A Media Guide on Sexual and Reproductive Health

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Margaret Sentamu-Masagazi
Executive Director – UMWA

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.

Maternal mortality rate is highest in Africa, where poor sexual and reproductive health is prevalent. UNFPA reports that illnesses and deaths from poor reproductive health account for one-fifth of the global burden of disease, and that only 20% of married women use modern contraception. Unfortunately, the media reportage and attention given to sexual and reproductive health remains low. This is due to several reasons including the inability or lack of motivation to report such issues and inadequate information and understanding of issues to do with these issues.

The media plays a vital role in galvanizing governmental and non-governmental support on issues related to SRHR by continually raising public awareness to a targeted audience such as policymakers, program implementers and other key stakeholders. As a result, reproductive health issues become more visible in developmental discussions. By promoting openness and public discussions, the media can help break the culture of silence and level of stigma and discrimination associated with SRHR issues. Also, bringing these issues to the fore will provide information that will positively affect reproductive health policy.

The media drives the news and decide how it is presented. It is also a major key in setting a nation's policy agenda. Before an issue can capture the attention of policy makers, the media must first report the issue, then present how it affects national development. Issues receive attention usually because it affects a large number of people or because inactions will lead to nationwide setbacks.

Mass media and new media have the potential to promote better outcomes for sexual and reproductive health. Media can persuade governments to increase funding for birth control, maternal health and safe child delivery and programs that promote safe sexual behaviour for the youth.

To grab the attention of high level policy makers, strategic and informed media coverage should be engaged by SRHR advocates, health personnel, as well as mass media and social media practitioners. It is imperative that they are familiar with the policies and programs needed to be addressed, so as to help shape policies and public opinion. Media attention is also crucial to holding policymakers accountable for spending and equitably maximizing resources allocated for SRHR projects, most especially in countries where corruption is endemic.

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:

- 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 Ugandan journalists educate the public and policymakers on these issues by bringing together the latest available data on sexual and reproductive health in comparison to some Eastern Africa countries in some cases.

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).

Sexual and Reproductive Health Rights

Sexual and reproductive rights (SRR) are enshrined in many international conventions, agreements, laws and declarations. The right to sexual and reproductive health provides that people are able to enjoy a mutually satisfying and safe relationship free from coercion or violence. These rights provide a frame work within which sexual and reproductive wellbeing can be achieved.

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.

Implicit in this last condition are the right of men and women to be informed and to have access to and utilize safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods to regulate fertility which are in conformity with the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

ICPD called for a people-centred 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 including Uganda 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.

At the national level the government of Uganda, with the stewardship of the Ministry of Health (MOH), developed the second National Health Policy (NHP II) to cover a ten-year period from 2010/11 to 2019/20. The third Health Sector Strategic Plan (HSSP III) was developed to operationalize the NHP II and the health sector component of the National Development Plan (NDP) 2010/11-2014/15, which is the overall development plan for Uganda.

The HSSP III provides an overall framework for the health sector. Its major aim is to contribute towards the overall development goal of the government of Uganda by accelerating economic growth to reduce poverty.

Uganda's Policy Framework on Sexual and Reproductive Health

Uganda's health sector is guided by the National Health Policy (NHP II) within which several other interventions have been developed to tackle the country's health challenges. The development of this NHP II was informed by the National Development Program (NDP) for the period 2009/10 - 2013/14, the overall development agenda for Uganda.

The NDP places emphasis on investing in the promotion of people's health, as a fundamental human right for all people. Constitutionally, the Government of Uganda (GoU) has an obligation to provide basic medical services to its people and promote proper nutrition.

The Constitution further provides for all people in Uganda to enjoy rights and opportunities and have access to education, health services and clean and safe water. Investing In the promotion of people's health shall ensure they remain productive and contribute to national development.

