Council's Reproductive Health Program focuses on improving sexual and reproductive health—especially for disadvantaged populations in developing countries—through the development and introduction of appropriate technologies, assistance to policymakers, and innovations in service delivery. The New York-based Council has regional staff around the world. **www.popcouncil.org**

Population Reference Bureau (PRB) aims to bridge the gap between research and policy on a wide range of topics including reproductive health, gender, global health priorities, population dynamics, the environment, and youth. The PRB website provides a wealth of population-related information including a graphics bank and tutorials on demographic issues. **www.prb.org**

United Nations Population Fund (UNFPA) helps governments formulate policies and strategies to reduce poverty, improve reproductive health, promote girls' and women's empowerment, and work for sustainable development. The Fund also supports data collection and analysis in select countries. **www.unfpa.org**

World Health Organization (WHO) is a UN agency established in 1948 whose mission is to help people attain the highest possible level of health. WHO monitors global health status and disease outbreaks, and publishes statistics on causes of death and disability by country and region. **www.who.int**

UNAIDS, the United Nations Programme on HIV/AIDS, was established to help countries establish policies and programs to prevent new HIV infections, care for people living with HIV, and mitigate the impact of the epidemic. UNAIDS provides annual reports and country-level reports on the status of HIV and AIDS throughout the world. **www.unaids.org**

COUNTRY	FEMALE POPULATION MID-2011 (MILLIONS)	% OF WOMEN AGES 20-24 MARRIED BY AGE 18	LIFETIME BIRTHS PER WOMAN (TFR)	% OF MARRIED WOMEN USING CONTRACEPTION		% OF BIRTHS ATTENDED BY SKILLED PERSONNEL	MATERNAL DEATHS PER 100,000 LIVE BIRTHS	LIFETIME CHANCE OF DYING FROM MATERNAL CAUSES 1 IN:	% OF ADULTS AGES 15-49 WITH HIV/AIDS, 2009		PREVALENCE OF FGM/C, AGES 15-49 (%)
				ANY METHOD	MODERN				FEMALE	MALE	
Ethiopia	43.8	49	5.4	16	15	6	470	40	na	na	74.3
Ghana	12.2	25	4.0	24	17	57	350	66	2.2	1.4	3.8
Kenya	21	26	4.6	46	39	44	530	38	7.6	4.9	27.1
Liberia	2.1	38	5.9	11	10	46	990	20	1.8	1.1	58.2
Madagascar	10.4	48	4.8	40	29	44	440	45	0.1	0.3	na
Malawi	8.1	50	5.7	46	42	73	510	36	13.2	8.9	na
Mozambique	12.3	52	5.1	17	12	55	550	37	13.6	9.2	na
Nigeria	80.7	39	5.7	15	10	39	840	23	4.4	2.9	29.6
Rwanda	5.4	13	5.5	36	27	52	540	35	3.5	2.3	na
Sierra Leone	3.1	48	5.1	8	7	42	970	21	1.9	1.3	94
Tanzania	23.2	41	5.4	34	27	51	790	23	6.8	4.5	14.6
Uganda	17.4	46	6.7	24	18	42	430	35	7.7	5.3	0.6
Zambia	6.8	42	6.2	41	33	47	470	38	15.0	11.1	na
Zimbabwe	6.6	34	3.7	60	58	69	790	42	17.3	11.2	na

Sources: Demographic and Health Surveys (Ethiopia 2005, Ghana 2008, Kenya 2008-2009, Malawi 2010, Rwanda 2007-2008, Tanzania 2010, Uganda 2006, and Zambia 2007); and Population Reference Bureau, *The World's Women and Girls 2011 Data Sheet*.

A JOURNALIST'S GUIDE to **SEXUAL** and **REPRODUCTIVE HEALTH** in EAST AFRICA

2011

POPULATION REFERENCE BUREAU

www.prb.org