Uganda's population is estimated at 33 million, as at 2010, with a life expectancy of 51 years for men and 52 years for women. With a population growth rate of 3.4% and total fertility rate of 6.2 children per woman, Uganda's population is projected to reach 58.8 million by 2025. Infant mortality is at 54 deaths per 1,000 live births, with neonatal mortality making 50% of the cases. The population is largely young with about 50% being children below 18 years. This large population of young people and women and men in their reproductive age which has implications for sexual and reproductive health commodities and services. The aim of the sexual and reproductive health is to reduce mortality and morbidity relating to sexual and reproductive health, and rights. Adequate financing of sexual and reproductive health is important as it seeks to reduce maternal mortality, under five mortality and total fertility rates; and improve sexual and reproductive health of the people.

Maternal mortality ratio is 435 per 100,000 live births with a life time risk of 1 in 25. For every maternal death, about 20 other mothers will have developed complications, including obstetrics fistula that is estimated at 2.6%, most of which have not been repaired. Infant mortality is at 55 per 1000 live births, with neonatal mortality making 50% of the cases. Though the adolescent age specific fertility rate is dropping, teenage pregnancy rate is at 24% (UDHS, 2011). The HIV/AIDS indicator survey, 2011 indicates that the HIV prevalence rate has recently risen to 7.3% from 6.7% previously. The contraceptive Prevalence Rate is 29.9%, and the unmet need for family planning stands at 34.3% (UDHS, 2011).

In response to the above, the Government of Uganda has developed various interventions to deal with these undesired situations. These include, the development and implementation of the National HIV/AIDS Strategic Plan; Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity; and the Strategy to Improve Reproductive Health in Uganda, among others.

The Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity In Uganda (2007-2015), together with the Strategy to Improve Reproductive Health in Uganda (2005-2010) set the basis for development of a Comprehensive Reproductive Health Plan, in line with priority policy issues in the National Health Policy II (2009/10 – 2019/20).

The Reproductive Health Commodity Security Strategic Plan is central to achieving targets set out in the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda. This was against the background of the poor state of Sexual and Reproductive Health and limited access to and use of reproductive health commodities for the majority of the population in Uganda, due to a number of challenges.

Among the challenges that were identified prior to establishment of the above framework, were weak policy and regulatory environment, lack of commitment by key actors, poor coordination, limited financial resources, capacity, non-availability of reproductive health commodities and lack of client awareness. Therefore the 5 year strategic plan on reproductive Health Commodity Security (2010/11-2014/15) was developed to address the above challenges affecting reproductive health in Uganda. The strategic plan objectives are:

- To increase the contraceptive prevalence rate from 23% to 50% and reduce the unmet need for contraceptive from 40% to 5% by 2015.

- Increase the proportion of health facilities with NO stock outs of selected Reproductive health commodities to 80% by 2015.

- To increase public sector/ government budget allocation and expenditure on reproductive health commodities, including contraceptives to 80% by 2015.

The Reproductive System

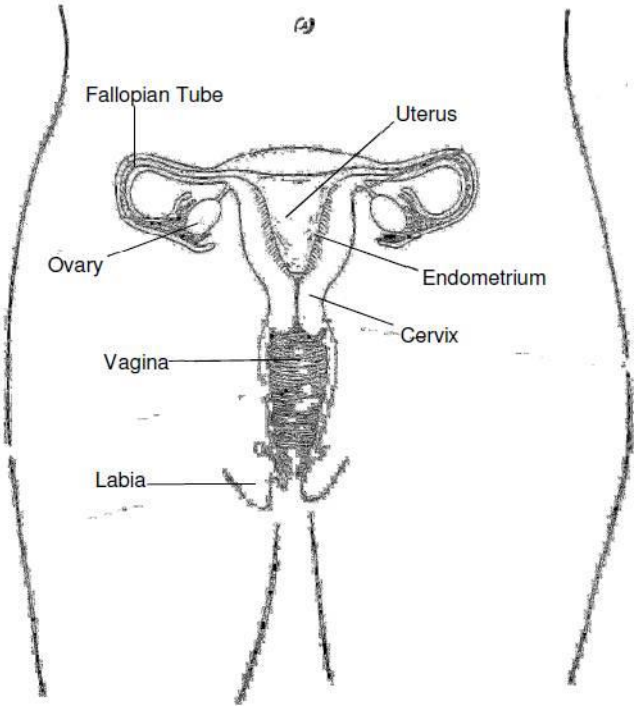
The Female Reproductive System

- 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 foetus. At birth, the foetus 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 torn or stretched during exercise or insertion of a tampon, and some women are born without a hymen.

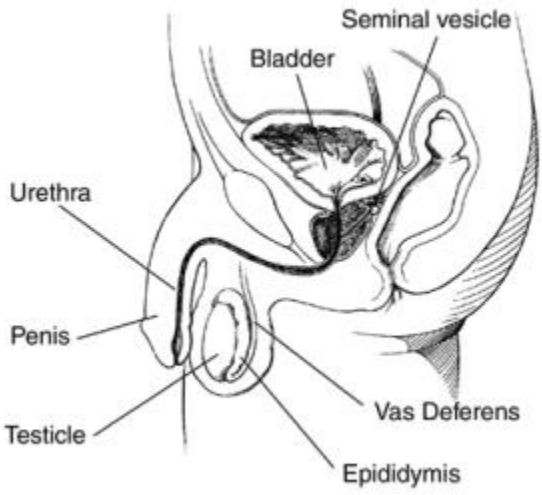
The Male Reproductive System

- 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).

- On average, a Ugandan woman would have 6.2 children by the end of her reproductive years if the current fertility pattern prevailed. The UDHS results show that fertility in Uganda has remained stable over the past decade. Although the total fertility rate (TFR) declined from 7.3 births per woman in 1986-88 to 6.2 births in 2011, the TFR has remained at the same level since then.

- Fertility declined only slightly between 2000-01 and 2006, from 6.9 children per woman to 6.7 children, and decreased further to 6.2 children in 2011.

- Childbearing begins early in Uganda. More than one-third (39 percent) of women age 20-49 gave birth by age 18, and more than half (63 percent) by age 20.

- About two thirds (66 percent) of births occur within three years of a previous birth; 25 percent occur within 24 months.

- Twenty four percent of women age 15-19 are already mothers or pregnant with their first child.

Table 1 Current fertility

Age-specific and total fertility rates, the general fertility rate, and the crude birth rate for the three years preceding the survey, by residence, Uganda 2011			
Residence			
Age Group	**Rural**	**Urban**	**Total**
15-19	91	146	134
20-24	205	350	313
25-29	194	318	291
30-34	171	248	232
35-39	87	187	172
40-44	16	82	74
45-49	(2)	26	23
TFR (15-49)	3.8	6.8	6.2
GFR	148	234	217
CBR	40.3	42.4	42.1
Notes: Figures in parentheses are based on 125-249 unweighted person-years of exposure. Age-specific fertility rates are per 1,000 women. Rates for age group 45-49 may be slightly biased due to truncation. Rates are for the period 1-36 months prior to interview. ***TFR:*** *Total fertility rate expressed per woman* ***GFR:*** *General fertility rate expressed per 1,000 women age 15-44* ***CBR:*** *Crude birth rate expressed per 1,000 population*			

How does fertility in Uganda compare to that in other countries?

According to findings from the 2000-2001 UDHS and data available from other DHS surveys, Uganda has the highest TFR of any nation in eastern and southern Africa.

Table 2: TFR in eastern and southern Africa, DHS surveys

Country	Year	TFR
Uganda	2011	6.7
Malawi	2010	5.7
Zambia	2007	6.2
Kenya	2008-2009	4.6
Mozambique	2003	5.5
Ethiopia	2011	4.8
Rwanda	2008	5.5
Tanzania	2010	5.4
Namibia	2006-2007	3.6
Lesotho	2009	3.3

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.

- 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):

Country	Year	Percentage
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 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 gonorrhoea 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

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 gynaecologists are the medical specialists to consult on questions of reproductive health and family planning.

Use this space
List the main international conventions, agreements, laws and declarations on Sexual and reproductive rights (SRR) your country has signed.

List some of the policies and frameworks guiding sexual and reproductive health in your country

Family Planning

Family planning refers to a conscious effort by an individual or a couple to limit or space the number of children they want to have through the use of contraceptive methods.

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.

The government of Uganda is committed to improving family planning use and access in the country as highlighted in various government plans and policies. The five-year National Development Plan (2010/11-2014/15) acknowledges that limited access to family planning services hinders overall development of the society and of women in particular. One of the goals outlined in the plan is to reduce unmet need for family planning by ensuring access to family planning services, especially in rural areas (NPA, 2010). Furthermore, the 2008 National Population Policy urges special emphasis on family planning and reproductive commodity security, including use of contraceptives (MoFPED, 2008). In addition, some of the strategies in the Health Sector Strategic and Investment Plan (2010/11-2014/15) are geared toward improvement of overall sexual and reproductive health and rights of the population. Goals include provision of integrated family planning services in all health facilities at all levels, procurement and distribution of contraceptives to men and women of reproductive age, and design of programmes to engage men in family planning services and use. Budget constraints, however, serve as a major impediment to these interventions (MOH, 2010b).

- In Uganda, the proportion of married women using any method of contraception (modern or traditional) is generally higher than unmarried women. Awareness of at least one method of contraception is nearly universal.
- Three in ten currently married women are using a method of contraception, with most women using a modern method (26 percent).
- Injectables remain the most commonly used method of contraception among currently married women (14 percent).
- The use of modern methods of family planning has consistently increased over the past decade, growing from 14 percent of currently married women in 2000-01 (excluding LAM) to 26 percent in 2011.

- The government sector remains the major provider of contraceptive methods for nearly half of the users of modern contraceptive methods (47 percent).

- Forty-three percent of family planning users in Uganda discontinue use of a method within 12 months of starting its use. Fear of side effects is the main reason for discontinuation (16 percent). The pill has the highest discontinuation rate (54 percent).

- Only one-third of the users of the rhythm/moon beads method know when the fertile period occurs.

- About one-third (34 percent) of currently married women have an unmet need for family planning services, with 21 percent in need of spacing and 14 percent in need of limiting.

Percent of Married Women Using a Modern or Traditional Contraceptive Method

Modern methods are more widely known than traditional methods; almost all women and men know of a modern method (98 and 100 percent, respectively) compared with 74 percent of all women and 83 percent of all men who know of a traditional method. Among both women and men, the male condom (97 and 99 percent, respectively), injectables (94 and 91 percent), and the pill (93 and 92 percent) are the most well-known modern methods, while LAM (13 and 11 percent) is the least known modern method.

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); 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.

- **Traditional methods** include periodic abstinence (also known as the calendar or rhythm method) and withdrawal.

Percentage of all respondents, currently married respondents, and sexually-active unmarried respondents age 15-49 who have heard of any contraceptive method, by specific method, Uganda 2011						
	Women			Men		
Method	All Women	Currently Married Women	Sexually active unmarried women1	All Men	Currently Married Men	Sexually Active Unmarried men1
Any method	98.2	98.7	99.5	99.7	99.9	99.9
Any modern method	98.1	98.6	99.5	99.7	99.8	99.9
Female sterilization	79.2	83.7	85.2	80.2	86.2	81.1
Male sterilization	**53.0**	**57.5**	**51.0**	**62.2**	**68.2**	**59.2**
Pill	92.6	95.2	93.8	92.0	95.1	95.9
IUD	70.2	75.4	75.6	65.5	73.0	74.0
Injectables	94.1	96.9	96.4	91.3	95.3	96.0
Implants	77.4	84.5	78.3	62.2	73.5	63.8
Male condom	96.6	97.1	98.9	99.2	99.3	99.9
Female condom	70.5	72.8	75.3	81.4	85.0	89.5
Lactational amenorrhoea (LAM)	13.0	14.6	10.5	11.4	13.5	13.9
Emergency contraception	30.7	32.1	39.3	37.1	40.4	51.7
Any traditional method	73.7	80.4	85.8	82.6	90.5	90.9
Rhythm/moon beads	53.3	58.0	58.3	68.7	76.8	75.5
Withdrawal	62.8	70.3	75.2	72.7	81.6	84.1
Folk method	9.5	11.6	8.6	3.5	4.1	5.2
Mean No. of methods known by respondents 15-49	8.0	8.5	8.5	8.3	8.9	8.9
Mean number of methods known by respondents 15-54	na	na	na	8.3	8.9	9.0
Number of respondents	0	0	0	2,295	1338	125
na = Not applicable **1 Had sexual intercourse within 30 days preceding the survey**						

Source: *Uganda Demographic and Health Surveys 2011*

- Users of the modern methods of contraception make up the large majority of all users. Among currently married women, 26 percent are using a modern method and only 4 percent are using a traditional method.

- The same pattern is observed among all women and unmarried sexually active women.

- The most commonly used modern method among all women and currently married women is injectables (used by 11 percent of all women and 14 percent of currently married women), while the most commonly used methods among unmarried sexually active women are the male condom (19 percent) and injectables (18 percent).

- Female sterilization is also becoming more common, but use of vasectomy in these countries is negligible.

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' behaviour. 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.

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

- 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

The mass media play an important role in communicating messages about family planning. Data on the level of exposure to radio, television, and printed materials are important for programme managers and planners to effectively target population subgroups for information, education, and communication campaigns.

- 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 high in Uganda with more than half of women have heard a message about family planning on the radio, on TV, or in a newspaper or magazine in the past several 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.

- Radio is the most popular source for family planning messages in Uganda, with 70 percent of women and 74 percent of men age 15-49 having heard a family planning message on a radio in the past few months.

- Among women, fifteen percent each report having seen a family planning message on television or in a newspaper or magazine, while among men these proportions are 17 percent and 25 percent, respectively.

- The second most popular source of messages is the print media (newspapers and magazines), with 15 percent of women and 25 percent of men having seen a family planning message in one or the other. Four percent of women and 9 percent of men had seen a family planning message in a video or film.

- Overall, 27 percent of women and 22 percent of men have not been exposed to any family planning messages in any of the four specified media sources.

- Women and men in urban areas are more likely to be exposed to family planning messages in the media than are their rural counterparts. Regional variations show that respondents in Karamoja are the least likely to be exposed to family planning messages from any sources,

- By contrast, women in Kampala and men in Central 2 have the lowest proportions of respondents (15 percent and 10 percent) who have not been exposed to any of the four media sources.

- The likelihood of exposure to media messages on family planning from any of the four media sources rises as the respondent's level of education and wealth increase.

Family Planning

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Notes and Tips for Journalists

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

Check your understanding (True or false)

1. A woman has an unmet need for family planning if she says she prefers to keep a pregnancy.

2. In Uganda awareness of at least one method of contraception is nearly universal.

3. Condoms remain the most commonly used method of contraception among currently married women

4. The most commonly used method of contraception among unmarried sexually active women are the male condom and injectables.

5. Unmet need is often highest among women with a primary school education.

6. Television is the most popular source for family planning messages in Uganda

Use the Space!

List some of the types of modern method contraceptives

List the two types of traditional method contraceptive

List some the reasons why women have an unmet need for family planning

L

List some of things that are likely to affect exposure to family planning messages

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.

- 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

- Adult mortality is slightly higher among men than among women (6.5 deaths and 5.3 deaths per 1,000 population, respectively).

- Twenty percent of women and 25 percent of men are likely to die between ages 15 and 50. These probabilities have decreased for both women and men since 2000-01, with most of the decreases occurring between 2006 and 2011.

- Maternal deaths account for 18 percent of all deaths to women age 15-49. The maternal mortality rate for the seven-year period preceding the survey was 0.93 maternal deaths per 1,000 woman-years of exposure.

- The maternal mortality ratio was 438 maternal deaths per 100,000 live births for the seven-year period preceding the survey. This ratio is not significantly different from that reported in the 2006 UDHS, but it is lower than the ratio reported in the 2000-01 UDHS.

- 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 labour without medical attention. In most cases, the baby dies and the woman is left with chronic incontinence and continuously leaking urine and/or faeces, 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 Uganda 95 percent of mothers receive antenatal care from a skilled provider. This proportion has not changed since the 2006 UDHS.

- Forty-eight percent of women make four or more antenatal care visits during their pregnancy, and this percentage has remained almost the same since 2006.

- The median duration of pregnancy for the first antenatal visit is 5.1 months. More than half (51 percent) of the mothers were informed of possible complications during pregnancy, an increase from 35 percent in the 2006 UDHS.

- Eighty-four percent of last-born children during the five-year period before the survey were fully protected against neonatal tetanus.

- 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 Uganda 58 percent of births in the past five years were assisted by a skilled provider, an increase from 42 percent in 2006.

- The percentage of births taking place in a health facility has increased noticeably in the past five years from 41 percent in the 2006 UDHS to 57 percent in the 2011 UDHS.

- One-third of women receive postnatal care in the first two days after delivery.

- For births in the two years preceding the survey, only 2 percent received a postnatal check-up within one hour, while 13 percent received a postnatal check-up within six days.

- Fifty-six percent of Ugandan women have heard of female circumcision while less than 2 percent of women have been circumcised.

- Two percent of Ugandan women have ever experienced obstetric fistula.

- To address complications, skilled attendants need access to medical equipment and a facility for emergency care. Emergency obstetric care includes: the ability to perform surgery (for Caesarean deliveries), anaesthesia, and blood transfusions; management of problems such as anaemia and high blood pressure; and special care for at-risk newborns.

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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.

Use the space!

List the direct causes of maternal deaths related to pregnancy and delivery

List the indirect causes of maternal deaths related to pregnancy and delivery
List the LL

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.

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.HIV/AIDS & Other

- 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	2.9 59	na	1.4
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

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).

HIV Epidemic Status In Uganda

While some knowledge of HIV is nearly universal in Uganda, 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.

- Uganda has the highest percentage of new HIV infections in the eastern Africa according to the joint UN program on HIV/AIDS (UNAIDS)

- Globally, the report puts Uganda in third position among the top 15 countries that accounted for more than 75% of the 2.1 million new HIV infections that occurred in 2013.

- South Africa tops the global list accounting for 16% new infections in the world, followed by Nigeria (10), and then Uganda with 7%.

- Other countries with high new infections include Kenya which tied with Mozambique in the fifth position and Tanzania in the ninth position.

- The report says AIDS-related deaths are at their lowest since the peak in 2005, having declined by 35%.

- According to the report, there was a 33% drop in new HIV infections among all ages in sub-Saharan Africa between 2005 and 2013 and a 19% reduction since 2010.

- Despite these gains, sub-Saharan Africa remains the region most severely affected, with nearly one in every 25 adults (4.4%) living with HIV.

- Uganda accounts for 10% of the 1.5 million [1.3 million–1.6 million] new HIV infections recorded in sub-Saharan Africa in 2013. This means at least 150,000 Ugandans got infected last year, up from the 143,000 recorded in the 2012.

- 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.

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.

- Gonorrhoea often does not have symptoms in women but, if left untreated, can lead to PID and infertility. In men, gonorrhoea 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

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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.

- 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.

Check your understanding

- How is does HIV cause AIDS?

- List the ways in with the HIV virus is transmitted

True or False

- HIV is present in blood, semen, and vaginal fluids of an infected person.
- The HIV can be transmitted through casual contact like shaking hands or hugging
- Using a male or female condom during sexual intercourse is the only effective means of protection from sexual transmission of HIV.
- Antiretroviral treatment for people with HIV cures the disease

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.

- 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.

- Although Uganda's law permits induced abortion only to save a woman's life, many women obtain abortions, often under unhygienic conditions. Small-scale studies suggest that unsafe abortion is an important health problem in Uganda, but no national quantitative studies of abortion exist.

- Each year, an estimated 297,000 induced abortions are performed in Uganda, and nearly 85,000 women are treated for complications. Abortions occur at a rate of 54 per 1,000 women aged 15–49 and account for one in five pregnancies. The abortion rate is higher than average in the Central region (62 per 1,000 women), the country's most urban and economically developed region. It is also very high in the Northern region (70 per 1,000). Nationally, about half of pregnancies are unintended; 51% of married women aged 15–49 and 12% of their unmarried counterparts have an unmet need for effective contraceptives.

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

- 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.

- Uganda's law permits induced abortion only to save a woman's life

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.
  - Counselling 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.

Abortion

- 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.

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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.

Check your understanding (True or False)

1. Abortion is legal in Uganda.
2. An abortion can be performed by any medical personnel.
3. Post abortion care is for all

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 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 labelled 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.

- In Uganda, FGM is practiced by a minority of the population, primarily the Sabiny (Sebei), Pokot, and Tepeth tribes, whose homes are in eastern Uganda adjacent to Kenya, on Mt. Elgon or in the Karamoja region. Parts of these areas are so remote and isolated that the people do not receive newspapers, radio or television signals, or visitors.

- Many people living here have never heard of the idea of not circumcising their daughters. Most have no knowledge of the new Ugandan law prohibiting the practice.

- For Sabiny and Pokot girls, the clitoris, labia minora, and sometimes labia majora are cut away with a ritual knife, without anesthesia, by a traditional surgeon, who usually has no knowledge of anatomy or hygiene. "Female circumcision," the preferred term, is a counterpart to male circumcision, and by tradition its practice is woven into every aspect of social life.

- Without being cut, a girl is not considered a woman. She may not marry, speak or dance in public, or touch food or eating utensils used by others. She is ostracized as being unclean and bad luck. Among the Sabiny, girls are expected to be cut around the age of 15, and among the Pokot, as young as 8 or 9 years old, at the earliest signs of puberty. In some cultures, girls are held down to be cut, but among the Sabiny and Pokot, a girl is not restrained, and she may not even blink an eye in reaction to the pain. If she shows fear, she will be shamed for a lifetime and will be unlikely to find a good husband.

- Although all girls are expected to endure genital cutting, partly to demonstrate their bravery, they cannot escape the physical consequences, sometimes immediately including death from hemorrhage or shock, or later, from infection or from HIV/AIDS acquired by sharing the circumcision knife.

- Because of extensive scarring and narrowing of the birth canal from FGM, childbirth is hazardous for both mother and baby.

- In addition, traditional surgeons' cuts sometimes go awry and cause lameness, incontinence, and many other lifelong problems. Psychological trauma also results. FGM is not reversible and has no therapeutic value.

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/

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.

Check your understanding (True or False)

1. Female Genital Mutilation (FGM) is considered a human rights abuse

2. FGM is a world-wide problem

3. FGM is legal in Uganda

4. FGM is reversible and has therapeutic value.

5. FGM is the same as female circumcision

6. FGM is more common in East Africa than any other region

Use this space
List some of the dangers of Female Genital Mutilation

List some of the cultural stereotypes associated with FGM

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), fuelling 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

- 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.

- 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 stands at 35 percent in Uganda.

- 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.

Uganda Trends

- The median age at first intercourse in Uganda is 16.' years and the median age at first marriage is 17.8 years.

- By age 15, 22.6% of females have had sexual intercourse and by 18 years 67% have had sexual intercourse whereas 53% are married by this age. It would appear that most of the sexual encounters in this age group are unprotected and they expose young girls to unwanted pregnancies and STIs including HIV. HIV/AIDS mainly affect individuals in the active reproductive age.

- The majority of cases (83%) are young adults aged between 15 - 40 years with 46 percent cases being 10-24 years.

- Stratification by age and sex reveal that a number of AIDS cases in the age group 15 - 19 years is four times higher among females than among males.

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).

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.

Check your understanding (True or False)

1. Young women ages 14 to 24 are two-and one- half times as likely as young men to be infected with HIV.

2. Teenage mothers face a greater risk of dying of pregnancy-related causes than women who give birth in their 20s and 30s.

3. Infants born to young mothers are more likely to have a low birth weight (less than 2,500 grams)

4. Women who give birth as teenagers are more often poorer than those who delay childbearing.

5. Child marriage is especially common among poor and rural families

6. One in three unintended pregnancies among adolescents is aborted

Use this space!

List the reasons why young women are more likely to be infected with HIV than young men

Sources of Information

Uganda Demographic & Health Survey 2011

Population Reference Bureau www.prb.org

Uganda Health Policy, Government of Uganda

National Guidelines and Service Standards for Sexual & Reproductive Health

National Adolescent Health Policy for Uganda